1.0 Title: Early Psychosis Clinical Procedures

2.0 Purpose: To provide clear direction and guidance for Mental Health Service (MHS) Staff regarding the appropriate service response to people presenting with a first episode of psychosis and their family/carers. The Australian Clinical Guidelines for Early Psychosis Second Edition (updated June 2016) should be thoroughly consulted for all aspects of treatment. These Clinical Procedures provide additional direction for clinicians. Furthermore, The RANZCP Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders provides valuable additional recommendations regarding the treatment of Early Psychosis and which are consistent with the Australian Guidelines for Early Psychosis.

3.0 Procedure
These procedures are consistent with the Principles of Person-Centred Care, Trauma-Informed Care and Recovery. See Box 25 p81 for the Key elements of recovery-oriented care. A summary of the recommendations for assessment and treatment for all phases of the illness and recovery can be found on pp6-14.

3.1 The Australian Clinical Guidelines for Early Psychosis Second Edition 2016 (hereafter referred to as ‘the Guidelines’) defines early psychosis as “the early course of psychotic disorder … specifically refers to the prodrome and the period up to five years from first entry into treatment for a psychotic episode” (p21). Whilst the Guidelines will refer to ‘young people’ it is recognised that older people may also experience a first episode of psychosis. The recommended interventions should be considered for all patients, regardless of age.

Clinicians should familiarise themselves with the Guidelines as it provides evidence based best practice recommendations regarding assessment and treatment.

The Guidelines provide detailed explanations and recommendations regarding all aspects of care including:
- Assessment
- Treatment:
Those at ultra-high risk
- Acute phase
- Early recovery
- Relapse
- Incomplete recovery, medication discontinuation and discharge
- Pharmacotherapy
- Psychological treatments.

- Principles pertinent across all phases:
  - Engagement
  - Physical health:
    - Cardio-metabolic screening and intervention
    - Oral health
    - Tobacco cessation.
  - Sexual health
  - Case management
  - Functional recovery
  - Trauma
  - Integrated specialist treatment
  - Least restrictive treatment
  - Family involvement
  - Goals to guide treatment
  - Group programs
  - Psychoeducation
  - Suicide prevention
  - Substance use
  - 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
  - Rural and remote communities
  - People identifying as LGBTIQ
  - People experiencing homelessness.

Orygen Health, the National Centre of Excellence in Youth Mental Health is the co-author of the Guidelines. They also have a number of other resource documents on their website which may provide further guidance:

- Addressing barriers to engagement: Working with challenging behaviour
- Assessing and managing risk of violence in early psychosis
- How to screen and intervene for positive cardiometabolic health
- Managing incomplete recovery during first episode psychosis
- Managing transitions in care for young people with early psychosis
- Preventing relapse in first episode psychosis

3.2 Procedures specific to Northern NSW LHD Mental Health services:
3.2.1 Those at Ultra High Risk of Developing Psychosis:
This group will include young people who display at risk mental state, which may or may not be associated with a developing psychotic disorder [table 5
Their symptoms do not meet the criteria for a diagnosis of early psychosis. Where possible, these young people should be referred to the nongovernment or private sector for treatment, unless there are other co-morbidities. If no other services are available, they may be offered services by the mental health service.

3.2.2 Key Worker Roles:
A key worker should be allocated as soon as early psychosis is identified. This key worker will provide continuity of care whenever possible and will be included as part of the treating team should the person require hospitalisation.

Consistency of key clinician is important in sustaining engagement, trust and belief in the treatment provided. This applies to the treating medical practitioner as well as case manager wherever possible.

The key worker will take an assertive role emphasising engagement and a strong therapeutic relationship. Contact should be actively pursued with the person and their family/carer/support persons for a minimum of 12 months and ideally for two years, if possible. There is strong evidence for recovery given access to and engagement with the right treatment.

3.2.3 Engagement with Families/Carers [pp90-92]:
The Guidelines emphasise the importance of 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.

In particular, see 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.

Carers often feel bewildered at what is happening, and this may be their first contact with mental health services. 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.

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.

The family/carer early psychosis group program is a valuable complement to collaborative care and should be offered whenever possible.

Referral of family members to the Mental Health Family and Carers Program and to other carer support services should be discussed with family/carers.
Thirteen-week reviews should actively seek family/carer input regarding progress, concerns, things that are working and not working as well as carer needs.

Families and carers have close knowledge of the history of the person’s development of psychosis and will often be able to provide crucial information regarding early signs of relapse. These must be carefully considered by the clinician even if the person insists that they are progressing well.

Clinicians can, and should listen to family/carers, even if they are not nominated as Designated Carers or Principal Care Providers.

See also NC-NNSW-PRO-6285-12 Family and Carer Clinical Procedures for Mental Health Services for guidance regarding family/carer engagement and how to navigate the complexities of confidentiality and duty of care.

3.2.4 Physical Health and Metabolic Syndrome:  
A young 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 [Box 8 p53]. The Guidelines recommend ten principles regarding the use of pharmacotherapy [Box 10 p57], and caution against use of Olanzapine with young people with FEP [Box 9 p56]. The Guidelines provide 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 [pp62-64].

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. 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 [p78].


The Metabolic Monitoring form is available in Ad hoc documents on EMR. Whilst it is not mandatory to complete this form, it is the responsibility of the
mental health service ensure that the physical health status of people under their care is actively monitored. This may be undertaken by the GP.

The Guidelines refer clinicians to the HETI Positive Cardiometabolic Health Algorithm for adults and for adolescents which provide guidance regarding the recommended responses to symptoms identifying problematic cardiometabolic health. This website also has resources developed by the University of NSW Sydney Department of Developmental Disability and Neuropsychiatry for working with people with intellectual disability and cardiometabolic issues.

The Concord Centre for Cardio-metabolic Health in Psychosis has a website for mental health clinicians which provides information on how to deliver cardio-metabolic and lifestyle services to improve the global health outcomes for those with mental illness. This includes video lectures on how to run a metabolic clinic, as well as other lectures on the issue, and information booklets useful to patients, carers and clinicians.

3.2.5 Suicide and Risk of Harm:
The risk of suicide and self-harm [p44] is heightened for this group of patients, particularly those whose pre-morbid functioning was high, and who experience multiple relapses. Co-morbidity of depression and anxiety with psychosis also raises risk.

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 service disengagement [p45-46].

See also NNSW-LHD-PRO-0314-18 Clinical Care of People Presenting to Mental Health Services Who May be Suicidal

3.2.6 Recovery Orientation:
Services should be provided with a view to maximising recovery. This will include the sustained provision of hope for recovery, advocacy, education to promote self-care and understanding of what is happening, collaborative care planning with the person and their family/carer, and re-connection with education, employment and other community based daily living strategies whenever possible.

3.2.7 Complex Needs:
Many people experiencing psychosis have co-morbidities – drug and alcohol use, physical health issues 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.

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 [p23], drug precipitated psychosis [p24] and acute relapse [p19].
4.0 Required Knowledge and Assessment to Perform this Procedure.
Mental Health Assessment, Mental State Examination, understanding of psychosis and other mental health diagnoses, ability to assess risk and develop appropriate care plans, knowledge of how to engage with families and carers.

5.0 Monitoring and Evaluation
Annual file audits.

6.0 Definitions
Psychosis:
Psychosis refers to symptoms in which there is misinterpretation and misapprehension of the nature of reality, for example disturbances in perception (hallucinations), disturbances of belief and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder).

Early Psychosis:
Early psychosis refers to the early course of psychotic disorder, including the prodrome and the period up to five years from first entry into treatment for a psychotic episode.

7.0 References


NSW Health GL2014_002 Mental Health Clinical Documentation Guidelines

8.0 Appendix
Nil
## 9.0 NNSW LHD Clinical Procedure Cover Sheet

<table>
<thead>
<tr>
<th>COVER SHEET</th>
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<tr>
<td>NNSW Local Health District CLINICAL Policy Framework</td>
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**Name Of Document**  
Early Psychosis

**Type of Document**  
Procedure

**Document Number**  
NNSW-LHD-PRO-0519-19

**Superseded Document**  
NC-NNSW-PRO-7647-16

**Sites/Services where compliance with this procedure is mandatory.**  
All NNSW LHD Mental Health Services

**Related Ministry of Health PDs, LHD Documents or Australian Standards:**
- PD2017_033 Physical Health Care Within Mental Health Services
- GL2017_019 Physical Health Care of Mental Health Consumers
- PD2016_007 Clinical Care of People Who May Be Suicidal
- NNSW-LHD-PRO-0314-18 Clinical Care of People Presenting to Mental Health Services Who May Be Suicidal
- NC-NNSW-PRO-6285-12 Family and Carer Clinical Procedures for Mental Health Services
- GL2014_002 Mental Health Clinical Documentation Guidelines

**Risk Management**  
This procedure provides best practice evidence to promote positive outcomes for patients and their families. Not complying with this procedure creates risk of injury, significant disability or death for the person with early psychosis, and potential injury or death of others.

**Current Risk Rating**  
H - Major / Possible

**Targeted Risk Rating**  
O – Moderate / Rare

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<table>
<thead>
<tr>
<th><strong>Author</strong></th>
<th>Dr Mim Weber, Mental Health Program Manager</th>
</tr>
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<tbody>
<tr>
<td><strong>Clinical Authority</strong></td>
<td>NNSW LHD Mental Health Clinical Governance Committee</td>
</tr>
<tr>
<td><strong>Management Authority</strong></td>
<td>NNSW LHD Health Care Quality Committee</td>
</tr>
<tr>
<td><strong>Executive Sponsor</strong></td>
<td>General Manager Mental Health and Drug &amp; Alcohol</td>
</tr>
<tr>
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**Signature NNSW LHD Chief Executive**

Wayne Jones