Invited Commentary

Early Psychosis Intervention Services: A Work in Progress

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The promise of early detection and intervention has generated great excitement and optimism in the scientific and mental health care communities for the future prospects for recovery of individuals experiencing psychotic disorders such as schizophrenia.1 (Here, we use the word recovery not to mean cure, but rather to suggest the opportunity for individuals to limit the morbidity of their illness and improve their health and wellness, live a self-directed life, and strive to reach their full potential.)2

Recent efforts to develop early detection and intervention services as a care model for psychotic disorders, nationally and internationally, represent an innovative, and potentially game changing approach to mental health care. However, in pursuing the appealing goal of interdicting these illnesses at their inception, it is important that we proceed deliberately, and establish solid evidentiary bases for the diagnostic methods, treatments, and service models that are to be employed.

In this context, the study by McFarlane et al3 (Early Detection and Intervention for the Prevention of Psychosis [EDIPP]) reflects an ambitious effort to add to the growing knowledge base in this area by demonstrating the feasibility and efficacy of early detection and intervention prior to or just at the time of the onset of psychosis. For these reasons, the degree to which the study faithfully applies the current “state of the art” is critical to its success and important for researchers, clinicians, patients, and policy makers. This commentary will briefly address the implications of the paper for therapeutic interventions in first episode psychosis beginning with the treatments that were provided.

The active experimental intervention in this study offers a variant of Family Aided Assertive Community Treatment (FACT).4,6 FACT provides a package of interventions consisting of psychoeducational multifamily group (PMFG) therapy, elements of assertive community treatment, supported education and employment, and psychotropic medication. Supportive counseling, assertive outreach, and in vivo treatment, ie, family-based and patient-centered are also included in the FACT model tested. The treatment components and treatment structures offered in this program are very consistent and compatible with generally accepted evidence-based approaches for individuals experiencing a more established first episode of psychosis. Addington et al7 conducted a 2-stage review based on the published literature combined with an expert-based consensus process designed to identify essential evidence-based components of first episode psychosis services; Heinssen and colleagues8 further synthesized the literature in preparation for the US expansion of funding for these services as part of the Federal Block Grant. To the extent that EDIPP’s approach is consistent with the treatment of individuals with sustained first episode psychosis, the transition to FEP care would be seamless and perhaps offer great advantage if such earlier treatment mitigated the psychosocial and biological impact of an enduring psychotic illness.

At the same time that the FACT model used in EDIPP, is largely consistent with recommended treatments for early psychosis, several elements require further consideration, beginning with the psychopharmacological approach. Individuals scoring a level of “4” on the Positive Symptom Scale of the SIPS were offered aripiprazole within a dosage range of 1–15 mg. If that was not tolerated, another antipsychotic medication was offered. Although standardization of drug treatment is desirable for research design purposes, the choice of antipsychotic medication is complex and highly individualized. In addition, aripiprazole is pharmacodynamically unique among the APDs and thus may not be representative of the response to this class of medications. As a partial agonist, rather than a full antagonist, the therapeutic effects of aripiprazole may not extend to as broad a population of schizophrenia patients as the other antipsychotics.9,10
Beyond the psychopharmacology, the appropriate elements of psychosocial treatment and individual support merit comment. While EDIPP specifies the provision of supportive therapy, it would be useful to understand if structured individual psychoeducation or cognitive behavioral therapy is offered, both of which have been found to be helpful in the treatment of FEP. A focus on resilience, wellness and recovery, and coping with the experience of psychosis may be critical components of FEP care. Attention to suicide prevention, substance abuse treatment, and peer support services are also desirable. Finally, with respect to family services, it would be important to ensure that families can receive support in a manner they prefer. Some families may not be willing to participate in structured groups.

The study will provide an opportunity to learn more about FEP care when authors provide more information on how much of each treatment component individuals actually received and whether different treatment exposures were associated with outcomes. Similarly, additional information about the types of medications used (antipsychotic and adjunctive), dosing, medication switches and side effects will be of interest. Along those lines, it would be helpful moving forward to know the specific fidelity criteria for each of the program components. Assessing fidelity to such a complex, multi-faceted intervention is a bit of a herculean task.

A particularly important issue for understanding and shaping the service needs of individuals experiencing FEP in this study is the attitude toward and use of services that are in the community—not the office. Assertive Community Treatment, which provides the foundation for EDIPP, is a costly service that was developed for individuals who were not benefitting from office based services and community based approaches were needed. The extent to which individuals who are clinical high risk or who are experiencing early psychosis actually require that most of their services in the community beyond assertive outreach is unknown. It is also possible that creating the expectation among individuals who are clinical high risk that services can routinely be given in the community may inhibit illness management skills. Clarifying the proper balance of community vs office-based services will be a challenge for all early intervention programs.

Beyond the specific treatments offered in the FACT care model, there are design features, which prevent meaningful interpretation of the study results and therefore require caution before embarking on broad dissemination efforts (this issue). As articulated in the commentary by Kramer, the use of the regression-discontinuity design under these circumstances severely limits the inferences that can be drawn. Thus, the major import of this well intended though methodologically limited study, may be its demonstration of feasibility and acceptance by consumers and providers.

Acknowledgment

Dr. Lieberman serves on the Advisory Board of EnVivo and Intracellular Therapies and does not receive direct financial compensation or salary support for his participation. He receives grant support from Biomarin, EnVivo, Genentech, Novartis, Psychogenics and Sunovion; is a member of the Advisory Board of Pear Therapeutics and holds a financial interest; and holds a patent from Repligen. Dr. Dixon may be part of training and consultation efforts to help training in first episode psychosis services. She would not expect to receive any personal compensation for any such training efforts, rather such efforts would be carried out as part of the work done for her employer and, in that sense, compensated.

References