



# QUICK QUERIES

Topical Questions, Sound Answers



## Psychosis: Catching It Early



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Psychotic disorders (schizophrenia spectrum and affective psychoses) have a prevalence of > 2% for non-affective psychosis alone<sup>1</sup> and an annual incidence of 30.4 per 100,000 of non-affective and affective psychosis.<sup>2</sup> Main features include:

- positive symptoms
  - delusions,
  - hallucinations,
  - disorganization of thought and behaviour
- negative symptoms
  - poverty of thought and affect,
  - apathy and emotional withdrawal,
- depressive (manic in case of bipolar) and anxiety symptoms with variable residual symptoms and
- social disability in the longer term.

As the onset of psychosis is typically between 14 years-of-age and 30-years-of-age, these disorders interfere with social and emotional maturation, higher education, employment, marriage and parenthood and are associated with high rates of substance abuse,

depression, suicide, violence and legal problems as well as enormous direct health care, and indirect costs through lost productivity.

Recent developments in improving outcomes are due primarily from changes to the nature and to the timing of treatment relatively early in the course of the illness through benefits of early intervention.

### FAQ

***What are the chances of remission of psychotic symptoms for a young person with a first episode of psychosis?***

With adequate treatment, 80% of young people will show remission of psychotic symptoms and 50% will show reduction in negative symptoms.

### ► ***What is EI?***

Early intervention (EI) in psychotic disorders encompasses two major elements.<sup>3</sup> The first element is a specialized approach to treatment of the first episode of psychosis (FEP) using



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biological and psychosocial treatments with proven efficacy, but are modified to suit the special needs of a young, treatment-naïve population. These services usually provide:

- rational pharmacotherapy with low dose novel antipsychotic medications,
- special emphasis on family intervention,
- close monitoring of symptoms, medications and functioning (delivered through variations of case management),
- special attention to problems of substance abuse and
- cognitive behaviour therapy for residual psychotic symptoms, depression and anxiety, which often accompany psychosis.

The second element of EI in psychotic disorders is early and easy access to a specialized service through a combination of an open referral system, assertive case finding and close collaboration with primary health care and educational institutions.

### ► *What is the rationale for an EI service for psychotic disorders?*

The long-term outcome of psychotic disorders consists of three major trajectories:

- favourable outcome (15% to 20%),
- lack of response to treatment with rapid decline (20% to 25%) and
- episodic course with residual symptoms, social and personal deficits and a deteriorating functional outcome (50% to 60%).

Adequate treatment is most likely to improve outcome during the critical period of three years to five years when these trajectories are established.<sup>4,5</sup> Further, delay in treatment after onset of psychotic symptoms of an average of 12 months is associated with a poor outcome.<sup>6</sup> Hence the need for establishing EI services to provide the most comprehensive treatment soon after the onset of illness.

### ► *What is the evidence to support EI?*

The short term (*i.e.*, one year to two years) benefits of this specialized approach to treatment of FEP are now well established including, two recent randomized controlled trials.<sup>7,8</sup> Patients treated in an EI service have:

- higher rates of adherence
- lower rates of:
  - substance abuse,
  - aggression/suicidal behaviour,
  - relapse and re-hospitalization and
- significantly better quality of life and functional outcomes compared to patients treated in routine care.<sup>9,10</sup>

However, it remains unclear how long such specialized interventions should be sustained in order to achieve long-term benefits.

#### FAQ

##### *What are the malleable factors that promote a better outcome in FEP?*

These include:

- shorter delay in initial treatment,
- adherence to antipsychotic medication,
- social and family support and
- absence of continued substance abuse.

#### FAQ

##### *Are there signs and symptoms before the onset of psychosis that can be treated to prevent psychosis?*

Most patients experience general psychiatric symptoms, such as depression, anxiety, social withdrawal and odd behaviour for months to several years before the onset of psychosis, but these are non-specific and cannot be targeted for treatment.

**FAQ**

***What are the early signs of psychosis?***

Psychosis should be suspected in a young person (14-years-old to 30-years-old) if there is significant change in behaviour (suspiciousness, social withdrawal from friends and family alike, odd behaviours) especially if there is positive family history or substance abuse (cannabis, amphetamines etc.)

***What is the role of primary care?***

Most patients with a FEP seek help through their families and often consult a FP (30% to 50%) or an emergency service (30% to 40%) as their first contact for help. Some also seek help from non-medical services such as school or college counsellors. Most do not receive appropriate treatment until after a few health contacts and further delay. Although the ER is a quick point of entry to treatment, it may interfere with early engagement in treatment. Physicians and other workers in health and education disciplines need to be sensitized to early signs of psychosis and the likelihood of the co-occurrence of substance use/abuse, especially cannabis and psychosis.

***What are the implications for mental health policy and services?***

Given the level of evidence to support EI services, mental health policy needs to be revised to give future generations of patients a chance for a better outcome. Several countries (e.g., the UK and Australia) are further ahead in this regard than Canada, despite clear evidence and support from the recent Senate Committee on Mental Health. In Canada, there have been some developments mostly through advocacy from clinicians, researchers and consumers. Most provincial governments have not made a policy commitment.

***Future developments***

We still need precise evidence regarding the optimum length of sustaining patients in EI services beyond the first two years and its cost-effectiveness. Secondly, prevention of the first episode of psychosis in individuals at ultra-high risk (UHR) has been investigated through use of low dose antipsychotic medications or cognitive behaviour therapy. However, there is no established evidence to put into practice. The majority of UHR cases do not convert to psychosis and could be harmed by unnecessary treatment.

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