Psychosis in Youth At A Glance*

Early identification of the earliest phases of psychotic disorders combined with optimal treatment is likely to reduce the burden of disease. Early treatment of active psychosis is beneficial in its own right, but the possibility exists that it will also improve long-term outcomes and reduce the prevalence of psychotic disorders.

The possibility of a psychotic disorder should be carefully considered in a young person who is becoming more socially withdrawn, performing worse for a sustained period at school or at work, or who is becoming more distressed or agitated yet unable to explain why.

Young people with an at-risk mental state need to be engaged and assessed; offered regular monitoring of mental state and offered support; specific treatment for syndromes, such as depression, anxiety or substance misuse, and assistance with problem areas such as interpersonal, vocational and family stress if present. They need to be provided with psychoeducation and encouraged to develop coping skills for subthreshold psychotic symptoms; offered family education and support and; provided information in a flexible, careful and clear way about risks for mental disorders as well as about existing syndromes.

Antipsychotic medications are not usually indicated unless the person meets criteria for a DSM–IV/ICD–10 psychotic disorder. Exceptions should be considered when rapid deterioration is occurring; severe suicidal risk is present and treatment of any depression has proved ineffective; or aggression or hostility are increasing and pose a risk to others. If antipsychotics are considered, ideally, atypical medications should be used in low doses and considered as a 'therapeutic trial' for a limited period. If there is benefit and resolution of symptoms after 6 weeks, the medication may be continued with the consent of the person served for a further 6 months to 2 years, following explanation of risks and benefits. After this period, a gradual attempt to withdraw the medication should be made if the person served agrees and there has been a good recovery. If the person served has not responded to one atypical antipsychotic, another may be tried if the above indications persist.

ACUTE TREATMENT

There are three targets for preventive interventions in early psychosis:

The prepsychotic phase is often prolonged and characterized by subtle and confusing symptoms. Much of the disability associated with the psychotic disorders is established and accumulates in this phase.

The period of untreated psychosis is a risk factor for a poor outcome. It has many determinants, but there is potential for intervention within communities to reduce the duration of untreated psychosis and the distress, risk and disability associated with untreated psychosis. The first psychotic episode and the critical period of the early years following initial diagnosis deserve optimal, comprehensive and phase specific treatment with the assurance of continuity of care.

Pharmacological treatments should be introduced with great care in drug naive persons. This will involve the use of the minimum effective dose of atypical or second-generation antipsychotics wherever possible. If typical or first-generation antipsychotics cannot be avoided then they should be used judiciously and at very low doses.

Examples of appropriate initial target doses for most persons are risperidone 2mg/day or olanzapine 7.5–10.0mg/ day. Initial target doses of other medication such as quetiapine, ziprasidoneand amisulpride are yet to be established. Half to two-thirds of persons served might be expected to

achieve a good response in positive psychotic symptoms within 3 weeks at the initial dose, but if necessary, the doses can be increased to 4mg/day risperidone or 20mg/day olanzapine. The level of clinical response and risk should be assessed frequently, but the dose of the antipsychotic should be increased only at widely spaced intervals (after initial titration, usually 14–21 days) if the response has been inadequate, and then only within the limits of sedation and the emergence of extrapyramidal sideeffects. However, extrapyramidal side effects should not be tolerated. If the response is not adequate at therapeutic doses by 6–8 weeks, another atypical antipsychotic should be tried. When use of typical antipsychotics is unavoidable, they should be commenced at very low doses (1–2mg haloperidol or equivalent) and titrated very slowly within the limits of extrapyramidal side effects. Generally, this will be a maximum of 4–6mg haloperidol or equivalent in first-episode psychosis.

Low doses of antipsychotic medication will not have a rapid effect on distress, insomnia and behavioral disturbances secondary to psychosis; skilled nursing care, a safe and supportive environment, and regular and liberal doses of benzodiazepines are essential interim components of management in many cases. Although some atypical antipsychotics have initial sedative side effects, treatment of psychosis should be separated conceptually from the need for tranquilization. If positive psychotic symptoms persist after a trial of two first-line atypical antipsychotics (around 12 weeks), the reasons for the failure of treatment should be reviewed. Possible contributing factors include adherence problems, family stresses and substance misuse. Slow recovery of early treatment resistance of this kind is of concern and requires more intensive intervention. Clozapine and cognitive–behavioral therapy for persistent symptoms are obvious alternatives to consider.

Psychosocial interventions have a fundamental place in early treatment, providing a humane basis for continuing care, preventing or resolving secondary consequences of the psychosis, and promoting recovery. Supportive crisis plans are needed to facilitate recovery and acceptance of treatment. Specific psychosocial strategies should be employed when poor adherence, family stresses, increased suicide risk and substance misuse occur. Families are usually in crisis at the point of initiation of treatment and require emotional support and practical advice. Family therapy may be indicated when there is a high degree of distress in the family.

STABILIZATION

Severe and potentially recurrent and disabling disorders of any kind in an adolescent or young adult can destabilize and distort the complex and often strained process of separation and individuation from the family. It is important to work within this context and not to misinterpret genuine attempts to cope. **Psychological and psychosocial treatments should be core elements in the critical period and should be used to assist resolution of enduring positive and negative symptoms, the management of secondary comorbidity, and the promotion of recovery and positive mental health.** Recovery work should emphasize the need to find meaning and develop mastery in relation to the psychotic experience.

STABLE PHASE

Strive to balance vigilance for early signs of relapse and ‘space’ to recover and resume the challenges of normal development. Antipsychotic medication reduces the risk of relapse in the early years after onset and, particularly when there is a diagnosis of schizophrenia, should be considered as essential for sustained recovery. Relapse is distressing and may increase the risk of treatment resistance and other ‘collateral damage’, including worsening stigma. Side effects of antipsychotic medication, i.e. weight gain, sexual dysfunction and sedation, can retard recovery and should be monitored regularly. Once there is sustained remission, slow reduction of antipsychotic medication should be tried, with the aim of determining the minimal dose necessary.

The optimal length of time that maintenance antipsychotic treatment is needed to minimize risk of relapse in first episode psychosis is not known. Current clinical practice varies from recommending continuation for 1 year after treatment initiation to indefinite duration of antipsychotic maintenance treatment. Against advice, many young persons served wish to cease medication. Individuals who elect to cease medication (prematurely or otherwise) should continue to be monitored frequently and receive ongoing support. In all instances, careful education about the risks and possible manifestations of relapse should be provided, accompanied by frequent review and support with unhindered access to early psychiatric treatment in the event of relapse.

In the absence of clear evidence about when to cease antipsychotic medication it is pragmatic to take into account the severity of the first episode. For example, a fully remitted person served may be presented the option of gradually withdrawing medication after full remission for 12 months; if the first psychotic episode was severe and slow to respond, continuation of medication for a 2-year period following remission might be suggested. If the person served makes an incomplete recovery but has benefited significantly from medication, then it should be continued for at least 2–5 years. Long-term medication is advisable for individuals who experience frequent relapses.

Early warning signs of relapse should be discussed with the person served and the family. If a person served who rejects treatment has persistent symptoms or experiences frequent relapses, with a pattern of high-risk, suicidal or aggressive behavior, and is poorly engaged in treatment, then involuntary community treatment with or without depot medication may be required. This undesirable outcome should be considered to be time-limited to allow intervention and/or time to assist with acceptance of treatment recommendations. Involuntary and other restrictive treatment practices should be subject to frequent review.

Persons served should remain in comprehensive, multidisciplinary, mental healthcare throughout the early years of psychosis and, once their acute symptoms improve, not be discharged or transferred to primary care without continuing specialist involvement. However, partnerships can be established between mental health practitioners, primary care and other support and community services that can contribute to optimal care. First-episode psychosis is difficult to treat well, confers high levels of risk, and is the phase with the potential for greatest cost-effectiveness of treatment. To treat in a reactive manner is less effective and misses the best opportunity for enhancing outcomes and quality of life for persons served and their families.

OTHER SPECIFIC TREATMENT ISSUES

For a subgroup of persons served (e.g. persons with personality issues and/or enduring positive symptoms) long-term psychotherapy may be indicated.

*Adapted from International Early Psychosis Association Writing Group. International clinical practice guidelines for early psychosis. Br J Psychiatry Suppl. 2005 Aug;48:s120-4.