Integrated Pathways of Care for Psychosis: An Overview

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Shanaya Rathod and Narsimha Pinninti

2.1 Introduction

Psychiatry has reached a crossroads with respect to the way we understand and treat psychotic symptoms. In the past, psychotic symptoms have been mainly studied in clinical situations and as a result, we have viewed them as pathological entities that more often than not result in psychiatric evaluation and treatment. In addition to that, individuals with mental illnesses have been portrayed, by the media, as unpredictable and violent. This leads to the perception in the general public that individuals with psychosis are violent (Athanasopoulou et al. 2015) and cannot recover or lead meaningful lives. These misrepresentations have not improved with time (Clement and Foster 2008). However, as described in Chap. 1 and elaborated upon below, information from many different sources make us rethink and possibly challenge this long held conceptualization of psychotic symptoms as pathological or leading to violence.

The first source is a strong voice using the growing influence of people with lived experiences who advocate that we look at psychotic symptoms from a much broader perspective than the current illness prism. Ignored for a long time, the viewpoint of individuals who experienced psychosis is now rightly being increasingly considered in the delivery of mental health services.

The second is the study of psychotic experiences in normal populations also highlighted in Chapter 1. Psychotic experiences (PE), i.e., delusions and hallucinations,

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S. Rathod, MD (✉)
Antelope House, Southern Health NHS Foundation Trust,
Southampton, SO14 0YG, UK
e-mail: Shanaya.rathod@southernhealth.nhs.uk; shanayarathod@nhs.net

N. Pinninti, MD
Department of Psychiatry, Rowan University SOM,
Suite 100, 2250 Chapel Avenue East, Cherry Hill, NJ 08034, USA
e-mail: Narsimha.Pinninti@twinoakscs.org; narsimhanrp@gmail.com

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are seen in about 15 % of the normal population at some point in their lives (Balaratnasingam and Janca 2015). Many of these individuals are not in treatment and do function normally. Of those who report PE, only 20 % go on to experience persistent PE, whereas for 80 %, PE reduces over time. Of those with baseline PE, 7.4 % develop a persistent psychotic disorder outcome. Another compelling finding is that the severity of psychotic symptoms is not correlated that well with the level of functioning, and individuals with same degree of psychotic symptoms have been shown to have quite different levels of functioning (Linscott and van Os 2013). There is also evidence that psychotic symptoms are on a continuum with normal experiences (Johns and van Os 2001). This means that our existing paradigm that psychotic syptoms are qualitatively different from normal experiences and pathological need to be reexamined.

The third source of information is from spiritual literature wherein experiences that are phenomenologically similar to psychosis are described in normal populations and in advanced spiritual practitioners (Rolland 1929; Epstein 1990). There have been attempts to distinguish spiritual from psychotic experiences. Some features that distinguish spiritual from psychotic experiences are lack of distress, lack of impairments in social and occupational functioning, compatibility with the patient's cultural background and recognition by others, absence of psychiatric comorbidities, control over the experience, presence of good level of insight, and personal growth over time (Wilber et al. 1986, 2013). We have also discussed this in Chap. 1.

The study of normal psychotic experiences supports a more benign view and the need for adopting a *wait and see approach* to the psychotic experiences. On the other hand, study of people with recurrent episodes or persistent psychosis shows that a key predictor of recovery in psychosis is the duration of untreated psychosis (DUP), which is the time between the onset of psychotic symptoms and the start of treatment. The longer the duration of untreated psychosis, the worse the outlook can be (McGorry et al. 1996). DUP is considered to be the strongest predictor of symptom severity and outcome (Drake et al. 2000). Delayed treatment can lead to significant impairments in social functioning and recovery which become increasingly difficult to repair (Birchwood et al. 1998). Evidence from transcultural and international research suggests that DUP ranges between 364 and 721 days (McGlashan 1999; Marshall et al. 2005), and therefore reducing DUP is of imminent interest internationally (WHO 2001). Hence, the treatment goals in psychosis are to identify the illness as early as possible, treat the symptoms, provide education and skills to individuals and their families, maintain the improvement over a period of time, prevent relapses, and promote recovery (Rossler et al. 2005).

Reconciling the two ends of the spectrum from the wait and watch approach of psychotic experiences to reducing DUP in persistent psychosis can be a clinical conundrum. Since the mid-1990s, individuals have been considered to be at ultra-high risk (UHR) for psychosis if they met at least one of three criteria: the presence of attenuated psychotic symptoms (APS); the presence of positive symptoms at full psychotic intensity for brief, limited time points (known as BLIPS); and/or a combination of genetic risk or schizotypal personality disorder accompanied by functional decline (known as genetic risk and decline syndrome [GRD]) (Fusar-Poli et al. 2015). However, the risk of psychosis of these different groups has remained unknown, and only recently, Paolo Fusar-Poli and colleagues (2015) analyzed the outcomes of 33 independent studies in a meta-analysis, including over 4,000 UHR individuals monitored for psychosis progression. The authors found that people with BLIPS had the highest risk of conversion to psychosis (39 % after 24 months), followed by APS (19 %) and GRD (3 %). They concluded that in addition, patients who had both APS and GRD had a similar risk of conversion to psychosis as those with only APS across all time points studied—suggesting GRD may not be a valid component of the UHR profile. Based on the information above, medically treating all psychotic experiences in order to reduce the duration of untreated psychosis may include people whose symptoms naturally resolve or are spiritual in nature. In these situations, we can accept a much broader understanding of psychotic experiences that views them as a variation in normal human experience and one that need not be medicalized. On the other hand, there is a risk that this approach can discourage people with persistent psychotic symptoms to seek helpful treatment, lengthening the duration of untreated psychosis and worsening the outcome.

What is required is an acknowledgment that our understanding of psychotic experiences is evolving and needs further research. On one hand, we do not know enough about the resilience of individuals who have these experiences and are able to integrate them into their life and function at a higher level. On the other hand, diagnoses such as schizophrenia are reliable, but their validity is being increasingly questioned (Johns and Van Os 2001). So the discourse at the level of the community should be changed from an assumption that psychotic symptoms are necessarily pathological to one that they could have a range of outcomes with psychological growth, spiritual progress, and higher level of functioning and progression at one end to persistent psychosis that requires ongoing monitoring and treatment at the other.

In the last two decades, evidence has built on the effectiveness of psychological therapies such as cognitive behavior therapy and family interventions for schizophrenia and other psychotic disorders (NICE 2014). There are therapies that target symptom dimensions such as positive symptoms as well as those targeting individual symptoms such as auditory hallucinations (Thomas et al. 2014). While most of the studies of psychological interventions have been conducted in people who are on antipsychotic medication, there is some evidence to suggest that people who do not want to take medication can still be helped by cognitive behavior therapy interventions (Morrison et al. 2014) and a proportion of individuals can be engaged with services if they are given the option to accept psychosocial interventions without medication. Other novel interventions that optimize recovery and aim to improve an individual's resilience through utilizing the entire social network of that individual using a "dialogical approach" to understanding psychotic experiences have shown that almost two thirds of individuals with psychosis could be managed without medication or on very small doses for brief periods of time and more importantly the duration of untreated psychosis in that community decreased to 3 weeks (Seikkula et al. 2011). While the idea of network therapy has originally come from the USA, managed care has limited its applicability (Seikkula et al. 2011) and similar discussions would be encountered in the NHS without changes to the current model (Razzaque and Wood 2015) of delivery of care.

There is a need to develop services that subscribe to this broad approach toward psychosis while making all medication and psychosocial interventions available to individuals at different stages of their experiences. The individual and their families and clinician decide on the best treatment approach for them at that particular stage of their experiences. This way the treatment is highly individualized and has the person with the psychotic experience at the center of decision-making. This type of individualized approach helps people engage with services, reduces stigma, and optimizes the use of limited resources.

2.2 Duration of Untreated Psychosis

The duration of untreated psychosis (DUP) remains high in most countries and is correlated with poor outcomes such as higher degree of positive symptoms, reduced overall functioning, and quality of life. Patients with a long DUP are significantly less likely to achieve remission (Drake et al. 2000; Marshall et al. 2005). In the USA, the duration of untreated psychosis in a community sample was found to be 74 weeks with 68 % of individuals with DUP greater than 6 months. Correlates of longer DUP included earlier age at first psychotic symptoms, substance use disorder, positive and general symptom severity, poorer functioning, and referral from outpatient treatment settings (Addington et al. 2015). Early intervention programs were developed in some countries to address the long duration of untreated psychosis and have been shown to reduce the DUP when first introduced. However, this effect was not sustained and for established early intervention centers did not reduce the duration of untreated psychosis (Marshall et al. 2014).

Longer durations of untreated psychosis can occur due to client-related factors or service-related factors. Client-related factors could be due to an inability to recognize early symptoms or due to the illness itself such as poor insight and social and emotional withdrawal (Connor et al. 2014) or due to cultural values systems like attributions to illness and help-seeking pathways into care (Rathod et al. 2015a). In people with first episode of psychosis, carers and families play a key role in determining and facilitating help-seeking behaviors (Logan and King 2001; Connor et al. 2014).

Community education and awareness campaigns have been tried to identify symptoms early with limited success (Lloyd-Evans et al. 2011). Educating general practitioners to reduce delays in referrals to secondary care services has had limited impact (Lester et al. 2009a) in increasing the number of referrals. Delays within secondary care mental health services have been found to be of most significance in the care pathways of those with long DUP (Birchwood et al. 2013; Norman et al. 2001). Paradoxically, Birchwood and colleagues (2013) found that first contact with an "acute service" (crisis team, home treatment, or admission) predicted shorter subsequent treatment delays within the mental health service and DUP overall. Similar trends have been reported through international research (Platz et al. 2006) and highlight the pressures on services that cope with routine referrals. Anderson and colleagues conducted a systematic review of international studies and concluded that a common theme is the need to understand the barriers faced when seeking help for psychosis, especially the response of service providers (2010). The Finnish open dialogue long-term studies show promise in addressing several of the barriers existing in other systems and facilitate help-seeking behaviors in individuals with and without psychosis while giving them as much say in decision-making as possible. The method consists of training entire staff in a geographical region and involving the networks of individuals who develop psychosis in the process of treatment. This approach has shown that the crises are detected early and the population is more trained in responding appropriately to crises leading to quicker resolution of psychosis and reduced incidence of new cases of schizophrenia. If these findings are replicated in other settings, it will have profound implications for models of services in psychiatry (Seikkula et al. 2011).

2.3 Current Service Models for Individuals with Psychosis

As currently delivered, there is a considerable unmet need in the way individuals with psychosis can access services and receive evidence-based treatments as prescribed by the National Institute for Health and Care Excellence (NICE) (2014) in a timely fashion. Early intervention in psychosis (EIP) teams had been set up in many countries like Australia and the UK for first-episode psychosis to improve access to services and interventions with limited impact on DUP (Lester et al. 2009b). The remit of the early intervention in psychosis teams had been to raise awareness in communities, education in schools and community programmers, and early identification and engagement with people who have early psychosis with a view to providing a range of interventions that include psychotropic medication and psychosocial therapies including family work and skills on relapse prevention. However, due to budgetary constraints, most EIP services, especially in the UK, have lost resources and many have been dissolved into community teams, thereby loosing quality (Rethink Mental Illness 2014; Rathod et al. 2014).

If the EIP services worked to their desired specification and therefore reduced the likelihood of relapse, or rates of detention under the Mental Health Act, in the UK alone, they could potentially save the NHS £44 million each year through reduced use of hospital beds (Rethink Mental Illness 2014) and reduce the risk of suicide from up to 15–1 % (Melle et al. 2006). Above all, it is difficult to put a price tag on the reduction in burden of illness for individuals and families.

In the USA as well, Mueser and colleagues (2015) replicated this comprehensive model of care called NAVIGATE that included four core interventions: individualized medication management, family psychoeducation, resilience-focused individual therapy, and supported employment and education. The model was delivered at community-based clinics to mirror real-world settings and demonstrated that the patients in the intervention arm experienced greater improvement in quality of life and psychopathology and experienced greater involvement in work and school compared with patients in community care. The study also confirmed that NAVIGATE participants with duration of untreated psychosis of less than 74 weeks had greater improvement in quality of life and psychopathology compared with those with longer duration of untreated psychosis and those in community care.

For people who have a relapsing and remitting psychotic illness, multiple admissions, and some disengagement from services, assertive community teams or assertive outreach teams have been set up in many countries like the USA and UK. Assertive community treatment teams are designed to be self-contained multidisciplinary teams that address all medical and psychosocial needs of the consumers by providing services that are round the clock, across different settings, and for an indefinite period of time (Schmidt et al. 2013). The remit of these teams had been to provide intensive support, assertive engagement, and work on relapse prevention. While the organization of community care around fidelity to a recognized model had developed in the USA and enabled the use of extensive research in comparing and refining service configurations or interventions, unfortunately the commissioning of assertive outreach services has not been closely defined in the UK, and many opportunities have been missed (Wharne 2013). Therefore, in the UK, with the redesigns, remodeling, and constant changes in community services, the majority of assertive outreach teams have been dismantled, with some functions integrated into community mental health teams (Firn et al. 2013; Rathod et al. 2014).

In addition to these specific psychosis services, in the UK, crisis resolution home treatment teams have been created that care for people when they are in crisis or require hospital admission but may benefit from intensive support at home rather than in the hospital (Johnson 2013). While the vision with the number of different teams that care for a person is aimed at reducing hospital admissions, it does cause fragmentation of care as people are cared for by a number of staff and therefore continuity of care can become an issue.

Some countries like the Netherlands developed the flexible assertive community team (FACT) model that is a variant on the original ACT model. Although designated teams do exist in the Netherlands, mostly in urban areas, about 70 % of teams providing services to people with psychosis are FAC teams. These combine functions that, in the UK context, would be provided by a variety of services, including assertive outreach, crisis resolution, recovery, and rehabilitation. The variety of need is met by providing two distinct levels of service within a single team: one which is high intensity, following the classic assertive outreach shared caseload approach, and the other offering low intensity, which is more like individual case management. Patients move easily between these levels depending on need, but the staff group remains the same, ensuring continuity of care (Van Veldhuizen 2007).

The Schizophrenia Commission Report (2012) and National Audit of Schizophrenia (2012) in the UK have highlighted deficiencies in psychopharmacological and psychological care and recommended changes to the way care is provided to people with schizophrenia. Spending is currently skewed toward the more expensive parts of the system, at £350 average cost per day for inpatient care compared with £13 average cost per day in community settings (Knapp et al. 2014). People from some minority communities are often overrepresented in the more intense and coercive forms of care, and this can be attributed to their nonengagement with services until a point of crisis (Mental Health Bulletin 2009) making a case for cultural adaptation of services and interventions (Rathod et al. 2015a, b).

Therefore, it would be reasonable to conclude that due to a lack of guidance and prescription around when interventions should be available to people who suffer with psychosis, the variations in the DUP and the length of time people have to wait before receiving interventions impact on poor prognosis.

In order to begin to address these issues and reduce the DUP, the Access and Waiting Time Standard (NHS England 2015) for first-episode psychosis has been established in the UK. This standard also aspires to address the issue of psychotic experiences in individuals that may never become persistent by prescribing a NICE concordant package of care for people with "at-risk mental state" (ARMS). The main modality of treatment in this group is nonmedical, but should they need to, they can be progressed to first-episode psychosis pathway. This new standard may catalize the reformation of EIP teams in the nation. However, the introduction of targets and policy is not enough. A social movement and cultural change are required to ensure that people who suffer with psychosis receive the right interventions in a timely manner and lead fulfilling lives. Integrated pathways that define time frames for delivery of treatments and a range of interventions personalized to an individual's needs and provide holistic care are key to this.

2.4 Case for Integrated Pathways

Evidenced-based integrated pathways have been used successfully in stroke and cardiovascular illness. They provide a standardized framework for good clinical practice, reduce variation in care, and have improved outcomes for patients through providing timely access and intervention. Standardized pathways improve quality by improving multidisciplinary communication with different care agencies and care planning and improve patient satisfaction (Campbell et al. 1998). While currently there are pathways and guidance available for psychosis care in some countries such as the UK (NICE 2014), they do not provide prescriptive time frames to improve access to care and interventions. In order to improve the DUP and outcomes for people who suffer with psychosis, there is a need for defined pathways prescribing key stages, timelines, and a range of evidence-based interventions matched to the diversity of presentations that occur with psychosis, e.g., comorbidity with substance misuse and trauma, which will improve access to evidence-based services and interventions and support recovery. It is also fundamental to improving the physical health and reducing premature mortality in people with psychosis as currently the average lifespan of people who suffer with psychosis is shortened by 15–20 years compared with the general population (Brown et al. 2010). Integrated pathways can ensure delivery of appropriate health promotion and prevention at key stages, e.g., weight gain from antipsychotic medication is especially pronounced in the first 8 weeks of administration, but it is rare that specific support is offered at this stage. Similarly, smoking cessation support and employment support can be built in at critical periods, e.g., on admission to hospital. In those countries where independent, unbiased, and expert guidance is not available from one source, creation of such an entity should be a priority (Vissers and Beech 2005) or a global approach to guidance can be considered.

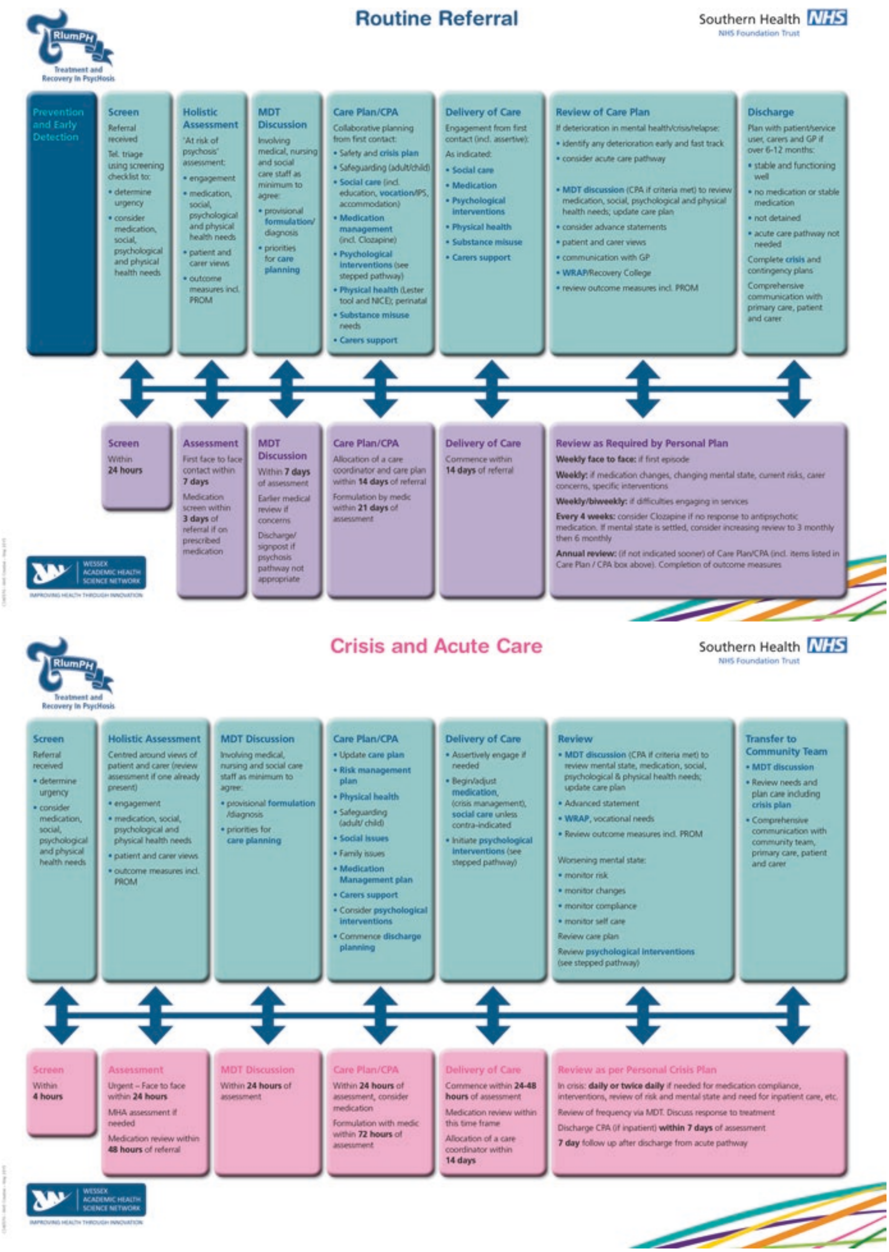

Fig. 2.1 Treatment and Recovery In PsycHosis (TRIumPH) pathway

For the first time in the history of mental health, an integrated care pathway called TRIumPH (Treatment and Recovery In PsycHosis) (Fig. 2.1)—that prescribes time frames around access and clinical interventions—has been developed and evaluated in the United Kingdom (Rathod and Psychosis Pathway Steering

Group 2015). The work has used a similar approach to that taken to improve stroke care, where there has been a demonstrable improvement in outcomes for patients and carers. The new psychosis pathway aims to reduce the impact of disease and promote recovery by ensuring that every individual gets the best evidence-based care at the right time and in the right place.

In developing the pathway, a multipronged approach has been used, using (i) research and data, (ii) coproduction with individuals with lived experience of mental illness and their carers, and (iii) engagement with clinicians and other stakeholders including commissioners, primary care, and third sector organizations (Rathod et al. 2015b). The approach has used a robust methodology which can be adapted and adopted nationally and internationally.

2.5 Delivery of Care: Treatment and Therapy Options

Traditionally, treatment in psychosis has meant the use of psychotropic medications which for very long time have been considered to be critical in the early treatment of psychosis. Chlorpromazine, introduced in 1952, was the first antipsychotic agent shown to have significant efficacy in the treatment of positive psychotic symptoms. It contributed to the reduction of inpatient population from its peak in 1950 to its current low in the USA. Antipsychotic medications range from the first-generation typical drugs like Chlorpromazine and Haloperidol to second-generation atypical medications like Olanzapine, Risperidone, and Aripiprazole. All antipsychotics block dopamine receptor pathways, but atypicals also tend to act on Serotonin receptors in addition. Neuromodulatory treatments for a very long time were limited to electroconvulsive treatment but now include transcranial magnetic stimulation (TMS) and transcranial direct current stimulation (TDCS). We now have evidence for the effectiveness of TMS in schizophrenia while the data is not yet adequate on TDCS (Cole et al. 2015).

Psychosocial interventions for psychosis can be classified as evidence-based or promising practices according to the extent to which efficacy is supported by meta-analyses, randomized controlled trials (RCTs), and best practice guidelines, e.g., NICE (2014). The best evidenced therapies for people with psychosis are currently cognitive behavior therapy (CBT) (Dixon et al. 2009; Wykes et al. 2008; Turner et al. 2014; NICE 2014), family interventions (FI) (Pharoah et al. 2010), and supported employment for psychosis (Dixon et al. 2009). Evidence is building for cognitive remediation therapy (CRT) although literature suggests that it is more effective when patients are clinically stable and stronger effects have been found when CRT has been combined with adjunctive rehabilitation (Wykes et al. 2011).

Promising psychosocial interventions include cognitive adaptive therapy, healthy lifestyle interventions, peer support services, physical disease management, prodromal stage intervention, social cognition training, supported education, and supported housing (Mueser et al. 2013). There are some innovative approaches, such as Finnish open dialogue and Avatar therapy (Leff et al. 2013; Seikkula 2002), and a new Yoga Mindfulness based cognitive therapy (Y-MBCT) for individuals with psychosis and significant trauma (Please see Chap. 5), currently under evaluation. Most of these interventions are delivered in individual format. However, group CBT has shown promising value (Gledhill et al. 1998; Wykes et al. 1999) in psychosis (Kumari et al. 2011) and has the added benefit of maximizing the available resources.

It is very tempting to suggest standard interventions in the name of uniformity of care. However, individuals vary very significantly in their symptoms, their coping skills, their cultural and familial background, and their resilience, and therefore, standards across the board interventions are not very helpful to everyone. Instead, people would benefit from a personalized approach to psychosocial interventions. Often, psychoeducation that is nonstigmatizing and hope engendering complimented with low-intensity interventions based on CBT principles of identifying and strengthening existing coping strategies or mindfulness (Walker et al. 2013) is helpful in meeting people at the level they are in and keeps them engaged in treatment. Any intervention should be person centered and needs-led. With this philosophy in mind, Rathod and colleagues (2015a, b) recommend a stepped care model and approach to providing psychological therapies as described below. Such an approach ensures that people who suffer with psychosis have access to interventions that are needs-led and cost-effective. A stepped care approach requires clinicians to work with patients based on a collaboratively agreed plan and helps patients prepare for further interventions like intensive CBT in the future. These are described below (Fig. 2.2).

2.5.1 Phase 1 Interventions

Current literature indicates a modest but growing evidence base for the following interventions:

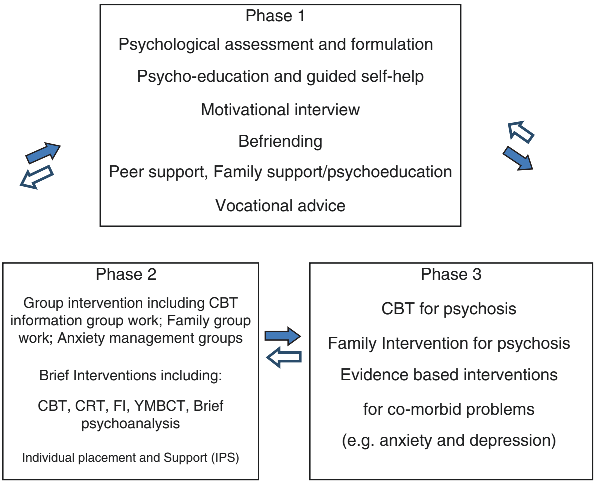

Fig. 2.2 Stepped care approach to psychosocial interventions (Ref: Adapted from Rathod and psychosis pathway steering group, 2015)

2.5.1.1 Psychoeducation and Guided Self-Help

Symptoms of psychosis can be frightening to many and, especially in the first episode, difficult to comprehend and understand. Psychoeducation and self-management help to improve the person’s understanding of their experiences, mental health needs, treatment options, and self-management skills. Psychoeducation should include the broad perspective of the psychotic experiences having very different outcomes and an acknowledgment that the understanding of the field about these experiences is still evolving. It is important to give examples of individuals who are diagnosed with psychotic symptoms and functioning at a high level. For many, the aim of psychoeducation is to improve understanding and functioning, reduce risk of relapse, and improve medication concordance (Gellatly et al. 2007; Xia et al. 2011). Psychoeducation should reduce stigma, provide a broad understanding of the symptoms and the available options, and empower individuals to make treatment choices that are consistent with their world view and belief systems. This would also mean that some individuals and families make a decision to delay pharmacotherapy and opt for more psychosocial interventions. Friends and family of all people who suffer with psychosis also benefit immensely through this package (NICE 2014) as it helps them understand the symptoms, mental health needs of the person they care for, and how to support recovery.

2.5.1.2 Peer Support

There is growing evidence that peer support may improve mental health, coping skills, use of inpatient services, and quality of life (Davidson et al. 1999, 2012). Furthermore, literature suggests that peer support can have a beneficial impact on people’s social networks (Castelein et al. 2008). In a review, the Centre for Mental Health analyzed six empirical studies to examine the economic case for peer support workers in mental health settings. The value of bed-days saved per peer support worker ranged from £42,653 to £146,330 over 6 months and from £44,578 to £245,515 over 12 months. Using a weighted average across all studies, the report concluded that £4.76 would be saved for every £1 invested (Trachtenberg et al. 2013).

The aim of peer support is to provide credible support from someone who has also experienced psychosis. This can include personal advice about living with psychosis and recovery (NICE 2014). One of the difficulties with psychosis is navigating a mental health system that is complex, fragmented, and not always client centered. A peer can be a navigator of the complex health system in addition to their role of providing mentorship, support and advice about recovery. A system of care where every individual with psychosis is paired with a peer navigator can go a long way in helping individuals work through their psychotic experiences.

2.5.1.3 Befriending

There is some evidence that befriending may be effective in reducing relapse and hospitalization (Buckley et al. 2007—Cochrane review). This intervention may also reduce depression (Mead et al. 2010) and implicitly challenge delusional beliefs (Samarasekera et al. 2007). Befriending involves the facilitation of longer-term friendships for social and emotional support, thereby providing an informal and flexible approach in supporting people.

2.5.1.4 Vocational Advice

Evidence suggests that educational and vocational support promote recovery (Killackey et al. 2008; Nuechterlein et al. 2008, 2013). There is a relationship between employment and severe mental illness like psychosis. People with mental health problems, especially psychosis, are much less likely than average to be in paid employment (Rinaldi et al. 2011) although they often wish to be. Vocational advice can include a number of different options like:

- Information gathering (NICE 2014) and identification of occupational short-/long-term goals
- Motivational interviewing regarding education and work
- Assessment of skill set
- Support with contacting job center
- Support with CV, forms, and interviews
- Support with return to work
- Coping strategies
- Individual placement support

2.5.2 Phase Two: Brief Interventions in Psychosis

The rest of the book will focus on this aspect of care for people with psychosis. The chapters that follow will focus on evidence-based interventions and discuss the evidence and feasibility of providing the interventions in a brief format. These interventions not only include psychological therapies but also social interventions like employment support. Each one of the chapters is written by experts or a group of experts in that particular intervention with the expressed idea of adapting it to the limitations of time and resources that we all have to work under. The brief interventions are essentially a solution to the current resource constraints that deprive people from receiving evidence-based care. So, for example, if a client is being monitored for medications, brief family intervention is integrated into the medication visit for someone with family conflicts. Alternately, if substance abuse is an issue, motivational interview is incorporated into the medication monitoring visit. The same goes to other interventions including cognitive behavior therapy, supported employment, etc. This allows practitioners to define treatment goals and work with clients in a more meaningful way.

In the case of some individuals, they may choose not to engage in intensive CBT and therefore, brief interventions like motivational interviewing and recovery-focused sessions may help engage them and prepare them for future CBT. The brief interventions per se may not be adequate for a number of people, and in those instances, the phase three interventions of a full course of CBT or family therapy would be incorporated into the treatment of the clients. As the reader goes through Chaps. 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12, they would be approaching them from a perspective of taking the brief interventions that can be incorporated into their regular practice settings.

Conclusion

It is time now that we review the way we provide care for people who suffer with psychosis. Evidence is emerging that a number of treatment modalities can be helpful to people in dealing with their symptoms and supporting them to achieve recovery so that they can lead meaningful lives.

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