



Perspectives in Early Intervention

Beyond early intervention: can we adopt alternative narratives like 'Woodshedding' as pathways to recovery in schizophrenia?

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Abstract

Aim: To consider how early intervention in psychosis can support a recovery paradigm.

Methods: Significant numbers of those developing a first episode of psychosis are on a path to a persisting and potentially life long condition. Constituting the schizophrenia spectrum disorders, such conditions demand the particular qualities and attitudes inherent within recovery-based practice. This paper explores some of these qualities and attitudes by examining the tension between a traditional 'clinical' narrative used by many health providers and a 'human' narrative of users of services and their families.

Results: We draw out key features and constructs of recovery practice as they

relate to the EI paradigm. These include: woodshedding, turning points, discontinuous improvement models, therapeutic optimism, gradualism and narratives of story telling. We also highlight the role of family members and other close supporters and believe their potential contribution requires greater consideration.

Conclusions: The early intervention (EI) paradigm can resonate and indeed offer a stronghold for recovery-based practice where traditional mental health services have sometimes struggled. Conversely, failure of caregivers to provide such an approach in the early phase of illness can cause unnecessary and sometimes disastrous consequences.

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INTRODUCTION

'I cannot show you the path but I know that paths are made by walking' (Traditional saying).

The focus for early intervention (EI) has been undifferentiated psychosis for understandable reasons such as plasticity of early diagnosis and the social baggage associated with the word schizophrenia. However, approximately 10–15% of individuals will not achieve remission following a first episode of

The idea for writing collaboratively came from two informal, moving and mutually enlightening encounters between Alan Rosen and Ann and David Shiers, one in Australia and the other in Copenhagen; these ideas then further honed by two subsequent reunions.

psychosis, and a further 44% go on to experience two or more relapses.¹ Furthermore, functional disability may be a prominent component of psychosis, often first appearing in the prodromal phase when it may be the most significant feature.² Thus, the EI has to face up to the reality that at 5 years a majority (55%) will be experiencing a schizophrenia spectrum disorder characterized by persisting symptoms and functional disability.³

In this paper, Ann and David first describe their family experiences and then join Alan to highlight how the use of narrative can challenge traditional concepts and provide a new context for thinking about the early phase of psychosis in relation to those destined to have a persisting disorder. Nor are narrative accounts of schizophrenia new. Nikolai

Gogol's classic short story⁴ *'Diary of a Madman'* (1834) offers one of the oldest and most complete descriptions. Such narratives of how sequential processes and patterns affect the course of psychiatric disorder can provide insights into its pathogenesis.⁵ These insights reveal that although disability may be pervasive, initially tenacious and disheartening, it can be overcome in part or whole by creating a map that illuminates a pathway to emerging ability and generates a hopeful landscape in which recovery may be more readily imagined, encouraged and realized.

THE JOURNEY TOWARDS RECOVERY: A FAMILY PERSPECTIVE

David and Ann first described their daughter's descent into madness⁶ 10 years ago and now offer a personal view of her recovery, and how this buffeting experience affected them as parents. This experience was to impel/propel David to campaign and collaborate with others to work towards the implementation of EI in psychosis strategies in England.

The descent

This was a severe illness. It transformed Mary from a carefree 16-year-old, to a tragic young woman, terrified, unable to think, communicate or participate in life. But we also felt the National Health Service (NHS) let her down. Diagnosis was followed by 12 months of children's clinic attendances for medication review and apologetic reassurances that adult services would be *'more into psychosis'*. Eventually home support became unsustainable and hospital admission followed. Our guilt at forsaking her to an acute adult ward turned into despair when 6 months later she entered the rehabilitation ward's 8-bedded *'Nightingale'* dormitory.

Through illness and three continuous years in hospital Mary, aged 20, stood on the threshold of the *'medium stay'* ward. In reality what the NHS was offering Mary and ourselves was a *'rest of her life'* ward.

The first steps to recovery

Two enduring memories stay with us from that bleak time. One was how, despite all that had happened and her apparent lack of progress, Mary could still reveal tiny glimpses of her old self be it to ask to go shopping or listen to her favourite pop star. The other was how as a family we were encouraged by one of her key professionals to write letters of

complaint, culminating in our being told-off by a senior health manager across a boardroom table. That combination of telling off and those reminders of what Mary still had within her provided us a raw emotional energy to challenge the systems of care. So although no tangible sign of improvement had yet shown itself, the possibility of improvement began to replace our previously dismal outlook.

Turning point

Her psychiatrist reported 'For nearly a year Mary asked me, and doubtless others every week whether in the ward or on the hospital corridors this repeating question *"When am I leaving here, when am I going to B . . . house?"*' We all had a clear reply, *'we don't know when, but you will be going'*. It was a symbol of hope that all of us needed. The emergence of this simple questioning seemed a key precursor for Mary to begin to develop the elements of her recovery. This coincided with the introduction of clozapine. Prior to this she had appeared completely adrift from reality unable to think or act in any coherent way. Within a few months of this change of medicines, Mary began to compare herself to others on the ward. *'Why were they moving on and not her?'* She demonstrated awareness of what other young people like to do – a desire to dance and to shop stood out. She became able to concentrate sufficiently to browse through teenage fashion magazines. Although her life at that time was defined by her inability to participate in these things, at least Mary's frustration was appropriate and indicated the restoration of some sense of purpose.

A way forward

It was a further two long years before Mary's needs were acknowledged. Our complaint finally resulted in a new young person's community-based service for her and 16 others. Within a matter of weeks of entering the new service, Mary began to improve. What felt different about this new service?

- *A supportive environment:* a modern, spacious home in the *real world:* her own private room, her pictures, her music. She had left behind her the older persistently ill people of the hospital ward. And she liked being with other young people. Her new environment provided a framework in the real world around which she could begin to rediscover her identity.
- *A service that actively focused on strengths, not deficits:* she tentatively explored her new surroundings, attended local college, went shopping

and began to enjoy family activities. Free from the ward regimen of excessive eating and inactivity she lost weight, enabling her to walk and swim without exhaustion. Her days took on meaning.

Initial critically important steps

The new service provided an ethos of enablement that encouraged a series of gradual and often very subtle changes to happen. Months would pass with little alteration and then without warning she would make a small advance. For example, sustained freedom from psychotic thinking allowed medication dose-reduction, which in turn improved her drooling and attentiveness, helping her look normal and us (Ann and David) feel better. Clearer thinking let her prepare food, bake cakes and bread, clear up after a meal, use buses or trains, become engrossed in drawing and painting, enjoy the cinema, go dancing and sustain relationships.

Incremental achievements

Taken individually, these steps might seem small, but combined over time they represented remarkable improvement. Eight years ago, she was able to move on to a supported home with far less formal supervision corresponding to her greater independence. So now, although disabled, Mary maintains her own room, reliably helps with tasks in her home, enjoys a small job waiting-on in a voluntary sector café and loves attending a centre for people with a wide range of physical and mental disability, where she thrives in an enabling environment. Accompanied, she has recently started to use trains and buses to enable her to go shopping. Inconceivable even 12 months ago, she declares *'I want to travel'* with its own range of new opportunities.

When asked now about life: *'I love College; dancing is great; I love shopping for clothes, having holidays, going out for pub meals, walking'*. And the old hospital days: *'it was just terrible, terrible. Don't talk about it'*. The symbolism of having her own place and a job is not lost on her. More than anything she wants to be like other young people. And the whole family are regaining hope and self-belief, bit by bit and not always predictably. We are firmly on our path to recovery.

The effect on Mary's parents, Ann and David

'Your daughter has schizophrenia – she is not a schizophrenic'. We still clearly remember this advice from our daughter's first encounter with a consultant psychiatrist. However, despite being ex-

perienced health professionals, nothing could have prepared us, as parents, for the distress and despair of those early years or the overwhelming sense of disempowerment. *'Why us?'* dominated our thinking as we struggled with guilt, anger, fear and grief. And yet now, 10 years on from Mary leaving hospital, that question no longer troubles us.

What helped us as carers integrate these raw emotions from those initial troubled times? Most importantly, we were encouraged to look outwardly by some enlightened health professionals. This exposed us to radically different ideas about the nature of early psychosis and what treatment and care might be offered. By visiting innovative services in Birmingham early in Mary's illness and more recently, in Australia, we were able to construct a new set of expectations and ultimately influence a very different personal narrative. Thus emerged a gulf between the reality of Mary's care and what we increasingly realized could and indeed should be achieved. We derived from this gulf an energy that we channelled both in terms of Mary's care and also that of others with similar difficulties. *'Put-up or shut-up'* became a personal challenge for David, consequently leading to a career change which enabled translation of personal experiences into a variety of initiatives to implement EI throughout England and internationally.

WOODSHEDDING AND PROFESSIONAL USES OF PERSONAL NARRATIVES

The traditional model of schizophrenia, first described by Kraepelin, continues to underpin many service approaches. We offer an alternative interpretation based on an understanding of personal narratives.

The traditional model

At the beginning of the 20th century, Kraepelin invoked the diagnostic term dementia praecox to explain the clinical course of the schizophrenias in terms of a model of psychopathology represented by a progressively destructive brain process. Likened to the fall of the British Empire, treating dementia praecox could thus be characterized at best as *'the orderly management of decline'*. And despite the fact that such a process in a schizophrenic brain had never been witnessed, the notion of dementia praecox underpinned a whole century of treatment approaches.

In 1977, Manfred Bleuler challenged and rejected Kraepelin's pessimistic construct in his classic

description⁷ developed from observations of the course of schizophrenia in 208 patients and families collected over 20 years. Bleuler concluded of the dementia praecox model '*it seems almost incredible how one-sided theories on the schizophrenias, upheld entirely by wishful thinking and unsupported by empirical fact, could propagate themselves*'. He went on to remind the reader that '*obsolete theories on schizophrenia without empirical foundations were not merely harmless assertions; they caused a great deal of harm*'. Bleuler brought a new way of looking at schizophrenia. By considering the long-term course of the disease, he exposed the problem inherent in the old idea of a long term progressively worsening condition. In the 1980s, Chompi⁸ and Strauss⁹ followed with further long-term studies to reveal that even the most severely affected could achieve positive outcomes amounting to partial or even complete recovery.

The 'stress/vulnerability' model gained support to explain the impact of environmental factors, for example, family behaviour,¹⁰ social networks, psychosocial treatments and life events. But this model itself, based on a notion that a person's level of vulnerability was fixed, was further challenged by Strauss. Strauss, informed by his research into narratives of people with persistent mental illness, discovered that their vulnerability varied and concluded that:

- the course of the disorder was strongly affected by interactions between the individual and their environment and
- individuals developed over time, that is, strengths and vulnerability change over time, usually in the direction of human development.

An alternative 'recovery' model

Mary's personal story illustrates how her recovery relied on her inner strengths, those of her family and those of the services she received. When Mary first became ill both she and her family descended into an alien world for which they had no preparation or understanding. The initial service response revealed traditional systems designed to support a Kraepelinian trajectory and with an inherent resistance to change. But Mary, her family and some key professionals ultimately rejected that path in favour of a very different one. Despite the trauma of the first 2 or 3 years Mary and her family collectively retained a small kernel of resilience that was recognized and encouraged by some enlightened practitioners and managers. There emerged a collective sense of wanting to move on.

WOODSHEDDING – THE CRITICAL FIRST STEP ON THE PATH TO RECOVERY

'Woodshedding . . . periods of no apparent improvement while acquiring subtle increments of self-esteem, competence, stamina, and social skills' (Strauss¹¹).

Strauss *et al.*^{11,12} had characterized this first critical step in a recovery path as '*woodshedding*', a phase in which the person, after an acute episode, may improve initially, but then seems to stop getting better for a period which is often long and frustrating. Given a therapeutic environment of patience and quiet but constant encouragement, this may be followed by a discontinuous leap into a higher level of function. Strauss¹¹ postulates such phases are regulatory mechanisms and timing arrangements to ensure that the person takes long enough to gather the surplus stamina and skills, required to negotiate the next major change towards recovery. For instance, when moving out of hospital or the parental home, or taking on a new job, not one demand is involved but many, and a long period of preparation may be needed, given the variations that exist in everyday environmental demands. Such phases are not exclusive to recovery from mental illnesses. Such phases occur all the time in the way young people learn, as any school teacher could tell you. Strauss, visiting Australia in 1996, was quizzed by Alan about the origin of the term which was only rarely alluded to (e.g. Strauss¹³) in his written work. Borrowed from his co-author, Paul Liebermann, college jazz radio announcer and psychiatrist, Strauss likened the process to when jazz musicians retreat into the woodshed to practice improvisation, thus sparing others until proficient. McGorry in 1992 adopted Strauss's concept of Woodshedding and suggested it entailed a period of withdrawal from public performance; furthermore, pointing out its relevance to secondary prevention and recovery in psychotic disorders.¹⁴ This intensive and usually private rehearsal facilitates 'errorless' learning to improve a particular skill in preparation for public performance. (Dr Anthony Lehman, pers. comm., 2008) Strauss endorses our distinction between clinical and personal narratives, and the use of the term Woodshedding 'based on an understanding of personal narrative' as he considers that many personal accounts, unlike this, are not really 'personal narratives'. To be categorized as the latter, Strauss further hypothesizes, it may need to be writing that is not afraid of also being art, and writing which expresses its subjectivity without insisting on anchoring it to objective

forms (Professor John Strauss, pers. comm., December 2007).

Woodshedding typically manifests itself at the end of a period of uneventful convalescence or quiet healing. Although there may be no further visible improvement post-remission, subjectively the experience may be described later as '*I am beginning to think about getting going*' (Professor Courtney Harding, pers. comm., 2003). Woodshedding is a metaphor that encapsulates that first critical step on the road to recovery. It is the essence of what an EI approach should espouse.

The turning point

Strauss recognized that low turning points are often identifiable on the brink of change (Professor Courtney Harding, pers. comm., 2003), marking a phase of transition from an initial rigid and narrow construction to a more adaptive and integrated approach.¹⁵ Turning points are also described in the literature on rites of passage and crisis intervention¹⁶ and may mark the beginning of a constructive awareness and may represent the seeds of crisis resolution phase. When Mary stood on the threshold of the 'medium-stay' ward, she had arguably been written-off. The reaction of both family and services were critical to her subsequent progress and proved the turning point. The family refused to accept the perceived inevitability that Mary should spend the rest of her life in an institution. Furthermore, some of the service professionals refused to condone this hospital environment as appropriate for the needs of this young woman. That shared belief from both family and key professionals eventually translated itself into a tangible alteration in the service provision. This marked a pivotal turning point from which time Mary's healing process, and indeed that of her family, commenced.

A model of discontinuous improvement

Mary's narrative demonstrates how step-wise discontinuous improvement may punctuate more quiet phases with little outward evidence of improvement. These periods may allow acquisition of subtle increments of self-esteem, competence, stamina and social skills. Better regarded as a regulatory mechanism, the recovering person may need these quiet periods to muster sufficient strength to overcome the next hurdle, for example, demands of a new job or leaving the hospital or parental home. What was clear from Mary's narrative was the importance of services not allowing a person to stagnate in the critical early phase. Because family

and key professionals were able to share an expectation of improvement, opportunities were actively sought and assertively promoted.

Readiness

Involving a person's readiness or preparedness for significant or even radical changes. Derived from both the narrative therapy field¹⁷ and psychiatric rehabilitation recovery work (Professor William Anthony, pers. comm., 2004), this concept is a reminder to EI practitioners that the service-user's timeframe of readiness to change must take preference over the service provider's timetable or imposed clinical clock of goal attainment. In common with other recovery narratives, a person's sense of readiness is an essential prerequisite to taking a substantial step or a sequence of multiple steps towards constructive change.

Therapeutic optimism

Therapeutic optimism invokes a mindset that acknowledges evidence of far greater recovery from schizophrenia than hitherto considered possible. These prospects highlight the importance of EI strategies¹⁸ in the critical period of the first 5 years of psychosis¹⁹ that can:

- improve outcomes from systematic family, cognitive and vocational interventions²⁰⁻²⁵ and
- optimize family, communal inclusion and cultural factors associated with better prognosis^{26,27} and reducing stigma.²⁸

Therefore *therapeutic optimism* has an evidence base, and relevant skills can be learned, taught and operationalized.

Gradualism

Particularly for those young clients similar to Mary with a more persistent early illness, an outlook of gradualism can provide a more appropriate framework for judging progress; being alert to and actively encouraging small incremental changes over long timeframes, tempered by apparent discontinuous improvement in the 'woodshedding' pattern. From the time of entering the enabling community environment, Mary demonstrated how one small advance opened up further possibilities. And as a family we learnt the importance of celebrating each little advance to secure the gain. Indeed this *newsworthiness*¹⁴ can be defined, that is, noticing and bringing positive change in behaviour, however small, to the attention of the service-user. The

therapist may become excited over new constructive behaviours, however transient and ask who else in the person's orbit might have noticed this change. If that new behaviour is not amplified as a unique positive outcome, then habitual patterns of behaviour may close over again and eclipse any advance. Indeed by reinforcing such gains one can build virtuous circles of improvement.

Story-telling

Life-enhancing potential of story-telling can encourage reclaiming authorship for one's life.²⁹ By learning how to retell their story in more hopeful terms than the dominant story in the clinical file, service-users and families can choose a destiny other than one which perpetually lives out a psychiatric career.

Good practice issues are summarized in Table 1.

The recovery paradigm is supported by these good practice issues and is summarized in Table 2.

CONCLUSIONS

Our experiences reveal the therapeutic pessimism inherent in Kraepelin's model of dementia praecox can still manifest itself today, albeit seductively modernized by biomedical advances. That pessimism was evident in Mary's earliest treatment encounters undermining hope and optimism at a critical early phase in the course of her illness. A key challenge and opportunity for EI is to call into question such a dismal construction, drawn from the dominant clinical narrative of schizophrenia, by generating alternative narratives derived from a mindset of hopeful expectation of gradual recovery. That recovery construct requires service providers, family support teams and local communities to jointly create an encouraging and nurturing environment, providing the person with schizophrenia a springboard of confidence and readiness to take the next discontinuous step towards their eventual recovery. This springboard should be provided from the onset of the illness via a pool of humane person-friendly multi-modal interventions, in recognition that schizophrenia is a condition of multi-factorial aetiology, requiring human engagement, and if possible, inspiration.

Relevance to service development

This is not just a statement of values – such care comes at a price: services should provide evidence based psychosocial interventions, which are

TABLE 1. Good practice issues for early intervention services in which context all technical or practical interventions should be offered

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- The principles of recovery-based practice are consistent whether applied to early or later phases of psychosis – and commence from the very first service experience.
 - There is no service-user for whom a next constructive step is not possible, given support and decent living conditions.
 - The term 'Maintenance Stream' should be discarded, as it implies settling for or striving to maintain a person at a possibly slightly improved but still impaired level of function. Historically this may have been seen as an advance on considering rehabilitation effort completely futile, where someone had been judged incapable of improvement. However, in a recovery context, this implies a mindset of resignation and low expectation in which the best that can be offered is to 'maintain' a holding pattern for the rest of someone's life.
 - The importance of offering hope for recovery is understood by Health professionals and conveyed through their language/therapeutic optimism, using structured approaches based on collaborative care rather than a chronic disease model³⁰
 - A 'strengths' orientation, valuing this particular person should be emphasized in both assessment, intervention and outcome measurement, rather than the traditional focus on symptomatic and functioning impairments and their reduction.
 - The service-user's future need not be a life sentence of dreary chronicity or worse, a dead-end – it is *their* future and it is in *their* hands. They are *not* their psychiatric diagnosis or case history.³¹
 - 'Medication review' should give way to regular 'collaborative review' of both psychiatric and physical wellbeing, which holistically covers all relevant bio-psycho-socio-cultural factors.
 - The term 'Chronicity' should be discarded along with the self-fulfilling prophecy embedded in the language and practices of 'chronicity'. Literally meaning 'in time', many service-users in traditional services are lost outside time, culturally in limbo³² in a state of 'dyschronicity' or 'achronicity'.³³ The mindset of chronicity creates ghettos of disability (whether in an institution or the community) or being otherwise marginalized.
 - Therapeutic interventions that improve subjective quality of life and daily functioning should trump those offering merely symptom relief. *Being with* the person is at least as important as *doing with*, which in turn is much more productive than *doing to*.
 - An ethical, respectful and trustworthy therapeutic relationship is a crucial clinical tool.
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oriented to recovery and deliver therapeutic optimism and hope-instilling psychotherapy. They are undoubtedly part of the core package to ensure more acceptable outcomes and must be funded to do so. Arguably, some elements of this springboard should be offered even during the prodromal and early recovery phases of first episode psychosis.

In the UK, David was able to translate Mary's clinical narrative into dissatisfaction with a 'one size fits all' service-led approach that challenged and ultimately influenced a more person-centred

TABLE 2. Recovery paradigm

- Commences from the very first contact with services.
- Ultimately aspires to healing and recovery.
- Offers a common language concept reflecting perceptions of service-users and their families, rather than that defined by clinicians.
- *'The journey is as important as the destination'*: recovery can be partial and a lifelong trajectory rather than complete and an arrival at a terminus.
- Entails having someone special to you who believes in you (not necessarily a service provider), healing at your own pace, and regaining the universal right and potential to develop and grow throughout life.³⁴
- Means receiving encouragement and sufficient support to retain/regain full citizenship.³⁵

service, sensitive to age and phase of illness. Grouping with some early adopters of EI, David encouraged a radical policy platform within an emerging National Service Framework for Mental Health³⁶ and notably in advance of a robust research-based argument. A 3-year EI service package³⁷ was supported by a national development programme (2004 onwards) jointly lead by David and Dr Jo Smith (Clinical Lead for Worcestershire Mental Health Partnership Trust), providing an authentic alliance of carer and clinical perspectives. The programme anticipates full national coverage by 2010.

Fourteen years on from Ann and David's first local complaint about Mary's care, we can recognize remarkable change. EI in Psychosis, from being an unheard term, has now become part of the everyday language of local service discussions. Perhaps Professor Appleby best sums up the achievements of EI teams and their practitioners in the UK:

'I have seen how much progress early intervention teams have made, how innovative they have been, and the impact they are having. I now believe that early intervention will be the most important and far reaching reform of the NSF³⁷ era. Crisis resolution has had the most immediate effect but I think early intervention will have the greatest effect on people's lives' (Professor Louis Appleby, National Director for Mental Health October 10th 2008 Policies and Practice for Europe (Dept Health/WHO Europe conference attended by 35 European Countries)).

However, it is vital to avoid complacency. Early reductions in suicide rates in the initial 3 years of an EI service can be lost by a rebound in the immediate period afterwards,³⁸ a reminder of how fragile the gains from EI can be and the importance of considering what happens all the way to the rehabilitation and recovery phases. Moreover, these young people

TABLE 3. Service example – the 'recovery phase subteam'

A 'Recovery Phase Subteam' operated in Alan's service in the North Shore of Sydney. Entitled Prevention and Community Care Team and using an assertive community treatment approach,^{41–43} this team worked with people up to the age of 35 or so, who had completed 2 or 3 years in the EI programme, but who still had persistent problems. Housed together in a community setting with the EI team, PACCT also provided access and daily support at supervised residential respite and ongoing tenure households. This subteam operated successfully for 10 years until it was administratively merged with other existing services. Early Psychosis Prevention and Intervention Centre, the pioneering EI service in North-West Melbourne, now part of Orygen, also developed a similar recovery subteam.

are not just at high risk of death from suicide. Ultimately a greater number will die from physical disorders, often cardiovascular and the result of smoking, obesity, lack of exercise and diabetes. Many of these risks have their origins in the first few years of treatment³⁹ and require a wholistic public health approach that promotes wellbeing, alongside the provision of general physical health and mental health assessment and review, for example, the Headspace model⁴⁰ as a rare example of such an approach. Remarkably, little evidence exists of systematic approaches to address these physical issues.

Is the current EI service provision for 1.5–3 years sufficient?

The current EI service model is geared to clients making full, or substantial and fairly uneventful recovery to a point where ongoing support by Primary Care, either alone or in collaboration with low-key community mental health team support is sufficient. However many of these young people will remain needy, vulnerable and with persistent symptoms/distress beyond the current tenure of a typical EI service model (internationally between 1.5–3 years). The authors believe for those clients there is currently a gap in provision that could be met by a recovery-focused service model with a low ratio staff/client + family (e.g. 1:10 maximum) aiming to deliver higher functioning and less crisis dependency (see Table 3 for service example). An essential component of this model would be a dedicated community-based 24 hours supervised residential respite and variably supervised ongoing residential support facilities. Such a community-based and intensive service model may be cost-effective, as EI has already demonstrated.⁴⁴

The current high profile of EI has helped reignite interest in the therapeutic strengths within home,

families and communities. However, from our national perspectives, we are aware that other parts of the service can perceive EI teams as elitist. EI teams must respond positively by being both good service neighbours whilst at the same time becoming ambassadors for continuing this approach for however long it takes, creating ripples into the sometimes still waters of systems of care further down the care pathway (for instance by promoting psychosocial interventions, family work, drug treatments) 'we have something we can bring to this – we are happy to share'.

Maybe we need a series of pools, each drawing on a renewed wellspring of hope for different phases, and each with their own sequential springboard of therapeutic optimism and creative inspiration. Just as 'engagement' is not solely an intervention applied at the beginning of the therapeutic encounter, but must keep being renewed throughout the therapeutic enterprise for each individual and family, so it is with hope-instilling and therapeutic optimism. The principles and practices of EI, with interventions directed towards more individually focused and hopeful ways of working and towards as complete a recovery as possible over whatever time it takes, should set ripples flowing out to all phases of care, and for mental health teams for all age groups and in all sub-specialties of psychiatry.

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