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A

GENERAL CONSIDERATIONS

TREATMENT

A. 1. TREATMENT OVERVIEW

AN OVERVIEW OF THE MODEL:

PEPP utilizes an assertive case management model, modified to suit the needs of mostly young people and their families, as its central framework and all aspects of assessment and treatment operate through this framework (See Figure 2).

The model involves a comprehensive approach with intensive medical and psychosocial management being provided by a nurse case manager (or social worker). In essence, a case manager walks the client through the mental health system, though whenever possible, relying on generic community services to reintegrate the young adult to his/her full potential over a two-year follow-up period. This model includes a close partnership with families.

The majority of case managers are registered nurses who often hold degrees in other social science programs. Professionals from other disciplines such as social work can be effective case managers and bring a unique set of skills to bear on their own work as well as that of other case managers. However, individuals from non-nursing disciplines must be prepared to take some ownership to provide comprehensive care including an involvement in monitoring of psychopathology and medical management. The case manager should possess a sophisticated level of knowledge in psychiatric disorders, particularly severe mental illness. It is equally important for case managers to be aware of and knowledgeable about the developmental stages of adolescence and young adulthood. Recognizing that adolescent turmoil is a normal stage of growth and development will help the clinician maintain perspective while working with youth who have experienced psychosis. Flexibility in work style is also a necessary characteristic as the model of care incorporates outreach, both direct and liaison contact on hospital units, as well as providing screening, assessment and treatment in the clinic setting, client's home, school or workplace. The case manager must work closely with other members of the interdisciplinary team on a formal and informal basis.

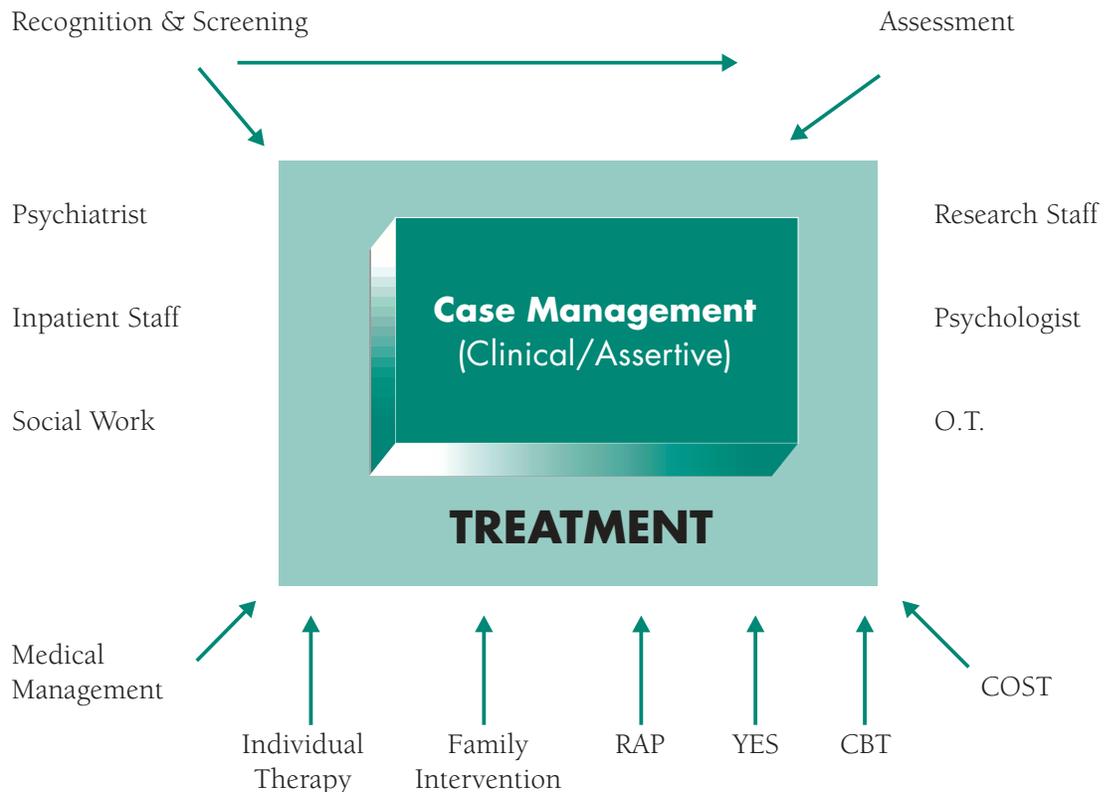
A. 2. ENGAGEMENT & THERAPEUTIC RELATIONSHIP

The case manager's role includes the functions of assessment, treatment and working through patient's recovery from a first episode of psychosis. Needless to say, the therapeutic relationship that develops throughout the two year follow-up is essential to each of these functions. Involvement in the direct delivery of one or more specific psychosocial group interventions is an important component of a case manager's role. An overview of each of the functions, including group interventions, follows:

A strong working relationship with the client is essential to the process of recovery and reintegration. It is likely that the client will have more contact with the case manager than with any other member of the interdisciplinary team. The case manager plans with the client and family, coordinates, and directly delivers a major portion of the care to the client and family. The case manager sees the client through states of acute symptomatology to full recovery with all the intervening ups and downs in achieving that goal.

The working alliance is nurtured from the very first contact, even though the client may be in a state of acute psychosis. All other interventions at this point are secondary to the respect, acceptance and understanding shown to the client. This is a difficult task as many clients and families will reject and sometimes deny any need for intervention. It is often through the ongoing and patient efforts of the case manager that treatment is initiated and maintained. Through ongoing dialogue and instrumental help from the case manager, the client is likely to develop trust and begin to confide personal concerns and experiences.

Figure 2



Confidentiality must be respected and maintained even though family involvement is necessary for a successful outcome. Goals articulated by the client and supported by the case manager and family are more likely to be successful than those articulated by the treatment team. However case managers must empower clients to make informed decisions by providing ample opportunities for learning and open discussion about psychosis with the treatment team and their own families.

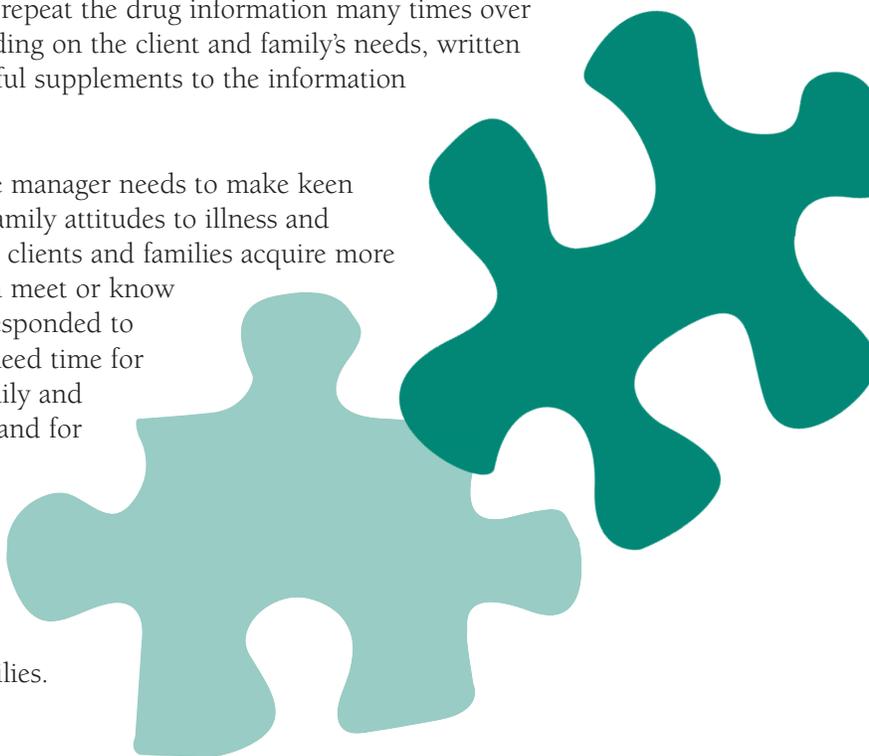
The case manager acts as the liaison between the psychiatrist and client, and is, therefore, in the position of reinforcing medical treatment recommendations, particularly medication. Case managers also advocate for the client bringing his/her difficulties and concerns to the psychiatrist. As well, the case manager can often find him/herself in the middle of family concerns and issues. In this situation, the case manager must be careful to acknowledge the client as his/her first priority. The strength of the therapeutic relationship is deepened through the case manager taking a very active role in helping the client acquire the necessary skills to negotiate the demands of the adult world.

A. 3. INITIATING DISCUSSION ABOUT TREATMENT

An obvious and important topic of discussion centres around the need for antipsychotic medication to treat the symptoms. Clients and families are often hesitant and wary, or have a divided view about the need for medication. The case manager's role in medical management begins with this discussion. It is his/her role to educate the client and the family about medication, after the issue of drug management is introduced by the psychiatrist.

The case manager may need to repeat the drug information many times over to the client and family. Depending on the client and family's needs, written and video information are helpful supplements to the information given by the doctor.

During the assessment, the case manager needs to make keen observations about client and family attitudes to illness and medication. For example, some clients and families acquire more trust and confidence if they can meet or know about other clients who have responded to medication, while others may need time for further consideration. Each family and client response may be unique and for that reason the case manager adjusts his/her skills to the specific situation. If case managers are knowledgeable about medications and side effects, they remain credible with their clients and their families.

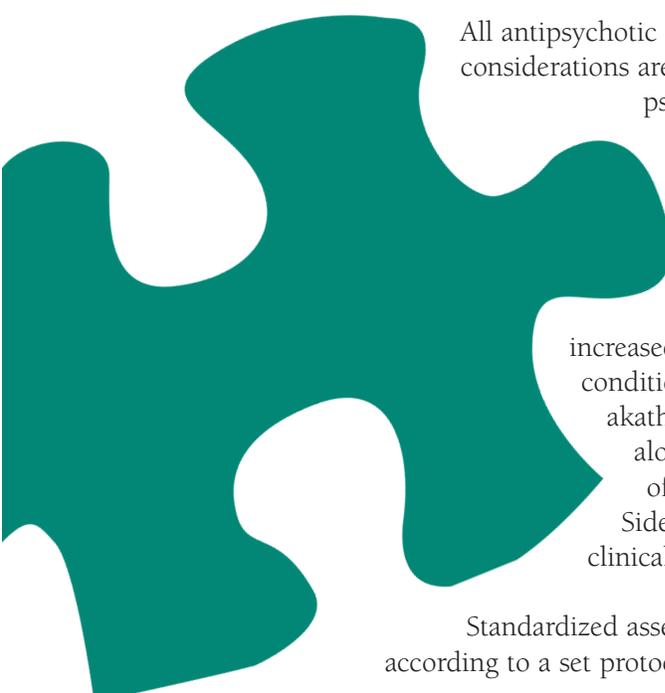


B

MEDICATION MANAGEMENT

Treatment usually begins with the initiation of antipsychotic medication. For those clients who initially refuse drug management, the case manager continues to provide support and education to the patient and family. The choice of antipsychotic medication is established through a treatment protocol (see Figure 3) which is explained to the client and family by the psychiatrist.

Antipsychotic therapy is the cornerstone of treatment of psychosis. While necessary, antipsychotic drugs are not sufficient in themselves to treat psychosis and must be integrated with other (psycho-social) treatments (described under section C).



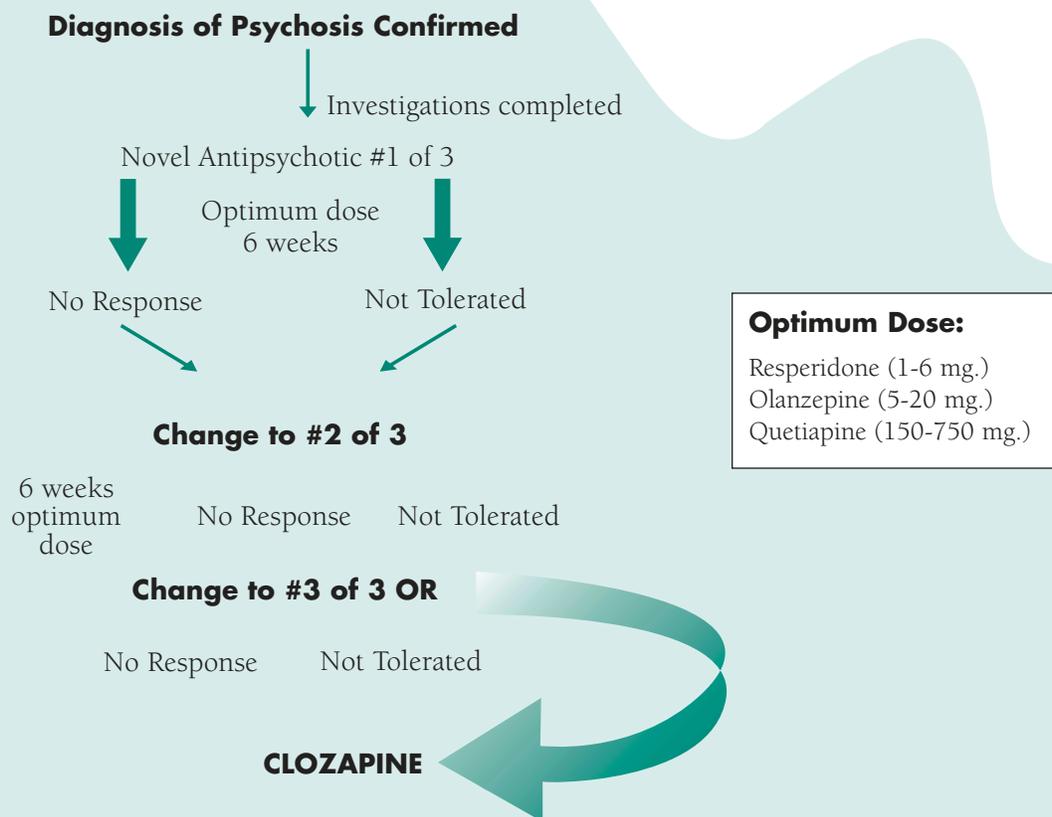
All antipsychotic drugs are more or less equally efficacious. However, special considerations are necessary when treating individuals with a first episode of psychosis, most of whom are young, and have never been exposed to these powerful agents. In order to avoid immediate discomfort associated with motor side effects and dysphoria associated with typical antipsychotic drugs, low doses of novel antipsychotic drugs are advised to be the first choice. In the PEP Program, patients are started on as low as 0.5 mg to 1 mg of Risperidone (or equivalent doses of other novel antipsychotics) and gradually increased to 2 mg a day over several days depending on patient's clinical condition and ability to tolerate the drug without any discomfort (such as akathisia). Novel antipsychotic drugs are used according to the protocol algorithm attached (see Figure 3). Initial treatment is started with one of the novel antipsychotic drugs (usually risperidone or olanzapine). Side effects are monitored closely for both in and outpatients by all clinical staff involved (in particular their case managers).

Standardized assessments for rating of symptoms and side effects are conducted according to a set protocol at regular intervals (see assessment protocol).

B. 1. PROCEDURE

If the patient is started on an antipsychotic medication on an outpatient basis and if this is the very first dose of an antipsychotic, the case manager keeps in close contact with the client. The case manager will then follow-up with a visit and telephone calls for the next few days. In the early stages of treatment, the majority of the case manager's time is spent helping the client and family adjust to the issues around antipsychotic medication including symptom relief, side effects, compliance, etc. After initiating antipsychotic therapy a patient is assessed by the psychiatrist in collaboration with the case manager weekly for the first two to four weeks and then biweekly for the first two months. The frequency of assessment by the psychiatrist is then reduced to once a month if clinically feasible. Although there is a recommended schedule for review of medications, the psychiatrist will see the patient as often as is seen clinically desirable.

The case manager's attitude and knowledge of the medication is of great importance for a number of reasons. Firstly, families and clients have unlimited access to the case manager and s/he, therefore, is their primary contact for obtaining the help and information they need. Secondly, the case manager plays an instrumental role in monitoring and occasionally administering the medications throughout the follow-up period. Enquiries about side effects are made on a regular basis. Thirdly, families and clients often feel more comfortable articulating their concerns and questions to the clinician with whom they have become familiar as a result of the close and frequent contact. The case manager plays a key role in communicating the client and family concerns regarding the efficacy and side effects of the medication to the psychiatrist.





PSYCHOSOCIAL INTERVENTIONS: CASE MANAGEMENT

C. 1. FUNCTIONS OF A CASE MANAGER

Case management initiatives with first episode clients tend to move away from liaison with those community agencies which more appropriately serve the needs of people with chronic psychiatric illness. The liaison in first episode work is mostly with generic community agencies. The goal is to normalize the young person's environment as soon as possible. The majority of instrumental case management work is in the areas of education and vocational reintegration. This means returning young adults to school or work as quickly as possible. This is often accomplished in coordination with an occupational therapist and/or clinical psychologist. The case manager is proactive in making timely and meaningful contacts with guidance counsellors, occupational workplace departments, employers, etc. The case manager can sometimes intervene to get a client reinstated if they have been dismissed due to symptoms, or negotiate a reduced schedule on return to work when sick leave is finished. At the same time, the case manager can educate the workplace personnel about the difficulties the client has been experiencing without stigmatizing the client in the process. The language used to mediate such negotiations needs to be devoid of medical/psychiatric lexicon. Using descriptions of cognitive difficulties such as poor concentration and memory, confusion, etc., are more meaningful than telling an employer that the person has psychosis or schizophrenia. Likewise, the case manager often needs to go out to secondary and post secondary educational institutions with the client to negotiate a feasible curriculum of study and facilitate a working relationship between the guidance counsellor, client and case manager. At times, the case manager will help the client arrange independent studies through correspondence or upgrade through specific educational facilities. The case manager uses the information made available through their client's completion of the (PEPP) cognitive testing battery to give added support to the planned psychosocial interventions. The timing of the cognitive tests is coordinated with the psychologist.

C. 2. HOUSING AND FINANCE

In terms of housing, the majority of clients presenting with first episode psychosis have stable housing with their families, usually parents. Some clients live in independent housing or post-secondary (college/university) residences. There is a concerted effort to avoid housing which is more suitable for clients with chronic illness as young clients may prematurely take on a sick role identity or become unduly concerned about managing future episodes of illness. Transitional housing may be necessary in some instances and therefore contact with more traditional mental health agencies may be required in such circumstances. Financially, young

clients are often dependent on parents. Some clients hold educational loans. They are often ineligible for social assistance such as welfare except on a temporary basis. PEPP discourages premature applications for disability benefits. The case manager can help clients negotiate finances and housing through interim arrangements with parents and/or the welfare office.

C. 3. LIAISON WITH OTHER PROFESSIONALS AND INTERVENTIONS WITHIN THE PROGRAM

Ongoing informal discussion with the psychiatrist, psychologist and occupational therapist about any new initiative is extremely valuable. The case manager is expected to link his/her client with other resources within PEPP. Most clients will require intensive assessment and treatment in the Recovery, Activity and Participation (RAP) Group which is available to new clients whether inpatient or outpatient for up to three months. It is expected that each client in PEPP participate in the Youth Education and Support Group (YES). Clients who require assistance in resuming their educational and vocational roles will benefit from the Cognitive Skills Training Group (COST). These interventions are described on Section E.

C. 4. FOLLOW-UP AND CASE MANAGEMENT

Throughout the follow-up period, the case manager continues to assess the client's psychosocial needs. This will include needs for housing and finance, interests, hobbies as well as peer group support and status of drug and alcohol use. For assistance with most of these needs a client is encouraged and, if needed, assisted to utilize generic community services. Although a major portion of the case management is dialogue-based, First Episode clients still require instrumental help in receiving the above community services.

C. 5. PEER GROUP

The young client's peer group is of particular significance. Knowledge about the client's peer group is essential in understanding who the client identifies with, what his/her interests might be, and how s/he spends time, etc. Of course, many clients can become isolated from their peer group due to the development of psychosis. In this case, the case manager will help the client re-establish a peer group. Initially, this can be accomplished by encouraging the client to attend the Recovery, Activity and Participation (RAP) Group or the Youth Education and Support Group (YES). Friendships are often forged during these groups. In some cases, the influence of the peer group can present obstacles to recovery for the client, eg., substance use/abuse. This points to the importance of the therapeutic alliance between the case manager and client. The power of persuasion on the part of the case manager often helps the client understand the dangers of using substances in the context of their vulnerability to relapse of psychotic episodes. The client must

feel sufficient trust and acceptance to confide personal information about drug and alcohol use. A critical and punitive attitude on the part of the case manager is very likely to push the client away. The case manager creates an environment of acceptance and at the same time educate the client about the dangers of drugs and alcohol. The Youth Education and Support Group (YES) will supplement the one-to-one education given by case managers. Clients often discuss drug and alcohol use when in the company of their own peers. In the group intervention, they have the opportunity to role play situations as a means of acquiring skills to say “No”.

C. 6. SUBSTANCE USE AND CASE MANAGEMENT

There may also be situations when the family is not aware of alcohol and/or drug use. The case manager may find him/herself in the awkward position of not being able to explain to families persistence of psychotic symptoms apparently unresponsive to treatment, when, in fact, substance abuse is a major contributor to the prevailing poor response. In this instance, case managers need to skillfully create and facilitate environments where the client can confide this information to his/her family. The case manager remains mindful of the confidential nature of the personal disclosure and is careful not to breach the trust that has developed. Referrals to Drug and Alcohol Programs are generally avoided except for liaison and assistance with assessment when necessary. It is always preferable that interventions directed at reducing or eliminating substance use/abuse are provided within the context of their primary therapeutic environment (program).

C. 7. RECOVERY AND TERMINATION

Each client is prepared for discharge from PEPP through each stage of treatment and recovery. Discharge is presented as a long-term goal and viewed as an accomplishment. Progress is to be reviewed at 3, 6 and 12 months on all goals identified at the initial assessment by the client, the family and the case manager. The 12 month review is more comprehensive in order to assist in reducing the intensity of case management. During the second year the patient is prepared for graduation to “medical management only” with one of the program psychiatrists or a shared care between the psychiatrist and the family physician is accomplished at the end of two years. However, if at the end of the two years the client has made little progress clinically, a multi-disciplinary review identifies need for an additional year of intensive case management and propose changes in medical and psychosocial treatment strategies. The decision for the nature of follow-up beyond the first two years is made by the interdisciplinary team in consultation with the client and family. A formal meeting is held where all the information pertinent to the client’s illness and functioning over two years is presented and discussed.

Approximately 10-15% clients are likely to require intensive case management services beyond the two year period. A smaller proportion of clients may require long-term intensive case management and arrangements are to be made with existent mental health services. Termination from PEPP occurs within the guidelines of PEPP case management providing care for the first two years (in rare circumstances, three years). All patients are offered longer term follow up with their psychiatrist in the program with direct involvement of their family physician in a shared-care model.



PSYCHOSOCIAL INTERVENTIONS : SPECIFIC INTERVENTIONS

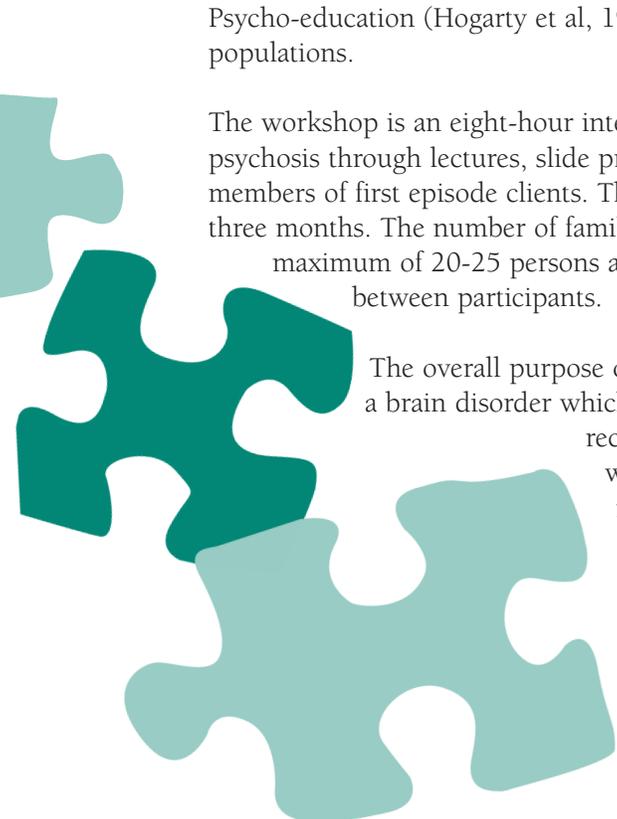
D. 1. FAMILY INTERVENTION

The PEPP Program offers support and education to families of clients who are experiencing a first episode of psychosis. The family intervention consists of two components: a psycho-educational workshop and individual family intervention provided by the social worker, case manager and psychiatrist. The following is a description of each intervention.

D. 1a. PSYCHO-EDUCATIONAL WORKSHOP ON PSYCHOSIS

The psycho-educational workshop is based on the Hogarty and Anderson model of Family Psycho-education (Hogarty et al, 1986). The model has been modified specifically for the target populations.

The workshop is an eight-hour interdisciplinary team effort which provides an overview of psychosis through lectures, slide presentations, video materials and open discussion with family members of first episode clients. The workshop is held in the Education Centre about every three months. The number of family members participating in the workshop is limited to a maximum of 20-25 persons as larger groups tend to reduce the informal interactions between participants.



The overall purpose of the workshop is to impress upon relatives that psychosis is a brain disorder which can be positively influenced by family participation in the recovery process. Of note, the information provided during the workshop is quite broad and not client specific. The information provided to families during that day often needs to be repeated many times over in the course of the two-year follow-up. A manual of the workshop proceedings is available and includes each segment of presentation material with overheads and video scenarios. The specific issues covered in the afternoon include dealing with diagnostic uncertainty, stigma, substance abuse, issues of identity and intimacy, resuming functioning for the patient and the family, etc.

The following is an outline of the workshop day:

FAMILY WORKSHOP ON PSYCHOSIS

8:45 - 9:00	Coffee and introductions of participants and staff
9:00 - 10:20	What is Psychosis? Nature, Symptoms and Course
10:20 - 10:40	Break
10:40 - 11:00	What Happens after a Psychosis? Consequences and Long-Term Outcome of Psychosis
11:00 - 12:00	Medical Treatment of Psychosis Drug Treatment, How it Works
12:00 - 13:00	Lunch with all participants and staff
13:00 - 13:40	The Family Face of Psychosis How Families React and Cope with Psychosis Family Role in Treatment
13:40 - 15:00	Living with a Person Affected by Psychosis* Common Day-to-Day Problems and How to Handle Them*
15:00 - 16:00	Question Period and Discussion and Introduction of Parent Support Group Evaluation of Workshop by Participants

(manual for details of each presentation outlined above may need to be consulted)

A description of the responsibilities of case managers prior to and on the day of the workshop can be found in the Workshop Manual.

D. 1b. INDIVIDUAL FAMILY INTERVENTION

PEPP provides individual family intervention to families of persons who are experiencing a first episode psychosis. Very often, the first contact with families is made during crisis. Successful engagement of these families is crucial for ongoing contact. The sensitivity shown to families during this time often sets the tone for ongoing treatment. The schedule for individual family intervention is unstructured and depends on family needs. It can be delivered in the environment of choice - home or clinic. Some families want frequent and consistent contact with the team while other families disengage after the crisis. The following is a description of the most common pattern of family contacts.

First Contact

Most often, family member(s) are seen for the first time during the screening interview which occurs during a time of crisis or prolonged stress of seeking help for their relative. Although the case manager may have had telephone contact with the family through the referral process, the screening interview is often the first face-to-face encounter. The assessment clinician (case manager) must be very sensitive to the circumstances and needs of family members at this time. The family should be given an opportunity to tell their story of the client's problem in a separate interview without the client and after the client has been seen. This opportunity may arise during the completion of the screening inventories. The first contact should be mainly confined to obtaining information rather than giving too much factual information about psychosis.

If the client has been identified through hospital admission, the inpatient social worker will conduct the initial family assessment. Every effort should be made to establish contact with families at the earliest possible time. Home visits to the family during the client's hospitalization are often a very effective means in engaging the family in the treatment process. Strong liaison between the social worker and the case manager is necessary.

Assessment Contact

If the family is not seen at the time of the outpatient screening, they are urged to attend the two-hour initial assessment. The psychiatrist interviews the client while the family meets with the case manager. The family often provides either the first pieces of information or additional information pertaining to the client's problem including birth history, milestones, school achievement, medical problems, peer relationships, drug and alcohol use, family history, etc. At the conclusion of the initial assessment, the case manager and family meet with the psychiatrist and client to share information and decide on a plan of care. The case manager schedules all future contacts. The psychiatrist may indicate when he/she would like to see the family again, but most likely he/she will rely on the communication from the case manager to set up appointment times.

The next most important step in the family intervention process is an invitation to the psychoeducational workshop which provides the foundation of the information that the family will require to help their relative. In the meantime, the case manager will continue to assess the family's needs and strengths in addition to providing individual support and education. The family intervention is guided by the Wisconsin Quality of Life measure that identifies their goals and concerns for the client and themselves.

Subsequent Contacts

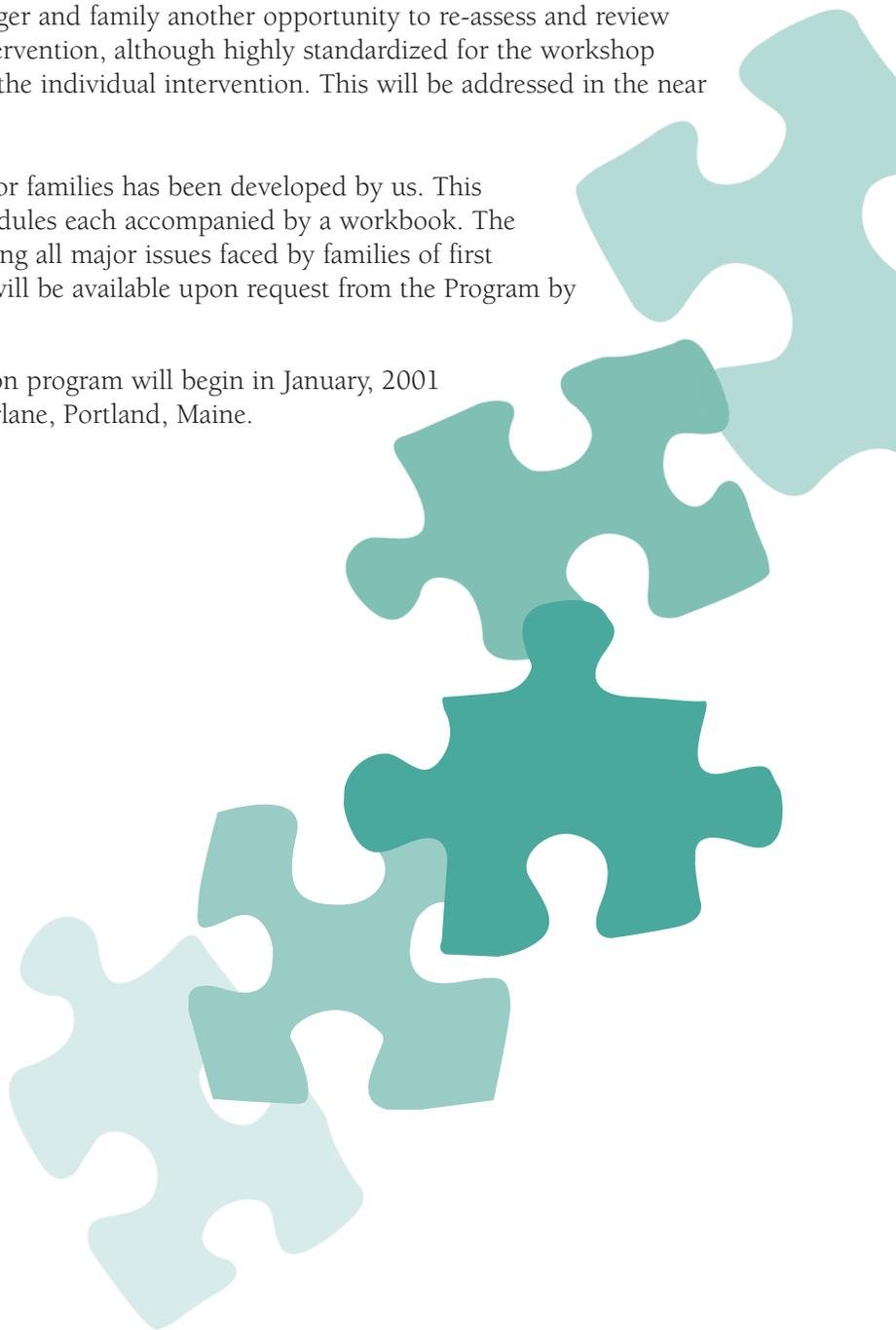
All subsequent contacts are carried out in the clinic or in the family home as dictated by needs and preference. Continual reference to the families' stated goals helps guide the frequency of contacts. It is necessary to have a proactive stance rather than a reactive one in meeting the

needs of families. Confidentiality may become an issue as the client recovers. The age of the client may also affect confidentiality. Young adult clients are often hesitant to let parents accompany them to appointments or to discuss illness related issues, whereas the adolescent client who is emotionally and financially dependent upon family is less hesitant, except in drug and alcohol related issues. The challenge for the case manager is to create ways of including family without sacrificing the therapeutic relationship and first priority of care to the client. Clients will be included in family contacts to avoid arousing uncertainty and mistrust. Contracting agreements with clients to allow family to communicate concerns about symptoms, treatment response and side effects are often helpful in promoting trust and a working partnership between the client, his/her family and the treatment team.

At the end of one year of treatment, the family is asked to complete the Quality of Life Inventory again. This provides the case manager and family another opportunity to re-assess and review goals and concerns. The family intervention, although highly standardized for the workshop segment, is not as well defined for the individual intervention. This will be addressed in the near future.

NOTE: A new teaching program for families has been developed by us. This consists of three separate video modules each accompanied by a workbook. The modules provide guidelines regarding all major issues faced by families of first episode psychosis patients. These will be available upon request from the Program by the beginning of October 2000.

A multiple family group intervention program will begin in January, 2001 in collaboration with Dr. W. Macfarlane, Portland, Maine.



E

GROUP INTERVENTIONS

E. 1. **RECOVERY through ACTIVITY AND PARTICIPATION (RAP)**

RATIONALE

After experiencing an acute psychotic episode, an individual may not be ready to return to school, work, or his/her daily activities right away. RAP provides simple low-stress activities that enhance daily functioning and work towards personal goals. It is a transitional group, monitoring individuals in their early stages of recovery, often providing the link between the inpatient unit and the community.

INTRODUCTION

RAP is a client-centered, activity-based group conducted twice a week in the out-patient setting. The activities are chosen by the group members and are graded to meet their current needs and accomplish the goals of the members at that time. Activities may include, for example, cooking, games, sports, guest speakers or community field trips. The occupational therapist and two case managers facilitate RAP.

GOALS

- To aid in the assessment of daily functioning
- To gain skills essential for role functioning
- To increase structure during the week
- To provide ongoing support and encouragement
- To increase social interaction
- To increase activity tolerance
- To encourage personal responsibility for recovery (attendance in groups and work towards personal goals)

CRITERIA

All individuals in RAP must be members of (admitted to) PEPP, who have experienced a recent psychotic episode with or without hospitalization. Typically, they have an impaired level of functioning secondary to the psychosis. Those who show gross behavioural disturbance or who are actively suicidal or aggressive requiring treatment in a secure room will not be able to participate in the group activities.

GROUP ENTRY

Group entry is facilitated by the occupational therapist and the patient's case manager once the client has been allocated to a case manager for PEPP. Inpatients are encouraged to attend the group prior to discharge and continue to attend as an outpatient.

PARTICIPATION IN THE GROUP

Throughout the duration of the group, attendance and progress of members is recorded on a weekly basis. Progress sheets are kept in the RAP binder, along with occupational therapy initial assessment, until the patient has completed the group.

GROUP EXIT

The member's goals and group discharge plans are re-evaluated with the case manager on an ongoing basis. Their readiness for exiting the group is discussed and depending on their goals and rate of recovery, alternative means of productivity or community involvement is explored. Optimally, all members exit the group in eight to twelve weeks. However, occasionally circumstances such as lack of response to medication and continued psychotic symptoms may inhibit their ability to move to other interventions at the end of 12 weeks. Clients are encouraged to move on to attendance at the Youth Education and Support group (see section 2).

E. 2. YOUTH EDUCATION AND SUPPORT (YES) GROUP**RATIONALE**

Adolescence is a time in life marked by conflicts, which lead to considerable anxiety and feelings of being separate and different, but when complicated by the onset of a psychosis, the conflicts are significantly greater and different. Onset of psychosis is also a form of severe trauma to the maturing identity of an adolescent and a young adult. Adolescents and young adults with psychotic disorders can benefit from having a place to openly explore a range of developmental and psychosis related concerns. Young people, being treated for their first episode of psychosis, need to know how to cope with the transition to adult life in terms of freedoms and responsibilities and how to adjust their young lives so as to minimize the impact of psychosis on their growth and development . A group of adolescents and young adults (15-24) can provide the opportunity to share common problems and to find ways to make responsible choices.

GOALS AND OBJECTIVES

The group is a place to gain support and understanding of the personal difficulties that each member is facing in dealing with conflicts and issues around treatment of psychosis. Participants will be encouraged to examine their values, behaviours, and relationships as it has an impact on their lives and is also relevant for symptom management. It will be up to the individual member to decide how much personal information he or she wishes to share with the group members.

The following are some general goals that help provide direction for individual members:

- To grow in self-acceptance and respect.
- To learn about psychosis in order to make treatment and other personal decisions based on the most up-to-date empirical findings about psychotic symptoms and their management.
- To explore ways of applying what is learned in the group to everyday situations encountered by young people.
- To provide and obtain support amongst peers who have similar experiences and concerns.
- To reduce the risk of future episodes of psychosis.
- To resume optimal functioning and positive approach to life as soon as possible.

TYPE OF GROUP

- This is a supportive group with an educational component for young clients between the ages of 15-24 who have experienced a first episode of psychosis.
- This group is not designed to treat persons who have been living with long-term mental illness. Instead, it is aimed at preventing further episodes of psychotic experience amongst those with recent onset.
- The group is time limited (8 weeks) and will consist of no more than six to ten members at a time.
- The group is led by two co-leaders who otherwise assume case management roles in the PEPP Program.
- The group meets weekly for two hours in the afternoon for eight weeks.
- It is preferred that prospective members not join the group unless they started with the first session.
- Membership is voluntary.
- A pre-requisite for joining this group is admission to the PEPP Program and completion of an individual screening and orientation to the group.
- Once the members have been assessed, there is a preliminary session designed to get acquainted with one another and to prepare the participants for a productive group experience. After this pre-group session, those participants who decide to participate in the group will be asked to make a commitment to attend all sessions for the eight-week period.

BASIC GROUND RULES

The group operates under the following rules:

- Members are expected to attend all the sessions and to participate at a level that is comfortable to them. Group members will, however, be reminded that making an effort to share and give feedback will most likely benefit them personally as well as others in the group.
- Members are asked to make an eight-week commitment, and if for some untoward reason the member cannot attend, he/she will contact one of the leaders so the information can be shared with all the members.

- Members must maintain the confidential disclosures of other group members.
- Members will come to group meetings drug and alcohol free.
- Members are asked to remain in the group room as much as possible. Juice, tea, coffee and snacks are provided at the scheduled break.

CRITERIA FOR INCLUSION

- Persons with first episode psychosis treated in PEPP.
- Persons whose symptoms are sufficiently stabilized and are judged to be able to meet the cognitive demands of the group.
- Persons who can commit to two-hour weekly sessions for eight weeks.

GROUP SESSIONS AND THEMES

Each session is divided into two segments. The first hour is spent in exploring the theme of the session. The second hour is spent in providing information about a specific aspect of psychosis which is related to the theme. The group facilitators (leaders) will make use of a variety of media to convey educational material to members. The following is an outline of the themes and education provided in YES.

Session 1: Introduction (goals and expectations)

- acquaint group members with each other via “ice breakers”
- write a “Dear Me” letter
- review ground rules
- discuss goals
- intro to “check out” exercise

Session 2: Self-Identity and What is Psychosis?

- intro to “check in” exercise
- intro to theme
- who am I exercise (profile)
- discussion of profiles
- film: “Get Help Early”¹ or “First Break”² (depending on group members)
- check out exercise

Session 3: Peer Pressure and Drug and Alcohol Use

- check in exercise
- intro to theme
- film - “The Truth About Drinking”³
- film - “Marijuana: Its Effects on Mind & Body”⁴
- jeopardy game (facts about drugs and alcohol)
- check out exercise

Session 4: Relationships and Medications

- check in exercise
- intro to theme

- discussion - hassles with parents
- small group work- psychological and physical side effects
- review of medications
- check out exercise

Session 5: Stigma and Strategies

- check in exercise
- intro to theme - what is stigma?
- Small group work - stigma at home, school work
- Film - “One in Five”¹
- Role playing situations - questions about illness, meds, etc.
- Check out exercise

Session 6: Social Skills and Recovery

- check in exercise
- intro to theme
- identifying social deficits - “depressed lady”
- role play scenarios
- check out exercise

Session 7: Return to School and Work and Early Warning Signs

- check in exercise
- review of skills necessary to return to work and school, i.e., attention
- early warning signs - personal profile - printout of personal prodrome list
- check out exercise

Session 8: Review and Celebration

- check in exercise
- P.S. to “Dear Me” letter
- Discussion of any material from previous sessions
- Pizza and movie (according to group consensus with discretion)

(Reader will need to consult the YES Manual for details of each session).

The documentation for the client's participation in each session is stored in the client's file. The documentation is completed on a standardized form which provides a brief account of the member's contribution to the theme. It also provides for comments as to the client's needs and strengths. The client's case manager will be notified immediately when any group member demonstrates increasing symptomatology and/or expresses suicidal ideation. Group members are encouraged to maintain ongoing contacts with co-members.

¹EPPIC Program, Dr. Patrick McGorry, University of Melbourne, Melbourne, Australia

²National Film Board of Canada

³Canadian Learning Company, The Teen Files Series

⁴Schlessinger Video Productions, Library Video Company

E. 3. COGNITIVELY ORIENTED SKILLS TRAINING (COST) GROUP

RATIONALE FOR THE GROUP

Cognitive deficits are common among persons experiencing a psychotic disorder. Such cognitive deficits have important implications for the community functioning of those with psychotic disorders independently of clinical symptoms. Recognition of the importance of cognitive deficits has resulted in increased focus on reduction of such deficits as an important clinical outcome.

Attention to cognitive concerns in the early phases of psychosis may prevent the discouragingly low rates of employment and self-sufficiency seen in later stages. The mandate of the Prevention and Early Intervention Program for Psychoses (PEPP) has been to examine the effect of early treatment in persons experiencing a first episode of psychosis. Given the age of the patient population in this program (late adolescence/early adulthood), many of the functional issues arising at the time of initial treatment relate to reintegration into and completion of high school or college/university studies. The cognitive difficulties commonly seen among our patients mirror those that have been reported in the literature and have clear implications for their future functioning at school or work. This population is clearly academically and vocationally vulnerable, thus the development of effective treatments to address these specific cognitive concerns is important.

Many of our patients have not had the opportunity to develop the necessary learning and study skills to manage the demands of a high school or post secondary. Their ability to maximize their cognitive potential has often been further compromised during a prolonged prodromal period. Thus significant declines in academic performance prior to program admission are commonly seen. All of these findings have led to interest in the potential remediation of such deficits and the timely provision of cognitive skills teaching.

BACKGROUND INFORMATION

Cognitive difficulties have been recognized as a component of psychotic disorders since the early twentieth century. In fact, the early name given to this disorder (dementia praecox) reflected these observations. Deficits in the areas of verbal learning and memory, attention/concentration, speed of thinking and executive functions (e.g. concept formation and abstraction) have been frequently identified.

Review of the cognitive rehabilitation literature reveals that four approaches have typically been utilized to remediate deficits: relearning and practice of the deficit skill; substitution of an intact skill to replace a weak one; use of prosthetic devices (e.g. calendars, notebooks); and adaptation of the physical and social environment. Research supports the efficacy of teaching compensatory cognitive and behavioral strategies rather than trying to rehabilitate targeted deficits. These findings have held true for patient with head injury as well as psychosis.

The direct and secondary benefits of a group model of cognitive skills instruction have also been reported and include: enhancement of attention and concentration through verbal and visual pencil and paper exercises, facilitation of communication and social skills building through interactions with others, stimulation of the unique skills of each member by the group process, and the opportunity to receive feedback and experience success in a structured and concrete format.

Unfortunately, there is little research examining cognitive skills development among first episode

patients who are in school or planning a return to their academic studies following stabilization of their symptoms. Much of the research to date has focussed on older and more chronic patients and either remediation of a specific aspect of cognitive functioning (e.g. attention) or performance on a specific test (e.g. Wisconsin Card Sorting). Research regarding the cognitive functioning of older and more chronic patients has demonstrated a trend towards deterioration over time, or the continuation of significant cognitive difficulties which act as a barrier to successful academic or vocational functioning. The use of this intervention in a program such as PEPP, which is designed to treat psychosis at an early stage, may be particularly appropriate.

OBJECTIVES OF THE GROUP

The cognitive skills group is designed to address deficits in functioning which relate to academic performance. It aims to teach cognitive and behavioral compensatory strategies specifically on the domains most commonly impacted among patients with psychosis. The direct focus of the group is for participants to:

- i. increase the use and effectiveness of study strategies
- ii. decrease frequency of cognitive complaints
- iii. improve attention and concentration
- iv. increase the use of learning and memory strategies
- v. improve academic performance

DESCRIPTION OF THE GROUP

Each client meets with a Research Assistant prior to commencement of the Cognitive Skills group for an individual pre-intervention assessment session. Tests used in this assessment include the following measures:

- Scale for Assessment of Positive Symptoms (SAPS) and Scale for Assessment of Negative Symptoms (SANS)
- Wide Range Achievement Test - Third Edition (as a measure of academic performance)
- California Verbal Learning Test (measure of auditory-verbal learning and memory, and use of learning strategies)
- Mental Control (measure of concentration and executive functioning)
- Digit Span (measure of attention/concentration)
- Rey Osterreith Complex Figure (measure of visual learning and memory, and executive functioning)
- Cognitive Failures Questionnaire/Memory Screening Questionnaire (self-report measures of cognitive complaints and use of strategy for learning)
- Cognitive Competency Test (Occupational Therapy measure assessing activities of daily living and cognitive skills required for independent living)
- Self-report Study Skills Questionnaire (assesses nature and frequency of study skills used)

The Cognitive Skills group meets for 2 hours weekly for 10 sessions, which is presented in a didactic format mirroring that of a classroom setting. Group size is limited to eight participants and is facilitated by the Program psychologist and occupational therapist. Following completion of the Cognitive Skills group, each member meets individually with the Research Assistant for post-intervention assessment involving repeat administration of the measures.

CRITERIA FOR THE GROUP

Patients who have been admitted into the Psychosis Program and plan to commence or continue with some form of academic studies are able to participate in the group.

Inclusion criteria must be met for participation in the group:

- an absence of psychotic symptoms or generally stable residual psychotic symptoms, and
- either current enrolment in an academic setting or plans to return to academic work.

Exclusion criteria:

- patients with active psychotic symptoms and suicidal behaviour, and
- patients with no plans to pursue academic studies.

Lesson I

- Review of group format and procedures
- Goal setting for group and review of principles
- Basic brain principles and different types of learning (i.e., visual, auditory, kinesthetic)
- Study habits questionnaire

Lesson II

- Inhibitors of studying and means of combating them
- What is concentration?
- What interferes with it? (i.e., internal and external distractions, lack of goals)
- How to improve concentration
- Benefits of improved concentration

Lesson III

- What is memory?
- Review of different types of memory (eg., short term, long term)
- Reasons for forgetting
- Strategies for remembering (eg., primary/recency effect, similarity effect, repetition)

Lesson IV

- Improving memory for studying
- Review of learning and forgetting curves
- Review and practice of different memory strategies (eg., chunking, visual association, mind maps, practicing output, memory aids, etc.)

Lesson V

- Components of time management
- Setting priorities and dealing with procrastination
- Elements and advantages of a good schedule
- Using “to do” lists and calendars
- Principles of divide and conquer and using fractions of time
- Mid-group review and revision of goals

Lesson VI

- The purpose of study reading
- How to make it more effective (i.e., survey, question, read, review, recall)
- Good and bad note making

Lesson VII

- Learning strategies to use before class lectures
- Learning strategies to use during class lectures
- Learning strategies to use after class lectures

Lesson VIII

- Secrets to success with papers and essays
- Steps to writing essays and basic essay structure
- Features of a good essay

Lesson IX

- Exam preparation during the course and immediately before writing the exam
- Exam writing tips
- Guidelines for multiple choice exams
- Guidelines for short answer and essay exams

Lesson X

- Review of any outstanding issues
- Review of goals and completion of study habits questionnaire
- Celebration and presentation of certificate

E. 4. OTHER SPECIFIC INTERVENTIONS

COGNITIVE BEHAVIORAL THERAPY (CBT)

RATIONALE FOR CBT

Cognitive behavioral approaches in the treatment of psychosis have become more prevalent in recent years for a number of reasons. Evidence has been available for the past two or three decades regarding the success of these techniques with other forms of psychopathology such as depression, anxiety disorders, and medical problems. Anxiety, depression and low self-esteem have been cited as the most common consequences of psychotic disorders. The observation has also emerged that many patients develop their own coping strategies for reducing the frequency, severity, and disruptiveness of their symptoms. There has also been increasing evidence regarding the influence of social environmental factors on the course of psychosis and the development of stress-vulnerability models to explain these relationships. Research suggests that 20 to 50 percent of persons with psychosis who receive neuroleptics continue to experience difficulties related to their psychotic symptoms.

BACKGROUND INFORMATION

On a clinical level, numerous case reports and several controlled trials of interventions using cognitive-behavioral strategies have demonstrated their efficacy in decreasing ratings of anxiety and depression, symptom severity and frequency, improving social functioning, and reducing hospitalization and relapse rates among patients with psychotic disorders. Such reports have typically been with reference to chronic patients for whom pharmacological interventions have failed to achieve total remission of symptoms.

Given the current evidence for the effectiveness of cognitive interventions with such patients, these may be even more efficacious in helping patients at early stages of psychosis or having prophylactic value in reducing likelihood or severity of future episodes of psychosis.

OBJECTIVES OF CBT

The objectives of individual CBT as provided by the Psychologist in this Program are as follows:

- to reduce comorbid psychopathology such as anxiety and depression
- to reduce psychotic symptoms
- to improve self-efficacy, self-esteem, and reduce self-stigmatization

These objectives are typically achieved through teaching and practice of cognitive behavioral techniques aimed at:

1. reduction of stress and building of skills for coping with stressors
2. building self-esteem and self-efficacy
3. identifying and coping with triggers for psychosis
4. disruption of symptoms
5. belief modification

DESCRIPTION OF CBT

Patients are identified through a multidisciplinary review process to require C.B.T. Initially they meet with the Psychologist for one hour on a weekly basis. Under some circumstances sessions may occur twice weekly or be shorter in duration (i.e. if the presenting problem is severe and requires more frequent contact or the cognitive functioning of the patient warrants a shorter appointment). Once some amelioration of the patients presenting problem has occurred and these gains are being maintained, contact is slowly tapered off to biweekly, followed by monthly sessions with the eventual goal of termination. While the exact duration of CBT will vary widely according to psychological, social and cognitive functioning of the patient, most people can expect to spend 6 to 12 months in treatment.

CRITERIA FOR CBT

Patients are referred to Psychology who have completed the “YES” group and continue to demonstrate a need for intervention regarding mood, anxiety, and adjustment related concerns and/or residual psychotic symptoms, or who are identified as requiring immediate intervention of this nature following completion of their intake assessment and stabilization of their symptoms.

In order for this treatment to produce the greatest benefit for patients, a certain level of cognitive and social skills is required. Patients functioning intellectually below the average range may experience difficulty understanding and utilizing various cognitive techniques. Patients who are acutely psychotic or experiencing pervasive negative symptoms are also likely to receive limited benefit from use of CBT. Research on the use of this therapy has reliably demonstrated that those patients who benefit most are verbal, highly motivated, and able to tolerate some anxiety generated by direct and open discussion of their concerns.

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