The concepts of FEP and DUP have been central in the development of early intervention in psychosis services throughout the world. Studies suggest that antipsychotic medication is effective both as an acute and maintenance treatment for patients with a first episode of psychosis. The duration of untreated psychosis is hence defined as the time period between onset of psychosis and the onset of adequate treatment.

Adequate treatment was defined by Birchwood et al as adhering to dosage levels recommended by the British National Formulary guidelines and either continued for at least one month or leading to a significant reduction in symptoms. Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16 published by NHS England in February 2015, states, with regard to FEP:

1. A maximum wait of two weeks from referral to treatment, and
2. Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia – either in children and young people CG155 (2013) or in adults CG178 (2014).

The guidelines focus on EIP services to deliver these targets. NHS England’s expectation is that an additional £40m funding being made available recurrently should be invested recurrently in EIP services to support sustainable delivery of the new access and waiting time standard. According to the Department of Health document, Achieving Better Access to Mental Health Services by 2020, the investment is aimed to achieve ‘treatment within two weeks for more than 50% of people experiencing a first episode of psychosis’.

However, EIP teams are not the only psychiatric services that come into contact with FEP. Our study therefore looks at the contribution of all psychiatric teams in starting treatment for FEP (effective dose of antipsychotic).

Aim
To investigate which psychiatric team starts an antipsychotic in the journey of a patient experiencing first episode of psychosis.

Methods
All case records within the early intervention service of Leicestershire Partnership NHS Trust, Psychosis Intervention and Early Recovery (PIER) held in March 2014 were looked at within a two-week period to find out in which psychiatric service had started the antipsychotic if a patient was being prescribed one, and discuss the contribution of teams other than EIP in reducing DUP.

<table>
<thead>
<tr>
<th>Service initiating antipsychotic</th>
<th>Total</th>
<th>Percentage of total prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIER (Psychosis Intervention and Early recovery)</td>
<td>63</td>
<td>22.50</td>
</tr>
<tr>
<td>Inpatient</td>
<td>126</td>
<td>45.00</td>
</tr>
<tr>
<td>CRT (Crisis team)</td>
<td>45</td>
<td>16.07</td>
</tr>
<tr>
<td>CMHT (Community mental health team)</td>
<td>12</td>
<td>4.29</td>
</tr>
<tr>
<td>CAMHS (Child and adolescent mental health services)</td>
<td>18</td>
<td>6.43</td>
</tr>
<tr>
<td>GP (General practice)</td>
<td>4</td>
<td>1.43</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.71</td>
</tr>
<tr>
<td>Not applicable</td>
<td>10</td>
<td>3.57</td>
</tr>
</tbody>
</table>

Table 1. Location of antipsychotic initiation for a first episode of psychosis
cases held, 37% had been referred from an inpatient unit, 21% from primary care, 16% from crisis and home treatment teams, 8% from community mental health teams, 6% from other early intervention services and 9% from child and adolescent mental health services (CAMHS).

Thirty eight per cent of patients had a diagnosis of schizophrenia, 19% were diagnosed with acute and transient psychosis, 12% had bipolar affective disorder and 3% had schizoaffective disorder. Five per cent had unspecified psychosis. Eight per cent of patients were diagnosed with substance-induced psychosis.

Two hundred and seventy patients (97%) were being treated with an antipsychotic. Out of 270, 126 (45%) patients had been started on an antipsychotic on an inpatient ward. Sixty three patients (22.5%) had been started on an antipsychotic by the PIER team. Forty five patients had been started on antipsychotics by the crisis resolution team (CRT)(16.07%) (see Table 1).

**Discussion**

There are three important questions that need to be addressed in the current scenario:

1. **Is it practical or evidenced that both medication and psychosocial treatments for FEP should start at two weeks?**

It is fairly established that medications, while assisting in symptomatic recovery, do not by themselves contribute to a return to functioning. This has led to an increased focus on the need to enhance social recovery, especially educational and vocational aspects, through the combination of effective psychosocial interventions with well-managed medication. However, McGorry also advocates that early intervention in psychosis be defined as comprising three foci or stages: ultrahigh risk, first episode and the recovery or critical period. The principal reason for making such distinctions relates to the underlying risk of chronicity, and specifically the timing and duration of prescription of antipsychotic medication, since psychosocial interventions are needed at all stages, though these interventions vary by stage. Hence the onset of effective treatment in FEP is mostly dependent on the start of antipsychotic medication, with psychosocial interventions coming in at appropriate times to further improve outcomes.

2. **Are EIP teams the only part of psychiatric services that should be focused on in terms of funding whilst aiming to reduce DUP?**

The finding in this study that 45% of FEP patients on an EIP caseload were initiated on medication on an inpatient unit and 16% under the crisis and home treatment team, does raise the question of whether CRT and inpatient units require training and resources in the process of beginning treatment for FEP. Due to the very nature of psychotic illnesses, it is not unusual for patients to lack insight and refuse treatment whilst experiencing FEP. Many of them may not be suitable for initiation of psychosocial interventions like cognitive behavioural therapy at a time when they are acutely psychotic and the initiation of an antipsychotic is key in helping them to start the process of recovery and subsequently engage in psychotherapeutic and vocational measures.

3. **Is reduction of DUP an appropriate measure of the effectiveness of an EIP service?**

Estimating DUP is challenging due to differences in establishing the date of onset of psychosis and establishing criteria for effective treatment. However, the initiation of adequate antipsychotic medication is the most widely accepted definition of effective treatment in ending DUP. Whilst EIP services do have a significant role in improving functioning in the long term and returning people to better quality of life, the initiation of antipsychotic medication does not necessarily have to happen with an EIP service. The current target of ‘treatment within two weeks for more than 50% of people experiencing a first episode of psychosis’, being solely seen as a remit of EIP teams can be misleading. The initiation of antipsychotic medication can happen in other acute settings and is likely to happen in more than half of FEP patients. A patient being taken on to the case load of an EIP team being proof of ‘treatment delivered in accordance with NICE guidelines’ could put pressure on services in a ‘target’ focussed way, which diverts attention from real clinical issues. For example, a patient assessed and taken on to the caseload of an EIP team within two weeks of referral but refusing medication, under the current criteria, is seen as having accessed services in target time; while a patient admitted to an inpatient ward and initiated on antipsychotic medication but not yet taken on to the case load is not seen as having received effective treatment.

The very nature of presentation in psychotic illnesses, which usually includes a lack of insight, may lead to patients accessing services only when the illness has erupted into an acute phase warranting a hospital admission or CRT input. The majority of patients are likely to go through a phase where their illness has not reached the standards of risk requiring a Mental Health Act assessment and they are refusing any intervention – a dilemma for the clinician faced with a patient who may be unwell but not unwell enough to be treated against their
Untreated psychosis

Original Research

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will. Hence the majority of early intervention patients being referred from inpatient or CRT settings rather than from primary care is an occurrence not difficult to explain. Expecting patients with psychotic illnesses to access a full package of treatment interventions within two weeks of the onset of illness may be unrealistic.

The authors suggest that socio-occupational functioning of patients at point of discharge from an EIP team should be a true measure of the effectiveness of an EIP team. FEP patients should be started on antipsychotics within two weeks of presentation to psychiatric services and that should be a clear target for mental health services as a whole, and not only for EIP services. The allocation of resources should be done fairly and appropriately in order to make sure that patients can access treatment in the right place at the right time.

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Declaration of interests

No conflicts of interest were declared.

References


POEMs

SSRIs have no effect on the progression of dementia

Clinical question

Do selective serotonin reuptake inhibitors alter the progression of dementia in patients with established dementia?

Bottom line

The current data suggest that selective serotonin reuptake inhibitors (SSRIs) have no effect, positive or negative, on the progression of dementia. (LOE = 1a–)

Reference


Study design: Systematic review  Funding source: Unknown/not stated  Setting: Outpatient (any)

Synopsis

These authors searched the Cochrane Dementia and Cognitive Improvement Groups special open-access registry of randomized trials that includes frequent searches of databases such as PubMed and EMBASE and a trial registry. They wanted to identify published placebo-controlled randomized trials of SSRIs in patients with established dementia of any type. This is probably not as robust as doing the full search themselves. Two authors independently assessed potential studies for inclusion and a third author helped adjudicate any discrepancies. When missing data were encountered, the authors attempted to contact the corresponding authors for supplementary data (the authors of 2 studies provided these data).

Ultimately, 12 small studies with nearly 1200 patients were included; 7 of which (N = 700) had enough data for meta-analysis. Eight of the studies evaluated only patients with Alzheimer dementia and 3 also included patients with vascular dementia. Four of the studies used sertraline, 3 used fluoxetine, 3 used citalopram, and one each evaluated paroxetine and fluvoxamine. The studies only lasted from 17 days to 39 weeks, perhaps not long enough to see meaningful changes. The authors found inconsistent reporting of outcomes across the studies. Overall, the SSRIs and placebo had similar effects on many measures of cognition, mood, agitation, and mortality, as well as independence in activities of daily living. The patients taking SSRIs experienced more adverse drug effects.

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