Early Intervention for Psychosis in Canada: What is the State of Affairs?

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Introduction

- Early intervention for psychosis (EIP) programs are now widely considered effective in the treatment of early psychosis, but are not yet available everywhere. Investigations in other countries have described a lack of uniformity among EIP programs.
- Some countries have developed clinical guidelines for EIP, and the literature highlights several elements considered essential for such programs. Canada has no national standards of care for EIP, but three provinces have their own guidelines, and Quebec's are in development.
- No study has been conducted with the goal of describing and comparing the practices of the various EIP programs across Canada. The Canadian Consortium for Early Intervention in Psychosis was formed in 2012. One of its main objectives being the standardization of service models and service delivery in EIP. Members of the Consortium designed this study.

Objectives

- To describe the current practices of different academic EIP programs across Canada
- To highlight the main similarities and differences among Canadian EIP programs
- To compare current Canadian practices with expert recommendations and existing guidelines for EIP

Method

- An on-line benchmark survey was administered in 2013 to 11 academic First Episode Psychosis clinics in Canada. Questions covered administrative, clinical, education and research topics.
- A literature review of existing guidelines for EIP and studies on essential components of EIP programs was performed using electronic databases (PsycINFO and Ovid Medline) and internet search using Google Scholar.
- The survey results were compared to data from the literature reviews.

Results

The 11 surveyed programs are located throughout the country (Figure 1); Ontario, British Columbia and Nova Scotia have provincial guidelines for EIP. Most elements considered important in reviewed guidelines for EIP are respected in Canadian programs, while some others are lacking in different programs (table 1). Various integrated psychosocial interventions are provided by all programs (Figure 2). Orientation of patients after discharge are presented in Figure 3.

Figure 1 : Distribution of Surveyed Programs and Existence of Provincial Guidelines for EIP

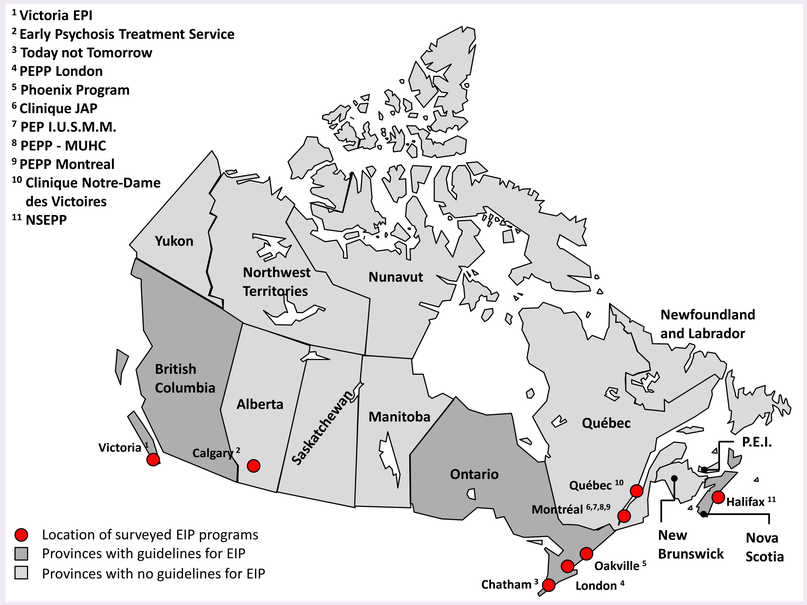

Figure 2 : Interventions Provided by Canadian Early Psychosis Programs

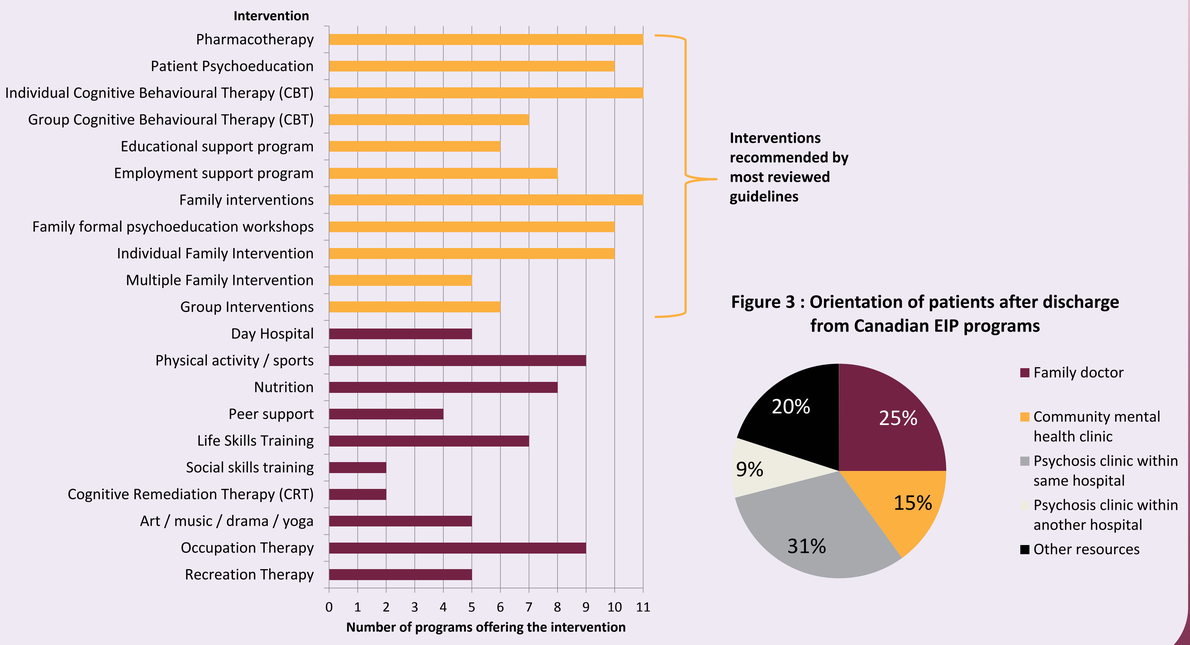

Figure 3 : Orientation of patients after discharge from Canadian EIP programs

Table 1 : Comparison of Main Elements of Reviewed Guidelines, Literature and Actual Practices Among Surveyed Programs

Topic	Recommendations found in most reviewed guidelines and literature	Practices among surveyed programs that are in line with recommendations	Practices among surveyed programs that might diverge from recommendations
Admission criteria	Flexible age range (around 14-35 years old)	All accept patients up to 30 or 35 years of age; most accept patients younger than 18 (8)	Some programs only accept patients older than 18 (3)
	Experience of psychosis (least exclusion criteria possible regarding required diagnosis)	All programs accept a wide range of schizophrenia spectrum diagnosis	Some programs don't accept patients with affective psychosis (4) or substance-induced psychosis (3)
	Least exclusion criteria possible regarding comorbidities	None exclude patients with comorbid substance use disorder	Some organic conditions are exclusion criteria in a few programs (ex: developmental disorders (5))
	Services for patients at ultra high risk for psychosis (UHR), also called "prodromal"	Some programs run clinics for UHR patients (3), and others offer follow-up.	Most programs do not offer formal services to these patients
Program characteristics	Program duration of about 2 to 5 years	Most programs last between 2 and 5 years (10); 70% last 2 or 3 years	
	Case management with small caseloads (around 8:1 to 15:1)	Most programs offer case management (10)	Caseloads range from 8:1 to 50:1 (70% of programs have 20-30:1 ratios)
	Multidisciplinary teams with psychiatrist as part of team	All programs operate with multidisciplinary teams comprising a psychiatrist	
	Hospital beds specific to the program available	Most programs have access to specific hospital beds (9)	
	Efforts to maximize engagement of patients : failure to keep appointments or take medication should not lead to discharge	Most programs focus on building treatment alliance with client by different means, including outreach in the patient's milieu	Patient non-compliance (3) or failure to keep appointments (1) can lead to discharge in some programs
Services offered	Pharmacotherapy; various individual and group psychosocial interventions; vocational services; family interventions	All programs offer a wide range of interventions (see Figure 2)	
	Outreach services	All programs offer outreach services (eg. home visits)	
Accessibility of services	Acceptance of multiple referral sources, including school, family, community and self-referral	Most programs accept a wide range of referral sources (9)	A minority of programs do not accept school, family, community or self-referral (2)
	Timely assessment (usually from 24h to 1 week depending on emergency)	Most programs (9) have established maximum delays for establishing a first contact after referral ; most are less than 72 hours (6), others are 1-2 weeks (3)	
	Development of community interventions to increase awareness and battle stigma	Seven programs engage in public education and/or direct education of sources of referral about psychosis.	
Program evaluation	Formal processes for evaluation of program	Eight programs have formal processes for evaluation of patient and treatment outcome and/or quality assurance	

Discussion

- As recommended by experts, most programs:
  - Have a duration between 2 and 5 years
  - Offer case management and operate with multidisciplinary teams
  - Offer an array of evidence-based integrated psychosocial interventions (family interventions, CBT, psychoeducation, etc.)
  - Have access to specific in-patient units
  - Offer rapid assessment of new patients
- However, some elements considered essential by many experts are lacking in some programs:
  - Admission criteria might be too restrictive in some programs (regarding for example age, diagnosis and comorbidities).
  - Accessibility is sometimes not prioritized:
    - Some programs do not accept community, school or self-referral
    - Some did not established maximum delays for assessment of new patients.
  - Patient to clinician ratios are too high in most programs.
  - Only a few programs offer formal services for patients at UHR for psychosis.
  - Formal processes for evaluation of quality and outcome of programs have yet to be developed in some programs.
- Programs following provincial guidelines seem to perform better in terms of program accessibility and evaluation of quality and outcome of services.

Conclusion

- Surveyed programs offer integrated psychosocial treatments, but vary in terms of admission and discharge criteria, length of treatment, accessibility of services and program evaluation.
- Canadian practices diverge in some cases from what is recommended by experts in areas of admission and discharge criteria, patient to clinician ratios, access to specific in-patient units, accessibility of services and program evaluation.
- Budgetary and administrative constraints might explain a number of discrepancies between recommendations in the literature and actual practice.

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This project was partially funded by unrestricted medical grants received from the following companies: Bristol-Meyers Squibb, Otsuka Canada Pharmaceutical Inc. and Lundbeck Canada Inc.