A Psychological and Communitarian Perspective of Early Attention to Psychoses

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ABSTRACT:

The authors discuss the characteristics and the preliminary findings of the Prevention in Mental Health - EAPPP (Early Detection & Attention of Patients with Risk of Psychosis), a team inserted in the public Primary Health Care System of Barcelona, Spain. Special attention is given to the four core domains of the team work: selection of target populations, the system for detection of first episode psychosis (FEP) and at-risk mental state (ARMS) subjects in the community, the close relationship with the social and educational systems, and the psychoanalytic components of the inter-paradigmatic framework. The community focused work and the psychological and inter-paradigmatic framework are core differential components of the EAPPP unit in the field of EPA (early psychosis attention).

Key-Words: Psychosis; Community Program First Episode; At-risk Mental State; Health Care.

INTRODUCTION: CORE CLINICAL ENDPOINTS AFTER TWO YEARS OF EAPPP EXPERIENCE

In general, the investigations focused on the identification of personal and social consequences of duration of untreated psychosis (DUP) suggest that longer DUP is associated with an unfavourable disorder outcome. Increased economic burden is consistently reported in these cases, most likely remaining higher for the duration of the disease. Additionally, some evidence suggests that it is precisely in this early phase that the psychosis is most active and where most of its long-term consequences are generated.

Consequently, developing strategies to reduce DUP and to intervene as soon as possible has become a priority for Mental Health Care systems. Two important cornerstones of this approach are the detection of people at-risk for psychosis (identifying the so called at-risk mental state – ARMS or EMAR in Spanish) and the diagnosis of psychosis as early as possible.

Accordingly, several approaches have been developed for detection on ARMS cases. Back in 2005, Catalonia saw the birth if its first pubic health system team fully dedicated to Early Detection and Attention (EAP) for "at-risk of Psychosis Patients" (EAPPP). Operating in Barcelona within Institu Català de la Salut – ICS, it became the first specialized and integral Spanish team dedicated to early psychosis detection and attention.

The general objectives set out for the team were: 1) Assisting patients with prodromal symptoms and first episodes psychosis (FEP); 2) Preventing, if possible, the development of psychoses by treating ARMS cases; 3) Decreasing social, family, and individual suffering and burden in these type of disorders. This service belongs to Primary Care Health services of a district with

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83.567 inhabitants in Barcelona, with predominantly worker and low-middle class population.

A set of secondary objectives were also put forward:

- Early attention in bio-psycho-social dimensions
- Decreasing individual, family and social suffering in two psychotic situations: FEP and ARMS
- Decreasing and potentially preventing psychosis chronicity
- Decreasing economic and social costs in these disorders.
- Optimizing Mental Health prevention in highly vulnerable children.
- Facilitating an integrative approach with health, education and social services in our geo-demographic sector.
- Preventing hospital admissions.

Three target population groups have been progressively defined: 1) People with Incipient Psychosis (FEP: first psychotic episode diagnosed in the previous 12 months); 2) Subjects at-risk for psychosis (ARMS group); 3) A third target, not frequently approached by international groups, was the "highly vulnerable minors" due high load of risk factors (HVM group).

The team consists of two psychiatrists, a psychologist trained in psychotherapy, a social worker, two mental health specialist nurses and administrative staff working in a 8 to 20 hours basis. The assigned population consists of 83.567 people (estimated to be nearly 100.000), inhabiting a central neighbourhood in Barcelona, incorporating middle and low-middle classes with a progressive increment of immigrant workers.

A screening instrument, the Early Recognition Inventory Checklist (ERIraos), was used by a network of community professionals to identify possible cases. This checklist is based upon the retrospective assessment of the onset and course of schizophrenia and others psychosis instrument (Iraos). Possible cases were referred to the consultants whenever any person rated 3 or more in the ERIraos, or when they rate one item in the second or third part of ERIraos and/or if they showed ARMS problems according to the information sessions conducted by the EAPPP. If the instrument had not been completed, it would be applied in the first visit to the team. Upon completion of the evaluations, the person might fulfil the ARMS or FEP criteria, be considered highly vulnerable children (HVM: highly vulnerable minors) or might not fulfil any criteria at all and therefore be referred to another specialised service in the mental health care network (table I).

Our intervention model is multi-dimensional, as we approach personal, family and social systems. In the evaluation and diagnostics

Table I – Referrals and exploration process.

REFERRALS AND EXPLORATION PROCESS

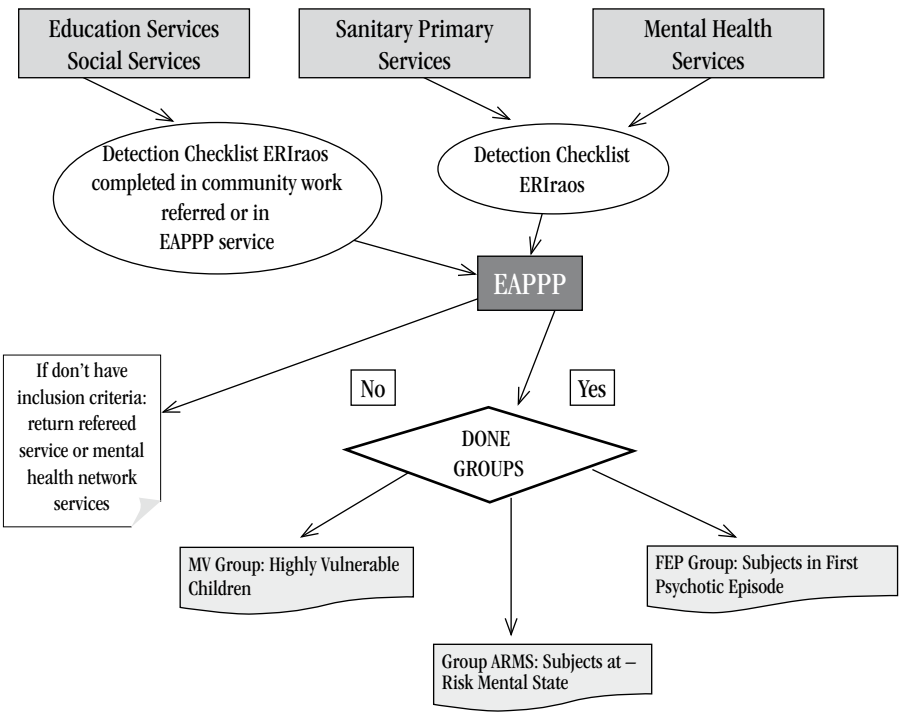
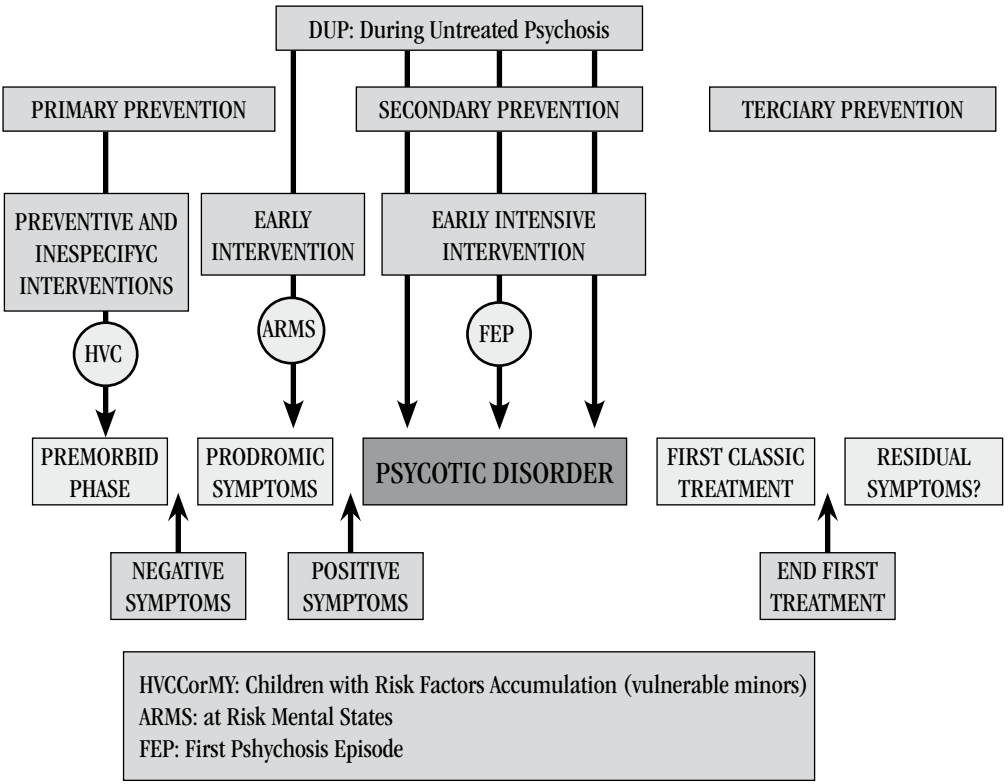


Table II – Types of Interventions.



phases we study the individual's capacities and the patient's internal world, their family relationships, the network of social relations, study and professional abilities and their history of contacts with the global social, medical and mental health system.

The therapeutic approach we have thus designed takes the name of *Need Adapted Treatment to Patients and Families in the Community* (TANC), and is inspired by the "*Need Adapted Treatment*" of Alanen and others Scandinavian authors. There is a set of techniques that need to be considered and used interchangeably in each patient and family system:

1. Individual psychoanalytic psychotherapy (when it is indicated and patient so agrees)
2. Psycho-educational groups, comprising with six sessions.
3. Psychopharmacological therapy, integrated and combined with other therapies.
4. Multifamily group therapy (open group for several patients and families)
5. Family interviews: They begin with a family diagnostic procedure, after witch the TANC approach is explained in an "extended family" and team interview. Family therapy and inclusion of family within the therapeutic effort is generally undertaken.
6. "Open attention": 12 hours open accessibility if patients or families do so require.
7. Cognitive rehabilitation, social abilities orientation and professional counselling.
8. Prevention Programs: namely the "Offspring of…" prevention program (directed at children of parents with severe mental disorders).
9. Visits in the environment: home, educative centre, hospital and others.

In order to better coordinate the intervention program in the target geo-demographic area, there are regular meetings with representatives from several local services, including health, educational and social services.

Reporting to a period of two years, we have detected and applied the treatment program to 17 FEP cases, 42 ARMS cases and 23 HVM subjects. Of the ARMS group, four subjects developed FEP. Sixteen additional persons were added to the "Others" group (family members & no EAPPP profile). Statistically, we obtained a mean "incidence in service per year" of 1'01 (FEP), 1'19 (overall "delusional psychoses"), 2'51 (ARMS) and 1'37 (MAV) per 10.000 inhabitants.

The ARMS incidence is obviously determined by the selection criteria established by the team. We detected 2,5 cases per year per 10.000 inhabitants, a somewhat higher incidence than reported in other studies. For example, the Cantabria's program (Spain) on early psychosis, which follows the Yung et al. criteria, detected 1 case per year per 10.000 inhabitants. This significant difference may occur due to distinct inclusion criteria. Our team recruits patients from 12 to 56 years old whilst the Cantabria's Program is more re-

strictive (14-30 years old age window). However, in our study there were no patients older that 30 years old and only 10% of the cases had between 12-14 years of age. Another possible explanation may be linked to a higher detection rate in our program, which led us to add 5 more criteria than the standard UHR (ultra high risk) protocol, in order to increase our specificity. International and national (Cantabria's) groups have traditionally got their referrals from the health care system while in our study between 40-50% of the patients were referred from non-health care services (social services, educational services, justice services, among other community institutions), which may explain our higher detection rate.

Evidence shows that both mental health care and general health care workers, if made aware of psychosis, do contribute significantly to detect psychosis in early phases and to proceed to appropriate referrals. Nevertheless, when the raising awareness strategies include other sectors, as educational services, there is a higher DUP reduction. In the EAPPP work, a third of our subjects were referred from social services. These are in daily contact with people with severe mental illness and in social risk, who might otherwise be alienated from the other community services, including educational and health services.

In summary, our initial experience tends to confirm our presumption that preventive work on the field of psychoses is feasible. It is possible to detect previously undiagnosed FEP cases and it's possible to detect ARMS subjects if we are integrated and sustained on the local networks through intense shared work with social, pedagogic and health community services. At this moment, the greatest challenge resides on the collaboration of the inpatient units for psychiatric emergencies, who have yet to be integrated with confidence in the EAPPP work.

ARMS AND ARMS DETECTION STRATEGIES OF THE EAPPP TEAM

In recent decades researchers have developed several strategies for the detection of persons at risk for psychotic disorders, the so-called "at-risk mental state" (ARMS). These include; 1) Positive symptoms of the late prodrome and risk factors for psychotic disorder (ultra high risk, UHR), 2) Extension of the previous strategy including the negative symptoms, 3) Strategies focusing on the "basic symptoms" of schizophrenia. Improving ARMS detection rate can also involve adjustments in the Primary Health Care Services catchments strategies, including recognition the help-seeking behaviour and optimization of pathways to care and availability of the care.

EAPPP's strategy to detect ARMS subjects involves two stages. In the first phase, a screening instrument used by referral professionals (ERIraos-15) is used to detect negative, positive

and unspecific symptoms. In a second phase, the team begins a thorough evaluation of negative and positive symptoms, as well as risk factors stratification and somatic evaluation protocol. These follow our own ARMS criteria, which are similar to UHR (ultra high risk) ones, but include yet more psychosocial items, narrowing the scope of the target population.

After two years of implementing this strategy, we have identified 59 out of 99 patients that met criteria for FEP or ARMS. They presented predominantly with social impairment and negative symptoms, which had greater intensity than positive symptoms. Nonetheless, most of the patients had subtle psychotic symptoms. In that way, the biphasic detection strategy, first focusing on negative and unspecific symptoms via a screening instrument, and secondly checking for specific symptoms like UHR or similar protocols, seems to constitute a good strategy for ARMS detection in the primary mental health care system. This approach might contribute to improve detection both on the early and late stages of the psychotic prodrome.

INTEGRATING SOCIAL SERVICES TEAMS IN PSYCHOSIS PREVENTION PROGRAMS

The prevention and treatment of early psychoses within the community is a primary goal for the improvement of the "community's mental health". That means to take care not only of the patient and his/her family, but also of the professionals who are in close contact with those individuals, that is, "to take care of the caregivers", trying to improve their sensitivity to psychosis.
Because our work takes place in such different settings, such as Social, Educational and Health Services, our approach to the multitude of specialized workers (social workers, nurses, teachers, general practitioners, clinical psychologists, among others) must be adjusted accordingly.
The fact that a third of our ARMS patients are referred from Social and Child Care Services, which is a an innovative result, considering the previous studies on early detection of psychoses, makes our EAPPP program experience somewhat different from other implementations.
What kinds of patients are referred from the Social Services? Why they don't come from closer services, like schools or general practitioners? Could we find and describe a specific profile that allows us to reach any conclusion? In order to answer these questions, let us to do a brief recall of the usual procedure regarding referrals. In most instances, when any professional in the network receives a request from an individual seeking help or detects a possible case, the situation is presented at the inter-consultation ("liaison") meetings, in order to ensure the success of the intervention. If the referral is perceived

as urgent, they will contact the EAPPP team via e-mail or telephone letting us know that the patient is being referred and informing us about the case.

Although the protocol allows that any network professional may refer possible cases without any previous meeting with the team, and thus devoid of any coordination, in practice there has been no such events during these two years of operation, as none of the referrals have entered the program without a previous contact from a professional. Some cases of self or family referral did occur, in instances where knowledge of the EAPPP program was available to the patient or his family.

For the first two years of operations, the ARMS subject referral pattern to the EAPPP was as follows: 55% came from health services and 45% from a non-health related services. Are there any difference between the people and their families that were referred from the health services and the ones that were referred from the social and educational services? Our preliminary data shows that in more than 70% of the cases referred by health services, the person or their relatives were the ones that sought help, and in less than 20% of the cases the professional was the one proposing the referral. However in the educational and social services the tendency is actually the opposite: in more than 80% of the cases the referral was proposed to the individual by the professional, and less than 20% were self-referrals from the family or the subject.

What where the families' characteristics that made them predisposed not to seek help? Our initial assumption was that in those families the presence of untreated mental disorders in the parents was much higher than in the cases where the family or the patient were the ones asking for help. However, the data from the two initial years of our program do not confirm this hypothesis at a statistical level, and actually tells us that all of the cases referred from the social services came from a family in which at least one of the parents suffered from a mental disorder, and more than 60% of those mental disorders were untreated. There were no significant differences between the social--economic profiles in the families that allowed us to come to any other specific perspective.

Our preliminary conclusions from the shared work with social and educational services include several highlights:

- Relying on community systems for the early detection and recruitment of cases implies having an account of and cooperation with social and educational services, an not only health services, especially more relevant as the public health services are constrained with limited resources.
- A significant share of the at-risk mental state (ARMS) subjects - 45% - has come to us through liaison with the non-health--related-services. This alternative method of contact allows technicians to be in contact

with people that for some reasons (health, social, emotional or cultural) are not aware that help is either available or desirable. This can be attributed to a lack of knowledge, inability to self-diagnose or defence mechanism and resistance in teenagers and other age groups.

- Therefore, to keep in contact with the social and educational services allows us to have more presence in the community and to offer a more democratic care for psychosis. Our preliminary findings leads us to realize that shared work with Social Welfare Services allows us to be in touch with those who are socially excluded, and as such not in contact with other services which are usually closer to the general population.
- The inter-consultation or "liaison" meetings promote collaborative work within the involved network of professionals and improves the quality of care through discussion. Our case-by-case approach encourages respectful practice and personalized treatment strategies, rather than simply implementation by routine mechanical practice.

Untreated mental disorders are often associated with poverty and social exclusion. As mental health and social worker professionals, being able to detect and treat the individuals coming from such background - which enhances their risk for psychosis - might provide the tools to decrease certain harmful family emotional and behavioural patterns, which are common in those mental disorders.

THE ROLE OF PSYCHODYNAMIC APPROACHES IN AN EARLY DETECTION & ATTENTION FOR PATIENTS WITH RISK OF PSYCHOSIS UNIT (EAPPP): A PROPOSAL

By the end of the third year of EAPPP functioning we aim to outlook some of its foundations, objectives and developments. The theoretical and technical foundations of our work are based on a "psychoanalytically informed" communitarian perspective. In that sense, our psychological and psychopathological formulations and techniques are "psychodynamic techniques" combined with biological, cognitive-behavioral, psycho-social and semi-professional techniques.

Since 1982 and having that in mind, we've developed some psychoanalytical applications, both for PHC (Primary Health Care) and, more specifically, for *Primary Mental Health Care* (PMHC) (Tizón 1997; 2007). We are currently developing a specific application for our Early Detection and Prevention of Psychosis (EDPP) program.

In general, we hold that psychoanalysis has been and will continue to contribute to PHC and EDPP in six basic ways: 1) proposing a developmental psychopathology applied to psychoses; 2) giving support to many of those who work in health, social and educational centres regarding personal development, setting preservation, professional training and group or-

ganization: they are our *clinical-preventive and developmental contributions*; 3) offering elements for the theoretical and epistemological basis, upon which the fundamental principles of PMHC can be laid out, constituting our *theoretical contributions*; 4) offering psychotherapeutic elements, which can be used by our team and by primary health care social and educational workers, constituting our *technical contributions;* 5) offering a series of *pragmatic elements* both to PHC-PMHC and social and educational teams; 6) offering elements of the previous five types for a renewed practice of Community Mental Health Care for the Psychosis and At-Risk of Psychosis persons and groups.

In conclusion, psychoanalysis could make valuable contributions to our work, specially regarding the clinical approach, by providing a theoretical knowledge that takes into account the internal world of the patient and by giving basic frames of reference for prevention and for integrated clinical assistance. However, we support the idea that psychoanalytical theories and techniques have to be complemented if we aim for an "integrated therapy". We call this model of treatment TANC (A Patients and Family's Need Adapted Treatment in the Community).

References

Alanen YO. Schizophrenia: Its Origins and Need-Adapted Treatment. London: Karnac 1999 (traducido en Madrid: Fundación para la Investigación y el Tratamiento de la Esquizofrenia y otras Psicosis; 2004).

Artigue J, Tizón JL, Parra B. Risk Factors for Psychoses: Their Detection with LISMEN (Mental Health Items List for Preschool and School Ages). Infant Mental Health Journal, 2008;29(3A), No. 54.

Bentall RP, Fernyhough Ch. Social predictors of psychotic expriences: specificity and psychological mechanisms. Schizophr Bull 2008;34:1012-20.

Cornblatt B, Lencz T,Smith C, Correll C, Auther A, Nakayama E. The Schizophrenia Prodrome Revisited: A Neurodevelopmental Perspective. Schizophr Bull 2003;29,4:633-51.

Cullberg J. Psicosis: Una perspectiva integradora. Madrid: Fundación para la investigación y el tratamiento de la esquizofrenia y otras psicosis, 2006.

Edwards J, McGorry P. La intervención precoz en la Psicosis: Guía para la creación de servicios de intervención. Madrid: Fundación para la Investigación y el Tratamiento de la Esquizofrenia y otras Psicosis, 2004.

Gavin B, Cullen W, Foley S et al. Integrating primary care and early intervention in psychosis services: a general practitioner perspective. Early intervent psychiatry 2008;2:103-7

Häfner H y Maurer K. Early detection of schizophrenia: current evidence and future perspectives. World Psychiatry. 2006;5(3):130-8.

Häfner H, Der Heiden W, Behrens S, Gattaz WF, Hambrecht M, Löffler W, et al. Causes and consequences of the gender difference in age at onset of schizophrenia. Schizophrenia Bull.1998;24:99-113.

Häfner H, Maurer K. Early detection of schizophrenia: current evidence and future perspectives. World Psychiatry 2006;5:130-8.

Johannessen JA, Martindale BV, Cullberg J. (editors). Evolving Psychosis: Different Stages, Different Treatments. London and New York: Routledge 2006 (edición española: Barcelona: Herder, 2008).

Johannessen JO, McGlashan TH, Larsen TK et al. Early detection strategies for untreated first episode psychosis. Schizophr Res 2001;51:39–46.

Knapp M. Schizophrenia costs and treatment cost-effectiveness. Acta Psychiatr Scan 2000;102:158-64.

Krstev H, Carbone S, Harrigan S, Curry C, Elkins K, .McGorry P. Early intervention in first-episode psychosis. The impact of a community development campaign Soc Psychiatry Psychiatr Epidemiol 2004;39: 711–9.

Lalucat L, (coord.). Programa d'Atenció Específica al Trastorn Psicòtic Incipient del Plá Director de Salut Mental i Adiccions de la Generalitat de Catalunya. Barcelona: Servei Catalá de la Salut 2007.

Larsen TK. Poor social and interpersonal functioning prior to diagnosis predicts poor outcome for people with first episode psychosis. Evid Based Ment Health. 2006; 9(1):5.

Mangalore R, Knapp M. Cost of Schizophrenia in England. PSSRU Discussion Paper 2376. 2006.

Marshall M, Lewis S, Lockwood A, et al. Association between duration of untreated psychosis and in cohorts of first-episode outcome patients: a systematic review. Arch Gen Psychiatry 2005;62:975–83

Maurer K, Hörrmann F, Schmidt G et al. The early recognition inventory ERIraos: a two--step procedure for detection of "at-risk mental states". Schizophr Res suppl 2004; 70: s76.

McGlashan TH. Duration of untreated psychosis in first episode schizophrenia: marker or determinant of course? Biol Psychiatry. 1999;46:899–907.

McGorry PD, Edwards J, Mihalopoulos C et al. EPPIC: An evolving system of early detection and optimal management. Schizophr Bull 1996; 22: 305-26.

McGorry PD, Singh BS. Schizophrenia: Risk and possibility. In: Raphael B, Burrows GD, eds. Handbook of Preventive Psychiatry, New York: Elsevier, 1995; 492-514.

McGorry PD, Yung AR, Phillips LJ. The 'close--in' or ultra high risk model: A safe and effective strategy for research and clinical intervention in prepsychotic mental disorder. Schizophr Bull 2003; 29: 771- 90.

Nelson B, Yung AR. When things are not as they seem: Detecting firs-episode psychosis upon referral to ultra high risk ('prodroma?) clinics. Early Intervention in Psychiatry. 2007;(1):208-11.

Olsen KA, Rosenbaum B. Prospective investigations of the prodromal state of schizophrenia: review of studies. Acta Pscyhiat Scan 2006; 113: 247-272.

Perkins DO, Gu H, Boteva K, Lieberman JA. Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis. Am J Psychiatry. 2005;162:1785-804.

Platz C, Umbricht DS, Cattapan-Ludewig K et al. Help-seeking pathways in early psychosis Soc Psychiatry Psychiatr Epidemiol 2006; 41: 967–74.

Read J, Mosher L, Bentall R. editors. Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia. London,UK: Brunner-Routledge, 2004. (Traducción Española: Modelos de Locura. Barcelona: Herder 2006).

Tizón JL. Psychoanalysis and Primary Health Care: Our Participation as Psychoanalysts in a Long-overdue Change in the Health Services. En J. Guimón J, y S. Zac (eds). Challenges of Psychoanalysis in the 21st Century. New York: Kluwer Academic / Plenun Books, 2001 (pp. 83- 101).

Tizón JL. Terapias combinadas en la esquizofrenia: ¿Agregamos , mezclamos y confundimos o bien de-construimos y combinamos? Revista de la Asociación Española de Neuropsi quiatría.2004;14(90):97-131.

Tizón JL. ¿Se puede pensar todavía en una "sociogénesis" y en una "psicogénesis" de las psicosis?. Archivos de Psiquiatría 2004;67(1): 67-72.

Tizón JL. Epidemiología de la psicosis desde los servicios comunitarios de salud mental y de Atención Primaria de Salud. Archivos de Psiquiatría. 2004;67(2):139-44.

Tizón JL. Psicopatología psicoanalítica especial de las psicosis. En A. Díez y R. Luque R (eds.). *Psicopatología de los síntomas psicóticos*. Madrid: Asociación Española de Neuropsiquiatría, estudios, 2006. (pp. 137-179) (pp. 137-178).

Tizón JL. Los cuidados democráticos de las psicosis como indicador de democracia social. Atopos: Salud mental, comunidad y cultura 2007;6:31-48.

Tizón JL. *Psicoanálisis, procesos de duelo y psicosis.* Barcelona: Herder Ed., 2007.

Tizón JL. Los cuidados comunitarios de las psicosis y la atención primaria a la salud mental en las psicosis. Atención Primaria 2007;39(Supl 2):85-6.

Tizón JL: Psicosis en Evolución: Diferenciando tratamientos en función de las necesidades del sujeto, su familia y la comunidad. Prólogo a la

traducción española al libro de JO Johannessen, B. Martindale y J. Cullberg. *Psicosis en evolución: Diferentes estadíos, diferentes tratamientos.* Barcelona: Herder; 2008. (pp 21-31).

Tizón JL. ¿Es necesaria una nueva "reforma psiquiátrica"? Una reflexión sobre la necesidad de cambiar nuestros sistemas, métodos y dispositivos teniendo en cuenta la experiencia asistencial y organizativa y los datos científicos actualizados. Siso-Saúde, Revista de la Asociación Galega de Saúde Mental.2008; 46--47: 69-77.

Tizón JL. Bases para un equipo de atención precoz a los pacientes con psicosis: clínica e investigación pueden aunarse. Revista de la Asoc. Española de Neuropsiquiatría 2009,103(29): 35-62.

Tizón JL, Artigue J, Parra B, Sorribes M, Ferrando J, Pérez C, Pareja F, Gomá M, Marzari B. Factores de riesgo para padecer trastornos psicóticos: ¿Es posible realizar una detección preventiva?. Clínica y Salud. 2008;19(1): 27-58.

Tizón JL, Ferrando J, Artigue J, Parra B, Parés A, Gomá M, Pérez C, Pareja F, Sorribes M, Marzari B, Quijada Y, Catalá L. Neighborhood differences in psychoses: Prevalence of psychotic disorders in two socially-differentiated metropolitan areas of Barcelona. Schizophrenia Research 2009;112(1-3): 143-148.

Tizón JL, San-José J, Nadal D. Protocolos y programas elementales para la atención primaria a la salud mental. Volumen I: Protocolos asistenciales para adultos. Barcelona: Herder 1997, 2000.

Tizón JL, San-José J, Nadal D. Protocolos y programas elementales para la atención primaria a la salud mental. Volumen II. Atención a la Infancia. Técnicas Grupales. Protocolos Preventivos. Barcelona: Herder, 1997.

Turpeninen-Saari P. Adolescencia, creatividad y psicosis. Barcelona: Herder, 2006.

Vallina O, Alonso M, Gutiérrez A et al. Aplicación de un programa de intervención temprana en psicosis. Un nuevo desarrollo para las unidades de salud mental. Rev Norte Salud Mental 2002; 4: 35-41.

Vallina O, Lemos S, Fernández P. Estado actual de la detección e intervención temprana en psicosis. Apuntes de Psicología. 2006;24(1-3):185-221.

Vázquez-Barquero JL, Cuesta MJ, de la Varga M, Herrera S, Gaite L, Arenal L. The Cantabria first episode schizophrenia study: a summary of general findings. Acta Psychiat Scand. 1995; 91:156-62.

Yung AR, Philips LJ, McGorry PD et al. Can we predict the onset of first episode psychosis in a high risk group? Int Clin Psychopharmacol suppl 1998; 1: 23-30.

Yung AR. Identification of the Population. En J. Addington, SM Francey & AP Morrison: Working with people at High Risk of Developing Psychosis: A Treatment Handbook. New York: John Wiley 2006 (p.7-23).