



CANADIAN MENTAL
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POUR LA SANTÉ MENTALE

EARLY PSYCHOSIS INTERVENTION

A Framework for Strategic Planning

Canadian Mental Health Association
April 2004

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ACKNOWLEDGEMENTS

This document was produced by the Canadian Mental Health Association, National Office as one component of its early psychosis intervention project, funded by the Population Health Fund of Health Canada. The contents herein do not necessarily represent the views of Health Canada.

Visit CMHA's web site at www.cmha.ca to find this report and other materials produced by CMHA's early psychosis intervention initiative. Resource materials are available in English and French.

April 2004

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Evolving research on early psychosis intervention suggests that the whole is potentially much greater than the sum of its parts.

It is of paramount importance for the integrity of the field and for the future of our young people that early intervention is “done right”.

INTRODUCTION

Since 1999, the Canadian Mental Health Association has been actively involved in promoting the importance of early psychosis intervention and, with it, the need for community awareness, clinical access and family/client education and support. A growing body of research, reflecting impressive Canadian and international efforts to intervene early in the course of psychotic disorders, suggests that radically improved outcomes may be possible for young people experiencing psychosis. Early psychosis intervention represents a new era of hope for those facing the challenges of serious mental illness.

Spurred on by this hope, more and more centres across Canada are keen to provide early intervention services. However, this rapid growth in interest runs the real risk of bringing an uneven understanding of the elements necessary for effective early psychosis intervention. In turn, this can lead to uneven practice: services and community-based initiatives being offered in the name of early psychosis intervention may lack fundamental components. This is a serious concern. The implementation of well intentioned but piecemeal interventions may be counterproductive.

To move forward productively, it is crucial to ensure that concerned Canadians share a common understanding of the field. Early psychosis intervention principles and practices now need to be integrated into a comprehensive policy in order to be consistent, coherent and sustainable in regions across the country. This document offers background information and relevant examples to provide such policy direction for early intervention in psychosis. It describes key elements that should be considered by policy makers, providers and other stakeholders as they grapple with the task of mitigating the potential impact of this serious but treatable condition.

BACKGROUND

Psychosis is a Major Public Health Issue

Psychosis is a condition characterized by impairment in reality testing and may involve severe disturbances in perception, cognition, behaviour, and feeling. It is a serious mental disorder affecting up to 3% of the population. Psychosis can have multiple causes including substance abuse or withdrawal, exposure to severe stress, medical conditions or diseases, and mood disorders. However, more often than not, it signals the onset of schizophrenia.

The burden of illness resulting from psychosis is enormous. Usually emerging during adolescence and young adulthood, psychosis can derail young lives. Late adolescence is a time for dealing with challenges in social, sexual, academic, and vocational arenas as well as consolidating one's personal independence, identity and values; the onset of psychosis in this period causes major disruptions in carrying out these life tasks. Persons in the throes of a psychotic episode usually suffer tremendous distress and may engage in actions that are dangerous to themselves and others.

- Family relationships are severely disrupted, and individuals experiencing psychosis are at significant risk for depression, substance abuse and anxiety disorders.
- Psychosis carries an increased risk of suicide; about half of the persons with schizophrenia who commit suicide do so in the first five years of illness. The rate of completed suicide in persons with schizophrenia is about 10-13%, a rate more than 25 times higher than in the general population.
- Cognitive deficits are present in both schizophrenia and other psychotic disorders. The available evidence suggests that most of the cognitive deterioration occurs near the time of onset and stabilizes within 5 years.
- Stigmatization, discrimination, poverty and poor physical health are further consequences for those individuals developing a psychotic disorder.
- Historically, outcomes have been poor. Relapse is common because of the nature of the illnesses and because those affected are at high risk for non-adherence with treatment. If recovery is defined as the absence of the necessity for treatment in the

Long durations of untreated psychosis are associated with slower and less complete recovery, more biological abnormalities, frequent relapses and poor long-term outcomes.

previous two years, the absence of symptoms, and a reasonable level of functioning, then the proportion of recovered patients is 16% for those with schizophrenia and 36% for those with other psychoses.

- Although the personal costs to individuals and families are substantial, the economic and societal costs are also immense. In Canada, severe mental disorders account for four of the ten leading causes of disability. About 300,000 Canadians experience schizophrenia. Overall annual costs of the disease are estimated at \$2.3 billion in direct costs plus an additional \$2 billion in indirect costs. Even following a policy shift to community treatment, schizophrenia alone still accounts for the use of 1 in 12 hospital beds in Canada.

Persistent Barriers to Successful Outcomes

Despite substantive pharmacological and psychosocial advances in the treatment of schizophrenia and bipolar disorder in the past 25 years, a number of barriers to effective treatment remain.

- **Long durations of untreated psychosis** – Research shows there is often a delay of years between the onset of psychosis and the initiation of effective treatment. Long durations of untreated psychosis are associated with slower and less complete recovery, more biological abnormalities, frequent relapses and poor long-term outcomes. For all psychotic disorders, the percentage of time a person spends with active psychotic symptoms in the first few years is the best predictor of how they will fare over time. In short, the better the short-term course, the better the long-term outcome.
- **Therapeutic nihilism** – Notwithstanding recent advances in treatment, many service providers and the public share the mistaken belief that all individuals with these disorders are doomed to extremely poor outcomes. This belief sometimes prompts clinicians to delay treatment while adopting a “wait and see” approach. Unfortunately, this approach carries potentially dire consequences since it typically leads to a worsening of the psychosis before appropriate treatment is initiated.
- **Outmoded treatment models** – Historically, treatment consisted of medication and case management designed to sustain individuals in hospitals or other institutions. For all its merits, de-institutionalization frequently was not accompanied by the development and application of appropriate community treatment models. Even when community services were developed, their focus was on providing for the needs of older individuals with chronic relapsing disorders. Little or no attention was paid to addressing the distinct needs of young persons experiencing the early phases of a psychotic illness.
- **Nonadherence to best practices** – Quality controlled research has generated reproducible advances in treatment. However, knowledge of these practices and consistent adherence to their correct application is frequently lacking in “real world” settings. Adherence to best practices is vital to the production of optimal outcomes. Unfortunately, evaluation of service delivery in terms of best practice approaches is usually inadequate or completely absent.

Early psychosis intervention, with its encouraging results, represents a significant innovative approach that addresses the above issues.

Early identification and treatment can result in reduced disability, fewer relapses and hospitalizations, reduced risk of suicide, maintenance of developmental course, reduced family and relationship disruption, and improved recovery.

THE PROMISE OF EARLY INTERVENTION

What is Early Intervention?

“Early psychosis intervention” (EPI) refers to an integrated constellation of approaches to the treatment of psychosis that emphasizes the importance of both the timing and types of intervention provided to persons experiencing a first episode of psychosis. “Early” is as early as possible following the onset of psychotic symptoms; the “intervention” is comprehensive, intensive, phase-specific and individualized. Early intervention should not be confused with primary prevention in which onset of an illness is prevented. At this time there is insufficient research data supporting the ability of specific interventions to prevent onset even when reasonable suspicion exists that onset may be approaching.

Why Early Intervention for Psychosis?

The research literature on early psychosis intervention was reviewed in the CMHA document, *An Introduction to Early Psychosis Intervention: Some relevant findings and emerging practices* (2000). This summary indicates that the duration of untreated psychosis (DUP) can be extensive, often lasting a year or two, and that the longer the duration, the poorer the outcome. On the other hand, outcomes can be substantially improved if appropriate interventions are begun as soon as possible following the onset of symptoms. Early identification and treatment can result in reduced disability, fewer relapses and hospitalizations, reduced risk of suicide, maintenance of developmental course, reduced family and relationship disruption, and improved recovery.

Typically, psychotic illnesses follow a relapsing course wherein periods of acute psychosis are preceded by periods of general disruption (a “prodrome”) and followed by several recovery stages. Unfortunately, often remissions are only temporary as the person cycles again through the prodromal phase and subsequent florid (active) symptoms of psychosis. Since greater numbers of psychotic episodes are associated with progressively greater impairment over time, it is particularly important to break this cycle as well as provide care and treatment that is appropriate to each stage of the disorder and to the developmental stage of the individual.

Emerging data in support of positive short and mid-term outcomes continue to accumulate. For example, the Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario reported preliminary results that indicate a significant difference in one-year remission rates related to DUP. Of those entering the program with less than six months DUP, 82% were in remission at one year compared to 58% of those with a DUP greater than six months. And with increasing public awareness and case detection initiatives in the London area, the duration of untreated psychosis has been decreasing.

The goals of early intervention for psychosis are to:

- Reduce the duration of untreated psychosis
- Reduce suffering for the individual and his or her family
- Increase speed of recovery, including personal, interpersonal and educational/vocational competence and role functioning
- Improve short and long term prognosis
- Reduce rates of hospitalization
- Reduce the burden of chronic illness on the health care system
- Reduce the incidence of secondary psychiatric and medical problems
- Reduce relapse risk.

The number of Canadian early psychosis services and initiatives rivals that of other developed countries. However, many of these countries have national mental health plans with early psychosis intervention specified as a priority.

EARLY PSYCHOSIS INTERVENTION IN CANADA

Canada has numerous well-established early psychosis clinical programs and a growing number of community-based early psychosis initiatives. The Canadian Mental Health Association's early psychosis intervention projects (1999-2004), funded by Health Canada, helped regions to develop capacity for local initiatives, raised awareness of the importance of early psychosis intervention, created and disseminated resource materials, and fostered the development of partnerships and networks. The number of Canadian early psychosis services and initiatives rivals that of other developed countries. However, many of these countries have national mental health plans with early psychosis intervention specified as a priority (see Appendix). In Canada, there continues to be no national mental health strategy, and in particular, no specific focus on early intervention for psychosis. At the provincial level, while several Canadian provinces have developed progressive mental health strategies (e.g., Ontario and Nova Scotia) there is relatively little emphasis on early intervention for psychosis in provincial policy.

British Columbia is one exception where the provincial mental health policy explicitly prioritizes early intervention for psychosis. BC's Mental Health Plan is outlined in *Revitalizing and Rebalancing British Columbia's Mental Health System* (1998). Within this plan, early identification and intervention are put forth as a priority. The Ministry of Health was mandated to work with other ministries to support the development of policies related to early intervention for serious mental health problems and to work with health authorities and others to develop protocols facilitating early identification. The Ministry of Health undertook a provincial early psychosis initiative involving multiple partners to develop early psychosis identification and intervention capabilities. This provincial initiative entailed education and training on early identification, establishment of a number of clinical service demonstration projects, and the development of a *Provincial Framework for Early Psychosis (2000)* and *Early Psychosis: A Care Guide (2002)*, that outlines evidence-based clinical practices.

A more recent development is the *Child and Youth Mental Health Plan for British Columbia (2003)*, which is the first of its kind within Canada. The *Plan* specifically highlights early psychosis intervention and specifies that components should include identification training and risk management, greater coordination of services, and use of evidence-based practices.

Within Ontario, the Working Group on Early Intervention in Psychosis, comprised of mental health professionals and family and consumer representatives, has developed a draft strategy for developing comprehensive early intervention capacity across the province. This strategy entails development of early intervention treatment and resource centers to provide specialized services and coordinate service delivery for surrounding communities.

The need for national and provincial mental health plans inclusive of early intervention has been identified by a number of advocacy groups and organizations (e.g. Canadian Mental Health Association, Schizophrenia Society of Canada, Ontario Working Group). Ensuing recommendations for policy development have been well documented (e.g., British Columbia Schizophrenia Society: *Our Abandoned Citizens – Policies for Change*; Ontario Working Group: *A Strategy for Ontario*).

Clearly, Canada with its growing base of knowledge and ongoing activity can only benefit from the development of a consistent and comprehensive approach to help guide this burgeoning field. Following is a presentation of those fundamental components and concerns that must be addressed to ensure steady and reliable progress in the field.

With its emphases on early identification, family involvement, access to appropriate services and a normalized recovery context, EPI is about much more than clinical practice alone. Clinical practice is embedded in a community context with significant implications for the educational needs and participatory roles of gatekeepers, family members, friends and other community members.

FUNDAMENTAL COMPONENTS OF EARLY PSYCHOSIS INTERVENTION

The practice of effective early psychosis intervention consists of multiple components that progress from recognition, to referral, to assessment and treatment, and ultimately to recovery of the individual and ongoing evaluation of EPI programs.

RECOGNITION – IMPROVING EARLY IDENTIFICATION SKILLS

Both public and professional education and training are required in order to improve the likelihood of recognizing psychosis in its early stages. Educational initiatives should be properly planned, resourced and recognized as a priority.

• Community Context

Increasing Public Awareness – Awareness campaigns should aim to educate the public about the nature of early psychosis intervention, the signs and symptoms of psychosis and the importance of receiving timely treatment. Public education should provide accurate information about psychosis and aim to dispel misconceptions.

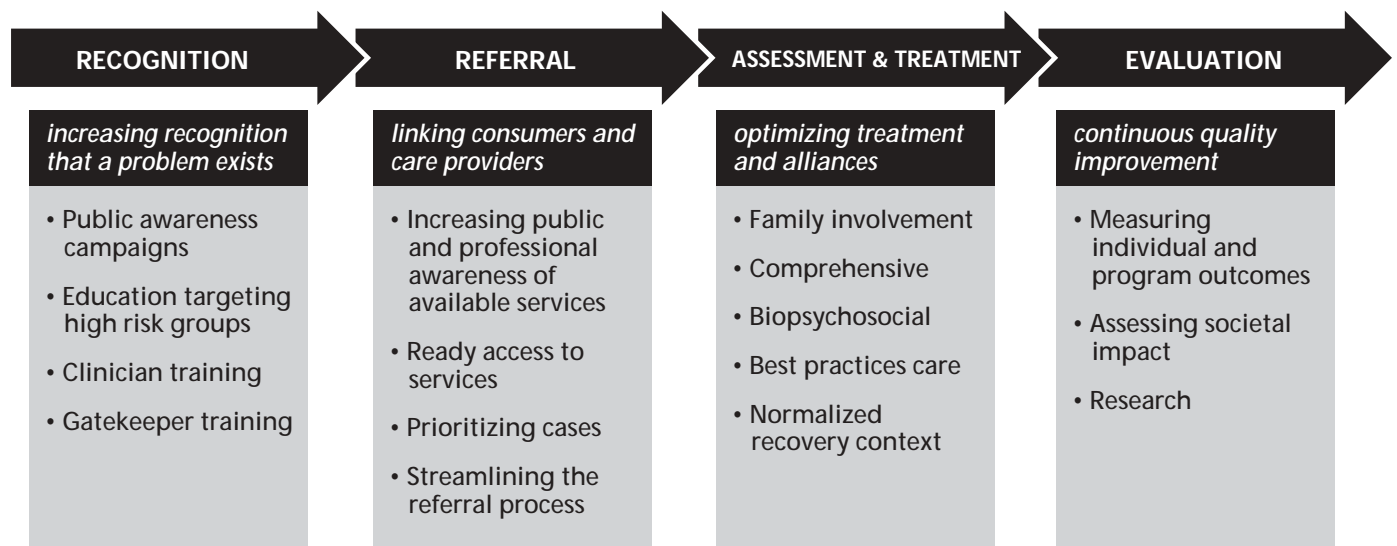
Focusing on High Risk Groups – Education should target persons at increased risk for developing psychosis. Education on psychosis should be incorporated into school settings and school curricula.

Training Gatekeepers – Professionals positioned to interact with individuals who may be experiencing incipient psychosis should be trained to recognize symptoms of psychosis and understand the importance of early intervention. This “gatekeeper” training should include groups such as teachers, school counselors, family physicians and forensic personnel. This training may be introduced as part of their educational curriculum and/or provided in the workplace.

• Clinical Context

Training Clinicians – Education should be provided to general practitioners, mental health clinicians, hospital and emergency room personnel to raise the “index of suspicion” that a psychotic process may be occurring. Education should correct negative misconceptions regarding prognosis and course still held by many clinicians. By providing a greater awareness of new developments in the treatment of early psychosis, education should produce realistic optimism rather than therapeutic nihilism. This would further serve to promote prompt action rather than adopting a passive “wait and see” approach.

Early Psychosis Intervention Pathway



Optimal care consists of comprehensive, integrated biopsychosocial approaches (i.e., medication, psychosocial interventions and client and family education) tailored to the unique characteristics of each individual and the phases of their illness.

REFERRAL – LINKING THOSE IN NEED WITH CARE PROVIDERS

When a psychosis is suspected, it is important both that appropriate services be available in the community and that they be easily accessible. By facilitating access to care, the harmful effects of delayed care can be minimized.

• Community Context

Increasing public awareness of available services – Gatekeepers, high-risk groups and the general public should be informed of available and appropriate clinical resources if early psychosis is suspected. Information should be provided on access to these services. Both the number of steps needed for a person to receive appropriate care and the time spent seeking treatment should be minimized.

• Clinical Context

Providing ready access – Services should be easily accessible, with a variety of referral methods possible including self-referral. Referral pathways should be clear and widely disseminated.

Providing rapid response – Response to referrals should be rapid and appropriate. Clinical services need to have a system for promoting, prioritizing, and streamlining the referral process.

ASSESSMENT AND TREATMENT – OPTIMIZING TREATMENT AND ALLIANCES

Optimal care consists of comprehensive, integrated biopsychosocial approaches (i.e., medication, psychosocial interventions and client and family education) tailored to the unique characteristics of each individual and the phases of their illness. Empirically – supported care that is socioculturally and age appropriate must be provided in a normalized recovery context.

• Community Context

Facilitating community-based supports – Services and supports must be comprehensive and involve multiple sectors (e.g. vocational, economic, physical health, educational and recreational). Communities need to ensure there are broad mechanisms to assist individuals and families in recovery including peer support, family support networks and other appropriate community-based resources.

Developing integrated care systems – Communities have an obligation to ensure that care is continuous over time and across involved systems. Care needs to be user-centered and seamlessly available for those from age 14-35. It should effectively integrate child, adolescent and adult mental health services and work in partnership with primary care, education, social services, youth and other relevant services.

• Clinical Context

Initiating care without delay – Services must ensure that any assessment and treatment delays are avoided to reduce the length of time young people remain untreated. Assessment must be comprehensive and performed by a skilled professional. The emphases of treatment should be on managing symptoms and role fulfillment rather than diagnosis. Note that in clinical practice, the focus of early intervention is on the early phase of psychosis. Treatment specific for psychosis should be initiated only when signs and symptoms of acute psychosis actually emerge. Treatment for individuals who appear to be at very high risk for psychosis should be limited to interventions for presenting complaints, stress management and close monitoring.

Focusing on the individual and family – Services should be youth-friendly and flexible in their approach. Assessment should be performed in the most comfortable environment possible (e.g. home visits and outreach). Family and other supports should be actively engaged from the outset. Care should address the “whole person” including their ethnic and cultural background, rather than solely the signs and symptoms of psychosis. The person and the family should be engaged as active collaborators in care.

Care should be intensive and comprehensive. Its focus is not on symptom remission, but rather on the active promotion of recovery during the early phase of illness with emphases on normal social roles and developmental needs (e.g. attaining educational, employment and social goals).

Engaging in best practices – Clinicians must have the time, knowledge, attitudes and skills to provide care based on best practices; the specific clinical skills needed for working with individuals with early psychosis are different than those needed for working with those with persistent and chronic psychotic disorders. Care should be intensive and comprehensive. Its focus is not on symptom remission, but rather on the active promotion of recovery during the early phase of illness with emphases on normal social roles and developmental needs (e.g. attaining educational, employment and social goals). The person and the family should be engaged for extended periods (perhaps several years or longer). At the end of the treatment period, care needs to be transferred thoughtfully and effectively to family health practitioners.

The fundamental principles of care in early psychosis, guiding clinical practice and service delivery, are outlined in several documents developed from the best available evidence (see references in Sources section). These principles of care and best practices are overarching and apply to all clinical components of early psychosis intervention, although it is important to recognize that in application they can be incorporated into a variety of delivery models appropriate to particular contexts.

EVALUATION – ENSURING CONTINUOUS QUALITY IMPROVEMENT

Evaluation and research constitute an additional key component in order to ensure that care corresponds to best practices, is continuously improving, and is based on our continuously expanding knowledge.

• Evaluation and research activities span community and clinical contexts

Evaluation strategy – The use of shared strategies and indicators across services and sectors will strengthen evaluation efforts. Information systems need to be built into programs as part of their basic operation and coordinated at the provincial and/or national level. Evaluation should directly assess the routine use of clinical guidelines and inform the teaching of best practices to professionals. Evaluation also needs to include parameters that reach beyond clinical service provision. This may consist of epidemiological research, medico-economic evaluation, assessment of training programs for new providers, and family input.

Research – Despite the recent growth of knowledge on early psychosis intervention, many unanswered questions still remain. Research should be an integral part of early intervention services that serves to continuously improve approaches to psychosis.

Accountability - Process and outcome evaluation need to be performed to assure quality service delivery and refine future services. Outcome evaluations must consider both individual cases and program outcomes. Services need to establish strong lines of accountability for the implementation of service standards and the routine use of outcome measures.

Economic Benefits of Early Intervention

1991 data indicated that when the duration of untreated psychosis was less than six months, the cost over the next three years averaged \$US 5,606. However, when DUP exceeded six months the average cost rose to \$12,283.

Alternatively the EPPIC program in Australia was able to demonstrate the cost effectiveness of their model. The average annual cost for program participants was \$Aus 16,964 compared with \$24,074 for equivalent individuals who were not involved in the program.

ONGOING IMPLEMENTATION CONSIDERATIONS

Many of the issues that must be considered as part of a viable policy framework for early psychosis intervention are not unique to psychosis but are applicable to mental health policy and practice in general. The following discussion highlights their relevance and implications for early psychosis programs without detailing specific strategies for resolution. The strategies for addressing these issues will, by necessity, vary across national, regional and administrative boundaries.

Funding for services needs to be sufficient to ensure comprehensiveness of service delivery and sustained to maximize the likelihood of positive outcomes. This may involve a protected envelope within existing budgets and/or prioritization within long-term plans. Given the competition for scarce resources for persons with long-standing illnesses, dedicated funding for early intervention programs can be difficult to ensure. Nevertheless, this is of particular importance for early psychosis services as the benefit of such programs, by definition, is only manifest at a later stage (i.e., reduced demand for more invasive and expensive health, legal or social services, as well as optimization of the likelihood that participants will be productive citizens).

The **housing, educational/vocational, and general healthcare requirements** of participants in mental health programs need to be addressed. Such determinants of health are strongly predictive of the onset of illness; access, adequacy and compliance with diagnosis and treatment; and likelihood and severity of relapse. This is particularly important for persons with psychosis. These individuals are at risk for interpersonal and social isolation as well as comorbid and untreated medical conditions. Furthermore, they typically manifest signs at a time when they are completing education and beginning careers, thus running a risk of lifelong under or unemployment and dependence. They are entitled to affordable and safe housing, access to medical care, adequate diet, and academic and vocational accommodation or assistance.

The recruitment and retention of a **trained healthcare workforce** is an ongoing challenge for Canada due to demographic trends, reductions in training programs and competition for workers from other countries. As noted previously, members of early psychosis intervention teams require specialized skills, education, and training, not to mention dedication and creativity. Such individuals will be in high demand and need ongoing support and professional development if they are to remain in this challenging area.

Another ongoing challenge in Canada is **access to care**. Despite a commitment to universality, there is considerable variability in pathways to timely and adequate assessment and treatment. Access is affected by a myriad of factors including socio-economic status, ethnic or cultural background and place of residence, predominantly for those in rural or remote settings, and is especially pertinent for mental health programs where the need far exceeds the availability of services. Lack of access too often leads to reactive and expensive crisis and/or acute services or, even worse, the absence of care with ensuing morbidity and mortality. This issue is integral to early psychosis intervention initiatives given that the fundamental goal of reducing the period of untreated psychosis requires rapid access to appropriate care within the individual's community.

Models of care determine how health care is delivered, typically ranging from the provision of community-based, primary care services to specialist services that often occur in a secondary or tertiary setting. The predominant model of care varies across and even within jurisdictions, depending on the funding structure (public versus private sector), availability of providers and socio-historical preference and precedent. This issue is particularly relevant in Canada at present given a strong federal commitment to primary care reform. A variety of models, such as shared care and stepped care, has been proposed with the goal of optimizing availability, effectiveness and efficiency of service delivery. The challenge for early psychosis intervention initiatives is to balance the commitment to minimally intrusive care within an individual's community with the provision of sufficient targeted services based on specialized multidisciplinary expertise.

In order to enhance early detection, the Early Psychosis Intervention Clinic in Montreal has worked closely with the Alliance for the Mentally Ill and local educational settings. Presentations and information sessions have been held with teachers and school counselors. Similar links have been established with community health centres, crisis units, emergency rooms and family physician offices.

Edwards and McGorry (2002) have described various models for care delivery, ranging from the establishment of centres of excellence providing a full range of services, to a “spoke and hub model” with regionalized services linked to a common centre.

Collaboration between governmental systems and agencies beyond healthcare is necessary for effective prevention, identification and treatment of illness. Policy needs to include mechanisms to facilitate reciprocal cooperation between diverse departments towards the achievement of common goals. Given that a fundamental objective of early psychosis initiatives is to ease the pathway to care, it is necessary to establish links beyond traditional mental health settings. In addition to collaboration with primary healthcare providers, relevant partners include educational, forensic and social service sectors.

The **transition between adolescence and adulthood** is inherently fraught with dramatic interpersonal, physical, cognitive and emotional challenges. Any policy intending to identify and address health issues for this population must be sensitive to this. The challenge for mental health services is heightened when the responsibility for service delivery shifts from one authority to another solely due to the chronological age of the individual. All too often this results in disruption, discontinuity, treatment drop out and the risk of “falling between the cracks”. As noted above, late adolescence and early adulthood is the most common period for the onset of psychosis, thus making this issue particularly important for early psychosis initiatives. In an effort to address this problem, some programs have developed a “wraparound” approach whereby services are tailored to individual needs and are maintained as required across time and agencies.

Continuity of care leads to better outcomes, satisfaction with care and maintenance of gains across time. Failure to adhere to treatment regimes exacts prolonged suffering and deterioration of health. Similarly, switching between health care providers is at best inefficient and sometimes dangerous. Early intervention in psychosis stresses the importance of engaging the young person and establishing a therapeutic relationship that maintains throughout their course of care.

Comorbidity is the presence of two or more disorders in a particular individual or population of interest over a designated period of time. These may be coincidental, preexisting or sequential and can include both physical or mental health disorders. Comorbidity challenges traditional assessment and treatment systems. Concurrent conditions often go unrecognized or, if identified, may render an individual ineligible for a particular program. Comorbidity can also undo otherwise helpful interventions by undermining compliance or increasing risk of side effects or complications. Amongst the most common comorbid concerns for persons with psychosis are substance abuse and developmental disability. Various models for sequential or integrated assessment and treatment have been proposed to address such populations.

Cultural and ethnic factors play a significant role in determining recognition of health difficulties, symptom manifestation, access to services and response to treatment. The situation is compounded when the dominant provider system lacks an adequate understanding of unique ethnocultural interpretations of illness, fears of stigma and distrust of public services. These concerns are heightened for indigenous peoples as well as refugee populations who often do not receive appropriate services despite the fact that they are at greater risk of illness. It is therefore important for early psychosis policy to explicitly strive to identify and address the needs and concerns of minorities. In addition to providing multilingual providers and materials, specialized services for those communities in which there is a high concentration of particular ethnic groups may need attention. Alternatively, some jurisdictions have developed programs utilizing a “cultural broker” whereby designated representatives mediate between mainstream services and ethnic consumers.

Appropriate funding and resources should be allotted to develop new early psychosis intervention initiatives. This demands careful planning and coordination across health and non-health sectors.

SUMMARY AND RECOMMENDATIONS

Early intervention offers the promise of immensely improving the quality of life for persons and families affected by psychosis. Innovative techniques supported by burgeoning research findings justify this new optimism. Early intervention is achievable utilizing existing knowledge and clinical expertise without major infrastructure enhancement or infusion of resources.

STRATEGIC PRIORITIES:

- **POLICY DEVELOPMENT**

A national action plan for mental health is needed. Early intervention in psychosis should constitute a fundamental plank of this national policy.

- **PUTTING POLICY INTO PRACTICE**

Appropriate funding and resources should be allotted to develop new early psychosis intervention initiatives. This demands careful planning and coordination across health and non-health sectors. An organizing body should be designated for planning, communication and coordination. In particular, this should include development and dissemination of standards, capacity enhancement amongst stakeholders and the collection and utilization of relevant information.

- **PRACTICE**

Early intervention strategies must adhere to the previously described fundamental principles and components specific to early psychosis across all of the four stages: recognition, referral, assessment and treatment, and evaluation. A piecemeal approach will not achieve the desired ends and runs the real risk of undermining potential benefits.

Contained within the *Blueprint* (1998) are specific early intervention recommendations for the Maori who tend to access services at a later stage of their illness.

Recommendations include:

- Expert diagnostic services within an appropriate cultural context
- Culturally appropriate community support
- More accessible disability support services, more accessible information about the onset of mental illness and service availability.

APPENDIX: OVERVIEW OF EARLY PSYCHOSIS POLICY DEVELOPMENT IN OTHER COUNTRIES

In addition to Canada, clinical and research programs with a focus on early psychosis are found throughout the world including Australia, New Zealand, United Kingdom, Germany, Sweden, Norway, the Netherlands, Hong Kong, United States, Switzerland and numerous other countries. Despite the burgeoning number of early psychosis programs worldwide, only a few governments have developed policies for early intervention of psychosis. Outlined below are some examples of the most prominent international policy developments on early psychosis intervention.

New Zealand

New Zealand's National Mental Health Strategy was launched in 1994 with the publication of *Looking Forward: Strategic Directions for the Mental Health Services*. The strategy has two key goals: 1) to decrease the prevalence of mental illness and mental health problems within the community, and 2) to increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

The strategy involves a shift from hospital-based services to community-based services. Priorities include better crisis intervention services, outpatient and outreach services, day programs, home-based services, and prevention and early intervention services. A major focus of the strategy is to attempt to decrease the stigma currently attached to mental illness and to change public attitudes so that early recognition and intervention can occur. Culturally appropriate early intervention programs are recognized as a high priority.

The National Mental Health Strategy was further developed in the National Mental Health Plan, *Moving Forward: The National Mental Health Plan for More and Better Services* (1997). The Plan reemphasizes the importance of early intervention and states that these services are to be expanded to ensure that all people who are newly presenting with major mental illness will get early intervention.

The Mental Health Commission developed the document *Early Intervention in Psychosis: A Guidance Note* (1997) in order to guide the care provided by clinicians and practitioners. The *Guidance Note* served as the basis for the early intervention plans laid out in the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998), which sets out the plan for delivering services and stipulates that all mental health services in all areas must include the capacity for early intervention.

These services may be offered separately from community teams as a local specialist service and while some of these services currently have a time limit on their use (e.g., 1 year), it is recommended that they should be available to people for as long as they require an intensive level of support to prevent relapses, maintain quality of life and prevent disability. Guidelines for caseloads are set at one clinical staff person for each 10-15 service users. Other priorities indicated in the *Blueprint* include assertive outreach and follow-up for those who are difficult to engage, primary care and general hospital liaison for those with mental health problems not accessing specialist mental health services, and people with combined alcohol and drug and mental health problems. *The National Mental Health Standards* (1997) provide quality parameters for the service components described in the *Blueprint* and prompted evaluation of early intervention services.

Australia

A major shift in mental health was made in Australia in 1992 when the *National Mental Health Policy and Plan* was adopted. This followed the earlier endorsement of the *National Statement of Rights and Responsibilities*. Together these documents form the National Mental Health Strategy. The National Mental Health Strategy aims to promote mental health, prevent mental disorders and reduce their impacts, and assure the rights of people living with mental disorders.

The Commonwealth Department of Health and Family Services (Mental Health Branch) funded the National Early Psychosis Project (NEPP; 1996-1998) under the National Mental Health Strategy. NEPP was managed by the Early Psychosis Prevention and Intervention Centre (EPPIC) and the Department of Psychiatry at the University of Melbourne. NEPP developed a national model of practice for early psychosis intervention. It entailed professional education and training, promotion of best practices, service and policy development and information dissemination. The result of NEPP was the development of multiple early psychosis projects and networks throughout Australia as well as the development of the *Australian Clinical Guidelines for Early Psychosis* (1998). NEPP also stimulated policy development at a state/territory level (e.g., New South Wales – *Getting in Early: A Framework for Early Intervention and Prevention in Mental Health for Young People in New South Wales*).

The Australian *Second National Mental Health Plan* (1998) identified partnerships in service reform, quality and effectiveness of service delivery, and promotion and prevention including early intervention for psychosis as priorities in its five year plan.

As a joint initiative between the Commonwealth and State/Territory Governments, the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* and *Promotion, Prevention and Early Intervention for Mental Health: A Monograph 2000* were published. These two documents provide the policy and conceptual framework for promotion, prevention and early intervention consistent with a nationally coordinated approach. The *National Action Plan* outlines a strategic framework and plan for action to implement promotion, prevention and early intervention priorities as outlined in the *Second National Mental Health Plan*. It identifies priority groups, key strategic sectors, settings and people for mental health partnerships and key strategic indicators and outlines the national actions that are to occur.

“Mental health is influenced by risk and protective factors that occur in the many different domains of everyday life. Consequently, effective action to promote mental health, prevent the development of mental health problems, and intervene early in mental disorders requires cooperation, commitment, and partnerships that reach well beyond mental health services. Effective action needs to encompass, not only the broader health sector, but family and community services, educational institutions, workplaces, correctional services, emergency services, and the sports, arts and business sectors, as well as carers and consumer groups. Indeed, mental health is an issue for the entire community, requires a whole community response, and delivers benefits for the whole community.”
(*Action Plan 2000*; p.1)

United Kingdom

The Government of the United Kingdom has outlined a new vision for mental health in *Modernising Mental Health Services: Safe, Sound and Supportive* (1998). This document establishes the guiding principles for further policy development and the new strategy promises extra investment and the development of new and better systems.

Guiding Principles (Modernising Mental Health, 1998)

People with mental health problems can expect that services will:

- ***Involve service users and their carers*** in planning and delivery of care
- ***Deliver high quality treatment and care*** which is known to be effective and acceptable
- ***Be well suited*** to those who use them and non-discriminatory
- ***Be accessible*** so that help can be obtained when and where it is needed
- ***Promote their safety*** and that of their carers, staff and the wider public
- ***Offer choices*** which promote independence
- ***Be well coordinated*** between all staff and agencies
- ***Deliver the continuity*** of care for as long as this is needed
- ***Empower and support*** their staff
- ***Be properly accountable*** to the public, service users and carers.

SOURCES AND RESOURCES

The key source for the statistics in this document can be found with full references in *Early Psychosis: A Care Guide*, T.S. Ehmann & L. Hanson, Senior Authors and Editors. Mental Health Evaluation and Community Consultation Unit. University of British Columbia, 2002. Available at:
<http://www.healthservices.gov.bc.ca/mhd/publications.html>

PRACTICE AND SERVICE GUIDELINES

- The International Early Psychosis Association (IEPA) has published a *Draft Consensus Statement: Principles and Practice in Early Psychosis*.
- Australia, New Zealand and the United Kingdom have also developed national sets of clinical guidelines. The Australian Clinical Guidelines for Early Psychosis are available at: <http://www.eppic.org.au>
- In Canada, several documents have been produced detailing best practices. See, for example, the (PEPP) program in London, Ontario (<http://www.pepp.ca>) and from British Columbia *Early Psychosis: A Care Guide*.
- Also see *Implementing Early Intervention in Psychosis: A Guide to Establishing Early Psychosis Services*, J. Edwards and P.D. McGorry, Martin Dunitz, 2002.

NEW ZEALAND

Policy and Practice Directions

<http://www.hrc.govt.nz/download/pdf/EIP.pdf>

Evaluation of Early Intervention for Psychosis Services in New Zealand: What Works?

<http://www.moh.govt.nz/mentalhealth>

Looking Forward

Moving Forward

Blueprint

<http://www.mhc.govt.nz/>

Mental Health Commission

AUSTRALIA

<http://www.auseinet.com/resources/auseinet/finalrpt/>

Auseinet Stocktake Report

<http://www.mentalhealth.gov.au/>

Second National Mental Health Plan

National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000

Promotion, Prevention and Early Intervention for Mental Health:

A Monograph 2000

<http://www.health.nsw.gov.au/policy/cmh/>

New South Wales – Centre for Mental Health

UNITED KINGDOM

<http://www.nhs.uk/>
NHS Plan

<http://www.doh.gov.uk/mentalhealth/>
Department of Health
Modernising Mental Health
National Service Framework
Implementation Guide

<http://www.iris-initiative.org.uk/>
Initiative to Reduce the Impact of Schizophrenia Guidelines

<http://www.rethink.org/>
National Schizophrenia Fellowship

CANADA

<http://www.cmha.ca/>
A Guide to Canadian Early Psychosis Initiatives
An Introduction to Early Psychosis Intervention:
Some relevant findings and emerging practices

<http://www.healthservices.gov.bc.ca/mhd/publications.html>
Adult Mental Health Plan
Child and Youth Mental Health Plan
Early Psychosis: A Care Guide