Early Intervention in Psychosis: Where to from here?

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OUTLINE

- Why is treating psychosis and related disorders important?
- What have we learnt about EI over the last 20 years
- An overview of selected international approaches to EI services
- The Opportunities and Challenges for EI in New Zealand over the next decade
SCHIZOPHRENIA & RELATED PSYCHOTIC DISORDERS

• Impact 1% of the population

• Significant proportion of the mental health budget

• High proportion of in-patient stays

• Poor physical health outcomes

• Poor social and vocational outcomes
PSYCHOTIC DISORDERS AND SERVICES IN NEW ZEALAND

- Last major reform in the 1990s - closing of the psychiatric hospitals
- Mental Health “Blueprint” established community based mental health services
- Early Intervention in Psychosis services established in Auckland & Christchurch in 1996
THE EVIDENCE
TREATING PEOPLE EARLY IS IMPORTANT

- Shorter DUP noticed to be associated with better outcomes in 1980s (Kane, Crow, Wyatt)
- Norwegian Treatment and Intervention in Psychosis (TIPS) study of 1997–2000
- Reduced the duration of untreated psychosis (DUP) in first-episode schizophrenia from 16 to 5 weeks using easy access detection teams (DTs) and a information campaign (IC)
- Compared with usually detected FEP patients in control sectors, these earlier detected and treated FEP patients displayed a disorder of milder severity at first admission and at 2, 5 and 10-year follow-ups
- A more recent British study suggested that the greatest delay was found within Mental Health Services (Birchwood 2013)

EI SERVICES ARE EFFECTIVE

- Improving outcomes in established cases of psychosis by *facilitating and consolidating recovery*

- 2 major RCTs in the UK (LEO trial) and Denmark (OPUS trial)

- Individuals experience better *clinical, social and vocational outcomes*, have reduced in-patient stays and are better engaged

- Highly valued by service users and their carers

*Singh, S.* The British Journal of Psychiatry Apr 2010, 196 (5) 343-345
DEDICATED TEAMS PERFORM BETTER

- Compared the outcome of a comprehensive EI team with a partial model (community mental health team (CMHT) plus specialist support) and traditional care (generic CMHT) over a 10-year period

- Only 15% of individuals made a full or partial functional recovery at 2 years under the care of a traditional generic CMHT

- 52% of the cases were making a full or partial functional recovery under the care of the comprehensive EI team

- 40% of the cohort receiving a comprehensive EI model made either a partial or full recovery at 1 year compared with 24% of the cohort receiving a partial EI mode

Fowler, D. Early Intervention in Psychiatry 3(4):282-8 · November 2009
THE DIFFERENCE IS NOT SUSTAINED

- 2 years of OPUS vs treatment as usual (TAU) within an FEP cohort, 10 years after inclusion.

- Differential 10-year course in the development of negative symptoms, psychiatric bed days, and possibly psychotic symptoms in favour of OPUS treatment, differences were driven by effects at earlier follow-ups and had diminished over time.

- There were no differences between OPUS and TAU regarding income, work-related outcomes, or marital status.

Secher RG. Schizophr Bull. 2015 May;41(3):617-26
UNLESS SERVICES ARE EXTENDED...

- Hong Kong RCT compared a 1-year extension of specialised early intervention with step-down care in patients who had all received a 2-year intensive early intervention programme for first-episode psychosis.
- Patients receiving an additional year of specialised intervention had better outcomes in functioning, negative and depressive symptoms and treatment default rate than those managed by step-down psychiatric care.
- OPUS now considering a 5 year trial.

(Wing CC. The British Journal of Psychiatry Jun 2015, 206 (6) 492-500)
EI SERVICES ARE COST EFFECTIVE (BUT NOT CHEAP)

- EI services have been shown to be cost effective in a number of settings (LEO, OPUS, Orygen)
- Either the same or cheaper than TAU
- Healthcare costs are lower primarily due to lower hospital in-patient bed use
- Wider societal savings due to better social functioning

Hastrup LH. *The British Journal of Psychiatry* Jan 2013, 202 (1) 35-41
APPROACHES TO EI SERVICES AROUND THE WORLD

- Australia - Youth “One Stop Shop” model - Headspace
- *headspace Youth Early Psychosis Programme (hYEPP)*
- Youth focussed, national programme launched in 2013
- Canada - varies by province
- British Columbia published its guide in 2010. Service age 13 - 35
The Role of EPI services in British Columbia

- Primary care physician
- Specialized acute care services
- Peer support services
- Other mental health and addictions services
- Recreational services
- Crisis Intervention
- Housing and residential care
- Educational and employment services
- Income Support

EPI
- Early identification
- Specialized assessment
- Medication management
- Psychosocial Interventions
- Family education and support
GLOBAL GUIDELINES

- UK - National policy since 2001
- 2014 NICE guidelines recommended extending EI to all ages
- Extend beyond 3 years
- Denmark - National policy with full roll out by 2013.
- Trialling a five year service
GLOBAL GUIDELINES

- Hong Kong - service launched in 2001 for ages 15 - 25
- Clinician to patient ratio of 1:80
- Direct referral and telephone screening
WHAT DOES THIS MEAN FOR US HERE IN NEW ZEALAND?

- Early Intervention in Psychosis remains a priority in “Rising to the Challenge” - our national mental health service development plan

- It fits well into the wider strategy outlined in Blueprint 2 - youth focused, identifying and supporting people earlier
THE FUTURE DIRECTION OF MENTAL HEALTH SERVICES

- Increasing cause of disability in the population
- Recognition of the need to increase access to services and treat early
- Poor physical health outcomes in people with mental disorders
- Poorly integrated physical and mental health services
- Need to “mainstream” mental health
THE CHALLENGES
THE ECONOMIC CLIMATE

Source OECD
Age distribution of permanent and long-term arrivals
Year ended June 1996-2013

Inter-regional Migration Rates
By age group
2001-06
As EI services diverge, how do we know how an EI service should be configured?

- Skill mix
- Training
- Geographical variation
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Table 4. Univariate and Multivariate (age, sex & ethnicity) Odds of Being Admitted to Hospital whilst in Early Intervention Services (*=p<0.05*)
LEARNING WHAT WORKS FOR US

- EI teams are highly innovative - peer support, employment, physical exercise
- Lost opportunities to rigorously test what works
- Research not well integrated into services
Mean = 18-Nov-2005
Std. Dev. = 1.570E3 days
N = 997
LOOKING TO THE WIDER HEALTH SYSTEM

- We need to start thinking about how EI integrates into the health, education and social systems
- CVD as an example of a broad approach
- Cancer services and their approach to improving assessment and access
SUMMARY

- Solid evidence base behind Early Intervention in Psychosis Services
- Starting to see some divergence in approaches
- A need to look at what works in New Zealand - service framework, skills, research