JOURNEYS WITH EARLY PSYCHOSIS INTERVENTION SERVICES IN AUSTRALIA
Improved Impact & Outcomes
Quantitative & Qualitative

Alan Rosen, Jo Gorrell, Louise Nash, Chris Tennant, Alison Cornish, Viv Miller, Bev Moss, David & Ann Shiers, Tom Callaly, Deb Howe
Italia & Australia

- Population 60 million
- Area 301,000 km²
- 200 people /km²

- Population 21 million
- Area 7,680,000 km²
- 2.7 people /km²

(Compared with China 141 people per square km)
TYPES OF CRISSES

2. Developmental stages of life – that we all go through, in every culture

3. Situational Crises
   – eg accident, burglary, loss of job or relationship
     - more specific to our culture

3. Complex Crises – including Psychiatric Crises – mental illness can be a cause or effect of a crisis
The Anthropology of Crisis Intervention:
Culturally Appropriate Interventions in both Diachronic Vs Synchronous Time
Stages of a Crisis

Stage I: mounting tension

Stage II: plateau of disorganisation and maximum tension

Stage III: mobilisation of resources

Stage IV (i): adaptation and crisis resolution

Stage IV (ii): maladaptation or pseudoadaptation

Stage IV (iii): major disorganisation

Steady state

Equilibrium restored

Degree of tension and arousal

Crisis stimulus

-
Stages of Crisis

Stage I: Mounting tension
- habitual problem solving responses in an attempt to maintain the person’s steady state

Stage II: Plateau of disorganisation
- feeling anxious and ineffectual, “at sea”, “chaotic” or “going mad”
- repetitive abortive attempts at problem solving
- stereotyped responses (like “hitting your head against a brick wall”)
- Increased dependence and ventilation needs
Stage III: Mobilisation of all internal and external resources

- maximum arousal, heightened suggestibility, increasing vulnerability to good or poor advice
- Emergency methods or creative, novel solutions may be attempted, resulting in a range of possible outcomes
Stages of Crisis

Stage IV: Adaptation or maladaptation

- Crisis resolution: adaptation to new circumstances. Stability and steady state restored at equal or higher level (most common outcome)
- Maladaptation: superficial “closure” or reactivation of past crises or recurrent medical symptoms and treatments
- Major disorganisation: crisis may be precipitated psychotic episodes or affective disorders if vulnerable
Principles of Crisis Intervention

I. ASSESS CRISIS

i. severity and duration

iii. psychiatric or physical symptoms

v. risk to self or other

vii. who else is affected
Principles of Crisis Intervention

II. ASSESS RESOURCES AVAILABLE TO THE PERSON IN CRISIS

– Their personal resources: eg buoyancy, resilience, confidence
– Their sustaining social resources: eg at least one confiding relationship
– Their cultural resources: rites of passage and extended kinship system eg for mourning a loss
– The available external or professional resources: only to bolster resources i, ii, or iii when over-stretched or deficient
Principles of Crisis Intervention

III. INTERVENTION (Most effective in Stage II of Crisis)

i. allow dependency
ii. frequent visits and easy access to counsellor during this phase
iii. reality focus
iv. maintain integrity of social network
v. couple or family counselling, education and support as required
Early Intervention in Psychosis

Bio-physical

Psycho-

Socio-

Cultural
Early Intervention in Psychosis

• Bio-physical
  – Low dose technologies
  – Low impact environments wherever possible
    • home-based care
    • voluntary admissions
    • unlocked facilities
    • oral medication
Avoid Over-enthusiastic Biophysical Monocultures
Early Intervention in Psychosis

• Psycho-
  • care coordinator/coach
  • supportive counselling
  • Cognitive Behavioural Therapies
  • Neurocognitive Remediation
  • finding a place for psychosis in your life
  • self-esteem
  • developmental milestones
Early Intervention in Psychosis

• Socio-
  • retaining and/or temporarily replacing social network
  • vocational and leisure rehabilitation
  • return to studies, skill training or work
  • group learning – eg that you are not alone
Recovering Together with Others’ help
Recovery by Encouragement & Social Acclaim
Early Intervention in Psychosis

• Cultural
  – working with the family
  – dealing with stigma and discrimination
  – recovery of your place in the community as a full citizen
Families are not an Optional Resource

THE FAMILY TEAM IS AN ESSENTIAL RESOURCE FOR RECOVERY
Stigma & Discrimination are more than a Shame

Recovery involves full membership of a community = Citizenship
Study aims

1. Compare service provision before and after the introduction of early psychosis intervention strategies
2. Assess the degree to which service provision is consistent with available guidelines for optimal early psychosis intervention
Early Psychosis Intervention Services

EPPINY : Early Psychosis Prevention and Intervention network for Young People, 1997-2001

AIMS OF EPPINY:

• To improve services to young people with psychotic disorders and their families
• Staff training
• Service restructuring
• Guidelines developed
• EPPINY Research Group to evaluate process
Northern Sydney Area Mental Health Service
Early Intervention in Psychosis
Structural Changes

- No new resources
- 3 EIP teams & 1 EIP respite house
- 3.5 – 4.5 interdisciplinary providers in each team
- 15 service-users per provider
Service Structural Change

- Youth friendly spaces
- Evening family education meetings
- Staff mobility (vehicles)
- Within 3 years: 3 of 4 sub-areas had EITs as part of adult community services
- Amalgamated with Semi-rural Area with well developed EIT
Triangulation of Methods

Can we increase confidence in findings from research if we perform a combination of quantitative & qualitative research methods?

• By demonstrating that independent methods agree, trend in the same direction, or at least don’t contradict each other

• Particularly useful if quantitative method is quasi-experimental or uncontrolled

• More palatable to service-users & families

• Multiple triangulation = combination of 2 or more of 4 basic types
## Triangulation Dimensions

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<th>Triangulation of</th>
<th>Research</th>
<th>Study</th>
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<td>Data Source</td>
<td>3</td>
<td>4</td>
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<td>Methods</td>
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Current pathways to care

• appropriate services were not available to relatives when required
• multiple contacts were made before admission
• relatives usually made appropriate contacts initially and when these proved unsuccessful turned to more unusual contacts
• police contact was distressing for relatives but they were grateful when it led to hospital care
Pathways to care in early psychosis intervention:
understanding treatment delay


• Fast Track (<4 weeks)
  DUP = 5 days
  Contact with health professional = 2 days
  From contact to treatment = 3 days

............20% recall suicidal ideas or behaviour
Pathways to care in early psychosis intervention: understanding treatment delay

• Mid-pathway (4 – 26 weeks)

DUP = 14 weeks
Contact with health professional = <6 weeks
From contact to treatment = <9 weeks

….43% recall suicidal ideas or behaviour
Pathways to Care in Early Psychosis: Understanding Treatment Delay

**Aim**
- Aims to reduce treatment delay and improve outcomes for early intervention.
- Focuses on understanding the delays and factors contributing to treatment delay.

**Method**
- Retrospective in-depth interviews conducted with young people and their families.
- Analysis of 28-week intervention treatments with community early psychosis teams.

**Sample characteristics**
- 78.6% male, average age 20.83 years, 55% had completed high school, 42% were in part-time education or employment, and 23% were unemployed.
- 9.5% had a diagnosis of schizoaffective psychosis, 16.5% mood disorder (21.4%), 11.5% substance use disorder (4.5%).

**Results**
- Treatment delay: 3-6 months.
- Long path group had significantly longer delays, longer hospital stays, and more medication changes.
- Missed opportunities for earlier intervention.

**Conclusion**
- Identifying and understanding factors contributing to treatment delay is crucial.
- Early intervention and support can significantly reduce delay and improve outcomes.

**Acknowledgements**
- Principal investigator: Prof P Ward (University of Sydney, NIMH, Royal North Shore Hospital, and Community Mental Health Services).

**Service**
- Early Psychosis Service: Northern Sydney Health.

**References**

**Images**
- Pathways to Care in Early Psychosis: Understanding Treatment Delay.
Pathways to care in early psychosis intervention: understanding treatment delay

- Long pathway (>26 weeks)

DUP = 115 weeks
Contact with health professional = 70 weeks
From contact to treatment = 45 weeks

....50% recall suicidal ideas or behaviour
More likely to be cannabis users
...who take longer to contact health professional
From contact to treatment: THC = non-THC users
Clinical outcome measures of Early Intervention for Psychosis in a real world context

L. Nash, J. Gorrell, A. Cornish, A. Rosen, V. Miller, C. Tennant, 2004

Symptomatology: n = 75 → 56 → 36 → 22

Intake → 3 months: no change

12 months: significantly lower – BPRS total score; Positive Psychotic Index; HoNOS total score; SANS Summary Score
Clinical outcome measures of Early Intervention for Psychosis in a real world context

• Impact of Service Improvements (n = 36)

Early entry group: significant decrease SANS
Mid : more decrease SANS
Late : most decrease SANS
12 month BPRS (neg) scores, by month of registration
Effect of E.I.P. staff training on attitudes

Stages of Concern (about implementing Early Intervention)

- Self concerns – what does this mean for me personally?
- Task concerns – how can I do the task/s?
- Impact concerns – what impact will this have on the person with psychosis, their family, the whole service, management, etc?
Effect of E.I.P. staff training on attitudes

J. Gorrell, V. Miller, A. Rosen, C. Tennant, A. Cornish, L. Nash, 2004

There was a significant shift in staff attitudes from self → task → impact concerns.
Early Psychosis Intervention
What are we doing differently?

A medical record audit

Jo Gorrell, Alison Cornish, Louise Nash, Alan Rosen, Chris Tennant, Bev Moss, Diana McKay

Northern Sydney Health
File Audit Method

- All inpatient and community records
- first 12 months of treatment
- All first episode clients aged 15-26
- 2 x 6-month intake periods
  - Pre = T1 (n=47)
  - Post = T2 18 months later (n=70)
- 23 clinical indicators
- chi square analyses
### Treatment recommendations & indicators

**Example:**

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<tr>
<th>ACG-EP strategy</th>
<th>Treatment recommendation</th>
<th>Clinical indicator</th>
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| 3. Involving families, carers & friends in the therapeutic process | Provide families with support and opportunity to be involved in assessment & treatment | a) Meeting with family occurs  
b) Families receive psychoeducation  
c) Family evenings offered  
d) Attendance at family evenings |
6. Provide families with support & opportunity to be involved in assessment & treatment

◆ 75% attended a family meeting
  50% within 5 days
  75% within 1 month
◆ 44% received psycho-education
◆ increase in:
  – offered multiple family evenings (6-43%)
  – attended multiple family evenings (2-13%)
But does it really work?

• Cochrane 2008—slight gains only
• Milhapoulos, Harris, Henry, Harrigan, McGorry, 2009– 8 year matched controls follow-up--- yes
• London School of Economics & Institute of Psychiatry Health Economics Groups--- yes
• Linzen et al--- yes, but need to continue the effort to sustain good results
Separate Early Intervention Teams or Combined with CMH Teams?

- No evidence that combining works
- Dilutes culture & intensity of practice
- Mixes age groups again
- But separate teams may cause problems in transfer to CMHT’s
How long should Early Psychosis teams retain clientele?

- 18 months? Eg research programmes
- 2 years? Eg early Eppiny
- 3 years? Eg current Eppiny
- 5 years? Future Eppiny?
- 10 years? Eg Young persons’ programme.
“The critical period is the first 2 – 5 years following the onset of psychotic illness when there is the maximum potential of deterioration and therefore the greatest opportunity to intervene to prevent the development of psychosocial disability” Birchwood et al (1993)

- Where deterioration occurs it does so aggressively in the first 2-3 years after experiencing a psychosis
- Some studies suggest that level of functioning 2 years after diagnosis predicts that at 15 years
- 2/3 of the 10%+ risk of suicide in Schizophrenia occurs in the 1st 5 years
Critical Period
Beyond early intervention: Can we adopt alternative narratives like ‘Woodshedding’ as pathways to recovery in schizophrenia?

- David Shiers, Alan Rosen and Ann Shiers

Rationale for services for the next 10 years after Early Intervention

• For service-users with Delayed Recovery
• Assertive Community Treatment (ACT) service delivery system
• Repertoire of Recovery oriented interventions
• Individual, Family & Group interventions
• Coaching in minimising metabolic effects of medications, and encouraging healthy living
Continuum of Care

Young Person’s Stream

- Crisis Intervention
  - Mobile
  - 7 day and night
- Early Intervention
  - in Psychosis Team
- Young Person’s Assertive Community Treatment and Residentials
- Continuity of Care
  - Case Management

Evidence-based Interventions, GP Shared Care & Peer Support Specialists
Woodshedding

• “Periods of no apparent improvement while acquiring subtle increments of self-esteem, competence, stamina and social skills”.
  J. Strauss, 1999

• Woodshedding typically manifests at the end of a period of uneventful convalescence or quiet healing and right at the beginning of the road to recovery.
  C. Harding, 2003
Importance of Human Story-telling

• Examining the tension between a traditional ‘clinical’ narrative used by many health providers and a ‘human’ narrative of users of services and their families.

• Individuals regaining personal control of their own stories.

• A ‘personal narrative’ expresses its subjectivity without insisting on anchoring itself to objective forms, & is not afraid of also being art (Strauss).
FEEL FREE TO SPEAK MY MIND.
Readiness

• = a person’s own preparedness for constructive or even radical change

• The service-user’s timeframe of readiness for change is more important than the provider’s timetable for goal attainment.
  
  - M. White & D. Epston, 1989
  - W. Anthony, 2004

• Recovery oriented services should provide a
Therapeutic Optimism

- a mindset acknowledging evidence anticipating far greater possibilities of recovery from an illness than hitherto considered possible.

- Has an evidence base, and relevant skills can be learned, taught and operationalized.

- P. McGorry et al, 1999

- D. Shiers, A. Rosen, A. Shiers, 2009
Early Intervention as Good Practice

• “Ripples” should spread to other phases of care eg rehabilitation-recovery. (Shiers & Rosen, 09)
• Other age groups eg less silos between adult and adolescent services, eg. women first episode often later
• Other subspecialties eg comorbidities with substance & alcohol abuse, forensic, learning disorders, personality disorders, intellectual disability, brain injury. (Byrne, Rosen, Lester)
The ORYGEN vision
McGorry P, et al

Youth health/ youth mental health precincts

- many locations – access should not be just a quirk of geography
- suitably trained GP’s
- One stop shop
  - interdisciplinary
  - Integrated care for multiple problems, health and mental health
- youth-specific & youth friendly
- Clinical, social, welfare, vocational
- involve families if possible
headspace
headspace

- Established and funded by the Commonwealth Government of Australia in 2006, headspace is the National Youth Mental Health Foundation.

- headspace provides mental and health wellbeing support, information and services to young people and their families across Australia.

- The people that work at headspace are providing solutions for young people aged 12 to 25 years.

- Mental Health Promotion for young people nationally.
With 30 one-stop-shops, headspace has a range of youth friendly health professionals who can help you with:

- General health
- Mental health and counselling
- Education, employment and welfare services
- Alcohol and other drug services
- Sexual health
- Family counselling
Young People & early Psychosis Intervention
headspace
Riverina

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DOCTORS ONLY

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Early Intervention Of Nearly Everything in Mental Health Services

- **Rationale** (Byrne P, Rosen A, Lester H):
  - A Public Health preventive approach
  - EI systems are broadly accepted in most Physical Disorders (eg breast cancer, cardio-vascular dis.)
  - Age, Gender, & Subculture specific approach
  - Interdisciplinary Teamwork
  - Wholistic, bio-psycho-socio-culturo-ecological approach
Multi-modal bio-psycho-socio-cultural intervention
The Multidisciplinary Team?
Early Intervention & Recovery-Orientated Services require a change of HEADSET.
WHY DO HOME-VISITS?
(within defined parameters of safety)

- Rosen A, MJA 1997
- Yellowlees P MJA 1997

A. For Crisis Assessment:

- Accurate Assessment and Review
  - more data eg living and social skills and social history
  - more "dramatis personae" and props of person's real live
  - more people involved in the relational crisis
  - less artificial (setting and interaction)
WHY DO HOME-VISITS?

A. For Crisis Assessment (cont.)

- Caring, honouring, respectful message
- "taking the trouble" to call in
- harking back to traditional medical or pastoral home visits or "night calls"
- health provider in the role of "invited guest" – etiquettes

- De-escalating
  - from emergency to crisis
  - less clinical props
  - consumer more in control: on their turf and their terms
WHY DO HOME-VISITS?

B. As an Intervention:

- A very potent intervention
- plan carefully
- clarify goals beforehand
- do not work alone
- allow plenty of time
- engagement, winning trust
- negotiating skills
- experiential learning, promoting change
WHY DO HOME-VISITS?

B. As an Intervention: (cont.)

- Have a good reason for visit

- be honest and direct
- **not** a social drop-in
- **not** political or product marketing
- explicit common goal

- Non-intrusive
  - phone ahead
  - show I.D.
  - seek invitation
  - ensure privacy, confidentiality
  - courteous and non-threatening
Ethics of Prevention & Early Intervention, Part I

- Intrusive research must be less important than practical utility for the individual & family
- Early Screening: NNT (Number Needed to Treat) must be balanced with NNW (Number Needed to Worry)
- Availability of information does not necessarily amount to Self Awareness: Respect for those who just don’t want to know
Ethics of Prevention & Early Intervention, Part II

- False positives far outweigh real positives....most early screening is therefore “pre-experimental” non-predictive and unjustified
- “Close-in” screening only, just before syndrome is likely to emerge, with additional predictive risk factors, for prodromal clinics
- No medicalisation or pathologising of ordinary distress
We can be more effective if we are on the same page