Research Brief

Psychosocial Interventions for First Episode Psychosis:

Research undertaken at St John of Gods Adult Community Mental Health Services

St John of God

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Glossary

Term	Definition
Psychosocial rehabilitation	Psychosocial Rehabilitation (PSR) is a comprehensive approach designed to help individuals with mental health disorders or disabilities regain independence and improve their quality of life. It focuses on enhancing social, psychological and occupational functioning through various therapeutic and supportive interventions.
Occupational	Occupational refers to activities of daily living encompassing productive, leisure, and self care occupations.
First episode psychosis	First Episode Psychosis (FEP) refers to the initial occurrence of psychotic symptoms, which can significantly disrupt an individual's thoughts, perceptions, emotions, and behaviours.
Phase specific	Phase-Specific interventions in healthcare refer to tailored strategies and treatments that are designed to address the unique needs and challenges faced by patients at different stages of a particular health condition or illness. These interventions are based on the understanding that a patient's needs can vary significantly throughout the course of their illness, and they require different support and treatment approaches at each phase.
Individual placement and support	Individual Placement and Support (IPS) is an evidence-based approach designed to help individuals with mental health disorders achieve competitive employment in the community
Public and patient involvement	Public and Patient Involvement (PPI) refers to the active participation of patients, caregivers, and the wider public in the planning, development, and evaluation of healthcare services and research

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Psychosocial Interventions for First Episode Psychosis: An overview of research undertaken at St John Of God Adult Community Mental Health Services

Purpose

This research brief synthesises published psychosocial research conducted within the St Jphn of God adult community mental health service, including the DETECT early intervention for psychosis component of the service. The aim of this publication is to describe our review and comparison of eight existing publications. Specifically, we examined the studies for recurring themes or patterns, and analysed the key findings reported in the papers.

The research brief begins with an introduction, a broad background of early intervention in psychosis (EIP), followed by an overview of DETECT's own EIP programme. We then outline a summary of findings from the included papers, concluding with a discussion of their implications for psychosocial rehabilitation practice and research.

Introduction

Psychosocial intervention is an umbrella term used to describe treatment or programmes that address individual's psychological, social, or occupational needs (Penn *et al.*, 2005). These interventions play a central role in the care of individuals with psychosis. Reflecting this, clinical guidelines such as NICE [1] recommend including several psychosocial interventions for the treatment of psychosis and schizophrenia (Kuipers *et al.*, 2014). Their importance has further evolved since the emergence of the early intervention in psychosis (EIP) paradigm as it recommends phase specific delivery of these interventions and places a strong emphasis on holistic, recovery-oriented approaches.

The shift to the EIP approach emerged in the 1980s when psychosis research began to focus on the first episode of psychotic illness. Seminal research found that treatment in the early stages of these condition was less intensive and often resulted in better response and prognosis (McGorry *et al.*, 1996). Prior to this, care for people with psychosis involved late-stage intervention with treatment often initiated after significant deterioration had already occurred. Dissatisfication with the traditional approach and its limited success fuelled interest in an alternative. Early intervention represented a departure from this model, emphasising early detection and timely interventions. Informed by this research, flagship EIP services were established in the 1990s in Australia, in the early 2000s in the United Kingdom, and in 2004 in Canada (Edwards and McGorry, 2002; Nolin *et al.*, 2016).

In 2005, growing recognition of the importance of early intervention for psychosis was formalised with the release of a joint consensus statement by the World Health Organisation and the IEPA[2]. This statement highlighted the need for the development of comprehensive early detection and intervention services for young people with psychosis (Bertolote and McGorry, 2005). It identified several essential elements for developing EIP services. It advocated for a new model of care built around multidisciplinary community-based teams specifically designed to address the needs of people presenting to services with psychosis for the first time. Typically, psychotic symptoms develop between the ages of 15-25. This contrasted with standard care at the time, which was often hospital-based and in response to symptoms which may have gone untreated for many months or years.

Following the publication of this international guidance, Ireland began to develop its own EIP services. The first, known as DELTA, emerged within a mental health service which has sustained a strong psychosis research programme since the early 1990's. It evolved into DETECT through joint funding by St John of Gods research funding and the HSE. A second Irish EIP service (COPE), was later opened in Cavan/Monaghan in 2012 (Nkire *et al.*, 2015).

1. National Institute for Health and Care Excellence
2. IEPA stands for the International Early Intervention in Psychosis

DETECT

The Dublin and East Treatment and Early Care Team (DETECT) is Ireland's first early intervention service for individuals experiencing their first episode of psychosis (FEP). Established within the mental health services of St John of God, it operates across three catchment areas in South Dublin and Wicklow, serving a population of approximately 372,000 people.

Referrals to the service come from local mental health services, GPs, and emergency departments. The service aims to begin assessments within 72 hours of receiving a referral. The service offers several psychosocial interventions such as cognitive behavioural therapy (CBT), occupational therapy, and family/carer education to all individuals diagnosed with FEP. DETECT operates as a tertiary service working in partnership with local community mental health teams to provide comprehensive care during the three years post first diagnosis.

Research Overview

St John of God Mental Health Services have a strong foundation in clinical research. A key area of this work involved evaluating the psychosocial interventions that were delivered as part of routine care for psychosis. Several interventions were studied through empirical investigations conducted prior to, and within the DETECT service. Topics researched included CBT, Individual Placement and Support (IPS), lifestyle coaching, and keyworker case management. The findings have contributed to the wider evidence base regarding how to support individuals with psychosis using psychosocial interventions. Appendix 1 provides a brief overview of the interventions, and the methods used to evaluate them. Table 1 provides the details of the included papers (Fanning *et al*., 2012; Madigan *et al*., 2013; Turner *et al*., 2019; Turner *et al*., 2008; Broughan *et al*., 2022; Gallagher *et al*., 2021; Gaynor *et al*., 2011; Gaynor *et al*., 2014). These papers were chosen as the interventions sought to address a psychosocial challenge known to be associated with having a psychotic condition.

Table 1

Reference	Title	Psychosocial intervention
Turner et al. (2008)	Evaluating psychosocial interventions in first-episode psychosis	Psychosocial group programme including personal development and vocational skill development
Gaynor et al. (2011)	Group cognitive behavioural therapy as a treatment for negative symptoms in first-episode psychosis	Group CBT
Fanning et al. (2012)	Group cognitive behavioural therapy for first episode psychosis: who's referred, who attends and who completes it?	Group CBT
Madigan et al. (2012)	A multi-center, randomized controlled trial of a group psychological intervention for psychosis with comorbid cannabis dependence over the early course of illness	Adapted version of CBT including motivational interviewing for substance misuse
Gaynor et al. (2014)	Predicting Uptake of Group CBT in a First-Episode Psychosis Cohort	Group CBT
Turner et al. (2019)	Improving vocational recovery among people with psychosis: a two-pronged approach	Individual Placement and Support
Gallagher et al. (2020)	Improved self-esteem and activity levels following a 12-week community activity and healthy lifestyle programme in those with serious mental illness: A feasibility study	Lifestyle programme
Broughan et al. (2022)	Keyworker mediated enhancement of physical health in patients with first episode psychosis: A feasibility/acceptability study	Case management keyworker

Study Designs

Several methodologies were used in the studies included in this research brief. Madigan et al. (2012) utilised a randomized controlled trial, while Gaynor et al. (2011) used a between-group comparison. Both studies evaluated the efficacy of CBT. Research described in Fanning et al. (2012) and Gaynor et al. (2014) employed a cross-sectional design to explore how demographical and clinical characteristics influenced engagement with CBT. Turner et al. (2008) and Turner et al. (2019) employed a longitudinal follow-up to evaluate different vocational recovery interventions. Gallagher et al. (2020) used a pre-post design to assess the impact of a community activity and healthy lifestyle intervention. Finally, Broughan et al. (2022) utilized a qualitative design to explore the feasibility and acceptability of a keyworker intervention that targeted the physical health needs of individuals experiencing a first episode of psychosis.

Findings

The findings of the studies reviewed in this brief were examined from two perspectives: (1) process variables and (2) outcome variables. Process related variables focus on how interventions are accessed and delivered, such as referral pathways, attendance, and completion. Whereas outcome variables relate to the effectiveness of interventions by measuring clinical, functional, or behavioural changes. Some papers examined both. Table 2 provides details of the research focus of each paper.

Table 2

Author and short title	Process	Outcome
Turner et al. (2008) Evaluating psychosocial interventions in first-episode psychosis	*	*
Gaynor et al. (2011) Group cognitive behavioural therapy as a treatment for negative symptoms in first-episode psychosis		*
Fanning et al. (2012) Group cognitive behavioural therapy for first episode psychosis: who's referred, who attends and who completes it?	*	
Madigan et al. (2012) A multi-center, randomized controlled trial of a group psychological intervention for psychosis with comorbid cannabis dependence over the early course of illness		*
Gaynor et al. (2104) Predicting Uptake of Group CBT in a First-Episode Psychosis Cohort	*	
Turner et al. (2019) Improving vocational recovery among people with psychosis: a two-pronged approach	*	*
Gallagher et al. (2020) Improved self-esteem and activity levels following a 12-week community activity and healthy lifestyle programme in those with serious mental illness: A feasibility study		*
Broughan et al. (2022) Keyworker mediated enhancement of physical health in patients with first episode psychosis: A feasibility/acceptability Study	*	*

Outcome related findings

Five papers included research questions related to outcomes. Improvement on some variables was noted in all the papers that utilised pre and post scores (Turner et al., 2008; Gaynor et al., 2011; Madigan et al. 2012; Gallagher et al., 2020). Specifically, an increase in quality of life was reported in two studies of CBT (Gaynor et al. 2011, Madigan et al., 2012) with one also reporting a reduction in positive symptoms and depressive symptoms (Gaynor et al. 2011). The study of a community exercise programme reported improvements in self-esteem and engagement in physical activity (Gallagher et al. 2020). Broughan et al. (2022)'s paper found that participants appreciated the input on a healthy lifestyle. The vocational intervention reported on in Turner et al., (2019) successfully enabled participants to attain and retain their productive role. The influence of participant characteristics on outcome was reported on in several papers. It is notable that no significant associations were found.

Process related outcomes

Five papers included process variables in their analysis. Findings on a range of predictors of referral, attendance and engagement were reported. Overlapping results across the studies were scarce. One study, Turner et al. (2008), identified that years of education, marital status, employment status, and premorbid adjustment influenced whether individuals were referred to a psychosocial intervention. While similar analysis was conducted in the other studies the findings were not replicated. Education was influential to attendance at a group CBT programme in Fanning et al. (2012). Age influenced engagement with a group vocational programme (Turner et al., 2012) but this was not found to be associated with intervention engagement in the other studies included in this brief.

Turner et al. (2008) reported symptom severity was not influential to referral, to engagement or completion of the psychosocial programme offered at the service however Fanning et al. (2012) reported that certain symptoms such as bizarre behaviour, poor attention and low insight were associated with these process variables in the study of a group CBT programme. Seperately Gaynor et al. (2014) reported that negative symptoms and scores on a measure for suitability for CBT independently predicted uptake of a group CBT programme.

Recruitment and Retention

Recruitment challenges were evident in several of the studies. Broughan et al. (2022) reported a participant recruitment rate of 35.3%. Gallagher et al. (2021) cited recruitment rates of 49% of the attending population (N = 72) which is in line with other published studies (Lal and Malla, 2015; Liu *et al.*, 2018). In the Turner et al. (2019) paper it was reported that of the 129 people offered the interventions, 64 accepted of whom 61 attended (47%). Of the 61 people who attended, 39 consented to participate in the research, equating to 30% of the total eligible population. In the Gaynor et. al. (2014) study 25 of the 50 potential participants (50%) engaged in the group CBT programme. Similarly, Madigan et al. (2012) recruited and randomised 88 (38%) from an initial pool of 230 referrals for the CBT intervention.

Retention was also problematic. The Fanning et al. (2012) data indicated that 40 out of the 53 participants (75%) who attended the group CBT programme adhered to the intervention. And while all participants who consented to take part in the research of the healthy lifestyle

programme completed it, there was poorer retention (54%) of participants who attended but did not consent to engage in the study (Gallagher et al. 2021). Gaynor et al (2014) reported 22 of the 25 completed treatment (88%). In the Broughan et al. (2022) study 19 participants provided baseline data, while 18 completed the intervention and were seen at follow-up for post-intervention interviews which equated to a participant retention rate of 75%.

Insights from Qualitative Studies and Feedback

Several papers provided qualitative results related to process variables. Fanning et al. (2012) reported issues such as language, disinterest, and moving out of the locality as explanations for why attendees at the EIP service were not referred to the CBT programme. Madigan et al. (2012) reported that participants most commonly declined randomization in an RCT of CBT due unwillingness to travel, low motivation to participate, and discomfort with the group-based format of the intervention. These findings highlight how varied the factors are which can influence engagement in psychosocial interventions and suggest personal circumstances are important predictors of engagement, possibly even more so than clinical characteristics.

Discussion

The studies included in this research brief contributed novel findings to the field of psychosocial interventions for people affected by psychosis. There were favourable findings in the majority of the studies with improvements in quality of life, attainment of vocational recovery, and reduction in debilitating symptoms. Notwithstanding the limitations associated with sample biases and research design, secondary analysis of the findings has highlighted several notable insights. First, it is evident that empirical research conducted on psychosocial intervention do not all concur on their positive impact. While some participants do benefit from attendance others do not. Currently, we are without strong evidence as to what influences effectiveness of interventions. Furthermore, findings on which specific participant characteristics influence process and outcome variables remains elusive. However, the direction of the relationships is noticeable. In general, samples with higher or more persevered relational, occupational or educational levels of functioning, were more likely to engage and benefit from the interventions.

The lack of commonality in findings regarding engagement is not unexpected. All studies had relatively small sample sizes and were not necessarily powered to detect subgroups. Each study was based on chronological referrals to the service and therefore samples recruited at different time points were not necessarily comparable.

As research has traditionally focused on the efficacy of psychosocial interventions there's an urgent need to examine process related variables, including service-related factors that impact the referral to, availability of, and uptake of psychosocial interventions. There may an interplay of factors including service, clinician, and patient-related elements. Maximising intervention uptake remains under-researched which, if undertaken, could have broad appeal to the field of psychosocial research.

Recruitment challenges are not unique to the studies included in this research brief, as they are a well-documented challenge in mental health research. A systematic review of recruitment within mental health studies reported an average recruitment rate of 23% (Liu et al., 2018). Furthermore, disengagement from psychosocial interventions has been problematic for both research and service delivery (Doyle et al., 2014; Lal and Malla, 2015). Qualitative research cited in this brief indicates that a range of person-centred and service-related factors hamper participation. Service adaptation such as flexible pathways to engagement, online programmes, or hybrid models of delivery could improve engagement rates however it is unclear what people who attend services would prefer most. Greater involvement of affected people themselves in planning research and

service delivery may amend this (Pizzo et al., 2015; Staley, 2015). The term public and patient involvement, or PPI, is now utilised as an umbrella term for this process. There are several good practice guidelines to support research teams to implement this meaningfully (Health Service Executive Research and Development, 2021). While some research has been conducted on the benefits of PPI, further research is needed, particularly regarding its cost effectiveness and the practical integration of PPI at all stages of the research process (Brett et al., 2014; Pizzo et al., 2015; Staley, 2015). Given the persistent challenges with recruitment and retention in psychosocial research, future research could examine whether PPI contributes to improving participation and retention rates.

Furthering and solidifying the evidence on engagement and outcome within the field of psychosocial rehabilitation for people affected by psychosis is critical for several reasons. Without clarity scarce resources cannot be targeted to those most likely to benefit; interventions cannot be adapted for those whom they are less likely to benefit. Furthermore, it is not clear which patients should be the target of focused engagement efforts to maximise the proportion of people with psychosis who gain from attending psychosocial interventions. It is likely that at least some of those who do not engage in psychosocial interventions, for whatever reason, would gain from participation. Future outcome studies may benefit from incorporating nested qualitative research particularly for individuals who decline to attend or do not experience positive outcomes from the intervention. Ongoing-research in this field will enable these interventions to evolve, undergo refinement, and become more widely available.

Appendix 1

DETECT Individual placement and support and workplace fundamental programmes

This study examined the impact of a two-part vocational intervention designed to support people with first episode psychosis (FEP) to re-enter employment or education or to maintain their productive role if they were engaged in one.

Participants who were not currently working or studying were offered Individual Placement and Support (IPS). It was delivered by a Supported Employment Specialist (SES), who was specially trained and was supervised by an Occupational Therapy Manager. The IPS model used in the study included some minor adaptations to fit the service, such as providing support for both employment and education, and providing continued assistance to help individuals maintain their employment or education roles.

Participants already in employment or education, took part in a job retention programme based on adapted from the Workplace Fundamentals Module (WFM) part of UCLA's Social and Independent Living Skills series. The programme ran over eight weeks in a group setting, with weekly two-hour evening sessions. It followed a standardised format including watching video demonstrations, role-plays, problem-solving tasks, and homework assignments. Participants were expected to trial what they had learnt in the work setting in between sessions. The sessions were co-facilitated by the SES and an occupational therapist. Participants could also contact the SES during working hours for extra support if needed.

Psychosocial Rehabilitation Programme (REACH)

REACH is offered to adults who have experienced serious mental illness. When the programme was operational in the early 2000's, the participants attended for 30 hours per week for 21 weeks. An optional further 11 weeks training in catering, accommodation (hospitality industry), or horticulture was available. The program was manualised in a training programme specification which details the aims, objectives and allocated training hours of each of the ten modules in the programme. Currently the programme is delivered through a weekly timetable of training activities covering the various modules. There is also a 3-week work experience module. To reinforce clients' sense of progress and build confidence, exercises for a recognized certificate are completed at the end of each module. The programme is facilitated by a multi-disciplinary team of occupational therapists, nurses, and trainers.

CBT and Motivational Interviewing Intervention for comorbid cannabis misuse

The group-based psychological intervention for individuals in the early stages of psychosis with comorbid cannabis dependence integrated cognitive based therapy (CBT) and motivational interviewing (MI). It was designed to help participants reduce their cannabis use and improve overall functioning. The intervention focused on challenging unhelpful thoughts and behaviours related to substance use while also enhancing motivation to change.

The intervention was provided by an experienced clinical psychologist. The programme involved weekly group sessions for 12 weeks and a 'booster' session 6 weeks post intervention. The sessions were grouped into six phases based upon motivational interviewing principles - 1. Entry:

engagement, gaining commitment to treatment and raising the issue of problem substance abuse (psychoeducation). 2. Commitment: building commitment to a goal of non-problematic substance misuse (motivational interviewing; harm reduction). 3. Goal Setting: reinforcing commitment to change and development of goal achievement strategies. 4. Challenges: withdrawal counselling and psychoeducation. 5. Relapse prevention and lifestyle: motivational interviewing and psychoeducation. 6. Maintenance: coping skills and time management. 7. Exit: termination; provision of resources.

DETECT Group CBT Programme

Individuals diagnosed with a first episode psychotic condition between February 2006 and February 2008 were referred to a group CBT programme. The DETECT group CBT is a 12-session programme provided on a weekly basis by a Principal Clinical Psychologist who specialises in CBT. The aim of CBT for psychosis is to help the individual make sense of or normalise their experiences and reduce the associated stress and negative effects on cognitive and social functioning.

Community Mental Health Service Group CBT Programme

The early iteration of the DETECT group CBT programme was delivered in a community mental health service. It was available to both people newly diagnosed with psychosis and those with schizophrenia of varying length of illness. The group was offered in weekly group sessions. It focused on helping people re-engage with everyday activities, improve motivation, and build social skills. Sessions included topics like goal setting, learning how to manage unhelpful thoughts, and practicing social interaction. The group setting encouraged shared learning and support from peers, and the therapy also touched on issues like low mood, anxiety, and preventing relapse. The overall aim was to help participants feel more confident, connected, and able to take steps toward recovery.

Lifestyle intervention

This 12-week community activity and healthy lifestyle programme was aimed at people with serious mental illness who were considered at risk for metabolic syndrome. The programme combined group exercise, nutritional education, and lifestyle advice. Participants took part in structured physical activities, attended group sessions covering topics like healthy eating, budgeting, and community engagement, and received nutritional consultations. Each participant outlined personal goals regarding their diet, exercise or social involvement. Their progress was tracked throughout the programme.

Keyworker intervention

A keyworker delivered intervention was introduced at the DETECT service to improve the physical health of individuals attending. The programme was designed to address common health concerns, such as obesity, smoking, and alcohol use. Keyworkers conducted physical health and lifestyle assessments and tracked the progress of participants' health goals. The intervention promoted health lifestyle changes including increased physical activity, improved diet and weight management. Keyworkers provided personalised support, facilitated access to primary care and coordinated with general practitioners. COVID-19 restrictions were introduced mid-way through the intervention leading to replacing face-to-face contact with remote (telephone) consultations for the remainder of the intervention.

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