

## Evidence Summary: Treatment of young people at risk of developing psychosis



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### Introduction

Over the past 20 years, in conjunction with the development of new models of care for treating psychotic disorders in young people, a series of studies have focussed on the prevention of psychotic disorders. This body of work has involved the identification of specific risk factors for the onset of psychosis, the development of criteria to identify those most at risk of developing a psychotic disorder, and the testing of interventions designed to ameliorate, delay or prevent the onset of psychosis. This approach also includes a focus on treating additional existing symptoms that young people are presenting with, such as depression or anxiety, and any functional impairment associated with this. This summary focuses on the evidence for different treatment options available to young people identified as being at increased risk of developing a psychotic disorder.

### Interventions to prevent psychosis: Overview

Since the development of criteria used to predict the onset of psychosis (see the Evidence Summary: Identification of young people at high risk of developing psychosis), a range of interventions have been trialled for their effectiveness in preventing psychotic disorders, including psychological interventions (1-6), antipsychotic medication (7-9) and omega-3 fatty acid (i.e., fish oil) supplementation (10).

A recent meta-analysis examined the ten randomised controlled trials that have been published from 2002-2013 and highlighted the overall effectiveness of the interventions in reducing the risk of onset of a psychotic disorder (11). The risk of being diagnosed with a psychotic disorder was reduced by up to 54% after one year, and by up to 37% after two-four years. In order to prevent one person from developing psychosis, nine people needed to be exposed to the intervention during the first year, or twelve in the two to four year period.

While there were stronger results for antipsychotic medication when compared with psychological interventions alone, the authors highlighted the need to consider the reported risks associated with medication use, such as significant weight gain and other cardiometabolic disturbances (11). This risk of adverse side effects along with the limited sample sizes of antipsychotic prevention studies, the historical decline of overall transition rates to psychosis, and the potential efficacy of more benign treatment options therefore place doubt on the need to use antipsychotic medication with the ultra-high risk population (12).

### Guideline recommendations

Based on this evidence, current clinical practice guidelines recommend the use of cognitive behavioural therapy, supportive counselling, omega-3 fatty acids and treatment of any non-psychotic mental disorders that may be contributing to the presence of attenuated psychotic symptoms (13). The use of antipsychotic medication is not recommended as a first-line treatment and should only be considered in low doses in the event that psychotic symptoms increase rapidly with associated significant functional decline in conjunction with elevated risk to self or others.

### Cognitive behavioural therapy (CBT)

CBT is an intervention that identifies and challenges thought patterns and their associated behaviour and emotional responses (14). As described in the Australian Clinical Guidelines for Early Psychosis (13), the focus of CBT in the UHR stage of psychosis is to:

- **Enhance the understanding of symptoms** (including, but not limited to psychotic symptoms) and commence the treatment of presenting issues with strategies such as:
  - Psychoeducation and normalisation of bizarre experiences by providing a general biopsychosocial model of these (i.e., place them in the context of their life stressors, etc.);
  - Challenging delusional thoughts and hallucinations with the aim of defusing or reducing the negative impact these experiences have on the individual;
  - Enhancing coping strategies related to positive symptoms (eg., distraction, withdrawal);
  - Encouraging and facilitating self-monitoring of symptoms to explore relationship between symptoms and stress/distress.
- In terms of negative symptoms, encourage clients to schedule and monitor mastery and pleasure activities and cognitive restructuring of dysfunctional, unhelpful and self-defeating thoughts; and
- **Strengthen resources for coping** to reduce the impact of stressors, with strategies such as:
  - Psychoeducation about the nature of stress and anxiety;
  - Consistent monitoring of stress/distress;
  - Stress management techniques;
  - Identifying maladaptive – and promoting adaptive – coping techniques;
  - Identifying thoughts associated with stress or anxiety and replacing these with more positive coping statements via cognitive restructuring;
  - Goal setting, time management, assertiveness or social skills training, and problem-solving skills.

### Omega-3 fatty acid (fish oil) supplementation

Omega-3 fatty acid – or fish oil – supplements are a natural product made from fish. Usually taken daily in capsules, fish oil adds omega-3 to the diet, and reduced the rate of progression to psychosis in one randomised controlled trial (10). While these results require replication, the low risk of short or long-term side effects in fatty acids, their low cost and general benefits to health support the use of fish oil supplementation in the prevention of transition to psychosis.

### Supportive therapy

Supportive therapy is consistently used in UHR services and consists of basic assessment, psychoeducation and unstructured support provided in a warm, empathetic way (15). As young people meeting the UHR criteria typically have high levels of anxiety prior to presentation (16), this approach aims to reduce stress and enhance coping skills.



The provision of supportive counseling with psychoeducation and support with social and other role functioning is considered a central tenet in UHR client care (17).

### Management of other mental health concerns

It is important that treatment planning considers the range of co-occurring conditions and functional difficulties often seen within UHR groups. The treatment guidelines recommend that psychological and, where appropriate, pharmacological treatments for the young person's non-psychotic mental health concerns should be prioritised in the treatment of UHR clients. Any treatment should be consistent with the guidelines for that given condition (e.g., Clinical practice guidelines: Depression in adolescents and young adults (18)) and should precede any pharmacological treatment of attenuated psychotic symptoms, as they may be the origin of, or contributing to, these symptoms. This could include treatment for depression, anxiety, substance abuse, and other mental disorders.

### Treatment approach

The approach will depend on what is available within your service. Resources will differ according to whether or not your service has an enhanced early psychosis team. Regardless, provision of treatment for presenting problems such as depression, anxiety and substance use issues are part of guideline-concordant care. Additionally, the provision of cognitive behavioural therapy (as described in CBT subsection above) and

case management that involves appropriate psychoeducation regarding the presence of psychotic symptoms may also be possible within your service, with consideration of referral to specialist services when necessary.

### Ethical considerations about treatment

Given the importance of ensuring ethical and sensitive treatment of young people meeting the UHR criteria, it is important to engage in evidence-based practice and provide treatment in line with clinical practice guidelines. The majority of studies in the area to date have been conducted within dedicated UHR clinics and research programs. The UHR criteria have not been validated outside of specialised or dedicated psychosis services. Assessing the capacity of your own service, and linking in with related services where necessary, is essential when devising treatment plans.

### Summary

It is now possible to identify young people who are at increased risk of developing a psychotic disorder. Appropriate treatment options are available and there are a number of considerations when determining the right plan for each individual client. Focusing on the evidence and needs of the young person will ensure that the most positive outcome is achieved for their personalised care.

### Tips when working with a young person meeting the UHR criteria

- **Ask for the young person's understanding of, and be transparent about, psychosis risk.** Begin with a psychoeducational discussion about psychosis and the risk for developing a psychotic disorder, and clearly state what the prevalence rates are. Be clear about describing psychosis as occurring on a continuum; many people experience psychotic-like experiences such as hallucinations, especially during periods of increased stress or distress (19). Be confident and base your information on up-to-date evidence (see Evidence Summary: Identification of young people at high risk of developing psychosis).
- **Be realistic and optimistic.** Communicate to the young person that while most young people meeting the UHR criteria do not transition to psychosis, they are still at an increased risk compared to the general population. Explain that we know about what can help young people in their situation and reassure them that help is at hand.
- **Engage in shared decision making.** When it comes time to look at treatment options, engage the young person in shared decision making (20) to make sure that the treatment is chosen based on evidence and the client's individual needs and preferences (see Evidence Summary: Shared decision making for mental health). Explain what the guideline-concordant treatment options are, what the potential risks and benefits are of each option, and ask them to clarify their personal preferences and values about these outcomes. Be mindful that as one of the UHR criteria relates to family history of a psychotic disorder in a first-degree relative, young people may be quite familiar with the symptoms and treatment options around full-threshold psychosis due to family member's symptoms, including treatment with associated stigma and side effects. It may be necessary to explore any negative past experiences the young person may have witnessed with family members symptoms and treatment, and reassure that their treatment options can be more positive.
- **Frame clients' concerns in their own language.** For example, the term 'stress' may have quite different meanings to individual clients, including being related only to situations with high levels of arousal. Stress for young people meeting the UHR criteria might be more related to experiences of low arousal (eg. withdrawal, anhedonia). Framing distress in their own words (eg. feeling 'flat', 'not caring', 'feeling bored') will ensure that the stress-vulnerability model will be more meaningful to clients and caregivers.
- **Engage in ongoing assessment of symptoms.** It's important to make sure you check in with the young person about attenuated psychotic symptoms they have already disclosed and also to ask about any new ones. Treatment should then be tailored accordingly.

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