

IRIS Initiative in the UK:
*Integrating Physical and Mental Health Services to Reduce the Duration of Untreated
Mental Illness*

Purpose:

This report will examine how an early intervention clinic in the UK went from being a small-scale program to becoming nationwide model for the Department of Health that illustrated how mental health services could and should be modernized throughout England. In 2000, the National Health Department announced that one of the top priorities of the National Health Plan would be to modernize mental health services. This announcement came as an agreement with a report from an independent group of experts that stated that England's system was highly un-modern. Similar to the reform process in Australia, changes were prompted by researchers demonstrating that costs for treatment could be reduced in the long-term if better "community-based" treatment was offered to British citizens – especially early treatment. The initiative therefore was doubted, *IRIS Initiative – Reducing the Impact of Schizophrenia*. The English government decided in late 2000 that they were going to make a 700 million pound increase in the years 2001-2003 in order to modernize mental health services. One of the ways they were going to do this was to dedicate 70 million pounds to implementing early intervention strategies.

The process of how IRIS was chosen to be the model program that would be replicated by other service providers throughout England is still unclear. I have contacted Professor Max Birchwood, who also happens to be a close colleague of Pat McGorry, our host at EPPIC in Australia. Professor Birchwood is on vacation until September 25th but his assistant assures me that Professor Birchwood would be more than willing to share his story of how he got a local policy leader, Anthony Sheehan to champion the IRIS model. UK political structure is similar to that in Australia, that is, the Health Department Heads are political positions. I look forward to Professor Birchwood explaining the path of how he convinced the Head of his district's mental health services (West Midlands District) to take this model program and then have it accepted on a National Scale.

Background: The IRIS Program

This particular method of reducing DUP is somewhat different because it focuses on strengthening detection of emerging psychosis through integrating health services, physical and mental. The tactic of integrating health services is because health services are nationalized, unlike services in the U.S. Despite this, examining the IRIS program's tactics for reducing DUP is helpful by giving a different perspective on early intervention efforts.

Program Principles – Coordinating Treatment with Primary Care Sector and other Community Services:

Using integrated health services to reduce DUP is not a relatively new idea. In fact, the foundation of the strategies evident in the IRIS program date back to one of the first early intervention programs, the Buckingham Project in 1984. The Buckingham project,

spearheaded by leading early intervention researcher Ian Falloon, sought to reduce DUP as well as prevent relapse by offering integrated health services and psychosocial support which focused on stress management. The project clinic sought to represent the ideal “community-based” health center where general practitioners were trained to note “early warning signs” of prodromal schizophrenia (Falloon et al., 1996). Falloon relied on the assumption that trust was already built into the relationship between an adolescent or young adult and their GP. Because this relationship exists, GPs, nurses and staff should be educated about how to properly assess “at-risk” mental statuses. This assessment also included an assessment of the stressors in the individual’s life as well as making sure that there was a support system for the individual at this time. The GP would then be the primary physician in the individual’s treatment. Mental health specialists would be brought in, but only for additional assessment and consultation – the GP remained the leading physician who continues to build a strong alliance with the individual through individualized care and home visits. Additional strategies used once assessment is concluded and the individual is receiving treatment: educate patient and caregivers immediately and thoroughly, focus work on stress management for the patient and the family, and target neuroleptic medication.

Evolving from this starting point, which already recognized the primary care sector must be thoroughly educated about how to detect the early signs of severe mental illness – The IRIS program emerged. In the IRIS program, the GPs and mental health professionals do not remain the only central figure in the young person’s treatment, but multiple community services providers are required to coordinate and work together as a team – a treatment team that is led by a social worker assigned to the individual. Mental health care and primary care providers should be responsible for having strong ties and the two different types of physicians should be treated as equals in terms of the importance of their work. The IRIS model stresses that youths are particularly untrusting of adults they don’t know – so treatment that includes their GP feels more secure but this does not mean that referral care to psychiatrist and psychologists is not as important. Unlike Fallon’s earlier model, IRIS is centered on an assertive outreach team – *The Birmingham Early Intervention Outreach Team*. This is exactly the same model as the Youth Assessment Team (YAT) at EPPIC. It may be helpful here to explain in detail all the components of Assertive Outreach, as it is the center of the early intervention programs such as EPPIC, TIPS, and PEPP.

Components of Youth Crisis Teams – Assertive Outreach

There are two key aims in the use of this model with young people with a first episode of psychosis: engage the individual and family in a collaborative relationship that will provide a backbone for ongoing support and efforts, and maintain continuity of contact through the critical early phase (they argue is 3-5 years).

Key Elements

1. Human Resources

Small caseload (client: team member ratio 10-15:1)

- Regular review of care plan for each client
- Team leader is a practitioner with a caseload
- Continuity of staffing
- Psychiatrist on staff (client: psychiatrist ratio of 100:1)
- Nurse on staff
- Substance misuse specialist on staff (client: team member with substance misuse training/experience ratio of 50:1)
- Employment rehabilitation specialist on staff (client: team member with employment rehabilitation training/experience ratio 100:1)
- Team consists of at least 10 staff.

2. Organizational Requirements

- Explicit admission criteria
- Intake rate of 6 clients per month or fewer
- Full responsibility for treatment
- Responsibility for crisis service /24 hour cover
- Responsibility for hospital admission
- Responsibility for hospital discharge planning
- Service not limited to specific time periods

3. Engagement and contact

- Team members work in the community in the clients' own settings
- Clients do not drop out but are maintained at a satisfactory level of engagement
- Assertive engagement mechanisms including street outreach
- Service is as intense as required
- Service contacts are as frequent as required
- Services work with families and with clients' own support system

There is strong evidence that demonstrates the effectiveness of intensive community support for people with severe mental illness who have a difficulty in accessing or accepting services. This is especially the case for the services applying assertive outreach approaches where staff have low caseloads. The evidence of good outcomes from assertive outreach models is clear in at least one respect: such specialist teams can engage and maintain contact with many of even the most difficult clients. Typically, studies have shown that at least 95% of clients are still in contact with services even after 18 months. It is for this reason that this model of sustained engagement is so relevant to people with a first episode of psychosis.

Client characteristics and needs: Many assertive outreach teams deliberately select people who have the most severe and complex problems. The typical user of such services can be described as “a single male in his early thirties who had been suffering from a schizophrenic illness for over a decade”. More than 80% of clients have at least one of the following factors; “history of self-harm, history of violence, non compliance with medication, non-co-operation with mental health services or admission within the past two years”. This would explain a large portion of the AB34 population, particularly individuals with the diagnosis of Schizophrenia. However, clearly it is the client with a first episode of psychosis that defines use of this model. It may well be that during the course of early engagement; some clients may not need the sustained level of contact explicit in the model.

Operational Practice: Central to the model of assertive outreach is the relationship between the staff member and client. This requires high staff-client ratios, typically a maximum caseload of 15 clients, and sometimes 10 clients or even fewer. Staff provide considerable face-to face care when necessary, and the approach is broad and client-centered. Equally important are liaison and co-operation between the team and GPs who play an important role in providing general healthcare for the client group. Working hours of most services are flexible, although 24-hour services are rare. It is essential that some form of back up from easily accessible and well-informed staff is available. This approach requires a multi-disciplinary team including psychiatrists, mental health nurses and social workers. Some team members have no formal professional qualifications. These staff are of particular importance in the engagement process. The team leader plays an important role in inspiring and supervising the team, and maintaining fidelity to the purpose of the program.

The Birmingham Early Intervention Outreach Team: The Birmingham Early Intervention Outreach Team provides intensive community support to people with a first episode of psychosis and during the first three years. The Early Intervention Service adopts the policy of small caseloads of about 15 clients per worker, and uses “the team” assertive outreach model. The team operates a no close policy so that clients who lose contact do not need to be re-referred. Clients can also be reassured that long-term support is available. One distinctive feature of the team is the use of the “team approach”, which means that all team members work with all clients and workers do not carry sole responsibility for a client. The team is thus enabled to work evenings and weekends.

As evident, the outreach team model functions much like both EPPIC's YAT/EPAT team and the teams designed to coordinate care for AB34 program participants. In addition, IRIS includes the same additional model components as EPPIC, TIPS, and PEPP. That includes a strong emphasis on family involvement and psychoeducation, relapse prevention that centers on psychoeducation, and vocational rehabilitation services which prepare the patient to return to school or the workforce.

Implementation of the IRIS model throughout England – Progress So Far:

Due to IRIS being identified as a model program that effectively reduces the impact of schizophrenia through use of early intervention strategies, the Department of Health has encouraged other service providers to establish programs that offer treatment modeled on the principles of IRIS. Newly established programs are not required to be “exactly” like IRIS and they cannot be because that would ignore the principles of IRIS. This is because service models should be designed based on what is the best way to coordinate existing resources in a particular community. Service models should also be designed according to the demographic demands of the community.

The Department of Health has warned interested providers that some communities simply may not be ready to try to erect a model that requires effective community service coordination. The Department feels that many communities need to work on improving service provision first before trying to implement a model that requires service collaboration as well as large-scale efforts to educate the primary care sector and the greater public. In order to prepare providers to move towards having early intervention service models, IRIS has developed many tools that assess if a community provider is capable of establishing an effective program. Once a community provider meets these criteria, IRIS has developed multiple tools that both train care providers and community partners in the skills needed for a successful program. IRIS also offers a 5-day training course for staff ranging from the directing psychiatrist to the administration staff. According to IRIS training staff, the most important skill to learn is the ability to engage young people. This requires staff to maintain a belief in the treatability of psychosis and to adopt a recovery model approach to treatment. Training also focuses on how developing bridges between children's services and adults services as well as services provided by primary care doctors and specialists, such as substance abuse counselors. Finally, evaluation measures have been developed by IRIS and treatment providers are encouraged to modify these measures to their service model.

So far, ten early intervention programs have been established since the initiative started in 2002. Most programs did not get up and running until early in 2001. In addition, the Department of Health, in conjunction with IRIS, has developed a specific document to assist with implementation as well as developed clinical guidelines and an informational website.

All of these materials are available from Stephanie upon request. In the interim, interested individuals should check out the website: <http://www.iris-initiative.org.uk>

