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EARLY INTERVENTION IN FIRST EPISODE PSYCHOSIS: HOPE FOR A BETTER FUTURE

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ABSTRACT

In the last two decades the clinical and research focus in psychotic disorders has shifted to first episode psychosis, early detection of the prodromal phase of psychosis and an effective integrated treatment model known as "Early Intervention". The first five years of psychosis that is described as a "critical period" is the most important time for recognition and treatment. Services for Early Intervention should be easily accessible, non-threatening and non-stigmatising. Effective treatment is based on successful engagement and the development of trust between patients, their families and the mental health professionals assisting them. Psychosocial interventions have a fundamental place in early treatment. They provide a humane basis for acute and continuing care, prevention or resolution of the secondary consequences of psychosis and the promotion of recovery. Antipsychotic medication is considered effective and is recommended by evidence based research in the treatment of first episode psychosis. A program of extensive public education and specific education for teachers, general health and mental health professionals about the prodrome and nature of first episode psychosis can reduce the duration of untreated psychosis and improve treatment outcome. Countries that do not have services for Early Intervention should seriously consider implementing this model.

Key words: prodrome; first episode psychosis; early intervention; recovery

INTRODUCTION

First episode psychosis and Early Intervention have attracted much attention in contemporary psychiatric research and clinical practice. The importance of detecting people at high risk for developing psychosis has been recognized as an important task in preventing and reducing the potentially debilitating consequences of psychotic disorders. Schizophrenia and other forms of psychosis (schizoaffective disorder, bipolar disorder with psychotic features and depression with psychotic features) that affect young people rank as the third most disabling conditions in the world. A prolonged duration of untreated psychosis is correlated with poorer response to treatment and a worse prognosis. Better treatment outcomes require improvement in mental health literacy, public awareness, education of primary care clinicians and general practitioners, as well as the creation of specialized Early Intervention services.

First episode psychosis should be viewed as a psychiatric emergency and treatment must be instituted as a matter of urgency. To argue against Early Intervention implies severe and misguided therapeutic nihilism [1].

DEFINITION

Psychosis is a syndrome that may be a feature of a number of disorders. First episode psychosis generally refers to the first presentation of a person with psychotic symptoms. The underlying assumption is that the development of psychosis is best accounted for by a stress-vulnerability model with predisposing factors such as genetics rendering a person susceptible and triggering factors causing the disorder to manifest. This applies to both the first and subsequent episodes of psychosis. The phases of first episode psychosis have been identified as the prodromal phase, the acute phase and the recovery phase. The prodromal phase is a time when psychotic symptoms have not yet manifested and it is best to consider the prodrome as an "at risk mental state". The acute phase is when a person is experiencing active positive symptoms of psychosis. The recovery phase begins when the mental state is stable or the patient develops some awareness of their own desire or need to regain a sense of self. Recovery is a process that encompasses all the life changes of the individual who has become unwell.

The first five years of psychosis during the prodromal and acute phase are called the "critical period". During the "critical period" the patient and family should receive appropriate treatment in order to prevent disabilities and relapses [2]. Early Intervention is a comprehensive program of prevention and treatment designed to detect and minimise the harmful effects of first episode psychosis. The Early Intervention model stresses the need to embrace the entire spectrum of a person's wellbeing rather than just focusing on the treatment of symptoms or disorders.

HIGH RISK POPULATION

On an average 20 people per 100.000 population will develop psychosis every year with rates ranging between 10-15 per 100.000 in less deprived areas compared to 55-60 per 100.000 in areas of high deprivation. About 80% of first episode psychosis presentations are young people between the ages of 16-39 with a median age of 19 years in males and 22 years in females. About 39% of males and 23% of females have the first onset of schizophrenia before the age of 19 years. Bipolar disorder has a slightly later onset with about 25% occurring before the age of 20 years [3]. Approximately 20-30% of young people who experience their first onset of psychosis are a danger to themselves or others and may have made suicide attempts before receiving effective treatment [4]. It is well known that 10-15% of people with psychosis commit suicide. The risk of suicide is the highest during the early stage of psychosis. Two thirds of suicides occur within five years of the onset of psychosis. Suicide is usually caused by the development of depression and hopelessness [5].

WHAT IS THE PRODROME?

The term "prodrome" is derived from the Greek word *prodromos* meaning the forerunner of an event [6]. The prodrome in first episode psychosis is the time interval from the onset of unusual behavioural symptoms to the onset of psychotic symptoms as recognized by the patient, family or friends [7]. Before the prodromal period there is a premorbid phase during childhood and usually at least part of adolescence in which emotional, cognitive and behavioural functioning are not obviously impaired. The prodromal period is usually characterised by a sustained and clinically important deviation from the premorbid level of function.

There are premorbid precursors of psychosis that may be relevant to early detection and intervention. There are early and late precursors. These refer to potential etiological factors, as well as signs or symptoms. Precursors that occur early in life include: a family history of schizophrenia or schizotypal disorder, a history of obstetric complications, maternal exposure to influenza, neurobehavioural deficits, early parental separation that results in institutionalisation and distressed family functioning. Late precursors that signal possible future psychosis include social and behavioural elements of sub-threshold positive symptoms that are not severe or persistent enough to meet criteria for a mental disorder. Research has shown that school teachers are able to correctly anticipate 35% of students who develop schizophrenia. Teachers and clinicians usually identify students who are emotionally labile and vulnerable to psychotic breakdown. Boys are more disruptive in classroom behaviour, have more disciplinary problems, more anxiety and suffer from rejection by their peers. These boys are more likely to have to repeat years at school. Girls who later develop psychosis are more nervous and withdrawn [8].

Not all the individuals presenting with apparent prodromal syndromes will make the transition to frank psychosis [9, 10]. The prodromal syndrome is better termed as an 'at-risk mental state", implying that the person is at risk of developing psychosis, but psychosis is not inevitable [10, 11]. The prodrome is a process involving changes in experiences and behaviour over time, rather than a simple list of symptoms at any one point. Commonly observed features of the prepsychotic prodromal phase are described as social withdrawal, poor performance at school or at work, unusual behaviour, symptoms of distress and agitation that a person has difficulty explaining, disturbances in motor function such as the loss of spontaneous movements and coordination, reduced concentration and attention, reduced drive and motivation, anergia, depressed mood, sleep disturbances, anxiety, suspiciousness and irritability [10].

The available data on the prodromal stage of affective psychosis is limited. Manic prodromes last an average of 20 days and are considerably longer than depressive prodromes that last an average of 11 days [12]. The common behavioural changes in mania include: increased activity, irritability, lability of mood, increased talking and rate of speech and sometimes euphoria and overconfidence. Thought content can be characterized by a preoccupation with sexual and religious themes [13]. In contrast, prodromes of depression are characterized by depressed mood, loss of energy and interests, poor concentration, decreased sleep and morbid thoughts [12].

The prodrome in psychosis is seen as a state as opposed to a trait risk factor for psychosis. This implies that the person with certain features, such as attention and perceptional difficulties accompanied by anxiety, may or may not develop psychosis [14].

If young people with an "at-risk mental state" are actively seeking help for the distress and disability associated with their symptoms, they need to be engaged and assessed. They should be offered support and regular monitoring of their mental state. Specific treatments for syndromes such as depression, anxiety and substance abuse are essential. Assistance with potential problem areas such as interpersonal, vocational and family stress should be provided.

Intervention during the prodromal phase may help to prevent the onset of psychosis. Preventative intervention should include early recognition, easy access to services and follow up activities with at risk groups. Psychosocial interventions are preferred during the prodromal phase [15]. These interventions include: engagement, cognitive behavioural therapy, stress management, vocational rehabilitation, family intervention, neuroprotective supplements such as omega-3 fatty acids, and where it is necessary medication. These include mainly selective serotonin reuptake inhibitors for anxiety and depression. During the earliest developmental phase of schizophrenia, the only intervention currently thought to help attenuate the rate of transition into psychosis is to reduce the use of cannabis during adolescence. A number of randomized

controlled trials indicate that the use of antipsychotics is able to postpone or inhibit the transition to psychosis [16]. About 15% of those presenting with schizophrenia-like symptoms during the prodrome completely recover within 4 months. The false positive rate for anticipating first episode psychosis remains substantial. Young people who do not go on to develop psychosis and receive medication treatment may suffer from the stigma attached to mental illness and may develop both physical and psychological adverse reactions to medication. Every decision about medical treatment should be carefully considered. If a young person who is engaged in the Early Intervention program during the prodromal phase develops psychosis, the patient enters his or her first episode in better health with less distress as a result of the psychosocial interventions and possibly the use of low dose antipsychotics. Early Intervention minimises the duration of untreated psychosis, reduces hospitalisations and other life style disruptions. In the prodromal phase co-occurring disorders such as depression and substance abuse are very important to identify and must be effectively treated.

Research findings suggest that the prodrome before the first episode of psychosis is often prolonged and may last many months and up to several years [10]. Antipsychotic medications are not usually indicated unless the person meets criteria for a psychotic disorder. An exception should be considered when rapid deterioration occurs, severe suicidal risk is present, treatment of any depression has proven ineffective and aggression or hostility are increasing. If antipsychotics are considered, ideally, atypical antipsychotics should be used in low doses in a therapeutic trial for a limited period. If there is a benefit and resolution of symptoms after 6 weeks, the medication may be continued with the patient's consent for a further 6 months to 2 years. After this period, a gradual attempt to withdraw the medication should be made if the patient agrees and if there has been a good recovery.

FIRST EPISODE OF PSYCHOSIS

Psychotic illnesses usually have their onset in late adolescence and young adulthood. This stage of life is important for the development of the individual and social identity, as well as establishing close emotional relationships and educational and vocational goals. In psychosis structural and functional changes in the central nervous system can interfere with the ability of the young person to achieve these tasks. Recent studies suggest that white matter changes may be the cause of dysfunctional neuronal connectivity proposed to underlie the symptoms of schizophrenia [17].

Individuals who manifest attenuated psychotic symptoms are at high risk for developing psychosis [18]. These symptoms include: ideas of reference, odd beliefs or magical thinking, perceptual disturbances, paranoid ideation, odd behaviour or appearance. Others who seem likely to make the transition from prodrome to psychosis have a history of brief, transient psychotic symptoms that resolve spontaneously. This group presents with at least one of the following transient symptoms: hallucinations, delusions, suspiciousness, or formal thought disorder.

The acute phase of psychosis is characterized by persistent, florid positive symptoms such as hallucinations and delusions and/or thought disorder. Depression, anxiety, substance abuse and other co-occurring mental disorders may be present. The presence of early negative symptoms is predictive of a poorer early and late outcome [19]. Historically most people have had active psychotic symptoms for 1-2 years before their disorder is recognized and treated [20]. This fact is one of the motivating factors for the development of Early Intervention, because prolonged delays in initiating effective treatment are associated with a poorer response to treatment and a less positive outcome [21]. The first episode of psychosis tends to be more responsive to treatment than subsequent episodes [22].

The early course of psychosis is often characterized by a changing pattern of symptoms and frequently a diagnosis of schizophrenia is given prematurely. In Early Intervention a diagnosis is not given for an extended period of time until it is clear whether or not patients meet criteria for a chronic psychotic disorder. A premature diagnosis of schizophrenia may have been given because of co-occurring symptoms and disorders. Conditions such as substance abuse, depression, suicidal thinking, social avoidance and posttraumatic stress disorder require concurrent assessment and treatment because of their potential to act as stressors that trigger the onset of psychosis [20].

Relapses are common during the "critical period", that is, the five years that follow the development of the first episode of psychosis [23, 24]. During this time people are at risk for worsening of substance abuse, vocational failure, family stress, homelessness and further disruption of their social network [22].

Suicide is common in first episode psychosis and occurs in up to 15% of young people usually as a direct consequence of psychotic thinking [25]. Death from suicide in psychosis is 20 times more frequent than for the general population. Pessimism and loss of self-efficacy can lead to depression and increased the risk of suicide. The predictors of suicide are: failed expectations in young people with a high IQ, good premorbid functioning, history of high attainment and the fear of mental disintegration in the presence of early relapse or disability [19]. The peak risk period for suicide in first episode psychosis is between the ages of 20-29 years [19].

EARLY INTERVENTION

Early Intervention in psychosis is an exciting and positive approach to conceptualize preventative and treatment options. In contemporary psychiatry it is a highly regarded movement that reduces people's suffering, instils hope and promotes a better quality of life. Patients with a first episode of psychosis are likely to obtain the greatest

benefit if the treatment provided is especially designed for this early phase of the illness. Early Intervention as a program is widespread in the UK, Australia, New Zealand, Scandinavia, Western Europe and Canada.

The aims of the Early Intervention program in these countries are:

1. To reduce the delay between onset of early psychosis and accessing expert assessment and treatment.
2. To raise community awareness of the signs of early psychosis and the availability of existing services.
3. To reduce hospital admission, relapse and suicide rates for young people with psychotic illness.
4. To minimize the stress and reduce the trauma of illness and treatment for people with psychosis and their families.
5. To maximize the chances of full recovery following the onset of first episode psychosis.
6. To prevent the development of secondary psychosocial disability.
7. To prevent secondary co-occurring disorders such as depression, anxiety, post-traumatic stress disorder, and substance abuse and actively treat these disorders when they arise.

The Early Intervention program utilizes an assertive case management model modified to suit the needs of young people and their families [26]. The case manager is the central clinician for each patient and works in a partnership model with the treating psychiatrist to provide a range of services to meet the needs of the patients and their families. This is achieved through close partnership with the families, a strong therapeutic alliance with the patient and, where it is possible, reliance on liaisons with community services, educational institutions and employers. The overall goal is to reintegrate the young person into his/her life and assist them in achieving their full potentials.

The primary functions of the case manager should include ongoing assessment and clinical interventions such as supportive psychotherapy, psycho-education and community liaison. The case manager should have frequent ongoing contacts with the patient and family relevant to the phase of illness and the patient's needs. The case manager should be responsible for the documentation and development of an individual treatment plan in collaboration with the patient and family.

Assessment and Engagement

The initial phase of assessment of people who have an "at-risk mental state" should include close, regular follow-up and on-going assessment for possible transition to psychosis or recovery. Assessment involves an interview of the referred person with the multidisciplinary team. The atmosphere of the assessment should be relaxed and non-clinical in nature. The goal of this approach is to promote a trusting relationship and help young people to identify their social and family concerns. The assessment should use a minimum of psychiatric jargon and explain the process and the purpose of the assessment [27].

The comprehensive assessment over a period of time should include: 1) a psychiatric history; 2) a mental status examination; 3) a risk assessment; 4) clarifying the presence of co-occurring disorders; 5) a physical examination including a head CT scan, Body Mass Index (BMI), serum glucose level, ECG, neurological examination for movement disorders and a neurocognitive screening exam; 6) a social functioning assessment; 7) a psychological assessment; 8) an occupational assessment; 9) a family-support system assessment; and 10) clarification of the patient's aspirations, level of understanding of their current situation and an understanding of their hopes and goals for the future.

TREATMENT

Comprehensive and sustained intervention should be provided during the initial years following the diagnosis of psychosis because the course of illness is strongly influenced by what occurs during this "critical period". Patients should not have to "prove chronicity" before they gain consistent access to specialist mental health services [22]. Treatment should be conducted in the least restrictive setting preferably in the community. Before initiating treatment, it is important to consider physical illnesses that can be the cause of psychosis.

Pharmacotherapy

Antipsychotic medication is the cornerstone of treatment. Atypical antipsychotics are the treatment of choice but conventional neuroleptic medications in low dosage may have a role in some patients. Clozapine should be considered if there is incomplete remission of positive symptoms following treatment trials with at least two other antipsychotic medications. Clozapine needs to be considered when there are pervasive negative symptoms or a significant and persistent risk of suicide. Therapeutic doses of medication should be maintained for at least one to two years [22].

Psychosocial interventions

Psychosocial interventions should be available routinely for all patients and provided by appropriately trained mental health professionals. General psychological approaches are used in forming a strong therapeutic alliance, establishing engagement with the patient and family and promoting recovery. Appropriate interventions include family psychoeduction and therapy, cognitive behavioural therapy, vocational rehabilitation, trauma therapy, psycho-education and therapy for co-occurring conditions particularly substance abuse disorders and anxiety.

Skills development can most often be done in a group setting and needs to include problem solving skills, social skills and cognitive skills. Group based education and interventions should be considered as adjunctive to individual psychotherapy.

Interventions should be tailored to the phase of the illness and to the gender and cultural background of the person. Group interventions are provided to address patient's needs specific to each stage of recovery.

RELAPSE

Relapses are common during the first five years after the onset of a first episode of psychosis. In the first year of the "critical period" the relapse rate is between 15-30%, in the first two years after onset the relapse rate is between 30-60% and within the first five years the relapse rate is over 80%. The most common causes leading to relapse are poor adherence to treatment associated with denial of having an illness, substance abuse, vocational failure, family stress with highly expressed emotions, hopelessness, depression, and negative symptoms [28]. One of the most important determinants of relapse is the duration of illness prior to starting antipsychotic medication. Each relapse increases the presence of residual symptoms such as hearing voices, paranoid ideation and more frequent periods of depression. These residual symptoms may exacerbate social disability.

Recommended interventions in acute relapse include establishing the cause for the relapse, optimizing or switching medication considering depot medication for non-adherence. Approximately 10-20% of patients fail to fully remit after a trial of two antipsychotic medications and are considered treatment resistant [22]. A Clozapine trial is recommended in these patients.

Maintenance medication is of proven prophylactic efficacy. It is essential that high quality and intensive biopsychosocial care is provided continuously and assertively during the critical period. Psychosocial interventions are support and counselling about the events surrounding the relapse, structured family intervention, relapse prevention, assertive community treatment and abstinence for substance abuse.

At present Early Intervention services tend to be funded for one to three years and disengage at precisely the time when they are most needed and could be of most value [22]. That is the reason why it is now suggested that Early Intervention treatment should be extended to five years from the time of onset of the first episode of psychosis.

REMISSION AND RECOVERY

Remission is understood to relate to the successful treatment of the positive symptoms of psychosis. The mean interval between initiating medication and achieving maximum improvement has been found to be about 36 weeks, with a median of 11 weeks. About 80% of patients with first episode psychosis will achieve full remission of positive symptoms within 6 months of starting treatment [29]. Remission means that the person is free of psychotic symptoms while recovery has a more comprehensive meaning.

Recovery is an active convalescent period of recuperation and readjustment where patients develop an understanding of what happened to them, integrate the experience and restore their self-esteem. Assessment of recovery should take into account the characteristic symptoms of the illness, the functional limitations and the disadvantage experienced by the patient in fulfilling normal roles such as student, worker, friend or family member. For some people, rapid return to their normal environment and responsibilities is helpful and may minimize stigma and inappropriate illness behaviour. For others there is a risk of precipitating a second episode of psychosis if reintegration is too rapid [30].

Recovery has an estimated time period of 6-18 months. The time periods for remission of symptoms and the risk of relapse are highly variable. [29]

Late recovery refers to a period usually commencing a year after the first onset of psychosis. This may relate to the period of time required for patients to respond to antipsychotic medication. One prospective study showed that 87% of patients responded to antipsychotic treatment within 12 months [23].

The most important issues that need to be addressed during the recovery phase are substance abuse, suicide prevention, personality difficulties, the consequences of trauma and the treatment of any other co-occurring disorders. Recovery interventions used to prevent relapse are psycho-education, multiple family groups, and social treatments that focus on the following needs: vocational, educational, recreational, health promotion, creative expression and personal development. Psycho-education with clarification of early warning signs and relapse prevention should be carefully discussed with the patients and their families and/or support system.

SERVICES

Early Intervention services can be an integrated part of a community mental health centre or they can be stand-alone independent programs. They are designed to target the high risk population group between 15 and 30 years of age. When appropriate they are able to accept older people with first episode psychosis up to the age of 45 years. A service with a catchment area of 200.000 residents would be expected to have around 50 cases per year [30].

Young people with first episode psychosis usually access mental health services as a result of a crisis or a formal hospital admission. They can also be referred by their general practitioners and families. To be maximally effective, early detection in primary care and facilitation

of help-seeking in the wider community must also be addressed. The community should be informed about psychotic disorders and how to obtain effective help. Community education programs need to promote a strong emphasis on destigmatisation of mental illness including psychosis.

Early detection of psychosis is a diagnostic challenge for general practitioners and other non-mental health professionals, as well as mental health professionals. Psychosis can take several months to emerge from a prodrome of non-specific psychological and social disturbances. These non-specific symptoms are difficult to distinguish from normal adolescent behaviour. Young people usually avoid seeing mental health professionals because they are ashamed and want to avoid the negative attitudes of their family and peers and the prejudice of society. In addition, young people are frightened of what is happening to themselves psychologically and usually do not share this with their family or friends. They also medicate themselves with substances of abuse. It is for these reasons that a program of extensive public education and specific education for teachers, youth workers, general practitioners and other mental health professionals about the prodrome and nature of first episode psychosis can facilitate referral and reduce the duration of untreated psychosis.

Early Intervention Services were first established by Professor Patrick McGorry in Melbourne, Australia and then replicated in Birmingham in the UK. From these services, the concept of Early Intervention spread throughout the world [31].

The structure of the Early Intervention team is based on the multidisciplinary approach that involves psychiatrists, psychologists, nurses, social workers and occupational therapists. Early Intervention teams are usually based in the community and provide an integrated treatment approach addressing biological, social and psychological interventions for the maximum benefit to the patient.

People in the Early Intervention program can also be treated in newly established intensive home-based services designed to replace hospital admissions. When there is a significant risk of self-harm or aggression or the level of support in the community or within the family is insufficient, however, admission to hospital is necessary. Home-based services are a new approach that includes strong family involvement and daily intensive home care by mental health professionals.

It is important to know that Early Intervention Services are time-limited and at some stage a young person will either be discharged as stable or in recovery or transferred to a continuing psychiatric team for further care.

The WHO Declaration for Mental Health in Europe recommends that specific care should be given to persons who develop mental illness for the first time. A set of standards that have been developed for Community Mental Health in Europe also recommends specific services for young patients who become psychotic for the first time [32].

CONCLUSION

In the past psychotic disorders like schizophrenia and schizoaffective disorder were considered to be devastating conditions that were likely to result in restricted options for the patient's future life and development. New hope for people with first episode psychosis has been instilled by the world-wide development of Early Intervention programs. Early recognition of prodromal symptoms, assertive case management and an integrated treatment model are powerful components of Early Intervention that may reduce the morbidity and mortality of psychosis. Specialized Early Intervention services are widely available in many countries in the world. Countries that do not have these services should seriously consider implementing Early Intervention programs.

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РАНА ИНТЕРВЕНЦИЈА КОД ПРВОГ ПСИХОТИЧНОГ ДОГАЂАЈА: НАДА У БОЉУ БУДУЋНОСТ

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КРАТАК САДРЖАЈ

У последњих двадесет година клиничка и истраживачка пажња у вези са психотичном болешћу усмерила се према првом психотичном догађају, раном откривању продромалне фазе и ефикасном интегративном моделу познатом као „рана интервенција". Првих пет година у развоју психозе означавају се тзв. критичним периодом, који представља најзначајније време за препознавање и лечење болести. Службе за менталну заштиту би требало да буду лако доступне и да носе у себи оптимистичку поруку која је лишена сваке стигме која обично прати психијатријске и психолошке проблеме младих људи. Ефикасно лечење је засновано на успешном ангажовању и развијеном поверењу између болесника, њихове породице и службе за менталну заштиту. Психосоцијалне интервенције имају најзначајније место у раном лечењу болести. Ове интервенције обезбеђују хуманистичке основе за акутно и дуготрајно лечење, превенцију и ублажавање секундарних последица психозе, као и унапређење процеса опоравка од болести. Антипсихотици су лек избора за ефикасно лечење првог психотичног догађаја. Едукација друштва и специфична едукација наставника и свих оних који се баве примарномедицинском, психолошком и менталном заштитом становништва у смислу препознавања првог психотичног догађаја може да утиче на скраћење времена у којем почиње лечење првог психотичног догађаја. Земље које немају службу за рану интервенцију требало би да озбиљно размотре увођење овог метода у превенцију и лечење првог психотичног догађаја.

Кључне речи: продром; први психотични догађај; рана интервенција; опоравак

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