Early Psychosis: Intervening Early for Lasting Recovery

Authored by

mohammad looti

June 17, 2026

Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of the new prevention paradigm for psychiatry and is leading to reform of mental health services, especially in the United Kingdom. There has been considerable academic interest over the past decade.

This approach centers on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed to be a critical period. The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long term impact of the condition. It is considered a secondary prevention strategy.

The duration of untreated psychosis (DUP) has been shown as an indicator of prognosis, with a longer DUP associated with more long term disability.

Components of the model

There are a number of functional components of the early psychosis model, and they can be structured as different sub-teams within early psychosis services. The emerging pattern of sub-teams are currently:

Early psychosis treatment teams

Multiple discipline clinical teams providing an intensive case management approach for the first three to five years. The approach is similar to assertive community treatment, but with an increased focus on the engagement and treatment of this previously untreated population and the provision of evidence based, optimal interventions for clients in their first episode of psychosis. For example, the use of low-dose antipsychotic medication is promoted ("start low, go slow"), with a need for monitoring of side effects and an intensive and deliberate period of psycho-education for patients and families that are new to the mental health system. Interventions to prevent a further episodes of psychosis (a "relapse") and strategies that encourage a return to normal vocation and social activity are a priority. There is a concept of phase specific treatment for acute, early recovery and late recovery periods in the first episode of psychosis.

Early detection function

Interventions aimed at improving the detection and engagement of those early in the course of their psychotic conditions. Key tasks include being aware of early signs of psychosis and improving pathways into treatment. Teams provide information and education to the general public and assist GPs with recognition and response to those with suspected signs, for example: EPPIC's Youth Access Team (YAT) (Melbourne); OPUS (Denmark); TIPS (Norway); REDIRECT (Birmingham);

LEO CAT (London).

Prodrome or "at risk mental state" clinics

There are specialist services for those with subclinical symptoms of psychosis or other strong indicators of risk of transition to psychosis. The Pace Clinic in Melbourne, Australia, is considered one of the origins of this strategy, along with the Institute of Psychiatry based service OASIS in South London, Yale Medical School based clinic, PRIME, The Center of Prevention and Evaluation (COPE) at the Columbia University Medical Center in New York City, the Recognition and Prevention Program based at the Zucker Hillside Hospital in Glen Oaks, New York, and the NAPLS site based at the Emory University Department of Clinical Psychology in Atlanta, Georgia. These services are able to reliably identify those at high risk of developing psychosis and are beginning to publish encouraging outcomes from randomised controlled trials that reduce the chances of becoming psychotic, including evidence that psychological therapy and high doses of fish oil have a role in the prevention of psychosis.

History

Early intervention in psychosis is a preventative approach for psychosis that has evolved as contemporary recovery views of psychosis and schizophrenia have gained acceptance. It subscribes to a "post Kraepelin" concept of schizophrenia, challenging the current assumptions originally promoted by Emil Kraepelin in the 19th century, that schizophrenia (or dementia praecox) was a condition with a progressing and deteriorating course. Psychosis is now formulated within a diathesis-stress model, allowing a more hopeful view of prognosis, and expects full recovery for those with early emerging psychotic symptoms. It is more aligned with psychosis as continuum (such as with the concept of schizotypy) with multiple contributing factors, rather than schizophrenia as simply a neurobiological disease.

Within this changing view of psychosis and schizophrenia, the model has developed from a divergence of several different ideas, and from a number of sites beginning with the closure of psychiatric institutions signaling move toward community based care. In 1986, the Northwick Park study discovered an association between delays to treatment and disability, questioning the service provision for those with their first episode of schizophrenia. In the 1990s, evidence began to emerge that cognitive behavioural therapy was an effective treatment for delusions and hallucinations. The next step came with the development of the EPPIC early detection service in Melbourne, Australia in 1996 and the prodrome clinic led by Alison Yung. This service was an inspiration to other services, such as the West Midlands IRIS group, including the consumer non-governmental organisation Rethink; the TIPS early detection randomised control trial in Norway; and the Danish OPUS trial. In 2001, the United Kingdom Department of Health called the

development of early psychosis teams "a priority". The International Early Psychosis Association, founded in 1998, issued an international consensus declaration together with the World Health Organisation in 2004. Clinical practice guidelines have been written by consensus.

Clinical outcome evidence

An early psychosis approach has been shown in formal studies to reduce the severity of symptoms, improve relapse rates, and decrease the use of inpatient care, in comparison to standard care, at 18 months follow up. These studies also clearly show greater levels of user satisfaction with the service. Although the evidence for an ongoing positive impact has yet to be established, some have noted that the underlying assumptions and lack of evidence for the current late intervention standard service approaches make the rationale early intervention "overwhelming".

The earlier 2006 Cochrane review continues to report a lack of strong research evidence for specific early detection and early intervention programmes, although it does acknowledge the need to intervene earlier for those with psychosis. Since that time, the emerging evidence on treatment outcome for early psychosis is positive.

Current literature on cost

Evidence from the United Kingdom suggests that the costs of an early psychosis service are considerably less compared to standard care with one year costs for early psychosis teams (£9,422) two thirds the cost of standard teams (£14,394). This is maintained at Year 3 and is thought to be due to the reduced inpatient costs with the more intensive community follow up provided by early psychosis services.

An Australian historical comparison of direct health costs found a clear economic advantage for an early psychosis approach compared to standard care, at 12 month follow up. Another report, commissioned by Orygen Research Centre in Melbourne, concludes: EI not only costs nearly AU$2000 less per person annually than TAU (treatment as usual) in trial-related costs, it also saves nearly AU$1500 in health system and other financial costs...total saving to society of nearly AU$9000 per patient per year. This does not take into account the potential benefits of EI in reducing suicides and positive impact on vocational outcomes.

Reform of mental health services

United Kingdom

The United Kingdom has probably made the most significant service reform with their adoption of

early psychosis teams, with early psychosis now considered as an integral part of comprehensive community mental health services. The Mental Health Policy Implementation Guide outlines service specifications and forms the basis of a newly developed fidelity tool. There is a requirement for services to reduce the duration of untreated psychosis, as this has been shown to be associated with better long term outcome. The implementation guideline recommends:

14 to 35 year age entry criteria
First three years of psychotic illness
Aim to reduce the duration of untreated psychosis to less than 3 months
Maximum caseload ratio of 1 care coordinator to 10-15 clients
For every 250,000 (depending on population characteristics), one team
Total caseload 120 to 150
1.5 doctors per team
Other specialist staff to provide specific evidence based interventions

Australia and New Zealand

Services have spread from the origin founding EPPIC initiative in Melbourne (Victoria, Australia) since the 1990s.

New Zealand has operated significant early psychosis teams for more than ten years, following the inclusion of early psychosis in a mental health policy document in 1997. There is a national early psychosis professional group, New Zealand Early Intervention in Psychosis Steering Group, organising training events and producing local resources.
Scandinavia

Early psychosis programmes have continued to develop from the original TIPS services in Norway and the OPUS randomised trial in Denmark.

North America

Canada has extensive coverage across most provinces, including established clinical services and comprehensive academic research in British Columbia (Vancouver), Alberta (EPT in Calgary), and Ontario (PEPP, FEPP). In the United States, the Early Assessment and Support Alliance is implementing early psychosis intervention statewide.

Asia

The first meeting of the Asian Network of Early Psychosis (ANEP) was held in 2004. There are now established services in Singapore and Hong Kong.

Delusional disorder

Delusional disorder is a psychiatric diagnosis denoting a psychotic mental disorder that is characterized by holding one or more non-bizarre delusions in the absence of any other significant psychopathology. Non-bizarre delusions are fixed beliefs that are certainly and definitely false, but that could possibly be plausible, for example, someone who thinks he or she is under police surveillance. For the diagnosis to be made, auditory and visual hallucinations cannot be prominent, though olfactory or tactile hallucinations related to the content of the delusion may be present.

To be diagnosed with delusional disorder, the delusion or delusions cannot be due to the effects of a drug, medication, or general medical condition, and delusional disorder cannot be diagnosed in an individual previously diagnosed with schizophrenia. A person with delusional disorder may be high functioning in daily life and may not exhibit odd or bizarre behavior aside from these delusions. The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines six subtypes of the disorder characterized as erotomanic (believes that someone famous is in love with him/her), grandiose (believes that he/she is the greatest, strongest, fastest, most intelligent person ever), jealous (believes that the love partner is cheating on him/her), persecutory (believes that someone is following him/her to do some harm in some way), somatic (believes that he/she has a disease or medical condition), and mixed, i.e., having features of more than one subtypes. Delusions also occur as symptoms of many other mental disorders, especially the other psychotic disorders.

The DSM-IV, and psychologists, generally agree that personal beliefs should be evaluated with great respect to complexity of cultural and religious differences since some cultures have widely accepted beliefs that may be considered delusional in other cultures. Specifically, to be a "delusion," a belief must be sustained despite what almost everyone else believes, and not be one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith).

Indicators of a delusion

The following can indicate a delusion:

The patient expresses an idea or belief with unusual persistence or force.
That idea appears to exert an undue influence on the patient's life, and the way of life is often altered to an inexplicable extent.
Despite his/her profound conviction, there is often a quality of secretiveness or suspicion when the patient is questioned about it.
The individual tends to be humorless and oversensitive, especially about the belief.
There is a quality of centrality: no matter how unlikely it is that these strange things are happening

to him, the patient accepts them relatively unquestioningly.
An attempt to contradict the belief is likely to arouse an inappropriately strong emotional reaction, often with irritability and hostility.
The belief is, at the least, unlikely, and out of keeping with the patient's social, cultural and religious background.
The patient is emotionally over-invested in the idea and it overwhelms other elements of their psyche.
The delusion, if acted out, often leads to behaviors which are abnormal and/or out of character, although perhaps understandable in the light of the delusional beliefs.
Individuals who know the patient observe that the belief and behavior are uncharacteristic and alien.

Features

The following features are found:

It is a primary disorder.
It is a stable disorder characterized by the presence of delusions to which the patient clings with extraordinary tenacity.
The illness is chronic and frequently lifelong.
The delusions are logically constructed and internally consistent.
The delusions do not interfere with general logical reasoning (although within the delusional system the logic is perverted) and there is usually no general disturbance of behavior. If disturbed behavior does occur, it is directly related to the delusional beliefs.
The individual experiences a heightened sense of self-reference. Events which, to others, are nonsignificant are of enormous significance to him or her, and the atmosphere surrounding the delusions is highly charged.

Types

Diagnosis of a specific type of delusional disorder can sometimes be made based on the content of the delusions. The Diagnostic and Statistical Manual of Mental Disorders (DSM) enumerates six types:

Erotomanic Type (erotomania): delusion that another person is in love with the individual, quite frequently a famous person. The individual may breach the law as he/she tries to obsessively make contact with the desired person.
Grandiose Type: delusion of inflated worth, power, knowledge, identity or believes himself/herself to be a famous person, claiming the actual person is an impostor or an impersonator.
Jealous Type: delusion that the individual's sexual partner is unfaithful when it is untrue. The patient may follow the partner, check text messages, emails, phone calls etc. in an attempt to find

"evidence" of the infidelity.
Persecutory Type: This delusion is the most common. It includes the belief that the person (or someone to whom the person is close) is being malevolently treated in some way. The patient may believe that he/she has been drugged, spied-on, harassed and so on and may seek "justice" by making police reports, taking court action or even acting violently.
Somatic Type: delusions that the person has some physical defect or general medical condition (for example, see delusional parasitosis).(Lippincott, 2008).
Mixed Type: delusions with characteristics of more than one of the above types but with no one theme predominating.

A diagnosis of 'unspecified type' may also be given if the delusions fall into several or none of these categories.

Causes

When delusional disorders occur late in life they suggest a hereditary predisposition. Researchers also suggest that these disorders are the result of early childhood experiences with an authoritarian family structure. According to other researchers, any person with a sensitive personality is particularly vulnerable to developing a delusional disorder.

Although its exact cause is unknown, it is believed that genetic, biochemical and environmental factors play a significant role in the development of delusional disorder.

Diagnosis

The symptoms expressed by a delusional disorder can also be part of a much more serious problem, such as bipolar disorder or schizophrenia, therefore diagnosing the delusional disorder is conducted partially by process of elimination. This occurs because delusions can be part of many other illnesses including dementia, schizophrenia and schizoaffective disorder. They may also be part of a response to physical, medical conditions, or reactions when drugs are ingested.

Interviews are useful tools to obtain information about the patient's life situation and past history to help identifying the delusional disorder. Clinicians may review earlier medical records, with the patient's permission. Clinicians also interview the patient's immediate family. This is a very helpful measure in determining the presence of delusions. The mental status examination is used to assess the patient's memory, concentration, and understanding the individual's situation and logical thinking.

Another psychological test used in the diagnosis of the delusional disorder is the Peters Delusion Inventory (PDI) which focuses on identifying and understanding delusional thinking. However, this

test is more likely used in research than in clinical practice.

Treatment

Treatment of delusional disorders includes a combination of drug therapy and psychotherapy although it is a challenging disorder to treat for many reasons such as the patient's denial that they have a problem of a psychological nature.

Atypical antipsychotic medications (also known as novel or newer-generation) are used in the treatment of delusional disorder as well as in schizophrenic disorders. Some examples of such medications are risperidone (Risperdal), quetiapine (Seroquel), and olanzapine (Zyprexa). These medications work by blocking postsynaptic dopamine receptors and reduce the incidence of psychotic symptoms including hallucinations and delusions. They also relieve anxiety and agitation. When these drugs are tried but the symptoms do not improve, other types of antipsychotics may be prescribed. Some examples are: fluphenazine decanoate and fluphenazine enanthate. One very effective drug in delusional disorders is also pimozide.

In some cases agitation may occur as a response to severe or harsh confrontation when dealing with the existence of the delusions. If agitation occurs, different antipsychotics can be administered to conclude its outbreak. For instance, an injection of haloperidol (Haldol) can decrease anxiety and slow behavior, it is often combined with medications including lorazepam(Ativan).

In cases when severely ill patients do not respond to standard treatment, Clozapine may be prescribed although it may cause drowsiness, sedation, excessive salivation, tachycardia, dizziness, seizures and agranulocytosis.

To treat long term symptoms, an oral novel antipsychotic is often prescribed on a daily basis. Antidepressants and anxiolytics are also prescribed to control associated symptoms.

Psychotherapy for patients with delusional disorder include cognitive therapy which is conducted with the use of empathy. During the process, the therapist asks hypothetical questions in a form of therapeutic Socratic dialogue. This therapy has been mostly studied in patients with the persecutory type.The combination of pharmacotherapy with cognitive therapy integrates treating the possible underlying biological problems and decreasing the symptoms with psychotherapy as well.

Supportive therapy has also shown to be helpful. Its goal is to facilitate treatment adherence and provide education about the illness and its treatment.

Furthermore, providing social skills training has been applicable to a high number of persons. It should focus on promoting interpersonal competence as well as confidence and comfort when

interacting with those individuals perceived as a threat.

Reports have shown successful use of insight-oriented therapy although it may also be contraindicated for delusional disorder. Its goals are to develop therapeutic alliance, containment of projected feelings of hatred, impotence, and badness; measured interpretation as well as the development of a sense of creative doubt in the internal perception of the world. The latter requires the empathy with the patient's defensive position.