

Early intervention in psychosis services

Key points

- The development of early intervention in psychosis (EIP) services has been informed by the experience of young people with psychosis and their families.
- The early phase of psychosis is now understood to be a critical period which provides a clear rationale for a specialist, intensive focus over this key time period.
- In treating young people with early psychosis, evidence suggests specialist EIP services are superior to generic community mental health team-based care on every outcome, including cost.
- There is a significant challenge to incentivise the health system (and other government departments) to maintain a long-term perspective in the current and future financial context.

In the current challenging financial climate, mental health organisations are looking at how they can do things differently to maximise resources and reduce costs while still improving people's care and their experience of services.

Community mental health services include community mental health teams, crisis and home resolution teams, assertive outreach teams and early intervention in psychosis teams, and all have a key role in preventing costly inpatient admissions. However, making efficiencies in community services has become a significant focus for many providers. This *Briefing* presents the evidence base and some key considerations which may helpfully inform and provide a focus for discussions between commissioners and providers in the planning and delivery of community mental health and early intervention in psychosis (EIP) services. There is a real challenge to maintain the effectiveness of EIP teams while making community services more cost effective, streamlined and easier to navigate by service users and other health and social care professionals.

Introduction

Adolescence and emerging adulthood are a high-risk time for developing mental disorders; in England 7,500 young people develop an emerging psychosis each year. The early phase of psychosis is a critical period affecting long-term outcomes. Failure to intervene early often has huge significant personal costs in terms of an individual having reduced capacity to reach their

social, emotional and vocational potential, as well as wider social and economic costs.

According to the World Health Organization's *World Health Report 2001*, schizophrenia and other forms of psychoses that affect young people represent a major public health problem. Worldwide, they rank as the third most disabling condition (following quadriplegia and dementia) and

pose an enormous burden in terms of human suffering. The economic and social cost of mental ill health has been estimated to be £105.2 billion in the UK.¹

Policy context

The Mental Health Strategy, *No health without mental health*, was published in February 2011 and consolidates the coalition Government's new approach to direction setting in mental health services. It is a marked departure from the National Service Framework and the accompanying policy implementation guidelines.²

The strategy sets out six objectives to improve mental health outcomes. Progress against those objectives will mainly be measured through indicators contained within the outcomes frameworks developed alongside the reform strategies for the NHS, public health and social care services. Organisations are driven to improve outcomes, with local partners working together to deliver them. How these outcomes are to be achieved will not be specified.

Key priorities running through the strategy include prioritising early intervention (EI) across all age groups, tackling health inequalities, and supporting people who experience mental ill health to recover meaningful lives. There are several outcomes that have particular relevance to improving the health and life chances of people with psychosis, which include employment, housing and physical health and mortality, as well as promoting personalisation approaches. The strategy is also

clear that these outcomes need to be improved while making efficiency savings. For further information, see our briefing *No health without mental health*.³

Community mental health services

EIP services are integral to comprehensive community mental health services. Their objective is to identify, assertively and early, people aged 14–35 years who are experiencing a first episode of psychotic illness, and follow them up in low stigma settings, maximising consistent engagement in treatment. This focus was established as necessary by evidence-based research and consumer campaigns in the 1990s, such as Rethink's *Reaching People Early*⁴, which highlighted the resultant suffering and cost implications when early detection and treatment were not provided consistently at such a crucial stage. EIP services were consequently established from policies the previous Government outlined in the NHS Plan (2001)⁵ and were supported by new and targeted funds.

Community services have a key role in preventing costly inpatient admissions, but making efficiencies in community services has also become a significant focus for many providers. Efficiency solutions that include merging specialist teams may initially seem attractive, such as placing EIP services into generic community mental health teams (CMHTs) to make savings. However, a particular feature of EIP service development has been the high-level scrutiny of its clinical and cost effectiveness.

Key questions for providers

- Could you streamline your community services to make them more efficient, simpler to access and navigate by service users and health and social care professionals, while also safeguarding the important functions and outcomes by EIP?
- How can the most cost-effective evidence-based services be expanded to drive improvements and efficiency in other parts of the organisation?
- How will people under the age of 18 presenting with psychosis access your services and be treated in the future?
- If you are redesigning your CMHTs, what is the evidence base for your decision? What are the long and short-term savings to be made?

There is considerable evidence to inform service planners about the effectiveness of EIP services. There is also evidence about the effective ingredients of EIP that can inform the service redesign debate and the question of whether the cost benefits of EIP can be maintained while providing an EIP service function from within a generic team.

EIP services

The Mental Health Strategy describes EIP services:

The last ten years have seen the establishment of a specialised service model that provides evidence-based interventions for treating psychosis in the early phase and at a relatively young

Key questions for commissioners

- What are the outcomes for young people with psychosis in your area?
- Is there a local, evidence-based strategy for improving these outcomes?
- Are your local mental health providers currently reviewing and redesigning their community teams?
- If so, are you familiar with the evidence base for their proposals and plan?

age (14–35 years old). There is an increasing body of evidence that supports this approach as more effective than the traditional generic community mental health team approach.⁶ This includes evidence that EI for psychosis results in a better course of illness, fewer symptoms at eight years on and a halving of the suicide rate.⁷

EIP teams promote early detection and engagement to reduce the duration of untreated psychosis to less than three months. They employ specialist staff to provide a range of interventions, including psychosocial interventions and anti-psychotic medications, tailored to the needs of young people with a view to facilitating recovery. EIP teams are distinguishable by their cultural sensitivity to the unique needs of younger adults, their focus on families, and their attention to the impact of interrupted development and the social consequences of serious mental illness. Ultimately, there are a set of values and

principles that define EIP.⁸ They seek to normalise experiences at a crucial developmental stage and offer therapeutic optimism, expertise and confidence in a recovery-based approach. Teams pride themselves on being person-centred, family-focused, responsive and engaging. Additionally they offer:

- optimised initial service experience, including home treatment and acceptable inpatient care
- positive risk management and expert management of suicide risk
- tolerance of diagnostic uncertainty while addressing

psychosocial problems

- management of co-morbid substance misuse
- recovery focus, with emphasis on personal empowerment, social and vocational outcomes
- early introduction of the principles of self-management and relapse prevention
- screening for and modification of physical health risks – to promote physical well-being
- cross-sector working with health, social, educational, vocational and third-sector providers
- sustained, maintained and continuous engagement.

Case study: Northumberland Tyne and Wear NHS Trust

The Northumberland EIP team became operational in 2002, and was one of the first services to follow the mental health policy implementation guidance. Adapted to suit a large rural county, a hub and spoke model was developed, with a central multidisciplinary hub supporting community psychiatric nurses embedded in rural CMHTs. The service had a strong psychosocial approach, with nurses able to deliver cognitive behavioural therapy interventions, with a clinical psychologist providing supervision and support. Carers were routinely involved in assessment, care planning and relapse prevention. The service took a positive risk management approach, trying to limit admissions and enable young service users to have the life experiences that promote developing maturity. Initially, psychiatry was provided by sector psychiatry, but in 2005 a part-time psychiatrist was appointed, alongside support time and recovery workers.

An audit project had been set up in 1998 to look at the first presentations of psychosis. Therefore, the service could evaluate itself against a baseline of treatment provided by the existing CMHTs. This demonstrated that the service had significantly improved engagement rates with young people, and had also significantly reduced the numbers of readmissions and total bed usage.⁹ Audit data also showed that over half of discharges at three years were back to primary care, and that 83 per cent of service users were not admitted to hospital in the two years following discharge. However, there appeared to be group of around 10 per cent of patients who experienced ongoing problems, often requiring assertive outreach services or rehabilitation.

EIP outcomes

EIP services have quickly demonstrated improved clinical outcomes combined with considerable cost savings through reduced use of hospital beds. In the longer term, reducing the number of young people remaining in mental health services with lifelong disability has the potential to save even more.

Service user experience

People who use EIP services seem to value the care they receive. A national evaluation of EIP services¹⁰ reported clients' experience, finding that EIP:

- offered activities and services that were youth friendly and made sense
- helped them come to terms with their illness and understand why they had become unwell
- worked with them over time to identify triggers and early warning signs.

The family and carer approach fostered by EIP has received positive comment from service users. Many felt their families were supportive in the care process, for example, advocating on their behalf, helping them cope with symptoms and helping develop and use relapse plans. This is not insignificant when the trauma and burden experienced by both service users and their families/carers when mental illness occurs is considered. In addition, it has long been established that evidence-based family interventions reduce the likelihood of relapse (see NICE guidelines, 2009).¹¹

People get better: reducing symptoms and hospital admissions

An early intervention in psychosis approach has been shown to reduce the severity of symptoms, improve relapse rates and significantly decrease the use of inpatient care, in comparison to standard CMHT care, at the 18 months follow up. Studies demonstrating this include the Lambeth Early Onset (LEO) study and the Danish OPUS study, which additionally demonstrated much greater levels of user satisfaction with the service.

The NICE review of schizophrenia guidelines also acknowledged the success of EI compared to CMHT care for people with psychosis.

Improved outcomes for BME groups

While the evidence for the incidence of mental health problems in black and minority ethnic (BME) groups is complex, we do know that some black groups have admission rates around three times higher than average. Migrant groups and their children are at two to eight times greater risk of developing psychosis.¹² There is evidence to suggest EIP services are already improving BME outcomes, and modelling based on LEO, the Association of European Schools of Planning (AESOP), the Count Me In census¹³ and a survey of London EI teams for the DRE programme¹⁴ has demonstrated benefits of the EIP model in terms of pathways to care, admission rates, hospital admissions, police contacts, visits to A&E departments and

'Despite the fact that CMHTs remain the mainstay of community mental health care (for psychosis), there is surprisingly little evidence to show that they are an effective way of organising services (for psychosis).'

NICE, 2009

costs. Indeed, given the increased disadvantage faced by BME communities in these fields, the proportional benefit of EIP is even greater for some communities.

The economic case: it saves money

Evidence suggests that the overall costs of an early psychosis service are considerably less compared to standard CMHT care, mainly as a result of reduced readmission rates (see Figure 1 on page 5).

The recent study by McCrone, Park and Knapp¹⁵ explored EI services and standard care focusing on the impact of vocational outcomes, homicide costs, suicide costs and the long-term economic impact of EI. The results suggest:

- EI results in substantially reduced costs of lost unemployment. 36 per cent of people receiving EI are in employment compared to 27 per cent in standard care. Using a minimum wage rate, the average saving is £2,087 per person in addition to healthcare savings.
- The cost of homicide is low for both EI and standard care. However, for EI the annual cost

of homicide (£6 per person) is £80 per person lower than for standard care which is £86.*

- Suicide is assumed to occur for 1.3 per cent of EI patients and 4 per cent of standard care patients. The estimated annual saving in suicide costs due to EI is £957 per person.
- The long-term impact of EI is dependent on what happens to readmission rates after discharge from the EI team. If the readmission rates remain constant then the expected saving over eight years is £36,632. If the rates immediately become equal to standard care after EI team discharge the figure is £17,427. Finally, if the rates converge gradually the expected saving is £27,029.

These studies conclude that comprehensive implementation of EIP in England could save up to £40 million a year and that this 'invest to save' approach can begin to release savings even within the first year of service provision. More work is needed to establish the longer-term impact of EIP services, particularly with regard to the impact of removing large numbers of people from being a continuing care burden to public services. Regardless of the potential long-term savings, it will be important to ensure that savings that are already being made are not lost.

*It is important to note that homicide committed by people with psychosis is rare although carries a high cost, however, suicide is more common in people with mental health problems. In both cases, the key costs are the loss of production and the impact the homicide or suicide has on those who are bereaved.

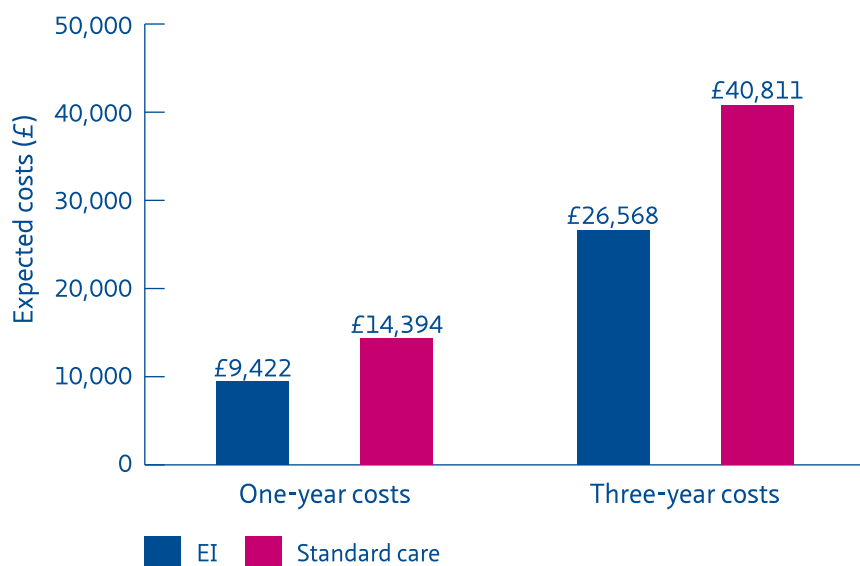
Case study: South London and Maudsley NHS Foundation Trust

Lambeth is the fifth most deprived borough in London and ranked nineteenth in the UK. It also has a high incidence of psychosis. There has been good recognition of the problem of mental health by the PCT and subsequently the Lambeth Early Onset services (LEO) are very well resourced. The EI services of LEO are highly valued and set an example of good clinical care, research and training for other teams. EI is at the forefront of local changes and unlike other parts of the country there is no talk of disinvestment. Instead Croydon, Lambeth, Southwark and Lewisham will merge their EIP services to become an early intervention care pathway.

The service does recognise it is privileged to be well resourced and has some unique functions. For example, there is a crisis and assessment and treatment team (CAT) which accepts referrals. 60 per cent of these are from GPs, and other sources include CMHTs, A&E, inpatient wards, child and adolescent mental health services, probation and the prodromal service OASIS. Referrals are seen from within two hours to two days at the first presentation of psychosis and people remain in CAT until the crisis is maintained and the person is engaged with treatment, which may include medication, cognitive behavioural therapy and mindfulness services.

LEO community service sees patients for two years after the initial contact and its main focus is relapse prevention. There is a dedicated inpatient setting that works well and is attractive to staff to work in and has a high number of applicants per post. CAT patients and families are taken to the LEO unit to see as a potential option for treatment. There is ongoing family interaction and intervention where appropriate.

Figure 1. The costs of early intervention in psychosis



Source: McCrone, Knapp, Dhanasari, Nov 2009, 3(4) p266-273

The effective ingredients of EIP

Researchers have become increasingly interested in what functions of the EIP service model make it so effective. Evidence from health economic studies and from naturalistic studies¹⁶ has tested the service delivery model that was first described in the policy implementation guidance accompanying the NHS Plan.

A systematic review of this evidence¹⁷ suggested that the efficacy of EIP was due to the model of service delivery enabling the implementation of NICE recommended guidelines for psychosis, particularly psychological therapies.

A key question is how does EIP differ from standard care? An important recent study¹⁸ examined the evolution over ten years of a comprehensive standalone EIP service out of a CMHT service. In 1998, only 15 per cent of individuals under the care of a traditional, generic CMHT made a full or partial functional recovery at two years. This compared with 52 per cent of the cases who were making a full or partial functional recovery under the care of a comprehensive EIP service in 2007. A large reduction in inpatient admissions was a further measured benefit from EIP. Moreover, with partial implementation, where specialist EIP workers were deployed within a traditional CMHT framework, only 24 per cent made a partial or full recovery. This is compelling evidence for the benefit of the service model described in the policy implementation guidance, and demonstrates how delivering

Summary of key findings

EIP services offer an evidence-based outcome-orientated approach to supporting people with first time psychosis. Findings suggest:

- the early phase is critical and requires a specialist intensive recovery focus intervention
- reducing the duration of untreated psychosis can improve life chances
- high service user and carer satisfaction
- compelling evidence of the clinical and cost effectiveness of EIP over standard care
- positive indicators for long-term savings
- cost savings can be quantified within the health sector as well as across wider society
- regardless of the long-term savings, the benefits of early savings are not lost
- opportunities to support delivery of key objectives within the Mental Health Strategy.

EIP within a specialist team model increases effectiveness.

The EIP service model also appears able to overcome many of the known problems in delivering effective mental health services, not least the challenge of translating new evidence into skilled practice.¹⁹ Key features of the EIP approach include reduced case loads, access to supervision, strong leadership and management support and ultimately a team culture that values the intervention and believes in recovery.

Opportunities for the future

EIP principles such as proactive engagement, family-centred care and the toleration of diagnostic uncertainty are recognised as having a wider utility in the new Mental Health Strategy.

Child and adolescent services and services for people with dementia have been singled out, but the EI premise is regarded as universally applicable. Recognised benefits from health promotion, prevention, secondary prevention and targeted recovery interventions aimed at social as well as health outcomes should be applied to all care and age groups.

Given that 75 per cent of mental health problems emerge before the age of 25, the need to develop better youth services is recognised: 'One quarter to one half of adult cases in the population might be prevented by effective treatment of youths with psychiatric disorders.'²⁰

EIP services demonstrate an effective 'invest to save' approach that could be a template for other youth mental health disorders, such as emerging personality

disorders. This more general EI in youth mental health could, like EIP services, reduce costs in mental health and other parts of public services. EIP services can play an important role in the continued evolution of mental health services.

Mental Health Network viewpoint

Making efficiencies in community services has become a significant focus for many providers, with some merging EIP teams into CMHTs. Careful planning may facilitate new ways of working that preserve EIP outcomes and make savings, as well as making them simpler to understand by users of and referrers to the service. However, to reap the clinical and cost benefits of the EIP model, the evidence suggests that services are required to deliver some core effective ingredients. Whatever service model is chosen, it must be able to address the issue of the age

of onset and guarantee sustained early engagement.

The Mental Health Strategy cites EI services as one of the ways to radically change how services are delivered so as to improve quality and to reduce costs, and EIP has a track record of delivery that clearly fits with the current quality, innovation, productivity and prevention (QIPP) agenda. Through innovative practice, EIP services have evidenced substantial clinical improvements, met productivity targets, reduced costs and, importantly, has been well received by the clients, families and the referral agencies that have experienced them. EIP services also offer mental health providers opportunities to support the delivery of key objectives within the Mental Health Strategy.

Therefore, we caution against hurried redesign of one of the areas of mental health provision where there is compelling evidence

to support the existing service model and opportunities to meet future objectives.

Both commissioners and providers could helpfully draw on this compelling evidence to inform the planning and investment in evidence-based services to support longer-term savings.

However, this is also a challenge for policy-makers to deter against disinvestment for short-term gains. There is a significant challenge to incentivise the health system (and other government departments) to maintain a long-term perspective in the reality of the current and future financial context, especially when not all of the benefits of its efforts will be reaped within its own sector.

For more information on the issues covered in this *Briefing*, please contact claire.mallett@nhsconfed.org

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The Mental Health Network

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For further details about the work of the Mental Health Network, visit www.nhsconfed.org/mhn or email mentalhealthnetwork@nhsconfed.org

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