Early intervention in psychosis services

INTRODUCTION

Early intervention (EI) in psychosis teams were introduced across the UK by the National Service Framework in 1999.[1] Patients can access this service in the first episode of psychosis and for up to 3 years thereafter. They offer standard pharmacological antipsychotic therapy, alongside psychological, social, occupational, and educational interventions.

EI teams aim to improve short- and long-term outcomes by reducing the duration of untreated psychosis (DUP), protecting social support networks, involving families in care, and providing prompt and intensive pharmacological and psychological treatment. There is a wealth of evidence to suggest that the DUP is a strong prognostic indicator. Psychotic illnesses such as schizophrenia also have negative and cognitive symptoms that are more difficult to treat, and often develop over time, which again can be avoided by early and assertive management.

With hindsight we can often identify a prodromal period for patients with emerging psychosis, but we are not as good at identifying prodromal schizophrenia prospectively. Prodromal psychosis often includes a period of functional impairment, becoming withdrawn, or perhaps doing less well academically, with no clear positive psychotic symptoms. Given that schizophrenia has its peak onset in late adolescence/early adulthood, it can be difficult to distinguish between prodromal schizophrenia and a normal variant of behaviour.[2] GPs need to be mindful of prodromal psychosis, especially in at-risk groups (those with a family history of schizophrenia, for example).

There is significant variation in EI provision across the UK, and more widely throughout the world. This makes it difficult to compare and assess the efficacy of early-intervention teams with standard treatment, which is also of variable quality.

KEY TRIALS

EPPIC

One of the earliest studies into EI was the Australian EPPIC study.[3] This evaluated the effect of an EI service, compared it with historical controls, and found that patients in EI services spent less time in inpatient care, had improved symptoms, and had improved quality of life.[3] These studies have been subject to much criticism surrounding their methodology. The comparison with historical controls who were treated as inpatients rather than in the community largely invalidates the claims of cost-effectiveness.[4] Furthermore, the EPPIC study has been excluded from the Cochrane review due to lack of randomisation.

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OPUS

The largest randomised controlled trial (RCT) comparing EI with standard care is the OPUS trial in Denmark.[5] It randomised 547 patients with a schizophrenia spectrum diagnosis not previously treated with antipsychotic medication into two arms (intervention and control), who were followed up at 1 year and after 2 years.[5] A total of 347 patients were followed up after 10 years.[6] The intervention arm consisted of assertive community treatment where each patient was assigned a case manager whose caseload was around 10 patients. Psychological therapies — 'psychoeducational family intervention' — and social skills training were also offered to the intervention group. The control arm received treatment as usual, which consisted of community mental health teams (CMHTs). Patients attended as outpatients, and each member of the team had a higher caseload of between 20–30 patients.

At 1 year the intervention arm saw statistically significant differences in positive and negative symptoms, and in global assessment of functioning (GAF) scores. The differences were maintained at 2 years. Patient satisfaction with treatment was also better within the intervention arm.[7] However, at 10 years no statistically significant differences in symptoms were found between the two arms.

The evidence from the OPUS trial is that any benefits from EI are sustained only for the duration of the intervention, which in this case was 2 years. After this point, when patients are returned to standard mental health care, the difference between the two arms of the trial rapidly diminishes until there are no clinically significant differences. This has prompted another trial, which is currently ongoing, to prolong the duration of intervention to 5 years.[8] The rationale for this is that the 'critical period' in early psychosis could be much longer than 2 years, and so, by intervening for longer, the positive outcomes may be sustained after the intervention has ended.

UK trials

RCTs of EI teams are scarce in the UK, as EI is now standard care and recommended by National Institute for Health and Care Excellence (NICE) guidelines.[9] There are RCTs including the Lambeth Early Onset (LEO) trial,[10] the subsequent Lambeth Early Onset Crisis Assessment Team study (LEO-CAT),[11] and a trial by Leavey *et al*.[12] The two latter trials, because EI is now standard care in the UK, take slightly different approaches from the OPUS trial. This is hardly surprising because it would not be possible to compare EI to treatment as usual, when EI itself is treatment as usual.

There was an RCT published before EI was implemented throughout the UK. It was not included in the Cochrane review

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of EI because it included patients in both the first and second episode of psychosis. However, it provides useful information because it compares a UK EI service (LEO) with CMHTs. The primary outcome measures were relapse rates and the rate of hospital readmission. A total of 144 patients were allocated to the two arms of the trial. After adjusting for sex, ethnicity, and previous psychotic episodes, there was no statistically significant difference in relapse rate between the two arms of the trial. Statistically significant differences were found in hospital readmission rates and dropout rates. This was an early study, and, although results seemed promising, it was suggested that the differences in outcomes could be attributed to the under-resourcing of CMHTs, rather than because the model of care in the EI team was superior. Also, this was a short-term study, considering outcomes at 18 months only.

CONCLUSION

In the UK we have embraced the EI in psychosis movement, and *The Five Year Forward View for Mental Health* has identified the need to target funding at EI service.[13] The evidence is clear that outcomes for patients in EI services are better than for standard care within CMHTs. This is hardly surprising given that staff in EI services have lower caseloads, have better access to psychological and social support and treatment, and can work more intensively with their patients and families. However, there is limited evidence in the UK that EI services have any impact on longer-term outcomes for patients with psychosis, and concerns that these patients do not maintain the benefits of EI when discharged from EI services to standard care. We also have concerns for patients who do not have a psychotic illness, for example, affective illness or personality disorder, and who do not have access to similar intensive specialist services.

For GPs and psychiatrists it is difficult to identify someone as psychotic until the hallucinations and delusions are evident. However, a well-recognised prodromal period has been described. It is important in those individuals who are at risk of developing psychosis that conversations are had at an early stage to promote good mental health, including abstinence from illicit drugs, including cannabis, and the novel psychoactive substances, and the importance of a good diet and exercise. For individuals where there are concerns about being increasingly socially withdrawn or there has been a marked change in behaviour, psychosis should be considered as a differential diagnosis and regular follow-up or a referral to an EI service may be appropriate. With individuals where there are concerns and who have a family history of psychosis, early referral is essential.

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