"Scorned as Timber, Beloved of the Sky"

~ *Emily Carr*

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EARLY PSYCHOSIS

A Guide for Physicians

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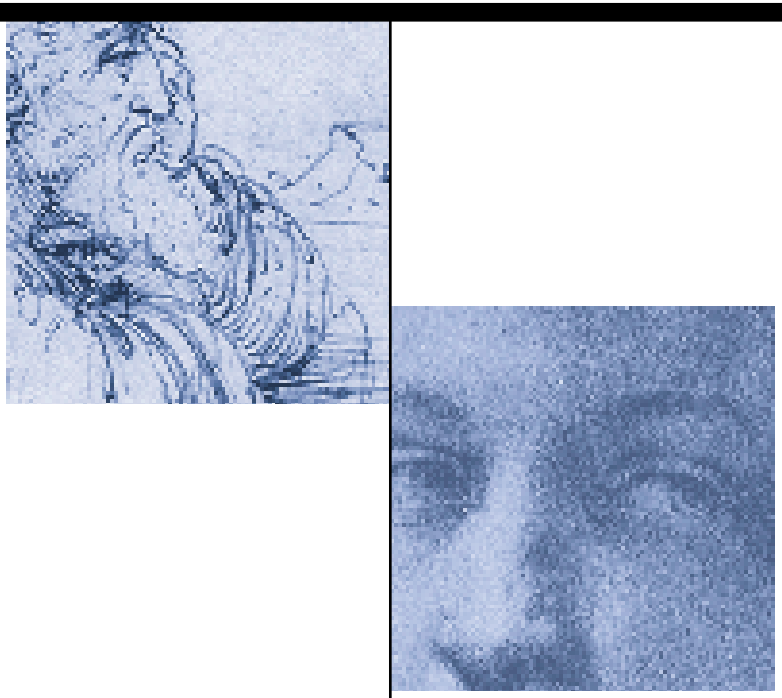

A GUIDE FOR PHYSICIANS

UBC Mheccu

Mental Health Evaluation
& Community Consultation Unit

YEAR 2000

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Practical Guidelines for First-Episode Psychosis

EARLY DETECTION

Prodromal symptoms

- Refer patient for psychiatric assessment
- Monitor patient's progress
- Support and counsel client and family

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- Refer promptly to a psychiatrist or mental health service for a more comprehensive work-up

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- Remain prepared to revise the provisional diagnosis
- Consider specialist reassessment

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- Strive to maintain continuity of care
- Treat the patient as an autonomous adult
- Foster collaboration with the patient in managing the illness

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- Maintain a patient register
- Develop management protocols for problems such as missed appointments, adherence to treatment
- Ensure multidisciplinary comprehensive assistance to patient and family

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- Maintain communication with the patient's psychiatrist or case manager

INVOLUNTARY ADMISSIONS

- Work with a mental health team if possible
- First ensure safety of self and others (involve police only if necessary)
- Use a non-threatening, non-confrontational approach
- Determine whether criteria for involuntary admission are present
- Follow procedures of the Mental Health Act - i.e. In order for a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion the patient meets ALL four criteria:

  1. *is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;*

  2. *requires psychiatric treatment in or through a designated facility;*

  3. *requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and*

  4. *is not suitable as a voluntary patient*

- Clearly explain and inform the patient of his or her legal status
- Ensure supervised transport to hospital
- Sedation may be clinically indicated

PHARMACOLOGICAL INTERVENTIONS

- Recognize your own limits and utilize specialists and other resources
- Antipsychotic drugs should be chosen after considering their relative side effects
- Use only one antipsychotic drug at a time
- Start low - go slow
- Use minimum dose required to maintain remission and avoid side effects
- Monitor symptoms
- Explore reasons for non-compliance

NON-PHARMACOLOGICAL INTERVENTIONS

- Develop a supportive therapeutic relationship
- Set realistic goals
- Provide reassurance and an opportunity to air emotions
- Educate the patient and family
- Encourage symptom self-monitoring and coping skills
- Ensure provision of multiple evidence-based interventions

Preface

This booklet was produced by Mheccu as a supporting document for the Early Psychosis Initiative (EPI) of British Columbia. A major goal of EPI is to enhance recognition of early signs and symptoms of psychosis so that effective treatment can be started promptly.

In the 1999/2000 fiscal year, the Ministry of Health (Province of British Columbia) undertook an initiative with bridge funding to further the goal of developing prevention and early intervention services for young persons at risk for severe mental illness as identified in the Mental Health Plan. In March 2000, the Ministry for Children and Families announced additional one-time funds to further inter-ministry goals in this area.

Partners with the Ministry of Health and the Ministry for Children and Families include regional representatives of the Ministry for Children and Families and regional health authorities, Ministry of Education and regional counseling and special services representatives, the BC Schizophrenia Society and the Canadian Mental Health Association. All health regions in the province are participating in EPI strategies aimed at improving services to young persons in the early stages of psychosis.

Mheccu (Mental Health Evaluation & Community Consultation Unit), the contractor for EPI, is a unit of the Division of Community Psychiatry, University of British Columbia.

For further information on EPI or how to obtain copies of this booklet contact:

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or via the website:

www.mheccu.ubc.ca/projects/EPI

Introduction

Approximately 3% of people will experience a psychotic episode at some stage in their life. Usually a first episode occurs in adolescence or early adult life, an important time for the development of identity, relationships and long-term vocational plans.

The initial episode of psychotic disorders is typically a confusing and disturbing process for the person and their family. Lack of understanding of psychosis often leads to delays in seeking help. As a result, these disorders are left unrecognized and untreated. Even when appropriate help seeking does occur, further delays in diagnosis and treatment may result from skill and knowledge gaps among professionals. Suspiciousness, fear and lack of insight also hinder contact with professionals.

Increasingly, attention is being paid to strategies that reduce the personal, social and economic strain of these conditions on affected individuals, their families and the community. Early intervention in first-episode psychosis is aimed at shortening the course and decreasing the severity of the initial psychotic episode, thereby minimizing the many complications that can arise from untreated psychosis. Appropriate early intervention can provide significant long-term benefits.

General practitioners, who are the major initial point of contact for people seeking help with physical and psychological health concerns, have a crucial role to play in ensuring that this early intervention occurs.

This booklet provides general practitioners with a brief overview of first-episode psychosis guidelines in order to promote early and appropriate intervention.

First Episode Psychosis

Psychosis and Early Intervention

Psychosis describes a mental state characterized by distortion or loss of contact with reality, without clouding of consciousness. Positive symptoms of psychosis include delusions, hallucinations and thought disorder.

Negative symptoms of psychosis such as affective blunting, poverty of thought or speech and loss of motivation can also occur. There are usually a number of other 'secondary' features, such as sleep disturbance, agitation, behaviour changes, social withdrawal and impaired role functioning. These secondary features often provide clues to the presence of psychosis.

Psychosis can be caused by certain medical conditions, drug and alcohol abuse, and a variety of psychiatric disorders such as schizophrenia, bipolar disorder, schizophreniform psychosis and schizoaffective disorder.

Early intervention involves investigating psychotic disorders at the earliest possible time and ensuring that appropriate treatment is initiated. Treatment should begin at the first sign of positive psychotic symptoms, but it may also be possible to intervene during the prepsychotic, prodromal phase. To date, antipsychotic medication has not been validated for use in the prodrome. Psychosocial interventions are indicated.

Achieving early intervention requires increasing community understanding of early signs and decreasing the stigma which can sometimes delay people from seeking help. It also requires improving skills and knowledge among health professionals positioned to detect and treat these disorders.

Why is Early Intervention Needed?

Numerous studies have shown there is often a significant delay in initiating treatment for people affected by a psychotic disorder. These delays vary widely but the interval between onset of psychotic symptoms and commencement of appropriate treatment is often more than one year.

As a consequence of these delays, significant disruption can occur at a critical developmental stage along with the formation of alarming secondary problems. The longer the period of untreated illness, the greater the risk for psychosocial disruption and secondary morbidity for the person and their family.

A psychotic episode commonly isolates the person from others and impairs family and social relationships. Difficulties in school and work performance arise and problems such as unemployment, substance abuse, depression, self harm or suicide and illegal behaviour can occur or intensify.

Some evidence shows that long delays in treatment may cause psychotic symptoms to become less responsive to treatment. Delays in receiving treatment are associated with slower and less complete recovery. Longer duration of psychotic symptoms before starting treatment appears to contribute to poorer prognosis and a greater chance of early relapse. It is hypothesized that untreated psychosis causes increased pathophysiological changes in the brain and that repeated episodes further erode long term functioning.

Delayed Treatment Can Result In...

- Slower and less complete recovery
- Interference with psychological and social development
- Strain on relationships, loss of family and social supports
- Disruption of parenting role in young mothers/fathers with psychosis
- Disruption of study or employment
- Increased family strain
- Poorer prognosis
- Depression and suicide
- Substance abuse
- Unnecessary hospitalization
- Increased economic cost to the community

Stress-Vulnerability Model of Onset

The onset and course of psychosis can be viewed in terms of a "stress-vulnerability" model (see Figure 1). Interactions between a biological predisposition (genetic and neurodevelopmental factors) and environmental stress can trigger active psychotic symptoms.

A positive family history of psychosis and particular personality disorders (i.e., schizotypal, schizoid, and paranoid personality disorders) are associated with an increased risk of vulnerability to psychosis. For example, the risk of developing psychosis associated with schizophrenia is 1% for the general population vs. 13% for the children of those with schizophrenia.

An estimated 80% of clients affected by a psychotic disorder experience their first episode between the ages of 16-30.

The median age of first onset of schizophrenia is 19 years, with females experiencing a first episode two to three years later than males.

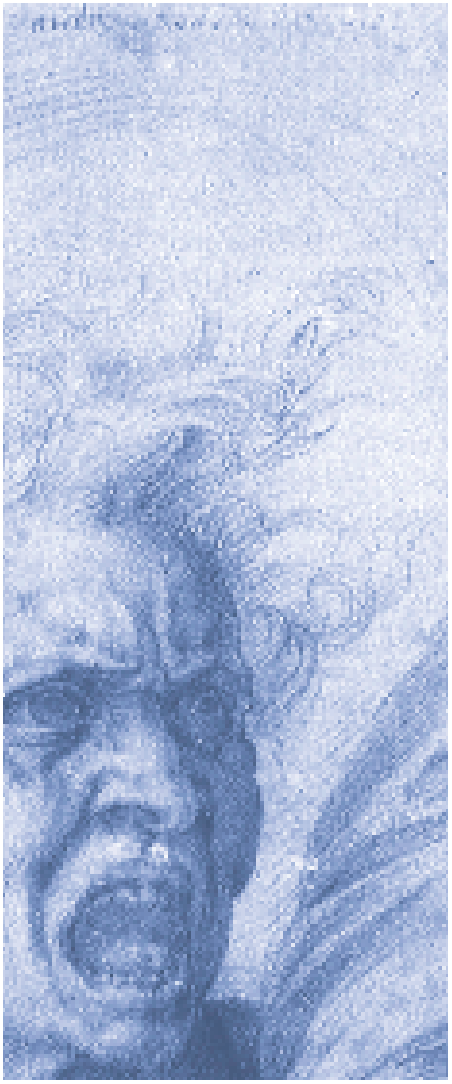
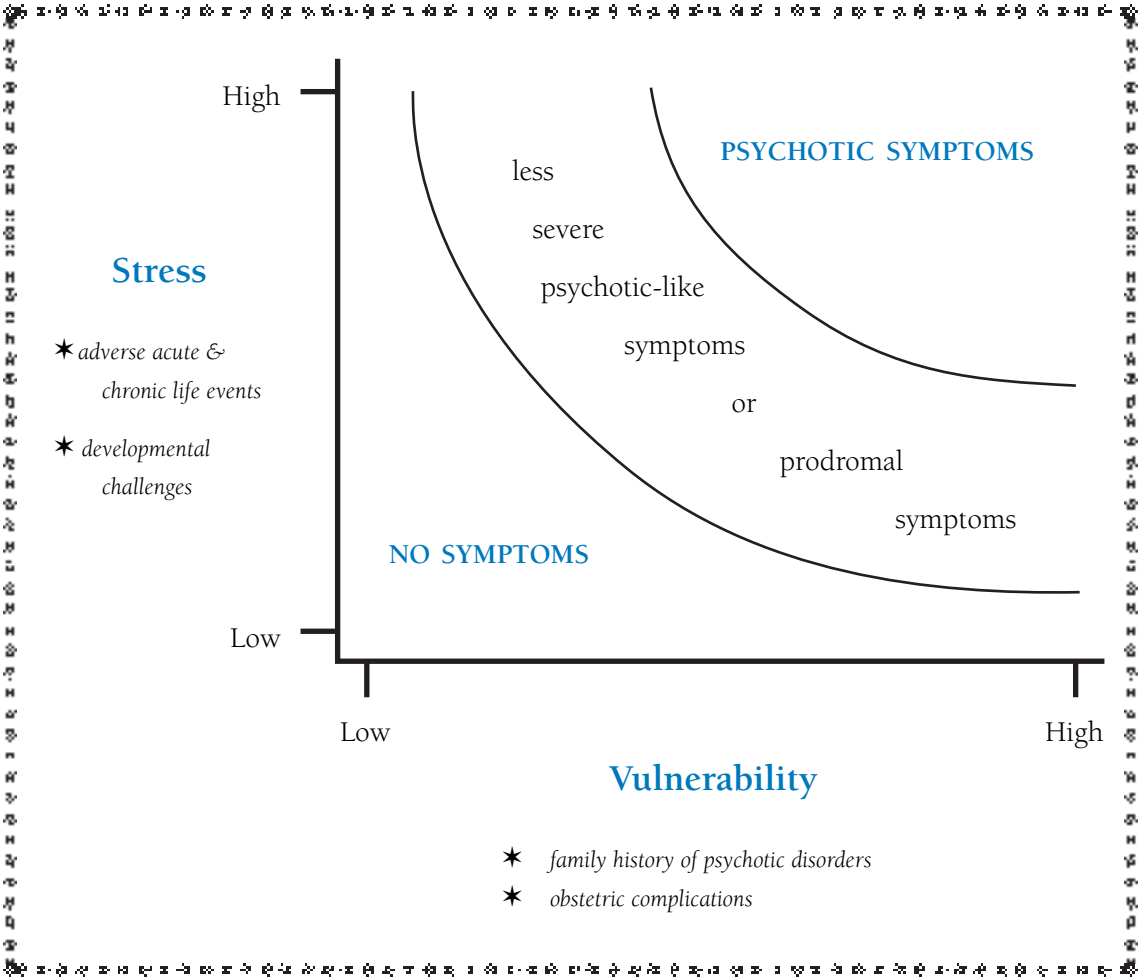


Figure 1

Stress-Vulnerability Model



Course of First-Episode Psychosis

The typical course of the initial psychotic episode can be conceptualized as occurring in three phases: prodromal, acute and recovery.

PRODROME

The prodromal phase occurs when the individual experiences changes in feelings, thought, perceptions and behaviour although they have not yet started experiencing clear psychotic symptoms such as hallucinations, delusions or thought disorder.

Prodromal symptoms vary from person to person and some people may not experience a prodrome. The duration is quite variable, although it usually spans several months. In general, the prodrome is fluctuating and fluid, with symptoms gradually appearing and shifting over time. Some areas where prodromal signs and symptoms occur include:

Emotion

Depression, anxiety, tension, irritability, anger or mood swings.

Cognition

Difficulty in concentration and memory, thoughts feel slowed down or speeded up, odd ideas, vague speech, overvalued ideas.

Sense of Self, Others or the World

Feeling somehow different from others, that things in the environment seem changed, suspiciousness.

Physical

Sleep disturbances, appetite changes, somatic complaints, loss of energy or motivation and perceptual aberrations.

Behavourial

Deterioration in role functioning, social withdrawal or isolation, loss of normal interests, preoccupations such as increased concern with spiritual/philosophical issues, uncharacteristic rebelliousness.

Clearly, these changes are non-specific and can result from a number of psychosocial difficulties, physical disorders and psychiatric disorders.

The key for early intervention in psychotic disorders is to keep the possibility of psychosis in mind when seeing a young person exhibiting these symptoms. It is especially important to determine if the changes in personality and behaviour are persistent or worsening. These changes should not immediately be dismissed as just being part of adolescence. Various explanations may exist, but prodromal psychosis is one of them and close review and regular monitoring of the person is advisable.

Acute Phase

During the acute phase, typical psychotic symptoms emerge. Positive symptoms such as thought disorder, delusions and hallucinations may become predominant. This phase usually continues until appropriate treatment is initiated.

Hallucinations are sensory perceptions in the absence of an external stimulus. The most common types are auditory hallucinations. Other types of hallucinations include visual, tactile, gustatory and olfactory. These are less common and other medical/drug causes may be contributory.

Delusions are fixed, false beliefs out of keeping with the person's cultural environment. These beliefs are often idiosyncratic, very significant to the individual, but hard for other people to understand.

Delusions often gradually build in intensity, being more open to challenge in the initial stages, before becoming more entrenched.

COMMON TYPES OF DELUSIONS INCLUDE:

- persecutory delusions
- religious delusions
- grandiose delusions
- delusions of reference
- somatic delusions and
- passivity experiences such as thought insertion/ broadcasting/withdrawal.

Thought disorder refers to a pattern of vague or disorganized thinking. Speech seems disjointed and hard to follow. Thought disorder may also refer to ideas of reference (special meanings that are found in words and events and are communicated to the person), "thought blocking" (an abrupt interruption to the flow of thought that can be interpreted as stolen thoughts), and "thought insertion" (sense that ideas seem alien and are often interpreted as the thoughts of others placed in the person's mind).

While delusions, hallucinations & thought disorder are definitive of psychosis, disturbances of mood, behaviour, sleep and activity may co-occur.

Many individuals with an underlying psychological/psychiatric disorder initially present with tiredness, repeated headaches, insomnia or vague physical symptoms.

The person's initial presentation is variable. The common presentation of positive symptoms and disturbed behaviour should not lull one into overlooking the quietly deteriorating "odd" individual whose psychosis leads to a predominantly negative presentation.

Negative symptoms such as decreased motivation, energy and interest, blunted affect and a decrease in the richness of inner mental life are common in the acute phase. These symptoms, along with vague somatic symptoms, may be misinterpreted as depression thereby increasing the duration of improperly treated psychosis.

Recovery Phase

With available treatments, the great majority of people recover well from their initial episode of psychosis.

The recovery process is affected by the treatment environment, medication and psychological therapies, personality style and factors within the person's family and social environment. The recovery process will vary in duration and degree of functional improvement.

Specific issues to be dealt with in the recovery phase include helping the person and family make sense of the illness experience restoring self-confidence and facilitating a return to premorbid levels of functioning. Problems such as post-psychotic depression, anxiety disorders, decreased self-esteem and social withdrawal need to be addressed. Assistance with housing, finances, employment and study may also be required.

To achieve maximal recovery, a supportive and collaborative approach utilizing specialist treatments and a comprehensive biopsychosocial approach is essential.

Medication is usually continued for at least twelve months after recovery from a first episode and then slowly discontinued while the individual continues to be monitored. Unfortunately, many people fail to continue with medication and relapse as a result.

Following recovery from a first episode, a significant number of people will never experience a recurrence of psychosis.

Others will develop recurring episodes of psychosis, but lead productive lives between episodes. During the recovery phase, a discussion of these possibilities should occur with the person and their family. Guidelines for recognizing and seeking treatment for relapses at the earliest possible stage should be established as part of the general focus on patients and family psychoeducation. Definitive prognosis is not possible.

Summary of First-Episode Psychosis

- A first episode typically occurs in adolescence or early adult life.
- It is confusing, distressing and disruptive for the person and their family.
- Symptomatic patients often remain undiagnosed and untreated for long periods. Failures to initiate treatment results from multiple factors (e.g., lack of insight and stigma), with delays in recognition representing a critical part of the problem.
- Increasing public and professional awareness of the symptoms and course of first-episode psychosis assists early case detection.
- The first episode usually occurs in three phases-prodromal, acute and recovery.
- Early intervention means intervention at the earliest sign of positive symptoms.
- Treatment should proceed in the least restrictive environment possible.

- Treatment requires a comprehensive biopsychosocial approach and a range of specialist treatments aimed at treating the person's primary psychotic symptoms and assisting them in overcoming the secondary personal and social difficulties that the illness often creates.
- Full symptomatic recovery from the first episode is the norm.

Early appropriate treatment can:

- reduce the degree of disruption created by the psychotic illness
- reduce secondary morbidity
- result in more rapid recovery
- improve outcomes

Role of the General Practitioner

While the presentation of first-episode psychosis is a relatively low frequency event, general practitioners have a crucial role to play.

General practitioners are the first point of contact for the majority of people seeking assistance for their health concerns, whether they are physical or psychological.

It is important you be aware of the usual presentations of psychotic disorders and proficient in performing a preliminary psychiatric assessment. You also need to be aware of the specialist psychiatric services available to assist your patients.

The key to early recognition of these disorders is maintaining a high index of suspicion, particularly when dealing with an adolescent or young adult with persistent psychological difficulties or deterioration in personality or behaviour.

If a psychotic disorder is suspected, a "wait and see" approach to assessment and treatment may not be in the person's best interest. Not infrequently, a diagnosis of depression is given (followed by treatment for depression) because of the pessimism and stigma attached to diagnoses such as schizophrenia.

Assessment

Typical Presentations

There are numerous ways in which a person experiencing their first episode of psychosis may come to your attention.

Psychotic illnesses rarely present “out of the blue”. They are typically preceded by a gradual change in psychosocial functioning. The family usually senses that something is not quite right and may initiate seeking help.

Even when the person does visit a clinician, the predominant presentation may consist of depression, anxiety-related problems, and cognitive or somatic complaints.

In the acute phase, psychotic symptoms may be evident but the client may be suspicious or attempt to conceal difficulties. Reassurance and gentle persistence may be necessary. Focussing on the concerns raised by the person's family and asking the individual for their point of view are usually fruitful approaches.

An Assessment Framework

When interviewing, it is helpful to have some sort of framework to assist you in exploring potential problem areas.

One commonly used framework is the mental status examination **(MSE)**. The major domains assessed by the MSE are represented by the letters of the mnemonic **"ABC STAMP LICKER"** (see Table 1).

Table 1

Components of a Mental Status Examination

The Mental Status Examination is a review of psychiatric symptoms. The following mnemonic may aid in remembering all of the areas to review.

ABC Stamp Licker	
Appearance	Note anything unusual in the person's self-care, dress, make-up or belongings.
Behaviour	Look for abnormal motor activities, level of activity, eye contact, mannerisms and posture.
Cooperation	Note the person's attitude toward the interview.
Speech	Look for any abnormalities in rate, tone and ability to express and comprehend language.
Thought	Assess both form and content. Note whether thoughts are connected and logical. Ask about delusions and unusual ideas.
Affect	Note untimely or excessive affect, lack of affective responses to emotionally-laden topics. Determine whether affect matches thought content.
Mood	Ask about depressive, anxiety and manic symptoms. Determine the intensity and stability of any mood symptoms.
Perception	Ask about hallucinations and perceptual disturbances in all sensory modalities.
Level of consciousness	Note how alert the person is during the interview and if the level of consciousness fluctuates.

Insight and judgement	Determine judgement through questions on specific, practical issues. Determine the client's insight into symptoms and need for treatment. Ask about their understanding and attitude towards treatments.
Cognitive functioning	Consider using a Mini-Mental Status Exam as a screening tool for any cognitive deficits. Orientation - ask about date, place and person. Memory - ask about memory problems. Note whether the person seems to have difficulty recalling either recent or remote events. Give the person a three to five word list and ask them to repeat it five minutes later. Attention and concentration - note whether the person attends to your questions; ask about capacity to attend to a TV show. Reading and writing - ask about reading ability. Ask the person to read several sentences aloud and to write a sentence.
Knowledge base	Note whether the person seems to have significant gaps in common knowledge. Ask about significant dates, names of current political figures, or recent newsworthy events.
Endings	Inquire about both suicidal and homicidal ideation. If any ideation, do a thorough risk assessment. Ask about plans, intent and lethality of method. Consider factors that increase the risk such as previous violence to self or others, drug and alcohol abuse, a recent triggering event, impulsiveness, severe personality disorders, organic and neurological conditions, mood and psychotic symptoms (especially command hallucinations).
Reliability	Note whether the information gathered from the interview and observations seems reliable.

The MSE is just one component of a psychiatric interview. For an interview to be comprehensive, it is essential to gather information in numerous other domains.

Psychiatric Assessment:

- MSE
- presenting problem
- personal history
- psychiatric history
- physical health (including head injury)
- developmental history
- family history (including family psychiatric history)
- interpersonal relationships (both social and family)
- role functioning (work, school, parenting, etc.)
- daily functioning
- drug and alcohol use
- sexuality

It is important to explore the hints and cues given by the patient. What underlies the anxiety? Why has the patient been having so many headaches? Why is he always so tired? Why has she stopped seeing her friends?

Ask specific questions to assess for the presence of particular syndromes such as depression, anxiety disorders and psychosis. Inquire about possible substance abuse. Assess the risk of suicide and whether the person poses a risk to others.

Physicians should inquire, matter-of-factly and without embarrassment, about the presence of psychotic phenomena. The following are sample queries to assess psychotic thinking:

> ***Sometimes people hear noises or voices when no-one is speaking and there is nothing to explain what they are hearing? Do you ever have something like that happening? If yes, what do they say? How many are there? Do they seem to be having a conversation among themselves about you? Do they comment on what you are doing?***
>
> ***Sometimes people have experiences that other people can't really understand. For example, sometimes people feel like they are under the control of some person or force that they can't explain,…that the radio or TV are referring to you, …that others can read your mind?***
>
> ***Is someone trying to hurt you or plot against you?***
>
> ***Is anything interfering with your thinking? Some people feel as if thoughts are being put into their heads that are not their own. Do you ever feel that your thoughts are broadcast out loud so that other people can hear what you are thinking,…feeling that thoughts are being taken out of your head against your will?***

If the person is clearly psychotic or quite disturbed, the assessment will be more focussed, but will always include an assessment of present problems, a mental status examination and a risk assessment.

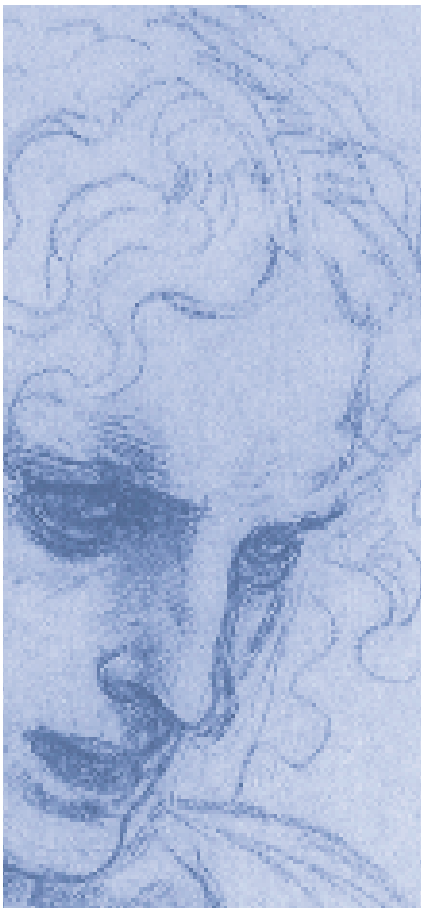
Interview Considerations

The interview starts the therapeutic process between yourself and the person. Therefore, a balance must be sought between assessment, assistance and rapport. Failure to develop good rapport is a major cause of treatment dropout, which itself predicts poorer long-term outcome.

It is better to ask specific questions about psychosis than to let it go undetected.

Obtain collateral information about the person from their family or others. Explain that you want to find out further information in order to provide better help. You are trying to obtain information from others, not tell them about the patient. Try to get the person to bring along a family member to an appointment.

The termination of the interview involves discussing your assessment and management plan and negotiating proposed treatment, review or referral. Fostering a collaborative partnership helps to counter the low self-esteem and demoralization that usually follows the experience of psychosis.



Discussing Confidentiality

With any new patient, it is useful to provide reassurance about the confidentiality of your discussions but also explain the limits of confidentiality.

Reducing the Tension

Acknowledge that the person may be nervous or wary and find some common ground for discussion, gradually building up towards more specific questions about their psychotic experiences.

If the patient attends with her/his parents, it usually works best to see the person alone before meeting with the family.

Taking Time

It may not be possible to develop rapport and perform a complete assessment in one session. Repeat visits over days or a couple of weeks often clarifies the picture.

The length of each session is also important. The person with psychosis can often 'hold it together' in brief or superficial conversation but the psychosis often becomes apparent in more lengthy or challenging conversations.

Do not hesitate to contact a person if they fail to turn up for their appointment. This is usually perceived as expressing concern rather than intrusiveness.

Don't let the patient drop out of sight as there is a significant risk of suicide. This may require making some sort of agreement with the patient at the end of the first appointment enabling you to make contact if they fail to attend.

Family Concerns

The family's distress, confusion or denial need to be acknowledged. Dismissing presenting problems invalidates the family's experience and may foster denial thereby delaying reassessment and eventual diagnosis and treatment.

Ask the family to describe specific examples of behaviour.

Assess the degree of change and its duration.

Gather information about the person's premorbid personality and functioning.

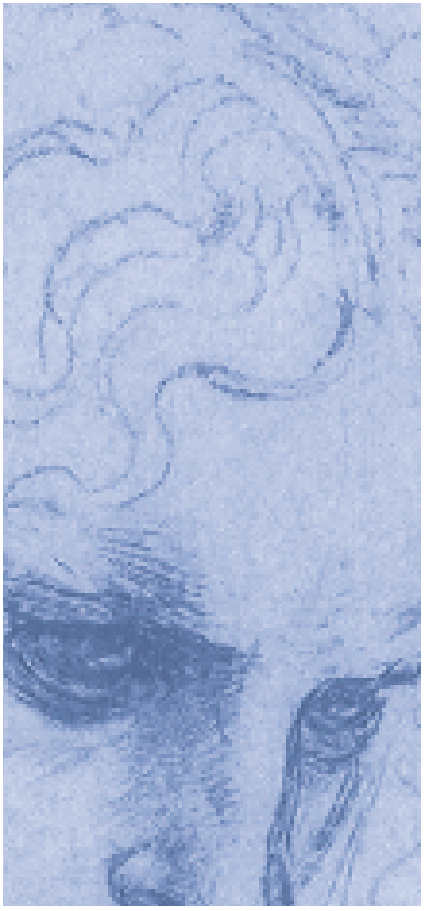
Clarify the family history including family history of psychotic disorders.

Ask specifically about the behavioural manifestations of psychosis, such as laughing or talking to themselves, poor self-care, increased or decreased motor activity, posturing, etc.

Determine the urgency of the situation. If things can wait, encourage the young person to come in and see you. If the situation seems serious and urgent, then an outreach assessment should be arranged.

If a home assessment is contemplated, the family has to be consulted. If there are indications of risk for violence to self or others, enlist the support of experienced community psychiatric workers.

Investigations in First-Episode Psychosis



Minimal appropriate investigations should include a drug screen, general chemistry, complete blood count and urinalysis. The physical examination and investigations are important to exclude possible medical and neurological conditions that may present with symptoms of psychosis (see Table 2). However, only about 3% of psychoses in the young are attributable to such medical conditions.

Brain imaging and neurocognitive testing for intelligence, memory, attention, executive function, language, visuospatial and motor skills are helpful if they can be arranged. A good MSE at least provides some indication of cognitive functioning.

Table 2

Selected medical and neurological conditions that may present with symptoms of psychosis

Disease	Presenting psychiatric signs/symptoms	Differential Diagnosis
Hypothyroidism	Lethargy, depressed mood, personality changes, manic-like psychosis, paranoia, hallucinations	Rule out pituitary disease, major depression, mania. May be secondary to lithium therapy.
Brain Tumor *(e.g. frontal, parietal, occipital lobes)*	Mood changes, irritability, impaired judgment, impaired memory, delirium, aura, visual hallucinations	Rule out aneurysm, subdural hematoma, seizure disorder, cardiovascular disease, depression, mania, dementia.
Head Trauma	Confusion, personality changes, impaired memory	History of blow to head. Rule out CVD, seizure disorder, alcohol dependence, diabetes, depression, dementia.
AIDS	Progressive dementia, personality changes, depression, loss of libido	Always consider in high-risk populations and young patients with signs of dementia.
Seizure Disorder	Confusion, psychosis, dissociation, catatonia	Consider complex partial seizures in all dissociative states.Rule out postictal states, schizophrenia.
Hyperparathyroidism	Depression, paranoia, confusion	Rule out major depression, schizophrenia.
Systemic Lupus Erythematosus	Depression, mood disturbances, psychosis, delusions, hallucinations	50% of SLE cases have psychiatric symptoms. Rule out depressive disorders, paranoid psychosis, schizophrenia.
Vitamin B12 Deficiency	Irritability, impaired attentiveness, psychosis, depression	May be due to pernicious anemia. Rule out dementia, mania, mood disorders.

Other medical conditions associated with psychotic symptoms

- Cerebrovascular disease; linked to late-onset psychosis
- Multiple sclerosis; especially when many periventricular lesions are present
- Huntington's disease; psychotic symptoms in 5%-10% of cases
- Cushing's syndrome; psychosis occurs in up to 20% of patients
- Hyperthyroidism and hypothyroidism
- Porphyria; acute intermittent porphyria and porphyriavariegata
- Wilson's disease

Referral Issues

Referral for specialist psychiatric assessment is usually appropriate in suspected or confirmed cases of psychosis.

Even though an assessment in the prodromal phase may be inconclusive, it is useful.

"Prodromal" symptoms may not actually signal psychosis but do suggest a mental health problem that needs to be addressed.

A positive encounter with a psychiatrist or mental health team establishes an important contact. The GP is able to provide continued support while diagnostic uncertainty remains by acknowledging problems and helping to implement any recommendations made by specialist services.

If the patient is unwilling to attend a private psychiatrist, assessment by a community mental health service or mobile psychiatric assessment team may be possible. Depending on the person's difficulties, available social supports and the assessment of possible risks to the person or others, outpatient treatment or home-based treatment may be a viable option. At other times, close monitoring of the patient by the family may be an option.

Hospitalization

Some people will require hospital admission for treatment or assessment. Hospitalization may be indicated if there are insufficient social supports for home treatment, or a period of observation may be needed for adequate assessment. It is important to ensure that transport to hospital and the admission itself, is also handled with care. Patients often experience a considerable degree of shame and distress if their hospitalization is violent and coercive. Frequently the person will accept the recommendation to be hospitalized.

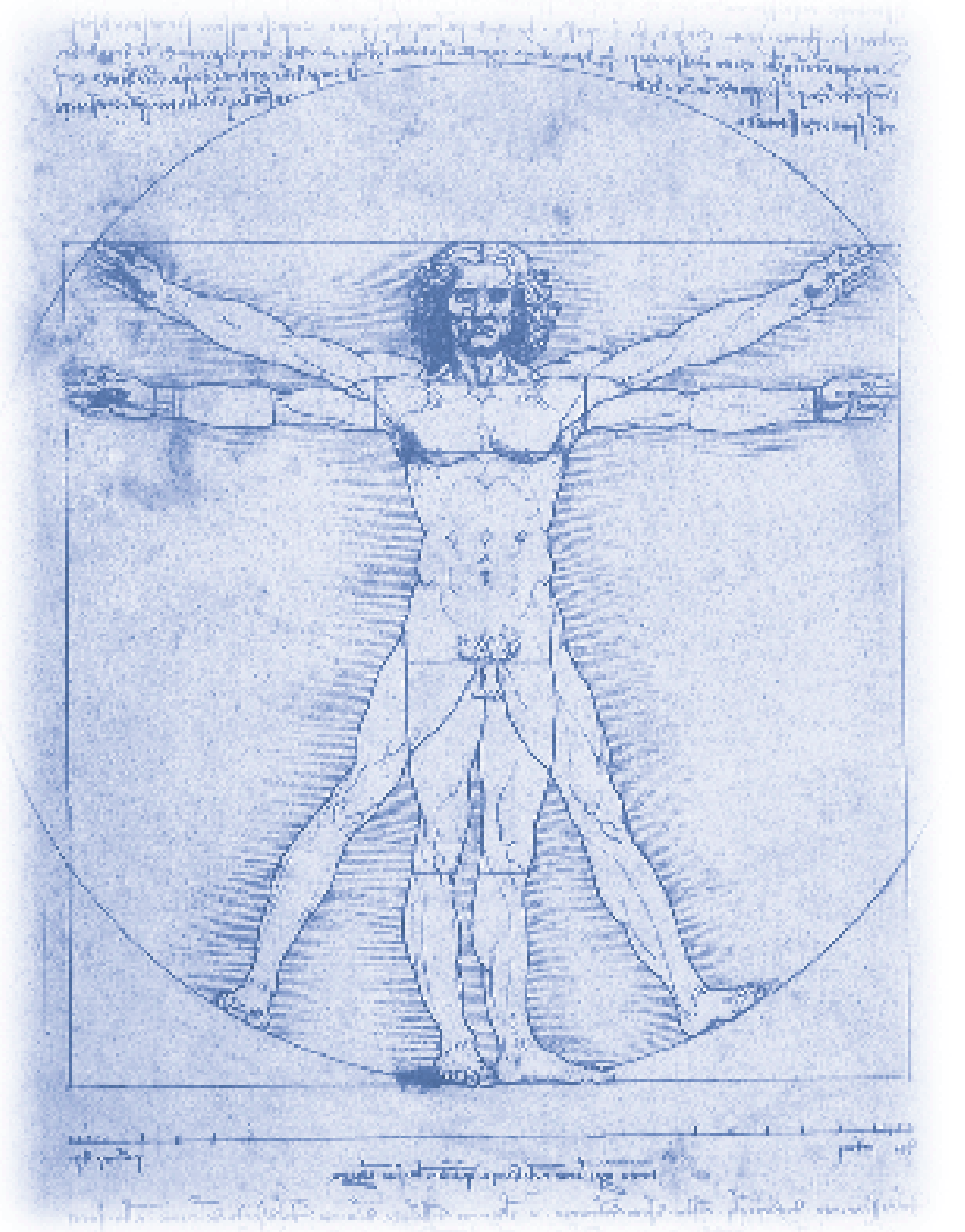
A person who refuses hospitalization may be admitted involuntarily because of risks to the person's health and safety or for the protection of members of the public. The person does not have to be assaultive to self or others.

According to the Mental Health Act in British Columbia (1999), there are three methods of arranging for involuntary admission:

1. through a physician's Medical Certificate (preferred method)
2. through police intervention
3. through an order by a judge

In order to fill out a Medical Certificate, the physician must have examined the person and be of the opinion that ALL four criteria are met:

1. is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
2. requires psychiatric treatment in or through a designated facility;
3. requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
4. is not suitable as a voluntary patient



Treatment

Guidelines

Medication and other treatment strategies are outlined in several publications including the Canadian Guidelines for the Treatment of Schizophrenia and the Australian Guidelines for Early Psychosis.

Initiating Treatment

Once it is decided that further assessment or treatment is required, all options should be presented to the person and their family.

Because the diagnosis of most psychotic disorders requires a certain duration, it is best to avoid the early use of specific diagnoses. Focus on assisting with the presenting problems. Patients are more likely to be receptive to obtaining assistance for concrete problems (e.g., confusion or sleep difficulties) while you 'check things out further'. By using this approach, patients can be encouraged to accept help in the early stages of psychosis. Additional education is ethically and therapeutically indicated before a substantial period of time has elapsed.

There is a growing recognition that the treatment approach required for a person with a newly diagnosed psychotic illness is different to the approach suitable for long-standing illness. One clear example of this difference can be seen in the area of psychopharmacological treatment.

Pharmacological Interventions

Antipsychotic Free Period

It is becoming common practice in first-episode psychosis, to provide an antipsychotic free period of several days. Any agitation, irritability or insomnia can be managed by the use of a long acting benzodiazepine.

This period gives physicians a chance to assess the person more closely to exclude more transient psychoses (such as a drug-induced psychosis). It also allows an opportunity to build up trust and rapport.

Pharmacotherapy Options

Consultation with specialists familiar with antipsychotic use in early psychosis is advised.

A person experiencing a first-psychotic episode is typically very sensitive to the pharmacological effects of these drugs and susceptible to side effects.

Antipsychotic drugs should only be chosen after considering their relative side effects. In general, low potency drugs are more likely to produce sedation, postural hypotension and anticholinergic side effects while high potency drugs produce more extrapyramidal side effects.

For first-episode cases, it is essential to start any antipsychotic medication at very low doses to minimize side effects. Side effects contribute to poor compliance. It is important to be patient with the "start low – go slow" approach to treatment with antipsychotics. Full remission takes time, but will occur in the majority of cases. Overall, around 60% of persons will respond by 12 weeks and another 25% will respond more slowly. Low doses are generally effective in treating psychotic symptoms in this population.

The adjunctive use of a long acting benzodiazepine over the first few weeks allows for sedation and control of agitation, until the antipsychotic starts having its full effect. In addition, the prophylactic use of anticholinergic drugs, such as benztropine, to protect against possible extrapyramidal side effects is also common. These are then gradually discontinued over the following weeks, unless extrapyramidal side effects remain a problem.

The advent of atypical medications is especially pertinent to first-episode cases because of their low propensity to generate extrapyramidal side effects. This decreases the need for anticholinergic drugs, which themselves produce adverse physical and cognitive side effects. The newer atypical antipsychotics are frequently used as front line medications because of their favourable side effect profiles.

Evidence-Based Non-Pharmacological Interventions

Although the general practitioner may not have the time or expertise to deliver all of these treatments, he/she should be able to provide some psychoeducation to all patients.

Psychoeducation

Psychoeducation for first episodes involves teaching people (including families) about mental illness while maintaining an ongoing, interactive psychotherapeutic relationship. In the case of psychosis it is important to impart a message of hope without downplaying the seriousness of the disease. Three inter-related issues that should be addressed are "meaning", "mastery" and "self-esteem".

Meaning refers to addressing the confusion surrounding the experience and introducing the concept of psychosis. Discovering the person's own explanatory model and resolving discrepancies between it and medical definitions is a key task.

Mastery involves instilling hope for recovery, building stress management and coping skills, learning to recognize possible signs of relapse and learning how to access needed resources in the future.

Cognitive Therapy

Cognitive therapy is a structured psychotherapy directed toward solving current problems by modifying distorted thinking and behaviour. It assumes that thoughts, beliefs, attitudes and perceptual biases influence emotions and behaviour. Realistic evaluation and modification of thinking produces improvement in mood and behaviour.

Cognitive therapy may be used to treat non-psychotic symptoms and adjustment issues (e.g., depression, anxiety, substance abuse) in patients with early psychosis. It is increasingly recognized to be of benefit in treating the positive symptoms of psychosis. It can be particularly useful for young people, as it offers a way of examining alternative explanations for delusions or fixed ideas before they become entrenched.

Coping Skills and Stress Management Approaches

Stress management approaches help people develop coping strategies and reduce vulnerability to stress-induced relapse.

Stress management also teaches people to monitor stress, recognize potential warning symptoms and modify the stressor by adjusting their environment or behavior.

Summary of Strategies for Early Intervention

1. General practitioners can play a pivotal role in ensuring early detection and intervention for psychotic disorders. The key is to maintain an index of suspicion.

2. Develop rapport, discuss confidentiality, reduce tension and take time. Family concerns should be addressed.

3. Use a framework to assist the assessment. Describe specific symptoms and behaviours in your documentation.

4. Inquire systematically about psychiatric syndromes and ask specifically for prodromal changes and psychotic symptoms.

5. Assess for potential to harm self or others.

6. Obtain collateral information, particularly from the person's family or living companions.

7 Perform physical examination and appropriate investigations.

8 Seek specialist psychiatric assistance if psychosis is overt or suspected.

9 If involuntary hospital admission seems necessary, the BC Mental Health Act should be consulted.

10 An antipsychotic-free period allows clinicians to observe symptoms and rule out more transient psychoses.

11 The "start low - go slow" approach to treatment with antipsychotics should be used.

12 Non-pharmacological treatments are beneficial and should not be neglected.

13 Assertively follow up patients if they do not attend. Keep in contact with their family.

Source Materials

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Some information contained in this booklet was adapted from the above publications.

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Other Resources

Canadian clinical practice guidelines for the treatment of schizophrenia. Canadian Journal of Psychiatry, 1998, 43(supplement 2).

The Early Psychosis Prevention and Intervention Centre
http://www.eppic.org.au/

British Columbia Schizophrenia Society
http://www.bcss.org/

Internet Mental Health
http://www.mentalhealth.com/

Mental Health Evaluation & Community Consultation Unit
http://www.mheccu.ubc.ca/projects/EPI

B.C. Ministry of Health site pertaining to mental health (including guide to Mental Health Act)
http://www.hlth.gov.bc.ca/mhd/index.html

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