The Australian Clinical Guidelines for Early Psychosis

2nd Edition EVIDENCE MAP QUICK REFERENCE

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Stage	Evidence-Based Recommendations	Evidence-Based Pharmacological Interventions	Evidence-Based Psychosocial Interventions	Expert Consensus Recommendations	Setting
Stage 1: Ultra High Risk for Psychosis	Commence with CBT alone; Antipsychotic medication should not be used until full threshold psychotic symptoms have been sustained for a week or more, or there is rapid deterioration accompanied by psychotic-like symptoms. In this case add a low dose atypical antipsychotic. Regularly monitor metabolic indices; Other syndrome-specific medications where indicated	Risperidone 1-3mg (+ CBT) (II)[1]	CBT alone (II)[2,3] or combined with compliant use of Risperidone (II)[1]	Family & Individual Psychoeducation	Specialised screening and treatment services
		Olanzapine 5-15mg for 8 weeks (II)[4]		Family Support	Community/low stigma setting
		Amisulpride 50-800mg (II)[5]		Vocational/Educational Support	
				Behavioural weight management	
				Accommodation Support	
Stage 2: First Episode of Psychotic Disorder	Integrated treatment (II)[6-8], which consists of a comprehensive package of: • assertive case management • appropriate trials of atypical antipsychotic medication(s)-regularly monitor metabolic indices • clozapine for high risk of suicidality • other syndrome-specific medications where indicated • multi-pronged psychosocial package of vocational, behavioural weight management, psychoeducation, CBT, social skills training and family work	An appropriate trial (up to 6 weeks) of an atypical antipsychotic (II)[9] (III-1)[10]	CBT alone (II)[11,12]	Provision of integrated treatment for a minimum of 3 years	Specialised early psychosis treatment services
		If high suicidality is present an early trial of clozapine may be warranted (II)[15]	Vocational Intervention (II)[13]	Continual risk assessments	Community/low stigma setting
			Behavioural weight management (I)[14]		Minimise in-patient hospitalisations. Use of specialist youth oriented ward
			Multi-Family Groups (II)[16]		
			Compliance Treatment (II)[17]		
Stage 3a: Relapse Prevention	Assertive maintenance treatment - regularly monitor metabolic indices	Maintain antipsychotic treatment (II)[18] and monitor compliance	Multi-Modal Individual and Family CBT (II)[19]	Consider long-acting atypical antipsychotics, where compliance is problematic	Specialised early psychosis treatment services
			Behavioural weight management (II)[14]	Continual risk assessments	Minimise in-patient hospitalisations. Use of specialist youth oriented ward
Stage 3b: Treatment Resistance	Clozapine in conjunction with CBT (regularly monitor metabolic indices)	Clozapine (I)[20]	CBT (II)[21]	Ongoing assertive case management	Specialised early psychosis treatment services
		Clozapine indicated for high suicidality (II)[15]		Provision of accommodation support	Minimise in-patient hospitalisations. Use of specialist youth oriented ward
				Continual risk assessments	

Stage 4: Severe, Unremitting, Chronic Psychotic Disorder

Refer to the Australian Clinical Practice Guidelines for the Treatment of Schizophrenia[22]

This information was produced by the Centre of Excellence in Youth Mental Health in conjunction with Orygen Youth Health Research Centre - www.oyh.org.au

NHMRC LEVEL BASIS OF EVIDENCE

I Evidence obtained from a systematic review of all relevant randomised controlled trials
II Evidence obtained from at least one properly designed randomised controlled trial
III - 1 Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III - 2 Evidence obtained from comparative studies (including systematic reviews of such studies) with concurrent controls and allocation not randomised, cohort studies, case-control studies, or interrupted time series with a control group
III - 3 Evidence obtained from comparative studies with historical control, two or more single arm studies, or interrupted time series without a parallel group
IV Evidence obtained from case series, either post-test or pretest/post-test

REFERENCES

1. McGorry P, Yung AR, Phillips LJ, Yuen HP, Francey S, Cosgrave EM, et al. Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. Archives of General Psychiatry. 2002;59:921-8.
2. Morrison AP, French P, Parker S, Roberts M, Stevens H, Bentall RP, et al. Three-year follow-up of a randomized controlled trial of cognitive therapy for the prevention of psychosis in people at ultrahigh risk. Schizophrenia Bulletin. 2007;33:682-7.
3. Morrison AP, French P, Walford L, Lewis SW, Kilcommons A, Green J, et al. Cognitive therapy for the prevention of psychosis in people at ultra-high risk: Randomised controlled trial. British Journal of Psychiatry. 2004;185:291-7.
4. Woods SW, Breier A, Zipursky RB, Perkins D, Addington J, Miller TJ, et al. Randomised trial of olanzapine versus placebo in the symptomatic acute treatment of the schizophrenic syndrome. Biological Psychiatry. 2003;54:453-64.
5. Ruhrmann S, Bechdolf A, Kuhn KU, Wagner M, Schultze-Lutter F, Janssen B, et al. Acute effects of treatment for prodromal symptoms for people putatively in a late initial prodromal state of psychosis. British Journal of Psychiatry. 2007;51:s88-95.
6. Craig TK, Garety P, Power P, Rahaman N, Colbert S, Fornells Ambrojo M, et al. The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. British Medical Journal. 2004;329(7474):1067.
7. Garety P, Craig TK, Dunn G, Fornells Ambrojo M, Colbert S, Rahaman N, et al. Specialised care for early psychosis: symptoms, social functioning and patient satisfaction. British Journal of Psychiatry. 2006;188:37-45.
8. Petersen L, Jeppesen P, Thorup A, Abel M-B, Ohlenschlaeger J, Christensen TO, et al. A randomised multicentre trial integrated versus standard treatment for patients with a first episode of psychotic illness. British Medical Journal. 2005;331:602-9.
9. McEvoy JP, Lieberman JA, Perkins DO, Hamer RM, Gu H, Lazarus A et al. Efficacy and tolerability of olanzapine, quetiapine, and risperidone in the treatment of early psychosis: a randomized, double-blind 52-week comparison. American Journal of Psychiatry. 2007;164:1050-60.
10. Kahn RS, Fleischhacker WW, Boter H, Davidson M, Vergouwe Y, Keet IP et al. Effectiveness of antipsychotic drugs in first-episode schizophrenia and schizophreniform disorder: an open randomised clinical trial. Lancet. 2008;371(9618):1085-97.
11. Lewis SN, Tarrier N, Haddock G, Bentall R, Kinderman P, Kingdon D, et al. Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: Acute-phase outcomes. British Journal of Psychiatry Special Issue: The European First-Episode Schizophrenia Network. 2002 Sep;181(Suppl43):s91-s7.
12. Tarrier N, Lewis S, Haddock G, Bentall R, Drake R, Kinderman P, et al. Cognitive-behavioural therapy in first-episode and early schizophrenia. 18-month follow-up of a randomised controlled trial. British Journal of Psychiatry. 2004;184:231-9.
13. Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. British Journal of Psychiatry. 2008; 193:114-20.
14. Alvarez-Jimenez, M, Hetrick, SE, Gonzalez-Blanch, C, Gleeson, JF, McGorry, PD. Non-pharmacological management of anti psychotic-induced weight gain: systematic review and meta-analysis of randomised controlled trials. British Journal of Psychiatry. 2008;193:101-107
15. Meltzer HY, Alphs L, Green AI, Altamura AC, Anand R, Bertoldi A, et al. Clozapine treatment for suicidality in schizophrenia - International Suicide Prevention Trial (InterSePT). Archives of General Psychiatry. 2003; 60:82-91
16. McFarlane WR, Lukens E, Link B et al. Multiple-family groups and psychoeducation in the treatment of schizophrenia. Archives of General Psychiatry. 1995; 52:679–687.
17. Kemp R, Kirov G, Everitt B, Hayward P, David A. Randomised controlled trial of compliance therapy: 18-month follow-up. British Journal of Psychiatry. 1998; 172:413–419.
18. Leucht, S., Barnes, T. R. E., Kissling, W., Engel, R. R., Correll, C., & Kane, J. M. (2003). Relapse prevention in schizophrenia with new-generation antipsychotics: A systematic review and exploratory meta-analysis of randomized, controlled trials. American Journal of Psychiatry. 160, 1209-1222.
19. Gleeson J. F. M., Cotton S., Alvarez-Jimenez M., Wade D., Gee, D., Crisp. K, Newman B., Spiliotacopoulous D., & McGorry P. D. (in press). A randomized controlled trial of CBT for relapse prevention for remitted first-episode psychosis patients. Journal of Clinical Psychiatry. (accepted July 1, 2008).
20. Wahlbeck K, Cheine MV, Essali A. Clozapine versus typical neuroleptic medication for schizophrenia. Cochrane Database of Systematic Reviews. 1999, Issue 3. Art. No.: CD000059. DOI: 10.1002/14651858.CD000059
21. Valmaggia LR., Van Der Gaag M., Tarrier N., Pijnenborg M. & Sloof CJ. (2005). Cognitive-behavioural therapy for refractory psychotic symptoms of schizophrenia resistant to atypical antipsychotic medication: Randomised controlled trial. British Journal of Psychiatry. 186(4); 324-330.
22. Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders: Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. Australian and New Zealand Journal of Psychiatry. 2005; 39:1-30

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