EARLY INTERVENTION IN PSYCHIATRY
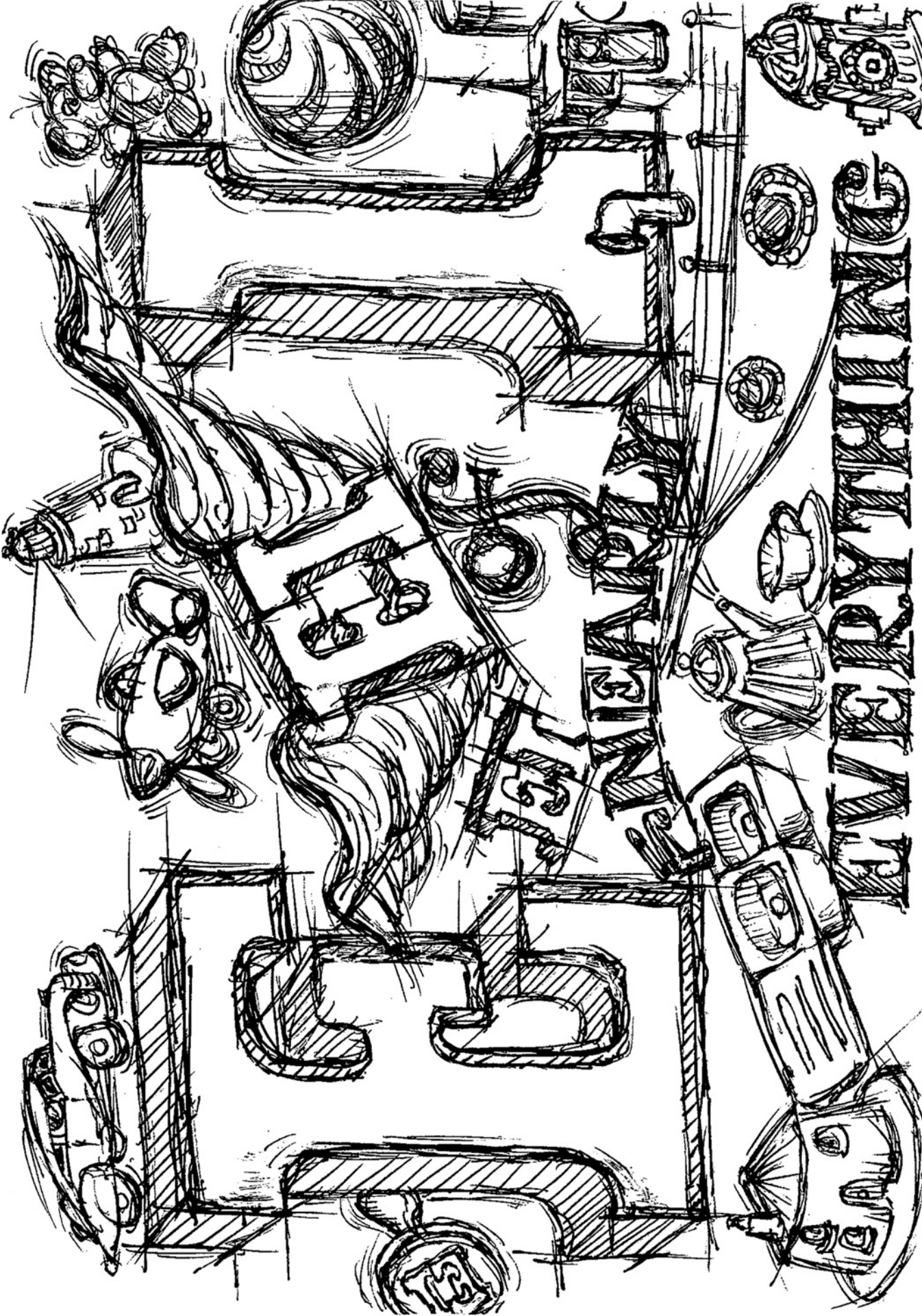
EI

of nearly everything for better mental health

EDITED BY

PETER BYRNE
ALAN ROSEN

WILEY Blackwell

Early Intervention
in Psychiatry

Early Intervention in Psychiatry

EI of nearly everything for better mental health

Edited by

Peter Byrne

Homerton University Hospital, London; Royal College of Psychiatrists, UK

Alan Rosen

School of Public Health, University of Wollongong
Brain and Mind Research Institute, University of Sydney
Mental Health Commission of New South Wales, Australia

Dedication

This book is dedicated to one of our Early Intervention of Nearly Everything *book co-authors, Professor Helen Lester, who died on this journey at the height of her academic and practical achievements, many of them concerning early intervention in primary care settings. She left a young family behind her. We also pay tribute to all the contributing authors in this book, from whom we have learned so much of value relevant to early prevention and intervention in a wider world. We acknowledge too all the people with lived experience of mental illnesses and their families, and the many dedicated service providers and researchers from whom we have learned about the immense value of earlier intervention approaches to many mental health conditions. Finally, we sincerely thank our families for their unflinching support for this, at least initially, quixotic dash into uncharted territory, and forbearance in living with our cognitive absences from them at times, due to our intermittent preoccupation with this most absorbing project.*

Contents

Part V   Conclusions

List of Contributors

Marco Armando   Child and Adolescence Neuropsychiatry Unit, Department of Neuroscience, Children Hospital Bambino Gesù, Rome, Italy; School of Psychology, University of Birmingham, Edgbaston, Birmingham, UK

Iyas Assalman   Newham Centre for Mental Health, London and East London Foundation NHS Trust

Jane Barlow   Mental Health & Wellbeing, Warwick Medical School, University of Warwick, UK

Arvin Bhana   School of Applied Human Sciences, Howard College, University of KwaZulu-Natal, Durban, South Africa

Maximilian Birchwood   YouthSpace; University of Warwick, UK

Sophie Bridger   Mental Health Foundation, UK

Helen Bruce   University College London, Institute of Child Health, London, UK; East London NHS Foundation Trust, London, UK; Barts and the London School of Medicine and Dentistry, London, UK

Peter Byrne   Homerton University Hospital, London; Royal College of Psychiatrists, UK

Tom Callaly   Barwon Health, Geelong, Victoria, Australia; School of Medicine, Deakin University, Geelong, Victoria, Australia

Andrew M. Chanen   Orygen Youth Health Research Centre & Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia; Orygen Youth Health Clinical Program, Northwestern Mental Health, Melbourne, Australia

Philippe Conus   Treatment and early Intervention in Psychosis Program (TIPP), Service of General Psychiatry, Department of Psychiatry CHUV, Lausanne University, Switzerland

Jayne Cooper   Centre for Suicide Prevention, Centre for Mental Health and Risk, University of Manchester, Manchester, UK

Patrick Corrigan   Illinois Institute of Technology, Chicago

Walter Cullen   Department of General Practice, University of Limerick Medical School, Limerick, Ireland

Franco De Crescenzo   Child and Adolescence Neuropsychiatry Unit, Department of Neuroscience, Children Hospital Bambino Gesù, Rome, Italy

Mark Deady   National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia

Linda Dowdney   University College London, Institute of Child Health, London, UK

Gráinne Fadden   Meriden Family Programme, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK; University of Birmingham, Birmingham, UK

Rick Fraser   Early Intervention in Psychosis Service, Sussex Partnership NHS Foundation Trust, Sussex, UK

Isabella Goldie   Mental Health Foundation, UK

Helen Herrman   Collaborating Centre for Mental Health, University of Melbourne, Parkville, Melbourne, Victoria, Australia

Rajeev Jairam   Gna Ka Lun Adolescent Mental Health Unit, South West Sydney Local Health District, Campbelltown, New South Wales, Australia; School of Medicine, University of New South Wales and University of Western Sydney

Nav Kapur   Centre for Suicide Prevention, Centre for Mental Health and Risk, University of Manchester, Manchester, UK

Tony Kendrick   Hull York Medical School, University of York, York, UK

Martin Knapp   Centre for the Economics of Mental and Physical Health, Health Service and Population Research Department, Institute of Psychiatry, King's College London, UK; Personal Social Services Research Unit, London School of Economics and Political Science, UK

Kristin Kosyluk   Illinois Institute of Technology, Chicago

Brian Lawlor   Mercer's Institute for Research on Ageing; Trinity College Dublin; St Patrick's and St James's Hospitals, Dublin, Ireland

Helen Lester   Primary Care, School of Health and Population Sciences, University of Birmingham, UK

Crick Lund   Department of Psychiatry and Mental Health, University of Cape Town, Rondebosch, Cape Town, South Africa

Craig Macneil   Treatment and early Intervention in Psychosis Program (TIPP), Service of General Psychiatry, Department of Psychiatry CHUV, Lausanne University, Switzerland

Karl Marlowe East London NHS Foundation Trust, London, England, UK

Paul McCrone   Centre for the Economics of Mental and Physical Health, Health Service and Population Research Department, Institute of Psychiatry, King's College London, UK

Andrew McCulloch   Mental Health Foundation, UK

Louise McCutcheon   Orygen Youth Health Research Centre & Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia; Orygen Youth Health Clinical Program, Northwestern Mental Health, Melbourne, Australia

Patrick McGorry   Orygen Youth Health Research Centre, University of Melbourne, Melbourne, Australia

David Meagher   Department of Psychiatry, University of Limerick Medical School, Limerick, Ireland

Nick Meinhold   Monash University, Victoria, Australia; University of Queensland, Brisbane, St Lucia, Queensland, Australia; Community Healthfulness Cooperative, Melbourne, Victoria, Australia

Irwin Nazareth   Department of Primary Care & Population Health, London, UK

Celia O'Hare   The Irish Longitudinal Study on Ageing (TILDA), Department of Medical Gerontology, Trinity College Dublin, Ireland

Nicola C. Newton   National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia

Inge Petersen   School of Applied Human Sciences, Howard College, University of KwaZulu-Natal, Durban, South Africa

Leora Pinhas   Eating Disorders Program, The Hospital for Sick Children, Toronto, Ontario; Department of Psychiatry, University of Toronto, Toronto, Ontario

Paddy Power   Treatment and early Intervention in Psychosis Program (TIPP), Service of General Psychiatry, Department of Psychiatry CHUV, Lausanne University, Switzerland

Rosemary Purcell   Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne, Victoria, Australia

Alan Rosen School of Public Health, University of Wollongong; Brain and Mind Research Institute, University of Sydney; Mental Health Commission of New South Wales, Australia

Hannah Schwartz   St. Mary's Hospital Center, McGill University, Montreal, Canada

Jan Scott   Newcastle University & Centre for Affective Disorders, Institute of Psychiatry, UK

David Shiers   National Early Intervention Programme, England; Leek, North Staffordshire, UK; National Mental Health Development Unit, London, UK

Jo Smith   National Early Intervention Programme, England; Worcestershire Health and Care NHS Trust, Worcester, UK; University of Worcester, Worcester, UK

Martin St-André   Sainte-Justine University Health Center, Université de Montréal, Montreal, Canada

Sarah Steeg   Centre for Suicide Prevention, Centre for Mental Health and Risk, University of Manchester, Manchester, UK

Danny Sullivan   Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne, Victoria, Australia; Victorian Institute of Forensic Mental Health, Clifton Hill, Victoria, Australia

Maree Teesson   National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia

Garry Walter   Discipline of Psychiatry, University of Sydney; Child and Adolescent Mental Health Services, Northern Sydney Local Health District, New South Wales, Australia

Amy C. Watson   Jane Addams College of Social Work, University of Illinois at Chicago, Chicago

Jennifer Wong   Eating Disorders Program, The Hospital for Sick Children, Toronto, Ontario

D. Blake Woodside   Department of Psychiatry, University of Toronto, Toronto, Ontario; University Health Network, Toronto, Ontario

Keiko Yoshida   Department of Child Psychiatry, Kyushu University Hospital, Fukuoka City, Japan

Foreword

Prevention of mental illness can take many forms and should be at the heart of mental health services. Traditionally, prevention has been classified into primary, secondary and tertiary. Virtually all psychiatric clinical practice is about secondary and tertiary prevention by treating the symptoms when they have developed and require intervention. In many cases, the development of these symptoms and the accompanying distress will determine where help is sought from and who is approached for intervention. The recognition of early distress has to be achieved carefully, as there is a serious danger that normal responses to stress or distress themselves may be pathologised and medicalised.

Early intervention can be seen at multiple levels – as an intervention at an appropriate stage before symptoms become resistant to intervention or as early recognition of the need to intervene. There are clearly ethical dilemmas which need to be resolved. Primary prevention is not only about mental health promotion and reduction in precipitating factors, but also about improving resilience. Early intervention is about treating people who are at risk of developing disorders as well as intervening at an early stage to improve the possibility of recovery. Clinicians as well as stakeholders need to be aware of the possibilities that early intervention in many conditions may help. We know that children with conduct disorders are more likely to develop personality disorders when they grow up. This development if averted may contribute to huge savings in the long run. One of the major challenges is for health to work with education, the criminal justice system and other departments to achieve this reduction. Another major challenge is where early interventions are based and placed – whether this is in primary care or secondary care. In either case, should they have strict boundaries? In which case, it is inevitable that further fragmentation and exclusion criteria come into play. The advantages of early intervention are many – through early and better engagement of the individuals and their carers and families – such approaches may reduce stigma and enable carers to learn about the illnesses and their consequences. For some psychiatric conditions, early intervention will take place in adolescence, whereas for others it will be in older age. These interventions need to be comprehensive, evidence based and interdisciplinary, no matter where they are placed.

Those individuals and families who may be at risk need to be educated and engaged in understanding what may precipitate certain illnesses, what the predisposing and perpetuating factors may be and how the individual, their families and society at large cope and manage these.

Interventions at antenatal stages, especially maternal support and abstinence from alcohol, smoking and drugs, can help. Postnatal support and educating about maternal and

parenting skills will enable the development of better attachment patterns in infants and children. Education about bullying and other factors at school will enable children to manage better in facing these and future adversities. Better physical health, physical exercise and employment all provide strategies for coping with stress and distress. There is compelling evidence that social inequalities, poor public transport, lack of green spaces can contribute to mental ill health.

It is heartening to note that there appears to be an increasing interest in prevention of mental ill health and mental health promotion. It is vital that these issues are taken up at both undergraduate and postgraduate levels. The present volume, with its array of topics and authors, will provide a further platform for ongoing discussion and debate but, more importantly, will contribute to practical advice which mental health professionals across disciplines will find helpful.

Dinesh Bhugra CBEPhD FRCPsych
Professor of Mental Health and Cultural Diversity
Health Service and Population Research Department
Institute of Psychiatry, King's College London
London, UK

I

The Rationale for Early Intervention in Nearly Everything

1
Introduction

Peter Byrne[1,2] and Alan Rosen[3,4,5]
[1] *Homerton University Hospital, London*
[2] *Royal College of Psychiatrists, UK*
[3] *School of Public Health, University of Wollongong*
[4] *Brain and Mind Research Institute, University of Sydney*
[5] *Mental Health Commission of New South Wales, Australia*

Early intervention (EI) is arguably the single most important advance in mental health care of the past decade. In terms of all-time advances in mental health care delivery, EI is up there with the consumer, family, recovery, and human rights for psychiatric disability movements, person-centred and holistic integrated services, effective psychotropic medications and psychotherapeutic interventions, evidence-based psychosocial interventions and mobile assertive community-centred service delivery systems. EI represents a key shift in both theoretical standpoint and service delivery, and marks an end to the first era of community psychiatry – where we set up 'accessible' clinical structures by locality, and patients were expected to adapt to these. With EI, practitioners reconfigure how they work to engage, negotiate and agree interventions support and care with their service users. From a general practitioner (GP) perspective, some modern community mental health teams (CMHTs) have 'raised the bar' to focus only on those with severe mental illness (SMI), now implicitly or formally defined as established psychotic disorders. Many CMHTs decline people in crisis or in the early stages of illness: by the time their referral is accepted later on, engagement is harder and many interventions have a reduced efficacy. Like all useful ideas, EI is a simple one and has instant appeal to people in early stages of illness (crucially often *before* insight is lost) and to their families. Key clinicians, notably GPs and mental health professionals also have a strong self-interest in designing and supporting efficient EI services. It is both self-evident to them, and increasingly evident from emerging studies, that such timely approaches could save much harder and longer clinical endeavour further down the track. We list the key pioneers later (Chapter 27), many of whom have contributed to this book. Their work, along with impressive citations at the

end of each chapter, should persuade readers new to EI that this will be a key component of the twenty-first century mental health care. This book's main aim is to affirm for every clinician, every purchaser of services and other interested parties the high value of EI in most care settings from cradle to grave.

Prevention

Caplan's three levels of prevention are well described [1, 2]. Primary prevention prevents the disorder from occurring in the first place, secondary restores health from an existing disorder, while tertiary attempts to claw back better function from persistent or long-term disorders. In mental health service delivery, most effort and money are devoted to tertiary prevention/maintenance treatment, where the quality of rehabilitation may be so variable that the term 'rehabilitation' may sometimes be a euphemism for habitual low-grade custodial care. Secondary prevention is the early recognition and treatment of psychiatric disorders: to date, the best evidence and best practice has been implemented in EI for psychosis in young people (see Chapters 7, 9, 15 and 21). This book will inform interventions in people from all age groups, building on the core components of excellent services: engaging, low (negative) impact practices that are culture- and age-sensitive with robust crisis interventions, assertive case management, flexible home visiting, family consultations and in and out of hours, active response services. EI teams should have a low threshold to identify individuals warranting assessment, monitoring and sometimes treatment, reduce stigma in patients and their local community, engage individuals with emerging symptoms and their family carers in low-key pre-emptive services even if formal treatment is not indicated, not wanted or not available, locally or anywhere. Their primary aim is to treat vigorously the first signs of the disorder in the first 3 years ('the critical period'). In managing a complex mix of possible noncases and cases, medication is only one option and part of phase-specific organic and psychosocial interventions: comprehensive therapeutic assessment, crisis intervention, education, family work, cognitive behavioural therapy, assertive community treatment, substance misuse and vocational interventions, to name but eight.

Overview: structure of this book

EI principles also support service users and carers in their individual recovery models, and dare to aim for full remission or generate hope that their symptoms do not develop into lifelong disability. A large part of primary care, child psychiatry and consultation–liaison (general hospital) psychiatry works as secondary prevention, but within large caseloads across secondary services including CMHTs, there are many opportunities for EI. This book's approach will be:

• Across the age spans, identifying the best EI practices in specific groups.

• Comprehensive: most common psychiatric disorders will be addressed – that is the 'nearly everything' of our subtitle. Because most psychiatric subspecialities have developed in isolation, they may be unaware of hard-won lessons from other colleagues in engaging and managing people from different demographic groups and cultures. Whether your patient is 8 or 80, there is much to be gained from an EI ethos.

- Evidence based, with an emphasis on **outcomes** (e.g. improvements in symptoms, social functioning, concordance, quality of life, service satisfaction) and **outputs** (e.g. interventions, contacts with services, clear care pathways that encourage referrals). Where these are available and reliable, screening instruments will be discussed.

- International, with authors and promising studies and experiences recounted from Asia, Australasia, Europe and North America.

- Practical: though it is challenging to cross different cultures and diverse health care provision, authors will try to answer readers' questions about how excellent EI service configurations might look (Section III), and which clinicians are best placed to intervene.

- Interdisciplinary and collaborative: this book was written for all interdisciplinary team members, our mental health and primary care colleagues (nurses, social workers, psychologists, occupational therapists, vocational rehabilitation and supported housing specialists, peer workers etc.), doctors (psychiatrists, GPs, public health doctors, paediatricians, adolescent specialists, physicians, geriatricians and more), managers, purchasers/commissioners and other health care providers. The book will also be useful to trainees in these disciplines, postgraduate students and commentators and to service user and family groups.

- Flexible and holistic: one of the key lessons from EI Psychosis Teams internationally has been NOT to send young people elsewhere (to another service) to address their substance misuse problems, or to separate organisations to deal with educational/training, housing, relationship problems. Although we did not brief authors about physical health care, this was raised frequently by the individual authors, and new approaches are set out later.

- Pragmatic: for clinicians with scarce resources, prioritising early identification (precursor symptoms and prodromes) to reduce current long durations of untreated illness and to set out core interventions that reduce psychological morbidity.

- Future proof: where evidence appears relatively sparse (e.g. eating disorders, learning disability, bipolar disorder) or where research continues apace (e.g. psychosis, dementia, delirium), expert clinicians will summarise the advances and predict where best practice will lie in the future. Though it may be attractive to researchers, the book is aimed primarily at clinicians, service planners and providers.

We begin with contributions from two key groups, whose interests mostly overlap – service users (consumers) and carers (families) – before hearing the economic arguments in the fourth chapter. The next six chapters have artificially divided the life span into five stages. Our needs change as we attach, individuate, enter adolescence then adulthood, before biology and our environment act upon us in middle age through to later life. We also include a key chapter on transition – from children's services to general adult psychiatry as Chapter 8. As health care providers this is an inevitable transition that should herald an orderly handover of care. Certainly in Europe, and we believe elsewhere, clinicians have not managed this well, and there are lessons to learn. Although artificial, we have laid out

settings and levels of prevention in the next five chapters. We accept the same patients are attending GPs (Chapter 13) as are admitted to general hospitals (Chapter 14), and every one of them benefits from primary prevention (Chapter 11) and voluntary sector activities (Chapter 12). Though this might seem theoretical, we think the principles that drive the evidence might be similar but the different settings require different strategies to deliver EI. Not least, each setting has a different story to tell about the institutional and other obstacles to EI.

Inevitably, we expect busy clinicians and students to go straight to the third section and Chapter 16 (the common mental disorders of depression and anxiety) and thence to the following eight chapters that are disorder specific. EI sceptics, and there are many, might need to explore the challenges from their comfort zones by looking at familiar diagnostic categories. We could have picked up to 10 additional, discrete disorders for this section but we think the material covered lends itself to the treatment of the 'nearly everything' our title boasts. Chapter 15 summarised the gains of EI Psychosis Teams across the world, but we felt strongly that bipolar disorder, still with the longest time to definitive diagnosis of any psychiatric condition, merited a separate space as Chapter 21.

In addition to Patrick McGorry's Afterword, we have three concluding chapters. Without the social movement described (and indeed led) by Shiers and Smith, allied to evidence-based stigma-reduction strategies (pioneered by Pat Corrigan and colleagues), EI would crash and burn. If our only arguments were short-term gains, especially financial, then the passion that drives EI would continue to shine brightly but would then move on to other challenges. The final concluding chapter contains a challenge to adapt our 'headsets' as Americans might say, to a public health oriented, preventionist and early intervention-ist approach to all substantial mental health disorders. It summarizes the strengths and benefits of this approach. It also contains cautions and caveats which urge us not to over-claim for this territory, and not to disband specific EI in psychosis teams or merge them with generic teams, on the perhaps illusionary rationale that such CMHTs could do a bit of EI of everything, as well as everything else they must do, and end up being nothing much to anybody.

What do we mean by prevention?

In primary prevention, it is easier to reduce precipitating factors (especially those prox-imal to illness onset) than predisposing factors, but some (coping style, social supports, resilience and other protective factors) are also amenable to interventions. Secondary prevention will remain mostly synonymous in this book with EI, and tertiary preven-tion, beyond the scope of this book, is the treatment and rehabilitation of established disorders. By this late stage, illness (disability) is long term: the person has developed recurrent severe depression, 'chronic' schizophrenia, or the medical complications of alco-holism/eating disorder, and the health professional's role is to 'pick up the pieces' in an attempt to reduce distress and restore a modest proportion of previous social function-ing. EI has the dual objectives of treating previously undiagnosed disorders and treating patients in the early stages of an illness where they have the highest chance of recov-ery. Ethical concerns (e.g. overdiagnosis – treating people who do not have, and will not develop, the disorder) will be covered in individual chapters and the concluding

chapter. They also focus on many of the initial benefits of EI (improvements in engagement, therapeutic alliances, less stigma and greater self-knowledge of relevant mental health disorders) and the prevention of collateral damage (comorbidities, losses of educational, employment and housing opportunities, disrupted relationships, widening health inequalities) which can both give a 'head-start' or provide a reserve of functionality and resilience to augment the effective management in patients who progress towards longer-term disability.

The how of prevention

Preconception advice and interventions, for example genetic counselling, are examples of primary preventative measures [3]. Similar measures are set out in individual chapters. Before a person becomes ill, and in the *lead in* time after someone develops symptoms ('biological disadvantage') but does not seek or achieve healthcare advice, most post industrial societies resource *universal measures* of prevention [1]. These are designed to help everyone: restrictions on alcohol sales and minimum pricing of alcohol to reduce general consumption and thereby alcohol consumption by people who are misusing alcohol, improved social capital, combating stigma through media campaigns. There are also *specific measures* [1] aimed at known, vulnerable groups: children from disadvantaged backgrounds, or people with chronic medical illnesses. Universally applied preventive measures are to be preferred for their greater potential to make a large positive effect on a population, and their less stigmatising impact on individuals. For this we need national initiatives, driven by research, where we end the artificial separation of the psychological from the physical [4].

Evidence

As we commissioned each chapter, we were aware that the practical gold standard for EI currently is the international effort to provide EI for young people with psychosis [5–7]. It is common, in EI psychosis services for example, to start secondary prevention for one disorder (typically anxiety, but frequently depression), in the context of simultaneous/parallel primary prevention for another (psychosis or comorbid substance misuse). The point here is that EI services (in any age group, any given disorder) need to understand and practice both primary and secondary prevention. While we can speak of general principles of EI, there is no assumption that these work in every (age) group, in every setting, at every stage of a (particular) disorder. To explore just one disorder, there are multiple differences in the detection and management of depression when this occurs in older people [8], women in the postpartum period [9], and in adolescents where classic presentation symptoms are the exception not the rule [10]. We have therefore encouraged the chapter authors to find the best evidence that should lead the best practice in their area, mindful that none of us, even in the developed world, have unlimited access to the resources necessary to run high quality mental health services. You will read about these age groups (Section II), settings (Section III) and disorders (Section IV) with no claim that 'one size fits all' in EI. As general psychiatrists, we were frequently pleasantly surprised to see impressive successful trials of treatments to challenge therapeutic nihilism in conditions like alcohol misuse [11] and eating disorders [12].

Parallels with medicine

At the time of writing, the Royal College of Psychiatrists (UK) in collaboration with service user groups has successfully lobbied the UK Government to sign up to *Parity of Esteem*. Parity of esteem (http://www.rcpsych.ac.uk/pdf/OP88.pdf) means that, when compared with physical health care, mental health care is characterised by:

- equal access to the most effective and safest care and treatment

- equal efforts to improve the quality of care

- the allocation of time, effort and resources on a basis commensurate with need

- equal status within health care education and practice

- equally high aspirations for service users and

- equal status in the measurement of health outcomes.

With this in mind, it would be unthinkable to deny or delay EI in cancer, myocardial infarction, stroke, or ANY serious physical illness. The consequences of late intervention in mental disorders mean more suffering for people with treatable disorders, and for their families. Because other bad things happen to people with severe mental illness (SMI), late intervention also means that our friends and family with SMI die between 10 and 20 years earlier than they would have if they never had a mental health problem (http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf). At time of submission, the Royal College of Psychiatrists' General Adult Faculty has set out 25 ideas to improve the poor physical health of people with mental illness as their first Faculty Report (https://www.rcpsych.ac.uk/pdf/FR%20GAP%2001-%20final2013.pdf). Appropriately, the first of these measures is the Lester Cardiometabolic Health Resource (www.rcpsych.ac.uk/quality.aspx) developed by Professor Helen Lester, who was third Editor on this volume, until illness prevented her from continuing with this project.

There is a second parallel with EI in medicine – the main down side of EI, overdiagnosis. Here, there are concerns that people (who by rights should not be just thought of as 'patients') are being 'overdosed, overtreated and overdiagnosed' [13]. Overdiagnosis, where asymptomatic people are 'diagnosed' with a disease that will not lead to symptoms or early death, is said to waste in excess of £128 billion in the US Healthcare system each year. Much debate prevails about disease mongering, overmedicalisation, mission (diagnosis) creep, and shifting thresholds to label people 'ill' and providing treatment that wastes their time and scarce resources [13]. Mental disorders fare relatively well in this critical review [13], with only attention deficit disorder getting a dishonourable mention. This is a complex condition, plagued by comorbidities, covered in Chapters 18 and 24. There is, however, no room for complacency in mental health: we will not medicalise behaviours (e.g. sex 'addiction') and do not advocate any potentially harmful treatments (by definition, medications) unless there is a safe, scientific prediction that individuals have or will go on to develop a treatable psychiatric condition. We now have highly reliable evidence that psychological and family interventions (but not necessarily anti-psychosis medication, except supplements like omega-3 fatty acids or fish oil) will prevent transition to psychosis in people with at-risk mental states [14].

And finally

We boast innovation in this book: we asked authors to write about their area of expertise on a blank page – with tips on how to deal with, overcome or effectively bypass the obstacles of 'unfit for purpose', ill-designed services, professional intransigence, the inertia of habitual practices and conventional wisdom. And to achieve change in the context of limited resources. The advantage of this endeavour has been to gather the best available evidence in one book – to enable busy clinicians and health care providers, among others – to make the arguments locally to get the effective services that individuals and families living with mental disorders deserve. Right now, they need ready access to the best services, as early as possible in the courses of their conditions. The unique purpose of this book is to gather the best available evidence of EI of many disorders and in many clinical systems, in one place. We anticipate that some will find gaps in the breath of coverage here, and expect that research will drive the evidence even further forward. At the very least, we hope to provoke and inspire.

References

1. Paykel ES and Jenkins R (eds). (1994). *Prevention in Psychiatry*. Gaskell.
2. Jenkins R and Ustun TB (eds). (1998). *Preventing Mental Illness: Mental Health Promotion in Primary Care*. Proceedings of a UN conference. John Wiley & Sons, Ltd.
3. Mario M, Juan JL, Norman S, et al. (eds). (2005). *Early Detection and Management of Mental Disorders*. Proceedings of a WPA conference. John Wiley & Sons, Ltd.
4. Jorm A and Reavley N. (2013). Preventing mental disorders: the time is right. *Medical Journal of Australia* **199**: 527.
5. Birchwood M, Fowler D and Jackson C. (2001). *Early Intervention in Psychosis*. John Wiley.
6. McGorry P and Jackson H. (1999). *The Recognition and Management of Early Psychosis: A Preventive Approach*. Cambridge University Press.
7. McGorry P (ed.) (journal) *Early Intervention in Psychiatry*. http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1751-7893/issues.
8. Sirey JA, Bruce ML and Alexopoulos G. (2005). The treatment initiation program: an intervention to improve depression outcomes in older adults. *American Journal of Psychiatry* **162**: 184–188.
9. Murray L, Wilson A and Romaniuk H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. *British Journal of Psychiatry* **182**: 420–427.
10. Babor TE, Ritson B and Hodgson RJ. (1986). Alcohol-related problems in primary health care settings: a review of early intervention strategies. *British Journal of Addiction* **81**: 23–46.
11. Thapar A, Collishaw S and Potter R. (2010). Managing and preventing depression in adolescents. *British Medical Journal* **340**: 245–258.
12. Shoemaker C. (1998). Does early intervention improve the prognosis in anorexia nervosa? A systematic review of the treatment-outcome literature. *International Journal of Eating Disorders* **21**: 1–15.
13. Moynihan R, Doust J and Henry D. (2010). Preventing overdiagnosis: how to stop harming the healthy. *British Medical Journal* **344**: 19–23.
14. Stafford MR, Jackson H, Mayo-wilson E, et al. (2013). Early interventions to prevent psychosis: systematic review and meta-analysis. *British Medical Journal* **346**: 12.

2
How Early Intervention Can Turn Things Upside Down and Turn a Patient Into a Psychiatrist

Nick Meinhold

Monash University, Victoria, Australia
University of Queensland, Brisbane, St Lucia, Queensland, Australia
Community Healthfulness Cooperative, Melbourne, Victoria, Australia

Introduction

When I became unwell I was placed in a system of early intervention and given 18 months of high quality care, encouragement and support. I have been given different diagnoses at various times and it is difficult to classify the symptoms I have experienced into a single mental health disorder. It is my opinion that early intervention is an effective system that is independent of a particular illness and beneficial for people experiencing mental ill health across the board.

The lead up to psychosis

Growing up can be a painful experience, and I was never one to do things the easy way. Plenty of excuses come to mind and I admit I tried on a few. My family went through some rough times and I lost things that I felt were very important. For much of my early adolescence I was focused on a career in basketball and this goal was well on track after state selection and a tour around America. Then multiple sports injuries requiring surgery forced me to take stock and finally I gave up my dream. There were also issues in my family, which broke apart when I was fifteen, but when I look back now it seems that

there was nothing entirely out of the ordinary to justify my anger at the world. Nothing that was not true for a lot of other people anyway.

I was angry and I made bad choices. Perhaps I lacked the foresight of age or the insight of maturity but I know in my heart that I had an urge to be destructive and I wanted to hurt myself. Maybe I just needed the world to see my pain.

Whatever the reason, my teenage years were an ever increasing cycle of self-destruction. Drugs and alcohol played a part but they were just the most readily available implements for the work of wreaking havoc on self. If no drugs had been available, I am sure I would have found something else. Whether it was relationships gone wrong, physical injury, legal consequences or horrible come downs, the results of bad choices were all fairly similar. They just bloody hurt.

You might wonder why someone would enter such a cycle. Why not just stop? I would like to be able to answer that question but I do not have an answer now just as I did not have then. Perhaps too many of the choices we make are on a level we do not have access to. Maybe we are subconsciously influenced by our relationship with ourselves, or maybe we just create situations that reflect the way we feel. I doubt I will ever really know. I have read a lot of theories on why people become self-destructive and how a negative self-image comes about. I wish we understood it in a way that we could discard unhelpful attitudes and stop creating unflattering and inaccurate ideas about ourselves. Personally I think that the issue of self-image is crucial, and where a constructive change can be most effective. A path that leads to pain, anguish and ill health has to begin somewhere.

As I destroyed my life I saw a lot of my friends take similar paths and I saw a reflection of my own anger and desire for self-destruction in their choices. The similarities drew us together and we pushed each other to ever-greater levels of chaos. We would consume any drugs we could find, get into fights and wreck whatever was in our way. Nothing justifies such terrible behaviour but perhaps we were trying to break the world in which we felt imprisoned. We were united by a desire to push until something shattered. Some of my friends are still at it and some are no longer around. Some found relationships and family or committed to jobs and careers. For me, I pushed until something shifted, but it was not the world that broke, it was my perceptions and reasoning and ultimately, my mind.

Amongst friends that often argued, trust was a fragile commodity. A slew of bad choices culminated in some major losses and I entered a downward spiral. Escalating levels of drug use and emotional turmoil felt like a weight dragging me down. I stopped doing anything that was remotely healthy. Eventually I even stopped eating and sleeping.

Psychosis and mania

Pushing a brain and body beyond their limits can only end badly. My thinking became focused around ideas of the future and I felt that I was able to perceive things I had not previously been aware of.

I was living at one of the colleges of Melbourne University, by nature a very competitive environment. As I gradually became unwell, my declining rationalisation fabricated conspiracies involving the college community and I managed to enrol some of my friends and a few members of the staff into my agenda. One such conspiracy that I remember centred on one of the staff, who also happened to be the father of a friend. I came to believe that he was controlling the other staff by blackmailing them with secrets of terrible acts

he had forced them to carry out. The delusions of an unwell mind can be incredibly elaborate in design and complex in detail. I am sure all of the people whom I believed I had convinced, in truth remained doubtful, but it is difficult to entirely disregard a passionate declaration of genuine conviction, no matter how bizarre the content. Of course at first, the theories I communicated were more unusual than inherently sinister, grandiose rather than conspiratorial, and we all love to be inspired.

The first stage of mania was an incredible feeling, like reaching the very pinnacle of joy and staying there, riding a wave. The incredible feeling eventually became an inflated sense of my own abilities and place in the world. Initially it was all very exciting but over time grandiose ideas became conspiratorial suspicions and my mind created elaborate stories with bizarre and complex causal relationships. In retrospect, there was a strong theme of control in my delusions and I became convinced that someone at my friend's work was controlling everyone with some kind of supernatural force, because particular words had been used in conversations. I do not remember the particular words or why I believed they had a particular meaning. I think this is part of the illness, to make connections that no rational mind would make and to take them on as truth.

Most of my memories of that time are very blurry but I have flashes of extreme emotional turmoil and psychological pain. Perhaps my mind created an alternative reality to escape into. I was certainly at the centre of the delusions I created, frightening and bizarre as they were. It seems counterintuitive to construct an illusion that creates so much misery but mental illness never seems to make much sense.

Involuntary treatment

My friends put up with my strange ideas and behaviour for as long as they could but eventually they agreed that the situation was more than they could deal with and contacted the local hospital.

I was couch surfing and moving around a bit but I had been spending a fair bit of time at one particular place. A friend owned a house in Melbourne and had seen other people become unwell with psychosis. He rang around and sorted out a Crisis Assessment Team (CAT) that included a psychiatric nurse and an occupational therapist. They came over and introduced themselves. I was in a very open state and told them everything they wanted to know. Perhaps it is contradictory but despite being unwell and delusional, on the whole I maintained a very truthful and candid manner throughout. Interestingly, I have found this to be true of many people I met who were struggling with their mental health.

I agreed to go for a ride and meet some new people. I am sure the CAT team had become very adept at using language that would create intrigue rather than suspicion and I do not see deception in the variation. I remember sitting in the back seat, feeling surrounded by nervous people. At one point I made a joke about the level of tension, which I did not understand and mistook as something others might have seen as fun, like we were playing a game and I had not been told the rules. The laughter was loud and sudden, like a release after a long period of suspense. I did not mean anyone any harm but I was aware that I no longer had any fear, which made people uncomfortable. We rode the rest of the way in silence and I watched the world slide by out of the window, no doubt in my mind that everything was as it should be.

Arriving at EPPIC

The Early Psychosis Prevention and Intervention Centre (EPPIC) was described to my friends as a lovely facility overlooking the Melbourne Zoo. There was indeed a view. Through the bars of the cage that surrounded the balcony we were allowed to smoke on, you could see the external fence of the zoo in the distance. I am sure this exaggeration of the facts was a part of the overall strategy of getting someone who was very unwell into a facility where they could be appropriately treated and I harbour no ill will towards the staff who created the small deception. In all of my experiences in the treatment of psychosis, the ideal situation seemed very far from the reality, but the people involved have always been well intentioned. Psychosis is a horrific experience for everyone involved and I believe we make the best of a very difficult situation.

On arrival, I was interviewed by a psychiatrist with a group of people in tow. I do not remember much of the conversation but I remember being excited about the idea of living at EPPIC, which was described as a wonderful place full of interesting people. The latter part of the statement proved to be quite accurate. I was taken up to my room and then left to my own devices.

I can of course only relay what remains of my memory of the events and there may well be interactions and situations that I have simply forgotten.

Meeting my housemates

The inhabitants of my new home were as disparate in appearance and character as any group I have ever encountered. The dynamics were complex but a clear hierarchy emerged. A giant Turkish guy who claimed he had killed and been to prison was the obvious leader. A young Maori kid was even bigger and they often clashed, with destructive results. When violence threatened to flare up, we all got out of the way and waited for the security guards to sort it out. Unfortunately the security guards were not always around and the ward at times felt like a dangerous place.

With so many extremely unwell young people thrown together in a relatively confined space, you had to stay alert. Delusions by definition were not based on evidence, often shifted quickly and seemed completely random. I had the sense that we were all trying to work out the meaning behind everyone else and decide how they all fit into our own constructed worlds.

Everyone was unpredictable, but there was a special kind of unpredictability in psychosis that came from abusing speed and ice. Most of the patients I spoke to had been using drugs of some kind and strangely, different kinds of illness seemed to spring from the various groups of drugs, though this may just have been my perception.

Living at EPPIC

Despite the potential danger, the facilities were wonderful, and the grounds quite beautiful. We also had plenty of activities to keep us occupied, everything from music sessions, where everyone ended up indiscriminately thumping their randomly assigned instruments, to art therapy where we created similar chaos with paint and craft supplies. Many found an

outlet and diversion in activities they had never previously had the opportunity to experience.

We were fed well despite meal times being a trial for the staff. Getting all of the inpatients together always had the potential for disaster. Being confined created a level of tension that could erupt in altercations in an instant and many delusions seemed to involve the food we were given. Apparently I stopped eating for some time as I became convinced there was a conspiracy to poison us. With so little control over our situation many took the opportunity to rebel by refusing their food or arguing over its contents. We were called in individually to a private room to take our medication and this also became a focus for many delusions, including my own.

Many of the delusions were very dark with themes of violence, conspiracy and sex being common. They often had a disruptive effect, to greater and lesser degrees. For example at one point, I offended the noses of my fellow patients for several days when I stopped showering, as I had become convinced I was going to be killed in the shower. Unfortunately it was not always just the sense of smell that was assaulted. Backing people into a corner, even if it is only in their minds, will of course produce varying results. Sometimes I was surprised that the staff could manage to keep everyone safe.

Maintaining control

As social animals, it seems isolation is the worst kind of punishment we can endure. At EPPIC there was an area I heard people call the ICA, where a patient could be viewed at all times from an adjacent office and any violent or unsafe behaviour could be immediately addressed. Most of the time I was there it was empty and the threat of being sent there and effectively isolated was a very potent form of control.

We were a group of agitated, often aggressive, unpredictable and extremely emotional young people. Most were naturally very angry at being detained and were eager to disrupt the control of their perceived captors. The measures that the staff employed to maintain that control were strict at times but never draconian. The security guards could be rough but if you did as you were told they left you alone. In an extremely tough situation I think that, on the whole, the staff did an incredible job of treating us with dignity and respect.

In fact, we were given the sense that we had control over our circumstances and ultimately our destiny, although I did not realize that at the time. When this occurred to me, I was recalling the balcony enclosed with prison style bars where everyone smoked profusely. One day, on exploring the extent of my detention I chanced upon the rubbish dump beneath the balcony that was a foot deep sea of cigarette butts. The sight disturbed me and I became determined to convert the butt wasteland into a clean environment. I imagine the futility of my task was not lost on the staff, but despite this, I was assisted with provision of the appropriate tools and encouraged to take charge of making a change that I felt was important.

Time to go

After roughly 2 weeks it was decided I could go home. Apparently I was still quite unwell but had passed a critical point. Someone suggested to my parents that they were unsure just how many of my responses were truthful, as I had demonstrated an ability to tell