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POUR LA SANTÉ MENTALE

THE JOURNAL OF
**BC's
Mental
Health**

VISIONS

PREMIERE ISSUE

Early Intervention



Who are the
gatekeepers of our
mental health?

How can people
reach out for
treatment earlier?

The Promise of Early Intervention

Dr. Peter Liddle

One of the strongest factors predicting poor outcome in schizophrenia is delay in engagement in treatment. For many individuals, over a year passes between onset of symptoms and engagement in treatment. During this time, there is risk of serious deterioration in occupational and social skills. On the other hand, over the past decade there has been a steady improvement in the treatments, both pharmacological and psychological, for schizophrenia. There is growing evidence demonstrating that if these treatments can be made available in a timely and non-threatening manner, the long-term disabilities of schizophrenia and other psychoses can be reduced.



Peter Liddle is Head of Schizophrenia Division at the University of British Columbia. He is currently working with partners in the mental health field to develop an early intervention model for use in BC.

It is essential that barriers to early engagement are broken down. Delay in engagement can be reduced by:

- Providing rapid assessment in a setting that minimizes stigmatization. In particular, assessment should be performed at sites that are not threatening, such as in the patient's own home, GP office, or other community agencies.
- Ensuring that GPs (and other community agencies) are informed about schizophrenia, and about the action required to obtain a specialist assessment.
- Minimal use of compulsory admission.
- Providing clear information for patients and families at first assessment.

- Adjusting medication to achieve optimum balance between therapeutic effects and side effects.

While there is strong evidence demonstrating that antipsychotic medication plays an important role in relieving symptoms of psychosis and reducing risk of relapse, high doses of medication can lead to mental and physical slowing. There is substantial evidence that the beneficial therapeutic effects can be achieved at relatively low doses in the early stages of the illness, especially if treatment is offered in the setting of a comprehensive program that provides psychological treatments aimed at enhancing recovery from the initial psychotic episode and fostering coping skills.

The Early Psychosis Prevention and Intervention Centre (EPPIC), in Melbourne, Australia, and also the first episode program at the Clarke Institute, Toronto, have demonstrated that within a specialized early psychosis program, it is practical to employ substantially reduced doses of antipsychotics. Furthermore, the availability of new atypical antipsychotic medications, effective against a wider range of symptoms than the typical antipsychotics, provides a better control of symptoms with fewer side effects, in many cases.

Much can be done to reduce the potentially devastating impact of schizophrenia and other psychoses. It is imperative that services are organized in a way that facilitates early engagement in treatment.

VISIONS

The Journal of BC's Mental Health is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the Canadian Mental Health Association, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of family members, service providers and community.

In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

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The Canadian Mental Health Association invites readers' comments and concerns regarding the articles and opinions in this journal. Please send your letter, including your name, address and phone number to: "Visions" Editor, Canadian Mental Health Association, BC Division, Suite 1200 - 1111 Melville Street, Vancouver, BC V6E 3V6 or e-mail to: office@cmha-bc.org

The opinions expressed are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its Branch offices.

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Intervention in First Episodes of Psychosis

Gatekeepers can help young people get help, earlier

As the stories of consumers and families attest, the first experience with a mental illness is extremely confusing, highly traumatic, and frequently disruptive, both to the lives of those suffering from the illness, and those who surround them.

Interpreting the potential signs of mental illness, deciding to seek help, and then negotiating the complex maze of our mental health care system are all fraught with difficulty, and represent major hurdles. Once "through the door" to the care system, people may be turned away without adequate diagnosis or treatment, as gatekeepers often miss signs of early mental illness (Johnstone et al, 1986).

These hurdles often lead to long delays, during which relationships suffer, work performance may falter, and danger and even suicide might result. As our editorial points out, we must do a better job at reducing delays in treatment, as a community, as mental health professionals, and as people involved in designing and improving systems of care, so that we can successfully engage people in preventively-oriented care.

Are you a gatekeeper of young people's mental health?

From a "system" point of view, we need to involve and educate gatekeepers, such as family doctors, school counsellors, clergy, youth agencies and others who may be a first point of contact for young people. Gatekeepers need to know about how to bet-

ter detect warning signs, and about the need for better coordination of care between front-line workers and specialty mental health services. It also means taking distressed young people seriously, and being less quick to attribute people's complaints as "just going through a phase." It means designing services which encourage young people to seek help voluntarily, rather than only serving them once they have lost touch with reality.

From a research standpoint, early intervention presents the challenge of how to better detect people who may be "at risk." This means establishing a better picture of what the mental state of an at-risk person might look like. Research is showing that apart from non-specific signs of deterioration such as insomnia, social withdrawal and increased anxiety, specific signs such as subtle movement disorders, difficulties in speech production, "magical thinking" and problems with information processing may be predictive of a first episode of psychosis. The task remains of developing these indicators into instruments that are sensitive to mental illness, yet create minimal false alarms for people and their families (Olin & Mednick, 1996).

Intervening before someone becomes acutely ill offers the possibility that the person may be more open to education and treatment, since insight into changes they experience may still be strong, while the underlying biology of the disease, and symptoms such as delusions, may not have progressed (Kingdon & Turkington, 1991). The challenge

of engaging people in treatment increases for those whose illness has progressed further.

Fostering engagement through the power of relationships is one seemingly obvious, yet often overlooked solution to this problem. For instance, it seems that people with a steady relationship with a family doctor or a professional who they know and trust are more open to seeking help voluntarily (McGorry, 1992). This aspect is equally important should the ill person require hospital care. Here, studies of what makes people feel unduly coerced show that negative pressure such as force and threats make them feel less favourably about continuing treatment. Conversely, being shown respect, concern and fairness - all of these being aspects of a healthy

interpersonal relationship - makes them more favourable to engaging in an ongoing care plan (Lidz et al, 1995).

Finally, successfully engaging people in care involves minimizing the traumatic experience of hospitalization that too often represents a person's first brush with the mental health system. This entails doing the early detection and education spoken of already. Should this not be enough to prevent a crisis, people need to be offered assessments and first treatment in as non-threatening a fashion as possible, through assertive outreach to people's homes. And if hospitalization is necessary, the trauma associated with the process should be recognized and kept to an absolute minimum (McGorry et al, 1991).

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People's stories tell us why we need to get help earlier

Hide and go seek

When mental illness begins and the barriers to seeking help never end

by Nan Dickie

Intervening at the onset of a person's mental illness is an enormous, if not impossible, challenge. Many years of intense pain and confusion may pass before other people recognize that something is wrong. From my perspective as a person with a mood disorder (recurring bouts of deep depression), the word I would use for why I remained isolated and in anguish is "hiding." I hid my mood disorder—my terrible secret—for 8 years until I was suicidal. I see that long process of my hiding and finally being found similar to that popular children's game of hide-and-go-seek.

"Hide..."

I couldn't and wouldn't reveal my inner hell until the pain became unbearable. My inner obstacles to any intervention were:

I was ignorant: I didn't know what was wrong in me. Was I "nuts?" I was afraid: my imagination convinced me I had "cancer of the mind," which carried, I assumed, an automatic and early death sentence.

I felt intense shame that I was a poisonous, useless, rotten girl, and guilt that I couldn't keep myself relatively happy like everyone else could. So, I became isolated.

I was alone with my torment. Others didn't know I was hiding or in deep pain, so couldn't seek me out, and help me.

"...and go seek"

The responsibility of intervention of mental illness does not rest entirely with the person with the illness, but also with the family, school system, society in general, and the medical profession. They

weren't much help to me 30 years ago.

Family obstacles

The lack of understanding about mental illness existed in my family. When I was in so much pain I couldn't hide my blackness, my mother would say, "You'll feel better, dear. This just goes with being a teenager."

When my father finally recognized that my periodic withdrawal and bleakness were similar to those he had faced silently for years, he sent me to a psychiatrist. At that time psychiatrists had a reputation of treating only "loonies," so I didn't say a word to him. As well, my parents coveted the apparent visible health of their offspring, so my treatment was all very hush-hush; I was, unfortunately, the victim of their pride.

School system obstacles

My school environment didn't provide me with any relief either. Teachers were uninformed about mental illness; they saw my problem as shyness. They assumed everyone could pull themselves up; after all, "we all get the blues now and then."

Other students were of no help. They had a marked prejudice against any differentness among their school-mates. The "loonie" label loomed large in my mind.

Commonly held beliefs

In the 1950s and 60s, the primary treatment for depressed individuals was to talk to a psychiatrist, and to mine I was faithfully silent. The only other "options for treatment" were in a psychiatric ward of a hospital, or—worse yet—in a psychiatric hospital. My youthful understanding of these places was that they were dreadful.

Once in, you never got out. In addition, the word around town was that those "shrinks" were administering electric shock therapy to "almost everybody." I dug even deeper in my pit.

Medical system

The medical profession itself was not yet able to cope successfully with mental illness when I first needed help. Research was underway but progressed slowly, and information and knowledge were still sadly limited. Because my difficulty was deemed "depressed due to age or circumstance," my problem "obviously" couldn't be treated with medication.

"You're it"

Early intervention of mental illness is a "you and me" affair, requiring the compassion and awareness of many people. There are fewer external obstacles now than before: My family and friends have gained a good understanding of the illness and recognize its symptoms, and encourage me to act sooner if I'm in a down-slide. Public perception is not quite so harsh or misinformed, and medical knowledge has advanced.

"I'm it"

Intervention is not a one-time, but an ongoing, matter. My disorder manifests approximately once every 3 or 4 years, and each episode presents obstacles to, and opportunities for, early intervention. My inner obstacle today is an understandable resistance to a trip to hell. However, my personal opportunity is to take measures to minimize the stay.

One of these days hide-and-go-seek will be only a game.

Sixteen, tied down and ...

Struggling under the great white coat

A teen's first experience facing mental illness

by Douglass Hume

I had lost most of my sense of reality as my parents and I entered the hospital's emergency doors. The mania had enabled me to thrive on my lack of sleep, my mind was racing faster and faster. Although there were a number of people in the waiting area we were soon ushered into an office, appropriately named, the family room. Not fully aware that I was the cause of our sojourn I expected to hear horrifying news of my father's health. He had had an operation a few weeks prior and was seated with my mother and I, speaking to the doctor.

After a long disjointed chat which seemed more of an interrogation there was a general consensus that I would be spending the night at the hospital. I began pacing in the office, out into the waiting area and even a few times outside, past the emergency doors. My agitated movements and erratic speech soon tired my parents as well as most of the staff on duty that night. Sixteen, tied down to a hospital bed and still struggling under the great white coat.

Aside from murky recollections of meals, visitors, orderlies and being untied, the next two days passed by uneventfully. Walking down the hall with an orderly on the third day was a challenge. I was trapped between the outgrowth of manic-depression and the results of the medication. Other patients soon filled me in on the ways of the ward.

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Family Perspectives

A Family member's perspective

The following was a letter in response to a survey sent out by CMHA BC Division and BC Schizophrenia Society, both of whom are involved in developing a program funding proposal for a made-in-B.C. early psychosis early intervention program. The survey asked about the issues of assessment & treatment, follow-up, family education, patient education, housing, vocational needs and rehabilitation.

As a brother of a family member who is challenged by schizophrenia, I feel that there were a lot of unmet needs in our family. In our case the home situation was dysfunctional.

I believe that in looking at this issue (early intervention), it would be interesting to see what if any differences exist for families (& individuals) who have only recently had to deal with psychosis (e.g. in the last 5-10 years) vs. over 10 years ago.

My brother, now 41 years old, was first hospitalized about 22 years ago in Toronto. He was nineteen. To this day I think that my family has not come to terms with his illness. In fact, he had disappeared from the family for over 15 years and I happened to find him living in the downtown eastside Vancouver where he has lived since about 1978.

In all the stories my brother has told me the theme is one of abandonment and lack of understanding of his needs. Admittedly, he has not always made his needs well known. From his perspective (and my interpretation), I would say that if 20-odd years ago, my brother had had more assistance, there would have been

tremendous differences in his and the family's lives.

As a blanket statement all of the issues dealing with treatment and recovermentioned (initial assessment and treatment, follow-up, family education, patient education, housing, vocation, and rehabilitation) need improvement. Had there been appropriate housing in place for my brother, had the family known more about his illness, had the services already in place been more accommodating and supportive of his needs, maybe our lives would have been different.

I think that an early intervention program needs to look at ensuring that all family members, no matter how old, are given information about the family member's illness. I think that parents need a great deal of support to encourage their ongoing unconditional support of their sick son/daughter. For the person challenged by mental illness, I believe that more intensive community support is needed from the very beginning stages (e.g. assertive case management 1:10 staff to client ratio). Today the "system" may be better than 20 years ago, but I know from working within it that it's bewildering trying to access services and trying to get the services that people need. The ill person would benefit immensely from a competent case management team.

These are my thoughts on the subject. I hope there may be something within this story to be of use.

Shawn Smith

"...some families learned to be more convincing about how they presented their stories, and some used personal connections to get help."

The family experience of the Pathway to Care

A recent Ontario study of families looked at their experience of the "pathway" to care. This included how they first detected mental illness, sought help from the mental health system, and the family perspective on care once it was eventually received. The study found significant barriers to detection, help-seeking and engagement with the system, all of which contributed to lengthy delays in getting relief from mental illness in its early stages.

A main barrier to detecting mental illness was the tendency of families (and their ill family member) to "normalize" the experience. For instance, the son or daughter may have been seen as "going through a phase". These beliefs may have been reinforced by family doctors or school counselors as well. In other cases, the family may have been puzzled by the person's withdrawal or strange behavior due to their lack of knowledge about mental illness. Even in families with some background in mental health, however, there was resistance to the idea that mental illness may have been involved. This was either because of stigma, or because their own unique experience didn't really match what was in the textbooks or pamphlets on mental illness they had read.

Not surprisingly, a major barrier to seeking help was lack of

knowledge about alternatives. Once possibilities were uncovered (e.g. the hospital, or mental health clinic) families and their loved ones struggled to access the system. They often continued to struggle until the situation deteriorated into crisis proportions, or until they had learned to "negotiate the ropes" of the confusing mental health system. For instance, some families learned to be more convincing about how they presented their stories, and some used personal connections to get help.

Once care was received, the experience was widely divergent. It ranged from relief that help was on the horizon, and that the inexplicable problem "had a name," to shock and anger at the sometimes traumatic and stigmatizing experience of hospitalization. The satisfaction with the treatment received was also mixed. Many were satisfied that their family member had been helped and stabilized. Others did not witness much active treatment or meaningful human contact being provided to their son or daughter.

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What does it look like in practice?

The two most prominent pioneering "model programs" of early psychosis intervention are the Buckinghamshire County (UK) program developed by Ian Falloon, and the Early Psychosis Prevention & Intervention Centre (EPPIC) in Melbourne, Australia, led by Patrick McGorry.

Taken together these programs represent promising approaches to early psychosis intervention. The Buckinghamshire County program may be more applicable to settings where collaboration between G.P.s, families and consumers may be more easily attained, such as non-metropolitan areas with more stable populations. Other aspects of early

psychosis intervention are applicable regardless of socio-demographic factors, such as the attempt to intervene in the very early stages of illness, and the use of stress-management techniques.

Details of the Melbourne program may be more instructive for people wishing to implement an urban, multiculturally-based program. The focus on assertive outreach after "first-break," rather than very early detection may be more necessary and realistic for settings where young people are more likely to be living away from home, and less likely to be connected to primary health care.

Buckinghamshire County, UK

This project began in 1984 in a semi-rural area of England with a population of 35,000 and a well-established network of family practitioners. The main strategy of the program was to fully integrate primary health care and mental health care services. This enabled early screening and detection before a psychotic episode occurred and meant ongoing teamwork between G.P.s and mental health specialists.

Mental health teams provided extensive case-related training with G.P.s to help them screen for and detect mental illnesses. This included assistance with the use of a ten-item screening interview and a checklist of early signs of mental illness. If the person in question was considered to be showing early signs of an illness, the mental health specialist assisted the family doctor to complete a comprehensive psychiatric assessment. This considered a person's present mental state, risk factors, and assessed their social environment: stressors and potential coping strengths of patients and their families. These assessments were then tailored into an intervention involving psychoeducation (see

elsewhere in this issue), stress management and medication.

Education started immediately by telling the person and family about the possibility of mental illness, while at the same time emphasizing the likelihood of recovery that treatment offered. Reaching shared understandings of the illness among all family members appeared to build collaboration and optimize caregiver support. Everyone involved found education done at this early stage to be highly reassuring. It meant that informed consent to treatment was sought and further treatment welcomed in all cases.

Stress management with respect to precipitating events and day-to-day stressors was carried out in frequent home sessions, from the entry into the program. Problem-solving techniques were taught according to the "behavioral family therapy" model developed by Falloon et al. (1984). These sessions continued until proficiency was attained, with the mental health clinician doing follow-up assessments and additional "booster" sessions if necessary at 3, 6, 12, and 24 month intervals. If difficulties or disabilities persisted, then psychosocial rehabilitation techniques were used.

In-home nursing care was available to all, backed by an assertive outreach team with the capacity to do crisis management. When signs of early illness ("prodromal features") were prominent, the family practitioner was advised to prescribe small-dose neuroleptics targeted at specific symptoms, such as sleep disturbance or concentration difficulties. Drug therapy was time-limited and seldom lasted more than a week. Patients and caregivers were trained to recognize specific prodromal signs, and were monitored with regular followups.

In the four-year program evaluation period only one case of schizophrenia emerged, with 15 others developing symptom patterns suggesting an early phase of the illness. None of these people's symptoms became severe enough to receive a diagnosis, and all showed a full and rapid recovery after the **brief integrated intervention** offered by the program. An effort to detect hidden cases outside the program revealed 6 additional definite cases of schizophrenia.

Taken together, these cases - when compared to incidence figures from an earlier World Health Organization study in Buckinghamshire County - amounted to a ten-fold reduction

in incidence of schizophrenia. Lack of controlled experimental circumstances surrounding this result, and the possibility that cases were missed or moved out of the area, mean that these results must be interpreted with caution. Despite this, the approach offers much promise for mental illness prevention.

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Early Psychosis Prevention & Treatment Centre (EPPIC) Melbourne, Australia

The Early Psychosis Prevention & Treatment Centre (EPPIC) model developed in response to "serious flaws in the way young people with psychotic disorders have been treated by adult psychiatry services." Clinical research done by the program developers showed that young people have been unnecessarily traumatized when treated in settings designed mostly for older patients with established illnesses.

The first home of the program was an inpatient unit, but the operation has recently moved to the newly established Centre for Young People's Mental Health, which is considered to be less stigmatizing than the original setting.

Unlike the Buckinghamshire model, EPPIC was developed in a multicultural urban milieu, where many young people were not connected with family doctors, and where many had moved away from the family home. Another significant difference is that the program concentrates on secondary prevention (i.e. reducing disability after first onset of acute mental illness) rather than trying to prevent the emergence of initial acute symptoms. The program is experimenting, however, in developing interventions prior to first signs of illness. (or in the prodromal stages).

EPPIC serves a catchment area of 800,000, which means between 200 to 300 clients. It also provides consultation services for the state of Victoria, Australia. The core services of EPPIC are:

- the early psychosis assessment and community treatment team (EPACT)

- outpatient case management
- an inpatient unit
- a group program
- cognitively-oriented psychotherapy for early psychosis (COPE)
- family work, and
- subprograms developed in response to emerging needs such as persistent positive symptoms, treatment resistance, homelessness, and preventive care (the Personal Assessment and Crisis Evaluation, or PACE, clinic).

The early psychosis assessment and community treatment team (EPACT) is a mobile assessment and treatment team, and the point-of-entry into the program. The team also plays an active role in community development (networking and educating gatekeepers such as G.P.s, school counsellors, youth agencies, etc.), which together with its assessment function attempts to address the problem of delayed case detection and engagement in care. Staff are available to conduct assessments in as non-threatening a setting as possible, such as home, school or doctor's office. Treatment is made available at home whenever possible (when adequate caregiver support exists, and when the situation is not dangerous). The team may make multiple visits to establish trust, and if hospitalization is necessary, care is taken to minimize the trauma traditionally associated with this event.

Once a person and their situation has stabilized, ongoing case management is provided regardless of whether the person has been treated on an inpatient or home basis. The case management program is based on "an explicitly documented recovery and preventive philosophy," including psychoeducation done within a therapeutic context, help with role functioning, and crisis inter-

vention if necessary. The person may remain for a period of up to two years under the care of the team. Support is provided through the case worker, but also in conjunction with the group program. Individually-based cognitive therapy is available for people vulnerable to depression, post-trauma reactions, anxiety disorders and lowered self-esteem.

The importance of families in supporting a young person through their first episode is highlighted and every effort is made to treat families as collaborators in the treatment process. Families are offered psychoeducation, practical problem-solving, supportive psychotherapy, and family therapy if appropriate. Psychoeducation is done through time-limited information sessions, and through ongoing family support groups.

A recent evaluation of the EPPIC program showed a number of positive results. First, there was an apparent reduction in treatment delays, compared to a historical (pre-EPPIC) sample. The EPPIC group also experi-

enced significantly fewer admissions, readmissions, and total hospital bed-days. Adherence to treatment was good in both test and comparison groups, however there was a substantial reduction in acute and post-acute levels of neuroleptic drug dosage in the EPPIC sample. Significantly, the EPPIC sample showed sharply decreased levels of negative symptoms at a twelve-month follow-up, as well as 25% improvement in functioning, at the reduced medication levels.

Resources

EPPIC Web Site: <http://www.vicnet.net.au/~EPPIC/about.html> (includes further information about core services, research, contact people, book reviews, etc.)

USERS GUIDE: Everything You'll Need to Know About EPPIC

Early Psychosis: A Booklet for General Practitioners (both publications available from CMHA BC Division)

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What does it look like in Canada?

A number of early psychosis intervention programs have sprung up across the country in the past several years, including the Early Psychosis Treatment and Prevention Program at the Foothills Hospital in Calgary, the First Episode Psychosis Program at the Clarke Institute of Psychiatry in Toronto, the Therapeutic Partnership model of the

Psychotic Disorders Clinic at Chedoke-McMaster Hospitals in Hamilton, Ontario, the Victoria Hospital program, in London, Ontario, and an early psychosis program in Halifax, Nova Scotia. The following article highlights the Halifax and Hamilton programs.

THERAPEUTIC PARTNERSHIP Psychotic Disorders Team, Hamilton Ontario

Therapeutic Partnership is a model developed by members of the Psychotic Disorders Team (PDT) at Chedoke-McMaster Hospitals. The PDT is an outpatient service which does assessment and treatment of young persons with psychotic illness. For most people, the clinic is their first contact with the mental health system. Ninety per cent of clients live with their families in western Hamilton or in neighbouring, smaller municipalities. Most treatment is done in the home.

The program has a catchment area of approximately 120,000. In the past year (its 4th year of operation) it served 177 people either directly or through consultation with family physicians. The program staff include a full-time psychiatrist, 1.5 nurse case-coordinators, a family educator, two part-time occupational therapists and consultation from a clinical psychologist, a psychometrist, and a pharmacist.

Therapeutic Partnership is considered most appropriate for people and families who are interested in self-management of mental illness in its early stages. The program works to create an alliance between the person, their family, and the clinical team,

and then develops short-term treatment and rehabilitation goals (typically lasting about 8 months). Family doctors are supported so that they are able to provide ongoing medical care, though anyone may easily reenter the program. This ongoing collaboration with the family physician is referred to as "Shared Care."

Therapeutic Partnership, in contrast to traditional case management, is characterized by short-term rather than ongoing support. The opportunity for people to reenter the program and the support of family physicians are considered an effective "safety net." The focus on early intervention and helping people to maintain valued social roles - such as student, worker, etc. - seeks to avoid the longer-term disability with which case management programs often deal.

In the assessment and treatment phase of the program, the focus is on individual and family-based psychoeducation. This involves "undoing" stigmatized images and creating a sense of mastery over the illness and the mental health care delivery system. The other focus is on low-dose medication treatment.

Before being discharged **Therapeutic Partnership** staff help the person in treatment and their family to recognize early warning signs of relapse, and coach them to access other mental health resources.

When a person is discharged, they're an "alumni". At this point, an alumni develops a consultative

relationship with the family doctor, including periodic check-ups (every 6 months). Any alumni may re-enter the program in the event of crisis, or to work on rehabilitation goals. Relapse is not viewed as a failure, but as an opportunity for learning and increased control over their illness.

In times of fiscal restraint this model - because it involves partnerships between the consumer, family, the PDT and family physician - is viewed as an effective use of resources. It's also an innovative way of reducing waiting lists and long initial treatment-delays for specialty mental health services. A formal program evaluation to measure the effectiveness of this model is progressing.

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EARLY PSYCHOSIS PROGRAM Halifax, Nova Scotia

This program was initiated by Dr. Lilly Kopala, who came to Halifax about a year and a half ago from the University of British Columbia. Dr. Kopala started out by offering consultation and advice on early psychosis on an individual basis. Since then, a three-part program has developed, including clinical care, research, and community education. Based in the Nova Scotia Hospital, the service cuts across service boundaries in Halifax, and provides consultation to the province as a whole.

One of the first developments was a "mentorship program" for professional education. This provided a way to build professionals' skills and created awareness of the early psychosis service. At present the active case load is approximately 65. In addition, 75 people are part of a follow-up program for research purposes.

Program resources include a psychiatrist, nurse, nurse researcher, a community educator and two research assistants. The research component is a major feature. It includes pharmacological studies, studies of the neurocognitive and perceptual aspects of early psychosis and an examination of the pathways to care, through surveys of GPs, families, and consumers.

This latter research, as with other "pathways" studies, shows

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New and emerging psychological approaches

As Dr. Liddle's editorial points out, treatment options for people experiencing a first episode are undergoing significant changes. Knowledge and practice about medication regimens are shifting. At the same time, mental health professionals, spurred by the consumer movement, are increasingly recognizing the patient as a person who is dealing with a profound psychological challenge.

Striving to understand a serious illness, adjust to its disruptive effective - while possibly dealing with issues such as secondary depression or post-traumatic stress disorder - are all issues that people need help addressing (Birchwood et al, 1993). As a result of these changes, promising new approaches such as psychoeducation, stress management and cognitive therapy are being tested and incorporated into early intervention practices.

Early evidence is suggesting that the outcome of these techniques (along with drug treatments) is a better therapeutic relationship, increased engagement in treatment, improved self-awareness, better symptom management and faster recovery. The most significant test of their ultimate success will be their ability to help people achieve life goals.

Psychoeducation

Psychoeducation for first episodes of psychosis involves teaching people (including families) the basic fact about mental illness. A consensus is developing that the most important message to impart is twofold: the seriousness of having a psychosis, balanced by hope for recovery.

While the task of providing education has traditionally been viewed primarily as didactic (that

is, of supplying information), it is now seen as requiring an ongoing, interactive psychotherapeutic relationship. The inter-related psychological issues of "meaning," "mastery" and "self-esteem" are recognized as crucial issues to address (McGorry, 1996).

Meaning refers to addressing the confusion over what has happened and introducing the concept of mental illness or psychosis. Discovering the person's own explanatory model and resolving discrepancies between this and medical definitions is a key task here. "

Mastery involves instilling hope for recovery, building stress management and coping skills, learning to recognize possible signs of relapse and learning how to access needed resources in the future.

Self-esteem concerns include helping the person to distinguish "between the person and the illness" and to counter stigmatized views that they may have internalized (e.g. that they are incompetent).

Clearly, all these issues must be addressed at the same time, for as consumer advocate Patricia Deegan says: "How are we going to accept our label, if there is no hope?" (Spaniol & Gagne, 1997).

Coping skills training and cognitive therapy, described below, are often presented as approaches in their own right, apart from psychoeducation. Since they contribute to resolving the issues of meaning, mastery and self-esteem, they can also be considered as **ways** of doing psychoeducation.

Cognitive Therapy (CT)

This technique is a systematic way of examining the beliefs peo-

ple hold about their symptoms or illness experience as well as understanding the relationship between those beliefs and behavior. Cognitive therapy then helps people examine the validity of those beliefs, by gradually helping them to consider and test alternative explanations. Cognitive Therapy has been used for first-episode psychoeducational purposes and for addressing specific symptoms such as delusions and hallucinations, both on a preventive basis and as a strategy for dealing with persistent symptoms which do not respond to medication.

For initial psychoeducation, cognitive therapy has helped people "de-catastrophize" beliefs about the mental illness label (e.g., by challenging the belief that schizophrenia means "madness," or inevitable deterioration). The approach may be particularly appropriate for young people, as it offers a way of examining alternative explanations for delusions or fixed ideas before they be-

come entrenched. For example, it is possible to enable young people with perceptual abnormalities (often part of schizophrenia) to understand delusions from a natural perspective, rather attributing religious significance to them (Roberts, 1992).

Cognitive therapy for persistent hallucinations involves gaining an understanding of the beliefs which reinforce the "engagement" people often show with auditory hallucinations. For example, one study showed that people pay attention to voices because they believe that voice to have special power (since it could read their thoughts). This belief made them more likely to comply with its urgings (e.g. quit your job).

Cognitive therapy involves gradually helping the person "test" their interpretations of voices (e.g. by showing them that the voice wasn't always right), by encouraging them to attribute hallucinatory experiences to a

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- "The Omnipotence of Voices: A Cognitive Approach to Auditory Hallucinations," by P. Chadwick & M. Birchwood. *British Journal of Psychiatry*, Vol. 164, pp. 190-201, 1994.
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The local story

Vancouver Working Group Developing Program Proposal

There is growing support and leadership from local mental health advocacy groups, researchers and practitioners for developing a state-of-the-art early intervention capacity in the Lower Mainland, and eventually throughout the province. Presently, representatives from the Vancouver Hospital, UBC, the BC Schizophrenia Society, the Mood Disorders Association of BC, Greater Vancouver Mental Health Services and the CMHA are in active discussions aimed at developing an early intervention program model and seeking ongoing funding.

This working group has relationships with the world pioneers of early intervention programming in Melbourne, Australia, as well as with Canadian research-

ers in the field. With these developing partnerships and expertise, Vancouver is poised to play a leadership role in establishing this important new service, both for the province and the country.

Contact Person: Dr. Peter Liddle, Head of Schizophrenia Division, University of British Columbia (604) 822-0737

Researching Consumer & Family Needs: CMHA Submits Funding Proposal to Vancouver Foundation

CMHA BC is in a position to play a unique role in this working group, and has submitted a proposal to Vancouver Foundation to carry out a province-wide consumer and family needs assess-

ment. We recently received word that the proposal was successful, and were given the go-ahead to embark on the project this summer.

Through province-wide focus groups we will gather and reflect the experience of consumers and families as they relates to: the barriers to early recognition and access to the mental health system; the actual experience with the mental health system once accessed, including the kinds of support they saw as helpful and not helpful.

Specific activities will be:

- Research and development of a user-friendly discussion document on key early intervention issues

- Organizing a series of five province-wide culturally representative stakeholder workshops, using the key issue document as a framework

- Compilation and analysis of stakeholder input on key issues
- Production of workshop report
- Dissemination of results to community members and early intervention program planners

This information will be valuable for system reform efforts, and will be incorporated into the program planning process, should the proposal for a province-wide early intervention service be successful.

Contact Person: Eric Macnaughton, Coordinator of Policy and Research, CMHA, BC Division, (604) 688-3234

New and emerging psychological approaches, continued from page 9

biological explanation (a brain process, rather than an external force) and by showing them they had some control over it (e.g. by showing them strategies for weakening the voice.) (Chadwick & Birchwood, 1994).

Coping Skills (Stress Management) Approaches

The stress/vulnerability model of mental illness suggests that a predisposition to mental illness is brought out by significant life events or ongoing daily stressors. Management approaches, accordingly, help people assess the sources of stress in their daily lives, develop coping strategies for dealing with these and thus reduce their vulnerability to re-

lapse. This could mean adjusting routines, or building coping skills for stressful situations which arise (relationships, jobs, social roles).

Stress management also typically entails teaching people to monitor the effects of stress, recognize potential warning symptoms and act to alleviate the stressor by adjusting their environment or behavior (e.g. by minimizing stimulation, or alternatively, avoiding too much isolation). Consumer-based research shows that many people develop such strategies independently. The task of the therapist is to recognize and support the person's own capacities for controlling the illness (Breier & Strauss, 1983).

Additional resources for Early Intervention

Recent Publications: Early Psychosis Intervention

Early Intervention & Prevention Applications of Clinical Psychology — P.J. Cotton & H. Jackson (eds.); Australian Academic Press, 1997.

The Prevention of Mental Disorders — by Mrazek & Haggarty

Preventing Mental Illness — by Jennifer Newton, Routledge Press

Preventing Mental Illness in Practice: Strategies that Work — by Jennifer Newton, Routledge Press

Recent Publications: Psychological Management of Psychosis

Cognitive-Behavioral Therapy of Schizophrenia — by David G. Kingdon & Douglas Turkington; New York City, Guilford Press, 1994

Cognitive Behavior Therapy for Psychosis: Theory & Practice — by D. Fowler, P. Garety & E. Kuipers; Chichester, John Wiley & Sons, 1995

Psychological Management of Schizophrenia — Max Birchwood & Nicholas Tarrier (eds.); Chichester, John Wiley & Sons, 1994

Cognitive Therapy for Delusions, Voices & Paranoia — by Paul Chadwick, Max Birchwood & Peter Trower; Chichester, John Wiley & Sons, 1996

Sixteen, tied down and ... struggling, continued from page 4

Each patient has their own student doctor who they might see as often as twenty minutes every day. I unfortunately had one with a neurotic desire for calm. Being extremely manic it made it nearly impossible for me to think or speak slowly. He would constantly interrupt, telling me to slow down what I was saying. Although I soon began receiving privileges, such as getting my clothes back and being able to walk around the hospital

grounds, he always left me with the sense I hadn't appeared at some fancy function the way he would have wished me to.

Once I realized that most of the observation of patients was carried out by the support staff I did my utmost to please them. I especially enjoyed occupational therapy where I would work on writing and crafts. Another favourite pastime was testing my lowered amounts of medication by playing pool or ping-pong with other patients.

As madness subsided, concepts of human development and behavior took up more of my

thoughts. Patients whose families and friends felt quite uncomfortable with mental health issues suffered the most from stigma. Certain confident personality types tended to receive more attention from patients and staff. Those who were always complaining tended to receive the least care. These observations though not earth shattering were new ideas that I took out of the hospital and thought back on as I met people later in life.

Since then, I have been hospitalized twice, at twenty-one and again at twenty-six. As my twenty-eighth birthday approaches I have been off all medication for the last year. Things are going well and I have learned to accept manic depression as well as take responsibility for my actions.

Being forcibly confined to a bed was probably the most traumatic experience of my life, second only to losing all grip on reality. Forcible confinement is a precautionary measure. Now I take my own precautions; proper rest, little caffeine or alcohol and awareness have turned out to be the keys to the door of a happy fulfilling life. Both good and bad days are an intrinsic part of our ability to find ourselves in the waves of life. When the waves are a little too high I do less and when the days are too calm I try to get out of myself and go for a walk on the beach.

What does it look like in Canada, continued from page 8

Early Psychosis Program, Halifax, Nova Scotia

tremendous variation, with some people being treated fairly quickly. However, there is a significant minority who take several years and repeated attempts at help-seeking before using specialized mental health services. This is seen to reflect outdated professional education, which has emphasized the so-called hallmark symptoms of delusions and hallucinations, rather than the more subtle negative symptoms and early signs of mental illness.

The *Early Psychosis Program* does community education using videos and raises awareness by promoting educational material through the local library system. The treatment phase of the program emphasizes the use of novel antipsychotics and group work. Interest is also shown in individual psychological treatments, such as the cognitive therapeutic methods of Max Birchwood of the UK (discussed elsewhere in this issue). The EPPIC model (Australia) with its focus on outreach and psychoeducation is another important influence on the program, although the service has not yet developed the

EPPIC-like capacity for outreach. **Contact Person:** David Whitehorn, Ph.D. Nova Scotia Hospital (902) 464-3457

Canadian Programs: Additional Resources

Early Psychosis Treatment & Prevention Program, information sheet (available from CMHA BC Division)

Contact Person: Jean Addington, Ph.D. Department of Psychiatry, Foothills Hospital, 1403, 29th St. NW, Calgary AB, T2N 2T9. (403) 670-4836

First Episode Psychosis Program, Clarke Institute of Psychiatry, information package (available from CMHA BC Division)

Contact Persons: Dr. Robert Zipursky, Kathy Ryan, RN (416) 979-2221

Early Psychosis Program, Victoria Hospital, London

Contact Persons: Dr. Ashok Malla, Dr. Ross Norman, WMCH Bldg., Rm. 126, 392 South St., London, ON, N6A 4G5 (519) 667-6773

Workshops Available
from CMHA BC

Team Building

A series of workshops designed to help your group come together as a team.

Reaching Consensus

Learn the advantages and disadvantages of the consensus model, and how to encourage discussion that leads to consensus.

Being an Active Group Member

Learn how you can make the most of working in a group. Develop the confidence to participate fully and constructively in your group.

Creating Synergy

Covers how groups form and how to encourage development of a group identity.

Intervening in Group Process

Find out which situations require intervention and develop techniques to keep communication open.

Facilitating Meetings that Work

What facilitation means, the role of facilitator, and leadership styles.

Power in Groups

Examines how individuals acquire power and how it affects group dynamics.

Conflict Resolution

Great for groups where diverse opinions and experiences come together. Develop communication skills to avoid and ease conflict situations.

For more information about these workshops or how to book a workshop, contact:
Annette Hathaway
CMHA, BC Division
(604) 688-3234

NEXT ISSUE:

Rehabilitation. What's new in the mental health field?

Fax or e-mail us your
address if you want to
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Helping Youth at Risk

An Early Intervention Initiative

"I went through many years of intense pain and confusion before other people recognized that something was wrong. I suffered with my mental illness (a mood disorder) for 8 years until I was suicidal.

"If I had been helped sooner, chances are things would have been different for me. That's why I was very



– Nan Dickie

excited to hear that the CMHA has the chance to become involved in research into the early intervention of mental illness.

With a solid early intervention program we have the chance to help hundreds of young people across British Columbia."

You can read more about my experience in my article "Hide and Go Seek" in this issue.

The need to provide appropriate care for young people when early symptoms of mental illness appear is imperative.

The sooner we can recognize and treat mental illness the greater chance we have of reducing the debilitating affects of the condition on the person, their family and the community.

It currently takes about 2 years for young people who first develop a mental illness to get treatment. The longer this initial delay, the worse the eventual outcome is for that person.

CMHA, along with other groups, are in the first stage of creating a state-of-the-art early intervention program for British Columbia. Through a series of province-wide focus groups CMHA's project will assess the needs of consumers and family members during the early stages of mental illness. Barriers to both early recognition of illness and access to the mental health system will also be examined. Additionally, the experiences of young people once they receive care will be collected. This information will then

be used to help the planning and program development phase of a provincial early intervention program.

You can be a part of this ground breaking work.

A donation made specifically to this first stage of a state-of-the-art early intervention program will enhance our ability to help the 300 young people in Vancouver alone who will develop a mental illness this year. *As part of our program you will receive an information sheet about our research project and biannual reports on our progress.*

Partial funding for the early intervention project has been made possible through the Vancouver Foundation with a grant of \$29,000. *The total cost of our program is \$60,000. We need your help to make this project a reality.*

"... all types of help – medical, psychological, social and community – must reach people with mental problems early to be truly successful. That is where this research project will be of great value to mentally ill people, and to those who are willing, and prepared, to help and support them." – Nan Dickie