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 are lacking in different programs (Table 1). Various integrated psychosocial interventions are provided by all programs (Figure 2). Orientation of patients after discharge is presented in Figure 3.

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

![Distribution of Surveyed Programs and Existence of Provincial Guidelines for EIP](image)

Figure 2: Interventions Provided by Canadian Early Psychosis Programs

![Interventions Provided by Canadian Early Psychosis Programs](image)

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

![Orientation of patients after discharge from Canadian EIP programs](image)

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendations found in most reviewed guidelines and literature</th>
<th>Practices among surveyed programs that are in line with recommendations</th>
<th>Practices among surveyed programs that might diverge from recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission criteria</td>
<td>Flexible age range (around 14-35 years old)</td>
<td>All accept patients up to 50 or 35 years of age, most accept patients younger than 18</td>
<td>Some programs only accept patients older than 18</td>
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<tr>
<td>Experience of psychosis (least exclusion criteria possible regarding required diagnosis)</td>
<td>All programs accept a wide range of schizophrenia spectrum diagnosis</td>
<td>Some programs don’t accept patients with affective psychosis (A) or substance-induced psychosis (S)</td>
<td></td>
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<tr>
<td>Least exclusion criteria possible regarding comorbidities</td>
<td>None exclude patients with comorbid substance use disorder</td>
<td>Some programs exclude patients with substance use disorder</td>
<td></td>
</tr>
<tr>
<td>Services at ultra high risk for psychosis (UHR), also called “prodromal”</td>
<td>Some programs run clinics for UHR patients (3), and others offer follow-up</td>
<td>Most programs do not offer formal services to these patients</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary teams with psychiatrist as part of team</td>
<td>All programs operate with multidisciplinary teams comprising a psychiatrist</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Care management with small caseloads (around 8-15:1)</td>
<td>Caseloads range from 8.5 to 51.7 (70% of programs have 20-30:1 ratios)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary teams with a psychologist as part of team</td>
<td>All programs operate with multidisciplinary teams comprising a psychologist</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hospital beds specific to the program available</td>
<td>Most programs have access to specific hospital beds</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Efforts to maximize engagement of patients: failure to keep appointments or take medication should not lead to discharge</td>
<td>Most programs focus on building treatment alliance with client by different means, including outreach in the patient’s milieu</td>
<td>Patient non-compliance (1) or failure to keep appointments (3) can lead to discharge in some programs</td>
<td></td>
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</tbody>
</table>

Discussion

- As recommended by experts, most programs:
  - Have a duration between 2 and 5 years
  - Offer care 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 establish 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.

References