

Mid-Valley Behavioral Care Network Official Practice Guidelines for Early Psychosis, Officially Adopted Version, 11/04

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 during the first two years there is a "window of opportunity" for reducing long-term disability associated with the condition.

The Mid-Valley Behavioral Care Network has 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). Each section contains a discussion of how the set of guidelines is implemented within the MVBCN.

Guideline/Criteria/Strategies
<i>I:</i> MVBCN is not currently providing a prodromal service. However, the following guidelines are useful for public education purposes, and for guiding service to young people who have a significant family history of schizophrenia, a deterioration in functioning, and brief symptoms which appear to be possible precursors of psychosis.
<i>Principles:</i> 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 psychos. Identifying, monitoring and providing needs-based care during a potential prodromal phase in early psychosis are optimal.
<i>Criteria/Strategies:</i>
1.1. Where a person has multiple risk factors for schizophrenia, assessment and careful monitoring of the precursor symptoms may help to reduce disability and prevent acute symptoms.
1.2. Psychosocial interventions are preferred during the prodromal phase at the present time.
1.3. Optimally the use of neuroleptics or other medication should be avoided during the prodromal phase.
1.4. 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.

2: Mental Health Services are accessible and provide a timely assessment for people experiencing or significantly at-risk of their first episode of psychosis and their families.

Principles:

Ease of access to mental health services is of particular importance for anyone experiencing a first episode of psychosis and their family. Access to services in first-episode psychosis should be considered a priority. 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.

Criteria/Strategies:

2.1. The mental health crisis service should be accessible 24 hours/day, seven days/week.

2.2. How to access crisis services and the early psychosis program and the hours of operation should be promoted and advertised to the community.

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

2.4. 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.

2.5. All new individuals with psychosis should be considered a priority. See Stage of Treatment and Acuity Guidelines in Appendix A for specific targets.

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

2.7. 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.

3: Individuals with psychosis and family members receive a comprehensive, timely and accurate assessment and a regular review of progress.

Principles:

A first presentation of suspected psychosis is considered a psychiatric emergency. The literature recommends that 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, 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 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:

Assessment

3.1. 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 neurological examination.

3.2. An assessment of risks for the client should be undertaken, to include; suicide, violence and victimization. This should also include an assessment of the client's potential to leave their usual residence or, if admitted, prematurely leave the hospital.

3.3. The psychiatrist 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
- Urinalysis, with microscopy
- B-12 and folate
- Thyroid screen (TSH, T4)
- MRI or CT

3.4. Wherever possible the family or other supporter should be contacted as soon as possible and no later than 48 hours from the time of the initial assessment and be provided with information and support.

3.5. See Stage of Treatment and Acuity Guidelines in Appendix A for further details of goals and frequency of contact.

3.6. 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.

3.7. The counselor takes primary responsibility for communicating the importance of a team approach to families, and for organizing the team meetings.

4: A counselor¹ and treating psychiatrist should be allocated to each client upon entry to service, and provide a range of services to meet the needs of the client and their family and carers.

Principles:

The counselor plays a central role in the ongoing management of the client and their family and other supports. The overarching goal for the counselor 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. Collaboration is essential between counselor, client and family. The counselor is responsible for assessment, treatment planning, discharge planning, treatment including cognitive behavioral therapy, psychoeducation of the individual and family, family support, coordination of supportive services, and advocacy.

The counselor is expected to have a thorough knowledge of biopsychosocial aspects of psychosis, recovery, rehabilitation, and therapeutic interventions. It is important that the counselor 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 counselor provides a point of service accountability regarding the client and works in partnership with the psychiatrist who also has clinical accountability.

A further part of the counselor's role is the task of ensuring continuity of care and the maintenance of the client's relationships with clinical staff. Establishing and maintaining an ongoing trusting relationship is critical. The counselor should have links with a range of mental health and community resources.

The primary goals of the counselor include:

- a. Developing a shared explanatory model with the individual and family which facilitates the person choosing active recovery;

¹ The term "counselor" refers to a clinical case manager. The clinical case manager role refers to a role which combines responsibility for clinical assessment and treatment, as well as community brokerage and advocacy. Clinical case managers in this model are also responsible for individual and family psychoeducation and support. The term "counselor" is used rather than "case manager" due to the need for sensitivity in language choice.

- b. Instilling a perspective of hopefulness and active choice;
- c. Providing the individual and family with information and tools for identifying, managing and coping with symptoms;
- d. Facilitating the individual's success in completion of personal goals and developmental tasks;
- e. Teaching the individual and family the skills they need to successfully manage symptoms and to direct treatment and achieve successful recovery.

Criteria/Strategies:

4.1. A counselor/case manager is allocated to every client upon entry to the service.

4.2. The counselor is the central clinician in each case to which he/she has been allocated, regardless of treatment setting, and works in partnership with the treating physician.

4.3. The counselor will provide a range of services to meet the needs of the client and their family in conjunction with the treating psychiatrist or medical practitioner.

4.4. The primary functions of the counselor include ongoing comprehensive assessment and clinical interventions such as psychotherapy, psychoeducation and community linkages.

4.5. The counselor should have frequent ongoing contact relevant to the phase of illness and the client need.

4.6. 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.

4.7. The counselor is responsible for documentation and development of the individualized treatment plan. Part of this process will include the referral of individuals to other agency/agencies at least two months prior to case closure. See Early Psychosis Documentation Guidelines for further detail

4.8. 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.

4.9. Transitions among counselors, physicians, or out of services should occur in a planful, gradual process whenever possible.

- a. Discharges and transitions should generally occur as gradually as possible, with a goal of a transition of 3-6 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:
 - a. 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;
 - b. A transition plan should be developed with the individual;
 - c. A closure session with the original treating clinician should be offered if at all possible;

A letter explaining the transition, options and rights should be sent after personal notification has occurred, or if the person cannot be reached.

5: 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 compliance.

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.

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:

5.1. All individuals with a first onset of psychosis should have a neuroleptic free period of at least 48 hours.

5.2. Novel antipsychotic medications are the first treatment of choice and dosage should not exceed 2 mg risperidone or 10 mg olanzapine within the first three weeks of treatment.

5.3. 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.

5.4. Benzodiazepines are generally preferred to neuroleptics for sedation where the management of sleep/agitation is required, for example; (temazepam 20 mg, noct3); (diazepam 10-30 mg, daily); and severely disturbed behavior with violence (IMI midazolam 5-15 mg). Longer acting drugs such as clopenthixol acetate should be reserved for situations where individuals repetitively refuse oral medication in order to avoid a series of IM muscular injections.

5.5. With the exception of the above, polypharmacy should be avoided, specifically the use of multiple neuroleptics.

5.6. Clozapine should be considered after two adequate trials of novel antipsychotics. CBT should also be considered an adjunctive form of therapy.

5.7. 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.

5.8. The psychiatrist or psychiatric nurse should continue to maintain contact with individuals who refuse medication, with the goals of

<p>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.</p>
<p>5.9. Six to 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>
<p><i>6: Psychological interventions are provided as part of the acute phase and ongoing management of recovery from psychosis.</i></p>
<p><i>Principles:</i></p> <p>The goals of cognitive behavioral therapy (CBT) in early psychosis are to preserve self esteem, to adapt successfully to changed reality; to promote mastery of symptoms, and to support the person’s progress toward developmentally appropriate goals. Cognitive behavioral therapy may be provided by the primary counselor or by a therapist specializing in CBT.</p>
<p><i>Criteria/Strategies:</i></p>
<p>6.1. 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>6.2. 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>6.3. Specific objectives of cognitive behavioral therapy 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>6.4. 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>6.5. Clinicians should incorporate dual diagnosis strategies where substance abuse is present or suspected.</p>

7: 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/carers 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 3.3.12.

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. For families which are dealing with ongoing psychosis, multi-family groups are a preferred method of treatment (McFarlane, 2002).

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 is 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.

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. The counselor and the treating psychiatrist (or medical practitioner) 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.

9: A comprehensive range of group programs specifically tailored to the needs of people with early psychosis should be available.

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.

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:

9.1. Group programs should be available in a range of clinical and community settings.

9.2. Wherever possible, individuals in recovery should be able to attend these group programs in the least restrictive environment.

9.3. 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.

9.4. 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.

9.5. 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.

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

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

<i>10: Individuals in recovery will receive treatment in the least restrictive manner whenever possible.</i>
<i>Principles:</i> 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). 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.
<i>Criteria/Strategies:</i>
10.1. Choice of treatment setting should be appropriate and convenient to the client's requirements.
10.2. Wherever possible, the mental health practitioner should aim to provide treatment for the client in the least restrictive environment. Wherever possible, voluntary approaches and hospital diversion options should be used.
10.3. Involuntary commitment should be pursued when the clinician determines that the individual cannot be maintained safely in the community and the person is unwilling to accept voluntary options. Involuntary commitment 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 (voluntary or involuntary), helping them to understand how the system works and proactively working to minimize trauma.
10.4. Wherever possible, 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.
<i>11. Non-English Speaking Background Individuals.</i>
11.1. Where required for the client and family, access to accredited interpreter services should be ensured.
11.2. Psychoeducational material should be made available in the client's language, if other than English.
11.3. Mental health professionals should receive training and consultation about cultural beliefs and how they may be manifested in psychosis.
11.4. Mental health professionals should be aware of the differing cultural beliefs regarding mental illness and the impact on the family.
11.5. Mental health professionals have should have access to Transcultural Mental Health staff when required.
<i>12. Rural and Remote Area Individuals</i>
12.1. Services should be provided in rural and remote areas as needed.
12.2. Community education and outreach should occur in rural areas.

Appendix A:

EAST Phase of Treatment Definitions and Guidelines

Screening Initial discussions to determine whether the individual is an appropriate fit for EAST or whether the person is willing to engage. Decision has not yet been made.

Assessment/Stabilization.

Person has been preliminarily determined appropriate to EAST. 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
- Provide education about condition and treatment
- Initiate medicine if appropriate*
- Maintain safety; develop a crisis plan
- Stabilize environment and symptoms

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 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

EAST Acuity definitions

Severe	<p>Highest risk of harm to self or others. Individual is in need of hospitalization or constant supervision to keep safe.</p> <p>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</p>
High	<p>Acute level of psychosis to extent that could result in inability to manage daily activities or potential for dangerous behavior</p> <p>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.</p>
Moderate	<p>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.</p>

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

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.