



Healthcare
Improvement
Scotland

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EIP National Network Event with guest speaker Prof Max Birchwood

Additional Q&A

Q: *Is the increase in digital appointments (caused by COVID) a challenge or an opportunity for implementing new EIP services in Scotland?*

A: Thanks for your question. Digital interventions from VR to remote treatment has occupied centre space in research atm. For example the EMPOWER programme led by Andrew Gumley in Glasgow has shown the attraction and high potential for relapse prevention using non-intrusive monitoring of well-being in vulnerable individuals. The COVID era has I suspect given all this quite a boost with many services, including I understand the Glasgow service conducting most psychological therapy and support online. There are opportunities for reach and efficiencies here. I recently completed a trial of collaborative care (primary-secondary collaboration in the management of SMI) which was not at all affected by the onset of COVID half way through. However, I do believe that for young people who have social anxiety or high disability there is a risk that this plays into and I would not want it to become the primary vehicle of care.

Q: *I share all your concerns about patients with psychotic illnesses who are bouncing between psychiatric services and primary care. I am very anxious about recent data that has been published about discharge pathways out of early intervention services in England. In some areas around England more than 70% of patients are being discharged from all psychiatric services directly to primary care by the specialist early intervention teams. In Oxfordshire as many as 83% of patients with psychotic illnesses are being discharged directly primary care after only a couple of years of treatment. Do you have any thoughts about what we should do about this?*

A: You raise a crucial point. First many of these YP will be well enough to be discharged and I guess many will feel a sense of agency and freedom at being discharged from the clutch of services rather than trepidation! But of course many will be vulnerable and I think there is a need to consider how we might support the folk in primary care without resorting to clunky re-referral and all that brings. I've just finished the NIHR PARTNERS2 trial of a model of collaborative care which aims to do just this: supporting clients in primary care if they need it; advising primary care; providing a fast conduit if things fall apart. While it doesn't in itself raise QoL, it showed that there was no increase in relapse/admission and was otherwise 'safe'; and also increased primary care contact and was v popular. Paper in submission at the moment. This was not for FEP alone but we examined the range of psychosis, including those with LT, but stable illness who had minimal contact in secondary care who were btw also being discharged without a plan, to free up CMHT capacity. Here is the protocol <https://bjgpopen.org/content/bjgpoa/5/3/BJGPO.2021.0033.full.pdf>. This kind of model is supported in the NHS plan for England.

Q: *Are we getting the public message about cannabis use right for young adults? Is this message appropriate for young people developing a psychosis?*

A: Great question. My view is that we would as a society be much better off if we emphasise the health risks of cannabis as we do alcohol and smoking rather than use legal sanctions. There has been a sharp decline in youth drinking and smoking. Cannabis is a risk factor for psychosis when exposure is in adolescence, so I would make it illegal to supply cannabis for this group with a strong public health message to YP and parents, as we do with drinking and smoking. In EIP services should lead the way on this messaging and build on the decline in use that is seen after FEP, but when use persists the harm to mental and physical health needs to be emphasised, ideally by other YP with psychosis <https://doi.org/10.1093/schbul/sbv154>.