I

The Rationale for Early Intervention in Nearly Everything
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 subspecialties 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.
OVERVIEW: STRUCTURE OF THIS BOOK

- 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 interventionist 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 overclaim 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 proximal 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 prevention, 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 alcoholism/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 functioning. 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 recovery. 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].
REFERENCES

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