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Early Intervention, Psyhosis and Functioning

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Early Intervention in Mental Health

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Foreward

There is an increasing acknowledgement of the importance of functional recovery for people with lived experience of schizophrenia and psychosis related conditions. In large part this is driven by listening to user voices and putting at the centre, their lived experience and beliefs about what they would like their recovery journeys to be like and their goals.

It is also driven from a human rights perspective in that people who wish to work, study, or participate and contribute in other ways in their communities and societies have a right to do so and a mental health problem should not be an obstacle. Finally, it is driven by the greater economic return on investment in treatments that results from helping people make functional recoveries.

The three pieces that follow here remind us of a number of important considerations in assisting people with their functional recoveries. The first consideration is the importance of early intervention, support and access to the right and evidence-based treatments. Reducing the amount of time that an individual has an untreated illness is crucial. During periods of untreated illness functional damage often occurs and accrues.

This damage can take the form of disengaging with education or employment, becoming socially isolated and negatively impacting relationships with family and friends, which can increase the likelihood of further difficulties and social exclusion.

So, getting in as early as possible is very important.

The second consideration is that once early intervention has occurred, recovery is best supported by a comprehensive range of interventions that ideally are tailored to the individual needs and goals of the service user. For many, this will include identification of the right medication and the best way to engage with this treatment. For many, comprehensive treatment will also include psychological and talking therapies, and other social and functional recovery-oriented interventions. History has shown that any one treatment, in isolation, will rarely lead to optimal functional or social recovery for most people.

A third consideration is to ensure to assess for, monitor and target different symptoms but particularly negative symptoms. These symptoms often get less considered in acute treatment but are great obstacles to functional recovery if not attended to. A range of intervention approaches must also be utilised to address negative symptoms.

Finally, and perhaps most important is hope. As David Fowler notes, hope must be conveyed to the person with the illness and to their family that recovery is possible and that they will be provided with the range of interventions to help them achieve it.

Eoin Killackey
President, IEPA

24%

Correll et al. 2018

"people receiving care at early intervention services had a 24% greater chance of achieving recovery"

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Early Intervention for Psychosis: Social Recovery

By David Fowler

'Social recovery' from an episode of psychosis, also called functional recovery, refers to a person achieving meaningful outcomes in terms of work, education and social activity. Personal social recovery is perhaps best defined as time spent by someone in activities that they value, that add meaning and purpose to their life.

Ensuring social recovery should be the heart of early intervention for psychosis. Without early intervention, the social outcomes following a first episode of psychosis can be poor. In services with long inpatient admissions and a lack of community-based multidisciplinary interventions, only around 15 per cent of people make a social recovery within two years of their first acute episode of psychosis. This means that for many, the key personal developmental milestones of young adulthood are missed. The loss of social, vocational and educational opportunities can alter their life course.

By contrast, when inpatient acute admissions are avoided (or minimised whenever possible) and optimal community-based care packages of pharmacological, psychological and social interventions are provided, up to 60 per cent of young people with first episode psychosis make a social recovery at two years.

This is a massive change for young people, which has health economic gains for society as well as for the individual in terms of personal gains in obtaining work and educational achievements over both the medium and long term.

In a clinical setting, social recovery intervention done well, is a gentle review of what is meaningful for an individual in terms of activities, and helping them get to where they want to go.

Early intervention for social recovery should start as early as possible to prevent loss of key social and interpersonal roles as a result of an acute episode. So what works? The key is thinking about how the whole early intervention system can promote social recovery. It is not a single, special intervention. It starts with maintaining a consistent message of hope for recovery – to the individual, their family, and those all around them – even when things feel difficult in the first psychotic episode. Messages of realistic hope are important to overcome stigma. This may be particularly important in some cultural contexts, especially where shame is associated with psychosis, which can lead people to withdraw from services.

Deliberate actions also need to be taken to ensure a young person's key personal contacts, friends and family are not lost as a result of the acute episode, and that existing educational, work and social opportunities remain open. If lost, such opportunities are very difficult to rebuild anew. Small interventions done with the young person and family, such as calling their workplace or education institution and helping negotiate a part-time return, can help. Similarly, support with phone calls to friends or contacts can help.

"Ensuring social recovery should be the heart of early intervention for psychosis"

Deliberate discussion is sometimes needed to work around fears held by the young person or their family, who can be understandably protective. It is about finding a reasonable balance between maintaining hope, encouraging activity and respecting the young person's need to rest and strategically withdraw from their usual activities for a time. They may fear relapse, and be sensitive to emotional issues such as anxiety and low-level paranoia, which can be triggered on returning to avoided activities. However, it is important to prevent persistent patterns of avoidance occurring after an episode of psychosis, as these not only lead to a loss of social opportunities but can also, in turn, lead to vicious cycles of additional stress and vulnerability.

Preventing loss of key social and interpersonal roles is crucial in the first phase of psychosis, and continues to be important throughout, but it does become progressively more difficult at later stages. Even with the best service provided, a large minority do not make rapid social recoveries. Often these cases have had longstanding social difficulties before the first acute episode, sometimes with long durations of untreated psychosis.

Sadly, often people most in need of social intervention are the least likely to engage or seek help. In busy services, the focus naturally is on acute care, and people who are withdrawn and avoidant might be discharged when a more detailed assessment might show residual positive and negative symptoms associated with social disability. These cases are not easy to help, and can require a gentle but persistent, assertive approach to build a relationship and re-engage them in treatment and activity.

Our Supereden3 study showed this is possible, and the message is to continue offering social intervention across the course of psychosis, and where possible, specifically target those who have persistent social disability problems as a second phase of early intervention.

Encouragingly, we have shown in our recent Prodigy study that young people with severe and complex mental health problems and social disability at an earlier stage, who have not yet had an acute psychotic episode but including those who have subthreshold psychotic symptoms, can make very good social recoveries if offered hope, a detailed assessment and guidance to take up the therapy and vocational services that are routinely available in UK services.

All participants in the trial, which included those with extreme social withdrawal who were hardly ever leaving the house to engage with any meaningful activity, made clinically significant gains in both symptoms and social recovery, when such structured routine help was offered by a combination of general practitioners, mental health workers and voluntary sector providers. Additional, highly specialised therapy that focused on social recovery was not needed.

This likely shows the benefit of all providers routinely offering comprehensive help and guidance about social recovery, as early as possible, and before the onset of psychosis (where such cases can be identified). Both the Prodigy and Supereden trials show there is real hope for meaningful change and social gains even with the most complex presentations, and highly complex interventions aren't always needed if the message is right

What is available and possible in services obviously varies, depending on resourcing, the availability of different interventions – and the social, economic and cultural context. It was well established some time ago by Richard Warner that the social course of psychosis is associated with the economic climate. The availability of work opportunities in wider society affects the opportunities open to those with the additional burden of recovering from psychosis.

The availability of community youth services and access to education opportunities is also key, and such factors are influenced by health inequalities and economic austerity.

The way psychosis is regarded culturally is also a factor that can significantly change what opportunities are made available to someone socially after an episode. However, some cultures, especially those with familial links to flexible working patterns, can work in someone's favour. For example, if a return to work part time can be negotiated with a relative.

What works in clinical early intervention services is creativity and flexibility when using the resources that are available, and keeping realistic hope in mind. What also works is recruiting community and family stakeholders wherever they are willing to offer help in a constructive way.

By working this way to build a social recovery 'web' within whatever is available in local communities, even a single case worker in a less resourced setting can make important changes for the young people in their care.

Professor David Fowler *is one of the original pioneers of cognitive behaviour therapy and early intervention in psychosis services.He currently leads a programme of research developing and evaluating psychological interventions and services for young people with severe mental illness and social disability. His work has informed the development of novel youth services in the UK and globally. Fowler also continues to contribute to development and evaluation of psychological interventions in psychosis which has completed a series of large national multicentre trials. Prof Fowler leads the youth mental health theme of the NIHR Kent Surrey and Sussex Applied Research Collaboration (KSS ARC) which links researchers with NHS and social service providers across the region and NIHR mental health researchers nationally.*

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Recovery from early psychosis is achievable but treatment approaches must focus on both medical and psychosocial interventions

By Christoph Correll, MD.

Why should we work closely with people experiencing a first episode of psychosis or first episode of schizophrenia to aim for recovery? Because they are the people closest to recovery.

'Recovery' in this case involves two components:

- symptomatic stability or remission, and
- improvement in functionality in terms of self-care, social interactions, leisure activities and education or employment status.

Recovery also means to be connected: connected to oneself, to others, to meaning through purposeful activities, and to life and hope.

To give people the best chance of recovery possible, we need to provide early access to care, since a shorter duration of untreated psychosis has been associated with better symptomatic and functional outcomes (Howes et al., 2021).

We also need to consider pharmacological treatment to prevent relapse (Leucht et al., 2012), as people who experience fewer episodes of psychosis and symptoms after they begin treatment have been shown to achieve better outcomes (Carbon & Correll., 2014). Someone who stays relapse-free has a high chance of maintaining treatment response, improving functioning and reducing illness burden (Correll et al.., 2018a).

"recovery is best supported by a comprehensive range of interventions "

"recovery is possible"

Importantly, we need to find each person a treatment or treatments that have only minimal or, at least, subjectively tolerable, side effects, so that their quality of life and functioning are not adversely affected. (Tandon et al., 2020).

Adding psychosocial interventions to pharmacological treatment is likely to yield the best results (WHO, 2009). Psychosocial interventions include individual and family psychoeducation, individual and group psychotherapy, case management, skills training, and supported employment and education.

Early intervention services that combined 3–4 of these psychosocial interventions with medication, in an integrated, multi-team member approach, have been shown to improve 15 outcomes significantly better than usual care interventions (Correll et al., 2018b), which usually are not well integrated and mostly focus on pharmacological treatment. In that meta-analysis, people receiving care at early intervention services had a 24% greater chance of achieving recovery.

Moreover, data suggest that the use of long-acting antipsychotics is associated with a reduced risk of treatment discontinuation, relapse, hospitalisation and even mortality (Taipale et al., 2018; Taipale et al., 2020; Kishimoto et al., 2021). Furthermore, treatment with a long-acting antipsychotic during the first episode of schizophrenia seems to markedly improve combined symptomatic and functional recovery, which was found to be as high as 44% in a 2-year follow-up study of 98 patients with a first episode of schizophrenia-spectrum disorders who received long-acting antipsychotics early on (Phahladira et al., 2020).

We still do not know the exact pathophysiology of the different forms of psychoses or schizophrenia, and pharmacological treatments currently treat symptoms rather than the illness itself. However, what we do know is that the use of medication and recovery-focused psychosocial care can yield results that go beyond symptomatic improvement and stability.

The key is finding a medication that works for each individual, that is not associated with relevant adverse effects, and which they are willing to take long-term – as well as taking advantage of psychosocial interventions. When treatment is managed in this way, people who are experiencing early psychosis should be hopeful that good symptomatic and functional outcomes are possible – meaning they can get back to the life they had before, and look forward to the future.

Christoph Correll *is Professor of Psychiatry at The Zucker School of Medicine at Hofstra/Northwell, New York, USA, and also Professor and Chair of the Department of Child and Adolescent Psychiatry, Charité University Medicine, Berlin, Germany. Prof. Correll's research and clinical work focus on the identification, characterization and treatment of youth and adults with severe mental illness, including psychotic and mood disorders. He further focuses on psychopharmacology, epidemiology, clinical trials, comparative effectiveness, meta-analyses, and the interface between physical health and mental health.*

He has authored over 650 journal articles, served on several expert consensus panels, and received over 40 research awards for his work. Since 2014, the year of inception of this metric, he has been listed every year by Clarivate/Web of Science as one of the "most influential scientific minds" and "top 1% cited scientists in the area of psychiatry" (https://hcr.clarivate.com).

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Don’t forget to focus on the negative

By Wing-Chung CHANG

What are negative symptoms?

Negative symptoms are an oft-neglected but core feature of schizophrenia and other psychotic illnesses. Broadly speaking, negative symptoms refer to the loss or diminution of normal functions related to motivation and emotional expression. This includes symptoms such as reduced social interaction, loss of motivation, reduced speech and loss of enjoyment in previous interests.

Negative symptoms are a discrete symptom dimension, separate from positive symptoms (i.e., hallucinations and delusions), disorganisation, mood symptoms and cognitive impairment. However, there has been limited progress in understanding the neurobiological mechanisms that underlie negative symptoms and therefore in developing effective treatment. Interest in studying negative symptoms is increasing, and a consensus was recently achieved on conceptualising negative symptoms as consisting of five domains. These five domains are avolition, asociality, anhedonia, blunted affect and alogia (Galderisi et al., 2018).

Despite receiving less attention historically than positive symptoms, negative symptoms are in fact prevalent in the early course of psychotic disorders, and they are among the most frequently observed symptoms in the prodromal phase (ie, symptoms experienced in the lead-up to a first episode of psychosis).

Importantly, negative symptoms are critically associated with poor psychosocial functioning, increased likelihood of unemployment and greater burden for carers in people with early psychosis.

Two main approaches have been adopted to classifying negative symptoms in clinical research and management. These are, (1) distinguishing between primary and secondary negative symptoms (Kirschner et al., 2017) and (2) dividing the five symptom domains into two subdomains: reduced motivation and interest ('amotivation'), comprising avolition, asociality and anhedonia; and diminished emotional expressivity ('diminished expression'), comprising blunted affect and alogia (Galderisi et al., 2018).

Why are they important?

Primary negative symptoms (PNS) are regarded as intrinsic to the illness process of psychotic disorders, while secondary negative symptoms stem from co-occurring conditions, such as depression, paranoid suspiciousness, antipsychotic-induced motor side-effects and environmental deprivation. Persistent PNS robustly predicts concurrent and longitudinal functional impairment in people with early psychosis.

Amotivation has been found to be more prevalent in the early stage of illness, and is a much stronger predictor of functional disability than diminished expression. Amotivation may be a key determinant of functional outcome in early psychosis, having a greater effect than cognitive deficits and other symptom dimensions (Chang et al., 2020).

"negative symptoms, especially amotivation, might be a pivotal therapeutic target in promoting early functional recovery"

Of note, it is well recognised that a significant proportion of people with first-episode psychosis (FEP) still experience persistent functional impairment even after achieving remission from acute psychosis. This indicates that negative symptoms, especially amotivation, might be a pivotal therapeutic target in promoting early functional recovery in first-episode populations.

How do we manage them?

Although negative symptoms don't respond well to medication, early detection and intensive phase-specific intervention for FEP can be effective in reducing negative symptom severity. Recent reviews have revealed that shortening delays in treatment for an initial psychotic episode (i.e., reducing duration of untreated psychosis) is associated with fewer negative symptoms at first presentation and better negative symptom outcome at follow-up.

Integrated early intervention services are effective for improving negative symptoms among people with FEP. There is also growing evidence that specific psychosocial interventions such as cognitive-behavioral therapy (CBT), cognitive remediation and social skills training can effectively alleviate negative symptoms (Lutgens et al., 2017). In particular, CBT that specifically tries to rectify unhelpful attitudes, including defeatist beliefs and low self-efficacy, has recently been shown to significantly improve amotivation and functional outcome in people with psychotic disorders.

As negative symptoms constitute a major barrier to functional recovery in the early phase of illness, it is crucial to incorporate regular, comprehensive assessment of negative symptoms within the early intervention framework. This will aid evaluation and enhancement of functional outcome in people experiencing a first episode. Specifically, to accurately capture the nature and magnitude of symptom severity, the use of second-generation negative symptom rating scales (i.e., Brief Negative Symptom Scale, BNSS; Clinical Assessment Interview for Negative Symptoms, CAINS), which were developed according to the current conceptualisations of negative symptoms and cover the five consensus domains, is recommended. This will in turn facilitate early symptom identification and provision of prompt, targeted interventions to prevent progression towards persistent negative symptoms and subsequent deterioration in functioning (Correll et al., 2020).

Careful assessment should also be conducted to differentiate between primary and secondary negative symptoms, as the latter can be treated by managing the underlying cause (Kirschner et al., 2017; Correll et al., 2020). For instance, antidepressant treatment for depression or antipsychotic dose reduction for motor side-effects.

Optimising treatment of negative symptoms is critical to attaining functional recovery in patients with early psychosis. Further research is warranted to clarify how early intervention services should be modified or which treatment elements should be strengthened so that the benefits of treatment are sustained after a person leaves early psychosis care.

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Glossary

Alogia: Reduction in verbal output and spontaneous elaboration

Anhedonia: Reduced experience of pleasure

Avolition: Reduced initiation and persistence of goal-directed activity due to decreased motivation

Asociality: Reduced social interactions and initiative due to decreased interest in and motivation for forming and maintaining relationships with others

Blunted affect: Decrease in non-verbal emotional expression and reactivity, as manifested in reduction in facial expression, vocal intonation and expressive gestures

Motor Effects: Stiffness and shakiness, uncomfortable restlessness, movement of the jaw, tongue or mouth

Pathophysiology: exact mechanisms by which the illness develops and evolves

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