Emerging Psychosis in Young People

Dr Richard Fraser
Consultant Psychiatrist
ORYGEN Youth Health

Background

Impact Of Mental Disorders

- "Mental Illnesses are the chronic diseases of the young" (Insel and Fenton 2005)
- One quarter of the population has a disorder each year (Kessler et al 2005)
- 50% lifetime prevalence - 75% onsets <24 yrs
- 60% serious or moderate in severity
- If serious (6% of population) - 88 days pa when unable to carry out normal activities

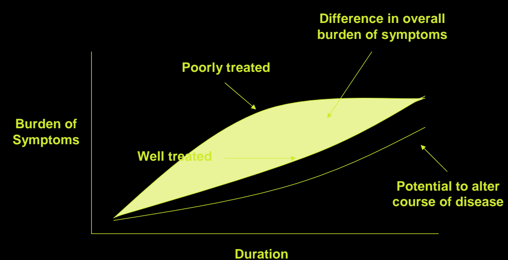
Impact Of Mental Disorders

- 1 in 4 young people between 15-24 will experience a mental disorder in any 12 month period
- 15 - 24 years old is the peak period for the onset of mental disorders
- Mental health issues are responsible for 65 - 70% of Burden of Disease for young people aged15-24
- Mental and substance use disorders frequently coexist (70% of help seeking cohorts)
- Pathways for young people to access health resources are limited as use of standard GPs is under-represented in this age group
- Although most young people experience recovery from symptoms of mental disorders, there is a significant negative impact on longer term vocational pathways and economic participation

Impact Of Mental Disorders

- In Australia 60% with MDs receive no treatment - the rest mainly see GPs
- Small minority even of severe disorders only have secure access to specialist mental health care
- Specialist mental health care is much lower quality than could be provided with present scientific knowledge and lower than other medical specialties
- Only 33% of treatment received meets minimal EBM standards
- Yet treatment is potentially more effective and evidence-based than ever before

Burden of Disease

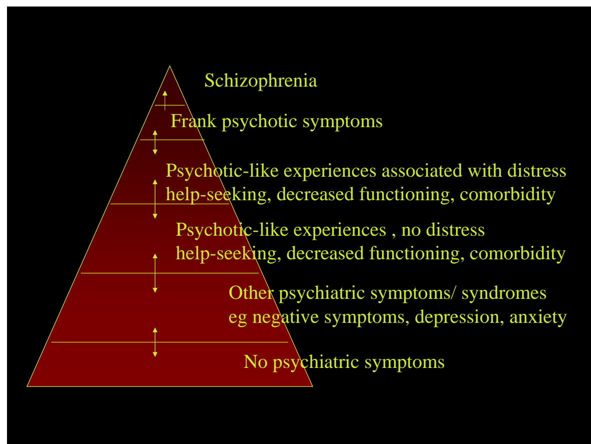


Classification of Psychosis

- Affective psychoses (bipolar and major depression with psychotic features)
- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Brief reactive psychosis
- Drug-induced psychosis
- Medical or neurological illnesses mimicking primary psychotic disorders

Phases of Psychosis

- At risk mental state (prodrome)
- Acute
- Early recovery
- Late recovery



At risk mental state (prodrome)

At risk mental state

- At increased risk of developing psychosis
- Sustained and clinically important deviation from premorbid level of experience and behaviour
- Low grade psychotic symptoms, poor functioning, depression and disorganisation
- Increased risk if first degree relative with psychotic illness

At risk mental state – symptoms

(Yung & McGorry 1996)

- Reduced concentration and attention
- Reduced drive and motivation
- Depression
- Sleep disturbance
- Anxiety
- Social withdrawal
- Suspiciousness
- Deterioration in role functioning
- Irritability

At risk mental state

- Not all those with at risk mental state will develop psychosis
- Retrospectively called prodrome
- Often difficult to distinguish from normal 'troubles/turmoil' of youth
- High index of suspicion if drop in functioning, non-specific psychiatric symptoms, attenuated psychotic symptoms and a positive family history
- Follow up to monitor at the very least
- May require more specific psychological interventions

At risk mental state

- Significant degree of disability associated with prodrome. May create a 'ceiling' for eventual recovery
- Focus of treatment is two-fold

  1) treatment of current symptoms and disability

  2) prevention of full-blown disorder (indicated prevention)

At risk mental state

- Early intervention may prevent , ameliorate or delay onset of psychosis
- Engagement at this stage improves the chances of future engagement when psychotic and allows for a more rapid response
- Attenuated psychotic symptoms do not inevitably develop into full-blown psychosis
- Mean duration of prodrome is between 3 and 5 years

At risk mental state
the role of the GP

- Advantages of GP include
  - Multidimensional view of patient since childhood including some knowledge of family and living situation
  - Low stigma environment to assess and treat
  - Can reassess over time if symptoms unclear

The first psychotic episode

ORYGEN Youth Health

The first psychotic episode

- Transition from prodrome to psychosis can be difficult to define
- Onset may be gradual or acute
- Fluctuations may occur
- Appraisal of symptoms may vary
- May not be distressed or disabled
- May have limited insight

The first psychotic episode

- Psychosis onset generally defined as:
  1) Psychotic symptoms. Presence of at least one of the following: ideas of reference, magical thinking, perceptual disturbance (eg auditory hallucinations), odd thinking and speech
  2) Duration of episode of greater than one week
  3) Frequency of symptoms – at least several times per week

The first psychotic episode
Initial presentation

- May present to GP first, often for other reasons
- GP should be aware that 'something is not quite right' and enquire about possible psychotic symptoms
- Care not to normalise changes and miss an opportunity to intervene
- Engagement is crucial

The first psychotic episode
Screening questions (1)

source ORYGEN Youth Health Assessment proforma

Over the past 12 months:

- Have you noticed yourself being paranoid or suspicious of others?
- Have you worried that somebody has been out to get you?
- Wanting to harm you?
- Do you feel like anyone is watching you, talking about you or laughing at you behind your back?
- Have you had the feeling that you have special powers that other people don't have or are especially important in some way?
- Have you seen or heard things that other people don't seem to hear or see?

The first psychotic episode
Screening questions (2)

- Have you felt that things around you had a special meaning intended just for you? For example have the TV or radio been sending you messages?
- Have you felt that someone or something outside yourself has been controlling your thoughts, feelings, actions or urges? Have you had feelings or impulses that don't seem to come from yourself?
- Have you felt that ideas or thoughts have been put into your head or taken out of your head by someone or something else?
- Have you felt your thoughts are less private than usual?
- Have you thought that your thoughts are broadcast so that everyone can know what you are thinking?
- Or that people can read your mind?

The first psychotic episode
Screening questions (3)

Observations during the interview:

- Are you (the interviewer) having any trouble following the client's answers, understanding what they are trying to say?
- Are they pressured in speech?
- Do they seem unable to answer questions because of being perplexed or thought-blocked?
- Do they go off the subject and get lost in their words?
- If the client has answered yes to any of these questions then further investigation of symptomatology and presentation will be required as the possibility of an emerging or active psychotic illness has to be considered.

The first psychotic episode
Assessment

- Suicide risk
  - Rate is high in early phase of illness
  - Crucial to assess and address
  - May require admission where available
- Psychiatric comorbidity
  - Substance abuse, depression, personality disorder
  - May interfere with treatment
  - Require treatment in their own right
  - Often complex and time-consuming

The first psychotic episode
Assessment

- Medical comorbidity
  - Increasing evidence that psychotic disorders (and their treatment) associated with diabetes, lipid abnormalities and cardiovascular disorders (Lambert T, 2004)
  - Need to investigate – eg blood tests (FBE, U&E, LFT, TFT, B12 & folate, random glucose, lipid profile), urine drug screen, ECG, CT/MRI, weight, EEG if indicated
  - Consider organic disorders which may present with psychosis (eg Huntington's disease, MS, temporal lobe epilepsy, HIV)
  - Antipsychotic medication may cause weight gain and glucose/lipid dysmetabolism (Lambert T, 2003)

The first psychotic episode
What to do next

- Early referral to specialist service where available – eg youth mental health service such as EPPIC in Melbourne
- Early intervention
- Reduce the duration of untreated psychosis (DUP)

The first psychotic episode
Remote or rural areas

- Some remote or rural GP practitioners may not have access to specialist mental health services
- Support may be limited
- Telemedicine or phone consultations may be available from specialist services in some areas
- There is also the GP Psych Support service which has been developed and funded by the Australian Government as part of the Better Outcomes in Mental Health Care initiative. This service provides GPs with on-line or telephone psychiatrist support via their website at www.psychsupport.com.au.

The first psychotic episode
Acute management

- Bio-psycho-social approach
- Ideally involving a multi-disciplinary team (where possible)
- Long term case management
  - Coordinate care
  - Promote development of individual
  - Minimise psychosocial stressors
  - Ensure ongoing treatment adherence and engagement with services

The first psychotic episode
Acute management

- Treatment adherence is often poor – approximately 60% for those with psychosis (Buchanan, 2005)
- 80% of those who cease medication will relapse within 5 years (Robinson, 1999)
- Likelihood of remission drops with every relapse (Lieberman, 2003)
- Engagement therefore essential

The first psychotic episode
Acute management

- Antipsychotic medication
- Psychological interventions
- Family work
- Psychoeducation
- Physical health

Antipsychotic Medication

- Newer atypicals recommended in first episode psychosis (olanzapine, risperidone, quetiapine and aripiprazole)
- Compared to older antipsychotics atypicals have fewer side effects (extra-pyramidal SEs, restlessness and sexual dysfunction)
- May enhance cognitive functioning (Buchanan, 2005) and protect the brain (Lieberman, 2005)
- Lower incidence of longer term SEs (tardive dyskinesia)
- May be better at treating negative symptoms (Voruganti, 2000)
- Because of better subjective tolerability they are less likely to be discontinued (Helliwell, 2001)

Antipsychotic Medication

- Atypicals have demonstrated efficacy in treating positive (hallucinations, delusions, thought disorder) and negative (social withdrawal, poverty of thought) symptoms associated with psychotic illnesses (Hunter, 2003)
- Atypicals have overall similar efficacy (Davis, 2003)
- Choice more dependent on side effect profile and patient preference
- Involvement of patient increases chance of adherence

Antipsychotic Medication

- Start low and go slow in first episode psychosis patients
- Weekly review of symptoms and SEs to establish lowest effective dose
- Antipsychotic medication usually takes 1 – 2 weeks to show symptomatic response
- If no improvement after 2 weeks the dose should be increased at fortnightly intervals until clear signs of response occur (within limits of SE emergence)
- Antiparkinsonian medication should only be given after extrapyramidal side effects appear, not as a preventative measure

Antipsychotic Medication
Dose recommendations in acute FEP

Suggested effective lowest dose to treat	Neuroleptic naïve first episode patients	Previously neuroleptic treated patients
Risperidone	2 mg/day	2-6 mg/day
Olanzapine	7.5 mg/day	15 – 30 mg/day
Quetiapine	200 – 300 mg/day	300 – 800 mg/day
Amisulpride	200 – 300 mg/day	400 mg/day
Aripiprazole	5 – 10 mg/day	10 – 30 mg/day

Antipsychotic Medication
Steps for dose increases

- 1 mg for risperidone
- 100 mg for amisulpride
- 5 mg for olanzapine
- 100 – 200 mg for quetiapine
- 5 – 10 mg for aripiprazole

Antipsychotic Medication
When to switch

- If unsatisfactory response after 6 – 8 weeks at an appropriate dose then switch to alternative atypical
- Cross tapering is preferred
- The antipsychotic medication resulting in symptomatic recovery should be continued for at least a year or longer
- Don't change gratuitously
- May have to negotiate intermittent antipsychotic medication rather than none at all

Treating comorbidity

- Agitation – benzodiazepines short term
- Depression and anxiety (50% FEP patients) – SSRIs

Treating comorbidity

- Substance use – treat withdrawal as per guidelines +/- specialist service
- Personality factors – complicate overall picture – common – need careful management as can affect clinical management

Psychoeducation

- 'Making your patient an expert'
- Providing information for patients and families is essential
- Early initiation
- Variety of media – spoken, written, audiovisual
- Message of hope and therapeutic optimism

Managing Risk

- Assessment of suicide and violence risk critical
- 10 – 15 % of psychotic patients will eventually commit suicide with greatest risk early on in illness
- Medication
  - Early use of clozapine for highly suicidal patients with schizophrenia
  - Lithium for affective psychoses
  - Antidepressants
- ECT
- Psychosocial and psychological interventions to reduce stress, support and decrease critical expressed emotion
- Violence – risk factors include male gender, substance use, previous violence and unemployment

Consequences Of Delay (pre-treatment) And Failed Access

- Substance Abuse (Hambrecht and Häfner 1995)
- Suicide (Bromet 1998; Melle 2006)
- Homelessness (Herman 1998)
- Offending Behaviour (Humphries 1994)
- Vocational Failure (Häfner 1995)
- Family Burden & Loss of Peer Network
- More 'Entry Trauma' (McGorry 1992)
- Biological Toxicity? (Wyatt 1991)

Consequences Of Delay (post-treatment)

- Slower and Less Complete Response (May 1976; Wyatt 1991; Loebel 1992; McGorry 1996)
- Increased Relapse (Crow 1986) BUT not seen in Robinson (1999)
- Increased Treatment Resistance (Edwards (1998)

Recovery phases

Psychological interventions

- Crisis work – problem solving
- CBT for psychosis and comorbid illness
- Family work – support, psychoeducation

Physical health

- Important opportunity exists to address physical health problems
- High rate of smoking
- Healthy living promoted
- Medication side effects regularly reviewed
- Annual physical health checks

Treatment refractory patients

- Up to 20% first episode psychosis cases fail to achieve remission after adequate treatment with 2 atypicals
- Firstly consider problems such as non-compliance, substance use, comorbidity such as depression
- With non-compliance, may need to use a long acting injection – risperidone consta
- Once clearly treatment refractory – early use of clozapine should be considered
- Clozapine is superior in efficacy compared to other atypicals
- Clozapine has important side effects including agranulocytosis, myocarditis, weight gain, diabetes
- ECT may be indicated in severe cases where a rapid response is required eg suicidal
- Multidisciplinary approach – primary and specialist

Longer term
Medication

- How long to continue?
  - For FEP patients 9 – 12 months after symptom-free it would seem reasonable to reduce antipsychotic medication and possibly cease
  - Acknowledge high rates of relapse
  - Best to work collaboratively wherever possible
  - If multiple episodes of psychosis then recommend antipsychotic medication for several years
  - Draw up a 'safety net' plan and communicate to all involved

Longer term
Medication

- How to stop?
  - Reduce in steps of at least one month apart
    - Risperidone 1 mg
    - Olanzapine 2.5 mg
    - Quetiapine 100 mg
  - Regular follow-up
  - Monitor for early warning signs of relapse and increase dose if necessary

Longer term
Beyond medication

- Symptomatic recovery in over 90%
- Functional recovery in approx 50%
- Vocational objectives important – role, self-esteem, socialisation, wages and indirectly improving adherence
- Accommodation
- Training and education

Relapse prevention

- Early warning signs – sleep disturbance, subthreshold psychotic symptoms
- Advance directives – can be useful – agree on these when well and insightful
- At first sign of relapse medication should be re-started before hospital admission necessary
- Choice of medication guided by previous response

Conclusion

Conclusion

- Multi-disciplinary approach to management of first episode psychosis
- Integration of services
- GPs play an important role in early detection and on-going management of psychosis
- Early involvement of specialist services where available
- Shared care model once stable

Thank you