Guideline One

A strategy for early detection and assessment of frank psychosis is an essential component of early intervention.

Background

Numerous studies have now confirmed early observations that the interval between first onset of psychotic symptoms and first treatment is approximately 12 months with higher figures in inner city areas (Birchwood et al, 1997). This treatment lag is linked with considerable distress, suicide and with increased probability of early relapse and residual symptoms. The causes of delay are varied and include problems of early identification, concerns about diagnosis, access to secondary core, stigma and other factors.

Requirements

1. An audit of pathways to accessing care can give insight into the nature of the untreated phase of illness, the variety of pathways to care (GP, police, neighbour, church etc.) and their relationships (see Tool Kit).

2. Consideration of pathways may identify training needs and challenge unhelpful service configurations.

3. As most cases of first episode psychosis pass through primary care, collaboration between primary and secondary care needs to be improved in order to promote early detection and treatment.

4. GPs need to feel confident in their ability to screen, detect and refer for specialist help. Inherent in this is a tolerance of diagnostic ambiguity and to operate within on operational framework focusing on dominant psychotic symptoms rather than diagnostic frameworks.

5. Early assessment in non-stigmatising settings is useful to offset the reluctance of young people to engage with traditional psychiatric services. Assessment, ideally, at home or the GP practice will be most likely to promote engagement with services.

6. Many potential cases of early psychosis will present ambiguously and not satisfy conventional diagnostic criteria and may not seem suitable for treatment. A 'watching brief' should be maintained in such cases for at least three months, offering support and intervention as is appropriate, since those at risk of psychosis are likely to progress within this time frame.

Getting it right....

Gary went to the GP shortly after a depressed episode end presented as slight y disinhibited and stating that he could predict the future. His wife was dearly concerned, especially since Gary's elder brother was well known to services end was diagnosed with a bi-polar disorder. The GP visited that day and contacted the CPN for on early assessment of a possible psychosis. The CPN visited that day. CPN visits were supportive to the family who wished Gary to remain at home. The psychiatrist assessed the individual and prescribed medication within 3 days whilst CPN visits were twice daily initially. Visits were reduced as Gary became more able to manage his symptoms. Primary and secondary care worked collaboratively throughout.

Where things can go wrong....

Diane visited the GP surgery after a period of depression which had necessitated referral to a psychiatrist. Diane was complaining of racing thoughts, irritability and inability to control emotions. Her odd behaviour had been escalating over the previous few days. Despite overt psychosis, the GP did not detect the risk In crisis, the GP did not make contact with any mental health professional for assessment until pressured to do so by a relative.

National Service Framework: **This guideline links directly to standards 2 and 3, which require services to provide clear pathways from primary to secondary care and to provide services which are accessible around the clock**