Early diagnosis and treatment of psychosis is central to the work of EIP teams worldwide. Accurate diagnosis at the first presentation is important for the planning of multidisciplinary treatment as this affects prognosis and long-term treatment plans. For example, how long is an antipsychotic to be continued and what are the chances of relapse on stopping it? EIP services should be less reluctant to diagnose schizophrenia, and that this diagnosis would help them provide the correct support for their patients.

Previous studies in this area have found that diagnosis changed in between 20.7% and 25% of patients. Bipolar affective disorder has also been found to have high prospective diagnostic stability, between 80% and 86.4%. The diagnostic subgroups with the least diagnostic stability are drug-induced psychosis and psychosis not otherwise specified (NOS).

This study aimed to look at the trends in diagnostic stability or otherwise in a population of patients who had been under the care of the PIER team in Leicester-shire Partnership NHS Trust, and to ascertain whether these patients followed trends reported in previous studies.

Methods
The authors identified 141 patients who had been discharged from the PIER team in a one-year period between May 2014 and April 2015.

The study was a retrospective cross-sectional survey in design. Records were reviewed to establish the diagnoses given at time of the patient being assessed and accepted into the PIER team caseload and subsequently at time of discharge.

Patients underwent a multidisciplinary assessment (involving a doctor and a care coordinator) in the PIER team and through three years of their journey in the team they were regularly reviewed by both a doctor and an allied mental health professional who was either a nurse or occupational therapist by background. On discharge a clinical letter went to the clinician/service that the patient was being discharged to. The diagnoses for the purposes of this study were taken from clinical letters from the assessment and discharge appointments, which also included ICD-10 codes.

We included patients who had spent the full commissioned three years with the PIER team or most part of it. Patients who had disengaged before one year were excluded as they did not give enough time for diagnostic clarification. Descriptive statistics were calculated.

• Firstly we identified how many patients had the same diagnosis between assessment and discharge from the PIER team.

• Secondly we explored the distribution of diagnoses where the diagnosis remained the same or changed.

Results
Twenty three of these patient records included patients who were discharged to other EIP services or disengaged before any confident diagnostic impression could be made. Hence they were excluded.
The stability of psychosis NOS is interesting. At entry eight out of 118 (7%) showed a diagnosis of psychosis NOS. At discharge this had increased to 17 (14%). Only three of the original diagnostic group retained the diagnosis, which showed that there were 14 patients re-diagnosed with psychosis NOS during their journey with the PIER team. This might reflect that as clinicians began to know their patients better they questioned the initial diagnosis and aspects of the presentation were felt not to fit categories of more specific psychotic disorders. Also, patients diagnosed earlier with acute and transient psychotic episodes would change over to a diagnosis of psychosis NOS if they continued to experience symptoms that did not fit into a more specific set of diagnostic criteria.

In our patient group, 40% of patients had a change in diagnosis. This is around 15% higher than is stated in the literature. The reasons might be the widening scope of early intervention services over time and increasing trend to regularly review diagnoses subject to increasing patient requests and awareness, according to the authors’ clinical experience. The authors would also like to consider the possibility of EIP services being reluctant to diagnose schizophrenia and bipolar affective disorder in

Diagnoses of 50% of patients remained the same between initial assessment and discharge, while diagnoses of 40% of patients changed between assessment and discharge. Two per cent of patient records did not have a diagnosis on assessment. Seven per cent of patient records did not have a diagnosis given at discharge. Two per cent of patient records did not have a diagnosis given at either assessment or discharge.

The results in Table 3 show that patients with schizophrenia and bipolar affective disorder had the greatest diagnostic stability. Acute and transient psychosis had the least diagnostic stability.

Discussion
At initial assessment, schizophrenia was the most commonly made diagnosis at 35%. This remained the most common diagnosis at discharge in spite of patients moving both in and out of the diagnostic group. Acute and transient psychosis showed the most significant change with 83% changing to another diagnosis.

from further analysis. This left 118 patients who were under the care of the PIER team for most of the three years of the commissioned service. The descriptive statistics were calculated for these 118 patients.

The diagnoses were reviewed and allocated into one of the following categories: acute and transient psychotic episode; schizophrenia; schizoaffective disorder; bipolar disorder; psychosis NOS; drug-induced psychosis, or delusional disorder. Table 1 shows the diagnostic distribution at initial assessment and at discharge.

We then looked at the proportion of patients where the diagnosis stayed the same between assessment and discharge, and where they had changed (Table 2).

We then looked at the diagnostic spread of psychotic disorders that had remained stable from entry into the caseload until the time of discharge (Table 3). This included 107 patients with an initial diagnosis of a psychotic disorder. The 11 patients who had no diagnosis or a diagnosis of a non-psychotic disorder were excluded from this table.

Table 1. Diagnostic spread at assessment and discharge (N=118)

<table>
<thead>
<tr>
<th>Diagnosis at initial assessment</th>
<th>Number</th>
<th>%</th>
<th>Diagnosis at discharge</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>41</td>
<td>35</td>
<td>Schizophrenia</td>
<td>41</td>
<td>35</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>2</td>
<td>2</td>
<td>Schizoaffective disorder</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>5</td>
<td>4</td>
<td>Delusional disorder</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>12</td>
<td>10</td>
<td>Bipolar affective disorder</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Acute and transient psychotic disorder</td>
<td>30</td>
<td>25</td>
<td>Acute and transient psychotic disorder</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Drug-induced psychotic episode</td>
<td>9</td>
<td>8</td>
<td>Drug-induced psychotic episode</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>8</td>
<td>7</td>
<td>Psychosis NOS</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Non-psychotic diagnoses</td>
<td>6</td>
<td>5</td>
<td>Non-psychotic diagnoses</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>No diagnosis given due to uncertainty</td>
<td>5</td>
<td>5</td>
<td>No diagnosis given due to uncertainty</td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 2. Changes in diagnosis between assessment and discharge

| Patients where diagnoses remained the same | 59 | 50% |
| Patients where diagnoses changed between assessment and discharge | 47 | 40% |
| Diagnosis not given at assessment | 2 | 2%  |
| Diagnosis not given at discharge | 8 | 7%  |
| Diagnosis not given at assessment or discharge | 2 | 2%  |
the initial stages of contact with the patient, perhaps preferring acute and transient psychoses, psychosis NOS and drug-induced psychosis, which are more likely to change over time.

The relative stability in the diagnoses of schizophrenia and bipolar affective disorder remains a finding consistent with earlier studies.1-3,6-8 This may result from the clinical caution to make diagnoses associated with serious enduring illnesses and perceived stigma. The diagnoses were thus made when clinicians had sufficient data to make a valid diagnosis as per ICD-10 criteria, which were likely to remain stable.

The findings, in addition to earlier studies, reiterate the need to prepare patients in relation to the relative stability or changeability of their diagnoses and how that would affect future prognosis and long-term care. It also demonstrates that the serious mental illnesses we encounter in clinical practice, ie schizophrenia and bipolar affective disorder, are more likely to remain stable than acute and transient psychotic disorder. The possibility of considering schizophrenia or bipolar affective disorder as a differential diagnosis when patients present with what initially might appear as an acute and transient psychotic disorder is a question of clinical significance. Should early intervention in psychosis services be preparing their patients better when they present with diagnoses that are more likely to change, such as acute and transient psychosis, psychosis NOS or drug-induced psychotic disorder? We think that the possibility should at least be discussed with patients and families. Some patients may retain less severe diagnoses, but preparing them for a possible change would make it easier for them in the longer term to accept more challenging prognoses.

The limitations of this study are a retrospective design, which makes it difficult to peruse all the records to see whether diagnoses have changed multiple times over the patient’s journey with the PIER team. Only diagnosis on assessment and discharge from the team were considered. Also, we did not consider whether diagnostic stability was affected by sociodemographic variables. This may have given more insight into the causes of diagnostic stability or otherwise, for example, are we more likely to give diagnoses of particular types to a specific sociodemographic profile?

In light of recent commissioning changes to the local EIP service, which would see us opening the accepting criteria to the entire age range of adult population in November 2016, in contrast to the current criteria, which accept patients up to 35 years of age, we feel that it would be extremely important to repeat this study at least three years after November 2016 to see whether our diagnostic spreads and diagnostic stabilities have changed. A patient population significantly older than the current early intervention in psychosis caseload could present with a different clinical range, which might change the findings of a similar study when repeated.

Dr Hobbs is a Specialty Trainee, Dr Stanbrook is a Foundation Trainee and Dr Chakraborty is a Consultant Psychiatrist at the PIER team (Psychosis Intervention and Early Recovery), all at Leicestershire Partnership NHS Trust, St Peters Health Centre, Leicester.

Declaration of interests
No conflicts of interest were declared.

References