Clinical stage definition	Who provides the care?	Potential interventions
0 Increased risk of anxiety or depression. Continuing daily stressors that may interfere with full functioning but no clearly defined serious symptoms.	School counselors, mental health counselors, volunteer and peer helpers, social workers, pastors, community agencies.	Primary intervention: Improved mental health literacy, psychoeducation for young person and family, effective counseling and guidance programs, listening skills, community action and social justice interventions.
1a Possible prodrome. Mild or nonspecific symptoms of depression or anxiety, including neurocognitive deficits. Moderate functional change or decline indicating risk. **1b** Prodrome and high risk of psychosis. Shown by significant drop in daily functioning.	Referral to medical personnel, but care staff noted above are likely to continue supportive treatment. McGorry's Early Psychosis Prevention and Intervention Centre (EPPIC) has specialized staff to work and consult at this level.	Increased primary intervention and counseling with prevention focus: Policy of avoiding medications. Interventions from previous clinical stage with more intensity, plus improved mental health literacy, family education and therapy, drug education, cognitive behavior therapy, motivational interviewing, and other appropriate theoretical approaches. Therapeutic life skills education and support. Relapse prevention becomes central.
2 Ultra high risk, acute. First episode of major depression or psychotic disorder with expected early recovery.	Medical and psychiatric staff takes charge and/or supervises counselors and other staff. EPPIC treatment plans are coordinated with original referring staff.	Secondary and tertiary treatment and prevention: Medication still avoided, but mood stabilizers, particularly antidepressants, given as necessary. Above treatments continue at a more intensive level. Omega-3 fatty acids, substance abuse reduction and relapse prevention. Vocational rehabilitation may be necessary to help families cope. Welfare agencies may be brought in, as well as drug and alcohol services.
3a, 3b Late/incomplete recovery or remission from first episode of care (note the positive emphasis of the word *recovery*).	The team approach continues, but primary and specialist care becomes key in guiding the process.	Tertiary interventions: Same early prevention services as above but with additional emphasis on relapse prevention plus medical and psychoeducational strategies to achieve full remission. Antipsychotics avoided or used carefully due to dangerous side effects and potential loss of gray and white matter as well as brain volume, thus producing a reinforcing cycle of illness.
3c Recurrent relapse of psychosis. This may stabilize with treatment, but there is residual dysfunction below best level after first episode.	Specialist care becomes more central, along with consultation with other agencies.	Tertiary interventions: Same as above with efforts directed toward long-term stabilization. Counselors external to the specialist (e.g., community clinics or school systems) will be helpful through frequent contact with the patient in the family. Considerable family support and psychoeducation needed.
4 Chronicity. Severe, persistent, unremitting illness as judged by symptoms, neurocognitive deficits and disability.	Specialist care with consultation with other agencies.	Tertiary treatment: Above methods but markedly increased emphasis on social participation, increased use of medications and antipsychotics (with awareness of long-term dangers). Medication remains as limited as possible.