We are writing in response to the inquiry into child and adolescent mental health services. We represent the Glasgow site of the Early Detection and Intervention Evaluation (EDIE-2) research study. EDIE-2 is a national randomised control trial of cognitive behavioural therapy (CBT) for individuals at risk of developing psychosis. The trial is funded by the Medical Research Council and is recruiting participants in Glasgow, Manchester, Birmingham, Cambridge and Norfolk. We aim to recruit 320 participants nationally before recruitment concludes in June 2009. The age range of our participants is 14-35 years, which reflects the period of peak risk for developing first episode psychosis.

The primary aim of EDIE-2 is to investigate the effectiveness of cognitive behavioural therapy (CBT) in reducing or delaying transition to psychosis in at-risk individuals. In addition to this, we hope to reduce the duration of untreated psychosis of individuals who make transition and develop an understanding of pathways to care for at-risk individuals. Our response to the questions listed below is therefore in specific reference to psychosis and related mental health problems. It is our view that the early detection and intervention of psychosis should be a key consideration of this review.

Introduction
Psychosis describes a mental state characterised by a loss or distortion of reality. Although not a diagnosis per se, psychotic experiences feature in several major mental health disorders, including schizophrenia, bipolar disorder and depression (APA, 1994). Psychotic experiences include delusions, hallucinations and thought disorder and represent a severe disturbance of emotion, cognition, perception and behaviour. Approximately 3% of individuals experience an episode of psychosis at some point in their life.

The majority of mental health problems begin in adolescence or early adulthood. Indeed the World Health Organisation has suggested that mental illnesses are the ‘chronic diseases of the young’ (WHO, 2004). This includes psychosis, which is most likely to emerge early in life (80% of first episodes of psychoses occur between 16 and 30 years of age). This is typically the time when individuals are attempting to secure work, develop relationships, pursue education or training, and develop social and economic autonomy. Psychosis therefore represents a potentially devastating disruption to an individual’s psychosocial development. The potential economic and social benefits of early detection and intervention in psychosis are therefore likely to exceed those of other health problems which typically emerge later in life.
How children and adolescents potentially at risk of developing mental health problems are identified and how those problems should be prevented?

How can we identify young people at risk of psychosis?

The past decade has seen growing evidence to suggest that the early detection and treatment of psychotic disorders can lead to improved treatment response and prognosis. Two recent systematic reviews have confirmed that long duration of untreated psychosis (DUP) is associated with poorer outcome (Marshall et al., 2005; Perkins et al., 2005). There has been extensive research interest in the early development of psychosis with a view to develop preventative interventions.

Psychosis often emerges following a period of altered mood, behaviour, cognition and functioning (Singh et al., 2005). Research at the PACE (Personal Assessment and Crisis Evaluation) clinic in Melbourne, Australia, attempted to identify individuals at imminent risk of developing psychosis. It is known that the highest incidence of psychosis occurs in adolescence and early adulthood (Hafner et al., 1994). In addition, specific clinical risk factors are associated with the onset of psychosis including functional decline and attenuated or isolated psychotic experiences (Yung & McGorry., 1996). Individuals who meet these risk factors are considered to be at ‘ultra high risk’ (UHR) of developing psychosis (Yung et al., 2004).

The PACE research group have developed prospective criteria that can identify UHR individuals. These criteria include operationally defined At Risk Mental States (ARMS) (Yung et al., 1996). High-risk ARMS criteria can be thoroughly assessed using the Comprehensive Assessment of At-Risk Mental States (CAARMS) (Yung et al., 2005). The CAARMS assesses all dimensions of ARMS criteria, including intensity, frequency, duration and recency of subthreshold psychotic symptoms and reports good validity (Yung et al., 2005). These criteria can identify clinical need and predict risk of transition to psychosis, with 35-40% of those meeting criteria developing psychosis within 12 months (Yung et al., 2003). To be considered at ultra high risk of psychosis, individuals must meet inclusion criteria for at least one of the following groups:

(a) attenuated psychotic symptoms group: have experienced sub-threshold, attenuated positive psychotic symptoms during the past year

(b) brief limited intermittent psychotic symptoms group (BLIPS): have experienced episodes of frank psychosis symptoms that have not lasted longer than a week and have been spontaneously abated

(c) trait and state risk factor group: have a first-degree relative with a psychotic disorder and who have experienced a significant decrease in functioning during the previous year.
Although these criteria carry a false positive rate of approximately 60%, all those identified are help seeking and in need of some intervention. While going from a population rate of 1% to identifying over 30% of individuals at risk represents significant progress in the accurate early detection of individuals at risk of developing psychosis (Drake et al., 2005). In addition to this, there is substantial psychological morbidity within this group even amongst those who do not make transition to psychosis. Within our local data, we have found that 55% of our ARMS sample met criteria for anxiety, mood or substance use disorders.

How can we prevent some of the problems associated with psychosis?

Early intervention in psychosis can mean improving outcome in established psychosis, detecting untreated cases in the community or preventing the development of psychosis by offering interventions to individuals who are at risk of developing psychosis (Singh & Fisher, 2005). The development of UHR criteria to identify at risk individuals has enabled preventative interventions targeted at this cohort to be developed and evaluated.

The primary aim of intervention at this stage is to prevent or delay transition to psychosis. However, as we have found in our local sample, comorbid problems are common in this group and interventions at this stage can identify and treat current problems, such as depression, anxiety and deteriorating psychosocial functioning (Broome et al., 2005). A secondary aim of early detection and intervention strategies is to reduce DUP and facilitate a smooth, non-traumatic care path to first episode services should transition occur.

There have been four published studies examining the effectiveness of interventions aimed at reducing or delaying transition to psychosis in UHR populations (Morrison et al., 2004; McGlashan et al., 2006; McGorry et al., 2002; Nordentoft et al., 2006). Three of these studies found a significant reduction in transition rates between intervention and control groups (McGorry et al., 2002; Morrison et al., 2004; Nordentoft et al., 2006), whereas a fourth found a non-significant trend (McGlashan et al., 2006). Two of the three studies that found a significant difference used a combination of psychosocial and pharmacological intervention whereas Morrison et al (Morrison et al., 2006) used cognitive therapy alone. McGlashan et al (2006) was the only study to assess a pharmacological intervention alone. These results would indicate that psychological or psychosocial interventions, either alone or in combination with pharmacological interventions are the treatment of choice in this population.

As a consequence of the false positive rates inherent in the UHR criteria described above, early interventions have been criticised as having the potential to stigmatise or expose individuals to treatments they do not need (Warner, 2005). Morrison et al (2004) specifically address these concerns in their single use of psychological intervention. Whilst attending psychological therapy could have potential to cause stigma, they argue that psychological therapy is less harmful than the side effects of medication. Although false
positives will still be a feature of identification of this population, the various comorbid problems associated with the UHR group are all potentially amenable to evidence-based cognitive therapy intervention, including depression (Hollon et al., 1996) and anxiety disorders (Clark., 1999).

The EDIE-2 study, which is due to complete in December 2009, is an expansion and replication of the Morrison et al study, assessing the effectiveness of cognitive therapy in reducing or delaying transition to psychosis within a large UHR sample.

What obstacles there are in identifying children and adolescents with mental health problems and how they might be overcome?

A lack of information and awareness regarding the identification and treatment of early psychosis is likely to be a key factor contributing to the length of DUP. Reducing DUP has been the focus of clinical interest, and the most promising way to reduce treatment delay is to introduce early detection strategies into early intervention (Melle et al., 2004). The DUP has been conceptualised as a treatment lag comprised of: 1) delay in help seeking, and 2) delay in referral to appropriate service (Bechard-Evans et al., 2007).

Despite recent advances in the understanding and development of UHR criteria, identification and engagement of these individuals in the community remains a challenge. The early recognition of UHR in the community depends on the awareness and understanding of psychosis within the general public, frontline NHS staff, social care workers, teachers, youth and community workers who have contact with young people. There also remains significant stigma regarding psychosis and poor understanding of the potential treatment and prognosis of the condition. Therefore, individuals need to be aware of what can be done to assist UHR individuals and how to access appropriate services. Therefore, in our view, the main obstacles to early detection and intervention in psychosis are: 1) lack of information regarding early signs and symptoms of psychosis, 2) stigma and lack of awareness regarding treatment options, and 3) access and understanding of services and treatments available to this group.

What action is being taken to facilitate early intervention and what else can be done?

The most effective way to increase health awareness is through community level education (Grilli et al, 2002). Information campaigns to raise public and professional awareness of psychosis are a key element of early detection. A good example of how such information campaigns can succeed in the early detection of psychosis is the Norwegian Early Treatment and Intervention in Psychosis Study (TIPS) which ran between 1997 and 2000 (Melle et al, 2004). This study significantly reduced DUP by introducing an education
campaign about psychosis directed at the general population, and targeted information campaigns directed at GPs, education, social work and voluntary sectors. In addition to this they established specialised low-threshold early detection teams that could be directly accessed by everyone. The education programme was on the premise that: 1) treatment delay was due to lack of awareness or prejudices about psychosis, 2) access difficulties for specialist services, and 3) delays in identifying cases and resource issues. Intensive community education and specialist assessment and treatment services significantly reduced the treatment delay compared to standard clinical care. Areas that received education also identified individuals 5 years younger, with lower symptoms severity and higher functioning (Melle et al, 2004).

While there has been considerable effort towards raising public awareness of mental health problems by the Scottish Government, a specific programme of awareness related to the early detection and treatment of psychosis could have similar impact as was found in Norway. In addition to raising awareness of the early course of psychosis, we need to provide accessible services that can offer evidence-based interventions for UHR individuals. Successful early intervention in mental health includes both the early detection of mental health problems and the availability and implementation of phase specific interventions.

Elsewhere in the UK, there are specialist early detection services and that provide a mental health service to individuals at risk of developing psychosis. In addition to this, they perform extensive activities to raise awareness of psychosis in the community. These include EDIT (Early Detection and Intervention Team) Salford, EDIT Birmingham, Outreach and Support in South London (OASIS) (www.oasislondon.com), and Insight, based within ‘The Zone’, which is a youth information and support service in Plymouth (www.thezoneplymouth.co.uk).

How access to services and ongoing support can be improved?

The early detection services listed above are good examples of how services can become more accessible to young people. Both EDIT Salford and Birmingham see individuals within primary care, usually at their GP practice. OASIS is based within residential housing in South London. Insight is based within a multipurpose youth friendly centre that provides information and support regarding a wide range of issues, including housing, activity and skills development, and general health advice. All of these measures significantly reduce the perceived sense of stigma that could prevent individuals from seeking help, as they can access assistance in normal community settings.

The Zone in Plymouth is a good example of partnership working between the NHS and non-statutory organisations. In our view, working closely with the voluntary sector has the potential to further dilute any stigma that is associated with attending mental health services. For many young people at risk of developing psychosis, their experiences may not feel like health.
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problems. There may be concern that their problems are not serious enough to approach health services, or on a related theme, concern about the impact and consequences of disclosing ARMS to individuals in traditional mental health settings. The stepped care approach of early detection services could facilitate the early engagement of individuals who are most at risk. This has the added advantage of being able to develop a smooth care pathway to other mental health services as appropriate.

What problems there are around transition from CAMHS to adult mental health services and how a smoother transition may be achieved?

In terms of assisting people who are at UHR of developing psychosis, the transition between CAMHS and adult mental health services does not present a problem within specialist early detection services. This is because these services are open to individuals within the age range that represents the period of highest risk of developing psychosis. This removes the difficult barrier between adolescent and adult services, which could result in a disruption to the continuity of care at a time of peak vulnerability. For example, OASIS accepts referrals for people between 14 and 35 years old, whereas ‘The Zone’, with its wider youth remit, is open to individuals between 13 and 25 years old. If services for young people are phase orientated and youth appropriate, then there need not be an arbitrary distinction between adolescence and young adulthood.

References


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20 January 2009