Emerging psychosis in young people – Part 3

Key issues for prolonged recovery

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BACKGROUND
After 18 months of specialist care only about half of all first episode psychosis patients achieve functional recovery, and about 10–20% patients will not respond to initial treatment and have persistent psychotic symptoms. These patients need special attention in order to minimise the burden of disease and prolonged disability.

OBJECTIVE
This article reviews the management of young first episode psychosis patients with incomplete recovery, and focuses on the general practitioner's role, how to deal with treatment resistance, vocational rehabilitation, and other aspects of patient care.

DISCUSSION
Once the acute episode has been treated, it is important to avoid complacency and address other aspects contributing to a patient's wellbeing including social welfare, physical health and vocational rehabilitation. The prevention of relapse and the psychosocial development of the individual are key in fostering and promoting a healthy lifestyle, leading to improved quality of life. Treatment refractory patients need specialist care.

About 80% of first episode psychosis patients will achieve a symptomatic recovery after 1 year of treatment, but only about 50% will achieve functional recovery.[1,2] About 10–20% of first episode psychosis patients will have treatment refractory symptoms, a figure which increases to 30–50% over the lifetime of patients.[3–5] Little attention is paid to the prolonged recovery phase after a first psychotic episode. This is surprising given the high relapse rate of 80% and the associated burden of disease.[6] In most areas of Australia, those first episode psychosis patients who are not acutely ill will be discharged from specialist mental health services once the psychotic symptoms have resolved, with a large proportion of patients being discharged to general practitioners. Some of these patients may have a symptomatic recovery but have not returned to their premorbid level of functioning. This article attempts to provide strategies to prevent long term disability in this vulnerable patient population.

The role of the GP

How long do I need to take medication?

Inevitably most patients will want to negotiate a reduction or discontinuation of medication once recovered from a first psychotic episode. It can be very hard to convince a patient to continue to take antipsychotic medication if they have recovered and been symptom free for several months, even so, most controlled discontinuation studies find very high rates of relapse.[7] In the 'real world' most patients will seek to cease medication at some point. Rather than risking disengagement, it is reasonable to attempt to reduce antipsychotic medication to the lowest effective dose or even to cease the medication in some cases. The most important issue is that the patient understands abrupt changes in dose are associated with a very high risk of relapse and that maintenance therapy is the safest option to remain relapse free. In first episode psychosis patients, 'prodrome based intermittent intervention' – meaning the recommencement of medication at the emergence of early warning signs such as sleep disturbance – seems to work well with respect to compliance and dosage required.[8]

Coming down – a dose reduction

At the Early Psychosis Prevention & Intervention Centre (EPPIC) we usually try to reduce the antipsychotic dose gradually in steps of at least 1 month apart (*Table 1*). If symptoms remain absent, then further gradual dose reductions are attempted. If early warning signs occur

(eg. sleep disturbance, subthreshold psychotic symptoms), the dose is increased again and the patient monitored closely (eg. twice weekly appointments or daily phone contact). There are some patients that remain stable on a very low maintenance dose (eg. 50 mg quetiapine) and others that need very high maintenance doses (eg. 1000 mg quetiapine per day).

'Just let me try without medication, please'

If a patient decides to cease medication despite medical advice, ongoing close monitoring of their mental state is essential as some patients will quickly relapse.[7,9] A 'safety net' plan should be carefully drawn up and communicated to all those involved in the patient's ongoing care. Advance directives are useful, whereby the patient and clinician agree on a treatment plan should relapse occur and insight or judgment become impaired. If this plan is comprehensive, transparent, well communicated and identifies early warning signs (relapse indicators), it can improve not only patient safety but also engagement and the therapeutic alliance.

Of those who relapse, it is crucial to detect this relapse early on, hence regular monitoring after reducing or discontinuing medication. At the first sign of relapse, medication should be re-started before deterioration necessitates a hospital admission.[9] Choice of medication should be guided by previous response. A short term prescription of benzodiazepines can be very useful in early relapse to decrease agitation and anxiety. Intensive social support for the patient and their family can also reduce stress at this time; potentially preventing a breakdown of social circumstances.

Protecting the brain – a long term investment

For those young people who have suffered multiple episodes of psychosis, it is likely that the protective value of long term antipsychotic medication will outweigh the inconvenience or possible side effects of ongoing pharmacotherapy and the risk of social and psychological decline in the context of repeated relapses.[8] If a first episode psychosis patient has experienced more than two psychotic episodes, we usually recommend maintenance antipsychotic treatment for several years until a stable life situation has been achieved before a second attempt to cease the medication is tried. The drug that produces a full recovery should be continued, even on a very low dose, as every further relapse is associated with a likely functional decline due to disruption, as well as a 15% decrease in likelihood to achieve remission.[2]

Table 1. Suggested monthly incremental dose reductions of antipsychotic medication

Suggested dose reductions per month	
Risperidone	1.0 mg
Olanzapine	2.5 mg
Quetiapine	100 mg

This high rate of relapse illustrates how important it is that GPs are up-to-date with current approaches to treatment of emerging psychotic disorders; remain involved on an ongoing basis in monitoring compliance; and also reinitiate treatment in cases of re-occurrence of early warning signs.

The insightless patient

A proportion of patients will attempt cessation of medication prematurely against medical advice and their psychiatric history may indicate that a potential relapse is too risky (eg. persecutory delusions with risk of harm to others or self). In these cases, once psychoeducational approaches have been given a fair trial and 2–3 relapses due to nonadherence occurred, a long acting intramuscular formulation of antipsychotic medication (eg. Risperidone Consta) with or without the use of a community treatment order should be considered. For the right patient, this can be extremely helpful in providing consistent treatment and preventing harmful relapses. This strategy should always be reviewed regularly, as the patient may adjust better to illness self management in the future and may be able to resume oral therapy and more personal responsibility. Usually the involvement of a specialist mental health service is required.

When response is limited – treatment refractory patients

Up to 20% of first episode schizophrenia-like cases fail to achieve remission after adequate treatment with at least two atypical antipsychotic agents.[1,10–12] In such cases it is important to consider and actively enquire about ongoing substance use as this is a common and extremely important factor in illness perpetuation.

Persistent psychotic and affective symptoms can be alleviated by cognitive behavioural therapy (CBT)[14,15] which has also been shown to be of benefit in the more acute phase of illness.[16] Cognitive behavioural therapy for psychosis focuses specifically on:

- automatic thoughts
- faulty processing styles and dysfunctional assumptions regarding the self
- core cognitions or self schema
- emotional and cognitive development, and
- interpersonal and interactional factors in addition to cognitions.[17]

For first episode psychosis patients treated with two antipsychotic medications at adequate doses and for sufficient time periods but with inadequate response, or patients with a high suicide risk, clozapine or electroconvulsive therapy are valid and highly effective treatment options and need to be considered. However, only accredited specialist services with appropriate training can perform these interventions. It is important to liaise early with specialist services as suicide rates are high in this early phase of illness.

Clozapine has shown superiority of efficacy over other atypical antipsychotic medications.[13] However, the risk of severe weight gain with associated complications such as diabetes and cardiovascular disorders, as well as the potentially lethal complications of agranulocytosis and drug induced myocarditis, have resulted in strict regulations governing its use. However, despite clozapine's side effect profile, it is important to consider its early use if there has been an incomplete response to at least two antipsychotic medications (if used long enough at appropriately high doses) or significant ongoing risk of suicide persists and outweighs the side effects associated with clozapine treatment.

In some very severe treatment resistant cases of first episode psychosis where there is significant affective disturbance together with poor treatment response, and also a sense of urgency, the use of electroconvulsive therapy can be extremely effective in 'turning things around' and allowing suitable pharmacotherapeutic and psychological

Case history Steve – treatment resistance in first episode psychosis

Steve has been diagnosed and treated for a first episode of psychosis. He is 24 years of age and lives with his family who support him with his illness. After an insidious onset of psychosis he was initially treated with olanzapine which produced only a partial response despite adequate dosage (20 mg per day) for 6 weeks. He was then switched to risperidone 2 mg per day which again provided only a degree of improvement with persistence of both positive and negative symptoms. The dose of risperidone was increased to 4 mg per day and then further increased to 5 mg per day. However at this dose he started to experience some side effects including akathisia and stiffness. Steve's family were sure that he had been taking the antipsychotic medication on a regular basis. They were also starting to find his behaviour more difficult to manage at home as he was becoming increasingly paranoid and aggressive.

Discussion – Steve's case has been refractory to treatment. Early use of clozapine should be considered in this case as prolongation of the psychosis will likely result in increased social disability as well as the potential for violence at home and a crisis admission to hospital. Many patients are admitted to hospital for initiation of clozapine, however it is possible to start this treatment in the home setting provided there is suitable support and the risks are not too great. Such risks would include a significant risk of suicide/self harm, aggression, physical ill health or treatment nonadherence. The decision to initiate clozapine treatment in the community is always made in conjunction with specialist services. In Steve's case admission may be necessary due to his deteriorating condition and aggression.

interventions to be initiated.[18]

A multidisciplinary safety net approach for complex, suicidal or treatment resistant/reluctant cases is essential and should be created in partnership with specialist mental health services (see *Case history*).

Employment and functional recovery

It is crucially important to the long term recovery of a young person with any mental illness, but particularly psychosis, that attention be paid to the functional aspects of recovery. Data from EPPIC shows that while over 90% of our patients make symptomatic recoveries, only half make a functional recovery – defined as returning to previous role (eg. as employee, student). Because of the phase of life in which psychosis tends to have its onset (15–25 years), it can derail important developmental tasks such as completion of education and initiation of vocational path. Data from EPPIC and other studies show that approximately half of young people with first episode psychosis are unemployed at the time they seek help.[19] Several other studies have documented that this level of employment rises to 75–95% for those who go on to develop a chronic illness.[19,20] This is compared to a background of 85% of young people being employed or in education in the general community.[21] Absence from employment and other functional roles are likely to contribute to the exacerbation of disability suffered by people with psychotic illnesses and are powerful risk factors for relapse. A vocational undertaking, be it employment or training, is of immense potential benefit to people with psychosis. It provides a time structure and a role that is valued by society much more than the sick role that is otherwise the lot of people with psychosis. In addition, the benefits in terms of wages, socialisation and improved self esteem provide an additional motivation to be compliant with medication in the face of side effects.

Supported employment

Fortunately, over the past 15 years an effective means of addressing vocational recovery for people with chronic schizophrenia has been developed and tested – 'supported employment'.[22,23] Supported employment requires a mental health service worker dedicated to vocational recovery, to work with patients who want to return to employment or education.[24] Such programs in Australia are a long way from being funded as part of mainstream services, despite evidence that these approaches may be efficacious in young first episode populations.[25,26]

In the absence of a local mental health service with a dedicated vocational worker, GPs could seek advice from, or refer patients to, local disability employment agencies. These agencies are funded by the Federal Department of Employment and Workplace Relations to work with people who have disabilities including mental illnesses, in order to assist them to return to or gain employment.

Problems that can arise in the pursuit of a vocational objective may have to do with a decision to disclose the illness or not to potential employers, asserting a right to workplace accommodations and choosing an appropriate workload.

In helping people with psychosis it should be remembered that gaining employment is their single most cited goal, and it is often their mental health workers rather than their illness that prevents them from pursuing it.

Other aspects of care

Patients with mental illness have higher rates of physical health problems compared with the general population.[27] Promoting the physical wellbeing of the patient has until recently been neglected within mental health[28] and is an aspect of continuing care that can be implemented within general practice. Annual physical health checks should be arranged, looking at weight, blood pressure, lipid profile, fasting blood glucose and an electrocardiogram (ECG) together with appropriate screening for other problems including breast, bowel and skin cancers.

As with other patients reviewed in general practice, smoking cessation should be addressed, exercise promoted, and a healthy diet encouraged. Sexual function should be enquired after, especially as many psychotropic medications negatively affect this aspect of a young person's life. Other side effects of medication should be reviewed including a 6 monthly check up for signs of tardive dyskinesia.

Aspects of social welfare should not be neglected and can often be addressed in conjunction with the social services and nongovernment organisations. Adequate provision for the patient's carers needs to be made which should include support, respite and a

carer's assessment in their own right if indicated.

Conclusion

Key factors in optimising outcome in the longer term for patients with first episode psychosis involve regular review of mental state, treatment response and side effects, together with an awareness that other aspects of care must not be neglected. General practitioners are well placed to monitor progress, detect secondary problems and pick up on early warning signs of relapse. They will also have an understanding of the patient's support network and social circumstances which are important in promoting development and social integration. General practitioners are in an optimal position to foster a sense of hopefulness for the young person and their family while providing a degree of normalisation through treatment within the primary care setting.

Dose reduction and treatment termination should be carefully planned and a safety net approach adopted, ensuring that the pros and cons of such strategies are discussed and safely implemented. Inevitably some patients with first episode psychosis will not respond to first line treatments and in these cases it is important to recognise resistance and treat early using medication such as clozapine, CBT, and active psychosocial interventions.

Ultimately, it is through integrated services, individualised treatment packages, rehabilitation and therapeutic optimism that young people with first episode psychosis, and their families, will better understand what has happened to them and find a useful place in society.

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