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Essential components of early intervention programs for psychosis: Available intervention services in the United States

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ABSTRACT

Programs providing interventions for early psychosis are becoming commonplace in the United States (U.S.); however, the characteristics of existing services remain undocumented. We examined program characteristics, clinical services, and program eligibility criteria for outpatient early intervention programs across the U.S. using a semi-structured telephone interview. Content analysis was used to identify the presence or absence of program components, based in part on a recent list of essential evidence-based components recommended for early intervention programs (Addington, MacKenzie, Norman, Wang and Bond, 2013) as well as program characteristics, including eligibility criteria. A total of 34 eligible programs were identified; 31 (91.2%) program representatives agreed to be interviewed. Of the examined components, the most prevalent were individual psychoeducation and outcomes tracking; the least prevalent were outreach services and communication with inpatient units. The populations served by US programs were most frequently defined by restrictions on the duration of psychosis and age. This study provides critical feedback on services for the early psychosis population and identifies research to practice gaps and areas for future improvement.

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1. Introduction

Early intervention programs for psychosis provide a number of benefits, including reduced morbidity, improved long-term prognoses, preserved social skills, higher quality of life, and a decreased need for hospitalization (Edwards et al., 2005; Marshall and Rathbone, 2011; McGorry et al., 2008). The mounting evidence in support for early intervention redefines the question from “should we intervene” to “what is the best intervention?” (Reading and Birchwood, 2005; Ruggeri and Tansella, 2011). While early intervention programs generally provide treatment and secondary prevention aimed at reducing relapse, coping with symptoms, and promoting recovery following the initial onset of psychosis (McGorry et al., 2008; Owen, 2003; Reading and Birchwood, 2005), little is known about the content of community-based early intervention services and how their target population is defined.

Early psychosis is used to describe a range of experiences, including early warning signs of psychosis (clinical high risk/prodromal), first-episode psychosis, and even multiple episodes early in the course of an illness (Addington et al., 2005). While no single determinant of early psychosis exists, three broad criteria are frequently used: duration from first treatment contact, duration of antipsychotic medication use,

and duration of symptoms of psychosis (Breitborde et al., 2009). Acceptable duration varies among programs and countries; this lack of a clear definition can be problematic for determining study eligibility criteria and for understanding best treatment options (Breitborde et al., 2009; Keshavan and Schooler, 1992; Kirch et al., 1992). For example, intervention studies may be very specific, requiring subjects be diagnosed with non-affective psychosis within the last 12 months without prior antipsychotic treatment, or broad, including anyone within 5 years of an initial onset (Bird et al., 2010; Malla et al., 2002). Identifying functional definitions used in early intervention settings may help narrow the focus to a single definition, which could improve comparability across programs and external validity of future early intervention studies.

Research findings support a number of key elements of early intervention programs, yet there is variability in their implementation (Catts et al., 2010; Ghio et al., 2012; McGorry et al., 2008; Srihari et al., 2012). Some programs stress the importance of case management, while others focus on medication or social and functional recovery (Garety et al., 2006; Spencer et al., 2001). Although variation exists, most studies indicate key components such as: pharmacological interventions, cognitive-behavioral treatment, family interventions, and vocational services (Allott et al., 2011; De Masi et al., 2008; Hill et al., 2012; Spencer et al., 2001). The extent to which each of these key components is used in practice has yet to be assessed, and the importance of other components has yet to be fully examined.

Recently, Addington et al. (2013) developed a model of evidence-based, essential components for early psychosis services. The research team reviewed empirical articles focused on components of early

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psychosis intervention programs and came to consensus on components and terminology. Using a Delphi consensus model, experts were presented an operational definition and supporting evidence for each component and rated their importance on a 5-point scale. Consensus on importance was calculated, resulting in 32 components.

While Addington et al. (2013) suggest that their list of components may lead to the development of an evidence-based fidelity scale, little is known about how these components are currently used. Further, unlike some countries (e.g., Australia Edwards and McGorry, 2002; McGorry et al., 1996, Italy De Masi et al., 2008, United Kingdom Department of Health, 2001), the United States does not have a systematic approach to defining and treating this population. Moreover, no study within the U.S. has examined services being offered at early intervention programs nationwide.

In the current study, we examined whether specific components are being implemented in early intervention programs across the U.S. This list of 32 components (Addington et al., 2013) has the capacity to act as a comprehensive starting point for a previously unexamined area. Moreover, as the list was derived from an empirically-sound, systematic literature review and consensus process with early psychosis experts, this study may inform the gap between research and practice that is occurring within U.S. early intervention programs. In addition to documenting current use of the 32 evidence-based components, we also explored program characteristics, definitions of the target population by means of program eligibility criteria, client requests, and perceived essential components.

2. Methods

2.1. Sample

Early intervention programs were identified via three processes. Initially, 37 programs were identified from online searches of each U.S. state using a combination of the state name and the following search terms: “early intervention,” “early psychosis,” “first-episode psychosis,” “prodromal intervention,” and “clinical high risk intervene.” An additional two programs were identified through literature searches, and seven programs were identified by snowball sampling. Programs were eligible for inclusion if they provided specialized services for early psychosis. Programs not providing specialized services or providing only assessment without intervention services were excluded. Programs providing services for recent-onset psychosis, clinical high risk for psychosis, and both subpopulations were included; as program identification progressed, it became apparent that many U.S. programs are serving both populations simultaneously; thus justifying the inclusion of clinical high risk programs. Whenever possible, initial study eligibility was assessed based on publically available information (e.g., websites). We contacted programs directly if eligibility could not be determined from external sources. For each eligible program, we recruited one key program employee (such as a program director) who was willing to complete an audio-recorded telephone interview.

2.2. Measures

We developed a semi-structured interview guide (available from the first author) with items asking about the 32 essential practices outlined by Addington et al. (2013), program characteristics (i.e. location, number of sites), and program eligibility criteria. Additionally, two open-ended questions were included to gain insight into the perceived client needs/requests and perceived essential components of early intervention programs (“What are the most common requests you are getting from clients?” and “What components or aspects of your program do you think are essential?”). The interview guide was piloted with a research team member who recently worked with an early intervention program and was revised as necessary throughout the interview process to ensure completeness. We created an on-line survey to ask the

dichotomous questions; participants were offered the option of completing a full telephone interview or the online survey and an abbreviated telephone interview.

All interviews were conducted by a doctoral student in clinical psychology, digitally recorded, and professionally transcribed. Participants were offered compensation of \$20.00. All procedures were approved by our Institutional Review Board.

2.3. Data analyses

Transcripts were analyzed using directed content analysis, applying pre-defined categories of interest, as well as conventional content analysis (Hsieh and Shannon, 2005). Pre-defined categories were generated from the list of 32 essential evidence-based components and program characteristics (Addington et al., 2013). All transcripts were coded for the presence or absence of the pre-defined categories by at least two independent coders (all doctoral students in clinical psychology), who then came to consensus.

Data for program characteristics, identified components, and program eligibility criteria were entered into SPSS 20.0. We examined descriptive statistics to explore use of essential components, program characteristics, and to summarize program eligibility definitions.

For the open-ended questions regarding perceptions of essential components and common client requests, we used conventional content analysis (Hsieh and Shannon, 2005). Responses to these questions were extracted from the transcripts and systematically reviewed by the first author. Emergent themes were identified through iterative readings; identified themes were developed into codes and systematically applied to all transcripts.

3. Results

3.1. Participants

Of the 47 potentially eligible programs identified, 34 met study criteria. Programs were excluded for: closing prior to contact ($n = 2$), not providing interventions ($n = 6$), not having a specialized treatment team ($n = 1$), or in the planning phase ($n = 2$). Contact information could not be obtained for the final two programs. Representatives from 31 (91.2%) programs agreed to be interviewed and were included for analyses.

3.2. Program characteristics

Eleven programs served the early psychosis population, 8 served the clinical high-risk population, and 12 served both populations. Most programs were located on the West coast (see Table 1), with the East coast being the second most prevalent region. More than half of programs were directly providing substance abuse support, supported employment, and education in-house. More than half of the programs were conducting research in addition to providing treatment ($n = 19, 61.3\%$).

All programs in this study were specialized treatment teams that were providing phase specific services on an outpatient basis. These programs were located within university medical centers ($n = 20$), teaching hospitals ($n = 4$), and specialized community based centers ($n = 7$). While 24 programs were affiliated with larger institutions or universities, no program was integrated within a general mental health care setting. Programs were initially created through a variety of mechanisms, with the majority of programs starting from individual initiatives of an interested psychiatrist or psychologist ($n = 11$) or through a state lead initiative to increase mental health services ($n = 11$).

3.3. Essential component use

Overall, the use of essential components was common across programs (see Table 2). All programs reported using two components:

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