



EPI Service and Clinical Guidelines

Early Psychosis Intervention Program

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Service and Clinical Guidelines

Early psychosis intervention is more than simply starting treatment early – it is an entire approach to care. Public education, referral, assessment and treatment guided by this approach are all different from “treatment as usual”. This approach improves outcomes in a number of ways. It instills hope, engages clients and families, and addresses the whole person not just their symptoms. When this approach is fully embraced, we witness many positive changes – client and family empowerment, faster recovery, fewer relapses and better quality of life.

Guidelines are helpful in ensuring that early intervention “is done right”. Successful implementation of guidelines results in improvements in service delivery and client outcome (see *Appendix I for strategies for successful implementation of guidelines*). But numerous guidelines for early psychosis are already available (see Appendix II). Why do we need another set of guidelines to ensure the EPI Program remains on track? The answer is simple: because EPI in the Fraser area is structured in a unique way. It is a community-based program that works within the existing systems under two ministries with a single point of entry. Any guidelines for this program must reflect this unique model of service delivery and capture the practices and procedures dictated by each of the two ministries.

The practices recommended here are based in research evidence and distilled from the comprehensive Guide to Clinical Care for Early Psychosis (Ehmann & Hanson, 2004). These practices are also adapted from a variety of sources including the Australian Clinical Guidelines for Early Psychosis, Initiative to Reduce Schizophrenia and National Schizophrenia Fellowship Clinical and Service Guidelines, New Zealand Guidance Note, British Columbia’s Early Psychosis Care Guide, World Health Organization and International Early Psychosis Association Consensus Statement, and the International Clinical Practice Guidelines for Early Psychosis (see *Appendix II for references*). These guidelines are based on a review of the literature across all levels of evidence. Priority was given to controlled trials where available. Where controlled trials were not available, uncontrolled trials and clinical consensus were used. The focus of the review was on evidence in early psychosis, a diagnostically mixed group. Where such evidence did not exist, evidence was gathered from the literature on schizophrenia, bipolar disorder and other disorders with psychosis.

These guidelines were originally developed by the EPI Central Team, EPI Clinicians, EPI Psychiatrists, and families within the Fraser South EPI Program. They have been revised for all three Fraser EPI Programs by a joint Fraser EPI Care Delivery Task Group.

These guidelines are standards for the EPI Programs to strive toward. Achieving all of the recommendations outlined in these guidelines will take time and effort. Progress toward achieving the guidelines must be regularly informed through data collection and program evaluation. This will allow for the identification of which recommendations are achieved consistently and which are not. Ongoing efforts will be necessary to meet those recommendations not consistently achieved.

Program Description

The EPI Programs in the Fraser area serve young people between the ages of 13 to 35 with early psychosis, and their families. The programs bridge youth and adult mental health services, and link community with hospital. The programs are community-based, and devote much effort to early detection and rapid assessment. The clinical services include single-entry intake and assessment, as well as treatment for people who have had their first episode of psychosis, whether affective or non-affective. Treatment components include individual, group and family intervention. Other program components include community education, evaluation, and research, as well as assessment and monitoring for young people at ultra high risk of developing psychosis.

The Fraser area of BC has three EPI Programs, situated in the south, north and east of the Fraser River. The programs have adopted the same Service and Clinical Guidelines, and the same hub-and-spoke organizational model to implement these guidelines. Each program serves its own sub-region and differs slightly in resources due to funding, length of time the program has been in existence, and geographical characteristics.

As shown in the hub-and-spoke diagram on page 4, a multidisciplinary Central Team serves as the hub for each EPI Program. The Central Team provides program direction and coordination, clinical consultation to the community teams, education for professionals and the public, evaluation of client outcome and service delivery, and research activities. The Central Team also provides the pathway through care and certain clinical services (e.g., groups, family intervention), sharing the care of clients and families with the Community Teams. The Community Teams in each sub-region serve as the spokes. They are comprised of designated specialists (EPI Clinicians, EPI Psychiatrists) providing ongoing early psychosis treatment and case management, according to locality and age.

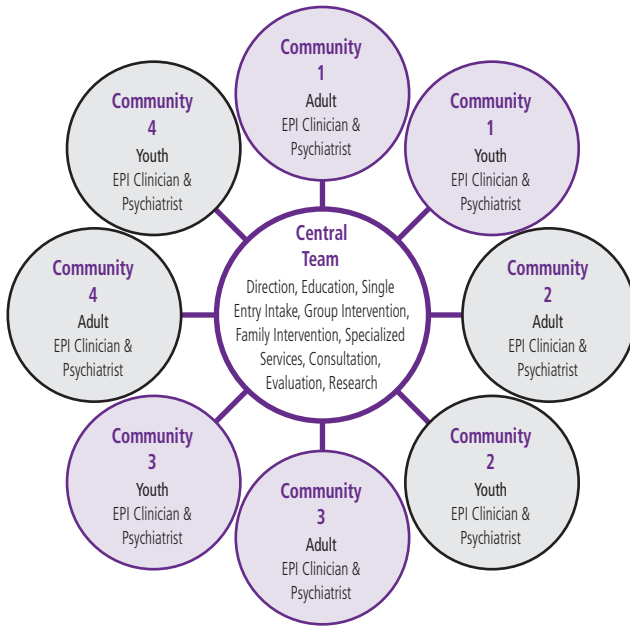
Community and hospital referrals are made to each program through a single point of entry, according to the Fraser sub-region. Central Teams coordinate all referrals, conduct initial and psychiatric assessments of community referrals, and prioritize cases. Upon identification of first episode psychosis, either through the community assessment or hospital admission, clients and families are provided with education and oriented to the program by a Central Team member. Clients in hospital are seen prior to discharge. The Central Team facilitates the transition from intake to the appropriate EPI Clinician and EPI Psychiatrist in the person's local community as quickly as possible.

Most of the ongoing EPI services are provided by the Community Team consisting of an EPI Clinician and EPI Psychiatrist who provide the long term treatment and case management in the client's own community. The EPI Clinician serves as the primary therapist and case manager, providing care to clients and families that include psychosocial treatment, education, support, and referrals to adjunct services. The Central Team shares care with the Community Teams by providing clinical consultation, urgent psychiatric follow up as needed, group and family intervention, and other specialized services depending upon sub-regional program resources (e.g. Vocational Rehabilitation).

Although group intervention is a vital part of optimal treatment, groups do not replace individual intervention. Group services include client education and/or treatment groups, peer support/activity groups, family psychoeducation groups, and family support groups. The type of groups offered and their frequency vary according to sub-region. More intensive family intervention is provided on a short-term basis, in conjunction with the support and education that EPI Clinicians provide to families. Information is shared between the Central Team and Community Teams through formal assessment and care plan reports, progress notes, and case consultations.

Occasionally, young people experience symptoms or problems in functioning that are suggestive of psychosis, but do not meet full criteria. If the assessment indicates that the client is at ultra high risk (UHR) of developing psychosis, the Central Team will provide support, education, monitoring, and outreach. At this time, the EPI Program is not prescribing antipsychotic medication for UHR clients due to the substantial risk of false positives. If a client has mental health issues that require intervention (e.g., anxiety, depression), the individual will be referred to a mental health team for treatment during which time the EPI Program will continue to provide support and monitoring.

Hub and Spoke Service Delivery Model



Guiding Principles

The following principles underlie all of the service and clinical guidelines.

Care is Recovery-Focused

- Strive for the best possible outcomes
- Focus on quality of life not just psychosis

Clients and Families are Partners in Care

- Increase clients' control over their illness
- Empower clients and families with confidence, knowledge and skills

Care is Respectful and Humane

- Avoid treatments that are intrusive
- Provide treatment in the least restrictive environment possible
- Respect individual and cultural differences

Optimal Care is Biopsychosocial

- Recognize the importance of both pharmacological and psychosocial care
- Provide treatments through multidisciplinary teams
- Strive for optimal care, by providing both core and needs-based treatments

Care is Developmentally Appropriate

- Target care to a client's developmental stage
- Develop goals that are appropriate for the stage of development

1. Recognize Psychosis Early

The first step in early intervention is raising community recognition when “something is not quite right”. The possibility of psychosis then needs to be considered. The public, gatekeeper groups, and professional groups should be provided with education on what psychosis is (as well as what it is not), why early intervention is important, and how to make a referral if psychosis is suspected. The goal of this education is to raise the index of suspicion when a young person starts behaving differently - not simply dismissing this as a “phase”. Misconceptions and stigma about psychosis can result in fear and the adoption of a “wait and see” approach. For this reason, it is necessary that education address misconceptions and stigma through an accurate and hopeful portrayal of psychosis. The message that psychosis is a treatable condition must be emphasized.

Detection is the necessary first step in early intervention

1.1 Increase Public Awareness

- Undertake public awareness campaigns to increase recognition of the signs and symptoms of psychosis and present the rationale for early intervention.
- Develop a strategy to reduce stigma associated with psychosis.
- Where possible, written material in multiple languages will be distributed.

1.2 Target Education to High Risk Groups

- Provide education to groups deemed at high risk (e.g., high school and college students, youth groups, etc.).
- Education efforts are made to include groups often not well connected to community services (e.g., homeless, certain cultural groups).

1.3 Train Gatekeepers and Health Care Providers to Recognize Psychosis

- Provide training to gatekeepers (e.g., teachers, forensic personnel, school and college counselors) and health care providers (e.g., nurses, physicians, alcohol and drug counselors) on how to recognize symptoms of early psychosis and make a referral.

2. Improve Access

Recognizing psychosis early will not result in reducing treatment delay if accessing care is difficult. The referral entry point should be widely known and easy to use. Referrals will be accepted from any source, thereby removing one barrier to care. Streamlining the referral process will help reduce the number of steps to care and the duration of untreated psychosis.

Access to care should be quick and simple

2.1 Increase Awareness of the Program

- Education about the EPI Program will be provided to a broad range of groups.
- Referral and contact information will be distributed widely through a variety of media.
- Print material in multiple languages will be made available, where possible.

2.2 Make Access to Services Quick and Simple

- There will be a single point of entry.
- Referrals will be accepted from any source.
- Access to hospital care will be facilitated when safety is an issue.

2.3 Respond to Referrals Rapidly

- Initial contact with referral sources will be within two working days from time of referral.
- Initial telephone screening of community referrals will be within three working days from time of referral.
- Intake face-to-face assessment of screened community referrals will be within three working days from date of screening.
- Intake may follow a triage model where cases are prioritized.
- Families will be involved in the intake process.
- The intake assessment will be informed by other collateral information whenever possible (e.g., general physician, school counselor, etc.).
- The client will be seen by a psychiatrist within ten days after the intake assessment.
- Clients referred via hospital will be seen by EPI staff prior to discharge. The family will also be seen prior to the client's discharge.
- Interpreter services will be arranged promptly.
- Assessments will be conducted in the client's preferred environment whenever possible.
- The outcome of the intake assessment will be conveyed to the client and family, to referrers and to the client's general physician within one week.
- Referrals not accepted (not psychosis; not first-episode) will be documented and referred to other services.

3. Focus on the Individual and Family

The evidence is clear: ongoing family involvement improves clients' outcome in the form of lowered relapse rates, improved client functioning, and enhanced family well-being. Nonetheless, delivery of mental health services to persons with psychosis often excludes the family. In the EPI Program, clients, families and others in the social network are integral members of the treatment team.

3.1 Assessment and Treatment

- Limits of confidentiality and client and family rights will be explained at the first face-to-face encounter.
- Clients are integrated into the treatment team.
- Families are actively engaged at the time of referral and integrated into the treatment team.
- Clients as well as families will be provided with verbal assessment feedback and asked to review and evaluate the care plan at the initial assessment phase and three-month updates.
- Regardless of the client's age and whether the client is living with their family or not, family involvement should be part of the treatment plan rather than informal and as needed.
- When a client refuses to have his or her family involved with his or her own treatment team and engaging the family threatens engagement with the client, the reasons for refusal will be explored and the importance of family involvement explained to the client. The potential for future family involvement will be negotiated with the client. In the meantime, efforts will be made to ensure families get the education and support they need from other service providers in the EPI Program or other sources (other treatment providers or support groups).
- Peer support and family support groups, co-facilitated with clients and families, are important adjuncts to service delivery.

Empower clients and families by encouraging them to be actively involved in the recovery process

3.2 Service Planning and Delivery

- Clients and families will have representation across all levels of the program in planning and decision-making (e.g., committees, task groups, etc.).
- Clients and families are encouraged to advocate for community resources and planning.
- Feedback from clients and families is sought to evaluate their own care and the program in general.
- Clients as well as families will have access to a formal complaints procedure through Fraser Health and MCFD.

4. Provide Optimal Care

Optimal care results in better clinical outcomes and quality of life. This care is guided by ongoing assessment, negotiated with client and family, addresses comorbidity, and ensures that all basic needs are met. Rather than await symptom remission, recovery is actively promoted during the early phase of illness with emphases on normal social roles and developmental needs (e.g., attaining educational, employment and social goals). Persisting symptoms are to be identified and treated early.

Care is not limited to psychosis but encompasses all aspects of life

4.1 Engagement

- Engagement is the most important initial therapeutic goal – most other aspects of care may be delayed if necessary until adequate engagement is achieved.
- A proactive approach helps ensure engagement.
- Families are actively engaged from the point of referral throughout the entire process of care.
- Failure to engage should intensify efforts (e.g., assertive outreach) and not lead to case closure.

4.2 Prompt Initiation of Care

- Clients will be seen by the EPI Clinician within one week after transfer from the Central Team.
- Clients will have a psychiatrist available to them from the time of intake throughout their care. When the client is transferred from the Central Team Psychiatrist, the client will be seen by a community EPI Psychiatrist within two weeks.
- Education about the program, treatments, and psychosis are provided within one week by a member of the Central Team and repeated as the client's mental state improves.

4.3 Comprehensive Assessment

- Comprehensive biopsychosocial assessment is performed by the EPI Clinician and Psychiatrist within the first few weeks of care.
- Assessment captures the following domains: detailed description of signs and symptoms, mental status exam and cognitive screen, comorbid conditions, risk, personal and family history, current stressors and methods of coping, medical examinations including body mass index, client and family's explanatory model, functioning across roles and domains, drug and alcohol use, social support networks, personal strengths and limitations, client and family goals, clinical formulation, preliminary diagnosis and care planning.
- Assessment is informed by direct contact with collateral sources including the family.
- The initial assessment, including an individualized care plan, should be written by the EPI Clinician and included in the client's chart within six weeks.

- The existence of cognitive problems is considered and, where available, neuropsychological testing should be arranged for clients with suspected cognitive deficits.
- Assessment updates should be completed by the EPI Clinician at three-month intervals and include the use of standardized clinical rating scales and an exploration of discordance between a client's perceived needs and those of the service providers.
- Assessment of risk, mental status, medication side effects, new stressors and treatment progress are conducted at each visit.
- High-risk for suicide, self-harm or violence activates the caution alert. A risk management plan is developed and other members of the treatment team are notified.
- Verbal feedback on assessments is provided to client and family including clinical formulation, treatment plans and progress.

Engagement is critical to assessment, treatment, and case management

4.4 Continuity of Care

- Clients are transferred from the Central Team following intake to the community EPI Clinician and Psychiatrist as quickly as possible.
- Due to the nature of the early course of illness, clients and families are expected to remain within the program for at least two years and then reviewed annually for continuation in the program. Those with earlier age at onset may benefit from being in the program longer, due to developmental issues.
- Changes to the treatment team are minimized.
- The EPI Clinician serves as the case manager who is an active treatment provider, not simply a broker of services.
- If the client so desires, the EPI Clinician will attend client visits with the psychiatrist.
- The EPI Clinician attends hospital discharge meetings for the index admission and any relapses.
- The client's general physician will be contacted at least twice yearly as well as when there are any significant changes made to medication or treatment plan. If a client does not currently have a general physician, this should be arranged within the first two weeks of treatment, where possible.
- Discharge or transition plans are developed in consultation with the client and family at least three months in advance. At least one joint transition meeting is held prior to transfer. A discharge summary is completed prior to discharge and sent to the client's physician and other treatment providers, as well as the Central Team.
- If transition from child and youth services to adult services is required, the transition protocol is followed. Co-management of care may be provided for some period of time to bridge the transition and provide access to the appropriate required services.

**Early intervention is not just starting treatment early.
For the best outcomes, optimal treatment must be maintained throughout the "critical period" – the first several years after onset of the first episode.**

4.5 Best Practices Care

Best-practices care consists of core interventions, offered to all early psychosis clients, and needs-based treatment components. All treatments offered will be based on available empirical evidence.

4.51 Contact

- Care by the EPI Clinician and EPI Psychiatrist will be phase appropriate and occur at least as often as listed below.

	EPI Clinician			EPI Psychiatrist		
	Acute including relapses	Early Recovery	Later Recovery	Acute including relapses	Early Recovery	Later Recovery
Client	2/week	1/wk	2/month	1/wk	2/month	1/month
Family	1/week	2/month	1/month	Twice	Twice	Twice

- During the acute phase, care should be provided in the least restrictive environment as preferred by the client. Hospitalization should be avoided when possible by intensifying contact, reducing stressors and using medication strategies to reduce distress, agitation and psychosis.

The therapeutic alliance is the cornerstone of treatment

4.52 Core Psychosocial Interventions

Education

- Education consists of the provision of information plus the acquisition of new skills.
- Education is provided as early as possible to clients and families and made appropriate to phase of illness, degree of insight and developmental stage.
- Education is individualized and provided regularly over an extended period of time (at least once every two weeks for six months).
- Education includes information about psychosis, treatments, confidentiality, medications and side effects, recovery, stress and coping, social supports, relapse prevention, drugs and alcohol, health education, and any developmentally-appropriate topics.
- Education is provided in the context of a multi-factorial framework, normalized recovery, and the client and family's explanatory model.
- Family education includes practical information and skills to enhance coping with their loved one's difficult behaviour. Family education aims to enhance family dynamics, decrease family members' distress and improve client and family quality of life and outcomes.

Providing education to clients and families is also an opportunity to assess the personal meaning, understanding and explanation of psychosis, and the family's support of and dynamics with the client. It is also a golden opportunity to enhance engagement and the therapeutic alliance.

Groups and Peer Supports

- Groups for education and intervention are made available to clients and families. Groups are a supplemental service and do not replace individual care.
- Clients receive an assessment for group participation before involvement.
- Progress notes are written for clients and families in education or intervention groups and sent to the primary clinicians for inclusion in their charts.
- Clients have the opportunity for peer support and learning from others who have recovered from psychosis. Families have the opportunity for family support and learning from others who have had similar experiences. If personal contact is not possible, opportunities are provided through stories, videotapes, websites and other media.
- Support groups should focus on issues pertinent to early psychosis as opposed to the issues relevant to more longstanding psychotic disorders. Specific groups for siblings or significant peers can enhance the social support network.

Stress Management

- Stress management should include a number of skills, some of which are incorporated into the relapse prevention plan.
- Goal setting and problem solving skills are both essential elements to stress management.
- The focus on skills related to goals and problems is considered in the context of both illness recovery and developmental appropriateness. Assessments of current abilities and preparation of plans for reintegration can be aided by an occupational therapist (e.g., activities of daily living), vocational rehabilitation counselor (e.g., vocational interests and skills), or a psychologist (e.g., cognitive functioning).

Relapse Prevention

- A relapse prevention plan is prepared in advance. The plan identifies the first symptoms that herald the arrival of a relapse and specific steps taken to avert it.
- An individualized relapse prevention plan is developed by all members of the treatment team, documented and reviewed regularly. This plan may include medication and psychosocial approaches in attempting to thwart an impending relapse.
- Relapse prevention plans should err on the conservative side. It is better to react several times unnecessarily, than to miss reacting to a true relapse.
- If relapse occurs, the relapse prevention plan is reviewed and refined. Education and core psychosocial interventions are reviewed in the context of relapse.

4.53 Needs-Based Psychosocial Interventions

- EPI Programs also offer an array of psychosocial treatment components that will be needed by many, but not all, early psychosis clients. These needs-based components may be offered by either an EPI Central Team or Community Team.
- The EPI Clinician connects clients and families to housing, vocational services, financial resources, community supports (e.g., youth care worker, community living support worker) and other resources if needed and available.
- Close monitoring and cognitive behavioural strategies are used with clients demonstrating persistent psychotic symptoms.
- Drug and alcohol issues are identified and treated using a harm reduction approach, which may include abstinence (either by EPI Clinician or integrated specialist service).
- Treatment plans will be developed, documented and implemented for all co-morbid conditions such as depression, suicide risk and anxiety.
- EPI Clinicians encourage building and maintenance of social skills and networks.
- Other needs, where effective treatments are available, will be treated by an EPI Central or Community Team, or may be referred to a specialist service.

4.54 Pharmacotherapy ¹

- Low-dose atypical antipsychotic medication are preferred.
- Benzodiazepines may be used to manage sleep disturbances, agitation, and anxiety.
- Lowest possible dose is used to avoid side effects.
- Closely monitor motor side effects, weight gain, metabolic side effects, sexual dysfunction and sedation.
- Clozapine is considered if a client does not adequately respond after two adequate trials of atypical antipsychotics.
- Polypharmacy is avoided to the extent possible.
- Clients and families are provided verbal and written information about medication(s), dosage, side effects, and adverse effects.
- Adherence strategies are negotiated with clients and families.
- An intermittent targeted approach with close monitoring may be considered for clients who are good candidates for medication withdrawal or are non-adherent.

**Side effects are a significant cause of treatment failure
and should be minimized**

4.55 Continuing Education

- Each EPI Central Team determines educational needs of their EPI Clinicians and Psychiatrists and coordinates this education.
- Each EPI Central Team ensures EPI Clinicians and Psychiatrists are kept abreast of new advances in early psychosis or changes to program.
- EPI Central Teams provide case consultation to EPI Clinicians and Psychiatrists through variety of means (telephone consultation, rounds, peer supervision, etc.).

¹ See Appendix III, Pharmacotherapy Flowchart

5. Evaluate and Improve Quality of Service

Evaluation reveals opportunities for continuous improvements in care through the systematic collection of standardized data. Applied and basic research on early psychosis will increase understanding of early psychosis, and include research on effective interventions and service delivery efforts. This may ultimately lead to better care and better outcomes.

Evaluation is central to ensuring consistent adherence to guidelines

5.1 Evaluation Strategy

- Each program will regularly prepare a plan for program evaluation.
- The programs will develop indicators to assess implementation of the guidelines.
- Program evaluation includes measures of process, outcome and societal impact across a variety of domains.
- Evaluation incorporates multiple perspectives including clients and families, EPI Clinicians and Psychiatrists, and Central Team members.
- The three programs will endeavor to standardize forms for data collection.
- The Community Carepath will be used by EPI Clinicians and Psychiatrists to ensure standardization of documentation and data collection.
- Carepaths will be audited at least once each year to ensure adherence to guidelines and look for opportunities to improve service delivery.
- The evaluation and audit process will be done in consultation with both ministries.
- All referrals (accepted or not accepted) are documented by the EPI Central Teams.

5.2 Research

- The EPI Programs conduct research to inform care and increase understanding of early psychosis.
- Research projects are approved by Fraser Health Authority ethics review committee and Ministry of Children and Family Development.
- Clients and families participating in research projects will first be provided with verbal and written information on their rights (including their right to discontinue at any time) and any potential risks or benefits and confidentiality limits.

Appendix I

Guidelines Can Make a Difference

Implementation of practice guidelines has been shown to improve both processes of care and patient outcomes

Successful implementation is facilitated by:

- Guidelines that are clear and practical.
- Support from colleagues and administrators.
- Reminder systems.
- Small group training sessions that aim to educate clinicians about the reasons behind practice recommendations.
- Recognition of the applicability of the guidelines to the clients seen in a particular setting.
- Incentives, practice feedback systems and audits to facilitate clinician adherence.
- Peer supervision meetings.
- Program evaluation and continuous quality improvement.

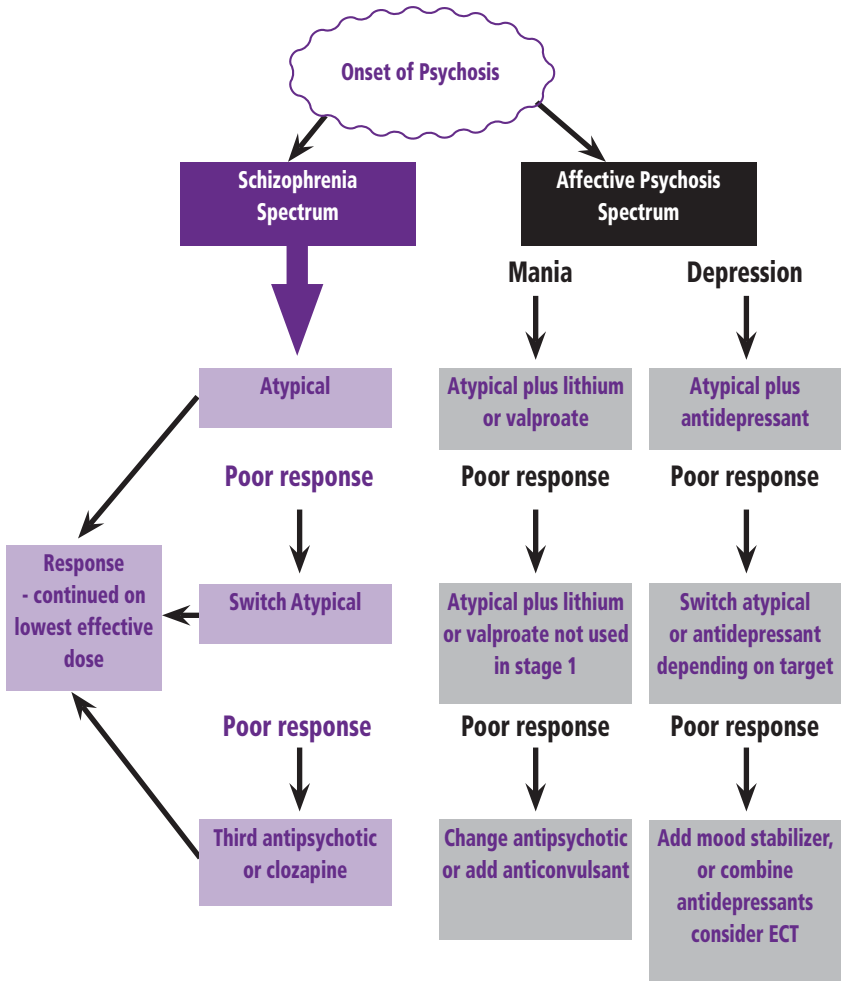
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Appendix III

Pharmacotherapy Flowchart



* Note – If history suggests schizoaffective bipolar type and patient presents in depressive phase, use antipsychotic and mood stabilizer and follow bipolar manic stream

Notes

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