

Implementation of Early Psychosis Intervention Program Standards in Ontario: Results of a Provincial Survey

A project of the Standards Implementation Steering Committee

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Key Messages

Survey Participation

- The rate of participation was very high, with responses received from 56 EPI program sites, including 52 with the young person experiencing psychosis as the client, 3 with the family as the client, and one with a regional coordination mandate. The results provide rich information for exploring program stakeholder perceptions about Standards implementation, challenges and facilitators to implementation, and potential opportunities for practice improvement.

Early Psychosis Intervention Program Profile

- The 52 sites serving the young person experiencing psychosis varied widely, with budgets from \$41,000 to \$2.6 million, clinical staff from 1 to 14 full time equivalent staff (FTEs), and total caseloads from 5 to 342. The programs were sponsored by both hospital and community agencies. Most were implemented after the government released the provincial EPI framework in 2004 and new EPI program funding was offered.
- Caseload size per clinical staff varied from 6 to 48, with a mean of 19. In international research and policy, caseloads of 10 to 15 are suggested, and in the present survey lack of staff time was often noted as a challenge to implementing the Standards. This especially related to developing referral networks, engaging psychiatry and primary care, and conducting proactive outreach to clients and families.
- EPI is a comprehensive service model that may be delivered by a dedicated, specialized team or by a small staff that accesses additional support for clients from other providers. The survey identified 21 “small” sites, with catchment area populations of less than 100,000 and 1 to 2 clinical staff. While small sites reported reasonable compliance with the Standards, challenges were noted in accessing psychiatric and general medical care, having time for outreach and education, and addressing the full range of client psychosocial needs.

Standards Implementation

- The assessed practices pertained to six Standards and multiple elements within each Standard. Perceived level of implementation varied across the elements. In general, implementation was higher where programs have more control over service practices (e.g., medications protocols, relapse prevention protocols, response times after client referral), and lower where programs are more reliant on other community services and supports (developing referral networks, working with inpatient units, linking clients with follow-up supports at discharge).
- Programs were least likely to fully implement Standards related to public education and early identification referral network development. Challenges implementing these elements have been reported in other jurisdictions. Outreach to referral sources requires time and persistence, and may receive a lower priority than clinical care when staff time is a concern.

Centrally provided support (e.g., information resources, outreach advocacy), staff time dedicated to this work, and clearly defined and monitored work plans may be helpful. Involving youth in public awareness presentations and campaigns was also suggested.

- Many programs reported that they can access psychiatric expertise to support rapid intake or as part of the initial comprehensive assessment. However, small programs reported lower levels of implementation. Some programs identified access to psychiatry as a significant challenge and put considerable time into developing and maintaining relationships with psychiatrists. Suggestions for increasing access included changes in funding support and mechanisms for disbursement, and psychiatrist training in the EPI model. A regional role was identified, perhaps through mobile treatment teams. Telemedicine was used by some programs although more often for the initial assessment than ongoing treatment. (Similarly, programs reported high rates of use of low dose antipsychotic medications when appropriate, but small and community programs reported more challenges related to medical monitoring.)
- Primary care (PC) physicians are important partners in EPI delivery. They make referrals, monitor medication side effects, and provide physical health care. However only half of program sites reported that most of their clients were being followed by a PC physician. Accessing PC physicians can be time consuming for EPI staff and frustrating for clients. Small programs may also lack nursing support. Suggestions to improve physical health monitoring included home visits by team nurses, referring clients without a regular PC physician to local clinics, educating clients about the need for health monitoring, and using health tracking sheets or shared electronic health information to communicate with PC physicians.
- Psychosocial supports can help clients maintain or resume their usual roles within the community. Many programs offered or enabled access to illness management and daily activities support, but provision of other supports (e.g., education, work, recreation) was lower. Least frequently offered was peer support. Programs reported that mainstream supports were often not appropriate or available, and, internally, they noted a lack of resources and staff time.
- Programs reported high levels of activity to support family involvement. About half have a dedicated family support worker and others distribute the role across several staff members. Time to engage (travel time, being available after hours) was a major challenge. Also, families may have their own mental health problems that need to be addressed. Greater use of technology (e.g., social networking sites, websites, E-mail, chat rooms) could be explored to engage with families.
- EPI is designed to be a time-limited service and the Standards indicate a length of stay of up to 3 years. The main challenges to meeting this element included lack of appropriate alternatives and clients not wanting to leave or engage with other services. Allowing more flexibility in client length of time in the program was raised. Step-down/transition options are being offered successfully in some Ontario programs, with one program showing that gains made by clients during the first 2 years were maintained at 5 years when a lower intensity level of specialized intervention was offered.

Implementation Supports

- Most sites were part of an EPI program network to support clinical care and/or non-clinical functions such as training, resource development, and community outreach. More information is needed about how the networks function and their potential to enhance practice among members, especially small program sites.
- Some small programs reported challenges in accessing necessary expertise and managing travel time. Telemedicine, travelling regional mobile teams and network partners can assist small programs to deliver care as required. More information is needed to understand what supports are received and what else could be offered.
- Most programs reported time challenges, especially for public education, referral network development, and developing linkages with other services and supports. Efficiencies could be achieved if some tasks were taken on or supported locally, regionally, or provincially, such as development of educational materials, outreach to referral sources, and outreach to other potential service collaborators (inpatient units, crisis services, vocational supports).
- The EPI model is complex, combining a number of evidence-based practices. Availability of written protocols to support implementation of the various model elements was generally low. However, use of tools to support more standardized care delivery (such as checklists, templates and assessment measures) was frequently suggested. These could be developed at a regional or provincial level. One network is already developing and sharing service protocols among its members. The Ontario Common Assessment of Need¹ may be helpful.
- Accessing medical care (psychiatric and primary care) was a challenge. Suggested strategies to facilitate access included funding support (e.g., sessional fees), medical staff training in EPI model, and greater use of mobile treatment teams and telemedicine.
- Most programs reported being able to meet the response time after referral targets set out in the Standards. However, a small minority reported keeping a waitlist and use of translation or interpretation services was low, raising questions about EPI program accessibility to all Ontarians in need.
- Cost of medications was a noted barrier to using low dose anti-psychotic medications. Better drug coverage in benefit plans and easier application processes (e.g., related to Ontario Disability Support Program (ODSP) and Trillium) were suggested.
- Many programs suggested increased use of social networking and youth friendly technology such as web, texting, e-mail. At present, policies in some organizations are not supportive of these approaches, especially hospital settings.

¹ Ontario Common Assessment of Need is a standardized client assessment being implemented in community mental health programs in Ontario.

Survey Limitations

- o The results represent the opinions of those who participated. Other EPI program staff and other stakeholders, including clients and their families, may have different views.
- o Results are based on staff perceptions rather than client level information (chart data, administrative data, survey data) related to service delivery.
- o Informants were asked about frequency of care delivery, not quality of care.
- o Programs where the family is the client represent an innovative approach to EPI delivery in Ontario. A separate effort is needed to adequately understand those services including where/how the provincial EPI programs Standards apply. Similarly, programs with a regional coordination or network 'hub' role warrant further exploration to identify their unique opportunities and challenges.

Next Steps

- o Consultation with EPI programs, OWG, LHINs and other stakeholders to discuss results and next steps, including opportunities to work with the LHINs and Ministry on issues related to Standards implementation.
- o Further exploration of emerging topics such as role of centralized supports (educational tools, training, and outreach), models for family work and models for network support.
- o Follow-up regarding Standards not addressed in the present survey including availability of client level data.
- o Knowledge transfer to audiences beyond Ontario.

Executive Summary

Introduction

Background

In 2011, the Ontario Ministry of Health and Long-Term Care (henceforth “the Ministry”) released the *Ontario Early Psychosis Intervention Program Standards*². These Standards built on previously published international guidelines and were released at a time when a growing body of international literature demonstrated the effectiveness of Early Psychosis Intervention (EPI) services compared to standard care.

The Ontario Standards for delivering EPI programs aim to reduce the duration of untreated psychosis, minimize the disruption in the lives of adolescents and young adults who experience psychosis, and minimize the societal impact of psychosis, including reduced demand in other areas of the mental health, health and social service systems.

To support the implementation of the Ontario EPI Program Standards, the Ministry formed a Standards Implementation Steering Committee (SISC) in 2012. The Committee includes representatives from the Ministry, the Local Health Integration Networks (LHINs), and the Ontario Working Group on Early Intervention for Psychosis (OWG), and is provided with technical support from the Centre for Addiction and Mental Health (CAMH). As a first step to understanding current EPI program delivery in Ontario in relation to the Standards, and facilitators or challenges to implementation, the Committee undertook a province-wide EPI program survey. The aims of the survey were to:

1. Describe organization and structure of Ontario EPI programs
2. Obtain feedback from Ontario EPI program regarding:
 - a. Perceived alignment of current practice with EPI program Standards
 - b. Perceived barriers and facilitators to Standards implementation

Fifty programs responded to the survey, representing a 90% participation rate. Of these, there were 46 programs with the individual experiencing psychosis as the client; 3 with the family as the client, and one with a regional coordination mandate.

The following section reports results for programs serving the young person experiencing psychosis. The survey was not suitable for programs where the family is the client and a separate effort is needed to adequately understand these services including where/how the provincial EPI programs Standards apply. Similarly programs with a regional coordination role warrant further exploration to identify their unique opportunities and challenges.

² Ministry of Health and Long-Term Care. (2004). *Program Policy Framework for Early Intervention in Psychosis*. Toronto, ON. <http://www.health.gov.on.ca/en/common/ministry/publications/reports/mentalhealth/psychosis.pdf>

Overview of EPI programs for individuals experiencing psychosis

The survey identified 46 programs delivering care at 52 clinical sites. Program sites varied widely in size and other characteristics. Sixty percent served catchment areas of greater than 100,000 population. These programs reported a mean program budget of \$340,000 or more, a mean caseload of 50 or more clients per site, employed 3 or more clinical staff and had 3 or more disciplines or specialties represented on their team. Referred to as *large program sites* in this report, these clinical sites were mainly located in major urban areas such as Toronto, Ottawa and London.

Forty percent of sites served catchment areas with a population of 100,000 or less. These programs reported a mean program budget of \$120,000 or less, and had a mean caseload of 19 or fewer clients per site. Referred to as *small program sites* in this report, they had 1.1 full time equivalent (FTE) clinical staff or less. Small program sites were located in mixed urban and rural areas or rural areas.

Models and Geography

The Standards describe different ways for EPI programs to work together to ensure delivery of the full EPI model of care in their catchment areas (page 31). Among the 52 surveyed sites, 9 networks (involving 47 sites) were identified. The networks varied in size from 3 to 11 members and were present in almost every LHIN. Networks included single organizations delivering EPI services through multiple clinical sites usually spread across a large geographic area, as well as partnerships among independent organizations to support service delivery. Networks also formed to share non clinical functions such as staff training, educational resource development, and community outreach. The survey did not examine network arrangements in depth and follow-up could explore the approaches and benefits of these different arrangements.

More than half of the surveyed program sites (58 %) reported being sponsored by hospital organizations. On average, these sites reported larger budgets and total caseloads compared to community agency sponsored sites. However there was considerable variation and overlap in features, and a number of small programs are hospital sponsored.

Standards Implementation

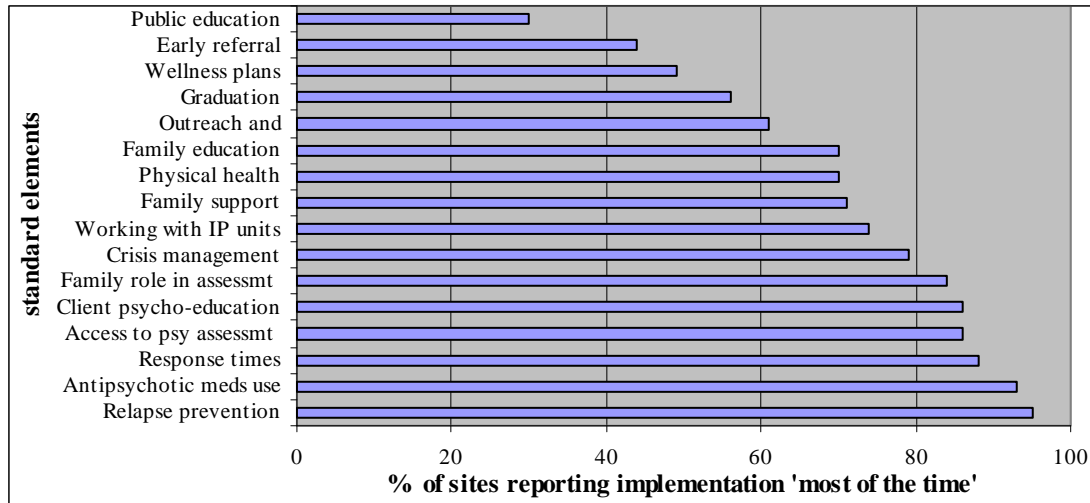
The survey covered 6 out of 13 Standards:

- Facilitating access & early identification
- Comprehensive client assessment
- Treatment
- Psychosocial support for client
- Family education & support
- Graduation from the program

Since each Standard addresses multiple service elements, a subset of key elements was identified to examine in the survey. Questions addressed: (1) global perception of how often sites were able to implement the element; (2) current practices; (3) current challenges; and (4) strategies that might facilitate/improve implementation.

The graph below reports global perception of implementation for 12 elements. Detailed results follow per Standard and element.

Figure 1: Percent of sites reporting ‘implementation most of the time’ per element



Standard 1 Results: Facilitating Access and Early Identification

1. Developing an early identification/rapid response system:

EPI programs should support local primary care providers, health and mental health services, the educational sector and others in contact with youth to identify symptoms of psychosis among young people and make timely referrals to EPI programs:

- Overall, programs indicated lower levels of implementation of this element than for other Standard elements; only 40% of sites reported being able to implement this element ‘most of the time.’
- Developing and sustaining an early identification and referral network was challenging regardless of whether the EPI program was larger or smaller, or hospital or community agency based. Challenges pertained to having time, getting access to audiences, maintaining persistent outreach.
- Implementation may benefit from local or regional support (e.g., to conduct outreach to area providers, develop educational resources), and from having a plan in place for implementing and monitoring this work.
- Programs reported some conflict with implementing this element. Outreach requires having the capacity to accept new referrals, and can be problematic if the program is operating at capacity already. In addition, programs are expected to respond quickly to referrals and are not supposed to keep a waitlist.

2. Public education

EPI programs should build awareness among parents, families, teachers and employers about the symptoms of psychosis in young people and how to seek help.

- Only 31% of sites overall reported being able to implement the Standards on public education ‘most of the time. This element was a challenge regardless of whether program served a large or small population catchment area or had a hospital or community agency sponsor.
- Similar to referral network development, implementation challenges pertained to having sufficient staff time and audience access.
- Having staff dedicated to this function was suggested as it requires a skill set that clinical staff may not possess; this could be a regional position.
- Program implementation may improve from having a clear plan for allocating time, setting targets and related monitoring.

3. Access to translation and interpretation services

Providing access to translation and interpretation services can help to facilitate equitable access to EPI services for all segments of a community.

- Almost all sites reported that translation or interpretation services were required for less than 10% of cases. This applied across the board.
- Fee-for- service was most common method of access to this service.
- 40% of programs had a related written policy but this rate was much lower in small programs.
- Main challenges pertained to funding and finding expertise.
- The demand for translation or interpretation services seems fairly low given characteristics of Ontario’s population and may point to difficulties for some communities in knowing about or accessing EPI services.

Standard 2 Results: Comprehensive Client Assessment

1. Time to respond after initial referral

Response time targets for EPI programs after client referral include: phone contact within 72 hours and face to face meeting offered within 2 weeks.

- Overall, 90% of EPI sites reported being able to meet the response times ‘most of the time.’ Across all programs, 76% of clients were contacted by phone within 72 hours of referral and 85% were seen within two weeks of referral.
- Only a small minority of programs reported keeping a waitlist (13%). These programs were somewhat more likely to be larger, and with community agency rather than hospital sponsorship. Programs with a waitlist reported more difficulty meeting the recommended response times after referral.
- Just over half the sites reported that they have a written policy on response times.
- Interpretation of these results requires some caution as there may be some variation in how programs track and record response times. For example, if there are upfront intake processes such as centralized intake or screening in the sponsoring organization, when does measurement of response time begin? If an individual cannot be reached or is unavailable to attend, how is time to first appointment measured? Are referrals not accepted if the program is at capacity?
- A final caution is that this Standard does not measure adequacy of system capacity and may be better interpreted as a measure of efficiency once a contact is made.

2. Family involvement in assessment

EPI programs should involve families during the assessment process, provided the client gives consent.

- High level of implementation with 83% of programs reporting being able to involve families in client assessment ‘most of the time’. Rates were lower for community agency sponsored and small programs.
- Challenges included scheduling and distances to travel, client resistance to family involvement and mental illness within the family system.
- Many programs (60%) indicated that their ability to deliver EPI would benefit from more time to work with families.
- Finding appropriate supports for family members with their own mental health needs was identified as important but can be difficult to address.

3. Access to psychiatric assessment

The EPI practitioner conducting the client assessment should have ready access to a psychiatrist and the comprehensive assessment includes as a minimum a psychiatric exam and history including assessing pre-morbid functioning and identifying co-morbid disorders.

- The issue of access to psychiatry was queried in several places on the survey (e.g., also in psychiatric medications treatment section).
- Over 80% of programs reported that they can access psychiatrist expertise to support rapid intake or as part of the initial comprehensive assessment ‘usually’ or ‘most of the time’. However, smaller programs reported lower implementation.
- In addition to fee-for-service, about half of sites reported using sessional fees to pay psychiatrists.
- Some programs reported putting considerable time and effort into developing and maintaining relationships with psychiatrists.
- About half of programs said their ability to deliver EPI would benefit from better access to psychiatry.
- System level suggestions for creating easier access to psychiatrists included education to increase the pool of psychiatrists familiar with the EPI model, more sessional funding and greater use of telemedicine or a regional outreach service.

4. Comprehensive (intake) assessment

EPI programs should offer a comprehensive assessment which includes active engagement with the client, assessing risk and presenting symptoms, assessing psychiatric, physical health and psycho-social dimensions, and consideration of vocational, educational and occupational domains.

- Programs reported that their comprehensive assessment ‘usually’ included a psychiatric exam, assessment of presenting symptoms, risk assessment, substance use assessment, developmental history, psychosocial assessment, cultural assessment, family information, review of client understanding.
- Less frequently addressed were education and vocational issues.
- Programs reported low frequency of providing a physical exam and neurological assessment, especially community agency sponsored and small programs.

- Psychiatric assessments were provided less often by small than large programs; developmental assessments were provided less often by community agency than hospital sponsored programs.
- a. Programs may benefit from written guidelines and use of tools such as the Ontario Common Assessment of Need (OCAN) to standardize the process, but may also need assistance to access necessary expertise.
- b. Some elements were not seen as immediate priority by staff and were assessed after initial assessment – physical, vocational.

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Standard 3 Results: Treatment

1. Wellness/recovery plans

Wellness plans should be negotiated by the client, family and EPI team and developed and documented within 4 weeks of the first appointment and updated regularly thereafter.

- Only 45% of all sites were able to develop wellness/recovery plans within 4 weeks of the first appointment and regularly update them ‘most of the time’.
- Only 41% of sites have written procedures in place for creating and regularly reviewing wellness/recovery plans.
- Implementation may benefit from a standardized process for generating and reviewing plans. This may include use of tools such as an electronic user-friendly template, computer system reminders, and recovery plan templates specific to EPI.
- Some programs may implement this element in concert with the client needs identified in the OCAN.

2. Outreach and client engagement

EPI programs should use proactive strategies such as home visits, outreach to families, and providing services as part of recreational opportunities in the community to keep clients engaged in treatment, reduce missed appointments and minimize program drop-out.

- Lower frequency of implementation with only 63% of sites overall reporting using proactive outreach for client engagement ‘most of the time’.
- Small programs and community agency sponsored programs were more likely than their counterparts to indicate higher implementation.
- Across all sites, approximately half of client face-to-face contacts occurred in offices, with the remainder in community locations. Hospital sponsored sites reported a somewhat higher rate of office contacts.
- Organizational policies may limit staff use of some outreach strategies such as transporting clients in staff vehicles, conducting home visits, and using mobile devices and e-communications to connect with clients.
- Time was noted as a limitation to outreach, especially in more rural areas where distance travel is required.

3. Anti-psychotic medications treatment

EPI programs should use low dose, slow increment anti-psychotic medication when clinically indicated as a first line therapy to treat psychosis and follow up through periodic psychiatric re-assessments.

- Almost all sites reported a high level of implementation, with 94% able to use low dose, slow increment anti-psychotic medication as first line of therapy ‘most of the time’.
- Most sites also reported high portions of clients (90% or more) on anti-psychotic medications, although rates were somewhat lower for small programs (76%).
- Many sites reported following protocol items for side effects monitoring (e.g., blood work and metabolic monitoring). However, implementation was lower in community agency sponsored and small programs.
- Less than half of sites have formal written procedures for anti-psychotic medication monitoring.
- While implementation was high, about half of sites reported that better access to psychiatry and primary care would help support efforts to implement this Standard.
- Cost of medications was an often cited barrier to use - improving drug benefit plans through existing programs such as Ontario Disability Support Program (ODSP) and Trillium was suggested.

4. Physical health monitoring

EPI programs should monitor side effects among clients taking anti-psychotic medication and address physical health issues in a timely fashion.

- Implementation was moderate for physical health monitoring, with 75% of programs reporting implementing this element ‘most of the time’; rates were somewhat lower in small program sites.
- Access to primary care (PC) physicians was identified as a challenge. Only 57% of program sites reported that most of their clients are followed by a PC physician, and the rate was lower for community agency sponsored sites. A further challenge was that clients may not see the value of visits for physical health monitoring.
- Creative approaches for client physical health monitoring were suggested – such as home visits by EPI team nurses, nurse medical assessment at every psychiatric visit, accessing PC physicians in local clinics when no family physician is available to take on the client.
- Active efforts are needed to help clients understand the need for health monitoring and adopt healthy behaviors.
- Using health tracking sheets or shared electronic health information may help establish regular and consistent communication between EPI staff and PC physicians.

5. Working with inpatient units

If a client requires in-patient treatment, the EPI team should continue to provide support to the client through in-reach services and to advocate on behalf of the client.

- Moderate frequency of implementation with 71% of all program sites reporting they are able to support and advocate for their clients when admitted to inpatient units ‘most of the time’; rates were lower in community agency sponsored sites (52%).
- Strategies for working with inpatient units include participation in unit rounds, care planning meetings and discharge planning.

- However, authorizations to visit the client on the inpatient unit are usually required and some units have low interest in collaborating.
- Inpatient psychiatrist views on treatment may differ from EPI program psychiatrists, which can present challenges to providing consistent treatment.
- Collaborations are generally easier to implement when the EPI program and inpatient unit are part of the same organization.
- Some EPI programs face resource limitations for conducting inpatient unit in-reach, for example related to staff visit and travel time.

6. Client and family psycho-education

EPI programs should provide ongoing education to client and families about the illness, role of treatment and medications, side effects, rights and responsibilities, sustaining recovery and preventing relapse.

- Overall, most sites (84%) reported being able to deliver psycho-education to clients ‘most of the time’; this rate was lower for family psycho-education, at 71%. For both groups, implementation was slightly lower in smaller program sites.
- Over a third of programs reported no implementation challenges. The main challenge noted was staff time – for example, to prepare and deliver materials, and meet with families.
- Almost all sites reported providing psycho-education materials specific to EPI.
- Other suggested strategies included offering peer support and fun activities for youth; use of group approaches; and utilizing web and social media to provide information and share materials for youth and families.

7. Crisis management

EPI program should prepare clients and families to manage crises by developing crisis plans, organizing after hours support, and linking with community crisis services.

- Most sites offer crisis management, with 82% reporting implementation ‘most of the time’.
- To support crisis management, most EPI sites provide education to area crisis programs but fewer have written agreements in place to support rapid access if it is needed and some noted difficulty finding after hours support.
- However, sites reported that the main challenge in crisis management is convincing clients to seek help.

8. Relapse prevention:

EPI program should assist clients and families in identifying client’s early warning signs for relapse as well as strategies to prevent or reduce the severity of relapse.

- Programs reported high rates of implementation, with 96% reporting that they were able to implement this element ‘most of the time’.
- Implementation was high for all program types.
- Social challenges (e.g., unstable housing, social support and finances) may contribute to relapse.
- Continued high level of implementation may be helped by having a written relapse prevention plan for each client that is updated as needed.

Standard 4 Results: Psychosocial Support for the Client

This Standard pertains to providing supports to help clients maintain or resume their usual roles within the community and promoting a culture of hope for the future. Programs were asked about their ability to deliver psychosocial support in 10 areas. Responses indicated that:

- Most programs are able to provide illness management most of the time.
- About 70% can provide/ensure access to activities of daily living, social relationship and substance use support most of the time.
- Rates were lower for education, income management, recreational, vocational and housing support (about half).
- Only 37% of sites were able to provide or ensure access to self-help or peer support most of the time.
- Psychosocial supports are provided either by internal staff or through referral. Many programs reported that mainstream supports were not appropriate (60%) or available (56%). Internally, programs noted a lack of resources (42%) and staff time (39%), especially for small programs.
- Proactive effort may help to make community specialized services more accessible and appropriate for EPI program clients – this could require area/network level effort.

Standard 5 Results: Family Education and Support

This Standard addresses active engagement of families (with client consent) in client care through education about psychosis, treatment, medications, side effects, substance abuse, and relapse prevention and strategies to support the client during treatment and recovery.

- Overall, 71% of sites reported being able to actively involve and support families ‘most of the time’; this was more challenging in small programs where 57% implemented ‘most of the time’.
- About half of sites have a designated family support worker; others reported sharing the responsibilities of this role across several staff members. Small programs were less likely to have a dedicated worker.
- The main challenge was finding time to connect with families (especially after hours) and to organize education and peer support activities.
- Greater use of technology (e.g., social networking sites, websites, E-mail, chat rooms) could be explored to improve engagement with families.

Standard 6 Results: Graduation from the Program

This Standard indicates that EPI services are designed to be a time-limited service, with most clients staying for up to 3 years and then being linked to the least intensive and least intrusive level of care to meet their ongoing needs.

- Implementation of this Standard was lower, with only 56% of sites implementing ‘most of the time’. This element was a challenge across all sites.

- About a third of programs reported that over 25% of current clients had been in the program for more than 3 years, and the portion was greater for community agency than for hospital sponsored sites (47% versus 21%).
- Upon graduation, clients are mainly referred to primary care, outpatient psychiatry services and - especially among community sponsored programs - case management.
- Clients may be referred to services within the same organization.
- The main challenges to transferring care at the end of 3 years included the lack of appropriate alternatives and clients not being ready to leave.
- Allowing more flexibility in the length of time clients can remain in the program was raised. Also suggested was providing a step-down/transition option, and exploring shared care options with family physicians.

Main Report

“It is now well appreciated that mental disorders in young people are the most prevalent medical conditions causing disability in this population. Most mental disorders begin prior to age twenty-five and tend to be chronic, with substantial negative short and long term outcomes. They are associated with poor academic and occupational success, substantial personal, interpersonal and family difficulties, increased risk for many physical illnesses, shorter life expectancy and economic burden. Good evidence exists to support specific interventions that can improve the mental health and wellbeing of populations. Early interventions and easily accessed effective treatments may improve both short and long-term outcomes. These outcomes include, but are not limited to, the prevention of some disorders, reduction in disability and enhanced civic and economic participation in a cost-effective manner. Presently, in Canada, few of these domains have been adequately addressed.”

Evergreen: A Child and Youth Mental Health Framework for Canada,
Mental Health Commission of Canada, 2010,

I Background

Rational for Early Psychosis Intervention (EPI)

In recent years there has been a growing interest in the implementation of early intervention for psychosis. Psychosis refers to a primary disturbance of thinking which is reflected in certain symptoms, particularly disturbances in perception (hallucinations), disturbances in belief and interpretation of the environment (delusions) and disorganized speech patterns (thought disorder).³ Psychosis may be caused by a psychiatric disorder such as schizophrenia or bipolar disorder. A first episode of psychosis most often occurs between the ages of 14 and 35, which is an important developmental period for adolescents and young adults.⁴

Untreated and unmanaged psychosis can cause multiple disruptions in many areas of development. Persons with psychosis may experience distress, anxiety, despair, and low self esteem. Their relationships with family or peers may become strained, and they may withdraw and become socially isolated. School and employment may be disrupted, and substance misuse may occur. An escalation in conditions may lead to a compulsory admission to an inpatient unit or legal problems, events which are traumatizing for the individual and can result in alienation from services.^{5,6}

The essence of the early intervention paradigm is that providing holistic and evidence based intervention as early as possible in the course of illness presentation is not only a clinical and humane imperative, but also has potential to reduce the impact of illness, even if continuing care is needed to maintain initial benefits.⁷ The opportunity to modify the personal, social and societal consequences of untreated psychoses provides a major justification for early intervention.⁸

Since individuals in the early phases of psychosis are generally young, it is important that treatment take their specific needs and life situations into account.⁹ Many are living with their families, and attempting to negotiate the normal developmental phases of late adolescence and young adulthood – related to social relationships, school, and work. They may be struggling with the initial trauma of psychosis and the question of whether a return to their usual level of functioning is possible. Families may want to be involved. These factors have helped to shape the model which includes outreach to engage youth in settings where they are comfortable; delivery of service in youth-friendly, low stigma environments; inclusion of family, with client

³ Turner, M., Nightingale, S., Mulder, R., & Maginness, A. (2002). *Evaluation of early intervention for psychosis services in new zealand: What works?* Auckland, New Zealand: Health Research Council of New Zealand.

⁴ McGorry, P. (2012). At issue: Cochrane, early intervention, and mental health reform: Analysis, paralysis, or evidence-informed progress? *Schizophrenia Bulletin*, 38(2), 221-224.

⁵ Turner et al., 2002

⁶ Singh, S.P., & Fisher, H.L. (2005). Early intervention in psychosis: obstacles and opportunities. *Advances in Psychiatric Treatment*, 11, 71-78.

⁷ McGorry, 2012

⁸ Singh & Fisher, 2005

⁹ Malla, A.M., & Norman, R.M.G. (2001). Treating Psychosis: Is There More to Early Intervention than Intervening Early? *Canadian Journal of Psychiatry*, 46, 645-648.

agreement; low caseloads (10 to 15 per clinical staff) to provide more comprehensive care and build relationships; and social interventions to help individuals maintain or re-establish community roles.^{10, 11}

Three potential periods or stages of treatment initiation have been identified for early psychosis intervention: stage (1): sub-threshold when individuals experience distress and impairments that may signal more serious disorder; stage (2): intervention as soon as possible after the onset of positive psychotic symptoms where the aim is to reduce the duration of untreated psychosis (DUP); and stage (3): intervention with established cases of psychosis, where the aim is to provide comprehensive treatment during the critical first few years of diagnosed illness.^{12, 13}

A growing body of research is emerging on the effectiveness of intervention at each of these stages. In a review of the benefits of early intervention services compared to standard care (stage 3), Bird¹⁴ showed that clients of EPI services were less likely to relapse or be admitted to hospital; had reduced symptoms, both positive and negative; were more likely to stay in treatment; and were more likely to receive psychosocial interventions. In reviews of the impact of stage 2 interventions to minimize DUP, studies have shown that a longer DUP is associated with poorer outcome once treatment is initiated.^{15, 16} Evidence on intervention at stage 1 is less conclusive and intervention at this stage has raised discussions about what is appropriate and ethical to offer. Regarding length of treatment, EPI has been presented as a time limited intervention of 2 to 3 years, but debate and research is emerging on the appropriate length of stay (perhaps tied to client needs) and what is needed to transition individuals successfully to other forms of support.^{17, 18}

Dr. Patrick McGorry was one of the founding developers of the Early Psychosis Prevention and Intervention Centre in Australia in the early 1990s. Since then, early psychosis intervention has been endorsed in numerous national policies/strategies. It is now well established as a therapeutic approach in North America, Europe and Australasia.¹⁹ In the UK, a policy commitment to EPI has been in place since 2001, and a recent report indicated 145 teams in operation, serving

¹⁰ Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J., & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry : The Journal of Mental Science*, 197(5), 350-356.

¹¹ Singh & Fisher, 2005

¹² McGorry, 2012

¹³ Singh & Fisher, 2005

¹⁴ Bird et al., 2010

¹⁵ Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P., & Croudace, T. (2005). Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: A systematic review. *Archives of General Psychiatry*, 62(9), 975-983.

¹⁶ Norman, R.M.G., Lewis, S.W., & Marshall, M. (2005). Duration of untreated psychosis and its relationship to clinical outcome. *British Journal of Psychiatry*, 187(suppl. 48), s19-s23.

¹⁷ Norman, R. M., Manchanda, R., Malla, A. K., Windell, D., Harricharan, R., & Northcott, S. (2011). Symptom and functional outcomes for a 5 year early intervention program for psychoses. *Schizophrenia Research*, 129(2-3), 111-115.

¹⁸ Singh, S. P. (2010). Early intervention in psychosis. *The British Journal of Psychiatry : The Journal of Mental Science*, 196(5), 343-345.

¹⁹ Marshall, M., & Rathbone, J. (2011). Early intervention for psychosis. *Cochrane Database of Systematic Reviews (Online)*, (6)(6), CD004718.

15,750 individuals.^{20, 21} International support is evident in the formation of the International Early Psychosis Association, creation of a peer reviewed journal called *Early Intervention in Psychiatry* (since 2007), and the release of a consensus statement on early intervention and recovery for young people with early psychosis by the World Health Organization and International Early Psychosis Association.²²

The History of Early Psychosis Intervention Programs in Ontario

First mention of Early Psychosis Intervention programs occurred in Ontario in a 1999 provincial policy framework report called *Making it Happen: Implementation Plan for Mental Health Reform*.²³ At that time, an Ontario Working Group on Early Intervention for Psychosis (OWG) formed to promote the need for early intervention services and to work with government to make these services a reality. Membership included providers; family members; and consumers. By 2003, most Ontario planning regions had identified early intervention programs for psychosis as a service priority, and by 2004, five EPI programs had been implemented by hospitals.

In December, 2004, the Ministry of Health and Long Term Care (henceforth “the Ministry”) released a ***Program Policy Framework for Early Intervention in Psychosis***²⁴ and announced new funding for EPI services. In the following 3 years, over 30 early intervention programs were implemented. In addition, the OWG membership grew significantly and, with additional funding from the Ministry, the working group started holding an annual provincial conference, developed a website, and supported a range of educational opportunities across programs. Still, without specific program guidelines, development of the new EPI programs was based mainly on the past experiences of providers and advice from the established EPI programs^{25, 26}

In 2006, the Ministry of Child and Youth Services published *A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health*.²⁷ This policy recognized the importance of early intervention with respect to first episode psychosis.

The Ministry released the ***Ontario Early Psychosis Intervention Program Standards***²⁸ in 2011. These Standards built on the international guidelines previously mentioned²⁹ and guidelines

²⁰ Bird et al., (2010)

²¹ Tiffin, P.A., Glover, G. (2007). From commitment to reality: early intervention in psychosis services in England. *Early Intervention in Psychiatry*, 1, 104-107.

²² Bertolote, J., & McGorry, P. (2005). Early intervention and recovery for young people with early psychosis: Consensus statement. *The British Journal of Psychiatry. Supplement*, 48, s116-9.

²³ Ministry of Health and Long-Term Care. (1999). *Making it Happen: Implementation Plan for Mental Health Reform*. Toronto, ON.

²⁴ Ministry of Health and Long-Term Care. (2004). *Program Policy Framework for Early Intervention in Psychosis*. Toronto, ON. <http://www.health.gov.on.ca/en/common/ministry/publications/reports/mentalhealth/psychosis.pdf>

²⁵ Archie, S., Hobbs, H., & Menezes, N. (2008). Translating best practices into service: Implementing early intervention for psychosis across Canada. *Psychiatric Annals*, 38(8),554.

²⁶ Cheng, C., Dewa, C.S., & Goering, P. (2011). Matryoshka Project: lessons learned about early intervention in psychosis programme development. *Early Intervention in Psychiatry*, 5, 64-69.

²⁷ Ministry of Children and Family Services. (November, 2006). *A Shared Responsibility: Ontario’s Policy Framework for Child and Youth Mental Health*. Toronto, ON.

developed by the National Health Service in the United Kingdom.³⁰ The guidelines are seen as organic in that they will continue to evolve as new evidence emerges about EPI and as Ontario programs gain more experience with implementation.³¹

The Standards set the following objectives for comprehensive early psychosis intervention programs:

- To reduce the duration of untreated psychosis through early and appropriate detection and response, thereby potentially reducing the severity of the illness.
- To minimize the disruption in the lives of adolescents and young adults who experience psychosis so they can maintain or re-establish educational, vocational, social and other roles.
- To minimize the societal impact of psychosis including reducing demand in other areas of the mental health, health, and social service systems, and reducing disruption in the lives of families.

The Standards are guided by the following principles;

- Services are client and family centred. Clients are engaged in their own care and treatment. Families are engaged in the client's care as much as possible.
- Services are youth friendly, age appropriate and sensitive to gender and culture.
- Services support clients in recovering and maintaining age-appropriate social roles (e.g., going to school, maintaining a job).
- Services are linked to other services and supports in the community, particularly primary care.
- Treatment is provided in the least restrictive and stigmatizing setting. Home-based treatment may be appropriate for adolescents and young adults.

Moving to System-wide Implementation of Evidence-Based Practices

The Ontario Standards are intended to support the delivery of comprehensive, high quality, evidence-based care for early psychosis treatment across the province. This aim is important because, as Drake et al³² recently noted, the preponderance of individuals with schizophrenia (as many as 95%) receive either no care or less than optimal care even though effective interventions have been identified. Many 'best practices' do not make the transition into routine care delivery,³³ and the decision to implement an evidence-based practice is not equivalent to its implementation.³⁴ Rather, the process of scaling up-from local or pilot programs to system wide

²⁸ The Ministry of Health and Long Term Care (2011) *Ontario Early Psychosis Intervention Program Standards*. Toronto, ON. http://www.health.gov.on.ca/english/providers/pub/mental/epi_program_standards.pdf

²⁹ Bertolote & McGorry, 2005

³⁰ Department of Health. *The Mental Health Implementation Guide*.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058960.pdf.

³¹ Ministry of Health and Long-Term Care. 2011

³² Drake, R. E., Bond, G. R., & Essock, S. M. (2009). Implementing evidence-based practices for people with schizophrenia. *Schizophrenia Bulletin*, 35(4), 704-713.

³³ Berwick, D.M. (2003). Disseminating innovations in health care. *JAMA*, 289(15), 1969-1975.

³⁴ Gotham, H.J.(2006). Advancing the implementation of evidence-based practices into clinical practice: How do we get there from here? *Professional Psychology-Research and Practice*, 37(6): pp. 606-613.

implementation needs to be planned and carefully monitored. It also takes time – e.g., 2 to 4 years for one agency and longer for a whole treatment system.^{35, 36}

The study of best practices for implementation has become a formal area of research over the last decade (‘implementation science’), and various frameworks have been proposed to guide the adoption/ implementation process.^{37, 38} Two framework components are particularly relevant to the EPI Program Standards. *Implementation drivers* influence the successful implementation of a new treatment and operate at multiple levels – individual provider (e.g. staff training, coaching, feedback evaluation), organizational (e.g., leadership, policies, data decision support systems, funding) and external (e.g., financial resources, human resources, training centre, practice Standards, monitoring feedback).³⁹ *Implementation outcomes* pertain to how a practice is being implemented and can indicate whether a practice has been implemented as envisioned. Good implementation outcomes are necessary preconditions for attaining desired changes in clinical or service outcomes.⁴⁰ In measuring both implementation drivers and implementation outcomes, a feedback process can be instituted whereby implementation drivers can be modified to move current practice closer to desired practice.^{41, 42}

The importance of monitoring and linking these components in a feedback process is acknowledged in the Ontario EPI Program Standards, where it is noted that the Standards provide a tool that can be used “to identify any weaknesses in current programs and services, and develop plans to fill any gaps”.⁴³ The Ontario Standards make reference to a number of strategies to support implementation including: program policies, procedures and service delivery protocols; supportive organizational structures; staff orientation and training; data collection and feedback. Supporting roles for the Ministry and Local Health Integration Networks (LHINs) are also identified.⁴⁴

³⁵ Gotham, 2006

³⁶ Fixsen, D. L., Blasé, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531.

³⁷ Gotham, 2006

³⁸ Damschroder, L.J., D.C. Aron, R.E. Keith, S.R. Kirsh, J.A. Alexander, and J.C. Lowery. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*.

³⁹ Fixsen et al., 2009

⁴⁰ Proctor, E.K., J. Landsverk, G. Aarons, D. Chambers, C. Glisson, and B. Mittman. (2009). Implementation Research in Mental Health Services: an Emerging Science with Conceptual, Methodological, and Training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), p. 24-34.

⁴¹ Fixsen et al., 2009

⁴² Gotham, 2006

⁴³ Ministry of Health and Long-Term Care. 2011 (p.9).

⁴⁴ Ministry of Health and Long-Term Care. 2011 (p.10).

II Survey Overview

Background

In 2012, the Ministry formed a Standards Implementation Steering Committee (SISC) to support implementation of the Ontario EPI Program Standards. The Committee includes representatives from the Ministry, the LHINs, and the OWG, and is provided with technical support from CAMH.

As a first step to understanding current EPI program delivery in Ontario in relation to the Standards, as well as facilitators and challenges to Standards implementation, the Committee undertook a province-wide EPI program survey. The intention at this early stage in release of the Standards was to seek feedback from the EPI programs about their current practices, and about the extent to which these aligned with the EPI Program Standards. Also of interest was learning about perceived drivers (facilitators and challenges) to implementation, to flag areas where additional support or intervention might be needed. Given that the Implementation Committee is chaired by the Ministry and includes regional (LHIN) and provincial (OWG) stakeholders, there was a particular interest in identifying organizational and external factors that impact implementation - where these stakeholders may have an influence. A final aim of the survey was to count and provide basic descriptive information (e.g., staffing complement and budget allocation) on the range of programs in the province that are delivering EPI services.

Survey aims:

1. Describe the structure and capacity of EPI programs in Ontario
2. Obtain feedback from Ontario EPI program regarding:
 - a. Perceived alignment of current practice with EPI Program Standards
 - b. Perceived barriers and facilitators to Standards implementation

Survey Development

A subcommittee of the larger Standards Implementation Steering Committee served as the working group for this initiative.

Development of the survey questionnaire occurred during the fall of 2011. The Ontario EPI Program Standards provided the general structure for the survey. Thirteen Standards address the broad range of community outreach, client outreach, family engagement, medical and psychosocial interventions that are considered to be part of an EPI service. Each Standard is a high level domain that is further articulated through a list of specific elements (up to 22 per Standard).

To manage the burden of survey completion, a decision was made to focus the survey questions on the following 6 out of 13 Standard domains:

- Facilitating access & early identification

- Comprehensive client assessment
- Treatment
- Psychosocial support for client
- Family education & support
- Graduation from the program

Within these domains, guided by the expert advice of the working group and drawing on the EPI literature, a subset of key elements was identified to examine. The survey was used to obtain key informant feedback related to implementation of these elements.

Programs answered a similar set of questions about implementation of each element as follows:

- Global perception of how often the element was implemented – ‘most of the time’, ‘some of the time’ or ‘not too often’
- Approaches/practices used
- Challenges
- Implementation strategies (currently used or suggested).

In addition, an initial set of questions requested program profile information (e.g., staffing complement, budget allocation, catchment area characteristics).

Data collection

Data collection occurred during February and March 2012. A list of potential EPI programs was constructed from the ConnexOntario health service database⁴⁵ and the OWG outreach and membership list, and a letter of invitation was sent to each program. It was suggested that one individual ‘who knows the program well’ take responsibility for completing the survey. Follow-up via email and telephone was conducted to encourage participation.

Out of an initial list of 68 potential EPI programs, Figure 2 reports program eligibility and final participation. The final sample included 56 surveys representing 52 program sites delivering service to young persons experiencing psychosis; 3 family programs; and 1 regional (non-clinical program). Among eligible programs a response rate of 90% was achieved.

⁴⁵ ConnexOntario maintains provincial databases for mental health, alcohol and drugs, and gambling services. It is funded by the Government of Ontario

Figure 2: Survey participation results

Stage	Response
Invited to participate	68 programs
Considered ineligible	10 programs <ul style="list-style-type: none"> • 8 did not provide the full basket of services associated with EPI programs (e.g., 1 program was a specialty addiction service linked to an clinical EPI site) • 1 was too new • 1 served mood disorders
Duplicate	2 programs listed twice
Declined	6 programs <ul style="list-style-type: none"> • 2 did not identify as EPI • 4 cited lack of time, low staffing
Final sample	50 unique programs including: <ul style="list-style-type: none"> • 46 (delivering service at 52 sites): person experiencing psychosis as client • 3: family as client • 1: regional (non-clinical) program

Analysis and Reporting

The present report provides results for the 52 clinical sites delivering care to the young person experiencing psychosis. The survey included both close-ended and open-ended questions. Descriptive statistics were used (counts, means, ranges) to report results for close-ended questions. These were calculated for the whole sample and then separately for: 1) hospital and community agency sponsored programs; 2) small and large catchment area population programs. The comparisons were used to illuminate differences in implementation, challenges and opportunities.

For the open ended questions, an iterative process was implemented where, per question, responses were first listed (retaining the language of the respondent), then tagged with theme codes, and finally grouped and reduced into common issues /themes.

There are a number of limitations to this survey approach. Results are based on staff perceptions rather than client level information (chart data, admin data, survey) about service delivery. In addition, informants were asked about frequency of care delivery, not quality of care. Also, the results represent the opinion of those who participated. Other EPI program staff and other stakeholders, including clients and their families, may have different views.

Three of the surveyed programs provide service to family members (but not to the person experiencing psychosis). While these programs represent an innovative component of the EPI initiative in Ontario, the survey was structured to obtain feedback from programs where the person experiencing psychosis is the service recipient. Thus, the family program survey results are not included in this report. Rather, a separate effort is needed to adequately understand the

services that they provide to family members, their relationship to other EPI services and the ill family member, and where/how the provincial EPI Programs Standards apply.

One of the surveyed programs has a regional coordination role and does not provide clinical services. As with the family programs, many sections of the survey were not applicable to their practice. A separate effort is needed to adequately understand the services they provide, their role in relation to other EPI services, and where/how the provincial EPI Programs Standards apply.

III Survey Results

Results are reported for the 52 program sites delivering care to young people with first episode psychosis. The following sections report program descriptive data and then the results for each Standard element, including quantitative results and key themes that emerged from the open text questions.

Provincial Programs Description

Program size and staffing by catchment area population size

As indicated in Table 1A, the catchment population size for the program sites ranged from small (serving a population base of less than 20,000) to large (serving a community of more than 500,000). Programs serving a larger catchment population tended to be located in urban or mixed urban/rural areas. These programs also reported higher budgets, total client caseload, and number and diversity of clinical (non-physician) staff. While caseload sizes per staff varied, there were no systematic differences between the programs with larger and smaller catchment population sizes.

Throughout this report, the category ‘**large program site**’ includes sites that served catchment population sizes of greater than 100,000 population (60% of sites). These program sites also:

- reported larger program budgets (mean budget of \$340K or more)
- were more likely to be located in major urban areas⁴⁶ (for example Toronto, Ottawa, London and other large Ontario cities);
- reported more total clients registered at their site (mean of 50 or more);
- employed more clinical staff (mean of 3.2 full time equivalent (FTE) staff or more)
- had more disciplines and specialties represented on their team (mean of 3.7 or more)

Comparatively, the ‘**small program site**’ category includes sites that served catchment population sizes of 100,000 or fewer people (40% of sites). These program sites also:

- reported smaller program budgets (mean budget of \$120K or less);
- were located mainly in mixed urban and rural areas;
- reported fewer total clients registered at their site (mean of 19 or less);
- employed fewer clinical staff (mean of 1.1 FTE staff or less)
- had fewer disciplines and specialties represented on the program site team (mean of 1.7 or less).

⁴⁶ While large programs tend to serve urban areas, there are programs in the ‘large program’ category that serve very large geographic areas (e.g., in the North). In this report, the results for large and small program sites are reported separately to illustrate differences these sites may experience in service delivery, in part due to urban/rural differences. However, this categorization may mask some of the challenges faced by large programs which also have large geographic catchment areas to serve.

Table 1A: Program details by catchment population size

Catchment Area Pop Size: (# programs)	Budget Mean:(range)	Catchment Area Type (% all programs)			Total Clients ² Mean (range)	Total Clinical FTEs ³ Mean (range)	Caseload Size ⁴ Mean (range)	# of disciplines & specialties on team: Mean (range)	
		Urban	Mixed	Rural				Employed	All ⁵
> 500K (N = 11)	1,132K (280K-2,600K)	82%	18%	0%	137 (47-261)	6.6 (3-14)	24 (7-45)	3.8 (1-7)	4.3 (1-7)
200-500K (N = 9)	698K (139K-2,000K)	11%	89%	0%	88 (8-342)	5.6 (1-13)	14 (6-27)	2.8 (1-6)	3.9 (0-6)
100-200K (N = 11)	340K (101K-721K)	27%	73%	0%	50 (13-161)	3.2 (1-7)	20 (7-48)	2.8 (1-5)	3.7 (1-5)
20-100K (N = 18)	120K (41K-210K)	6%	73%	22%	19 (5-37)	1.1 (1-2)	20 (10-37)	1.3 (1-3)	1.6 (0-2)
< 20K (N = 3)	85K (70K-100K)	0%	33%	67%	14 (11-20)	1.0 (1-1)	14 (12-17)	1.7 (1-2)	1.7 (1-2)
Total (N = 52 ¹)	428K (41K-2,600K)	27%	62%	12%	62 (5-342)	3.7 (1-14)	19 (6-48)	2.4 (0-7)	3.0 (1-7)

¹ Total sample was smaller for 2 data elements: budget - reported by 47 out of 52 programs; total clinical FTEs - reported by 48 out of 52 programs

² E.g., currently registered in the program

³ E.g., non-physician clinical FTE staff allotment for EPI program from EPI budget

⁴ E.g., ratio of clients to clinical FTE staff (calculated for 48/52 programs)

⁵ E.g., includes employed or with a dedicated time commitment to program

Program size and staffing by sponsorship

The Standards state that “all EPI programs are managed by sponsoring agencies that are accountable to their own Board of Directors” (page 9). The survey asked programs for their parent agency name and type (hospital or community agency).

As indicated in Table 1B, more than half of sites reported being sponsored by hospitals. On average, these sites reported larger budgets and total caseloads compared to community agency sponsored sites. However, there was wide variation and many hospital sponsored programs were small. For example, 48% of hospital and 60% of community agency sponsored sites reported budgets of less than \$250,000. Similarly, both reported many sites with caseloads of less than 40 (40% of hospital and 59% of community agency sponsored sites).

In the results tables provided in this report, the term **‘hospital’** will refer to sites sponsored by hospital organizations and **‘community’** for sites sponsored by community organizations.

Table 1B: Program details by sponsor type

Sponsor Type (# programs)	Budget Mean (range)	Catchment Area Type (% all programs)			Total Clients ² Mean (range)	Total Clinical FTEs ³ Mean (range)	Caseload Size ⁴ Mean (range)	Disciplines & Specialties: Mean (range)	
		Urban	Mixed	Rural				Employed	All ⁵
Hospital (N = 30)	506K (41K- 2,600K)	37%	57%	7%	79 (5-342)	3.9 (1-14)	23.1 (6-37)	2.0 (0-6)	3.3 (1-6)
Community (N = 22)	321K (66K- 1,462K)	14%	68%	18%	39 (8-170)	3.3 (1-11)	14.6 (7-48)	2.4 (0-7)	2.6 (1-7)
Total (N = 52 ¹)	428K (40K- 2,600K)	27%	62%	12%	62 (5-342)	3.7 (1-14)	19 (6-48)	2.4 (0-7)	3.0 (1-7)

¹ Total sample was smaller for 2 data elements: budget - reported by 47 out of 52 programs; total clinical FTEs - reported by 48 out of 52 programs

² E.g., currently registered in the program

³ E.g., non-physician clinical FTE staff allotment for EPI program from EPI budget

⁴ E.g., ratio of clients to clinical FTE staff (calculated for 48/52 programs)

⁵ E.g., includes employed or with a dedicated time commitment to program

Program Networks

The Standards indicate that EPI programs should establish formal collaborations with other EPI programs when needed to ensure delivery of the full EPI model of care (page 31). While it is expected that some programs will be able to provide most services from within their team (stand-alone), many will develop associations with other programs (program networks) to support service delivery.

Data were collected on whether or not programs were part of a network arrangement. Among the 52 surveyed sites, 47 sites reported being part of a network arrangement and 9 networks were identified. These varied in size from 3 to 11 member sites, and were located across the province (present in almost every LHIN). The network arrangements varied, including single organizations delivering EPI services through multiple clinical sites usually spread across a large geographic area, as well as partnerships among independent organizations to support EPI service delivery across a larger catchment area. Some networks reported a hub and spoke type functional model, where the hub was a larger (usually urban) site that provided some support to smaller partner service sites located in more rural areas. Networks also formed to share non clinical functions such as staff training, educational resource development, and community outreach.

The survey did not examine network arrangements in depth and follow-up could explore approaches and benefits of these arrangements.

Appendix A includes a list of program networks by LHIN.

Standards Implementation Results

As noted earlier, the following similar set of questions explored implementation for each element:

- Global perception of how often able to implement – most of the time, some of the time, not too often
- Approaches/practices used
- Challenges
- Strategies to support implementation (currently in use or that would help).

The following sections report results for each element – in narrative text and tables. In each table, the relevant survey question is indicated in brackets (Q#).

Standard 1: Facilitating Access and Early Identification

The survey examined the following elements in Standard 1:

4. Developing an early identification/rapid response system
5. Public education
6. Access to translation and interpretation services

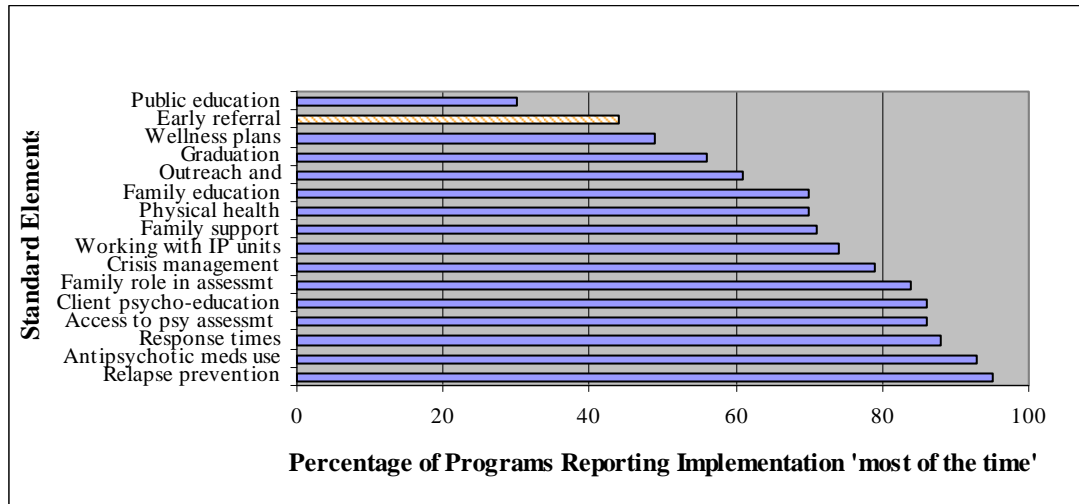
1. Developing an early identification/rapid response system

Standard 1 indicates a role for EPI programs in identifying and supporting area providers and organizations to assist with early identification and referral of individuals experiencing signs or symptoms of psychosis. The premise is that primary care providers, school or university health services, youth agencies, mental health services and other organizations who regularly connect with youth and young adults have the potential to recognize signs and symptoms of psychosis, make timely referrals to EPI programs for assessment, and assist in engaging the individual. EPI programs use a variety of strategies to build and strengthen an Early Identification/Rapid Response network in their communities.

Summary of Results:

- Overall, programs indicated lower levels of implementation of this element than for other Standard elements, with only 40% of sites able to implement this element ‘most of the time.’
- Developing and sustaining an early identification and referral network was challenging for EPI services regardless of whether the program was larger or smaller, or hospital or community agency based. Challenges pertained to having time, getting access to audiences, maintaining persistent outreach.
- Implementation may benefit from local or regional support (e.g., for outreach to area providers, development of educational resources), and from having a plan in place for implementing and monitoring this work.
- Programs reported some conflict with implementing this element. Outreach requires having the capacity to accept new referrals, and can be problematic if the program is operating at capacity already. In addition, programs are expected to respond quickly to referrals and are not supposed to keep a waitlist.

Chart 1: Referral network development: Implementation* relative to other elements (Q34)



* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 2: Referral network development: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q34: How often able to implement this element	% sites implementing 'most of the time'	40%	39%	43%	37%	46%

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Referral sources:

- The most common referral source for programs were hospital inpatient units (77% of sites reported receiving 25% or more of referrals from inpatient services), followed by family physicians (64%), families (50%) and community mental health services (CMHAs) (45%). Less frequent referral sources were emergency departments (31%), schools (23%) and clients (16%).
- Hospital sponsored programs were more likely to get referrals from inpatient units, family physicians and emergency departments while community programs are more likely to get referrals from CMHAs. Similarly, larger programs were more likely to get referrals from hospital inpatient units and family physicians; smaller, more rural programs were more likely to get referrals from CMHAs.

Approaches used by programs for developing referral networks (see Table 3):

- Almost all programs worked with primary care providers, schools and hospital inpatient units; many worked with youth services and hospital emergency departments; fewer worked with police and shelters.

- Outreach most often included providing *referral information*; many programs also provide *education*, especially to schools and youth services.
- Screening tools were used much less frequently - about 40% of sites provided primary care providers with *screening tools* and fewer provided such tools to hospital, schools or other community referral sources.
- Program differences were only evident regarding education outreach. Larger programs were more likely to provide education to primary care and hospital programs than smaller programs, and community agency sponsored were more likely than hospital sponsored programs to provide education to youth services and shelters.
- While programs reported disseminating referral information, conducting education and sometimes providing screening support, it is unclear how consistent and comprehensive this outreach is. Challenges of EPI program staff time and staff turnover were noted.

Table 3: Outreach Strategies used with Referral Sources (Q 35)

Referral Sources	Outreach Strategies		
	Referral Info	Education	Screening Tools
Family Physicians	96	65	39
Hospital Emergency	89	37	23
Hospital Inpatient Unit	90	62	29
Schools	87	92	25
Youth Services	83	71	19
Shelters	48	40	4
Polices, Corrections	62	48	4

Main challenges to developing referral networks noted by programs (see Table 4):

- Staff time was mentioned by almost all sites.
- Access to the audience was mentioned by 60%, with specific reference to getting into schools and family physician offices, and connecting with the police and Children’s Aid Society (CAS).
- Maintaining ongoing contact with referral sources was mentioned by about half, and may also reflect the challenge of staff turnover.
- Receiving inappropriate referrals was noted more often by larger urban programs, whereas not receiving referrals that should be made was noted more often by community sites.

Table 4: Main Challenges to Developing a Referral Network

Main Challenges	Response (% yes)
Staff time	87
Access to audience	60
Ongoing contact	54
Services who should be referring	50
Inappropriate referrals	46
Tools/resources	0

Strategies suggested by programs for developing referral networks:

- Suggestions for conducting outreach included: use of program web site; participating in community fairs and stakeholder consultations; offering in-service training; organizing or attending brown bag lunches.
- Being persistent/ consistent: E.g., having dedicated staff time and resources for developing and maintaining the referral network; Developing a plan for undertaking this work.
- Suggestions for working with schools included: Being available to see clients in the school setting; joining (or establishing) committees which include school board personnel; presenting to students in school based educational events such as workshops in classrooms or information fairs; Presenting to educators and school board staff in professional development days.
- Suggestions for achieving efficiencies for above included:
 - Regional network role – could assist programs by providing regional workshops for physicians, nurse practitioners and community mental health workers
 - Interagency partnerships among local providers – for example, to develop screening tools, deliver joint presentations to hospital staff, present at community health care conferences, participate in system central intake initiatives, school/school board outreach.
- Some of the above could be developed and assessed in pilot projects.

What would help programs to develop referral networks?

- Roughly 70% of program sites reported that their ability to deliver EPI would be helped by more time to develop relations with the community and network. This might be obtained through increased or dedicated staff time, reduced caseload size, resources for referral network development.
- Centrally provided assistance (e.g., from regional networks, the OWG, LHINs, Ministry) was suggested to get EPI specific information out in a systematic way to key audiences such as schools, family care practitioners, hospital inpatient units. Assistance could include development of educational resources; web resources; media engagement.
- More formal partnerships between EPI services and area community agencies and school boards, utilizing an memorandum of understanding (MOU) (perhaps centrally negotiated)
- Provide more clarity and consistency to referral sources about eligibility criteria and the program response (including for prodromal referrals).

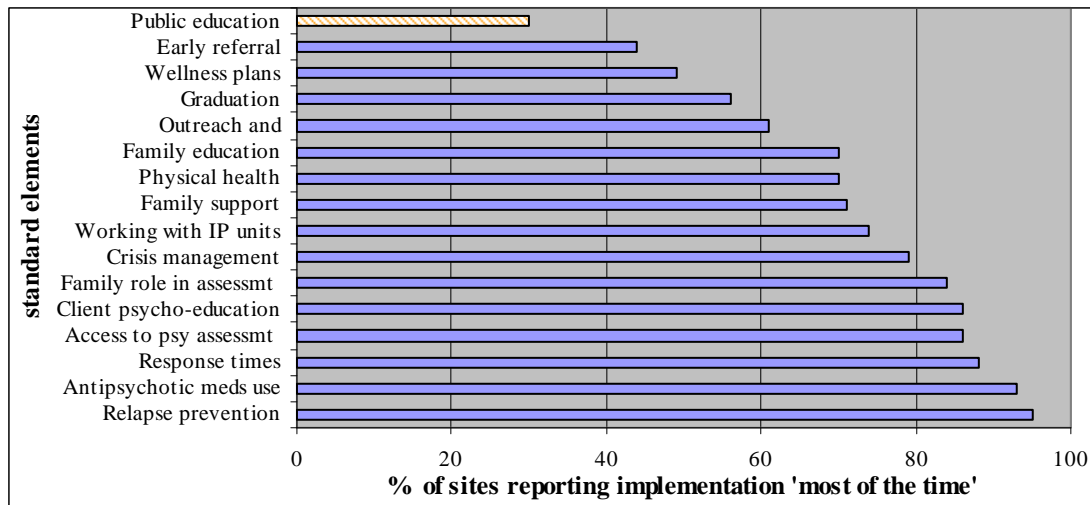
2. Public education

Standard 1 recognizes the importance of public education in building awareness among parents, families, teachers and employers of the signs and symptoms of psychosis in young people and how to seek help. EPI programs use a variety of strategies in pursuing public education goals.

Summary of Results:

- Only 31% of sites overall reported implementing the Standards on public education ‘most of the time. This element was a challenge regardless of whether program served a larger or smaller population catchment area or had a hospital or community agency sponsor.
- Similar to referral network development, implementation challenges pertained to having sufficient staff time and audience access.
- Having staff dedicated to this element was suggested as this element uses a skill set that clinical staff may not possess; this could be a regional position.
- Program implementation may improve from having a clear plan for allocating time, setting targets and related monitoring.

Chart 2: Public education: Implementation* relative to other elements (Q 43)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 5: Public education: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q43: How often able to implement this element	% sites implementing ‘most of the time’	31	29	33	27	36

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for public education:

- These are similar to those suggested for referral network development.
- Most programs reported working with schools, e.g., professional development to school staff; information to school staff working with program clients; presentations to students – high school and college
- Work with professional groups occurred through in-service and speakers on request

- Work with general community through events such as community fairs, youth mental health forum, community wide advertising – e.g., billboard and bus
- Print materials were distributed by most programs and web approaches were used by slightly more than half, although less so in community programs.

Main challenges to public education noted by programs:

- Most programs noted staff time (83%); some noted problems with audience access (42%).
- Few programs have a written plan to define and monitor this type of work (12%).

Strategies suggested by programs for public education:

- A number of programs reported examples of leveraging capacity and resources across organizations, e.g.:
 - incorporating EPI education into activity/role of the parent organization (e.g., health promotion team)
 - joining a network where agreement is reached for this function to be performed centrally for all network members
 - function performed by regional organization for area EPI programs
 - sharing educational materials across programs
- Outreach to area family physicians by distributing an educational binder - brochures, business cards and large sign for office.
- Engaging current and former clients as consumer champions in presentations and public awareness campaigns
- Staff position dedicated to education generally or for specific target such as in schools – e.g., one program staff delivered over 100 presentations in one year

What would help program to deliver public education:

- Having a plan to allocate time, set targets and monitor
- Having dedicated staff, staff time, resources – ‘it uses a different skill set that is not possessed by a clinical staff’; this could be an ‘area’ position.
- Systematic process for engaging and training peer educators.
- Access to standardized education tools i.e., DVDs, PowerPoint presentations, resources.
- Target general community (not mental health) – e.g., offer family forums; May need extra funds to target “difficult” to reach groups such as police officers.

3. Translation and Interpretation Services

Standard 1 includes provision of access to translation and interpretation services as one strategy to facilitate early identification and access to EPI services for members of diverse communities served by EPI programs.

Summary of Results:

- Almost all sites reported that translation or interpretation services were required for less than 10% of cases. This applied across the board.
- Fee-for- service was most common method of access to this service

- Overall, 40% of programs had a related written policy but this rate was much lower in small programs.
- Main challenges pertained to funding and finding expertise.
- The demand for translation or interpretation services seems fairly low given characteristics of Ontario's population and may point to difficulties for some communities in knowing about or accessing EPI services.

Table 6: Translation or interpretation services: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q38: What is the % of clients (consumer or family) where interpretation is needed?	% programs reporting <10%	89%	87%	91%	90%	86%

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs to provide translation/interpretation services:

- Fee-for-service translators or interpreters were used by almost one third of sites and in-house services were reported by 15%. This latter approach may reflect a contribution of EPI program sponsoring agencies.
- Few sites reported using assistance of clients and families.
- 40% of sites reported that they had a written policy on translation and interpretation services, and this rate was lower in small programs (19%).

Main challenges to providing translation/interpretation services noted by programs (Table 7):

- Reported challenges pertained to funding, finding the required expertise and organizing access. Result is client may not be seen as often.
- However, almost half of sites had no challenges to report, more so for small programs. This may reflect low use of interpreters or lack of/low recognition of clients perceived to need them.

Table 7: Main challenges to implementing Standards related to translation/interpretation services

Survey Question	Response (%yes)	Large area	Small area	Hospital	Community
40. Written policy	39	52	19	37	41
41. Main challenges:					
- None to report	48	36*	67	47	50
- Funding	21	26	14	27	14
- Expertise	29	45*	5	23	36
- Organizing access	14	19	5	17	9

Strategies suggested by programs for providing translation/interpretation services:

- Accessing staff/resources in sponsoring organization.
- Inter-agency partnerships, such as with the Canadian Hearing Society or a local mental health agency to access expertise or specific language skills.
- Translating brochures and materials into relevant languages.

What would help programs to provide translation and interpretation services:

- Education for program staff on how to obtain translation and interpretation services within the community.
- Funding for translators.
- Written policy to standardize and guide response.

Standard 2: Comprehensive Client Assessment

The survey examined the following elements in Standard 2:

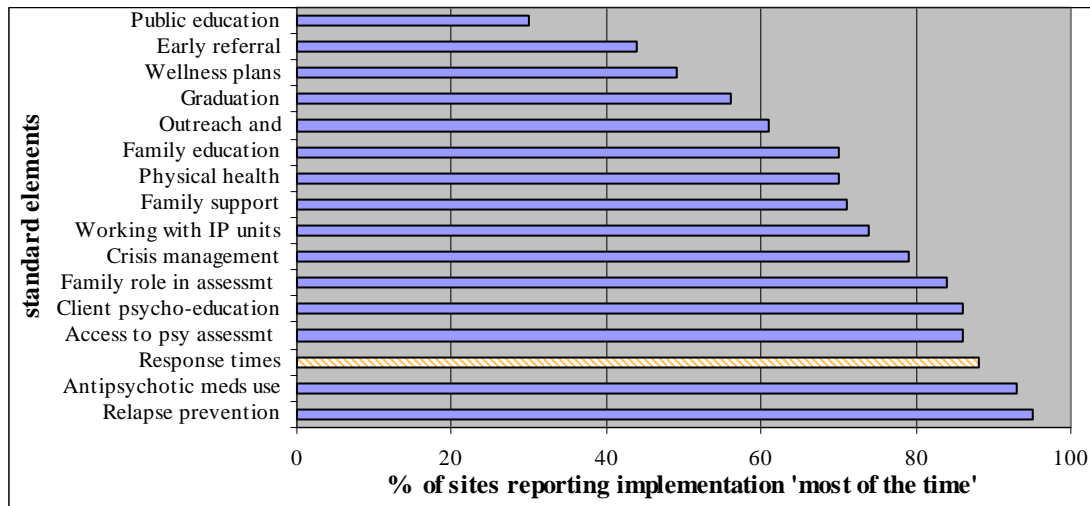
5. Time to respond after initial referral
6. Family involvement in assessment
7. Access to psychiatric assessment
8. Comprehensive (intake) assessment

1. Time to respond after referral

Standard 2 sets out expected response times after client referral: phone contact within 72 hours of client being referred for a comprehensive assessment and a face to face meeting offered to be held within two weeks.

Summary of Results:

- Overall, 90% of EPI sites reported meeting the response times ‘most of the time.’ Across all programs, 76% of clients were contacted by phone within 72 hours of referral and 85% were seen within two weeks of referral.
- Only a small minority of programs reported keeping a waitlist (13%). These programs were somewhat more likely to be larger, and with community agency rather than hospital sponsorship. Programs with a waitlist reported more difficulty meeting the recommended response times after referral.
- Just over half the sites reported that they have a written policy on response times.
- Interpretation of these results requires some caution as there may be some variation in how programs track and record response times. For example, if there are upfront intake processes such as centralized intake or a screening process in the sponsoring organization, when does measurement of response time begin? If an individual cannot be reached or is unavailable to attend, how is time to first appointment measured? Are referrals not accepted if the program is at capacity?
- A final caution is that this Standard does not measure adequacy of system capacity and may be better interpreted as a measure of efficiency once a contact is made.

Chart 3: Time to respond: Implementation* relative to other elements (Q 49)

* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 8: Time to respond: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q49: How often able to implement this element	% sites implementing 'most of the time'	90	97	81	90	91

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to meeting response times targets noted by programs:

- 40% of programs noted no challenges.
- When challenges were reported, they pertained to insufficient staffing (1/3 of programs) and lack of access to psychiatry (1/4 of programs).
- Staff time may be a limitation if extra time is required to connect (e.g., when travel is required) or if an individual declines the service (also addressed in outreach).
- Psychiatry support is needed for initial assessment.
- Centralized access via a parent organization may be a strength but may also contribute to longer response times if individuals are required to go through an initial screening before referral to the EPI program.
- The issue of inappropriate referrals can come into play in meeting Standard response times as these can reduce staff capacity to deal with all referrals.
- The very small number of programs that kept a wait list reported more challenges.

Strategies suggested by programs for meeting response times:

- Meeting with clients at a location and time that suits them (also relevant to outreach)
- Dedicated intake staff.
- Having sufficient psychiatry resources available on a consistent basis.
- Making rapid response a priority for the team.
- Proactive discharge planning to manage caseloads.

What would help programs to meet Standard response times:

- More or flexible staffing resources, including having dedicated intake staff or capacity to add additional staff during periods of high volume of referrals.
- Increased psychiatry resources to meet program need, included psychiatrists well versed in EPI evidence based practices.
- Time to train rural clinicians in EPI Standards of care (general capacity building for rural areas).

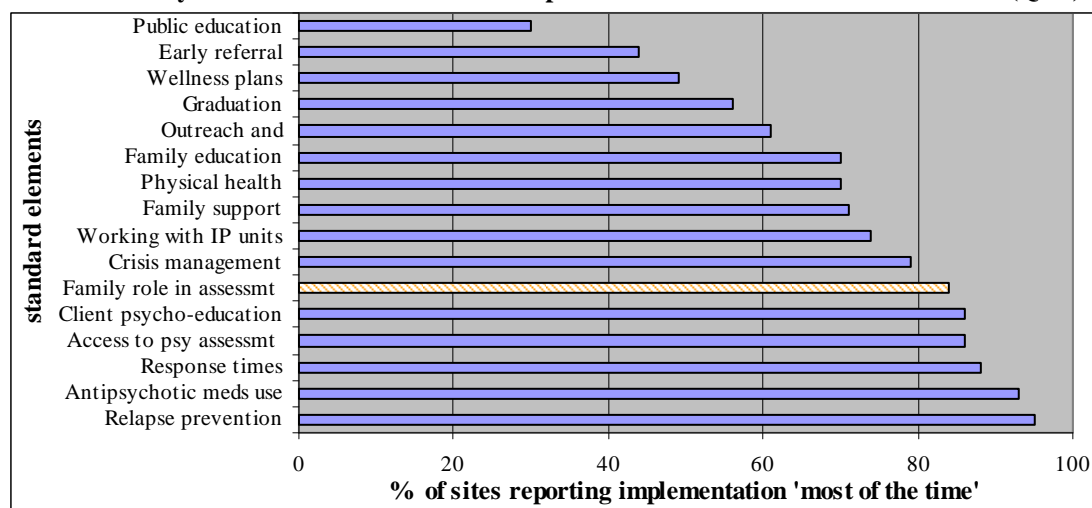
2. Family involvement in assessment

Standard 2 outlines a client centered approach to assessment. In addition to actively involving the client in the assessment, family involvement during the assessment process is encouraged, provided the client gives consent.

Summary of Results:

- High level of implementation with 83% of programs reporting being able to involve families in client assessment ‘most of the time’.
- Community agency sponsored and small programs were more likely to report challenges in implementation.
- Challenges included scheduling and distances to travel, client resistance to family involvement and mental illness within the family system.
- Across the board, 60% of programs indicated that their ability to deliver EPI would benefit from more time to work with families.
- Finding appropriate supports for family members with their own mental health needs can be difficult to address.

Chart 4: Family involvement in assessment: Implementation* relative to other elements (Q 56)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 9: Family involvement in assessment: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q56: How often able to implement this element	% sites implementing 'most of the time'	83	90	71	93	68

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs to involve families in the client assessment:

- Discussing the results of assessments with families, reported by 100 percent of respondents
- Use of printed materials (booklets about EPI services and psychosis) reported by over 90% of sites
- Providing written summary of team roles (over 50% of sites)

Main challenges to involving families in the assessment noted by programs:

- Clinician and family availability, scheduling and distances to travel
- Clients resistant to family involvement
- Mental illness within the family system
- Language or cultural barriers
- Staff time

Strategies suggested by programs to involve families in the assessment:

- Assertive outreach to families, including travelling long distances, meeting in the family home, or using phone contact
- Educating family members that their involvement is a key element of assessment and recovery process.
- Beginning engagement with families as early as possible.
- Obtaining relevant information from other service providers to minimize the need for the family to tell their story repeatedly.

What would help programs to involve families in the assessment:

- Additional staff resources which in some cases could mean staff dedicated to family work and in other cases would simply allow for extended hours or more support available for families. (Currently 47% of programs report having a family support worker on the team).
- Increase family access to psychiatry to debrief on the assessment.
- Legislative changes related to family involvement and consents.
- Foster (with the staff and the families) the value of families being actively engaged in client care.
- Community referrals to help family members with their own mental health struggles but appropriate services can be difficult to find.
- Providing family-specific education and resource material, that has a strong focus on recovery. While almost all sites reported providing materials to families, these may not be family specific. This may be an opportunity for central support.

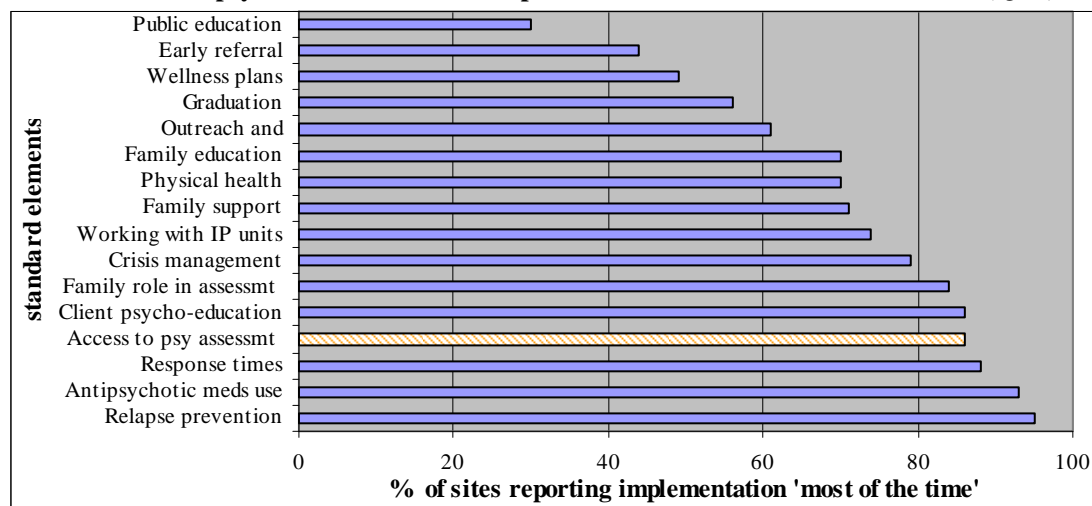
3. Access to psychiatric assessment

Standard 2 requires that the practitioner doing the client assessment have ready access to a psychiatrist. In addition, the minimum requirements of the comprehensive client assessment include a psychiatric exam and history, including assessing level of pre-morbid functioning and identification of co-morbid disorders.

Summary of Results:

- The issue of access to psychiatry was queried in several places on the survey (e.g., also see psychiatric medications treatment section).
- Over 80% of programs reported that they can access psychiatrist expertise to support rapid intake (Q60) or as part of the initial comprehensive assessment (Q66) ‘usually’ or ‘most of the time’.
- However, smaller programs reported lower implementation and about half of programs said their ability to deliver EPI would benefit from better access to psychiatry.
- In addition to fee-for-service, about half of sites reported using sessional fees to pay psychiatrists.
- Some programs reported putting considerable time and effort into developing and maintaining relationships with psychiatrists.
- System level suggestions for creating easier access to psychiatrists included education to increase the pool of psychiatrists familiar with the EPI model, more sessional funding and greater use of the Ontario Telemedicine Network (OTN) or a regional outreach service.

Chart 5: Access to psychiatric assessment: Implementation* relative to other elements (Q 60)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 10: Access to psychiatric assessment: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q60: How often can you access psychiatrist to support rapid intake and initial assessment?	% sites implementing 'most of the time'	87	97	71	87	86
Q66: How often is psychiatric exam included as part of comprehensive assessment?	% usually	81	97	57	87	73

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for accessing psychiatric assessment:

- Most programs reported having formalized access to psychiatrists (89%) via contractual arrangement or on staff, although the rate was lower for programs in smaller areas (76%).
- Payment methods were mixed; in addition to fee for service (FFS), about half of sites reported using sessional fees.

Main challenges to accessing psychiatric assessment noted by programs:

- About half of programs said psychiatrist availability was a challenge, and this rate was similar regardless of program size or sponsor.
- Specific challenges included finding psychiatrists with EPI experience; getting consistent and sufficient time commitment from psychiatrists, and having sufficient resources to pay psychiatrists.
- Also noted was program time required to actively recruit psychiatrist support, with uncertain outcome.
- Lack of access to family physicians for medical monitoring was noted by ¼ of community programs, but was not raised by hospital sponsored programs

Strategies suggested by programs for accessing psychiatric assessment:

- Use of resources of parent organization.
- Obtaining ongoing commitment from psychiatrist - for example, specific consultation times, or to see clients within 1-2 weeks of initial contact.
- Flexible use of psychiatrist time – in one program psychiatrists convert dedicated follow up time to consultation slots when appropriate
- Flexible use of other staff to reduce psychiatrist need – e.g., psychiatric nurse/SW screen out inappropriate referrals; psychiatric residents and fellows complete assessments;
- Use of OTN.
- Regional program hires a psychiatrist.

What would help program access to psychiatric assessment:

- Leveraging other resources – e.g., access psychiatrists affiliated with the parent organization (e.g., hospital).

- More funding and more consistency in funding policy, including availability and use of salary and sessional fees. One specific suggestion was to adjust the provincial physician (OHIP) fee schedule to include incentives for serving EPI clients.
- Regional or network program role – for example, a regional program could have a dedicated psychiatrist/mobile medical team that travels to the communities and/or is available via OTN for regular follow-up and accessible by phone.
- Increasing system capacity – explore different strategies to develop EPI interest/expertise among psychiatrists – to create a larger pool of EPI aware psychiatrists to draw from.
- Family physician pool – explore strategies to develop EPI interest/expertise among family physicians including awareness of the need for medical monitoring.

4. Comprehensive assessment

Standard 2 sets out the minimum requirements for a comprehensive assessment for clients who are referred to EPI programs and appear to meet the eligibility criteria. The requirements include active engagement with client, assessing risk and presenting symptoms, assessing psychiatric, physical health and psycho-social dimensions, in addition to consideration of vocational, education and occupational domains in the individual's life.

Summary of Results (see Table 11):

- Programs reported that their comprehensive assessment 'usually' included a psychiatric exam, assessment of presenting symptoms, risk assessment, substance use assessment, developmental history, psychosocial assessment, cultural assessment, family information, review of client understanding.
- Less frequently the assessment addressed education (62%) and vocational issues (52%).
- Programs reported low frequency of providing a physical exam (23%) and neurological assessment (15%), especially for community agency sponsored and small programs.
- Psychiatric assessments were provided less often by small than large programs; developmental assessments were provided less often by community agency than hospital sponsored programs.
- Programs may benefit from written guidelines and supporting tools such as the Ontario Common Assessment of Need⁴⁷ to ensure routine focus on all elements, but may also need assistance to access necessary expertise.
- Some elements were not seen as immediate priority by staff and were assessed after initial assessment – physical, vocational.

⁴⁷ Ontario Common Assessment of Need is a standardized client assessment being implemented in community mental health programs in Ontario.

Table 11: How often programs include the following elements in the assessment process (Q 66)

Assessment Element	Response	All Sites	Large	Small	Hospital	Community
Presenting symptoms history	% usually	100	100	100	100	100
Risk assessment	% usually	96	94	100	97	96
Psychiatrist exam	% usually	81	97	57	87	73
Physical exam	% usually	23	29	14	30	14
Neurological screen	% usually	15	23	5	20	9
Substance use assessment	% usually	89	87	91	93	82
Justice system use history	% usually	85	84	86	87	82
Developmental history	% usually	83	84	81	93	68
Psychosocial assessment	% usually	96	97	95	100	91
Education assessment	% usually	62	68	52	67	55
Vocational assessment	% usually	52	58	43	50	55
Client understanding of episode	% usually	90	90	91	83	100
Assess cultural/gender issues	% usually	83	77	91	77	91
Information from family	% usually	89	94	81	87	91

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to providing a comprehensive assessment noted by programs:

- Access to physical and neurological assessments.
- Educational and vocational – lack of expertise within team, lack of access to area vocational assessment services
- Developmental – difficult to access assessment for intellectual challenges and learning disabilities for adults no longer in the school system; harder to assess when clients do not consent to family involvement
- Some elements were perceived as intrusive by clients/families – e.g., neurological screen.
- Some elements were not seen as immediate priority by staff and were assessed after initial assessment – physical, vocational.

Strategies suggested by programs for providing comprehensive assessments:

- Interdisciplinary approach
- Developing a systematic, standardized approach/protocol - e.g., using tools/ standardized checklist to ensure comprehensive exam.

What would help programs to provide comprehensive assessments:

- Better access to psychiatry, psychology, and primary care.
- Increased system integration to support access to relevant community services and supports, including vocational, educational, and psychological assessment.
- Additional EPI program staffing and funding to facilitate access to external resources and reduce time pressures.
- Staff training on standardized assessment and introduction/use of supporting tools including the Ontario Common Assessment of Need.
- Increased program focus on vocational and educational assessment, perhaps through written guidelines.

Standard 3: Treatment

The survey examined the following elements in Standard 3:

9. Wellness/recovery plans
10. Outreach and client engagement
11. Anti-psychotic medications treatment
12. Physical health monitoring
13. Working with inpatient units
14. Client and family psychoeducation
15. Crisis management
16. Relapse prevention
17. Use of Ontario Telemedicine Network

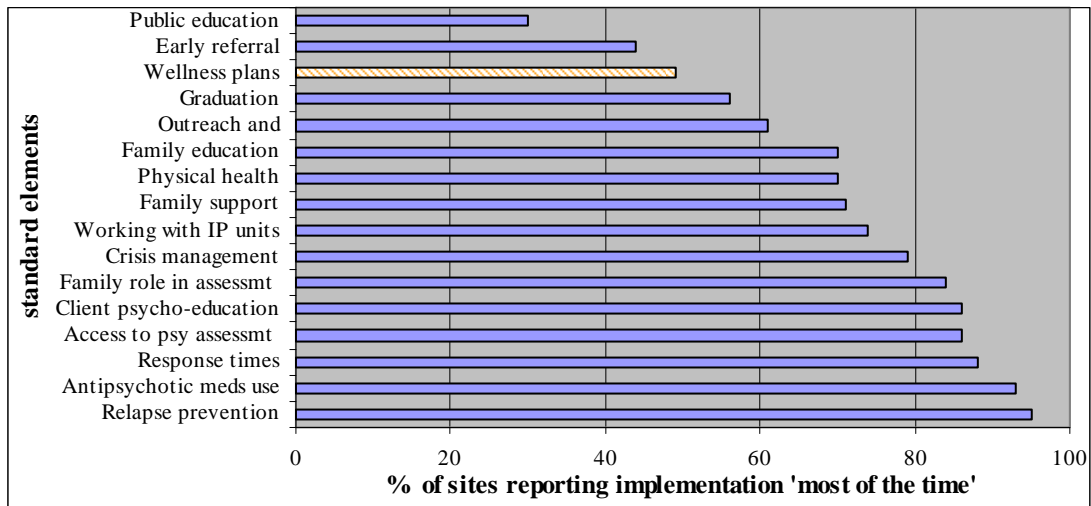
1. Wellness/recovery plans

As part of the approach to working with EPI clients, Standard 3 stipulates that individualized and client-centered wellness/recovery plans be negotiated by the client, family and EPI team. The intent is for the plans to be developed and documented within 4 weeks of the first appointment and be updated regularly. Wellness/recovery plans include agreements on medical treatment, crisis and relapse prevention, as well as direction on education, psychosocial support for the client, family support and graduation from the program.

Summary of Results:

- Only 45% of all sites were able to develop wellness/recovery plans within 4 weeks of the first appointment and regularly update them 'most of the time'.
- Only 41% of sites have written procedures in place for creating and regularly reviewing wellness/recovery plans.
- Implementation may benefit from a standardized process for generating and reviewing plans. This may include use of tools such as an electronic user-friendly template, computer system reminders, and recovery plan template specific to EPI.
- Some programs may implement this element in concert with the client needs identified in OCAN.

Chart 6: Wellness/recovery plans: Implementation* relative to other elements (Q70)



* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 12: Wellness/recovery plans: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q70: How often able to implement this element	% sites implementing 'most of the time'	45	50	38	57	29
Q71: Have written procedure	% yes	41	37	48	43	38

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to developing wellness/recovery plans noted by programs:

- Client circumstances (e.g., readiness, attendance, engagement, wellness).
- Staffing, time and resource constraints.
- 4 week timeframe-client may still be experiencing symptoms at 4 weeks; staff may not know client well enough at 4 weeks to develop meaningful plan.
- Lack of standardized program approach for regularly generating and reviewing plans.

Strategies suggested by programs for developing wellness/recovery plans:

- Using OCAN as part of wellness plan.
- Systematic program procedures (e.g., regularly review plan with clinical team).
- Client engagement-provide education so development of wellness plan can be collaborative.
- Involve other organizations as relevant to developing/implementing wellness plan (e.g., addiction services, crisis services).

What would help programs to develop wellness/ recovery plans:

- Standardized processes and tools (e.g., development of an electronic user-friendly template; computer system reminders when plans are due; development of recovery plan specific to EPI).

- Team processes (e.g., regular team meetings to develop/discuss care plan, lower caseloads).
- Regular contacts with clients for ongoing monitoring.

2. Outreach and client engagement

Standard 3 sets out the expectation that EPI programs use proactive outreach strategies such as in home visits, outreach to families, and services provided as part of recreational opportunities in the community, with the goal of keeping clients engaged in treatment, and reducing missed appointments and program drop-out.

Summary of Results:

- Lower frequency of implementation with only 63% of sites overall reporting using proactive outreach for client engagement ‘most of the time’.
- Small programs and community agency sponsored programs were more likely than their counterparts to indicate higher implementation (71% versus 57%, and 76% versus 53% respectively able to implement most of the time)
- Across all sites, approximately half of all client face-to-face contacts occurred in offices with the remainder in community locations. Hospital sponsored sites reported somewhat higher rate of office contacts (60%) (Table 13).
- Organizational policies may limit staff use of some outreach strategies such as transporting clients in staff vehicles, conducting home visits, and mobile devices/e-communications to connect with clients.
- Time was also noted as a limitation to outreach, especially in more rural areas where longer distance travel is required.

Chart 7: Outreach and client engagement: Implementation* relative to other elements (Q74)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 13: Outreach and client engagement: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q74: How often able to implement this element	% sites implementing 'most of the time'	63	57	71	53	76
Q75: Where do face-to-face contacts occur:	-Office site (% yes)	50	54	43	59	36
	-Community (% yes)	47	43	53	38	61

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for proactive outreach (Table 14):

- Almost all programs reported contact with family (93%) and visiting clients in home or community settings (92%).
- Many reported e-communications (50%).
- Some programs transported clients in staff vehicles (42%) but this occurred more often in smaller and community agency sponsored programs.
- Use of peer outreach was low (23%).
- Also noted by some respondents were: visiting program clients who were receiving care in an inpatient unit; meeting with the client in the school setting; using recreational opportunities as a vehicle for engaging clients; accompanying clients to other community services.

Table 14: Outreach practices used by programs (Q 76)

Outreach Practices	Response	All Sites	Large	Small	Hospital	Community
Contact with families	% yes	93	94	91	93	91
Visits in home/community	% yes	92	90	95	93	91
E-communications	% yes	50	55	43	60	36
Transporting in staff vehicles	% yes	42	29	62	27	64
Accompanying on public transit	% yes	37	58	5	37	36
Peer outreach	% yes	23	26	19	27	18

Main challenges to proactive client outreach noted by programs:

- Half of sites reported organizational policies that limit outreach practices, and this was higher for hospital than community sponsored sites. Organizational policies may limit staff ability to transport clients, conduct home visits, and use mobile devices and e-communications to connect with clients.
- About half of sites said travel time was a challenge; and this was higher for hospital (63%) than community agency sponsored sites (41%).
- 29% of sites reported staff safety as a challenge.
- Some individual sites mentioned staffing and resource limitations.

Strategies suggested by programs for proactive client outreach and engagement:

- Making proactive client outreach a program priority.
- Respecting client preferences such as where he or she is most comfortable meeting

- Using social media and youth friendly strategies.
- Staff using their own vehicles to transport clients.
- Having a safety strategy in place for staff working in the community.
- Fostering interagency collaboration to access spaces to meet with clients in the community and facilitate referrals.

What would help programs to conduct proactive outreach with clients:

- More youth-friendly program setting (noted by 30%).
- More supportive organizational policies that allow more flexible communication (e.g., phone, email) and staff transport of clients.
- Developing written procedures for missed appointments or situations when the client refuses care – only ¼ of sites currently have these in place.
- Having staff safety protocols in place when working in the community.
- Additional staffing, lower caseloads, and resources to support travel, especially in more rural settings.

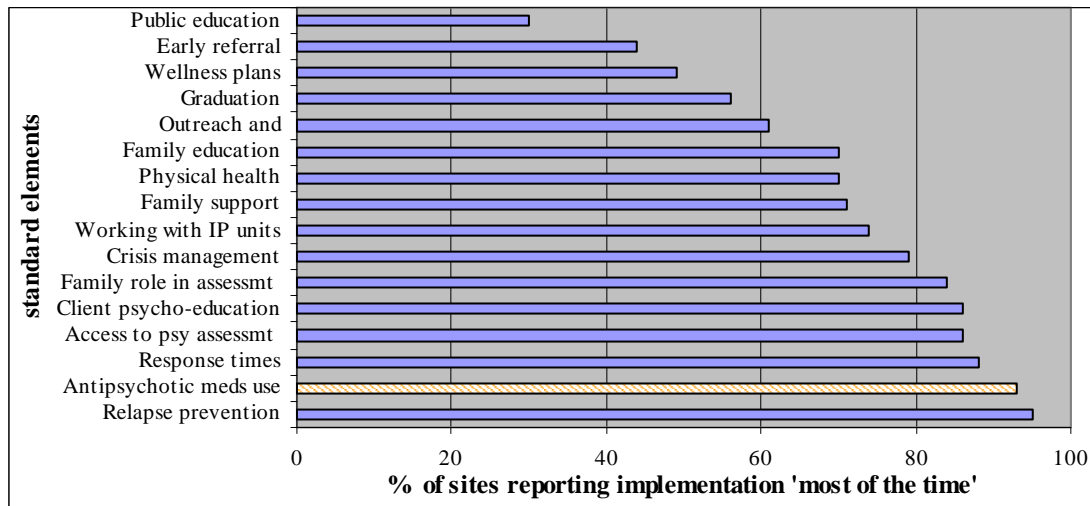
3. Anti-psychotic medication treatment

Standard 3 indicates use of low dose, slow increment anti-psychotic medication when clinically indicated as a first line therapy to treat psychosis, and periodical psychiatric re-assessments.

Summary of Results:

- Sites reported a very high level of implementation, with 94% able to use low dose, slow increment anti-psychotic medication as first line of therapy ‘most of the time’.
- Most sites also reported high portions of clients (90% or more) on anti-psychotic medications, although rates were somewhat lower for small programs (76%).
- Many sites reported following protocol items for side effects monitoring (e.g., blood work and metabolic monitoring). However, implementation was lower in community agency sponsored and small programs.
- Less than half of sites have formal written procedures for anti-psychotic medication monitoring.
- While implementation was high, about half of sites reported that better access to psychiatry and primary care would help support efforts to implement this Standard.
- Cost of medications was an often cited barrier to use - improving drug benefit plans through existing programs such as ODSP and Trillium was suggested.

Chart 8: Anti-psychotic medication treatment: Implementation* relative to other elements (Q83)



* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 15: How often programs implement Standards related to using low dose, slow increment anti-psychotic medication

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q83: How often able to implement this element	% sites implementing 'most of the time'	94	97	91	97	91
Q138: Would your ability to deliver EPI be helped by better access to psychiatrists	Great deal /fair amt (%)	47	39	57	36	59
Q138: Would your ability to deliver EPI be helped by better access to primary care?	Great deal/ fair amt (%)	61	58	67	60	64

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for anti-psychotic medication monitoring (Table 16):

- 85% of sites reported monitoring for side effects, 79% monitor metabolic changes and weight gain. Medication administration protocols also included blood work (69% of sites) and obtaining informed client consent (65% of sites)
- These rates were lower in small sites.
- Some programs reported providing client and family education about medication and side effects.

Table 16: Procedures and protocol for anti-psychotic medications monitoring

Survey Question	Response (% yes)
Q85: Program has written procedures for anti-psychotic medications monitoring	45
Q86: Items in monitoring protocol:	
- Side effects	85
- Metabolic disruption/wt gain	79
- Blood work	69
- Informed consent	65

Main challenges to administering anti-psychotic medications noted by programs:

- Cost of drugs for clients was noted by 64% of sites
- Some sites mentioned: access to medical expertise (15%), medical support for clients under 16 (10%); staff skills (8%); providing medical monitoring (15%).
- Also noted by some sites were: client compliance and choices, lack of knowledge of EPI practices among some medical professionals, medications not being effective, and constraints due to staffing and psychiatry resources.

Strategies suggested by programs for administering anti-psychotic medications:

- Developing relationships with pharmaceutical company reps to obtain free drug samples and a compassionate supply.
- Medications-related education and support for the client and family.
- Nursing staff on EPI team; also offering capacity to do injections in the home.

What would help programs for administering low dose anti-psychotic medications:

- Improved client access to drug benefits through existing programs such as ODSP and Trillium, & access to compassionate supply of medication if needed.
- Education for health care professionals working with EPI clients to be more knowledgeable about best practices in EPI.
- Prioritizing ongoing and consistent monitoring of clients for compliance and side effects.
- Additional staffing and physician resources, and increased capacity to be able to offer an injectable service.

4. Physical health monitoring

Standard 3 outlines expectations related to ongoing medical assessment and general physical health monitoring. This includes closely monitoring clients taking anti-psychotic medications for side effects, and addressing physical health issues in a timely fashion either directly or through referrals to other services.

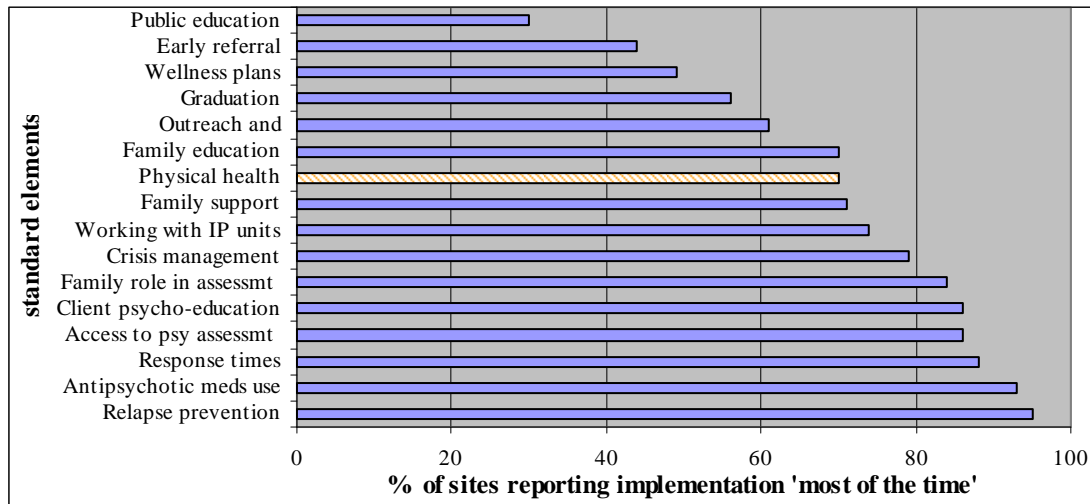
Summary of Results:

- Overall moderate implementation of Standard related to physical health monitoring with 75% of programs reporting implementing this element ‘most of the time’; rates were somewhat lower in small program sites (57%).
- Access to primary care (PC) physicians was identified as a challenge. 57% of program sites overall reported that most of their clients are followed by a primary care physician, and the

rate is lower for community agency sponsored sites. A further challenge is that clients may not see the value of visits for physical health monitoring.

- Creative approaches for physical health monitoring were suggested – such as home health visits by EPI team nurses, nurse medical assessment at every psychiatric visit, accessing PC physicians in local clinics when no family physician is available to take on the client.
- Active efforts are needed to help clients understand need for health monitoring and adopt healthy behaviors.
- Using health tracking sheets or shared electronic health information may help establish regular and consistent communication between EPI staff and PC physicians.

Chart 9: Physical health monitoring: Implementation* relative to other elements



* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 17: Physical health monitoring: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q89: How often able implement this element	% sites implementing 'most of the time'	75	87	57	73	76

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches to physical health monitoring noted by programs (Table 18):

- Across all sites, physical health monitoring was most often conducted by primary care physicians. Team nurses were also involved, suggesting that physical health monitoring may be shared between the team staff and family physicians.
- However, small sites do not have the same opportunity to arrange for physical health monitoring from within the team; only 38% noted use of a team nurse.

- In addition, some programs noted physical health monitoring through psychiatrists, physicians in hospital, linked to a local mental health or other clinic, and in several instances through the hospital emergency.

Table 18: Physical health monitoring

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q90: What portion of clients is being followed by a primary care physician?	Most of the time (%)	57	60	52	70	38
Q91: Assesses physical health issues:						
- PC physician	% yes	85	84	86	83	86
- Team nurse practitioner	% yes	6	3	10	0	14
- Team nurse	% yes	65	84	38	67	64

Main challenges to physical health monitoring noted by programs:

- Access to primary care physicians – due to low availability in the area, also in some cases, PC physicians being unwilling to take on clients with serious mental illness.
- Long wait times to see physicians.
- Client poor attendance for lab work visits and difficulty making lifestyle changes to address health issues (e.g., weight gain).
- EPI staff effort and time in following up with client and/or primary care physician to ensure lab work is done, appointments are kept and information is shared.
- Inconsistent monitoring and sharing of information when clients are being seen by psychiatrists outside of EPI programs who are not familiar with EPI protocols for physical health monitoring.

Strategies suggested by programs for physical health monitoring:

- Educating clients about importance of physical health care, teaching about healthy lifestyle, offering on-site fitness and cooking classes.
- Establishing clear communication process with family physician – e.g., via sharing assessment results, regular updates, health tracking sheet.
- Having access to a nurse (on the team or elsewhere) for physical health monitoring.
- Having physical health assessed at each psychiatric appointment.
- In small program sites, having psychiatrist assist with vitals monitoring when on site.
- Have psychiatrists who are dedicated to the EPI service for greater consistency in protocols and better communication.
- Having a clinical nurse available in the districts when psychiatry comes (so clients have vitals done on same day that they see the psychiatrist)
- Accessing a PC physician in a local clinic for individuals without a regular family physician

What would help program to provide physical health monitoring:

- Access to more health professional resources (dietician services, primary care physicians, clinical nurse/nurse practitioner).
- Better communication and relationships with physicians.
- More flexible policies within sponsoring organization, such as being able to transport clients

to the lab.

- Electronic transmission of information in real time between the client’s partners in care.
- Client consent to work with his/her primary care physician on health issues, increased medication compliance, and regular attendance at appointments.
- Use of a physical health monitoring tracking sheet and process to ensure results go back to the team (systematic documentation and feedback loop).

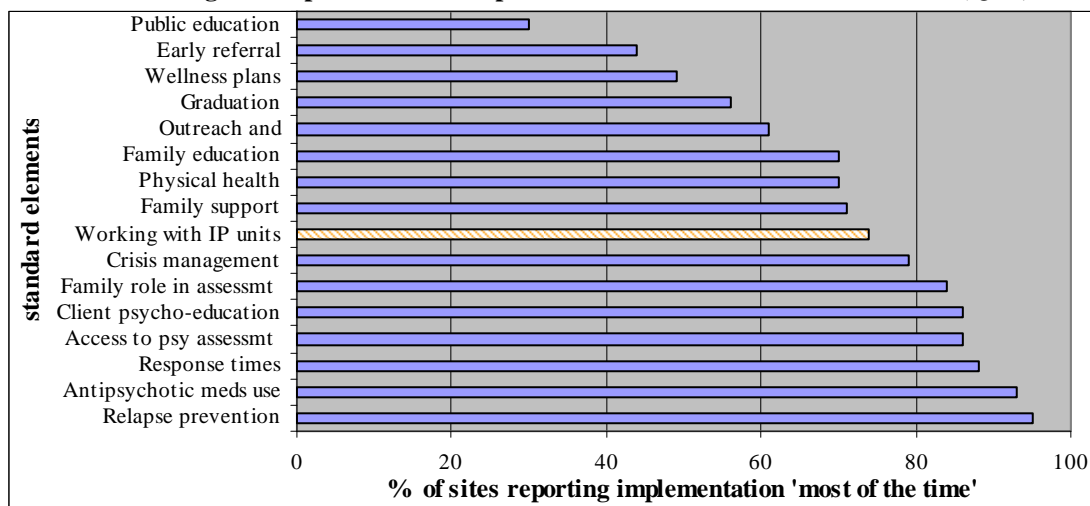
5. Working with inpatient units

Standard 3 indicates that in-patient treatment only be provided when absolutely necessary and in age-appropriate locations (where available) that support EPI principles. The EPI team continues to provide support for clients in the in-patient setting (through in-reach services) and advocates on behalf of the client to ensure she/he receives consistent treatment during the hospital stay.

Summary of Results:

- Moderate frequency of implementation with 71% of all program sites reporting they are able to support and advocate for their clients when admitted to inpatient units ‘most of the time’; rates were lower in community agency sponsored sites (52%).
- Strategies for working with inpatient units include participation in unit rounds, care planning meetings and discharge planning.
- However, authorizations to visit the client on the inpatient unit are usually required and some units have low interest in collaborating.
- Inpatient psychiatrist views on treatment may differ from EPI program psychiatrists which can present challenges to providing consistent treatment.
- Collaborations are generally easier to implement when the EPI program and inpatient unit are part of the same organization.
- Some EPI programs face resource limitations for conducting inpatient unit in-reach, for example related to visit and travel time.

Chart 10: Working with inpatient units: Implementation* relative to other elements (Q 94)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 19: Working with inpatient units: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q94: How often able to implement this element	% sites implementing 'most of the time'	71	77	62	83	52

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to working with inpatient units noted by programs:

- Psychiatric care difficulties. For instance, confusion over which psychiatrist (inpatient or EPI) provides care; differences between EPI and inpatient psychiatrist approaches to illness management (e.g., some psychiatrists do not support EPI, changing client's medications).
- Staff attitudes in inpatient unit or emergency department and their understanding of community support programs.
- Client negative responses to hospitalization (e.g., minimizing symptoms to shorten admission, instability)
- Poor communication between inpatient unit and EPI program, for example, EPI program staff not allowed to view documentation of admitted clients, not notified that client has been admitted until after discharge or no protocol for communication.
- EPI program not involved in discharge planning from inpatient unit and client not prepared or well enough to be discharged.
- EPI program resource limitations for visiting inpatient units, which include staff time, geography and travel.
- Access when inpatient unit is in distant location.

Strategies suggested by programs for working with inpatient units:

- Conduct proactive outreach to build rapport with hospital team, educate about the EPI program and establish processes and communication strategies for client management.
- At EPI client program admission, obtain client/family consent to communicate relevant information with inpatient unit if needed.
- Participate in unit rounds, care planning meetings and discharge planning; visit clients throughout their admission.
- If a discharge referral is received, visit client on the unit and assess suitability for program.
- These collaborations may require authorizations and formal protocols between hospital unit and EPI program.
- Hospital sponsored EPI programs reported some home organization benefits – e.g., notification if EPI client is admitted to their hospital, access to unit charts for EPI clients and other documentation, communication between EPI program and inpatient physicians.

What would help programs for working with inpatient units:

- Improved communication between EPI programs and inpatient units, at time of admission, during treatment in inpatient unit and at time of discharge planning
- Access to electronic charts or inpatient program notes – may require policy change.

- Participation in discharge planning and patient care meetings.
- Consistency in psychiatric care.
- Reduced caseload/increased staff resources.

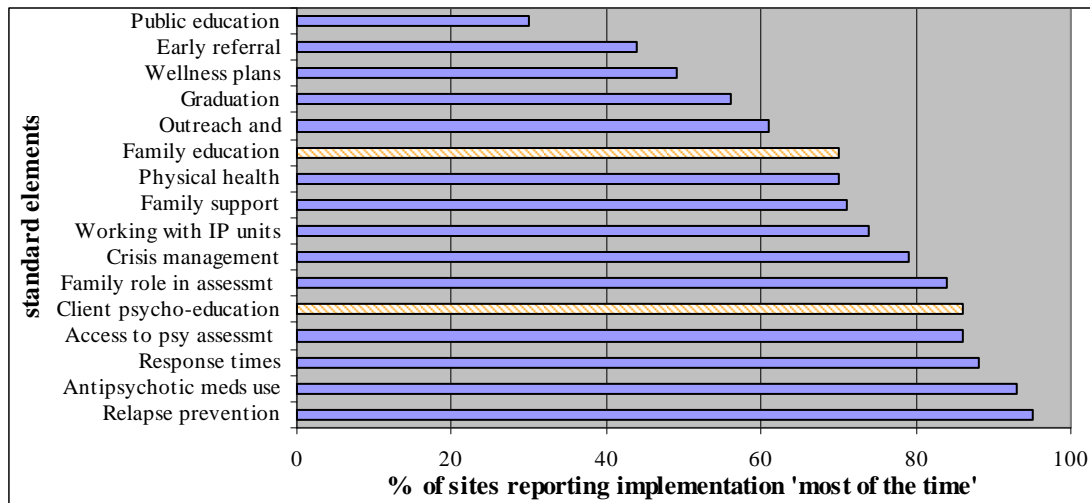
6. Client and family psycho-education

Standard 3 indicates that EPI programs provide ongoing education to the client and family on a variety of topics including: the illness, role of treatment and medications, side effects, rights and responsibilities, sustaining recovery and preventing relapses.

Summary of Results:

- Overall, most sites (84%) reported being able to deliver psycho-education to clients ‘most of the time’; this rate was lower for family psycho-education, at 71%. For both groups, implementation was slightly lower in smaller program sites.
- Over a third of programs reported no implementation challenges. The main challenge noted was staff time – for example, to prepare and deliver materials, and meet with families.
- Almost all sites reported providing psycho-education materials specific to EPI.
- Other suggested strategies included offering peer support and fun activities for youth; use of group approaches; and utilizing web and social media to provide information and share materials for youth and families.

Chart 11: Client and family psycho-education: Implementation* relative to other elements (Q98, Q99)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 20: Client and family psycho-education: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q98: How often able to implement this element <u>for clients</u>	% sites implementing 'most of the time'	84	90	76	90	76
Q99: How often able to implement this element <u>for families</u>	% sites implementing 'most of the time'	71	77	62	70	71

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to delivering psycho-education noted by programs:

- Over a third of programs reported no challenges.
- The main challenges reported were staff time (1/3 of sites), and difficulty accessing appropriate materials (15%). This latter challenge was mainly noted more by the larger and hospital sponsored (23% versus 5% and 20% versus 9%).
- Other challenges included: client/family willingness to participate (due to circumstances or stage of the illness); client not consenting to family involvement; availability of family; travel, distance and hours of operation as barriers to participation; and staffing and resource needs.

Table 21: Main challenges to implementing Standards related to delivering psycho-education

Q101: Main Challenges	All Sites	Large	Small	Hospital	Community
None to report	37	32	43	33	41
EPI program staff time	37	36	38	32	40
Accessing appropriate materials	15	23	5	20	9

Strategies suggested by programs for delivering client and family psycho-education:

- Providing resource materials to clients and families.
- Having a designated staff/family educator. (Note: In a later question, about half of sites reported having a designated family support worker).
- Use of OTN for family support and/or education groups.
- Offering group psycho-education for clients, with benefits of peer support and fun activities.
- Individual session that take into account the client or family's abilities for understanding and retaining materials; monitoring need and progress over time.

What would help programs to provide client and family psycho-education:

- Developing web resources and social media opportunities for clients and families to access to view information and share materials
- Developing/upgrading/identifying educational materials specific to EPI (e.g., more youth-friendly materials in multiple languages).
- Explore community partnerships for family support groups.

- More staffing and program resources (e.g., dedicated EPI clinician, more time for psycho-education related tasks, greater flexibility of hours, a family worker).

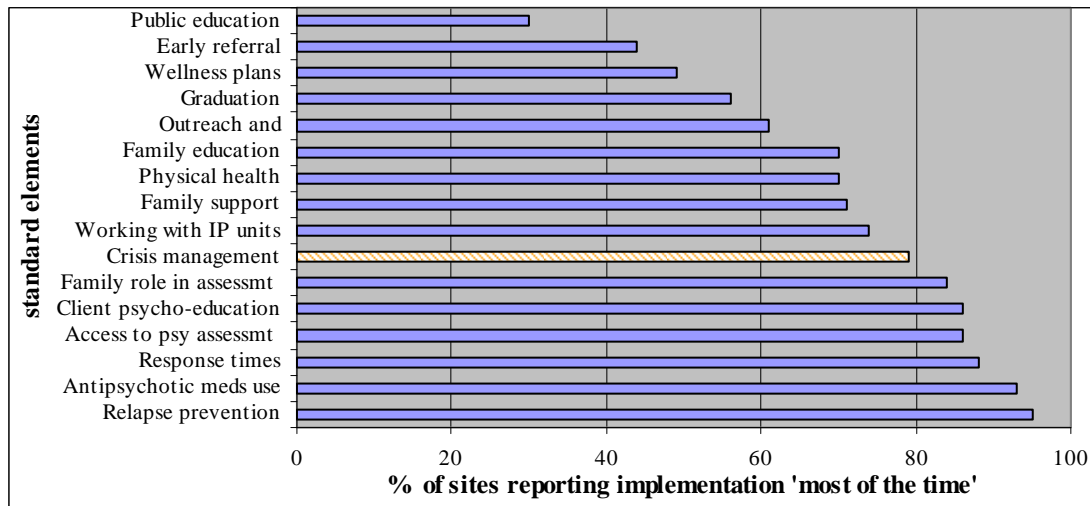
7. Crisis management

Standard 3 indicates that programs prepare clients and families to manage crises, for example by developing crisis plans, organizing after hours support, and establishing linkages with community crisis response services where available.

Summary of Results:

- Most sites offer crisis management, with 82% reporting implementation ‘most of the time’.
- To support crisis management, most EPI sites provide education to area crisis programs but fewer have written agreements in place to support rapid access if it is needed and some noted difficulty finding after hours support.
- However, sites reported that the main challenge in crisis management is convincing clients to seek help.

Chart 12: Crisis management: Implementation* relative to other elements (Q103)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 22: Crisis management: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q103: How often able to implement this element	% sites implementing ‘most of the time’	82	83	81	77	91

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for crisis management (Table 23):

- Almost all programs reported providing education to area crisis programs.
- 2/3 of programs reported developing written crisis plans for clients.
- Fewer have agreements for rapid access with area crisis programs (55%) or withdrawal management programs (12%).

Main challenges to crisis management noted by programs (Table 23):

- Across all programs, the greatest challenge was convincing clients to seek help.
- Challenges were also reported for identifying after hours supports and getting cooperation from local services. These were reported more often by hospital sponsored sites.
- Also reported by some programs were: unhelpful family attitudes and responses, inadequate responses from community and hospital crisis services; and EPI staffing resources.

Table 23: Crisis management strategies and challenges (% yes)

Strategies and Challenges	All Sites	Large	Small	Hospital	Community
Q104: Strategies used for crisis management:					
- Education to area crisis programs	90	90	91	90	91
- Written crisis plan	67	70	62	60	76
- Agreements with crisis programs for rapid access	55	50	62	47	67
- Agreements with withdrawal management prgms	12	10	14	3*	24
Q105: Main challenges:					
- None to report	17	13	24	17	18
- Identifying supports after hours	29	32	24	37	18
- Cooperation from local services	27	29	24	30	23
- Convincing clients to seek help	73	77	67	70	77

Strategies suggested by programs for crisis management:

- Use of in-house crisis service within the sponsoring organization, including providing the crisis service with a written crisis plan for the EPI client.
- Including the client and family in the development of the crisis plan and allowing for ongoing discussion and psycho-education.
- Fostering linkages with community and hospital crisis services to support client and family access.
- Formal documentation for recovery and relapse plans for clients and families that include plans for crisis management

What would help programs in crisis management:

- Additional capacity in community crisis services.
- Providing families with information for rapid access to community crisis services (e.g., telephone numbers, pamphlets and cards).
- More staff time (e.g., smaller caseloads) to educate stakeholders in the community on crisis management for early psychosis.
- Having written crisis plans for clients.

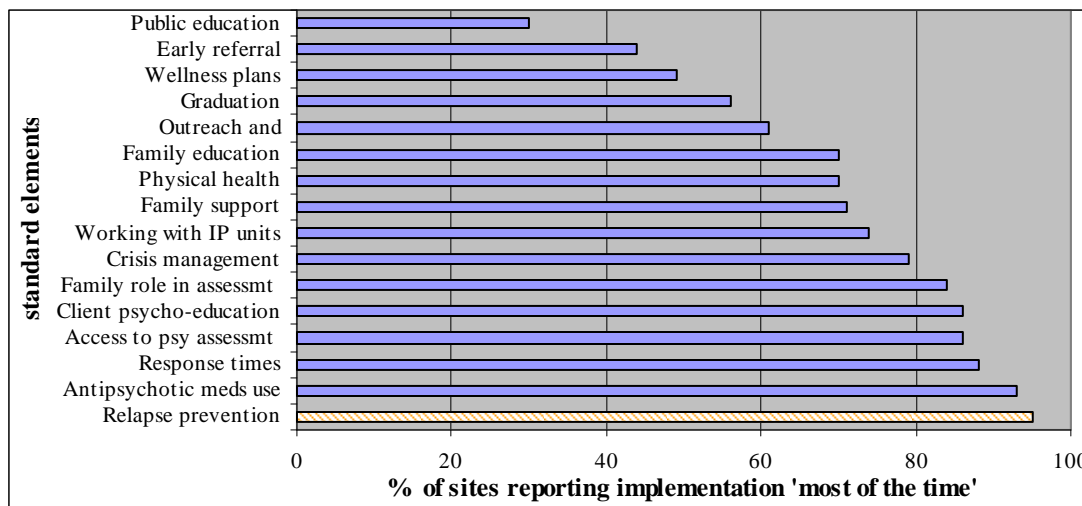
8. Relapse prevention

Standard 3 indicates that programs work with clients and families to identify the client’s early warning signs for relapse as well as strategies to prevent or reduce the severity of a relapse. This element also includes the program having capacity for ongoing monitoring and rapid response if relapse occurs.

Summary of Results:

- Programs reported high rates of implementation, with 96% reporting that they were able to implement this element ‘most of the time’.
- Implementation was high for all program types.
- Social challenges (e.g., unstable housing, social support and finances) may contribute to relapse.
- Continued high level of implementation may be helped by having a written relapse prevention plan for each client that is updated as needed.

Chart 13: Relapse prevention: Implementation* relative to other elements (Q 107)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 24: Relapse prevention: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q107: How often able to implement this element	% sites implementing ‘most of the time’	96	97	95	100	91

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to relapse prevention noted by programs:

- Non-compliance by client and families with medication and treatment.

- Difficulties with client and family engagement, insight and awareness.
- Substance use.
- Unstable housing and social supports, specifically social isolation and lack of connection with community and family.
- Financial stress, including poverty and limited access to benefits and transportation.
- Access to medical personnel limited by travel, long wait lists, availability.

Approaches used by programs for relapse prevention (Table 24):

- Almost all programs provided education to clients and families about early warning signs (98%) and response strategies (92%).
- Many (about 2/3) reported having a protocol for assessing/treating relapse and had assessment tools to monitor symptoms.
- Fewer (1/3) had developed a written plan for each client.
- Some programs reported using blood work and urine tests to measure medication levels and increasing contact with clients.

Table 24: Strategies used for relapse prevention (Q108)

Main strategies for relapse prevention	% used
Education about early warning signs	98
Education about response strategies	92
Protocol for assessing/treating relapse	64
Assess. tools to monitor symptoms	64
Written plan for each client	37

What would help programs to provide relapse prevention?

- Making client/family engagement a high and ongoing priority.
- Developing capacity among all members of the treatment team for rapid response.
- Reduced financial stress on clients/families through access to drug benefits.
- Increasing the client focus on harm reduction, medication adherence, reduced substance use and self and peer identification of symptoms.
- A written relapse prevention plan for each client that is updated as needed after each session.

9. Use of Ontario Telemedicine Network

The Ontario Telemedicine Network (OTN) uses live, two-way videoconferencing systems to deliver clinical care and distance education among health care professionals and to patients in more than 1175 sites across the province. OTN is an independent, not-for-profit organization funded by the Government of Ontario.

Use of OTN was asked in the survey. Use of OTN is not mentioned in the Standards but is a tool for supporting Standards implementation.

Summary of Results:

- About ¼ of program sites are using OTN to support care delivery, with use higher among small sites and those with community agency sponsorship.
- Telemedicine is used more often with psychiatrists (25% of sites) than family physicians (17%), and for one time assessments than ongoing client treatment.
- Other uses for telemedicine include consultations with allied health providers and educational events.

Table 25: When and how often telemedicine used

Survey Question	Response		All Sites	Large	Small	Hospital	Community
Q111: Use OTN	% yes		28	20	38	23	33
Q112: When and with whom is OTN used	One time client assess.	Psychiatrist	25	19	33	23	27
		Physician	4	7	0	3	5
	Ongoing client treat.	Psychiatrist	17	19	14	17	18
		Physician	0	0	0	0	0

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Main challenges to using telemedicine noted by programs:

- Client and family access, especially for community agency sponsored sites, in part due to location and availability after-hours.
- Some sites reported discomfort for clients with the approach.

What would help programs to use telemedicine?

- Available and reliable equipment, with staff trained to use it.
- Dedicated psychiatric resources that could be accessed via OTN for better continuity of care.

Standard 4: Psychosocial Support for the Client

Standard 4 indicates the importance of psychosocial supports to help clients to maintain or resume their usual roles within the community, and to promote hope for the future. Psychosocial care is to be provided consistently and assertively, and tailored to the needs of the client. Supports may be offered within the team or through agreements with local providers of educational, vocational, skills development, housing or other services.

Summary of Results:

Programs were asked about their ability to deliver a range of psychosocial supports. Responses indicated that:

- Most programs are able to provide illness management most of the time.
- About 70% can provide/ensure access to activities of daily living, social relationship and substance use support most of the time.
- Rates were lower for education, income management, recreational, vocational and housing support (about half).
- Only 37% of sites were able to provide or ensure access to self-help or peer support most of the time.
- Psychosocial supports are provided either by internal staff or through referral. Many programs reported that mainstream supports were not appropriate (60%) or available (56%). Internally, programs noted a lack of resources (42%) and staff time (39%), especially for small programs.
- Proactive effort may help to make community specialized services more accessible and appropriate for EPI program clients – this could require area/network level effort.

Table 26: How often able to provide/ensure access ‘most of the time’ (Q 116)

Supports for Clients	% yes
Illness management	89
Substance use service	71
Social relationship development	69
Activities of daily living support	69
Educational support	62
Income management support	60
Recreational support	54
Vocational support	52
Housing support	46
Self-help/peer support	37

Table 27: What would assist in program ability to deliver EPI

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q138: Would your ability to deliver EPI be helped by better access to addiction services	Great deal /fair amt (%)	60	55	67	67	50
Q138: Would your ability to deliver EPI be helped by better access to vocational/training/ education services	Great deal/ fair amt (%)	80	66	100	83	78

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs to provide psycho-social supports:

The Standards identified different approaches for accessing community psychosocial supports for clients, including through formal service agreements with other programs (Table 28).

Related to use of formal agreements with outside providers to access supports:

- About 1/3 of sites had agreements to access housing and substance use services.
- Only 1 in 10 sites had formal agreements to access vocational assessments and training, although despite this, about half indicated that these assessments could be accessed within 3 months if needed.
- Related to vocational assessments, small programs reported fewer formal relationships with community programs and lower access for clients.

Related to accessing academic or vocational assessment:

- Half of program sites can offer clients an academic or vocational assessment within 3 months of referral, but this rate is lower for smaller program sites (33%).
- Reasons not able to offer clients academic or vocational assessment within 3 months: limited capacity within team; limited access in community or use outside resources.

Table 28: Formal agreements with outside provides to access supports and ability to offer academic or vocational assessment

Survey Response	Response (% yes)
Q117: Formal agreements with outside providers to access:	
- Housing supports	37
- Addiction treatment services	37
- Educational programs	21
- Vocational assessments	10
- Vocational training programs	8
Q118: Able to offer academic or vocational assessment within 3 months	52

Main challenges to providing psycho-social supports noted by programs:

- Many programs reported that mainstream supports are not appropriate (60%) or available (56%). Internally, programs noted a lack of resources (42%) and staff time (39%), especially for small programs.

Strategies suggested by programs for providing psychosocial support:

- Use of individualized case management to help client reach goals.
- Ensure range of disciplines on team to deliver range of psychosocial supports – for small programs this might require area/network support.
- Proactive support to help clients connect with community resources (e.g., providing transportation, accompaniment).
- Proactive effort to make community specialized services accessible and appropriate for EPI program clients – this could be area/network level effort.
- Access to research evidence on how to effectively deliver psychosocial support to young people (knowledge to practice).

What would help programs in addressing client psychosocial needs:

- Formalized community partnerships and better access to appropriate resources for clients in the community (e.g., mainstream supports for young people, vocational resources, affordable resources for clients).

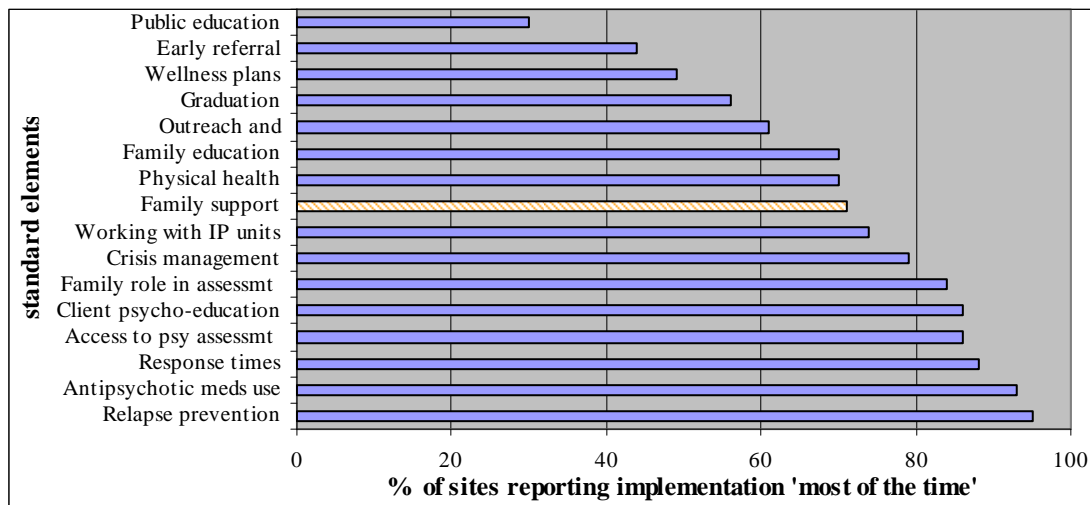
Standard 5: Family Education and Support

Standard 5 indicates that programs support families, using proactive strategies when necessary. The goal is to actively involve the family in the client's care, providing that the client consents and to offer opportunities for families themselves to secure the support that they need. Family education is to include topics such as information about psychosis and symptoms; approaches to treatment and medication; understanding side effects; impact of substance abuse; supporting the client during treatment and recovery; and preventing relapses.

Summary of Results:

- Overall, 71% of sites reported being able to actively involve and support families 'most of the time'; this was more challenging in small programs where 57% implemented 'most of the time'.
- About half of sites have a designated family support worker; others report sharing the responsibilities of this role across several staff members. Small programs were less likely to have a dedicated worker.
- The main challenge was finding time to connect with families (especially after hours) and to organize education and peer support activities.
- Greater use of technology (e.g., social networking sites, websites, E-mail, chat rooms) could be explored to improve engagement with families.

Chart 14: Family education and support: Implementation* relative to other elements (Q 123)



* % programs reporting implementation 'most of the time' versus 'some of the time' or 'not too often'.

Table 29: Family education and support: Implementation by program type

Survey Question	Response	All Sites	Large	Small	Hospital	Community
Q123: How often able to implement this element	% sites implementing 'most of the time'	71	80	57	76	64

Large: catchment area population > 100,000 population (31 program sites)

Small: catchment area population < 100,000 population (21 program sites)

Hospital: hospital is parent organization (30 program sites)

Community: community agency is parent organization (22 program sites).

Approaches used by programs for supporting families (Table 30):

- About half (47%) of sites reported having a designated family support worker, with others reporting a distributed role (26%) or other arrangement (27%). Small programs were less likely to have a dedicated worker (33%). Other approaches included designating a partial clinical staff role for supporting families, or referring families to other community services.
- Few reported conflict of interest concerns when the same staff serves both clients and their families.
- Strategies to connect family members with other families included: referring family members to family groups (92%); connecting families through retreats, conferences and workshops (73%); linking with another individual family (47%); telemedicine (16%); encouraging participation in EPI program advisory committees (20%); E-mail and chat rooms (10%).
- Use was similar across program types.

Table 30: Strategies to connect families with other families (Q 126)

Strategies	% used
Referral to family groups	92
Retreats, conferences, workshops, etc.	73
Link with another individual family	47
Participation in EPI program advisory committee	20
Telemedicine (e.g., OTN)	16
E-mail/chat room	10

Main challenges to family support noted by programs:

- Almost three quarters of program sites were challenged to find time to connect with families that are difficult to reach. Sites also reported distance (54%) and time to organize education and peer support activities (42%) as main challenges to working with families.
- Other challenges include, limited staffing resources; availability of family members; family readiness and limited resources within family to support client (e.g., stigma, denial and low-functioning family); limited engagement between family and client and client not wanting family involvement.

Table 31: Main challenges to family involvement and support (Q 127)

Main Challenges	% yes
Time to connect with families	73
Distances	54
Time to organize education and peer support	42
Finding resources	19

Strategies suggested by programs for supporting families:

- Family-centered programming.
- One-on-one contact with families, which could include providing a different case manager when needed for family and client.
- Dedicated family workers.
- Use of OTN to connect families, especially when travel is an issue; OTN can be used to hold family forums and for regular family peer support sessions.

What would help programs in supporting families:

- Time and staffing resources-helpful to have clinician start earlier/work later to connect with families during off times
- Resources for engaging families such as increased use of technology (e.g., social networking sites, websites, E-mail, chat rooms), more family-friendly recovery-based educational materials and materials in different languages
- Families allow their education and support to be a priority.

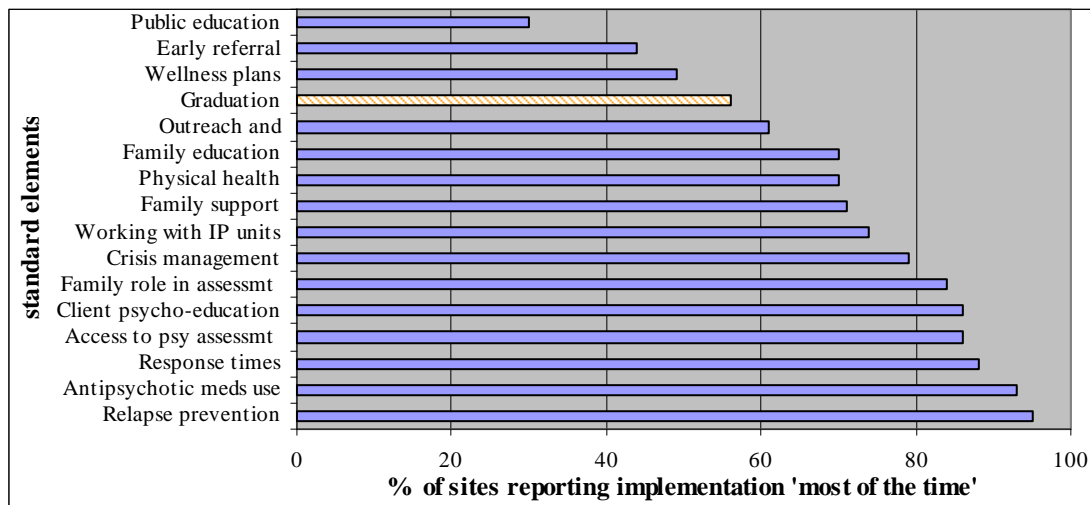
Standard 6: Graduation from the Program

Standard 6 indicates that EPI is designed to be a time limited service. Most clients will stay for up to 3 years and when they graduate, they should be linked to the least intensive and least intrusive level of care required to meet their ongoing needs.

Summary of Results:

- Implementation of this Standard was lower, with only 56% of sites implementing ‘most of the time’. This element was a challenge across all sites.
- About a third of programs reported that over 25% of current clients had been in the program for more than 3 years, and the portion was greater for community than for hospital sponsored sites (47% versus 21%).
- Upon program graduation, clients are mainly referred to primary care, outpatient psychiatry services and - especially among community sponsored programs - case management.
- Clients may be referred to services within the same organization.
- The main challenges to transferring care at the end of 3 years included the lack of appropriate alternatives and clients not being ready to leave.
- Allowing more flexibility in the length of time clients can remain in the program was raised. Also suggested was providing a step-down/transition option, and exploring shared care options with PC physicians.

Chart 15: Graduation from the program: Implementation* relative to other programs (Q 130)



* % programs reporting implementation ‘most of the time’ versus ‘some of the time’ or ‘not too often’.

Table 32: Client referrals as part of discharge planning (Q 133)

Where are clients referred post discharge	% programs referring clients often to ...
Case management	31
PC providers only	29
Outpatient psychiatry	25
College or university MH services	8
Other community MH agency	8
Other comm. addictions agency	6
ACT team	4

Main challenges to client graduation within 3 years noted by programs (Table 33):

- Programs noted lack of appropriate alternatives (67% of sites), clients not being ready to leave (65%) and staff not ready to let go (12%).
- Specific challenges noted:
 - Difficulty transferring clients to new services due differences in care, inconsistent follow-up or loss of contact with client.
 - Clients who do not meet eligibility criteria for other services or the referral process is unclear, complex or lengthy.
 - Long wait times for other services, especially community services, case management, and psychiatry.
 - Also noted were concerns about relapse.

Table 33: Reasons clients stay longer than 3 years (Q 132)

Reasons clients stay > 3 yrs.	% yes
Lack of appropriate alternatives	67
Clients not ready to leave	65
Staff not ready to let go	12

Strategies suggested by programs for client graduation:

- Planning ahead with clients and their families, which can be done using a discharge protocol and providing written materials to support the protocol
- Beginning referrals in advance of discharge.
- Alumni program activities, either through a graduation celebration for clients and peer support opportunities or by using a shared-care model with PC physicians
- Programs provide consultation support (some for more than a year) to providers who are working with discharged clients, and 1/4 offer an alumni program, although no sites in small catchment area sizes offer this option.

What would help programs with client graduation:

- Almost all programs (87%) said that more services for graduating clients would help their delivery of EPI.
- Access to information about community resources, for example a centralized access registry of community providers accepting graduated clients.
- Peer support workers who can help clients with the transition process.

- An alumni program and services, which could include recognition ceremonies and the ability to buy graduation gifts or provide a “step down” period similar to Assertive Community Treatment (ACT).
- Flexibility in the EPI Standards, such as having more time before clients need to graduate, having a formal process to creating an alumni program, establishing criteria for connection.
- Improved collaboration between EPI program and community services.
- More capacity re: appropriate services, especially in the community, for example, a young adult ACT team and more recovery-based and family friendly services.

IV Next Steps

This report is intended to support quality improvement work related to implementation of the Ontario Ministry of Health and Long Term Care EPI Program Standards in Ontario.

Dissemination of the Report

The Standards Implementation Steering Committee (SISC) plans to make the full version of this report available electronically to all EPI programs in Ontario. In addition all programs included in the survey are receiving a shorter report which allows them to compare their data to that of other programs in their network (if applicable) as well as to the provincial mean.

Each LHIN will receive the executive summary of the report, main messages, and data for the programs in their jurisdiction. SISC members will meet with the mental health leads from the LHINs to brief them about the findings and discuss implications. The full report will also be available to the LHINs and the Ministry.

Sector Consultation

SISC members will convene opportunities through regular OWG meetings, regional network meetings and the annual conference to consult with EPI practitioners and program staff and discuss the findings of the report. Topics for consideration include:

- Using the findings as a tool to identify opportunities for improving or enhancing clinical practice
- Identifying ways that program networks can further support individual programs in implementing the Standards
- Identifying priority projects and actions for the OWG to undertake to support Standards implementation
- Facilitating opportunities to work with LHINs and the Ministry on issues related to Standards implementation
- Sharing feedback on Standards implementation and action steps through the OWG.

Knowledge Transfer

As there is little literature to date on supporting system-wide implementation of EPI Standards in any jurisdiction, the SISC recognizes the importance of sharing the findings of this study provincially, nationally and internationally. SISC members are identifying opportunities for knowledge transfer such as journal articles, webinars, and conference presentations. The first opportunity is a poster presentation at the International Early Psychosis Association conference in San Francisco in October 2012.

Topics for Further Investigation

The survey findings suggest the need to further explore a number of topics, including:

- Opportunities to define and share practice protocols related to implementation of specific Standards elements
- Opportunities for centralized supports such as educational tools, training, and outreach
- The nature and function of program networks among EPI programs in Ontario
- Models of service delivery for family work and an assessment of the challenges and opportunities related to implementing Standards related to family work
- The availability of client level data

Further, the SISC has identified the need to plan for a second phase of this process to look at the seven EPI Standards that were not included in this study.

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Appendix A:

Participating EPI program sites by LHIN & network affiliation (n=52)

Program Location	Service area LHINs	EPI program name	Sponsoring organization name	Sponsoring organization type	Network Affiliation	Network name
LHIN 1						
Chatham	1	Today Not Tomorrow (TNT)	Chatham Kent Health Alliance	Hospital	None reported	
Windsor-Essex County Branch	1	Early Intervention Program	Canadian Mental Health Association	Community agency	None reported	
LHIN 2						
Elgin	2	PEPP Elgin	Canadian Mental Health Association	Community agency	Yes	Prevention & Early Intervention in Psychosis (PEPP)
London	2	Prevention and Early Intervention Program for Psychoses	London Health Sciences Centre	Hospital	Yes (hub*)	Prevention & Early Intervention in Psychosis (PEPP)
Owen Sound	2	Prevention and Early Intervention Program for Psychosis (PEPP)	Grey-Bruce Health Sciences	Hospital	Yes	Prevention & Early Intervention in Psychosis (PEPP)
Oxford	2	Prevention and Early Intervention Program for Psychosis (PEPP)	Woodstock General Hospital	Hospital	Yes	Prevention and Early Intervention in Psychosis (PEPP)
LHIN 3						
Cambridge	3	1 st Step	Trellis Mental Health and Developmental Services	Community agency	Yes	Trellis Mental Health and Developmental Services
Fergus, Mount Forest	3, 5	1 st Step	Trellis Mental Health and Developmental Services	Community agency	Yes	Trellis Mental Health and Developmental Services
Guelph	3	1 st Step	Trellis Mental Health and Developmental Services	Community agency	Yes	Trellis Mental Health and Developmental Services
Kitchener	3, 5	1 st Step	Trellis Mental Health and Developmental Services	Community agency	Yes (hub*)	Trellis Mental Health and Developmental Services
LHIN 4						
Caledonia, Simcoe, Townsend	4	Early Psychosis Intervention	Community Addiction and Mental Health Services of Haldimand & Norfolk (CAMHS)	Community agency	Yes	Cleghorn
Hamilton	4	Cleghorn Program	St. Joseph's Healthcare Hamilton	Hospital	Yes (hub)	Cleghorn
Ohsweken	4	Cleghorn	Six Nations Mental Health Program	Community agency	Yes	Cleghorn
Niagara	4	West Niagara Mental	West Lincoln	Hospital	Yes	Cleghorn

		Health	Memorial Hospital and St. Joseph's Healthcare Hamilton			
Thorold	4	Early Intervention Niagara Region/Community Mental Health Program	Niagara Region	Community agency	Yes	Cleghorn
LHIN 5						
	See LHIN 3					
LHIN 6						
Acton, Georgetown, Milton	6	Phoenix	Region of Halton Healthcare Department-Community Health Services	Hospital	Yes	Phoenix
Burlington	4	Halton Phoenix Program-JBMH site	Joseph Brant Memorial Hospital Corporation	Hospital	Yes	Phoenix
Burlington, Oakville, Acton, Georgetown, Milton	4, 6	The Phoenix Program-Early Intervention Service	Halton Healthcare Services	Hospital	Yes (hub)	Phoenix
Mississauga	6	First Assessment Clinical Team (FACT) Peel	Centre for Addiction & Mental Health	Hospital	Yes	Toronto Early Intervention in Psychosis Network
LHIN 7						
Toronto	7	Early Intervention Clinic for Affective Psychosis	Centre for Addiction and Mental Health	Hospital	Yes	Toronto Early Intervention in Psychosis Network
Toronto	7	First Episode Psychosis Clinic (FEPC)	Centre for Addiction and Mental Health	Hospital	Yes	Toronto Early Intervention in Psychosis Network
Toronto	7	Home Intervention for Psychosis Program (HIP)	Centre for Addiction and Mental Health	Hospital	Yes	Toronto Early Intervention in Psychosis Network
Toronto	7	New Outlook Early Intervention Program	Central Toronto Youth Services (CTYS)	Community agency	Yes	Toronto Early Intervention in Psychosis Network
Toronto	7	STEPS for Youth	St. Michael's Hospital	Hospital	Yes	Toronto Early Intervention in Psychosis Network
LHIN 8						
Toronto/North York	8	MOD Early Intervention Program	Canadian Mental Health Association	Community agency	Yes	Toronto Early Intervention in Psychosis Network
York Region, Aurora	8	Help Overcome Psychosis Early (H.O.P.E.)	Canadian Mental Health Association	Community agency	Yes	Toronto Early Intervention in Psychosis Network
LHIN 9						
Toronto	9	Culturally Oriented Psychosis Education and Early Intervention (COPE)	Community Resource Connections of Toronto (CRCT)	Community agency	Yes	Toronto Early Intervention in Psychosis Network
Scarborough	9	First Intervention Treatment Team (F.I.T.T.)	Rouge Valley Health System	Hospital	Yes	Toronto Early Intervention in Psychosis Network

Campbellford	9	Lynx	Campbellford Memorial Hospital	Hospital	Yes	Lynx
City of Kawartha Lakes, Lindsay	9	Lynx Early Intervention	Ross Memorial Hospital-Paymaster CMHA Peterborough	Hospital	Yes	Lynx
Cobourg	9	Lynx Early Psychosis Intervention Program	Northumberland Hills Hospital	Hospital	Yes	Lynx
Minden	9	Lynx Early Psychosis Intervention	Haliburton Highlands Health Services Corporation	Hospital	Yes	Lynx
Peterborough	9	Lynx	Peterborough Regional Health Centre	Hospital	Yes	Lynx
Whitby	9	Durham AMAZE EPI Program	Lakeridge Health Corporation	Hospital	None reported	
LHIN 10						
Belleville, Napanee	10	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program	Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston	Hospital	Yes	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program
Brockville, Smith Falls	10	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program	Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston	Hospital	Yes	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program
Kingston	10	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program	Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston	Hospital	Yes (hub)	Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program
LHIN 11						
Hawkesbury	11	On Track	Centre Royal Comtois Centre/ Hôpital Général de Hawkesbury and District General Hospital Inc.	Hospital	Yes	On Track
Ottawa	11	On Track	The Ottawa Hospital	Hospital	Yes (hub)	On Track
Pembroke	11	On Track-Community Mental Health Services First Episode Program	Pembroke Regional Hospital-Community Mental Health	Hospital	Yes	On Track
LHIN 12						
Barrie	12	Youth Experiencing Success (YES)	Canadian Mental Health Association	Community agency	None reported	
Bracebridge, Huntsville, Muskoka	12	Early Intervention Psychosis	Muskoka-Parry Sound Community Mental Health Service	Community agency	Yes	*Parent organization has linkage with Northeast Regional Program
LHIN 13						
Cochrane Iroquois Falls	13	Early Intervention in Psychosis	Minto Counselling Centre	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Cochrane Timiskaming/ Timmins	13	Early Intervention in Psychosis	Canadian Mental Health Association	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis

Englehart, Kirkland Lake, New Liskeard	13	Regional Early Intervention in Psychosis	Timiskaming Health Unit	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Hearst, Kapusksasing	13	Early Psychosis Intervention	Hearst Kapuskasing Smooth Rock Falls Counselling Services/Services de counselling de Hearst, Kapuskasing	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Moosonee	13	Early Episode Psychosis Program	Weeneebayko Health	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
North Bay	13	District Early Intervention in Psychosis	North Bay Regional Health Centre	Hospital	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
North Bay	13	Regional Early Intervention in Psychosis Program	North Bay Regional Health Centre	Hospital	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Sault Ste. Marie	13	Strategies for Treatment of Early Psychosis (S.T.E.P.)	Sault Area Hospital	Hospital	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Sudbury	13	Health Sciences North/Horizon Santé- Nord	Health Sciences North-Early Psychosis Intervention Program	Hospital	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
Parry Sound, Sundridge	13	Early Intervention Psychosis	Muskoka-Parry Sound Community Mental Health Service	Community agency	Yes	Northeast Regional Program (NBRHC) Early Intervention in Psychosis
LHIN 14						
Thunder Bay	14	First Place Clinic & Regional Resource Centre	Canadian Mental Health Association	Community agency	None reported	
FAMILY PROGRAMS						
Toronto	7	Ask the Expert: Early Intervention Family Support Group	Schizophrenia Society of Ontario	Community agency		
Toronto	7	Family and Youth Program	Mood Disorders Association of Ontario	Community agency		
Toronto	7, 9	Family Outreach and Response Team (FOR)-with Haste	Community Resources Connections of Toronto	Community agency		