

services, based on evidence-based public policies and practices on a national level. International research groups, including scientists and service users from low- and middle-income countries, are the key to the collection and timely dissemination of data on the best models and practices, with the goal to provide the evidence for sustainable acute psychiatric care delivery.

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1. Johnson S, Dalton-Locke C, Baker J et al. *World Psychiatry* 2022;21:220-36.
2. Richter D, Bonsack C, Burr Furrer CM et al. *Swiss Arch Neurol Psychiatry Psychother* 2021;172:w03158.
3. Thome J, Deloyer J, Coogan AN et al. *World J Biol Psychiatry* 2021;22:516-25.
4. Bolsinger J, Jaeger M, Hoff P et al. *Front Psychiatry* 2020;10:965.
5. Schneeberger AR, Kowalinski E, Fröhlich D et al. *J Psychiatr Res* 2017;95:189-95.

6. Fasshauer JM, Bollmann A, Hohenstein S et al. *J Psychiatr Res* 2021;142:140-3.
7. Molewijk B, Kok A, Husum T et al. *BMC Medical Ethics* 2017;18:1-14.
8. Huber C, Sowislo J, Schneeberger A et al. *Swiss Arch Neurol Psychiatry Psychother* 2015;166:224-32.
9. Pinals DA, Fuller DA. *Psychiatr Serv* 2020;71:713-21.

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After the acute crisis – engaging people with psychosis in rehabilitation-oriented care

Johnson et al¹ make a forceful argument for the need to improve quality and access to acute psychiatric services. However, once the acute crisis abates, there are usually enduring symptoms and functional deficits associated with mental illness, notably for people living with psychotic disorders, such as schizophrenia. These individuals need access to rehabilitation-oriented services to prevent relapses and subsequent return to crisis services, and to help them achieve their personal recovery goals.

As Johnson et al note¹, there is evidence that early intervention for psychosis services (EIPS) are associated with reduced risk of relapse and re-hospitalization compared to treatment as usual². The rationale for EIPS is that most disability associated with psychotic disorders occurs during the first few years after an initial psychotic episode, and that much of this disability can be prevented or reduced with comprehensive care focusing on risk factors for functional deterioration. These include disruption of peer and family networks, unemployment, stigma, discrimination, demoralization and trauma².

The goal of EIPS is to provide integrated care so that the acute crisis of a first episode of psychosis is followed by a focus on recovery, tailored to the individual's needs². A range of psychological, psychosocial and pharmacological interventions is available to individuals within EIPS, although these

vary across different services. Frequently used interventions include well-monitored pharmacological treatment, family psychoeducation, individual cognitive behaviour therapy (CBT), social skills training and vocational education².

EIPS show improved rates of remission and clinician- or researcher-defined recovery compared to treatment as usual. However, there is now a vast movement away from clinical classification of “recovery” as absence or reduction in symptoms, improvement in functioning and/or reduction in mental health service use, with instead an emphasis on personalized recovery, as defined by the person with lived experience³.

While EIPS can improve outcomes for people in the early stages of psychotic illnesses, there are some individuals who have suboptimal response or fail to recover. Those at highest risk for poor outcomes are individuals with long duration of untreated psychotic symptoms prior to their first episode of psychosis, poor premorbid adjustment, high levels of negative symptoms at baseline, and poor cognitive functioning⁴. Further, while antipsychotics improve psychotic symptoms in most people, up to one in three people with schizophrenia will develop treatment resistant illness⁵. This is defined by ongoing psychotic symptoms and functional deficits following at least two adequate trials of first-line antipsychotic medications.

Many risk factors for poor outcome can be identified early in the course of a first episode of psychosis. There is therefore an opportunity to develop stratified pathways of care, in which those at highest risk for poor outcome are monitored closely and offered specialized treatments early. For example, those at high risk for persistent positive symptoms and functional decline could be offered early use of clozapine.

Clozapine is the most effective medication for reducing both positive symptoms of schizophrenia⁶ and psychiatric hospitalizations⁷. Despite its widely accepted superiority for treatment resistant schizophrenia, there is often a delay of many years between onset of treatment resistant symptoms and commencement of this medication. Improving early access to clozapine in both high-income and low- and middle-income countries is essential to reduce the need for acute psychiatric care among people living with treatment resistant schizophrenia. This would also increase the chance for many more people living with schizophrenia to enjoy a good quality of life.

Early and persistent negative symptoms are another risk factor for poor outcome in early psychosis. Their underlying aetiology is unknown, and there are no evidence-based treatments for them. Antipsychotics, antidepressants, stimulants – including methylphenidate, d-amphetamine and modafinil – and anticonvulsants have all been trialled, but meta-analyses

suggest that their effectiveness is poor. Further trials are needed for these disabling symptoms.

Over and above pharmacological interventions for people with enduring psychosis, there is a need for a whole person approach including rehabilitation-oriented psychosocial interventions to reduce the need for acute crisis services⁸. Evidence-based rehabilitation-oriented interventions include CBT for psychosis (CBTp) and social cognition training to assist in managing the distress associated with psychotic symptoms and improving psychosocial functioning.

A subset of people with early psychosis will have high levels of cognitive impairment at initial presentation. Routine screening and comprehensive assessment of cognitive ability early in illness course can help identify these people. Early provision of interventions such as cognitive remediation may improve cognitive functioning and has been shown to improve psychosocial functioning in early psychosis patients⁹.

Family based interventions, notably psychoeducation, have been shown to reduce rates of acute presentations and need for re-hospitalizations. Employment oriented interventions such as individual placement and support can assist in returning people living with psychosis to meaningful social roles through employment and education. Further research is needed to identify predictors of treatment response, so that these

interventions can be targeted to those most likely to respond.

Comorbid alcohol and substance misuse can negatively impact the mental health trajectory of people living with enduring psychosis, leading to an increased need for acute psychiatric care. Evidence-based interventions, including motivational enhancement and relapse prevention, should be delivered as part of an integrated mental health care package to reduce acute relapse⁸.

People living with psychosis have much higher rates of avertable physical health comorbidity, leading to a 20-year reduction in life span. This is driven by the higher rates of cardiometabolic illness, due in part to higher genetic risks, poor diet, increased sedentary behaviour, higher rates of smoking, and glucose dysregulating adverse drug reactions of second-generation antipsychotics. Early access to evidence-based physical health interventions to prevent obesity is crucial to reduce cardiometabolic illness burden, and acute physical health care needs. Multidisciplinary lifestyle interventions, including diet and exercise, have been repeatedly shown to be effective in reducing cardiometabolic comorbidity. Pharmacological interventions, notably metformin, can also modify weight gain as both primary prevention and secondary treatment. These interventions must commence in concert with early psychosis treatment.

There is an urgent need to improve qual-

ity and access to acute psychiatric services. However, these services – in both high-income and low- and middle-income countries – need to be backed up by rehabilitation-oriented services for people with psychosis. These early and enduring psychosis treatment services are crucial to break the cycle of reliance on acute crisis care for people living with psychosis, and to improve their quality of life.

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1. Johnson S, Dalton-Locke C, Baker J et al. *World Psychiatry* 2022;21:220-36.
2. Correll CU, Galling B, Pawar A et al. *JAMA Psychiatry* 2018;75:555-65.
3. Law H, Gee B, Dehmahdi N et al. *J Ment Health* 2020;29:464-72.
4. Santesteban-Echarri O, Paino M, Rice S et al. *Clin Psychol Rev* 2017;58:59-75.
5. Siskind D, Orr S, Sinha S, Yu O et al. *Br J Psychiatry* 2021:1-6.
6. Siskind D, McCartney L, Goldschlager R et al. *Br J Psychiatry* 2016;209:385-92.
7. Land R, Siskind D, Mcardle P et al. *Acta Psychiatr Scand* 2017;135:296-309.
8. Dixon LB, Dickerson F, Bellack AS et al. *Schizophr Bull* 2010;36:48-70.
9. Lee R, Redoblado-Hodge M, Naismith S et al. *Psychol Med* 2013;43:1161-73.

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