

OMH First Episode Psychosis (FEP) Practice Guidelines	
Updated Guideline for 2021	
<b>SOURCE</b>	National Institute of Mental Health
<b>PUBLISH DATE</b>	2014
<b>WEBSITE</b>	<a href="https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf">https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf</a>
<b>GUIDELINE OVERVIEW</b>	
<b>General Considerations</b>	Approximately 100,000 adolescents and young adults in the United States experience FEP each year (calculated from McGrath, Saha, Chant, et al., 2008). With a peak onset occurring between 15-25 years of age. Psychotic disorders such as schizophrenia can derail a young person’s social, academic, and vocational development and initiate a trajectory of accumulating disability. Both meta-analytic and narrative reviews of randomized and quasi-experimental treatment studies conclude that early intervention services for psychosis can improve symptoms and restore adaptive functioning in a manner superior to standard care.
<b>Summary of Recommendations</b>	<p><b>Coordinated Specialty Care (CSC)</b> is a team-based, multi-element approach to treating FEP. Component interventions include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents.</p> <p>At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants.</p> <p>CSC provides six critical functions for young people experiencing a first episode of psychosis:</p> <ol style="list-style-type: none"> <li>(1) access to clinical providers with specialized training in FEP care.</li> <li>(2) easy entrée to the FEP specialty program through active outreach and engagement.</li> <li>(3) provision of services in home, community, and clinic settings, as needed.</li> <li>(4) acute care during or following a psychiatric crisis,</li> <li>(5) transition to step-down services with the CSC team or discharge to regular care after 2-3 years, depending on the client’s level of symptomatic and functional recovery.</li> <li>(6) assurance of program quality through continuous monitoring of treatment fidelity.</li> </ol>
<b>Treatment Resources</b>	<p><a href="https://www.nimh.nih.gov/health/topics/schizophrenia/raise/state-health-administrators-and-clinics">https://www.nimh.nih.gov/health/topics/schizophrenia/raise/state-health-administrators-and-clinics</a></p> <p>The RAISE Connection Program clinical manuals were revised and adapted for use in the implementation of a statewide CSC program, ‘OnTrackNY.’ These materials will be available for download at <a href="http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx">http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx</a>.</p>