



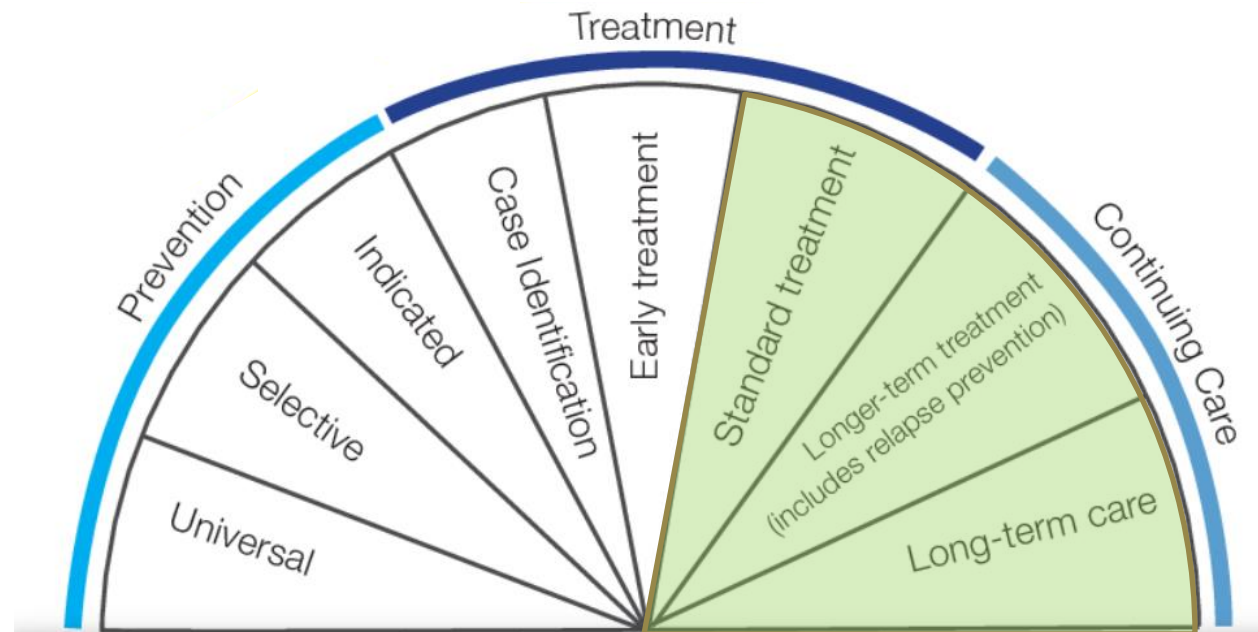
TROUBLES PSYCHIQUES: AGIR TÔT C'EST SOIGNER MIEUX

*Exemple de l'intervention précoce dans les
troubles psychotiques*

Prof Philippe Conus

L'INTERVENTION EN MATIÈRE DE SANTÉ MENTALE

Dans le passé...



Prendre soin de la chronicité
Bonne volonté et bienveillance

MAIS

Approche pessimiste
Stigmatisation élevée
Faible responsabilisation des patients
Mauvais résultat...

Figure 1: Mrazek & Haggerty's model of the spectrum of interventions for mental health problems and mental disorders50

L'INTERVENTION EN MATIÈRE DE SANTÉ MENTALE 1990 : un besoin de changement !

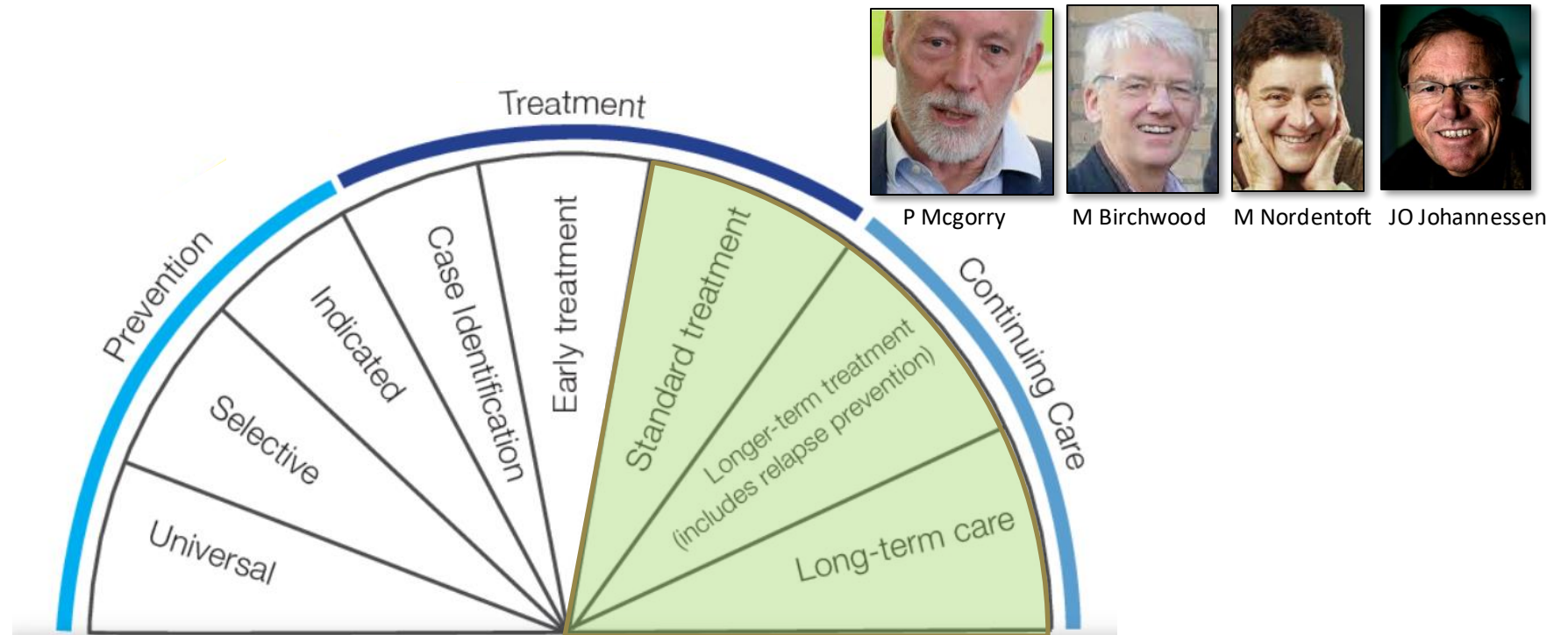
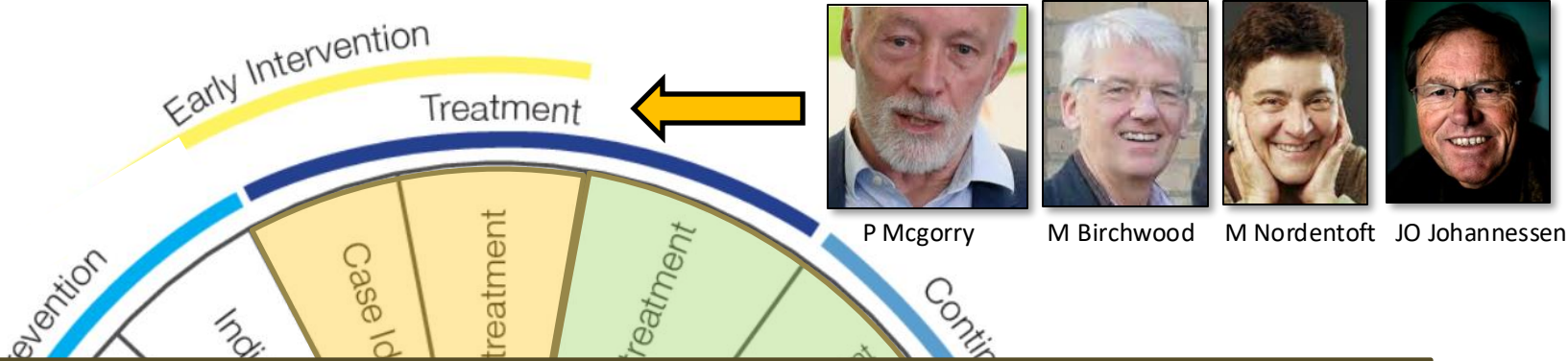


Figure 1: Mrazek & Haggerty's model of the spectrum of interventions for mental health problems and mental disorders50

L'INTERVENTION PRÉCOCE EN MATIÈRE DE SANTÉ MENTALE



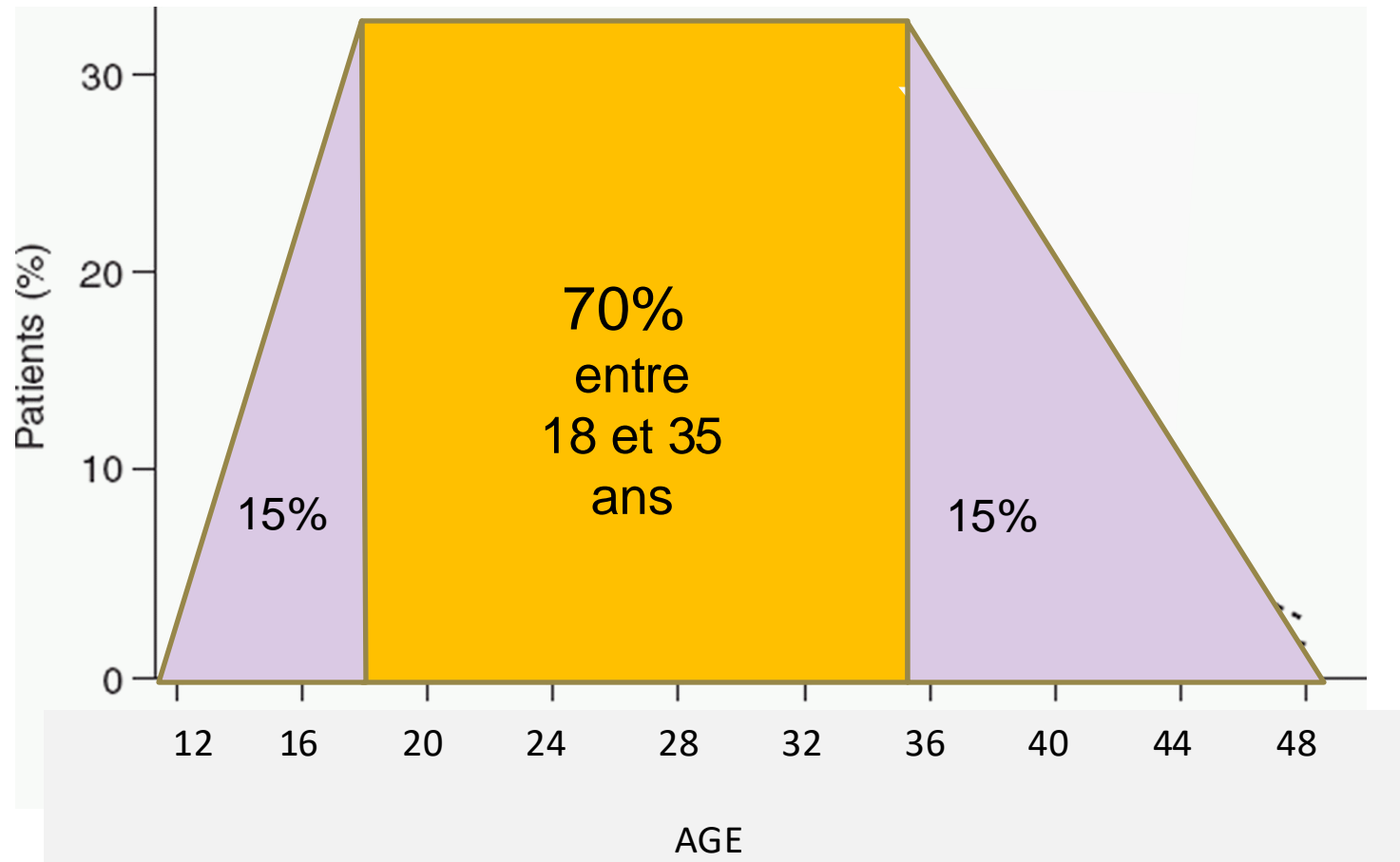
L'exemple de l'intervention précoce pour la psychose

Figure 1: Mrazek & Haggerty's model of the spectrum of interventions for mental health problems and mental disorders50

Définition de la psychose

- Perte de contact avec la réalité
 - Survenue de troubles de la pensée, émotionnels, perceptifs, et/ou du comportement liés à une perte de contact avec la réalité
- Définition CIM 10 de la psychose :
 - Terme descriptif sans référence théorique à des mécanismes psychopathologiques, utilisé simplement pour indiquer la présence
 - *d'hallucinations,*
 - *d'idées délirantes,*
 - *de désorganisation de la pensée ou*
 - *de comportements manifestement anormaux*
- Les symptômes psychotiques peuvent s'observer dans le contexte de diverses catégories diagnostiques (schizophrénie, trouble bipolaire, trouble schizo-affectif...): leur seule présence ne permet pas de poser un diagnostic précis
- *La psychose est donc une dimension symptomatique commune à divers troubles, et pas un diagnostic en soi (comme la fièvre par exemple...)*

A quel âge émergent les psychoses?

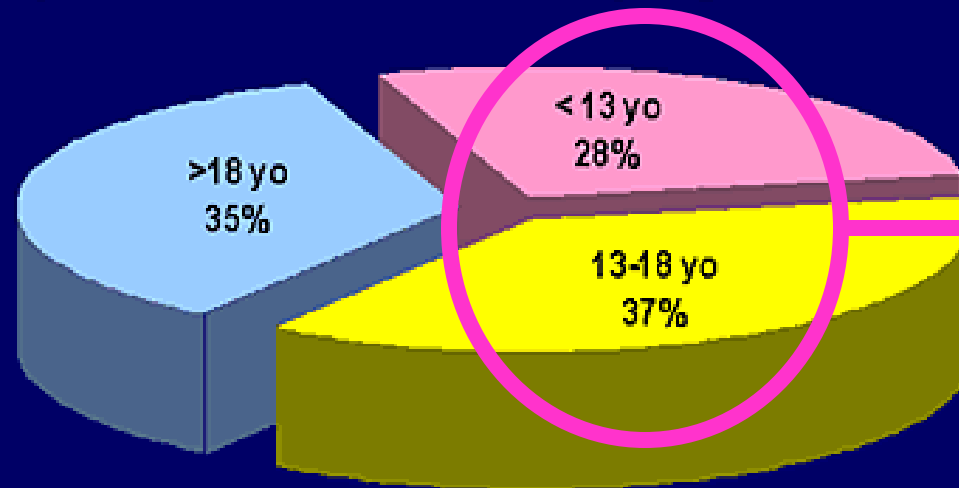


Dans la grande majorité des cas, les psychoses émergent à la fin de l'adolescence ou au début de l'âge adulte

A quel âge émergent les troubles bipolaires?

Onset Age in BD

- Retrospectively determined from 983 patients in the STEP-BD program



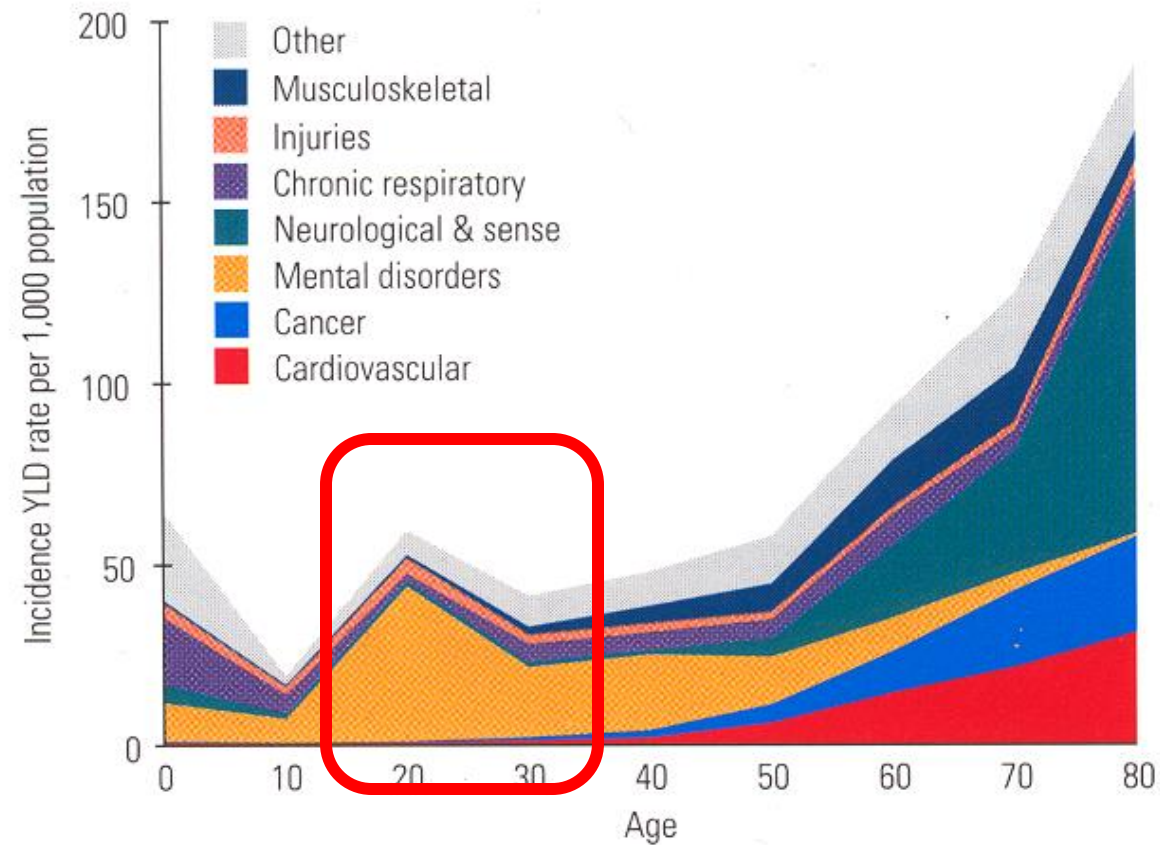
Dans 65% des cas, le trouble bipolaire émerge avant l'âge de 18 ans

A quel âge émergent la majorité
des troubles psychiatriques?



Des pathologies à fort impact fonctionnel En particulier chez les jeunes!

Figure 6 Incident YLD Rates per 1,000 Population by Age and Broad Disease Grouping, Victoria 1996



Des pathologies à fort impact fonctionnel
En particulier chez les jeunes

75% des problèmes d'invalidité des jeunes sont liés
à des problèmes psychiatriques

ADOLESCENCE: PLUSIEURS DEFIS

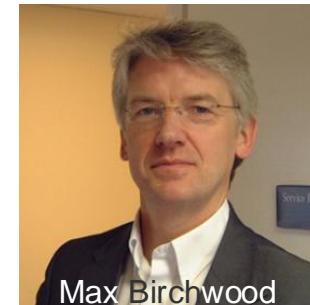
- Définition de son **identité**
- **Emancipation** du milieu familial
- Finalisation son **éducation**
- **Choix** de trajectoire
- Construction d'un **réseau social**
- Expériences de **relation intime**



- **L'émergence d'une psychose ou d'un trouble de santé mentale dans un tel contexte fait dérailler la résolution de plusieurs de ces défis**

POURQUOI L'INTERVENTION PRECOCE DANS LES TROUBLES PSYCHOTIQUES?

- « La grande majorité des patients souffrant de psychose accèdent au traitement beaucoup trop tard » *HS Sullivan, 1947*
- Trois observations en étudiant ces patients:
 - ***Effet négatif d'un long délai entre apparition des symptômes et début du traitement (Durée de Psychose non Traitée; Duration of Untreated Psychosis; DUP)***
 - ***Période critique de 2 à 5 ans après laquelle l'amélioration est très difficile***
 - ***Les stades précoces de la maladie nécessitent un traitement spécifique***



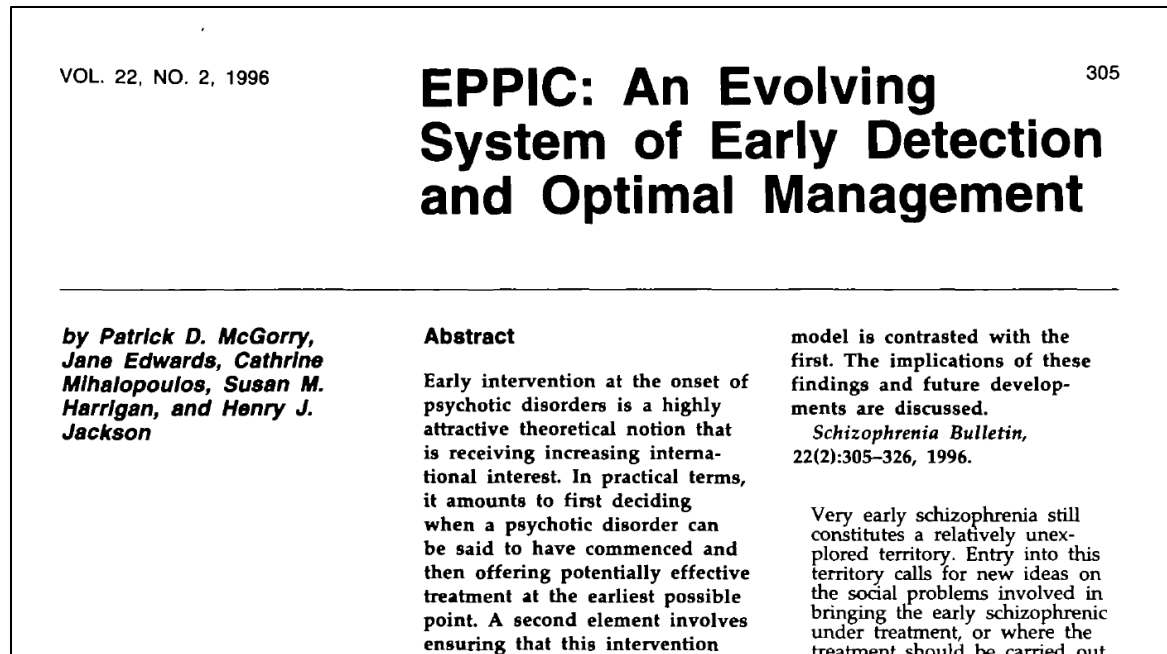
IMPACT D'UNE LONGUE Durée de Psychose Non Traitée

- *Suicide (15% tentative avant traitement)*
- *Moins bonne réponse au traitement médicamenteux*
- *Mauvaise évolution fonctionnelle*
- *Développement de comorbidités*
- *Impact socio-économique*

- *Détresse des parents, frères et sœurs et des proches*

1990: Changer l'approche des troubles psychotiques

- Ne pas attendre la chronicité pour soigner
- Détecter les patients plus rapidement
- Proposer des soins spécifiques et efficaces
- Avoir une approche ambitieuse et optimiste



P McGorry

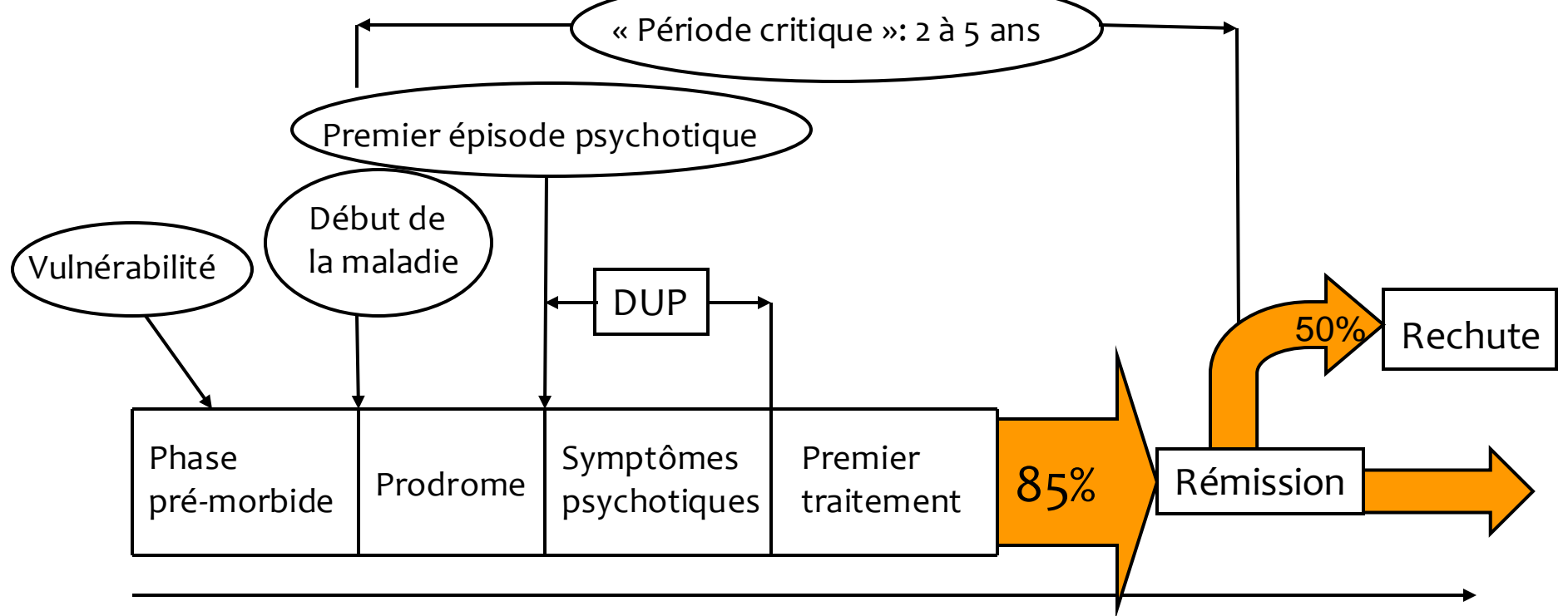


J Edwards

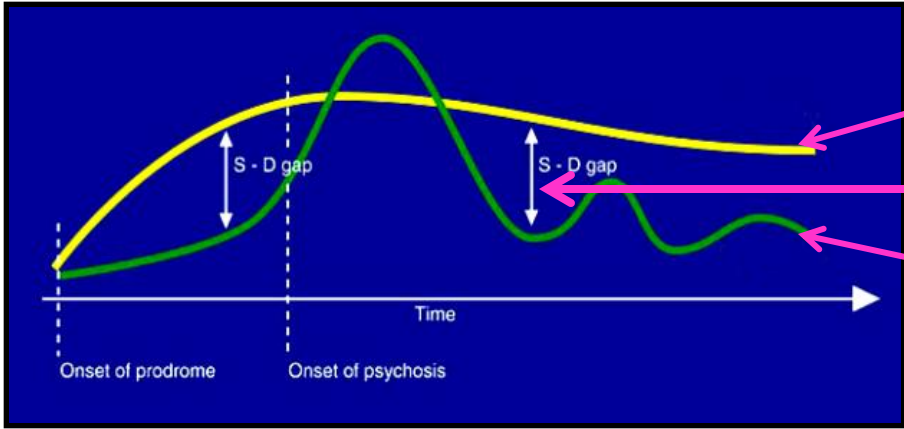


H Jackson

PHASES SUCCESSIVES D'UN TROUBLE PSYCHOTIQUE



Temps

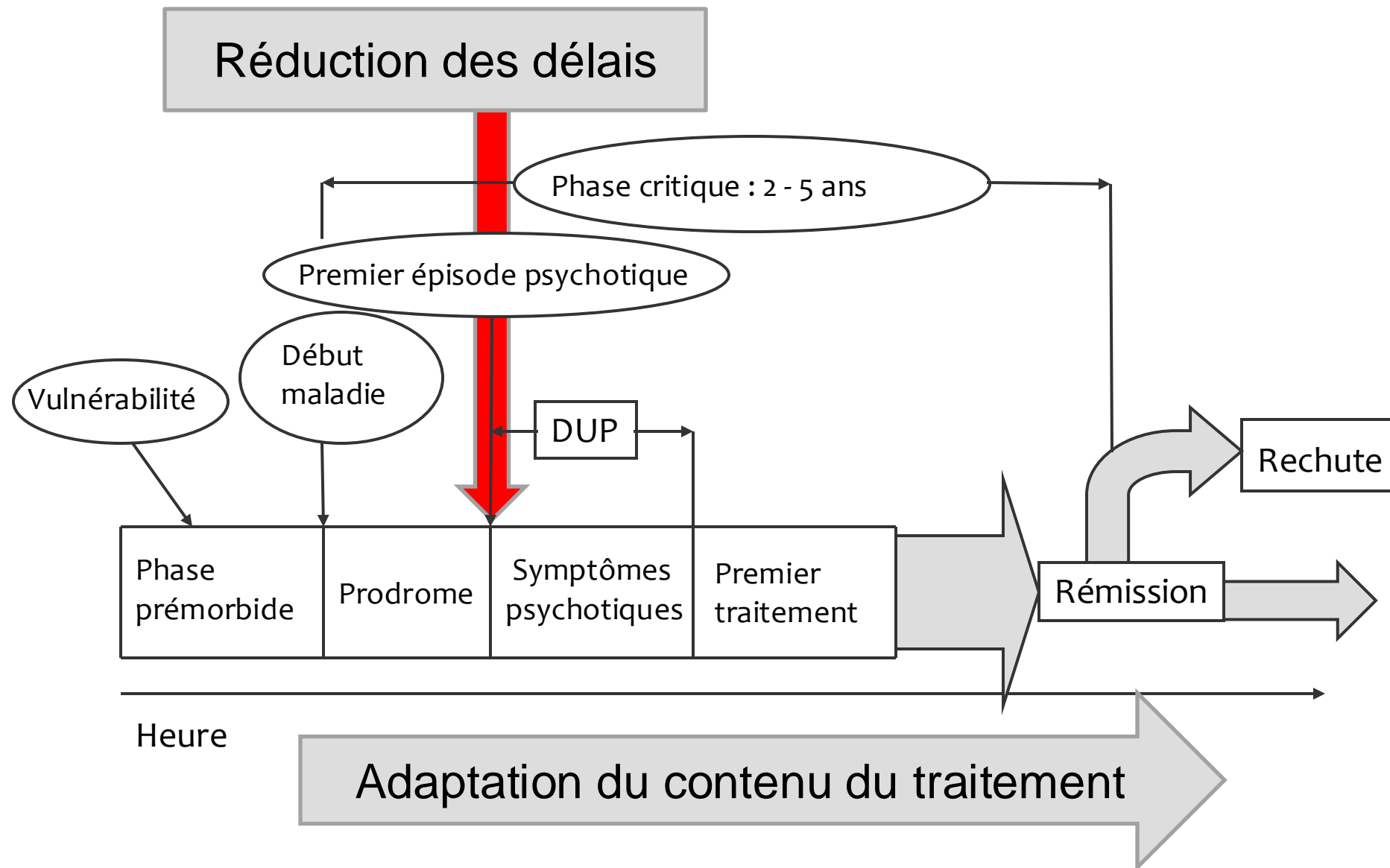


Handicap fonctionnel (troubles cognitifs)

« Symptom-disability gap »

Symptômes

Cibles et stratégies d'intervention précoce dans la psychose :



Deux réactions fréquentes après un premier épisode psychotique



Le déni



Le désengagement

Deux réactions fréquentes après un premier épisode psychotique



Le désengagement

Un défi: rendre les soins accessibles



Services standard: quel engagement des patients?

MÉMOIRE ORIGINAL

Insertion dans les soins après une première hospitalisation dans un secteur pour psychose

C. BONSACK⁽¹⁾, T. PFISTER, P. CONUS

L'Encéphale, 2006 ; 32 : 679-85

Linkage to care after first hospitalisation for psychosis

Summary. Background. First hospitalisation for a psychotic episode causes intense distress to patients and families, but offers an opportunity to make a diagnosis and start treatment. However, linkage to outpatient psychiatric care remains a notoriously difficult step for young psychotic patients, who frequently interrupt treatment after hospitalisation. Persistence of symptoms, and untreated psychosis may therefore remain a problem despite hospitalisation and proper diagnosis. With persisting psychotic symptoms, numerous complications may arise: breakdown in relationships, loss of family and social support, loss of employment or study interruption, denial of disease, depression, suicide, substance abuse and violence. Understanding mechanisms that might promote linkage to outpatient psychiatric care is therefore a critical issue, especially in early intervention in psychotic disorders. **Objective.** To study which factors hinder or promote linkage of young psychotic patients to outpatient psychiatric care after a first hospitalisation, in the absence of a vertically integrated program for early psychosis. **Method.** File audit study of all patients aged 18 to 30 who were admitted for the first time to the psychiatric University Hospital of Lausanne in the year 2000. For statistical analysis, χ^2 tests were used for categorical variables and t-test for dimensional variables; $p < 0.05$ was considered as statistically significant. **Results.** 230 patients aged 18 to 30 were admitted to the Lausanne University psychiatric hospital for the first time during the year 2000, 52 of them with a diagnosis of psychosis (23%). Patients with psychosis were mostly male (83%) when compared with non-psychosis patients (48%). Furthermore, they had (1) 10 days longer mean duration of stay (24 vs 14 days), (2) a higher rate of compulsory admissions (53% vs 22%) and (3) were more often hospitalised by a psychiatrist rather than by a general practitioner (83% vs 53%). Other socio-demographic and clinical features at admission were similar in the two groups. Among the 52 psychotic patients, 10 did not stay in the catchment area for subsequent treatment. Among the 42 psychotic patients who remained in the catchment area after discharge, 20 (48%) did not attend the scheduled or rescheduled outpatient appointment. None of the socio-demographic characteristics were associated with attendance to outpatient appointments. On the other hand, voluntary admission and suicidal ideation before admission were significantly related to attending the initial appointment. Moreover, some elements of treatment seemed to be associated with higher likelihood to attend outpatient treatment: (1) provision of information to the patient regarding diagnosis, (2) discussion about the treatment plan between in- and outpatient staff, (3) involvement of outpatient team during hospitalisation, and (4) elaboration of concrete strategies to face basic needs, organise daily activities or education and reach for help in case of need. **Conclusion.** As in other studies, half of the patients admitted for a first psychotic episode failed to link to outpatient psychiatric care. Our study suggests that treatment rather than patient's characteristics play a critical role in this phenomenon. Development of a partnership and involvement of patients in the decision process, provision of good information regarding the illness, clear definition of the treatment plan, development of concrete strategies to cope with the illness and its potential complications, and involvement of the outpatient treating team already during hospitalisation, all came out as critical strategies to facilitate adherence to outpatient care. While the current rate of disengagement after admission is highly concerning, our findings are encouraging since they constitute strategies that can easily be implemented. An open approach to psychosis, the development of partnership with patients and a better coordination between inpatient



Sujets: 50 premières hospitalisations pour un trouble psychotique en 2000

Caractéristiques à l'entrée:

- Longue DUP (2 ans)
- 50% comorbidités
- 15% tentative suicide
- 40% rupture avec la famille
- 50% ni études ni emploi

- **Moins de 50% des patients se rendent au premier rendez-vous ambulatoire après une première hospitalisation**
- **Sans organisation spécialisée, l'engagement dans les soins est mauvais**
- **Il en découle des rechutes, un retard de traitement et une évolution vers la chronicité**



Comment favoriser l'engagement des patients?

- 1. Organiser des soins accessibles**
- 2. Favoriser l'engagement dans les soins par le biais d'approches cliniques adaptées et de soins dans le milieu de vie**
- 3. Identifier les patients les plus à risque de désengagement**

1. ORGANISER DES SOINS ACCESSIBLES

P P « Case manager clinique »

- Infirmier, assistant social, psychologue
- Fil rouge de la prise en charge pendant 3 ans
- Prise de contact très précoce (en cours d'hospitalisation, à domicile, chez le médecin installé)
- Nombre limité de patients (~35)
- Peut se déplacer à domicile ou dans le milieu (2x/sem)
- Fait équipe avec le médecin psychiatre
- **Rôle et missions:**
 - Engagement des patients / partenariat
 - Continuité des soins
 - Information des patients et de leurs proches
 - Rôle psychothérapeutique

Famille
Généraliste
Psychiatre
Institut
DP-CHU

TRAITEMENT
Institution
Psy privé
Généraliste
Séjour nécessaire

1. ORGANISER DES SOINS ACCESSIBLES

Programme TIPP: Traitement et Intervention dans la phase Précoce des troubles Psychotiques

**Familles
Généralistes
Psychiatres
Institutions ps
DP-CHUV**

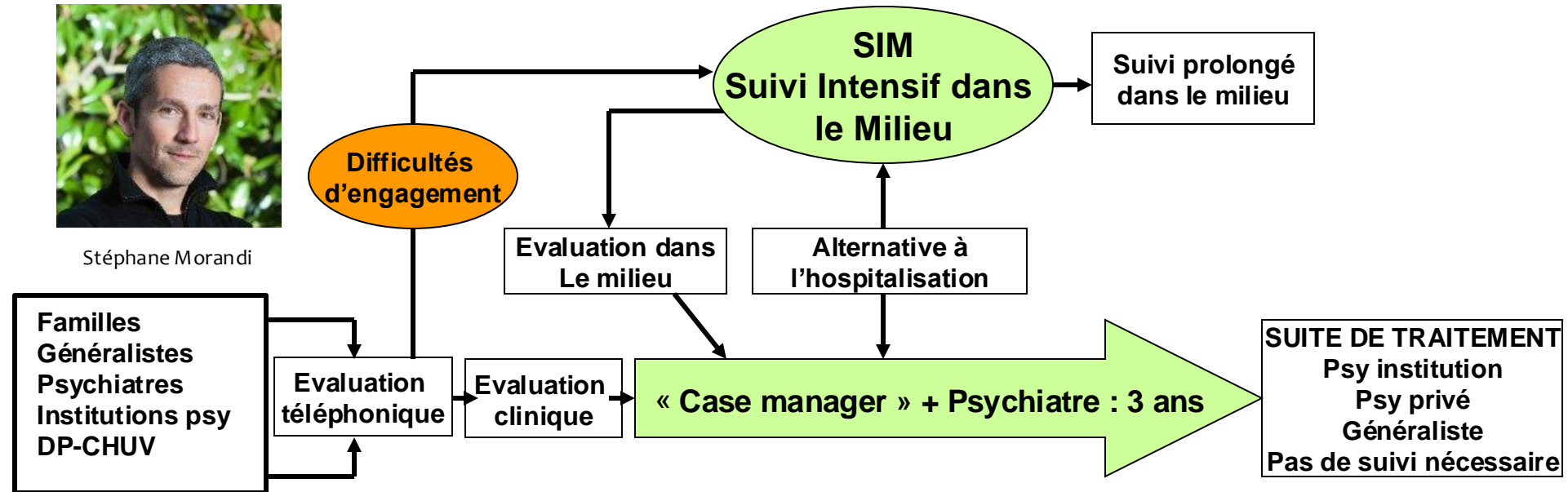


Luis Alameda

**SUITE DE TRAITEMENT
Psy institution
Psy privé
Généraliste
Pas de suivi nécessaire**

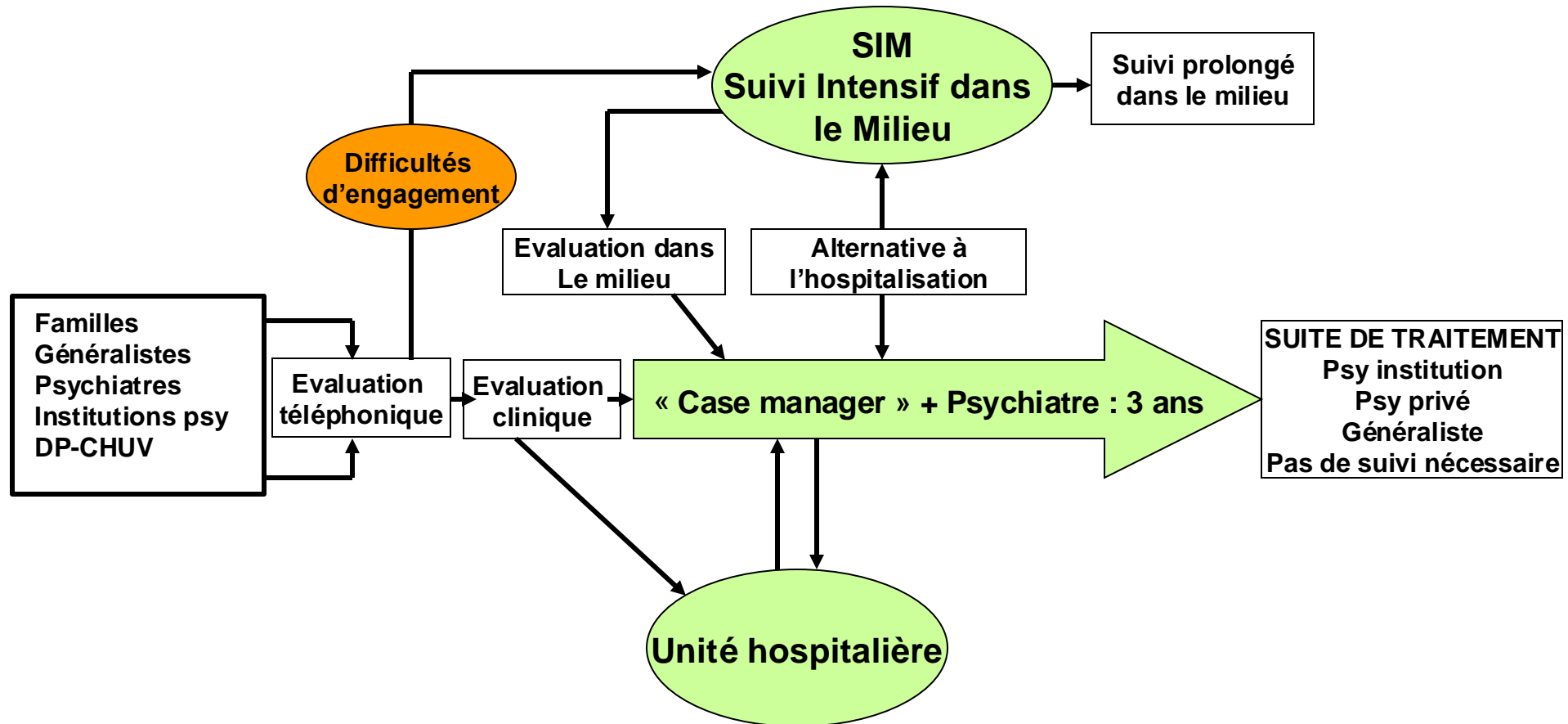
1. ORGANISER DES SOINS ACCESSIBLES

Programme TIPP: Traitement et Intervention dans la phase Précoce des troubles Psychotiques



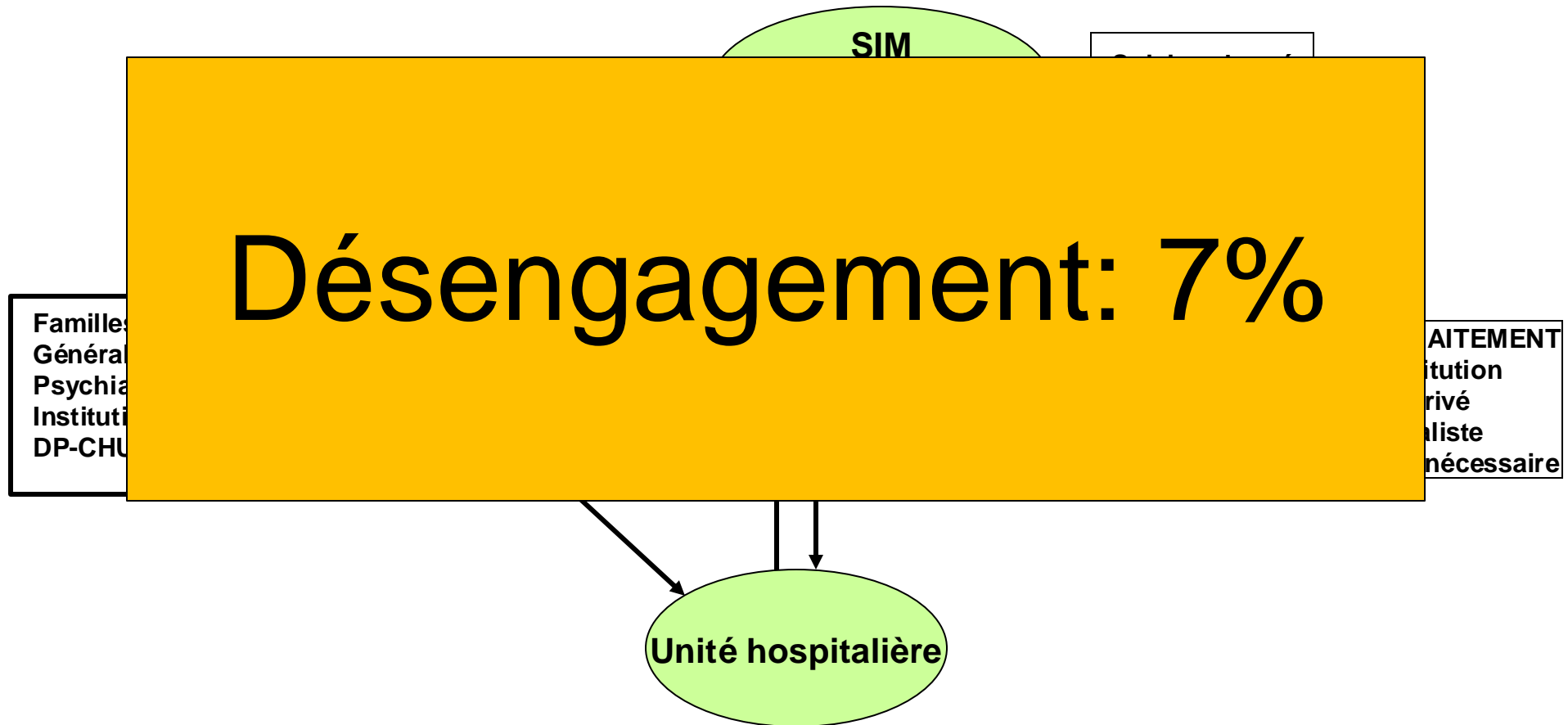
1. ORGANISER DES SOINS ACCESSIBLES

Programme TIPP: Traitement et Intervention dans la phase Précoce des troubles Psychotiques



1. ORGANISER DES SOINS ACCESSIBLES

Programme TIPP: Traitement et Intervention dans la phase Précoce des troubles Psychotiques



1. ORGANISER DES SOINS ACCESSIBLES

- Critères d'inclusion
 - *18 – 35 ans*
 - *Trouble psychotique*
 - *Moins de 6 mois de traitement pour le trouble psychotique (exception pour les patients pris en charge en pédopsychiatrie)*
 - *Domicile secteur centre (330'000 habitants)*
- 45-55 nouveaux patients par an
- Près de 1000 patients pris en charge dans le programme depuis sa création en 2004

2. Favoriser l'engagement des patients

INTERVENTION INSIGHTS



The therapeutic alliance: is it necessary or sufficient to engender positive outcomes?

Craig A. Macneil¹, Melissa K. Hasty¹, Melanie Evans¹, Cassie Redlich¹, Michael Berk^{1,2,3,4}

Acta Neuropsychiatrica 2009; 2:95–98

2. Favoriser l'engagement des patients

- Garantir la **continuité des soins (case manager)**
- **Adapter l'intervention** au stade de conceptualisation du patient
- Prendre le temps de **comprendre la personne dans son ensemble** plutôt que de ne se focaliser que sur les symptômes
- **Explorer les ressources** et les projets, pas seulement les déficits
- Identifier les **priorités du patient**
- Comprendre le **modèle explicatif du patient**
- Soutenir l'**optimisme réaliste**
- Etre prêt à **faire face à des ruptures** qui peuvent aussi permettre des expériences et à terme renforcer l'alliance
- L'engagement est un processus progressif: **être persévérant**
- **Se laisser toucher** par l'histoire du patient

3. Prévenir la rupture

Schizophrenia Research 118 (2010) 256–263



Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres



Rate and predictors of service disengagement in an epidemiological first-episode psychosis cohort

Philippe Conus^{a,b,*}, Martin Lambert^c, Sue Cotton^b, Charles Bonsack^a, Patrick D. McGorry^b, Benno G. Schimmelmann^d

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^b Orygen Youth Health and Research Centre, Centre for Youth Mental Health, University of Melbourne, Melbourne, Australia

^c Psychosis Early Detection and Intervention Centre (PEDIC), Centre for Psychosocial Medicine, Department for Psychiatry and Psychotherapy, University Medical Centre Hamburg-Eppendorf, Germany

^d Child and Adolescent Psychiatry, University of Bern, Switzerland

ARTICLE INFO

Article history:

Received 29 October 2009
Received in revised form 13 January 2010
Accepted 29 January 2010
Available online 4 March 2010

Keywords:

First-episode psychosis
Disengagement
Treatment adherence
Schizophrenia

ABSTRACT

Objectives: To assess the prevalence and predictors of service disengagement in a treated epidemiological cohort of first-episode psychosis (FEP) patients.

Methods: The Early Psychosis Prevention and Intervention Centre (EPPIC) in Australia admitted 786 FEP patients from January 1998 to December 2000. Treatment at EPPIC is scheduled for 18 months. Data were collected from patients' files using a standardized questionnaire. Seven hundred four files were available; 44 were excluded, because of a non-psychotic diagnosis at endpoint ($n = 43$) or missing data on service disengagement ($n = 1$). Rate of service disengagement was the outcome of interest, as well as pre-treatment, baseline, and treatment predictors of service disengagement, which were examined via Cox proportional hazards models.

Results: 154 patients (23.3%) disengaged from service. A past forensic history (Hazard ratio [HR] = 1.69; 95%CI 1.17–2.45), lower severity of illness at baseline (HR = 0.59; 95%CI 0.48–0.72), living without family at discharge (HR = 1.75; 95%CI 1.22–2.50) and persistence of substance use disorder during treatment (HR = 2.30; 95%CI 1.45–3.66) were significant predictors of disengagement from service.

Conclusions: While engagement strategies are a core element in the treatment of first-episode psychosis, particular attention should be paid to these factors associated with disengagement. Involvement of the family in the treatment process, and focusing on reduction of substance use, need to be pursued in early intervention services.

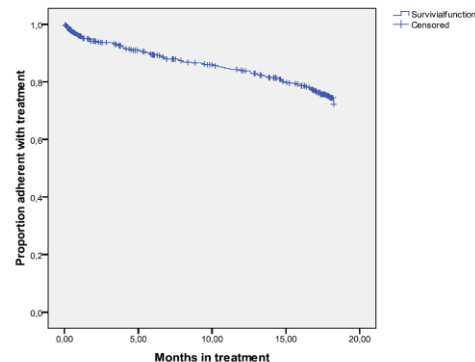
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3. Prévenir la rupture

- Buts de l'étude: Identification de facteurs prédictifs de la rupture dans un échantillon épidémiologique de 704 premiers épisodes de psychose

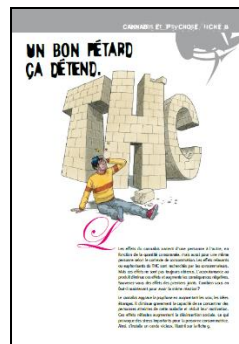
Figure 1. Estimated rate of service disengagement over time



- TAUX DE RUPTURE sur 18 mois: 23%
- FACTEURS PREDICTIFS
 - *Passé judiciaire (OR = 1.7)*
 - *Absence de liens avec la famille (OR = 1.7)*
 - *Persistance d'abus de substance (OR = 2.3)*

3. Prévenir la rupture

- ENGAGER LES FAMILLES DANS LE TRAITEMENT
 - Séance avec famille
 - Visites à domicile
 - Groupes d'information pour les parents
- TRAVAILLER SUR L'ABUS DE SUBSTANCE
 - >50% des patients consomment des substances
 - Le plus fréquent: Cannabis



A SAVOIR

Deux réactions normales et fréquentes après un premier épisode psychotique



Le déni



Le désengagement

Deux réactions normales et fréquentes après un premier épisode psychotique



Le déni

Deuxième défi:

**favoriser le développement de
l'insight**

**(Insight = prise de conscience de
la maladie; contraire du déni)**

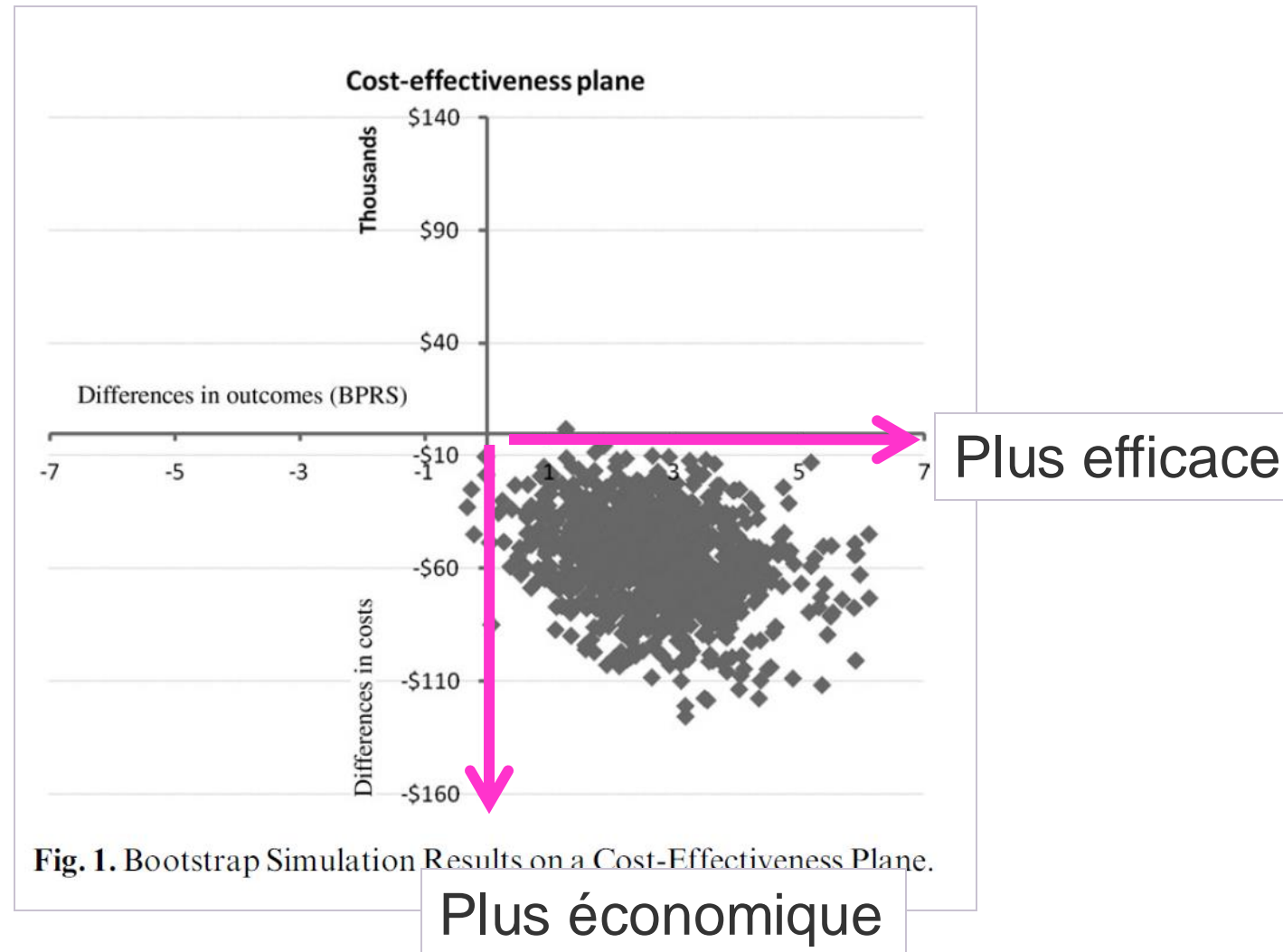
Conséquences de l'insight

- CONSEQUENCES POSITIVES DE L'INSIGHT
 - Facilite l'établissement d'une relation thérapeutique
 - Permet de meilleures relations avec la famille
 - Meilleure adhérence au traitement? Oui mais...
 - Corrélation modérée
 - Certains patients adhèrent au traitement même sans insight...
 - Globalement: meilleure évolution à moyen
- CONSEQUENCES NEGATIVES POSSIBLES DE L'INSIGHT:
 - Peut parfois aggraver les choses
 - Risque élevé de dépression
 - Risque d'auto-stigmatisation
- IL EST DONC IMPORTANT DE PRENDRE SON TEMPS!
 - Tolérer que le déni est parfois salvateur en début de prise en charge
 - Explorer ce domaine progressivement avec le patient

Is Early Intervention in Psychosis Cost-Effective Over the Long Term?

Cathrine Mihalopoulos^{1,2}, Meredith Harris³,
Lisa Henry^{4,5}, Susy Harrigan^{4,5}, and Patrick McGorry^{4,5}

Schizophrenia Bulletin vol. 35 no. 5 pp. 909–918, 2009
doi:10.1093/schbul/sbp054
Advance Access publication on June 9, 2009



L'INTERVENTION PRÉCOCE EN MATIÈRE DE SANTÉ MENTALE

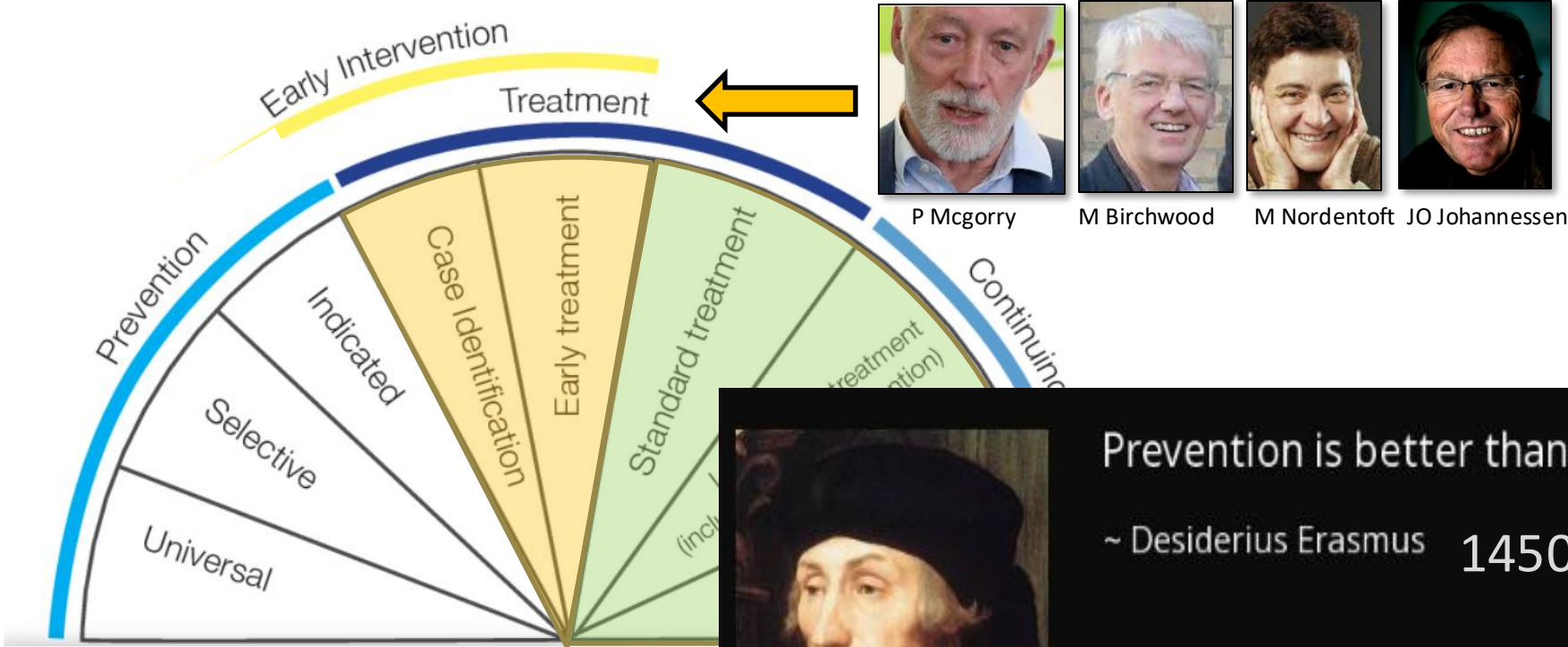



Figure 1: Mrazek & Haggerty's model of the spectrum of interventions for mental health disorders



Prevention is better than cure.
~ Desiderius Erasmus 1450

INTERVENTION PLUS PRÉCOCE EN MATIÈRE DE SANTÉ MENTALE



Alison Yung



Pat McGorry



Scott Woods



Barnaby Nelson

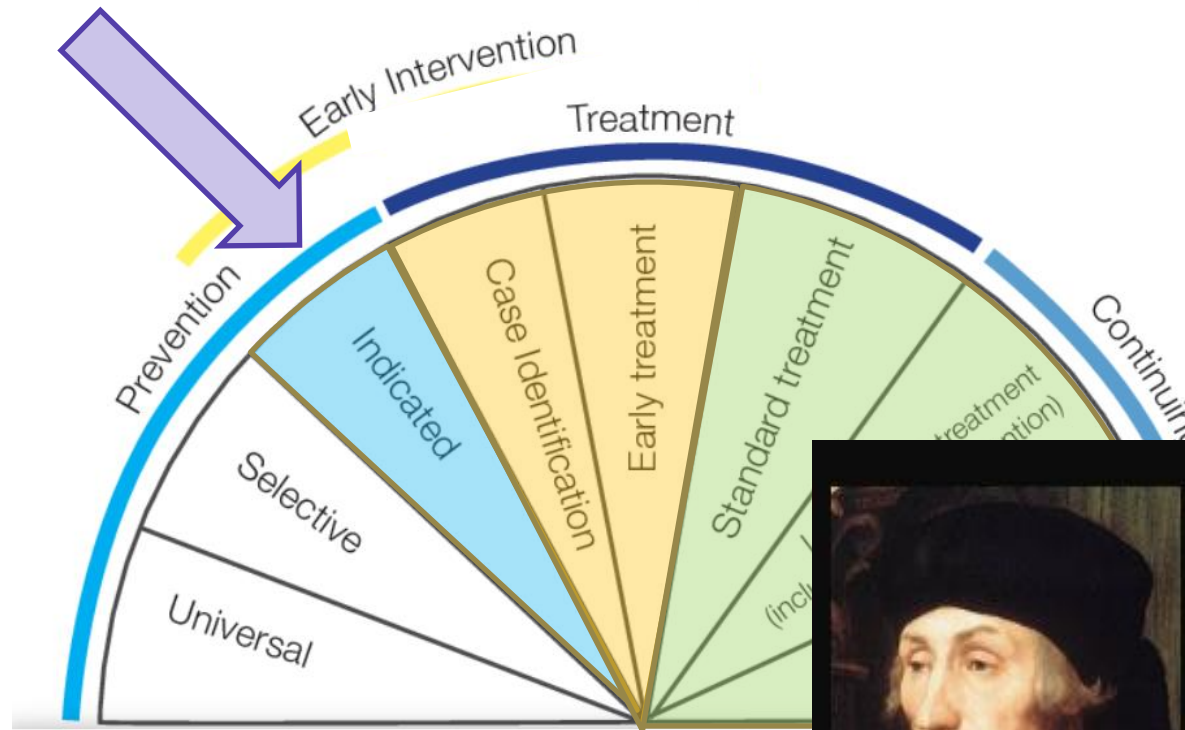


Figure 1: Mrazek & Haggerty's model of the spectrum of interventions for mental disorders50

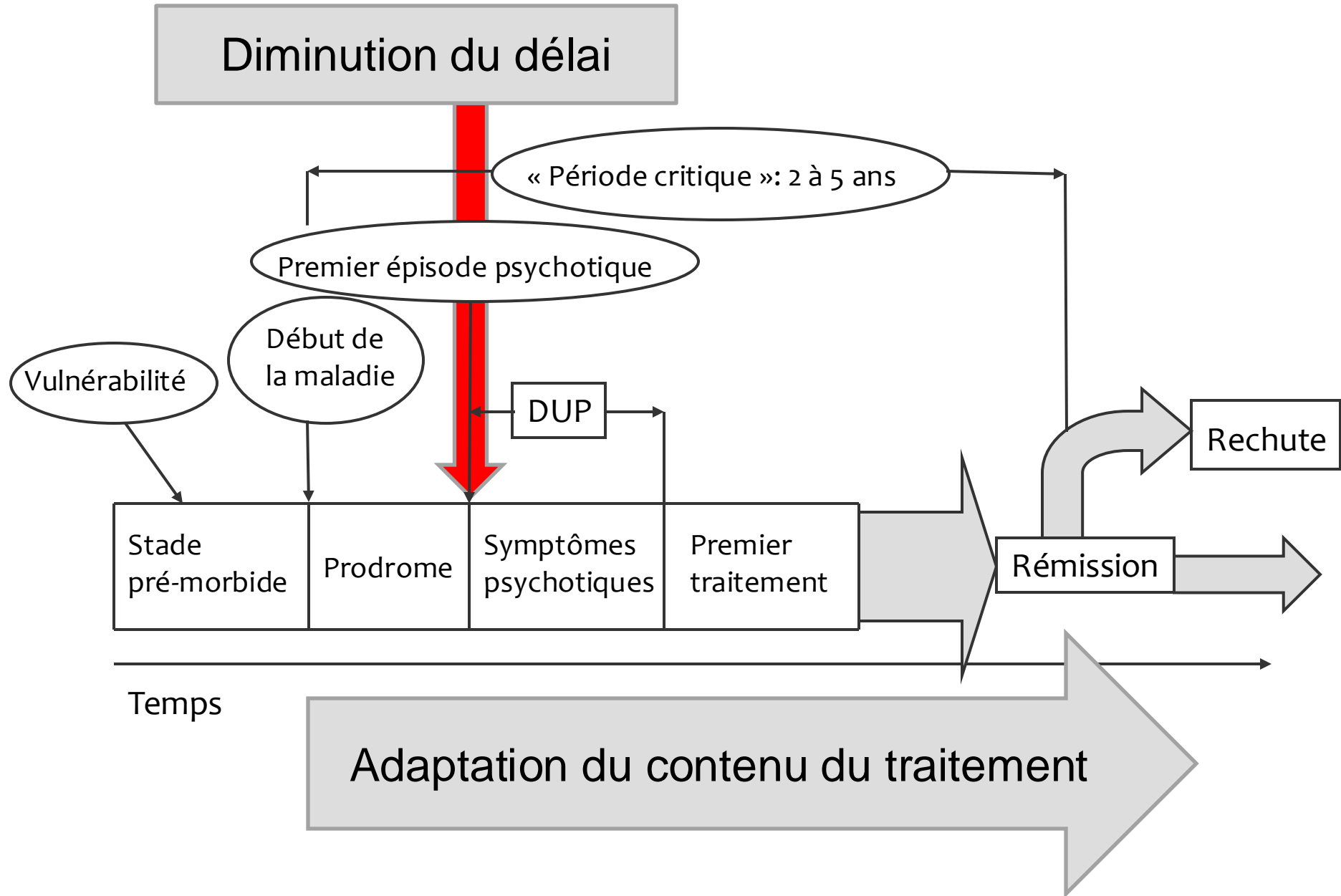
Prévention indiquée :
stratégies destinées aux personnes identifiées comme ayant une vulnérabilité accrue ou présentant des symptômes prodromiques qui restent en deçà du seuil de diagnostic.



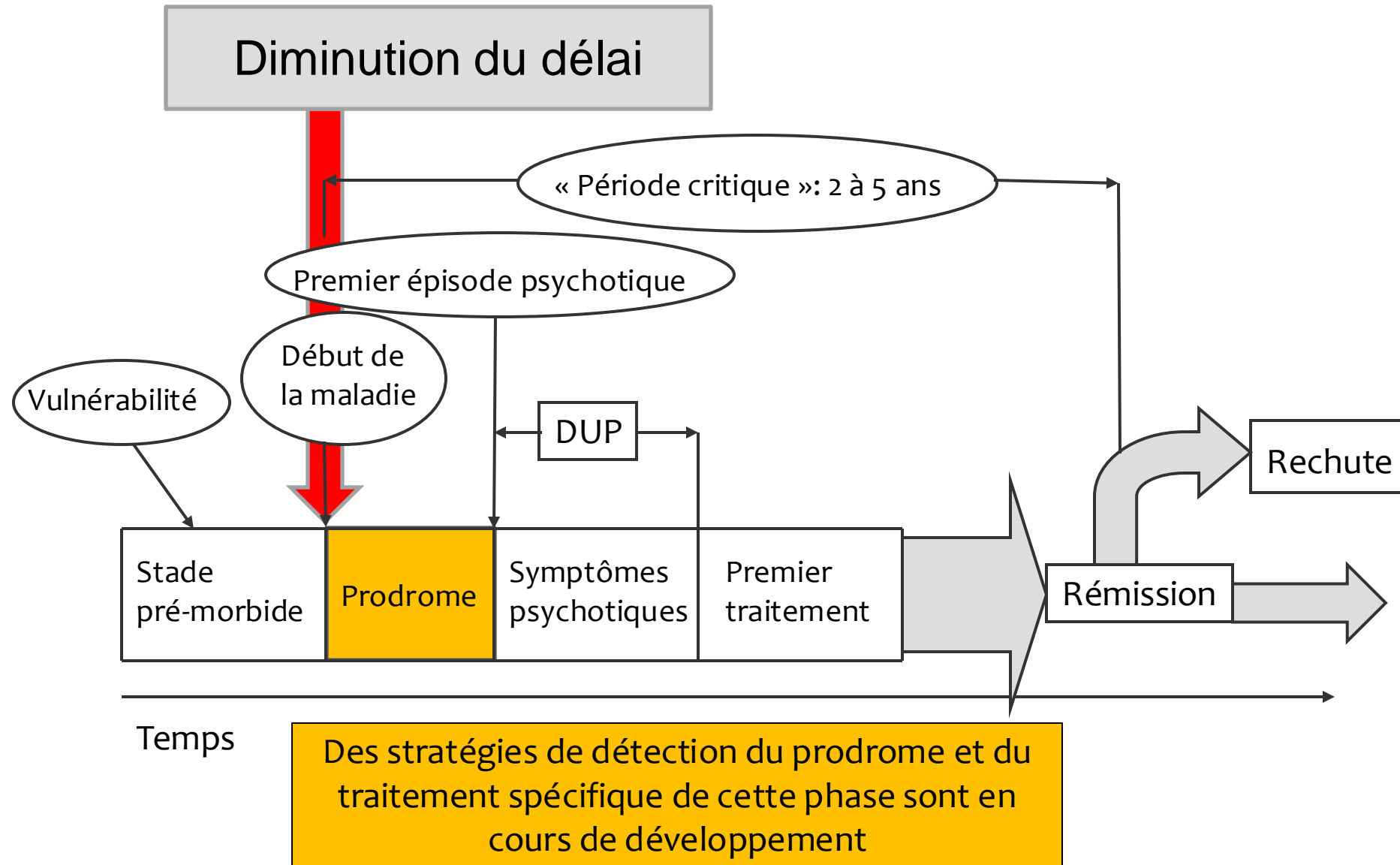
Prevention is better than cure.

~ Desiderius Erasmus 1450

Cibles de l'intervention précoce



Cibles de l'intervention précoce



DIAGNOSTIC PAR LE GENERALITSE

OBSERVATION DES PROCHES

- Dépression
- Anxiété
- Repli sur soi
- Irritabilité
- Suspicion
- Baisse rendement scolaire

VECU DU PATIENT

- Changements d'humeur, manque motivation
- Troubles du sommeil
- Difficultés de concentration, compréhension
- Pensées ralenties
- Sentiment d'irréalité, d'étrangeté
- Modification de perception de l'entourage

Manifestations souvent très
peu spécifiques

Penser à un trouble psychotique en présence de FACTEURS DE RISQUE

- **AGE:** Adolescent ou jeune adulte
- **RISQUE CONSTITUTIONNEL:** Anamnèse familiale de psychose, complications obstétricales, retard de développement, trouble schizotypique
- **RISQUE ACQUIS:** Evénement stressant ou trauma récent, abus de substance

Etablir lien de confiance
Explorer les éléments psychotiques
Référer à un centre spécialisé

PSYYOUNG : un projet pour
favoriser l'implantation de
programmes de détection
précoce de la psychose





Projet «PsyYoung – Détection et intervention transcantonales précoces chez les adolescent-e-s et les jeunes adultes avec statut de risque»



- Projet transcantonal: Vaud – Genève – Bâle
- Psy adulte et pédopsychiatrie
- Développer un modèle d'implantation
- Proposer des recommandations d'implantation

Consultation psychothérapeutique

L'EPFL dispose d'une consultation psychothérapeutique assurée par des psychiatres et psychologues du Département de psychiatrie du CHUV.

**Consultation
psychothérapeutique
pour étudiants
EPFL, Unité
ambulatoire
d'accueil et
interventions
brèves**



Demande de rendez-vous

consult.psy-epfl@chuv.ch

Réponse tous les jours ouvrables de l'année

La phase prodromique ou l'état mental à risque

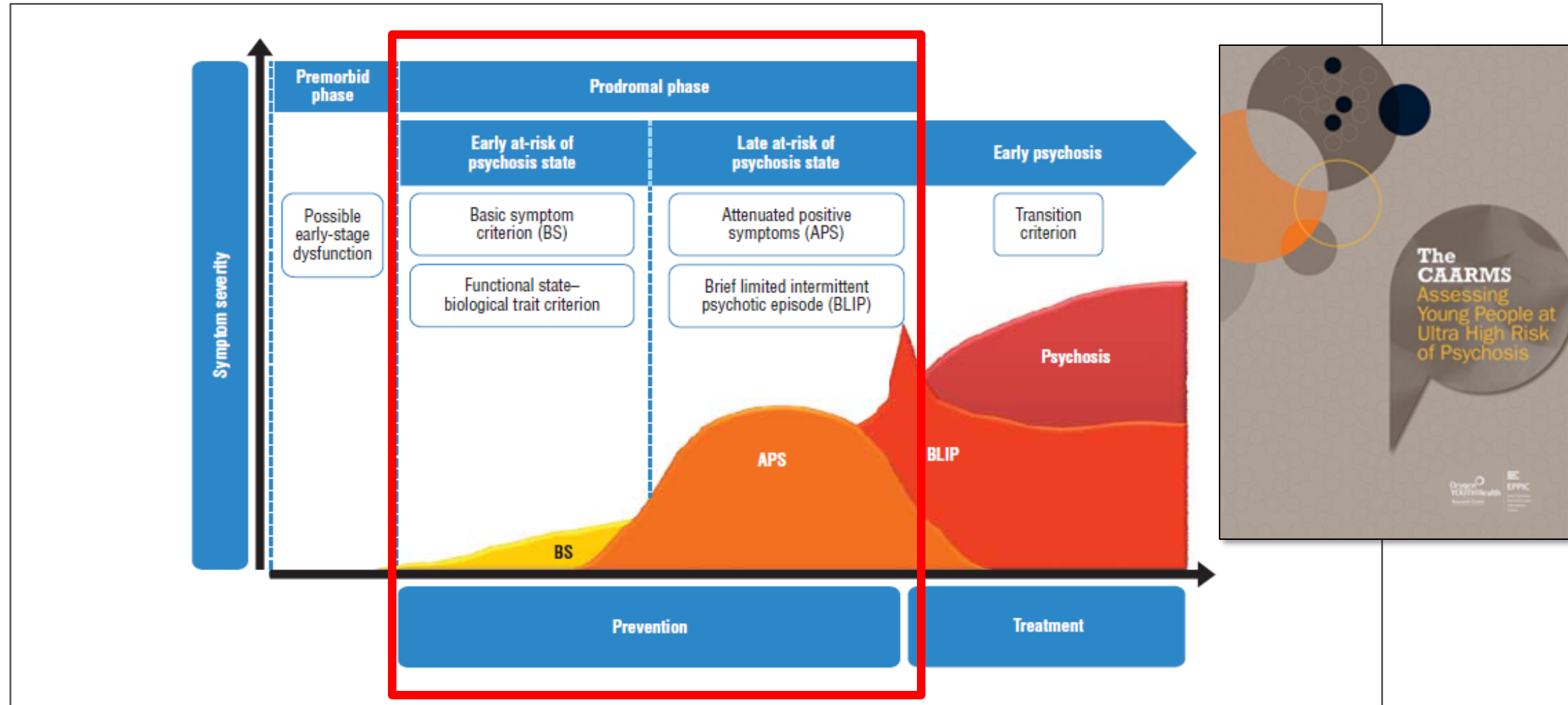


Figure 3. Model of psychosis onset from the clinical high-risk state. The higher the line on the y-axis, the higher the symptom severity.

Validité prédictive : taux de transition vers la psychose au fil du temps

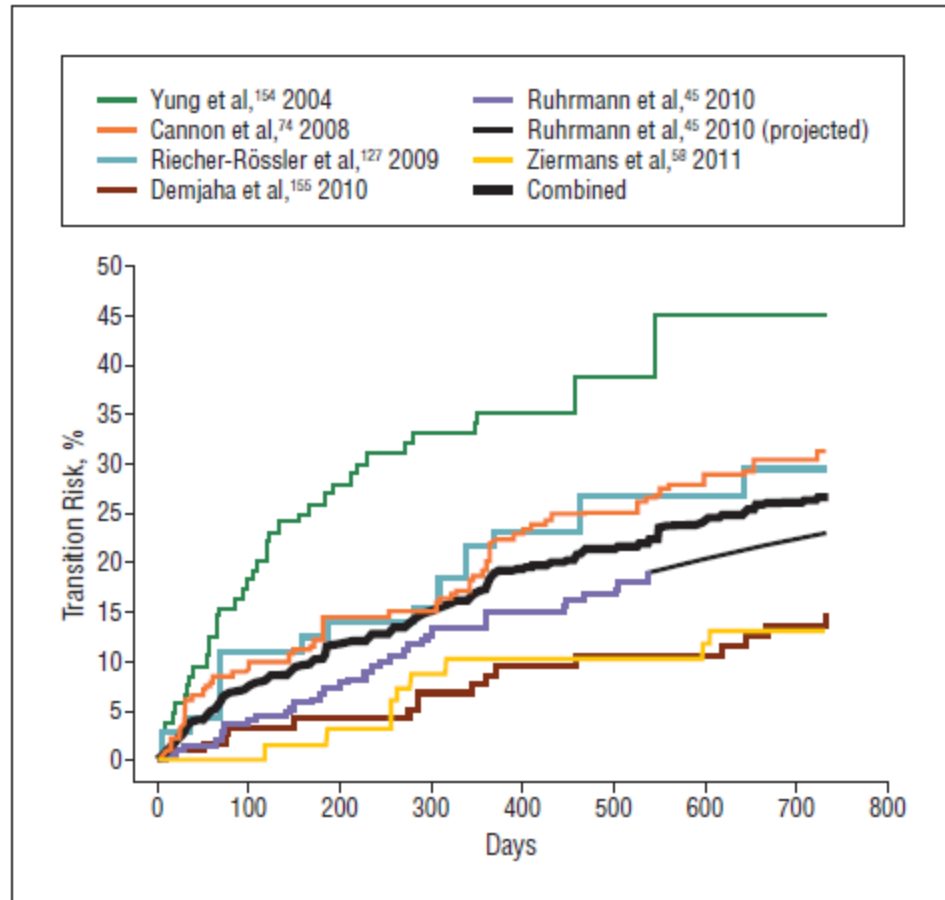


Figure 4. Meta-analysis of transition risks in studies reporting Kaplan-Meier estimates of psychosis transition over time in the high-risk state ($n = 984$ individuals) (for details of the study, see Fusar-Poli et al.⁷⁵). These risks are based on treated cohorts with no standardized treatment, so transition risk estimates are not for natural course or untreated cases.

Métanalyse sur 2500 ARMS patients (*Fusar-Poli 2013*)

6 mois	18 % de la population
12 mois	22%
24 mois	32%
36 mois	36%

De nombreux patients ne développent pas de psychose :
Faut-il cesser de s'en préoccuper ?

Review article

Disorder, not just state of risk: meta-analysis of functioning and quality of life in people at high risk of psychosis

Paolo Fusar-Poli,* Matteo Rocchetti,* Alberto Sardella, Alessia Avila, Martina Brandizzi, Edgardo Caverzasi, Pierluigi Politi, Stephan Ruhrmann and Philip McGuire

Background

The nosology of the psychosis high-risk state is controversial. Traditionally conceived as an 'at risk' state for the development of psychotic disorders, it is also conceptualised as a clinical syndrome associated with functional impairment.

Aims

To investigate meta-analytically the functional status of patients at high clinical risk for psychosis and its association with longitudinal outcomes.

Method

Three meta-analyses compared level of functioning ($n=3012$) and quality of life (QoL) ($n=945$) between a high-risk group, a healthy control group and group with psychosis, and baseline functioning in people in the high-risk group who did or did not have a transition to psychosis at follow-up ($n=654$).

Results

People at high risk had a large impairment in functioning

($P<0.001$) and worse QoL ($P=0.001$) than the healthy control group, but only small to moderately better functioning ($P=0.012$) and similar QoL ($P=0.958$) compared with the psychosis group. Among the high-risk group, those who did not develop psychosis reported better functioning ($P=0.001$) than those who did.

Conclusions

Our results indicate that the high-risk state is characterised by consistent and large impairments of functioning and reduction in QoL similar to those in other coded psychiatric disorders.

Declaration of interest

None.

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The clinical state of high risk of psychosis defines a condition characterised by attenuated psychotic symptoms, brief limited intermittent psychotic episode, genetic vulnerability or the presence of basic symptoms.¹ As the name suggests, these diagnostic criteria were originally developed to identify people at high risk of developing a psychotic disorder over time. Under this conceptualisation the condition would allow detection and treatment of a group at very high risk of developing a severe and full disorder longitudinally. This paradigm would fit the aims of indicated prevention in this group,² who have up to 30% risk of developing psychosis, mostly schizophrenia spectrum disorders,³ within the following 2 years. Accordingly, preventive treatments primarily aim at reducing the risk associated with the condition and thus preventing the outcome.^{4,5} The 'high risk' paradigm does not explicitly require functional impairments as inclusion criteria,⁶ with the exception of the genetic risk and deterioration subgroup, which however is traditionally small. On the other hand, over the past few years a competing paradigm has emerged. The 'attenuated psychosis' syndrome (APS) has been published in DSM-5.^{7,8} The APS construct specifically requires patient distress or disability, which has not explicitly been part of the high-risk concept, although distress and disability are implicit in the symptom severity ratings that are required for the research diagnosis of high risk,⁹ defined as ultra-high risk (so not basic symptoms). In this sense the APS better resembles the clinical condition of angina pectoris, which is *per se* associated with signs and symptoms impairing the quality of life (QoL) and level of functioning of the individual. The APS diagnosis has been relegated to the research appendix of the DSM-5 because of lack of consensus among researchers on the validity of this category

as a syndrome and for the inconclusiveness of data supporting its diagnostic reliability.⁹

One way to partially circumvent this controversial issue is to clarify the functional status of people at high risk at the time of their presentation to prodromal services and independently from their longitudinal outcomes. In fact, according to the DSM criteria,⁷ an impairment of functioning along with significant distress are basic criteria for the conceptual validity of all psychiatric disorders,¹⁰ differentiating a physiological trait or asymptomatic risk factor from a disorder and determining the patient's need for treatment: 'mental disorders are usually associated with significant distress in social, occupational, or other important activities'.⁷ A number of studies investigating functioning or QoL in people at high risk have been published in recent years. Surprisingly, to date no quantitative synthesis has been published regarding the functioning and QoL of such people when they are seeking help from prodromal clinics. The results are particularly controversial when people at high risk are compared with patients with established psychosis.^{11–14}

Our first aim was to investigate validity of the high-risk state by addressing consistency and magnitude of baseline functioning and QoL in high-risk individuals compared with a healthy control group and people with a frank diagnosis of psychosis. We additionally investigated the impact of baseline difference in high-risk functioning on the longitudinal development of psychotic disorders.

Method

The main research hypothesis and the study protocol were decided *a priori*. We used a systematic search strategy to identify relevant articles. Two investigators (A.S. and A.A.) conducted a two-step

*joint first authors.



Paolo Fusar-Poli

L'état à haut risque se caractérise par

- les altérations du fonctionnement
- réduction de la qualité de vie
- intensité similaire à celle d'autres troubles psychiatriques.

Développement de traitements préventifs

Schizophrenia Research 228 (2021) 344–356

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Intervention strategies for ultra-high risk for psychosis: Progress in delaying the onset and reducing the impact of first-episode psychosis

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ARTICLE INFO

Article history:
Received 1 May 2020
Received in revised form 2 October 2020
Accepted 31 December 2020
Available online 2 February 2021

Keywords:
Ultra-high risk
Clinical high risk
At risk mental state
Psychosis
Randomized controlled trials
Meta-analysis

ABSTRACT

Over a quarter of a century ago, the formalisation of the “at risk mental state” and operational criteria to prospectively identify individuals at “clinical” or “ultra-high risk” (UHR) for psychosis created a global wave of research momentum aimed at predicting and preventing first-episode psychosis. A substantial number of randomized controlled trials (RCTs) were conducted to determine if transition to psychosis could be delayed or even prevented. The efficacy of a range of interventions was examined, with standard meta-analyses clearly indicating that these could at least delay transition for 1–2 years and that outcomes improve. Recently, network meta-analyses have attempted to identify the most effective intervention. These highlighted the fact that no one form of intervention is superior to the rest, a finding interpreted in such a way as to create doubts concerning the value of intervening. These doubts have been reinforced by a subsequent Cochrane review which judged the quality of the evidence as low or very low. Here, we report a narrative review of findings from RCTs and meta-analyses on the efficacy of interventions in UHR. We also critique the network meta-analyses and the

1. Introduction

The creation of the “at risk mental state” to identify individuals at “clinical” or “ultra-high risk” (UHR) for psychosis was the catalyst for global research seeking the elusive goal of preventing the onset of psychotic disorder (Cannon et al., 2008; Yung et al., 1996; Yung et al., 2003). A paradigm shift led to a range of candidate interventions being tested to determine their efficacy in preventing transition to psychosis and improving symptomatic and functional outcomes.

Results from initial randomized controlled trials (RCTs) were encouraging and assembled conclusive Cochrane level 1 evidence demonstrating that intervening could reduce the risk of transition from UHR state to a psychotic disorder by around 50% for at least 1–2 years and relieve current symptoms (Preti and Cella, 2010; Stafford et al., 2013; van der Gaag et al., 2013). As with treatments for other mental disorders, notably depression (Amick et al., 2015; Barth et al., 2013), several different interventions were equally effective, with similar effect sizes and

effective as each other, and further concluded that there was a current lack of evidence to support the use of any specific intervention across a range of outcomes, including transition to full threshold psychosis and attenuated psychotic symptoms (Davies et al., 2018a; Davies et al., 2018b; Devoe et al., 2019a). However, there are problems with the choice of research questions and methodology in these recent network meta-analyses (NMAs) (Stein and Norman, 2019), notably treating active control conditions as the equivalent of placebo. Further doubts about the efficacy of treatments in the UHR group were recently reinforced by, in our view, a confusing review published by the Cochrane Schizophrenia Center (Bosnjak Kuharic et al., 2019). While it may be the case that no specific intervention is more efficacious than any other for the UHR group, the interpretation of recent NMAs have served to obscure the benefits of cognitive behaviorally influenced psychosocial interventions. Cognitive behavioral therapy (CBT) is safe and relatively potent (Hutton and Taylor, 2014). It remains the recommended treatment in the National Institute for Health and Care Excellence guidelines (NICE, 2013; NICE, 2014), the British Association of

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<https://doi.org/10.1016/j.schres.2021.12.026>
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Barnaby Nelson

....on met en évidence les avantages cliniques d'un traitement psychosocial dans le cadre de l'UHR/ARMS

Développement de traitements biologiques préventifs

ORIGINAL ARTICLE

Long-Chain ω -3 Fatty Acids for Indicated Prevention of Psychotic Disorders

A Randomized, Placebo-Controlled Trial

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Context: The use of antipsychotic medication for the prevention of psychotic disorders is controversial. Long-chain ω -3 (omega-3) polyunsaturated fatty acids (PUFAs) may be beneficial in a range of psychiatric conditions, including schizophrenia. Given that ω -3 PUFAs are generally beneficial to health and without clinically relevant adverse effects, their preventive use in psychosis merits investigation.

Objective: To determine whether ω -3 PUFAs reduce the rate of progression to first-episode psychotic disorder in adolescents and young adults aged 13 to 25 years with subthreshold psychosis.

Design: Randomized, double-blind, placebo-controlled trial conducted between 2004 and 2007.

Setting: Psychosis detection unit of a large public hospital in Vienna, Austria.

Participants: Eighty-one individuals at ultra-high risk of psychotic disorder.

Interventions: A 12-week intervention period of 1.2-g/d ω -3 PUFA or placebo was followed by a 40-week monitoring period; the total study period was 12 months.

Main Outcome Measures: The primary outcome measure was transition to psychotic disorder. Secondary outcomes included symptomatic and functional changes. The ratio of ω -6 to ω -3 fatty acids in erythrocytes was used to index pretreatment vs posttreatment fatty acid composition.

Results: Seventy-six of 81 participants (93.8%) completed the intervention. By study's end (12 months), 2 of 41 individuals (4.9%) in the ω -3 group and 11 of 40 (27.5%) in the placebo group had transitioned to psychotic disorder ($P = .007$). The difference between the groups in the cumulative risk of progression to full-threshold psychosis was 22.6% (95% confidence interval, 4.8-40.4). ω -3 Polyunsaturated fatty acids also significantly reduced positive symptoms ($P = .01$), negative symptoms ($P = .02$), and general symptoms ($P = .01$) and improved functioning ($P = .002$) compared with placebo. The incidence of adverse effects did not differ between the treatment groups.

Conclusions: Long-chain ω -3 PUFAs reduce the risk of progression to psychotic disorder and may offer a safe and efficacious strategy for indicated prevention in young people with subthreshold psychotic states.

Trial Registration: clinicaltrials.gov Identifier: NCT00396643

Arch Gen Psychiatry. 2010;67(2):146-154

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EARLY TREATMENT IN SCHIZOPHRENIA and other psychoses has been linked to better outcomes.¹ Given that subclinical psychotic symptoms may predict psychotic disorder² and psychosis proneness in a population may be related to the rate of psychotic disorder,^{3,4} intervention in at-risk individuals holds the promise of even better outcomes, with the potential to prevent full-blown psychotic disorders.

In the 1990s, a series of prospective studies validated criteria that are capable of identifying individuals with subthreshold symptoms at ultra-high risk of psychosis.⁵

Neuroanatomical changes observed in ultra-high-risk individuals who progress to psychotic disorder suggest an active biological process during this transition, raising the possibility that intervention might be indicated before expression of frank psychotic symptoms.⁶ To date, 3 randomized controlled studies have evaluated the efficacy of antipsychotic medication and/or cognitive therapy to reduce the conversion to psychosis rate in ultra-high-risk groups.^{7,8} These studies support the ongoing evaluation of interventions for the prevention of conversion to psychosis.¹⁰

Based on findings of reduced long-chain ω -3 and ω -6 polyunsaturated fatty

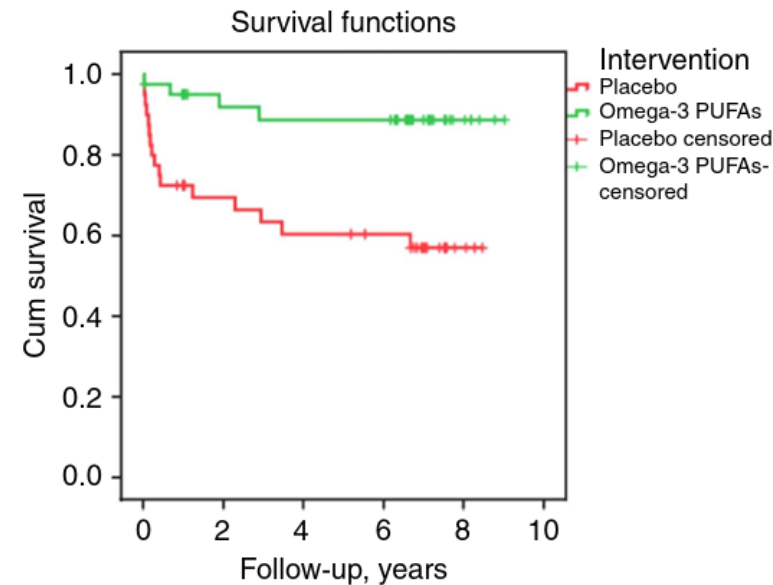


Figure 2 | Kaplan-Meier estimates of the risk of progression from the at-risk state to psychotic disorder in participants assigned to omega-3 PUFAs or placebo. Four of 41 individuals from the omega-3 PUFA group

STRATEGIES SIMILAIRES DANS D'AUTRES TROUBLES

- Troubles bipolaires
- Troubles de personnalité
- Troubles alimentaires

- Alzheimer et autres démences

CONCLUSION

- Les troubles de santé mentale débutent en grande majorité entre 15 et 25 ans
- L'intervention précoce améliore l'évolution de la maladie
- Contrairement au passé, on cherche maintenant à identifier ces troubles précocement, déjà avant le développement complet des symptômes
- Ces interventions sont bien définies dans la psychose et se développent également pour les autres troubles
- En cas de doute ne pas hésiter à consulter un spécialiste
- Une consultation spécialisée existe à l'EPFL

Merci pour votre attention