Early Intervention in severe mental illness: an unavoidable future

Memorandum for the Development of Mental Health Services aimed at prevention and focused on young people

AIPP – Italian Association for Early Intervention in Psychosis
A Special Section of the Italian Society of Psychiatry

> "Moving backward in time with psychotic disorders toward prevention is the guiding idea and direction of the IEPA. It promises to transform our work from that of alienists caring for the chronically ill to that of clinicians treating risk and protecting health. It is a new and sometimes uncomfortable reorientation of our perspective, but it is the future."
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> T. Mac Glashan, IEPA document, 2006.

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A. Introduction

The Laws 180 and 833 of 1978set their main objectivesin the overcoming of asylums as an organization, and gave general recommendations regarding the organization and supply of servicesto be implemented through clearly targeted projects, and managed by professionals and public administrators (Amaddeo et al., 2012; Ferrannini et al., 2014). In the following decades, the expertise concerning severe mental illness and treatment options was further developed and enriched. Unluckily it did not become shared common knowledge and it was not applied to shapetreatment options that would be consistent with the targets of the SSN (the Italian National Health-Care System), as evidenced by the gap between the SSN itself and university teaching (Furlan et al., 2013). General awareness and the social context have greatly changed in the meantime. Mental illness is no longer perceived as a "taboo", a threat or a final sentence. Persistent stigma-focused attitudes have fallen apart (Angermeyer et al., 2014).

In fact, mental healthcare services didnot receive all the maintenance they requiredin terms of operational directions and health-care policies.They remained stuck to conservative perspectives out offearthat any change would entail the comeback of asylums - a laughable and unfeasible perspective.

B. The need to change grounded on scientific data: prevention-focused perspective and early intervention

In the past two decades, scientific knowledge has made gigantic leaps forward. The most important advancement has been the consolidated certainty, confirmed by grounded epidemiologic studies, that almost all disorders – and severe disorders mostly – have their onset at a very young or young age (between 14 and 24 years of age) often vaguely, but progressively. However they are identified and treated as severe mental disorders much later, whensymptoms have stabilized and have caused non-reversible damage (Kessler et al., 2007; de Girolamo et al., 2012). When they start treatment, young patients have already interrupted their school education or vocational training, often experience depletion and deterioration of their social context (end of friendships and sentimental isolation); some have established deviant relationships, which lead to breaching of the

law, or have started using psychotropic drugs, both legal and illegal, and display the negative consequences of substance abuse.
It is only during the early stages, when the disorder is still flexible and disability and loss have just started, that it is possible to counteract and prevent its consequences by identifying it and implementing early intervention actions, protecting and improving the psychological and social functioning of young people, as well as their lifetime projects (Yung et al., 2007; McGorry et al., 2009; 2011).

Given this background, the obvious conclusion is that the future of mental health should be tiedmainly to a **prevention perspective**, which is defined by the theoretical and clinical approach called**"early intervention**" by the scientific community (Birchwood 2014; Cocchi et al. 2014). At the moment this approach concerns specific or selective preventive actionsonly, which rest between primary and secondary prevention, and consistin recognizingthe first signs and risk factors of the disease in a prompt and effective manner, and in modulating the effective and technically correct procedures that are now available. The main actions include orienting professionals and reorganizing services towards the early identification and intervention on the disorder **in settings that are specifically designed for young people, strictly according to criteria based on scientific knowledge**. For years the legislation in several countries (UK, Singapore), in provinces (Canada), or passed by governments (Australia) has been moving in this direction, as have many experiences and studies made in most European countries (Scandinavian countries, Germany, the Netherlands, Switzerland, Spain, etc), made by universities or by the administrative counterparts of the ItalianMental-Health Departments (Reading and Birchwood, 2005; Farooq et al., 2009; Stafford et al., 2013), with the support of specific health care policies. The goal is to oppose and reduce the risk of chronicity, and thus achieve **"savings"** in terms of less pain for patients and their families, and for the society as well, leading the way to **economic saving** (cost curbing) given the lower requirement for long-term care (Valmaggia et al., 2009, Cocchi et al., 2011, Mihalopoulos et al., 2012).

These goals can be achieved only by means of a focused intervention that may involve the system. To this aim, in Italy there already exist dedicated guidelines (SNLG 2007, De Masi et al., 2008); research works by the CCM Medical Committee (see the Report delivered to CCM on January 31st, 2010, concerning research and intervention in the years 2007-2009 and its related publication; Cocchi et al., 2014); research works ex Article 12;local government acts affecting Italian regions; the implementation of Programma 2000 in Milan (Meneghelli et al., 2010), the pioneer in this topic; and the opening of some Mental Health Departments and Universities (Cocchi et al., 2008; Ghio et al., 2012).

C. The full realization of these goals requires a radical reorganization of services, the redefinition oftasks, and the organization of Mental Health Departments in terms of "functions" instead of "facilities", as they are organized nowadays.

Mental-health services need to be redesigned in terms of competences and organization within the framework of Mental-Health Departments (a well-defined catchment area, therapeutic continuity, commitment to users).

The organization and structure of services has to be redefined; in the pastit was organized by **facilities** (CSM, SPDC, centers, daytime facilities, residences), while now it needs to be based on **functions (prevention, acute phase, medium and long term rehabilitation, forensic aspects, training and research).**This process would also enhance the motivation of professionals on tangible and innovative goals, meeting users' needs and expectations. Limitations and obstacles against the reorganization of mental health services are many, but they can be overcome by gradual steps. By way of example, such obstacles are inertia against change on the part of healthcare professionals

and the bureaucratic structure, culture, prejudices related to mental illness, well-rooted interests, and the content of professionals' training.

In this long-sighted framework specific clinical areas can be identified that have a low access threshold, which are**addressed to young people**and could benefit from thetechnical expertise of Child and Adolescent Neuropsychiatry, as well as of Adult Psychiatry (Paul et al., 2014), with the support of institutions (the school system and general practitioners), and volunteer associations operating on the same territory.
The first implementation of this program – as challenging as it can be at a time of limited resources and growing demand for urging interventions – may benefit from the "continuous education in medicine" program. The much-felt need for motivation by professionals and the dissemination of the model can be achieved thanks to a training program, geared towards knowledge of protocols and teaching of the operating skills required for its implementation. The current early intervention protocols are based on cornerstone principles, easy to apply (and already applied in other countries), and each proving fundamental for the intervention's success.

Since interventions' effectiveness depends upon compliance with the model, a parallel program – to be financed with resources by CCM, AIFA or similar organizations – could verify compliance with the model by those services where the early intervention program is already operating.

In this regard Italy can already boast some experiences, regarding both training and assessment of interventionsthat could serve as a pilot program with a view to national implementation.

The Board of AIPP (Italian Association of Early Interventions in Psychosis-AssociazioneItaliana di InterventiPrecocinellePsicosi) submits the following requests to the Italian Ministry of Health:

1. to launch a program for the partial redesign of services, by establishing **"work settings**"to be co-managed by Adult Psychiatric Services and Child and Adolescent Neuropsychiatry Services, and **addressed to young people** in a prevention perspective based on scientific knowledge;

2. to designa **training and information program** addressed to the professionals working in DSMs, to be implemented gradually starting from the central institutions (for example, the ISS – National Institute of Health), to be tested afterwards in pioneer regions and to be applied later in all regions of Italy;

3. to launch a simple protocol aimed at assessing and addressing adherence to the model, in order to avoid squandering of resources; and

4. to invite this Scientific Society (AIPP) to the main venues where discussions and debates are held. Italian institutions should not neglect that the AIPP counts some prestigious members and that this Society has carried out outstanding work in the past decade, so much so that Italy has been chosen as the venue for the 10th World IEPA (International Early Psychosis Association) Conference in 2016.

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Angelo Cocchi, AIPP President

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