ASSESSING FIDELITY TO THE EPPIC MODEL OF CARE USING THE 'REVISED EPPIC MODEL INTEGRITY TOOL' (REMIT)

GUIDE FOR HEADSPACE EARLY PSYCHOSIS SITES

WHAT IS A FIDELITY REVIEW?

This service model fidelity review is used to assess how closely real-world practice at the headspace Early Psychosis (hEP) sites is faithful to the components and practice of the Early Psychosis Prevention and Intervention Centre (EPPIC) model. Early intervention services in psychosis have been established to be effective and meta-analyses demonstrate superior functional and symptomatic outcomes for young people. To ensure the maximum efficacy of these services, use of a fidelity scale is important for successful implementation of evidence-based practice – that is, services have 'high fidelity' to the EPPIC model.

The **R**evised **E**PPIC **M**odel **I**ntegrity **T**ool (REMIT, and formerly the EPPIC Model Integrity Tool (EMIT) was developed based on the sixteen core components of the EPPIC model, existing research and extensive consultation with headspace Early Psychosis leadership, headspace National Office and staff at the headspace Early Psychosis sites. The redesign of REMIT from EMIT has involved further review of recent developments in fidelity measures in mental health services used around the world (e.g. Addington's First Episode Psychosis Services Fidelity Scale (FEPS-FS), updated in 2021, for use in the USA), as well as consultation with fidelity experts and current clinical staff.

HOW IS FIDELITY AT HEP SITES MEASURED?

The fidelity review uses the REMIT to assess fidelity. The tool has 11 components which each have between 1 and 8 individual items. Each item is scored on a scale of 1-5, denoting the extent to which the service element reflects fidelity to the EPPIC model. The reviewing team will score each item individually and these scores are informed by data obtained from clinical file review, the headspace Early Psychosis minimum data set (MDS) via hAPI, and interviews with staff, service users and their families and carers. This will provide an overall fidelity score, as well as assist to identify areas where the service has higher fidelity to the EPPIC model, as well as areas where fidelity to the EPPIC model is lower.

WHAT HAPPENS DURING A REMIT FIDELITY REVIEW?

A reviewing team will visit the service over one or two days. There are usually two reviewers from Orygen conducting the fidelity review. The reviewers will work together, combining their observations to reach a fidelity score for each of the questions in the tool. Using more than one reviewer is designed to increase the consistency and reliability of review scores. The fidelity ratings will be based on current practices of the headspace Early Psychosis.

The reviewers will look at case file records, paperwork maintained at the site, data from the headspace Early Psychosis MDS and records from fidelity interviews. Information from all sources will be considered in making the fidelity rating for each item.

WHO WILL BE INTERVIEWED?

The reviewing team need to talk to the following people during the review. Estimated maximum times are given:

- Operations manager - one hour at the start of the visit and 30 minutes at the end for clarifying questions and closing
- Medical/clinical director - could meet at the same time as the operations manager or meet separately (needs to include discussion of medical items)
- MATT team leader and clinicians – 45-60 minutes
- CCT team leader and clinicians - 1 hour: team leaders and clinicians from hub and spoke to be interview together
- Community engagement team leader – 30 minutes
- Functional recovery team leader - 1 hour. Could include vocational consultant and/or group program coordinator
- Senior psychologist – 30 minutes
- Youth participation coordinator and youth reference group representatives – 30 minutes
- Peer support workers – 30 mins
- Family program team leader/clinician – 45 minutes
- Data systems project manager – 30 minutes
- Young people and carers (approx. 6) – 30 minutes each.

The REMIT Interview Schedule will guide the content of the interviews (see appendix A).

Prior to the scheduled fidelity review, a timetable for the above interviews will need to be provided, including contact made with young people and carers to explain that their consent will be required to take part in the interview.

PREPARING FOR REMIT FIDELITY REVIEW:

The following documents should be provided at least a week before the fidelity review:

1. Staffing profile and FTE: Does the service have: Senior family worker, senior psychologist, hEP community engagement and activity (CE&A) worker/s, youth and family peer support workers, vocational consultants, youth participation coordinator or noting vacancies in these key positions. It is useful to provide discipline data so that the questions about multidisciplinary teams can be rated. Names are not required, but seniority would be useful to note.
2. List of CE&A activities undertaken including community services /individuals targeted, purpose of session and hEP staff (including clinicians) involved over the last 12 months.
3. Copy of current group program including what involvement YPs have had in their development.

4. Physical health screening and intervention procedures.
5. Any updated or new policies that would inform the fidelity process that you would like to discuss
6. Evidence of process for annual formal staff appraisal and records of the occurrence of regular clinical supervision

Patient records will also be used to inform the fidelity review. A file audit tool will also be used to assess fidelity with the following process:

1. 10 FEP and 10 UHR files will be randomly selected and audited using the REMIT fidelity audit tool criteria (see appendix B)

The file audit tool can be completed by a clinician or the DSPM at each site, or by Orygen review staff during the visit.

YOUNG PERSON AND FAMILY INTERVIEWS

A key part of the REMIT is ensuring we seek evidence from a wide range of stakeholders. As part of this we want to talk to a small sample of young people and their carers/families. Sites will therefore be asked to nominate 5 young people and 5 family-member/carers who provide consent to be interviewed by the reviewing team. A mix of FEP and UHR is preferable. These can be undertaken face to face on the day of the review or via the telephone if preferred by the individual. Each interview will take no more than 30 minutes and individual will be reimbursed for their time ($30 per individual). Interviewees will be required to provide informed consent and have signed a Participant Information and Consent Form (PICF).

Please gather preferred times that the young person and family members wish to be met/called on the day of the review and provide these to the reviewer on the day.

WHAT HAPPENS AFTER THE REVIEW?

Following the conclusion of the scheduled interviews, audit of young people's clinical files and analysis of hAPI MDS data, the reviewers will discuss and score each item on the REMIT fidelity scale. A detailed feedback report will be provided within 6 weeks of the assessment consisting of scores for all items and components; an overall REMIT score, identified areas of strength and areas for improvement alongside recommendations to assist in improving practice in certain aspects of the service. Opportunity is given to provide feedback and discuss any queries.

For further information pertaining to the REMIT fidelity review process, please contact:

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REVISED EPPIC MODEL INTEGRITY TOOL (REMIT)

Community education & awareness

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
1. DUP is measured for all young people with suspected first-episode early psychosis (FEP)	HAPI	The proportion of young people with DUP recorded via scale provided in HAPI MDS	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

The measurement of DUP has been included as part of the Early intervention for psychosis model and provides a tangible measure of the impact of community education and awareness (CE&A) activities. It is anticipated that DUP will shorten due to effective CE&A program.

Scoring guidance:

Response recorded for DUP items First Threshold-Level Psychotic symptom (FPS) date **and** Date commenced prescribed (not PRN) anti-psychotic medication in HAPI MDS) or treatment starting.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
2. The hEP service carries out a comprehensive range of activities with a focus on case detection and promoting referrals	P, M, S	Evidence of frequent education to first-contact individuals and groups (i.e. direct GP contacts, GP forums, information sessions to NGO's, school welfare, social media, communications)	
Scoring		5 = >12 times a year 4 = 10-12 times a year 3 = 6-9 times a year 2 = < 6 times a year 1 = No education provided	**ITEM SCORE**

Purpose:

Promoting the hEP services to potential referrers is a core element of improving case detection.

Scoring guidance:
Evidence of community education activities as documented in paperwork – meeting minutes, diary events.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
3. The sources of referrals to the hEP service are varied:	HAPI	Referrals are received from a wide range of sources including from: 1) healthcare providers (e.g. community-based mental health service, public specialist healthcare) 2) private psychiatrists/psychologists 3) headspace primary services 4) family/friends 5) community services (welfare/employment agency, legal/justice/child protection AOD services) 6) Schools or higher education settings 7) community-based specialist services (inpatient services, emergency department)	
Scoring		5 = Referrals received from across 5 or more sources 4 = Referrals received from across 4 sources 3 = Referrals received from across 3 sources 2 = Referrals received from across 2 sources 1 = Referrals received from only 1 source	**ITEM SCORE**

Purpose:

Demonstrating that the service is well known in the local area and that community awareness activities are having an impact on referral sources

Scoring guidance:

Data from Tableau regarding young person referral source (Young Person Report V3/5.0 Assessment)

Home-based care & assessment

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace MDS data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/ Partially met/Unmet
4. Initial assessments are conducted as soon as possible from date of referral to the hEP services with feedback provided to families (unless contraindicated)	HAPI	A) The proportion of assessments conducted (initiated) face-to-face within 3 days of referral for FEP and within 5 days for UHR	
	F, M, S, FF	B) The proportion of families who receive feedback after the assessment is completed with their young person	
Scoring		5 = A and B both fully met 4 = One fully met, one partially met 3 = A and B both partially met 2 = Only one partially met 1 = Both criteria not met	ITEM SCORE

Purpose:

To measure whether the service provides a timely face-to-face assessment for all suspected FEP referrals.

EPPIC Model & Service Implementation, page 140. Standards First Group: Minimum standards: 3.1 with timeframe adapted to include triaging processes at headspace Early Psychosis sites.

Scoring guidance:

A) Using HAPI MDS – calculate the proportion of clients where the Days between referral date and first direct OoS where service type = Intake or Assessment and service mode = face-to-face is less than/equal to 3 days for FEP and 5 days for UHR. Fully met = over 80%, partially met = over 50%, not met = under 50%.

B) Primarily assessed through file audits with support coming from interviews if necessary.. Fully met = over 80%, partially met = over 50%, not met = under 50%.

Exclude YPs for whom family contact is contra-indicated (details would be expected to be found in files through file audit).

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
5. hEP services are flexible and provide outreach services in when and where they see a young person	F, P, M, S, SU, FF	A) The proportion of young people that have been seen at any point in a setting not at the hEP site e.g. at home, school, coffee shop, park? This includes being seen on an inpatient ward when appropriate.	
		B) Out of hours care is provided across the following hours: • 7-9am, 5-8pm, 8-10pm, weekends	
Scoring		5 = A and B both fully met 4 = One fully met, one partially met 3 = A and B both partially met 2 = Only one partially met 1 = Both criteria not met	ITEM SCORE

Purpose:

To measure, that where needed, the service provides not only assessment but also treatment in the young person's home/chosen location.

EPPIC Model & Service Implementation, page 140. Standards First Group: Minimum standards: 3.6

Scoring guidance:

Primarily assessed through file audits with support coming from interviews if necessary.

A) Fully met = evidence that 80% of young people are seen off-site at some point during their care, including initial assessment. Partially met = evidence that 50% of young people are seen at some point off-site during their care. Not met = minimal evidence of off-site visits

B) Fully met = team available at least 3/4 of the OOH options. Partially met = team available at least 2/4 of the OOH options.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
6. Qualified professionals deliver a variety of different interventions	F, P, M, S	1) case management/care coordination, 2) physical health interventions and support, 3) psychological interventions, 4) substance use management, 5) vocational support, 6) family education and support, 7) patient psychoeducation, 8) pharmacotherapy	
Scoring		5 = Team delivers all items 4 = Team delivers 7 items 3 = Team delivers 6 items 2 = Team delivers 5 items 1 = Team delivers 4 or fewer of the listed items	**ITEM SCORE**

Purpose:

To ensure the headspace Early Psychosis program offers a comprehensive service in line with best practice guidelines

Scoring guidance: Evidence is sighted/recorded showing that the different interventions are delivered

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
7. Caseload per cluster meets the targets set out	DM, P, M, S	Caseload is calculated based on each 1.0EFT CCT clinician in the service	
Scoring		5 = Caseload is at 20-23 per 1.0EFT case manager 4 = Caseload is 16-19 or 24-29 per 1.0 EFT case manager 3 = Caseload is 12-15 or 30-33 per 1.0 EFT case manager 2 = Caseload is 8-11 or 34-40 per 1.0 EFT case manager 1 = Caseload <8 or >40 per 1.0 EFT case manager	**ITEM SCORE**

Purpose:

To measure whether appropriate caseload levels are maintained in accordance with targets set

Scoring guidance:

Using data from data managers, the average caseload per 1.0EFT CCT clinician is calculated. Additional data could come from paperwork such as case allocation spreadsheets and interviews with managers and staff.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
8. Engagement with case manager occurs within a timely manner from their acceptance into hEP	DM	A) The proportion of young people who are allocated to a case manager occurs within 5 days of acceptance to program	
		B) The proportion of young people seen (face-to-face or telehealth) by case manager within 1 week of allocation	
Scoring		5 = A and B both fully met 4 = One fully met, one partially met 3 = A and B both partially met 2 = Only one partially met 1 = Both criteria not met	**ITEM SCORE**

Purpose:

To measure timely allocation to case manager and handover process following acceptance to headspace Early Psychosis for young people experiencing FEP. There must be an allocation process in place, of which all staff members are aware

Scoring guidance:

A) met = evidence that 80% of young people are allocated to case manager within 5 days. Partially met = evidence that 50% of young people are allocated to case manager within 5 days. Not met = minimal evidence of timely allocation

B) Fully met = evidence that 80% of young people are seen by case manager within 1 week of allocation. Partially met = evidence that 50% of young people are seen by case manager within 1 week of allocation. Not met = minimal evidence.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/ Partially met/Unmet
9. Each young person should have an Individual Treatment Plan (also called a Care/Wellbeing/ Recovery Plan in some places) which is reviewed and updated every 90 days.	F, SU, FF	A) The proportion of young people who have an ITP within 6 weeks from allocation/handover from MATT. These should be co-developed and reviewed by a senior clinician, and a documented copy is offered to the young person and family with feedback incorporated.	
		B) Young people's progress is reviewed every 90 days and ITP updated	
		C) Relapse planning is part of the ITP, which includes a focus on self-management strategies	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met and one is partially met 3 = 2 criteria are fully met and one is not met OR one criteria is fully met and two are partially met 2 = Only one criterion is fully met and at least one is unmet 1 = No criteria are fully met	**ITEM SCORE**

Purpose:

To measure if care/treatment planning is conducted with an ITP in place by 6 weeks and that development of ITP involves a collaborative process with the young person and their family. ITP's should be reviewed regularly and include a relapse action plan, the development of these should include discussion about identifying early warning signs, what to do if the young person begins to feel unwell again and who they should contact. Action plans must be documented, and a copy provided to the young person and their family (unless contra-indicated).

Scoring guidance:

Primarily assessed through file audits with support coming from interviews if necessary. Evidence of ITP doesn't need to be separate document, but evidence of planning care and revisiting these plans should be sighted.

A) Fully met = over 80% YPs, partially met = over 50% YPs, not met = limited evidence of ITPs being completed.

B) Fully met = over 80% YPs, partially met = over 50% YPs, not met = limited evidence of ITPs being reviewed.

C) Fully met = over 80% YPs, partially met = over 50% YPs, not met = limited evidence of relapse planning being documented.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services.

Item	Informant	Scoring criteria	Met/Unmet
10. Incomplete recovery is identified at 6 months, and this triggers a specific response aimed to facilitate recovery	P, F, M, S	A) Strategies are in place to identify young people with incomplete recovery by 6 months. E.g. reviewing scores on BPRS, SOFAS, K10/clinical review and progress notes maintained/contacting F&F at 6 months.	
		B) The young person is reviewed by a senior clinician and action plan recorded	
		C) The young person is reviewed by a senior clinician and a psychiatrist (Consultant/Registrar) and action plan recorded.	
		D) Specific strategies to facilitate recovery are identified and documented, shared with YP and F&F and documented.	
Scoring		5 = All 4 criteria are met 4 = 3 criteria are met 3 = 2 criteria are met 2 = 1 criteria is met 1 = No systems in place to identify young people with incomplete recovery	**ITEM SCORE**

Purpose:

To measure that there is a process for identifying young people experiencing persistent psychotic symptoms (e.g., 90-day review) and where present, specific strategies to facilitate further recovery are identified, documented and reviewed regularly.

Definition of incomplete recovery =

1. Treatment resistance, which refers to situations where people are receiving appropriate evidence based treatments but are inadequately responding to the treatments and consequently have persistent symptoms and disability.
2. Resistance to treatment, which refers to the situations where people have access to treatment but are non-adherent or are disengaged.

Scoring guidance:

Identify if these criteria are met through reviewing paperwork and interviews with staff members. File audits may provide evidence of action plans recorded and who reviewed these.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
11. The hEP service promotes proactive engagement throughout episode of care	F, P, M, S,	A) Proactive engagement with young people is encouraged through supporting designated time to be spent out of the office for example community engagement activities	
	HAPI	B) Drop out from service is monitored and minimised	
	F, M, S,	C) Discharge planning commences more than 3 months before discharge	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met + 1 partially met 3 = 1 criteria is fully met + 2 partially met 2 = 2 criteria partially met **or** 1 fully met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

Use of proactive outreach by a designated team member, including community visits to engage individuals with FEP and reduce missed appointments

Scoring guidance:
Use combination of file audits, paperwork review and interviews to establish how regularly staff members spend time outside of the office to support active engagement

A) Fully met = all evidence supports adequate time (around 40%) being spent out of the office. Partially met = some evidence to support some time (20%) being spent out of the office. Not met = Minimal evidence of minimal time.

B) Drop out rates calculated from data from HAPI. The ratio of the number patients who dropped out of program in the last year to the total current caseload. Fully met: <= 0.10 (1 in 10 drop out), partially met: = <=0.25 (1 in 4 drops out), not met: = >0.25 (more than 1 in 4 drops out)

C) Evidence of discharge planning commencing more than 3 months before discharge is documented in client files. Support from SU and FF interviews if necessary. Fully met = evidence for at least 80%, partially met = over 50%, not met = under 50%

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
12. The hEP service promotes continuous engagement through to the end of tenure of care	HAPI, F, P, M, S, SU, FF	A) Young people are assessed/reviewed every 90 days during their care	
		B) Tenure of care - young people with FEP receive at least 2 years of care and those with UHR receive at least 6 months of care. E.g. engagement with service supported when starting education or employment	
		C) Young people are seen face to face at least every month throughout their care	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met + 1 partially met 3 = 1 criteria is fully met + 2 partially met 2 = 2 criteria partially met **or** 1 fully met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

Young people are continuously engaged throughout their episode of care and remain in service for the maximum length of care as determined by their stream

Scoring guidance:
Complement data from HAPI with a combination of file audits, paperwork review and interviews to establish how regularly staff members spend time outside of the office to support active engagement

A) Percentage of eligible 90 day reviews adequately completed on HAPI. Fully met = 80%, partially met = 50%, not met = under 50%. Adequately refers to at least the following being completed: BPRS, K-10, SOFAS, MLT
B) Percentage of YPs receive the maximum length of care as determined by their stream. Fully met = 80%, partially met = 50%, not met = under 50%
C) Face to face care is received by a YP at least every month. Fully met = 80%, partially met = 50%, not met = under 50%

Medical treatments

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
13. Young person accepted onto the hEP program receives medical review within appropriate time frame (unless reviewed in assessment phase).	HAPI	A) The proportion of young people reviewed by doctor within 72 hours of acceptance to FEP or within 2 weeks to UHR.	
	HAPI	B) The proportion of young people reviewed by psychiatrist within 14 days	
	SU, FF, F, P	C) At the time of referral, it is explained that psychiatry registrars will offer time limited support as per their clinical rotation.	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met, 1 partially met 3 = 1 criteria is fully met, 2 partially met, OR all 3 criteria partially met 2 = 2 criteria partially met, one not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To ensure all young people experiencing FEP have timely access to medical review following acceptance into service unless reviewed in assessment phase.

Doctor = consultant or registrar or GP

Scoring guidance:
Criteria A & B: Data from HAPI; Days between episode commencement and first direct OoS where service mode = face-to-face and service provider type = Psychiatrist or Psychiatric Registrar or Medical Officer. And then Psychiatrist only for (B).

Complete for both FEP and UHR individuals

Fully met = over 80%, partially met = over 50%, not met = minimal evidence/under 50%

Criteria C: Fully met = all evidence supports this occurring, partially met = Some evidence to support this occurring, not met = minimal evidence to support this occurring.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
14. Antipsychotic Dosing within Recommendations for Individuals with Psychosis	F	Percentage of young people who received antipsychotic dosing within guidelines	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

Antipsychotic dosing is within government-approved guidelines for second-generation antipsychotic medications, and between 300 and 600 chlorpromazine equivalents for first-generation antipsychotics 6 months after admission to FEP service.

Scoring guidance:

During their treatment at the hEP, the YP receive antipsychotic medication within the correct recommended dosing as per Medication Dosing Appendix.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully Met/Partially Met/Unmet
15. Clozapine is used appropriately for young people with medication resistant psychotic symptoms	F, P, M, S	A) Has inhouse processes to manage clozapine (following initiation in state based services, dependent on local guidelines)	
		B) Physical health monitoring is undertaken as per guidelines	
		C) Physical health monitoring is uploaded into clinical notes	
		D) The correct percentage (10%) of young people who have medication resistant psychosis are prescribed clozapine after they do not adequately respond to two courses of first line antipsychotic medications	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met, 2 partially met 3 = 1 criteria is fully met, 3 partially met, OR all 4 criteria partially met 2 = 2 criteria partially met, 2 not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To measure use of clozapine in individuals with schizophrenia spectrum disorder (SSD) does not adequately respond to two courses of first-line antipsychotic medication

Scoring guidance:

A-C) Review paperwork around clozapine commencement

D) Fully met = 10%, partially met = 5%

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
16. The physical health of young people in hEP is supported through a range of interventions	F, P, M, S, SU, FF, O	Program takes steps to support patient health through the following: 1. Ensure young person has a GP, support them to engage when necessary; 2. Measure and provide feedback on weight gain at least **quarterly** in the first year of care; 3. Assess sexual health; 4. Monitor and document (extrapyramidal) side effects*; 5. Monitor triglycerides and glucose/Hb A1c **annually***; 6. Monitor and document cigarette smoking habits **quarterly**; 7. Prescribe pharmacological supports to smokers wishing to quit; 8. Provide feedback on weight gain and general advice on diet and exercise; 9. Deliver physical health based interventions/groups around exercise and/or diet; 10. Communicate regularly with the GP	
Scoring		5 = At least 9 of the items are provided 4 = At least 7 of the items are provided 3 = At least 5 of the items are provided 2 = At least 3 of the items are provided 1 = Minimal attention to physical health is paid	**ITEM SCORE**

Purpose: Individuals with severe and persistent mental disorders such as schizophrenia have their lifespan

shortened by at least a decade in part due to increased mortality from a range of physical illnesses. Connecting individuals to primary care, monitoring

health indicators, and promoting smoking cessation can all impact health status.

Scoring guidance:

Consistent evidence of these items being provided must come from a variety of sources, e.g. from interviews with staff and YPs and from file reviews.

*** if not on medication, 4 and 5 would be N/A**

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
17. Physical health screening and monitoring is regularly carried out	HAPI, F, P	Percentage of young people who were offered physical health screening and have this recorded in their patient files every 90-days. This includes: blood pressure, BMI, waist circumference, metabolic bloods (glucose and lipids)	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

To ensure all young people receive appropriate physical health screening in accordance with headspace Early Psychosis policy.

Scoring guidance:

<u>hAPI:</u> Data extracted from hAPI on rates of %age of YPs who were offered physical health screening and have this recorded in hAPI every 90-days. This includes: blood pressure, BMI, waist circumference, metabolic bloods (glucose and lipids)

<u>File audit data:</u> evidence of routine physical health screening sighted in EMR files.

N.B. This is unless declined by YP and this is noted in their files, or unless they are not on medication and then metabolic bloods would not be required every 90 days.

Psychological interventions

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
18. Goals for psychological treatment are reviewed and reflected in treatment plan at each 90-day review	F	Percentage of young people who had psychological treatment goals reviewed at each 90-day review	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

To ensure all young peoples psychological treatment goals are regularly reviewed

Scoring guidance:
File audit identifies evidence of goals being reviewed at every 90 day review.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
19. CBT is provided for symptoms and comorbidities (e.g. positive psychotic symptoms, anxiety, depression, adaptation to illness, substance use) that have been identified and documented in the treatment plan?	F, HAPI	Percentage of young people who received CBT at some point in their care	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

To measure whether services are identifying and addressing the needs for psychological therapy for all young people accepted into the service.

Scoring guidance:
File audit identifies evidence of CBT being provided, supplemented by evidence from hAPI data.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
20. Availability of cognitive or neuropsychological assessment	P, M, S	See below:	
Scoring		5 = Has cognitive or neuropsychological assessment available as part of the team 4 = Has arrangements with external cognitive or neuropsychological assessment for YP to be assessed within one month of referral 3 = Has arrangements with external cognitive or neuropsychological assessment for YP to be assessed within three months of referral 2 = Provides YP/family with details of external organisations who can undertake cognitive or neuropsychological assessment 1 = No cognitive or neuropsychological assessment available to them within the local area	**ITEM SCORE**

Purpose:

To ensure that cognitive/neuropsychological testing is available to young people who require a comprehensive neuropsychological assessment. Neuropsychological tests administered by clinicians who are trained to do so (i.e., WISC, WAIS) meet criteria for this item.

Scoring guidance:

Evidence that neuropsychological tests are available to young people in the program (i.e., tests on site, agreement with university).

Functional and psychosocial recovery program

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
21. Functional recovery goals (i.e. vocational, educational, social, relational, occupational) and strategies to achieve them are documented	F, P	The proportion of young people who have functional recovery goals and strategies to achieve them documented in their clinical files.	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

To measure whether clinicians are discussing and identifying psychosocial recovery goals with all young people. Recovery goals should be documented in ITP/Care/Wellbeing/Recovery plans.

Scoring guidance:

File audit identifies evidence of goals and strategies being documented.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
22. Functional and recovery orientated groups are run or accessible by young people attending hEP	P, S, SU	A) Groups have been designed to cover for each of the following four functional recovery domains: 1. social and recreational, 2. vocational and educational, 3. psychoeducational and personal development 4. creative and expressive	
		B) There is more than one group run/accessible at a time per term	
		C) Young people are regularly consulted about the running of the group program	
Scoring		5 = All 4 domains available and B&C is met 4 = 3 domains and B or C are met 3 = 2 domains and B or C are met, or 3 domains 2 = 2 domains available 1 = Only one domain available	**ITEM SCORE**

Purpose:

Groups can be delivered in house or available externally if young people are supported to attend these by clinical staff

Scoring guidance:

Predominantly paperwork review, with further evidence recorded from interviews were needed.

Intensive mobile outreach

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
23. There is a locally specific system in place to identify young people in need of intensive mobile outreach	P, S, M	1) System in place to identify young people in need of mobile outreach	
		2) Criteria in place to identify young people in need of mobile outreach	
		3) Standard Operating Procedure (SOP) in place	
		4) Fortnightly case review led by senior clinician	
		5) Fortnightly case review led by senior clinician and consultant psychiatrist	
		6) Weekly case review led by senior clinician and consultant psychiatrist	
Scoring		5 = Team delivers all items 4 = Team delivers 5 items 3 = Team delivers 4 items 2 = Team delivers 3 items 1 = Team delivers 2 or fewer of the listed items	**ITEM SCORE**

Purpose:

A set criteria and process is in place for identifying young people in need of intensive mobile outreach. Established criteria will be particularly important when services are at full capacity with limited resourcing to provide outreach. It is intended that clinicians will use set criterion to decide which young people have the greatest need for mobile outreach.

Scoring guidance:

Predominantly paperwork review, with further evidence recorded from staff interviews were needed.

Family program

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/Partially met/Unmet
24. Engagement with family/friends is promoted through contact with clinicians and family peer workers	HAPI, F, O	A) The proportion of families that are contacted by a clinician within 48 hours of entry to service and provided with psychoeducation	
		B) The proportion of families that are contacted by a family peer support worker within 7 days of entry to service	
Scoring		5 = A and B both fully met 4 = One fully met, one partially met 3 = A and B both partially met 2 = Only one partially met 1 = Both criteria not met	**ITEM SCORE**

Purpose:

To measure if there is timely contact by a clinician with family members (unless contra-indicated) of a young person newly accepted into the service. MATT, Medical or CCT clinicians will be accepted. Any type of contact is accepted e.g. SMS, phone

Scoring guidance:

A) Days between: Service date of first direct OoS where service type= Intake or Assessment and Service mode = face-to-face *AND*; Service date of first direct OoS where service type does not equal group work; service mode does not equal SMS and service provided to = Young person with family/friend present or Family

B) Days between: Service date of first direct OoS where service type= Intake or Assessment and Service mode = face-to-face *AND;* Service date of first direct OoS where service provider = Family peer worker, service mode does not equal SMS and service provided to = Young person with family/friend present or Family.

Supporting information provided by interviews with family members and FPWs.

Fully met = over 80%, partially met = over 50%, not met = minimal evidence/under 50%

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
25. Family work is considered at clinical case review or 90-day review	F, M, S	Percentage of clinical case reviews or 90-day reviews considered need for family work	
Scoring		5 = >=80% 4 = 60-79% 3 = 40-59% 2 = 20-39% 1 = 0-19%	**ITEM SCORE**

Purpose:

To ensure that the headspace Early Psychosis is prioritising providing family interventions and support and regularly reviewing the needs of families in the young persons episode of care

Scoring guidance:

Evidence of this found in file audit. Where necessary, evidence can gathered from staff interviews.

Youth peer support program

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
26. Peer support workers engage in appropriate support work with young people and receive appropriate supervision in their role	M, S, SU, FF, O	A) Peer workers undertake **one-to-one** work with young people and/or lead peer support groups	
		B) Peer workers have access to regular supervision with an appropriate peer support co-ordinator	
Scoring		5 = A and B both fully met 4 = One fully met, one partially met 3 = A and B both partially met 2 = Only one partially met 1 = Both criteria not met	**ITEM SCORE**

Purpose:

To ensure that peer support workers employed by the headspace Early Psychosis are provided with adequate training and support to provide care to young people in the program

Scoring guidance:

A) Fully met = All evidence corroborates this occurs regularly. Partially met = Some evidence that this occurs regularly. Not met = minimal evidence that this occurs regularly.

B) Fully met = All evidence corroborates this occurs regularly. Partially met = Some evidence that this occurs regularly. E.g. peer supervision occurs but not from senior peer worker Not met = minimal evidence that this occurs regularly.

Youth participation

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
27. Youth participation is embedded in the headspace Early Psychosis program	P, S, SU	Young people are supported to participate in the hEP through the following activities:	
		A) YP's are regularly invited to be involved in 1. Management meetings 2. Staff interviews 3. Committees 4. Policy documents that are written 5. Consultation processes 6. Co-design	
		B) Being remunerated for their time involved in these activities	
		C) Provided with pre-reading before these meetings and are remunerated for time preparing for these activities	
		D) Young people actively co-designed groups ran by the group program.	
Scoring		5 = 4+ of the listed activities in A occur and 2+ of B/C/D also occurs 4 = 4+ of the listed activities in A occur and 1 of B/C/D also occurs 3 = 4+ of the listed activities in A occur or 2-3 listed activities in A occur and B or D also occurs 2 = 2-3 of the listed activities in A occur 1 = One or less of the listed activities in A occur	**ITEM SCORE**

Purpose:

To measure if young people are involved in management meetings (i.e., clinical governance/risk meetings), if they appropriately remunerated for their participation (that is reimbursed in money- not vouchers) and that a system exists to best support young people in this role.

Scoring guidance:

Criterion A/B/C/D: Evidence of these activities occurring can be found within paperwork and through consultation with staff.

Workforce

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/ Partially met/ Unmet
28. Peer support workers (PSWs, this includes family PSWs) are active in the hEP program and accurately reflect the population they are working with	P, S, M, SU	A) PSWs are actively employed in the program	
		B) The role of PSWs is clear within the hEP team	
		C) The PSWs available have lived experience of FEP or being at UHR status	
		D) Family PSWs have a lived experience of having a young person who was FEP or at UHR status	
Scoring		5 = 3+ criteria are fully met 4 = 2 criteria are fully met, 2 partially met 3 = 1 criteria is fully met, 3 partially met, OR all 4 criteria partially met 2 = 2 criteria partially met, 2 not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To measure whether a peer support program is available to all young people in the service and that peer support workers are well supported by the headspace Early Psychosis program.

Scoring guidance:

A) Fully met = PSWs are present at least 4 days/week. Partially met = PSWs available 2-3 days/week. Not met = not available or only 1 day/week.

B) Fully met = All source agreement on what the role of PSWs is in the program. Partially met = Some evidence of understanding. Not met = limited evidence.

C) Fully met = all PSWs have lived experience of FEP or UHR and been through the hEP system. Partially met = 50% or more of PSWs have lived experience of FEP/UHR **OR** not been through hEP system.

D) Fully met = all FPSWs have lived experience of FEP or UHR and been through the hEP system. Partially met = 50% or more of FPSWs have lived experience of FEP/UHR **OR** not been through hEP system.

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/ Partially met/ Unmet
29. The hEP service provides new staff with a comprehensive induction programme and ensures there is ongoing support through adequate supervision and annual appraisals.	P, S, M	A) hEP induction package exists for new staff and is completed by all new staff	
		B) Formal supervision is regularly provided for all clinical staff	
		C) Staff have had a formal appraisal in the last year	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met, 1 partially met 3 = 1 criteria is fully met, 2 partially met, OR all 3 criteria partially met 2 = 2 criteria partially met, one not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To ensure new staff are adequately prepared and supported to fulfil their role in the hEP and continue to receive ongoing supervision and support.

Scoring guidance:

A) Fully met = Evidence of induction pack and training logs sighted. Evidence supported by staff interviews. Partially met = Mixed evidence from sources. Not met = no evidence

B) Fully met = 80% of clinical staff receive at least fortnightly supervision from a (more) senior clinician. Pro-rata supervision is acceptable for part time staff. Partially met = 50% staff receive at least fortnightly supervision OR 80% staff receive monthly supervision. Not met = No formal supervision arrangement or only peer supervision is available.

C) Fully met = Evidence of formal appraisals for at least 80% staff in the year, partially met = at least 50%, not met = under 50%

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
30. Staff engage with and complete the training that is available to them.	AEPP hub completion rate, M, S	A) Clinicians have completed the basic EIP model training via LMS/AEPP hub modules	
		B) Clinicians delivering psychological interventions have undertaken training via LMS and/or AEPP face-to-face or online training	
	P, M, S	C) Attendance at Continuing Professional Development (CPD) events is supported and encouraged	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met, 1 partially met 3 = 1 criteria is fully met, 2 partially met, OR all 3 criteria partially met 2 = 2 criteria partially met, one not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To ensure that staff are provided with adequate training to provide up-to-date evidence based care to young people in the headspace Early Psychosis program

Scoring guidance:

Criteria A/B: Evidence from AEPP logs of training completion rates. Fully met = over 80% of clinically facing staff completing training, partially met = over 50%, not met = minimal evidence/under 50%.

Criteria C: Evidence of this comes from paperwork review and staff interviews

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Met/Unmet
31. The clinical teams within hEP consists of a range of multidisciplinary specialities	M, P, S	A) Team includes dedicated time from: i) psychiatrist, ii) nurses, iii) psychologists, iv) Occupation Therapists, v) Social Workers, vi) family workers, vii) AOD workers, viii) peer workers, ix) vocational specialists, x) neuropsychologists, xi) art therapists, xii) cultural liaison worker	
		B) The team leader is a practicing clinician who is closely involved in the day to day clinical operations	
Scoring		5 =Team includes 7 or more of the listed staff groups and B is met 4 = Team includes 5 of the listed staff groups and B is met 3 = Team includes 3 of the listed staff groups and B is met OR 5 of the groups and B not met. 2 = Team includes 4 of the listed staff groups 1 = Team includes 3 or fewer of the listed staff groups	**ITEM SCORE**

Purpose:

To ensure the team has a true multi-disciplinary approach

Scoring guidance:

Criteria A: Use staffing profiles of the service to count the number of different professions on the staff of a service.

Criteria B: Assess if the team leader undertakes a range of clinical duties such as providing clinical supervision and direct clinical service if required through interviews

UHR detection and care

Evidence sources: F = file audit, P = paperwork review; M = manager interview, S = staff interview; HAPI = headspace tableau data; DM = Data Managers SU = service user interviews; FF = Family/carer interviews; O = interviews with staff from other mental health services

Item	Informant	Scoring criteria	Fully met/ Partially met/ Unmet
32. Determination of UHR vs. FEP status using structured assessment	HAPI, DM	A) Percentage of young people whose UHR/FEP status is determined using CAARMs/psychotic item of BPRS in hAPI	
		B) Percentage of young people with UHR status who have CAARMs completed at 90-day review	
		C) Transition from UHR to FEP services is recorded and monitored	
Scoring		5 = All criteria are fully met 4 = 2 criteria are fully met, 1 partially met 3 = 1 criteria is fully met, 2 partially met, OR all 3 criteria partially met 2 = 2 criteria partially met, one not met 1 = Maximum of 1 criteria partially met	**ITEM SCORE**

Purpose:

To measure if best practice in determining whether young people are at ultrahigh risk (UHR) of developing psychosis is adopted by the service, this includes the use of clinical assessment tools. Clinicians should be appropriately trained in administering the CAARMS before use to assess risk of psychosis and BPRS.

Scoring guidance:

Data either from HAPI or DM's as per sites internal processes

A) Fully met = over 80%, partially met = over 50%, not met = minimal evidence/under 50%

B) Fully met = over 80%, partially met = over 50%, not met = minimal evidence/under 50%

C) Evidence of process to monitor this and records routinely keep up to date = fully met. Some evidence of this = partially met. No evidence = Not met

APPENDIX 1. REMIT FIDELITY INTERVIEW GUIDE

MANAGER, STAFF AND SERVICE USER/FAMILY & FRIENDS INTERVIEW GUIDES

The REMIT (**R**evised **E**PPIC **M**odel **I**ntegrity **T**ool) interviews are structured interviews. The REMIT comprises 3 components to assess fidelity to the EPPIC model at the headspace Early Psychosis sites – structured interviews, file auditing and use of data from the headspace Early Psychosis minimum data set.

The following interview templates are for use with headspace Early Psychosis sites operations managers, clinicians, and other staff, as well as young people engaged in the service and their families and carers.

MANAGER & STAFF INTERVIEW

Questions	Responses
Community Education & Awareness	
2. Can you tell me about how you facilitate case detection and promote referrals to the service? • What activities are undertaken for case detection? • What stakeholders are targeted in these activities? • What proportion of your site's referrals come from tertiary mental health – i.e., inpatient unit and emergency department? • Do you have a strategic plan for case detection and community education and awareness?	
Home-based Care and Assessment	
4. Can you tell me about your initial assessment processes for FEP and UHR? • How do you provide feedback to families/carers of young people at the completion of the assessment?	
5. Can you give me some examples of how you operate flexible outreach services? • How often are young people able to be seen at locations outside of the hEP site? • Is a young person able to choose where they wish to be seen?	

- Do you offer after hours and weekend service to young people?

6. Which of the following are offered at this hEP?

- Case management/care coordination
- Physical health interventions and support
- Psychological interventions
- Substance use management
- Vocational support
- Family education and support
- Psychoeducation
- Pharmacotherapy

7. Does your site's caseload meet the targets set out?

- What is the caseload per full time clinician?
- How are caseloads titrated for part time and new staff?

10. How do you identify and respond to incomplete recovery at 6 months?

- Are strategies such as reviewing scores on BPRS, SOFAS, K10, and progress notes and contacting family of the young person used?
- When incomplete recovery is identified does the young person receive:
  - Review from a senior clinician with an action plan recorded?
  - Review from a consultant psychiatrist with an action plan recorded?
  - Specific strategies to facilitate recovery which are documented and shared with the young person and their family and carers?

11. How does the hEP service promote proactive engagement throughout the episode of care?

- How is outreach work promoted and supported?
- Is the engagement of young people supported if they are involved in education and/or employment? I.e., offering flexible appointments
- How do you monitor and minimize dropout from the service?
- When does discharge planning commence?

12. How does your hEP promote continuous engagement through to the end of tenure of care?

- Are young people assessed or reviewed every 90-days?
- How long do young people stay in your service for?
- How often are young people seen throughout their tenure of care?

Medical Treatments

15. How do you promote the use of clozapine for appropriate young people?

- Is clozapine provided and monitored in house or is use of state-based services required?
- Is physical health monitoring undertaken as per clozapine treatment guidelines?
- Is physical health monitoring activity uploaded into clinical notes?
- What % of young people who have medication resistant psychosis are prescribed clozapine after they do not adequately respond to two courses of first line antipsychotic medications?

16. How do you support the physical health of young people in hEP?

- Does the hEP ensure a young person has a GP and support them to engage when necessary?
- Does the hEP measure and provide feedback on weight gain and advice on diet and exercise?
- Is a young people's sexual health assessed?
- Are extrapyramidal side effects monitored and documented?
- Are triglycerides and glucose/HbA1C monitored annually?
- Are cigarette smoking habits monitored and documented?
- Are smokers wishing to quit supported by the prescription of pharmacological supports?
- What physical health interventions are delivered at the hEP ?

Psychological Interventions

20. What processes do you have in place to assist young people to access a cognitive or neuropsychological assessment? E.g. in house, referrals to community services.

Functional and Psychosocial Recovery Program

22. What functional and recovery orientated groups are run or accessible by young people currently?

- Which of the following do you cover?
  1. social and recreational,
  2. vocational and educational,
  3. psychoeducational and personal development
  4. creative and expressive
- How do you consult with young people about what they want from the group program?
- Are group programs accessible to young people at all the sites your hEP offers?

Intensive Mobile Outreach

23. What systems do you have in place to identify young people in need of intensive mobile outreach?

- Is there a standard operating procedure to identify and support those with incomplete recovery?
- Do young people identified as having incomplete recovery receive the appropriate case review involving senior clinician and consultant psychiatrist?

Family Program

25. How do you ensure that family work is considered at clinical case review or 90-day review?

Youth Peer Support Program

26.What work do peer workers engage in at your service?

What supervision arrangements are in place for them?

Youth Participation

27. How is youth participation embedded in your service?

- What regular meetings are YPs invited to be involved in?
- Are they paid for their time? And for time undertaking pre-reading?
- Are YPs actively involved in co-designing the group program?

Workforce

28. How are Family/Peer Support Workers involved in the hEP program?

- How do you ensure clarity of F/PSW roles in the team?
- Have the F/PSWs employed here experienced a FEP or being at UHR status? (or a family member with FEP or at UHR)?
    - Have they previously attended the service they are working in?

29. How are new staff supported when they join the hEP?
    - What induction program do you run?
    - What supervision arrangements are there in place?
    - How do you ensure that annual appraisals for staff occur?

30. How are staff supported to engage with and complete the training that is available to them?
    - Is attendance at CPD events supported and encouraged?
    - Are clinicians supported to complete the early intervention in psychosis modules via the LMS/AEPP hub?
    -

31. Does your team include the following?
    - Psychiatrist
    - Nurses
    - Psychologists
    - Occupational therapists
    - Social workers
    - Family workers
    - AOD workers
    - Peer workers
    - Vocational specialists
    - Neuropsychologists
    - Art therapists
    - Cultural liaison worker
    - Is your manager a practicing clinician who is closely involved in the day to day clinical operations?

Do you have anything else you would like to share with us?

Questions	Responses
Home-based Care and Assessment	
4. Was the initial assessment into service conducted soon after you/your young person were referred to the service? • Did your family/you receive feedback after completion of the assessment?	
5. Was the service flexible about where they saw you/your young person? • Did you need to access them outside of 9-5 Mon-Fri at any point? • If you wanted to meet at home or outside of the headspace site was this supported?	
9. Did you feel you had the option to contribute to the plan of care (sometimes called an Individual Treatment Plan) that was created for you? • Were your wants and needs incorporated into the care you received at hEP? • Was this updated every 3 months? i.e. do you remember going back over your current wants/needs regularly and update things as necessary?	
12. Were you/your young person seen regularly throughout your/their time at hEP and receive the appropriate length of care? (at least 2 years for FEP and 6 months for UHR) • How often did you/your young person see their treating clinician? • How long did you/your young person remain in the hEP program?	
Medical Treatments	
13. Were you/your young person informed that psychiatric registrars may offer time limited support as per their clinical rotation?	
16. How is your/your young person's physical health supported by the service? • Do they support you to engage with a GP when necessary? • Do they measure and provide feedback on weight gain and advice on diet and exercise? • Do they assess your sexual health? • Are the side effects of your medication monitored and documented?	

- Are your bloods taken annually?
- Are your cigarette smoking habits monitored?
- If you smoke and wanted to quit, have they offered you support?

Functional and Psychosocial Recovery Program

22. Can you tell me about the groups you/your young person has attended as part of the service?
    - Did you have the opportunity to attend groups? If a group was offered at another centre in the hEP cluster, could you attend?
    - Did you attend them? Can you tell me a bit more about them?

Youth Peer Support Program

26. Have you had any input from a peer worker?
    - What did they do?
    - Do you remember clinicians explaining to you about the option of having input from a peer worker?

Youth Participation

27. Can you tell me about any involvement you've/your young person has in the youth participation program?
    - i.e. were you made aware of the Youth Advisory Group/Youth Reference Group/Youth Ambassador Group and how you could contribute to that in time?

Workforce

28. Have you had any input from a family peer worker around supporting your young person?
    - What did they do?
    - Do you remember clinicians explaining to you about the option of having input from a family peer worker?

Do you have anything else you would like to share with us?

APPENDIX 2

REMIT FILE AUDIT TOOL

Today's date: _____ Fidelity interview dates: _____

Site name: _____ Reviewers names: _____

ITEM	1	2	3	4	5	6	7	8	9	10
HAPI ID#										
4. Evidence of family received feedback after initial assessment is completed with their young person Y/N										
5. Evidence of YP being seen in a setting other than the hEP site at any point in their care e.g., at home, school, coffee shop, park Y/N										
6. Evidence of following interventions delivered:										
1) case management/care coordination	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___
2) physical health interventions and support	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___
3) psychological interventions	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___
4) substance use management	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___
5) vocational support	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___
6) family education and support	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___
7) patient psychoeducation	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___
8) pharmacotherapy	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___
9. Individual Treatment Plan in place?										
1) Care plan/ITP is completed within 6 weeks of allocation	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___
2) Care plan/ITP includes relapse planning	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___
3) Care plan/IPT reviewed, and updated every 3 months	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___

10. Incomplete recovery is identified at 6 months, 1) The young person is reviewed by a senior clinician and an action plan recorded 2) Young person is reviewed by a consultant psychiatrist and an action plan is recorded 3) Specific strategies to facilitate recovery are identified and documented, 4) Specific strategies are shared with YP and F&F and documented Y/N/NA	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**	**1)___** **2)___** **3)___** **4)___**
12. Discharge planning is evident more than 3 months before discharge Y/N/NA										
14. Antipsychotic Medication Prescription (indicated in psychiatrist notes/prescription copy) Or evidence cited of medical decision making around non-prescribing Y/N										
14. Antipsychotic Dosing within Guidelines for Individuals with Psychosis – at 6 month 1) Medication 2) Daily dose	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**
14. Second antipsychotic medication prescribed at 6 months? 1) Medication 2) Daily dose	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**	**1)** **2)**
15. Prescribed Clozapine? Y/N										
16. The physical health of young people in hEP is supported through a range of interventions										

1)	Ensure young person has a GP and support them to engage when necessary	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___	**1)**___
2)	Measure and provide feedback on weight gain and advice on diet and exercise	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___	**2)**___
3)	Assess sexual health	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___	**3)**___
4)	Monitor and document extrapyramidal side effects	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___	**4)**___
5)	Monitor triglycerides and glucose/Hb A1c annually	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___	**5)**___
6)	Monitor and document cigarette smoking habits	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___	**6)**___
7)	Prescribe pharmacological supports to smokers wishing to quit	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___	**7)**___
8)	Deliver physical health-based interventions/groups around diet	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___	**8)**___
9)	Deliver physical health-based interventions/groups around exercise	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___	**9)**___
10)	Communicate regularly with the GP	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___	**10)**___
18. Evidence that a young person's psychological treatment goals are reviewed every 90-days	Y/N									
19. CBT need and sessions received are documented in the treatment plan?	Y/N									
21. Functional recovery goals and treatment plan documented	Y/N									
25. Family work need is considered at clinical case review or 90-day review and evidence recorded	Y/N									

REMIT Item	Abstractor's comments
4. Initial assessments are conducted as soon as possible from date of referral to the hEP services with feedback provided to families (unless contraindicated)	
5. hEP services are flexible and provide outreach services when required	
6. Qualified professionals deliver a variety of interventions	
9. Each young person has a Individual Treatment Plan (also called a Care/Wellbeing/ Recovery Plan in some places) which is reviewed and updated every 3 months	
10. Incomplete recovery is identified at 6 months, and this triggers a specific response aimed to facilitate recovery	
12. The hEP service promotes continuous engagement through to the end of tenure of care	
14. Antipsychotic dosing within recommendations for individuals with FEP	
15. Clozapine is used appropriately for young people with medication resistant psychotic symptoms	

16. The physical health of young people in hEP is supported through a range of interventions	
18. Goals for psychological treatment are reviewed and reflected in treatment plan at each 90-day review	
19. CBT is provided for symptoms and comorbidities (e.g. positive psychotic symptoms, anxiety, depression, adaptation to illness, substance use) that have been identified and documented in the treatment plan?	
21. Functional recovery goals (i.e. vocational, educational, social, relational, occupational) and strategies to achieve them are documented	
25. Family work is considered at clinical case review or 90-day review	

APPENDIX 3

REMIT SCORING SHEET

Today's date: _____ Fidelity interview dates: _____

Site name: _____ Reviewers names: _____

Item	Score
1. DUP is measured for all young people with suspected first-episode early psychosis (FEP)	
2. The hEP service carries out a comprehensive range of activities with a focus on case detection and promoting referrals	
3. The sources of referrals to the hEP service are varied	
4. Initial assessments are conducted as soon as possible from date of referral to the hEP services with feedback provided to families (unless contraindicated)	
5. hEP services are flexible and provide outreach services in when and where they see a young person	
6. Qualified professionals deliver a variety of different interventions	
7. Caseload per cluster meets the targets set out	
8. Engagement with case manager occurs within a timely manner from their acceptance into hEP	
9. Each young person should have an Individual Treatment Plan (also called a Care/Wellbeing/ Recovery Plan in some places) which is reviewed and updated every 3 months	
10. Incomplete recovery is identified at 6 months, and this triggers a specific response aimed to facilitate recovery	
11. The hEP service promotes proactive engagement throughout episode of care	
12. The hEP service promotes continuous engagement through to the end of tenure of care	
13. Young person accepted onto the hEP program receives medical review within appropriate time frame (unless reviewed in assessment phase).	
14. Antipsychotic Dosing within Recommendations for Individuals with Psychosis	
15. Clozapine is used appropriately for young people with medication resistant psychotic symptoms	
16. The physical health of young people in hEP is supported through a range of interventions	
17. Physical health screening and monitoring is regularly carried out	
18. Goals for psychological treatment are reviewed and reflected in treatment plan at each 90-day review	
19. CBT is provided for symptoms and comorbidities (e.g. positive psychotic symptoms, anxiety, depression, adaptation to illness, substance use) that have been identified and documented in the treatment plan?	
20. Availability of cognitive or neuropsychological assessment	
21. Functional recovery goals (i.e. vocational, educational, social, relational, occupational) and strategies to achieve them are documented	
22. Functional and recovery orientated groups are run or accessible by young people attending hEP	

23. There is a locally specific system in place to identify young people in need of intensive mobile outreach	
24. Engagement with family/friends is promoted through contact with clinicians and family peer workers	
25. Family work is considered at clinical case review or 90-day review	
26. Peer support workers engage in appropriate support work with young people and receive appropriate supervision in their role	
27. Youth participation is embedded in the headspace Early Psychosis program	
28. Peer support workers (PSWs, this includes family PSWs) are active in the hEP program and accurately reflect the population they are working with	
29. The hEP service provides new staff with a comprehensive induction programme and ensures there is ongoing support through adequate supervision and annual appraisals.	
30. Staff engage with and complete the training that is available to them.	
31. The clinical teams within hEP consists of a range of multidisciplinary specialities	
32. Determination of UHR vs. FEP status using structured assessment	
Total mean fidelity score (S.D)	

APPENDIX 4

MEDICATION PRESCRITION GUIDELINES

Generic Name	Proprietary Name	Approved Dose Range	Prescribing Restrictions
Aripiprazole Oral	Abilify	10-15mg daily; up to 30mg daily Trials have been completed in those aged 13-17 for up to 30mg daily	Diagnosis of schizophrenia
Aripiprazole IM LA	Abilify Maintaina	Initially 400mg once a month, reduced to 300mg once a month if this is not tolerated (Minimum 26 days between injections)	Diagnosis of schizophrenia
Asenapine	Saphris	5-10mg twice daily (10mg twice daily may not provide additional benefit and increases risk of adverse effects) For those aged up to 17 – 2.5mg-10mg adjusted for response and tolerability. Start at 2.5mg twice daily for 3 days, then increased to 5mg twice daily then 5-10mg twice daily after an additional 3 days. This population is more sensitive to dystonia if titration schedule not followed	Diagnosis of schizophrenia, acute mania or mixed episodes OR bipolar I disorder
Brexpiprazole	Rexulti	2mg-4mg daily Initially 1 mg once daily on days 1–4, then increase to 2 mg once daily on days 5–7, then to 4 mg once daily from day 8, depending on response Not approved for use in children under 18	Diagnosis of schizophrenia
Chlorpromazine	Largactil	25mg-100mg 3 or 4 times a day; adjusted according to response Dosing range not well defined – 500-600mg per day is generally adequate	N/A
Clozapine	Clopine	200-600mg daily (maximum 900mg daily) 12.5 mg on the first day, increased to 25–50 mg on second day. If well tolerated, increase in 25–50 mg increments to 300 mg daily within 2–3 weeks. Then increase in 50–100 mg increments at 4–7-day intervals if required	Diagnosis of schizophrenia
Flupentixol IM LA	Fluanoxol	20mg-40mg every 2-4 weeks. Usual maximum 100mg every 2 weeks Give a 5–20 mg test dose to patients not previously treated with long-acting antipsychotic injections to check for adverse effects Not recommended for use in children under 18	
Haloperidol	Serenace	5mg-10mg every 2 hours as needed Maximum 100mg/day Children 13 and initially 0.25mg-1mg daily in 1 or 2 doses; gradually increased by 0.5mg-1mg over a period of weeks to a maximum 10mg daily in 1 or 2 doses	
Haloperidol Deconate IM LA		50mg-300mg every 4 weeks 25mg test dose followed by 10-15 times the previous dose of oral haloperidol (not to exceed 100mg) every 2-6 weeks depending on response Not approved for use in children under 18	
Lurasidone	Latuda	Initially 40mg once daily, usual range 40mg-80mg (maximum 160mg daily) For children 13-17 years – initially 40mg daily, increased to maximum 80mg if clinically indicated	Diagnosis of schizophrenia
Olanzapine	Zyprexa	Initially 5mg-10mg daily, increased by 2.5mg-5mg per week as clinically indicated Maximum 20mg per day	Diagnosis of schizophrenia OR bipolar I disorder

Olanzapine IM LA	Zyprexa Relprevv	*Long-acting IM*, once every 2 or 4 weeks. If the previous oral olanzapine dose is: • 10 mg daily, then use 210 mg IM every 2 weeks or 405 mg IM every 4 weeks for the first 2 months, then 150 mg IM every 2 weeks or 300 mg IM every 4 weeks. • 15 mg daily, then use 300 mg IM every 2 weeks for the first 2 months, then 210 mg IM every 2 weeks or 405 mg IM every 4 weeks. • 20 mg daily, then use 300 mg IM every 2 weeks. Not recommended for use in children under 18	Diagnosis of schizophrenia
Paliperidone	Invega	Initially 6mg daily increased by 3mg at 4–5-day intervals as clinically indicated Usual dose ranges 3mg-12mg daily Not recommended for use in children under 18	Diagnosis of schizophrenia
Paliperidone IM LA	Invega Sustenna Invega Trinza	Sustena (monthly) - 150 mg on day 1, then 100 mg on day 8, then 75 mg 1 month later (maintenance dose). Give the maintenance dose once a month and adjust as required (range 25–150 mg once a month). Trinza (3-monthly) - once every 3 months and adjust dose according to response. If the previous paliperidone once-monthly long-acting injection dose is: • 50 mg, then use 175 mg IM. • 75 mg, then use 263 mg IM. • 100 mg, then use 350 mg IM. • 150 mg, then use 525 mg IM. To switch from 3-monthly long-acting injection to the once-monthly long-acting injection, divide dose by 3.5 and give this dose when the next dose is due. Not recommended in children under 18 years	

Pharmacological treatment for first episode non-affective psychosis

Add benzodiazepine

- Agitation/aggression e.g. diazepam
- Anxiety, e.g. lorazepam
- Sleep disturbance e.g. temazepam

Psychiatric and physical assessment

Allow antipsychotic drug-free assessment phase

Psychiatric emergency

Long-acting injectable antipsychotic medications can be administered as a first-line treatment within a shared-decision making framework

Start antipsychotic treatment

Start low, go slow

Differential diagnosis

If manic or depressive symptoms evident, consider other disorders which involve psychosis:

- Bipolar I disorder with psychotic features
- Schizoaffective disorder
- Major depressive disorder with psychotic features

Amisulpride

Start with: 50-100mg/day
Initial target dose: 300-40mg/day
Highest dose: up to 800mg/day

Aripipazole:

Start with: 5-10mg/day
Initial target dose: 15-20mg/day
Highest dose: up to 30mg/day

Quetiapine

Start with: 25-50/day
Initial target dose: 300-40mg/day
Highest dose: up to 750mg/day

Risperidone

Start with: 0.5-1mg/day
Initial target dose: 2-3mg/day
Highest dose: up to 6mg/day

Ziprasidone

Start with: 20-40mg/day
Initial target dose: 80-120mg/day
Highest dose: up to 160mg/day

Start low dose

then slowly increase according to efficacy and tolerability
to initial target dose

Non-adherence:

- Discuss with patients and carers, analyse reasons and optimise treatment, give compliance therapy
- For non-adherence because of side effects: try another antipsychotic drug
- Consider trial of depot medication (e.g. atypical depot agents or low-dose typical drugs)
- Improved adherence: go on with treatment or switch to other antipsychotic if no response

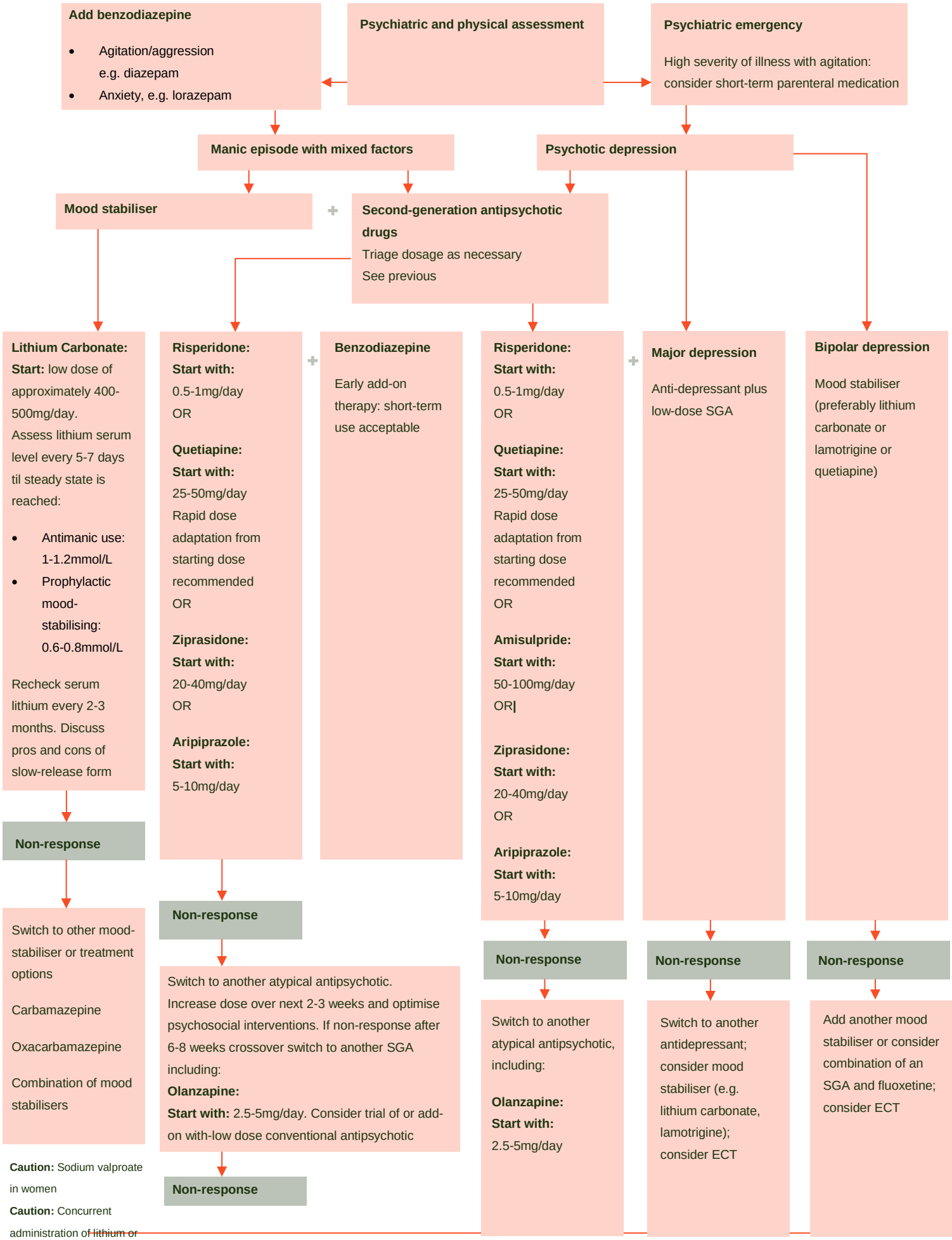
Response:

- Continue treatment for at least 2-5 years
- If incomplete remission or treatment resistance, consider long-term treatment
- If discontinuing, stop gradually over at least 3-6 months with close follow-up

If insufficient response after 3 weeks:
Increase dose over next 2-3 weeks and optimise psychosocial interventions
If non-response after 6-8 weeks:
Cross-over switch to another SGA
If non-response to second antipsychotic trial:
review reasons for failure e.g. adherence, substance use, family stresses etc
Consider olanzapine
(use with caution)
Start with: 2.5-5mg/day
Initial target dose: 10mg/day
Highest dose: up to 20mg/day

Consider switch to clozapine:
Start with: 25mg/day
Initial target dose: 300mg/day
Highest dose: 900mg/day
If not possible, consider add-on or trial of low dose typical antipsychotic or mood stabiliser or (other) antipsychotic combination therapy

Pharmacological treatment for first episode affective psychosis



Pharmacological treatment for first episode non-affective psychosis

Pre-commencement protocol:

- Assess current smoking status
- Review and document medical history
- Provide and explain clozapine information to consumer and family/carer
- Complete local clozapine prescribing requirements
- Inform local authorities as required
- Provide pharmacist with blood test results and prescription
- Complete all locally required authorisations

Complete clozapine monitoring:

Bloods:

- Full blood count (FBC)
- White blood cell (WBC)
- Neutrophils
- Eosinophils
- Troponin
- C-reactive protein (CRP)
- Electro cardiograph
- Liver function test (LFT)
- Urea & electrolytes (U&E)
- Blood group
- Plasma glucose – fasting
- Total cholesterol fasting
- Low density Lipoprotein (LDL)
- High density Lipoprotein (HDL)
- Triglycerides – fasting
- Beta Human Chroironic Gonadotropin – female (HCG)
- Cardiac ECHO
- Clozapine level

Full physical exam: weight, height, waist, BMI, smoking

Provide initial dose of clozapine:

- Take and record pulse, respiration (TPR), and lying and standing blood pressure prior to administration of clozapine
- Administer clozapine at 12.5mg mane
- Repeat above vital observation every 30 minutes for 2 hours, then hourly for 4 hours

Vital signs outside normal parameters

Seek medical review

Vital signs within normal parameters

Provide subsequent dose of clozapine:

- Take and record TPR and lying and standing blood pressure pre-dose, and 4-6 hours post-dose
- Administer 25mg clozapine mane

Day 7:
Blood & physical monitoring:
- FBC
- Neutrophils
- Eosinophils
- Troponin
- CRP
- ECG
- Clozapine level
- Weight, BMI, smoking

Day 14:
Blood & physical monitoring:
- FBC
- Neutrophils
- Eosinophils
- Troponin
- CRP
- ECG
- Clozapine level
- Weight, BMI, smoking

Day 21:
Blood & physical monitoring:
- FBC
- Neutrophils
- Eosinophils
- Troponin
- CRP
- ECG
- Clozapine level
- Weight, BMI, smoking

Day 28:
Blood & physical monitoring:
- FBC
- Neutrophils
- Eosinophils
- Troponin
- CRP
- ECG
- Clozapine level
- Weight, waist, BMI, smoking

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Morning	12.5mg	25mg	25mg	25mg	25mg	25mg	25mg	25mg	50mg	50mg	50mg	50mg	50mg	50mg
Evening	X	X	X	25mg	25mg	50mg	75mg	100mg	100mg	100mg	125mg	125mg	125mg	150mg

Note: Guidelines are not a substitute for clinical knowledge. The range of treatment doses and dose increases should take into account clinical presentation

Quetiapine (quetiapine fumurate) in this algorithm refers to the non-extended-release formulation