

Guidelines for Oregon Early Psychosis Program Dissemination, January 28, 2008

Mid-Valley Behavioral Care Network, and now the Oregon Department of Human Services Office of Mental Health and Addictions Services, have made it a priority to implement evidence-based best practices with the goal of minimizing disability associated with psychosis. The following practice guidelines provide the framework for system change and service implementation. The goal is to provide intervention as quickly and flexibly as possible, with a minimum of barriers.

These guidelines were developed based on the Australian Practice Guidelines for Early Psychosis (published by EPPIC/University of Melbourne, 1998), more recent guidelines from SAMHSA about multi-family psychoeducation, assertive community treatment and supported employment, McFarlane's "Family Assisted Community Treatment" model which combines these elements, as well as more recent international practice guidelines (British Journal of Psychiatry, supplement 48, 2005 and British guidelines developed as part of the national Initiative to Reduce the Impact of Schizophrenia, or IRIS).

According to the World Health Organization, schizophrenia, bipolar disorder and major depression are three of the ten leading causes of disability worldwide. Schizophrenia is of particular concern since the typical age of onset is during the key developmental years of adolescence and young adulthood, and because the disability caused by schizophrenia often persists throughout the person's life. Research suggests that the early period of illness (the first two to five years) is a "critical period" which may impact the long-term level of disability. Psychosis, whatever the cause, can create rapid and devastating consequences for the individual, family and community. Access to appropriate treatment is critical to prevent unnecessary trauma and disability.

Equally important is that the voice and needs the individual and family being served should drive all services. Services in the early phase should equip them to be effective self-advocates at both individual practice and system levels. Attention needs to be given to removing barriers and accommodating individual needs.

Early psychosis intervention is a rapidly evolving field, and the consensus of "best practices" continues to develop with new research and experience. These guidelines will need to be periodically revisited and revised. Clinicians involved with this work will need to maintain awareness of new research and developments.

1. Systemic infrastructure: Successful implementation of early psychosis intervention requires changes significant system-level commitment and intervention in order to support changed practices.

Principles:

Early psychosis intervention requires systemic as well as practice changes. Ongoing attention to system redesign will be required:

- a. Early intervention for psychosis should be part of a broader commitment to recovery-oriented system change. To be most effective, ongoing services should become consistent with early psychosis intervention strategies.
- b. Mid-managers and clinicians implementing early psychosis programs are likely to encounter a range of policy, funding, procedural and personnel system barriers to implementing new practices. Senior managers and policy leaders will need to support staff charged with implementation by identifying and removing these barriers wherever possible.
- c. Services require a transdisciplinary approach with an adequate level of service intensity to respond to the acute and emerging needs of individuals referred, as well as the range of services they need.

Criteria/Strategies

1.1. It is preferred that most individuals involved in early psychosis work be assigned to early psychosis functions at least half-time, with full-time preferred. Where individuals have additional job responsibilities, those responsibilities should be carefully assessed to ensure the ability to be flexible, responsive and proactive in providing early psychosis supports.

1.2. Staffing should be based on an assertive community treatment standard. Reduced caseload sizes are especially important for newer or more acute situations. Across the transdisciplinary team, a staff to client ratio of 1:10 is optimal.

1.3. The following treatment elements are considered core to providing appropriate services:

- Psychiatry and nursing
- Social work/psychology/counselors
- Occupational therapy
- Substance abuse expertise
- Supported employment/education specialists
- Peer support

1.4. Bilingual-bicultural staff are optimal to reflect local populations and reduce barriers to access.

1.5. All team members should be trained and supported in serving both youth under 18 and young adults.

1.6. Implementation of early psychosis intervention requires attention to each of the following core elements:

- Education of all potential sources of referral within the existing mental health program in order to expedite appropriate access.
- Generally, the early psychosis team should be responsible for its own intake process.
- Integration of early psychosis responsibilities into job descriptions and evaluation.
- Modification of productivity standards to address the need for additional outreach and community education.
- Support for staff to provide services out of the office and during flexible evening and weekend hours.
- Crisis coverage can be outside of the early psychosis team, but should be available 24/7.

1.7. Programs will need to be prepared to pursue and bill a range of insurance and other funding.

2. Prodrromal focus: *Early psychosis programs should integrate information about early signs and risk factors into their education and treatment approach.*

Principles:

The prodrome may be considered to be the earliest form of psychotic disorder, or an at-risk mental state (Eaton et al, 1995; McGorry & Singh, 1995). Changes in subjective experiences and behavior, as well as the onset of neuropsychological deficits, characterize the prodromal phase of early psychosis. Identifying, monitoring and providing needs-based care during a potential prodromal phase in early psychosis are optimal.

Statewide implementation in Oregon is focused on first episode rather than prodromal services. However, integrating current knowledge about the prodrome is important for the following reasons:

- a. The prodromal period is often when the most disabling symptoms develop, particularly associated with cognitive changes. Early detection and response to these changes may prevent school drop-out and long-term functional disability. Suicide risk may also be higher in the prodromal period. Family conflict and emergence of substance abuse may also result. Additional assessment, monitoring and support for youth with prodromal symptoms may detect emerging symptoms and prevent much of the acuity of the initial emergence of psychosis.
- b. Since psychosis is a cyclical condition, a thorough understanding of early symptoms can help begin to develop a “relapse signature”, or predictable early signs of relapse.
- c. Later stage prodromal symptoms often are very similar to the acute form of illness. However, in the prodromal period, insight is typically retained, families are less impacted, individuals are often more likely to recognize the need for outside assistance, and non-pharmaceutical approaches may be more successful since the individual is better able to engage in interactive therapy.
- d. Public education about gradual onset and common prodromal symptoms may help to increase the speed and effectiveness of early identification.

Criteria/Strategies

2.1. Where a person has multiple risk factors for a psychotic illness, assessment and careful monitoring of the precursor symptoms may help to reduce disability and prevent acute symptoms.

2.2. Psychosocial interventions are preferred during the prodromal phase at the present time.

2.3. Optimally the use of neuroleptic or other medication should be avoided during the prodromal phase, unless there is a very rapid deterioration or risk of harm to self or others. In this instance a time limited trial of low dose neuroleptics could be used.

2.4. Promotion of awareness and education about risk factors and signs and symptoms associated with the prodromal phase should occur to inform parents, teachers, school counselors, general practitioners, health professionals and other relevant groups.

3. Community Education and Awareness: *A key element of early psychosis services is a proactive and ongoing campaign to increase knowledge and reduce attitudinal barriers among individuals most likely to encounter early psychosis.*

Principles:

Systematic community education is a critical element of early psychosis intervention. Goals of education include:

- a. Increasing the awareness and skill level of likely referents in identifying signs of psychosis and facilitating referrals;
- b. Increasing community awareness of the existence and accessibility of early psychosis services as a distinct element of the mental health system of care;
- c. Communicating a positive understanding of psychosis as a common, highly treatable condition in which positive outcomes are expected with early intervention.

Criteria/Strategies

3.1. Adequate staff and funding capacity should be set aside in order to ensure that community education activities are not overshadowed by clinical demands.

3.2. Community education strategies should target specific groups rather than “the general public.” Messages should be tailored to the particular values and interests of each group. Specific groups which should be targeted include medical primary care providers, school professionals, parents and others who come in contact with youth. Education of youth may also reduce stigma and facilitate referrals.

3.3. Communications about psychosis should carry a positive, hopeful message about early recovery and should combat negative preconceptions about this common illness.

3.4. Specific information about observable early symptoms should be routinely included in order to facilitate early recognition.

3.5. Systematic efforts to reach out to smaller communities will be necessary in rural areas.

4. Accessibility: *Mental Health Services are easily and quickly accessible for people experiencing or significantly at-risk of their first episode of psychosis and their families.*

Principles:

A first presentation of suspected psychosis is considered a psychiatric emergency. Ease of access to mental health services is of particular importance for anyone experiencing a first episode of psychosis and their family. Individuals experiencing early psychosis and their families are often unfamiliar with psychiatric illness or psychiatric services, and psychosis is a highly distressing event for most families. As a general principle a partnership should be developed with close family members or others on whom the individual relies for support.

Delayed access to mental health services in early psychosis has been associated with slower recovery or less complete recovery and increased risk of relapse during the subsequent two years. Reducing delays into treatment through a clearly defined process of entry into specialist services can have positive outcomes such as reducing the risk of relapse and lowering the levels of medium term disability.

Individuals with first episode psychosis are at high risk of hospitalization, re-hospitalizations, and even state hospitalization. Hospitalization is often a traumatizing experience, and disconnects the person from the supports which foster their recovery. Use of local hospital alternatives should be pursued wherever possible.

Criteria/Strategies

4.1. The mental health crisis service should be accessible 24 hours/day, seven days/week. A strong linkage between crisis services and the early psychosis program should be developed.

4.2. Information about how to access early psychosis services should be promoted and advertised to the community.

4.3. The early psychosis program should accept potential new referrals from a wide range of individuals, families and friends, and primary care services.

4.4. The mental health program should provide education regarding early intervention to individuals most likely to come in contact with first episode psychosis (doctors, schools, etc.), and the wider community.

4.5. The referent should be notified of the outcome of the initial assessment and be provided with written feedback.

4.6. The location of the initial assessment should be community based and at a place of convenience to the individual with psychosis and family, wherever possible.

4.7. If the individual is hospitalized at or after referral, a clinician from the outpatient team should reach out to the family and come to the hospital to initiate contact prior to discharge. The local early psychosis team should participate in hospital discharge planning, as well as admissions for existing clients.

4.8. Team members should be supported in traveling to smaller communities and accessing needed translation/cultural resources in order to reduce barriers to care.

4.9. Team members will need to be aware of a variety of barriers to care, and supported in assisting families in addressing those barriers. Examples include transportation, insurance status, legal issues, child care, and cultural and language issues.

5. Assessment and treatment planning: *Individuals with psychosis and family members receive a comprehensive, timely and accurate assessment and a regular review of progress.*

Principles:

The initial assessment should take place in an environment where the individual perceives him/herself as having a degree of control, where practical. Any decision-making regarding treatment should involve the individual and their family wherever possible.

Assessment procedures for individuals experiencing first-episode psychosis should incorporate strategies to promote engagement (Kulkarni & Power, 1998). The assessment itself should gather information on phenomenology, primary and secondary symptoms, course and duration, prodromal symptoms, precipitants, relieving factors, explanatory model, effect of any treatment already tried, associated physical conditions, current and past substance use (utilizing ASAM criteria), family and personal history, the strengths of the client and their families, their cultural beliefs and practices, and premorbid functioning (EPPIC, 1997). In addition to gathering information, the initial assessment should provide the opportunity to develop a therapeutic alliance with the client and with the family or other significant others.

Assessments should be conducted by appropriately qualified and experienced mental health professionals who have been trained in such procedures.

Criteria/Strategies

5.1. A comprehensive biopsychosocial assessment should be provided and recorded including a Mental State Examination, risk assessment, drug and alcohol use, personal history and family history. This assessment should also comprise a screening for neurological concerns.

5.2. An assessment of risks for the client should be undertaken, to include; suicide, violence and victimization, disorganization, impulsivity, and delusional content which might lead them to potentially harmful behavior/leaving precipitously. This should also include an assessment of the client's potential to leave their usual residence or, if admitted, prematurely leave the hospital.

5.3. The psychiatrist, nurse and case manager should facilitate completion of a comprehensive physical examination, including medical tests: CBC with differential; chemistry panel (with liver enzymes, electrolytes, BUN, Cr, calcium); urine drug screen; thyroid screen (TSH, T4). As appropriate, the physician may request urinalysis with microscopy, B-12 and folate and MRI or CT.

5.4. The doctor, counselor, client and family should meet to clarify needs and expectations, plan treatment and review progress at the following junctures:

- a. Initiation of the assessment process;
- b. After completion of assessment;
- c. Every 90 days;
- d. When initiating transition into ongoing services.

5.5. Treatment plans should be written primarily in the individual's own words, should be routinely reviewed and updated.

6. Transdisciplinary team: *The treatment team, while bringing unique skills and knowledge, aspire to learn from each others' expertise, share responsibilities and provide back-up and support to each other.*

Principles: The treatment team should work together closely to maximize the benefit of each discipline, provide the individual and family with the most useful knowledge and support, and maintain an ability to cross disciplines when appropriate.

The individual and family are core members of the team, and all services are individualized based on their unique strengths, needs and perspective.

The overarching goal of the team is the promotion of recovery and prevention of relapse and ongoing disability. This can be achieved through assisting the client and their family to develop an understanding of psychosis, the recovery process, skills for coping and symptom management, and resources that will assist them in the future. The team also provides consultation and collaboration with others who are important supports, such as teachers and employers.

Team members are expected to have a thorough knowledge of biopsychosocial aspects of psychosis, recovery, rehabilitation, and therapeutic interventions. It is important that the team matches the therapeutic interventions provided with the needs of the client at the relevant stage of psychosis and is able to access more specialized support as required.

The primary goals of the team include:

- a. Engaging the individual and family into a trusting and supportive relationship;
- b. Developing a shared explanatory model with the individual and family which facilitates the person choosing active recovery;
- c. Instilling a perspective of hopefulness and active choice;
- d. Encouraging active participation in multi-family groups and other aspects of treatment;
- e. Providing the individual and family with information and tools for identifying, managing and coping with symptoms;
- f. Facilitating the individual's success in completion of personal goals and developmental tasks;
- g. Teaching the individual and family the skills they need to successfully manage symptoms and to direct treatment and achieve successful recovery.

Criteria/Strategies

6.1. Team members should coordinate services closely. The team should meet frequently, preferably two times each week to review client needs and coordinate services. Each client should be reviewed weekly.

6.2. Team members should have frequent ongoing contact relevant to the phase of illness and the client need.

6.3. Team members routinely cross disciplines, within skill levels and appropriateness. For example, multi-family groups can be co-facilitated by any team member.

<p>6.4. Team meetings should routinely focus on telling success stories.</p>
<p>6.5. A lead counselor is assigned to each person and takes the lead in establishing a relationship with the family, introducing the individual to other team members, and the ongoing management of assessment, treatment planning, discharge planning, and treatment coordination. The counselor acts as a clinical case manager, providing treatment including cognitive behavioral therapy/motivational interviewing, psychoeducation of the individual and family, family support, and community linkages and advocacy. The lead counselor is responsible for continuity of care in the community, including reaching out to hospital units when the individual is hospitalized.</p>
<p>6.6. A psychiatrist and nurse should be assigned to each individual at intake. Psychiatric appointments should be available within one week for new referrals. The psychiatrist and nurse should provide ongoing physical assessment, coordination with primary care, careful monitoring of health status and side effects, and wellness support.</p>
<p>6.7. Each individual entering into services should receive an occupational therapy evaluation, including information on daily functioning, symptom manifestation and management, sensory and cognitive processing. The occupational therapist should make recommendations to the individual, family and other team members, and be available to help refine strategies.</p>
<p>6.8. The team should include vocational and education specialists who provide support to individuals in defining academic/vocational goals and entering and sustaining academic and/or vocational activities.</p>
<p>6.9. Peer support or mentor roles can be important for individuals to maintain a sense of hopefulness and to overcome external discrimination and internalized stigma which frequently accompany psychotic illness. Optimally, some of the members of the paid treatment team should be individuals who have had direct experience with psychotic illness in addition to their professional credentials. The team should also offer opportunities for individuals who are in the program to meet and learn from others with similar experience.</p>
<p>6.10. Treatment should include substance abuse treatment consistent with dual diagnosis best practice guidelines. Psychoeducation and ongoing counseling should discourage the use of unprescribed psychoactive or mood altering drugs, and utilize motivational interviewing techniques to facilitate reduced use/harm reduction.</p>

7. Family partnership: Family and other individuals on whom the client relies are involved in the assessment, treatment and recovery process in episodes of acute psychosis.

Principles:

Family support and involvement are important contributors to a successful outcome.

First-episode psychosis can have a distressing effect on family members. Their passage to receiving appropriate psychiatric assistance may not have been straight forward and initial contact may reveal feelings of guilt, anger, sadness and loss. The first contact with the family often functions as a debriefing session and an opportunity to explain mental health services and how their involvement will benefit the person who has experienced the psychosis.

Some of the key components regarding the role of the family in early psychosis include:

- Family work needs to be developed within a collaborative framework.
- Family work should be tailored to the needs of each individual family.
- The main aim of family work should be to empower the family to cope and adjust to the crisis of psychotic illness within the family.
- Pre-existing problems within the family should be directly addressed only to the degree that they impact the person's recovery from psychosis. Pre-existing problems should be referred for ongoing counseling/treatment outside the early psychosis program, as appropriate.

It is important to clarify the client's wishes regarding the involvement of the family in their recovery. In some instances, individuals in recovery do not want their families involved. The basis for this feeling should always be carefully explored.

Criteria/Strategies

7.1. Initial contact is made with the family or others acting as family within 48 hours of the initial assessment of the client so that crisis intervention, support and psychoeducation can be provided.

7.2. The initial interview with the family should explore and gain a clear understanding of the family's level of knowledge of psychosis and identify their current needs. Family history and observations of the person's behavior are an important part of the diagnostic process.

7.3. The family should be part of the ongoing review process, as specified under Guideline 5.4.

7.4. The key foci for family intervention are: the impact on the family system, the impact on individual family members, including the client, and the interaction between the family and the course of the psychosis.

7.5. Psychoeducation and support should be provided for the family on an initial, ongoing and "as needs" basis through both individual work and group programs.

7.6. Multi-family psychoeducation is a preferred method of treatment for most families (McFarlane, 2002). Where groups are not available, single family psychoeducation can be done following the same format. Fidelity to multi-family psychoeducation standards in each of the key stages is critical: joining sessions, family workshop, and carefully structured initial and ongoing problem solving sessions.

8. Psychoeducation for individuals in recovery and families is an essential component of the treatment process in early psychosis.

Principles:

Psychoeducation aims to develop a shared and increased understanding of the illness for both the client and the family (Glick et al, 1994). It has been suggested that psychoeducation can contribute to better adaptation and a reduction in relapse (McGorry, 1995b).

Psychoeducation may be delivered in a variety of modes, such as one to one, group sessions or family work. Psychoeducation should be considered an ongoing process and the material used for psychoeducation purposes should be reviewed and updated constantly. The material supplied to individuals and families should be appropriate to early psychosis. The content of any written information provided should also be explained.

Group programs are an effective means of imparting information for individuals with early psychosis. Psychoeducation sessions in a group format can offer the opportunity for individuals in recovery to participate in paired discussions, brainstorming as part of the larger group and role playing.

Criteria/Strategies

8.1. The material used should be appropriate for individuals experiencing early psychosis, and additionally should reflect the individual's requirements and take into account how the individual usually learns or absorbs new information. Frequently used materials should be translated as needed, and reviewed for cultural appropriateness.

8.2. Individuals experiencing psychosis and their families should be given initial and appropriate written and verbal information about early psychosis within 48 hours from the time of their initial assessment.

8.3. All team members are responsible for ensuring the provision of psychoeducation.

8.4. Individuals in recovery should have access to group programs and activities that provide education about early psychosis and the opportunity to discuss and assimilate information.

8.5. Psychoeducation should explain:

- the nature of the illness;
- options available for treatment and recovery;
- the patterns and variable nature of recovery;
- the prospects for the future and what individuals in recovery and their supporters can do to influence this;
- success stories of others in similar situations who have achieved successful recovery/illness management;
- what agencies and personnel will be involved in their treatment;
- legal rights;
- specific strategies for symptom management, coping, and establishing appropriate accommodations;
- relapse planning;
- how to select and work effectively with professionals;
- resources available to enhance recovery.

<p>9. Counseling: <i>Counseling interventions are provided as part of the acute phase and ongoing management of recovery from psychosis.</i></p>
<p>Principles: Motivational Interviewing, cognitive behavioral therapy (CBT), and supportive counseling all play a role in helping individuals with early psychosis symptoms to adapt successfully to changed reality, to master symptoms, and to support the person's progress toward developmentally appropriate goals.</p>
<p>Criteria/Strategies</p>
<p>9.1. Psychotherapeutic techniques should be applied in such a way as to facilitate a focus on positive attributes in recovery and develop coping resources to deal with negative factors.</p>
<p>9.2. The determination of the specific psychological intervention techniques to be applied should be based on sound clinical judgment by the individual's counselor and in consultation with the multi-disciplinary team.</p>
<p>9.3. Specific objectives of counseling in early psychosis are:</p> <ul style="list-style-type: none"> ● to form a therapeutic alliance with the client; ● to effect clinical stabilization; ● to provide education about the nature of the symptoms; ● record negative or distressing thoughts and their context; ● become more conscious of thoughts and assumptions; ● learn alternative strategies to deal with stressful situations; ● to promote adaptation and recovery; ● to protect and enhance self-esteem; ● to focus upon stigma issues and develop effective coping strategies; ● to utilize cognitive strategies to prevent and reduce secondary morbidity and comorbidity.
<p>9.4. Counselors should be aware of the potential for trauma caused by crises associated with psychosis and emergency response. Counselors should recognize, acknowledge, and use techniques to minimize the impact of traumatic occurrences. Counselors should take steps to prevent avoidable trauma, such as accompanying the individual to the crisis service where necessary, and letting people know what to expect.</p>
<p>9.5. Clinicians should incorporate dual diagnosis strategies where substance abuse is present or suspected.</p>
<p>9.6. Use of Illness Management and Recovery (IMR) techniques (SAMHSA toolkit) can be helpful, although it will need to be modified for an early psychosis focus. IMR integrates psychoeducation, motivational interviewing and cognitive behavioral therapy, using a framework consistent with early psychosis work (emphasis on a strengths vulnerability approach).</p>

10. Group programs: Development of group programs may help facilitate recovery goals.

Principles:

Group work interventions for people experiencing early psychosis can be both efficient and effective in promoting recovery and involvement in community life, reducing the development of disability and facilitating the achievement of personal goals. They can play a preventive role in improving recovery levels and preventing a decline in psychosocial functioning in vulnerable subgroups (Albiston et al, 1998). Group work interventions complement the other clinical interventions within a biopsychosocial model as they can provide positive outcomes across a number of broad life areas. Members of groups are linked by particular perceptions, motivation and purpose and as such the peer process is central as it provides a forum for the disclosure of personal information (Bloch & Harari, 1994). Group participation facilitates the feeling that other people have similar experiences and learning can occur through observation of others.

It is important in assembling groups to consider the impact of mixing people who are different ages or have different levels of acuity/chronicity. To the greatest degree possible, the group should consist of individuals with similar situations in order to facilitate a positive, hopeful interaction. In order to respond to the diverse clinical and developmental needs of young people, a wide range of group programs should be developed. These are particularly important during the critical recovery period following the onset of psychotic disorder in young people (Albiston et al, 1998). Specific areas to focus on include:

- Coping and stress management skills;
- Psychoeducation;
- Vocational and educational planning and training;
- Social and recreational skills;
- Health promotion;
- Lifestyle issues such as drug use and safe sexual practices; and
- Personal development.

A collaborative approach is essential in group work interventions where the client takes an active role. Staff involved in the facilitation of groups should play a non-directive, supportive and encouraging role (Hoge et al, 1988).

Criteria/Strategies:

10.1. The development of the content of group programs should be based on the identified needs and goals of the individuals in recovery. People in the acute and recovery phases of illness have differing needs which should be reflected in the types of group programs available.

10.2. The development of any group programs should be based on a thorough group planning process which includes needs assessment, the setting of objectives, development of content areas and establishment of evaluation strategies.

10.3. Decisions regarding participation in any group program should be made collaboratively with the client based on an understanding of the potential benefits for that person.

10.4. The process for engaging and supporting individuals in recovery in group programs should be established by the counselor or group program staff.

10.5. An effective interface between the group program and the counselor and multi-disciplinary team needs to be established.

11. Psychopharmacological interventions: *Psychopharmacological interventions are to be provided during the acute phase and ongoing management of recovery from psychosis.*

Principles:

The aim of psychopharmacology in first-episode psychosis should be to maximize the therapeutic benefit for the client while minimizing side effects. A number of issues need to be considered when prescribing medication for individuals with first-episode psychosis. These issues include: choice of medication, optimal dosage, side effects, method of administration, changing medication and adherence.

Novel antipsychotics are generally preferred over typical antipsychotics because they are less likely to cause extrapyramidal side effects (EPS) and are considered more efficacious than conventional neuroleptics in the treatment of negative symptoms. However, careful monitoring of weight gain and changes in lipid profile are essential, along with coaching regarding diet and exercise.

Optimally, drug treatment in early psychosis should be delivered in the context of a therapeutic relationship which promotes adherence. The central theme in psychopharmacotherapy in early psychosis is ‘start low; go slow’, that is, use very low doses of neuroleptics and titrate very slowly.

Criteria/Strategies

- 11.1. Novel antipsychotic medications are the first treatment of choice and dosage should not exceed 15 mg Abilify; 2 mg risperidone; 400 mg Seroquel; 120 mg Geodon, or 10 mg olanzapine within the first three weeks of treatment.
- 11.2. Individuals who are experiencing a comorbid manic syndrome should receive a mood stabilizer. If psychotic symptoms are present a low dose neuroleptic will also be required.
- 11.3. Benzodiazepines are generally preferred to neuroleptics for sedation where the management of sleep/agitation is required (i.e. Lorazepam .5-1 mg 3X/day). For severe agitation use Zyprexa 10 mg 2x/day as needed
- 11.4. With the exception of the above, polypharmacy should be avoided, specifically the use of multiple neuroleptics.
- 11.5. Clozapine should be considered after three adequate trials of novel antipsychotics. CBT, occupational therapy strategies, and other psychosocial treatment should also be considered an adjunctive form of therapy.
- 11.6. Oral treatment is the preferred method rather than depot medication for both acute and recovery phases except in exceptional circumstances and after other options, for example psychoeducation and compliance therapy (Kemp et al, 1996) have been tried.
- 11.7. The psychiatrist or psychiatric nurse should continue to maintain contact with individuals who chose not to take or to discontinue medication, with the goals of building trust, encouraging the individual to make healthy choices, addressing objections and concerns to the use of medicines, and monitoring ongoing symptoms and safety. Communication with the family is particularly important for those individuals who are unwilling to take medicine, with a focus on maintaining safety, encouraging healthy empowerment of the individual, and supporting family coping.
- 11.8. Psychiatric visits should occur weekly during the initial phase, and should occur at least monthly for most people. Most routine visits should last at least 30 minutes.
- 11.9. Many individuals will prefer to end antipsychotic medications after a period of stability, and some can do so successfully. Nine months following full clinical remission, an incremental decrease in the medication dose should be considered. Decreases in medication dosages should occur with close monitoring of symptoms, over many weeks with a view to cessation over a three to six month period. A relapse plan should be well-developed and agreed upon.

<p>12. Transition planning: <i>The program is transitional in nature, and services should prepare the individual for long-term success.</i></p> <p><i>Principles:</i></p> <p>Early psychosis services are normally conceptualized as a transitional service, with the goal of best preparing the individual and family for successful long-term illness management. Individuals may be transitioned into ongoing public services where appropriate, but will also commonly be transitioned into ongoing private resources.</p> <p>To support long-term recovery, transitions need to be carefully planned and implemented gradually. Transition planning should always include the family.</p> <p><i>Criteria/Strategies</i></p> <p>12.1. The program should be described as transitional from the beginning, and the treatment plan should address long-term issues of transition from the inception of services.</p> <p>12.2. Treatment plans should be primarily in the individual’s own language describing his/her goals. Plans should be reviewed and agreed to with the family and all members of the individual’s team. Ongoing services should reflect the goals identified in the treatment plan.</p> <p>12.3. Where appropriate, relapse plan/advanced directive should be developed and shared with all who need to be involved for each individual, identifying preventive measures, the person’s relapse signature, and planned response to relapse.</p> <p>12.4. Choice of provider matters because of the importance of compatibility, mix of skills, and the need for a high level of trust and communication. Individuals and families should be informed from the outset, and it should be reinforced over time, that they have the choice of which clinician they work with, within the limitations of availability. Every effort should be made to accommodate individual and family preferences in clinician.</p> <p>12.5. Transitions among counselors, physicians, or out of services should occur in a planful, gradual process whenever possible.</p> <ol style="list-style-type: none"> a. Discharges and transitions should generally occur as gradually as possible, with a goal of a transition of 6 months at time of discharge. b. Records should be transitioned and the individual should have engaged with the new provider prior to discharge from the original provider. c. If transitions are due to personnel or agency changes, a careful, timely transition process should occur: <ol style="list-style-type: none"> 1) Notification should occur in person by the original treating clinician if at all possible; if not, notification should occur in person by the clinical supervisor; 2) A transition plan should be developed with the individual; 3) A closure session with the original treating clinician should be offered if at all possible; 4) A letter explaining the transition, options and rights should be sent after personal notification has occurred, or if the person cannot be reached. <p>12.6. Prior to discharge, the person should have met with an ongoing prescriber and counselor, and issues of housing, economic stability, and access to medications should be addressed.</p>

<p>13. Least restrictive setting: <i>Individuals in recovery will receive treatment in the least restrictive manner whenever possible.</i></p> <p>Principles: Choice of treatment setting is a very important component in the overall management of people with first-episode psychosis. While the decision regarding treatment setting should be based on the level of severity of presentation and the assessed level of risk, the optimal treatment setting is considered to be the client's home (Fitzgerald & Kulkarni, 1998).</p> <p>Minimization of trauma to the client and their family should be upper most in the minds of mental health professionals when determining the treatment setting for each individual. Dislocation from their usual environment may be detrimental to the client and hinder their recovery. Where an inpatient admission is necessary, choice of facility is important, particularly for younger people. Facilities that have adopted practices compatible with the early psychosis program are preferred. In addition, impact of exposure to individuals with more chronic illness should be considered when determining the most appropriate placement.</p> <p>Criteria/Strategies</p> <p>13.1. Choice of treatment setting should be appropriate and convenient to the client's requirements.</p> <p>13.2. Wherever possible, the mental health practitioner should aim to provide treatment for the client in the least restrictive environment. The team should routinely meet people in their homes and in the community.</p> <p>13.3. The primary treatment location should be in the most non-stigmatizing location possible.</p> <p>13.4. Where involuntary commitment becomes necessary, it should occur in a respectful manner, providing the individual opportunities to voice concerns and preferences, with a clear expression of concern for the individual's well-being and explanation of why the process is occurring, and without deception. The primary counselor should accompany the individual and family through the process of hospitalization (admission to discharge, voluntary or involuntary), helping them to understand how the system works and proactively working to minimize trauma.</p> <p>13.5. Wherever appropriate, the counselor should facilitate the creation of an advanced directive which identifies the individual's preferences related to treatment in the event that symptoms worsen and involuntary commitment may become necessary. Every effort should be made to communicate and advocate for these preferences.</p>
<p>14. Non-English Speaking Background Individuals</p> <p>14.5. Access to transcultural mental health staff is optimal.</p> <p>14.1. Where required for the client and family, access to accredited interpreter services should be ensured.</p> <p>14.2. Psychoeducational material should be made available in the client's language, if other than English.</p> <p>14.3. Mental health professionals should receive training and consultation about cultural beliefs and practices, and how they may be manifested in psychosis.</p> <p>14.4. Mental health professionals should be aware of the differing cultural beliefs regarding mental illness and the impact on the family.</p>
<p>15. Rural and Remote Area Individuals</p> <p>15.1. The full range of services should be provided in rural and remote areas as needed. Some methods may need to be modified in order to meet the needs of rural residents.</p>

Appendix A:

Phase of Treatment Definitions and Guidelines

- Screening** Initial discussions to determine whether the individual is an appropriate fit for THE EARLY PSYCHOSIS PROGRAM or whether the person is willing to engage. Decision has not yet been made.
- Assessment/Stabilization.** Person has been preliminarily determined appropriate to THE EARLY PSYCHOSIS PROGRAM. Person remains in assessment phase until counselor and psychiatric evaluations are completed and until lab tests are completed with results reviewed by the psychiatrist.

Assessment/Stabilization Goals (Month 1-3):

- Get to know the person and family, including strengths, goals, experience to date, needs, etc.
- Pull together social supports
- Initiate needed medical tests to rule out medical conditions
- Complete comprehensive assessment, including medical/psychiatric, psychosocial, occupational therapy, initial vocational
- Provide education about condition and treatment
- Initiate medicine if appropriate*
- Maintain safety; develop a crisis plan
- Stabilize environment and symptoms
- Refer to multi-family group

Person has completed assessment/stabilization phase when:

- A crisis plan has been developed and implemented
- Severe symptoms are resolved
- Person and family are actively engaged in treatment
- Medical tests are completed and reviewed by psychiatrist
- Environment is stabilized
- Person and family members have received basic information about psychosis, stress-vulnerability model, community resources, coping skills, recovery

Early Recovery Definition

A person is in Early Recovery when they have completed the Assessment/ Stabilization phase and they are actively involved in treatment.

Early Recovery Goals (Month 2-6)

- Continue to address symptoms and side effects through skill development, medicines, and therapy
- Develop a relapse plan identifying early symptoms and strategies
- Teach coping skills
- Provide mentoring relationships
- Support individual goals (work, family, relationships, independent living, etc.)

A Person has Completed Early Recovery when:

- They have developed an effective relapse plan which identifies specific symptoms and strategies.
- Except for temporary relapses, the person's most challenging symptoms are under control.
- Key family members have received an education about the person's condition and how to be helpful.
- The person is actively engaged in normal activities of daily living (work, relationships), and is utilizing appropriate accommodations.
- The person has an educated support system (goal: 5 people)

Late Recovery Phase (Month 4-12)

Individuals who are have completed early recovery enter the late recovery phase.

Goals:

- Teach self-advocacy skills
- Address persistent symptoms
- Support individual goals
- Encourage involvement in mentoring and service oversight
- Identify and implement transition plan
- Establish ongoing supports

Prolonged Recovery Phase (Month 7-?)

Individuals whose symptoms or functioning do not stabilize enter a prolonged recovery phase. Goals in prolonged recovery:

- Stabilize symptoms
- Teach person coping skills for dealing with persistent symptoms
- Develop supportive living environment
- Establish supportive friendships
- Address economic and other living needs
- Establish long-term plan for services

Relapse:

A relapse is defined as a recurrence of symptoms severe enough to interfere with functioning.

Discharge:

- Symptoms are stabilized
- Extensive psychoeducation of individual and family has occurred
- “On track” developmentally OR in need of long-term intensive services
- Transition in place and has occurred successfully

Acuity definitions

Severe	Highest risk of harm to self or others. Individual is in need of hospitalization or constant supervision to keep safe.
	Optimal level of contact: Individual should be hospitalized or under constant supervision. In the event that this is not possible, daily contact with the individual and family should be established (by phone or in person); should be strong family involvement/outside support.
High	Acute level of psychosis to extent that could result in inability to manage daily activities or potential for dangerous behavior
	Optimal level of contact: Minimum 2X/week with regular contact by informal supports and well-thought-out and well-communicated crisis plan. Crisis respite or other intensive supervision should be considered.

Moderate Person has active acute symptoms which are being managed with some difficulty. A plan is in place for responding to crisis and family or support system are educated and informed about how to respond.

Optimal level of contact: 1-2 contacts/week, including 1 contact with family/week

Low Person is in remission from acute symptoms, and the person's environment/stressors are not currently placing them at risk.

Optimal level of contact: 1 contact/2 weeks; once/month for family

Late remission Person is stabilized, has good relapse plan, and is making progress toward developmental milestones.

Minimal level contact: 1 contact/3 months

Transitional When an individual has low symptom acuity, he/she will often enter into major life transitions such as moving into an apartment for the first time or starting a new job. During these times of transition, the risk of relapse is increased. The level of contact should be increased correspondingly to monitor emerging symptoms, promote effective adaptation and prevent relapse.

Factors to consider in determining acuity:

- Past history of self harm or harm to others
- Level of impulsiveness
- Paranoia directed at others
- Access to weapons
- Strength of support system and ability to manage behaviors
- Level of current symptomology
- Participation in active treatment
- Substance abuse

APPENDIX B

Early Psychosis Documentation Guidelines

Written documentation since the last visit should be made available to the psychiatrist, and doctor's notes should be kept in the counselor's chart. Specific documentation for which counselors are responsible include:

- a. Completion of a referral form informing the regional coordinator that a referral has been received;
- b. Documentation that the individual has received information about legal rights, and completion of releases of information following HIPAA standards;
- c. Completion and refinement of risk assessments and crisis plans;
- d. Completion of a comprehensive mental health assessment (initial assessment to psychiatrist within the first 2 weeks; final assessment within 1 month);
- e. Completion of an Individual Recovery Plan (treatment plan) which reflects the individual's and family' goals, strengths and needs;
- f. The Individual Recovery Plan should be agreed upon by the client, psychiatrist, and close family members/key supporters, which is indicated by documentation in progress notes and signature on the plan;
- g. Progress notes documenting all contacts with the client and family;
- h. Periodic documentation of clinical progress, through use of a tool such as the BPRS;
- i. Completion of a relapse plan and, where the person desires, an advanced directive;
- j. Annual re-assessment;
- k. Transition plans;
- l. Discharge summary.