Early Intervention in Psychosis.

WPA Education Committee’s
Recommended Roles for the Psychiatrist:

Introduction

Definitions:
Early intervention in psychosis may refer to services that are organised to:
   a) detect and treat patients who have developed a first episode of psychosis
   b) detect young people at elevated risk for psychosis (i.e. in a prodromal state)

Purpose of this document
To provide psychiatrists with guidance as to:
   a) recent developments in the conceptualisation and knowledge of psychosis onset and their implications for early detection and effective intervention strategies
   b) the roles for psychiatrists in early detection and intervention
   c) the scientific literature relevant to early intervention in psychosis

The Education Committee of the World Psychiatric Association fully endorses ‘Early intervention and recovery for young persons with early psychosis: consensus statement’, a declaration on behalf of the World Health Organisation and the International Early Psychosis Association. This statement (reprinted in Appendix 1) spells out the elements of a comprehensive programme and proposes strategies that would have measurable five year outcomes (according to levels of resources in different regions of the world). These aim to:

- minimise duration of untreated psychosis by utilising primary care and community care for early detection and treatment without delay
- reduce involuntary institutional and coercive treatments in psychosis
- reduce suicide rates in the first years of psychosis
- ensure availability of psychological, psychosocial and pharmacological interventions
- achieve meaningful, early and appropriate ongoing involvement with family members and other key members of patients’ support network
- educate all young people, families, teachers, relevant professionals, communities, health, social care and employment personnel about psychosis; and form relevant policies and programmes for early detection and intervention in psychosis
- set goals for recovery which includes satisfying relationships, education and employment
- develop other relevant indicators and monitors of progress in early intervention
- support further research on the psychological, social and neurobiology of psychosis onset and strategies for prevention and treatment
Changing perspectives

a) Psychoses are nowadays recognised as a range of disorders that result from complex interactions between environmental stressors, constitutional and proximal and distal developmental factors. There is now good evidence that outcomes from the psychoses, including ‘schizophrenia’, can be more favourable, on a range of meaningful variables, than was often previously realised. This has led to more active attempts to engage with patients early in the onset of psychosis and to detect at risk people. In both groups, in addition to the psychosis, early engagement, a benign psychotherapeutic attitude aiming to reduce anxiety, depression and social anxiety and isolation should minimise psychosocial decline. Community services should be easily accessible by the patient and their family and be available without delays and waiting lists.

c) Overarching systems of care are vital in determining positive outcomes for both individuals and cohorts of people who have experienced psychosis.

d) An increasing evidence base shows that after onset of a psychosis, a wide range of psychological, psychosocial and biological interventions tailored to the individual and his or her setting can favourably influence outcome toward the recovery of a meaningful life in the community and reduce relapse and suicide rates. Cultural factors may also account for the considerable variation in outcomes in different parts of the world.

e) The understanding of pharmacological interventions has become more sophisticated and there is a wider range of medications.

The role of Psychiatrists

Psychiatrists and representatives of psychiatric organisations should play an active part in ensuring that local, regional and national mental health policies include an early intervention and recovery policy and have programmes that at least match the WHO / IEPA consensus statement. Psychiatrists should ensure effective means of measuring the outcomes of such programmes.

The training of Psychiatrists

I) All psychiatrists

All curricula for the training of psychiatrists and examinations for certification of psychiatrists should include understanding of the theory and practical application of early interventions in psychosis relevant to psychiatrists and to the functioning of multi-disciplinary teams and to the organisation of services in and with the local community.

II) Psychiatrists who specialize in first episode of psychosis will need the following

a) the competence to work flexibly and in various settings including homes to maximise chances of engagement with young persons and to be able to foster an atmosphere of trust and confidence from the patients

b) the competence to engage with families and to assist them and other key persons in the patient’s life.
c) an understanding of how services can be organised to minimise duration of untreated psychosis.

d) an understanding of how psychiatrists and mental health services can contribute to minimising stigma.

e) an understanding of the notion of diagnostic uncertainty in the early phases of a psychosis, and the maintenance of a broad therapeutic approach during this phase.

f) An understanding of and capacity to register and creatively respond to the personal issues often contained within psychotic phenomena, to manage the interpersonal consequences of psychosis and their manifestation in relationships with psychiatrists and others.

g) a capacity to make an individual ongoing formulation within a sophisticated stress-vulnerability paradigm to inform treatment and recovery.

h) an understanding of the role in some cultures of physiological stressors provoking psychosis, such as fever, childbirth and very hot weather.

i) expertise in minimizing relapses and readmissions through leadership of early intervention teams.

j) familiarity with a range of psychological and psychosocial interventions so as to support the skills of other staff and agencies and to function as a member of a multidisciplinary service.

k) an understanding of how psychiatrists can assist services be organised to support ‘recovery’ for patients in terms of meaningful relationships, education and vocation. This implies an understanding of the resource implications and such matters as staff continuity and skill level to maintain meaningful engagement.

l) competence in working with those who misuse substances and who have personality difficulties complicated by psychosis.

m) ensure systems are in place to regularly monitor the physical health of patients with psychosis.

n) an appreciation of the problematic aspects of many contemporary in-patient services and the possibilities of improving these and the value of alternative small houses in the community for respite and recovery.

o) an appreciation of the early intervention in psychosis approach as a paradigm for a more preventative psychiatry and the restructuring / refocusing of mental health services.

p) ensuring that mental health organisations set service wide standards such as duration of untreated psychosis and meaningful family engagement and continuity of care and organise service audits to ensure the continuing of service development.

**Psychopharmacology and early intervention in psychosis**

a) the role of anti-psychotic medication in pre-psychotic (prodromal) states remains controversial.

b) first episode psychosis patients will benefit from reduction of stressful factors, good sleep and restoration of basic physical needs in a low stimulus environment. Short term minor tranquillisers and
psychological approaches will assist in regaining sleep patterns, reduce excess anxiety, agitation and panic.

c) typical or atypical medication should be used in minimal effective doses according to recent clinical and PET studies. General principles include clinicians having a very low acceptance of side effects and clinician awareness of the possibility of several days between a dosage increase and reduction in psychosis.

.d) some studies, especially from Scandinavia, indicate that when there is ready access to high quality psychological and social interventions for patients and families that a minority of patients with good pre-morbid functioning and acute onset may recover without anti-psychotic medication. Other reports also indicate a good prognosis acute onset non-affective remitting psychosis group commoner in developing countries in both adolescents and young adults for whom a short course of anti-psychotic medication and good psychotherapeutic support is indicated with careful follow up.

e) the majority of other patients should be offered anti-psychotic medication titrating from very low doses, and using the minimum effective dosages. Except in the above group and those likely to be suffering substance induced psychosis, medication should be continued for at least a year especially in those in the poorer prognosis groups; longer periods are recommended for those who show signs of relapse. First episode and early psychosis patients usually require far lower anti-psychotic doses than more established cases.

f) psychiatrists should be competent at helping those will not take neuroleptics by maintaining engagement and assisting in other ways of helping patients to manage their psychosis and related problems and support the provision of psychological interventions if they do not have the skills themselves.
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