



## Early intervention for psychosis in New Zealand

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Psychosis is defined as a primary disturbance of thinking, which is reflected in certain symptoms—particularly disturbances in perception (hallucinations), disturbances in beliefs and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder).<sup>1</sup>

There are multiple causes of psychosis—including substance abuse, exposure to severe stress, inherited and acquired medical conditions or diseases, and mood disorders. Historically, the outcomes for those with psychosis have generally been thought to be poor.

### Early intervention for psychosis

In recent years, there has been a growing interest in the concept of early intervention for psychosis. Wyatt's influential paper<sup>2</sup> reviewed 22 studies in patients with schizophrenia. This review suggested that poor outcome (long associated with an insidious onset) had as much to do with delayed use of antipsychotics as the illness process itself. Wyatt concluded that early intervention with neuroleptics in first-episode schizophrenia patients may increase the likelihood of improved long-term course.

Three types of early intervention for psychosis have been described: primary prevention, secondary prevention, and tertiary prevention.<sup>3</sup>

#### Primary prevention

*Early intervention* before or during the prodromal phase involves *indicated primary prevention* and should lead to a decrease in the incidence of psychosis. Several groups are currently researching the feasibility of designing screening procedures to identify those with an 'at risk mental state'.<sup>4</sup> Authors widely acknowledge the existence of early specific and non-specific signs preceding the first psychotic episode; however, they have yet to clearly demonstrate their ability to predict and specify the transition to psychosis<sup>3</sup> leading to clinical and ethical concerns about initiating (antipsychotic medication) treatment at this stage.

#### Secondary prevention

*Secondary prevention* means intervention in the early stages of the development of a psychotic disorder, during the prodromal phase or onset of the first episode. While secondary prevention may be initiated before the development of frank psychotic symptoms (ie, during the prodromal stage), the majority of services concentrate on reducing the 'duration of untreated psychosis' (the period from the onset of psychosis to the implementation of 'adequate treatment'). Several studies have reported that the longer people remain psychotic before beginning treatment, the more likely they are to suffer relapses.<sup>5</sup> Patients gain less benefit from receiving maintenance antipsychotic medication,<sup>6</sup> and from intense treatment.<sup>7</sup>

Further, long delays (between the onset of psychosis and treatment) are associated with greater cognitive impairment, more severe negative symptomatology, and poorer personal and social outcomes.<sup>8,9</sup> Recognition and intervention at the earliest possible stage of florid psychosis could contribute to earlier symptom remission, delay in relapse and prevention of psychosocial deterioration.<sup>2</sup>

### **Tertiary prevention**

*Tertiary prevention* is not an early intervention strategy and has more to do with the timing, duration, and content of adequate treatment aimed at reducing the morbidity of the disorder.<sup>3</sup> Along with considerations of the importance of the duration of untreated psychosis, evidence is also emerging of a 'critical period' for vulnerability to relapse and development of secondary handicaps during the first 3 years following the onset of a first psychotic illness.<sup>10</sup>

Birchwood et al<sup>11</sup> have suggested that when disabilities develop following a first episode of psychosis they usually do so during the first 3 years. Unemployment, impoverished social networks, and loss of self esteem can develop rapidly during this 'critical period'. The longer these needs are not dealt with, the more entrenched they become. It has therefore been proposed that timely and effective intervention at this stage might alter the subsequent course of the illness and reduce the social toxicity of psychosis.

Early intervention for psychosis in the New Zealand context generally involves recognition and intensive phase-specific intervention from the time the individual becomes psychotic (although many services will accept those with a suspected prodromal presentation). This involves a combination of secondary and tertiary prevention strategies. In this case 'early' refers to treatment 'earlier than usual' in order to reduce the duration of untreated psychosis (secondary prevention). The 'intervention' is comprehensive, intensive, phase-specific and individualised treatment for these individuals<sup>12</sup> aimed at reducing the morbidity associated with first episode psychosis (tertiary prevention).

Early Intervention for Psychosis (EIP) services aim to provide intensive multidisciplinary treatment during the early phase of psychosis (typically in New Zealand for the first 2 years, although international research indicates that 5 years may be more appropriate.<sup>25</sup>)

Briefly, EIP services should provide<sup>1,13,25</sup>:

- An early detection programme.
- Use of appropriate low-dose atypical antipsychotics and other medications as appropriate.
- Psychoeducation.
- Family interventions.
- Cognitive behavioural therapy for acute phase/persistent symptoms.
- Motivational interviewing for substance abuse.
- Social interventions.
- Assertive outreach.

A key document outlining the style of service provision for New Zealand services is the *Early intervention in psychosis: guidance note*<sup>1</sup>

While *early* intervention is considered advantageous to optimal recovery, a consistent finding from the literature is that the duration of untreated psychosis is long, with a median of approximately 26 weeks.<sup>3,7,9</sup> Examination of the help-seeking behaviour of individuals with first-episode psychosis suggests that the individual and their family members may try a number of times to obtain help before adequate treatment is obtained.<sup>5,14</sup>

One of the important aspects of EIP services is an early detection programme and in this regard, General Practitioners and other social agencies have the potential to play a crucial role.<sup>15</sup>

## **Relationship to general practice and other agencies**

A large part of the delay in referring people with first episode psychosis is associated with the non-specific and insidious nature of the early signs of psychosis.

Key features that may indicate the presence of psychosis or its prodromal stage include<sup>1</sup>:

- Marked unusual behaviour.
- Feelings that are blunted or seem incongruous to others.
- Speech that is difficult to follow.
- Marked preoccupation with unusual ideas.
- Ideas of reference—things having special meanings.
- Persistent feelings of unreality.
- Changes in the way things appear, sound, or smell.

Lester<sup>18</sup> provides a useful checklist on what to look for in a GP consultation for first episode psychosis. She concludes that it is important to not just 'wait and see' what happens, or to dismiss symptoms (such as social withdrawal as part of adolescence; or as secondary to drug misuse).<sup>18</sup> People with suspected first episode psychosis should be referred to early intervention services for further clarification of symptoms, and appropriateness for early treatment. Further guidelines for GPs are available online from <http://www.eppic.org.au/resources/earlydiagnosisbooklet.html>

In Australia, the average GP will have 3-4 patients with schizophrenia at any one time, and might be involved in the diagnosis of 4-5 patients with schizophrenia in their career.<sup>16</sup> International estimates suggest there are approximately 11 new cases of psychosis per 100,000 population per year.<sup>17</sup>

The main problem is that prodromal-like symptoms are extremely common in adolescence and early adulthood, and health professionals must decide whether symptoms are just normal adolescent behaviour—or something more serious. The non-specific nature of symptoms combined with a low incidence rate means that primary healthcare professionals may overlook this diagnosis. However, it is estimated that half of the people with first episode psychosis have had contact with a

GP prior to commencing effective treatment.<sup>14</sup> Preliminary data from Totara House Early Intervention Service (in Christchurch) indicates that in the 6 months prior to referral, 60 out of 122 people with first episode psychosis had contact with a GP. Eleven (18.3%) of these people were referred to treatment at Totara House (Turner; unpublished data; 2004).

This high rate of contact with GPs makes them an important group to target with regard to any effort to reduce the duration of untreated psychosis. In New Zealand, and in many other countries, most people with first-episode psychosis appear to present to EIP services through acute inpatient services.

Totara House figures show that 54% of clients are referred following admission, and a further 19% from the Psychiatric Emergency Service at Christchurch Hospital. This suggests that the early signs of psychosis are unrecognised, and that people are only being seen once inpatient treatment is required. Of particular concern is the fact that the early signs of psychosis in Maori (and Pacific Peoples) may be missed by health practitioners, and that Maori (and health professionals) may reframe psychosis in a cultural context (Mason Durie; personal communication; April 2002).

To examine issues associated with the early identification and treatment of psychosis, New Zealand is currently involved in an international study examining GPs knowledge of first-episode psychosis. The results of this study will help service development for primary healthcare professionals involved in the management of early psychosis. This research is timely given the move to a primary mental health care strategy.

While General Practitioners, in particular, have an important role to play as 'gatekeepers' for early identification of first episode psychosis, there are many other agencies who may be able to detect the first signs of a developing psychotic illness (or at least notice that 'something is not quite right' and make appropriate referrals). For example, follow-up and follow-back studies have shown that teachers are capable of identifying individuals who later develop serious mental illness including psychosis.<sup>19</sup> Others include school guidance counsellors, personnel managers with major employers, and a range of counselling and support agencies. Identification of pathways to care and education aimed at these agencies should be seen as a priority in New Zealand early intervention services.

## **Early intervention for psychosis services in New Zealand**

A further potential barrier to early referral to specialist EIP services is the lack of knowledge of the existence of such services. There has been a steady growth of specialist services that work with people with first episode psychosis. In 2000, there were 18 statutory mental health services that work, wholly or partly, as early intervention services for young people. Twelve of these were established in or after 1998, through funding following the *Mason Report*.<sup>20</sup>

A systematic survey was conducted by the authors on the availability of EIP services in New Zealand.<sup>13</sup> A detailed description of each service is available on the Internet from the Mental Health Research and Development Strategy website:

[http://www.mhrds.govt.nz/files/4\\_29\\_71\\_98\\_EIP.pdf](http://www.mhrds.govt.nz/files/4_29_71_98_EIP.pdf)

Overall, New Zealand's main city centres are able to deliver quality care utilising the principles of EIP services.<sup>1</sup> Services appear to be well-informed and familiar with the

literature—and they are adapting it well to their local conditions. However, there are many other areas with enthusiastic early intervention staff frustrated by the lack of resourcing and support/understanding from those unfamiliar with the principles of early intervention.

Improving the responsiveness of mental health services is one of the five service delivery areas on which the Government wishes the health sector to concentrate in the short-to-medium term.<sup>21</sup> In addition, the targeting in this strategy of public health and primary healthcare provide the platform for the emergence of early intervention for psychosis as a central consideration for mental health services under the *New Zealand Health Strategy*.<sup>21</sup>

Public health initiatives aimed at mental health promotion and increased co-ordination between primary healthcare providers and secondary service providers (such as early intervention services) are core requirements of the Government's strategy.

EIP services are an important response to the increased awareness and acceptance of mental illness promoted by public health campaigns such as the 'Like Minds Like Mine' (<http://www.likeminds.govt.nz/>) project. '*...the inclusion of prevention activities highlights the growing importance and contribution of early detection towards the effective management of mental health problems and of improved community mental health outcomes...*'<sup>22</sup>

Projects aimed at reducing the stigma associated with mental illness may mean that people are more likely to seek help when (or even before) a crisis develops. This may be particularly beneficial for professionals who identify symptoms but then face resistance from clients regarding referral for appropriate assessment.

Similarly, with the development of public education, the various support agencies are likely to become better informed about the signs of first-episode psychosis, and about the availability of EIP services. Should this prove to be the case, appropriate services ought to be available to meet this increased demand.<sup>23</sup>

The dual developments of early intervention for psychosis and public education may have an increasing impact over the next generation as the *New Zealand Health Strategy*<sup>21</sup> is implemented. However, evaluation of the efficacy of these programmes is necessary to ensure the money is well spent.

## Conclusion

A review of the literature<sup>3</sup> suggests that early intervention for psychosis is successful in reducing the initial morbidity and distress associated with the first psychotic episode; however, it is unclear whether it leads to better long-term outcome. There is evidence that the earlier treatment is given following the onset of psychosis, the more favourable the outcomes<sup>9</sup>—at least in the short term. This implies that attention should be paid to reducing the duration of untreated psychosis by providing education to those professionals who may come in contact with people who are experiencing first-episode psychosis.

EIP services can be justified clinically; it is sensible to treat people with first-episode psychosis (as soon as possible after symptoms develop) with intensive, comprehensive treatments. Whether it is superior to existing treatments remains unclear. A feature in the *British Journal of Psychiatry*<sup>24</sup> debated whether 'early

*intervention for psychosis is a waste of valuable resources*'. The article concluded that they remain, at least, an example of *'basic aspects of good practice in the management of psychotic disorders'* (page 196).

In summary, EIP services have a significant positive effect for clients while in treatment. Although there is still insufficient evidence regarding the long-term benefits of early intervention services, we recommend referring clients to these services where they are available.

Furthermore, early referral to specialist services may lead to better outcomes for those with first-episode psychoses—particularly earlier psychotic and negative symptom remission, less psychosocial deterioration, and increased treatment adherence.

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