

AUSTRALIAN CLINICAL GUIDELINES FOR EARLY PSYCHOSIS

A Brief Summary for Practitioners

 **Orygen**
The National Centre of Excellence
in Youth Mental Health



EPPIC

Early Psychosis
Prevention and
Intervention
Centre

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Corrections

Any correction or comments may be directed to info@orygen.org.au and should be marked attn: *Australian Clinical Guidelines 2nd Edition*.

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What is this practitioner guide?

This practitioner guide is a summary of the second edition of the Australian Clinical Guidelines for Early Psychosis, developed at EPPIC Statewide for the Orygen Youth Health Research Centre. We strongly encourage readers to refer to the full guidelines if possible; they are available via the Orygen, The National Centre of Excellence in Youth Mental Health Website at www.orygen.org.au.

The guidelines were published in order to assist health practitioners make appropriate decisions (i.e., based on good evidence and/or the consensus of a panel of experts) in service provision to those with early onset psychosis. The guidelines relate both to those with a first psychotic illness and those who have been identified as being at “ultra high risk” [UHR] of developing psychosis. Our aim in the guidelines, and in this practitioner guide, is to outline best practice in the provision of services to young people experiencing the early stages of a psychotic disorder, and to their families and friends. The guidelines are not a substitute for individual clinician knowledge and judgment within the context of a specific therapeutic relationship.

All references in this document relate to the Australian Clinical Guidelines.

Key recommendations

Access to Care

Early intervention in psychotic disorder allows reduction of distressing experiences as quickly as possible. Longer durations of untreated psychosis [DUP] are also both a marker and a risk factor for poor outcome in first episode psychosis [FEP]. Longer DUP is related to short-term factors such as slower and less complete recovery, poorer response to antipsychotics, interference with social and psychological development, and an increased risk of relapse. It is also likely related to medium-term outcome. Early intervention does reduce DUP, is associated with better short-term outcome, and appears to be more cost-effective than standard services.

A critical implication of this is that better outcomes will result from earlier detection and treatment of psychotic disorder. Services should provide assistance as soon as possible after help has been sought; highly accessible specialist services should enable this. Reducing DUP requires not only enabling access to mental health services, but initiating treatment as soon as possible. Examples of timely care include assessment within 48 hours of referral to a service; being seen by a consultant psychiatrist within one week of assessment; and having at least some contact with a case manager within five days of assessment. Detection of psychotic disorder, by reducing the time period between onset of symptoms and help seeking, is also likely to be enhanced by community education initiatives directed at primary care.

Recommendations

1.1	Mental health services should be accessible and provide a timely assessment for people experiencing their first episode of psychosis. ^{GPP}
1.2	Enhancing help-seeking:
1.2.1	Mental health services should provide education about early intervention to primary carers and the wider community. The community needs to be well informed about psychotic disorders and how to obtain effective help. Community-wide initiatives to increase knowledge and reduce the stigma associated with psychosis should be implemented. ^C
1.3	Enhancing professional identification of psychotic symptoms:
1.3.1	Primary health care professionals should be competent in eliciting and recognising the early clinical features of psychotic disorders. ^{GPP}
1.3.2	Primary care professionals should be trained in identifying psychosis and given information about how to refer to specialist services. ^C
1.3.3	Undergraduate and postgraduate medical education should be developed to allow for better training in assessment and treatment of emerging mental illness. ^{GPP}
1.3.4	Close links should be developed between primary and specialist mental health services to facilitate assessment and treatment of emerging mental illness. ^{GPP}
1.4	Enhancing connection to appropriate services:
1.4.1	Specialist early detection teams should be set up to enable timely access to care ^C
1.4.2	The means to access the service and the hours of operation should be promoted and advertised to the community. ^{GPP}
1.4.3	The mental health service should be accessible 24 hours/day, 7 days/week. ^{GPP}
1.4.4	The service should accept potential new referrals from a wide range of individuals, family and friends, and primary care services. A low threshold for expert assessment should be set for any person suspected of developing a psychotic disorder for the first time. ^{GPP}

Assessment

The purposes of assessment are complex but include:

- engaging the young person
- facilitating the development of a therapeutic alliance
- gaining information enabling diagnosis
- formulation of the person's difficulties, including understanding its personal context.

These factors both inform treatment planning and are vital in providing a foundation for further successful treatment. Good assessment can be a form of early treatment in its own right.

Those who seek help may not do so for psychotic symptoms, but rather nonspecific symptoms such as depression, anxiety, or concerns about decline in functioning, making it particularly important that clinicians be skilled in identifying signs of early psychotic disorder.

Although only 3% of FEP has an organic origin, the initial assessment is the most appropriate time for this to be examined. Biological examination can also serve other useful purposes, including:

- detection of medical comorbidities
- identification of risk factors for future medical disorders
- identification of risk factors for incomplete remission or treatment resistance
- and identification of a baseline against which pharmacological complications and side-effects can be assessed.

Cognitive assessment can allow interventions, particularly psychological interventions, to be appropriately tailored to the young person's cognitive function and growth areas, for example, by taking cognitive deficits into account in the delivery of therapy, or making cognitive deficits a focus of intervention.

Assessment of comorbid disorder requires assessment of substance use and other psychiatric disorder.

Risk assessment should be broad, including:

- risk of suicide
- deliberate self-harm
- violence
- neglect and victimisation
- non-adherence to treatment and service disengagement.

Engagement with families and other relevant social networks should be a priority at this time, not only for their own sake, but also because these people can operate as partners in care. This assists in gaining an understanding about how best to conduct an assessment and engage the young person, as well as providing preliminary information about the young person's difficulties. An assessment should therefore also consider the immediate needs of the family. In some instances, however, young people may be reluctant to allow communication between services and family. An early step is to explain to the young person that the involvement of families is routine and a useful part of their overall care. If a young person continues to decline family involvement in assessment and/or treatment, careful and ongoing exploration of reasons is warranted. In the FEP group, the assumption is made that families deserve general support from clinical services even when clients are reluctant for them to be involved in ongoing care.

Client and service rights and responsibilities should be canvassed throughout service engagement with consumers and their families and other networks, but assessment is the most appropriate time to initially communicate them in user-friendly ways.

It is both ethically sound and good practice to provide the young person, and, where appropriate, their support networks with feedback regarding the assessment process, particularly diagnosis and any formulation that the assessor may be considering of the client's difficulties. Feedback should be provided to the referrer and where possible to the young person's general practitioner. A particular sensitivity is required in the UHR group, where information about the nature of symptoms and the level of risk of transition should be carefully provided within a framework of therapeutic optimism.

Recommendations

2.1	Assessment begins therapeutic engagement and treatment, so establishing rapport should be a priority. ^{GPP}
2.2	Assessment is an ongoing process, not just restricted to initial entry into service. ^{GPP}
2.3	Assessments should occur as soon as practicable after referral, and within 48 hours in the case of a suspected FEP. ^{GPP}
2.4	All clients should have a comprehensive biopsychosocial assessment by the acute treating team. This should include developing an understanding of the personal context of illness and developing a case formulation; mental state examination; physical examination and investigations; cognitive assessment; assessment for comorbid disorders; and risk assessment. ^{GPP}
2.4.1	Assessment of the personal context of illness should include developing an understanding of the longitudinal course of symptoms and how they are regarded by the young person; and the young person's strengths, resources (including family resources), and skills in managing these symptoms specifically and other stressors more broadly. ^{GPP}
2.4.2	Mental state examination, assessing signs, symptoms, and insight, is aided by an antipsychotic-free period of assessment. ^{GPP}
2.4.3	Physical examination, including baseline assessment of metabolic functioning (see guideline 3.2.1) and related lifestyle factors (such as diet and exercise) should occur to rule out an organic basis to illness, guide appropriate treatment, and enable monitoring of side-effects. Basic metabolic monitoring should be ongoing and include regular weight and waist circumference measurement. ^{GPP}
2.4.4	Assessment for comorbid disorders should include thorough and regular assessment of substance use (including cigarette use) and other psychiatric disorders. ^{GPP}
2.4.5	Risk assessment:
2.4.5.1	Risk assessment should be undertaken and documented at each visit, and should include routine assessment of depressive symptoms, hopelessness, suicidal intent, the effect of returning insight, and the role of psychotic features on mood. ^{GPP}
2.4.5.2	Risk assessment should take into account the fluctuating nature of suicidality in young people. ^{GPP}
2.4.5.3	Risk assessment should also include assessment of risk to others, risk attributable to neglect and victimisation by others, and risk of non-adherence to treatment (including absconding). ^{GPP}
2.5	Where possible, informants (particularly referrers, but also other key members of the young person's social networks) should be drawn upon as valuable sources of information about the trajectory and nature of the young person's difficulties. Assessment should also consider needs of the family, their knowledge of psychosis, the impact of psychosis on the family, and their strengths and coping resources. ^{GPP}
2.6	Feedback regarding assessment (particularly the fact of contact with the service, diagnoses and possible formulation of the young person's difficulties) should be provided to the young person; briefly and within 48 hours to referrers (in writing) and general practitioners; and, where appropriate, to other key supports of the young person. ^{GPP}
2.7	Rights and responsibilities, as well as treatment and service available within the service, should be communicated to clients and their key supports within 48 hours of entry to the service, including in writing (see guideline 3.4.3 for further information about confidentiality). ^{GPP}

Treatment during the Pre-Psychotic Phase (Ultra-High Risk for Psychosis)

Anti-psychotic medication should not be considered as a first treatment option during the pre-psychotic phase.

The possible prodromal phase or symptomatic ‘at-risk mental state’ is usually characterised by a sustained and clinically significant deviation from the premorbid level of experience and behaviour. The staging model around which these guidelines are structured conceive of two forms of this possible prodrome – a period of mild or nonspecific psychotic symptoms, and a period of increased symptom activity which still does not meet criteria for a full-threshold psychotic episode. This period is called the ‘at risk mental state’ rather than the prodrome, as this period can only be definitively identified as the prodrome in retrospect (i.e., once it is clear whether the young person has later experienced a psychotic episode).

Intervening during this period has a number of advantages, including identifying people during a phase in which subtle yet tenacious disability is possibly laid down; facilitating engagement with services by managing current difficulties before the person is too unwell; reducing the severity of psychosis, and associated burdens, as well as the need for hospitalization, by enabling early intervention if symptoms do progress. It also appears that specific interventions during the symptomatic at-risk period can ameliorate, prevent or delay transition to psychosis in a subset of clients.

There is evidence to indicate psychological treatments (specifically CBT) as well as omega-3 fatty acids may prevent or delay transition to psychosis in identified UHR populations. There is also preliminary research to indicate that anti-psychotic medication (in combination with supportive psychotherapy (CBT or TAU in mental health service)) may also be helpful in preventing and/delaying transition to psychosis.

There are significant risks in identifying young people as at ‘ultra’ high risk of developing psychosis, particularly the inevitability of ‘false positives’ (identifying young people as at elevated risk when in fact they are not, and would not in any case have gone on to develop psychosis). The risks of ‘false positives’ suggest caution in intervention, particularly interventions with potentially problematic consequences. Although CBT is unlikely to have clearly negative outcomes, antipsychotics may due to their side-effects. Given this, the use of antipsychotics in the UHR group is not recommended, particularly as the empirical evidence for their efficacy in preventing or delaying psychosis onset is limited. On the other hand, although the empirical data is also small, omega-3 fatty acids may reduce the rate of progression to psychosis with very few side effects and so are an appropriate treatment intervention in the high-risk period. Pharmacological treatment of comorbidity is also appropriate where evidence justifies this for example the use of anti-depressant medicine for people with depression.

Recommendations

3.1.1	Omega-3 fatty acids may prevent or delay transition to psychosis. ^B
3.1.2	Psychological and, where appropriate, pharmacological treatment of comorbidities should be prioritised and consistent with guidelines on those comorbidities. Pharmacological treatment of comorbidity should be considered before specific pharmacological treatment of attenuated psychotic phenomena since this comorbidity may be the origin of, or contributing to, the prominence of, attenuated psychotic symptoms. ^{GPP}
3.1.3	Antipsychotic medication should NOT be considered as the first treatment option for UHR. However, if rapid worsening of psychotic symptoms occurs together with significant deterioration in functioning related to these symptoms and elevated risk to self or others, a low-dose atypical antipsychotic may be considered, in conjunction with close monitoring and support. Note that this is not justified in the majority of such situations. ^{GPP}
3.1.4	CBT may reduce or obviate the need for antipsychotic medication in the pre-onset phase. ^B
3.1.5	CBT may reduce psychotic symptomatology and prevent or delay transition to psychosis in the pre-onset phase. ^B
3.1.6	CBT may improve social functioning in the pre-onset phase. ^C
3.1.7	Supportive counselling alone may improve social functioning in the pre-onset phase.

Treatment in acute FEP

The acute phase can be characterised by the presence of psychotic features such as delusions, hallucinations, and formal thought disorder. Pharmacological interventions are the first-line treatment for young people with first episode psychosis; clients may find it difficult to engage in other interventions until florid symptoms of psychosis resolve, at least in part. While pharmacological treatment guidelines for people with established schizophrenia may be partially relevant, they are not sufficient for treating people with FEP. There are a number of qualities of the FEP group that suggest a specifically tailored or staged approach. For example, FEP patients appear to be particularly sensitive to a number of side-effects of medications such as weight gain, sedation, and extrapyramidal side-effects.

Possible prescribing algorithms for FEP are outlined in the Guidelines. Broadly, the limited research available to date suggests that tolerability is greater for second-generation antipsychotics [SGA] than first-generation antipsychotics [FGA] in FEP. People with FEP respond to antipsychotic medication more quickly and to a greater extent, and generally require lower doses to do so, than those with more established illness. Further, side-effects of antipsychotics are dose-dependent and are often caused by rapid titration. For these reasons, a 'start low, go slow' prescribing approach is warranted; use the lowest possible dose to treat symptoms.

Given different treatment recommendations in the acute phase (especially the utility of adding a mood stabiliser to the pharmacotherapeutic regime), a key early distinction between affective and non-affective presentations must be made.

There is presently limited evidence to suggest an increased treatment response when combining antipsychotic medications in schizophrenia. Combining antipsychotic medications also increases the risk of side-effects, non-adherence, and adverse drug interactions.

The majority of guidelines for schizophrenia recommend against the use of more than one antipsychotic, except for possible augmentation with clozapine in treatment-resistant cases or when changing medication. Although there have been no direct randomised controlled trials in FEP populations, the increased propensity for side-effects in this population would not support polypharmacy in this group.

Medication non-adherence appears particularly prevalent in FEP. Although there is limited empirical research on this issue, strategies for managing non-adherence may include employing problem-solving skills, direct instruction, and motivational interviewing approaches.

Antipsychotic medication can cause side-effects which are distressing or disabling for clients. These include weight gain, sexual and endocrine side-effects, extra-pyramidal motor symptoms and tardive dyskinesia, and metabolic side-effects. In particular, antipsychotic medication is associated with a cluster of interrelated risk factors for developing type 2 diabetes and cardiovascular disease, known as metabolic syndrome. The core components of metabolic syndrome are central obesity, hypertension, raised glucose and dyslipidaemia. Metabolic side-effects can develop quickly, are generally distressing, and have significant long-term medical consequences. Guidelines for detection and management of metabolic syndrome are outlined in the Guidelines.

Interventions to monitor and prevent metabolic side effects

Metabolic monitoring

Baseline

- Weight measures including weight, BMI and waist/hip circumference
- Blood pressure
- Fasting blood glucose
- Fasting blood lipid (full profile)
- Smoking status
- Exercise status

Monitor at 1, 3, 6, 12, and 18 months and then yearly

Interventions

- Dietary advice/exercise and lifestyle education and behavioural interventions (possibly with specialist dietician involvement)
- Consider change to less "metabologenic" antipsychotic medications
- Consider other pharmacotherapy e.g., statins with GP/specialist input

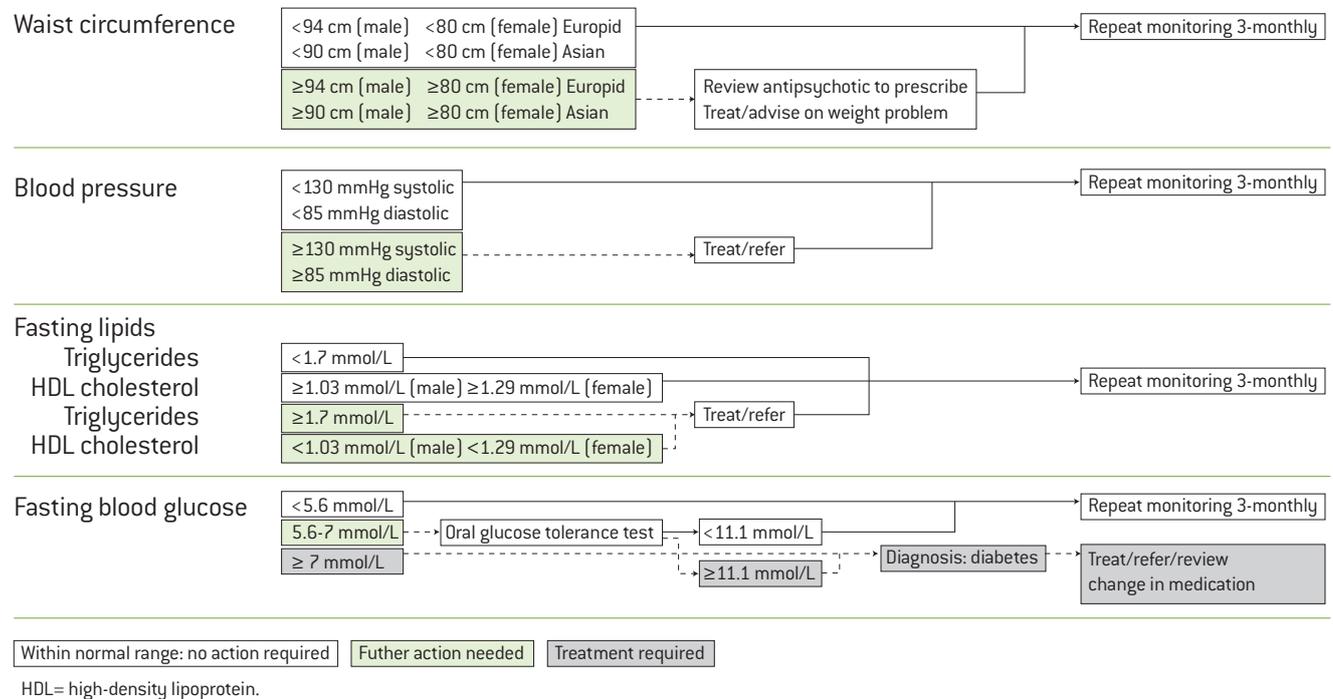
Treatment non-response four weeks after commencement should be an alert for possible longer-term non-response, especially in combination with other factors that predict poor response, including a GAF score ≥ 70 in the year prior to onset; highest level of schooling \leq year 10; a current GAF score ≤ 30 ; male gender; and meeting friends no more than two or three times per month.

Provision of either supportive counselling or CBT during the acute phase can have immediate and long-term effects on symptoms, with CBT having additional effects in the immediate term. CBT may lead to better early recovery, but that other interventions (e.g., supportive therapy/befriending) may be of similar benefit later in the recovery process.

Recommendations

3.2.1.1	All clients should be seen by a doctor within 48 hours after entry to service. ^{GPP}
3.2.1.2	All clients should be seen by a consultant psychiatrist within one week after entry to service. ^{GPP}
3.2.1.3	All clients should be seen at least twice weekly in the acute phase by the acute treating team, or case manager, and a doctor. ^{GPP}
3.2.1.4	All families should be seen or contacted at least weekly in the acute phase by the acute treating team or case manager. ^{GPP}
3.2.1.5	Antipsychotic medication should not be used during the first 24/48 hours of treatment in young clients with a first episode of psychosis. ^{GPP}
3.2.1.6	SGAs should be used in preference to FGAs. ^{GPP}
3.2.1.7	Side-effect profile should guide choice of SGA. ^{GPP}
3.2.1.8	Affective and non-affective psychosis should be distinguished to enable appropriate treatment (i.e., appropriateness of use of a mood stabiliser). ^{GPP}
3.2.1.9	Pharmacological treatment should proceed with a ‘start low, go slow’ approach. ^{GPP}
3.2.1.10	Adherence should be monitored and explicitly addressed where necessary. ^{GPP}
3.2.1.11	Oral treatment should be used except in exceptional circumstances where other efforts to improve adherence have been unsuccessful. ^{GPP}
3.2.1.12	Benzodiazepines may be a useful short-term adjunct in florid psychosis for sedation. ^A
3.2.1.13	Potential side-effects (including metabolic side-effects, weight gain, extrapyramidal motor symptoms, and sexual side-effects) should be noted and discussed with clients prior to pharmacotherapy commencement, monitored, managed and addressed early, with a prevention model if possible (e.g., weight management strategies implemented prior to treatment initiation). ^{GPP}
3.2.1.14	Treatment of the primary psychotic disorder should be prioritised unless co-morbidity leads to high levels of risk to self/ others or clinical judgement considers that the comorbidity has a major impact on the primary psychotic disorder (e.g. cannabis dependence). ^{GPP}
3.2.1.15	With the exception of the above situations, polypharmacy should be avoided, specifically the use of multiple antipsychotics. ^{GPP}
3.2.1.16	CBT ^A , supportive therapy ^B , or befriending ^B should be provided during the acute phase, with CBT having the most immediate benefit.
3.2.2.1	Treatment response and adherence should be regularly reviewed. All clients should be seen at least weekly by a case manager and at least fortnightly by a doctor in the early recovery phase. ^{GPP}
3.2.2.2	All families should be seen or contacted at least fortnightly during the early recovery phase ^{GPP}
3.2.2.3	Early response to antipsychotic medication should be considered as a prognostic sign. ^{GPP}
3.2.2.4	CBT interventions may be indicated in this group, speeding up recovery, reducing the period of hospitalisation ^D , enhancing short-term adaptation to illness ^B , reducing positive symptoms ^D , and improving personal goal attainment. ^D
3.2.2.5	The possibility of relapse should be discussed with clients and families along with education regarding early warning signs and the development of a ‘relapse action’ plan. ^{GPP}

Clinical algorithm for monitoring the metabolic syndrome in people treated with antipsychotic medication from Waterreus, A. J., & Laugharne, J. D.



³³⁷ Waterreus, A. J et al. Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. MJA 2009; 190: p185-189. ©Copyright 2009. *The Medical Journal of Australia* – Reproduced with permission.

Relapse Prevention and Management in FEP

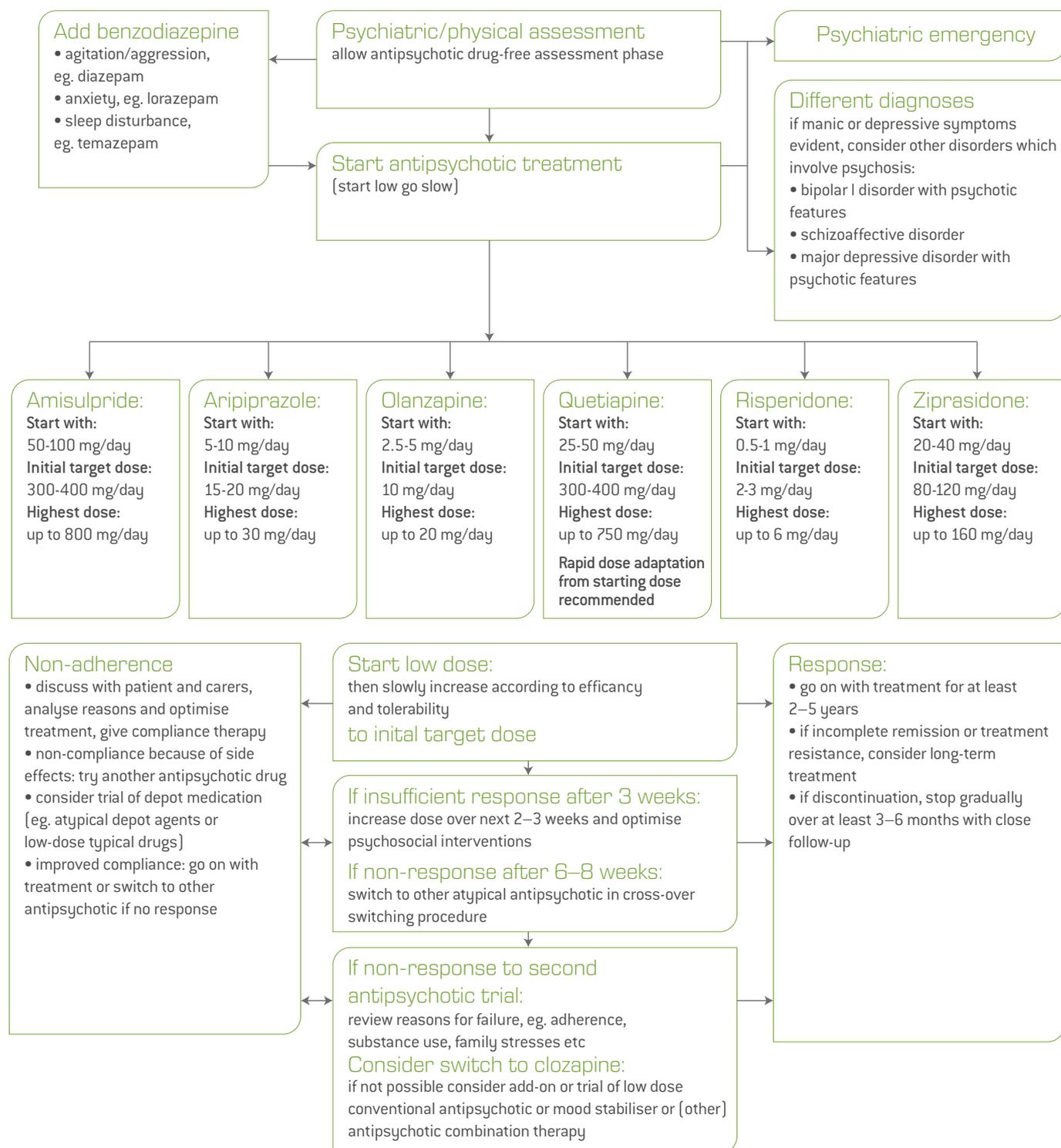
Psychotic symptoms will remit in most young people with a first episode of psychosis, but there is a high rate of subsequent relapse. Relapse is almost always preceded by non-psychotic symptoms such as anxiety and depression and low-level psychotic symptoms. Primary prevention of relapse involves intervention during the period in which subsyndromal symptoms re-emerge, while secondary prevention includes early identification of, and intervention for, relapse once symptoms have passed an established psychosis threshold.

Families as well as clients may assist in early identification of risk factors for relapse, and coping strategies to respond to these. First episode programs prevent relapse to a greater degree than treatment as usual [TAU]. Individual cognitive-behavioural interventions without a specific relapse prevention focus may not show additional benefits over FEP programs, or supportive counselling or TAU. Individual and family interventions may be of more benefit than specialist FEP services; however, long-term effectiveness remains to be established.

Recommendations

3.2.3.1	Medication should be recommenced or increased at early signs of relapse. ^{GPP}
3.2.3.2	The advantages of maintenance antipsychotic therapy in relapse prevention should be weighed against any impact of side-effects on functioning. ^{GPP}
3.2.3.3	Relapse prevention strategies (including more regular review and provision of information about rapid access to care) are particularly indicated if medication dosages are decreased or medication ceased. ^{GPP}
3.2.3.4	Combined family and individual CBT specifically focusing on preventing relapse should be used ^B
3.2.3.5	Family interventions alone may be helpful in preventing relapse in FEP. ^C

Figure 1: Pharmacotherapy for first episode non-affective psychosis

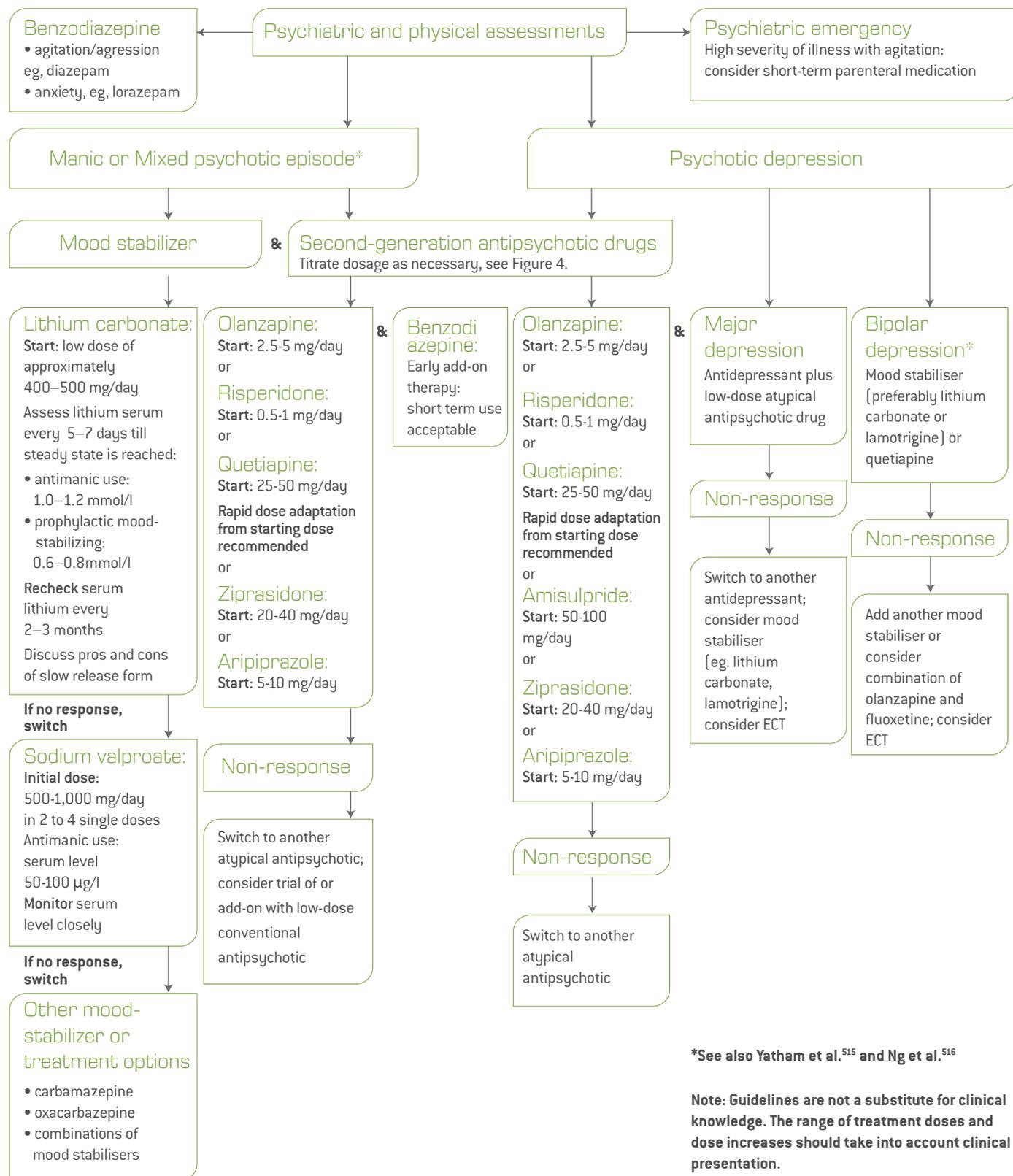


Note: Guidelines are not a substitute for clinical knowledge.

The range of treatment doses and dose increases should take into account clinical presentation.

Quetiapine (quetiapine fumarate) in this algorithm refers to non extended release formulation.

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 190.

Figure 2: Pharmacotherapy for first episode affective psychosis*See also Yatham et al.⁵¹⁵ and Ng et al.⁵¹⁶

Note: Guidelines are not a substitute for clinical knowledge. The range of treatment doses and dose increases should take into account clinical presentation.

Quetiapine (quetiapine fumarate) in this algorithm refers to non extended release formulation.

Caution: Sodium valproate in women

Adapted from *The recognition and management of early psychosis: a preventive approach, 2nd Edition* Henry J. Jackson, Patrick D. McGorry, Editors. 2009, Cambridge University Press: Cambridge.p 192.

Maintenance Treatment and Problematic Recovery in FEP

The ‘critical period’ hypothesis would suggest that for some clients, a conservative approach of maintenance pharmacological treatment over the three to five year period of hypothesised vulnerability to relapse and suicide may be appropriate. There has, however, been limited empirical exploration of the period over which maintenance treatment should be considered post-recovery. Current data suggest that pharmacological treatment periods should possibly extend at least over the first two years of illness. Guided discontinuation six months post-recovery (with close monitoring) may however be successful in the minority of cases. Initial response to treatment, diagnosis (affective/non affective psychosis), the impact of antipsychotic side-effects on functioning, and good and bad prognostic factors (such as long DUP and poor premorbid functioning) should also guide this decision.

The process of withdrawing medication must be carried out slowly (over a number of months) and with careful monitoring that extends for several months after medication ceases.

Further factors emerging later in treatment are clearer markers of problematic recovery. These include a long duration of untreated psychosis, a diagnosis of schizophrenia, and poor premorbid psychosocial functioning in childhood and adolescence. This group must be distinguished from those who have not been adequately treated with first-line pharmacological and psychosocial interventions. A key implication of the DUP literature is that problematic or incomplete recovery should be identified and managed early. No published papers have addressed the issue of pharmacotherapy for problematic recovery in the FEP area.

However, guidelines for incomplete recovery in schizophrenia have received widespread acceptance. The early introduction of clozapine may need to be considered in response to trials of at least two different antipsychotic agents, at least one of which is an SGA, given clozapine’s specific efficacy in treating resistant positive symptoms and its impact on negative symptoms. Although response to clozapine should emerge within eight weeks of reaching therapeutic dose, a trial of six months is recommended. There is limited empirical evidence beyond case reports on pharmacological strategies should clozapine be unsuccessful in managing incomplete recovery in the FEP phase.

General medical care also becomes a priority at this stage, given the high rates of physical morbidity and premature mortality in this group. This period may also include revisiting the degree to which medication side-effects outweigh benefits, given the medical and social consequences of some medications.

Few psychological interventions have been specifically designed for those with FEP who experience prolonged recovery, with those that have, using a CBT approach. Despite the paucity of evidence examining the appropriateness of psychological therapy in early recovery, it seems good clinical care to consider its delivery during this phase. It seems particularly appropriate to consider offering treatments that recognise the impact of illness on the sense of self, attempts to improve social and vocational functioning, and considers the possibility of relapse and plans for this.

Some data suggest a positive relationship between length of the recovery process and familial distress. These families may therefore have a particularly strong need for supportive and other interventions.

Recommendations

3.2.4.1	All clients should be seen at least fortnightly by a case manager, and at least monthly by a doctor, during the late recovery phase ^{GPP}
3.2.4.2	All families should be seen or contacted at least every two months by the treating team during the late recovery phase
3.2.4.3	People with persisting positive or negative symptoms should be identified early. ^{GPP}
3.2.4.4	Clozapine should be considered for those who have not responded to adequate trials of two antipsychotic medications, of which one is a SGA. ^A
3.2.4.5	If a satisfactory response occurs, treatment should be continued for at least two years. ^{GPP}
3.2.4.6	CBT should be considered as an adjunctive therapy during late/problematic recovery. ^{GPP}
3.2.4.7	All families should be seen or contacted at least every two months by the treating team during the late recovery phase ^{GPP}
3.2.4.8	Families of young people with a slow or difficult recovery or frequent relapses may benefit from more intensive and structured interventions, emphasising problem solving and communication skills. ^{GPP}
3.2.4.9	Support should be provided to the young person and their family specifically around the discharge process. ^{GPP}
3.2.4.10	The treating team should assertively liaise with ongoing treatment providers prior to and during the discharge process. ^{GPP}
3.2.4.11	All young people should be linked in with a GP on discharge. ^{GPP}

General principles relating to treatment in early intervention for psychotic disorders

Integrated interventions refer to the collaborative provision of biological and psychological interventions, along with assertive case management and other psychosocial interventions (such as vocational or group interventions). Integrated treatment approaches appear to be more effective than standard care in the short-term treatment of early psychosis, although their efficacy in the medium term is less settled. There are at least two ways of implementing integrated early intervention services: as a specialist, stand-alone model; and a partial model, in which early intervention specialists are situated within existing service structures. The relative advantages and disadvantages of each model have not been explored empirically in any significant detail.

Recommendations

3.3.1	Integrated specialist services are more effective than standard services in the treatment of people with FEP. ^A
3.3.2	Milieu therapy ^C , supportive psychodynamic therapy ^C , and cognitive remediation therapy ^D may be useful in treating symptoms and/or improving functioning in FEP.

The importance of engagement.

Effective engagement is vital. The engagement phase is crucial in all forms of psychiatric treatment, with the strength of the therapeutic alliance a moderate-to-strong predictor of outcome, regardless of therapeutic approach, including with young people.

Recommendations

3.3.4.1	Engagement should be prioritised as the foundation of treatment. ^{GPP}
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Treatment within the least restrictive environment.

For those requiring acute treatment, restrictive treatment mechanisms can imperil engagement with services for some time to come, with the likely outcome being a poorer prognosis. Further, involuntary treatment and hospitalisation may be appraised as a particularly powerful stressor. Minimising the trauma of both symptoms and the way in which these are treated should be an important consideration. For all of these reasons, treatment should be offered in the least restrictive environment possible. When admission is necessary, clinical experience suggests that it is most appropriate that clients are seen in specialist adolescent/youth facilities or, at the least, have an adolescent/youth specialist involved in their care.

Recommendations

3.4.2.1	Young people should receive treatment in the least restrictive manner possible. Whenever possible, the location of the initial assessment should be community-based and at a place that is convenient to the young person and their family. ^{GPP}
3.4.2.2	A range of treatment settings should be available to the young person, including home based support, supported accommodation, rooming in, outpatient services, and inpatient care. ^{GPP}
3.4.2.3	The levels of risk (to self and others), the available resources (including community support) and the needs of the client and family should be assessed to determine whether the young person can be managed at home. ^{GPP}
3.4.2.4	Where hospitalisation is required, the young person should be admitted to a facility that can cater for, and is appropriate to, the young person's age and stage of illness. Where streaming is not possible, a special section may be created in a general acute unit for young recent-onset clients. ^{GPP}
3.4.2.5	Community Treatment Orders should be used for the minimum duration required to meet specified treatment goals. ^{GPP}
3.4.2.6	Involvement of police to enforce treatment should be kept to a minimum and used as a last resort in the case of immediate risk. ^{GPP}
3.4.2.7	The use of seclusion (if used at all) should be kept to the minimum frequency and duration to meet the treatment aims when managing high risk clients. ^{GPP}

Family involvement.

Psychosis (both emergent and established) can have an enormous impact on the family system, as it can lead to bewilderment, fear, grief and suffering for both the person with the illness and their families. This may particularly be the case with early psychosis, as most young people are living with their families when psychosis begins. Additionally, families may play a vital role in supporting the young person and facilitating engagement in treatment, thereby improving client prognosis. The combined aims of alleviating distress in families and maximizing client prognosis suggests the importance of the provision of support to families.

The evidence base for family intervention in the pre-onset and FEP stages is therefore not established; however, there are compelling reasons for this to be regarded as good clinical care, including the need to support those who are supporting clients, and the likelihood that, consistent with the diathesis-stress model more broadly, at least some part of the family environment (although perhaps not yet examined empirically yet) will influence client progress. Family peer support workers - family members of clients who have been through a clinical service before – may be particularly helpful. These workers can provide assistance and reassurance to families, having experienced the process of caring for a young person with emerging psychotic illness.

Recommendations

3.4.3.1	The needs of individual family members should be recognised and addressed (where appropriate, within clinical services, or alternatively, by referral to external agencies) at all stages of the young person's recovery. ^{GPP}
3.4.3.2	The case manager should have frequent contact relevant to the phase of illness and the needs of the young person and family. ^{GPP}
3.4.3.3	Family attendance and involvement should be reviewed as part of the clinical review process. ^{GPP}
3.4.3.4	The treating clinician should assist the family by providing information about psychotic disorders (including the recovery process); and by helping the family, where necessary, develop skills in problem solving and enhanced coping strategies. ^{GPP}
3.4.3.5	The treating clinician should maximise the responsiveness of the family to early warning signs in order to facilitate relapse prevention. ^{GPP}
3.4.3.6	Where necessary, the clinician should prepare the family to deal with crises. ^{GPP}
3.4.3.7	Peer family support workers may be a useful resource for information and emotional support, particularly in situations when the young person does not wish the involvement of their family and carers. ^{GPP}
3.4.3.8	Families with more complex needs, such as those with a history of sexual and/or other abuse or long-standing emotional conflict, may need to be referred to specialist agencies. ^{GPP}

The role of case management.

The goal of the case manager or treating clinician in early psychosis in particular is to promote recovery and to prevent relapse and ongoing disability. This can be achieved through assisting the young person and the family to understand psychosis and to develop resources that will assist them in the future. The case manager is the key psychotherapeutic contact and should use a case formulation, developed collaboratively with the young person and in concert with the rest of the treating team, to guide treatment. The case manager provides a point of service accountability, and works in partnership with the psychiatrist, who has key clinical accountability. Case managers are also responsible for continuity of care. They should also have links with other specialist providers, as well as existing mental health and community services, being able to utilise them as needed in response to the young person's needs.

Recommendations

3.4.4.1	The case manager or treating clinician coordinates the treatment and care of the young person throughout the episode of care. ^{GPP}
3.4.4.2	The case manager should be present at the client's doctor appointments to ensure continuity of care. ^{GPP}
3.4.4.3	A case formulation, including provisional diagnosis and management plan, should be completed by the case manager and/or treating team within six weeks of discharge from acute treatment. ^{GPP}
3.4.4.4	The case manager should facilitate the person's access to necessary accommodation, vocational, recreational, welfare and primary health services. ^{GPP}
3.4.4.5	The case manager should regularly consult with the client's GP, and at least every six months. ^{GPP}

Goals as guides to treatment.

Treatment goals are key reference points for assessing client progress and treatment effectiveness. In contrast to the model of clinician as ‘expert’ and client as ‘passive recipient’, collaborative treatment planning aims to empower clients in their own recovery.

Recommendations

3.4.5.1	Both the case manager and doctor should meet with the client and, where possible, the family, and develop an individual service plan (ISP) within four to six weeks after entry to the service. ^{GPP}
3.4.5.2	The case manager should regularly review the ISP with the client. ^{GPP}

Recommendations

3.4.6.1	Group programs should be offered to those with FEP ^B and at UHR. ^{GPP}
3.4.6.2	Group programs should be available in a range of clinical and community settings. ^{GPP}
3.4.6.3	Group programs should be tailored to the different needs of young people at different phases of illness. ^{GPP}
3.4.6.4	Decisions about participation in any group program should be made collaboratively with the individual, based on an understanding of the potential benefits for that person. ^{GPP}
3.4.6.5	Goals should be set collaboratively and progress of participants towards these goals should be regularly reviewed. ^{GPP}
3.4.6.6	The development of group programs should be based on a thorough planning process which includes needs assessment, the setting of objectives, development of content areas and establishment of evaluation strategies. ^{GPP}
3.4.6.7	Where appropriate, group program staff should assist clients in finding meaningful psychosocial activities (such as other groups/activities) external to clinical services. ^{GPP}
3.4.6.8	There should be an effective clinical interface between the group program and the case manager (or treating clinician) or multidisciplinary team. ^{GPP}

Psychoeducation.

Psychoeducation aims to develop a shared and increased understanding of the illness for both the young person and their family. Needs for information are, however, likely to differ across clients. Family psychoeducation may also reduce relapse rates. Psychoeducation can be delivered in a variety of modes, including one-to-one interactions, group sessions, peer support sessions, and family work. This material should contain specific early psychosis information.

Group programs.

Psychosis disrupts social networks, which in turn can worsen the outcomes of illness. Group work can meet a number of needs in early psychosis, including reducing social isolation and experiences of stigma and providing specific content that may assist in recovering from psychotic experiences. Group work may provide a medium for therapeutic change beyond this ‘normalising’ element, using a diverse range of theoretical frameworks and approaches. Sound clinical practice requires effective liaison between the treating team and the group program, to ensure clinicians are working together in meeting the client’s needs.

Psychoeducation in the first episode field needs to be particularly aware of healthy resistance to the psychological threat of self-stigmatisation with associated poorer insight and reluctance to engage in the psychoeducation process. Timing of psychoeducation is also important – during acute exacerbation of mental state abnormalities, basic practical information is essential, but more detailed and comprehensive psychoeducation should be deferred until this has settled. Psychoeducation in the UHR group may also usefully include an awareness of the possibly stigmatising effect of an ‘at risk’ diagnosis, a discussion of the risk of false positives in identifying those at UHR and in particular to address fatalism about psychosis onset.

In both the UHR and FEP phases, psychoeducation should not be limited to psychotic symptoms and should extend to any substance or psychiatric comorbidities that the client is experiencing.

Recommendations

3.4.7.1	Psychoeducation should be provided for young people with early psychosis and their families. ^{GPP}
3.4.7.2	The case manager and the treating doctor are responsible for ensuring access to psychoeducation. ^{GPP}
3.4.7.3	The material should be appropriate for young people and for early psychosis. ^{GPP}
3.4.7.4	Psychoeducation and support should be provided for the client and family on an initial, continuing and ‘as needed’ basis through individual work, group programs and consumer support groups or a family participation program. ^{GPP}
3.4.7.5	Clients and families of a culturally or linguistically diverse background should have access to information in their own language, using interpreters where appropriate. ^{GPP}

Vocational and educational services.

Most social, academic, and occupational role functioning loss associated with psychotic illness occurs during the prodromal phase of illness and during the first few years of the critical period and then tends to reach a plateau. Specialist vocational and educational services, provided early in the course of illness or in the putative prodrome, may serve to halt or even reverse deterioration in functioning. Individual placement and support (IPS) has good support in FEP. There is no current empirical evidence exploring appropriate vocational interventions for the pre-onset phase, but similar principles are likely to be relevant.

Recommendations

3.4.8.1	Case managers should facilitate access to educational and vocational services to the FEP ^B and pre-onset ^{GPP} groups.
3.4.8.2	Employment and educational consultants should be integrated within FEP services as much as possible. ^{GPP}
3.4.8.3	Employment services for people with FEP should be consistent with an Individual Placement and Support model. ^B
3.4.8.4	Given the age group of this population, return to education or training is seen as an acceptable vocational outcome. ^{GPP}

Suicide prevention.

Evidence suggests suicide rates are lower in early intervention services than in previous cohorts of young people with FEP treated in generalist services. Data suggests the key risk factor to address in reducing suicide is appropriate pharmacological treatment of psychotic and other psychiatric disorders, and adherence to this treatment. Evidence regarding specific psychological treatments to reduce suicide risk in FEP is equivocal.

Recommendations

3.4.9.1	Intensive treatment should be provided during high-risk phases of illness. ^{GPP}
3.4.9.2	Services should develop and implement appropriate, evidence-based interventions for deliberate self-harm. ^{GPP} The LifeSPAN program is likely to be of some benefit for suicidal clients. ^B
3.4.9.3	Atypical antipsychotics ^B , especially clozapine ^A may be useful for suicidality.

Substance use (including cigarette use).

Interventions provided to young people to treat substance use issues should recognise the features of this population including their young age, the circumstances that brought them into treatment, widespread substance use among peers, and cognitive difficulties arising from substance misuse. Integrated treatment is likely to have the best effect, and can be provided either within a single service or in collaboration with a drug treatment service. Provision of feedback about assessment may be therapeutic in its own right, providing an opportunity to give psychoeducation about risks to mental and physical health associated with substance use, especially links between regular substance use and poor clinical outcomes. Harm minimisation strategies may also be helpful to reduce harmful effects associated with substance use and build motivation to change. Evidence is equivocal regarding the effectiveness of CBT interventions beyond psychoeducation in reducing substance use in FEP. Good clinical care also requires an awareness that families of those with comorbid substance use and FEP may be particularly distressed and burdened, and require additional assistance.

Recommendations

3.4.10.1	Psychoeducation and CBT may help reduce substance use in those in the pre-onset phase ^{GPP} and with FEP ^B .
3.4.10.2	Treatment of psychosis and comorbid substance misuse (including tobacco use) should be integrated. ^{GPP}
3.4.10.3	Acceptance policies should be inclusive of individuals with comorbid substance misuse. ^{GPP}
3.4.10.4	Policies and procedures should be developed regarding substance misuse and its behavioural consequences, including the possibility of substance use while within the service. ^{GPP}
3.4.10.5	The service should develop minimum standards for clinicians regarding their knowledge about the assessment and integrated treatment of substance misuse. ^{GPP}
3.4.10.6	Where appropriate, clinicians should have access to specialist consultation to provide assessment, supervision, advice or co-management for comorbid substance misuse (including tobacco use). ^{GPP}
3.4.10.7	Where clients are receiving treatment within a drug treatment service, clinicians should actively collaborate and communicate about the individual treatment plan. ^{GPP}
3.4.10.8	Individual treatment plans should routinely include additional treatment goals relevant to substance misuse. ^{GPP}
3.4.10.9	Support should be offered to family and friends, including psychoeducation on comorbid mental illness and substance misuse. ^{GPP}
3.4.10.10	Discharge planning should include attention to ongoing treatment of substance misuse. ^{GPP}

Treatment of psychiatric comorbidity.

Comorbidity can worsen prognosis in UHR and FEP; treatment is therefore vital. There is no empirical evidence relating to issues of sequencing in treatment of comorbidities in UHR and FEP, i.e., whether it is more effective to sequentially treat (either pharmacologically or psychologically) psychotic symptoms and comorbid disorders or to treat them simultaneously as far as possible.

Recommendations

3.4.11.1	Treatment of psychiatric comorbidity should be conducted in a consistent manner with available clinical guidelines. ^{GPP}
3.4.11.2	Although treatment of psychosis often remains paramount, the sequencing of treatment of comorbid conditions should be driven by the symptoms/disorder that is most distressing/disabling and whether it poses further risks to the client or others. ^{GPP}

Consumer participation.

Participation is an established right for users of the mental health system, as supported by the National Standards for Mental Health Services. The involvement of consumers in service planning, delivery, monitoring and evaluation also seems more likely to result in services that are accessible and appropriate to service users, with more responsive providers, better quality care, and more empowered clients. Early psychosis services should involve consumers in the planning, implementation and evaluation of their service, for the sake of both service users and the services themselves.

Recommendations

3.4.12.1	The culture of the organisation should respect consumers and validate their input. ^{GPP}
3.4.12.2	All consumer participation initiatives should be jointly planned with consumers from the outset, and based on the needs and interests of consumers. ^{GPP}
3.4.12.3	Consumers participating in the service should receive some payment, and funding should be available to allow consumers to acquire any specialist skills that they may need in their role. Consumers should also receive ongoing supervision and support from a clinical mentor. ^{GPP}

Carer participation

The National Standards for Mental Health Services state that carer participation is an established right for family and other carers who have a relative receiving services from the mental health system. Early psychosis services should involve family carers in the planning, implementation and evaluation of their service. Carers' expertise gained through their 'lived experiences' provides novel perspectives and skills about the treatment and care of young people with early psychosis. Participation by family carers is likely to enable them to better manage their own circumstances, and provides an avenue for them to share their experiences with other families and clinicians, and to further develop the service.

Recommendations

3.4.13.1	Family carers should be accepted as partners in treatment and care strategies, and their needs respected and supported. ^{GPP}
3.4.13.2	Family participation will need strong initial support and facilitation by a staff member involved in family support. ^{GPP}
3.4.13.3	Family carers participating in the service should receive some payment, and funding should be available to allow family carers to acquire any specialist skills that they may need in their role. Family carers should also receive ongoing supervision and support from a clinical mentor. ^{GPP}

Information about specific populations

The full guidelines contain information about appropriate service delivery to specific populations, including Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, and rural and remote populations.

Recommendations

4.1.1	Clinicians should be especially alert to side-effects of antipsychotics when working with people from Aboriginal and Torres Strait Islander communities. ^{GPP}
4.1.2	Indigenous health or mental health practitioners should be involved in the assessment and treatment of young indigenous people with emerging psychosis, to facilitate engagement and reduce stigma. ^{GPP}
4.1.3	Clinicians should practice in a manner consistent with relevant guidelines on working with people from indigenous communities (e.g., Aboriginal Mental Health First Aid Training and Research Program, 2008; http://www.mhfa.com.au/Guidelines.shtml). ^{GPP}
4.2.1	Consumers and carers who cannot speak English, or who speak limited English, should be able to access professional interpreting and translating services where significant decisions are concerned and where essential information is being communicated.
4.2.2	Clinicians should be guided by appropriate guidelines when working with interpreters (e.g., http://www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf)
4.2.3	Clinicians should be guided by appropriate recommendations when working with people from NESB (e.g., http://www.vtpu.org.au/cald.htm)
4.3.1	Early psychosis prevention and intervention information should be readily available at key locations in rural and remote areas, for example in GP's waiting rooms and community centres. ^{GPP}
4.3.2	Mental health service should provide tertiary consultation and education services to health practitioners in rural and remote areas. ^{GPP}
4.3.3	Telepsychiatry and other technological facilities should be made available to mental health practitioners in rural and remote areas to facilitate links with early psychosis services. These should not, however, be seen as a replacement for visiting specialists ⁵¹³ . ^{GPP}

