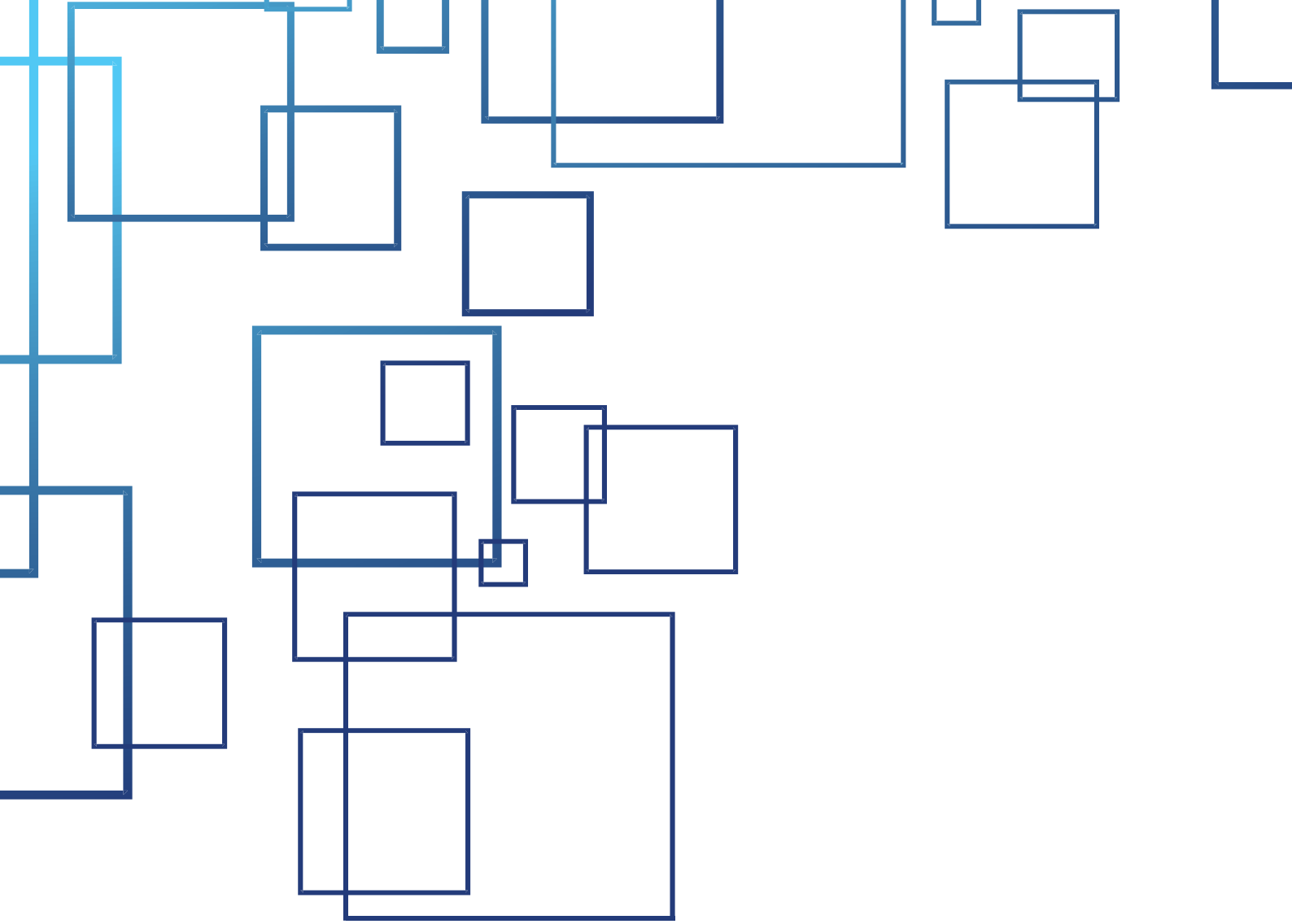

AUSTRALIAN CLINICAL GUIDELINES FOR EARLY PSYCHOSIS

SECOND EDITION

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FOREWORD

It is an exciting time to be working in mental health.

Unprecedented levels of community concern and advocacy in recent months have led to a renewed focus on mental health reform, and a determination to do better. The Prime Minister has identified mental health as an area of particular importance for increased Government investment and service growth.

Supporting mental health clinicians to provide the best quality care is central to the Australian Government's vision of mental health reform. A readily available workforce that confidently and skilfully implements the latest best practice is essential to ensuring that Australians can access quality mental health care.

This set of Clinical Practice Guidelines presents the current thinking in the important area of the treatment of people experiencing emerging and first episode psychosis in Australia. The publication of these guidelines is timely as the Australian Government has recently committed to ensuring that more young Australians with early psychosis get access to Early Psychosis Prevention and Intervention Centre (EPPIC) model services. In implementing this reform, the Australian Government understands the importance of supporting clinicians in new EPPIC services with clear guidelines about the delivery of evidence based care.

When originally published in 1998 these guidelines became the foundations from which many of the reforms in mental health we now take for granted took place. Building on more than a decade of new knowledge and experience, this updated set of guidelines is poised to play a similar role in a new wave of reform and investment in mental health.

The success of that reform is significantly dependent on the dedication and talent of the Australian mental health care workforce. I am therefore pleased to note the international leadership role that Australian researchers and clinicians have played in innovations and service improvements in mental health care. In particular, I want to take this opportunity to acknowledge the contribution that EPPIC and its subsequent incarnation as Orygen Youth Health has made to both our international reputation and service quality at home.

I believe that the release of these second edition guidelines will significantly positively impact on the care of people with emerging and first episode psychosis.

It is with great pleasure that I congratulate all involved in the production of this document and encourage all clinicians reading these guidelines to implement them in their practice.

I look forward to working with you all to close the gaps in mental health care, and improving services for all who live with mental illness.

The Honourable Mark Butler MP
Federal Minister for Mental Health and Ageing
Canberra
October 2010

FOREWORD

I feel honoured to have been asked to write this foreword and I am thankful that my personal journey of psychosis and recovery through early intervention can contribute to this important work.

My contact with mental health services began when I was eighteen. I was into drugs, like a lot of my friends. I was troubled, pushed the limits and eventually found myself confined to a psychiatric ward with psychosis. In the following eighteen months as an outpatient, I was diagnosed with bipolar and later schizoaffective disorder. I do not fully accept those labels, but I know I was experiencing life-threateningly intense mood swings and paranoid delusions. Over the next five years or so, I fought my own mind every second of every day and slowly climbed out of the dark place in which I had found myself.

Without the incredible support of some amazing people I probably would not be here today. Ultimately though psychosis is a deeply personal battle and the treatment that people receive needs to be respectful, supportive and based on their individual needs. Someone experiencing psychosis has had their control taken away on many levels – primarily by the illness itself, but also by people genuinely doing their best to help. They may be physically or chemically restrained and traumatised by their experiences. For this reason, I believe that medical care for psychosis needs to take into account people's need for control by involving them as much as possible in their treatment.

My journey along the path of recovery has been a long one and I would be lying if I said it wasn't incredibly difficult at times. After psychosis it can be scary to really believe in anything. There is an ongoing question of "is my belief real?; is it OK?" For a long time I found it necessary to actively push away belief in anything in order to keep psychosis at bay, including belief in myself.

Having regular appointments to talk to someone was really helpful. My case manager was a constant source of positive energy and inspiration and created a familiar link between busy psychiatrists and overwhelmed family and friends. The eighteen months I spent as an outpatient of EPPIC was a buffer separating acute care and the challenge of finding my feet in every day life. People from the outpatient program acted as a vital lifeline in times of need and for my family, feeling we were part of a community that was equipped to deal with the situation was invaluable.

After psychosis many of my memories and abilities were lost but with the support I received I rebuilt my life. I am now half way through a medical degree and collaboratively leading a community of people affected by mental ill health, working to support each other and exploring ways to take our quality of life to new levels.

I believe that this document provides a chance to make a significant difference in many people's lives. Psychosis may never have an easy cure but early intervention offers hope for a life after psychosis that is meaningful and amazing. I am hopeful that in the future more people will be surrounded by the message that recovery from psychosis is possible for anyone.

As a beneficiary of early intervention, I was prescribed acceptance, support and a healthy dose of understanding, to which I owe much of where I am today. To the people that made early intervention a priority and a reality, you have my heartfelt thanks and eternal appreciation.

Nicholas Meinhold
Melbourne 2010

ACKNOWLEDGEMENTS

Second Edition

The second edition of these guidelines have been long in the making and a large number of people have assisted in their development, review, editing and writing. A list of contributors is in the Appendices and we would like to thank all our colleagues for their assistance in this task.

We specifically thank the project writers without whom this project would not have been possible:
Dr Catharine McNab (2009-2010)
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Dr Helen Krstev (2000-2002)

All design of this document has been performed by the Orygen Design Team.

The editors:
Professor Patrick McGorry
Simon Dodd
Associate Professor Rosemary Purcell
Professor Alison Yung
Dr Andrew Thompson
Dr Sherilyn Goldstone
Associate Professor Eoin Killackey

We would also like to acknowledge and thank our clients and their families.

From the First Edition

We would specifically like to acknowledge the support of the Mental Health Branch, Commonwealth Department of Health and Family Services through the National Mental Health Strategy; particularly the efforts of Katy Robinson and the late Charles Curran, in the completion of these guidelines; and the support of each of the health departments of the participating state and territory governments.

The National Early Psychosis Project is indebted to the many individuals and organisations who have provided advice, assistance and comments which have enabled the document to be developed to this point. These individuals, groups and organisations are listed in the appendices. The National Early Psychosis Project would also like to thank Amanda Price for writing the Guidelines and Dominic Miller and Jenny Mercer for their invaluable assistance in the preparation of this manuscript.

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Corrections

Any correction or comments may be directed to **info@orygen.org.au** and should be marked *attn: Australian Clinical Guidelines 2nd Edition.*

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PREFACE

There has been substantial growth in the number of early psychosis services around the world in the decade since the publication of the Australian Clinical Guidelines for Early Psychosis in 1998. In addition, new clinical research has strengthened the evidence base for interventions, as well as raising new issues to explore. A new edition of the guidelines, based on the first but appropriately reflecting these developments, appears timely.

This second edition differs from the first in a number of ways:

(i) It is more clearly 'evidence-based' than the first edition, given the significant increase in clinical research in early psychosis since the publication of the first guidelines. The quality of this evidence is reflected in the document by providing each recommendation with its NHMRC-related 'grade of evidence';

(ii) It includes guidelines for identifying and treating (where appropriate) those young people who may be at 'ultra' high risk of developing psychosis, within the broader context of the clinical staging model;

(iii) It includes a package of electronically-available related resources at the Early Psychosis Prevention and Intervention Centre website, **www.eppic.org.au**, and the headspace centre of excellence, **www.headspace.org.au/knowledge-centre**

The format of the guidelines follows the course of service engagement; i.e. from access to assessment and treatment. Some treatment guidelines are specific to phase of illness; these are presented first, ranging from guidelines specific to the group identified as at risk of psychosis, to the acute, early recovery, relapse, and late/problematic recovery and discharge phases. Other guidelines are likely to apply regardless of stage of illness; these are presented next. Issues relevant to specific populations (indigenous and culturally and linguistically diverse groups, rural and remote communities) are addressed in their own sections.

Our aim in these guidelines is to outline best practice in the provision of services to young people experiencing the early stages of a psychotic disorder, and to their families and friends. A broader challenge for guidelines such as these is to remain useful to, and used by, clinicians, and to empower consumers and families to expect and receive the best possible care. We hope their wide dissemination, and the availability of related resources, meets this broader challenge.

SUMMARY OF RECOMMENDATIONS

Access to Care

- Mental health services should be accessible and provide a timely assessment for people experiencing their first episode of psychosis. This includes:
  - Being assessed within 48 hours of referral to a service;
  - Being seen by a consultant psychiatrist within one week of assessment;
  - Linking in with a case manager within five days of assessment;
- Mental health services should be accessible 24 hours a day, seven days a week.
- A low threshold for expert assessment should be set for any person suspected of developing a psychotic disorder.

Assessment

- Assessment is an ongoing process, not just restricted to initial entry into the mental health service.
- All clients should have a comprehensive biopsychosocial assessment by an acute treating team. This should include developing an understanding of the personal context of illness and developing a case formulation; mental state examination; physical examination and investigations; cognitive assessment; assessment for comorbid disorders; and risk assessment. Where indicated, assessment is aided by an antipsychotic-free period.
- Where possible, informants (particularly referrers, but also other key members of the young person's social networks) should be drawn upon as valuable sources of information about the trajectory and nature of the young person's difficulties.

Treatment during the Pre-Psychotic Phase (Ultra-High Risk for Psychosis)

- Antipsychotic medication should not be considered as the first treatment option during the pre-psychotic phase.
- Cognitive behaviour therapy (CBT) may reduce or obviate the need for antipsychotic medication in the pre-onset phase, and may prevent or delay transition to psychosis.

Treatment of First Episode Psychosis (Acute Phase)

- Antipsychotic medication should be avoided if possible during the first 24/48 hours of treatment in young clients with a first episode of psychosis.
- second generation antipsychotics (SGAs) should be used in preference to first generation antipsychotics (FGAs). Side-effect profile should guide the choice of SGA.
- Pharmacological treatment should proceed with a 'start low, go slow' approach. Polypharmacy, specifically the use of multiple antipsychotics, should be avoided.
- Affective and non-affective psychosis should be distinguished to enable appropriate treatment (i.e. appropriate use of a mood stabiliser).
- Adherence should be monitored and explicitly addressed with the client. The side-effects of antipsychotic medication should be thoroughly monitored.
- CBT should also be provided during the acute phase.
- Integrated, streamed specialist services provided in stigma-free community-based settings are more effective than standard adult mental health services in the treatment of people experiencing first episode psychosis.

Relapse Prevention and Management

- Two years of compliance should be encouraged, but if unacceptable to client then close monitoring and relapse prevention is required.
- The advantages of maintenance antipsychotic therapy in relapse prevention should be weighed against any impact of side-effects on functioning.
- Treatment (including medication) should be recommenced or increased at early signs of relapse.
- Relapse prevention strategies - including more regular review and provision of information about rapid access to care - are essential if medication dosages are decreased or medication ceased.
- Combined family and individual CBT specifically focusing on preventing relapse should be used.
- The use of longer term prophylactic antipsychotic medication appears to reduce relapse rates.

Maintenance Treatment

- People with persisting positive or negative symptoms should be identified early.
- Clozapine should be offered for those who have not responded to adequate trials of two antipsychotic medications, of which at least one is a SGA.
- CBT should be considered as an adjunctive therapy during late or problematic recovery.
- Families of young people with a slow or difficult recovery or frequent relapses may benefit from more intensive and structured interventions, emphasising problem solving and communication skills.

SECTION 1

INTRODUCTION

What are clinical practice guidelines?

Clinical practice guidelines are defined as systematically developed statements, based on the best available evidence, to assist practitioners and clients make decisions about appropriate healthcare. They form part of the larger model of evidence-based practice, which integrates the best available evidence, clinical expertise, and client preferences.

The initial guidelines and the rationale for early intervention in psychotic disorders

The initial guidelines were developed in response to growing research and clinical interest in a model of psychosis that challenged the pessimism prevailing at the time regarding the prognosis of people with psychosis. This earlier model developed from the Kraepelinian concept that true psychotic disorder was degenerative, and therefore could only be validly characterized by poor outcome[1]. The alternative model advocates that young people should receive timely and comprehensive intervention during the critical years following onset, and that 'withholding treatment until severe and less reversible symptomatic and functional impairment has become entrenched represents a failure of care' (McGorry et al., p. 148[1]). Specifically, the model proposed in the first edition of the guidelines suggested that intervening early in the course of acute psychosis is crucial for a number of reasons:

- It enables timely reduction of distressing experiences;
- It was thought that early intervention would reduce the duration of untreated psychosis (DUP), one of the few obviously malleable candidate risk factors for poor outcome;
- It was proposed to be associated with better outcome in the short-term, perhaps because of an effect it may have on DUP;
- It was believed to be cost-effective; and
- In the case of the putative prodrome, it was thought early intervention might prevent onset of psychotic disorder.

The need for revision

Significant changes have occurred since the development of the initial guidelines. There is increasing evidence demonstrating the effectiveness of early intervention in psychotic disorders. Now, many of the proposals of the early proponents of early intervention are supported by a more substantial evidence base. For example, it is now clear that DUP is related to outcome in first episode psychosis, with longer DUP being related to short-term factors such as slower and less complete recovery, poorer response to antipsychotics, interference with social and psychological development, and an increased risk of relapse[2-7] and likely medium-term outcome as well[8, 9]. Early intervention does reduce DUP[10], is associated with better short-term outcome, and appears to be more cost-effective than standard services[9, 11, 12]. Additionally, empirical evidence now suggests that intervention during the putative prodrome may prevent or delay transition to psychosis[13-15]. New guidelines are therefore required that reflect these developments.

This additional evidence has prompted widespread national and international efforts for reform in services and treatment approaches for early psychosis[16, 17]. There are now close to 200 early intervention centres worldwide, which focus on the special needs of young people and their families[18, 19]. Clinical practice guidelines relating to assessment and treatment of early psychosis now exist in a number of countries (e.g., Canada, the UK, the US), and international clinical practice guidelines and a consensus statement have been published[19, 20]. The International Early Psychosis Association reflects this groundswell of support for the continued exploration of an evidence-based adoption of principles of early intervention. Given the increasing interest in early intervention models, further services are likely to develop, rendering it appropriate to provide guidelines for best clinical practice based on the experiences of existing services.

The National Health and Medical Research Council (NHMRC) has also, since the last guidelines, updated its designation of levels of evidence, as outlined in Table 1. More broadly, the NHMRC has created 'grades' of recommendations which take into account not only the evidence base (quantity and quality), but also the consistency of findings constituting the evidence base, the clinical impact of findings, the generalisability of findings to all those to whom the guidelines are likely to be applied, and their applicability to the Australian health care context[21]. This edition of the guidelines therefore makes reference to these grades (as outlined in Table 2) when making any recommendation.

The following recommendations are based, where possible, on meta-analyses or systematic reviews of the available evidence from randomised controlled trials for treating individuals with early psychosis (i.e., level I evidence). Where such systematic evidence is not available, lower order evidence has been used. We are aware that evidence does not exist regarding all domains of treatment in early psychosis, and the absence of this evidence does not necessarily mean practices or interventions are ineffective. In partial recognition of this, in the absence of any evidence base, guidelines that reflect good practice according to expert consensus (as reflected in other guidelines, such as the previous edition of these guidelines or the WHO/IEPA consensus statement[20]) are given the designation GPP (good practice point).

Table 1: Levels of Evidence Ratings (National Health and Medical Research Council, 1998)

NHMRC Level	Basis of evidence
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III – 1	Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III – 2	Evidence obtained from comparative studies (including systematic reviews of such studies) with concurrent controls and allocation not randomised, cohort studies, case-control studies, or interrupted time series with a control group
III – 3	Evidence obtained from comparative studies with historical control, two or more single arm studies, or interrupted time series without a parallel group
IV	Evidence obtained from case series, either post-test or pre-test/post-test

Table 2: NHMRC Grades of Recommendation

Component	A	B	C	D
	Excellent	Good	Satisfactory	Poor
Evidence base	Several level I or II studies with low risk of bias	One or two level II studies with low risk of bias or a SR/multiple level III studies with low risk of bias	Level III studies with low risk of bias, or level I or II studies with moderate risk of bias	Level IV studies, or level I to III studies with high risk of bias
Consistency	All studies consistent	Most studies consistent and inconsistency may be explained	Some inconsistency reflecting genuine uncertainty around clinical question	Evidence is inconsistent
Clinical impact	Very large	Substantial	Moderate	Slight or restricted
Generalisability	Population/s studied in body of evidence are the same as the target population for the guideline	Population/s studied in the body of evidence are similar to the target population for the guideline	Population/s studied in body of evidence differ to target population for guideline but it is clinically sensible to apply this evidence to target population	Population/s studied in body of evidence differ to target population and hard to judge whether it is sensible to generalise to target population
Applicability	Directly applicable to Australian healthcare context	Applicable to Australian healthcare context with few caveats	Probably applicable to Australian healthcare context with some caveats	Not applicable to Australian healthcare context

THE PROCESS, STRUCTURE, AND SCOPE OF THE REVISED GUIDELINES

Process of guideline development

The original guidelines were developed to address clinical 'best practice' in early psychosis prevention and intervention. A Working Group comprising the State and Territory Coordinators of the National Early Psychosis Project (NEPP), the national project manager and the project director convened to determine the content of the clinical practice guidelines.

The development process involved:

1. Initial drafting of the guidelines. This was performed by a consultant in conjunction with the NEPP Working Group, a number of expert consultants with clinical and research experience, State-based steering committees and individuals in the field.
2. Development and dissemination of the draft for national consultation. State and Territory coordinators were responsible for distributing the document to key stakeholders in mental health and early psychosis.
3. Integration of reviewers' comments into the document and the preparation of the final draft.

The first phase of the revision process ensured that the Australian guidelines were consistent with the International Clinical Practice Guidelines for Early Psychosis[19]. The second phase of the revision process involved a literature review, focusing on publications since 1998. This literature review used the following databases: Medline, PsychINFO, and the Cochrane Library. Searches were restricted to publications in English.

Structure of the second edition

The format of the guidelines follows the different phases of service engagement of access, assessment, and treatment. Guidelines relating to access and engagement are broadly similar across the 'ultra' high risk and first episode populations. However, some treatment guidelines are specific to the ultra-high risk stage and others to the period after the onset of psychosis. Treatment guidelines may also be specific to the various stages after the onset of frank psychosis. Other issues are likely to be relevant regardless of stage of illness (i.e., both the putative prodrome and post-onset of acute psychosis).

For these reasons, treatment guidelines are first presented with respect to the 'ultra' high risk period, and then guidelines relating to the various stages of illness post-onset are outlined. The final treatment guidelines are those that apply across all stages of illness, including both the ultra-high risk and first episode stages.

Issues relevant to specific populations (culturally and linguistically diverse groups, rural and remote communities) are addressed in their own sections. Each section has introductory information, and then specific recommendations, accompanied by the level of evidence on which they are based.

Scope of the guidelines

These guidelines have been developed as an evidence-based resource for mental health practitioners who treat people experiencing early psychosis. It may also be used as a reference for individuals outside specialist mental health services, particularly in the primary health care sector. The authors recognise that the structure and resources of mental health services vary considerably among the States and Territories, but this should not be viewed as an impediment to implementing an appropriate early psychosis prevention and intervention strategy. The fundamental principle is that all Australians with emerging psychotic disorders have a right to early diagnosis and quality treatment. Therefore, the guidelines have been framed in terms of optimal service provision, while also providing a real-world focus. The recommendations operate as evidence-based guidelines rather than hard-and-fast rules, and should be used together with the preferences of the client and the clinical judgement of the clinician.

Limitations of these guidelines

These guidelines are limited primarily by a focus on published English-language evidence published prior to May 2010. It is possible that incorporating unpublished evidence or evidence in other languages may have altered our recommendations.

THE NATURE OF PSYCHOSIS

Psychosis refers to symptoms in which there is misinterpretation and misapprehension of the nature of reality, for example disturbances in perception (hallucinations), disturbances of belief and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder). Psychotic *symptoms* need to be distinguished from psychotic *disorder*, as outlined below. Diagnostic classification systems (e.g., Diagnostic and Statistical Manual of Mental Disorders, or DSM[22]; International Statistical Classification of Diseases and Related Health Problems, or ICD[23]) generally list specific psychotic disorders rather than psychosis or psychotic disorder more broadly. The DSM, for example, identifies the psychoses as schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified (NOS). Meeting diagnostic criteria for any one of these disorders is generally regarded as the threshold for treatment. Such diagnoses, however, require both clear symptom profiles, and a specified duration of these symptoms, which appears more appropriate in the context of chronicity.

Making the distinction between diagnostic categories early in the course of psychosis may be difficult. This may be because of fluidity of acute symptoms, or the vagaries of nosologies themselves[24]. Initial diagnoses of first episode brief psychotic disorder, psychosis not otherwise specified, substance-induced psychosis, and schizophreniform disorder are particularly likely to change over follow-up periods[25-29]. Additionally, the traditional pessimism associated with the diagnosis of schizophrenia has permeated professional and popular culture to some extent[30]. Making rigid and too specific diagnoses may therefore not only be unreliable but have iatrogenic effects on both clinician and client optimism and the potential for recovery. For these reasons, these guidelines refer to the psychoses broadly, as shorthand for psychotic disorders, rather than being limited to a specific psychotic disorder.

'Early psychosis' refers to the early course of psychotic disorder, and in these guidelines specifically refers to the prodrome and the period up to five years from first entry into treatment for a psychotic episode (i.e., first episode psychosis, or FEP).

Aetiology

Many factors may be causally linked to the development of psychiatric disorders, but they can be summarised within three main groups; *biological, psychological* and *social. Biological* factors arise from physiology, biochemistry, genetics and physical constitution, and may be present from birth. The young person's upbringing, emotional experiences and interaction with other people constitute *psychological* factors. *Socia*l factors are associated with the young person's present life situation and sociocultural background. The *biopsychosocial* model acknowledges the role of these biological, psychological, and social factors in the onset and course of psychiatric disorder and forms a framework within which more specific models may be developed.

The aetiology of psychosis is generally accepted as resulting from the impact of stress and other risk factors upon a biological predisposition: the stress vulnerability interaction[31,32]. Stress-vulnerability models have been applied to schizophrenia, but are equally applicable to early psychosis, and emphasise genetic, neuronal, life stress and physical vulnerabilities[31,33]. The greater the person's vulnerability, the less stress is required to trigger psychosis[34-36].

Factors that may influence levels of vulnerability and/or stress, and therefore predict psychotic onset, are outlined in Table 3.

Table 3: Risk factors for psychosis onset

Distal (premorbid) risk factors	Proximal risk factors
Foetal life: • Maternal pregnancy complications/perinatal trauma, esp foetal hypoxia) (e.g., Hultman et al.,[37]) • Family history of psychotic disorder (for a review, see Olin & Mednick,[38]) • Candidate genes (DTNBP1, NRG1, DAOA, RGS4, COMT, DISC1, DISC2, BDNF: for a review, see Weinberger & Berger,[39]) • Developmental delay (for a review, see Rustin et al.,[40]) • Season of birth (late winter/early spring, e.g., Baron & Gruen,[41]; cf., Hettema et al.,[42]) • Ethnic minority group membership (e.g., Cooper et al.,[43])	**Late childhood/adolescence:** • Age (Häfner et al.,[47]) • Urbanicity (e.g., van Os et al.,[48]) • Substance (esp cannabis) use (e.g., Haroun et al.,[49]) • Traumatic head injury (for a review, see Kim et al.,[50]) • Stressful life events (for a review, see Phillips et al.,[51]) • Subtle impairments in cognition (for a review, see Pantelis et al.,[52]) • Poor functioning (e.g., Yung et al.,[53,54]) • Cognitive, affective, and social disturbances subjectively experienced by the client ('basic symptoms': e.g., Schultze-Lutter,[55]) • Migration (e.g., Coid et al.,[56])
Early life: • Quality of early rearing environment • Trauma (abuse or neglect) (e.g., Shevlin et al.,[44]) • Vulnerable personality (e.g., schizoid personality: Cuesta et al.,[45]; Dalkin et al.,[46])	

Epidemiology

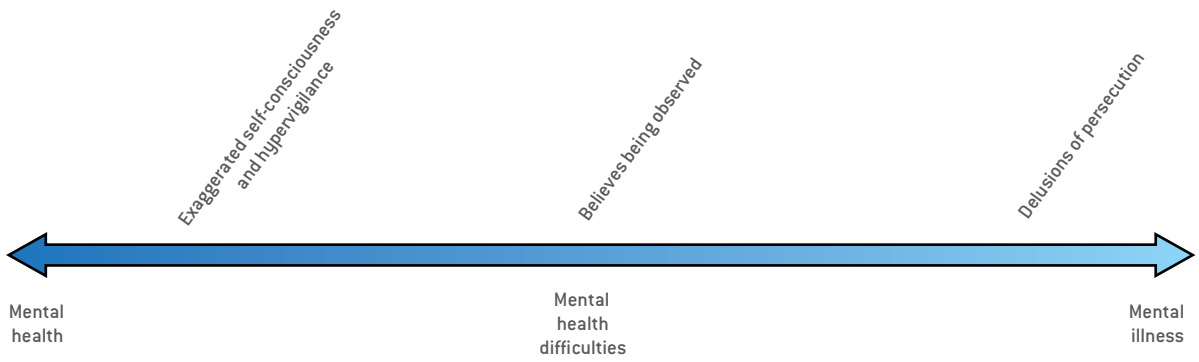
Psychotic disorders usually emerge during adolescence or early adulthood. They tend to be characterised initially by impaired social functioning and non specific 'neurotic' symptoms which are then followed by attenuated or sub-threshold forms of psychotic symptoms and which emerge just prior to the development of frank psychosis[57].
For example, in one study the prodromes of major depression and schizophrenia have been found to be indistinguishable[58].

Estimates of the incidence of early psychosis vary widely[59]. An Australian study of low prevalence psychiatric disorders found the prevalence of clients with psychosis engaged in treatment in a 1-month period was 4.7 per 1,000 adults[60]. This is likely to be an underestimate of the true prevalence of psychotic disorders, as it did not include people in the community who were not receiving treatment[61].

Schizophrenia is the third leading cause of burden and injury in young men aged 15-24 years, and the fifth in young women of the same age[62].

Experiencing psychotic symptoms does not, however, necessarily indicate the presence of a disorder. Psychotic symptoms seem to be part of the continuum of normal experiences, with a median prevalence of 5% and incidence of 3%; between 75% and 90% of psychotic experiences are transitory and disappear with time[63]. The continuum of psychotic-like experiences is outlined in Figure 1.

Figure 1: Example of the continuum of psychotic-like experiences



Course of illness

The previous edition of these guidelines focused on a 'stage' model of psychosis, encompassing the four stages of the (i) prodrome, (ii) acute onset of psychotic disorder, (iii) early recovery, and (iv) late/problematic recovery. There has been a recent argument for shifting the lens through which early intervention specifically, and psychiatric nosology in general, is viewed[64], with a focus on the concept of the clinical staging model.

This section defines the clinical staging model and reviews its different stages, with a particular focus on the putative prodrome.

The clinical staging model

The clinical staging model differs from conventional diagnostic practice by defining the course of illness as a continuum[64]. Clinical staging models assume that treatments that are offered earlier in the course of an illness have the potential to be safer, more acceptable and more effective, as well as more affordable than those offered later in the course of disorder. Interventions can then be evaluated in terms of their ability to prevent or delay progression from earlier to later stages of illness, and can be selected by consumers and clinicians on the basis of defined risk/benefit criteria which are likely to differ across different stages of illness.

Such models are widely used in mainstream medicine; their application to psychiatry appears both appropriate and, given the increasing interest in models of early intervention in psychiatry, timely. Such a model can guide the logic and timing of interventions in psychosis and psychiatry more broadly, enabling the use of practical, preventive strategies routinely embraced in other types of mainstream health care[1]. The clinical staging model of psychosis can also provide a clinically meaningful framework for disseminating knowledge and research findings. Table 4 outlines the clinical staging model in its application to psychotic disorders.

Table 4. Clinical staging model framework for psychotic disorders

Clinical stage	Definition	Definition in the 'phase' model	Target populations for recruitment	Potential interventions
0	Increased risk of psychosis No symptoms currently	Premorbid	1st degree teenage relatives of the person with the disorder	Indicated prevention of FEP • Improved mental health literacy • Family education, drug education • Brief cognitive skills training
1a	Mild or non-specific symptoms of psychosis, including neurocognitive deficits. Mild functional change or decline	Possible prodrome	Screening of teenage populations *Referral by:* primary care physicians; school counsellors	Indicated secondary prevention of FEP • Formal mental health literacy • Family psychoeducation, formal Cognitive Behavioural Therapy (CBT) • Active reduction of substance misuse
1b	Ultra-high risk of psychosis: Moderate but sub-threshold symptoms, with moderate neurocognitive changes and functional decline to caseness or chronic poor functioning (≥30% drop in SOFAS in previous 12 months OR <50 for previous 12 months)	Possible prodrome	*Referral by:* educational agencies; primary care physicians; emergency departments; welfare agencies; school and university counsellors	Indicated secondary prevention of FEP • Psychoeducation, formal CBT • Active reduction of substance misuse • Omega-3 fatty acids • Atypical antipsychotic agents • Antidepressant agents or mood stabilisers
2	First episode of psychotic disorder: Full threshold disorder with moderate-severe symptoms, neurocognitive deficits and functional decline (GAF 30-50) Includes acute and early recovery periods	Acute and early recovery	*Referral by:* primary care physicians; emergency departments; welfare agencies; specialist care agencies; drug and alcohol services	Early intervention for FEP • Psychoeducation, formal CBT • Active reduction of substance misuse • Atypical antipsychotic agents • Antidepressant agents or mood stabilisers • Vocational rehabilitation
3a	Incomplete remission from first episode of care	Late/incomplete recovery	Primary and specialist care services	Early intervention for FEP As for '2', but with additional emphasis on medical and psychosocial strategies to achieve full remission
3b	Recurrence or relapse of psychotic disorder which stabilises with treatment but at a level of GAF, residual symptoms, or neurocognition below the best level achieved following remission from first episode	Late/incomplete recovery	Primary and specialist care services	Early intervention for FEP As for '3a', but with additional emphasis on relapse prevention and 'early warning signs' strategies
3c	Multiple relapses, with objective worsening in clinical extent and impact of illness	Late/incomplete recovery	Specialist care services	Early intervention for FEP As for '3b', but with emphasis on long-term stabilisation
4	Severe, persistent OR unremitting illness as judged by symptoms, neurocognition and disability criteria	Chronicity	Specialist care services	As for '3c', but with emphasis on clozapine, other tertiary treatments, and social participation despite ongoing disability

Adapted from McGorry, P.D., et al., Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. Aust N Z J Psychiatry, 2006. **40**(8): p. 616-22.

Stage 0: The premorbid phase

The traditional approach to identifying individuals at risk of schizophrenia is to study family members of clients with the disorder[66, 67]. This is known as the 'high risk' approach. Assessments usually begin when subjects are children, with follow-up continuing over many years, with the aim of detecting the development of psychotic disorder at some stage in the person's life span. Researchers using the high risk family history approach acknowledge that the transition rate to a psychotic disorder is not likely to be large and results may not be generalisable beyond the genetically defined high-risk group[66, 67]. Those who have this increased genetic risk may be at stage 0 of psychotic disorder, but of course may not, given the lack of sensitivity of a solely genetic model of risk. Furthermore intervention in these 'at-risk' individuals is neither practical nor ethical, as the degree of risk is low, those possibly 'at-risk' are not symptomatic, and the timing of onset of psychotic disorder not known. Indeed, these genetic high risk studies never claimed early intervention as a goal, focusing instead on investigating causal pathways into schizophrenia and other psychotic illnesses.

Mednick et al. [68] modified the genetic high risk strategy by focussing on adolescent offspring who were entering the peak age of risk (i.e., they added in the risk factor of age). This approach made the high risk paradigm more practical. However, the number developing a psychotic disorder from this cohort is still not expected to be large, and the number of false positives too high to make any intervention practical.

Similarly, the Edinburgh High Risk Project[69-71] studies individuals with presumed high genetic liability for schizophrenia, including both first and second degree relatives of schizophrenia probands. Like the Mednick approach, this study also recruits young adults (aged 16-25) who will pass through the period of maximum risk of developing schizophrenia during the planned 10 years of the study. Recently reported data revealed that 13 out of 162 subjects (about 8%) had developed schizophrenia to date, six years after study commencement[72].

Thus although this rate of onset of schizophrenia is well above the expected community rates, recruitment of large numbers is needed in order to clarify other risk factors for development of schizophrenia and to eventually identify a group for whom preventive treatment is justified.

Stages 1a and 1b: The possible prodrome

The *possible prodromal phase* or symptomatic '*at-risk mental state*' is usually characterised by a sustained and clinically significant deviation from the premorbid level of experience and behaviour[57, 73, 74]. The staging model conceives of two forms of this possible prodrome – a period of mild or nonspecific psychotic symptoms, and a period of increased symptom activity which still does not meet criteria for a full-threshold psychotic episode.

Identifying the prodrome

The operationalisation of the 'at-risk' criteria (i.e., the mental state that is thought to place the individual at incipient or 'ultra' high risk of developing a psychotic disorder) differs across different groups, and includes the 'psychosis proneness' research of Chapman and Chapman et al. [75-77], the basic symptoms method[78, 79], and the Ultra High Risk method[53, 80, 81]. All of these groups share a model that suggests that a constellation of difficulties emerge in the psychosis prodrome that may be able to be identified, with the aim of prevention of the onset of psychosis. Examples of such difficulties are outlined on the following page.

Table 5: Common problems of young people with an 'at-risk' mental state: modified from Yung, Phillips and McGorry[81]

1. Neurotic symptoms	Anxiety
	Restlessness
	Anger, irritability
2. Mood-related symptoms	Depression
	Anhedonia
	Guilt
	Suicidal ideas
	Mood swings
3. Changes in volition	Apathy, loss of drive
	Boredom, loss of interest
	Fatigue, reduced energy
4. Cognitive changes	Disturbance of attention and concentration
	Preoccupation, daydreaming
	Thought blocking
	Reduced abstraction
5. Physical symptoms	Somatic complaints
	Loss of weight
	Poor appetite
	Sleep disturbance
6. Attenuated or subthreshold versions of psychotic symptoms	Perceptual abnormalities
	Suspiciousness
	Change in sense of self, others or the world
7. Other symptoms	Obsessive compulsive phenomena
	Dissociative phenomena
	Increased interpersonal sensitivity
8. Behavioural changes	Deterioration in role functioning
	Social withdrawal
	Impulsivity
	Odd behaviour
	Aggressive, disruptive behaviour

Chapman and Chapman and colleagues[75-77] attempted to identify individuals at risk of psychosis, or those they called "hypothetically psychosis-prone", by focusing on attenuated and isolated psychotic symptoms. In addition to these 'positive' psychotic phenomena, they also theorized that people who displayed physical and social anhedonia and impulsive non-conformity were also at risk. Chapman et al.[77] also noted the need to focus on people at or near the age of greatest risk for schizophrenia, that is late adolescence and early adulthood, and so studied college students. A sample of college students with high levels of self-reported 'psychotic-like' symptoms were followed longitudinally over time and compared with a group of controls. At 10-15-year follow-up, students who scored highly on scales of perceptual abnormalities and magical thinking were more likely to have developed a psychotic disorder than comparison subjects. Social anhedonia, physical anhedonia and impulsive non-conformity were not predictive of psychotic disorder at follow-up, although high scores on the Social Anhedonia scale correlated with high levels of psychotic-like experiences at follow-up. However the actual numbers of students who developed a psychotic disorder after 10-15 years was low: 11 out of 375 or 2.9%. Students with sub-threshold forms of delusions and hallucinations seemed to be more at risk of subsequent full-blown psychotic disorder than those without these symptoms. However, many students with high levels of magical ideation and perceptual abnormalities did not develop a psychotic disorder. To date, because of the low numbers developing a psychotic disorder, the high number of false positives and the long time frame of the follow-up, the psychosis-proneness research has not been able to be used as the basis for any preventive intervention.

The two other approaches – the basic symptoms and 'ultra' high risk methods – focus on identifying those at risk of psychosis using clinical, rather than population, samples. The 'basic symptoms' approach, used primarily in German-speaking countries, shares with the 'psychosis proneness' approach a focus on symptoms as markers of risk. Basic symptoms are subjectively experienced abnormalities in the realms of cognition, attention, perception and movement. They have also been described as 'self-experienced neuropsychological deficits'[79]. Basic symptoms are assessed by the Bonn Scale for the Assessment of Basic Symptoms (B-SABS[82]) and, more recently, the Schizophrenia Prediction Instrument, Adult Version (SPI-A[83]). Basic symptoms in the absence of other symptoms would likely qualify an individual for stage 1a rather than stage 1b membership.

In contrast to genetic high risk studies, which focus purely on genetic risk for psychosis, Bell[84] proposed a 'multiple gate screening' or 'close-in' approach of combining risk factors beyond symptoms (for example, genetic factors) to optimise prediction of those at high risk for disorder. Yung and McGorry[57] describe the application of this model to define at-risk mental states (ARMS) for psychotic disorder. As noted earlier, most frequently occurring prodromal features are non-specific and could be the result of a number of conditions (e.g., major depression, substance abuse). Further, both attenuated and frank psychotic symptoms are relatively common in the general community. This model of identification of the 'at-risk' group therefore requires the presence of a number of risk factors beyond symptoms or genetics alone. The primary state criteria identified to date to define the 'at-risk' group are age (falling with the peak age range of onset of psychotic disorder, i.e., adolescence and young adulthood), combined with either attenuated positive psychotic symptoms (i.e., positive symptoms that occur below psychotic threshold with respect to frequency and/or intensity), or a brief period of supra-threshold frank psychotic symptoms that resolve spontaneously. The criteria also continue to evoke a trait factor – presence of a first degree relative with a psychotic illness. However, both this group and the 'mildly symptomatic' group also superimpose an additional state factor of functional decline or of long-standing poor functioning. There is also an assumption that those meeting criteria are help-seeking and/or distressed by their symptoms, even if these symptoms are not those which qualify the individual as at 'ultra' high risk. This then excludes those who have psychotic-like experiences but are functioning adequately with their symptoms. Those who meet these criteria would qualify for stage 1b membership.

Box 1: Features of ultra-high risk or at-risk mental state :

- Young people between 14 and 30 years of age.
- A change in subjective experience and behaviour in recent months or within the past five years (which may fluctuate but is progressive)

PLUS
EITHER

- Sub-threshold positive symptoms not severe or persistent enough to be regarded as evidence of sustained frank psychosis sufficient for a diagnosis of a psychotic disorder

OR

- history of brief self-limited psychotic symptoms (frank psychotic symptoms that resolve within seven days)

OR

- a genetic vulnerability, operationalised as either the presence of schizotypal disorder, or a first degree relative with a history of any psychotic disorder

PLUS

functional decline to caseness (≥30% drop, at any time in the previous 12 months, in scores on the Social and Occupational Functioning Assessment Scale/SOFAS:[85]) or longstanding poor functioning (SOFAS <50 for previous 12 months)

The dominant method of assessing the at-risk mental state is through semi-structured interview, by the Comprehensive Assessment of At Risk Mental States (CAARMS:[86]) or the Structured Interview for Prodromal States (SIPS) and related instruments[87,88]. The CAARMS has two functions: to provide a comprehensive assessment of psychopathology thought to indicate imminent development of a first episode psychotic disorder; and to determine if an individual meets UHR status or has crossed the threshold for a psychotic disorder based on criteria derived from the CAARMS assessment. It includes scales for assessing in detail threshold and sub-threshold psychotic phenomena and other symptoms and signs which occur in the psychotic prodrome, including negative, dissociative and 'basic' symptoms. Its subscales are outlined in box 2.

The CAARMS shows good to excellent reliability, and both overall scores and negative symptoms in particular are predictive of psychosis onset[86].

Box 2: CAARMS subscales

- Unusual Thought Content (assessing delusional mood, bizarre experiences)
- Non-bizarre Ideas (overvalued ideas and delusions)
- Perceptual Abnormalities (assessing distortions, illusions and hallucinations)
- Disorganised Speech (assessing subjectively experienced difficulties with forming thoughts as well as objectively assessing degrees of formal thought disorder)
- Motor Changes (assessing subjectively experienced difficulties with movement as well as objective signs of catatonia)
- Concentration and Attention (again assessing both the subjective experience and objective rating)
- Disorders of Emotion and Affect (assessing subjective sense of change in emotions and objective rating of blunting of affect)
- Subjectively Impaired Energy (a basic symptom)
- Impaired Tolerance to Normal Stress (a basic symptom)

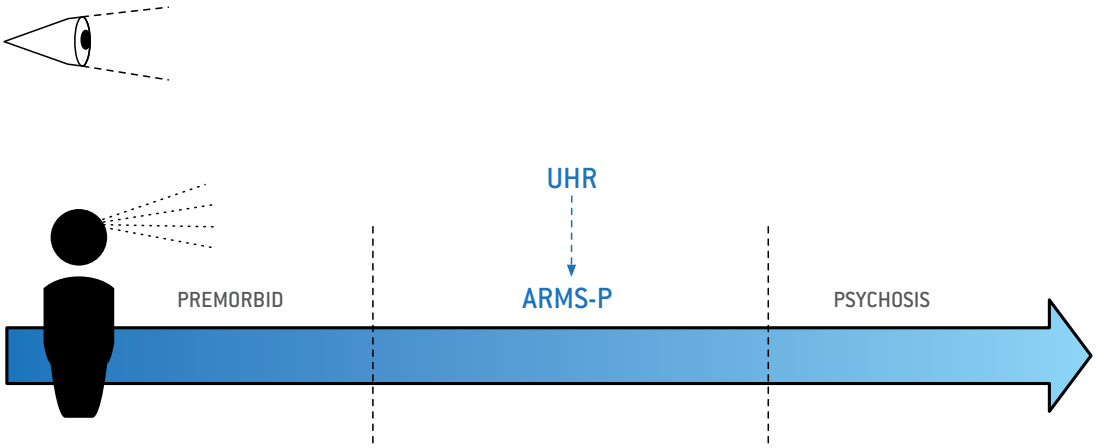
The 'clinical high risk' approach adds further criteria to the 'ultra-high risk' method of identifying the prodrome by focusing not only on attenuated positive psychotic symptoms (the clinical high risk-positive group), but also on enduring specific combinations of cognitive, academic, and social impairments and disorganisation/odd behaviour which represent possible attenuated negative psychotic symptoms (the clinical high risk-negative group[89]). These two groups are proposed to characterise the progression of the prodrome, with the clinical high risk-negative group representing the earliest possible stage of identification of the prodrome (stage 1a membership), which may then progress into the 'late prodrome' clinical high risk-positive group identified by the CAARMS and the SIPS.

Without effective preventive intervention, this group may develop 'schizophrenia-like psychosis' (full-blown psychotic symptoms of brief duration, not yet meeting criteria for schizophrenia), a group that those adopting the model of Cornblatt et al.[90] regard as still being within the prodrome, given their focus on prediction and prevention of schizophrenia rather than psychotic disorders more generally.

The degree to which these measures accurately identify the prodrome can only be retrospectively determined, by exploring the proportion of this 'at-risk', or putatively prodromal, group who go on to develop psychosis. For this reason, stages 1a and 1b represent a *possible* prodrome. Figures 2.1 and 2.2 provide a graphical representation of the distinction between the prospective and retrospective identification of the prodrome. Figure 2.1 identifies the challenge of identifying the prodrome prospectively, given that the term 'prodrome' can only apply when there is certainty that the full-blown disorder has emerged. Figure 2.2 demonstrates the appropriate retrospective identification of a prodrome. Focusing on individuals with apparently prodromal symptoms and signs and identifying them as those likely to develop a psychotic disorder will lead to the problem of a large number of false positives: most people with these features would not make the transition to a full-blown psychotic disorder.

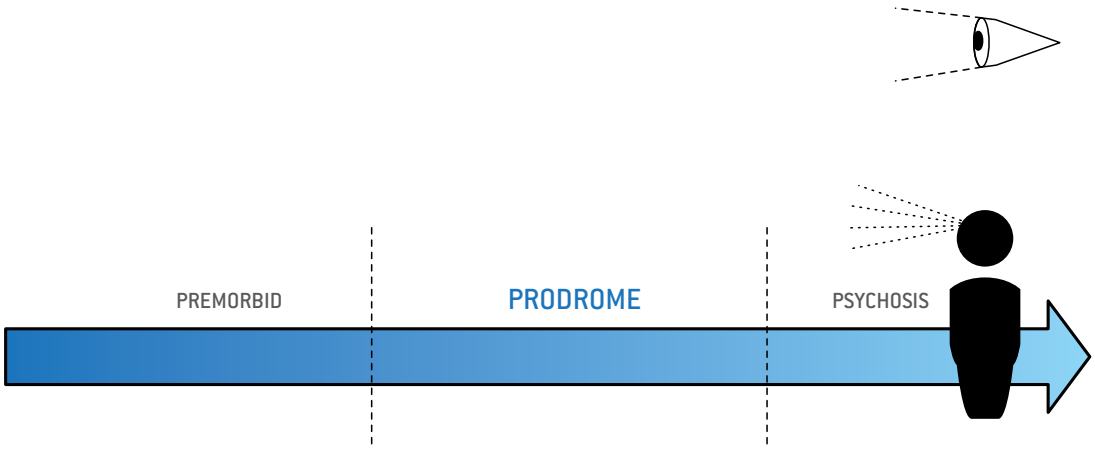
The identification of the prodrome

Figure 2.1 Prospective identification of a possible prodrome



Rates of conversion to psychosis are influenced by inclusion criteria, population sampled and treatment provided[91]. As such, transition to psychosis within 12 months of being initially assessed as 'at risk' has varied considerably, between 9.4% and 70%[92]. There is some evidence that transition rates have fallen across most research centres in recent years, possibly because of earlier detection and treatment of ARMS[93]. Thus, the syndrome which seems like, or could be, a prodrome should not be thought of as a disease entity, but rather as a state risk factor for a full-blown psychotic disorder. That is, the presence of the syndrome implies that the affected person is at that time more likely to develop psychosis in the near future than someone without the syndrome. Instead of being labeled as "prodromal" the person should be thought of as having an 'at-risk mental state' (or 'at risk mental state for psychosis' ARMS-P)[53]. This terminology highlights the risk factor approach, suggesting that the syndrome is a risk factor for incipient onset of full-blown psychosis in the near future[53, 80, 81].

Figure 2.2 Retrospective identification of the prodrome



Potential advantages of identification and intervention at stages 1a and 1b include:

- Identifying people during a phase in which subtle yet tenacious disability is possibly laid down. Much of the psychosocial disability observed in first-episode psychosis is difficult to reverse in the absence of targeted interventions such as vocational recovery, even when the core symptoms remit with effective antipsychotic treatment (as they do in up to 90% of cases). Intervention in the pre-psychotic stages may prevent the entrenchment of such psychosocial disability.
- Facilitating engagement with services by managing current difficulties, before the person is too 'out of touch'. Engaging young people in this early phase of illness might facilitate more timely and effective treatment than among those with entrenched psychotic symptoms[81,94]. Additionally, should progression to frank psychosis occur, this pre-existing engagement with mental health services may enhance medication compliance and engagement with outpatient care[94].
- Reducing the severity of psychosis, and therefore the burden of trauma, stigma, acute or embarrassing behaviour, and the need for hospitalisation, by enabling early intervention if symptoms do progress.
- Potentially preventing or delaying transition to psychosis in a subset of clients.

Preventive intervention strategies for the possible prodrome currently include early recognition and access to services through increasing the awareness of specific groups (for example, parents, teachers, school counsellors, general practitioners and health professionals). Most research, however, has centred on more active and specific interventions of psychological therapies and medication trials in the at-risk group. Evidence from trials conducted in clinics in Australia, the US, UK and Europe demonstrate that specific interventions can ameliorate, delay and even prevent the onset of first-episode psychosis in some people. These interventions include cognitive behavioural therapy (CBT) combined with an atypical antipsychotic[14], CBT alone[15,95], or antipsychotics alone[13], and are outlined in more detail in section 2.

There are, however, risks in attempting to identify, and intervene in, the pre-psychotic phase. These include:

- The 'false positive' scenario, where individuals are identified as at risk of developing a psychotic illness who were not in fact at risk. There is a potential risk of self-stigmatisation for those who do not develop a persistent psychotic illness[96-98].
- Side-effects of any intervention, especially antipsychotic medication, used to treat psychotic symptoms during this stage; especially given these treatments may be unnecessary in the case of 'false positives'.

These concerns have led to a preference in some countries for 'naturalistic designs' over randomised trials of intervention (including the use of antipsychotics) in the at-risk group. This in turn, paradoxically, has led to widespread and uncontrolled use of off-label medication for which there is currently no evidence of efficacy in treating psychotic symptoms in the at-risk group and/or preventing transition to psychosis[1]. It must be emphasized that use of antipsychotics in the UHR group is not recommended. There are however a small number of situations in which the introduction of an antipsychotic in a client at UHR may be justified. These situations are outlined in guideline 3.1.

Given the risks of intervention in the pre-psychotic stages, and the limited (although consistent) research to date, more evidence is required before definitive recommendations regarding treatment in these stages can be made. The development of psychotic disorder from premorbid and 'prodromal' mental states needs to be better understood. Further research is needed to determine which treatment strategies are effective in reducing symptoms and disability and the risk of progression to Stage 2, acute onset of FEP. Such research must meet the highest ethical standards, and clients must give genuine informed consent and be free to withdraw from the research at any time. Non-participation in research must not affect access to appropriate clinical care. Finally, research should be led by local clinicians and researchers so that culturally normal experiences and behaviours are not misconstrued as signs and symptoms of illness.

Stage 2: The acute period, early recovery, and the 'critical period'

Stage 2 encompasses the initial acute treatment phase and the early recovery phase of the first three to six months following the onset of psychosis[99].

The acute period

The acute phase can be characterised by the presence of psychotic features such as delusions, hallucinations, and formal thought disorder. The psychotic episode may also occur with comorbid conditions of depression, obsessive-compulsive disorder, post-traumatic stress disorder, anxiety disorders, or substance use difficulties. It is usually during this phase that the client first comes into contact with mental health services. The client's presentation will determine the setting in which they receive treatment and the urgency with which they are assessed.

Recovery

Lieberman[100] has defined recovery as a two year duration of:

(1) Remission of symptoms;

(2) Engagement in productive activity, like work or school;

(3) Independent management of day-to-day needs;

(4) Cordial family relations;

(5) Recreational activities; and

(6) Satisfying peer relationships.

Early recovery constitutes the first three to six months where these factors are present. Lieberman proposes that there may also be a subjective component to recovery that includes factors such as hope, empowerment, self-help, peer support, and coping with the effects of stigma. These subjective components are consistent with the concept of recovery developed by consumers, rehabilitation practitioners, and researchers in related fields. Beyond remission of symptoms, this incorporates a 'higher hurdle and long-term goal' (van Os et al.,p. 92[101]), an experiential process in which autonomy and self-determination, as well as functional recovery and quality of life, are key[102,103]. These factors may be present even in the absence of symptom recovery.

As Warner[104] states, 'one of the most robust findings about schizophrenia is that a substantial proportion of those who present with the illness will recover completely or with good functional capacity' (p. 375). Recent evidence suggests that over a two year period up to 50% of those with early onset psychosis have recovered symptomatically, with up to 25% of these also recovering functionally[103, 105, 106].

Predictors of short-term (two to five year) recovery in first episode psychosis include:

- Earlier intervention/shorter DUP [3, 5, 6, 103, 106-109].
- Female sex[110-112].
- Older age at onset[113, 114].
- Better premorbid functioning[103, 106, 108, 115].
- Severity of psychopathology, particularly negative symptoms[106, 116-118].
- A subjective sense of hope[119].
- Absence of substance abuse[120-122].
- Adherence to treatment[106, 123].
- Social and family contacts[119, 124].

Some of these factors are more clearly malleable than others, with DUP, adherence to treatment, comorbid substance use, and a subjective sense of hope being the clearest malleable factors. A goal of treatments during stage 2 is not only to manage current symptoms, disability, and distress, but also to prevent further deterioration and progression to stage 3 and/or stage 4.

Stage 3: Late/incomplete recovery, relapse with poor outcome, and the 'critical period'.

In contrast to Kraepelin's model of progressive psychopathology in the psychoses, Bleuler noted that psychopathology and disability emerged rapidly early in the course of illness, plateauing thereafter. This suggests a relatively brief, active phase of deterioration, with a subsequent level of diminished functioning that stays stable for some years[125]. This has been coined the 'critical period'[126], a period of up to five years after the onset of psychosis, after which the level of functioning attained endures for the long term. Intervening during this phase of aggressive deterioration post-onset of acute psychotic symptoms may halt its progression and hence reduce the likelihood of incomplete recovery. Interventions may include providing effective treatment of psychotic symptoms and associated sequelae in as timely a fashion as possible throughout this five year period (i.e., by reducing DUP, preventing relapse, and managing psychosocial and psychological comorbidities of psychosis). Stage 3 includes this 'critical period' phase.

Early evidence backed up Bleuler's proposal[127-129], although there has been more recent suggestions that the 'critical period' should include the prodrome[130, 131]. The implication of the critical period is that intervention provided during late/incomplete recovery may not only halt deterioration and improve functioning in the short term, but be a positive prognostic factor into the medium and long term.

Problematic or incomplete recovery is generally defined by the persistence of positive symptoms. However, it is likely to be better operationalised in a multidimensional manner which focuses on key predictors of disability, such as symptom domains, behaviour, function, suicidality, and ability to work.

Other factors that may be markers of problematic recovery include ongoing negative symptoms, depression and anxiety, social deficits (especially difficulties in age-appropriate social and vocational functioning), and cognitive deficits. Incomplete recovery can be identified as early as three months after the onset of the acute episode[99].

The staging model envisages three forms of incomplete recovery – one in which premorbid levels of functioning or symptom status are not reached after onset of FEP; another where premorbid levels of functioning or symptom status are initially reached in recovery from FEP but subsequent relapse leads to less positive outcomes; and a third in which multiple relapses occur with associated ongoing deterioration. These forms of incomplete recovery can be distinguished from stage 4, in which no significant recovery seems to have taken place and symptoms or functioning appear to have progressed into a chronic course of illness.

Stage 3a: Incomplete recovery without relapse

Addington et al.[99] identify factors relevant in establishing and perpetuating incomplete recovery in psychosis, as listed in Table 6. Intervening during this phase requires targeting those factors that are potentially modifiable, including treating comorbidity, providing appropriate psychosocial services (such as vocational rehabilitation), facilitating psychological adjustment to psychosis, and enhancing adherence. The possibility of treatment-resistant illness can be entertained after these avenues have been exhausted. Between 10-50% of FEP clients experience treatment resistance[132-134]. The focus of treatment during stage 3a is on marshalling additional pharmacological and psychotherapeutic strategies to manage the potentially modifiable factors outlined in Table 6 and hence achieve full remission.

Table 6: Factors relevant in establishing and perpetuating incomplete recovery in psychosis

Factors	Unmodifiable	Potentially modifiable
Client	Poor prognosis factors: male, single, intellectual disability Diagnosis of schizophrenia	Comorbidity: substance-use disorders, depression Psychological adjustment: sealing over versus integration recovery style Psychosocial milieu including family
Illness	Poor premorbid adjustment Marked cognitive impairment Early and/or insidious onset Longer duration of prodrome, delays in treatment initiation, and/or longer duration of untreated psychosis Organic factors: abnormal brain features, indicated by computed tomography, magnetic resonance imaging, baseline abnormal electroencephalograph; poor integrity of the dorsolateral prefrontal cortex	Severity of psychopathology Negative symptoms at first admission +/- poor functioning Poor awareness of negative symptoms Poor cognitive function at stabilisation
Treatment	Pharmacokinetics: incorrect dose, drug-drug interactions, bioavailability problems, therapeutic windows	Impaired adherence: psychosocial treatments, medical treatments Inadequate rehabilitation programme or lack of services and resources Side-effects (e.g., extrapyramidal symptoms, metabolic, cognitive etc)

From Addington et al.[99], based in part on Pantelis and Lambert[135].

Stages 3b and 3c: Single or multiple relapse with poor outcome

90% of clients with FEP experience full or partial remission of positive psychotic symptoms within 12 months of treatment commencement[136]. Relapse is, however, common – naturalistic studies suggest 70-82% of people with FEP relapse within five years[137-139]. Each relapse increases the risk of persistent, and particularly negative, symptoms developing[134], as well as other challenges inherent in the 're-recovery' process, such as post-psychotic depression and suicide[140, 141] and broader psychosocial complications such as disruptions to vocational, educational, and social networks[142]. Relapse can also increase burden for family members and carers[143].

Risk factors for relapse in many ways mirror those for onset, and are outlined in Table 7.

Table 7: Summary of predictors of psychotic relapse following FEP

Domain	Predictors
Client-related factors	Poorer premorbid adjustment Antisocial personality (positive); agreeableness (negative) Cannabis use Nonadherence to medication Cognitive flexibility (negative)
Environment-related factors	Stressful life events Expressed emotion

Adapted from The recognition and management of early psychosis:a preventive approach, 2nd Edition Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge P 352.

Treatment in stages 3b and 3c focuses on ongoing relapse prevention, continuing pharmacological and psychosocial interventions for long-term stabilisation, and intervening in functional domains such as vocational recovery to prevent disability.

Stage 4: Prolonged/treatment refractory illness

Individuals may enter stage 4 at first presentation (i.e., from stage 2) by meeting the specific clinical and functional criteria of this stage, as reflected in symptoms, neurocognition, and disability criteria. They could also progress to stage 4 by failure to respond to treatment, as indicated in stage 3a.

Even in the presence of ongoing disability, health and good quality of life can emerge. The primary issues during this stage of psychosis include managing the illness itself, its physical and mental sequelae, and psychosocial correlates such as strained relationships with family members, social isolation, and unemployment[145]. Clinical strategies include continuing relapse prevention and the psychological consequences of persistent illness, such as demoralisation, depression and suicide. Contrary to the therapeutic nihilism often seen at this stage, some agents may continue to be of benefit, including clozapine and CBT.

General medical care also becomes a priority at this stage, given the high rates of physical morbidity and premature mortality in this group, as in many highly disadvantaged groups in society[146,147]. This period may also include revisiting the degree to which medication side-effects outweigh benefits, given the medical and social consequences of some medications, including obesity, lipid abnormalities, cardiac abnormalities and impaired glucose tolerance. The preventive focus in stage 4 therefore includes prevention of mortality.

Summary

The application of the clinical staging model to psychiatry is in its early phases. Given this, these guidelines by and large use more familiar concepts, such as putative prodrome/acute onset/recovery/relapse/problematic recovery. However, the staging model shows significant promise in providing a heuristic around which timely and effective interventions in psychiatric illness can be understood and delivered.

SECTION 2

CLINICAL PRACTICE GUIDELINES

The previous section serves as background and rationale to the clinical practice guidelines themselves, which provide principles (and the evidence for these) for the care of people with early psychosis. Regardless of the stage of illness, some elements of care for those with psychosis are universal. These include timely access to care and comprehensive assessment processes. Guidelines 1 and 2 outline recommendations relevant to access and assessment in the pre-onset and first episode domains. Guideline 3, Treatment, covers principles specific to particular phases of illness, as well as those that apply generally to the treatment of young people with psychosis.

Guideline 1: Access

Background

The importance of the duration of untreated psychosis (DUP) in first episode psychosis has been established following the publication of two systematic reviews [3, 6]. These reviews indicate that longer DUP is both a marker and an independent risk factor for poor outcome. The Scandinavian Early Treatment and Identification of Psychosis – or TIPS study[148] demonstrated that reducing DUP leads to both early and sustained benefits in reducing the severity of illness and improving social functioning[149]. Comparing two regions with an early psychosis detection programme to two areas without, this study found that DUP could be substantially reduced via community education and the use of mobile detection teams[5]. The early detection program included targeted campaigns for GPs, social workers, and school welfare workers, as well as provision of information from the early detection teams. Patients who subsequently entered care in the early detection sectors were also in better clinical condition and at less risk of suicide[4, 5]. These positive clinical differences were maintained at three month follow-up, and at one year, the level of negative psychotic symptoms was significantly less in the early detected sample[150]. While replication studies in other countries will be valuable to confirm the evidence for early detection, the programme of Norwegian research makes a compelling case for establishing early detection and engagement strategies to reduce treatment delays.

In reducing the DUP the two key components of intervention, as demonstrated by the TIPS study, are community awareness and mobile detection services. When both are in place, it is possible to achieve very low levels of DUP (a median of only a few weeks). These strategies also result in a less traumatic or 'crisis-driven' mode of entry into care and enable patients to be engaged without a surge of florid psychotic symptoms or disturbed behaviour being necessary in order to gain entry into service systems.

The relationship between DUP and outcome is robust, being sustained over many years of follow-up, including eight[151] to over 15 years[152]. However these studies show that, although it is a malleable risk factor, DUP accounts for a relatively modest amount of outcome variance, suggesting the importance of treatment access and quality during the early stages of illness.

A critical implication of the DUP literature is that better outcomes will result from earlier detection and treatment of psychotic disorder. Despite the severity of frank psychosis, the mean time between onset of symptoms and treatment is generally in the range of one to two years, with median values being around four to six months and including delays of 15 years or more[153]. Even those who seek help (and many may do so even prior to the onset of psychotic symptoms – e.g., Yung & McGorry,[73]; Preda et al.,[154]) may not do so for psychotic symptoms, but rather nonspecific symptoms such as depression, anxiety, or concerns about decline in functioning (e.g., Norman et al.,[155]), making it particularly important that clinicians be skilled in identifying signs of early psychotic disorder. Additionally, regardless of the impact of DUP on outcome, ease of access to care is important because it provides relief from the distress that psychotic and non-psychotic symptoms can cause[18].

Note: 1

Timely access to care might include:

- Being assessed within 48 hours of referral to a service
- Being seen by a consultant psychiatrist within one week
- Linking in with a case manager within five days of assessment

Norman and Malla[153] outline that these delays may be influenced by two distinct factors – the period of time between onset of symptoms and seeking help from a professional health provider; and the time between this help-seeking and the commencement of appropriate treatment. Table 8 outlines different sources of delay and interventions that may affect these. It is difficult to disentangle the relative effectiveness of these strategies to reduce DUP by promoting help-seeking and accurate identification of early psychosis, as in most studies a number of interventions have been combined. Community-wide initiatives to increase knowledge and reduce stigma associated with psychosis appear to be effective in reducing delay in help-seeking[5, 156-159]. Training primary care practitioners (such as GPs) has also demonstrated some success in reducing DUP, although data is less consistent[148, 157, 158, 160, 161].

Table 8: Sources of delay in accessing services, correlates, and ways to manage these

Stage of possible delay	Help seeking by patient and/or family	Identification of psychotic symptoms by generic services	Connection to appropriate services	Commencement of treatment
Influenced by	Stigma (Gerson et al.,[162]) Nature and extent of social network Nature of onset: precipitous/insidious; characterised by negative symptoms (Bechard-Evans et al.,[163]) Younger age (Bechard-Evans et al.,[163])	Training of provider to whom first presents (36%-43% of the time, this will be a GP: Norman & Malla,[153]; see also Bechard-Evans et al.,[163]) Age at onset	Presence of early detection teams (e.g., Johannessen et al.,[148])	Patient insight and engagement with services Practitioner awareness of nature of appropriate treatment, importance of prompt treatment, and methods of effectively engaging patients
Intervention	Mental health literacy e.g., mental health first aid for general public	Training service providers (e.g., support agencies, schools, GPs, emergency departments: Norman et al.,[155]; Johannesen et al.,[148]) to recognise psychotic symptoms	Implementation of early detection teams	
	Some evidence that these two strategies combined may be effective in reducing DUP[158]			
	Some evidence that these three strategies combined may be effective in reducing DUP[148,157]; but may also detect those with very long DUP[166].			

Recommendations

1.1	Mental health services should be accessible and provide a timely assessment for people experiencing their first episode of psychosis. [GPP]
1.2	Enhancing help-seeking:
1.2.1	Mental health services should provide education about early intervention to primary carers and the wider community. The community needs to be well informed about psychotic disorders and how to obtain effective help. Community-wide initiatives to increase knowledge and reduce the stigma associated with psychosis should be implemented. [C]
1.3	Enhancing professional identification of psychotic symptoms:
1.3.1	Primary health care professionals should be competent in eliciting and recognising the early clinical features of psychotic disorders. [GPP]
1.3.2	Primary care professionals should be trained in identifying psychosis and given information about how to refer to specialist services. [C]
1.3.3	Undergraduate and postgraduate medical education should be developed to allow for better training in assessment and treatment of emerging mental illness. [GPP]
1.3.4	Close links should be developed between primary and specialist mental health services to facilitate assessment and treatment of emerging mental illness. [GPP]
1.4	Enhancing connection to appropriate services:
1.4.1	Specialist early detection teams should be set up to enable timely access to care [C]
1.4.2	The means to access the service and the hours of operation should be promoted and advertised to the community. [GPP]
1.4.3	The mental health service should be accessible 24 hours/day, 7 days/week. [GPP]
1.4.4	The service should accept potential new referrals from a wide range of individuals, family and friends, and primary care services. A low threshold for expert assessment should be set for any person suspected of developing a psychotic disorder for the first time. [GPP]

Guideline 2: Assessment

Background

The purposes of assessment include engaging the young person and enabling the development of a therapeutic alliance; and gaining information enabling diagnosis and formulation of the person's difficulties, including understanding its personal context. These factors both inform treatment planning and are vital in providing a foundation for further successful treatment. Although it is placed in its own section in these guidelines, it is clear that assessment must be an ongoing process. In practice, assessment and treatment often merge[164]. Good assessment can not only enable treatment but can be a form of early treatment in its own right.

Rapport and the timing of assessment

Assessment procedures for young people experiencing FEP should incorporate strategies to promote engagement[165]. First contact with mental health services is likely to occur in the context of crisis or personal disaster for young people and/or their families[166], with some possible trauma involved in referral to mental health services[167]. Therefore, although it is important that an assessment thoroughly cover the domains detailed below, this should not occur at the expense of the developing therapeutic relationship. A range of factors may increase the likelihood of the first contact serving as a solid foundation for ongoing rapport:

- Well-trained and experienced staff;
- An individually adapted interview situation (calm, friendly, safe, and sufficient time);
- Consistency of care throughout assessment and into treatment as far as possible;
- An appropriate interview technique (listening carefully, taking client's concerns seriously, dispelling client's fears, establishing trust, trying to identify common ground, optimistic and supportive atmosphere, using open-ended questions where possible: see Power and McGorry,[164].

Reducing DUP requires not only enabling access to mental health services, but initiating treatment as soon as possible. This suggests that assessment should occur as quickly as practicable, for both the UHR and FEP groups, but particularly the latter.

Domains of psychiatric assessment in early psychosis

Clinical and personal history

The personal context of illness is a useful place to start an assessment. By focusing initially on understanding the experience of the young person and his/her family, a context is provided for signs and symptoms, and engagement is enhanced. As noted in Power and McGorry[164], important questions to answer in establishing this context include:

- How, and how rapidly, did the psychosis and prodrome evolve? To what degree are symptoms ego-syntonic or attributed to something other than illness?
- Who is being affected by psychosis and how are they coping with it? What is the client's premorbid personality structure, self-concept, and phase of development? What are his/her coping and problem-solving skills, current conflicts, social strengths and resources, including issues such as accommodation, financial issues, occupation, and cultural factors? How do these influence how the client is relating to his or her symptoms?
- What family supports exist and how does the family respond to illness?

Mental state examination

Following (and during) the taking of a clinical and personal history, assessment of signs and symptoms, via a mental state examination, including assessment of the presence, severity, and duration of difficulties, can occur. Insight is particularly important and should also be assessed, bearing in mind that it has both a state and trait component and may be culturally specific[168-171]. Elements of insight to assess include whether the client recognises they have an illness; that the illness is a mental disorder, and that treatment is required. This assessment is aided by having a neuroleptic-free assessment period[164].

Biological assessment

Although only 3% of FEP has an organic origin, the initial assessment is the most appropriate time for this to be examined[172]. Biological examination can also serve other useful purposes, including:

- Detection of medical comorbidities;
- Identification of risk factors for future medical disorders;
- Identification of risk factors for incomplete remission or treatment resistance; and
- Identification of a baseline against which pharmacological complications and side-effects can be assessed[173].

Box 3: Recommendations for biological assessments in FEP

Physical status

- Medical history
- Family history
- Smoking history
- Physical activity levels
- Physical exam
  - Neurological examination
  - Waist/hip circumference or BMI

Vital signs

- Blood pressure, pulse, temperature

Laboratory tests

- Haematology
- Liver function test
- Renal function (blood urea nitrogen/creatinine ratio)
- Thyroid function tests (basal thyroid-stimulating hormone, total and free triiodothyronine/thyroxine)
- Electrolytes
- Serum calcium and phosphates
- Fasting blood lipids (including triglycerides, total cholesterol and high and low density lipoprotein cholesterol)
- Fasting blood sugar
- Prolactin test sample (always drawn at the same time, morning)
- B12/folate
- Blood coagulation (if indicated)
- Urine illicit drug screen (if indicated)

Other Tests

- Electrocardiogram
- Electroencephalography
- Magnetic resonance imaging or computer tomography
- Neuropsychological testing (including attention span, concentration, memory)
- Assessment of metabolic syndrome
- Lumbar puncture (if indicated)
- Pregnancy test (if indicated)
- HIV testing
- Ceruloplasmin

This list of tests is not exhaustive but represents merely one possible initial work up for first-episode psychosis. Other tests should be also considered if the clinical history and the clinical picture suggest that they might be diagnostically useful

See also Freudenreich et.al. [172]

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.

Biological assessment in UHR has received far less attention. There is no consistent standard battery of physical tests employed by UHR clinics worldwide. Often assessment of biomedical problems has begun in earnest when an individual makes a "transition" to a frank psychotic disorder. However, screening for underlying pathology that may be responsible for the psychotic or psychiatric phenomena; for general medical morbidity; and for a medical baseline for those starting psychotropic medications would be advisable in this population. For these reasons, good practice suggests a general medical assessment in the UHR phase that mirrors that in FEP (see Box 3). However, one should bear in mind that the possibility of medical problems unrelated, incidental or not causative of psychotic phenomena might be higher in this population.

Cognitive assessment

Cognitive deficits are present at the first episode and show little alteration thereafter[174, 175]. They also seem to predate onset[176], with UHR groups generally demonstrating neuropsychological impairment[177-180], sometimes despite normal intelligence[178, 181], although generally to a lesser extent than in FEP and established schizophrenia samples[178, 179]. Cognitive deficits predict functional outcome in FEP, and may be linked to other clinical variables such as insight, medication adherence, substance use, and likely participation in therapy[182-184].

Social cognition (the way that people think about themselves and others, such as the capacity to recognise emotion and to understand others have desires and beliefs that may be different to one's own, as well as one's attributional style) has been demonstrated to be poorer in schizophrenia than control groups (for a review, see Couture et al.,[185]) and in FEP (e.g., Edwards et al.,[186]) and first episode schizophrenia[187], as well as those at risk of developing psychosis[188-190]. Social cognitive deficits also seem particularly related to psychosocial functioning in first episode schizophrenia[187].

Cognitive assessment can therefore allow interventions, particularly psychological interventions, to be appropriately tailored to the young person's cognitive function and growth areas, for example, by taking cognitive deficits into account in the delivery of therapy (such as poor working memory), or making cognitive deficits a focus of intervention (e.g., emotion recognition).

Assessment of comorbid disorders

Substance misuse

Levels of substance misuse in the UHR group range from 7% to 40%[191-196]. Although substance misuse typically precedes psychosis onset, the direction of any causal relationship between the two remains unclear. One possibility is that the onset of psychosis is due solely to substance abuse[197]. Alternatively, the onset of symptoms may lead to the use of alcohol or drugs to modify their distressing symptoms[192]. Cannabis specifically is likely to be a contributing factor to psychosis onset[198, 199], especially in those with other vulnerabilities, such as functional polymorphism of particular genes[34, 200]. Substance use may also result in delays in accessing treatment for psychosis because symptoms are mistakenly attributed to substance use.

Substance misuse is common in FEP. Individuals with FEP have significantly higher levels of substance misuse than non-psychotic peers (e.g., Hambrecht & Hafner,[201]), with most studies in Australia suggesting between 60-70% of those with FEP report substance misuse at some stage in their life prior to presentation. Cannabis and alcohol are the most frequently misused substances (e.g., Lambert et al.,[202]; Wade et al.,[122]), with use of opioids, cocaine, inhalants, and sedatives being relatively rare. As well as being related to onset in the UHR group, substance misuse, particularly cannabis use, is also a frequently-identified poor prognostic factor in FEP, including severe positive psychotic symptoms[122, 203], disengagement from services[204, 205], increased rates of relapse in positive symptoms[122, 206]; increased rate of inpatient admission[122,203] and suicidal ideation and behaviour[207]. Rates of alcohol misuse in FEP vary between 10% and 33% but studies have not found any correlation between alcohol use and positive symptoms[208] or outcome[203]. Assessment of substance misuse enables the implementation of interventions to improve outcome and accurate identification of current prognosis. Early detection of comorbid substance misuse in people with first-episode psychosis may reduce the course and severity of both disorders[209].

Tobacco use is given far less attention in the literature than other substances, but is both prevalent and problematic in the early psychosis population. Tobacco is the most commonly used substance in people with mental illness: for example, the rate of smoking is up to three times higher in people with schizophrenia than in the general population. In a study among young people with first-episode psychosis, about 70% were smoking regularly[210]. Studies in populations with chronic schizophrenia suggest that clients may 'self-medicate' with tobacco to reduce negative symptoms[211], probably through the effect of nicotine on dopamine release in the brain. Smoking may also attenuate some side-effects of antipsychotic medication including drowsiness[212]. However, in addition to adverse physical effects, smokers with psychosis have higher levels of positive symptoms[213], which increase further on tobacco withdrawal[214]. The half-life of antipsychotic medication is significantly shorter in smokers than non-smokers[215], probably because hepatic aryl hydrocarbon hydroxylases are induced by polycyclic aromatic hydrocarbons present in cigarette smoke, which increases the metabolic clearance of drugs that are substrates for these enzymes[216]. Smoking may also increase the risk of tardive dyskinesia[217].

Given the relationship between substance use and poorer outcome, therefore, assessment is a key preliminary step for appropriate intervention.

Other psychiatric disorders

Other psychiatric disorders are also common in both the UHR and first episode phases. In Phillips et al.[219], 87% of their UHR sample met criteria for at least one Axis I disorder, with the most common being major depression. Myles-Worsley et al.[220] suggest that depression is a key component of the psychotic prodrome, reporting that 84% of their sample reported 'abnormal' depressive symptoms, and that positive and depressive symptoms build in parallel to onset. Similarly, Yung et al.[221] suggest that low mood increases the likelihood that psychotic like experiences will develop into psychotic disorder, and that treating depressive symptoms may prevent onset of psychosis (see also Cornblatt et al.[222]).

Svirskis et al.[223] noted that mood and anxiety disorders are particularly common in the UHR group, with higher levels of psychotic symptomatology associated with more Axis I diagnoses. More broadly, Woods et al.[224] reported that comorbidities were common in their UHR sample, with 69% having one or more mood/anxiety diagnoses, and 44% with one or more Axis II diagnoses. Other psychiatric disorders are also seen in around half of the FEP group[225-228] and in schizophrenia more broadly[229], and may be associated with poorer symptomatic and functional outcome[230-233]. Given that comorbid psychiatric disorders are associated with onset in the UHR group and poorer outcome in the FEP group, assessment and treatment of these disorders is vital.

Risk assessment

Identifying whether there is significant risk of adverse outcomes is likely to enhance attempts to prevent them. Although the most commonly canvassed risk is that of suicide, other risks that can affect mortality and morbidity include risk of violence, neglect and victimisation, and non-adherence to treatment or service disengagement; these are discussed in turn below.

Risk of suicide

The one to two year incidence rates for suicide range from 0.3% to 2.9% in the FEP population[234-236]. Two studies have reported suicide rates over a longer follow-up period: Clarke et al.[237] report a four year incidence rate of 3%, whist Bertelsen and colleagues[238] report a five year rate of approximately 1%. Suicide attempt (SA) is more common and is the single greatest predictor of future suicide[235]. Between 10% and 25% of people with FEP report either deliberate self-harm (DSH) or a SA prior to presentation for treatment[234, 235], and 50%-65% will have experienced recent thoughts of suicide[235-237, 239, 240].

Rates remain high following the commencement of treatment. One-year prevalence rates of SA range from 2.9% to 11%[234-236]. Longer term follow-up studies have reported a two year prevalence rate of 11.3%[207] and a four year prevalence rate of 18.2%[237].

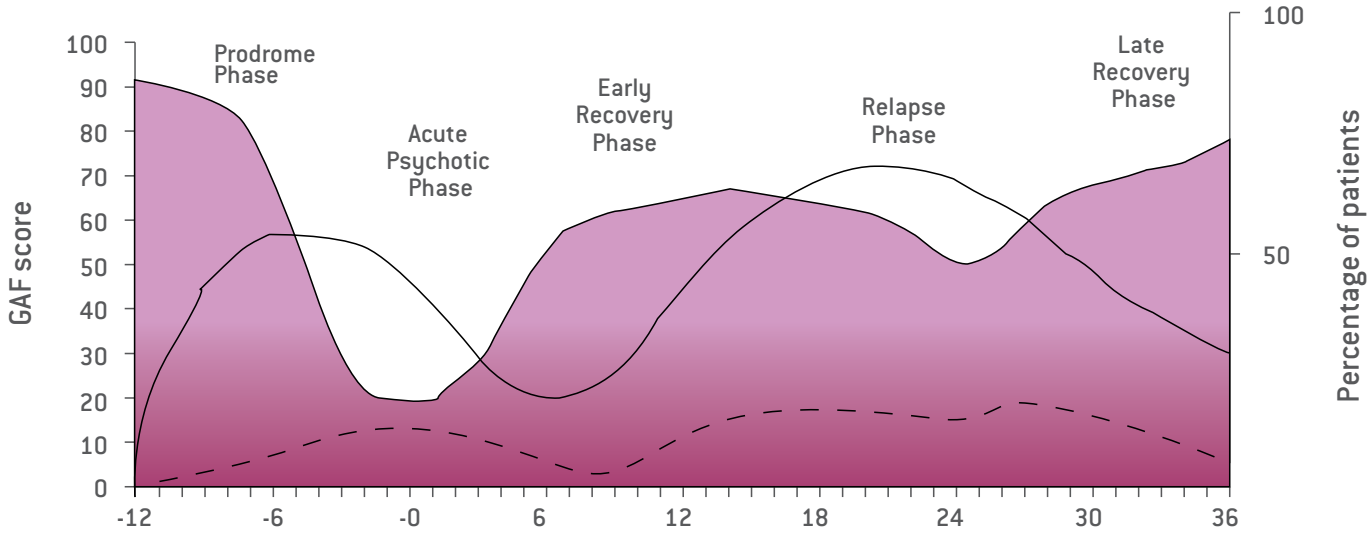
There is considerably less information available on rates of suicide, suicidal ideation, SA, and DSH in the UHR group. Data suggests between 25%-92% of those at UHR experience suicidal ideation[241]. Between 10%-24% of people identified as UHR have attempted suicide prior to identification[241, 242], with no difference in rates of suicide attempt between the UHR and FEP groups. Yung and McGorry[73] found that 14.3% of their small UHR sample reported a history of DSH, while in a larger study Phillips et al.[219] found that 64.8% of their UHR sample reported at least one incidence of DSH in their lives.

Risk factors: Risk factors for suicide and suicide attempt in psychosis include being younger, male, single, having experienced a recent loss event and having high levels of premorbid functioning plus anxiety regarding current mental deterioration[141, 243-245]. Greater insight, longer DUP and substance misuse have also been cited as risk factors, along with depression and hopelessness[246, 247], yet depression is often under-diagnosed, possibly due to a focus on psychotic symptoms which may mask depressive features[248]. Poor adherence to treatment has been shown to be associated with risk, in particular with regard to failure to attend follow-up appointments and poor medication compliance[243].

Suicide risk may be reduced in the presence of psychotic features and negative symptoms[235, 249], however there is debate in the literature about this[243] and a small number of clients commit suicide in response to command hallucinations[250]. In the only UHR study to date, a family history of psychiatric illness and problematic substance use predicted suicide attempts[242].

Known periods of risk include the early stages of illness, often following an acute psychotic episode[164, 240, 245] and during the post-psychotic early recovery phase[247]. This may reflect the distinction between the initial influence of psychotic features on self-harm behaviours, which may then be followed by a more prolonged rise in suicidality in response to the struggles of the recovery process[251], as well as developing insight, hopelessness and depression, which are associated with suicidal ideation and SA[252-254]. The period immediately following discharge from hospital is also known to be a period where risk is elevated[255, 256], as is the time of transition from prodrome to psychosis, and the occurrence of a relapse[164].

Figure 3: The course of suicidality in early psychosis



Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 262.

Suicidality can change rapidly. A system of routine assessment of suicide risk, including suicidal ideation and the presence or absence of known risk factors, is likely to reduce such risk. Examples of screens include the monthly use of the suicidality item on the Brief Psychiatric Rating Scale[140], or a zoning system, in which clients are identified on a daily basis according to three levels of risk (low, green; moderate, amber; high, red: Ryrie et al.,[257]).

Box 4: Periods where suicide risk assessment is particularly indicated

Transition from prodrome to psychosis
Early phase of recovery
Early relapse
During rapid fluctuations of mental state
Prior to granting hospital leave
On discharge from the service
Following any incident of deliberate self-ham
Following loss events

Systemic issues to consider if client is identified as high risk

Informing consultant psychiatrist
Discussing with clinical supervisor
Development and documentation of immediate risk management plan in conjunction with the client, carers, consultant psychiatrist, and other members of the treating team

Risk of violence

The majority of people with severe mental illness are not violent. Nonetheless, there is an accepted association between established schizophrenia and increased rates of violence and criminal offending[258]. For example, compared with the general population, individuals with schizophrenia are four times more likely to have been convicted of a violent offence and ten times more likely to have been convicted of homicide[259]. These rates increase substantially when substance abuse, personality disorder and social disadvantage are included. There is no indication of the rates of violence in FEP or UHR samples however research demonstrates that the majority of violent and offending behaviours in the mentally ill occurs prior to first psychiatric contact and treatment[260]. Indeed there is a significant association between duration of untreated psychosis and homicide, such that clients who experience a longer period of untreated illness are more likely to have committed homicide[261]. As early intervention reduces the delay in treating mental illness, it has been suggested that this approach may be critical to reducing forensic outcomes such as violence[261].

Given the association that exists between psychosis - particularly early psychosis - and offending, assessment of the risk of harm or violence to others should be regarded as part of the comprehensive package of routine clinical care in early psychosis services. Where there are concerns regarding a client's potential risk of violence or offending, structured clinical assessment using tools, such as the HCR-20[262] are recommended rather than unstructured clinical interview. This is due to greater accuracy of structured risk assessment, and its facilitation of transparency in guiding decision making, which may be especially relevant in the event of external scrutiny[263]. Structured clinical assessment tools such as the HCR-20 assess both static (unchanging) and dynamic (modifiable) risk factors for violence. These tools provide guidance as to a client's level of risk (e.g. low, moderate or high), but more importantly provide opportunities for interventions to manage relevant dynamic risk factors, such as active symptoms, substance abuse, medication non-compliance, or lack of personal support. Assessing the risk of violence (or any risk) is futile if identified risks are not managed.

For a thorough discussion of violence risk assessment and management in mental health, see Maden[263].

Risk of neglect and victimisation

A history of neglect and victimisation is related to psychotic disorder, both cross-sectionally (e.g., Vogel et al.,[264]), and in predicting onset in those at UHR[265, 266]. A recent study suggested that 34% of those with FEP have experienced sexual or physical abuse[267]; another study reported that 30% of FEP clients experienced child sexual abuse and another 14% experienced physical abuse[268]. In psychosis broadly, the British National Survey of Psychiatric Morbidity found that victimisation in almost all its forms (i.e., sexual abuse, bullying, being taken into care, experiencing violence in the home, running away from home, spending time in a children's institution, being homeless, being a victim of serious injury, or experiencing violence at work) was more frequent in people with psychosis than those with other psychiatric disorders and the general population[269]. A recent systematic review found that criminal victimisation was up to 140 times greater in those with psychosis than in the general population[270]. Recent studies suggested that 16-25% of people with schizophrenia are reported to be victims of violence at some time in their lives[271, 272].

Men with schizophrenia have an increased risk of dying by homicide than the general population, especially when involved in alcohol and drug use[273]. Rates of sexual and physical abuse in women with serious mental illness are twice those for women in the general population[274-276]. This history of neglect and victimisation may influence the way psychosis presents[268]; for example, Thompson et al.[277] found that those at UHR who had experienced sexual trauma were more likely to report attenuated psychotic symptoms with sexual overtones.

A number of factors could be responsible for these links: psychosis may cause neglect and victimisation; neglect and victimisation may cause psychosis; or some third variable may be responsible for both psychosis and neglect and victimisation. There is limited data to suggest the first option, although some authors (e.g., Goodman et al.[275]) suggest that cognitive and behavioural symptoms of schizophrenia, such as impaired judgement, planning difficulties, and difficulties with social relationships, result in greater vulnerability to abuse. There are also instances in which treatment for psychosis becomes associated with neglect and abuse (such as abuse on psychiatric inpatient units[278]). Iatrogenic neglect may also occur if clinicians are not assiduous in detecting and treating comorbid physical conditions that can affect mortality, such as HIV and pulmonary illness[279]. Maltreatment may lead to psychotic disorder. On the other hand, other factors (such as premorbid cognitive deficits or problems with interpersonal functioning, with associated poor social supports and disadvantage such as homelessness) may be associated with both psychosis and risk of maltreatment[269].

Risk of non-adherence to treatment and service disengagement

Although there has been no empirical research comparing service engagement across different phases of psychotic illness, the risk of non-adherence and service disengagement may be substantially greater in FEP than in more chronic samples[137, 280], reflecting a normative denial process[164] as well as other factors that contribute to non-adherence in more chronic samples, such as substance use and poor therapeutic alliance[281, 282].

Particular risk factors for disengagement from FEP services include past forensic history, lower severity of illness at baseline, living without family at discharge, and persistence of substance use throughout treatment[204, 283]. A protective factor identified in psychosis broadly is a good relationship with clinicians[284].

Summary

Risk assessment includes suicide risk assessment, but also a broad range of other risks, including violence, neglect/victimisation, and disengagement from treatment. All should be assessed on a regular basis, to ensure treatment is appropriate to the individual's needs and to prevent clinical collusion in any ongoing risk the client experiences.

Use of informants during assessment

During the assessment process, as much information as possible should be gathered from referring sources and other key people in the young person's network. This not only assists in gaining an understanding about how best to conduct an assessment and engage the young person, but also provides some preliminary information about the young person's difficulties. However, it should be borne in mind that not only symptoms but also accessing services may be as anxiety-provoking and possibly traumatic for the social network of the client as for the client. Engagement with families and other relevant social networks should be a priority at this time, not only for their own sake but as partners in care[164].

Note: 2

Where possible, initial contact should be made with the family/carer soon after assessment (ideally within 48 hours), so that support, crisis intervention, and psychoeducation can be provided.

An assessment should therefore consider the immediate needs of the family, addressing their understanding of psychosis, its treatment and prognosis; the family's previous experience with psychosis, and the family's explanatory model of the psychosis; the practical, cognitive and emotional impact of the psychosis on individual family members; the family's strengths and coping resources, including members' perceptions of their strengths and coping resources; its experience in dealing with stress; its appraisal of the resources available to support them; and the patterns of communication within the family (how the family relates to and communicates with the person with the illness[164].

In some instances, however, young people may be reluctant to allow communication between services and family. An early step is to explain to the young person that the involvement of families is routine and a useful part of their overall care. If a young person continues to decline family involved in assessment and/or treatment, careful exploration of the reasons is warranted. In rare cases, such as severe estrangement or abuse, involvement of the family might be deemed inappropriate. Further discussion of issues of family involvement in care and confidentiality is in guideline 3.4.3, Family Involvement.

Communication of rights and responsibilities

Rights and responsibilities of mental health service users and providers are outlined in the federal Mental Health Statement on Rights and Responsibilities (Mental Health Consumer Outcomes Taskforce,)[285] and various state documents (e.g., Victoria: Charter of Human Rights and Responsibilities; NSW: Department of Health Charter for Mental Health Care in NSW), as well as the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

Although these rights and responsibilities should be canvassed throughout service engagement with consumers and their families and other networks, assessment is the most appropriate time to initially communicate them in user-friendly ways.

Note: 3

Communication of rights and responsibilities should occur in a timely fashion (ideally within 48 hours of assessment) This includes:

- Information packs about treatments and services available
- Written and verbal information regarding rights (especially privacy rights) and responsibilities after entry to the service, particularly with respect to involuntary admissions and treatment
- Ways to access complaints procedures

Provision of feedback and diagnosis

It is both ethically sound and good practice to provide the young person, and, where appropriate, their support networks with feedback regarding the assessment process, particularly diagnosis and any formulation that the assessor may be considering of the client's difficulties. Feedback should be provided to the referrer and where possible to the young person's general practitioner.

Note: 4

In the case of the UHR group, information about the nature of symptoms and the level of risk of transition should be carefully provided within a framework of therapeutic optimism, confirming that the current problems can be alleviated, that progression to psychosis is not predetermined, and that effective and well-tolerated treatments are readily available. The person can be reassured that if a more severe disorder were to develop, treatment would be available immediately.

Recommendations

2.1	Assessment begins therapeutic engagement and treatment, so establishing rapport should be a priority. GPP
2.2	Assessment is an ongoing process, not just restricted to initial entry into service. GPP
2.3	Assessments should occur as soon as practicable after referral, and within 48 hours in the case of a suspected FEP. GPP
2.4	All clients should have a comprehensive biopsychosocial assessment by the acute treating team. This should include developing an understanding of the personal context of illness and developing a case formulation; mental state examination; physical examination and investigations; cognitive assessment; assessment for comorbid disorders; and risk assessment. GPP
2.4.1	Assessment of the personal context of illness should include developing an understanding of the longitudinal course of symptoms and how they are regarded by the young person; and the young person's strengths, resources (including family resources), and skills in managing these symptoms specifically and other stressors more broadly. GPP
2.4.2	Mental state examination, assessing signs, symptoms, and insight, is aided by an antipsychotic-free period of assessment. GPP
2.4.3	Physical examination, including baseline assessment of metabolic functioning (see guideline 3.2.1) and related lifestyle factors (such as diet and exercise) should occur to rule out an organic basis to illness, guide appropriate treatment, and enable monitoring of side-effects. Basic metabolic monitoring should be ongoing and include regular weight and waist circumference measurement. GPP
2.4.4	Assessment for comorbid disorders should include thorough and regular assessment of substance use (including cigarette use) and other psychiatric disorders. GPP
2.4.5	Risk assessment:
2.4.5.1	Risk assessment should be undertaken and documented at each visit, and should include routine assessment of depressive symptoms, hopelessness, suicidal intent, the effect of returning insight, and the role of psychotic features on mood. GPP
2.4.5.2	Risk assessment should take into account the fluctuating nature of suicidality in young people. GPP
2.4.5.3	Risk assessment should also include assessment of risk to others, risk attributable to neglect and victimisation by others, and risk of non-adherence to treatment (including absconding). GPP
2.5	Where possible, informants (particularly referrers, but also other key members of the young person's social networks) should be drawn upon as valuable sources of information about the trajectory and nature of the young person's difficulties. Assessment should also consider needs of the family, their knowledge of psychosis, the impact of psychosis on the family, and their strengths and coping resources. GPP
2.6	Feedback regarding assessment (particularly the fact of contact with the service, diagnoses and possible formulation of the young person's difficulties) should be provided to the young person; briefly and within 48 hours to referrers (in writing) and general practitioners; and, where appropriate, to other key supports of the young person. GPP
2.7	Rights and responsibilities, as well as treatment and service available within the service, should be communicated to clients and their key supports within 48 hours of entry to the service, including in writing (see guideline 3.4.3 for further information about confidentiality). GPP

Guideline 3: Treatment

'Detecting an illness early is of value only if effective treatment is readily available' (Falloon et al.,p. 33[286]). Some principles apply regardless of phase of illness, and in many ways reflect good practice points in working with young people broadly. The pre-onset and first episode periods do however have their own specific treatment issues. Further, different approaches are likely to be indicated across the different phases of acuity in the FEP group (acute phase, early recovery, relapse, and late recovery/discharge). This section outlines:

- Principles specific to the UHR group
- Principles specific to the FEP group, including the FEP group broadly and the different phases of acuity, i.e., the acute phase, early recovery, relapse, and late/problematic recovery
- Principles related to discharge from the clinical service
- Principles that operate regardless of illness phase.

Guideline 3.1: Treatment guidelines for the pre-onset phase

Background

This is an area of burgeoning research, a number of review articles and books are available on psychological intervention in the pre-psychotic phase that provide more detailed information than these guidelines can outline (e.g., McGorry et al.,[1]; Yung et al.,[287]). There is much more limited information on medical management of this phase. A summary of relevant issues is offered here. Case management is clearly an intervention in its own right; the principles of case management in both UHR and FEP are reviewed in guideline 3.4.4. This section focuses on the evidence surveying specific interventions implemented in a stand-alone manner. Evidence concerning both cognitive behavioural therapy (CBT) and supportive therapy when combined with other interventions in the UHR period is discussed below.

Psychological therapies for UHR

There have been considerable advances in the use of psychological therapies as a component of treatment for psychosis. They can be helpful as specifically targeted elements of treatment, for example addressing the distress caused by hallucinations, and more generally in areas such as engagement with treatment.

CBT has been the primary stand-alone psychological intervention explored in empirical research in the UHR phase, with a particular focus on reducing psychotic symptoms and/or delaying or preventing transition to psychosis. CBT is an intervention which challenges patterns of thought and the behaviour associated with these thoughts[288, 289]. An overarching paradigm within the CBT model of psychosis is the stress-vulnerability model outlined above.

Box 5: CBT's focus in the UHR phase is to:

- Enhance understanding of symptoms being experienced (including psychotic symptoms, but not exclusively so) and target these, through strategies such as:
  - Psychoeducation and normalisation of anomalous experience by provision of a general biopsychosocial model of these;
  - Challenging and 'reality testing' of delusional thoughts and hallucinations;
  - Enhancing coping strategies regarding positive symptoms (such as distraction and withdrawal, as well as more general coping strategies outlined below);
  - Encouraging self-monitoring of symptoms to establish any relationship between symptoms and stress;
- With respect to negative/depressive symptoms, encouraging of scheduling and monitoring of mastery and pleasure activities and cognitive restructuring of negative and self-defeating cognitions; and
- Strengthening coping resources to ameliorate the impact of stressors and, hence, vulnerability to developing further or more severe symptoms, via strategies including:
  - Psychoeducation about the nature of stress and anxiety,
  - Monitoring of stress,
  - Introduction of stress management techniques,
  - Identification of maladaptive coping techniques and promoting more adaptive responses to stress,
  - Identification and restructuring of cognitions associated with stress or anxiety, and replacement of these with more positive coping statements,
  - Goal-setting, time management, assertiveness training, and problem-solving skills[287, 290].

Studies from two research groups have examined the efficacy of CBT as a stand-alone intervention in treating symptoms and social functioning in the UHR period.

Morrison et al.[15, 291] reported that cognitive therapy (CT) alone (up to a maximum of 26 sessions over six months, with an average number of 12 sessions) significantly reduced the likelihood of transition to psychosis (as operationalised by either scores on the Positive and Negative Symptom Scale or meeting criteria for a DSM-IV psychotic disorder) and prescription of antipsychotic medication by an independent medical practitioner at 12-month follow-up. CT also predicted prescription of antipsychotics, and transition to psychosis (but on the PANSS only, and only when controlling for baseline cognitive factors such as metacognitive beliefs) at three year follow-up. Social functioning and distress were however unaffected by CT. Treatment is described in the treatment manual in more detail[292], but in brief, included the development of a case formulation and shared goals, with treatment techniques such as examining pros and cons of particular ways of thinking and behaving, considering evidence and alternative explanations for beliefs, and behavioural experiments to evaluate beliefs.

Häfner et al.[293] described a CBT intervention for those in the 'early initial prodromal state', i.e., experiencing basic symptoms and/or experiencing functional decline plus other risk factors such as family history of psychotic disorder, rather than meeting UHR criteria. This CBT intervention, using a stress-vulnerability framework with a focus on improving coping resources and stress management, consisted of 30 individual sessions, 15 group sessions, 12 sessions of cognitive remediation, and three sessions of family psychoeducation. Targets of therapy included basic symptoms, negative symptoms, anxiety, depressive symptoms, family issues, and social functioning. In an early small uncontrolled study, Bechdolf et al.[294] reported large and significant effects of CBT on both prodromal symptoms and social functioning. In a larger report, Bechdolf et al.[95], in evaluating the effect of this intervention on social functioning, found it was not superior to supportive counselling (basic assessment, psychoeducation, and unstructured counselling provided in a supportive, warm, and empathic manner). Both led to significant improvements at 12-month follow-up. These authors are yet to report on other outcomes in the larger sample that may have been influenced by the CBT program delivered.

In summary, it appears that CBT and supportive counselling are effective interventions in the pre-psychotic phase, possibly preventing or delaying transition to psychosis.

Medication

Information to date suggests that medication, particularly low-dose antipsychotic medication, may be effective in preventing or delaying transition to psychosis in the short-term when combined with CBT (2mg risperidone;[14, 295]). Antipsychotic medication may also be helpful in ameliorating symptoms and preventing transition to psychosis when used alone. The PRIME study was a randomised double-blind trial of comparing the efficacy of 5-15mg olanzapine with placebo. Eight-week follow-up suggested that olanzapine was associated with significantly greater improvement in psychotic symptoms than placebo[296]; there was a trend for those in the olanzapine group to be less likely to transition to psychosis at one year follow-up. However, there was no difference approaching significance at two year follow-up[297].

These data suggest a possible role of antipsychotic medication in preventing or delaying transition to psychosis. There are, however, a number of concerns about prescribing antipsychotic medication to the UHR group. These include the potentially serious side effects of antipsychotic medications which may be particularly distressing to young people (e.g., weight gain, sexual dysfunction, extra-pyramidal side-effects); self-stigmatisation; the need to prioritise pharmacological treatment of comorbid disorders; and the fact that pharmacological interventions for psychotic symptoms in the UHR group may be less acceptable to consumers, given drop-out rates in trials using pharmacological interventions[219]. These are particularly salient in the UHR group because of the 'false positive' phenomenon noted earlier – individuals may be prescribed antipsychotic medication and experience these adverse events when they were not at risk of psychosis in the first place.

Preliminary naturalistic data also suggests that antidepressants (i.e., pharmacological treatment of depression) may be associated with lower rates of transition to psychosis than antipsychotics[222, 298]. Additionally, omega-3 fatty acids reduced the rate of progression to psychosis in comparison with placebo in one recent randomised controlled trial[299]. Thus treatments that are more benign than anti-psychotics may be effective[1]. For these reasons, further research is required before antipsychotic medication can be recommended for treatment of the UHR group[300].

However, in exceptional circumstances a low-dose atypical antipsychotic medication may be indicated. One example would be if there were rapid worsening of psychotic symptoms together with significant deterioration in functioning related to these symptoms as well as elevated risk to self or others. In this case anti-psychotics would be used not only to prevent onset of psychotic disorder but also to ameliorate distress and the deteriorating social functioning associated with this state. This is not justified in the majority of such situations (see recommendations 3.1.1).

These data should not, however, preclude the pharmacological treatment of comorbid psychiatric disorders, notably depression, in accordance with relevant treatment guidelines.

Integrated treatment

Integrated treatment refers to packages combining psychological and pharmacological interventions, together with needs-based case management. The Early Psychosis Prevention and Intervention Centre (EPPIC) in Victoria pioneered the development of such systems, and showed that they were superior to historical and generic models of care[301]. Many of the trials in this group compare an active intervention with treatment as usual within this specialist paradigm; fewer studies have examined the difference between treatment as usual within a specialist integrative service and less broad-based approaches.

In the pre-onset group, results of trials implementing integrated therapy have emerged from two countries, Australia and Denmark. The Australian study examined the influence of CBT combined with either low-dose risperidone or placebo, or supportive therapy (aimed at helping people to cope with current problems, primarily social relationships and vocational and family issues, without CBT) plus placebo, in the UHR group. All groups received needs-based case management, and pharmacological treatment of comorbid disorders if necessary.

The authors found that those in the supportive therapy control group (n=28) were more likely to transition to frank psychosis than those in the intervention group (n=31), but this difference was no longer significant at one year follow-up, six months after treatment had ended[14] or at three to four year follow-up[295]. These findings suggest that the combination of antipsychotic medication and CBT may delay but not always prevent transition to psychosis in the UHR group.

The Danish study (OPUS[302]) evaluated an intervention package including assertive community treatment (with a focus on symptom monitoring and treating comorbid substance use), social skills treatment, and psychoeducation for clients and families in multi-family groups. Results suggested that there was a lower transition rate from schizotypal to psychotic disorder for those receiving the integrated treatment than those receiving treatment as usual at 12-month follow-up. These data suggest that this integrated intervention at the least postponed and possibly prevented transition to psychosis.

Recommendations

3.1.1	Omega-3 fatty acids may prevent or delay transition to psychosis. [B]
3.1.2	Psychological and, where appropriate, pharmacological treatment of comorbidities should be prioritised and consistent with guidelines on those comorbidities. Pharmacological treatment of comorbidity should be considered before specific pharmacological treatment of attenuated psychotic phenomena since this comorbidity may be the origin of, or contributing to, the prominence of, attenuated psychotic symptoms. [GPP]
3.1.3	Antipsychotic medication should NOT be considered as the first treatment option for UHR. However, if rapid worsening of psychotic symptoms occurs together with significant deterioration in functioning related to these symptoms and elevated risk to self or others, a low-dose atypical antipsychotic may be considered, in conjunction with close monitoring and support. Note that this is not justified in the majority of such situations. [GPP]
3.1.4	CBT may reduce or obviate the need for antipsychotic medication in the pre-onset phase. [B]
3.1.5	CBT may reduce psychotic symptomatology and prevent or delay transition to psychosis in the pre-onset phase. [B]
3.1.6	CBT may improve social functioning in the pre-onset phase. [C]
3.1.7	Supportive counselling alone may improve social functioning in the pre-onset phase.

Guideline 3.2: Treatment guidelines for FEP

Most empirical research in early psychosis, particularly in psychological therapies, tailors treatment to the specific phase of psychotic illness. Guidelines relevant to the acute, early recovery, relapse, and late/problematic recovery and discharge phases are outlined in turn below. Some psychological therapies have been applied across all stages of illness, and are outlined in section 3.3.

Guideline 3.2.1: The acute phase

Background

It is usually during the acute phase that the young person first contacts mental health services. The presentation will determine the initial setting for treatment (i.e., inpatient or outpatient care). This first presentation of suspected psychosis is considered a psychiatric emergency requiring immediate treatment, in order to reduce both DUP and client and caregiver distress.

The overall aims of treatment during the acute phase are to:

- Monitor the client's mental state;
- Gain a thorough understanding of the person and their situation as quickly as possible;
- Ensure the safety of the individual and others;
- Reduce delay in effective treatment by treating or preventing:
  - Positive symptoms of psychosis and disturbed behaviour;
  - Negative symptoms and coexisting problems such as depression, mania, anxiety or panic attacks and substance abuse.
- Build a sustainable therapeutic and supportive relationship with the individual and carers;
- Develop a management plan to aid recovery from the acute episode, reduce risk of relapse and promote long-term well-being;
- Minimise trauma;
- Instil realistic hope;
- Provide an acceptable explanatory model, with education about psychosis and its treatment;
- Inform and support the family to relieve their distress and to promote optimal family functioning.

Medication

Pharmacotherapy is a first-line treatment in psychotic disorders; engagement in other forms of therapy (especially psychological therapy) for many clients may be difficult until some symptom relief is gained through use of medication. Although some research with limited attention to controlled methodology suggests that intensive psychosocial treatment may be more effective than antipsychotic medication alone[303-306], the relative absence of controlled research in this area militates against recommending psychosocial treatment in the absence of pharmacotherapy, especially in the acute phase.

While treatment guidelines for people with established schizophrenia may be partially relevant, they are not sufficient for treating people with FEP. There are a number of qualities of the FEP group that suggest a specifically tailored or staged approach. For example, FEP patients appear to be particularly sensitive to a number of side-effects of medications such as weight gain, sedation, and extrapyramidal side-effects. It should be emphasised that this first experience of antipsychotic medication is likely to have considerable influence on engagement and subsequent adherence to treatment .

Possible prescribing algorithms are outlined in Figures 4 and 5.

Box 6: Particular pharmacotherapy issues in the FEP group

FEP patients are usually antipsychotic-naive

First experience of antipsychotic medication will influence engagement and adherence

Diagnostic instability in FEP may require ongoing adaptation of pharmacological interventions

FEP patients generally show more rapid improvement in symptoms than in established schizophrenia[307-313]

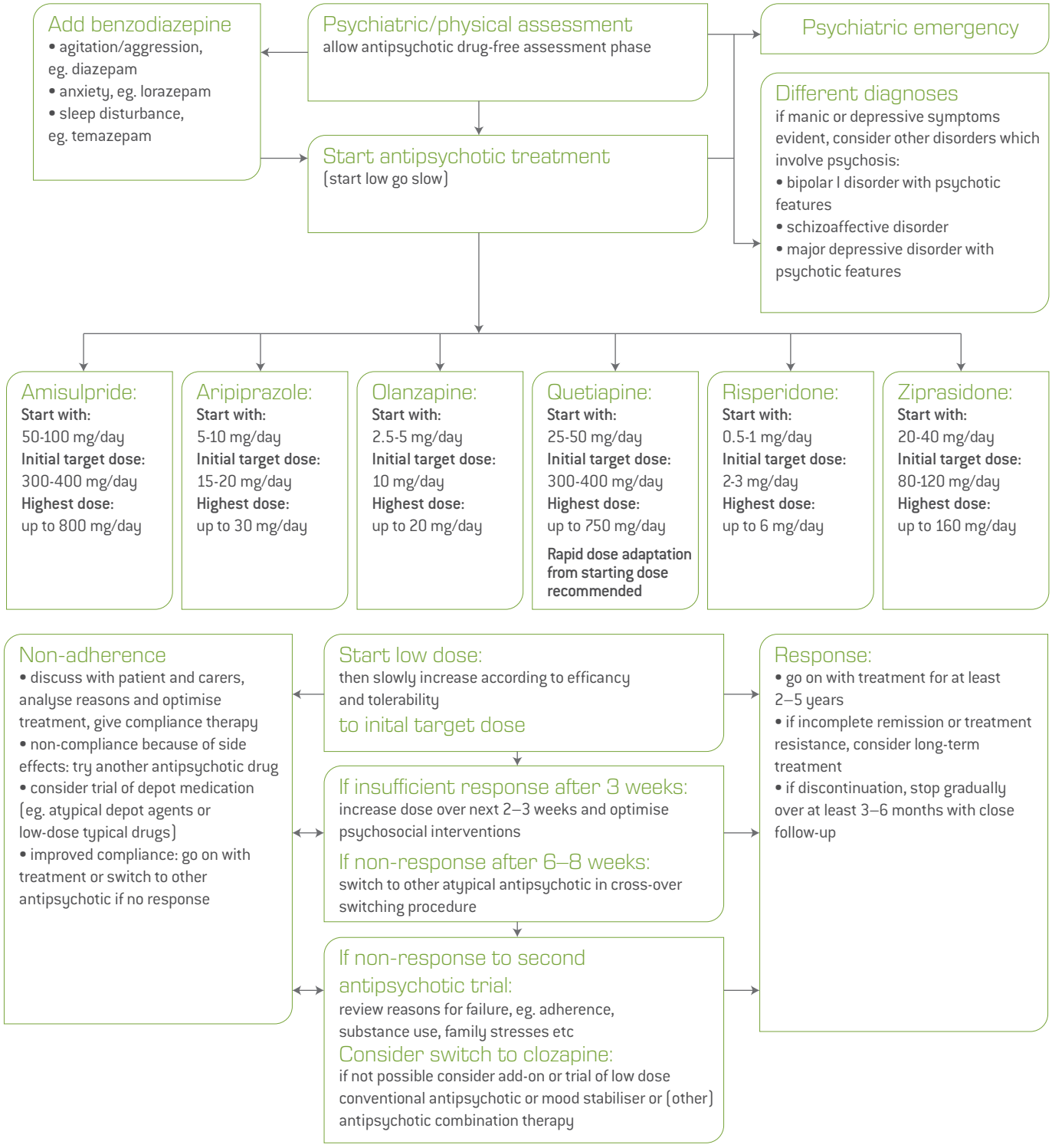
Positive symptoms in FEP patients are generally responsive to treatment in terms of overall response rate and degree of symptom reduction[314-316]

FEP patients often improve at low antipsychotic doses[138, 315, 317, 318]

FEP patients may be particularly sensitive to extrapyramidal side-effects

FEP patients are more susceptible to antipsychotic-induced weight gain and metabolic side-effects than those with more chronic illness due to younger age and often being neuroleptic naive[308, 313, 319-321]

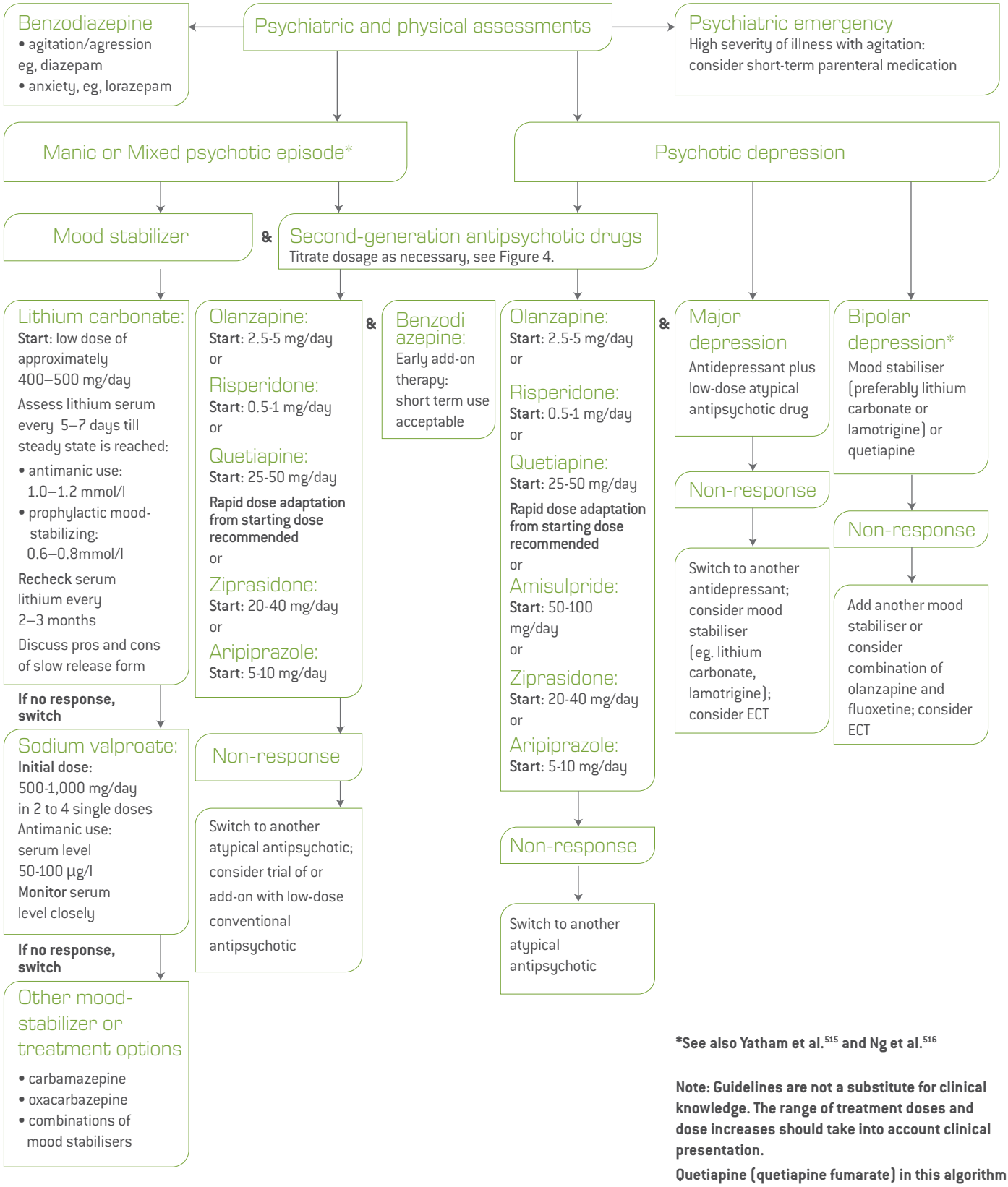
Figure 4: Pharmacotherapy for first episode non-affective psychosis



Note: Guidelines are not a substitute for clinical knowledge.
The range of treatment doses and dose increases should take into account clinical presentation.
Quetiapine (quetiapine fumarate) in this algorithm refers to non extended release formulation.

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 190.

Figure 5: Pharmacotherapy for first episode affective psychosis



***See also Yatham et al.[515] and Ng et al.[516]**

Note: Guidelines are not a substitute for clinical knowledge. The range of treatment doses and dose increases should take into account clinical presentation.

Quetiapine (quetiapine fumarate) in this algorithm refers to non extended release formulation.

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 192.

There is minimal evidence that any SGA has clinical advantages over any other in treatment of acute psychosis[138]. There is limited evidence regarding a host of important variables, such as objective treatment differences (including symptomatic improvement or lower rates of admission to hospital) and compliance rates, across SGAs compared with FGAs. There is some evidence regarding continuation or drop-out rates, summarised below. More broadly, Hamann et al.[322], in their review of two of the three studies comparing FGAs and SGAs in FEP (Emsley,[307]; Sanger,[312]; excluding Kahn et al.[317]), suggested that the combined sample size was too small to allow conclusions on the relative efficacy of SGAs and FGAs. However the Kahn et al.[317] study was clear in demonstrating the superior tolerability and hence utility of the SGA medications in comparison to the FGAs. Early data relating to relapse prevention also suggest SGAs have advantages over FGAs with respect to relapse prevention[323]. Principles of pharmacotherapy in FEP are outlined in turn below.

Principle 1: Take side-effect profiles into consideration

The limited research available to date suggests that tolerability is greater for SGAs, in the case of first episode psychosis at least. Preliminary data from one study suggests SGAs as a class appear to have advantages over FGAs (in this case, haloperidol) with reference to discontinuation for any reason, discontinuation because of insufficient efficacy, discontinuation due to side-effects[317]. Some critics assert that this study's unblinded design renders its results less conclusive than might otherwise be the case, however all cause discontinuation is a more robust outcome in this regard than rating scale evaluations of efficacy. Both Emsley[307] and Sanger[312] suggested that the discontinuation rate due to adverse events (especially movement disorders) was higher for haloperidol than SGAs.

A recent meta-analysis found no difference between FGAs and SGAs in discontinuation rates or acute symptomatic effect, but that those taking SGAs gained on average an extra 2kg in comparison with those on FGAs, while the FGA group experienced significantly more extrapyramidal symptoms[324]. Given these differences, the tolerability of any antipsychotic will depend on its match with the client, especially its side-effect profile. Common side-effects such as sedation can occasionally be beneficial in the short term where sleep disturbance, agitation and anxiety are problematic. Whenever possible clinicians should take into account baseline factors such as weight, smoking, concurrent medical conditions, other medications the client takes, and symptom profile in the choice of antipsychotic medications. Psychoeducation for both client and carers with regard to possible benefits of medication and potential side-effects is important and may improve compliance. Involving the client in the decision making process if possible is good practice. Well-known side-effects for atypical antipsychotics current at the time of writing are outlined in Table 9.

Table 9: Side-effect profiles of commonly used antipsychotics

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 194.

Atypical antipsychotic	Severe side effects	Commonly reported side effects[a]	EPMS liability	Most common EPMS reported
Amisulpride	Elevated prolactin levels; can cause EPMS at higher dosage	Insomnia, anxiety	Low (at low dosage)	Akathisia
Aripiprazole	Can cause EPMS at higher dosage	Restlessness, sleep disturbance, anxiety	Low (at low dosage)	Tremor, akathisia
Clozapine	Weight gain; metabolic syndrome with possible diabetic complications; agranulocytosis; cardiovascular / respiratory arrest	Hypersalivation, sedation, cognitive deficits	Extremely low	Bradykinesia, akathisia
Olanzapine	Weight gain; metabolic syndrome with possible diabetic complications	Cognitive deficits, insomnia, anxiety	Very low	Tremor, subjective akathisia
Quetiapine	Moderate weight gain	Somnolence, dizziness, orthostatic hypotension (mostly in elderly)	Extremely low	Tremor, akathisia
Risperidone	Elevated prolactin levels, can cause EPMS at higher dosage; moderate weight gain	Headaches, insomnia, anxiety	Low (=4 mg/day)	Acute dystonia, parkinsonism, few cases of tardive dyskinesia
Ziprasidone	Prolongs QT interval	Somnolence, dizziness	Very low	Tremor, akathisia
Zotepine	Can cause electrocardiographic changes; moderate weight gain	Nausea, somnolence, dizziness	Low (at low dosage)	Acute dystonia, parkinsonism

EPMS, extrapyramidal motor system.

[a] All antipsychotic drugs are associated with hyperglycaemia and possible diabetes mellitus.

Principle 2: Treat psychiatric emergencies

Initial containment of aggression or agitation may be necessary before full assessment or engagement can occur. Humble and Berk[325] note this can be a 'watershed' event, when many clients first enter the psychiatric system and when their families gain their first impressions of the care this system can provide. For these reasons, the safe and respectful management of psychiatric emergencies is paramount.

Services often have their own policies for the treatment of psychiatric emergencies and such policies are subject to regular change and review. However, general principles do not vary. The goal of emergency management is to assure safety for clients and staff and to resolve the situation without harm and traumatic experiences[326].

First-line psychological and practical attempts at "de-escalation" of an aggressive/agitated client are strongly encouraged. This may include the use of "time out" or attempting to reduce a high stimulus situation and consideration of the most appropriate environment in inpatient settings.

If such strategies are not successful, then medication should be offered in order to reduce the symptoms as well as maintain the safety of the client and workers. A clear rationale of what the medication is targeting is important. Medication should not be used in a punitive manner and explanation of the rationale for the use of medication should be given to the client.

Oral medication should be offered in the first instance. Services often use a benzodiazepine and/or an antipsychotic as a pharmacological strategy. Dissolvable preparations are often used. There is limited data specifically in FEP populations, or in fact in psychosis more broadly (c.f., other psychiatric conditions such as Alzheimer's disease:[327]) but both medications appear to be efficacious in reducing agitation and aggression, with SGAs likely to be more effective than FGAs (e.g., Aleman & Kahn,[328]; for a review, see Humble & Berk,[325]).

Intra-muscular (IM) medication is occasionally necessary in emergency situations where oral medication is not accepted. As with general medication principles in this group, the lowest possible dose to treat the symptoms is advised and the use of multiple antipsychotics is discouraged.

The client should have regular medical monitoring following the IM injection. Recent data suggests IM olanzapine may have an advantage with respect to efficacy and tolerability over other IM SGAs[329]. The use of medium-acting IM injections should be limited to those individuals with severe ongoing psychotic symptoms and/or aggression who are not responding to current management strategies and may require multiple short-acting injections.

Debriefing for staff, clients and others (such as family, non clinical stuff) following such situations is also recommended and services should develop their own processes for this to occur appropriately.

Despite common practice, there is no evidence to date that benzodiazepines control symptoms of aggression and agitation better than antipsychotics (primarily FGAs) in schizophrenia apart from providing some short-term sedation (for a meta-analysis, see Volz et al.[330]). However, further research is clearly required, given that few studies to date comparing benzodiazepines and antipsychotics in psychiatric emergencies report usable data.

The theoretical advantage of benzodiazepines acutely is that they may allow patients to remain below the "neuroleptic threshold" at which aversive neurological events occur (see principle 4). This "neuroleptic sparing" aspect of benzodiazepines needs to be formally evaluated. However no data yet exist to illuminate this issue in the FEP field.

Principle 3: Distinguish between affective and non-affective psychosis

Given different treatment recommendations in the acute phase (especially the utility of adding a mood stabiliser to the pharmacotherapeutic regime), a key early distinction between affective and non-affective presentation must be made[331].

Principle 4: 'Start low, go slow'

People with FEP respond to antipsychotic medication more quickly and to a greater extent, and generally require lower doses to do so, than those with more established illness. Further, side-effects of antipsychotics are dose-dependent and are often caused by rapid titration. For these reasons, a 'start low, go slow' prescribing approach is warranted; use the lowest possible dose to treat symptoms.

Principle 5: Avoid antipsychotic polypharmacy

There is presently limited evidence to suggest an increased treatment response when combining antipsychotic medications in schizophrenia[332].

Combining antipsychotic medications also increases the risk of side-effects, non-adherence, and drug-drug interactions (e.g.[333]). The majority of guidelines for schizophrenia recommend against the use of more than one antipsychotic, except for possible augmentation with clozapine in treatment- resistant cases or when changing medication (e.g.[19, 334]). Although there have been no direct randomised controlled trials in FEP populations, the increased propensity for side-effects in this population would not support this practice.

Principle 6: Monitor adherence

Medication non-adherence appears particularly prevalent in FEP, as noted above. Although compliance therapy has been proposed as a way to manage noncompliance with a range of treatment interventions, there is insufficient evidence to date to suggest that it influences adherence with pharmacological treatment[335]. Although there is limited empirical research on this issue, alternative effective strategies for managing non-adherence may include employing problem-solving skills, direct instruction, and motivational interviewing approaches[281].

Principle 7: Monitor and manage adverse events and side-effects

Antipsychotic medication can cause side-effects which are distressing or disabling for clients, regardless of clinicians' objective assessment of side-effect severity[283]. Well known side-effects are outlined above, and their management discussed below. Validated self-report instruments of side-effects (e.g., Liverpool University Neuroleptic Side-Effect Rating Scale[336]) may be useful adjuncts to active enquiry regarding presence or absence of side-effects or concerns of clients, carers, or other staff.

Metabolic syndrome and diabetes

Antipsychotic medication is associated with a cluster of interrelated risk factors for developing type 2 diabetes and cardiovascular disease, known as metabolic syndrome[337]. The core components of metabolic syndrome are central obesity, hypertension, raised glucose and dyslipidaemia (see Table 10). Metabolic side-effects can develop quickly, are generally distressing, and have significant long-term medical consequences. Guidelines for detection and management of metabolic syndrome are outlined below. An alternative screening algorithm and an example of a monitoring regime is presented in Watterrus and Laugharne[337].

Table 10: International Diabetes Federation metabolic syndrome world-wide definition (Adult)

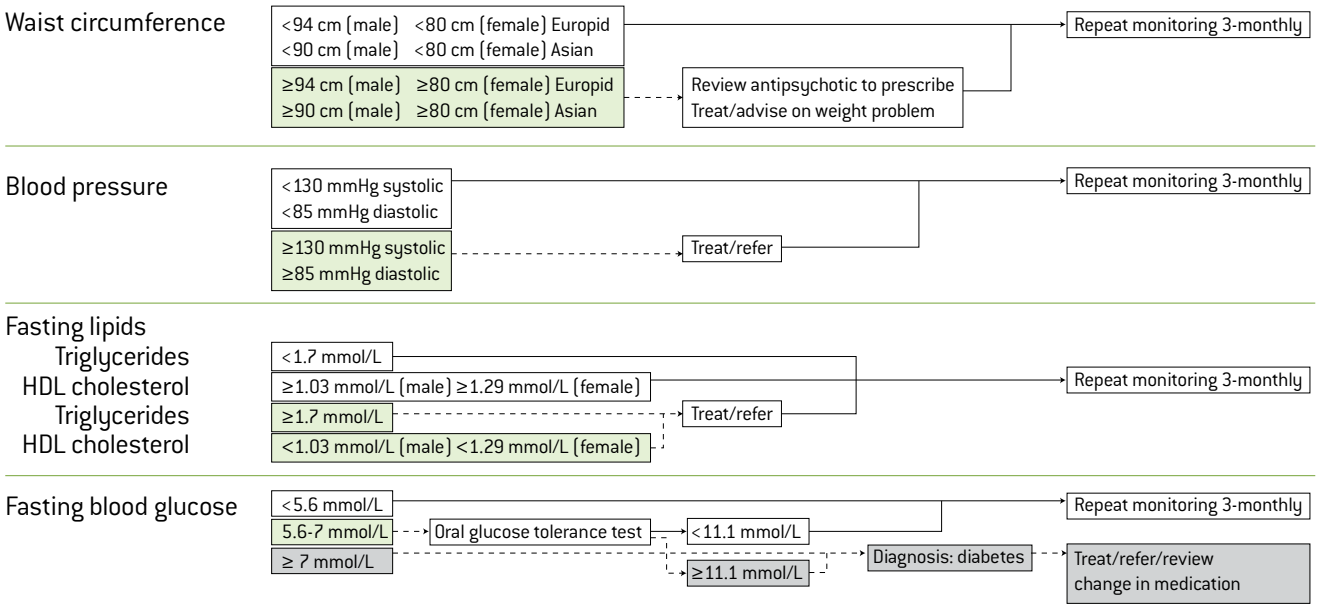
Central obesity	Waist circumference †–ethnicity specific plus any two of the following
Raised triglycerides	≥1.7 mmol/l (150 mg/dl) or specific treatment for this lipid abnormality
Reduced HDL-cholesterol	<1.03 mmol/l (40 mg/dl) in males <1.29 mmol/l (50 mg/dl) in females or specific treatment for this lipid abnormality
Raised blood pressure	Systolic:≥130 mmHG or diastolic: ≥85 mmHg or treatment of previously diagnosed hypertension
Raised fasting plasma glucose‡	Fasting plasma glucose ≥5.6 mmol/l (100 mg/dl) or previously diagnosed type 2 diabetes If >5.6 mmol/l or 100 mg/do, oral glucose tolerance test is strongly recommended but is not necessary to define presence of the syndrome

†If body mass index is > 30 kg/m^2 then central obesity can be assumed, and waist circumference does not need to be measured.

‡In clinical practice, impaired glucose tolerance is also acceptable, but all reports of the prevalence of the metabolic syndrome should use only the fasting plasma glucose and presence of previously diagnosed diabetes to assess this criterion. Prevalences also incorporating the 2-h glucose results can be added as supplementary findings.

Adapted from Alberti, Zimmett, & Shaw (2005) Metabolic syndrome: A new worldwide definition. Diabetic Medicine, 23, 469–480, p 475

Table 11: Clinical algorithm for monitoring the metabolic syndrome in people treated with antipsychotic medication from Waterreus, A. J., & Laugharne, J. D.



HDL= high-density lipoprotein.

[337] Waterreus, A. J et al. Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. MJA 2009; 190: p185-189. ©Copyright 2009. *The Medical Journal of Australia* – Reproduced with permission.

Box 7. Interventions to monitor and prevent metabolic side effects

Metabolic monitoring

Baseline

- Weight measures including weight, BMI and waist/hip circumference
- Blood pressure
- Fasting blood glucose
- Fasting blood lipid (full profile)
- Smoking status
- Exercise status

Monitor at 1, 3, 6, 12, and 18 months and then yearly

Interventions

- Dietary advice/exercise and lifestyle education and behavioural interventions (possibly with specialist dietician involvement)
- Consider change to less "metabologenic" antipsychotic medications
- Consider other pharmacotherapy e.g., statins with GP/ specialist input

Weight gain and obesity

Weight gain is a well-known side-effect of almost all antipsychotic drugs, with clozapine and olanzapine showing the greatest risk[338]. The maximal increase in body weight normally occurs after the first couple of months after initiation of treatment[339], with some data suggesting this plateaus over a time period between a few months and up to four years[340, 341]. Clients with a body mass index greater than 25 should be treated with medications with the least propensity to cause weight gain. Early identification and intervention in weight gain is also important, including considering change of pharmacotherapy. A recent systematic review and meta-analysis suggests that a range of psychosocial interventions – including group and individual treatment, and CBT and nutritional counselling – are effective in reducing or attenuating weight gain compared to treatment as usual[320]. Further management recommendations are outlined in Faulkner et al.[342] and Marder et al.[147].

Extrapyramidal motor symptoms (EPMS) and tardive dyskinesia

The risk of EPMS and tardive dyskinesia is generally low in the therapeutic dose range for atypical antipsychotic medication[343, 344], in contrast with conventional antipsychotics, for which the therapeutic dose and the dose required for the development of EPMS are similar[345]. Use of second-generation antipsychotics is therefore a key preventive strategy, as is early identification of motor side-effects by weekly assessment of acute EPMS and akathisia until medication dose is stabilised, and regular assessment of tardive dyskinesia (six monthly in the case of first generation antipsychotics and yearly in the case of second-generation medications)[147].

Endocrine and sexual side-effects

Sexual side-effects may be a particular issue for the FEP group, given the development of sexual identity during adolescence and early adulthood and the fact that sexuality can be more intertwined with the self construct at this age than at any other. Sexual side-effects are more common with conventional than most atypical medications[346]. If sexual symptoms occur, and are assessed as pharmacotherapy-related, dose reduction and/or antipsychotic switch is recommended[331].

Principle 7: Identify failure to respond but provide a sufficient period for treatment response and remission

Symptom response and remission can be defined in a number of ways, including via symptoms themselves (total score reduction of ≥ 20% on the PANSS or a reduction of ≥ 2 on the Clinical Global Impression Severity scale) or subjective wellbeing (≥20% increase in the Subjective Wellbeing Under Neuroleptic treatment Scale: Lambert et al.[347, 348]). Some researchers show symptoms will generally respond to treatment within six to eight weeks[345], 10-15% of FEP clients require sevent to ten weeks for symptom response or remission[349-351]. However, Lambert et al.[348] suggest that incomplete response within four weeks of treatment predicts non-response at three months, which in turn predicts incomplete remission at 24 months[347].

Given the difference between these suggestions, we propose that treatment non-response four weeks after commencement should be an alert for possible longer-term non-response, especially in combination with other factors that predict poor response, as outlined below and appropriate use of clinical judgement. Predictors of poor response include a GAF score ≤ 70 in the year prior to onset; highest level of schooling ≤ year 10; a current GAR score ≤ 30; male gender; and meeting friends no more than two or three times per month[352].

Principle 8: Treat comorbidities

As noted above, substance use and psychiatric comorbidity is common in FEP, and are likely to be a risk factor for incomplete remission and suicidal ideation or completion. Therefore treatment of comorbidities is important and should be determined by clinical judgement of the influence of the comorbidity both on the primary psychotic disorder but also on the individual's functioning and risk of harm to self or others. If the comorbidity is felt to be influencing the primary psychotic disorder assertive treatment of both is recommended.

Psychological therapies: CBT, supportive therapy, and 'befriending'

Cognitive-behavioural therapy (CBT) is the most widely-examined psychotherapeutic intervention for FEP. As in the UHR phase, CBT practitioners working with people with psychosis encourage the client to learn alternative ways of thinking about particular situations or experiences and to develop adaptive strategies for dealing with stressors[353, 354]. Most CBT interventions are specific either to phase of illness (e.g., acute/early recovery/prolonged recovery) or to specific issues (e.g., suicidality), and are outlined in relevant sections. Other models of psychological intervention have been applied without such phase-specificity (e.g., psychodynamic therapy; milieu therapy); these therapies are outlined in 3.3.1. Supportive therapy and befriending have also been used as 'control therapies' in the acute phase (as well as CBT for acute psychosis); as outlined below.

Although psychological therapies are generally confined to the recovery phase (c.f., Drury et al.[355, 356]), two studies have examined the role of CBT in the acute phase (the Study of Cognitive Realignment Therapy in Early Schizophrenia, or SoCRATES, study:[357, 358]; and the Active Cognitive Therapy for Early Psychosis, or ACE, project:[359]).

The model of the therapy used in SoCRATES is described elsewhere[360], but in summary, aimed for intense treatment during the acute phase (15-20 hours within a five week treatment period, with booster sessions at two weeks, and one, two, and three months). The stages of this therapy were:

- Engagement and detailed assessment of mental state and symptom dimensions, to enable a cognitive-behavioural case formulation. Engagement was facilitated by using the paradigm of the stress-vulnerability model to explain links between biological and psychological features of illness;
- Development of a problem list and prioritising of this according to associated distress;
- Intervention (especially for positive symptoms, by generating alternative hypotheses for abnormal beliefs and hallucinations, alleviating precipitating factors, and attempting to reduce distress associated with symptoms) and
- Monitoring.

An initial study examined the impact of this intervention over the very short term, in a sample of 315 people with FEP (83% of the sample) or second-episode psychotic disorder randomised to the intervention plus routine care, supportive counselling plus routine care, or routine care alone[358]. The nature of the supportive therapy was unclear, but appears to have followed similar guidelines to those used in Haddock et al.[357]. Supportive therapy in that study was non-directive and unstructured, with primary goals to provide clients with positive regard, emotional support, and social contact. These data found that those receiving the cognitive-behavioural intervention scored lower than those receiving routine care alone on positive and negative symptoms in general and positive symptoms and delusions in particular; and lower on auditory hallucinations than those receiving supportive counselling plus usual care. These effects were noted at four week follow-up but not at six week follow-up. At 18-month follow-up, there were significant advantages for CBT and supportive counselling over usual care on symptom measures, but not on relapse or rehospitalisation; there were no differences in the effectiveness of CBT and supportive counselling[361].

It seems, therefore, that provision of either supportive counselling or CBT during the acute phase can have immediate and long-term effects on symptoms, with CBT having additional effects in the immediate term.

The ACE project entailed the provision of cognitive therapy to young people in the acute phase of illness (within four weeks of acceptance into a first-episode service) in the form of a maximum of 20 sessions of therapy over 14 weeks. The therapy focused on a hierarchy of presenting problems such as risk, positive psychotic symptoms (if present and distressing), comorbidities, negative symptoms, issues of identity (using modules from the Cognitively Oriented Psychotherapy for Early Psychosis (COPE) intervention outlined below at 3.2.2), and relapse prevention. Further information is available in the ACE manual[362]. The control condition was 'befriending', an intervention that allowed for social contact but not emotional support, with a focus on 'pleasant chat' about neutral topics[359]. Published data from this trial suggest that, at mid-treatment, ACE outperformed the control condition of befriending with respect to functioning, but not symptomatology; however, at 12-month follow-up, there was no significant difference between the ACE and befriending groups, with the befriending group 'catching up' with respect to functioning. As in the SoCRATES trial, this data suggests that CBT may lead to better early recovery, but that other interventions (e.g., supportive therapy/befriending) may be of similar benefit later in the recovery process.

Recommendations

3.2.1.1	All clients should be seen by a doctor within 48 hours after entry to service. [GPP]
3.2.1.2	All clients should be seen by a consultant psychiatrist within one week after entry to service. [GPP]
3.2.1.3	All clients should be seen at least twice weekly in the acute phase by the acute treating team, or case manager, and a doctor. [GPP]
3.2.1.4	All families should be seen or contacted at least weekly in the acute phase by the acute treating team or case manager. [GPP]
3.2.1.5	Antipsychotic medication should not be used during the first 24/48 hours of treatment in young clients with a first episode of psychosis. [GPP]
3.2.1.6	SGAs should be used in preference to FGAs. [GPP]
3.2.1.7	Side-effect profile should guide choice of SGA. [GPP]
3.2.1.8	Affective and non-affective psychosis should be distinguished to enable appropriate treatment (i.e., appropriateness of use of a mood stabiliser). [GPP]
3.2.1.9	Pharmacological treatment should proceed with a 'start low, go slow' approach. [GPP]
3.2.1.10	Adherence should be monitored and explicitly addressed where necessary. [GPP]
3.2.1.11	Oral treatment should be used except in exceptional circumstances where other efforts to improve adherence have been unsuccessful. [GPP]
3.2.1.12	Benzodiazepines may be a useful short-term adjunct in florid psychosis for sedation. [A]
3.2.1.13	Potential side-effects (including metabolic side-effects, weight gain, extrapyramidal motor symptoms, and sexual side-effects) should be noted and discussed with clients prior to pharmacotherapy commencement, monitored, managed and addressed early, with a prevention model if possible (e.g., weight management strategies implemented prior to treatment initiation). [GPP]
3.2.1.14	Treatment of the primary psychotic disorder should be prioritised unless co-morbidity leads to high levels of risk to self/others or clinical judgement considers that the comorbidity has a major impact on the primary psychotic disorder (e.g. cannabis dependence). [GPP]
3.2.1.15	With the exception of the above situations, polypharmacy should be avoided, specifically the use of multiple antipsychotics. [GPP]
3.2.1.16	CBT [A], supportive therapy [B], or befriending [B] should be provided during the acute phase, with CBT having the most immediate benefit.

Guideline 3.2.2: Early recovery

Background

The focus of management during the recovery period is not only to treat symptoms (a necessary but insufficient criteria for recovery[101]), but also to:

- Manage comorbidity, including substance abuse;
- Engage the person in their own treatment;
- Increase adherence to treatment;
- Help the person understand their experience of illness;
- Assist the person in reconstructing and reorienting their lives (including helping them re-engage with educational or vocational activities);
- Provide the person with a sense of empowerment rather than passive acceptance of a withdrawn and disabled role[104];
- Prevent relapse; and
- Assist the person in developing resources for the future.

For some people a paced approach is appropriate, with one stressor or step tackled at a time in working towards realistic and achievable goals. Contact with the treating team may be less frequent than during the acute phase, but still needs to be regular.

Box 8: Essential features of the recovery process[18]:

Psychotic symptoms can subside relatively rapidly with medication, but in some cases this may take several months. The concept of 'relapse' is categorical (that is, relapse either occurs or does not occur) and is a poor way of describing the fluctuations in symptoms that can occur during recovery.

Recovery is a convalescent period of recuperation and readjustment.

Recovery is an active process for patients and families.

As part of recovery, patients should develop an understanding of what has happened to them, integrate the experience and restore self-esteem.

There may be a plateau in recovery when little appears to be happening. This may reflect a period when the person is struggling with subtle psychotic symptoms or has been depressed or 'shut down'.

For some people, a rapid return to their normal environment and responsibilities is helpful and may minimise stigma and inappropriate illness behaviour. For others, there is a risk of precipitating a second episode of psychosis if reintegration is too rapid. Predicting the best approach is difficult.

An insidious onset of illness and a long duration of untreated psychosis with a slow remission may suggest that a gentle reintegration is preferable. That being said, it is important to support the young person in pursuing their goals and not to take a patronising attitude of 'clinician knows best'.

Families and friends need to understand that this plateau is part of recovery; they need to keep the environment calm, positive and free of distress. Continuing their usual activities may help to alleviate pressure on the young person. Families and friends may also need support with this from the clinical team.

Adapted from Edwards, J. and P.D. McGorry, *Implementing early intervention in psychosis: a guide to establishing early psychosis services.* 2002, London: Martin Dunitz.

Box 9: Ensuring adequate response to treatment is enabled by adopting principles regarding frequency and type of contact during early recovery, such as:

- Clients to be seen by a case manager weekly during the early recovery phase
- Clients to be seen fortnightly by a doctor during the early recovery phase
- Families to be seen or contacted at least fortnightly during the early recovery phase
- Families to be seen with the case manager and client to ensure consensus regarding action plans

Medication

Many principles of medication management are outlined in 3.2.1. During the early recovery phase, frequent progress reviews are likely to assist in early identification and management of poor efficacy, poor tolerability, and problems with adherence. If adherence difficulties are pronounced during this phase, long-acting intramuscular injections may be indicated, consistent with the general preference in FEP for SGAs. In this instance, frequent risk-benefit monitoring is required.

Psychological therapies

At least three psychological interventions have been developed specifically examining recovery from FEP. The first, COPE, focuses on psychological impact of the psychotic disorder on the sense of self rather than symptom profile (c.f., studies focusing on positive symptoms and distress associated therewith, e.g.[363]). COPE consists of four phases, outlined below; further information on COPE is available in the COPE manual[364].

An RCT of this intervention (n=80) found that the COPE group scored better on adaptation to illness, quality of life, and insight, with lower scores for negative symptoms. However, medium-term advantages seem fairly circumscribed (at 12-month follow-up, limited to the degree to which the young person has integrated the psychotic experience or is using a 'sealing over' coping style:[365]) and there are no clear advantages over the provision of a specialist service only at four year follow-up[366].

Box 10: Phases of COPE

Engagement

Develop a therapeutic relationship

Assessment

Develop an understanding of the patient's explanation of disorder and of psychosis in general

Adaptation

Promote an adaptive style of recovery from psychosis, with a focus on helping the patient comprehend the vulnerability-stress model, reducing distress associated with altered self-perception post-psychosis and the possibility of ongoing vulnerability

Prevention and treatment of secondary morbidity

Prevention and management of secondary issues such as depression, anxiety, and stigma[367, 368]

A second intervention is described in Jolley et al.[369]. This intervention, focusing on the adjustment process rather than the acute phase of illness, includes emphases on:

- Processing experiences of psychosis;
- Making sense of these experiences with reference to a personal formulation of illness that is as non-stigmatising as possible;
- Coming to terms with loss and change as a function of illness, and generating realistic plans for the future that are also imbued with hope and optimism; and
- Preserving social, occupational, and education functioning or rapid re-engagement with these.

A very small RCT of this intervention (n = 21) found at six month follow-up that those who received it spent less time in hospital than those receiving treatment as usual.

More recently, Waldheter et al.[370] developed the Graduated Recovery Intervention Program (GRIP), an intervention that focuses specifically on three domains of recovery in FEP: symptom improvement, optimism and self-efficacy with respect to illness, and functional recovery (including meaningful relationships and academic/occupational functioning). With an overall focus on identifying and working towards personal goals to engender a sense of hope and optimism, and recruiting external supports to maximise engagement, GRIP comprises four phases:

- Engagement and wellness management (including psychoeducation, goal-setting, symptom management and relapse prevention, using strategies such as motivational interviewing and behavioural tailoring and identification of relapse signatures and triggers, with the development of coping strategies).
- Substance use (using motivational interviewing strategies).
- Persistent symptoms (covered in further detail in 'late recovery').
- Functional recovery (including social skills and social support, role functioning, recreational activity, and self-esteem/stigma, using external support agencies, social skills training, and activity scheduling, focusing on positive qualities).

All clients receive the first two phases of treatment (across 12 sessions), regarded as the "minimal effective dose' given they cover critical illness management issues. Clinicians and client collaboratively determine whether additional treatment is necessary and further treatment is then individually tailored to the client.

Only one non-randomised study to date has explored GRIP's effectiveness and suggests some clinical and psychosocial benefits, especially with respect to levels of positive symptoms and personal goal attainment comparing pre- and post-intervention for treatment completers. However, its non-randomised nature, absence of a control group, and very small sample size (n=10) militates against any conclusions regarding effectiveness.

Despite the paucity of evidence examining the appropriateness of psychological therapy in early recovery, it seems good clinical care to consider its delivery during this phase. It seems particularly appropriate to consider offering treatments that recognise the impact of illness on the sense of self, attempts to improve social and vocational functioning, and considers the possibility of relapse and plans for this (see 3.2.3 for further information on relapse).

Recommendations

3.2.2.1	Treatment response and adherence should be regularly reviewed. All clients should be seen at least weekly by a case manager and at least fortnightly by a doctor in the early recovery phase. [GPP]
3.2.2.2	All families should be seen or contacted at least fortnightly during the early recovery phase [GPP]
3.2.2.3	Early response to antipsychotic medication should be considered as a prognostic sign. [GPP]
3.2.2.4	CBT interventions may be indicated in this group, speeding up recovery, reducing the period of hospitalisation [D], enhancing short-term adaptation to illness [B], reducing positive symptoms [D], and improving personal goal attainment. [D]
3.2.2.5	The possibility of relapse should be discussed with clients and families along with education regarding early warning signs and the development of a 'relapse action' plan. [GPP]

Guideline 3.2.3: Relapse

Background

Psychotic symptoms will remit in most young people with a first episode of psychosis, but there is a high rate of subsequent relapse. Up to 90% of individuals achieve remission from symptoms in the first 12 months of treatment[132, 136], but 70-80% experience a relapse within three to five years[134, 315, 371]. Relapse can range from mild to severe, and the severity of symptoms can fluctuate. Given these high rates of relapse in FEP, it is important to avoid the risk of providing unrealistic reassurance regarding prognosis for fear of being pessimistic or affecting client and carer hope. Instead, the client and family should be prepared for risks ahead, while monitoring levels of anxiety, hopelessness, or denial of risk[372].

A number of factors may increase the risk of a young person experiencing a relapse[372]. Assessment of such factors and a formulation of relapse risk can guide future treatment. There are benefits in educating the young person, family and carers to recognise early warnings signs of relapse and to develop strategies to respond[254].

Medication

A recent meta-analysis outlines the evidence for pharmacological strategies in preventing and treating relapse in FEP[323]. This review proposes that some limited data suggests that FGAs may be more effective than placebo in preventing relapse in FEP. There have been no studies testing the effectiveness of SGAs vs placebo in relapse prevention. Exploratory pooled analysis suggests that SGAs as a class (but not individual SGAs to date) may be more effective than FGAs in preventing relapse; this requires further replication and confirmation.

Psychological interventions

Relapse is almost always preceded by non-psychotic symptoms such as anxiety and depression and low-level psychotic symptoms (see Gumley et al.,[374] for a review). The modal period in which changes in cognition, emotion and perception transform into psychotic symptoms is four weeks[375]. Primary prevention of relapse involves intervention during this period, while secondary prevention includes early identification of, and intervention for, relapse once symptoms have passed an established psychosis threshold[375]. Families as well as clients may assist in early identification of risk factors for relapse.

First episode programs prevent relapse to a greater degree than treatment as usual (TAU)[323]. Individual cognitive-behavioural interventions without a specific relapse prevention focus may not show additional benefits over FEP programs, or supportive counselling or TAU. However, one study[373] combined individual and family interventions (the former implemented fortnightly over a seven month period and including intervention strategies below; the latter including the above where relevant and assessment of family burden and coping, and more intensive communication skills training and problem solving where indicated).

This study reported that, at the cessation of the intervention, relapse rates were lower and time to relapse was longer for those receiving the intervention compared to those receiving treatment as usual. Data suggests that this intervention may be of even more benefit than specialist FEP services[323].

However, long-term effectiveness remains to be established. Only two studies have examined the effectiveness of family interventions alone in the FEP group, with inconsistent results; one study showed positive effects utilising a combined group-individual intervention over an 18-month period[376], while the other was a seven-session psychoeducation intervention and demonstrated no additive effect[377], suggesting longer family interventions may be required to prevent relapse in those with FEP.

Recommendations

3.2.3.1	Medication should be recommenced or increased at early signs of relapse. GPP
3.2.3.2	The advantages of maintenance antipsychotic therapy in relapse prevention should be weighed against any impact of side-effects on functioning. GPP
3.2.3.3	Relapse prevention strategies (including more regular review and provision of information about rapid access to care) are particularly indicated if medication dosages are decreased or medication ceased. GPP
3.2.3.4	Combined family and individual CBT specifically focusing on preventing relapse should be used B
3.2.3.5	Family interventions alone may be helpful in preventing relapse in FEP.C

Note: 5

Psychological relapse prevention strategies may include:

- Developing a shared, written formulation regarding relapse risk
- Developing an awareness of risk factors for relapse and how to minimise or manage them
- Identifying a relapse signature of early warning signs for relapse (from client and family) and developing a relapse plan
- Treatment of comorbid substance use and psychiatric disorders and managing non-adherence to treatment
- Parallel individual and family intervention focused on relapse prevention (given links in people with more chronic illness between EE and patient outcome)
- Supervision specifically focusing on relapse issues (see Gleeson et al.,[373] for further details)
- Family interventions

Guideline 3.2.4: Late/problematic recovery, medication discontinuation, and discharge

Background

Those likely to have a problematic recovery can often be identified as early as three to six months after an acute episode[18]. Predictors of prolonged recovery include a long duration of untreated psychosis[378], a diagnosis of schizophrenia[379], and poor premorbid psychosocial functioning in childhood and adolescence[380]. This group must be distinguished from those who been not been adequately treated with first-line pharmacological and psychosocial interventions. A key implication of the DUP literature is that problematic or incomplete recovery should be identified and managed early.

Note: 6

Early identification of problematic recovery and relapse can be facilitated by:

- Review by the treating team every three months after entry to the service
- Fortnightly contact between the case manager and the patient during late recovery
- Monthly contact between the doctor and patient during late recovery
- Monthly contact between the case manager and family during late recovery

Some data suggest a positive relationship between length of the recovery process and familial distress (e.g.,[381, 382]). These families may therefore have a particularly strong need for supportive and other interventions.

Discharge and closure planning are integral components of the late recovery phase. Timing of the cessation of treatment will be influenced by factors including the level of remission, the duration of untreated psychosis, whether positive symptoms are persisting, comorbid substance misuse, ongoing stressful life circumstances, and the level of functioning in a normal living situation[18]. Linkages should be established for the young person with a local GP, private psychiatrist or area mental health service, and social and vocational services.

The box below outlines minimum standards relating to referral to new treating teams post-discharge.

Note: 7

Liaison with new treating teams should include:

- Contact at least two months prior to discharge to discuss referral
- Sending of a discharge summary in a timely fashion

Note: 8

Support provided to patients and families at discharge can include:

- Discussing discharge at least three months before it occurs
- Providing patients and families with a 'discharge pack' outlining sources of future support
- A joint handover with new treatment providers

Medication for problematic recovery and withdrawal of medication

No published papers have addressed the issue of pharmacotherapy for problematic recovery in the FEP area. However, guidelines for incomplete recovery in schizophrenia (including the Texas Medication Algorithm Project[383]; and the PORT group[384]) have received widespread acceptance. The early introduction of clozapine may need to be considered in response to trials of at least two different antipsychotic agents, at least one of which is an SGA[385-388], given clozapine's specific efficacy in treating resistant positive symptoms[389] and its impact on negative symptoms[390]; a recent meta-analysis found that clozapine is the most effective antipsychotic for treatment resistance at present[391]. Although response to clozapine should emerge within eight weeks of reaching therapeutic dose, a trial of six months is recommended[281]. There is limited empirical evidence beyond case reports on pharmacological strategies should clozapine be unsuccessful in managing incomplete recovery in the FEP phase[281]. Low-dose (100-300mg) amilsupride may be beneficial for negative symptoms[392, 393].

The process of withdrawing medication must be carried out slowly (over a number of months) and with careful monitoring that extends for several months after medication ceases. There is no clear evidence in FEP as to the period of time following remission that an individual should stay on an antipsychotic medication.

The 'critical period' hypothesis would suggest that for some clients, a conservative approach of maintenance treatment over the three to five year period of vulnerability to relapse and suicide may be appropriate.

There has, however, been limited empirical exploration of this issue. Robinson et al's[137] five year follow-up of people with first-episode schizophrenia showed that relapse rates rose quickly to 51% over the first two years after index admission, and then plateaued to a certain extent, reaching 78% by five years. This suggests that treatment periods should possibly extend at least over the first two years of illness. Wunderink et al.[394], in a study comparing guided discontinuation and maintenance treatment with low-dose antipsychotics six months post-recovery, found that the relapse rate in the maintenance treatment group was half that of the guided discontinuation group (43% vs. 21%). Only 20% successfully discontinued treatment in the discontinuation group, with recurrent symptoms prompting reinstatement of medication in 30%, with the remainder unable to be discontinued at all. No differences emerged between maintenance treatment and discontinuation with respect to days in hospital or social functioning. This suggests maintenance treatment as the rule of thumb if remission has been achieved for six months or less; at least one year following remission would be recommended on current practice and previous placebo controlled studies[395] although some experts would suggest a longer period of treatment given high rates of symptom re-emergence up to two years post-cessation of treatment[396], even after a year of maintenance medication (e.g.,[397]). Guided discontinuation six months post-recovery (with close monitoring) may however be successful in the minority of cases. Initial response to treatment, diagnosis (affective/non affective psychosis), the impact of antipsychotic side-effects on functioning, and good and bad prognostic factors (such as long DUP and poor premorbid functioning) cited in this document should also guide this decision.

Psychological interventions

Few interventions have been specifically designed for those with FEP who experience prolonged recovery. Edwards and colleagues have developed an intervention (Systematic Treatment of Persistent Psychosis, or STOPP therapy) to address prolonged recovery in the FEP group[398].

This intervention includes four phases:

1 Developing a collaborative working relationship,

2 Exploring and coping with psychosis (including discussing the client's subjective response to psychosis and increasing the client's knowledge, considering and implementing strategies to manage and treat symptoms, and learning to tolerate the emotionality associated with managing psychotic phenomena);

3 Strengthening the capacity to relate to others (with themes of increasing the client's sense of integration by developing awareness of personal strengths, the client's capacity to interact with others by questioning psychotic beliefs of others); and

4 Finishing and moving on.

Preliminary data suggests a negative relationship between the number of sessions of STOPP received and negative symptoms.

The GRIP intervention outlined above also contains a phase focusing on persistent symptoms, with the goal to reduce distress and/or impairment caused by these. The specific interventions employed depend on the symptom domain, as outlined at right. These interventions draw on interventions developed for people with more chronic psychotic disorder (e.g.,[353, 354, 361, 399, 400]). Again, however, there are limited empirical data on the effectiveness of these interventions in the FEP group.

Note: 9

Possible interventions for persistent symptoms: the GRIP approach[370]

Delusions

- Increasing cognitive flexibility through generating alternative explanations
- Engaging in behavioural experiments to evaluate the veracity of one's beliefs
- Examining the internal consistency of beliefs

Auditory hallucinations

- Enhancing coping strategies (e.g., managing antecedents differently)
- Modifying interpretations of voices
- Behavioural experiments

Negative symptoms

- Targeting consequences of these, such as low activity and social withdrawal, through behavioural activation and cognitive restructuring

Recommendations

3.2.4.1	All clients should be seen at least fortnightly by a case manager, and at least monthly by a doctor, during the late recovery phase [GPP]
3.2.4.2	All families should be seen or contacted at least every two months by the treating team during the late recovery phase
3.2.4.3	People with persisting positive or negative symptoms should be identified early. [GPP]
3.2.4.4	Clozapine should be considered for those who have not responded to adequate trials of two antipsychotic medications, of which one is a SGA.[A]
3.2.4.5	If a satisfactory response occurs, treatment should be continued for at least two years. [GPP]
3.2.4.6	CBT should be considered as an adjunctive therapy during late/problematic recovery. [GPP]
3.2.4.7	All families should be seen or contacted at least every two months by the treating team during the late recovery phase [GPP]
3.2.4.8	Families of young people with a slow or difficult recovery or frequent relapses may benefit from more intensive and structured interventions, emphasising problem solving and communication skills. [GPP]
3.2.4.9	Support should be provided to the young person and their family specifically around the discharge process. [GPP]
3.2.4.10	The treating team should assertively liaise with ongoing treatment providers prior to and during the discharge process. [GPP]
3.2.4.11	All young people should be linked in with a GP on discharge. [GPP]

Guideline 3.3: General principles regardless of FEP stage

Integrated, stand-alone treatment in FEP

As noted above, integrated interventions refer to the collaborative provision of biological and psychological interventions, along with assertive case management and other psychosocial interventions (such as vocational or group interventions). Six European centres have conducted randomised controlled trials to evaluate the effectiveness of specialist first episode psychosis (FEP) services. In addition to the pre-onset study, the OPUS trial in Denmark randomly assigned 547 FEP clients to either an integrated treatment in which they were provided with two years of enhanced service, or to standard treatment[401]. The integrated treatment was more intense and assertive (caseload 1:10) and covered additional domains such as family therapy and social skills training. The more assertive nature of the early intervention model is seen in the fact that clients in the integrated treatment had an average of 77 contacts over the two year study compared to 27 in the standard treatment group, which additionally had a higher caseload (1:25). The results indicated that the integrated treatment had beneficial effects on symptomatic and functional outcome at one and two year follow-up[401, 402], as well as a perceived reduction in family burden[403].

At five year follow-up, those receiving the intervention package were less likely to be living in supported housing and had been hospitalised for fewer days, but otherwise there was no difference between integrated and standard treatment[8].

This suggests that early intervention may need to be sustained to be effective. The second trial was the Lambeth Early Onset (LEO) trial in England[2]. The LEO trial randomised FEP clients (or clients experiencing a second episode of psychosis where there had been failure to engage previously) to receive either treatment from standard services, or from an early intervention service. The results demonstrated a beneficial effect of early intervention on hospital re-admissions, relapses and drop-outs. The early intervention group were also more adherent to medication, spent more time engaged in educational or vocational pursuits, and established or re-established relationships better than those receiving standard treatment[404].

In other words, the LEO trial showed that early psychosis intervention systems can produce gains in clinical, functional and social recovery, although there are some difficulties in drawing firm conclusions given the relatively modest sample size. More substantial improvement in vocational recovery however remains a critical frontier in early psychosis intervention.

In Norway, Gråwe et al.[405] reported on an integrated treatment that included pharmacotherapy, case management, structured family psychoeducation, family communication and problem-solving skills within a CBT framework, home-based intensive crisis management, and individual CBT for residual symptoms and disability. This integrated care demonstrated a greater impact than standard treatment on negative symptoms, 'minor' psychotic episodes, and positive symptoms, but not on hospital admissions or 'major' psychotic episodes.

In Sweden, the Parachute Project[305] compared an integrated treatment approach (including structured crisis intervention, lowest optimal doses of neuroleptics, recurrent family meetings, cognitive therapy, and access to low-stimulus overnight care) with a historical and a prospective control group. The intervention group used fewer inpatient bed days than both control groups and received lower neuroleptic doses than the historical control group, and functioning was higher at 12-month follow-up in the intervention group compared with the historical control group.

In a study based in Bedfordshire, Agius et al.[406] reported that an integrated treatment approach (including an assertive follow-up model, structured psychoeducation, relapse prevention and other psychosocial interventions, and use of atypical antipsychotics at the lowest dose possible) was associated with, among other things, higher functioning, lower levels of depression and lower rates of involuntary treatment, relapse and rehospitalisation than those receiving standard care. Data were however based only on clinical notes, mitigating the empirical validity of the study.

In contrast to these findings, Kuipers et al.[407] evaluated a South London early intervention service which offered an integrated treatment including atypical antipsychotics, psychological interventions (individual CBT and, if appropriate, family intervention), and vocational and other assistance as needed. They reported that the integrated treatment had no demonstrably greater effect on client outcome than standard treatment.

As it stands, therefore, integrated treatment approaches appear to be more effective than standard care in the short-term treatment of early psychosis, although their efficacy in the medium term is less settled.

There are at least two ways of implementing integrated early intervention services: as a specialist, stand-alone model; and a partial model, in which early intervention specialists are situated within existing service structures. The relative advantages and disadvantages of each model have not been explored in any significant detail. Recent British data using historical control as comparison suggests an advantage of the stand-alone model over a partial model with respect to days admitted to hospital and functional recovery over both one- and two-year follow-up, with the partial model demonstrating some superiority with respect to functional gains to a generic approach in which there was no specialist early intervention involvement[408].

Miscellaneous psychological therapies

There has been less specificity with respect to phase of intervention in other psychological therapies than in CBT. Other psychological interventions have included cognitive remediation therapy; milieu therapy; psychodynamic therapy; and family therapy. The latter is outlined in a later section about family involvement and therapy (Guideline 3.4.3), while the former three are discussed below.

Cognitive remediation therapy

Cognitive remediation therapy specifically addresses cognitive deficits often seen in psychotic disorders by teaching information processing strategies through guided exercises. Wykes et al.[409] found in a single-blind randomised controlled trial in a group of young people with 'recent onset schizophrenia' that CRT delivered over three months, with at least three sessions per week, was associated with improved cognitive flexibility to a greater extent than treatment as usual; improved cognitive flexibility was associated with better clinical and functional outcome. In contrast, however, Ueland and Rund[410, 411] detected very few differences in clinical or cognitive outcome between those provided with cognitive remediation plus psychoeducation, and those provided with psychoeducation alone.

Milieu therapy

Milieu therapy[412] focuses on therapeutically designing everyday interactions and events in inpatient therapeutic communities to build social skills and confidence, generally in the absence of medication. Bola and Mosher[303] examined the impact of milieu therapy on a group of young people newly diagnosed with schizophrenia, and found that completing milieu therapy conferred greater advantages at two year follow-up than engaging in treatment as usual with respect to psychopathology, and those in the milieu therapy condition were less likely to be prescribed antipsychotic medication. Given the extended inpatient context of this model, however, its practical applicability is likely questionable.

Psychodynamic therapy

There is some evidence for the effectiveness of supportive psychodynamic therapy in treating FEP. The Danish National Schizophrenia Project reported that both an integrated treatment group (part of the OPUS trial: see below) and supportive psychodynamic group therapy (receiving one 45-minute session per week for one to three years) improved to a greater extent in social functioning and negative symptoms than a treatment as usual group[413]. Methodological flaws and other considerations mean that this model may not, however, be feasible or justified in the Australian context.

In summary, there is some, although equivocal, evidence for cognitive remediation therapy; there is also some limited support for milieu therapy and supportive psychodynamic therapy.

Recommendations

3.3.1	Integrated specialist services are more effective than standard services in the treatment of people with FEP.[A]
3.3.2	Milieu therapy [C], supportive psychodynamic therapy [C], and cognitive remediation therapy [D] may be useful in treating symptoms and/or improving functioning in FEP.

Guideline 3.4: General principles related to treatment in early intervention for psychotic disorders

Some key principles apply regardless of phase of psychotic illness (the UHR phase, acute psychosis, early recovery, relapse, or late/problematic recovery). Many of these reflect good clinical practice with clients of mental health services generally or young people more particularly; some do, however, have a strong evidence base, hence the incorporation of these more general principles in this document.

Box 11: Relevant principles across all phases of psychosis

Engagement

Least restrictive treatment

Family involvement

Case management

Goals as guides to treatment

Group programs

Psychoeducation

Vocational and educational services

Suicide prevention

Treatment of substance use comorbidity

Treatment of psychiatric comorbidity

Consumer participation

Carer participation

Guideline 3.4.1: The importance of engagement

The engagement phase is crucial in all forms of psychiatric treatment, with the strength of the therapeutic alliance a moderate-to-strong predictor of outcome, regardless of therapeutic approach[414], including with young people[415]. Effective engagement at the time of the initial assessment can expedite the formation of a therapeutic alliance. General psychotherapeutic skills enable the clinician to gain a better understanding of the young person and, in conjunction with medication, form the foundation for more specific recovery promoting strategies.

Recommendations

3.3.4.1	Engagement should be prioritised as the foundation of treatment. [GPP]

Note: 10

Enhancing engagement

Communicate to clients they are being listened to and treated seriously

Offer practical help

Prioritise working with the client's primary worry and source of distress

Be flexible with timing and location of treatment as far as possible

Explain the process of treatment

Provide information and education about symptoms

Work with family members if indicated

Set goals collaboratively

(Phillips & Francey[290])

Guideline 3.4.2: Least restrictive treatment

Background

Choice of treatment setting is an important element in the management of people with psychiatric illness. This is particularly salient in the instance of early psychosis, given that restrictive treatment mechanisms may imperil engagement with services for some time to come, with the likely outcome being a poorer prognosis. Further, involuntary treatment and hospitalisation may be appraised as a particularly powerful stressor, and serve as a catalyst for the development of post-traumatic stress disorder symptoms[167, 416], although psychotic symptoms themselves are likely to be more traumatic than the treatment for these[417, 418]. Minimising the trauma of both symptoms and the way in which these are treated should be an important consideration. Additionally, treatment in an unfamiliar environment may hinder recovery by inhibiting the degree to which skills learned during treatment are generalisable to the individual's normal environment.

For all of these reasons, treatment at home is optimal. The choice of setting should be based on the severity of presentation, the assessed level of risk, and the extent and quality of social and family support. Home treatment is likely to be most appropriate for those with social support and, in the case of FEP, a shorter DUP[419]. Specialist teams, rather than generic crisis teams, may be in the best position to prevent admission[420].

When hospital admission is necessary, clinical experience suggests it is not appropriate to admit younger adolescents to adult facilities that are dominated by clients with long-term mental illness. When hospital admission is necessary but the facility is not considered appropriate, an adolescent or youth specialist should be involved in the person's care.

Recommendations

3.4.2.1	Young people should receive treatment in the least restrictive manner possible. Whenever possible, the location of the initial assessment should be community-based and at a place that is convenient to the young person and their family. GPP
3.4.2.2	A range of treatment settings should be available to the young person, including home based support, supported accommodation, rooming in, outpatient services, and inpatient care. GPP
3.4.2.3	The levels of risk (to self and others), the available resources (including community support) and the needs of the client and family should be assessed to determine whether the young person can be managed at home. GPP
3.4.2.4	Where hospitalisation is required, the young person should be admitted to a facility that can cater for, and is appropriate to, the young person's age and stage of illness. Where streaming is not possible, a special section may be created in a general acute unit for young recent-onset clients. GPP
3.4.2.5	Community Treatment Orders should be used for the minimum duration required to meet specified treatment goals. GPP
3.4.2.6	Involvement of police to enforce treatment should be kept to a minimum and used as a last resort in the case of immediate risk. GPP
3.4.2.7	The use of seclusion (if used at all) should be kept to the minimum frequency and duration to meet the treatment aims when managing high risk clients. GPP

Guideline 3.4.3: Family involvement

Background

For the purposes of these guidelines, 'family' is used in a broad sense to include parents, siblings, partners, carers, extended family members and close friends. This section refers specifically to family involvement in the young person's treatment and the provision of supportive and other interventions to families; families' contribution to service development is outlined in Guideline 3.4.13, Carer Participation.

Note: 11

Specific issues for families in early psychosis

The heightened emotional impact of a young person experiencing difficulties for the first time, possibly maximised if the family's pathway to receiving appropriate psychiatric assistance was not straightforward

The special needs for information and education as families:

- *Deal with possibly severe psychiatric illness for the first time*
- *Cope with diagnostic ambiguity and variable outcome*
- *Are faced with unfamiliar and often bewildering symptoms*

Psychosis (both emergent and established) can have an enormous impact on the family system, as it can lead to bewilderment, fear, grief and suffering for both the person with the illness and their families[421-423]. This may particularly be the case with early psychosis, as most young people are living with their families when psychosis begins[421, 424]. Family members can experience stigma, embarrassment, isolation, loss of mastery and control, decreased self-worth, and disruption to educational and/or vocational trajectories[425]. Very few studies have evaluated the emotional impact of early psychosis on families, but some studies suggest onset of psychosis is a particularly distressing time for families[426, 427].

Families may play a vital role in supporting the young person and facilitating engagement in treatment, thereby minimising lengths of hospitalisation[428] and possibly preventing first psychotic relapse[144]. The combined aims of alleviating distress in families and maximizing client prognosis suggests the importance of the provision of support to families.

Family work should be developed within a collaborative framework, in which the clinician works in partnership with the family. The family should be promoted as active members of the treatment team. The aims of family interventions are to minimise the disruption to the life of the family and the risk of acute stress, high levels of burden and long-term grief, and to maximise the adaptive functioning of the family.

Family work should be flexible and tailored to the needs of each individual family. It should empower the family to cope and adjust to the crisis of the psychotic illness. The underlying assumption should be that the family is no different to any other in their response to crisis and their ability to solve problems. Interventions are therefore aimed at promoting coping skills, support and education rather than addressing 'dysfunction'. Given the equivocal evidence to date linking expressed emotion (EE; an interactional style characterized by criticism, hostility, and/or emotional over involvement) and outcome in early psychosis, and the absence of any demonstrated link between EE and outcome in the UHR group (for a review, see[429]; see also[430]), it is not clear that family interventions in this group should include an EE component.

A range of interventions have been employed with families in the FEP empirical literature, including therapies with an emphasis on psychoeducation alone (offered individually or in multifamily groups), to broader interventions including a focus on early warning signs, stress management, problem solving skills, affect regulation, attributing maladaptive behaviour to illness, communication skills training, and reduction of high EE (see McNab and Linszen[429] for further details on empirically-explored family interventions in FEP). It is therefore difficult to identify which components of family interventions are key. Further, these interventions sometimes have little impact on client outcome (e.g.,[431]) or paradoxically appear to be associated with worse client outcome[432]. Additional methodological problems with this evidence preclude any firm conclusions being made about the efficacy of these interventions. There is no evidence to date exploring the efficacy of family interventions in the UHR stage. The evidence base for family intervention in the pre-onset and FEP stages is therefore not established; however, there are compelling reasons for this to be regarded as good clinical care, including the need to support those who are supporting clients, and the likelihood that, consistent with the diathesis-stress model more broadly, at least some part of the family environment (although perhaps not yet examined empirically yet) will influence client progress.

On a more general level, the initial stages of family intervention may need to deal with feelings of guilt, anger, sadness and loss, and the first contact with the family often functions as a debriefing session. It also provides an opportunity to explain mental health services and the benefits of the family's support. Targets of intervention include the impact on the family system, the impact on the family members, and the interaction between the family and the course of the psychosis. Emotional and practical support can assist this process. Responses to pre-existing problems within the family should be guided by general crisis intervention principles. Guidelines for working with families are presented below.

Box 12: General principles for working with families with an early psychosis member

Recognise the phase nature of the patient's illness, and that family work needs to be adaptable and flexible in approach.

Recognise that families will have a range of different feelings, worries and questions.

Recognise that families need time and an opportunity to deal with the crisis and ensuing stressors.

Recognise that the explanations that families have for what has happened to them need to be heard and understood.

Recognise that families need a framework for understanding.

Recognise that families also need a recovery time and may go through particular stages.

Recognise that the family work may change over time, ranging from a maintenance role to dealing with longer-term, ongoing issues.

Recognise that family work is a preventive intervention. It is aimed at addressing levels of distress, burden, coping, social functioning and general health for all family members.

Adapted from Gleeson, J., et al., *Family intervention in early psychosis*, in *The recognition and management of early psychosis: a preventive approach*, P.D. McGorry and H.J. Jackson, Editors. 1999, Cambridge University Press: Cambridge. p. 376-406.[433]

In implementing the following guidelines, it is important to respect the young person's right to confidentiality while providing support and information to the family. This can be a particularly fraught area with young people; their rights to confidentiality may not be well understood by family, and the limits of this right may not be well understood by clients and clinicians.

Guidelines written by Rethink **http://www.rethink.org/about_mental_illness/talking_to_doctors/confidentiality.html** and the Institute of Psychiatry **http://www.mentalhealthcare.org.uk/content/?id=45** regarding confidentiality may be useful to provide to clients, carers and clinicians. Although empirical evidence is lacking, anecdotally it is in these instances that family peer support workers – family members of clients who have been through a clinical service before – may be particularly helpful. These workers can provide assistance and reassurance to families, having experienced the process of caring for a young person with emerging psychotic illness. This approach may be more acceptable to young people than clinicians having contact with family, given concerns about possible confidentiality breach. Such workers are not part of the clinical team, so do not have access to confidential client information.

For further details about how such a scheme might operate, see Leggatt[423]; for example, EPPIC guidelines propose that all families should have access to a family peer support worker, perhaps even despite client objection, except in exceptional circumstances (such as the unawareness of the family of the client's involvement with services, or longstanding familial abuse).

Note: 12

Supporting families requires having regular contact with them. Needs for contact are likely to vary across phase of illness. Suggestions about frequency of contact according to phase of illness are outlined in each specific phase.

Recommendations

3.4.3.1	The needs of individual family members should be recognised and addressed (where appropriate, within clinical services, or alternatively, by referral to external agencies) at all stages of the young person's recovery. GPP
3.4.3.2	The case manager should have frequent contact relevant to the phase of illness and the needs of the young person and family. GPP
3.4.3.3	Family attendance and involvement should be reviewed as part of the clinical review process. GPP
3.4.3.4	The treating clinician should assist the family by providing information about psychotic disorders (including the recovery process); and by helping the family, where necessary, develop skills in problem solving and enhanced coping strategies. GPP
3.4.3.5	The treating clinician should maximise the responsiveness of the family to early warning signs in order to facilitate relapse prevention. GPP
3.4.3.6	Where necessary, the clinician should prepare the family to deal with crises. GPP
3.4.3.7	Peer family support workers may be a useful resource for information and emotional support, particularly in situations when the young person does not wish the involvement of their family and carers. GPP
3.4.3.8	Families with more complex needs, such as those with a history of sexual and/or other abuse or long-standing emotional conflict, may need to be referred to specialist agencies. GPP

Guideline 3.4.4: Case management

Background

Case management developed out of the deinstitutionalisation movement, which led to an associated increase in the need for community resources to assist people with psychiatric illness. Case management in general aims to assist clients navigate the complex elements of psychiatric care. This extends beyond 'formal' psychiatric treatment to other needs, such as accommodation, food, and employment, physical treatment, and broader needs, including family and social relationships, leisure activities, and spiritual needs[434]. Assertive community treatment, typified by, amongst other things, low caseloads, team caseworking, in vivo treatment, assertive engagement, and frequent contact, is the model of case management with the best evidence, reducing lengths of admission, improving engagement with services, independent living skills, compliance with medication, and client satisfaction[435-437]. There is some evidence to suggest that assertive case management may benefit those with early psychosis more than those with long-term schizophrenia, although methodological problems with this research mean it needs to be replicated before firm evidence-based recommendations can be made[438].

The goal of the case manager or treating clinician in early psychosis in particular is to promote recovery and to prevent relapse and ongoing disability. This can be achieved through assisting the young person and the family to understand psychosis and to develop resources that will assist them in the future. The case manager is expected to have a thorough knowledge of psychopathology and to have psychotherapeutic expertise; the case manager is the key psychotherapeutic contact and should use a case formulation, developed in concert with the rest of the treating team, to guide treatment. The case manager provides a point of service accountability, and works in partnership with the psychiatrist, who has key clinical accountability. Case managers are also responsible for continuity of care. They should also have links with other specialist providers, as well as existing mental health and community services, being able to utilise them as needed in response to the young person's needs.

Recommendations

3.4.4.1	The case manager or treating clinician coordinates the treatment and care of the young person throughout the episode of care. GPP
3.4.4.2	The case manager should be present at the client's doctor appointments to ensure continuity of care. GPP
3.4.4.3	A case formulation, including provisional diagnosis and management plan, should be completed by the case manager and/or treating team within six weeks of discharge from acute treatment. GPP
3.4.4.4	The case manager should facilitate the person's access to necessary accommodation, vocational, recreational, welfare and primary health services. GPP
3.4.4.5	The case manager should regularly consult with the client's GP, and at least every six months. GPP

Guideline 3.4.5: Goals as guides to treatment

Background

Treatment goals are key reference points for assessing client progress and treatment effectiveness[439], and have been found to have positive effects on both client motivation and outcome[440, 441]. More recent policy initiatives have placed a greater emphasis on collaborative goal-setting, increasing the active participation of consumers in the planning and implementation of their own treatment. In contrast to the model of clinician as 'expert' and client as 'passive recipient', collaborative treatment planning aims to empower clients in their own recovery[442].

The most frequent operationalisation of collaborative treatment planning is the Individual Service Plan, an agreement between a client and the case manager (as a representative of the service) about diagnosis, goals for treatment and how these might be achieved. They may detail:

- The major problems
- Treatment goals
- Strategies to achieve goals
- People involved and their responsibilities
- Time frames for achieving or reviewing goals

Note: 13

Regular review of patient treatment goals should occur at least every three months.

These should be documented early in the course of treatment and regularly reviewed to ensure progress is being made towards treatment goals and that all parties, including clinicians and clients, are satisfying key requirements and responsibilities.

The Office of the Chief Psychiatrist Victoria has published useful guidelines as to what a treatment plan should include: **http://www.health.vic.gov.au/chiefpsychiatrist/treatmentplan/forum-feedback.pdf**.

Recommendations

3.4.5.1	Both the case manager and doctor should meet with the client and, where possible, the family, and develop an individual service plan (ISP) within four to six weeks after entry to the service. [GPP]
3.4.5.2	The case manager should regularly review the ISP with the client. [GPP]

Guideline 3.4.6: Group programs

Background

Psychosis disrupts social networks, which in turn can worsen the outcomes of illness[124, 142]. Group work can meet a number of needs in early psychosis, including reducing social isolation and experiences of stigma and providing specific content that may assist in recovering from psychotic experiences. Group programs provide an opportunity to reduce isolation, build self-esteem, and provide peer support[443]. Interacting with people who share similar experiences and understand the impact of psychosis is highly valued by group participants.

Group work may provide a medium for therapeutic change beyond this 'normalising' element, using a diverse range of theoretical frameworks and approaches including experiential learning, CBT, psychotherapy, psychoeducation, systems theory and occupational science. Areas of focus include coping and stress management skills, psychoeducation, therapeutic groups for specific comorbid disorders such as anxiety and depression, vocational and educational planning and training, social and recreational skills, health promotion, lifestyle issues such as drug use and safe sex practices, and creative expression and personal development. A non-directive, supportive, and encouraging attitude on the part of staff is likely to optimise treatment gains in the group setting[444].

Note: 14

As with individual treatment, regular and ongoing review of involvement in groups is indicated; at least every three months and at discharge from the group program.

Malla et al.[117] suggest that a relatively short course of group treatment is more likely to retain interest and engagement in younger people. The group context may also differ in the early onset population from those with more established illness because clients may be more naïve regarding the mental health system; be more willing to exercise control over treatment and their future; and have a higher potential for substance use problems and impulsivity. Group interventions should take these factors into account, for example by incorporating specific substance abuse interventions, or providing ample opportunity for young people to guide group program development and evaluation.

There has been limited empirical examination of the effectiveness of group interventions in FEP clients. Data suggests that those referred to group programs may have poorer functioning prior to referral, which involvement in groups may effectively remediate[445]. A group stress management programme designed for FEP clients has recently been found to reduce hospitalisation rates over and above standard FEP services[446]. One very small open trial (n=5) found that participants were very satisfied with CBT delivered in group format and reported a reduction in psychotic symptoms after the group intervention[447]. Qualitative data also suggests that young people appreciate groups as valuable sources of information, therapy, and support[448]. There is no evidence to date exploring the efficacy of group programs for UHR clients; intuitively, however, the above principles would seem to apply to that group as much as to FEP clients, with the exception of the 'recovery' paradigm. Sound clinical practice also requires effective liaison between the treating team and the group program, to ensure clinicians are working together in meeting the client's needs.

Recommendations

3.4.6.1	Group programs should be offered to those with FEP[B] and at UHR.[GPP]
3.4.6.2	Group programs should be available in a range of clinical and community settings. [GPP]
3.4.6.3	Group programs should be tailored to the different needs of young people at different phases of illness. [GPP]
3.4.6.4	Decisions about participation in any group program should be made collaboratively with the individual, based on an understanding of the potential benefits for that person. [GPP]
3.4.6.5	Goals should be set collaboratively and progress of participants towards these goals should be regularly reviewed. [GPP]
3.4.6.6	The development of group programs should be based on a thorough planning process which includes needs assessment, the setting of objectives, development of content areas and establishment of evaluation strategies. [GPP]
3.4.6.7	Where appropriate, group program staff should assist clients in finding meaningful psychosocial activities (such as other groups/activities) external to clinical services. [GPP]
3.4.6.8	There should be an effective clinical interface between the group program and the case manager (or treating clinician) or multidisciplinary team. [GPP]

Guideline 3.4.7: Psychoeducation

Background

Psychoeducation aims to develop a shared and increased understanding of the illness for both the young person and their family[449]. In the broader medical literature, it is clear that access to quality information facilitates client and family decision-making and encourages consumers and their families to take a more active role in managing their own health (e.g.,[450, 451]). Data in established schizophrenia suggest that client psychoeducation significantly reduces relapse and re-admission rates and length of stay when rehospitalised[452]. It is also possible that psychoeducation improves compliance with medication and has a positive effect on wellbeing[452]. One study has examined the role of a 'psychoeducational treatment program' in adolescents with psychosis, but it is difficult to draw conclusions from this study regarding psychoeducation specifically, as the 'psychoeducational program' included educational seminars for parents, problem-solving sessions, and engagement with social networks (including schools and vocational support:[453]). To date only one study has investigated the impact of seven sessions of specific psychoeducational strategies for pre-psychotic clients, and reported significant reduction in psychopathology and lessened locus of control as well as an improvement in knowledge, global functioning and quality of life[454]. However, the uncontrolled nature of this study, and its small sample size (n = 16), significantly limit its generalisability. Further research is required before psychoeducation alone can be said to have an empirical evidence base as an intervention in the pre-psychotic or FEP groups. Despite this, however, and particularly given its impact in established psychotic illness, provision of psychoeducation is good clinical care.

Note: 15

Psychoeducation can include explanation of:

- The nature of illness/es (in the case of comorbidity) (including the diathesis-stress model)
- The range of treatment options available
- The patterns and variable nature of recovery
- The prospects for the future and how these can be influenced
- Agencies and personnel involved in treatment

Qualitative research suggests a distinction between information for the purpose of settling and reassurance, and information provided to educate the young person or family. These data also reinforce the need to make psychoeducation an ongoing and individualised approach; young people who had experienced FEP noted that they felt insignificant and not worthy of information if needs for information were not recognised and met during treatment, and were more likely to disengage from treatment[455]. Needs for information are, however, likely to differ across clients, as are the most appropriate media through which to deliver information. Peer-to-peer psychoeducational approaches, for example, have been shown to be effective in adults with psychosis, and may be particularly palatable to adolescents[456].

Family psychoeducation may also reduce relapse rates (see[457-459]) but, as noted previously, it is unclear whether psychoeducation alone in the FEP or UHR groups shows positive effects, given that most family interventions used in the FEP literature include psychoeducation as one amongst many interventions.

Psychoeducation can be delivered in a variety of modes, including one-to-one interactions, group sessions, peer support sessions, and family work. This information should be specific to early psychosis. Psychoeducation in the first episode field needs to be particularly aware of healthy resistance to the psychological threat of self-stigmatisation with associated poorer insight and reluctance to engage in the psychoeducation process[460]. Psychoeducation is also not a standalone intervention, but should be seen in the broader context of the overall therapeutic task with several overall objectives, including enhancing the client's sense of meaning, mastery, and self-esteem. Timing of psychoeducation is also important – during acute exacerbation of mental state abnormalities, basic practical information is essential, but more detailed and comprehensive psychoeducation should be deferred until this has settled[460]. Group programs may be a particularly effective way to provide psychoeducation, using facilitating techniques such as paired discussions, 'brainstorming' and role-playing. Regardless of the format, frequent checks that clients and families understand psychoeducational material may be appropriate, as the emotional impact of psychosis can make it difficult to absorb new information. Information should be provided at an appropriate pace, taking into account individual client and family factors and the stage of illness; the emotional impact of psychosis can make it difficult to absorb information in the very early stages. It should also take into account how the person usually learns or absorbs new information

There are likely to be some similarities between psychoeducation for FEP and for those at UHR, particularly the diathesis-stress model and the experience of psychotic symptoms. There are key differences, however, given the UHR group is yet to experience psychosis onset. Psychoeducation in this group may also usefully include an awareness of the possibly stigmatising effect of an 'at-risk' diagnosis, a discussion of the risk of false positives in identifying those at UHR and in particular to address fatalism about psychosis onset (see Yung et al.[287] for further details). In both the UHR and FEP phases, psychoeducation should not be limited to psychotic symptoms and should extend to any substance or psychiatric comorbidities that the client is experiencing.

Recommendations

3.4.7.1	Psychoeducation should be provided for young people with early psychosis and their families. GPP
3.4.7.2	The case manager and the treating doctor are responsible for ensuring access to psychoeducation. GPP
3.4.7.3	The material should be appropriate for young people and for early psychosis. GPP
3.4.7.4	Psychoeducation and support should be provided for the client and family on an initial, continuing and 'as needed' basis through individual work, group programs and consumer support groups or a family participation program. GPP
3.4.7.5	Clients and families of a culturally or linguistically diverse background should have access to information in their own language, using interpreters where appropriate. GPP

Guideline 3.4.8: Vocational and educational services

Background

The social functioning of people with psychotic illness is poorer than the general population. Most social, academic, and occupational role functioning loss associated with psychotic illness occurs during the prodromal phase of illness and during the first few years of the critical period and then tends to reach a plateau[380, 461, 462]. It is premorbid social functioning, rather than improvement in symptoms, that predicts later social functioning (e.g.,[463]). Pointing specifically to vocational functioning, Killackey et al.[464] note that "the majority of people who develop psychosis do so at a time in their lives when they are just beginning to develop vocational interests and directions. Not surprisingly, the experience of psychosis derails this aspect of their development and either leads, or contributes significantly to, a rapid decrease in their likelihood of employment." (p. 333). A lack of employment leads to other losses such as income, social contact, and external structure[465, 466], as well as less direct losses of quality of life, community participation, and a sense of productivity[467].

Box 13: Defining features of Individual Placement Support (IPS)[468, 469]

Focused on competitive employment or education rather than sheltered or transitional employment

Service open to any person with mental illness who chooses to look for work or education, so that acceptance into the programme is not determined by measures of work readiness or illness variables

Job searching commences directly on entry into the program

The IPS program is integrated with the mental health treatment team, rather than constituting a separate vocational rehabilitation service

Potential jobs are chosen based on consumer preference

The support provided in the program continues after employment is gained, rather than termination at a set point, as needed by the individual

The IPS services are provided in the community, rather than at the mental health or rehabilitation facility

Specialist vocational and educational services, provided early in the course of illness or in the putative prodrome, may serve to halt or even reverse deterioration in functioning. Individual placement and support (IPS) has good support in general psychiatric samples. Its defining features are outlined above. IPS is the model primarily used in FEP to date, with positive outcomes that may lead to even greater success rates than when IPS is provided in the chronic psychosis context[470-473]. Recent data suggest that people with FEP with access to specialist vocational interventions following the IPS model have odds of achieving vocational recovery 3.53 times that of those not receiving the intervention[471].

There is no current empirical evidence exploring appropriate vocational functioning or vocational interventions for the pre-onset phase, but similar principles are likely to be relevant, particularly given functioning deteriorates during this pre-onset period. For this reason, provision of IPS in the pre-onset period should be regarded as good clinical care.

Further principles and processes to achieve them are outlined in the international consensus statement on supporting young people with psychosis in education, training, and employment[474].

Recommendations

3.4.8.1	Case managers should facilitate access to educational and vocational services to the FEP[B] and pre-onset [GPP] groups.
3.4.8.2	Employment and educational consultants should be integrated within FEP services as much as possible. [GPP]
3.4.8.3	Employment services for people with FEP should be consistent with an Individual Placement and Support model. [B]
3.4.8.4	Given the age group of this population, return to education or training is seen as an acceptable vocational outcome. [GPP]

Guideline 3.4.9: Suicide prevention

Background

Evidence suggests suicide rates are lower in early intervention services than in previous cohorts of young people with FEP treated in generalist services (e.g.,[4, 234, 238]). However, the 'active ingredients' of the model in reducing risk are unclear, and once treatment has terminated this effect seems to diminish[238, 240, 475]. Whilst the efficacy of early intervention services remain the focus of significant debate, evidence suggests that extending this model of care beyond the initial 18-month to two year period could reduce suicide risk over time for this population.

A number of strategies can be employed to prevent suicide. Universal service-wide suicide prevention strategies involve training staff and carers in order to increase confidence and skills in detecting, assessing, and managing suicide risk. Selective strategies to reduce suicide risk include screening and monitoring via routine risk assessment and the development of risk management systems, and are generally appropriate across all clients presenting with suicide risk factors. Indicated interventions, or specific treatments for those identified as at high risk at the screening stage, include acute suicide risk containment (including increasing frequency of contact and support or hospitalisation), pharmacological and physical treatments specifically for suicide risk, psychological interventions, psychosocial interventions, and self-help.

However, the additional benefit of these interventions is generally small[476, 477], with data suggesting that the key risk factor to address in reducing suicide is appropriate pharmacological treatment of psychotic and other psychiatric disorders, and adherence to this treatment[243]. As with all therapies, these interventions must be tailored to the individual, taking into account the range of factors that could be contributing to suicide risk, including acute psychotic symptoms, comorbid mood disorder, other comorbidities such as personality disorder, psychological reactions to psychotic illness, external factors such as reactions of significant others and losses, and reactions to suicidality in others, including post-traumatic reactions and suicide pacts between clients[236].

Pharmacological and physical treatments include, for the FEP group, the use of atypical rather than typical antipsychotics (Barak et al.,[478]) and clozapine (Meltzer et al.,[479]). Empirical evidence outside the first episode field suggests other interventions. For example, the affective psychosis literature suggests electroconvulsive therapy can be helpful for suicidality (Tanney,[480]); and those with more established illness have shown improvements in suicidality when treated with antidepressants (c.f., in the absence of this: e.g., Parker et al.,[481]), and possibly lithium[482].

Psychological interventions in early psychosis are rarely designed specifically to reduce suicide risk. The only specific intervention for suicidality in the FEP group, LifeSPAN, is a 10-session individual CBT program creating a formulation of short-and long-term factors contributing to suicidality and treating short-term factors. Evidence to date suggests LifeSPAN is associated with significant reductions in hopelessness and suicidal ideation, but not in suicide attempts[140]. CBT for psychosis (c.f., suicidality in FEP) alone does not appear to reduce risk of suicidal behaviour in FEP clients over and above supportive counselling or treatment as usual[483]. Psychosocial interventions such as provision of support, encouragement of daily activity, and supporting peer relationships and work and vocational involvements may reduce suicide risk[246, 484], although this has not been explored in the FEP field specifically. Self-help resources may also be useful, although again their impact in early psychosis has not been examined.

Adequate and appropriate pharmacological treatment of depression would also likely reduce suicide risk, given the relationship between depressive disorder and risk in the FEP group[238, 239]. Similarly, improving adherence to treatment would likely reduce risk[243], as would working with young people around deliberate self-harm, given its relationship to suicide.

Recommendations

3.4.9.1	Intensive treatment should be provided during high-risk phases of illness. [GPP]
3.4.9.2	Services should develop and implement appropriate, evidence-based interventions for deliberate self-harm. [GPP] The LifeSPAN program is likely to be of some benefit for suicidal clients. [B]
3.4.9.3	Atypical antipsychotics [B], especially clozapine [A] may be useful for suicidality.

Guideline 3.4.10: Substance use (including cigarette use)

Background

Interventions provided to young people to treat substance use issues should recognise the features of this population including their young age, the circumstances that brought them into treatment, widespread substance use among peers, and cognitive difficulties arising from substance misuse[485]. Integrated treatment is likely to have the best effect, and can be provided either within a single service or in collaboration with a drug treatment service[486].

Provision of feedback about assessment may be therapeutic in its own right, providing an opportunity to give psychoeducation about risks to mental and physical health associated with substance use, especially links between regular substance use and poor clinical outcomes[218, 487]. Harm minimisation strategies may also be helpful to reduce harmful effects associated with substance use and build motivation to change.

Psychological treatments can be successful in reducing substance use, in particular cannabis use. For example, motivational interviewing aims to move the person from the pre-contemplative stage to the contemplation or action stage in changing their substance use, usually by increasing their awareness that substance use may thwart their pursuit of personal goals[486]. CBT can also be used to challenge the beliefs that individuals hold about their ability to change and their need to use substances. It focuses on developing skills such as refusal rehearsal, stress management and problem solving to assist in changing behaviour and preventing relapse. Particular strategies are outlined in box 14.

CBT has been effective in the general population in improving abstinence and reducing drug-related problems[488]. There have been no empirically-evaluated interventions targeting substance use in the pre-onset phase. The Cannabis And Psychosis (CAP) therapy project is the only trial of a psychological intervention specifically designed to address cannabis use in those with early psychosis (specifically FEP:[489]). Implemented during the early recovery phase (10 weeks post-clinical stabilisation), this intervention is delivered over three months, ideally with 10 weekly sessions and a 'booster' session via telephone three months post-completion. Using a motivational interviewing paradigm, CAP starts with engagement and detailed assessment, followed by education about links between cannabis and psychotic symptoms and addressing motivation to change. Subsequent therapy sessions are guided by the client's motivation to change, and may include additional education about cannabis and psychosis, motivational interviewing strategies, goal setting and achievement strategies, and relapse prevention (see[487, 490] for further details). No differences were detected between CAP and psychoeducation in a sample of 47 young people with FEP, with both groups reporting significantly lower level of cannabis use at six month follow-up. This suggests that psychoeducation alone may be of significant benefit in reducing cannabis use in those with FEP.

Another CBT intervention has been designed to treat substance misuse more generally in psychosis, the Start Over and Survive (SOS) program, a three hour intervention offered over six to nine sessions and usually completed within seven to ten days. The program initially focused on engagement while participants are acutely symptomatic, progressing to motivation enhancement and selection of goals for change.

If participants identified these goals, specific plans were made within therapy and problem-solving strategies applied to expected high-risk situations (including avoiding high-risk situations, increasing enjoyable alternatives to substance use, and engaging supportive others). Social skills strategies (such as modelling and rehearsal) were used to practise drug refusal. SOS was associated with lower levels of substance use at six and 12 months, in contrast to those who received standard care. However, those receiving SOS also had more support from families, so it is difficult to determine whether the intervention or family support was responsible for these findings[491].

To date there have been no studies in early psychosis focussing on treatment for alcohol dependence or abuse.

Box 14: Strategies for substance reduction (adapted from Wade et al.,[218]):

Setting realistic, achievable and short-term goals that are clearly defined in behavioural terms.

Providing regular monitoring of attempts to achieve goals

Engaging supportive others to assist with plan to reduce substance use

Encouraging the individual to keep a list of reasons for wanting to change substance use to help maintain motivation

Teaching the individual to challenge cognitions associated with substance use (e.g., positive drug expectancies) and/or negative affective states and to use problem solving to address high risk situations

Providing personalised handouts of plans to reduce substance use

Identifying high risk situations for substance use

Practising refusal skills for use in high risk situations

Providing education about cravings and withdrawal symptoms and practicing coping strategies to manage these difficulties

Developing a plan to deal with lapse of problematic substance use

Clinical practice suggests that acute withdrawal raises its own issues. Withdrawal management may include education on the symptoms of withdrawal and relaxation and coping skills to manage symptoms, detoxification (either home-based or inpatient, depending on the individuals' needs), pharmacotherapy (especially for opiate and alcohol dependence), and specialist drug treatment services to advise on or manage detoxification or pharmacological interventions.

Pharmacological interventions such may also be appropriate in managing various phases of the substance use reduction process, such as acute detoxification, craving reduction, and treatment of protracted withdrawal symptoms (see[492] for a review of the pharmacological treatment of substance use disorders in schizophrenia).

Although no links have been detected between family burden and presence of comorbid substance use in FEP[422], data exists suggesting a relationship between the two in chronic schizophrenia[493]. Good clinical care therefore requires an awareness that families of those with comorbid substance use and FEP may be particularly distressed and burdened, and require additional assistance.

Recommendations

3.4.10.1	Psychoeducation and CBT may help reduce substance use in those in the pre-onset phase [GPP] and with FEP [B].
3.4.10.2	Treatment of psychosis and comorbid substance misuse (including tobacco use) should be integrated. [GPP]
3.4.10.3	Acceptance policies should be inclusive of individuals with comorbid substance misuse. [GPP]
3.4.10.4	Policies and procedures should be developed regarding substance misuse and its behavioural consequences, including the possibility of substance use while within the service. [GPP]
3.4.10.5	The service should develop minimum standards for clinicians regarding their knowledge about the assessment and integrated treatment of substance misuse. [GPP]
3.4.10.6	Where appropriate, clinicians should have access to specialist consultation to provide assessment, supervision, advice or co-management for comorbid substance misuse (including tobacco use). [GPP]
3.4.10.7	Where clients are receiving treatment within a drug treatment service, clinicians should actively collaborate and communicate about the individual treatment plan. [GPP]
3.4.10.8	Individual treatment plans should routinely include additional treatment goals relevant to substance misuse. [GPP]
3.4.10.9	Support should be offered to family and friends, including psychoeducation on comorbid mental illness and substance misuse. [GPP]
3.4.10.10	Discharge planning should include attention to ongoing treatment of substance misuse. [GPP]

Guideline 3.4.11: Treatment of psychiatric comorbidity

Background

As noted above, comorbidity can worsen prognosis in UHR and FEP; treatment is therefore vital. It is beyond the scope of these guidelines to provide details regarding appropriate treatments for possible comorbid psychiatric disorders. Reference should in this instance be made to other relevant clinical guidelines (e.g., Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression: **http://www.nzgg.org.nz/guidelines/0095/Depression_Clinican_Full.pdf**; Australian and New Zealand Clinical Practice Guidelines for the Treatment of Panic Disorder and Agoraphobia: **http://www.nzgg.org.nz/guidelines/0093/Panic_Disorder_and_Agoraphobia_Clinician_Full.pdf;** Australian and New Zealand clinical practice guideline for the management of adult deliberate self-harm: **http://www.nzgg.org.nz/guidelines/0096/APY_541.pdf**; Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: **http://www.acpmh.unimelb.edu.au/resources/resources-guidelines.html#1**).

There is no empirical evidence relating to issues of sequencing in treatment of comorbidities in UHR and FEP, i.e., whether it is more effective to sequentially treat (either pharmacologically or psychologically) psychotic symptoms and comorbid disorders or to treat them simultaneously as far as possible. There is mounting evidence that SGAs may have a direct antidepressant effect, as well as an indirect effect via improvement in psychotic symptoms[494]; this requires exploration in the emergent psychoses.

Recommendations

3.4.11.1	Treatment of psychiatric comorbidity should be conducted in a consistent manner with available clinical guidelines. GPP
3.4.11.2	Although treatment of psychosis often remains paramount, the sequencing of treatment of comorbid conditions should be driven by the symptoms/ disorder that is most distressing/disabling and whether it poses further risks to the client or others. GPP

Guideline 3.4.12 Consumer participation

Background

Empirical research suggests that consumers who understand their health conditions and are actively involved in decisions about their own care value treatment programs more and have better health outcomes[495]. The involvement of consumers in service planning, delivery, monitoring and evaluation also seems more likely to result in services that are accessible and appropriate to service users, with more responsive providers, better quality care, and more empowered clients[496].

Note: 16

Ways to involve consumers include:

- Ensuring a clear and accessible feedback and complaints system with transparent resolution processes
- Developing a consumer advisory group
- Facilitating consumer representatives on boards and committees
- Facilitating consumer involvement in staff selection
- Facilitating consumer involvement in education programs
- Developing a peer support program that could include training service users to staff a 'drop in' support room or to visit inpatient units

Staff support is necessary and one key worker should be assigned for consumer representative liaison.

Beyond the benefits of consumer participation, it is an established right for users of the mental health system, as supported by the National Standards for Mental Health Services[497].

Note: 17

Consumers should be recognised for their contribution to the service, including:

- Payment for time contributed
- Provision of travel subsidies
- Provision of childcare if required
- Provision for other supports to encourage involvement
- Provision of funding for training to facilitate participation (e.g., meeting procedure)
- Enabling development into more advanced roles

Participation provides an avenue for consumers to process their experiences and use them for the community's good, and it can have a positive effect on consumer health outcomes[495]. If participation is to be genuine, tokenism must be avoided. For example, consumers should be invited to participate in relevant decision-making processes rather than participating after decisions have been made. Consumers have rights to participation and services are required to ensure consumer, carer, and advocate involvement in planning, managing, and evaluating mental health service provision[285]. The Consumer and Carer Participation Policy[498] of the National Mental Health Consumer and Carer Forum provides guidelines for all mental health organisations to develop and implement consumer participation.

Early psychosis services should involve consumers in the planning, implementation and evaluation of their service, for the sake of both service users and the services themselves[499]. Early psychosis services should ensure that their processes are 'youth-friendly' and that sufficient support, training and resources are provided to facilitate the participation processes. Rather than expecting young people to adapt to service mechanisms, the service should adapt to young people's needs.

A range of processes can be used to account for the differing abilities, interests and commitment of service users. Examples are outlined above. Involvement of more than one consumer representative in any one project is likely to engender greater confidence to participate.

Recommendations

3.4.12.1	The culture of the organisation should respect consumers and validate their input. GPP
3.4.12.2	All consumer participation initiatives should be jointly planned with consumers from the outset, and based on the needs and interests of consumers. GPP
3.4.12.3	Consumers participating in the service should receive some payment, and funding should be available to allow consumers to acquire any specialist skills that they may need in their role. Consumers should also receive ongoing supervision and support from a clinical mentor. GPP

Guideline 3.4.13: Carer participation and support

Background

The *National Standards for Mental Health Services* state that carer participation is an established right for family and other carers who have a relative receiving services from the mental health system[497].

Early psychosis services should involve family carers in the planning, implementation and evaluation of their service. Carers' expertise gained through their 'lived experiences' provides novel perspectives and skills about the treatment and care of young people with early psychosis. Participation by family carers is likely to enable them to better manage their own circumstances, and provides an avenue for them to share their experiences with other families and clinicians, and to further develop the service. As with consumer participation, participation should be genuine rather than token.

Early psychosis services should understand the importance of involving family carers in the service. They need to ensure that processes are supportive of family carers' participation, and that sufficient support, training and resources are provided. Clinicians should understand that participating family carers are there to help other families, as well as to support clinicians in their interactions with families.

Family participation can be developed in many ways to suit the different talents and interests displayed of family carers. Participation could include:

- A family working group comprised of staff and family carers for the purpose of developing services to families
- Attendance at service planning meetings
- A family resource room managed by family support workers
- Selection of family carers to be trained to help and support other family carers (family peer support workers)
- Carer representation on boards and committees
- Providing training to staff about carer concerns
- Carer involvement in staff selection
- Carer participation in advocacy for better mental health services through the media and approaches to politicians

Recommendations

3.4.13.1	Family carers should be accepted as partners in treatment and care strategies, and their needs respected and supported. GPP
3.4.13.2	Family participation will need strong initial support and facilitation by a staff member involved in family support. GPP
3.4.13.3	Family carers participating in the service should receive some payment, and funding should be available to allow family carers to acquire any specialist skills that they may need in their role. Family carers should also receive ongoing supervision and support from a clinical mentor. GPP

Guideline 4: Specific populations

Guideline 4.1: Aboriginal and Torres Strait Islander communities

Background

There is no conclusive national data relating to prevalence of psychiatric disorders broadly, or psychotic disorders specifically, in Aboriginal and Torres Strait Islander peoples. The data which exists is limited to hospitalisation and mortality, and it suggests that Aboriginal and Torres Strait Islander people have a three to five times greater risk of being admitted involuntarily than the non-Aboriginal population; that Aboriginal people are admitted to hospital for 'mental and behavioural disorders' at a higher rate than non-Aboriginal people; and that rate of hospitalisation for 'mental and behavioural disorders' secondary to psychoactive substance use is four to five times higher than the general population[500, 501]. Death rates from suicide in indigenous people are around twice the rate of the non-indigenous community, with the young adult years being a period of particularly high risk[502]. Individual and community experiences that may in part account for these figures include social exclusion and marginalisation, stress/trauma (including historically and currently, leading to increased exposure to psychosocial stressors and violence), and substance use.

Many initiatives have been developed for Aboriginal and Torres Strait Islander communities through State and Territory mental health programs, but few have specifically addressed early psychosis. Until clinical expertise is better developed in this area, it is recommended that early psychosis services consult with local Aboriginal mental health professionals.

A useful resource on providing mental health services to Aboriginal and Torres Strait Islander people is the Aboriginal Mental Health First Aid Training and Research Program's guidelines* on cultural considerations and communications techniques. The key points of these guidelines are outlined at right.

*** http://www.mhfa.com.au/Guidelines.shtml**

Note: 18

Key principles in working with Aboriginal and Torres Strait Islander communities

Learn about the other person's culture and their concept of mental illness

Know what is normal, and what is not, in the person's culture

Know what is culturally appropriate communication

Do not shame the person, their family, or their community

Use community and family supports

Of particular relevance in treatment of psychotic symptoms in Aboriginal and Torres Strait Islander people is the need to be aware of physical side-effects of antipsychotics; failure to monitor these appropriately could be particularly problematic for these individuals given higher rates of medical difficulties in general and specifically disorders that can also emerge consequent to antipsychotic medication (such as cardiovascular disease, diabetes, and obesity).

The CAARMS may also require some modification in order for its use to be valid in Aboriginal peoples, given recent data suggesting its use leads to greater 'false positives' in Aboriginal than non-Aboriginal people[503].

Recommendations

4.1.1	Clinicians should be especially alert to side-effects of antipsychotics when working with people from Aboriginal and Torres Strait Islander communities. GPP
4.1.2	Indigenous health or mental health practitioners should be involved in the assessment and treatment of young indigenous people with emerging psychosis, to facilitate engagement and reduce stigma. GPP
4.1.3	Clinicians should practice in a manner consistent with relevant guidelines on working with people from indigenous communities (e.g., Aboriginal Mental Health First Aid Training and Research Program, 2008; **http://www.mhfa.com.au/Guidelines.shtml**). GPP

Guideline 4.2: Culturally and linguistically diverse communities

Background

People from non-English speaking backgrounds (NESB) are less likely to be consumers of mental health services (both inpatient and outpatient) than the Australian-born population, but are more likely to be admitted involuntarily in the context of mental health treatment[504]. A key element of providing psychiatric care is facilitating communication, a process which can become more complicated when working with people from NESB whose English proficiency can be more limited. If not sufficiently addressed, this can lead to misdiagnosis and inappropriate treatment. This requires not only working with interpreters when appropriate (see standard 1.7, National Standards for Mental Health Services[497]: 'The mental health service upholds the right of the consumer and their carers to have access to accredited interpreters'), but also working with them effectively. Relevant guidelines offer suggestions about key principles in this area (e.g., see the Victorian Transcultural Psychiatry Unit website; **http://www.vtpu.org.au/links/#culturally**) and are summarised below.

Box 15: Good practice in working with interpreters in mental health settings (VTPU)

Ensure that you know which language (and dialect) the consumer speaks: do not assume the language spoken from the consumer's country of birth

Check whether there may be an ethno-political divide between consumer and interpreter

Check whether the gender of the interpreter is important to the interview

Ensure that the interpreter knows the purpose of the interview

Be aware of the needs of the interpreter (particularly in stressful and difficult circumstances) and keep in mind the complexity of the interpreter's task

Introduce all people present to one another and explain the role of each person

Explain to the consumer and carers/family members that the interpreter is bound by a code of ethics and is required to observe confidentiality

Speak to the consumer directly: do not say to the interpreter "Ask her if..."

Use short simple sentences and speak in plain English, avoiding the use of jargon, slang, and colloquialisms

Allow enough time for questions and answers to be interpreted - this may extend the time needed for the interview

Do not ask for a 'literal translation' as mental health terms may not have a direct translation in the consumer's language. The interpreter's role is to convey an equivalent meaning.

Be aware that the interpreter is not a mental health expert and should not be asked about the mental state of the consumer

Although the interpreter may be asked about cultural background issues, he/she is not a cultural consultant, and may be from a different class or culture to the consumer

Review the session with the interpreter after the interview, and ask whether there were any interpreting difficulties

Include the interpreter in any debriefings necessitated by incidents or occurrences that he or she was party to.

It is important to bear in mind that issues in accessing services, assessment, and treatment may still emerge if a client is proficient in English, if they or their family are overseas-born. These include challenges of resettlement and acculturation for young people and/or their families, such as contending with any history of trauma experienced in a country of origin; 'parentification' of children if they are the key nexus of interaction between family and the dominant society; cross-generational conflict that may at times represent conflict between the original and new cultures; and racism and media stereotypes (Black Dog Institute, **http://www.blackdoginstitute.org.au/docs/CALDpaper.pdf**). Principles of working with people from Aboriginal and Torres Strait Islander communities also apply to non-Australian born consumers. Various State bodies provide useful resources covering practical strategies to address common challenges in working with people from NESB (e.g., Victorian Transcultural Psychiatry Unit: **http://www.vtpu.org.au/cald.htm**).

Recommendations

4.2.1	Consumers and carers who cannot speak English, or who speak limited English, should be able to access professional interpreting and translating services where significant decisions are concerned and where essential information is being communicated.
4.2.2	Clinicians should be guided by appropriate guidelines when working with interpreters (e.g., **http://www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf**)
4.2.3	Clinicians should be guided by appropriate recommendations when working with people from NESB (e.g., **http://www.vtpu.org.au/cald.htm**)

Guideline 4.3: Rural and remote populations

Background

There is limited data comparing the prevalence of early psychosis between urban and regional/remote areas. However, young people who do not live in major population centres may experience considerable difficulties in accessing specialised mental health care. This may be because of lack of service providers, fear of stigma, stoicism, and travel and financial barriers[505-507]. Some progress has been made towards remedying this situation in Australia with federal funding for psychological services (Access to Allied Psychological Services projects, funded under the Better Outcomes in Mental Health Care initiative); the uptake of these services has been proportionally greater in rural/remote than urban areas[506].

Note: 19

Features of early psychosis services in rural/remote communities[508]

Engagement of community and educational agencies in raising awareness of symptoms of psychosis and collaborating in the task of early identification of these

Strong GP liaison and primary care structures

Accessible expert consultation, such as via telepsychiatry

Availability of clinical guidelines and protocols

Regardless of availability of services, what may be suited for a densely populated urban area may not be appropriate for rural areas that do not have a critical mass of incidence of early psychosis (e.g.[509]). In reviewing the three studies that have detailed provision of early psychosis services in rural/remote communities, two in Australia[510, 511] and another in Canada[512], Welch and Welch[508] note some commonalities between the services, outlined above. Further exploration is necessary to establish what constitutes most effective service delivery for early psychosis in rural/remote areas, including an examination prevalence and context of early psychosis in rural/remote communities, to ensure early psychosis services are appropriately tailored to this group.

Recommendations

4.3.1	Early psychosis prevention and intervention information should be readily available at key locations in rural and remote areas, for example in GP's waiting rooms and community centres. GPP
4.3.2	Mental health service should provide tertiary consultation and education services to health practitioners in rural and remote areas. GPP
4.3.3	Telepsychiatry and other technological facilities should be made available to mental health practitioners in rural and remote areas to facilitate links with early psychosis services. These should not, however, be seen as a replacement for visiting specialists[513]. GPP

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APPENDICES

Glossary of terms

Acute Phase Psychosis	The period in which a person is experiencing frank psychotic symptoms (positive or negative symptoms). It begins when active symptoms commence until the start of treatment.
Adolescence	A transitional stage of mental, physical development occurring between childhood and adulthood. Generally occurring between the ages of 13 and 19 but may vary.
At Risk Mental State ARMS (ARMS-P)	A state in which predictive criteria are met in which the person has an increased chance of developing a psychotic illness
Attenuated Psychotic Symptoms	Psychotic symptoms that are of a reduced intensity or frequency than those with a psychotic disorder i.e. not severe enough to elicit a psychosis diagnosis
Brief Limited Psychotic Symptoms	Psychotic symptoms that are short in duration (less than one week) and self limiting (BLIPS)
Duration of Untreated Illness	Time interval between the onset of psychotic symptoms and initiation of treatment plus the prodrome (DUI)
Duration of Untreated Psychosis	Time interval between the onset of psychotic symptoms and initiation of treatment (DUP)
Early Intervention	Interventions targeting individuals displaying the early signs and symptoms of a mental health problem or mental disorder. Early intervention also encompasses the early identification of people suffering from a first episode of disorder
Early Psychosis	While there is no single authoritative definition of 'early psychosis', it clearly has an onset focus. It includes the period described as the prodrome and is also considered to include the critical period up to five years from entry into treatment for the first psychotic episode.
First-Episode Psychosis	The first onset of a psychotic disorder in the lifetime of an individual. In this context it represents the first treated episode of psychosis experienced by an individual in their lifetime.
Functional Recovery	A recovery in which there has been improvement in the persons practical life skills (social and vocational)
Incomplete Recovery Phase	A phase in which active symptoms and/or functional impairment remains
Negative psychotic symptoms	The group of symptoms that are "negative" in the sense that they remove capacity from the individual. They refer to experiences that should be present, but are absent. (e.g. amotivation, alogia, blunted affect)
Positive Psychotic Symptoms	The group of symptoms that are "positive" in the sense that they present in the person's experience but should be absent. (e.g. hallucinations, delusions, thought disorder)
Pre-Morbid Phase	A period in which the person has no pathological process. Normal development and activity is occurring.
Prodrome (Prodromal)	A medical term describing a symptom or group of experiences that precede the definitive symptoms of a disorder. A retrospective concept.
Prodrome Phase Psychosis	A retrospective concept – after people have experienced a psychotic episode the prodrome is a the period of pre-psychotic symptomology and behaviour change
Psychosis	A group of disorders in which there is misinterpretation and misapprehension of the nature of reality as reflected in certain symptoms, particularly disturbances in perception (hallucinations), disturbances of belief and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder).
Psychosis Spectrum	An illness in which the symptoms of psychosis are present. Includes schizophrenia, bipolar disorder, and major depressive disorder with psychotic features.
Recovery	A variable and a non-linear process. Generally defined as an outcome that occurs after an illness at a specific time, more complete than remission, when an individual returns to a healthy or healthier state.

Schizophrenic Spectrum	An illness in which the diagnostic features fit within the family of schizophrenia illnesses. Includes, but is not limited to: schizophrenia, schizophreniform psychosis, delusional disorder, schizoaffective disorder, and brief psychotic disorder
Schizotypal Personality Disorder	A DSM IV diagnosis within the personality disorders – cluster A.
Sub-threshold Psychosis	A cluster of psychotic or psychotic like symptoms that are of a reduced intensity or frequency. Less than severe enough to elicit a psychosis diagnosis
Ultra High Risk UHR	A state in which specific predictive criteria are met in which the person has an increased chance of developing a psychotic illness. Persons meeting the criteria of ultra high risk of developing a psychotic disorder include: those with trait risk factors (vulnerability) and a decrease in functioning; sub-threshold psychotic symptoms (attenuated psychotic symptoms); or recent history of psychotic symptoms that spontaneously resolved (brief limited psychotic symptoms - BLIPS)
Vulnerability to Psychosis	A person that has an increased risk of developing a psychotic disorder
Youth	A description of an age range that overlaps the periods of adolescence and young adulthood. Generally defined as between the ages of 15 to 25.

List of Abbreviations

ARMS or ARMS-P	At Risk Mental State of psychosis	**ICD 10**	International Classification of Diseases 10' Edition
BLIPS	Brief Limited intermittent Psychotic Symptoms	**IMI**	Intramuscular Injection
CAARMS	Comprehensive Assessment of At Risk Mental State	**LEO**	Lambeth Early Onset
CALD	Culturally And Linguistically Diverse	**MHS**	Mental Health Services
CBT	Cognitive Behavioural Therapy	**MSE**	Mental State Examination
COPE	Cognitively Oriented Psychotherapy in Early Psychosis	**NEPP**	National Early Psychosis Project
DSM IV	Diagnostic and Statistical Manual of Mental Disorders 4th Edition	**OCD**	Obsessive Compulsive Disorder
DUI	Duration of Untreated Illness	**PACE**	Personal Assessment and Crisis Evaluation
DUP	Duration of Untreated Psychosis	**PTSD**	Post Traumatic Stress Disorder
EPPIC	Early Psychosis Prevention and Intervention Centre Melbourne	**STOPP**	Systematic Targeting of Persistent Psychosis
EPS	Extra-pyramidal Side Effects	**SGA**	Second Generation Antipsychotic
FEP	First Episode Psychosis	**TAU**	Treatment As Usual
FGA	First Generation Antipsychotic	**UHR**	Ultra-high Risk of psychosis

The Liverpool University Neuroleptic Side-Effect Rating Scale(LUNSERS:[336])

The following scale is intended to be self-administered. Please indicate how much you have experienced each of the following symptoms in the last month by ticking a box for each of the 51 items.

Name: ..... Date: .....

	Not at all (0)	Very little (1)	A little (2)	Quite a lot (3)	Very much (4)
1. Rash					
2. Difficulty staying awake during the day					
3. Runny nose					
4. Increased dreaming					
5. Headaches					
6. Dry mouth					
7. Swollen or tender chest					
8. Chilblains					
9. Difficulty in concentrating					
10. Constipation					
11. Hair-loss					
12. Urine darker than usual					
13. Period problems					
14. Tension					
15. Dizziness					
16. Feeling sick					
17. Increased sex drive					
18. Tiredness					
19. Muscle stiffness					
20. Palpitations					
21. Difficulty in remembering things					
22. Losing weight					
23. Lack of emotions					
24. Difficulty in achieving climax					
25. Weak fingernails					
26. Depression					
27. Increased sweating					
28. Mouth ulcers					
29. Slowing of movements					
30. Greasy skin					
31. Sleeping too much					
32. Difficulty passing water					

	Not at all (0)	Very little (1)	A little (2)	Quite a lot (3)	Very much (4)
33. Flushing of face					
34. Muscle spasms					
35. Sensitivity to sun					
36. Diarrhoea					
37. Over-wet or drooling mouth					
38. Blurred vision					
39. Putting on weight					
40. Restlessness					
41. Difficulty getting to sleep					
42. Neck muscles aching					
43. Shakiness					
44. Pins and needles					
45. Painful joints					
46. Reduced sex drive					
47. New or unusual skin marks					
48. Parts of body moving of their own accord eg. foot moving up and down					
49. Itchy skin					
50. Periods less frequent					
51. Passing a lot of water					

LUNSERS-RECORDING SHEET

DATE				
OVERALL SCORE				
ITEMS RATED				
VERY LITTLE (1)				
LITTLE (2)				
QUITE A LOT (3)				
VERY MUCH (4)				
EXTRA-PYRAMIDAL SE				
SCORE				
ANTICHOLINERGIC SE				
SCORE				
OTHER AUTONOMIC SE				
SCORE				
ALLERGIC REACTIONS SE				
SCORE				
PSYCHIC SE SCORE				
HORMONAL SE SCORE				
MISCELLANEOUS SE SCORE				
RED HERRINGS SCORE				
CURRENT MEDICATION				

LUNSERS – SIDE EFFECTS BY GROUP

EXTRA-PYRAMIDAL SIDE EFFECTS

19 – MUSCLE STIFFNESS
29 – SLOWING OF MOVEMENTS
34 – MUSCLE SPASMS
40 – RESTLESSNESS
43 – SHAKINESS
48 – PARTS OF THE BODY MOVING OF THEIR OWN ACCORD
e.g. FOOT MOVING UP AND DOWN
37 – OVER WET OR DROOLING MOUTH

POSSIBLE RANGE 0-28

PSYCHIC SIDE EFFECTS

2 – DIFFICULTY STAYING AWAKE DURING THE DAY
4 – INCREASED DREAMING
9 – DIFFICULTY IN CONCENTRATING
14 – TENSION
18 – TIREDNESS
21 – DIFFICULTY IN REMEMBERING THINGS
23 – LACK OF EMOTIONS
26 – DEPRESSION
31 – SLEEPING TOO MUCH
41 – DIFFICULTY GETTING OFF TO SLEEP

POSSIBLE RANGE 0-40

ANTICHOLINERGIC SIDE EFFECTS

6 – DRY MOUTH
10 – CONSTIPATION
32 – DIFFICULTY PASSING WATER
38 – BLURRED VISION
51 – PASSING A LOT OF WATER

POSSIBLE RANGE 0-20

OTHER AUTONOMIC

15 – DIZZINESS
16 – FEELING SICK
20 – PALPITATIONS
27 – INCREASED SWEATING
36 – DIAORRHOEA

POSSIBLE RANGE 0-20

ALLERGIC REACTIONS

1 – RASH
35 – SENSITIVITY TO SUN
47 – NEW OR UNUSUAL SKIN MARKS
49 – ITCHY SKIN

POSSIBLE RANGE 0-16

HORMONAL SIDE EFFECTS

7 – SWOLLEN OR TENDER CHEST
13 – PERIOD PROBLEMS – WOMEN ONLY
17 – INCREASED SEX DRIIVE
24 – DIFFICULTY IN ACHIEVING ORGASM
46 – REDUCED SEX DRIVE
50 – PERIODS LESS FREQUENT – WOMEN ONLY

POSSIBLE RANGE WOMEN 0-24, MEN 0-16

MISCELLANEOUS

5 – HEADACHES
22 – LOSING WEIGHT
39 – PUTTING ON WEIGHT
44 – PINS AND NEEDLES

POSSIBLE RANGE 0-16

RED HERRINGS

3 – RUNNY NOSE
8 – CHILBLAINS
11 – HAIR LOSS
12 – URINE DARKER THAN USUAL
25 – WEAK FINGERNAILS
28 – MOUTH ULCERS
30 – GREASY SKIN
33 – FLUSHING OF FACE
42 – NECK MUSCLES ACHING
45 – PAINFUL JOINTS

POSSIBLE RANGE 0-40

POSSIBLE RANGE FOR TOTAL SCORES:

LUNSERS SIDE EFFECT SCORES ONLY
WOMEN 0 – 164
MEN 0 – 156

LUNSERS ALL 51 ITEMS
WOMEN 0 – 204
MEN 0 - 196

Contributors to the Second Edition

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Ms Dianne Albiston
Ms Swagata Bapat
Professor Michael Berk
Dr Enrico Cementon
Mr Kingsley Crisp
Ms Karen Dickinson
Mr Stephen Druit
Associate Professor Jane Edwards
Ms Kathryn Elkins
Associate Professor Paul Fitzgerald
Dr Shona Francey
Dr Rick Fraser
Ms Donna Gee
Ms Meredith Harris
Dr Tracey Harrison
Ms Sal Hosking
Mr Frank Hughes
Dr Margaret Leggatt
Ms Vivien Lebnan
Dr. Iain Macmillan
Ms Mary Macrae
Ms Pauline McEntee
Ms Beverly Moss
Dr Barnaby Nelson
Ms Helen Osman
Dr Alexandra Parker
Dr Lisa Phillips
Ms Deepika Ratnaike
Ms Jo Robinson
Dr David Shiers
Dr Gordon Shymko
Ms Esther Singer
Dr Russell Slater
Dr Ben Thomas
Mr Ned Tkalcevic
Ms Gina Woodhead
Dr Paul Woodhouse
The Victorian Youth Early Psychosis Services (YEPS)

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Any correction or comments may be directed to **info@orygen.org.au** and should be marked *attn: Australian Clinical Guidelines 2nd Edition*

Contributors to the First Edition:

Ms Jane Edwards

Ms Di Albiston

Central Coast Area Health Service - NSW

Mr C Curran

Dr P Dignam

Dr N Ford

C Gardner

Gold Coast Psychiatric Services - QLD

Ms B Hocldíng

Dr H Hustig

Associate Professor H Jackson

Ms J Jones

Associate Professor F Judd

Ms V Miller

Mr Michael Mooney

Dr P Morgan

Dr L Nash

Ms W Radcliffe

Ms K Robinson

Ms V Ryan

Ms K Scanlon

Professor B Singh

Western Australian NEPP Steering Committee

Western Sydney Area Mental Health Service - NSW

Swan Hill Community Mental Health Services

Ms L O'Brien

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Ms Hilary Berry, Northern Territory (State Coordinator)

Ms Bernadette Dagg, New South Wales (State Coordinator)

Mr Stephen Haines, Victoria (State Coordinator)

Mr Peter Handley, Tasmania (State Coordinator)

Ms Amanda Urbanc, Australian Capital Territory (State Coordinator)

Mr Christopher Wigg, South Australia (State Coordinator)

Ms Julie Kempton, Queensland (State Coordinator)

Ms Bernadette Pound, Western Australia (State Coordinator)

Further Information on Early Psychosis Services

www.iepa.org.au

For further information on how to obtain a copy of The Australian Clinical Guidelines for Early Psychosis: second edition contact:

www.orygen.org.au and follow the links to resources

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info@orygen.org.au and should be marked *attn: Australian Clinical Guidelines 2nd Ed*