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# ‘SOMETHING HAS CHANGED’. DEVELOPING EARLY INTERVENTION IN SERVICE IN TRIESTE

**Barbara Bavdaž**

*Department of Mental Health, WHO – CC, Trieste, Italy*

***SUMMARY***

*The purpose of this project is to optimize early detection and early intervention in psychosis, in adolescents and young adults. The goal is to reduce DUP (Duration of Untreated Psychosis) through the integrated work of trans-disciplinary teams and youth-friendly (health and social) services. This should lead to a reduction of stigma and an improved accessibility to appropriate care. The aim we wish to achieve is a reduction of the incidence and prevalence of psychosis in the area covered by the Department of Mental Health of Trieste.*

***Key words:*** *youth-friendly early intervention service - reduction of DUP - 16-25 age group - trans-disciplinary dedicated teams - reduction of incidence and prevalence of psychosis*

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Adolescence, post-adolescence and early adulthood are a transitional age and include, certainly within Europe and in the last decades, people up to the age of 30. Aristotle (384-322 b.C.) stated that the transition to adulthood occurred at 21, so it does not seem that we have experienced dramatic changes over time in our conception of adulthood.

This age is characterized by a great vulnerability in the face of risk factors and stressful life-events, while at the same time facing new social challenges and trying to find one’s role in society. This is a time when coping skills are in some way reset and these seem to be weaker than they were during childhood.

In the development of schizophrenia there are a number of typical features which present themselves during three phases, which are then followed by the so-called critical period (McGorry et al. 2006). The first phase is a premorbid period, which can start during the very first years of life and can be possibly identified through delays in early neurodevelopment such as early pediatric milestones, and changes in cognition with poor scholastic functioning (Jones et al. 1994, Cannon et al. 2003). Family risk factors can also have a strong impact in this phase and there is often a delayed social and sexual development with social isolation, but adjustment is still possible.

The prodromes should preferably be called states at (high) risk; in adolescents the term ‘at risk of developing a psychotic disorder’ should be used rather than a diagnosis being made. This phase can last for as long as five years. The young person becomes progressively aware of a change (subjective awareness) and there is an objective awareness of a change as well (i.e. by family members); there is an acknowledgement of the change as a problem, and this is soon followed by the identification of its mental health nature. It presents itself with non-specific psycho-social difficulties such as marked social isolation, marked reduction of functioning, marked peculiar behavior, marked neglect of personal hygiene, suspiciousness and lack of energy. The person with subclinical symptoms can develop schizophrenia, or experience mood disorders, or recover. In this phase it is vital to allow people to seek help and facilitate the referral and access to appropriate mental health services in order to avoid psycho-social impairment, including disruptive social isolation and interpersonal difficulties. It is also of utmost importance to avoid self-stigma, which has a negative impact on self-esteem and self-efficacy.

If there is an acute onset of symptoms or a first episode psychosis, the two to three years that follow are known as the most crucial period of time: this is the ‘critical period’ (Birchwood 1998). The years following the onset of the psychotic illness play a crucial role in its evolution; there is no natural evolution in psychosis. On the contrary, in that period there is the maximum potential for deterioration, and therefore the greatest opportunity to intervene in order to prevent the development of psychosocial disabilities.

When a florid psychotic episode occurs, it is necessary to reduce DUP (Duration of Untreated Psychosis). A prolonged DUP means, among others, a longer duration of the acute episode, prolonged morbidity and severe psychosocial decline. There is a higher chance of a delayed graduation and of dropping out, less chances of getting a job and the risk of longer periods of unemployment. There is a direct connection between a prolonged DUP and a poor outcome, as rehabilitation and recovery progress slowly and may negatively affect the long-term quality of life after treatment. The delay in treatment also leads to increased costs in care, which can even be doubled: there are more frequent admissions and longer periods of hospitalization with an unnecessary disruptive impact on a young person’s self-esteem and self-confidence.

Finally, a prolonged DUP can lead to substance misuse, relationship problems with the family and peers, an increased risk of suicide, and possible legal problems due to increasing criminal acts and antisocial behavior.

It is vital to improve the therapeutic relationship between the user and the team and to immediately put in place effective pathways towards recovery. The focus is to intervene well rather than early, in the sense of developing and evaluating interventions that better meet the needs of patients and families (carers). Early intervention helps to reduce the iatrogenic effect on personal development and on the social environment, allows a rapid access to medication (second generation antipsychotics), prevents relapses and the decline of social skills, allows a reduction of the costs of care, has a better outcome and leads to a shorter duration of the acute episode (Agius et al. 2007).

There is ongoing debate over some possible issues related to early intervention which include the ‘false positives’, the issue about stigma, the possible iatrogenic effects (NNT= 4), and the cost effectiveness. As Pat McGorry wrote in 2000, ‘The Early Intervention field must maintain a balance between enthusiasm and sound research evidence’.

The Department of Mental Health of Trieste is a WHO Collaborating Centre and Lead for Service Development in Europe; this is mainly due to the important and radical reform that prof. Franco Basaglia and his team started in the early seventies, which led to a progressive closure of the local psychiatric hospital. This was completely replaced by a well developed community based mental health care system. The Centers for Mental Health are today accessible, opened 24/7, flexible and non-selective; multidisciplinary teams provide care through admissions to community- based crisis beds, provide comprehensive treatment and support based on detailed care plans, help towards psycho-social rehabilitation, provide carers support and work on specific projects focused on women mental health, immigrants and refugees needs, old-age population needs. There are well developed projects for people who are detained, for those with a double diagnosis, for families at risk and CAMH teams users. There is a strong and consistent effort to provide young users with working grants and employment at social cooperatives in order to facilitate their social empowerment and rehabilitation.

Nevertheless, towards the late nineties we started to consider an evident contradiction. The first contact with young people with mental health problems or at risk of developing one, continued to be requested and provided in the emergency service, mainly in an acute condition, often with no previous attempt to get help from friends, family or even the GP. This was possibly due to various factors: prejudice among the general population and stigma towards mental health problems, insufficient information (i.e. to families) about pathways, no young-people friendly (walk-in) access or dedicated service. GPs are able to identify more than two thirds of psychiatric problems with or without any specific training, they know the family and are aware of the personal history, they are usually trusted by their patients and there is no stigma related to their role. However when they encounter a young person with a mental state at high risk, they offer some resistance when it comes to contacting the appropriate services and referring their young clients. A similar attitude also seems to involve teachers, who are on the front line, but are rarely pro-active, in terms of referring a student with possible mental health problems to the appropriate services, or even involving the family.

The DSM in Trieste initiated a specific teaching and training program for carers in 1991, and years later in 2002, started a teaching and training program for GPs, PCTs, Social Services and for ‘first episode 18-30-year- old’ families and carers. In that same year a number of shared protocols were approved involving services for people with learning disabilities, families and adolescents at risk, and users with a double diagnosis (alcohol and substance misuse).

In 2003 the first Something has Changed project was started, with an annual plan (2003-2005) meant for 16-30 year- olds: with at- risk mental states, frankly psychotic symptoms or severe personality disorders.

The dedicated multidisciplinary team was initially composed by members of the Department of Mental Health, from the PCT and CAMHT, members of the Drug and Alcohol Services and 4 social workers from the Municipal Social Services.

The action was focused on raising the awareness of social and health services within the community for these issues through training, conferences and public meetings. Special attention was put on information through the media by members of the dedicated team participating in radio and television programs, and through the distribution of leaflets and booklets. The information was meant to reach families and young people at risk, but also teachers and the general student population, GPs, cultural and leisure clubs, volunteer associations, the police, emergency services and the judiciary. 150 GPs were helped to implement their diagnostic skills through formal training and 30 teachers were helped to implement the recognition of difficulties in school. An emergency help-line was set up to facilitate walk-in access for 16-30 year old people seeking help.

The family had to be involved within 48 hours of the assessment with information, support, and advice about practical matters. Separate specific advice and peer groups for families and users were set up in order to provide independent support to each of them on a short as well as on a long-term basis. There was a huge effort to provide appropriate pharmacological treatment as well.

This plan was meant to achieve a reduction of DUP, an increase of referrals to community- based services, a reduction in admissions to the crisis in-patient ward and a profound cultural change, helped by better information and a related reduction of stigma.

The data is partial due to changes in service provision and is the following. In 2003, 20 people were referred to the dedicated team, 18 people in 2004, 10 in 2005, and only one of these was later admitted. In 2008, 29 people were referred, 16 males and 13 females out of a total of 146 people under the age of 25 (90 males and 56 females) who were in contact with the Community Mental Health Centers. 15 people had to be admitted with a total of 383 days of admission throughout the year.

In terms of the diagnosis, 40 of them where diagnosed with Schizophrenia and other Psychotic Disorders, 39 with Anxiety and Somatoform Disorders, 17 with Personality Disorders, 16 with Mood Disorders, 13 with Other Diagnosis, 10 with Learning Disabilities, seven with Drug and Alcohol Misuse, one with social problems, and for three the assessment was not completed.

In 2010 a review of the previous work was carried out and a new project focused on 16-25 year old people was approved, which should complete the initial (2003) 'Something Has Changed' project.

This age (16-25) is characterized by high personal vulnerability and social fragility, there can be problems with schooling and vocational training; there are frequent problems for parents regarding parenting or they themselves can suffer from mental health problems. Parents are also often unaware of the problem or are not kept involved with issues related to contraception, sexuality, and substance misuse. At this age young people are 'low attenders' as they rarely or ever go to visit their GP; they mainly go or are accompanied to A&E when (already) in crisis.

One of the issues in Trieste is a poor integration between the local pediatric hospital and the community-based services; therefore it was decided that the integration and interaction of all the teams and institutions involved would be implemented: it was necessary to move from multidisciplinary teams ('working in parallel') to trans-disciplinary teams characterized by collaboration, joined activity and shared responsibility.

Special attention is currently addressed to:

- Early detection - prevention and support to adolescents and young adults with mental health problems or those who are at risk because their parents suffer from mental health problems.
- Carers' support - empowerment of all families, helping users and carers to join first-episode peer groups.
- Appropriate and personalized treatment, pharmacotherapy and individual/family psychotherapy included, of a duration of at least six months, and to be monitored for at least a further six months.

This is a pilot project which is aimed at reducing the incidence and prevalence of psychosis in 16-25 year olds and achieving a better general outcome. This is done by building new skills for the professionals involved, improving the programmes and projects already in place (16-30y), disseminating information about youth friendly access points, finding specific and exclusive spaces when an admission is necessary, and implementing home treatment.

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*Correspondence:*
*Barbara Bavdaž. Psychiatrist, CMHC 4*
*Department of Mental Health, WHO – Collaborating Centre*
*Trieste, Italy*
*E-mail: bbavdaz@gmail.com*