FIRST EPISODE PSYCHOSIS – THE LAST OPPORTUNITY IN A SEVERE MENTAL ILLNESS TO ACHIEVE REMISSION?

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Severe mental illness such as schizophrenia and bipolar affective disorder usually afflict younger people. 80% of first episodes of psychoses occur between 16 and 30 years of age. This is a critical time in the emotional and social development and emerging personal autonomy[1]. It is perhaps not surprising that long term follow up studies show that outcomes at two years strongly predict outcomes 15 years later[2]. We also know that upto 70-80% of people suffering from FEP achieve remission. This reduces dramatically in patients who suffer from more than one episode. This effectively means that first episode provides us the last opportunity for achieving remission in significant proportion of patients. It is therefore crucial that we target the FEP for all the intensive efforts which can help to achieve and most importantly sustain remission. This can only be achieved by involving young people in their treatment, continuing medication and targeting negative symptoms.

The most important target in this population should be to maintain treatment adherence. Even a break of medication for few days in this population is associated with worsening of symptoms. Subotnik et al showed that among patients with recent-onset schizophrenia spectrum disorders even mild non adherence, defined as compliance with only 50%–75% of a prescribed oral antipsychotic medication for 2 consecutive weeks or longer, was associated with a clinically meaningful increased risk of psychotic exacerbation[3]. It is alarming to note that all subjects examined by Subotnik et al were participants in a research study and received individual case management and therapy in addition to medication treatment[3]. Despite this, only 32% were fully adherent to antipsychotic medication during the follow-up period.

Marinating treatment adherence is a challenge equally for the first episode and multi episode patients. Many factors such as lack of insight, severe positive symptoms, substances abuse etc are associated with poor or non adherence by all patients, whether multi episode or first episode. However there are certain factors which may be specific for the recent-onset psychosis. Younger people as a group generally find difficult to accept that they are afflicted with severe *mental illness.* Further, continuing maintenance treatment involves acceptance of current side effects for avoiding a future return of symptoms. Patients and their families are not aware of the adverse consequences of repeated psychotic relapses. Direct exposure to the side effects but lack of direct experience of the benefits which patients will gain from prevention of relapses with medication adherence, means that assessment of the relative benefits of maintenance antipsychotic treatment is limited[4]. In young patients drug abuse further complicates compliance with the treatment.

It is commonly thought that partial or non adherence with medication results in relapse. It is often not realized that partially treated symptoms and incomplete remission may be responsible for partial or complete non adherence with medication. Hence non adherence or partial adherence with medication may be a consequence of partially controlled illness, rather than the cause. This can give rise to a vicious cycle of non adherence with medication and increasingly severe psychotic symptoms with further lack of insight and disengagement with the treatment. It is therefore, important that symptoms are treated aggressively and completely to achieve and *maintain* remission.

The challenge therefore is to achieve and sustain remission, arguably at any cost in first episode patients. In developed countries, this realization has resulted in establishing early intervention services. Most of these services actually serve first episode patients, providing assertive outreach with greater involvement of the multidisciplinary team members. In resource poor settings, the feasibility and cost effectiveness of these services remains questionable. It is however, possible to use the available resources and strategies to prevent the relapses.

Clinicians working in developing countries have long known that families can be enlisted to assist with medication adherence and engagement. This has not been used and evaluated systematically. Now, in a randomised controlled trial, Farooq et al (2011) have shown that the family can supervise and administer the medication effectively to maintain treatment adherence[5]. In this RCT, which involved a brief intervention to educate family members about the illness and medication supervision, the rates of adherence with medication was significantly better in the group which received active intervention compared to those who received usual care.

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This was reflected in improvement in symptoms and functioning as well. Although the sample in this trial was not limited to first episode patients only, this approach can prove effective in involving the patients and family members to improve the treatment adherence. However, family based supervision of medication administration may exacerbate tension within some families and is often not sustainable for long periods. Farooq et al, therefore suggest that persons suffering from schizophrenia should be provided treatment under family supervision for an initial 2-year period in the course of illness, the *critical period* in the entire course of illness[5].

Another potential intervention to maintain adherence is the use of long-acting antipsychotic medication early in the course of treatment. Long-acting formulations eliminate the covert non adherence that can occur with oral tablets and is quite common. Although long acting injections are rarely considered in the First episode psychosis, it is important that this option is discussed with patients and families, before non adherence becomes established. Long-acting formulations have advantages that may be especially relevant with recent-onset patients. Oral preparations are potentially more likely to be missed by young patients, who are with their peers on job or in academic institutions and may feel embarrassed to take medication in presence of others or simply forget medication in busy routines. Once a month injectable medications can help to maintain confidentiality. Recent-onset patients tend to be responsive to monotherapy with antipsychotics without the need for supplementation with oral medications. Two studies have demonstrated that agreement to injections can be obtained with a substantial percent of recent-onset patients[6, 7].

There is robust evidence that patients who do not response early in the course of illness are unlikely to respond to the same treatment later[8]. It is therefore important that the progress in treatment is monitored closely and alternative options such as Clozapine and other augmentation strategies are considered at the earliest possible stage. Clozapine is one of the interventions which is grossly under-utilised. There is a long delay before Clozapine is initiated[9]. Although evidence for use of Clozapine in first episode psychosis is not robust, but Clozapine must be considered following guidelines which suggest Clozapine should be drug of first choice when patient has not responded to trial of two antipsychotics, irrespective of the fact whether the episode is recent onset psychosis. Considering the scarcity of resources, it is of utmost importance that we provide continuity of care, and most effective interventions to achieve and sustain remission in first episode psychosis. The first episode may be our last opportunity in the majority of cases to expect a symptomatic and functional recovery. We should grab this with both hands, literally!

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