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RESEARCH ARTICLE

PRACTICAL AND APPROPRIATE APPROACHES TO THE TREATMENT OF YOUTH WITH FIRST-EPISODE PSYCHOSIS AND SUBSTANCE USE DISORDERS

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Abstract

Introduction: Many young adults with first-episode psychosis also have substance use disorders (SUDs). For this population, persistent SUDs negatively impact symptomatic and functional outcomes and problem management.This review aims to identify and synthesize the best therapeutic approaches for the treatment of young adults with co-occurring disorders (FPE and SUD) and to present practical and tailored approaches for the assessment and follow-up of these individuals.of individuals with concurrent FPE and SUD.

Method: This review of the literature used the following databases: PubMed; science direct; psychinfo. We used the following

Results: Several studies demonstrate the utility of early intervention services for psychosis (EIS) in managing substance use disorders, with a decrease of approximately half of substance use disorders during the first year of follow-up.To date, clinical guidelines suggest tailored and integrated treatment of psychosis and substance use disorders and recommend the use of a variety of approaches such as case management, comprehensive assessment and feedback on substance use disorders and psychosis and their interaction, risk reduction interventions, motivational interviewing, cognitive behavioral therapy, and pharmacotherapy.It is proposed here that treatment be proactively adjusted to take into account the severity of the disorder, its impact on the various dimensions of psychosis outcomes, the youth's developmental stage, and his or her stage of change with respect to substance use.

Conclusion: Some approaches appear to have the potential to improve the clinical evolution of youth living with such disorders, particularly if tailored to this population. In addition, research and innovation, which is relatively limited, in the management of co-occurring disorders, must continue to provide more appropriate care for young adults with early psychosis and substance use disorders.

Objective: The purpose of this work was to identify and synthesize the best therapeutic approaches for the treatment of young adults with co-occurring disorders (First Psychosis Episodeandsubstance use disorders),and to present practical and tailored approaches for the assessment and follow-up of these individuals. of individuals with concurrent psychaiatric disorders.

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Introduction:-

Early intervention for psychosis offers adapted services for young adults with early-onset psychosis.

However, the management of those with concurrent first-episode psychosis (FPE) and substance use disorder (SUD) presents a greater challenge.

For example, in a prospective longitudinal study carried out in Montreal (Canada) of 212 young people being followed for a first episode of psychosis, 59% were found to have SUD at admission: 43% with cannabis, 19% with alcohol, 15% with amphetamines and 7% with cocaine. Of these, more than 20% had more than one SUD (Abdel-Baki et al., 2017).

This co-occurrence brings with it diagnostic challenges in determining whether it is an induced psychotic disorder versus a primary disorder comorbid́ with an SUD (Ouellet-Plamondon et al., 2019a). These challenges are often the cause of delays in diagnosis and initiation of effective treatment required.

This, in turn, lengthens the duration of untreated psychosis, which has a negative impact on the prognosis of this condition (Penttilä et al., 2013). SUDs in themselves have major impacts on the course of psychosis: more positive symptoms (Abdel-Baki et al., 2017; Addington J and Addington D., 2007; Harrison et al., 2008; Wade et al., 2007), depressive symptoms (Harrison et al, 2008), hospitalizations (Abdel-Baki et al., 2017), psychotic relapses (Malla et al., 2008; Alvarez-Jimenez et al., 2012), as well as poorer social and occupational functioning (Wade et al., 2007; Abdel-Baki et al., 2017). In addition to negative individual consequences, SUDs and psychosis (schizophrenia mainly studied) represent a high societal cost related to required healthcare such as hospitalizations, emergency room visits and medical follow-up, lost productivity, difficulty in maintaining employment and secondary legal problems (Canadian Substances Use Cost and Harm, 2014; Chong et al., 2016).

The aim of this review is to identify and synthesize the best-proven therapeutic approaches for the treatment of young adults with co-occurring disorders (PEP and SUD) and to present avenues for practical, tailored approaches to the assessment and follow-up of people with co-occurringFPE and SUD.

Method:-

This review of the literature on the treatment of young adults with concurrent disorder (PEP and TUS). Included articles were identified from the Pubmed informatized database using the following keywords: ([early psychosis] OR [first episode psychosis]) AND ([concurrent disorder] OR [substance use disorder] OR [substance abuse] OR [dual disorder] OR [addiction]) AND ([detection] OR [early detection] OR [intervention] OR [early intervention] OR [treatment]) as well as additional searches in the bibliographies of selected articles.used the following databases: PubMed; science direct; psychinfo. We used the following

key words:
first episode psychosis, substance use disorder, addiction, early intervention, concurrent disorder, treatment.

Results:-

Titles and abstracts were reviewed and relevant articles were read and included in this review. The number of systematic reviews (N = 1), studies (N = 9) and guidelines (N = 4) specifically addressing the treatment ofFPE with co-occurring SUD was 14 documents in total. One systematic review on the per os pharmacological treatment of co-occurring disorder (SUD and psychotic disorder [not specificallyFPE]) was included, as there were no studies specifically addressing this topic in the population with co-occurringFPE and SUD. Three practice guidelines on psychotic disorders were also included, as some portions were relevant toFPE and/or concurrent disorder (psychosis and TUS).

Best practices for the co-occurrence ofFPE and TUS

1-Study results on psychosocial interventions for co-occurringFPE-TUS.

There is little conclusive evidence that specific interventions targeting substance use in FPE are superior in terms of efficacy. A systematic review focusing specifically on the course and treatment of SUD in people with FPE examines studies published between 1990 and 2009 (Wisdom et al., 2011), reporting that FPE without a specialized

SUDprogram (some longitudinal) showed a reduction in substance use of around 50%, often within weeks or months of starting treatment. On the other hand, she identifies 5 studies looking at specialized programs targeting SUD within FPEPs: none demonstrated superioritý in terms of abstinence or reduction in use compared with regular treatment offered in FPEPs (see Table 1: Addington and Addington, 2007; Carr et al., 2009; Edwards et al., 2006; Gleeson et al., 2009; Kavanagh et al. 2004). Other studies have also been carried out on populations presenting with emergent psychosis withSUDtreated in a FPEPs.

Two studies demonstrated a superiority of specific interventions for SUD at 6 months, but methodological limitations limit the generalizability of one of these studies (Kemp et al., 2007). As for the second study, despite a reduction in cannabis use and greater confidence in the ability to change use patterns at 3 and 6 months, it failed to demonstrate a sustained effect 6 months post-intervention (Bonsack et al. 2011). The use of cognitive behavioral therapy (CBT) and motivational interviewing did not demonstrate superiority in 4 randomized controlled trials (RCTs), on either functional improvement or substance use reduction (Barrowclough et al., 2014; Cather et al., 2018; Hjorthoj et al., 2013; Madigan et al., 2013). On another note, a RCT comparing FPEPsversus FPEPs treatment as usual with the addition of contingency treatment did not demonstrate intervention superiority (Johnson et al., 2019). Lastly, one study evaluated the impact of adding a specialized sub-team for homeless youth with co-morbid FPE andSUDwithin FPEPs.At 2-year follow-up, there was an advantage in terms of speed of return to stable housing and fewer days of hospitalization, while there was no difference attributable to the interventions in terms of factors related to substance use (Doré-Gauthier et al., 2020).

2-Results of studies investigating pharmacotherapy for comorbid First Psychotic Episode and/or Psychotic Disorder-TUS.

In a cohort study including all young people presenting with FPE with SUD followed by 2 FPEPs (N = 237), long-acting intramuscular antipsychotic medication was shown to reduce the risk of relapse and rehospitalization and increase the time to them (Abdel-Baki et al., 2020).

A systematic review and meta-analysis of 19 RCTs (27 references, including 1,742 participants, median number of participants per study: 30 [4-643]) focused on antipsychotic medication (per os) for people with schizophrenia (not specifically young people withFPE) and TUS. The TUS types were SUD-cannabis (6studies), SUD-cocaine (4 studies),SUD-alcohol (2 studies), unspecified substance use for person with cannabis-induced psychotic disorder (2 studies) and amphetamine-induced psychotic disorder (1 study). The antipsychotic prescribed had no significant influence on the number of people using (primary outcome, 4 studies each with fewer than 50 participants; olanzapine vs risperidone; olanzapine vs haloperidol; aripiprazole vs perphenazine).In respect of reduced substance use (secondary outcome), 2 studies found no difference between different antipsychotics (clozapine vs. ziprazidone; olanzapine vs. risperidone) and 1 study demonstrated that clozapine was superior to the "other antipsychotics" group.

Risperidone reduced the craving for cannabis more than olanzapine (secondary outcome, 1 study). Other secondary outcomes were change in symptoms of psychotic illness, dropouts, quality of life, social functioning and side effects. The Authors point out that firm conclusions are difficult to draw as the studies have small samples, are sometimes not very detailed and the risk of bias is high e.g., 74% do not detail the randomization procedure and information on the data and selection process is often missing (Krause et al., 2019)

3-Practice guidelines for the concomitant disorder FPE and TUS

Integrated interventions for SUD and FPE

The intervention offered by FPE, which appears to be beneficial in reducing SUD, includes various components: case management offered by focal workers as the cornerstone of follow-up (EPPIC, 2001), psychiatric follow-up including low-dose medication, group interventions, CBT for psychosis, employment and educational support, as well as family interventions including family support and education. (Bertulies-Esposito et al., 2019; Bertulies-Esposito et al., 2022; EarlyPsychosis Guidelines Writing Group and EPPIC National Support Program, 2016; Ministère de la Santé et des Services sociaux, 2017).

Psychological education on psychosis and recovery (vulnerability-stress-protective factors model) offered by EPPIC suggests avoiding alcohol and drug use, the latter being identified among the risk factors for psychotic relapse.

On the basis of the promising results of integrated treatment for people with severe and persistent mental health disorders concomitant with SUD (Drake et al, 1998), many practice guidelines for early intervention for psychosis recommend integrating care for SUD and psychosis into their programs, through the inclusion of SUD treatment expertise within programmer FPE itself and, where appropriate, through close collaborations with an addictions service (Early Psychosis Guidelines Writing Group and EPPIC National Support Program, 2016; Department of Health and Human Services, 2017; Substance Abuse and Mental Health Services Administration: First- Episode Psychosis and Co-Occurring Substance Use Disorders, 2019).

It was suggested that time-limited interventions (weeks/months) be considered first before trying longer treatments, since they have not been shown to be superior, as described in the previous section.

The contribution of the contingency approach, peer support and family approaches should be considered to improve the effectiveness of interventions (Substance Abuse and Mental Health Services Administration: First-Episode Psychosis and Co-Occurring Substance Use Disorders, 2019).The importance of taking different factors into account in interventions for young people with FPE and SUD is emphasized: age and developmental stage, circumstances leading up to treatment, widespread substance use among peers and cognitive difficulties secondary to substance use. Special attention to the families of these young people is mentioned, as the distress and burden associated with the co-occurrence of disorders and their consequences may require additional attention (Early Psychosis Guidelines Writing Group and EPPIC National Support Program, 2016).

Components of integrated intervention

No studies have focused on identifying the specific components of FPE treatment related to the observed reduction in substance use. Different modalities, useful for SUDs without co-occurring disorders, are suggested in practice guides as preferred ingredients.

Use the case management approach
Comprehensive initial assessment of SUD, psychosis and their interrelation Assessment and monitoring of substance use, integrated with FPE treatment
Providing post-assessment feedback on the severity of SUD and its impact1,3. It can be therapeutic in its own right, and is an opportunity for psychological education on the physical and mental health risks of substance use, including explaining the link between regular use of psychoactive substances and a poor prognosis for psychosis, general health or social functioning. Substance use assessment and monitoring, integrated with FPE treatment
UtiliUsing a harm reduction approach.
Integrating evidence-based psychological treatments such as motivational interviewing and cognitive-behavioural therapy, with lifestyle interventions. For youth who do not reduce their use with the usual treatment offered by FPE, interventions targeting substance use should be offered. However, no rigorous study has clearly demonstrated the superiority of a specific intervention for youth with FPE versus usual treatment that includes psychological education on psychosis and substance use.
Use of pharmacological interventions, as needed, during certain phases such as acute detoxification, craving management and withdrawal e.g., use of benzodiazepines to prevent alcohol withdrawal complications.
Provide evidence-based treatments for both conditions, with a benefit from combining antipsychotic treatment with psychosocial interventions targeting SUD.
When drug consumption remains present and dangerous, consider involuntary admission to hospital and/or referral to rehabilitation services for long-term SUD .
Interventions addressing SUD should be offered in a manner that is culturally sensitive.

1- Early Psychosis Guidelines Writing Group and EPPIC National Support Program, 2016; 2- Substance Abuse and Mental Health Services Administration: First-Episode Psychosis and Co-Occurring Substance Use Disorders, 2019 ; 3- National Institute for Health and Care Excellence (NICE), 2014 ; 4- Galletly et coll., 2016 ; 5- Crockford et Addington, 2017 ; 6- Lo et coll., 2016.

4-The pharmacotherapy of SUD for people with psychotic disorder and concomitant SUD (not specifically FPE)

In the British Psychopharmacological Association's practice guide on medication for schizophrenia (Barnes et al., 2020), it was recommended to use the medication that has been proven effective for each SUD: varenicline, bupropion or nicotine replacement therapy for SUD-nicotine; naltrexone or acamposate for SUD-alcohol; opioid agonist treatments for SUD-opioids. For cannabis, cocaine and other stimulants, there is no proven effective medication.

Ultimately, the use of stimulant medication for attention deficit hyperactivity disorder is not recommended in people with concomitant psychosis and SUD (Galletly et al., 2016).

5-Substance-induced psychosis

As the risk of psychotic disorder is high following a diagnosis of substance-induced psychotic disorder (schizophrenia and related psychoses or bipolar disorder) (Starzer et al., 2018), referral to a PPEP and an SUD specialist is recommended in such cases (Galletly et al., 2016). The Canadian guidelines for schizophrenia and related psychoses with co-occurring SUD (Crockford and Addington, 2017) recommend that a substance-induced disorder be treated as a primary psychotic disorder with the initiation of antipsychotic medication for 12 to 18 months aiming for the lowest effective dose, taking into account the expected benefits versus risks and side effects. Furthermore, it has been suggested that discontinuation of antipsychotic medication should only take place under medical supervision (Galletly et al., 2016).

Discussion:-

According to this review of the literature about the treatment of co-occurring disorders (FPE and TUS), only 2 studies of specific psychosocial interventions demonstrated a short-term effect in reducing substance use that was superior to the usual programme of FPE treatment, and no study demonstrated a sustained effect over time.

Pharmacologically, one study demonstrated the superiority of long-acting antipsychotics in preventing psychotic relapse and rehospitalization in this population.

As for practice guidelines, they stress the importance of integrated treatment of the 2 disorders and suggest the use of case management, in-depth assessment followed by feedback on both disorders and their interaction, harm reduction, and the most evidence-based psychological interventions (EM, CBT) combined with antipsychotic treatment, if necessary, with specific treatment for SUD. They also suggest adapting interventions to the developmental phase, taking into account cognitive disorders and the impact on families.

Limits:

This review of the literature traces the most evidence, but it is possible that innovative or ongoing studies were not included by our search method. The method used (narrative review) has its limitations.

Articles published in English and French only are included.

Despite the many studies listed, the level of evidence remains low. Several methodological limitations are present such as the small sample sizes limiting statistical power and populations varying from one study to another (e.g. some studies include a mixture of people with cannabis use and cannabis-USDwhile other studies focus on individuals with SUD [one or more substances combined]; some studies only include people whose SUD persists after 12 months of follow-up, while others include individuals regardless of how long the SUD persists; many studies do not take into account the stage of change of young people or include them even if they are not ready to change their habits).furthermore, control groups often receive an effective intervention for the reduction of already very intensive and enhanced SUD

(FPE programming which, in spite of clear guidelines, may vary from place to place). In addition, the intensity and duration of interventions vary from study to study, as do the length of study and the type of psychosocial intervention assessed. In addition, most studies are limited to cannabis. Several studies do not seem to take into account the interaction between multiple SUD often present in the same individual (Abdel-Baki et al., 2017). It is possible that youth with concurrent disorders may be divided into subgroups with different cognitive abilities and

needs, which vary depending on the substances used and the severity of the disorders, which could influence the response to treatment, in particular psychotherapeutic approaches.

Practical and adapted approaches for the assessment and monitoring of people with FPE and SUD.
granted the limited level of evidence, we propose below practical and adapted approaches for the assessment and monitoring of people with concomitant FPE and SUD based on the literature, including practice guides.valuing and managing person with concurrent disorders is complex.

We cannot claim to be able to generalize these recommendations, because certain circumstances and particular populations may have different specific needs, We want to emphasize the importance of being sensitive in our approach to the equity, diversity and inclusion aspects that, while extremely important, exceed the objective of this review and have not been addressed.

1 Detection and assessment of concurrent disorders.
In decree to facilitate access to services, appraisal of concurrent disorder should be possible in SUDservices as well as mental health services (Crockford & Addington, 2017). It seems important to raise awareness and inform about the nature and consequences of the pair disorders.the various person concerned who can meet and evaluate young people with FPE and Sud: nurses and doctors working in the emergency department, community resources for youth, the homeless and addictions network, and health professionals.

A detailed assessment of the chronicle of substance use and current use allows for a portrait of the type of consumer and the development of personalized therapeutic interventions. genetic predispositions and the substances used (present-day and preceding, including tobacco) and the habits surrounding consumption are documented: the patter of consumption (ingested, smoked, intranasal, injected), quantity, frequency, the context, the period of the first take of the day, the stop tests (duration, withdrawal, support received or not, reason/context of relapse), reasons for consumption...

A comprehensive questionnaire of the various psychoactive substances is useful, since youthful population may forget or not think to mention certain relevant substances and details.

For example, concern cannabis drugs, we are interested at the percentage of THC and CBD and the source, legal or not.

We need to not forget the use of caffeine (coffee, energy drinks), often trivialized, but which can have a significant clinical impact by generating insomnia, anxiety or hypomaniac symptoms. Behavioural dependencies such as gambling and the problematic use of the Internet furthermore need to be explored predetermined the frequent concomitance of different impulse control disorders. Their clinical impact can lead to a very precarious and isolated situation, which in turn affects the young person's mental health.

The clinical analysis should include the risks that may be associated with consumption's drug: STI and blood infections, risk behaviours such as sharing of consumer equipment, prostitution, sexual exploitation, violence, abuse, harm to obtain use (theft, sale of substances, etc.), impaired driving and trauma.

A significant proportion of psychotic disorders diagnosed as "induced" in the emergency department will eventually evolve into a primary disorder (schizophrenia spectrum, bipolar disorder) in nearly 50% of cases for cannabis, 30% for amphetamines and 20% for cocaine or alcohol (Starzer et al., 2018).

We must therefore remain vigilant in the front of induced psychotic disorder, which can very often be the first manifestation of a primary psychotic disorder.

2 Commitment to follow-up
The youth'sexperienceof the health systemand social services will influence theirwillingness to use them or not for help. Aquick response, a welcome without anappointment or an appointment offered veryquickly with an empathetic, warm, unbiasedattitude, reinforcing the current approach ofcoming for services, are most useful. Since these youths are often unstable, mayhave cognitive impairments related topsychosis and substance abuse,difficultyincaring for their health, and impaired self-criticism, it is useful for pivotal caregivers touse outreach

outside the clinic and to beflexible at the beginning of follow-up in order to establish a collaborative approach that willestablish a clear therapeutic framework. Plansshould be made to recall appointments, toreinstate in case of absence by various meansagreed in advance with the youth, and toschedule appointments whenever possible attimes that will facilitate attendance (e. g.avoid the mornings for the youth who wake uplate). Regular meetings at a fixed time canhelp patient with memory and organizationaldifficulties to attend.

Ideally, it is suggestednot to close the file when there is repeatedabsenteeism, or at least to provide a simpleadministrative process to resume follow-upwithout delay when the youth reconnect. Young people often come back after monthsof absence and at that point they are moremotivated to follow up, often in a crisis period. Moreover, technology plays an important role in the lives of young people, we must try to adapt our approaches to reach them by the means they use (correspondence by text or email, sharing of resources via the web).

The integration of telemedicine, without being a complete substitute for in-person monitoring, can have several advantages:

1. promote observance to follow-up
2. maintaining contact in the event of a schedule that is difficult to assure, displacement or temporary removals (Lal et al., 2020).
3. It can facilitate the implementation of integrated treatment with joint meetings with partners from other organizations and to meet families difficult to reach otherwise.
4. Helping the young person strengthen ties or reconnect with their significant loved ones will allow the young person to have a stronger support network. The possibility of involving relatives in follow-up can also promote the youth's involvement.

Having common objectives is the cornerstone of successful monitoring.

For some young people, motivation for follow-up begins with concrete goals that are not directly related to their disorders, but that flow from them. The role of the pivot is central to using these opportunities to create an alliance and start collaboration.

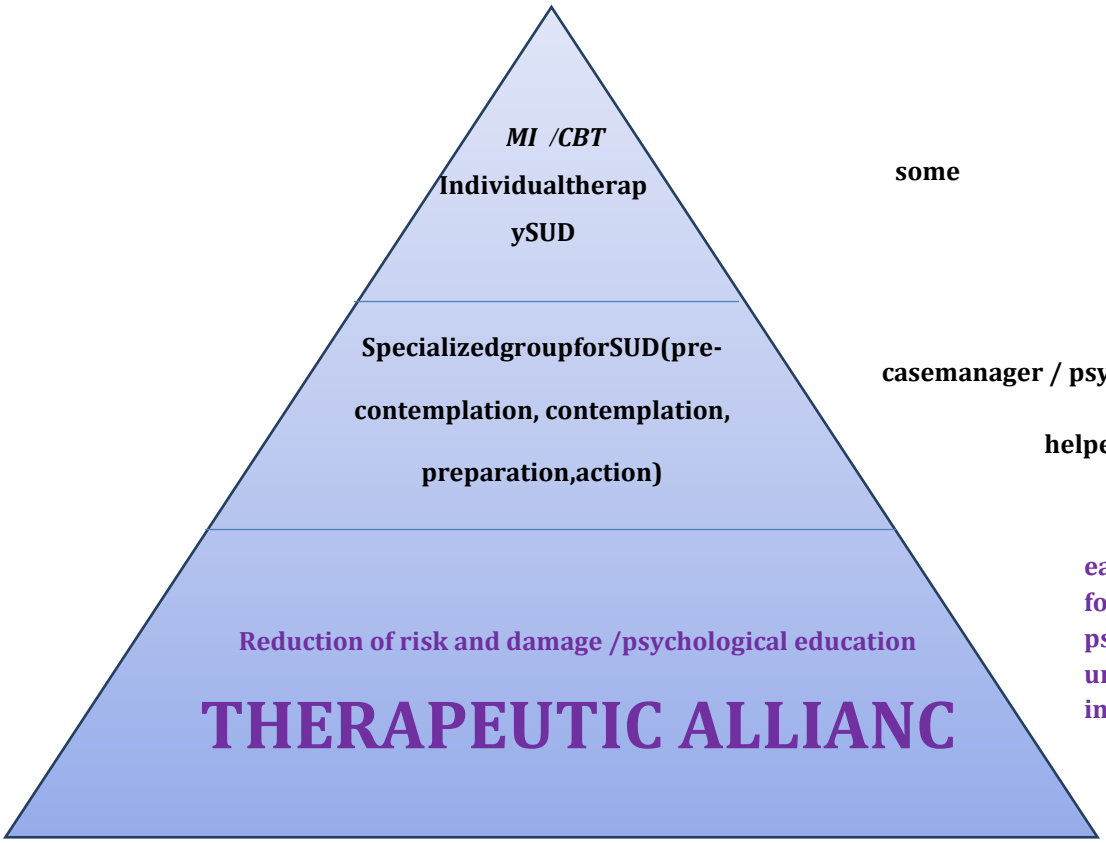
It is important to consider the developmental stage of young adults (Ouellet-Plamondon et al., 2012). consumption can be an opportunity and a pretext for socialization, especially for some youth with cognitive disabilities and social skills difficulties. acquisition to set limits is often a major challenge

3 Provide integrated and individualized treatment for youth with FPE and SUD

Supporting young adults with FPE and SUD in their recovery remains a challenge, both to allow access to care, assessment, accurate diagnosis and commitment to follow-up. This requires a great deal of adaptation, flexibility, tolerance, patience, hope and perseverance for health care teams, but also for young people and their families. The severity of disorders, both psychotic and substance use, and the stage of change in relation to use (precontemplation, contemplation, preparation, action, maintenance, relapse [Prochaska and DiClemente, 1984]) are 2 key considerations for tailoring interventions to make sense to the individual. It is customary to navigate from one stage of change to the next quickly.

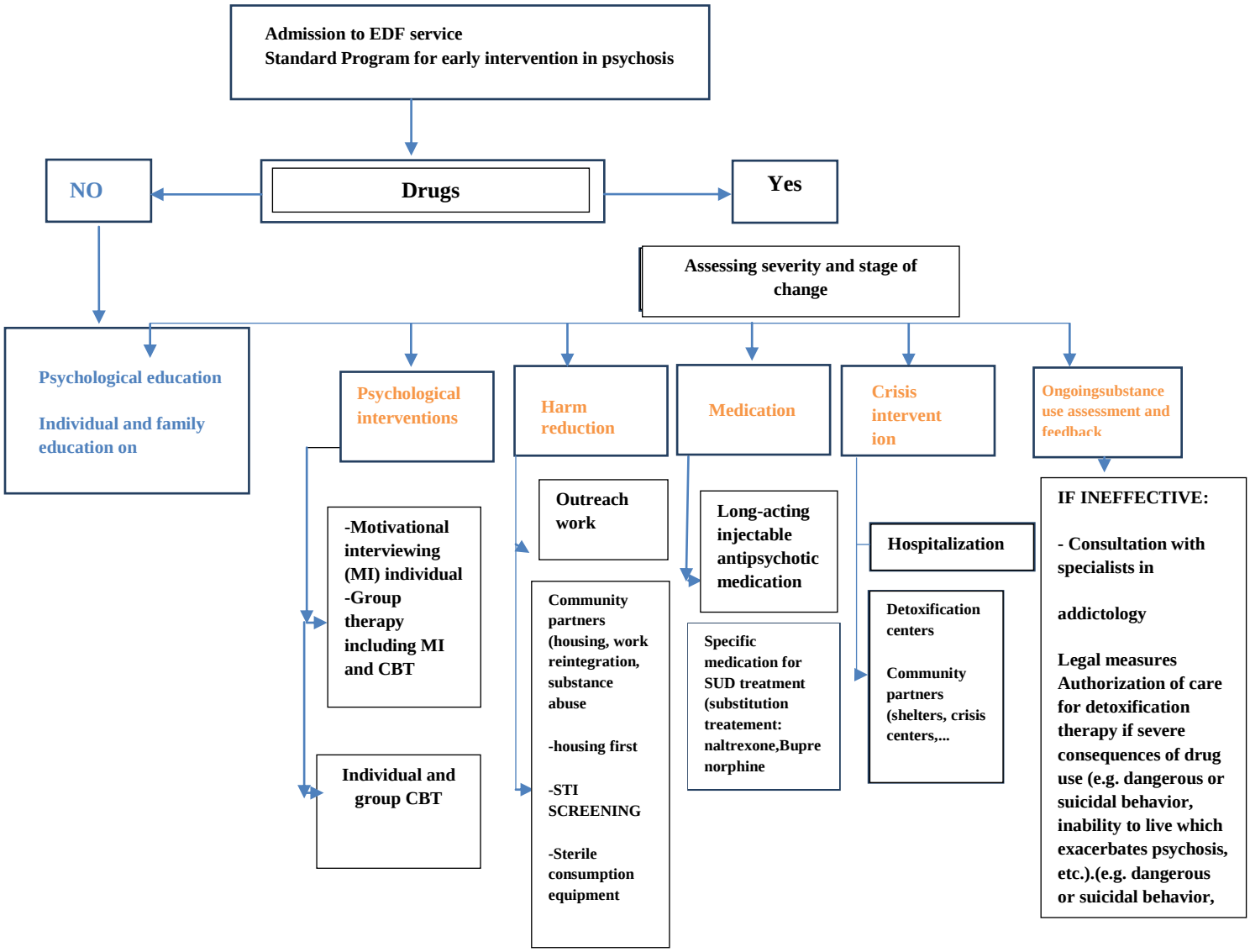
Figure1:- Details of treatment taking into account the stage of change and Figure 2 : summarizes the different components of treatment to be considered.

Figure 1:- Stepped interventions for people with concurrentFPE and SUD



MI : motivational interview
CBT :Cognitive behavioral therapy

Figure 2:summarizes the different components of treatment to be considered.



Conclusion:-

There are many challenges in working with young people with concurrent disorders.

Best-practice data on the treatment of co-occurring FPE-SUD is relatively limited.

Some of these approaches do appear to have the potential to improve the clinical outcome of young people living with such conditions, especially if they are tailored to this population.

Sustained efforts must be made to pursue research and innovation in the management of co-occurring disorders, in order to optimize and diversify available interventions, and ultimately to offer better adapted care to young adults living with a First Episode Psychotic Disorder and SUD.

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