Early Psychosis

A CARE GUIDE

SUMMARY

Senior Authors

TOM EHMANN, Ph.D.

LAURA HANSON, Ph.D.

UBC

Department of Psychiatry
Faculty of Medicine
The University of British Columbia

Mheccu

Mental Health
Evaluation & Community
Consultation Unit

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SENIOR AUTHORS AND EDITORS

Tom Ehmann, Ph.D.

Laura Hanson, Ph.D.

QUALIFYING STATEMENT

This summary highlights the approach and principal recommendations contained in the Early Psychosis Care Guide. The care guide provides an overview of the practices believed by the authors to be optimal for treating early psychosis. Information and advice provided in the guide are based on:

- a thorough review of published research evidence, including comprehensive published reviews (emphasis was placed on controlled studies, with uncontrolled trials and quasi-experimental designs used only where they provided information unavailable through controlled trials); priority was given to literature specific to early psychosis
- examination of existing clinical practice guidelines
- direct consultation with experts concerning current clinical practices.

To enhance the guide's readability, references and citations have been omitted. Readers will also find that the guide is not a standard of care and does not stipulate a single correct approach for all clinical situations. Decisions regarding specific procedures for specific individuals with psychosis remain the responsibility of the attending professionals.

Please see the entire guide (available online at **http://www.mheccu.ubc.ca/**) for detailed discussions regarding the principles, procedures, and recommendations covered in this summary.

UBC Department of Psychiatry
Faculty of Medicine
The University of British Columbia

Mheccu Mental Health Evaluation & Community Consultation Unit

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Mental Health Evaluation

& Community Consultation Unit

2250 Wesbrook Mall

Vancouver, BC V6T 1W6

http://www.mheccu.ubc.ca/

Senior Authors and Editors

Tom Ehmann, Ph.D.

Laura Hanson, Ph.D.

Contributors

Sean Flynn, M.D.

Robin Friedlander, M.D.

John Gray, Ph.D.

Josephine Hua, B.Sc.

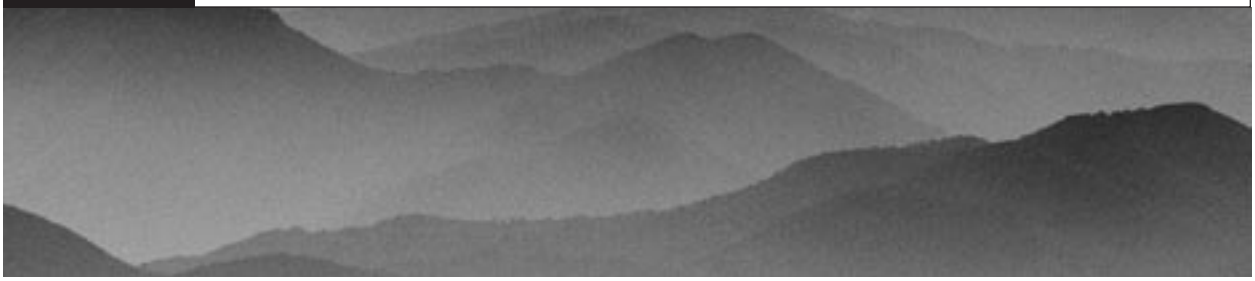
Irfan Khanbhai, M.D.

Eric MacNaughton, M.A.

Otto Lim, M.S.W.

Richard Williams, M.D.

Fred Ott, B.Sc. O.T.



Goals of the care guide

The care guide has been designed to:

- increase understanding of the rationale behind early intervention and the guiding principles of care for persons in the early phase of psychotic disorders
- guide clinicians in specific aspects of management
- reduce unwanted variations in clinical practice by encouraging the use of appropriate procedures and services
- act as a planning vehicle to improve service delivery systems and guide policy makers in implementing changes to mental health systems and policies

Rationale for early intervention

The most common diagnoses associated with psychosis are schizophrenia, schizophreniform disorder, schizoaffective disorder, bipolar disorder, and major depression with psychotic features. Despite advances in pharmacological and psychosocial treatments, outcomes for the major psychotic disorders are often poor, and sufferers tend to relapse. After five years of illness only 20-30% of patients with schizophrenia experience good outcomes. Even if psychotic symptoms abate, individuals with psychosis tend to experience decreased social and occupational functioning, poor quality of life, and increased mortality (particularly due to suicide).

For all psychotic disorders, the better the short-term course, the better the long-term outcome. Many studies found long delays before treatment began in first episode cases. Long durations of untreated psychosis have been associated with slower and less complete recovery, more biological abnormalities, more relapses, and poorer long-term outcomes. Introducing effective treatment sooner may be one way of achieving improvement in long-term outcomes.

Onset of psychosis typically occurs in late adolescence or early adulthood, thereby causing a major disruption in the ability of individuals with the disorder to meet developmental challenges such as

- pursuing academic or vocational goals
- developing sexual and social relationships
- managing independent living
- establishing personal values and identity.

At the same time, persons in the throes of a psychosis usually experience tremendous distress and may engage in actions that are dangerous to themselves and others. Family relationships may be affected, and individuals experiencing psychosis may also be prone to suicide, depression, aggression, substance abuse, cognitive impairment and anxiety disorders.

Effective early intervention seeks to address these problems by

- providing age-appropriate support to minimize disruption in the lives of these individuals and enable them to more successfully meet their developmental challenges
- limiting the suffering and possible negative repercussions of psychotic behaviour
- assisting families
- remaining sensitive to factors that may hinder successful ongoing treatment and lead to relapse, such as
  - > iatrogenic effects generated by aversive procedures
  - > medication side effects
  - > stigma and other impediments to collaborative relationships
- providing treatment for associated problems such as suicidal tendencies, depression, aggression, substance abuse, cognitive impairment, and anxiety disorders, rather than simply assuming that these features are secondary phenomena
- providing appropriate treatments that seek to produce better long term outcomes, quicker recoveries, lower use of hospitalization,

Early intervention

An early intervention approach implies the following basic actions:

- identification and referral early in the course of the illness
- rapid and appropriate response to the referral
- significant efforts made to develop a long-lasting therapeutic alliance
- prompt initiation of suitable treatments
- minimization of negative effects associated with assessment and treatment
- provision of relapse prevention service
- completion of outcome assessments to assure quality service delivery and refine future services.

These actions require the existence of a suitable service-delivery system, including both inpatient and outpatient capabilities. Although early intervention hopes to avoid hospitalization through early identification and avoid re-hospitalization by decreasing relapse, 50% of first-episode patients will be hospitalized within a week of first making contact with psychiatric services. 80% will require some hospitalization within three years.

Ideally, specialized inpatient units catering to the unique needs of young persons with early psychosis would be available. Unfortunately, the development of such units would be restricted to large urban areas, and the vast majority of early psychosis cases will present to general inpatient units. Unit managers should be aware of optimal early psychosis practices and strive to incorporate them into daily practice. One initial strategy might be to provide staff training in these issues and assign those with the greatest interest and expertise to first-episode admissions.

If outpatient services are ongoing before a first admission is needed, the outpatient mental health worker should be involved in the intake procedures, throughout the period of hospitalization, and in discharge planning. Links with community services should be established if the patient has no history of contact with these services. This will help ensure smooth transition and reduce the likelihood of the patient becoming lost to the system after discharge from hospital.

The development of multidisciplinary community teams is now the predominant model of care in many jurisdictions. Case management is at the center of comprehensive treatment of psychosis. Case management tasks will vary according to phase of recovery. It is recommended that either assertive community treatment teams or designated lead clinicians using intensive case management with team back-up be employed to provide community care to individuals with early psychosis. Group education and treatment programs should be considered as an adjunct (not an alternative) to individualized services for patients.

In addition, early identification will be enhanced by educational programs aimed at people in a position to recognize and refer an individual who is becoming psychotic. Teachers, the general public, students, family physicians, professionals and paraprofessionals working in health, forensic, educational, or business settings are examples of such people. Educational content should include signs and symptoms that may indicate psychosis, the potential benefits of early intervention, and information on accessing appropriate services.

Assessment

Assessment should be ongoing, competently conducted, informed by high-quality measurement, and broad in scope (e.g., taking account of collateral information). Semi-structured interviews and the use of standardized clinical rating scales are recommended, since they increase diagnostic reliability, ensure consistent coverage, quantify symptom severity, permit later comparisons, and are useful for program evaluation. Regardless of the stage of illness, comprehensive, reliable assessments of symptoms and functioning are essential. Particular attention should be paid to any indication that there may be a risk of suicide, homicide, or victimization.

Psycho-social assessment should aim to obtain information on

- the status of social relationships, school and/or work performance, recreational pursuits, finances, ability to manage money, self-care, religious activities, domestic roles, housing and clothing
- the assessment of strengths and intact functions (this will help clinicians target intervention and support the patient's self-efficacy)
- the rate of change in these functions
- cognitive and intellectual functions (a preliminary estimate can be derived from the mental status exam)
- stressors, coping abilities, personality, and beliefs about illness
- birth and development, medical, psychiatric, forensic, academic/occupational, recreational, and social histories.

Physical assessment should include basic neurological and general physical examinations that include

- identification of movement abnormalities prior to initiating antipsychotic drug treatment
- urinalysis and complete blood count (urine and blood analysis can help reveal systemic infections)
- electrolyte and glucose measurements
- tests for hepatic, renal, and thyroid function
- determination of HIV and STD status
- a toxicology screen
- assessment of heart function (antipsychotic medications may have adverse cardiac effects)
- measurement of the patient's weight and body mass index before beginning treatment.

Accurate assessment of current medical problems is important, as these can contribute to more severe psychosis and depression, and a greater likelihood of suicide attempts. Although CT scans may reassure patients and families and rule out certain neurological causes of psychosis, the lack of specificity of abnormal findings associated with psychoses suggests that neuroimaging is not necessarily indicated if the neurological exam and history are normal.

Assessment feedback should provide realistic expectations of recovery and avoid speculation. Diagnostic reassessment several times per year is recommended (e.g., using diagnostic criteria checklists or direct consultation of DSM-IV). Failure to re-diagnose can result in the application of inappropriate treatments, both currently and in the future. It can also result in the provision of inappropriate educational information and the development of misleading expectations on the part of both patient and treatment professionals.

General treatment principles

The development of a strong working alliance facilitates successful ongoing treatment.
Development of the therapeutic relationship may take precedence over treatment initiation in order to increase the probability of long-term success.

The patient's initial discomfort should be minimized.
There are many opportunities for the person with psychosis to become distressed or traumatized. These can include the nature of the symptoms, insight that something is terribly wrong, coercive and confusing admission or assessment procedures, and problematic side effects from treatment.

Treatment should target a broad range of treatment goals.
Assessment and treatment inform each other and can be conceptualized as one process. Treatment should be comprehensive, individually tailored and adhere to best practices. Appropriate goals for treatment include amelioration of psychotic symptoms, rapid and effective re-entry into the person's normal roles and environments, prevention of secondary morbidity, prevention of relapse, retention of a positive self-concept and self-efficacy and maximization of quality of life. Treatment of other psychiatric conditions in those with psychosis should be aggressive, given that comorbidity rates may be up to 50% in first episode cases. Functional decline, the need for treatment, and stigma can damage self-esteem.

Professional involvement should be ongoing and intensive, and significant interruptions should be avoided.
The concept of a critical period, in which early course predicts later course, suggests that ongoing intensive involvement should occur for at least several years after resolution of the initial episode. Further, discontinuities in care can confuse and upset a patient. These disruptions pose potential threats to engagement and may lead to relapse either directly or via non-adherence. In many jurisdictions the transition from youth to adult services is especially awkward.

Practices should be age-appropriate and stage-appropriate.
Specific interventions are appropriate to different stages of a disorder. Both pharmacological and psychosocial interventions are affected by this principle. Similarly, the content and process of interventions should be consistent with the developmental stage of the individual.

The pace and timing of reintegration should be carefully considered.
Successful rapid reintegration back into social, occupational/scholastic and other roles is a primary goal of early intervention. The pace and extent of return to each area calls for sensitive handling, however. Confidence and self-esteem can easily be damaged if the individual experiences failures rather than successes.

Family involvement is important.
The alleviation of family disruption should be fostered along with engagement of the family as a therapeutic agency. Family involvement should begin as early as possible.

Acute inpatient presentations

Inpatient staff should be cognizant that the experience of the first-episode patient is markedly different from the experience of someone who has been hospitalized repeatedly. Numerous reports indicate that first-episode patients find their initial hospital experience traumatizing. Treatment should be based on the following general principles.

Pharmacotherapy

Acute-phase pharmacotherapy

On balance, it is recommended that treatment of early psychosis begin with one atypical antipsychotic, since atypicals

- are effective at treating psychotic symptoms
- are at least as effective as typicals at treating negative symptoms
- are less likely than typicals to cause adverse side effects that produce non-adherence
- appear to have some beneficial effects on cognition
- appear to effectively treat some non-psychotic symptoms
- may be associated with less hospitalization

Olanzapine and risperidone are the only atypicals that have reported data from clinical trials showing efficacy in early psychosis.

Young persons and first-episode patients tend to be more sensitive than older patients to the effects of all antipsychotics. Therefore, much lower doses are needed to effectively treat symptoms and avoid the emergence of side effects. Doses should start low and proceed upwards slowly If initial presentation suggests the presence of an affective disorder, then an appropriate mood stabilizer or antidepressant should also be started. Some evidence suggests that antipsychotics are helpful in treating depression, anxiety, aggression and cognitive deficits. Both typical and atypical antipsychotics are effective in treating mania. Assessment of response to treatment should be multi-dimensional, with consideration given to psychotic symptoms, mood, social and occupational functioning, acute and chronic side effects, cognition, subjective response, and quality of life.

Pharmacotherapy / continued . . .

Recommended Starting and Lowest Effective Doses in First-Episode Psychosis

Medication	Starting Daily Doses	Lowest Effective Daily Dose
Haloperidol	1-2 mg	2 mg
Risperidone	0.5-1 mg	1.5 – 2 mg
Olanzapine	2.5-5 mg	5 mg
Quetiapine	To be established (50-100 mg ?) *	150 mg ? *
Ziprasidone	To be established (5-20 mg ?) *	? *

*** ? signifies lack of published studies to confidently inform first-episode response**

The vast majority of patients with schizophrenia or schizoaffective disorders will show a good symptomatic response to antipsychotic medication. The following, however, may all exhibit a poorer initial response to medication in early psychosis: males, women with a history of obstetrics complications, persons with more severe symptoms, those who are younger at initial onset, those who have a poorer premorbid adjustment and patients who develop parkinsonian symptoms.

An initial period of about one week should allow the clinician to determine if the patient is tolerating the medication. Positive symptoms and general symptoms such as anxiety and agitation often show discernible improvement within one week. Most improvement tends to occur within the first six months of treatment. About 30% of first episode cases of schizophrenia will not respond within six weeks of treatment. Since non-responders taking reasonable doses do show adequate binding to D2 receptors, it is unlikely that dose increases will be effective. Instead, switching to another medication should be considered.

Side effects of pharmacotherapy

When very low doses of typical antipsychotics or risperidone are used, the rates of extrapyramidal side effects are low and anticholinergic medications are not needed. In general, rates of extrapyramidal side effects are lower for all atypicals than for typicals. The atypicals, with the exception of risperidone, are much more prolactin-sparing than the typicals. If extrapyramidal side effects develop during treatment with an atypical, the dose should be lowered.

Weight gain

All antipsychotic medications can cause weight gain. Among atypical antipsychotics, clozapine appears to cause the most weight gain followed by olanzapine, quetiapine, and risperidone. Body Mass Index should be calculated monthly for the first 6 months, or weekly if rapid weight gain is occurring. Significant weight gain could increase for the risk of non-adherence, especially among young females. It also poses increased risk for other obesity-related disorders such as diabetes and heart disease. Dietary control and exercise remain the principal treatments for weight gain. Risperidone appears to be the sole atypical that has not been implicated in reports of impaired glucose regulation. Caregivers in both community and inpatient settings should take baseline glucose measures and continue monitoring over time.

Sedation

Low-potency medications such as clozapine and chlorpromazine are more likely to produce sedation than most high-potency typicals. However, olanzapine, quetiapine and risperidone all appear to be more sedating than haloperidol. Atypicals given in doses appropriate for early psychosis generally do not produce many anticholinergic effects.

Overdose

Overdose of antipsychotic medications rarely causes death, unless accompanied by alcohol/drug ingestion or preexisting medical conditions. Treatment of overdose is symptomatic and supportive.

Smoking

Smoking can lower antipsychotic blood levels by up to 50%. Successful-smoking cessation programs have been reported.

NMS

Neuroleptic Malignant Syndrome has been associated with all antipsychotic medications including atypicals. If neuroleptic malignant syndrome occurs, antipsychotic medications should be discontinued immediately and symptomatic treatment instituted.

Utility of other drugs

Little is known about the use of adjunctive agents such as antidepressants, benzodiazepines, and mood stabilizers in first-episode cases of schizophrenia, because most studies have utilized refractory chronic patients. The use of two antipsychotics in first episodes, is generally unwarranted.

The benzodiazepines are helpful in managing sleep disturbances, agitation, and anxiety very early in the treatment process. Benzodiazepines also appear to have some antipsychotic effect, albeit considerably less than antipsychotic medications. Their use can foster greater diagnostic clarity and improve engagement. If a benzodiazepine is used with an antipsychotic, the dose of antipsychotic should be lowered.

If a first-episode psychosis patient presents with mania and the clinician suspects bipolar disorder, treatment with an antipsychotic and either lithium or valproate is recommended, with benzodiazepines to be considered if severe behavioural disturbance is present. Failure to obtain a good response after three weeks may prompt use of a second mood stabilizer (e.g., carbamazepine) or switching antipsychotics. Atypicals appear to hold promise in the treatment of bipolar disorder.

Lithium used alone for schizophrenia is likely to be ineffective or even to worsen symptoms, but it may enhance the effects of antipsychotics when given adjunctively. Lithium should not be employed before an adequate trial of an antipsychotic alone. The lithium add-on should show a beneficial response within four weeks.

Although antidepressants, ECT, and mood stabilizers are all effective treatments for depression in bipolar patients, their place in treating schizophrenia is less clear. Antidepressants may not be particularly helpful once the illness is established. Nevertheless, the use of antidepressants in schizophrenia is justified if antipsychotic monotherapy fails to adequately treat depressive syndromes.

Switching medication

A failure to show significant improvements within four to six weeks should prompt consideration of switching to another antipsychotic. Clozapine is regarded as the gold standard in treatment-resistant cases. Clozapine should not be considered before at least two trials, at least one of which should be either risperidone or olanzapine. Each trial should last at least four to six weeks, unless discontinued earlier due to side effects. Several switching paradigms exist and none is unequivocally superior. A poor initial response is not cause for pessimism since about 16% of early unremitting cases will achieve late-phase recovery.

Maintenance-phase pharmacotherapy

It is recommended that patients with first-episode schizophrenia remain on maintenance medication for a minimum of one to two years. Psychotic disorders other than schizophrenia merit shorter maintenance periods after symptomatic recovery (e.g., bipolar patients need only remain on an antipsychotic for six to twelve months before discontinuation is considered).

Patients frequently discontinue medications when they have recovered from a first episode. One medication strategy developed to deal with this situation is to discontinue all medication once symptoms have disappeared and then restart the antipsychotic at the first signs of a relapse. Relapse rates are higher when this "intermittent targeted" approach is used, however, than when medication is continuously prescribed. If the person has had only one episode, experienced a complete symptomatic recovery, and is willing to be closely followed but is very reluctant to take medication, the intermittent approach might be an option. However, for someone who has relapsed quickly and who appears to have schizophrenia, medication should be maintained for at least five years.

In general, a patient in the maintenance phase is best served through close monitoring, periodic review of the diagnosis, maintenance on the lowest possible dose, ongoing psychosocial interventions, and easy access to services if a relapse appears possible.

The role of psychoeducation

Psychoeducation fosters the knowledge, attitudes, skills, and abilities necessary for self-management of an illness and improvement of quality of life. Psychoeducation also addresses the emotional aspects of the illness experience. Treatment adherence and relapse prevention are usually considered the main aims of psychoeducation. Psychoeducation should be offered to all persons with a psychotic disorder, family members, spouses or partners, and other potentially supportive individuals.

The benefits associated with psychoeducation include: improved knowledge, decreased negative symptoms, improved interpersonal skills, decreased relapse rates, and abbreviation of lengths of stay or illness duration. The greatest benefits accrue when both family and patient are regularly involved for about one year.

Psychoeducation should occur during all phases of the illness including during help-seeking and initial entry into mental health services. During the early assessment phase, clinicians should convey their familiarity with the condition, the need for prompt intervention, and the message that the psychosis should respond well to treatment. People will also require clear explanations about the roles of the involved professionals, treatment options, legal rights, and available supports appropriate to their situation.

Content of psychoeducation

The main topics of psychoeducation include information on psychosis (symptoms, risk factors, etc.), treatments, recovery, relapse prevention, stress management, and lifestyle issues including health education.

The usual framework for presenting information is the stress-vulnerability model. Within this context, one can present both biological and psychosocial strategies to reduce the risk of psychosis and prevent relapse: complying with medications, avoiding substance use, managing interpersonal conflict, making use of peer support, identifying and managing environmental stressors, learning the "early warning signs" of the illness, developing and planning proactive coping and help-seeking strategies. By presenting recovery from a first episode as an active process that occurs in recognizable stages, the educator helps both the individual and family to normalize their own experiences and to recognize the value of their own contribution to the recovery.

Throughout psychoeducation, issues of stigma and demoralization should be addressed. Although most psychoeducational programs initially focus on providing information about the illness and move towards enhancing coping skills, there is no invariably best sequence for introducing individual components of psychoeducation. Techniques such as structured problem solving and social skills training help individuals assimilate and apply information by actively rehearsing the knowledge, skills, or strategies in question.

Having the clinician meet with the patient and/or the family is the preferred way to initiate psychoeducation, because people have differing requirements for information, learning styles, explanatory models, emotional needs, and capacities to participate. Involving the family in psychoeducation allows for more opportunity for the family and patient to learn about the illness together and appreciate each other's perspective. Group approaches are frequently effective, since they make efficient use of therapist time, allow members to share experiences, and foster social supports.

Skill building

Problem solving

Training in structured problem solving has been associated with improvements in functioning, especially when provided to both patient and family. Problem-solving is a technique that is used in conjunction with a number of different interventions – including stress management, relapse prevention, cognitive behaviour therapy, and social skills training.

Social skills training

Deficits in social functioning and interpersonal problem-solving skills are present early on in the course of psychosis. Training in social skills has been well-described in the literature and includes: education, modeling, role-play or behavioral rehearsal, coaching, feedback, and positive reinforcement. Social skills training should incorporate problem-solving, as this results in greater benefits, including wider "generalizability."

Cognitive rehabilitation

Early psychosis patients frequently show a large generalized neuropsychological deficit along with more selective deficits in attention, learning, memory, speeded visual-motor, and executive functions. These cognitive deficits appear to be related to interpersonal problem-solving and social functioning, activities of daily living, and vocational pursuits. Cognitive rehabilitation aims to directly remediate cognitive deficits through special training exercises or to provide strategies that help patients adapt to the deficits. Until there is more evidence supporting the efficacy of cognitive remediation, strategies that help patients adapt to the deficits should form the primary focus of cognitive rehabilitation.

Family communication training

There is little evidence that expressed emotion is associated with relapse in early psychosis patients or that family work designed to decrease expressed emotion reduces relapse. It may be that expressed emotion develops over time in families that have difficulties adjusting to the psychotic illness. To address this possibility, key interventions during the early phases would include training in problem solving, enhancement of coping mechanisms, and help in developing social networks.

Cognitive therapy

Cognitive therapy involves altering dysfunctional patterns of thinking that are linked to pathological feelings and behaviour. Cognitive therapy can help ameliorate both psychotic symptoms and secondary psychological disturbances such as depression. Additional benefits may include decreases in preoccupation and distress due to delusions, abbreviated length of hospital stay, increased insight and perceived control over the illness, and improved mood. Cognitive therapy should be undertaken by individuals with demonstrated qualifications and competence. It should be considered a useful adjunct to pharmacotherapy and psychoeducation.

Stress management

Stress management enhances the ability of patients to cope with life events, daily hassles, and the manifestations and consequences of the psychotic illness. Problem-focused strategies tend to yield more benefits than emotion-focused efforts. Since no single coping strategy is always effective for all individuals, problems, or situations, training should focus on helping the patient develop a variety of coping strategies. . Planning for the use of specific strategies in well-defined situations should be coupled with evaluation of their success and subsequent revision. A variety of coping strategies specific to psychotic symptoms may be useful. For example, procedures that are simultaneously engaging and relaxing appear to be particular helpful.

Relapse prevention

The majority of persons with early psychosis will experience a relapse within five years. Patients experiencing a first relapse are likely to experience second and third relapses. Subsequent relapses are associated with more social impairment, higher levels of secondary morbidity, and more residual symptomatology. Maintenance medication, case management, psychoeducation, and family involvement are all associated with lower relapse rates.

Changes seen prior to the re-emergence of psychosis have been referred to as both the “relapse prodrome” and "early warning signs." Although the combination of non-specific and psychotic-like symptoms predicts relapse better than vague symptoms alone, neither approach is particularly accurate. Regardless of whether the early warning signs vary or form a predictable pattern in any individual, an action plan for the patient and family should be developed for use when they believe relapse may be starting.

Cessation of medication is especially associated with relapse. Use of the lowest possible dose of medication improves adherence by minimizing side effects. Further, patients are more likely to continue taking needed medication if their treatment program includes psychoeducation, behavioural components and motivational strategies. A relapse should prompt reevaluation of the person's knowledge of the illness and refinement of preventive strategies such as stress management and help-seeking.

Promoting community functioning

One of the goals of early intervention is to return people to their normal environments as soon as possible. Readiness for reintegration depends upon the rate of recovery. Recovery from symptoms frequently occurs within days or weeks, allowing a rapid return to community activities. Despite the laudable goals of quick reintegration, interviews with patients suggest that many people try to resume normal community activities too quickly.

The clinician should facilitate the return to social functioning by providing psychoeducation and by using psychosocial rehabilitation techniques (or referring the patient to rehabilitation services). The ultimate goal is to help the individual independently negotiate his or her support needs. Rehabilitation methods include helping the person explore interests, strengths, and values in relation to work and school before setting social and vocational goals. Patients may need to be educated and advised regarding their eligibility for financial assistance and the advantages and disadvantages of receiving disability benefits. They may also need assistance in disclosing their disability, obtaining support within a setting (e.g., modifications to school curriculum, acquisition of study aids), and finding accommodations.

Safe and affordable housing should be available to patients whose current living situation is unsafe or detrimental. The type of housing placement should take account of the individual's level of functioning, goals, and financial resources. When shared accommodations are considered, it is preferable to place the patient with others who are of approximately the same age and level of functioning. Using small therapeutic houses might help reduce length of hospitalization (especially when housing is an issue) and facilitate group recovery and reintegration.

At-risk or prodromal individuals

The term prodrome may be used to describe a period of signs and symptoms before an individual becomes psychotic for the first time. The prodrome is diagnosed only after the development of florid features of psychosis. It is not possible to accurately predict if a person displaying features suggestive of a prodrome will make the transition to psychosis. For this reason, and because little is known about how to prevent onset of psychosis, psychosis-specific treatments (e.g., antipsychotic medications and education about psychosis) should not be implemented until a psychosis is definitely present. When an individual appears to be prodromal,

- he or she should be engaged, treated for presenting complaints (e.g., depression, anxiety, insomnia) and closely monitored
- a stressor that could exacerbate the condition should be addressed by modifying it, by finding ways for the patient to avoid it by shifting the patient's perception of the stressor to render it less threatening, and/or by decreasing the patient's attendant physiological arousal.

Substance abuse

It is estimated that approximately 20-30% of early psychosis patients have a substance abuse problem. In early psychosis, cannabis and alcohol appear to be the two most frequently abused substances. There is no consensus on whether substance use itself can cause a longstanding psychotic illness such as schizophrenia. However, certain substances (e.g., amphetamines) can induce a brief acute episode of psychosis.

The separation of mental health and substance abuse services is associated with poorer outcomes. Integrated services can successfully be developed in a number of different clinical settings and appears to improve patient outcomes, although available research data is sparse. Integrated treatment emphasizes long-term care, harm reduction and motivational techniques as opposed to short-term treatments, abstinence, and confrontational strategies. Given their very high attrition rates, dual-diagnosis group interventions appear to be insufficient for the majority of patients and should be regarded as adjunctive.

Developmental disability

Developmental disability is a term increasingly used to refer to individuals with mental retardation. The prevalence of schizophrenia in this population is about the same as or slightly higher than in the general population. For those with a mild developmental disability, the clinical phenomena of psychosis are not particularly distinctive. Because of verbal difficulties, most experts believe it is not possible to reliably diagnose psychosis in those with an IQ of less than 50.

The primary assessment considerations include

- giving greater weight to observable phenomena and collateral information in low-verbal patients
- avoiding the assumption that aberrant behaviour is always a manifestation of the developmental disability
- recognizing that certain phenomena may not be indicative of psychosis (e.g., imaginary friends)
- minimizing the tendency to say "yes" to questions
- allowing for concentration deficits.

The use of antipsychotics in this population is associated with greater risk of movement disorders and cognitive impairment. Adaptation of existing psychoeducational materials is needed and should include topics relevant to developmental disability and the consequences of the dual diagnoses. There is a need for specialized day treatment programs. For individuals with IQ below 50, consultation with, or referral to a specialized mental health team is advised.

Involuntary admissions

Involuntary admission and treatment (committal) should be considered when a person needs psychiatric treatment but refuses it, and without treatment the person is likely to suffer significant harm. In British Columbia the criteria and processes regarding committal are included under the *Mental Health Act.*

Service delivery measurement tools

Outcome measurement is useful in helping clinicians, administrators, and/or researchers

- assess the effectiveness of intervention efforts
- allocate resources effectively
- maintain accountability
- assess the fidelity of services to their purported models of care.

Service delivery measurement tools should include indicators of outcome as well as indicators related to process and implementation. The use of rating scales, forms, or other psychometric instruments merely formalizes the processes clinicians already engage in. Several validated scales are identified in the guide.

Mheccu

Mental Health
Evaluation & Community
Consultation Unit

2250 Wesbrook Mall,

Vancouver, BC V6T 1W6

www.mheccu.ubc.ca