Annexure G

Procedure

NSW GOVERNMENT | Health Mid North Coast Local Health District

Document Number: **MNC-PRO-0060-17**

Title: Early Psychosis Procedure

Site document is utilised: District

Background and purpose: Early Psychosis intervention is a core component of the Mid North Coast Local Health District (MNCLHD) mental health service delivery. The Early Psychosis Policy and Procedure have been developed in order to establish and provide a service and evidence based practices across the MNCLHD and to ensure best practice in the management of Early Psychosis.

Keywords: Early Psychosis, Early Intervention, psychotic episodes, MHS

Responsible Directorate: Integrated Mental Health, Alcohol & Other Drugs

National Standard: NS05 Comprehensive Care

Replaces Existing Guideline: **false**

Registration Number of Superseded Document(s): [Superseded Document ID]

Related Legislation, NSW Health Policy or Circular, or other MNCLHD Documents:

- National Standards for Mental Health Services 2010
- NSW Carers (Recognition) Act 2010
- NSW Health GL2021_006_Physical Health Care for People Living with Mental Health Issues
- NSW Health PD2017_033 Physical Health Care Within Mental Health Services
- NSW Mental Health Act 2007 Mental health - Legislation (nsw.gov.au)
- NSW Health PD2022_043 Clinical care of people who may be suicidal
- The Australian Clinical Guidelines for Early Psychosis Second Edition 2016
- The RANZP Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders

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Aboriginal Health Impact Statement Required? No

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MNCLHD Procedure **Document Registration Number:** **MNC-PRO-0060-17**	Health Mid North Coast Local Health District

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Director:	Director, Mental Health and Drug and Alcohol Services
Clinical Consultation:	MNCLHD Mental Health Services – all staff and programs MNCLHD global distribution all staff
Clinical Authority:	Mental Health Services Policy and Procedures Committee
Management Authority:	MNCLHD Senior Executive Team Meeting

1.0 Title

Early Psychosis Procedure

2.0 Related Policy

- MNCLHD Collaborative Care Planning
- MNCLHD Mental Health Services Family and Carer Policy
- MNCLHD Mental Health Services Family and Carer Procedures
- MNCLHD Safety and security for mental health workers providing home visits and/or working in community environments
- MNCLHD Transfer of Care
- MNCLHD Clinical Reviews in Mental Health
- National Standards for Mental Health Services 2010
- NSW Carers (Recognition) Act 2010
- National Standards for Mental Health Services 2010
- NSW Carers (Recognition) Act 2010
- NSW Health GL2021_006_Physical Health Care for People Living with Mental Health Issues
- NSW Health PD2017_033 Physical Health Care Within Mental Health Services
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- The Australian Clinical Guidelines for Early Psychosis Second Edition 2016
- The RANZP Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders

3.0 Purpose

Early Psychosis intervention is a core component of the Mid North Coast Local Health District (MNCLHD) mental health service delivery. The Early Psychosis Pathway has been developed to provide evidence-based practices and to ensure best practice in the management of Early Psychosis across the MNCLHD.

This procedure has been based on the Australian Clinical Guidelines for Early Psychosis 2nd Edition (2016). The procedure is intended for all clinicians and staff in Mental Health Services involved in the provision of care to consumers experiencing early psychosis.

The RANZCP Clinical Practice Guidelines for the Management of schizophrenia-disorders- cpg.aspx (ranzcp.org) provides additional recommendations regarding the treatment of early psychosis and which are consistent with the Australian Guidelines of Early Psychosis.

4.0 Risk Management

"Staff compliance with this procedure will ensure that the risk of harm to staff, patients and/or visitors is minimised. Failure to comply with this procedure may result in adverse clinical outcomes for consumers, staff and visitors. Generic information on Risk Management for use in documents can be accessed at: http://int.mnclhd.health.nsw.gov.au/clinical-governance/enterprise-wide-risk-management http://int.mnclhd.health.nsw.gov.au/clinical- governance/enterprise-wide-risk-management/

5.0 Procedure

Early Psychosis refers to the first episode of psychosis, including the prodromal period, and includes the critical period up to five years from entry into treatment for the first psychotic episode.

Whilst the first episode of psychosis (FEP) usually occurs with young people, the Early Psychosis procedure are relevant to any person who is experiencing their first episode of psychosis, regardless of age.

A diagnosis of psychosis can lead to experiences of significant distress, grief, hopelessness, and a change in function. Family and carers may also report similar experiences. be significantly affected.

A diagnosis (of schizophrenia, bipolar disorder, psychotic depression or other less common psychotic disorder) is usually made, it can take months for a final diagnosis to be clarified. However, treatment can begin as soon as a provisional diagnosis of first episode psychosis is made. A pervasive sense of hope and an optimistic outlook for recovery are important for the treating team to promote with individuals and their families/carers.

The procedure is consistent with key Mental Health Service principles including person centred care, trauma informed care, recovery and family focused recovery.

The following procedures are organised as follows:

1. General principles for all mental health service delivery;
2. The Australian Clinical Guidelines for Early Psychosis Second Edition 2016 Clinicians need to familiarise themselves with the guidelines as it provides evidence-based recommendations regarding assessment and treatment.
3. Specific considerations for Mid North Coast Local Health District Mental Health Services

5.1 General Principles

Mental health service provision may occur in a range of locations, including the home of the person, carer or significant other (such as a family member) or in a clinic or another community facility.

i. **Person Centred Care** with the consumer, carer and family is a priority and provides the foundation of treatment**.** Reorganising the individual as capable of self-determination who brings a lived experience, knowledge and preferences.
ii. **Least restrictive treatment** provisions apply;
iii. **Trauma Informed Care** is based on the understanding that a significant number of people living with mental illness and their families may have experienced trauma and that trauma may be a factor in their distress. It is important for services to provide trust, safety, choice collaboration,

respect and empowerment to consumers. It is important to consider the particular impact of intergenerational trauma when working with Aboriginal people accessing mental health services.

iv. **Recovery** the achievement of an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental health issue. Recovery is based on providing hope, development of appositive identity, a sense of meaning and personal responsibility.

v. **Collaboration** to support family focused recovery with the aims of family interventions to maximise the adaptive function of the family and minimise:
- The risk of acute stress and expressed emotion;
- High levels of burden and long-term grief.
- The context and potential for family/carer support should be carefully explored;
- Family interventions should be developed within an inclusive framework in which the clinician works in partnership with the family;

vi. **Diversity Commitment** IMHAOD are committed to working to meet the needs of people from diverse background. IMHAOD staff should seek advice and education around the cultures of the people they are working with in order to work in a culturally sensitive way.

Aboriginal consumers, families/carers

It is imperative that services ensure cultural safety for Aboriginal consumers, families/carers. All Aboriginal consumers accessing mental health services must be offered appropriate cultural support, this may include referral to an Aboriginal Liaison Officer and/or maintaining close links with the local Aboriginal Controlled Health Services (ACHS) may be an appropriate response. Aboriginal people engaged with MNCLHD Mental Health Service should be offered to work with Aboriginal Clinicians or staff as a part of service provision.

Culturally and Linguistically Diverse (CALD) consumers, families/carers

The use of the Translator and Interpreter Service (TIS) may be essential for communication with CALD consumers and families. Providing services that are easily accessed by people from diverse cultural backgrounds and people whose first language is not English. Consider the impact of trauma when working with refuges and work from a trauma informed perspective.

5.2 The Australian Clinical Guidelines for Early Psychosis Second Edition 2016

The Australian Clinical Guidelines For Early Psychosis provide detailed explanations and recommendations regarding all aspects of care including:

- Assessment
- Treatment at each stage of care:
  - Ultra High Risk
  - Acute Phase
  - Recovery Phase
  - Relapse
  - Incomplete recovery, medication discontinued and discharge
  - Pharmacotherapy
  - Psychological treatments- Should be based on individual needs and presentation Cognitive Behavioural Therapy for Psychosis (CBTp) is outlined as best practice.

- Principles across all phases
  - Engagement
  - Physical health:
    - Cardio-metabolic screening and intervention
    - Oral Health
    - Tobacco cessation
  - Sexual Health
  - Case management
  - Functional recovery
  - Trauma informed
  - Integrated specialist treatment
  - Least restrictive
  - Family involvement
  - Goals to guide treatment
  - Group programs
  - Psychoeducation
  - Suicide Prevention
  - Substance misuse
  - Comorbidities
- Considerations for particular populations (pp102-109)
  - Children
  - Women of child-bearing age and during pregnancy
  - Breastfeeding women
  - People identifying as Aboriginal and/or Torres Strait Islander
  - Culturally and linguistically diverse communities
  - People experiencing homelessness

5.3 Procedures Specific to Mid North Coast Local Health District Mental Health services:

5.3.1 Ultra High Risk of Developing Psychosis-

This group will include people who display at risk mental state, which may or may not be associated with a developing psychotic disorder (The Australian Clinical Guidelines For Early Psychosis table 5 p26). Their symptoms do not meet the criteria for a diagnosis of early psychosis.

Where possible, these people should be referred to the non-government or private sector for treatment, unless there are other comorbidities that require care from MNLCHD Mental Health Services. If no other services are available, they may be referred to the mental health service for further Assessment with Safeguards Child and Adolescent Mental Health Services or the Acute Care Service.

5.3.2 Multidisciplinary Review-

A multi-disciplinary team (MDT) approach to assessment, treatment and review is required to address complex mental health needs associated with early psychosis. MDT review treatment and establish care plans for ongoing treatment. Care plans should consider psychological treatment options in the context of the individuals presentation and needs considering access to CBTp via the Mental Health service or linking to private psychological services.

The MDT provide professional based expertise for assessment and treatment. This can consist of Psychiatry, Nursing, Medical, Peer Worker, Aboriginal Mental Health Clinicians and Allied Health.

Care and progress should be presented to the MDT at a minimum of13 week reviews in which time care plans for treatment are updated this provides team interface for best practice. The MNCLHD Procedure: Clinical Reviews in Mental Health offers specific details about the clinical review of care provided. MNCLHD-PDS - Document Contents (sharepoint.com)

5.3.3 Case Managers Role-

A case manager should be allocated as soon as early psychosis is identified to provide continuity of care and will be inclusive of care across all services including interface during hospitalisation. MNCLHD will endeavour to link the person with the same case manager throughout their care wherever possible to provide consistency in care.

Consistency in case management supports trust, engagement and collaboration in treatment provided. Case managers will aim to provide assertive follow-up to support engagement and strong therapeutic alliance. Case management and associated contact should be actively pursued for 12 months and ideally for 2 years wherever possible. Mental Health services may provide shared care alongside community manager organisations or private services to meet individual needs over the 2nd year. This may result in case managers completing at a minimum 13 week reviews with the individual, family and key stakeholders to reduce risk of individuals falling through the gap in services. Mental Health clinicians regularly consult with the consumer's General Practitioner, every 13 weeks in line with clinical review or when clinical change occurs resulting in a change in treatment.

If an individual or family choses to access private or nongovernment services re-referral process should be clearly provided to the individual, family and services.

Consent to share information should be sought to support ongoing treatment. The privacy manual for health information states that consent is not required to release discharge summary to an individual's GP where the individual or their authorised representative has provided GP details or for current or ongoing care and treatment purposes where the individual has been made generally aware that the information may be used in this way.

5.3.4 Peer Workers

MNCLHD Mental health Services requires that individuals are provided with access to peer support as a part of early psychosis treatment. This should be discussed with the person and their family with particularly emphasis on the aim to improve mental health and wellbeing, challenge stigma associate with mental health and promotes recovery. Sharing life experiences with other individuals can help with understanding of their own situation and reduce social isolation.

Peer workers are engaged by the multidisciplinary team and case manager to provide complementary supports.

Peer workers are specifically employed to work from their personal lived experience of mental illness and recovery. Further a peer worker is required to use their lived experience purposefully to provide support and model hope for recovery, in addition to using their professional experience, training and array of abilities.

Peer support programs in early psychosis recognises that people with lived experience are in an ideal place to provide valued support to individuals experiencing similar issues.

By sharing their experience of a psychosis and their involvement within a mental health service, peer support workers help enable optimism for the individual and their families.

5.3.5 Engagement with Family/Carers

The Australian Clinical Guidelines For Early Psychosis emphasise the importance of early engaging with carers and meeting with them frequently, especially in the acute phase. Family work should be developed within a collaborative framework in which the clinician works in partnership with the family. The family should be promoted as active members of the treatment team. Refer to The Australian Clinical Guidelines For Early Psychosis Box 28 p90 Specific issues for families in early psychosis; and Box 29 p91: General principles for working with families with an early psychosis member.

Education about psychosis, suicide, medication, signs for relapse, managing crises and safety concerns, possible impact on the person's physical health, what mental health services can and cannot do, explanation of different clinician roles, and carers own self-care are all important aspects of care. Families and carers supporting a person experiencing a first episode psychosis can be overwhelmed at times. The consumer and families/carers should be provided with psycho-education initially and on a continuing and "as needed: basis. Family/carers will need clinician's understanding of their distress, explanations repeated if required, and clarity regarding what is happening. Working collaboratively with the person and their family/carers regarding care planning and reviewing progress is crucial to recovery, and to enabling carers to provide the appropriate care required for recovery.

It is imperative that families and carers are a part of care planning with the person experiencing first episode psychosis consent. Families and carers opinions should be a part of care planning and presented at routine 13 week reviews with the treating team. The case manager should meet with the treating Psychiatrist, the consumer and carer/family, to develop an individual care plan within two weeks after entry to the service. Families and carers should be informed around medication and therapeutic treatments. Family and carers will be informed around suicide risk for people experiencing psychosis.

IMHAOD staff should be provided and seek advice and education around the cultures of the people they are working with in order to work in a culturally sensitive way.

When working with Aboriginal people it is important to engage family to provide support, cultural concepts and to understand culturally appropriate communication. It is important for those working with Aboriginal family to avoid communication or behaviour that my lead to feelings of shame for the individual, family or community. Aboriginal people experience first episode psychosis and their family should be offered support from Aboriginal Mental Health staff.

People with early psychosis or family members who cannot speak English or speak limited English should be able to access professional interpreter services and have access to written information in their language.

Linking family/cares to early psychosis group programs or online resources will support connections for families/carers with those who have similar experiences.

Referral of family members to the Mental Health Family and Carers Program and to other carer support services should be discussed with family/carers.

MNC-PRO-0047-16 - Mental Health Services Family and Carers Procedure

5.3.6 Physical Health and Metabolic Syndrome

A person diagnosed with First Episode Psychosis (FEP) is often antipsychotic naïve and may be more susceptible to weight gain and the development of metabolic syndrome

The Australian Clinical Guidelines for Early Psychosis recommend ten principles regarding the use of pharmacotherapy (Box 10 p57), and caution against use of Olanzapine with young people with FEP (Box 9p56). Providing a clear description of potential side-effects of anti-psychotic medication (p58).

Special care should be taken when prescribing for specific populations: children, women of childbearing age and during pregnancy, breastfeeding mothers, young people with diabetes (p62-64 The Australian Clinical Guidelines for Early Psychosis).

Metabolic monitoring and intervention must begin as soon as the person is prescribed anti-psychotic medication. Education regarding the potential for weight gain and the development of metabolic syndrome must be provided to the person and their family/carers. Life-style strategies regarding diet and exercise must be explained with potential referral to an Exercise Physiologist and/ or Dietitian and/or pharmacists. **It is not adequate to wait until there is evidence of weight gain.**

At the first signs of the development of metabolic syndrome discussions should be initiated by the treating Psychiatrist regarding changing the person to an antipsychotic which has less adverse metabolic effects. The Guidelines recommend that if lifestyle interventions have been tried over a three month period, and targets for weight, lipids and glucose have not been achieved, metformin and antihypertensive medication may be considered (The Australian Clinical Guidelines For Early Psychosis p78).

IMHAOD case managers and treating psychiatrist are to provide up to date medication treatment to the GP of a person with first episode psychosis to monitor weight gain.

5.3.7 Suicide and Risk of Harm-

The risk of suicide and non-suicidal self-injury is heightened for people experiencing psychosis, particularly those whose previous functioning was high, and people who experience multiple relapses.

Co-morbidity of depression and anxiety with psychosis also raises risk. The Australian Clinical Guidelines state that 10 - 25% of people with early psychosis report that they have engaged in non-suicidal self-injury or had a suicide attempt prior to presenting for treatment. A further 50-65% of people with FEP report recent thoughts of suicide and these rates remain high after commencement of treatment. One year prevalence rates of suicide attempt range from 2.9 to 11%, and longer-term studies show a prevalence of 11.3% at 2 years and 18.2% at 4 years.

Risk assessment should include comprehensive review of the persons mental state, specifically mood, routine assessment of depressive symptoms, hopelessness, suicidal intent, the effect of returning insight, and the role of psychotic features on mood.

Other risks that require assessment and monitoring are risk of violence, risk of neglect and victimisation and the risk of non-adherence to treatment and disengagement with services.

MNCLHD IMHAOD have adopted the Safeside Framework as a pathway for working with people who are suicidal including risk formulation and collaborative interventions. It is the responsibility of Mental Health Services and clinicians to identify suicide risk early, completed a comprehensive assessment and formulation of risk based on individual circumstances and respond with brief interventions and ongoing treatment that includes clear transfer of care processes that ensure the person is supported through transitions of care.

5.3.8 Complex Needs-

Many people experiencing psychosis have complex co-morbidities – drug and alcohol use, physical health issues and social and psychiatric co-morbidities, including suicidality and self-harm. Clinicians should consider accessing complex case review processes and the establishment of clear care plans which include strategies for when the person presents repeatedly to the Emergency Department or meets other clinical indicators as outlined in the MNCLHD Procedure: Complex Care Planning in IMHAOD Services.

Drug and Alcohol

The RANZP Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders also provides clear evidence-based recommendations regarding the management of comorbid substance use, drug precipitated psychosis and acute relapse pages 19-24.

5.3.9 Transition/Transfer of care or Discharge-

Can represent a period of increased risk for people with early psychosis, including increased risk of suicide, disengagement with services and further decline in functioning.

A review of risks should be completed as a part of any transition. Having clear care plans that are developed in collaboration, documented and provided to the individual, family/carers and key stakeholders will assist with transitions of care.

Inpatient Units- a planed for transition of care to the community should start early in the admission process, with referral to the relevant community mental health team of any admissions of individuals experiencing early psychosis in hospital to support swift allocation of community case management.

Community case manager will commence their care relationship with the consumer and family/ carers as a part of the IPU admission, be available for psychiatrist interviews and care planning. Be a key point of contact prior to discharge for inpatient facility for family and carers.

Upon time of discharge from inpatient facility, the consumer should have a good understanding of their care requirements and who the key stakeholders are. The MNCLHD does not have a local Child and Adolescent Inpatient Unit therefore the consumer may be away from home and key supports for treatment. It is important that key supports including family/carers and local CAMHS are included in telehealth reviews to support transition back to the MNCLHD.

Transition from Child and Adolescent Mental Health to Adult Mental Health

This period can be challenging with multiple barriers for the child, young person and families and carers to accessing services. Children and young people have increased vulnerabilities at time of transition between services including falling through the gaps in care and poor experience of care.

Transition of care is negotiated with the child or young person and is a collaborative process between the child, young person, family, carer, GP and referrer where possible. Safety and Care Plan are established to maintain mental health in the community.

When indicated, transfer to other services should be communicated, proactively planned and collaboratively managed to ensure successful engagement/transition. Young people often benefit from a graded transition to adult services with joint appointments with family/carer, current and new case management teams and psychiatry.

MNC-PRO-0083-17 - Transfer of Care from Mental Health Inpatient Units

MNC-PRO-0066-19 - Collaborative Care Planning in Mental Health Services

6.0 Monitoring, Evaluation and Review

Evaluation of this procedure is covered by the Patient Documentation audit.

7.0 Key words

Early Psychosis, Early Intervention, psychotic episodes, MHS

8.0 Definitions

Early Psychosis	*Early Psychosis* refers to the first five years after a first episode of psychosis regardless of the number of times that an episode of psychosis has occurred. Early psychosis includes those episodes with organic causes, including drug induced psychosis. MNCLHD IMHAOD will actively contact individuals with early psychosis for 12 months and work with individuals with early psychosis for two years in line with best practice or longer if indicated. Mental Health services may provide shared care alongside community manager organisations or private services to meet individual needs over the 2nd year. This may result in case managers completing at a minimum 13 week reviews with the individual, family and key stakeholders to reduce risk of individuals falling through the gap in services. If an individual or family choses to access private or nongovernment services discharge within the 2 year timeframe may be indicated. In this instance re-referral process should be clearly provided to the individual, family and services. It will also be important to obtain consent to provide treatment plans to services taking over care including the individuals General Practitioner.

9.0 References

1. Early Psychosis Guidelines Writing Group and EPPIC National Support Program, Australian clinical guidelines for early psychosis. 2nd ed. Melbourne; Orygen, The National Centre of Excellence in Youth Mental Health; 2016. [cited 2022 October 14] Available from: https://www.orygen.org.au/Training/Resources/Psychosis/Guidelines/Australian-Clinical-Guidelines-for-Early-Psychosis
2. Galletly C, Castle D, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Australian and New Zealand Journal of Psychiatry. 2017; 50(5);1-117. [cited 2022 October 14] Available from: Schizophrenia CPG and associated resources | RANZCP
3. NSW Health GL2014_002 Mental Health Clinical Documentation Guidelines (nsw.gov.au)
4. NSW Health PD2022_043 Clinical care of people who may be suicidal (nsw.gov.au)
5. PD2022_023 - Enterprise-Wide Risk Management Policy

Acknowledgements to

6. NNSW LHD for kindly agreeing to share the NNSW LHD Early Psychosis Clinical Procedure.
7. NSLHD for kindly agreeing to share the Early Psychosis Intervention Services Model of Care.

8. CCLHD for kindly agreeing to share the Young People and early Psychosis Intervention Model of care
9. Early Psychosis Procedure working party- Leith Holding (RN), Katie Sullivan (CNS2), Vee Teh (CNC1), Matthew Pearce (NUM2), Justin Leary (Consumer representative) and Josh Tobin (Psychiatrist).

10.0 Appendices

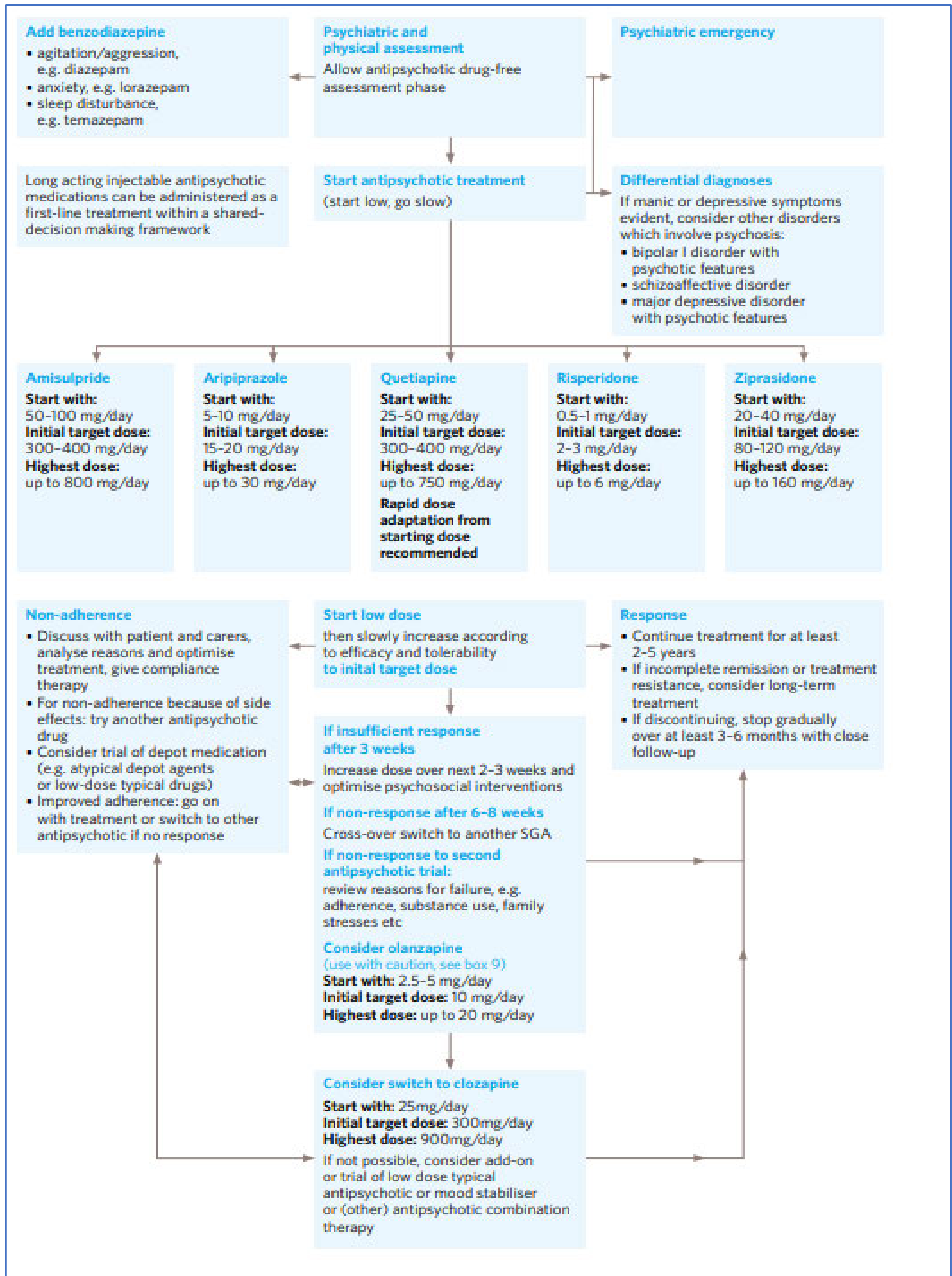
Appendix 1 Figure 1. Pharmacotherapy for first episode non-affective psychosis

Appendix 2 Figure 2. Pharmacotherapy for first episode affective psychosis

Appendix 3 Implementation Checklist

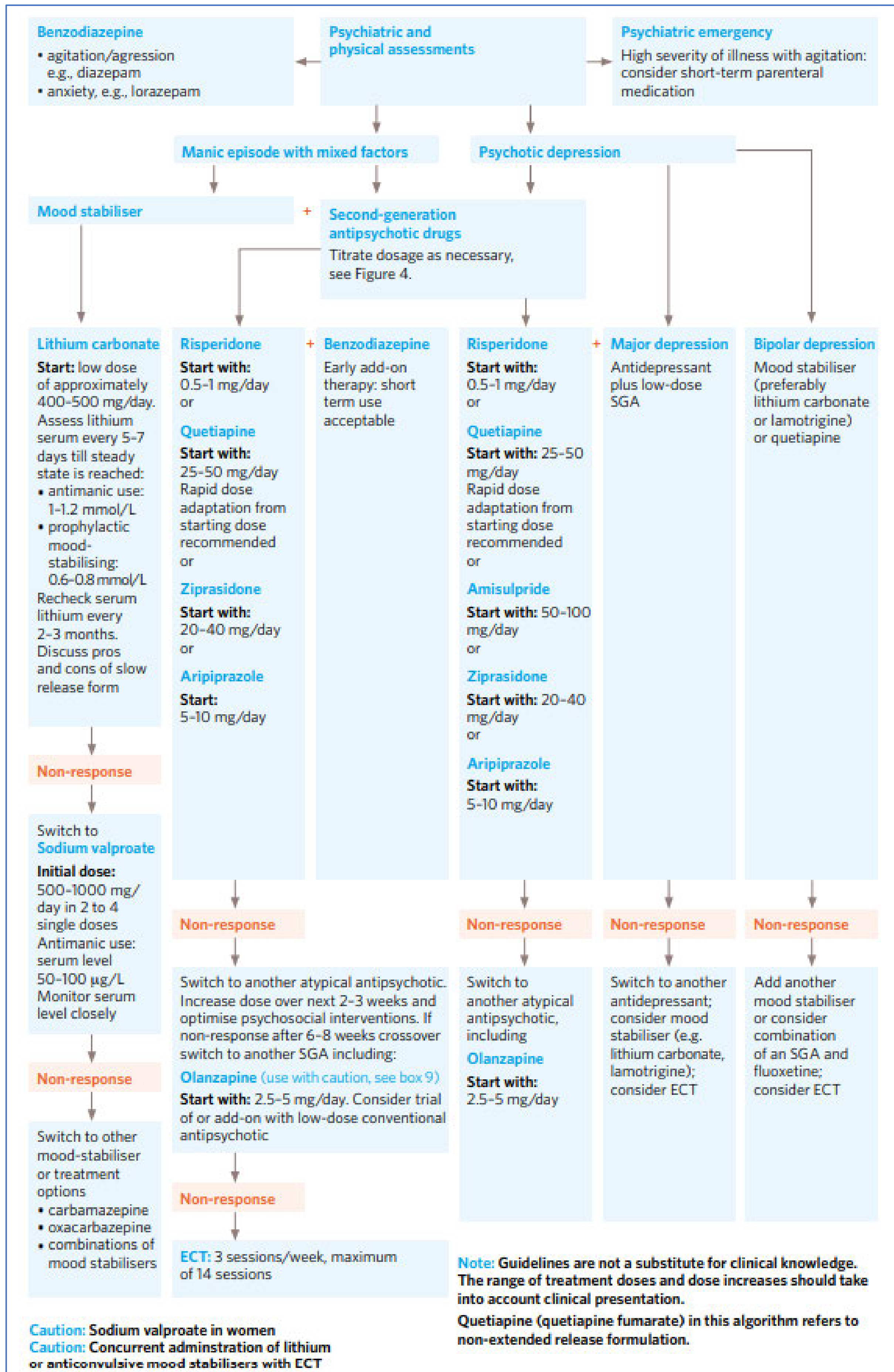
10.1 Appendix 1. Pharmacological treatment for first episode non-affective psychosis

Page 54- Australian Clinical Guidelines for Early Psychosis



10.2 Appendix 2. Pharmacological treatment for first episode affective psychosis

Page 55- Australian Clinical Guidelines for Early Psychosis



10.3 Appendix 3 -Early Psychosis Procedure Implementation checklist

Directorate Assigned Responsibility for Implementation:	**Mental Health Services**		
NSW Health Policy Document Number & Title			
MNCLHD document ID number			
Document to be Maintained by: **Mental Health Services Procedures and Protocols Committee**	**Name/Position:**		
Timeframe for Implementation :	**Date of Review:**		
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
Generic Requirements			
Ensure that relevant managers are aware of policy requirements and understand their obligations	❑	X❑	❑
	Notes:		
Identify and assign responsibility within the Directorate for implementing policy requirements applicable to the MNC LHD	❑	❑X	❑
	Notes		
Distribute policy documents to relevant staff within the Directorate and to any other persons or organisations that are required to comply as a result of a funding agreement or other contractual obligation managed by the MNC LHD	X❑	❑	❑
	Notes:		
Identify competency and training requirements of managers, staff and other persons who are required to implement the policy. Ensure that there are proper strategies to manage the training requirements.	X		
	Notes:		
. Establish mechanisms for monitoring & evaluation as per the document		X	
	Notes:		

Provide an evaluation on the implementation of policy obligations as required by the document to the Directorate, Executive Team.	x❑	❑	❑
	Notes:		
Document Specific Requirements			
	❑	❑	❑
	Notes:		
	❑	❑	❑
	❑	❑	❑
	Notes:		
	❑	❑	❑
	❑	❑	❑