Multiple choice questions

1. The ‘critical period’ following a first psychotic illness is:
   a the time during which individuals decide whether or not to stop treatment
   b inversely related to the duration of untreated psychosis prior to admission
   c a period during which relapse is common
   d associated with increased risk of suicide
   e a period when it is important to offer intervention.

2. In the pharmacotherapy of first-episode psychosis:
   a it is often sufficient to treat with benzodiazepines
   b novel antipsychotics are the first-choice treatment
   c in most cases, remission of symptoms can be expected within 6 months
   d symptoms often remit with low doses of an antipsychotic
   e treatment can usually be safely stopped 6 months after remission of symptoms.

3. Best-practice management of first-episode psychosis includes:
   a a strategy for the early detection of psychosis
   b the early establishment of a definite diagnosis
   c early admission and assessment in hospital
   d the maintenance of valued social roles
   e a strategy for relapse prevention.

4. Psychological adjustment following a first-episode psychotic illness:
   a is usually uncomplicated if psychotic symptoms resolve completely
   b is helped by developing a sense of mastery
   c can be problematic if the individual feels trapped by the illness
   d is nearly always successful if the individual accepts the illness
   e is helped by learning how to self-manage relapse.

5. Therapeutic engagement of young people with a psychotic illness:
   a improves if staff insist that the young person accepts the diagnosis as soon as possible
   b is helped if staff search for common ground to understand clients’ experiences
   c can be helped by an assertive outreach approach
   d requires regular out-patient appointments
   e is helped by persistent contact with a keyworker.

MCQ answers

1		2		3		4		5	
a	F	a	F	a	T	a	F	a	F
b	F	b	F	b	F	b	T	b	T
c	T	c	T	c	F	c	T	c	T
d	T	d	T	d	T	d	F	d	F
e	T	e	T	e	T	e	T	e	T

Commentary

Shôn Lewis & Richard Drake

Since the 1970s, the focus of mental health policy in the UK has been on those with severe, enduring psychotic illness, relocating the care for such people from the hospital to the community. This has now been largely achieved. The policy focus is now shifting to the other end of the process, establishing specific services for those with early psychosis, as flagged in the NHS National Plan. Spencer *et al* describe the principles underlying the Birmingham Early Intervention Service. This is the first and best developed such service in the UK, its ethos based on the work evaluating early intervention and relapse prevention done by Max Birchwood and colleagues.

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The principles underlying a comprehensive first-episode service are cited by Spencer *et al*: early detection; early, effective working to normalise individuals' experience of psychosis; and relapse prevention.

Early detection aims to reduce the duration of untreated psychosis (DUP), a well-replicated and surprisingly strong predictor of short- and long-term outcome. Average or median DUP in most systematic UK studies tends to be shorter than Spencer *et al* suggest, at least for positive symptoms. However, this does not mean that working to reduce it is any less important. Drake *et al* (2000) found the median duration to be 12 weeks in a large sample of first-admission patients. The longer the DUP, the more severe was the symptom level at baseline, but even controlling for this effect, DUP was the single strongest predictor of symptomatic outcome at 3 months. Drake *et al*'s study modelled DUP against short-term outcome and found a non-linear relationship. This suggests that bigger gains in improving outcomes would be made by bringing forward treatment by 1–2 weeks in cases of relatively short DUP than by bringing forward treatment by 1–2 months in those with long DUP. In this respect, adjustments to service configuration, such as assessing all new cases of psychosis within 1 day, should have an impact. Further steps include training general practitioners; targeting high-risk groups such as those with a family history; and even high-profile public education campaigns for whole communities. Using all these approaches together (details available from S.L. upon request) showed a reduction in median DUP in a Norwegian county from 26 to 5 weeks, with a corresponding reduction in how severely ill patients were when they presented.

The next step is early, effective and acceptable treatment. Antipsychotic drug treatment remains a central part of the management of the first episode. Which class of drug to choose and which individual drug within that class is still a matter of debate. What is clear is that people in their first episode are sensitive both to the therapeutic effects and the side-effects of drug treatment. As a class the new atypicals offer a lower incidence of neurological side-effects than do the conventionals, although speed of remission in the first episode has been shown to be the same for conventionals and atypicals. Advantages of new atypicals are more likely to emerge in the longer-term prevention of relapse.

Offering a conventional drug first line is still a legitimate strategy, with two caveats. First, there is increasing evidence that low dosages are effective in treatment-naïve patients. From the viewpoint of basic pharmacology, doses equivalent to as little as 2 mg haloperidol daily will give 80% dopamine D2 receptor blockade. In a trial in which clinicians titrated haloperidol dose blindly against clinical response in 130 first-episode patients, the mean dose at the end of 12 weeks' treatment was found to be about 4 mg daily, with only 4 % of patients needing more than 6 mg (details available from S.L. upon request). Given its high rate of extrapyramidal side-effects (EPS), it may be that haloperidol is not the best conventional to choose in the first episode. Its high potency means it has a narrow therapeutic range between the dose needed to work and the dose at which EPS will emerge.

The second caveat if using a conventional drug first line is to assess and monitor symptoms and side-effects regularly and to change to an atypical the moment poor response or side-effects emerge. Rating scales to assess these issues are underused. Health commissioners will be much happier to fund drugs they view as expensive if clinicians can show they are monitoring outcomes and side-effects objectively.

Data are emerging that point to the effectiveness of adjunctive cognitive–behavioural therapy (CBT) in accelerating remission from acute symptoms in the first episode. In a large trial, 316 patients, of whom 80% were first admissions, were randomised a mean of 6 days after admission to receive a 5-week package of CBT in addition to routine care, or a 5-week package of supportive counselling in addition to routine care, or routine care alone. Assessments blind to treatment allocation showed that the group receiving CBT improved significantly more rapidly over 50 days in terms of delusions and hallucinations than did the other groups (details available from S.L. upon request).

The real challenge in longer-term management is to prevent relapse. Data from Lieberman's group (Robinson *et al*, 1999) and others remind us that, whereas over 80% of cases of first-episode schizophrenia will achieve good remission at an average of 3 months after starting treatment, one in six of these will have relapsed within 1 year and, by 5 years, five out of six will have relapsed. Moreover, cohort studies have confirmed how the speed and quality of remission are progressively impaired after the first and subsequent relapses. Relapse prevention depends not only on maintenance drug treatment, but also on family intervention, tackling comorbid drug misuse and the use of targeted individual psychological techniques such as monitoring of early signs and compliance therapy.

Strictly speaking, randomised controlled trials are still needed to confirm the effectiveness of early detection and intervention services. However, the testimony of patients and families, non-randomised evaluations of services such as those provided by the Early Psychosis Prevention and Intervention

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Centre service and obvious validity or common sense supports their wider introduction.

A first-episode service has potential benefits not only for patients and families: good organisational opportunities may also be taken by providers in setting up such a service. These include: emphasis on secondary prevention and normative models; prioritising of work issues; a built-in evaluative culture; strongly multi-disciplinary teamwork; built-in dual-diagnosis services; opportunities for cross-boundary initiatives including health, social services and the voluntary sector; inclusion of users and carers in planning and delivery of services; increased liaison with primary care; and opportunities for research in epidemiological cohorts. Evaluation at both the service and the individual level is crucial. There are snags that need to be thought through too, such as the danger of taking resources from hard-pressed general adult services; how a first-episode service relates logistically to the general adult service; and whether general clinicians excluded from such a service end up feeling further demoralised.

References

Drake, R. J., Haley, C. J., Akhtar, S., *et al* (2000) Causes and consequences of duration of untreated psychosis in schizophrenia. *British Journal of Psychiatry*, **177**, 511–515.

Robinson, D., Woerner, M. G., Alvir, J. M. J., *et al* (1999) Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry*, **56**, 241–247.

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