



Past, present and future of Early Psychosis Services in UK".

Max Birchwood

What is early intervention?

- Early detection and intervention in emerging psychosis ('Ultra high risk')
- Reducing treatment delay at the first episode (DUP)
- Intensive intervention during the first 3 years ('critical period' intervention), usually with specialised teams

Early intervention is crucial to improving outcomes. The Commission's view is that Early Intervention in Psychosis (EIP) has been **the most positive development in mental health services** since the beginning of community care.

We recommend that all Clinical Commissioning Groups commission Early Intervention in Psychosis services with sufficient resources to provide fidelity to the service model. It is crucial that the NHS Commissioning Board holds local commissioners to account for this and we recommend that early intervention services are included in the NHS Commissioning Outcomes Framework.

"We can be really proud of our early intervention services which are popular and have been shown to work. Now we need to build on that success by extending the approach to cover the whole service."

Liz Meek, Member of the Commission

THE ABANDONED ILLNESS

A report by the Schizophrenia Commission



November 2012

Where did it all start?

Care for FEP ca. 1990..

- Low engagement of YP in services & treatment (and poor early outcome)
- Long treatment delay (DUP 1-2 years)
- High use of coercion at entry to services
- 'CAMHS don't do psychosis and AMHS don't do young people'
- High suicide rate in first 3 years

NICE Guidelines for schizophrenia(2009/2014)

“Despite the fact that CMHTs remain the mainstay of community mental health care, there is surprisingly little evidence to show that they are an effective way of organizing services. As such, evidence for the effectiveness of CMHTs in the management of schizophrenia is insufficient to make any evidence-based recommendations” (P261)



Lost Generation

Why young people with psychosis are being left behind, and what needs to change.

Early intervention:
an international paradigm change
in the management of psychosis



28-29 June 1996

The First International Conference
on Strategies for
Prevention in Early Psychosis

Verging on Reality

Hyatt Hotel,
Melbourne, Australia

Hosted by
Eppic

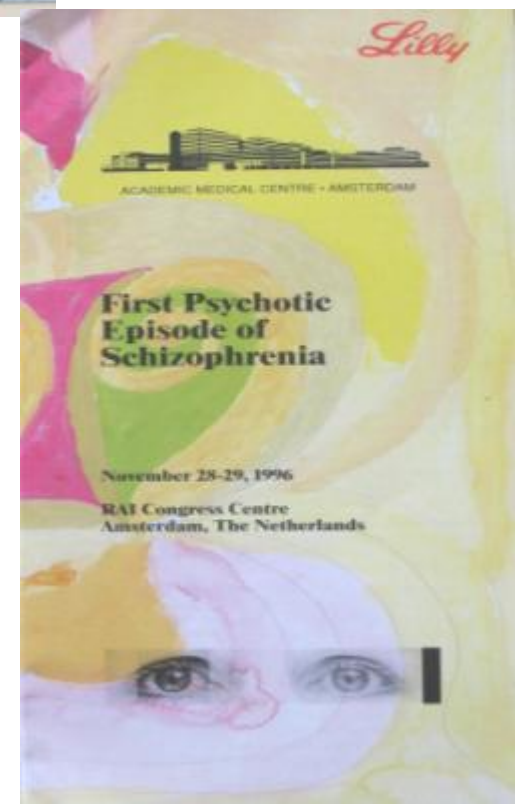


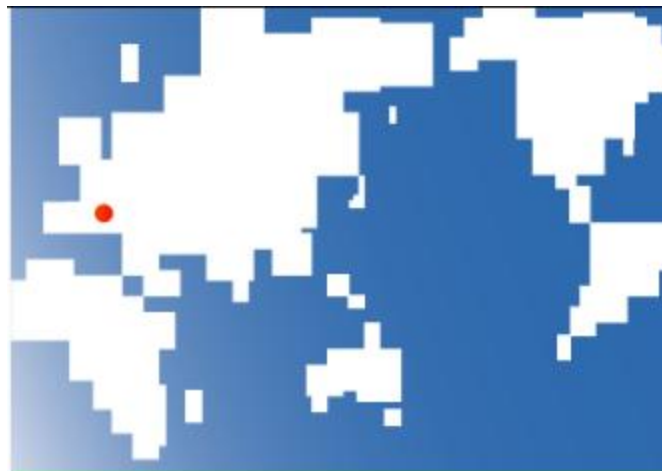
First UK International Conference on EARLY INTERVENTION IN PSYCHOSIS



Stratford-upon-Avon, England

2nd and 3rd June 1997
(CPD Validation applied for)





10th International Conference
On Early Psychosis

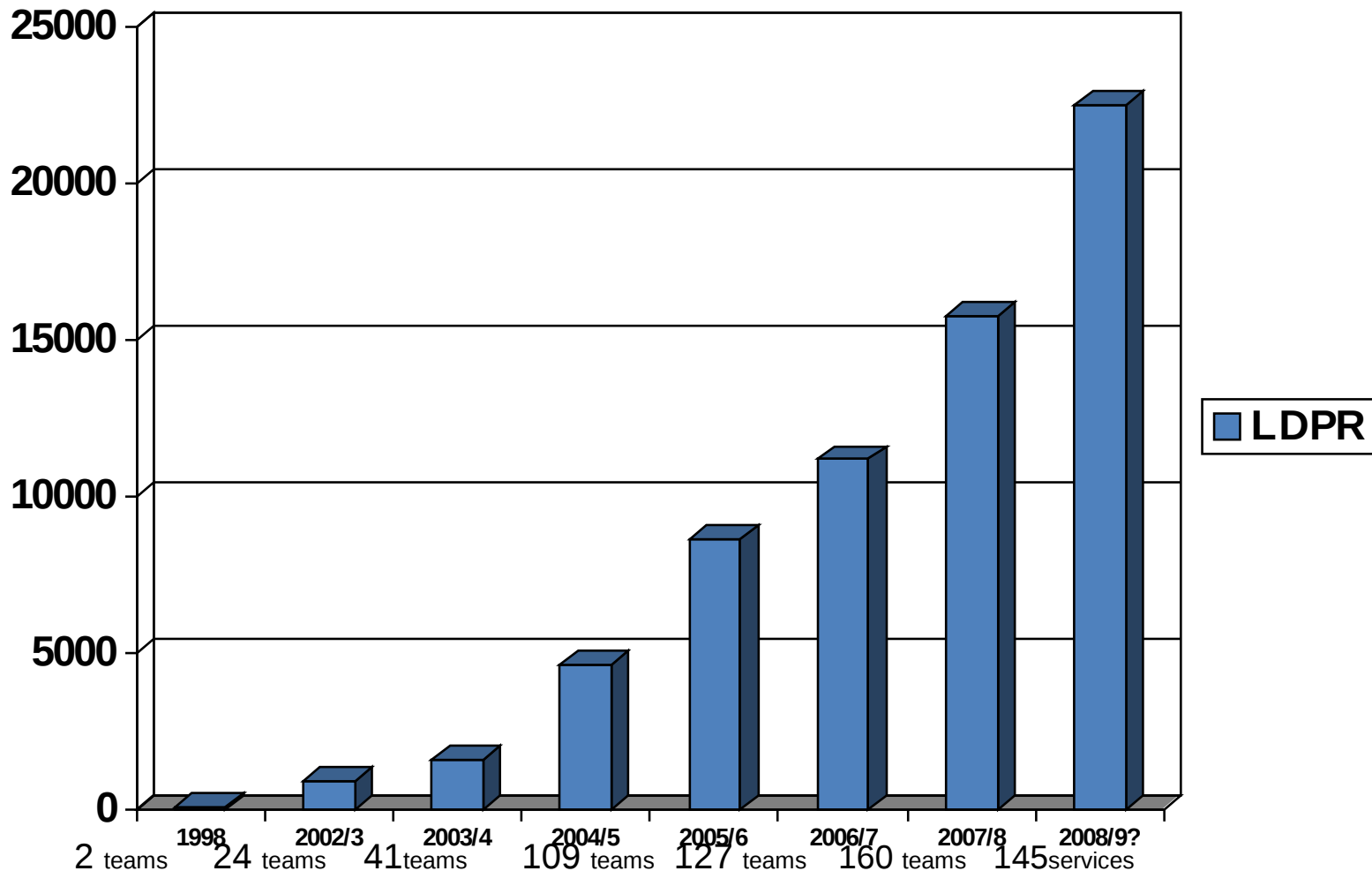
LOOKING BACK
MOVING FORWARD

20th – 22nd October 2016
Milan Marriott Hotel
ITALY



EI provision across England

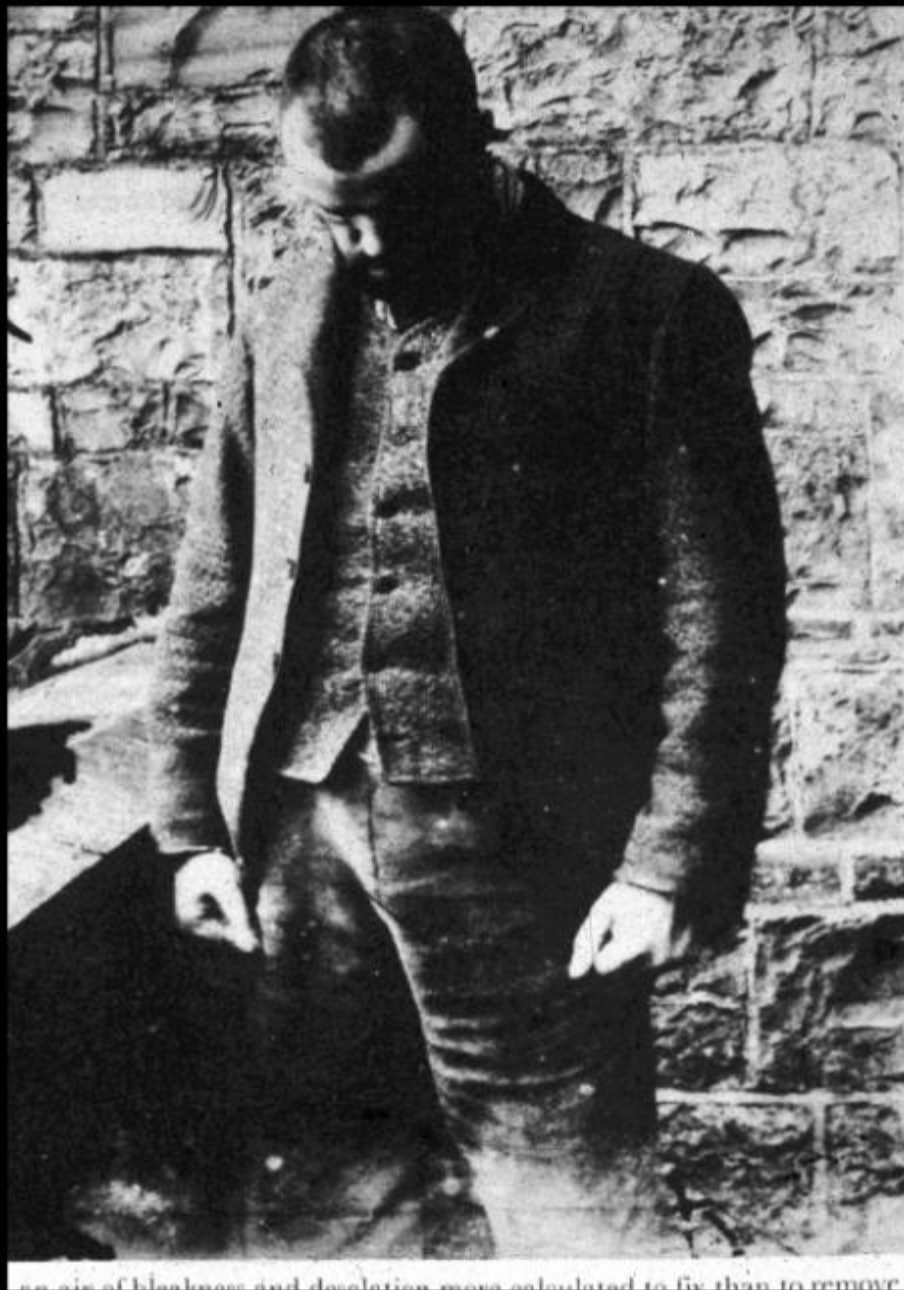
(15,750 cases at end of March 08)



Key questions

- Does the introduction of EIS reduce DUP; how do we meet the 2 week standard?
- Are EIS acceptable to young people; what don't they find acceptable?
- EIS non-responders? Severe social disability.
- Relapse prevention: use of ambulatory digital tech
- How can we maintain gains, post-EIS?
- Improving health and longevity

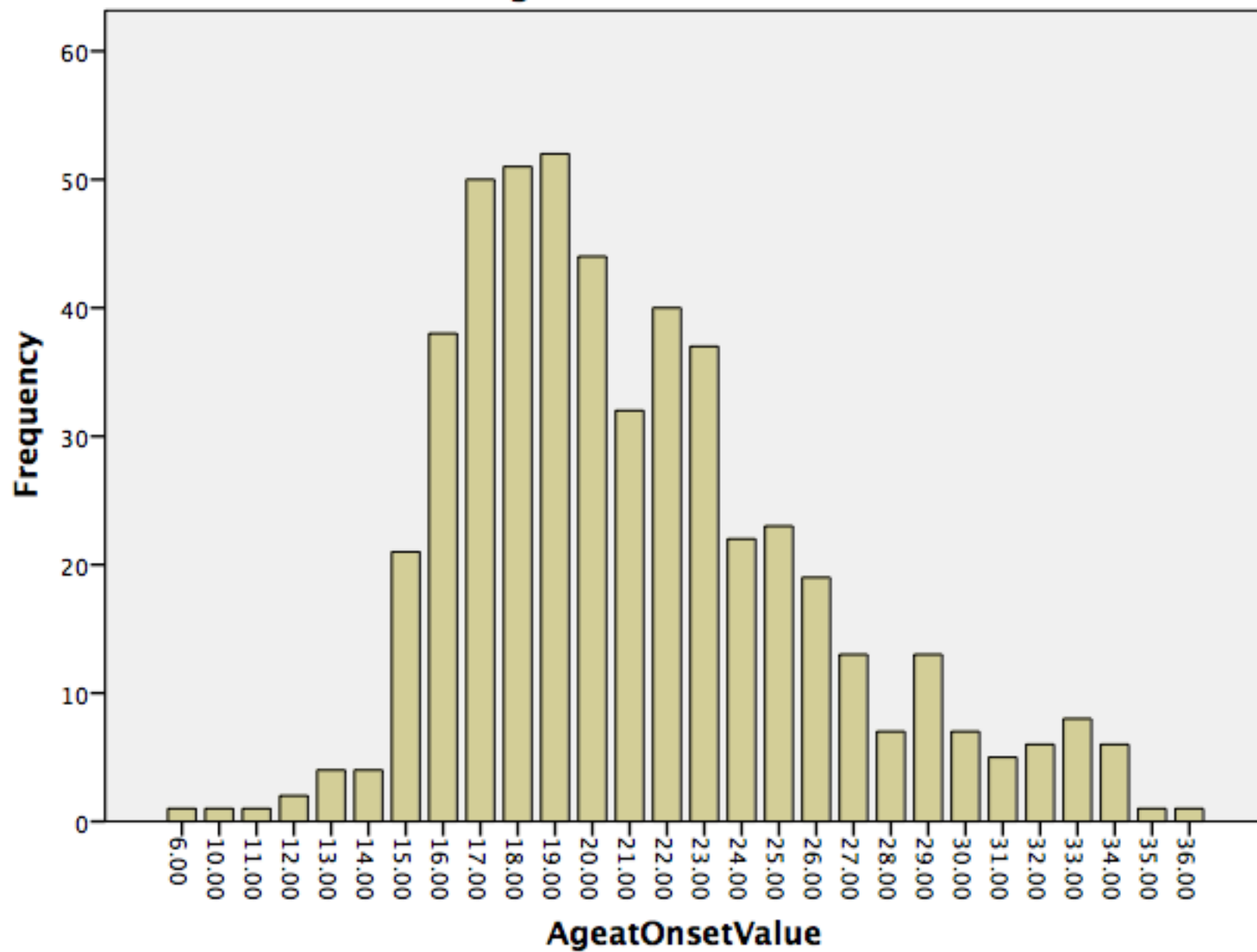
The psychoses



... of idealism and desolation seems calculated to fix than to remove

“An air of desolation more calculated to fix than to remove”

AgeatOnsetValue



“Mental disorders are the chronic diseases of the young”

Insel TR, Fenton WS. Psychiatric epidemiology: it's not just about counting anymore. Arch Gen Psychiatry. 2005; 62(6): 590-2.

THE CRITICAL PERIOD

“Early phase of psychosis is a stormy one ,plateauing thereafter”

- Early trajectories predict long term trajectories
- The *plateau effect*: ceiling of disability/symptoms early in manifest course (Bleuler)
- Adolescent social functioning best predictor of early phase social functioning

From :Birchwood,M and Macmillan,JF (1993) Early intervention in schizophrenia
Australia & New Zealand Journal of Psychiatry 27 374-8

Recovery from psychotic illness: a 15- and 25-year international follow-up study

G. HARRISON, K. HOPPER, T. CRAIG, E. LASKA, C. SIEGEL, J. WANDERLING,
K. C. DUBE, K. GANEV, R. GIEL, W. AN DER HEIDEN, S. K. HOLMBERG,
A. JANCA, P. W. H. LEE, C. A. LEÓN, S. MALHOTRA, A. J. MARSELLA,
Y. NAKANE, N. SARTORIUS, Y. SHEN, C. SKODA, R. THARA, S. J. TSIRKIN,
V. K. VARMA, D. WALSH and D. WIERMSMA

“The predictive strength of early pattern of course and socio-cultural setting support the case for early intervention strategies with social and drug interventions” (p516)

Road to full recovery: longitudinal relationship between symptomatic remission and psychosocial recovery in first-episode psychosis over 7.5 years

M. Álvarez-Jiménez^{1,2*}, J. F. Gleeson^{2,3}, L. P. Henry^{1,2}, S. M. Harrigan^{1,2}, M. G. Harris⁴, E. Killackey^{1,2}, S. Bendall^{1,2}, G. P. Amminger^{1,2,5}, A. R. Yung^{1,2}, H. Herrman^{1,2}, H. J. Jackson⁶ and P. D. McGorry^{1,2}

Background. In recent years there has been increasing interest in functional recovery in the early phase of schizophrenia. Concurrently, new remission criteria have been proposed and several studies have examined their clinical relevance for prediction of functional outcome in first-episode psychosis (FEP). However, the longitudinal interrelationship between full functional recovery (FFR) and symptom remission has not yet been investigated. This study sought to: (1) examine the relationships between FFR and symptom remission in FEP over 7.5 years; (2) test two different models of the interaction between both variables.

Method. Altogether, 209 FEP patients treated at a specialized early psychosis service were assessed at baseline, 8 months, 14 months and 7.5 years to determine their remission of positive and negative symptoms and functional recovery. Multivariate logistic regression and path analysis were employed to test the hypothesized relationships between symptom remission and FFR.

Results. Remission of both positive and negative symptoms at 8-month follow-up predicted functional recovery at 14-month follow-up, but had limited value for the prediction of FFR at 7.5 years. Functional recovery at 14-month follow-up significantly predicted both FFR and remission of negative symptoms at 7.5 years, irrespective of whether remission criteria were simultaneously met. The association remained significant after controlling for baseline prognostic indicators.

Conclusions. These findings provided support for the hypothesis that early functional and vocational recovery plays a pivotal role in preventing the development of chronic negative symptoms and disability. This underlines the need for interventions that specifically address early psychosocial recovery.

The Lifetime Risk of Suicide in Schizophrenia

A Reexamination

Brian A. Palmer, MD, MS, MPH; V. Shane Pankratz, PhD; John Michael Bostwick, MD

Background: The psychiatry literature routinely quotes a lifetime schizophrenia suicide prevalence of 10% based on 1 meta-analysis and 2 studies of chronic schizophrenics.

Objectives: To build a methodology for extrapolating lifetime suicide prevalence estimates from published cohorts and to apply this approach to studies that meet inclusion criteria.

Data Sources: We began with a MEDLINE search (1966-present) for articles that observed cohorts of schizophrenic patients. Exhaustive bibliography searching of each identified article brought the total number of articles reviewed to 632.

Study Selection: Studies included in the meta-analysis observed a cohort of schizophrenic patients for at least 2 years, with at least 90% follow-up, and reported suicides. Articles are excluded for systematic age bias (ie, adolescents).

Data Extraction: Extracted data included sample size, number of deaths, number of suicides, percentage of follow-up, and diagnostic system used. Data were ex-

tracted independently by 2 of us, and differences were resolved by consensus after re-review.

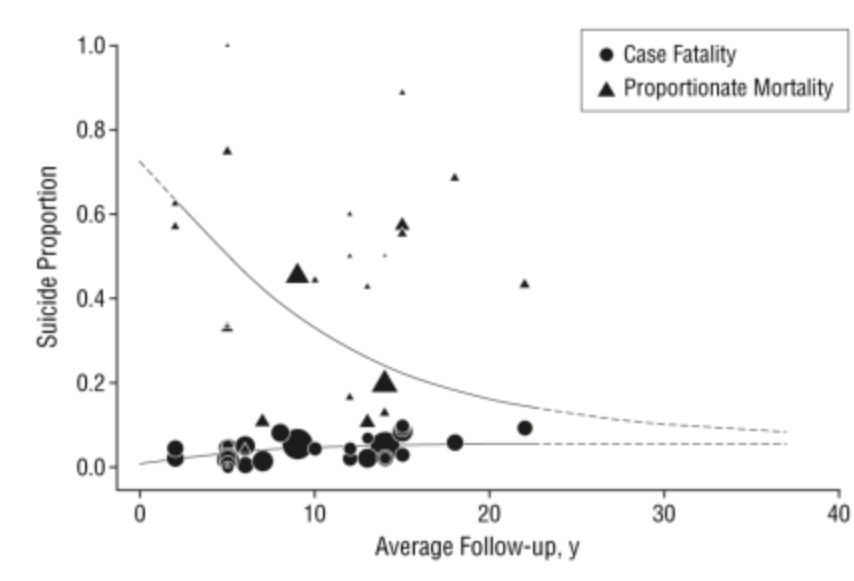
Data Synthesis: Studies were divided into 2 groups: 32 studies of schizophrenics enrolled at various illness points (25 578 subjects) and 29 studies of schizophrenics identified at either illness onset or first admission (22 598 subjects). Regression models of the intersection of proportionate mortality (the percentage of the dead who died by suicide) and case fatality (the percentage of the total sample who died by suicide) were used to calculate suicide risk in each group. The estimate of lifetime suicide prevalence in those observed from first admission or illness onset was 5.6% (95% confidence interval, 3.7%-8.5%). Mixed samples showed a rate of 1.8% (95% confidence interval, 1.4%-2.3%). Case fatality rates showed no significant differences when studies of patients diagnosed with the use of newer systems were compared with studies of patients diagnosed under older criteria.

Conclusion: This study estimates that 4.9% of schizophrenics will commit suicide during their lifetimes, usually near illness onset.

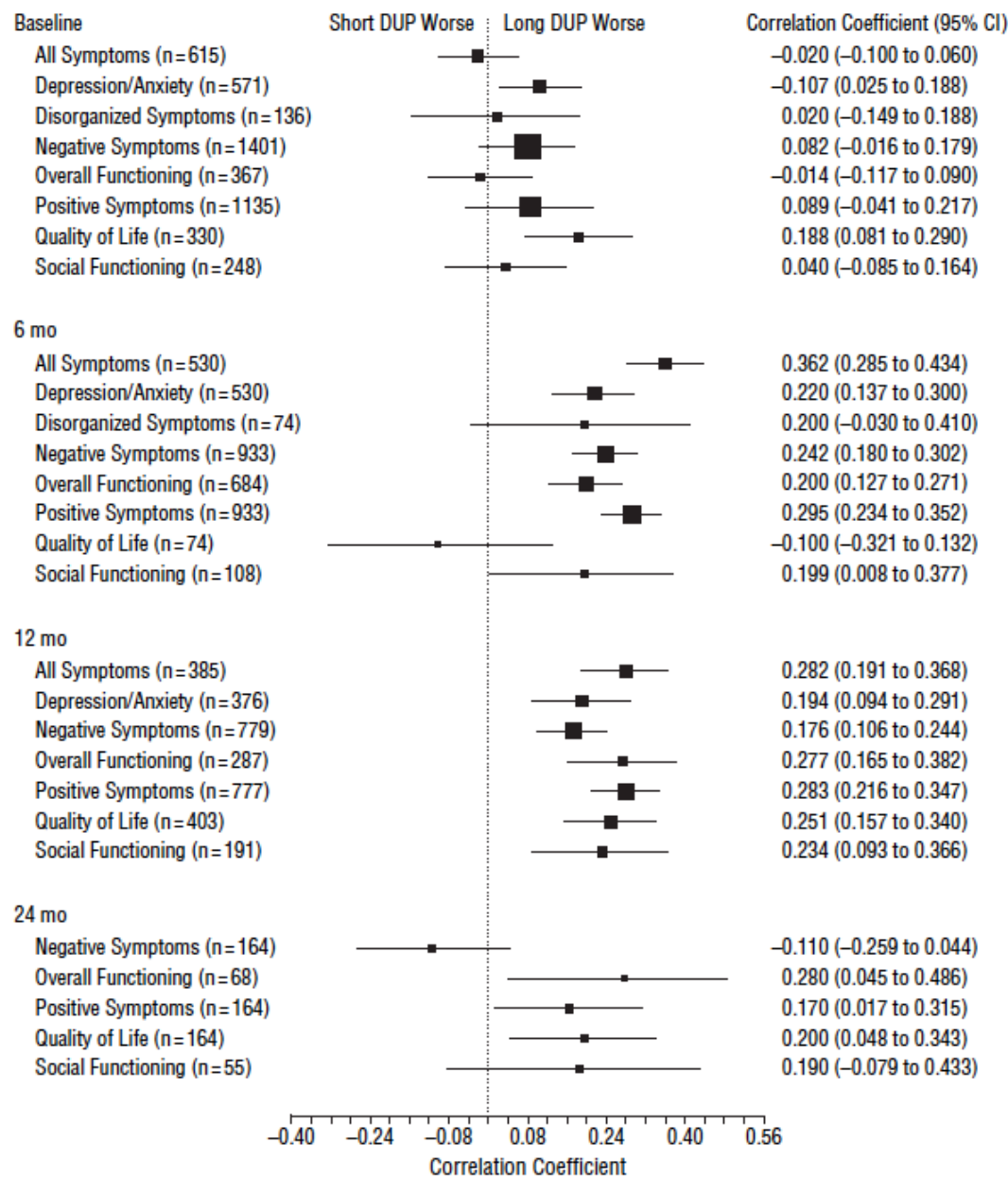
Arch Gen Psychiatry. 2005;62:247-253

From: **The Lifetime Risk of Suicide in Schizophrenia: A Reexamination**

Arch Gen Psychiatry. 2005;62(3):247-253. doi:10.1001/archpsyc.62.3.247



Duration of Untreated Psychosis



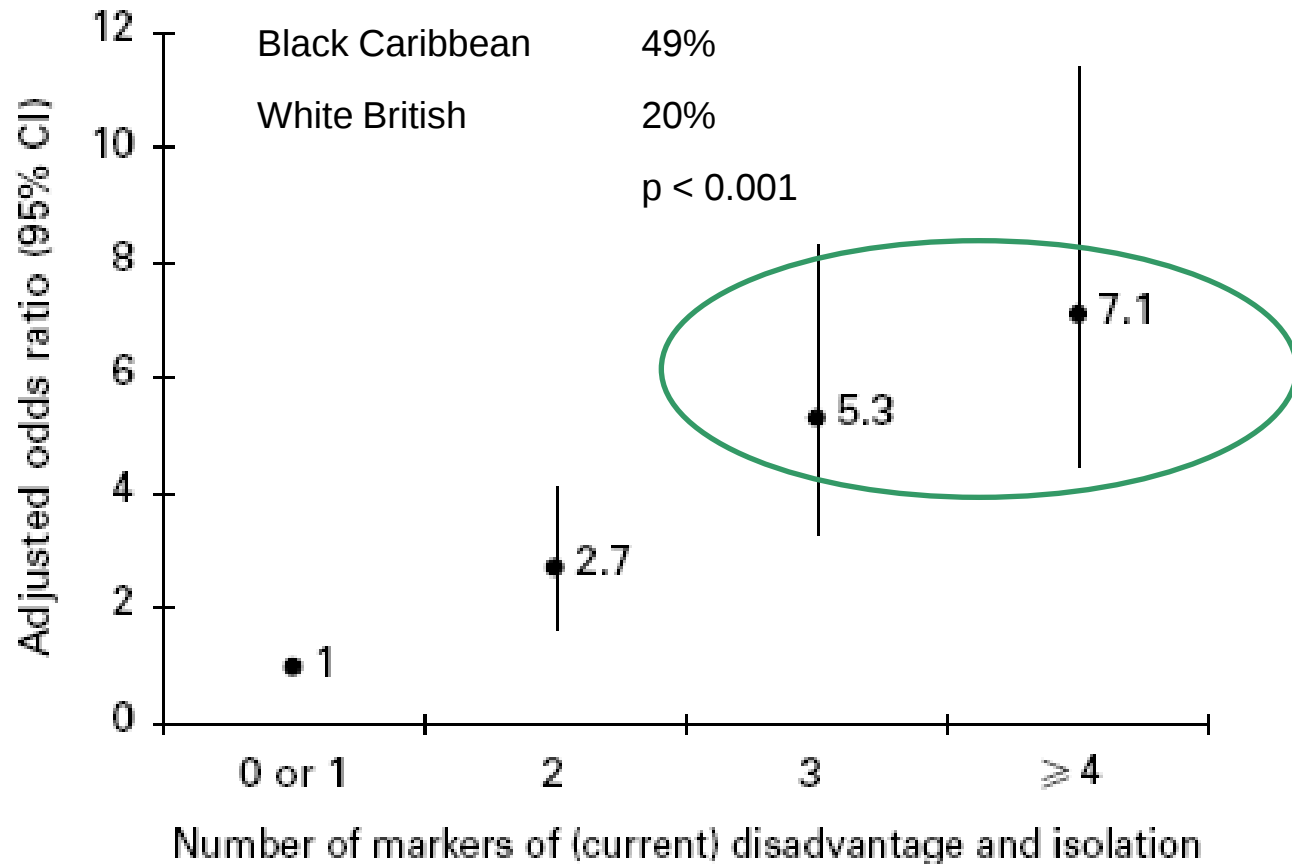
Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients

A Systematic Review

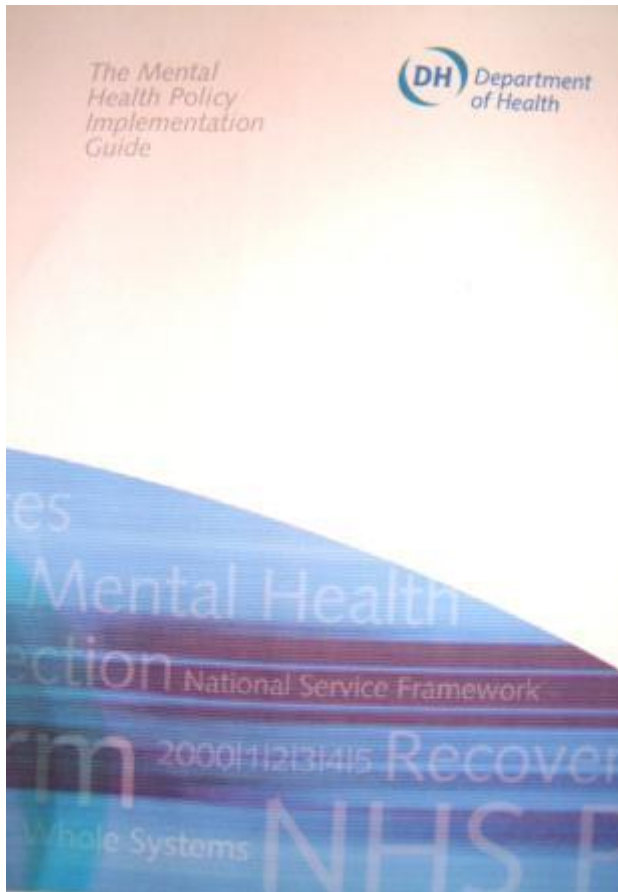
Max Marshall, MD; Shon Lewis, MD; Austin Lockwood, RMN;
Richard Drake, PhD; Peter Jones, PhD; Tim Croudace, PhD

Figure 1. Summary correlations between duration of untreated psychosis (DUP) and outcomes by follow-up point. CI indicates confidence interval. The squares are roughly proportioned to the amount of data available.

Indicators of adversity in early adulthood and risk of psychosis late adulthood



Sustaining engagement and intervention through the 'Critical Period' with specialised teams



EIS model was a 'best guess' in 2001.

Progenitor service, 1994- : Birmingham.

- Adapted ACT model
- 1:15 case ratio
- 3 years
- Emphasis on psychosocial + vocation interventions
- Engagement in low stigma channels
- Youth sensitive and youth co-designed



PSYCHOSIS AND SCHIZOPHRENIA IN ADULTS

THE NICE GUIDELINE ON TREATMENT AND MANAGEMENT

UPDATED EDITION 2014

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

14.3 FIRST EPISODE PSYCHOSIS

14.3.1 Early intervention in psychosis services

14.3.1.1 Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. [new 2014]

14.3.1.2 People presenting to early intervention in psychosis services should be assessed without delay. If the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self- or carer-referral. [new 2014]

14.3.1.3 Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline. [2014]

14.3.1.4 Consider extending the availability of early intervention in psychosis services beyond 3 years if the person has not made a stable recovery from psychosis or schizophrenia. [new 2014]

Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program

John M. Kane, M.D., Delbert G. Robinson, M.D., Nina R. Schooler, Ph.D., Kim T. Mueser, Ph.D., David L. Penn, Ph.D., Robert A. Rosenheck, M.D., Jean Addington, Ph.D., Mary F. Brunette, M.D., Christoph U. Correll, M.D., Sue E. Estroff, Ph.D., Patricia Marcy, B.S.N., James Robinson, M.Ed., Piper S. Meyer-Kalos, Ph.D., L.P., Jennifer D. Gottlieb, Ph.D., Shirley M. Glynn, Ph.D., David W. Lynde, M.S.W., Ronny Pipes, M.A., L.P.C.-S., Benji T. Kurian, M.D., M.P.H., Alexander L. Miller, M.D., Susan T. Azrin, Ph.D., Amy B. Goldstein, Ph.D., Joanne B. Severe, M.S., Haiqun Lin, M.D., Ph.D., Kyaw J. Sint, M.P.H., Majnu John, Ph.D., Robert K. Heinssen, Ph.D., A.B.P.P.

Objective: The primary aim of this study was to compare the impact of NAVIGATE, a comprehensive, multidisciplinary, team-based treatment approach for first-episode psychosis designed for implementation in the U.S. health care system, with community care on quality of life.

Method: Thirty-four clinics in 21 states were randomly assigned to NAVIGATE or community care. Diagnosis, duration of untreated psychosis, and clinical outcomes were assessed via live, two-way video by remote, centralized raters masked to study design and treatment. Participants (mean age, 23) with schizophrenia and related disorders and ≤ 6 months of antipsychotic treatment ($N=404$) were enrolled and followed for ≥ 2 years. The primary outcome was the total score of the Heinrichs-Carpenter Quality of Life Scale, a measure that includes sense of purpose, motivation, emotional and social interactions, role functioning, and engagement in regular activities.

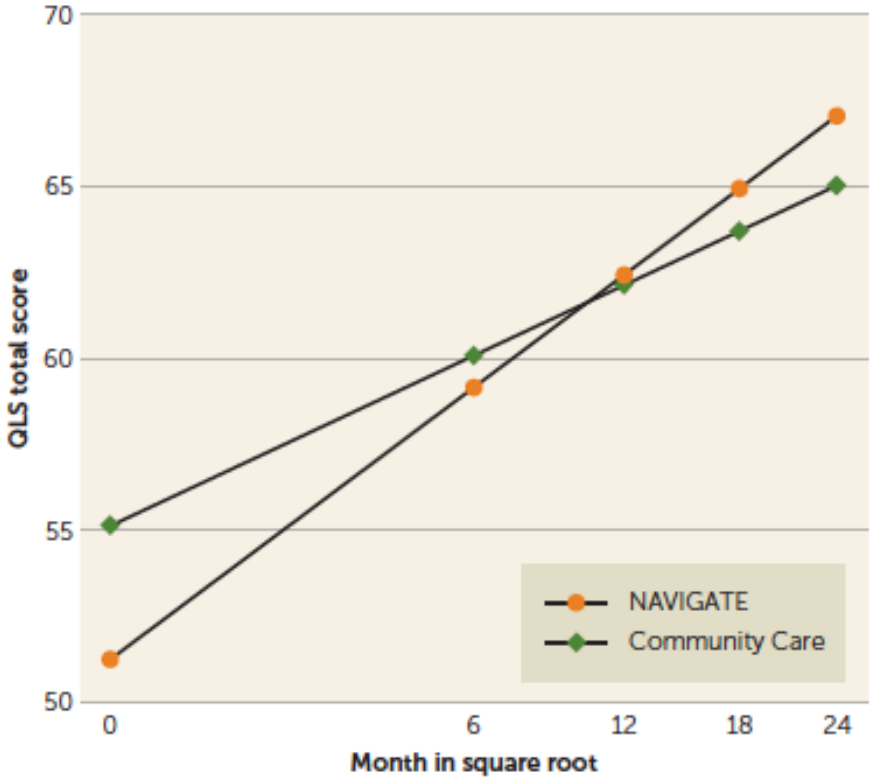
Results: The 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life and psychopathology, and experienced greater involvement in work and school compared with 181 participants in community care. The median duration of untreated psychosis was 74 weeks. NAVIGATE participants with duration of untreated psychosis of < 74 weeks had greater improvement in quality of life and psychopathology compared with those with longer duration of untreated psychosis and those in community care. Rates of hospitalization were relatively low compared with other first-episode psychosis clinical trials and did not differ between groups.

Conclusions: Comprehensive care for first-episode psychosis can be implemented in U.S. community clinics and improves functional and clinical outcomes. Effects are more pronounced for those with shorter duration of untreated psychosis.

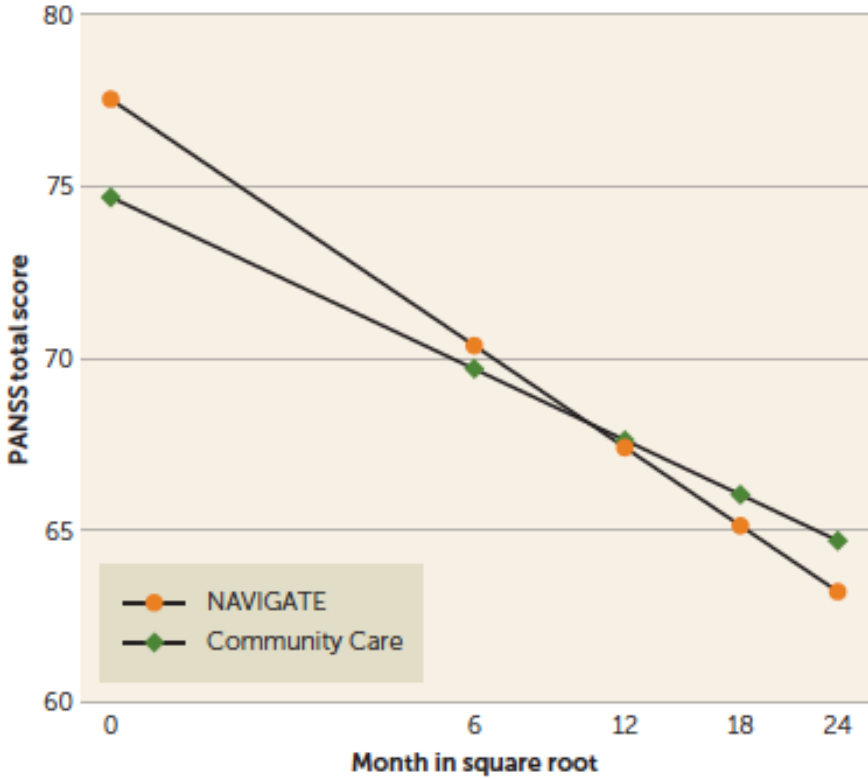
Am J Psychiatry 2016; 173:362–372; doi: 10.1176/appi.ajp.2015.15050632

FIGURE 2. Model-Based Estimates of Heinrichs-Carpenter Quality of Life (QLS) Total Score and PANSS Total Score^a

A. QLS total score^b



B. PANSS total score^c



^a PANSS=Positive and Negative Syndrome Scale.
^b Treatment by square root of time interaction, p=0.015.
^c Treatment by square root of time interaction, p=0.016.

NICE Guidelines for schizophrenia(2009/2014)

“Despite the fact that CMHTs remain the mainstay of community mental health care, there is surprisingly little evidence to show that they are an effective way of organizing services. As such, evidence for the effectiveness of CMHTs in the management of schizophrenia is insufficient to make any evidence-based recommendations” (P261)

Table 2 Contact with mental health services and uptake of treatment over 18 months for patients receiving care for early psychosis. Values are numbers (percentages) of patients unless stated otherwise

Variable	Specialised care group (n=71)	Standard care group (n=73)	Odds ratio (95% CI)
In contact with index team	54 (76)	43 (59)	2.4 (1.2 to 4.9)
In contact with any mental health service	60 (85)	46 (63)	2.9 (1.2 to 6.7)
Psychosocial treatment:			
Psychological interventions	39 (55)	20 (27)	3.2 (1.6 to 6.5)
Family interventions	40 (56)	17 (33)	4.3 (2.1 to 8.7)
Vocational interventions	36 (51)	17 (23)	3.4 (1.6 to 6.9)



NIHR SUPEREDEN programme grant

Sustaining Positive Engagement and Recovery

The next step after Early Intervention for Psychosis

Lead: Birmingham and Solihull Mental Health Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust EIS

Cheshire and Wirral Partnership NHS Trust EIS

Lancashire NHS Partnership Trust EIS

Norfolk & Waveney Mental Health Partnership Trust EIS

Devon and Cornwall Partnership Trust EIS

University of Birmingham

University of Bristol

University of Cambridge

University of East Anglia

University of Manchester

University of Warwick

King's College London



NHS
**National Institute for
Health Research**

The National/SUPER EDEN sites

Lancashire + Wirral
5 teams
(Marshall/Lewis/Sharma)



Birmingham
5 teams
(Birchwood/Lester)



East Anglia
4 teams
(Jones/Fowler)



Cornwall 2 teams
(Amos/Harrison)



Cost-effectiveness of an early intervention service for people with psychosis[†]

Paul McCrone, Tom K. J. Craig, Paddy Power and Philippa A. Garety

Background

There is concern that delaying treatment for psychosis may have a negative impact on its long-term course. A number of countries have developed early intervention teams but there is limited evidence regarding their cost-effectiveness.

Aims

To compare the costs and cost-effectiveness of an early intervention service in London with standard care.

Method

Individuals in their first episode of psychosis (or those who had previously discontinued treatment) were recruited to the study. Clinical variables and costs were measured at baseline and then at 6- and 18-month follow-up. Information on quality of life and vocational outcomes were combined with costs to assess cost-effectiveness.

Results

A total of 144 people were randomised. Mean costs were £11 685 in the early intervention group compared with the standard care group, with the difference being non-significant (95% CI -£8128 to £30 500). When combined with improved vocational outcomes it was shown that early intervention had a very high likelihood of being cost-effective.

Conclusions

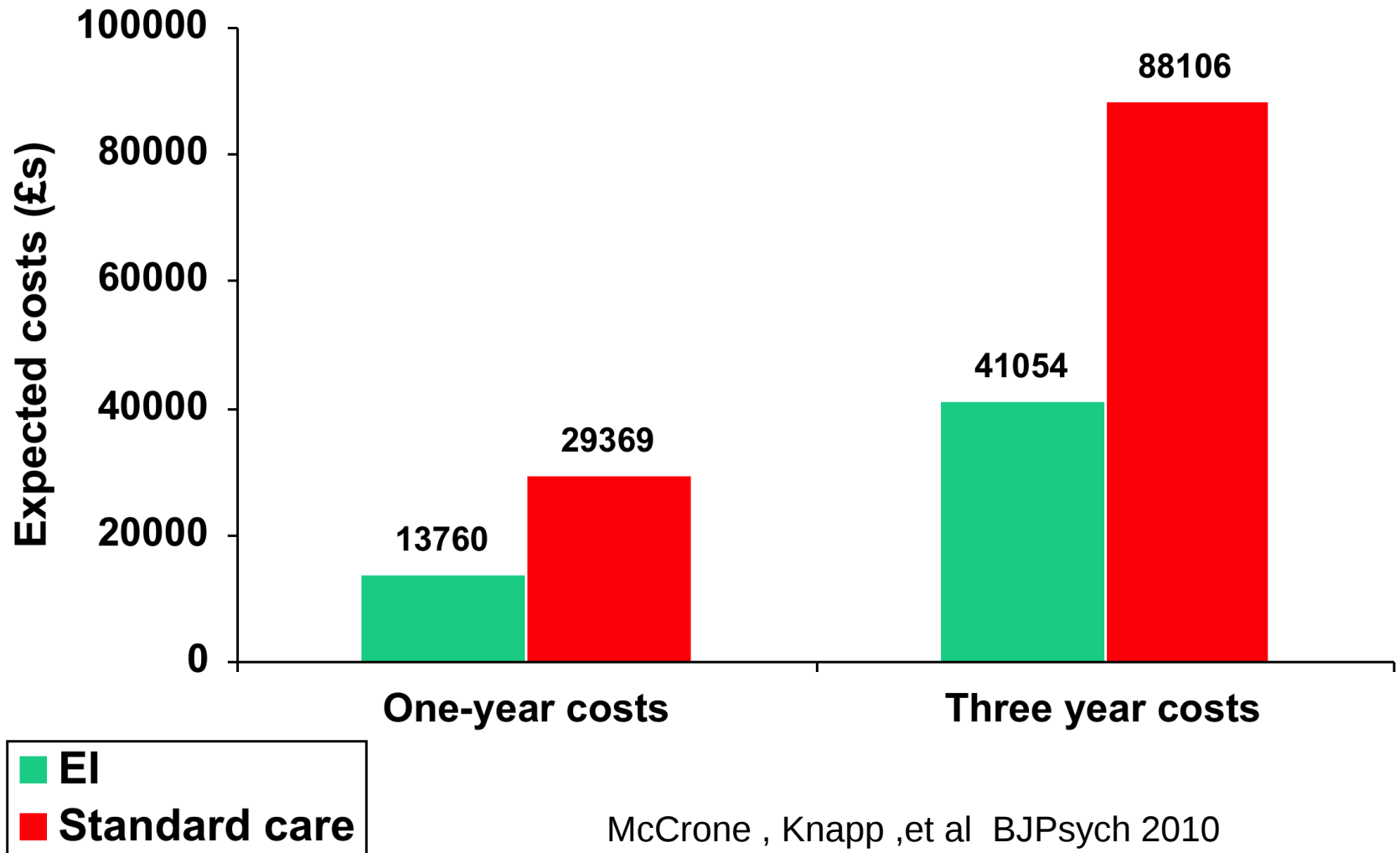
Early intervention did not increase costs and was highly likely to be cost-effective when compared with standard care.

Declaration of interest

None.

Early intervention did not increase costs and was highly likely to be cost-effective when compared with standard care.

Cost Economic Data: EI vs Standard CMHT Care



Do EIS meet with uniform
user/carer approval?

Mostly, but many users find the
assertive outreach aspect outlives its
usefulness and intrusive...

Development and implementation of early intervention services for young people with psychosis: case study

Helen Lester, Max Birchwood, Stirling Bryan, Elizabeth England, Helen Marshall, and Namita Sirvastava

Background

The development of early intervention services for young people with first-episode psychosis is a priority internationally.

Aims

To evaluate the development, implementation and impact of existing and newly formed early intervention services in England.

Method

Multiple-case study involving staff, users, carers and commissioners of 14 early intervention services.

service users 12 months after service introduction. It was valued by users and staff that contrasted with the targets linked to funding of survival strategies.

Conclusions

Early intervention services can engage users and implement strategies.

Research

Helen Lester, Nagina Khan, Peter Jones, Max Marshall, David Fowler, Tim Amos and Max Birchwood

Service users' views of moving on from early intervention services for psychosis: a longitudinal qualitative study in primary care

Views of Young People in Early Intervention Services for First-Episode Psychosis in England

Helen Lester, M.B.B.Ch., M.D.
Max Marshall, M.B.B.S., M.D.
Peter Jones, M.B.B.S., Ph.D.
David Fowler, Ph.D.
Tim Amos, M.B.B.S., M.R.C.Psych.
Nagina Khan, Ph.D.
Max Birchwood, D.Sc.

Objective: This study described the views over time of young people referred to early intervention services (EIS), particularly as they relate to the importance of relationships. **Methods:** A cohort of people aged 14 to 35 enrolled in a large multisite study of EIS for psychosis in the United Kingdom were recruited for a qualitative, longitudinal study in which they were interviewed within six months of admission to EIS and 12 months later. Transcripts of the interviews were analyzed using Charmaz's constructivist grounded-theory methodology. **Results:** A total

Psychosis is a serious and potentially life-changing condition. Although some people make a full recovery, many develop a lifelong illness (1,2).

Early intervention services (EIS) for young people with a first episode of psychosis were introduced into the

INTRODUCTION

Psychosis is a serious and potentially life-changing condition. Although some people make a full recovery, many develop a lifelong illness.¹

Early intervention services for young people with a first episode of psychosis were introduced into the healthcare systems of many countries across Europe, the US, and the UK from the early 1990s. The motivation for this reform included significant and

mandated in guidance or explored through research. The policy implementation guidance suggests that, if stable and well, the service user should be discharged to primary care and that mental health team follow-up should be arranged in all other circumstances. Ideally, transition should be a planned, orderly, and purposeful process of change, taking into account both personal and illness-specific needs.

The role of primary care for young people

it

nd

primary care for young people with and transitions between specialist (th services and primary care, are red areas, both clinically and in rms.

Does the introduction of EI
teams reduce DUP in UK?

YES.

But there's work to do, especially re
care pathways within mental health
services



Contents lists available at [ScienceDirect](#)

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres



Impact of early intervention services on duration of untreated psychosis: Data from the National EDEN prospective cohort study



Max Marshall ^{a,*}, Nusrat Husain ^a, Natalie Bork ^a, Imran B. Chaudhry ^a, Helen Lester ^b, Linda Everard ^b,
Swaran P. Singh ^c, Nick Freemantle ^d, Vimal Sharma ^e, Peter B. Jones ^f, David Fowler ^g, Tim Amos ^h,
Barbara Tomenson ^a, Max Birchwood ^b

^a School of Medicine, University of Manchester, United Kingdom

^b University of Birmingham, Birmingham, United Kingdom

^c Health Sciences Research Institute, University of Warwick, Warwick, United Kingdom

^d Department of Primary Care and Population Health, University College, London, United Kingdom

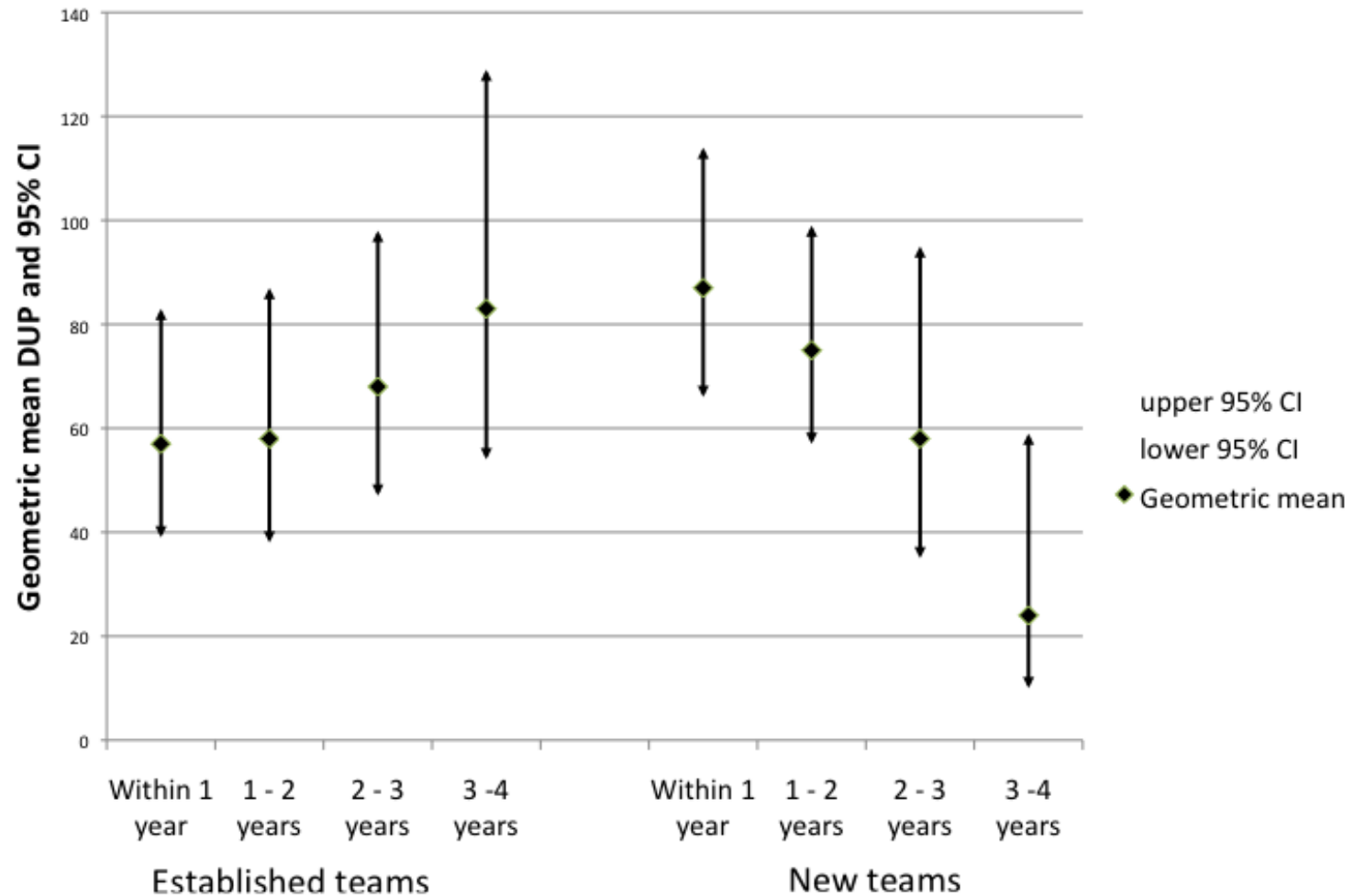
^e University of Cheshire, United Kingdom

^f Department of Psychiatry, University of Cambridge, Cambridge, United Kingdom

^g School of Medicine, University of East Anglia, United Kingdom

^h Academic Unit of Psychiatry, University of Bristol, Bristol, United Kingdom

Figure 1. Geometric mean DUP with 95% confidence interval by time from start date for team for new and established teams separately.



Reducing duration of untreated psychosis: care pathways to early intervention in psychosis services

Max Birchwood, Charlotte Connor, Helen Lester, Paul Patterson, Nick Freemantle, Max Marshall, David Fowler, Shon Lewis, Peter Jones, Tim Amos, Linda Everard and Swaran Singh

Background

Interventions to reduce treatment delay in first-episode psychosis have met with mixed results. Systematic reviews highlight the need for greater understanding of delays within the care pathway if successful strategies are to be developed.

Aims

To document the care-pathway components of duration of untreated psychosis (DUP) and their link with delays in accessing specialised early intervention services (EIS). To model the likely impact on efforts to reduce DUP of targeted changes in the care pathway.

Method

Data for 343 individuals from the Birmingham, UK lead site of the National EDEN cohort study were analysed.

Results

One-third of the cohort had a DUP exceeding 6 months. The greatest contribution to DUP for the whole cohort came from delays within mental health services, followed by help-seeking delays. It was found that delay in reaching EIS was strongly correlated with longer DUP.

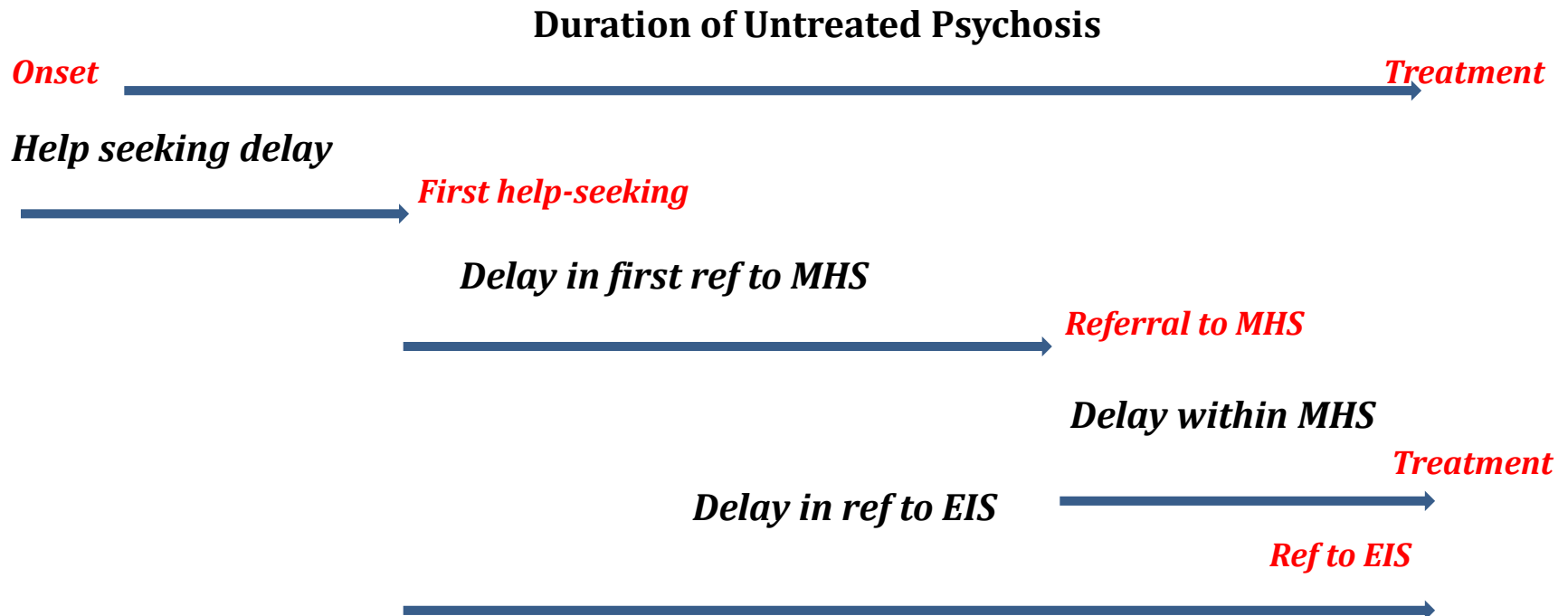
Conclusions

Community education and awareness campaigns to reduce DUP may be constrained by later delays within mental health services, especially access to EIS. Our methodology, based on analysis of care pathways, will have international application when devising strategies to reduce DUP.

Declarations of interest

None.

Duration of Untreated Psychosis – component delays



Mean (s.d.)

260.3 (472.5)

36.6 (44.7)

Table 1 Duration of untreated psychosis (DUP) and component delays

	DUP		Delay in help-seeking		Delay in referral to mental health services		Delay within mental health services		Delay reaching EIS (T_1) (first help-seeking to EIS acceptance)		Delay reaching EIS (T_2) (first mental health referral to EIS acceptance)	
	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median
All patients ($n=343$)	260.3 (472.5)	50	93.8 (274.1)	0.00	58.1 (228.9)	0.00	108.7 (308.9)	8	353.7 (607.0)	111	187.5 (353.4)	49
Patients with DUP < 6 months ($n=228$)	36.6 (44.7)	19	12.7 (27.9)	0.00	8.2 (55.32)	0.00	15.7 (28.2)	1	267.7 (493.1)	66.5	144.2 (246.9)	36
Patients with DUP > 6 months ($n=115$)	704.2 (603.3)	518	254.6 (429.7)	66	157.0 (375.9)	4	292.6 (482.1)	141	510.1 (760.1)	212	273.3 (492)	87
EIS, early intervention services.												

Why is DUP still so long?

1/3 still have long DUP (> 6 months)

Mostly accounted for by delays
within mental health services

Table 1 Duration of untreated psychosis (DUP) and component delays

	DUP		Delay in help-seeking		Delay in referral to mental health services		Delay within mental health services		Delay reaching EIS (T_1) (first help-seeking to EIS acceptance)		Delay reaching EIS (T_2) (first mental health referral to EIS acceptance)	
	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median
All patients ($n=343$)	260.3 (472.5)	50	93.8 (274.1)	0.00	58.1 (228.9)	0.00	108.7 (308.9)	8	353.7 (607.0)	111	187.5 (353.4)	49
Patients with DUP < 6 months ($n=228$)	36.6 (44.7)	19	12.7 (27.9)	0.00	8.2 (55.32)	0.00	15.7 (28.2)	1	267.7 (493.1)	66.5	144.2 (246.9)	36
Patients with DUP > 6 months ($n=115$)	704.2 (603.3)	518	254.6 (429.7)	66	157.0 (375.9)	4	292.6 (482.1)	141	510.1 (760.1)	212	273.3 (492)	87
EIS, early intervention services.												

Impact of the first mental health contact

CAMHS/CMHTs linked to longer DUP



Table 2 Delays associated with first mental health service contact

First mental health service contact	Mean (s.d.)		
	Delay within mental health services	Delay reaching early intervention services	Duration of untreated psychosis
Community mental health team (<i>n</i> = 164)	174.37 (411.04)	469.23 (727.76)	367.70 (579.41)
Child and adolescent mental health services (<i>n</i> = 22)	205.95 (326.58)	360.36 (376.23)	283.82 (334.63)
Home treatment team (<i>n</i> = 84)	21.52 (62.22)	173.30 (299.30)	129.05 (238.45)
Psychiatric hospital (<i>n</i> = 43)	36.25 (97.03)	313.79 (639.75)	166.82 (423.64)

Why does first contact with CMHT/CAMHS prolong DUP?

Premature discharge from CMHT common → lengthens DUP

Table 4 Community mental health team response, mental health service delay and duration of untreated psychosis				
Outcome	Mental health service delay		Duration of untreated psychosis	
	Mean (s.d.)	Median	Mean (s.d.)	Median
Referred to home treatment team	92 (233.5)	13	306 (501.3)	68
Discharged	482.9 (784.8)	172	631 (848.7)	299
Referred to early intervention services	91 (139.7)	52	420 (508.1)	203

Why?
Delays access to EIS, which prolongs DUP

	DUP		Delay in help-seeking		Delay in referral to mental health services		Delay within mental health services		Delay reaching EIS (T_1) (first help-seeking to EIS acceptance)		Delay reaching EIS (T_2) (first mental health referral to EIS acceptance)	
	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median	Mean (s.d.)	Median
All patients ($n=343$)	260.3 (472.5)	50	93.8 (274.1)	0.00	58.1 (228.9)	0.00	108.7 (308.9)	8	353.7 (607.0)	111	187.5 (353.4)	49
Patients with DUP <6 months ($n=228$)	36.6 (44.7)	19	12.7 (27.9)	0.00	8.2 (55.32)	0.00	15.7 (28.2)	1	267.7 (493.4)	66.5	144.2 (246.9)	36
Patients with DUP >6 months ($n=115$)	704.2 (603.3)	518	254.6 (429.7)	66	157.0 (375.9)	4	292.6 (482.1)	141	510.1 (760.1)	212	273.3 (492)	87
EIS, early intervention services.												

2 months or more after EIS acceptance. The delay in reaching criteria treatment within mental health services was strongly correlated ($r=0.68$, $P<0.001$) with delay in accessing EIS (T_2), following referral to mental health services when psychotic.

Can DUP be reduced?

Connor et al. *BMC Psychiatry* (2016) 16:127
DOI 10.1186/s12888-016-0816-7

BMC Psychiatry

RESEARCH ARTICLE

Open Access



Don't turn your back on the symptoms of psychosis: the results of a proof-of-principle, quasi-experimental intervention to reduce duration of untreated psychosis

Charlotte Connor^{1*}, Max Birchwood¹, Nick Freemantle², Colin Palmer¹, Sunita Channa¹, Clare Barker³, Paul Patterson⁴ and Swaran Singh¹

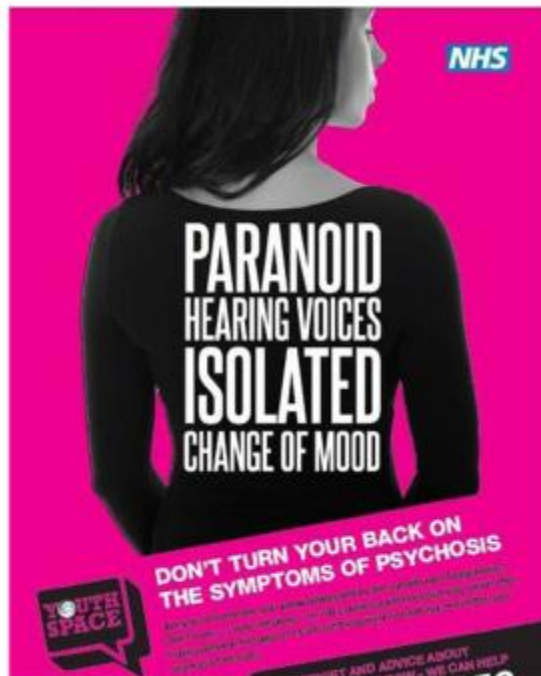


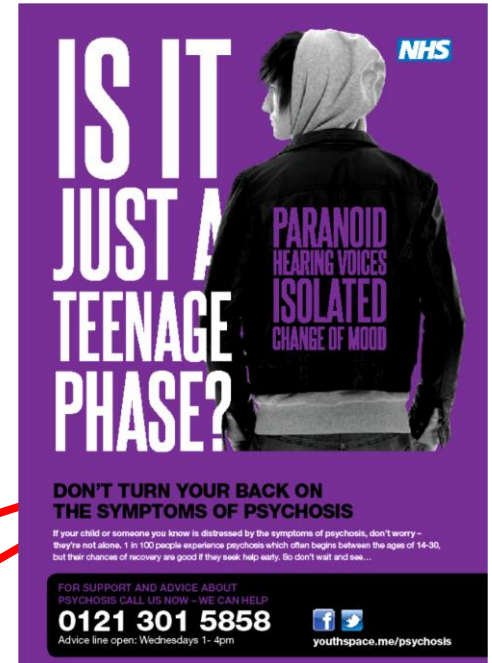
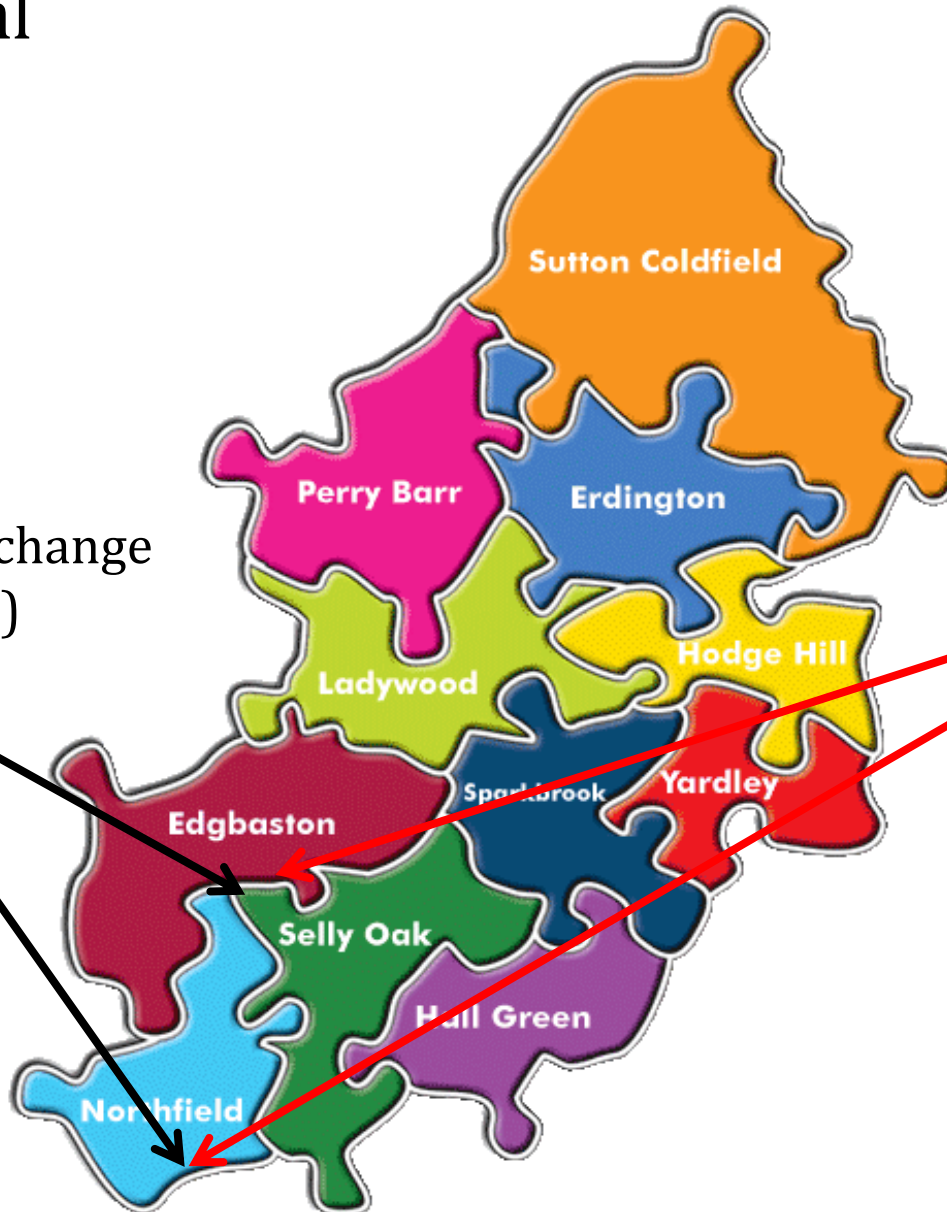
Fig. 1 Example of campaign poster



Birmingham pathways study: A quasi-experimental pilot trial



Care pathway change
(16-25 service)



Psychosis awareness
campaign

Yes: target care pathways!

Table 5 DUP for EIS clients in intervention and control areas during trial (July 2011 – Dec 2013)

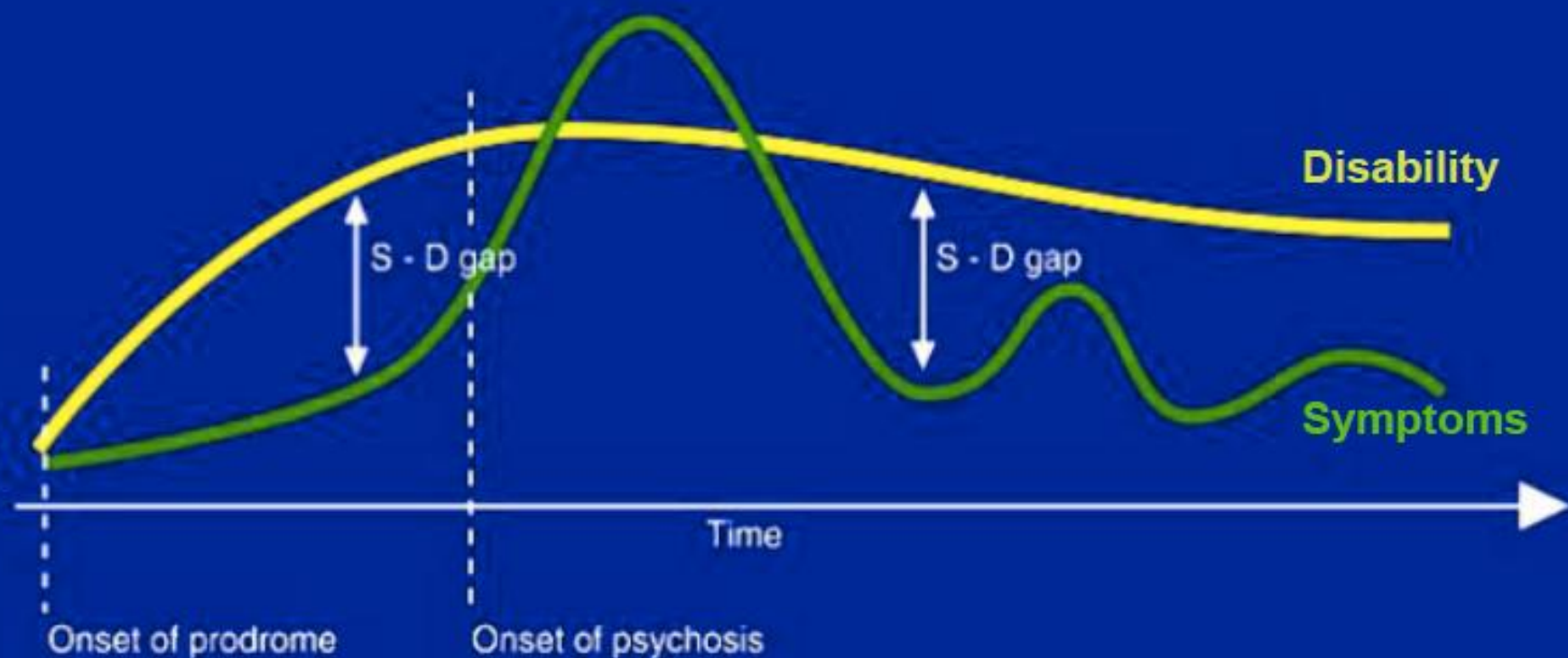
		Help-seeking delay	Delay within MHSs	Delay in reaching EIS	DUP	N = 151
Control area	Mean	116.97	124.19	162.30	216.43	74
	Median	11.50	21.00	44.00	79.50	
	St Dev	229.02	216.45	242.84	335.86	
Intervention area	Mean	41.49	42.32	130.57	103.82	77
	Median	1.50	6.50	40.50	39.00	
	St Dev	105.93	86.74	225.89	155.00	

The bold text is to highlight the mean scores

EIS non-responders?

Those emerging from adolescence
with severe social disability

Symptom-Disability Gap in Early Psychosis



- Providing access during usually prolonged phase when major psychosocial disability develops (Agerbo et al 2003)

Investigating trajectories of social recovery in individuals with first episode psychosis: a latent class growth analysis

Jo Hodgekins, Max Birchwood, Rose Christopher, Max Marshall, Sian Coker, Linda Everard, Helen Lester,* Peter Jones, Tim Amos, Swaran Singh, Vimal Sharma, Nick Freemantle and David Fowler

Background

Social disability is a hallmark of severe mental illness yet individual differences and factors predicting outcome are largely unknown.

Aim

To explore trajectories and predictors of social recovery following a first episode of psychosis (FEP).

Method

A sample of 764 individuals with FEP were assessed upon entry into Early Intervention for Psychosis (EIP) services and followed up over 12 months. Social recovery profiles were examined using Latent Class Growth Analysis.

Results

Three types of social recovery profile were identified: Low Stable (66%), Moderate-Increasing (27%), and

High-Decreasing (7%). Poor social recovery was predicted by male gender, ethnic minority status, younger age at onset of psychosis, increased negative symptoms, and poor premorbid adjustment.

Conclusion

Social disability is prevalent in FEP, although distinct recovery profiles are evident. Where social disability is present upon entry into EIP services it can remain stable, highlighting a need for targeted intervention.

Declaration of interest

None.

Copyright and usage

© The Royal College of Psychiatrists, all rights reserved.

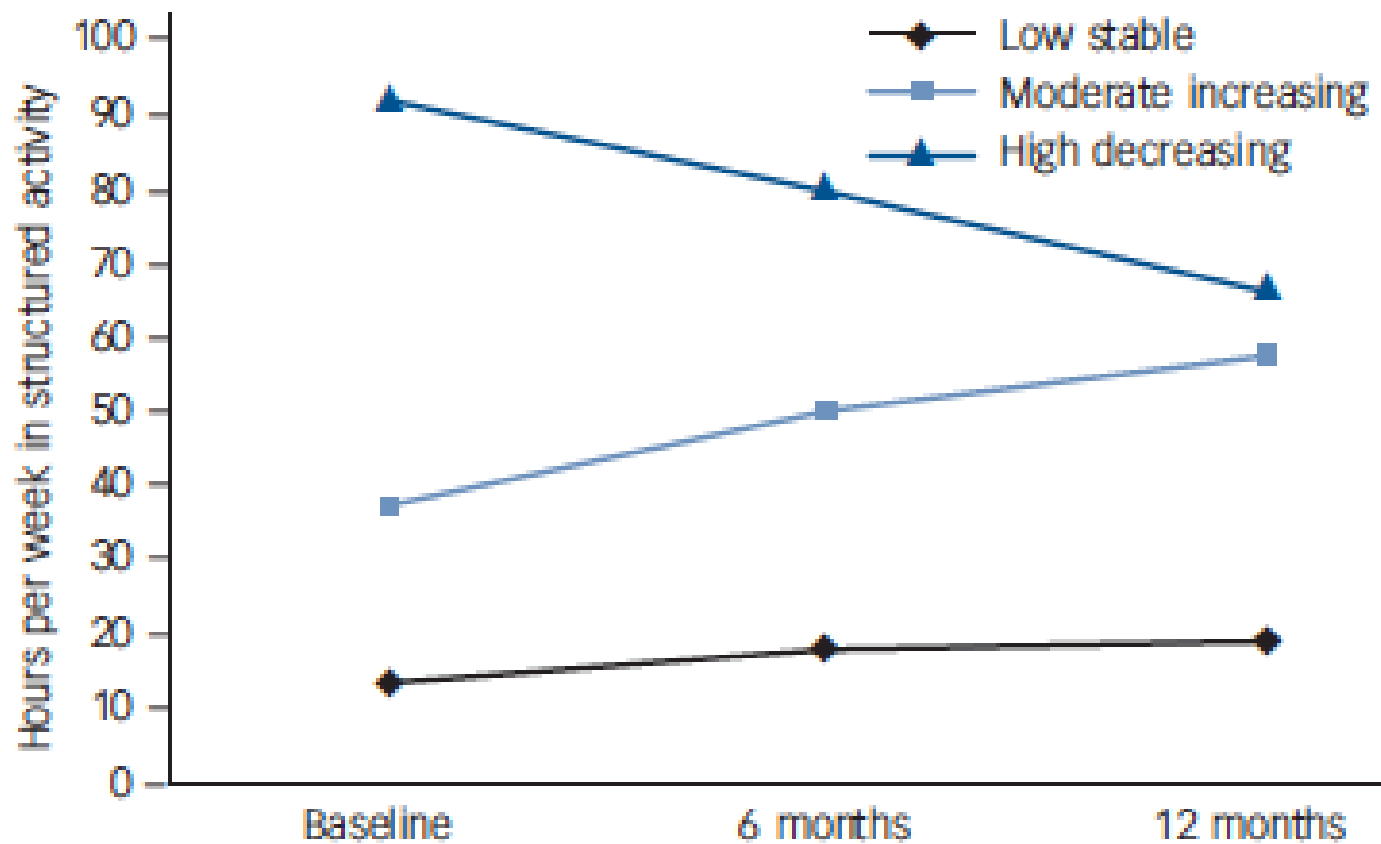
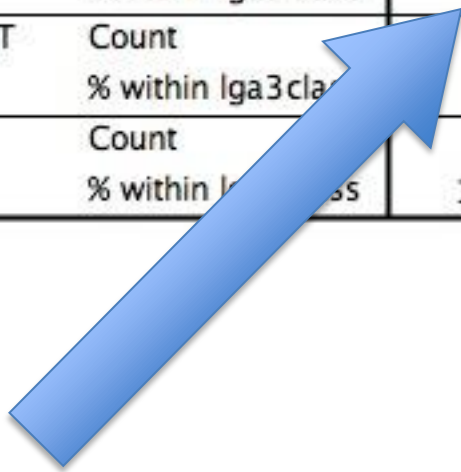


Fig. 1 LCGA model with three social recovery trajectories.

Those with low, stable activity are at very high risk of NEET

NEET X social recovery trajectory

			Social recovery trajectory			Total
			Low stable	Moderate increasing	High decreasing	
NEET	NEET	Count	362	60	15	437
		% within lga3class	71.7%	29.9%	28.3%	57.6%
EET	EET	Count	143	141	38	322
		% within lga3class	28.3%	70.1%	71.7%	42.4%
Total		Count	505	201	53	759
		% within lga3class	100.0%	100.0%	100.0%	100.0%



SRCBT for severe social disability in first episode psychosis

The SUPEREDEN trial



Social Recovery orientated Cognitive Behavioural Therapy (SR-CBT)

- Overcome blocks to activity (eg. Hopelessness, social anxiety, family acceptance, stigma); and to create motivation to change ('where would you like to be in 5 years?')
- Behavioural activation

Objectives

Primary hypothesis

is that the intervention will lead to improvements in the time spent in structured activity.

Design

- Single blind, ITT pragmatic trial
- 9 month treatment envelope
- Follow up at 9 and 15 months.

At baseline

10/155 in some level of paid employment.

Mean 7.45 hour/week of structured activity (1.5-1

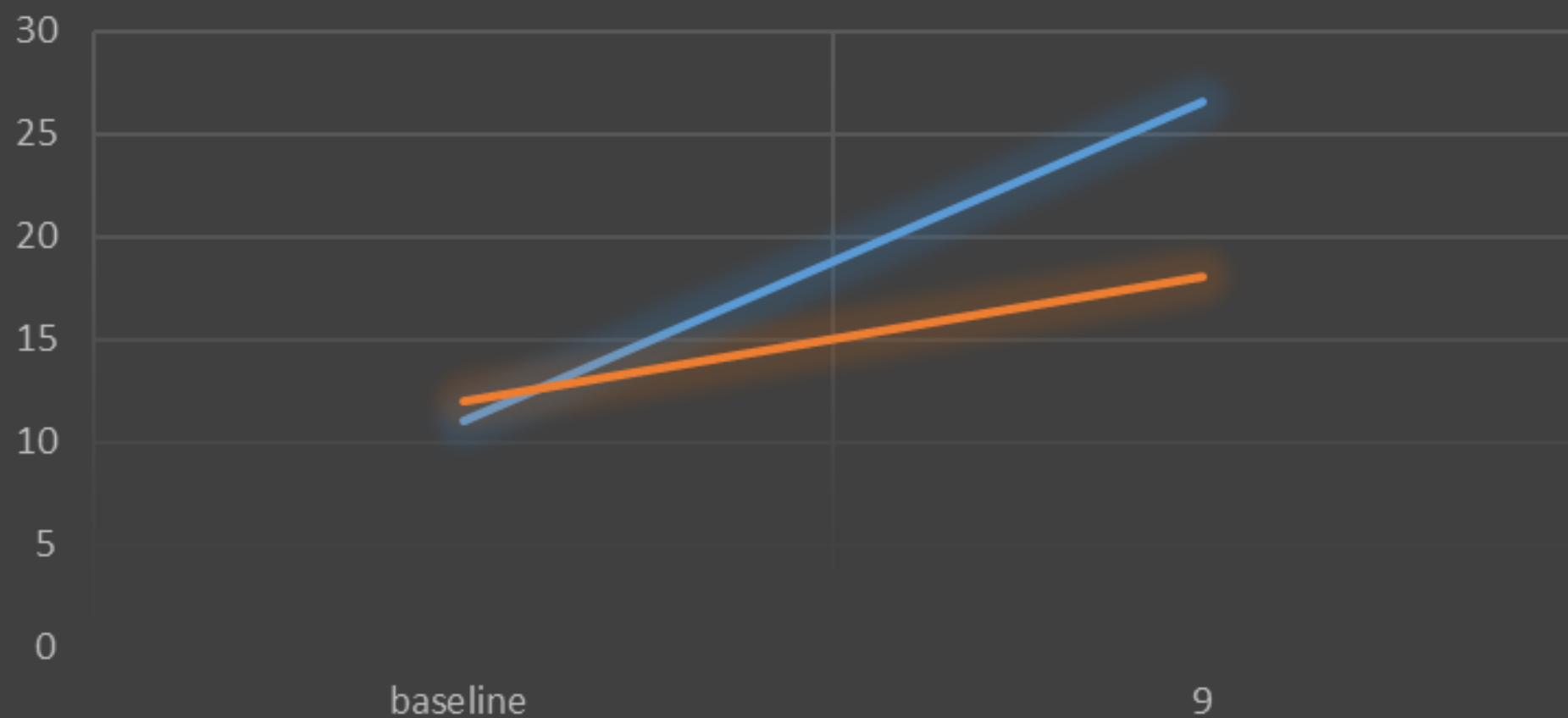
Baseline data: complex co-morbidities

SIAS= 39.5 (15.3). 56% above threshold for social anxiety

BDI= 18.7 (11.8) 46% 'moderate or severe'; 19% 'severe'

Supereden effects on time use

— SRCBT — Standard



Medication discontinuation for those in full early remission?

Evidence that it can improve long-term functional recovery

Why?

- Concern over toxic effects of antipsychotic medication on developing brain
- Reduced life expectancy (20 years less) linked to metabolic side effects and weight gain

Original Investigation

Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy Long-term Follow-up of a 2-Year Randomized Clinical Trial

Lex Wunderink, MD, PhD; Roeline M. Nieboer, MA; Durk Wiersma, PhD; Sjoerd Sytema, PhD; Folklo J. Nienhuis, MA

IMPORTANCE Short-term outcome studies of antipsychotic dose-reduction/discontinuation strategies in patients with remitted first-episode psychosis (FEP) showed higher relapse rates but no other disadvantages compared with maintenance treatment; however, long-term effects on recovery have not been studied before.

OBJECTIVE To compare rates of recovery in patients with remitted FEP after 7 years of follow-up of a dose reduction/discontinuation (DR) vs maintenance treatment (MT) trial.

DESIGN Seven-year follow-up of a 2-year open randomized clinical trial comparing MT and DR.

SETTING One hundred twenty-eight patients participating in the original trial were recruited from 257 patients with FEP referred from October 2001 to December 2002 to 7 mental health care services in a 3.2 million-population catchment area. Of these, 111 patients refused to participate and 18 patients did not experience remission.

PARTICIPANTS After 7 years, 103 patients (80.5%) of 128 patients who were included in the original trial were located and consented to follow-up assessment.

INTERVENTION After 6 months of remission, patients were randomly assigned to DR strategy or MT for 18 months. After the trial, treatment was at the discretion of the clinician.

MAIN OUTCOMES AND MEASURES Primary outcome was rate of recovery, defined as meeting the criteria of symptomatic and functional remission. Determinants of recovery were examined using logistic regression analysis; the treatment strategy (MT or DR) was controlled for baseline parameters.

RESULTS The DR patients experienced twice the recovery rate of the MT patients (40.4% vs 17.6%). Logistic regression showed an odds ratio of 3.49 ($P = .01$). Better DR recovery rates were related to higher functional remission rates in the DR group but were not related to symptomatic remission rates.

CONCLUSIONS AND RELEVANCE Dose reduction/discontinuation of antipsychotics during the early stages of remitted FEP shows superior long-term recovery rates compared with the rates achieved with MT. To our knowledge, this is the first study showing long-term gains of an early-course DR strategy in patients with remitted FEP. Additional studies are necessary before these results are incorporated into general practice.

TRIAL REGISTRATION Isrctn.org Identifier: ISRCTN16228411.

JAMA Psychiatry. 2013;70(9):913-920. doi:10.1001/jamapsychiatry.2013.19

Editorial page 898

- Guided reduction/discontinuation in those with full remission
- Does lead to relapse but Meds reintroduced if relapse begins.
- 15% can manage without meds without impact on illness in the remainder

Author Affiliations: Department of Research and Education, Friesland Mental Health Services, Leeuwarden, the Netherlands (Wunderink, Nieboer); Department of Psychiatry, Rob Giel Research Center, University Medical Center Groningen, University of Groningen, Groningen, the Netherlands (Wunderink, Wiersma, Sytema, Nienhuis).

Corresponding Author: Lex Wunderink, MD, PhD, Department of Research and Education, Friesland Mental Health Services, Somerstraat 2, PO Box 8932 PS, Leeuwarden, the Netherlands (lex.wunderink@friesland-mentalhealth.nl).

From: **Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-term Follow-up of a 2-Year Randomized Clinical Trial**

JAMA Psychiatry. 2013;70(9):913-920. doi:10.1001/jamapsychiatry.2013.19

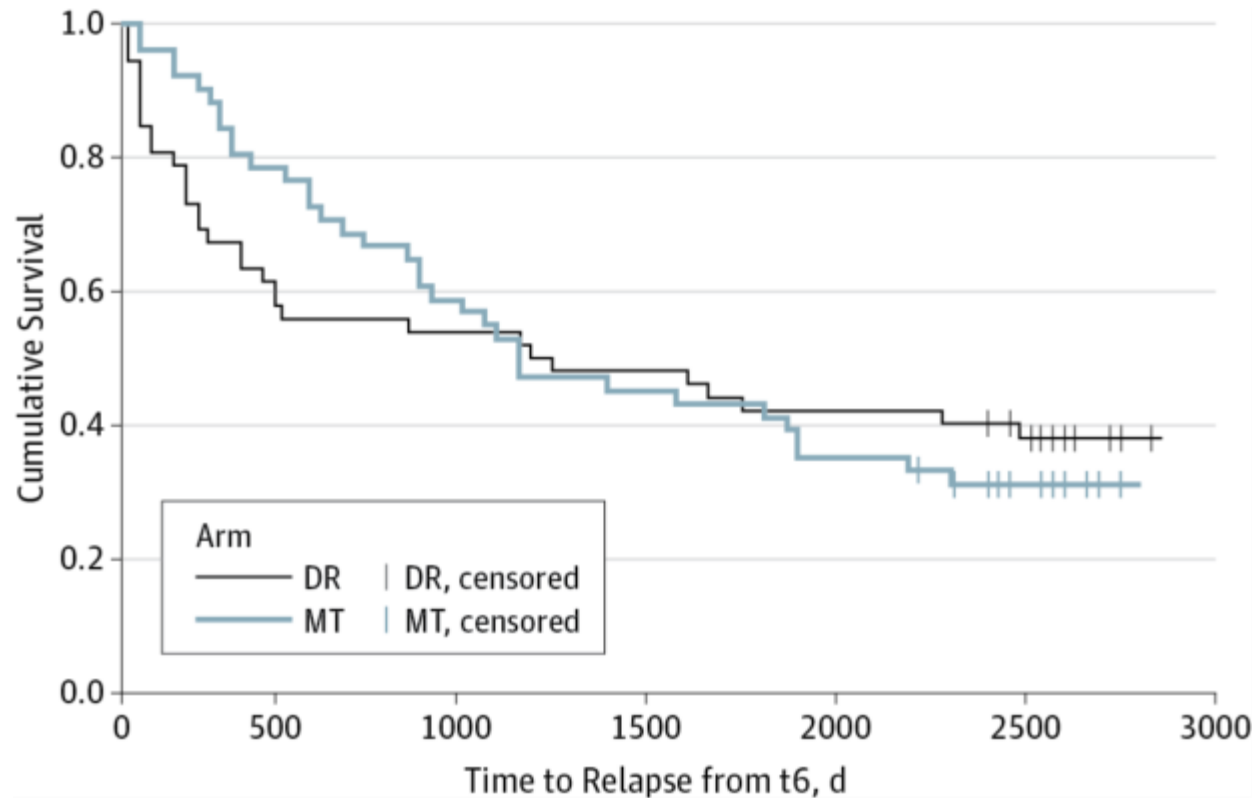


Figure Legend:

Kaplan-Meier Survival Analysis Time to first relapse after first remission (t6) during 7 years of follow-up in patients assigned to 18 months (547 days) of dose reduction/discontinuation (DR) or maintenance treatment (MT).

From: **Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-term Follow-up of a 2-Year Randomized Clinical Trial**

JAMA Psychiatry. 2013;70(9):913-920. doi:10.1001/jamapsychiatry.2013.19

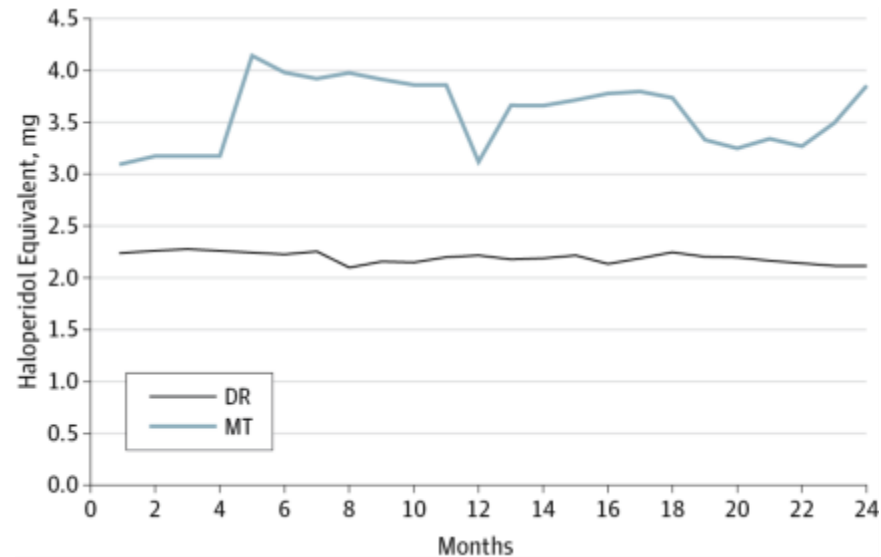


Figure Legend:

Mean Daily Dose in Dose Reduction/Discontinuation (DR) and Maintenance Treatment (MT) During the Last 2 Years of 7-Year Follow-up

Table 2. Recovery, Symptomatic Remission, and Functional Remission After 7 Years of Follow-up

Characteristic	No. (%)		Total Sample (n = 103)
	DR (n = 52)	MT (n = 51)	
Recovery	21 (40.4)	9 (17.6)	30 (29.1)
Remission			
Symptomatic	36 (69.2)	34 (66.7)	70 (68.0)
Functional	24 (46.2)	10 (19.6)	34 (33.0)

Abbreviations: DR, dose reduction/discontinuation; MT, maintenance treatment.

CONCLUSIONS AND RELEVANCE Dose reduction/discontinuation of antipsychotics during the early stages of remitted FEP shows superior long-term recovery rates compared with the rates achieved with MT. To our knowledge, this is the first study showing long-term gains of an early-course DR strategy in patients with remitted FEP. Additional studies are necessary before these results are incorporated into general practice.

Psychological Medicine, 1989, 19, 649–656

Printed in Great Britain

Predicting relapse in schizophrenia: the development and implementation of an early signs monitoring system using patients and families as observers, a preliminary investigation*

MAX BIRCHWOOD, JO SMITH¹, FIONA MACMILLAN, BRIDGET HOGG,
REKHA PRASAD, CATHY HARVEY AND SANDY BERING

From the Department of Clinical Psychology and Academic Unit, All Saints Hospital, Birmingham

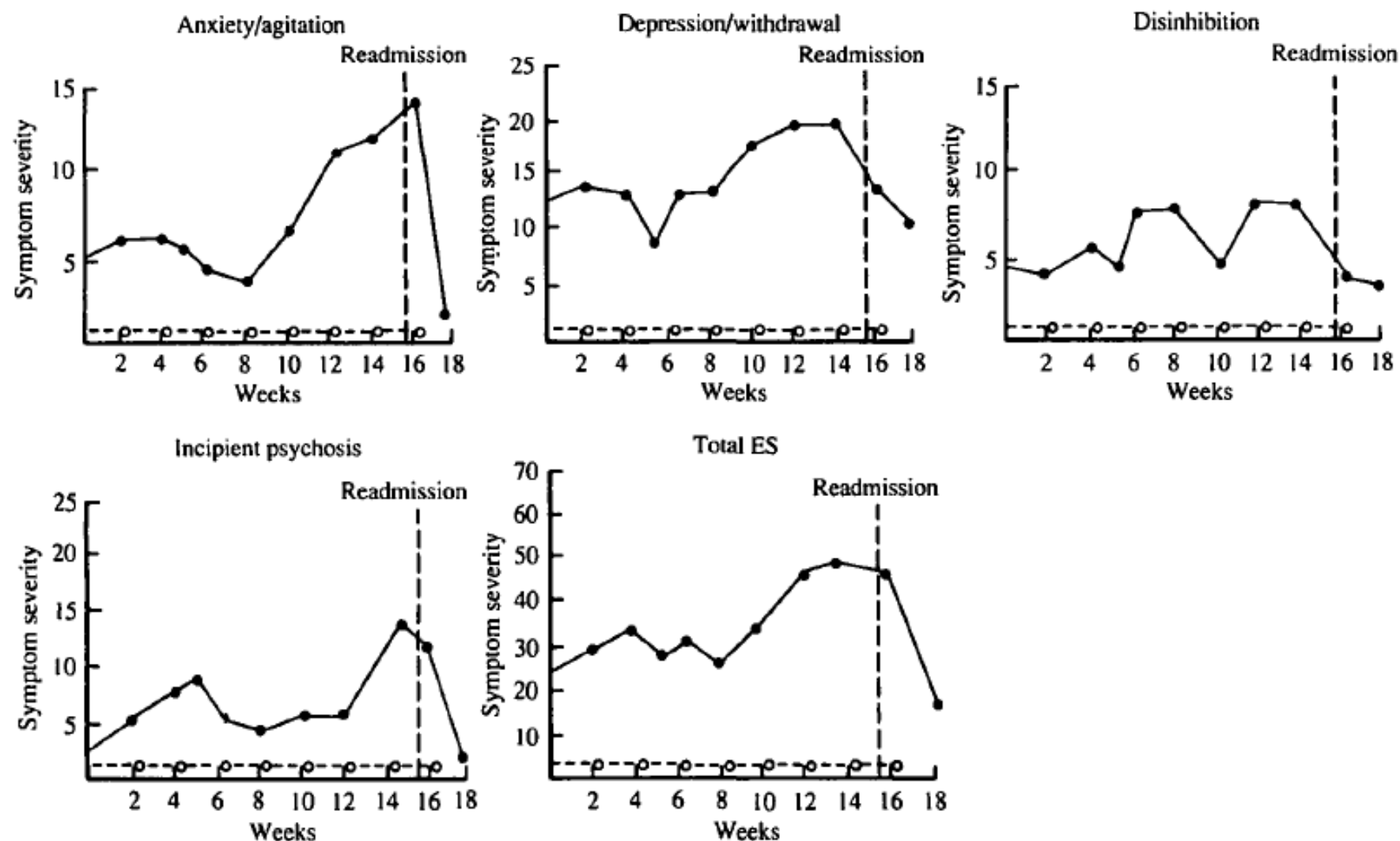


FIG. 2. Case example illustrating an increase in early signs prior to relapse. ●—●, Self-report; ○----○, observer.

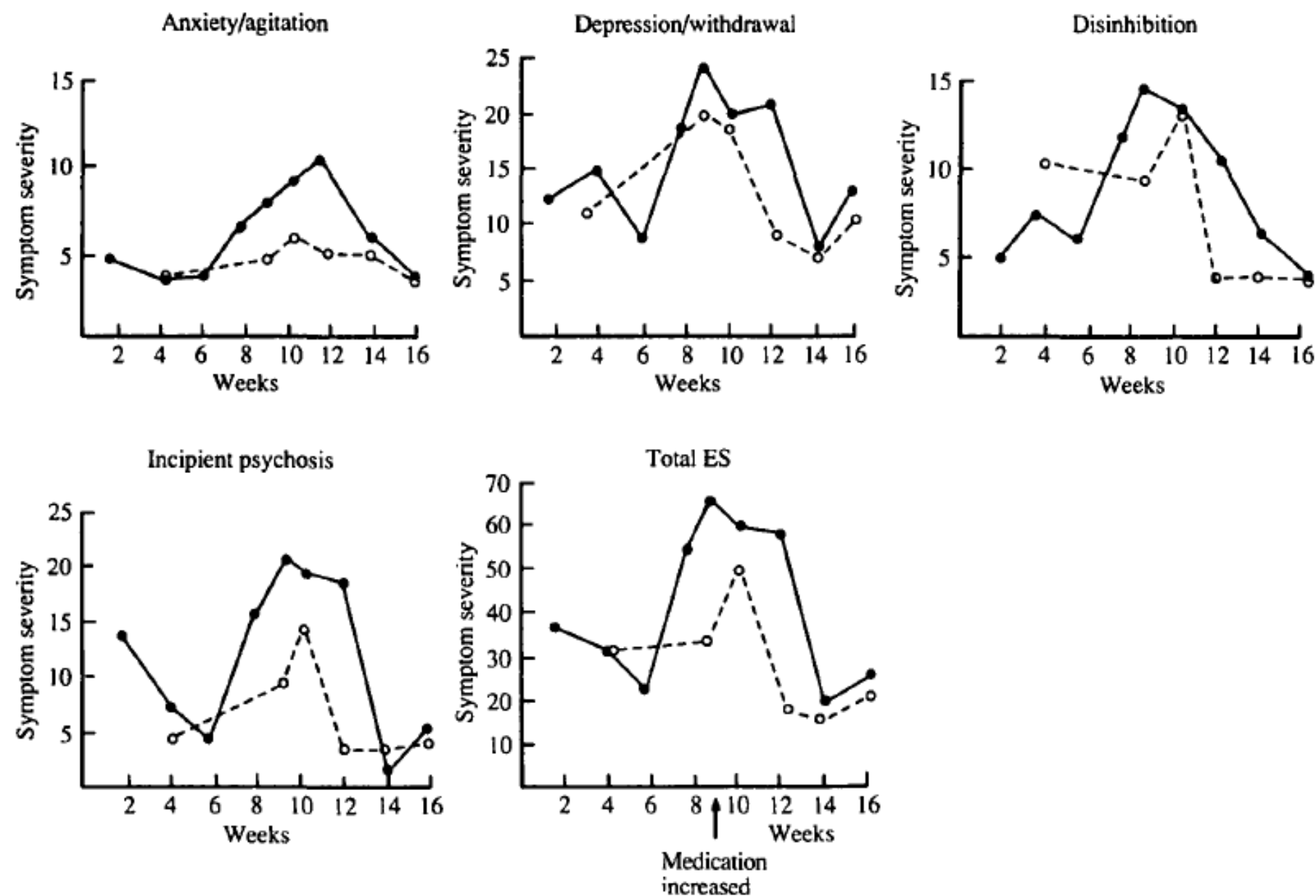


FIG. 4. Case example illustrating the impact of increasing medication during the prodromal period.

●—●, Self-report; ○----○, observer.

Training to recognise the early signs of recurrence in schizophrenia (Review)

Morriss R, Vinjamuri I, Faizal MA, Bolton CA, McCarthy JP



SUMMARY OF FINDINGS FOR THE MAIN COMPARISON *[Explanation]*

Early warning signs training and treatment as usual compared to treatment as usual for schizophrenia

Patient or population: patients with schizophrenia

Settings: secondary care

Intervention: Early warning signs training and treatment as usual

Comparison: treatment as usual

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)	Comments
	Assumed risk	Corresponding risk				
	Treatment as usual	Early warning signs training and treatment as usual				
Relapse: Rate of relapse Follow-up: 3 to 36 months	432 per 1000	229 per 1000 (155 to 341)	RR 0.53 (0.36 to 0.79)	1502 (15 studies)	⊕○○○ very low ^{1,2,3}	
Relapse: Time to relapse Follow-up: 12 to 18 months	See comment	See comment	HR 0.53 (0.27 to 1.06)	550 (6 studies)	⊕○○○ very low ^{2,3,4}	The data were added to the meta-analysis as generic inverse variance
Service use: Rate of re-hospitalisation Follow-up: 2 to 36 months	385 per 1000	185 per 1000 (135 to 254)	RR 0.48 (0.35 to 0.66)	1457 (15 studies)	⊕○○○ very low ^{2,6,7}	
Service use: Time to re-hospitalisation Follow-up: 12 to 24 months	See comment	See comment	HR 0.58 (0.33 to 1.04)	1149 (6 studies)	⊕○○○ very low ^{2,3,5}	The data were added to the meta-analysis as generic inverse variance

Following exit from EIS, are
gains maintained...?

Five-Year Follow-up of a Randomized Multicenter Trial of Intensive Early Intervention vs Standard Treatment for Patients With a First Episode of Psychotic Illness

The OPUS Trial

Mette Bertelsen, MSc; Pia Jeppesen, MD, PhD; Lone Petersen, PhD; Anne Thorup, MD, PhD; Johan Øhlenschläger, MD, PhD; Phuong le Quach, MD; Torben Østergaard Christensen, PhD; Gertrud Krarup, MD; Per Jørgensen, MD; Merete Nordentoft, MD, PhD, MPH

Table 5. Remission and Relapse During Last 2 Years Before 5-Year Follow-up^a

	5-Year Follow-up, No. (%)		
	Intensive Early-Intervention Program (n=151)	Standard Treatment (n=150)	Differences in Percentages (95% CI)
Episodic course of illness ^b	21 (14)	19 (13)	-2 (-0.06 to 0.1)
Continuous course of illness ^c	67 (45)	65 (44)	-2 (-0.12 to 0.1)
Not psychotic ^d	62 (41)	64 (43)	2 (-0.13 to 0.09)

Abbreviation: CI, confidence interval.

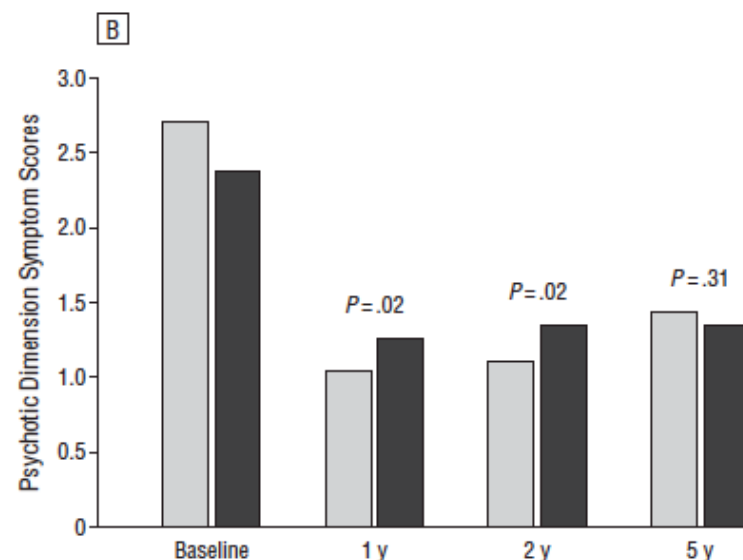
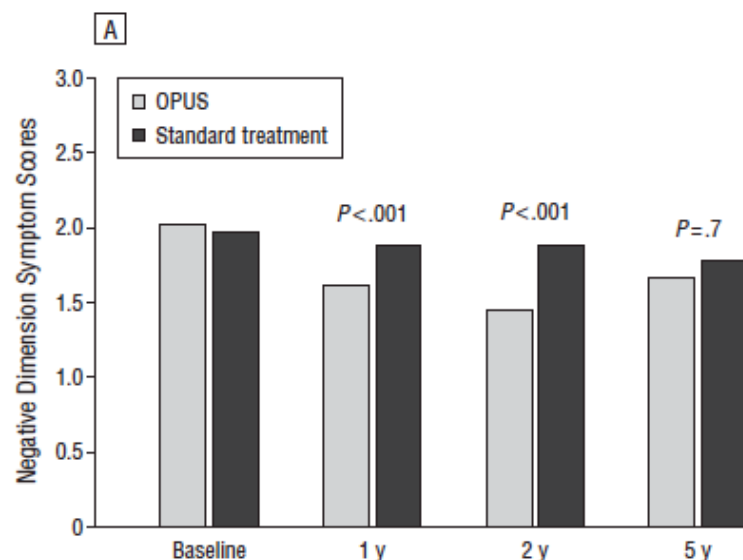


Figure 2. Mean symptom values for patients in the intensive early-intervention program (OPUS) vs standard treatment, according to the Scale for Assessment of Psychotic Symptoms and Scale for Assessment of Negative Symptoms²⁵ at baseline, 2-year follow-up, and 5-year follow-up for the negative (A) and psychotic (B) dimensions. Values range from 0 to 5.

10-year outcome study of an early intervention program for psychosis compared with standard care service

S. K. W. Chan^{1*}, H. C. So², C. L. M. Hui¹, W. C. Chang¹, E. H. M. Lee¹, D. W. S. Chung³, S. Tso⁴, S. F. Hung⁵, K. C. Yip⁶, E. Dunn⁷ and E. Y. H. Chen^{1,8}

¹ Department of Psychiatry, The University of Hong Kong, Hong Kong

² Department of Psychiatry, Queen Mary Hospital, Hong Kong

³ Department of Psychiatry, Tai Po Hospital, Hong Kong

⁴ Department of Psychiatry, Castle Peak Hospital, Hong Kong

⁵ Department of Psychiatry, Kwai Chung Hospital, Hong Kong

⁶ Department of Psychiatry, Kowloon Hospital, Hong Kong

⁷ Department of Psychiatry, Pamela Youde Nethersole Eastern Hospital

⁸ The State Key Laboratory of Brain and Cognitive Sciences, The University of Hong Kong, Hong Kong

Background: Despite evidence on the short-term benefits of early intervention (EI) services for psychosis, long-term out-



RESEARCH

Five years of specialised early intervention versus two years of specialised early intervention followed by three years of standard treatment for patients with a first episode psychosis: randomised, superiority, parallel group trial in Denmark (OPUS II)



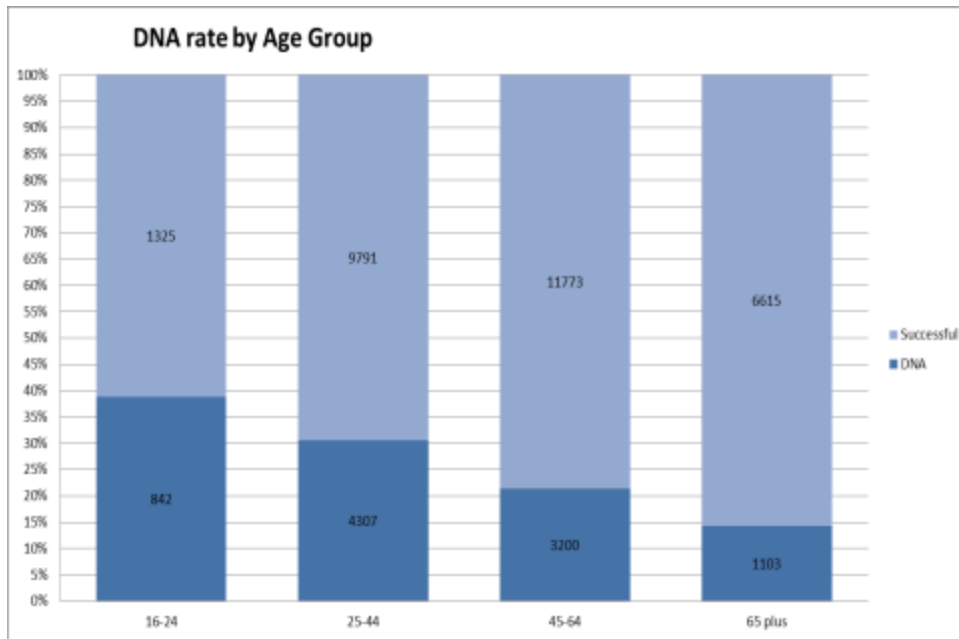
Nikolai Albert *PhD fellow*¹, Marianne Melau *postdoctoral researcher*¹, Heidi Jensen *research assistant*¹, Charlotte Emborg *consultant*³, Jens Richardt Mollegaard Jepsen *senior researcher*⁴, Birgitte Fagerlund *senior researcher*⁴, Christian Gluud *head of department*⁵, Ole Mors *professor*², Carsten Hjorthøj *senior researcher*¹, Merete Nordentoft *professor*¹

Following exit from EIS gains
not always maintained...

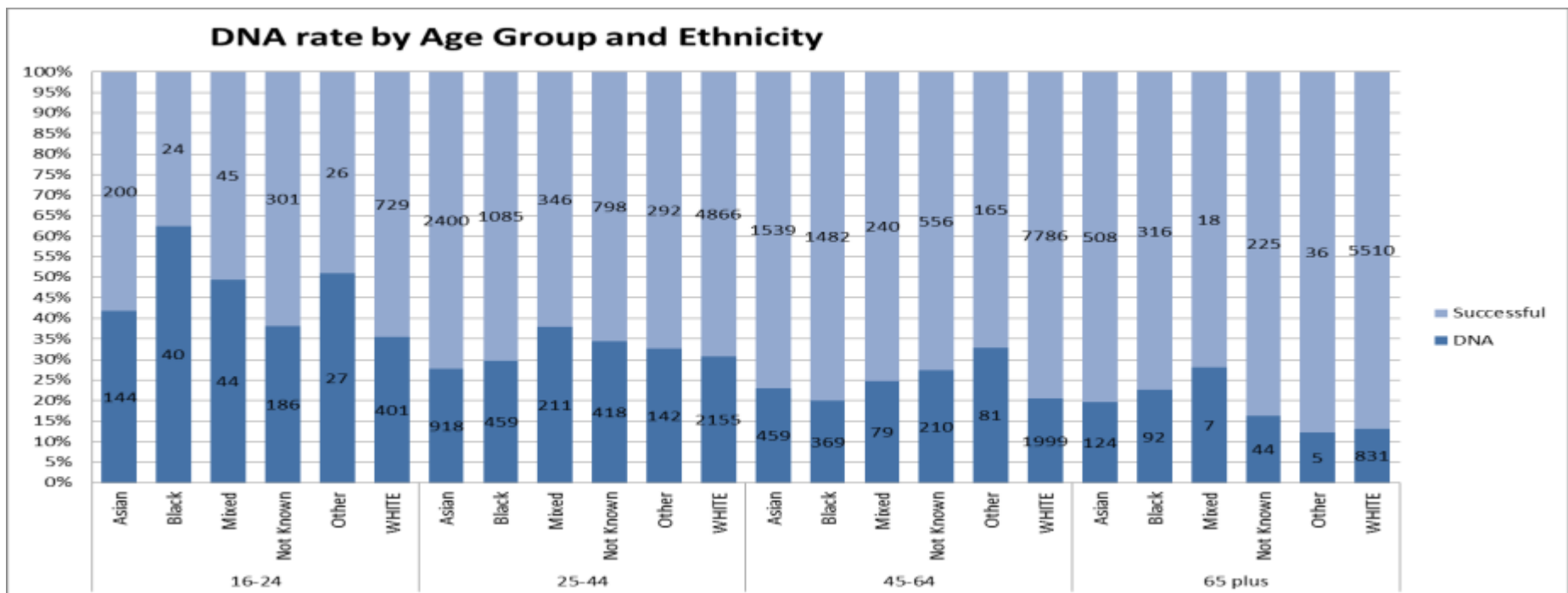
Why?

Generic services are failing to
engage young people..

BSMHFT DNA analysis



It appears that service users become less likely to DNA with age. Although the 16-24 year old age group are the smallest cohort of patient they have the highest rate of DNA.



Improving Children and Young Adult Community Mental Health Services across Birmingham

New mental health service for Birmingham's children and young adults

Birmingham South Central Clinical Commissioning Group, (CCG), Birmingham CrossCity CCG, Sandwell and West Birmingham CCG and Birmingham City Council have worked together to improve the Community Mental Health Services provided to children and young adults within the Birmingham area.

We appointed Forward Thinking Birmingham to provide the new community mental health services for children and young adults aged up to 25. The new service will start to go live from October 2015 and will be fully operational by the end of March 2016. This partnership is led by Birmingham Children's Hospital NHS Foundation Trust, which is working with Worcestershire Health and Care NHS Trust, Priory Health Care, Beacon UK and The Children's Society. It offers a completely new way of providing mental health services and has some creative solutions to making services accessible to young people.

Emotional and mental wellbeing is a critical part of all our health, especially for children and young adults. Around half of all mental health illnesses begin by 14 years of age and three-quarters by 24 years. We need to identify mental health issues as early as possible to ensure the best outcomes for our children and young adults. We're proud that we've worked with patients to create a ground-breaking new community mental health service in Birmingham for children and young adults aged up to 25.

Forward Thinking Birmingham's service is based around prevention, choice and personalised care. Its innovative approach and range of entirely new services and facilities, are focused around the individual needs of 0-25 year



Latest Updates

August 2014

Documents

- Consultation Delegates List 30.01.2014
- Final Business Case June 2014
- Appendix 1 Case For Change
- Appendix 2 Young Peoples Mental Health
- Appendix 3- JSNA Mental Health V28 Format
- Appendix 4 Framework For Scope Of Services
- Appendix 5 Service Specification
- Appendix 6 Market Research
- Appendix 7 Benefits Appraisal
- Appendix 8 Benefits Realisation Plan
- Appendix 9 Risk Appraisal
- Appendix 10 Risk Mitigation Plan
- Appendix 11 Procurement Costs
- Appendix 12 Contract

The headlines

- Existing CAMHS and young adult services de-commissioned.
- New service specification developed for 0-25 age group
- Commissioned under competitive tender (£124m over five years)



Youth Mental Health: New Economic Evidence

Martin Knapp, Vittoria Ardino, Nicola Brimblecombe,
Sara Evans-Lacko, Valentina Iemmi, Derek King,
Tom Snell, Silvia Murguia, Henrietta Mbeah-Bankas,
Steve Crane, Abi Harris, David Fowler,
Joanne Hodgekins, Jon Wilson

January 2016

What have we learned?

- EIS transforms engagement, delivers more treatment, improves outcome, saves money.
- EIS reduce DUP, but there are delays in DUP before accessing EIS.
- Enjoy high acceptability among users and carers
- BUT The EIS model needs upgrading based on evidence with the model over last 10+ years

The early intervention upgrade



Brought to you by TheAppleLounge.com
Proudly written in Helvetica neue Ultralight.
Yes, aligning dots is a drag.



iPhone 4



iPhone 4S



iPhone 5



Control Center



Panorama (same as iOS 6)



Filters (in camera)



Filters (in Photos)



Square, video formats,
swipe to capture



Multitasking



Notification Center



AirDrop



www.theapplelounge.com



iTunes Radio (U.S. only)



Thank you

m.j.birchwood@warwick.ac.uk

Service contact, relapse,
recovery and readmission: keep
up with the trials?

Yes

	Raw12 month readmission rate	Bed days in follow-up
National EDEN	16.7%	15.6 days
(Birmingham)	13%	17.5
LEO EI	23.3%	23.3
routine	35.8%	36.6

LEO data courtesy of Tom Craig