EPION

EARLY PSYCHOSIS INTERVENTION ONTARIO NETWORK

After Release of the Ontario Early Psychosis Intervention (EPI) Program Standards:

Results of the 2014 EPI program survey of current practices in relation to the Standards

Executive Summary

A project of the Standards Implementation Steering Committee

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camh PSSP Provincial System Support Program

The Early Psychosis Intervention Ontario Network (EPION) is a province-wide volunteer network of service providers, persons with lived experience, and families. EPION currently includes over 50 programs and satellite partners across Ontario. The network facilitates collaboration, training, resource sharing, and quality improvement efforts. EPION is funded by the Ministry of Health and Long-Term Care. For more information, visit http://epion.ca/ or http://eenet.ca/the-early-intervention-in-psychosis-for-youth-community-of-interest/.

Executive Summary

Background and Ontario Context

In 2011, the Ministry of Health and Long-Term Care (the Ministry) released the *Ontario Early Psychosis Intervention Program Standards*[1] to support consistency and quality in the delivery of early psychosis intervention (EPI). Approximately 3% of the population will experience an episode of psychosis in their lifetime and, for the majority, it will occur between the ages of 14 and 35.[2]

The EPI model targets this age group, consistent with Ontario's commitment to early intervention (Pillar 2 of the Comprehensive Mental Health and Addiction Strategy[3]). The model builds on input from families and service users, and reflects evidence-based assumptions and care components as follows:

- The early phase of psychosis is a critical period, with a high risk for complications such as isolation from family and friends, suicidal acts, substance use, and dropout from school and work.[4]
- Engaging young people earlier in treatment (i.e., reducing the duration of untreated psychosis) is associated with reduction of symptoms and improved functioning at 6, 12 and 24 months after treatment initiation.[5]
- The core features of the EPI model include an interdisciplinary treatment team, low caseloads (i.e., 10 to 15 clients per staff), assertive outreach to engage youth, and delivery of support in a low-stigma, youth-friendly setting.[6]
- The model offers both medical interventions (e.g., medication management, physical health monitoring) and psycho-social interventions (e.g., psycho-education, employment support, addictions treatment) to help young people stabilize their symptoms and re-establish or maintain their roles in the community.[7]
- Families are supported and, with client agreement, included in the treatment process.
- Compared to standard treatment, clients using specialized EPI services show better outcomes after 2 years, with lower severity of symptoms and fewer hospital admissions. They stay in care longer, are more satisfied with treatment, and are more likely to receive psychosocial interventions.[8,9,10]

The EPI model has been implemented in a number of countries[11] and a consensus statement on the model was released in 2005 by the World Health Organization and International Early Psychosis Association.[12] In Ontario the number of EPI programs has grown from five in 2004 to over 50 today. The growth of EPI has been supported by the Early Psychosis Intervention Ontario Network (EPION), an active volunteer network that includes over 50 EPI programs as well as consumers, family members, decision makers, and researchers.

The *Ontario Early Psychosis Intervention Program Standards* outline 13 practice domains that constitute delivery of the model. These standards are based on international guidelines and the best available evidence, and they are tailored to the Ontario context. For example, while a stand-alone multidisciplinary specialist team is advocated as the gold standard to deliver EPI, a full team is not

always feasible in more dispersed population areas.[13] To help address this challenge in Ontario, the standards recommend that EPI programs form service delivery networks so that, together, they can deliver the full model. There is no specific network arrangement recommended. Rather it is suggested that arrangements be adapted to the needs of the local programs and setting.

Supporting EPI Standards Implementation in Ontario

After the Ontario standards were released, the Ministry established a *Standards Implementation Steering Committee* (SISC). Over the past decade there has been increasing recognition that active support is required to implement and sustain evidence based practices in routine practice.[14] The SISC is currently a standing working group within EPION. SISC members include representatives of EPI programs, the Local Health Integration Networks (LHINs), the Ministry, and the Centre for Addiction and Mental Health (CAMH). CAMH is assisting with planning, monitoring, and other activities to support implementation of the standards.

The Terms of Reference for the SISC include immediate aims of learning about current program practices, gaps, and support needs in relation to the standards. Longer term aims pertain to developing measures and a formal structure to monitor and evaluate program performance.

To date, the SISC has focused on examining current practice. A 2012 survey sought feedback from programs on the first six practice domains, which pertain to service delivery (i.e., early identification, assessment, treatment, psychosocial support, family support, and transition to other services). Survey topics included adherence to the standards, implementation strategies, and areas where more support was needed. Fifty-two EPI program sites completed the survey (92% participation). The final report can be found at http://eenet.ca/wp-content/uploads/2012/12/EPI-Program-Survey-Final-Report-October-2012-pdf-pdf.pdf.

Some key findings include:

- There was variation across the programs in extent of implementation of the components of EPI.
- Many respondents reported having difficulty implementing outreach to promote early detection and transitioning clients to other needed services and supports.
- Suggestions for improvement included developing written protocols to support more consistent delivery of care, central development and sharing of tools and resources, and collaboration on tasks such as community education and referral networks.
- Small programs, with two or fewer clinical full-time equivalent (FTE) staff represented 40% of all program sites and mainly served rural areas.
- Small programs reported moderate to high rates of delivery of multiple EPI components. Still, implementation was generally lower than for large programs, and medical components (e.g., medication or metabolic monitoring) were particularly challenging to deliver.

EPION shared the survey results with EPI programs across the province, LHINs, and academic audiences. The results also helped to generate stakeholder think tanks on community education and outreach, metabolic monitoring, psychological interventions, family work, and knowledge exchange.

2014 EPI Program Key Informant Survey Results

In 2014, EPION conducted a second survey to obtain feedback on the remaining seven standards. These pertain to practices to support high quality service delivery (i.e., training and education, evaluation, barrier-free delivery, and network collaboration) and compliance with regulatory requirements (i.e., record keeping, complaints resolution, and accountability reporting).

Program sites funded by the LHINs to deliver the full EPI model[15] were invited to complete the survey. All 56 program sites responded (100% response rate), showing high sector engagement in efforts to improve quality of care.

Survey results are available at http://eenet.ca/products-tools/implementation-of-early-psychosis-intervention-program-standards-in-ontario-results-from-a-provincial-survey/. Some key findings include:

EPI program capacity

- 220 clinical staff members provide EPI services to almost 4000 clients across the province.
- Programs vary widely in size, from a single service provider working in a rural area to interdisciplinary teams of 15 staff operating in highly populated urban areas.
- 25 EPI program sites have two or fewer clinical FTEs and rely on varying arrangements with other programs to deliver the EPI services (see section on Networks).
- Average caseloads of 21 clients per clinical staff are higher than the recommended 10 to 15.
- These capacity issues can limit time for clinical and other essential activities mandated by the standards.
- Learning more about EPI program clients, their length of time in the program, and their pathways in and out of EPI can inform efforts to understand how program capacity aligns with population needs and resource allocations in Ontario.

Training

- Programs are actively using a variety of training and education activities to prepare their staff to deliver EPI.
- Still, more training time and resources are desired, given the complexity (e.g., multiple components) of the model, the continually expanding evidence base, and the challenges of staff turnover and multiple program sites.
- Future training could support implementation of specific practice protocols and include systematic feedback on training effectiveness.
- As well, developing and sharing core training resources such as new staff orientation could achieve some efficiencies and consistency across programs.

Monitoring and Evaluation

- Overall, this was the standard where programs reported the lowest rates of use and the most challenges.

- While many programs regularly collect data on client outcomes, they need more time and expertise to use the data for monitoring and to improve service delivery. Few programs have a designated support person for monitoring and evaluation, or a written evaluation plan.
- At the same time, programs described some creative and effective uses of data, including to advocate for more program resources, to motivate staff by providing feedback on client outcomes, and to inform improvements to quality of care.
- Regular reporting of quality indicators can inform programs' improvement activities and discussions with LHINs about the service they are providing.

Barrier-free Service and Health Equity

- This standard is concerned with program access for groups who are often excluded, for example, those facing language, culture, or economic barriers. Equity has been identified as a key component of quality of health care in Ontario.
- However, the use of strategies to improve access and responsiveness of care was inconsistent and only one-third of programs were regularly monitoring and reporting on their performance.
- Some programs wanted more clear policies and support to offer services to specific groups, including First Nations communities and individuals with developmental disabilities.
- Setting access goals and regular reporting can make health equity monitoring more systematic and inform efforts to address gaps in access and responsiveness of care.

Networks

- Most provincial EPI programs (95%) are part of a network, which provide a number of supports, including access to specialist consultation, training, tools and other materials. Networks are particularly important for small programs, enabling them to deliver EPI outside of the province's large urban centres.
- Challenges faced by networks include communication, inconsistent availability of services across sites, and time requirements.
- Follow-up can help us further understand the range of EPI network arrangements in the province and explore how network benefits can be enhanced.
- Strategies used to deliver EPI services by programs that are not part of a network were not examined in the survey and need to be explored.

Accountability

- Many programs have implemented or are developing a process to review their compliance with the standards.
- Reporting relationships and communications between LHINs and programs regarding compliance with the standards varies widely across the province.
- The standards provide a foundation for developing more consistent and effective strategies to communicate with the LHINs.

Small programs

- Delivery of the EPI model in more rural and less populated areas is an internationally recognized challenge.[16]
- About 45% of EPI programs are operating with 2 or fewer clinical FTEs, and all rural areas are served by small programs.
- The survey identified few systematic differences between large and small EPI programs in their implementation of training, evaluation, barrier-free access, and strategies to support compliance with regulations. As intended, small programs reported much higher use of and benefit from network involvement.
- Approaches to rural delivery of EPI may be of interest to other jurisdictions and can inform efforts to improve the reach and quality of EPI care in Ontario.

Survey Limitations

- The results of this survey represent the perceptions of the respondents and may not align with the views of other program staff.
- Excluded from the survey were programs that do not intend to deliver the full EPI model (e.g., educational or step-down programs) or that exclusively serve families.
- Responses represent a high-level view; follow-up is required to obtain more in-depth understanding of current practices.

Next Steps

The standards provide a foundation on which to build quality improvement and accountability activities. The two surveys conducted by the SISC represent an initial effort to engage the EPI program sector and obtain basic information.

Results will be shared with programs and quality improvement opportunities will be explored. EPION has already hosted a number of think tanks and formed working groups to examine areas identified as challenges and lead improvement projects (e.g., for metabolic monitoring, public education, and school outreach).

EPION and the SISC are at the beginning stages of developing ways to communicate more effectively with the LHINs, building on provincial mental health and addictions priorities and the needs of EPI programs. They are also beginning work to develop, in collaboration with stakeholders, a formal structure for monitoring program performance. Longer term aims are to support program improvement and the sustainability and currency of the standards.

References

[1] Ministry of Health and Long-Term Care. *Ontario Early Psychosis Intervention Program Standards.* 2011 http://www.health.gov.on.ca/english/providers/pub/mental/epi_program_standards.pdf

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[9] Lester et al., 2009

[10] Bird et al., 2010

[11] McGorry PD, Killackey E, Yung A. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 2008; **7**: 148–56.

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[14] Fixsen DL, Blase KA, Naoom SF, Wallace F. Core Implementation Components. *Research on Social Work Practice* 2009; 19: 531-540

[15] Excluded were a small number of programs that did not deliver the full model (e.g., educational or step down programs) or provided care exclusively to families.

[16] Murphy & Brewer, 2011