Early Intervention in Psychosis Guidance Note

This publication has been produced by the Mental Health Commission to provide mental health services with a guide to what they can best do for people presenting with a first episode of psychosis.

The need for this document arose from discussions between the Mental Health Commission and the New Zealand Early Intervention Interest Group in 1997. A panel of five people representing existing early intervention services and consumers, met to plan the guidance note according to current practices and available literature. This initial document was then the subject of wide consultation including families, consumers, Maori and Pacific people as well as workers in the field.

People who have experienced psychosis for the first time frequently state that their goal is to ‘lead a normal life’. To help people reach this goal, comprehensive programmes are needed to address the unique needs of individuals in the early stages of recovery.

Mental health services should be actively promoting awareness about psychosis to encourage people to seek treatment as early as possible. Early treatment can prevent the development of a chronic illness. While, in larger centres, early intervention programmes may operate as separate teams, this guidance note has been designed to assist all who may be involved with people experiencing, or at risk of, a first episode of psychosis. It is intended as a guide only, and practitioners should exercise their professional judgment in the treatment of each individual. Whilst it is aimed at providers of services, it may be a reference for consumers, families or others who have an interest.

We welcome your feedback on this publication.

Barbara Disley
Chair
Mental Health Commission

1 Whitehorn, Lazier, Kopala, 1998
Recovery

The focus of this guidance note is on recovery from first episode psychosis. A recovery approach is consistent with the guiding principles of the Government’s National Mental Health Strategy. The Strategy states that services must empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society. This focus on recovery reflects the shift of thinking which is happening throughout the sector.

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

The recovery approach requires mental health services to work in partnership with those accessing services and to treat them at all times with dignity and respect. It requires identification and elimination of discrimination against people with mental illness, which occurs within services and in the wider community.

Historically, mental health services have not used a recovery approach. Recovery could never take place in an environment where access to good treatment was not available early in the course of illness, where people were isolated from their communities, where power was used to coerce people, where there were no choices, and where the prevailing expectation was that people with mental illness did not get better.

The pathways to recovery are many and varied. There is evidence that early intervention in psychosis is a major factor in aiding recovery from an episode and in facilitating more positive longer term outcomes for those who experience it. Early intervention helps to keep or strengthen the important significant relationships and connections in a person’s life.

Some people have experienced recovery without using mental health services. Others have experienced recovery in spite of them. But most will do much better if services are designed and delivered to facilitate their recovery. Virtually everything the mental health sector does can either assist or impede recovery.

The recovery process for people presenting with first episode psychosis needs to begin with the first person they come into contact with from the mental health service.
**Definition of Early Psychosis**

Psychosis is a syndrome, which may be a feature of a number of disorders. It refers to a primary disturbance of thinking which is reflected in certain symptoms, particularly disturbances in perception (hallucinations), disturbances in belief and interpretation of the environment (delusions) and disorganised speech patterns (thought disorder).

Early psychosis includes the prodrome phase and is the critical period up to 5 years from the entry into treatment for the first episode. First episode generally refers to the first presentation for treatment of psychosis in the lifetime of an individual. Experience elsewhere has suggested that intensive early intervention programmes are best targeted at the first two years after presentation with a psychotic episode.

Theories of aetiology are complex but an episode of psychosis is considered to be the result of a biological predisposition on which psycho-social factors have a modifying impact. This view of aetiology is known as the stress-vulnerability model and has implications for optimal treatment.

Early psychosis occurs most frequently in adolescence or young adult life. Exact incidence is not known as it may occur as an isolated episode or as part of a range of disorders. Schizophrenia, which is one cause of symptoms of psychosis, has a lifetime prevalence of 0.5 – 1.0 percent.

Three phases of early psychosis have been identified:

1. **Prodrome.** The majority of people who develop psychosis will have experienced non-specific changes in behaviour and mental state prior to the onset of the disorder. These non-specific changes may predate the onset of psychosis by a short period of a few days or may evolve over an extended period of years. This may be an early form of psychosis or an “at risk mental state”. Key features that may indicate the presence of psychosis or its prodromal state include:
   - sleep disturbance
   - appetite disturbance
   - marked unusual behaviour
   - feelings that are blunted or seem incongruous to others
   - speech that is difficult to follow
   - marked preoccupation with unusual ideas
   - ideas of reference - things have special meanings
   - persistent feelings of unreality
   - changes in the way things appear, sound or smell.

2. **Acute phase.** This is when the symptoms of hallucinations, delusions and/or thought disorder are fully developed, often along with other psychiatric symptoms (for example, changes in behaviour, depression, anxiety). Psychosis may be present with other conditions.
3  Recovery phase. This is the period following treatment of the acute phase, when the symptoms are reduced or absent. Most people who have experienced a psychotic episode experience some level of difficulty making sense of the experience, and returning to ‘normal’ during this phase.

In the early phase of illness, symptoms should be identified and treated rather than the focus being on a diagnosis. A diagnostic approach using DSM or ICD classifications systems is difficult early in the course of psychosis. In up to 40 percent of individuals the initial diagnosis is changed within three months. In addition, an early diagnosis of schizophrenia may hinder recovery because of the stigma associated with the diagnosis, and the false but widely held perception that this diagnosis is always associated with failure to recover.

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7 Fennig, Kovatsnay & Rich, 1994; McGorry, 1994

8 McGorry, Edwards, Mhalopoulos, et al., 1996
Rationale for Early Recognition, Treatment and Support

People are more likely to have better outcomes the sooner psychosis is recognised and treated.

- During the early phase of illness intensive treatment and support may assist recovery and may minimise later problems or side effects caused by the treatment itself. This relates particularly to the trauma of hospital admission.\(^9\)
- If people are not responsive to initial treatment, the newer drugs and psycho-social supports may help to prevent relapse, treatment resistance and disability.\(^{10}\)
- Preventing or limiting relapse may contribute to improving outcomes.\(^{11}\) The more people remain well, the greater their chances of recovery.

Aims of Early Psychosis Services

The aims are:

- to reduce the delay between onset of early psychosis and accessing expert assessment and treatment, by developing clear strategies to identify and overcome barriers and improve access to care. This should include particular attention to problems of access faced by Maori and other cultural groups
- to raise community awareness of the signs of early psychosis, of the existence of a service to assess and treat early psychosis, and how to access this service
- to minimise the stress and reduce the trauma of illness and treatment for people with psychosis and their families
- to maximise people’s chances of recovery and a good quality of life
- to prevent the development of secondary disabilities
- to reduce secondary mental health problems (for example, depression, anxiety disorders, post-traumatic stress disorder, substance abuse) and actively treat these when they occur
- to increase people’s chances of staying linked with their families, and communities.

\(^9\) McGlashan, 1998; McGlashan & Johannessen, 1996
\(^{10}\) Wyatt, 1991
\(^{11}\) McGorry, Edwards, Mihalopoulos, et al., 1996
Principles of Early Psychosis Services

Services need to have a specialist, skilled, intensive, multi-disciplinary team approach with a strong individual and family focus. A holistic approach needs to be taken rather than a focus on psychosis or drug treatments alone. People with mental illness need to be empowered to take control of their own recovery and their connections with family, school and work must be kept strong.

Rapid Access

- There should be rapid access to psychiatric services for those individuals experiencing symptoms of possible first episode psychosis.
- Where there are safety issues, access should be immediate. Mental health services need to be accessible 24 hours a day, seven days a week.
- In most centres it is likely that after-hours work is undertaken by an emergency service or shared with other services. In this case the specialist service should be involved as soon as possible and the emergency service skilled in principles of early intervention.
- The service, and how to access it should be promoted and advertised to the community.
- The service should accept referrals from a wide range of individuals, family and friends and primary care services.
- The service should accept everyone who comes for assistance and have the ability to refer people elsewhere if the service is not appropriate for them.

Culturally Appropriate Services

Services for Maori

All services must find more effective ways of reaching Maori earlier in the course of their illness. Maori need to have choice as to the type of service they wish to access. All early intervention services must be culturally safe and responsive to Maori.

- Services for Maori should be provided by mainstream early intervention services or where possible by specialist kaupapa Maori services.
- Service provision should be based on the Treaty of Waitangi. Maori must be consulted on all matters that affect them.
- The foundations for service delivery for Maori should be based on the Whare Tapa Wha model which identifies four dimensions of health – taha wairua (spiritual), taha hinengaro (mental and emotional), taha tinana (physical), and taha whanau (family).
- Wherever possible, Maori staff should be employed.
All tangata whaiora (people seeking wellness) should have access to a Maori mental health worker, to interpreters and to advice from kaumatua.

The environment should be safe and appropriate.

Staff must be aware of other Maori services that are available.

All staff who are not Maori should have had bi-cultural training.

More detail on the provision of effective services for Maori is available in the Blueprint for Mental Health Services in New Zealand, December 1998\textsuperscript{12}.

**Services for Pacific People**

Services for Pacific people should be provided in ways which meet their cultural needs. The service should acknowledge that mental well being is dependent on spiritual, physical, emotional and family needs. Where possible a team member of the same culture should be included in the treatment team. If not, it is important that links with Pacific health workers are in place. Access to interpretation services for the individual and/or their family should be available.

More information on services for Pacific People is available in the Blueprint for Mental Health Services in New Zealand\textsuperscript{13}.

**Services for Other Cultures**

Services for all people should recognise their cultural, language, spiritual and family needs, and be consistent with the National Mental Health Standards\textsuperscript{14}. There should be access to interpreters and cultural advisors whenever necessary.

**Developmentally Appropriate Services**

Because early psychosis tends to span adolescence and early adulthood, services need to particularly cater for this age range. There is a need for appropriately qualified staff to work with both adolescents and adults. Services need to cater to the person’s developmental level as well as their chronological age. Staff must be able to effectively communicate with young people and be able to create an environment that is open, friendly, welcoming and inclusive. The location, decor and physical environment are important in creating a more acceptable setting.

**Service User Participation**

People having a first episode of psychosis must be involved with staff in planning their care. Working in partnership in treatment is essential to enabling people to take an active role in their recovery. Every person will have a very different set of needs and it is only through active communication and participation that both the treatment team and the individual can develop an effective treatment programme.
At a service level, people using mental health services should also be involved in service development and evaluation.

**Family Involvement**

Families can play a vital role in supporting their family member to actively engage in and remain in treatment\(^{15}\). Family support and continued connections to strong social support networks can improve relapse rates and social outcomes thereby reducing long-term negative affects of illness.

There needs to be a strong emphasis on family support and education. Family members often have their own stress and coping difficulties. By creating an environment where these can be effectively dealt with, services help promote a more supportive family environment which in turn can influence relapse patterns.

There is an expectation that services will involve families, partners or close friends in treatment planning unless the person vetoes their involvement.

**Treatment is Received in the Most Open, Safe and Familiar Environment Possible**

Decisions regarding treatment settings should be based on the level of severity of presentation and the assessed level of risk. The optimal treatment setting is considered to be the person’s home where circumstances support this\(^{16}\).

When determining the treatment setting, minimisation of trauma should be utmost in the minds of the treatment team.

**Accurate Assessment**

Staff need to be skilled in accurate assessment of mental disorders recognising the high co-morbidity of other disorders with psychosis particularly alcohol and drug disorders and anxiety disorders. An appropriate person must assess cultural elements of the person’s symptoms and experience.

\(^{15}\) EPPIC, 1997

\(^{16}\) Fitzgerald & Kulkarni, 1998
Specific Expertise Required by Early Psychosis Teams

Within teams there will be areas of expertise required by all team members such as in care management (also known as case management or care brokerage). Other areas of expertise are likely to be more discipline-specific with the understanding that knowledge will always be shared where appropriate and specific expertise can be called upon as necessary.

Care Management

The care manager is the central clinician for a person experiencing psychosis for the first time and should work with the treating psychiatrist or medical practitioner in partnership with the person and their family, to assess the range of needs of the person and their family and co-ordinate provision of the services required to meet these identified needs.

The primary functions of the care manager should include ongoing comprehensive assessment, and clinical assistance such as psychotherapy, psycho-education, and family support and community linkages appropriate to the stage of psychosis.

The care manager should have frequent ongoing contact tailored to the phase of illness and the person’s need. The manager needs to have access to other specialised support as required and should have links with specialist service providers within and beyond the mental health service. People in the process of recovering from a psychotic episode who lack motivation need special support and understanding.

The care manager should be responsible for the documentation, and the co-ordination and development of an individual treatment plan (including wellness maintenance/relapse prevention plan). This includes helping the person prepare to leave the service or transfer to another service. Where possible, family should also be involved in developing the plan.17

Assessment

Skilled assessment is required to take a full psychiatric history and undertake a mental state examination that identifies co-morbid conditions in addition to psychosis. Family problems also need to be assessed. The assessor should endeavour to find out about recent or past events in the person’s life, such as stressful or traumatic events and abuse, that may need to be dealt with.

Physical Health

It is important to identify physical factors that may be contributing to mental health problems.

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17 See Blueprint for Mental Health Services in New Zealand, p.38 for more details of what could be in a recovery plan
Psychopharmacology

Psychiatrists and other medical staff need to be highly skilled in modern pharmacological management of psychoses using low dose strategies and must use atypical antipsychotics. This includes knowledge of the full range of treatment options particularly when symptoms persist.

Family Support

In first episode psychosis family involvement is vital. Clinicians need to be skilled in interviewing, assessing, educating and supporting families (see “Treatment” below).

Psychological Therapy and Support

Early psychosis teams must be able to offer people a range of psychological therapies and education. Teams need to have skills to:

➢ provide group and individual educational sessions
➢ support to deal with the trauma of the psychotic episode and its sequelae, for example, aggressive behaviour or hospital admission
➢ prevent and treat co-morbidity
➢ prevent disablement and prolonged dependence on mental health services
➢ ensure the person’s safety and the safety of people around them
➢ apply or use cognitive behavioural strategies.

Group Work

Many people recovering from a psychotic episode benefit from group work. Staff need to have expertise in group development and facilitation. Also, group support can be run by peers.

Education and Support for Recovery

Consistent with the aims to promote recovery and prevent secondary disability, services need to be expert in assessing people’s ongoing education, training, personal development and employment needs. Services must be delivered in a way that enhances self-esteem and maintains hope of recovery. Other social, recreational, employment, housing, income and relationship needs should be assessed and assistance provided to have these addressed. Teams must have the skills and information to address these wider needs with a focus on self esteem and hope. There needs to be strong links to welfare and educational services and any other agencies or places that the person interacts with.18

18 See Blueprint for Mental Health Services in New Zealand, p.38 for more details
Specific Expertise in Early Psychosis

In addition to skills already listed, team members need to be fully conversant with the early psychosis model and rationale for early intervention. This means keeping up to date with current literature and being aware of different approaches.

There are a number of approaches to early intervention all based on the principles discussed in this document\textsuperscript{19}. Teams need to be aware of these approaches and adapt them to their own local situation.

Cultural Expertise

Mainstream services (that is, those that are not kaupapa services) should always include Maori cultural expertise. The need for team expertise in cultures other than Maori would depend on the cultural mix in the population served. There should always be access to interpreters and expert advice. This includes the deaf population and other groups with special needs.

Consumer Expertise and Advice

All early psychosis services need to use consumer expertise and advise. Consumers can be ideal for offering people using the service individual peer support, recovery education and support groups. All mental health services are required to take advice from consumer experts or representatives on the planning, evaluation and improvements to the service. It is important that consumers involved have had experience in psychosis, and reflect the age and cultures of those who use the services.

Consumers may also be full members of the team, either in traditional roles such as psychiatrists or nurses, or in consumer support and advice roles. Most importantly, the service providers need to work in partnership with the individuals using the service. They must always be treated with respect and given hope for the future. Their insights, aspirations and opinions must be given the highest consideration, and incorporated into their treatment and support plans. Their experience of using the service must be sought and fed into planning and quality improvement processes.

Evaluation and Research

It appears that early intervention into psychosis can significantly reduce the recurrence rate and severity of the illness\textsuperscript{20}. However, this is not proven. People working in this area need to have policies and systems for evaluating their methods and need to be supported when they seek to change current practices to provide a better service.
Treatment and Support

Prodrome

- Treatment and support during the prodrome phase may help to prevent the onset of psychosis\(^{21}\).
- Prevention strategies include education of specific groups (for example, parents, teachers, school counsellors, general practitioners and health professionals) in early recognition of symptoms and warning signs and knowledge about how to access to services. Identification and follow-up educational and support activities with at-risk groups is also important.
- There should be formal links between primary and secondary mental health services to identify people with risk factors or early signs of psychotic disorders\(^{22}\).
- If early signs of psychosis are suspected, the person should be assessed and monitored for the precursor symptoms. Other risk factors for early psychosis should be identified.

Psychosocial treatments are preferred during the prodromal phase. The use of antipsychotic or other medication should usually be avoided, as there is, as yet, no data to support its efficacy prior to an initial psychotic episode\(^{23}\).

As the potential range of symptoms which may indicate the possibility of a potential psychotic disorder is large and non-specific, early intervention services will need to decide whether working with people who may be experiencing early symptoms or signs is included in their core work or is done in more general services and youth services. If these people are followed up in a service other than a specialist early intervention service, expertise in early intervention should be available to the person and there should be close liaison with the specialist service.

Acute Phase

Assessment

- Initial assessment should be community based and, where possible, conducted at a convenient and safe place for the person and their family.
- A comprehensive bio-psycho-social assessment should be provided and recorded including a mental state examination, drug and alcohol use and history of use, medical history, personal history, and family history. Where indicated this should include a cultural assessment.
- Attention should be paid to safety and the risks of suicide, violence and victimisation need to be assessed.
- This assessment should also comprise a physical examination, particularly a neurological examination, and appropriate investigations to rule out other physical illness or organic causes of psychosis.
Wherever possible, family and others close to the person should be involved in the assessment and, if not, should be contacted as soon as possible.

The initial assessment should also provide the opportunity to develop a good relationship with the person and their family or carer.

Appropriately qualified and experienced mental health professionals should conduct assessments.

**Care manager and treating psychiatrist**

A care manager and treating psychiatrist should be allocated to the person on entry to the service (see section on “Specific Expertise” above, for role of care manager). The number of people each manager is responsible for should be kept low (ten to fifteen) because of the amount of work involved, and they should have the assistance of support staff.

**Decision making**

Decision making about treatment should involve the person and unless that person refuses, their family. They must have access to understandable information, preferably oral and written, to allow them to participate properly in decision making. Developing an initial comprehensive treatment plan with the person and their family or carer is the most critical task following the completion of the assessment phase.

**Family and friends’ involvement**

Wherever possible a partnership should be developed with the person’s family or friends and regular communication should be maintained. These people need to be involved in all phases of assessment and treatment unless the person refuses. Families need to be assisted in taking an active role in supporting the person to manage their disorder24, and family work must be done collaboratively25.

Family work must be tailored to the needs of the particular family with the family’s strengths and problems identified. Intensive education for the family is required.

Families may need assistance with communication skills, problem solving/goal planning and with identifying and developing the social support they need26.

**Education**

There needs to be a strong focus on education as there is evidence that education is important for engaging individuals and families in treatment and promoting recovery. Education needs to be available to both the individual with the illness and family members. Education has also been shown to decrease perceived burden, distress and anxiety among family members.

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24 World Schizophrenia Fellowship, 1998; Falloon, Boyd & Pederson, 1987
25 EPPIC, 1997
26 World Schizophrenia Fellowship, 1998
Education should begin in the acute phase and continue well into the recovery phase. Education aims to develop a shared and increased understanding of the illness for both the person who is recovering from a psychotic episode and their family\textsuperscript{27}. Education can make a solid contribution to recovery and reduce the probability of a relapse\textsuperscript{28}.

Education should explain:

- the nature of the illness
- the range of treatment and support options available and evidence for their effectiveness
- the importance of medication and associated issues (for example, beneficial effects, side effects, adherence, effect on preventing relapse)
- how to identify and manage environmental stresses
- how to identify and develop social supports
- the patterns and variable nature/time course of recovery
- the prospects for the future and what service users and carers can do to influence this
- what agencies and personnel will be involved in their treatment
- provide the person and their family with the skills to identify relapse signs early and to seek help for these.

Above all, education should be positive. It must give the person and their family hope and optimism.

**Psychopharmacology**

The use of medication is an essential component of the acute phase. However the aim should be to maximise the therapeutic benefit while minimising side effects.

Issues include:

- choice of medication, optimal dosage, side effects, routine, changing medication and effectively using medication\textsuperscript{29}.
- Current research has indicated that clozapine and the atypical antipsychotics (risperidone, olanzapine, quetiapine, sertindole and ziprasidone) are less likely to produce extrapyramidal side effects (EPS) and are more effective than conventional antipsychotics in the treatment of negative symptoms\textsuperscript{30}. In addition, clozapine is more efficacious for positive symptoms than conventional antipsychotics\textsuperscript{31}. People with psychosis generally dislike the older medications, preferring the new medications.
- Drug treatment should be delivered with the person’s understanding and willingness to participate. The central theme in psychopharmacotherapy is “start low, go slow”. Use very low doses of antipsychotics and titrate very slowly.

\textsuperscript{27} Glick, Burti, Okonogi, et al., 1994
\textsuperscript{28} McGorry, 1995
\textsuperscript{29} McGorry & Kulkarni, 1994
\textsuperscript{30} Carman, Peuskens & Vangeneugden, 1995; Kane, Honigfeld, Singer, et al., 1988
\textsuperscript{31} Kane, Honigfeld, Singer, et al., 1988
If possible, and depending on the severity of the person’s psychosis, it is advisable for the person to have the first 48 hours free of antipsychotic medication. This enables staff to closely familiarise themselves with the person and their symptoms and gather further information, particularly if there is doubt about the nature of symptoms or aetiology.

Other medications may be required, for example, mood stabilisers in those with manic symptoms or benzodiazepines when sedation is required. As a principle, however, polypharmacy should be avoided, specifically with the use of multiple antipsychotics.

Oral treatment is the preferred method because the person taking the medication is in control of the process. Clozapine should be considered if a person is still experiencing distressing or disabling symptoms after two adequate trials of other antipsychotics. This would generally be from three to six months after treatments were started.

**Psychological therapy and support**

Psychological therapy and support are important in all phases of illness. It is through psychological intervention that the person gains a sense of control over their life and an understanding of what has happened to them. The goals (adapted from the Australian Clinical Guidelines)\(^{32}\) are to:

- form a good professional relationship with the person
- assist the person to gain a sense of stability in their life
- provide the person with education about their illness and the nature of their symptoms
- normalise the person’s non-pathologic problems
- undertake and promote ongoing debriefing with the person of any post-trauma effects
- protect and enhance the person’s self-esteem
- help the person develop effective coping strategies to deal with stigma and discrimination
- help the person learn alternative strategies to deal with stressful situations
- treat the person’s co-morbid symptoms and disorders, particularly anxiety
- explore strategies and methods of helping the person deal with the effects the illness has on their thinking.\(^{33}\)
- try to identify, and help the person identify early warning signs and develop relapse prevention strategies
- work with the person to deal with any stresses and trauma that preceded their psychotic episode.

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\(^{32}\) National Mental Health Strategy, 1998

\(^{33}\) Jackson, McGorry, Edwards, et al., 1998
Intense care and support

People need ongoing support, understanding and attention during the acute phase. The appropriate environment for treatment is the least restrictive environment, if possible, the person’s home. Teams should see the person at least daily during this phase. The person and their family need to be regularly involved in discussion about treatment and have options for treatment explained in lay persons’ terms. They need to be updated on progress, and have their views listened to, as part of the evaluation of progress.

Identification and treatment of co-morbidity

The early intervention team should aim to identify other psychological disorders when doing their initial assessment and diagnosis of the person’s symptoms and should call on advice and expertise from other specialist teams as required.

This is particularly important for alcohol and drug disorders and anxiety disorders because the most appropriate course of treatment is usually quite different from that of a person who does not have other disorders accompanying psychosis. It is also important where evidence of abuse, including sexual abuse, exists that the trauma related to abuse is addressed.

Recovery Phase

The treatment discussed in the acute phase continues when that phase has passed. As a part of ongoing review of the treatment plan, it is critical early in this phase for the mental health workers and the person who is recovering to identify together early signs of possible relapse. They need to develop a clear wellness maintenance or relapse prevention plan, with clear and agreed steps for all to take in managing early relapse. The person and their family can generally be seen less frequently over time as the person gets better and they are empowered to identify warning signs themselves and seek help where required. As the acute phase passes, the person often needs help to pick up from where they were before they became ill.

Guarding against isolation

A key element of psychosis can be social isolation and specific training is required to overcome this. Maintaining a network of friends and feeling part of the community probably protect against relapse. Family support is also often important in reducing isolation.

Leisure/interest development

Often, a person who has recently had a psychotic episode will need help to develop interests or regain interest in the things they used to do for leisure. Confidence and a person’s self concept can be quite negatively affected by a psychotic episode and additional encouragement and support
may need to be provided to enable a person to participate in activities enjoyed before the episode. Lack of motivation should never be a reason to exclude a person from a programme. If a person is not motivated by the programme offered, it could be that the programme is not suited to the person and other options should be sought. Or they could require more support to be able to participate.

**Vocational and educational planning and training**

Disruption of education and/or work is common for most people after their first episode of psychosis. It is important to keep disruption to a minimum and maintain good liaison with work and teaching institutions.

People need to be assessed for realistic work and educational aspirations. This may involve psychological and occupational therapy assessment and early use of appropriate work assessment, support and placement services both within and outside the mental health service. Staff may need to liaise with employers and teachers to facilitate successful re-integration into the workplace/school. Such liaison should be fully discussed with the individual using the service.

**Healthy lifestyle**

Maintaining good physical health is important in aiding recovery and promoting good self-esteem. Sometimes following an episode of illness, a person may need to be encouraged and supported to look after their health by eating well, getting sufficient exercise and sleep, learning relaxation and stress reduction techniques, reducing cigarette smoking and practising safe sex.
General

Services should provide both individual and group work.

Group Education and Therapy

Group experiences can play a role in improving recovery and preventing decline in the person’s psychosocial functioning\(^35\). It can help the person to become involved in community life and achieve their personal goals\(^36\).

Group programmes can complement other treatments. Members of groups gain strength from learning that other people have similar experiences, that they find difficult to talk about in a one-to-one situation\(^37\).

A wide ranging group programme should be developed, incorporating, where appropriate, the essential aspects of education and treatment already discussed. A group programme should address the needs of the people currently within the service and should change according to the changing needs.

Treatment Setting

- A range of treatment settings need to be available to accommodate the needs of different people. These include home-based, supported housing, community-based services and inpatient units.
- Where a person requires hospitalisation they should be admitted to a facility that can cater for and is appropriate to their age and stage of illness.
- A person who is having their first psychotic episode should not be placed with people who may upset or distress them.
- Staff in hospital inpatient units need specific training in early intervention.
- When a person goes into a hospital, community care managers should stay involved throughout the admission.

Audit, Evaluation and Research

Audit – Teams should regularly audit all aspects of their practice to ensure ongoing high standards of practice. It is important that the practices that contribute to effective treatment are identified and that services audit themselves to see how well they are doing. For example, early intervention services want to work in better partnership with their clients so they need to establish what this would mean in practice or decide how they would audit their performance on these practices.

Evaluation – This should include feedback from the person and their family on quality of care, including cultural safety, and quality of life both inside and outside of care facilities or services.

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\(^{35}\) Albiston, Francey & Harrigan, 1998
\(^{36}\) National Mental Health Strategy, 1998
\(^{37}\) Bloch and Harari, 1994
**Research** - Early intervention in psychosis is an area where a lot of practices have not been fully evaluated\(^\text{38}\). Ongoing research should therefore be an integral part of any treatment team.

Teams need to keep pace with evidence-based literature and consumer feedback and where applicable, incorporate new information into practice.

**Promoting Awareness**

All evidence indicates that the longer a person’s psychosis remains untreated, the more difficult it is for them to become well again and stay well\(^\text{39}\). Early treatment and support programmes must create strong links with primary care, including school counsellors, and have an active outreach education programme. There should be links with local Maori and Pacific people and these groups should run their own education programmes.

**Access to Advocacy Services**

Everyone using the service needs to be given clear information on their rights as health and disability consumers and access to local advocacy services. The Health and Disability Commissioner has set up advocacy services throughout the country. There are also consumer-run advocacy services in some areas.

**Access to Information Services**

Everyone using the services must be offered clear, up to date information on their condition and treatment options, support options, the recovery approach and other services and agencies which may assist them.

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\(^{38}\) Sheitman, Lee, Strauss, R, et al., 1997

References


Mental Health Commission (1998) Blueprint for mental health services in New Zealand: the way things need to be. Wellington, NZ: Mental Health Commission

Ministry of Health (1997) Moving forward. The National mental health plan for more and better services. Wellington, NZ: Ministry of Health


New Zealand Early Intervention Interest Group (1996) Consensus Statement: Early Intervention Services for People Developing Psychotic Illnesses


EARLY INTERVENTION IN PSYCHOSIS

Guidance Note

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Contents

Recovery ................................................................................................................. 3
Definition of Early Psychosis .................................................................................. 4
Rationale for Early Recognition, Treatment and Support ........................................ 6
Aims of Early Psychosis Services ............................................................................ 6
Principles of Early Psychosis Services .................................................................... 7
Rapid Access .......................................................................................................... 7
Culturally Appropriate Services .............................................................................. 7
Services for Maori .................................................................................................. 7
Services for Pacific People ...................................................................................... 8
Services for Other Cultures .................................................................................... 8
Developmentally Appropriate Services ................................................................. 8
Service User Participation ....................................................................................... 8
Family Involvement ................................................................................................. 9
Treatment is Received in the Most Open, Safe and Familiar Environment ............ 9
Possible .................................................................................................................. 9
Accurate Assessment .............................................................................................. 9
Specific Expertise Required by Early Psychosis Teams .......................................... 10
Care Management .................................................................................................. 10
Assessment ............................................................................................................. 10
Physical Health ...................................................................................................... 10
Psychopharmacology .............................................................................................. 11
Family Support ....................................................................................................... 11
Psychological Therapy and Support ...................................................................... 11
Group Work ........................................................................................................... 11
Education and Support for Recovery ..................................................................... 11
Specific Expertise in Early Psychosis ..................................................................... 12
Cultural Expertise .................................................................................................. 12
Consumer Expertise and Advice ............................................................................ 12
Evaluation and Research ...................................................................................... 12
Treatment and Support .......................................................................................... 13
Prodrome ................................................................................................................ 13
Acute Phase ........................................................................................................... 13
Assessment ............................................................................................................. 13
Care manager and treating psychiatrist ................................................................. 14
Decision making ...................................................................................................... 14
Family and friends' involvement ........................................................................... 14
Education ................................................................................................................ 14
Psychopharmacology ............................................................................................. 15
Psychological therapy and support ....................................................................... 16
Intense care and support ......................................................................................... 17
Identification and treatment of co-morbidity ......................................................... 17
Recovery Phase ..................................................................................................... 17
Guarding against isolation ..................................................................................... 17
Leisure/interest development ................................................................................. 17
Vocational and educational planning and training ................................................ 18
Healthy lifestyle ...................................................................................................... 18
General .................................................................................................................... 19
Group Education and Therapy .............................................................................. 19
Treatment Setting ................................................................................................ 19
Audit, Evaluation and Research ............................................................................ 19
Promoting Awareness ........................................................................................... 20
Access to Advocacy Services ................................................................................. 20
Access to Information Services ............................................................................. 20
References .............................................................................................................. 21