

Foreword

Mental health services have an unparalleled status in government thinking on priorities. Never before has a policy platform provided such a tangible basis for innovation and change. Modernisation is the watch-word. Bringing about greater clarity, consistency, co-ordination and quality in service provision is the order of the day. This is not rhetoric either; a strategy, a framework, real investment and now hard service targets within a National Plan for the NHS requires action from providers, clinicians and commissioners alike.

What's important about the National Plan is firstly the way mental health sits with Coronary Heart Disease and Cancer as the three key service areas for change. Secondly the National Plan focuses on the centrality of the service consumer. It is their needs and those of their families which hold sway. No longer can a particular ideology, institution or discipline be at the centre; best practice, backed up by evidence focused on need can.

That's where IRIS fits in; with its sharp focus on the needs of young people with psychosis; with its attention to family support and needs; with its unrivalled attention to evidence in the systematic care and treatment of emergent psychosis and the value of reducing treatment delay. IRIS has articulated the following three positions:

- Early assessment and intervention can improve long-term outcome
- To focus on youth; developing services which are responsive to the specific needs of young people with psychosis and their families.
- To develop effective partnerships between users, family and friends, and professionals from within the community and specialist service.

These clinical guidelines and service frameworks provide coherent practical information on what needs to happen locally to put early intervention in to practice as required by the National Plan. They set out the requirements for a modern and sensitive approach. They are easy to endorse, long overdue and very welcome.

Early intervention in psychosis

Early intervention to reduce the period of untreated psychosis in young people can prevent initial problems, and improve long-term outcomes:

“Fifty early intervention teams will be established over the next three years to provide treatment and active support in the community to these young people and their families.... by 2004 all young people who experience a first episode of psychosis, such as schizophrenia, will receive the early and intensive support they need. This will benefit 7,500 young people each year.”

Number of services aren't the only issue. We are looking to establish quality services through a development process and following these guidelines will ensure fidelity. Only in this way can we bring together a match between services that young people need and evidence-based practice. Only in this way can we make sure that every young person with a psychosis gets the service they need.



John Mahoney



Antony Sheehan

Joint Heads of Mental Health Services, Department of Health

Preface

“I didn't give anyone permission to write about me. That's too close, too personal, too private. You don't need to know about that stuff. And you don't need to know my name. Here's what you do need to know:

I got help early, and when I needed it, and so did my family. We were able to see doctors and others who were smart, well trained, and knowledgeable about where, when and how to make referrals. We saw people who respected us and taught us. We saw people who liked their jobs and felt respected and valued in them.

I had a place to get away to regroup and hide out that was quiet, safe, gentle, and like a home away from home. People respected my privacy. I never had to go before a judge, or a magistrate, and no one in my family had to act in a punitive way to get help for me or for themselves. No one ever locked me up or made me take medications against my will.

The people in my family understand that it's not my fault and not all their fault. They understand that there are no simple answers and they don't see me as a disease. I got to go to school, live in a decent place, get money, have my pets, have a life without giving up everything else like my dignity and my hopes for a future I want to be in.

No one hassled me about how sick I was or whether I deserved to get help. I just got it. And when I talked, people listened. What I said, felt, and wanted made a difference. I didn't always get what I wanted when I wanted it. But people listened, no b.s., honesty is what I got.

”

I know this all sounds too good to be true. It is. That's the only tragedy here.

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Introduction

“If only we could have spotted the illness earlier...”. “My son needed the best treatment earlier, not when everything else failed”. “If only I had this information and help at the beginning, all this pain and uncertainty could have been prevented.”

These comments from people with psychosis and their relatives will be familiar to most mental health professionals. Indeed many mental health professionals would concur, but the classical teaching of psychiatry urges caution: schizophrenia was coined on the assumption that these disorders are malignant and deteriorating in nature. This teaches us to ‘wait and see’ which prognostic path the individual may follow, so overlooking major opportunity for secondary prevention.

Breakthrough research in the UK over the last few years has shown that the early years of psychosis is a ‘critical period’ influencing the long term course of psychosis and the delays in first treatment increase early relapse. (Macmillan et al, 1986)

Early intervention comprises two approaches:

The early detection and treatment of psychosis

The provision of treatment, and psychological Intervention during the ‘critical’ early phase.

The National Mental Health Strategy (Modernising Mental Health Services, DOH, 1999) recognises the central importance of this new approach, “early intervention matters to prevent relapse, reduce the risk of suicide and ensure public safety.” “Central to the strategy is the development of early intervention and its implementation in a variety of services.”

These guidelines have been developed to assist those intending to follow the Government’s lead and develop early intervention approaches. They address the issue of best practice and synthesise the views of users and carers, mental health professionals and leading experts in the field.





How To Get The Best From These Guidelines

These clinical and service guidelines have been developed to ensure that young people in the crucial early phase of psychosis receive the highest standards of care wherever they live in the West Midlands. This document describes best practice for people with a first episode of psychosis including: early detection, treatment, psychosocial intervention and service configuration. The principles and guidelines are “glued together” by many real examples of treatment and practice from around the region and the country. The companion ‘Tool Kit’ includes a handy set of assessments, treatment protocols and procedures which will help to translate ‘theory into practice’. These include a step by step guide to assist mental health services and purchasers in developing services configured to the need of the locality.

The Process

A working group prepared an initial draft drawing upon the knowledge of a number of experts and was particularly impressed by the Australian Guidelines which emerged during their deliberations (NEPP, 1998). The draft then went to extensive consultation locally and nationally; and from this the final document emerged. Kaleidoscope, a mental health social firm managed by the National Schizophrenia Fellowship, put together several versions of how the final document might look. After much consultation from everyone involved production and printing of the folders containing the Guidelines and Tool Kit finally started.

Acknowledgements:

We would like to acknowledge Professor Pat McGorry and the EPPIC group for access to the Australian Guidelines; and to Professor Anthony Sheehan, National Policy Lead for Mental Health Services of the West Midlands NHS Executive, for his inspired support of the IRIS initiative.

What is early intervention in psychosis?

‘Early intervention in psychosis ‘amounts to deciding if a psychotic disorder has commenced and then offering effective treatment at the earliest possible point and secondly ensuring that intervention constitutes best practice for this phase of illness, and is not just the translation of standard treatments developed for later stages and more persistently ill subgroups of the disorder’

(McGorry et.al., 1996 p.305).



Why intervene early in psychosis?

In most cases the delay between the onset of psychotic symptoms and first treatment is surprisingly long:

The mean duration of psychosis before first treatment is one to two years. (McGorry and Jackson, 1999).

The longer individuals with psychosis remain untreated, the greater the opportunity for serious physical, social or legal harm:

The long period of untreated psychosis before first treatment has been shown to involve distress for individuals and their relatives including ineffective and demoralising attempts to get help and various traumatic events. Approximately 20 to 30% of young people experiencing their first onset of psychosis have been found to have been a danger to themselves or others before receiving effective treatment, including suicide attempts (Lincoln and McGorry, 1999).

Social and personal disability develops aggressively in the ‘critical period’:

Where disabilities develop, they usually do so during the first 3 years – the so called ‘critical period’. Unemployment, impoverished social network, loss of self esteem can develop aggressively during the critical period; the longer these needs are not dealt with, the more entrenched they become. (Birchwood et al, 1998)

Early treatment with antipsychotic medication has been shown to improve the long term course of psychosis:

Long duration of psychosis prior to treatment with antipsychotic medication has consistently been shown to be related to poor long term outcome: giving neuroleptic treatment early, improves outcome (Carbone et al, 1999; Wyatt, 1991).

Delays in the treatment of psychosis have been associated with substantially higher health care costs for at least three years after first treatment.

Longer untreated illness is associated with longer first and second admissions to hospital (Wiersma et al, 1998), giving rise to higher healthcare costs. (McGorry and Jackson, 1999).

Long term ‘treatment resistant’ symptoms develop during the ‘critical period’.

Long term, persisting, troublesome symptoms develop within the ‘critical period’ (Mason et al, 1995; Harrow et al, 1995).

The ‘revolving door’ begins in the ‘critical period’.

Where a pattern of repeated relapse develops, it begins during the critical period (Mason et al, 1995; Wiersma et al, 1998).



Why treat people with first-episode of psychosis in a specialised manner?

The prospects of short term recovery in this group are good:

With sustained treatment over 80% of individuals achieve remission of symptoms from their first episode of psychosis within 6 months (Lieberman et al, 1993).

*As a clinician, how many clients can you recall who were under 25 years old who did not achieve discharge after their first episode?
As a clinician, how many clients are in 24 hour nursed care, (under your care), and not yet 25 years old?
Most clinicians can recall only a tiny number.*

Relapse in the early phase of psychosis is associated with increased probability of further relapse and persisting symptoms (Wiersma et al,1998)

This suggests that attention to early relapse prevention or minimisation in this group is vital, particularly as over two thirds of people will relapse within 3 years of first presentation which sets the scene for a future cycle of repeated relapse.

As a clinician, can you think of clients who relapse every two years, or more often? Usually they are young, and clinicians can identify from memory several individuals.

When a decline in functions occurs in psychosis, it does so early in the course of the illness, even during the 'prodromal' period, prior to the onset of clear psychotic symptoms. This makes early psychosis a biologically 'critical period':

Many abnormal biological features usually seen in people with well established schizophrenia can also be seen in a subgroup during their first psychotic episode. Cognitive problems associated with schizophrenia emerge at the onset of psychosis and quickly stabilise (Chatterjee and Lieberman, 1999).

The early years of psychotic illness also constitute a psychosocial ‘critical period’.

10 to 15% of people with psychosis commit suicide and the risk of this is greatest early in the illness (two thirds of suicides occur within 5 years). Suicide is preceded by factors such as depression and particularly hopelessness, which are potential targets for psychosocial interventions.

Most clinicians can recall the death by suicide of a young person with psychosis, usually with some shock attached to the event. Only in retrospect is the evidence for demoralisation clear, as often the young person has made a fair recovery from the psychosis.

The early phase is also a critical period for return to stable employment. The longer the delay before resumption of work or continuation of the path to work, the greater the likelihood of long-term difficulty.

Adverse outcomes from psychiatric hospitalisation suggest the need to stream the treatment naïve client into a special environment.

45% of people with first-episode psychosis have been found to have symptoms similar to Post Traumatic Stress Disorder linked to their illness and its treatment. Early use of the Mental Health Act and high doses of antipsychotics with side effects contribute to this. These factors also increase the risk of long term treatment reluctance and service disengagement.

Alice repeatedly described the onset of her illness, the terrifying nature of her experience, the trauma of admission and assessment by a range of unknown professionals. Despite a good recovery, the fact that these events occurred three years ago, and current excellent engagement in the service, she struggled to come to terms with that first contact, and never a day passed when she did not recall these events.



Guiding Principles

Early detection and intervention in psychosis requires the maximum involvement of clients and their natural social networks, including primary care.

Here, we outline the core principles that we believe must be embraced if this radical approach to the treatment of severe mental illness is to be realised:

1 A youth and client centred focus

Psychosis is mainly a problem affecting young people. It can damage key aspirations such as work, self-determination and relationships. These aspirations of youth must be reflected in the services they receive, including the approach to engagement, and in the interventions and opportunities presented by services. Young people with psychosis should be encouraged to remain in contact with other young people. This can help to increase a sense of hope for the future, and to regain or further develop their former skills, interests and life goals.

2 Failure to engage should not lead to case closure

Achieving full and ongoing support and treatment in the early phase of psychosis can be compromised by a failure to engage with services (not attending out patient appointments, non-compliance with medication). The temptation to 'wait and see' by professionals until a further crisis emerges is strong. Valuable opportunities for intervention and prevention are not grasped, and may jeopardise constructive engagement. A proactive approach to engagement both to the client and his/her immediate social network is crucial and must be sustained.

3 An emphasis on social roles

Maintaining social roles and goals, particularly work, is highly prized by young people and improving self esteem can positively impact on the psychosis itself (Warner, 1994). Conversely, depression and suicidal thinking in psychosis have been linked to loss of valued social roles and prevent the individual from asserting an identity (Rooke & Birchwood, 1998).

4 Psychiatric treatment should be provided in the least stigmatised setting and emphasise choice and low dose neuroleptics

45% of clients hospitalised for an acute psychotic episode have been found to have symptoms of post traumatic stress disorder related to their psychosis and its treatment (McGorry et. al., 1991). The treatment of clients in low stigma settings with medication regimes causing the minimum possible side effects is not only indicated but has been found to be feasible. (Kulkarni & Power, 1999)

5 The embracing of diagnostic uncertainty

“Schizophrenia does not present in neat parcels” (Thara et. al., 1994, p54)

The diagnostic systems of DSM-4 and ICD-10 are working models of mental disorder. This is particularly relevant to the early phase of psychosis where the reliability of diagnosis is modest at best, and the longitudinal stability of symptom presentation is low (McGorry 1991, 1992). Such uncertainty in diagnosis should not delay treatment, rather treatment should focus on the presenting symptoms. The avoidance of a syndromal diagnosis until symptoms stabilise (usually within the first 2 years of treatment) does not represent clinical or intellectual sloppiness, but a genuine response to the reality of the clinical situation. The embracing of diagnostic ambiguity is crucial when attempting to identify clients in the prodromal phases of psychosis, since non-specific symptoms often found in prodromal psychosis are frequently found in normal teenagers (McGorry et.al., 1995), and even with expert assessment, false positive rates are high. Those professionals and agencies working at the point of first contact must feel free to refer clients for expert assessment of symptoms based on a suspicion rather than a certainty of psychosis.

6 A family-orientated approach

Working closely with the family is a key ingredient to the success of the engagement process. Thinking of the family as part of a natural support network sets the stage for clinicians sensitively reconciling the apparent dilemma of client confidentiality with the family’s need to know. Coping with psychosis is not easy and we should also acknowledge the impact of psychosis on families and their legitimate needs for help and support. There is overwhelming evidence for the positive contribution families can make to the welfare of people with psychosis, particularly when those families are actively supported by psychoeducative interventions. We should recognise the valuable information families can offer clinicians about their relative’s problems in helping to formulate more effective treatment and rehabilitation plans and in helping to formulate more effective relapse and recovery plans and alerting services when things go wrong. There is a need for a clear ethical framework for supporting interventions to the family derived from a shared shared value base, and which balances the interests of its members with informed consent and confidentiality issues.



Clinical Guidelines

Guideline One

A strategy for early detection and assessment of frank psychosis is an essential component of early intervention.

Background

Numerous studies have now confirmed early observations that the interval between first onset of psychotic symptoms and first treatment is approximately 12 months with higher figures in inner city areas (Birchwood et al, 1997). This treatment lag is linked with considerable distress, suicide and with increased probability of early relapse and residual symptoms. The causes of delay are varied and include problems of early identification, concerns about diagnosis, access to secondary care, stigma and other factors.

Requirements

- (i) An audit of pathways to accessing care can give insight into the nature of the untreated phase of illness, the variety of pathways to care (GP, police, neighbour, church etc.) and their relationships (see Tool Kit).
- (ii) Consideration of pathways may identify training needs and challenge unhelpful service configurations.
- (iii) As most cases of first episode psychosis pass through primary care, collaboration between primary and secondary care needs to be improved in order to promote early detection and treatment.
- (iv) GPs need to feel confident in their ability to screen, detect and refer for specialist help. Inherent in this is a tolerance of diagnostic ambiguity and to operate within an operational framework focusing on dominant psychotic symptoms rather than diagnostic frameworks.
- (v) Early assessment in non-stigmatising settings is useful to offset the reluctance of young people to engage with traditional psychiatric services. Assessment, ideally, at home or the GP practice will be most likely to promote engagement with services.

(vi) Many potential cases of early psychosis will present ambiguously and not satisfy conventional diagnostic criteria and may not seem suitable for treatment. A ‘watching brief’ should be maintained in such cases for at least three months, offering support and intervention as is appropriate, since those at risk of psychosis are likely to progress within this time frame.

Getting it right....

Gary went to the GP shortly after a depressed episode and presented as slightly disinhibited and stating that he could predict the future. His wife was clearly concerned, especially since Gary’s elder brother was well known to services and was diagnosed with a bi-polar disorder. The GP visited that day and contacted the CPN for an early assessment of a possible psychosis. The CPN visited that day. CPN visits were supportive to the family who wished Gary to remain at home. The psychiatrist assessed the individual and prescribed medication within 3 days whilst CPN visits were twice daily initially. Visits were reduced as Gary became more able to manage his symptoms. Primary and secondary care worked collaboratively throughout.

Where things can go wrong....

Diane visited the GP surgery after a period of depression which had necessitated referral to a psychiatrist. Diane was complaining of racing thoughts, irritability and inability to control emotions. Her odd behaviour had been escalating over the previous few days. Despite overt psychosis, the GP did not detect the risk. In crisis, the GP did not make contact with any mental health professional for assessment until pressured to do so by a relative.



National Service Framework Links:

This guideline links directly to standards 2 and 3, which require services to provide clear pathways from primary to secondary care and to provide services which are accessible around the clock.

Guideline Two

A key worker should be allocated early following referral of the case in order to develop engagement and rapport and to ‘stay with the client and family/friends through the first 3 years (the ‘critical period’) preferably within an assertive outreach model

Background

A positive trusting relationship between the worker, client and their family/ friends is the bedrock on which recovery is based. This is particularly important at the time of first contact with services where the client’s and families’ impressions of services are formed. The process of engagement should be viewed separately from the offer of treatment.

The development and implementation of a programme of intervention requires ongoing effort and continuity of contact with the case manager. Early identification of relapse, adherence to treatment regimes and the promotion of psychosocial recovery all require consistent and steady input throughout the critical period.

Requirements

- (i) A case manager needs to be allocated to each client with a first episode on referral and following assessment to ‘stay with’ him/her for 3 years, preferably within an assertive outreach framework. Continuing support needs should be reviewed at this stage.
- (ii) Engagement and relationship building is a therapeutic goal itself and should always involve the client’s family and social network.

Getting it right....

Christopher was seen at the GP surgery by a CPN after the GP was concerned about the onset of a mental illness. Whilst Chris was reluctant to see a psychiatrist, and failed to attend an appointment, the CPN was able to contact and arrange supervision between psychiatrist and GP to organise neuroleptic prescribing. The CPN maintained regular contact with Chris in person or by phone. Liaison with family members was also continued even at times when Chris declined contact. The keyworker arrangement provided a link and clear pathway should Chris deteriorate.

Where things can go wrong....

Steven was referred for assessment by his probation officer who was concerned about his deteriorating mental health and grasp on reality. At times, he presented well but on closer examination, had persecutory beliefs and issued death threats. He was admitted to hospital for assessment prior to a court appearance by the on-call psychiatrist. During his 5 day stay on the ward, he did not display any overt psychosis. He was discharged by the area psychiatrist as it was assumed that follow up would be given by the rehabilitation team. A month later, Steven was readmitted under section as he had been walking the streets with live ammunition.

ASK YOURSELF....

- v *How many young people with psychosis (under 25 years) have continuing key worker contact, even when they are medication free/non-compliant?*
- v *How many of them already have a key worker who has met the family before an admission?*
- v *How many cases have been closed, with or without key worker allocation, when there has been a suspicion of psychosis; and how many are closed by “default”, ie. the client closes or declines contact?*
- v *What do you do when someone persistently declines your service?*

National Service Framework Links:

Standard 4 requires services to optimise engagement, using assertive outreach where appropriate; and to have a written care plan which includes action to be taken in a crisis. This is to be undertaken within the framework of the Care Programme Approach.

Guideline Three

An assessment plan and collaborative assessment of needs should be drawn up which is both comprehensive and collaborative, and driven by the needs and preferences of the client and their relatives and friends.

Background

The needs and preferences of clients embrace areas that are not always consistent with the needs identified by care professionals, yet the meeting of such needs holds the key to engagement (Sainsbury Centre For Mental Health, 1997).

Requirements

1. A full assessment will incorporate mental state, vulnerability, psychosocial factors involving both the client and their family (see Tool Kit).
2. The client's expressed needs should be given priority in the formulation of an intervention plan.
3. Mental state assessment during the acute and recovery phase should follow normal clinical practice. The recovery phase is a high risk period for early relapse, and suicidal thinking should be carefully monitored.
4. Assessment and action plans are likely to need review more frequently than statutory requirements. We would suggest assessment at six weekly intervals initially.

Getting it right....

An 18 year old young man living alone accessed services via his college tutor who was concerned about his general well being, self-care, vagueness and social isolation. He ensured that the GP, social services and mental health professionals were informed. The concerns were discussed with his family. A professional assessed and collaborated on a needs plan to promote his well being. The plan was devised with him to meet his health, social and occupational needs as well as those of his family.

Where things can go wrong....

John had a history of criminal behaviour with some risk of violence and was known to probation services. He also had a learning disability. He was admitted to hospital in crisis with psychosis under the Mental Health Act via the police station after a disturbance at home. His mother, who had physical health problems, was frightened of him. Some professionals felt that his parents were disinterested owing to non-attendance at ward rounds (at a hospital 10 miles away). No advice was sought from the learning disabilities team. He was discharged home whilst follow up was still being negotiated.

ASK YOURSELF....

- v *Is there a care plan available to the client and family and friends (and shared by professionals)?*
- v *Does the plan reflect needs other than those met by health resources, eg, financial concerns?...*
If not, it probably should!



National Service Framework Links:

Standard 4 requires a comprehensive care plan to be available within the Framework of the Care Programme Approach, to involve all players: client, carer, professional

Guideline Four

The management of acute psychosis should include low dose, preferably atypical antipsychotics and the structured implementation of cognitive therapy.

Background

Adherence to medication regimes and developing an acceptable quality of life are likely to be hindered by uncomfortable medication side effects (McGorry et al., 1996; Falloon, 1996). Outcome studies in the service delivery settings (McGorry et al., 1996), medication trials (McEvoy et al., 1991; McGorry et al., 1997) and neuro-imaging studies have indicated that most people with first-episode psychosis will respond to doses of antipsychotics much lower than those conventionally used.

We believe there is a particularly strong case for using atypical antipsychotics as a first line treatment given their low rates of extrapyramidal side effects, especially in first-episode psychosis clients compared to those with established illnesses (Emsley et al., 1995). Such distressing effects can be crippling and stigmatising to this young client group and may lead to later treatment reluctance and disengagement.

Requirements

- (i) If possible, the introduction of antipsychotic medication should be delayed for at least two days until the presence of psychosis is confirmed and organic causes are excluded. Provision for adequate support during this time needs to be available.
- (ii) Ideally a low dose atypical anti-psychotic drug should be started initially, titrating slowly over one to two weeks, depending on side effects. Long acting benzodiazepines, rather than neuroleptics should be used for sedation and containment of disturbed behaviour, during the acute phase.
- (iii) Regular reviews should be built into the management plan no less frequently than six weekly (more frequently in the initial phase of treatment to help identify lack of treatment response or development of side effects). Since, with sufficiently assertive treatment, psychotic symptoms in the vast majority of clients with first-episode psychosis eventually remit (Lieberman et al., 1993), resolution of positive symptoms rather than adjustment to symptoms should be the goal.
- (iv) Since most clients with first-episode psychosis who respond to medication do so early (i.e. often within one month but mostly within six months) (Lieberman, et al. 1993; Szymanski et al. 1996), positive symptoms should not be allowed to linger. The presence of more than mild positive symptoms of psychosis after a six week trial of the maximum tolerated dose of neuroleptic should lead to a review of treatment, including a consideration of diagnosis, treatment of comorbidity and a change of medication.

Assessment of negative symptoms should form a routine part of the clinical assessment. Studies have found little improvement in negative symptoms after six months of therapy (Lieberman et.al. 1993; Szymanski et. al. 1996). The presence of disabling negative symptoms after this point should prompt a review of treatment, including the use of atypical neuroleptics and intensive psychosocial rehabilitation.

(v) The decision to cease medication should, if possible, be planned between client and treatment team and will depend on degree of symptom remission, emerging syndromal diagnosis, comorbid substance misuse and the presence of remediable risk factors for relapse. Medication regimes should be reviewed routinely as part of the regular review process.

Getting it right....

Chris was experiencing passivity ideas and voices for two weeks. He refused hospital admission but accepted a small dose of medication (2mg Haloperidol) provided by his GP and within 10 weeks his symptoms abated.

Where things can go wrong....

Jane grew convinced that her life was in grave threat and at one point threatened her parents whom she believed she could not trust. She was compulsorily detained and believing she was under attack, hit out. She was given 20mg Haloperidol, she was sedated and developed parkinsonian side effects. She responded to treatment but subsequently refused help, fearing a repeat of side effects.

ASK YOURSELF....

- v *As a clinician can you recall your last three young psychotic clients in inpatient care? How many suffered clear and unpleasant side effects? How many began treatment at “fairly high doses”, despite being treatment naïve? How many had exposure to several anti-psychotic regimes in a short space of time?*
- v *Was there any opportunity to start low dose treatment before inpatient care occurred? Was there any opportunity to start at low dose on inception, if necessary using anxiolytics to address disturbed behaviours?*

National Service Framework Links:

Standard 5 requires the least restrictive form of care and the use of structured rehabilitation techniques.

Guideline Five

Family and friends should be actively involved in the engagement, assessment, treatment and recovery process

Background

The effectiveness of family intervention in relapse prevention is well established. Many families themselves describe difficulties in coping with the emergence of psychosis and the burden this creates (Fadden, 1998). Effective family interventions have been developed which should be made available routinely. The seeds of longer term family difficulty are sown in the early phase. The first episode of psychosis is as distressing for family and friends as it is for those who experience it: they may experience feelings of sadness and a sense of loss of the person they knew (Birchwood & Smith, 1987). The pathway to services is not always straightforward and initial contact with relatives may reveal feelings of anger and frustrations with services. These feelings should be responded to directly and families provided with information about the services and their role in the individual's recovery. Developing an alliance with the family holds the key to engagement of the client and prepares the ground for later collaboration, for example in times of crisis.

The main aim of the involvement of family in the early phase is to:

- 4 **Provide a complete picture of the build up to psychosis;**
- 4 **To engage them in a collaborative therapeutic process;**
- 4 **To deal with the crisis of psychotic illness in the family;**
- 4 **To identify and respond to the needs of individual families.**

Requirements

(i) The process of engagement of the client should always embrace the family. Initial contact with the family should be made within one week of presentation so that crisis support, debriefing and the family's perspective can be gained.

(ii) The initial contact should be at the home including a 'debriefing' session, giving the family opportunity to 'tell their story' about the build up to psychosis and to air their feelings and concerns.

(iii) Straightforward psychoeducation and support should be provided as needed (see Tool Kit) as well as access to a support group.

(iv) Psychoeducational Family Intervention should be available focusing on:

- 4 **On-going relationship problems in the family**

- 4 Unresolved loss and despair in key relatives
- 4 Stress management for individual family members
- 4 Problems of coping with psychosis-related behaviour at home

- (v) Family and friends should, with the agreement of the client, be part of the ongoing review process.

Getting it right....

Joanna, aged 17, became ill over a period of around 6 months and exhibited various psychotic phenomena. She was reluctant to accept her illness initially and engage with services. Her parents were very distressed and supported her as best they could, giving her 24 hour support as they did not wish her to go into hospital. CPN contact was arranged as well as out-patient (psychiatric) appointments. Over a few weeks, the CPN discussed the illness and offered practical advice and information. After several visits, the family and Joanna felt able to meet together and work as a family on their difficulties and facing the future.

Where things can go wrong.....

Margaret's husband had been supporting her for around 5 years through what was in retrospect an insidious onset of psychosis. He had coped by giving up all his hobbies and limiting his social life. Margaret was admitted to the psychiatric hospital during an acute episode of psychosis precipitated by a family illness. She was discharged one month later with 6 monthly reviews. Her husband receives anti-depressants to cope with the stress of managing the situation without support or any information about her illness.

ASK YOURSELF....

About your service – ie, CMHT or inpatient service:

- v *Does the family know who is the CPN/named nurse?*
- v *Do they know who to speak with if this person is not available?*
- v *Are you able to visit at a time convenient to that family?*
- v *Has the family been consulted as part of the assessment process?*
- v *Have the family had face to face contact with professionals for a dedicated time to discuss the situation?*
- v *Has a professional visited at home? (once/twice/thrice?)*

National Service Framework Links:

Standard 6 requires that carers' own needs be assessed and addressed, using where appropriate structured family intervention techniques.

Guideline Six

A strategy for relapse prevention and treatment resistance should be implemented.

Background

The avoidance of early relapse is crucial, as frequent, or long untreated episodes of psychosis increase the risk of further relapse. The presence of more than one relapse and residual symptom in the first two years is a major prognostic factor in its own right. Relapse risk has also been linked to acute and chronic stress (Kuipers and Bebbington, 1994).

Requirements

Relapse Prevention

- (i) Clients and families should be informed about the risk for relapse and how they can help to reduce this.
- (ii) Relapse risk assessment should form part of the ongoing assessment process and embrace:
 - 4 Vulnerability: untreated psychosis, previous exacerbations
 - 4 Prophylaxis: utility of and adherence to medication regimes
 - 4 Stressors: both acute (life changes, cannabis abuse) and long-term (intrafamilial stress, unstable life patterns)
- (iii) An individualised, shared and documented relapse prevention plan should be developed and rehearsed with the client and social network (see Tool Kit). This should include:
 - 4 Individualised signs of relapse ('relapse signature')
 - 4 Development and rehearsal of a linked 'relapse drill', involving, where appropriate, targeted and time limited neuroleptic medication.
 - 4 An active relapse monitoring procedure.
- (iv) The experience of relapse/exacerbation should be viewed as an opportunity to review the relapse signature and operation of the relapse prevention procedure.

Treatment Resistance

1. The continued experience of psychotic symptoms within 6 months of first treatment suggests that such symptoms are likely to continue (Lieberman et al, 1993). The review at this point should declare the presence of drug resistant symptoms and determine an appropriate strategy (see Tool Kit).
2. The trial use of atypical antipsychotics such as Clozapine should be considered.

The combinations of cognitive therapy with medication has also shown considerable promise for drug resistant symptoms (Garety et al, 1997) and should be considered.

3. Teaching clients and carers how to deal with and cope with such symptoms to minimise distress may be required (TARRIER et al, 1998).

Getting it right....

Simon has a 2 year history of psychotic illness. After two lengthy hospital admissions under section he is now agreeing to try medication and to accept follow-up from the CPN team. His medication has helped with sleep, concentration and clarity of thought but he remains low in mood, poorly motivated and finds it difficult to mix socially. Using early signs monitoring and family support, Simon is learning to recognise his symptoms of relapse. He agreed to attend a day unit informally when he felt depressed and was able to share his worries with the CPN. His admissions and relapses have reduced.

Where things can go wrong....

John was discharged after a 12 week hospital admission with hypomania to his parents home. He had previously been living alone. He was to be followed up by another team but the referral letter was not written until 4 weeks after discharge. Whilst on the ward, John had indicated his reluctance to adhere to medication and, in fact, did not obtain a repeat prescription. His parents are worried about what to do in the event of deterioration. Last time, he left home and caught a train when acutely disturbed prior to his admission and the family are worried that police will have to be involved again.

ASK YOURSELF

Does the family/client/keyworker/GP know what to do (in writing) with clear practical steps to take, if things go wrong, including:

v Advice on medication adjustment to manage over the weekend and at night, to defuse an escalating crisis?

v A clear plan to access respite/day/inpatient care?

v A clear plan to access out-of-hours support?

v A clear plan of who to contact in the absence of a named worker?

Does the letter/summary to the GP contain the above information in a clear form?

Is there a service response time standard which is audited?

National Service Framework Links:

Standards 4 and 5 repeatedly require clarity about action to be taken in a crisis and for this to be shared between client, carer and professional.

Guideline Seven

A strategy to facilitate clients' pathway to work and valued occupation should be developed during the critical period

Background

Whilst accessing welfare benefit systems can be helpful in early stages, it is essential to encourage steps towards a meaningful vocation. Valued and, where possible, paid employment is a vital part of client's care and provides a major source of self-esteem, social contact and money. The longer the individual remains out of work in the early phase the harder it becomes to gain employment later on. Early access to Disability Living Allowance (DLA), can become an impediment to long term employment.

Requirements

- (i) An assessment of client's best ever educational/vocational functioning, work experiences and their educational or employment aspirations should be made as part of the assessment plan and reviewed regularly.
- (ii) A user led vocational or educational training programme should be available. Where possible this should be implemented in conjunction with training, education, employment and other relevant agencies.
- (iii) Resources within the mental health services should be exploited to provide valuable job training opportunities. Service users have invaluable experience of psychosis and of mental health services and where appropriate their employment in mental health services can be very valuable and provide an important stepping stone to gaining employment.
- (iv) A strategy to develop training and work experience through linkage with key agencies and schemes, e g, further education colleges, 'New Deal' and voluntary organisations.

Getting it right....

Spiro came into contact with an early intervention service as he was showing persecutory ideas a few months after withdrawing from a university course. Following recovery he was provided with a vocational assessment but his confidence was low. He was given some work experience in the Trust's finance office and is subsequently attending college reading Business Studies.

Where things can go wrong....

Margaret gave up her job on the advice of her family to reduce the stress in her life and they hoped this would keep her well. However, she is regularly alone for long periods which she finds boring and also allows her to ruminate on negative thoughts. Her husband is now working increased hours to compensate for the lost wage. She rarely sees anyone in the day and feels guilty that her husband is keeping her.

ASK YOURSELF

- v *Has the client had a vocational assessment?*
- v *Is the best vocational/educational attainment of the client easily identified in the care plan, or do you have to seek it out within the documentation?*
- v *Has the client been engaged with occupational therapists?*
- v *Is a method of documenting unmet needs in place; has the need for vocation ever been recorded as an unmet need for a young psychotic person?*



National Service Framework Links:

Standards 4 and 5 emphasise the imperative of responding directly to clients' expressed needs which often revolve around meaningful employment.

Guideline Eight

Ensuring that basic needs of everyday living – housing, money, practical support are met.

Background

People with a first episode of a psychosis often access care after a long period of active psychotic symptoms which can lead to impoverished personal circumstances. Unstable living and financial circumstances are known vulnerability factors for relapse.

Requirements

- (i) To make available appropriate accommodation of the client's choice in the short to medium term.
- (ii) To assess the individual's eligibility for benefits, grants etc.
- (iii) To get specialised help when needed: legal aid, social work, CAB etc.
- (iv) Assessments and action plans are likely to need review more frequently than statutory requirements. We would suggest assessment at six weekly intervals initially.

Getting it right....

Donald had deteriorated in his high rise flat due to his psychosis. He had been burgled several times and had no heating or light. His keyworker arranged a move to a housing association supported scheme and the occupational therapist helped him with cooking and budgeting.

Where things can go wrong....

Brian was admitted to the ward for a brief stay after he complained of low mood and difficulty coping. He was discharged after a few months without follow up. Six months later he was admitted after concerns were expressed about his safety. He had smashed up his flat, had few possessions and appeared to have given money away to youths who lived nearby. He was also expressing psychotic thoughts. A full assessment initially may have highlighted his needs more easily.

ASK YOURSELF....

For the last four young people with psychosis you have seen professionally:

- v *Can you name the social worker?*
- v *Have they had social work contact, other than that associated with the Mental Health Act?*
- v *Have the family had a social needs assessment?*



National Service Framework Links:

Standard 4 requires a written comprehensive assessment of personal and mental health needs.

Guideline Nine

Assessment and treatment of 'comorbidity' should be undertaken in conjunction with that for psychosis

Background

The co-occurrence with psychosis of a variety of problems is well documented. These include substance misuse, depression and suicidal thinking, social avoidance and PTSD-like phenomena. These problems may arise as responses to the impact of psychosis and its treatment including for many, a sense of loss (Rooke and Birchwood, 1998).

Requirements

- (i) Substance misuse, depression/suicidal thinking, social avoidance and intrusive memories linked to the psychosis should be assessed regularly.
- (ii) Opportunities for personal counselling on matters concerning the development of and adaption to psychosis should be made available. This might take the form of a structured recovery programme (see Tool Kit), including an opportunity to form alliances with others facing similar difficulties.
- (iii) Specialised help for substance misuse should be available including information about the risk for relapse associated with heavy cannabis use and the use of motivational interviewing.
- (iv) Social avoidance in psychosis has many origins and requires careful assessment. This might range from catastrophic loss of confidence, low level paranoid thinking or 'normal' beliefs associated with social phobias.

Getting it right....

Tony was dealing in drugs and using heroin on a regular basis. He had been threatened on many occasions by fellow dealers and suppliers and had once been beaten up. He was found a flat on the other side of the city and despite reluctance was put in touch with the community drugs team.

Where things can go wrong....

Tom, 25 years old, was admitted via a court diversion scheme as he appeared psychotic and was exhibiting overt signs of psychosis whilst in police custody. He had several sentences for theft and ABH and was a known substance misuser. Professionals involved in his care were unsure whether his psychosis was related purely to his substance misuse. He was not assessed by the substance misuse team nor was a comprehensive history taken of onset of psychosis and substance use. He is now in prison again without support.

ASK YOURSELF....

Think of the last three young people with psychosis you have seen...

- v *Did you assess for substance misuse, depression, suicidal thinking and/or social avoidance?*
- v *Were many of these problems identified as targets for intervention in the care plan?*
- v *How many individuals with comorbid substance misuse have you referred for specialist help for their substance misuse problems?*



National Service Framework Links:

Standard 4 requires a comprehensive assessment of all mental health needs including problems of substance misuse.

Guideline Ten

A strategy to promote a positive image of people with psychosis needs to be developed locally

Background

Psychosis is a highly stigmatising illness. Attitudes among the general public to people with psychosis are almost wholly negative. Whenever people with psychosis are portrayed in the media, it is usually in a pejorative and unhelpful way.

Those working in the health service have a responsibility to accurately inform both the public and primary health care workers about the nature and reality of psychosis.

Requirements

- (i) A local community education programme. This should emphasise the treatability of psychosis and counteract negative social attitudes regarding psychosis. This should be targeted at professional and voluntary sectors likely to encounter young people with psychosis; for example student health services, schools, police, homeless agencies, and religious or cultural organisations.
- (ii) Local media support. An attempt should be made to form positive relationships with journalists from local newspapers, radio and television, in order to correct mistaken beliefs about psychosis. This might include local success stories both of individuals and services.

Getting it right....

Kate had been working within the telephone sales section of a local firm before she became unwell. Her Community Psychiatric Nurse and doctor liaised with the staff health department of the firm to discuss the impact of Kate's psychosis and how she might best be supported by her employer and to allay their concerns about her ability to cope with the demands of the post. Kate successfully returned to her former position and continues to be supported by her employer receiving assistance with her medication regime and given time off work to attend hospital appointments.

Where things can go wrong....

Tony returned to work following his psychosis and experienced considerable stress related to the insensitivity of his work colleagues who teased and taunted him describing him as 'mad' and 'loony' and who made constant references to his time in the local 'bin'. Tony's confidence was quickly undermined and he found himself becoming quiet and withdrawn and getting increasingly anxious about the thought of going to work and having to face his colleagues. He started having time off work and was eventually forced to give up his job. He remains unemployed and is fearful of returning to a work situation where he may be exposed to similar teasing and intimidation again.

ASK YOURSELF....

- v *Is there anyone in your local area community who may possibly by virtue of personal and family experience have a sympathetic and realistic view of psychosis?*

- v *Do all the voluntary agencies that work in local health provision (i.e. the District General Hospital), have input to mental health?*



National Service Framework Links:

Standard 1 requires that services should promote mental health for all, working with individuals and communities to cease discrimination against people with mental health problems.

What kind of service delivery is appropriate?

Why consider options?

Early intervention in psychosis involves the identification of people suffering from psychosis at the earliest possible opportunity.

The delivery of timely interventions should be appropriate not only to the stage of the psychotic illness, but also to the developmental stage of the client. As such, it involves a number of processes including: service promotion; referrer education; client identification, classification and monitoring; early engagement and delivery of stage-appropriate interventions; and continuing care of non-recovered clients. Similarly, non-clinical processes including research, staff training and clinical supervision may be involved to a greater or lesser extent.

The following gives guidelines about how such processes may be implemented. Not all services will be able to furnish comprehensive interventions within current resources and it may be necessary to

prioritise these projects.

However, the clinical processes appropriate to early intervention in psychosis do not imply the necessity of a specific model of service delivery and thus may be delivered by mental health services with varying resources, and in a range of settings.

A specialised stand-alone early intervention service may be created: at the other extreme, appropriate early intervention strategies may be implemented by staff who are totally integrated into mainstream psychiatric services. Apart from these models, various ‘hybrids’ have been developed for particular settings and needs.

The ‘specialised service’ model

In this model, a stand-alone service responsible for the management of all clients in the early phase of psychosis is constructed. Multidisciplinary staff whose sole or main responsibility is the management of first-episode psychosis clients are ‘ring fenced’ from the mainstream service. Comprehensive biopsychosocial interventions are delivered by this team.

This model has a number of strengths: staff expertise and team coherence are encouraged by the consistent experience of managing similar clients and the informal supervision and sharing of ideas that occur when a team is housed on one site; the creation of a concrete ‘service’ allows easy identification of the service by the referrers (who might include other clients and families); it is possible to create a separate point of entry for direct referrals, thus increasing ease of referral; the existence of a concrete team with a physical location allows the creation of an actual youth friendly ‘space’ which may promote client engagement.

There are also some drawbacks to this model: staff may become overloaded with clients if the entry criteria are not matched to the level of resources and if appropriate exit criteria are not set; unless the service is integrated with mainstream services there is a danger of the service becoming isolated with difficulties in providing after hours cover and in ensuring continuity of ongoing care to non-recovered clients who are discharged from the service; in attempting to run a comprehensive service accepting both referrals and providing ongoing management. The users may have to face reengagement with another service at a future time point, most commonly within the 5 year period of high suicidal risk; mainstream staff may lose current skills with young people with psychosis.



IRIS



The Birmingham Early Intervention Service provides treatment and support to people with a first episode of psychosis from different racial and cultural backgrounds living in the inner-city - an area of exceptionally high morbidity. The service operates an assertive outreach model having access to its own community respite facility. The EIS provides comprehensive care for 3 years. Interventions include: relapse prevention, family intervention, access to work and training. The service is embedded in a community mental health service. A joint proposal of North and South Birmingham Mental Health Trusts to develop the approach across the city has been accepted. This will involve three elements:

*The first will involve a dedicated assertive outreach model across the inner-city (the 'hub'); services to clients outside of the hub are proposed through clinical protocol; the third element is an early identification/treatment project in collaboration with primary care and other community agencies, operated through low stigma youth agencies . **Contact Professor Max Birchwood***

The 'mainstream services' model

Another model provides appropriate services entirely integrated within mainstream psychiatric services. In this model, clients with early psychosis are identified and appropriate interventions are delivered by staff who are employed throughout the existing mainstream psychiatric services. This is most commonly guided by intervention protocols. Thus, principles of early intervention (such as the provision of a youth friendly environment and the streaming of first-episode psychosis clients away from more chronically ill clients) can be implemented by methods such as the use of single hospital rooms and special nurses, the provision for families to 'room in', and the allocation of young key workers etc. The strengths of this model are as follows: since staff in all parts of the mental health service will be responsible for the care of first-episode psychosis clients, liaison with after-hours services should be enhanced and clients might

experience a smoother transition to continuing care services on exit from the period of specialised early intervention; the pool of staff available to manage these clients is increased, decreasing the possibility of services becoming overwhelmed with clients and unable to accept new referrals. Continuity of care within mainstream services is more assured; dissemination of the concept more widespread.

There are also weaknesses due to the lack of an identifiable 'early intervention team' housed in a specific site; staff expertise in the area may be less well developed; the service may be difficult to promote among mainstream services, reducing the frequency of identification of cases; a physical space dedicated to youth friendly activities may be difficult to achieve; adherence to protocols may be difficult to monitor; without thoughtful modifications to the medical record procedure it may be difficult to keep track of which clients are, or who should be receiving the specialised interventions.

Identification of staff responsible for co-ordinating and promoting early intervention

Between these two options various models exist. Generally these involve the nomination of a small number of staff who are identified as responsible for promoting early intervention in psychosis. For example, such staff may be responsible for service promotion, education of referrers, supervision of adherence to protocols, co-working, clinical supervision, staff education, record keeping or the provision of youth-appropriate recovery and rehabilitation activities.



Some recent service initiatives



Wolverhampton Healthcare NHS Trust

*Wolverhampton Healthcare NHS Trust has secured funding to create and develop an Early Intervention Service (EIS), underway in April 2000. It has achieved this through collaboration between the Psychology Service and the Mental Health Directorate of the Trust, the Health Authority and Social Services. The process of securing funding for the EIS began in 1997 with a Clinical Psychologist, with previous experience of early intervention and psychological treatment of psychosis, initiating a training programme in psychosocial interventions with psychosis, open to mental health workers in both health and social services. By 1998, a significant number of community mental health team members and ward staff had been trained in psychosocial approaches for people with psychosis. This provided an impetus to change the structure of how mental health services could be delivered. Following this, a draft document proposing the development of an EIS was circulated to key stakeholders including trust managers, senior clinicians and social service managers. This resulted in a proposal for a 'hub and spoke' model being adapted. The central 'hub' of the service will be located in the area of Wolverhampton with the highest incidence of emergent psychosis. Dedicated 'spokes' of the EIS will be located within the four Wolverhampton community mental health teams. This final proposal resulted in a successful bid for funds to launch the service. Wolverhampton Health Care NHS Trust provides an example of good practice in that it shows how mental health service providers can work together in a co-operative and creative way to develop an EIS tailored to meet the needs of local service users. **Contact: Dr Mike Drayton***



Worcestershire Community and Mental Health NHS Trust

Worcestershire Health Authority, Social Services and the Community Trust have been planning a Joint Strategy for Mental Health Services in Worcestershire. Within the strategy, one of the developments identified is an Early Intervention Service to identify and respond to the specific needs of individuals with a first episode psychosis and their families during the early critical phase of the disorder. A second and unrelated initiative within the county, is that Hereford and Worcester Community Council, in partnership with Social Services, have secured three year funding to assist voluntary organisations to develop preventative early intervention services in the county. A context and potential for partnership has developed to progress the notion of early intervention in psychosis.

*Mental Health Partnership monies from the Health Authority has allowed us to carry out an audit of current practice in relation to the clinical management of individuals with a first episode of psychosis. The audit has focused on first episode individuals having contact with the service within the past three year period from point of diagnosis or first treatment with anti psychotic medication. The audit has collected information on pathways to care, duration of untreated psychosis, prescribing practices, care plans, engagement, professional and other contacts over this period. The data will be compared with the 'best practice' guidelines for early intervention to identify strengths and potential target areas for change when trying to develop early intervention services locally. It is hoped that the audit will serve as a catalyst for discussion and change, and provide a vital information source on local practice that will act as a baseline measure against which changes in practice might be assessed. **Contact: Dr Jo Smith***



Walsall Community NHS Trust

Walsall is enthusiastically adopting the principles of IRIS. Fiona Macmillian and David Shiers have enlisted a design team of professionals and service users whose practical knowledge of local services has ensured relevance to Walsall's needs and at the same time achieving local ownership. The local strengths of Walsall are partially important for the resulting shape of this project and these are:

- q Community Trust commitment reflected in CPN, ASW and clinical psychology skills in family intervention and the motivation of the individuals concerned.*
- q Local National Schizophrenia Fellowship involvement, its quality reflected by Beacon status.*
- q User participatory appraisal as a well advanced technique for evaluation.*
- q Commitment to strong partnership between all major health and local authority agencies reflected in significant inward investment from successful single reintegration bids and HAZ status.*
- q Health Authority Public Health and Primary Care are well networked.*

The emerging project will begin to roll out next year as the design group transforms into a steering and networking group, managing action sub-groups that run the individual element. These elements will split into four broad areas:

- i) Support for professionals working at the point of first contact (e.g:GP's, youth services, court diversion services and others) – looking at training needs, facilitating simpler paths to skilled assessment, better communication and interagency working.*
- ii) Innovating assessment and engagement responses which encourage agencies to be more flexible and appropriate to the needs of this young client group and their families.*
- (iii) Developing a range of interventions appropriate to the early phase of illness with two particular aims:
 - 1. Empowering primary and community services, recognising them to be inherently less stigmatising.*
 - 2. Promoting the paradigm of recovery around issues of employment, housing, finance, etc.**
- (iv) User focussed outcomes with a radical development of user and carer appraisal as a major audit tool.*

*This short account is a superficial description of work by a motivated and enthusiastic group of people serving an area of high deprivation empowered by the key agencies. **Contact: Dr David Shiers***



Black Country Mental Health NHS Trust

The Black Country NHS Trust has embraced the concept of “recovery” as its goal of treatment and care. This combined with well established multi-agency models of service provision and the opportunities provided by government initiatives has produced the fertile ground for thinking about a new way of approaching the treatment of psychosis.

They are now in the process of considering an early intervention service or a family focussed service functioning within an assertive outreach ideology to proactively engage with clients and their families on an extended hours basis (9am – 9pm).

Data on the incidence of psychosis in the Black Country is not specific though further research is being undertaken in the next 6 months. However, a middle range estimate of the likely incident would be 12 new cases of psychosis in the age range 16 – 30, per 100,000 total population. This would suggest a total annual incidence from the Black Country of 36.

Over these years, the caseload of an early intervention service appears likely to grow to more than 100. After 3 years, service models suggest that clients should then be transferred to the most appropriate service to meet their needs at that time. In some cases this will be primary care.

An early intervention service will be developed in partnership with PCGs, Child and Adolescents services and including mentally disordered offenders.

*This service will seek to be family based and it is anticipated that consultation and outline planning work will begin in October with a team in place in 2001. **Contact: Mr Ralph Hall***



North Staffordshire Combined Healthcare NHS Trust

North Staffordshire Health Authority have recently supported a “pathways to care” audit of young people admitted to hospital with a first episode of psychosis over a one-year period.

The young people, their family or friends, and professionals involved from the onset of psychotic symptoms have been interviewed to identify the nature of their route into mental health services. A multi-professional IRIS Development Group has examined the information collected to identify examples of good practice locally and make recommendations for future service delivery and staff training.

*The work alongside the IRIS regional guidelines has been disseminated to each of the six resource centre areas promoting further interest in devising an integrated early intervention approach. Recommendations from the group have been fed into each of the strategy groups developing projects based on the seven National Service framework standards to ensure that early intervention remains at the heart of service development. **Contact: Ms Diane Ryles***



East Gloucestershire NHS Trust

Within the Cheltenham area, in the last five years we have made strenuous efforts to promote the use of psychosocial interventions to help those people with serious and enduring mental illness. As well as promoting training for our staff we are also committed to increasing the emphasis on Early Intervention. A group of interested clinicians based at a mental health resource centre in Cheltenham are working to bring this about. An Early Intervention protocol has been produced. Initially, the multi-disciplinary team will designate workers who have space on their caseloads for early intervention clients.

*We would then look to expand the service locally and collaborate with our neighbours in Severn NHS Trust. During the present development we would hope to also make contact with GPs and also the Child and Family Team. The use of early Intervention approaches will form a major part of new urban and rural outreach teams across Gloucestershire as well as existing community mental health teams. **Contact: Dr Eric Davis***

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Glossary of terms

Antipsychotic medication	Medication prescribed for psychotic illness, often called neuroleptic medication.
Atypical Antipsychotics	Relatively new medications which claim to treat positive and negative symptoms and have fewer side effects. They are more expensive than older neuroleptic drugs.
Care Programme Approach (CPA)	A written plan of care after collaboration between the client, family and professionals involved in treatment and recovery. A keyworker is responsible for co-ordinating the plan of care.
Cognitive problems	Difficulties with perception, attention or memory.
Cognitive therapy	A collaborative treatment which supports a person in reviewing thoughts or attitudes which impede recovery.
Comorbidity	Having symptoms of two or more diagnoses e.g. psychosis and substance misuse.
Critical period	The first 3 years of a psychotic illness which is the optimal time for interventions and influences the long-term course of illness.
Keyworker	A service providing practitioner who has most contact with the client and co-ordinates care.
Negative Symptoms	Symptoms of a psychotic illness affecting energy and emotion e.g. lack of activity, loss of interest. May be wrongly attributed to “laziness”.
Positive Symptoms	Symptoms of a psychotic illness which affect perception e.g. hallucinations and delusions.
Prodromal Period	A period prior to the onset of positive psychotic symptoms associated with a change in the person’s functioning or personality e.g. social withdrawal.

Prophylaxis	Preventative treatment e.g. continuing to take antipsychotic medication when not experiencing symptoms to avoid relapse.
Psychoeducation	Explaining about the cause, nature and treatment of symptoms of mental illness, including medication and ways of keeping well.
Psychosis	The name given to an experience where a person has unusual perceptions e.g. hallucinations, delusions which may be accompanied by a reduced ability to cope with usual daily routines.
Psychosocial Interventions	Self-help interventions aimed at identifying helpful and unhelpful environmental factors which may influence wellbeing e.g. dealing with anxiety-provoking situations, increasing pleasurable activities.

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*positive
response to
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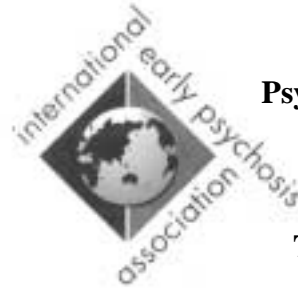
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