Emerging Psychosis and Dual Diagnosis

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Emerging Psychosis

- The term ‘psychosis’ covers a range of symptoms where a person’s beliefs, thoughts, feelings, perceptions or behaviors are affected. An episode of psychosis can be distressing and confusing for someone who doesn’t know what’s going on.
- Emerging psychosis is a complex presentation that warrants a considered approach right from the initial assessment. Research from epidemiological studies indicates that at least 75% of mental health disorders commence before 24 years of age with mental illness accounting for 50% of the total disease burden among young people aged 12 – 25 years in Australia.
- The ages between 15 and 24 years are a crucial time in the development of a young person across many domains. It is a time of biological changes including those affecting neurological development.

Emerging Psychosis

CRITERIA FOR IDENTIFICATION OF ULTRA HIGH RISK (UHR) OR AT-RISK MENTAL STATE

Young people between 15 and 25 years of age.

A change in subjective experience and behavior in recent months or within the past five years (which may fluctuate but is progressive)

Plus/Either

Subthreshold positive symptoms not severe or persistent enough to be regarded as evidence of sustained frank psychosis sufficient for a diagnosis of a psychotic disorder

or

history of brief self-limited psychotic symptoms (frank psychotic symptoms that resolve within seven days)

or

a genetic vulnerability, operationalized as either the presence of schizotypal disorder, or a first-degree relative with a history of any psychotic disorder

Plus

functional decline to caseness (< 30% drop at any time in the previous 12 months in scores on the Social and Occupational Functioning Assessment Scale (SOFAS)

or

longstanding poor functioning SOFAS < 50 for previous 12 months)

Dual Diagnosis

Dual diagnosis refers to one or more diagnosed mental health problems occurring at the same time as problematic drug and alcohol use. A dual diagnosis condition can include:

- a mental health problem or disorder leading to or associated with problematic alcohol and/or other drug use
- a substance use disorder leading to or associated with a mental health problem or disorder
- alcohol and/or other drug use worsening or altering the course of a person's mental illness.

Dual Diagnosis

Young people with dual diagnosis are particularly at risk of experiencing poor clinical outcomes. The age, stage of physical, neurological, psychological and social development makes young people more vulnerable.

Research shows that compared with people with a single disorder (a mental illness or a substance use disorder), people with dual diagnosis have higher rates of:

- Severe illness course and relapse
- Violence, suicidal behaviour and suicide
- Infections and physical health problems
- Social isolation and family/carer distress
- Poor service use
- Anti-social behaviour and incarceration
- Homelessness

Diagnostic Hierarchy Model

1. Organic
2. **Substance use disorders**
3. Psychotic spectrum disorders
4. Affective spectrum
5. Anxiety, trauma, eating disorder and OCD
6. Personality factors

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Dual Diagnosis Hypothesis

Drug and alcohol act as biological predisposing factor to psychiatric illness.

- Biological predisposition hypothesis
- Affect regulation hypothesis
- Self medication hypothesis
- Peer facilitation or social facilitation hypothesis

Substance Use Disorder

Substance use disorder (SUD) is a psychiatric condition characterized by a hazardous use of a legal or illegal drug or medication and an inability to reduce the frequency of consumption. The essential feature of SUD is a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant problem (DSM-5, 2013).

Substance misuse is common in FEP. Individuals with FEP have significantly higher levels of substance misuse than non-psychotic peers, with most studies in Australia suggesting 60–70% of people with FEP report substance misuse at some stage in their life prior to presentation. Cannabis and alcohol are the most frequently misused substances with use of opioids, cocaine, inhalants, and sedatives being relatively rare (Orygen, 2016).

An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with sever disorders. The behavior effects of these brain change may be exhibited in the repeated relapse and intense drug craving when the individuals are exposed to drug–related stimuli (DSM-5, 2013).

Substance Use Disorder

DSM-5 acknowledges ADHD and ASD as two prominent neurodevelopmental disorders. High rates of SUD have been found in ADHD and high comorbidity of ASD with ADHD generate a substantial susceptibility for SUD in many individuals.

"I was friendless through high school, but when I started meeting people who smoked cannabis I found it much easier to make friends with them." ADHD FEP – EPS Consumer

"When I was drunk . I was so much more relaxed and more sociable. I could have conversations with people. I can walk up to people and introduce myself." ASD, GAD, FEP – EPS Consumer

Outcome of Substance Use disorder in FEP – ORYGEN STUDY

62% with SUD at start of 18 months treatment → 36% at completion

Reduced or cessation of use → better outcomes

Persistent use → non compliance, treatment drop-out & poor remission

Possible relationships between substance use and outcomes

Persistent SUD → Biological, psychological changes preventing FEP remission

Improvement in FEP symptoms → Reduce or stop substance use

Emerging Psychosis - Treatment Goals

- Early identification and treatment of the primary symptoms of psychotic illness
- Improve access and reduce delays in initial treatment
- Educate the young person and family about the illness
- Reduce the frequency and severity of relapse
- Reduce the risk of other health-related problems developing
- Reduce disruption to social and vocational functioning
- Promote wellbeing among family members and carers
- Support the young person during their recovery
- Develop a plan for maintaining mental health

FEP - Interventions

Principles of pharmacotherapy in FEP

Principle 1. Take side effect profiles into consideration
Principle 2. Prevent and treat psychiatric emergencies
Principle 3. Distinguish between affective and non-affective psychosis
Principle 4. 'Start low, go slow'
Principle 5. Avoid antipsychotic polypharmacy
Principle 6. Monitor adherence and address non-adherence
Principle 7. Monitor and manage adverse events and side effects
Principle 8. Treat comorbidities
Principle 9. Identify failure to respond but provide a sufficient period for treatment response and remission
Principle 10. Use special care when prescribing for specific populations

Key features and components of FEP treatment across all phases

- Engagement
- Physical health
- Sexual health
- Case management
- Functional recovery
- Trauma
- Integrated treatment
- Least restrictive treatment
- Family involvement
- Goals as guides to treatment
- Group programs
- Psychoeducation
- Suicide prevention
- Substance use
- Treatment of psychiatric comorbidity
- Miscellaneous psychological therapies
- Youth participation and peer support
- Family participation and family peer support

Supportive interventions for co-occurring substance use

Young people with dual diagnosis are particularly at risk of experiencing poor clinical outcomes. The age, stage of physical, neurological, psychological and social development makes young people more vulnerable.

- Screening for AOD problems should use measures validated for use with young people.
- A young person's culture, diversity, language and background should be considered when conducting screening, assessment and treatment planning.
- In addition to collecting information related to diagnostic criteria and severity of the problem, assessment should involve evaluating the young persons 'readiness for change', especially given that some young people may view their AOD use as a solution rather than a problem.
- The widely used 'harm reduction' approach is recommended. This approach is frequently used because a goal of abstinence may not be realistic or achievable for many young people.
- Being mindful that young people may not readily disclose and may have fears about parents or police being notified of their substance use. Being transparent about confidentiality requirements of the organization and regulatory body from the outset of the assessment.
- If a young person's AOD problem is severe, or you believe treating the AOD problem is beyond your clinical expertise, enlist the support of a specialized AOD worker/service i.e., specific psychosocial approaches MI, AA, modified CBT, rehab support and SUD pharmacotherapies.

Screening and Assessment Tools

- Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide. niaaa.nih. gov/alcohols-effects-health/professionaleducation-materials/alcohol-screening-andbrief-intervention-youth-practitioners-guide
- AUDIT: Alcohol Use Disorders Identification Test. auditscreen.org/translations/
- Get the CRAFFT. crafft.org/get-the-crafft/
- headspace Psychosocial Assessment for Young People. headspace.org.au/assets/Uploads/ headspace-psychosocial-assessment.pdf
- Screening & Assessment. werryworkforce.org/ cep/screening#Screening
- Screening to Brief Intervention (S2BI). drugabuse.gov/ast/s2bi/#/
- Management of substance abuse: The ASSIST screening test version 3.0 and feedback card. who.int/substance_abuse/activities/assist_v3_ english.pdf
- GAIN Instruments. gaincc.org/instruments/

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THANK YOU

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