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A psychological and communitarian approach to treating early psychoses: A service description with some initial findings

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The authors describe the characteristics and the preliminary findings of the Early Care Team for At-Risk of Psychosis Patients (EAPPP), within the public Primary Health Care System of Barcelona, Spain. The community-focused work and the psychological and inter-paradigmatic framework are highlighted as core components of the EAPPP unit in the field of Early Care of Psychosis. Some initial findings in relation to three groups of patients are presented.

Keywords: early psychosis; community prevention; first episode of psychosis; at-risk mental state; need adapted treatment

Introduction

Psychotic syndromes are the mental disorders that are likely to carry the largest individual, micro- and macro-social suffering and direct and indirect budget costs (Knapp, 2000; McGorry et al., 1996). Moreover, for almost two decades there have been conflicting findings about the importance of reducing DUP (duration of untreated psychosis) (Marshall et al., 2005). Despite the methodological, clinical and social disparities between such studies' approach (Olsen & Rosenbaum, 2006; Perkins, Gu, Boteva & Lieberman, 2005), almost all show that months or years can go by between the first symptoms and the first treatment.

Taking this into account, deploying strategies to reduce DUP (Ultra High Risk (UHR), European Prediction of Psychosis Study (EPOS) strategy and others) and to develop early interventions becomes a necessary goal and a priority for mental health care (Alanen, 1999; Klosterkötter et al., 2005; Yung, Phillips & McGorry, 2004).

Methods

Setting description

In 2006, a public health system team dedicated to Early Detection and Care for "At-Risk of Psychosis Patients" (the EAPPP: Early Care Team for At-Risk of Psychosis Patients) was started in Catalonia. Operating in Barcelona within the Catalan Public Health System (ICS), the EAPPP became the first specialized and integrated Spanish team fully dedicated to the early detection and treatment of psychosis. There are now

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10 similar programmes inside the Catalan Health System. The EAPPP service belongs to Primary Care Health services of a Barcelona health district.

The general objectives set out for the team were: (1) assisting patients with prodromal symptoms and first episodes of psychosis (FEP); (2) preventing, if possible, the development of psychoses by treating “at-risk of psychosis patients” (ARMS); and (3) decreasing social, family, and individual suffering and burden.

The team consists of two psychiatrists and a psychologist, all trained in psychotherapy (5–8 years of training), a social worker, two mental health nurses and administrative staff. The team is available from 8 a.m. to 8 p.m. every day. The catchment area is inhabited by 83,567 people (estimated to be nearly 100,000 when including not totally legal residents), inhabiting a neighbourhood in central Barcelona, incorporating middle and low-middle classes with a progressive increment of immigrant workers.

Three target population groups or profiles have been defined: (1) people with FEP diagnosed in the previous 12 months; (2) subjects at risk for psychosis (ARMS group); (3) children (0–12 years) with a high burden of risk factors (highly vulnerable children: HVC group). This is a group frequently not considered by international teams for psychosis early care, but which is important to include if we are to address DUP and the duration of prodromal states of psychosis comprehensively (Addington et al., 2008; Hafner & Maurer, 2006; Johannessen, Martindale & Cullberg, 2006).

Clinical core points

The theoretical and technical foundations of our work are based on a “psychoanalytically informed” relational and communitarian perspective: the framework of “primary care for mental health” (PCMH; Tizón, 2001). This theoretical and technical framework has led teams using it to achieve a high incidence of access to services, which must be responded to with structured non-professionalizing techniques. It is impossible to care in a “medicalized” or “biologistic” way for the 21% of the population that have had contact with the services organized according to the PCMH theoretical framework (Tizón et al., 2009). Integrating mental health services with social and educational services, both at detection and treatment level, is critical in this perspective, as well as integrating cognitive-behavioural advances in the field.

A screening instrument, the Early Recognition Inventory Checklist (ERIRAos: Häfner & Maurer, 2006) is used by the network of community professionals working with the EAPPP (primary care health services, social services, psycho-pedagogic services, mental health services, legal services, etc.) to identify possible cases. Possible cases were referred to the EAPPP whenever any person rated “positive” in the ERIRAos, and/or if they showed ARMS problems according to the information and inter-consulting shared sessions conducted by the EAPPP (about 50 a year). Upon completion of the evaluations (Table 1) including SIPS/SOPS interview (Structured Interview for Prodromal Syndromes: Miller et al., 2003) and medical examinations (blood and urine analysis, electrocardiogram, electroencephalogram, magnetic resonance imaging or computerized axial tomography, etc.), the subject might fulfil the ARMS or FEP criteria, be considered HVC, or might not fulfil any EAPPP assistance profile at all and therefore be referred to another mental health service (see Figure 1 and Table 2).

Our intervention model is multi-dimensional, integrating the individual, family and social levels. Our therapeutic approach – Needs-adapted treatment for patients

Table 1. Inclusion criteria for the ARMS[†] group in EAPPP Team (derived from UHR, EPOS & EAPPP criteria).

Presence of 4 from 8 criteria (at least 2 of 1–4).

1. **Attenuated positive symptoms.**
2. **Brief limited/intermittent psychotic symptoms** (Delusions, Conceptual disorganization, Grandiosity, Hallucinations, Suspiciousness).
3. **Familial risk plus reduced functioning** (reduction of 30% or more on the GAF).
4. **Positive in ERraos Screening test.**
5. Risk factors accumulation (in Healthy Child Programme, or >20 in LISMEN).*
6. Subject without a continued linkage with mental health network having occasional contacts with highly specialized services: hospital or psychiatric emergencies, psycho-pedagogic services, specialized social services, law and minors services ...
7. Dysfunctional or unstructured family (with LISMEN definition*).
8. Evaluated cognitive impairment or detection of evident consequences in job or scholarship.

* LISMEN: from Artigue et al. (2004).

Table 2. Clinical summary of a two-year period (June 2006–June 2008).

EAPPP: clinical referrals (2 years)	Total cases	Incidence in service year /10,000 inhabitants
Referrals for evaluation	139	
Included in programmes	99	
FEP	17	1.01
ARMS (Transition to FEP: 4 cases)	42	2.51
HVC	23	1.37
Others	17	

and families in the community (TANC) – was inspired by the “need adapted treatment” of Yrjo Alanen and other Scandinavian authors (Alanen, 1999; Johannessen et al., 2006). There is a range of techniques that are available for use depending on the needs of each patient and family system: family interviews, “12-hour availability”, individual psychotherapy, psychopharmacology, psycho-educational groups, multi-family therapy, social skills orientation, “parallel groups” for ARMS subjects and their families, preventive programmes for offspring and families, visits in the environment and home, and regular meetings with community services.

Some initial results

Over a period of two years, we have detected and applied our treatment programmes (the needs-adapted treatment for patients and families in the community) to 17 FEP cases, 42 ARMS cases and 23 HVC subjects (Tables 1–4). Sixteen additional persons were added to the “Others” group (family members and not-EAPPP profile). We obtained a mean “incidence in service per year” of 1.01 (FEP), 1.19 (for overall “delusional psychoses”), 2.51 (ARMS) and 1.37 (HVC) per 10,000 inhabitants. Over a period of two years, 4 ARMS cases developed a first episode of psychosis (Table 2).

We have written other papers about the EMAR detection (Quijada, Tizon, Artigue & Parra, 2010) and about the initial symptoms in FEP (in preparation). Our ARMS or

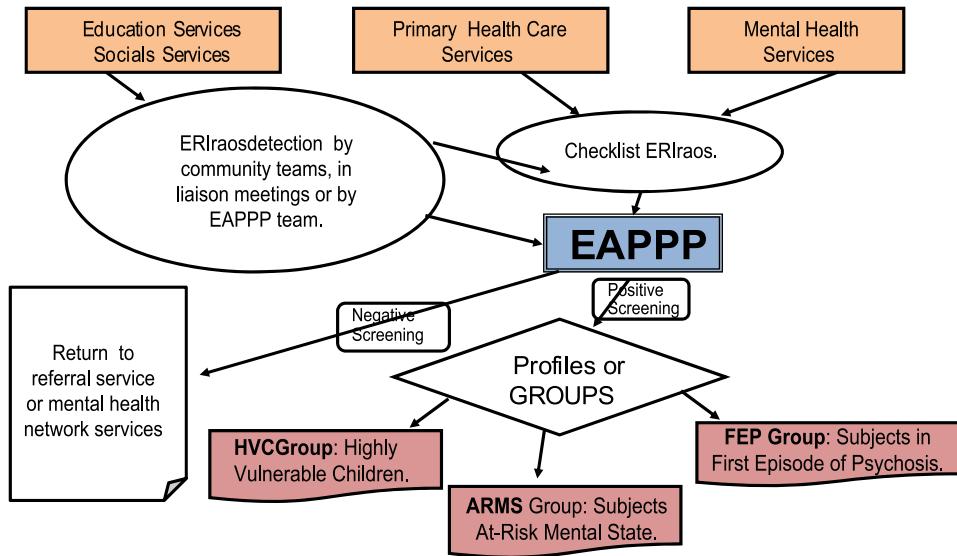


Figure 1. Referrals and exploration process.

FEP service incidence are bigger than in other studies (Vallina, Lenos & Fernandez, 2006). From our ARMS group, defined with restrictive criteria (Table 1), four patients have developed FEP (9.52%). The ARMS group characteristics are: mean age 15.8, 60% male, mostly with secondary education level, not especially low socio-economic level and referred from health, education and social teams. The GAF mean score is 50.8, with high difficulties in “depressed mood”, “reduction of motivation”, “poor work and school performance” and “decrease in the ability to maintain or start social relationships”, as measured by ERIRAOS. Negative symptoms were more severe than positive ones in the PANSS. In the SOPS’s item “Odd behaviour or appearance” the mean intensity was low to moderate (Table 3 reproduced from Quijada et al. 2010).

Discussion

About results and general background

We must remember that ARMS and UHR are only technical constructs trying to serve a new clinical and research perspective in the field of Early Care of Psychosis. In that sense, ARMS incidence is obviously determined by the selection criteria established by the team. We have considered and compared two detection strategies: the UHR strategy (Yung et al., 2004, 2006) and the strategy used by the EPOS Study (Klostekötter et al., 2005; Olsen & Rosenbaum 2006). Our screening criteria for – inclusion in the ARMS group today are the UHR criteria, but with some qualifications from the EPOS and five criteria based on sociological risk factors and psychosocial studies, added in order to increase our detection specificity (Table 1). Despite these stricter criteria, we detected 2.5 cases per year per 10,000 inhabitants. In our country, the team *p3* (Cantabria, Spain) has published an incidence of 1% (Vallina et al., 2006). Many other international teams do not report the incidence with respect to the reference population.

Table 3. Baseline of At-Risk Mental State group.

	ARMS
GAF [†] : mean (IC)	50.8 (46.9–54.6)
ERIRAOS [‡] (%)	
Depressed mood	85
Reduction of motivation and poor work and school performance	80
Decrease in the ability to maintain or start social relationships.	70
Social withdrawal	55
Maniac and dysphoric symptoms	30
Disturbed body functions	30
Suspiciousness/distrust	28.6
Feeling of slowing down, reduced energy and affect	23.8
Odd behavior	23.8
Rumination (without inner resistance)	14.3
Depersonalization and derealization	14.3
Ideas of reference and paranoid symptoms	9.5
Preoccupation with mysterious things/unusual thought contents	4.8
(Pre-)psychotic thought disorders	4.8
Abnormal perceptions and hallucinations	4.8
PANSS [§] : mean (IC)	
Subscale positive	13.4 (11.3–15.5)
Subscale negative	15.8 (13.2–18.3)
Subscale general	35.6 (30.8–40.32)
SOPS [¶] mean (IC)	
SOPS [¶] Positive	6.3 (4.6–8)
SOPS [¶] D1 (Odd behaviour or appearance)	2.9 (2.24–3.56)

[†]Global Assessment Functioning; [‡]Early Recognition Inventory; [§]Positive and negative symptoms scale; [¶]Scale of prodromal symptoms.

Our ARMS incidence, despite the restrictive criteria used (Tables 2–4), can be explained by the higher detection rate working in a primary care setting, with its accessibility to the general population, and by the cooperation received by professionals in other social networks. International and national groups (Addington et al., 2008) have traditionally received their referrals from the health care system, but in the two years of our programme, almost 45% of the patients overall (and 62% in the ARMS group) were referred from non-health care services (social services, educational services, legal system services, and other community institutions). This may partly explain our higher detection rate as well as our accessibility, based on the principles of the PCMH.

About the social and educative services relevance

The fact that almost a third of our ARMS patients are referred from Social and Child Care Services is an innovative result considering the previous studies on early detection of psychoses, and makes our EAPPP programme experience somewhat different

from others. Our approach integrates social and educational services into our preventive tasks, by using regular meetings with representatives from all the community local services (more than 50 meetings per year).

Untreated mental disorders – such as psychosis — are often associated with poverty, psychosocial risk factors and social marginalization. As mental health and social work professionals, being able to detect and treat the individuals coming from such backgrounds – which enhances their risk for psychosis – might provide the tools to decrease harmful family emotional and behavioural patterns, which are common in those mental disorders (Bentall & Fernyhough, 2008; Morgan, Mackenzie & Fearon, 2008; Tizón et al., 2009).

Persistent problems

In summary, our initial experience tends to confirm our belief that preventive community work in the field of psychoses is feasible. It is possible to detect previously undiagnosed FEP cases, and ARMS subjects, if we create integrated and sustained local networks through intense shared work with social, educational and health community services. Currently in Barcelona the greatest challenge resides in the collaboration of the inpatient units for psychiatric emergencies: They usually do not refer their admitted FEP cases to EAPPP. From our perspective, some of them have an excessively biological framework – a bio–bio–bio framework (Read, Bentall & Fosse, 2009) – and it is difficult for them to accept integration into a communitarian network for early care of psychosis. This has the consequence that the relationships between the Early Care Team for At-Risk of Psychosis Patients and psychiatric emergency and inpatient services are sometimes dysfunctional. We hope these difficulties will prove surmountable.

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