# Coordinated Specialty Care for Early Psychosis in Massachusetts

## A Model to Implement Evidence-Based Practices

mapnet

Mass DMH Department of Mental Health

# Acknowledgements

This document was prepared by Emily R. Kline, PhD and Kelsey A. Johnson, MPH at Beth Israel Deaconess Medical Center (BIDMC) on behalf of the Massachusetts Psychosis Network for Early Treatment (MAPNET).

Please cite as:

Kline, E. R., & Johnson, K. A. (2021). *Coordinated specialty care for early psychosis in Massachusetts: A model to implement evidence-based practices* [White paper]. Massachusetts Psychosis Network for Early Treatment. www.mapnet.online/treatment-manuals

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As well as the mentorship and vision of Larry Seidman, PhD & Suzannah Zimmet, MD

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# Introduction

An estimated 3% of the population will develop a psychotic disorder in their lifetime, with the onset of these disorders peaking in adolescence and young adulthood (Kessler et al., 2005). Psychotic disorders can lead to a number of distressing outcomes for young people, not least of which being frequent hospitalizations and a derailment of functioning in school, work, and relationships. These disorders are thought to result from a combination of vulnerability factors within an individual (ex. genetics, perinatal complications, history of traumatic brain injury) and external stressors (ex. trauma, financial stress, substance use), which can accumulate throughout prenatal, infant, childhood, and adolescent development (Figure 1). In this critical period of development, there is strong evidence that early identification and intervention (EI) can reduce the disability caused by psychotic disorders (Correll et al., 2018).

Hand-in-hand with the concept of EI is an observed phenomenon of significant treatment delays following the initial presentation of psychotic symptoms, labelled the duration of untreated psychosis (DUP). Studies across a number of healthcare contexts have identified a delay of months to years between a person's first experience of psychosis and their first interaction with specialized treatment (Perkins et al., 2005). Longer DUP is associated with poorer treatment outcomes, including increased hospitalization and re-hospitalizations, poorer social functioning, lower quality of life, and diminished neurocognitive functioning (Albert et al., 2017; Keshavan et al., 2003; Penttilä et

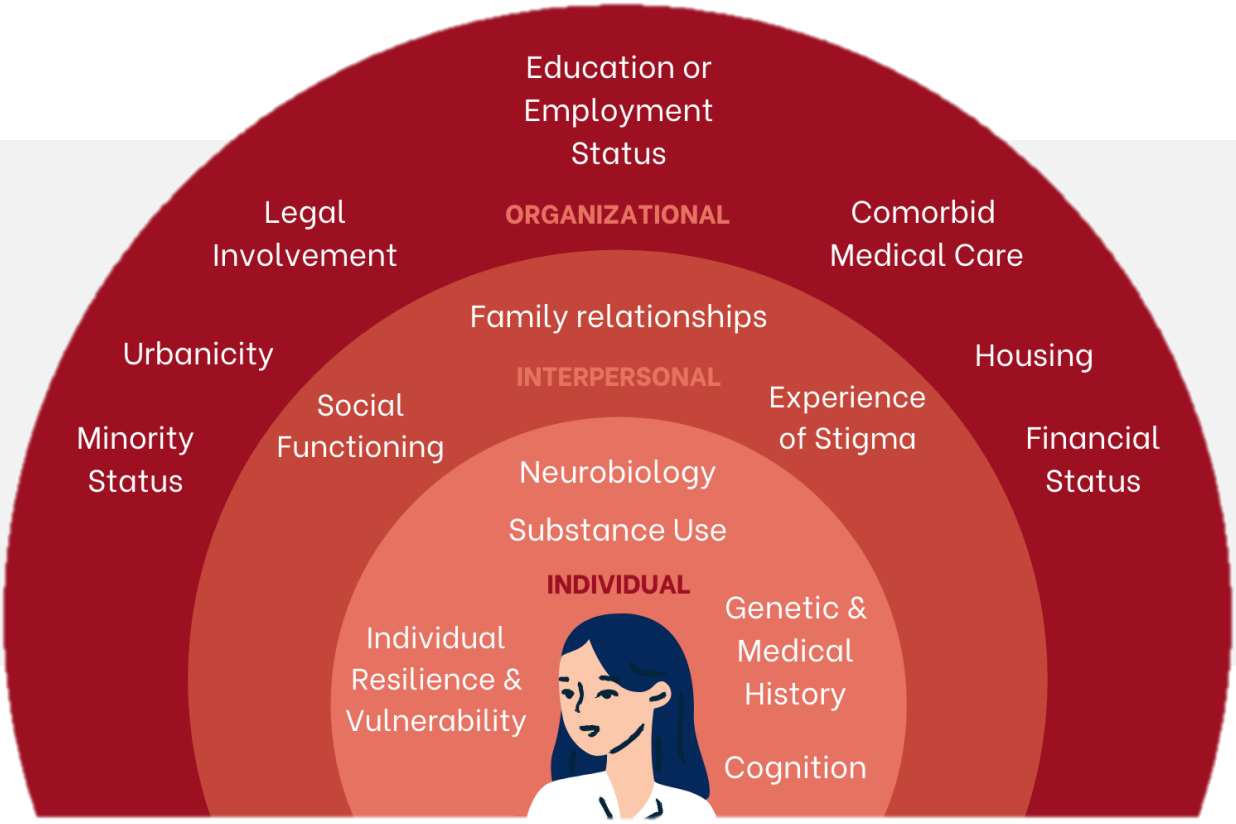



Figure 1. Risk & protective factors for psychotic disorders

al., 2014). It is also important to note that suicide risk is high in the first 5 years of a psychotic disorder, with nearly 50% of all suicides occurring in this time frame (Dutta et al., 2010). As such, effective and timely EI can be life-saving. There is a clear need for readily accessible interventions that can reduce treatment delays, arrest biological and social declines, prevent suicide, and help youth to get back on track after a psychotic episode.

On a positive note, interventions to reduce DUP are known to improve long-term treatment outcomes for young people (Hegelstad et al., 2012). This may be because the brain is more plastic during adolescence and early adulthood, and is still in the process of maturing cognitive, emotional, and social functions (Fisher et al., 2013; Spear, 2013). In acknowledging this along with the factors outlined above, the United States government has allocated a percentage of funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop treatment models for EI in psychosis (*Senate Report No. 113-171*, 2013). The years since this 2014 legislation have provided valuable experience in the state of Massachusetts regarding the translation of evidence-based coordinated specialty care (CSC) to real-world clinical settings. In this document, we outline key takeaways from this experience and propose a model of care that addresses the observed needs of young people and their families during the early years of a psychotic disorder.

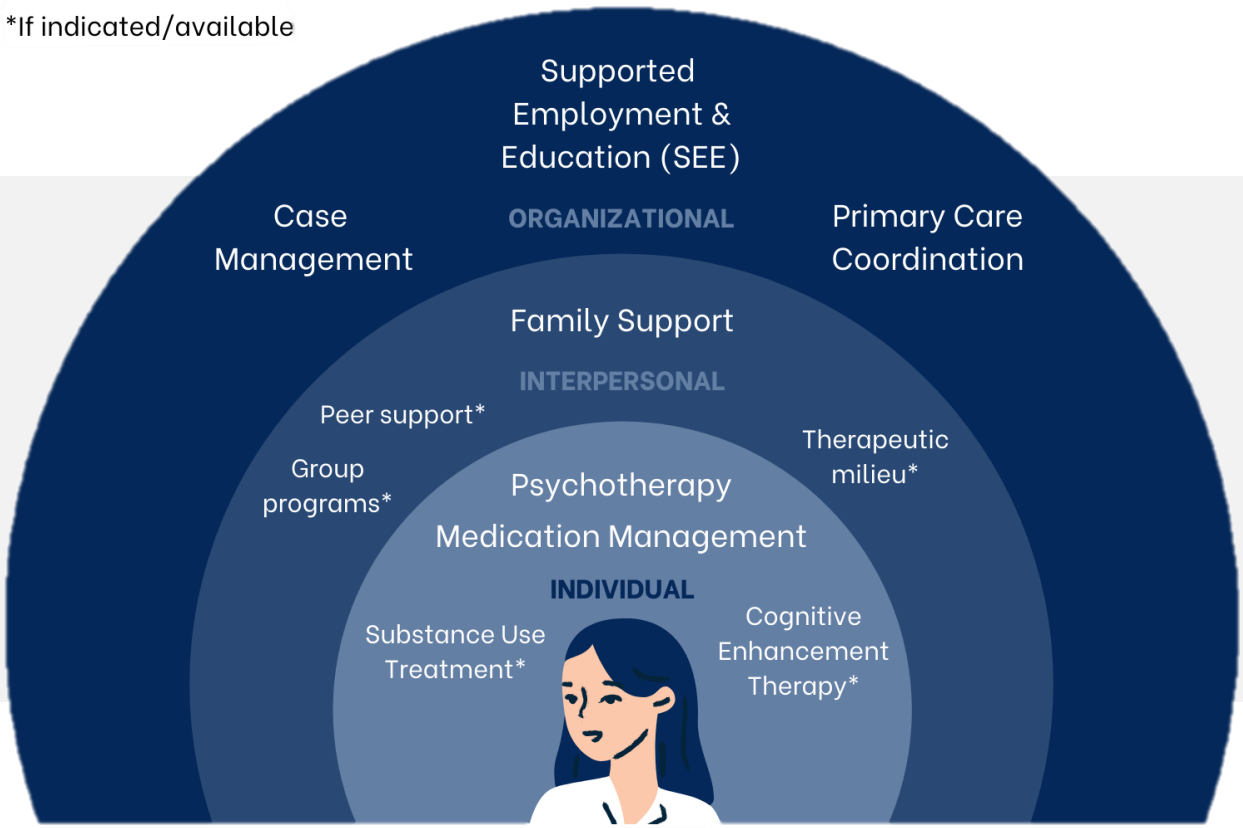



Figure 2. Components of care for early psychosis

# Principles of Care

While there are many different ways to implement evidence-based care for FEP, all programs must embody a humanistic, developmentally sensitive, and evidence-based approach to early intervention in psychosis. Regardless of program elements included in the model, all treatment should strive to embody the following principles, many of which have been implemented in an international context (Corsico et al., 2018) in countries such as Australia (Early Psychosis Guidelines Writing Group and EPPIC National Support Program, 2016) and Canada (Mental Health Evaluation & Community Consultation Unit, 2000).


## Engagement First: Prioritizing DUP Reduction

Most of the evidence favoring early intervention in psychosis takes as a basic premise that *when* treatment is offered may be as important to *what*, specifically, is included in the intervention. Long duration of untreated psychosis is associated with diminished treatment response and worse functional outcomes, and the extent to which CSC models succeed is moderated by the DUP of clients receiving the care (Kane et al., 2016). Therefore, finding clients early in their illness and offering services that promote engagement and retention during this critical period is a priority.

In practical terms, this means that offering **rapid access to care** should be a guiding priority. Long waitlists for services undermine the principle of DUP reduction and weaken the impact of any intervention for FEP. CSC providers should aim to offer an initial therapeutic encounter as soon as possible, preferably within seven days of determining that a referral is a good fit.

A second practice that follows from the principle of DUP reduction is some degree of **tolerance for diagnostic uncertainty**. Often it is unclear at the onset of psychosis whether the client will ultimately be diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or a brief psychosis. For many cases, the diagnostic process involves observation over time. A clear diagnostic consensus is not critical for initial engagement and intervention, so long as there is a clear indication of recent-onset psychotic symptoms that are impairing functioning and persist beyond a period of intoxication or delirium. An accurate diagnosis often takes months, or even years of careful observation.

Depending on the culture and preferences of the clinic and clients served, CSC teams should also consider the following practices to promote engagement and retention in care:

- **Flexibility** with times and locations (e.g., evening, in-home, and/or telehealth services).
- **Social groups** and/or peer support in the form of drop-in social hours, peer mentorship, or loosely structured activities like basketball or art groups.

- **Shared decision making** documented for all services, with clients (and their families and/or other caregivers) consulted about their treatment preferences and affirmatively agreeing to treatment decisions.
- **Inviting, age-appropriate environment** which strives to avoid overly pediatric settings (for instance, with ABC's or train sets decorating the walls). Providers might also consider separating waiting and social areas for those with recent-onset illness from those for clients with chronic disabilities.
- **Efforts to ensure continuity of care** and re-engagement, such as as-needed contact with hospital-based, school-based, and primary care providers.

## Whole Person Care

Psychosis is rarely the "only" challenge in a person's life. Teens and young adults experiencing recent-onset psychosis are often struggling with psychosis as well as issues such as substance use, housing instability, loneliness, racism, trauma, family conflict, sexual health, and uncertainty about their educational and occupational futures (Ballageer et al., 2005; Dvir & Frazier, 2013). FEP providers should also assume that FEP clients have experienced trauma either in their developmental history or as a consequence of their psychosis. CSC programs should strive to create treatment plans that incorporate these diverse challenges, rather than isolating psychosis as the only problem for which they can provide support.

With this in mind, treatment must be explicitly oriented around recovery within the context of the client's social support system (usually their parents and family) and sensitive to developmental and cultural context. More often than not, teens and young adults experiencing FEP live with and receive support from their parents, and thus involving parents in the process of engagement, learning about the history, setting recovery goals, and providing support and education is a critical aspect of CSC (McFarlane, 2016). Just as critical is appreciation for the impact of both chronic and acute social stressors such as racism, bullying, poverty, and loneliness. Although clinicians may feel helpless to *intervene* upon chronic external stressors, they can create space and trust to openly discuss with clients and families the impact of these factors on clients' mental health and functioning.

## Conceptualization-Based, Individualized Treatment

Given the principles of engagement-first, whole-person care, it follows that treatment must be individualized and based upon a biopsychosocial conceptualization (Engel, 1977). Based on their understanding of the client's biology, psychology, and social context, providers must ask themselves, "Based on what I know about this person, what led to their illness? What is in the way of recovery? What is the way forward?" The answers to these questions are the basis of a clinical conceptualization, which in turn should suggest relevant interventions.

Evidence-based treatment components such as employment support, psychoeducation, and antipsychotic medication may be part of the individualized treatment plan. Manualized treatment protocols such as "NAVIGATE" offer excellent, modularized interventions that can be used within the context of individualized treatment plans. However, the plan itself should be conceptualization-driven, rather than pre-determined. In other words, manualized treatments

such as NAVIGATE should be deployed to fit the individual needs of the client, rather than requiring clients to satisfy the dictates of the manual.

Individualized treatment plans should also strive to do the following: update regularly, identify needs and goals (including vocational/educational goals), identify service preferences, specify a course of action for therapeutic intervention, and assess whether clients met the goals outlined in the prior treatment plan. Clients should be involved in the creation and review of treatment plans, and plans should be reviewed in multidisciplinary team meetings.

## Recovery Orientation

Treatment should have the ultimate goal of symptomatic, functional (educational, occupational), and personal recovery wherein the experience of illness is integrated with one's overall sense of self (Best et al., 2020). This is in contrast to the goal of simply reducing or controlling *symptoms* – hallucinations, delusions, unusual behavior – as the end result of treatment. In the context of substance use, treatment should be organized around the principle of leading a valued life, rather than eliminating or minimizing use of drugs and alcohol per se. Clinicians should not *ignore* symptom recurrence or drug and alcohol use, but rather assess symptoms or use of substances in the context of how these may impair patients' progress toward important goals such as participation in the workforce, completing their education, establishing romantic or social relationships, or living independently.

# Elements of FEP Care

The core elements of CSC are:

- Individual or group psychotherapy which includes education about psychosis
- Individualized psychopharmacological intervention
- Education and support for families (either individually or in groups)
- Individualized support with returning to school or work
- Case management (i.e., assistance with basic needs such as transportation and housing)

These **core service elements** should be coordinated by a multidisciplinary treatment team that meets regularly to review clients' needs and progress. The services are described in detail below (for review, see Table 1), with fidelity benchmarks that teams should strive to achieve.

Other **promising practices** include peer support from persons with lived experience of mental illness, interventions targeting cognitive recovery, physical fitness promotion, substance use treatment, and social support in the form of exercise or activity groups (Heinssen et al., 2014). These practices can complement the basic elements of CSC, but do not replace them.

Table 1. CSC Core Service Elements

| *Service* | *Description* | *Team Member* |
|---|---|---|
| Team Leadership & Coordination | Coordination of care via a team leader who supervises staff, oversees administrative functions, leads team meetings, & directs overall clinic flow | Team Leader: Minimum MA level clinician located on-site |
| Individual Psychotherapy | Individual therapy that promotes recovery in functioning and symptomology, addresses comorbid conditions, & offers psychoeducation | Psychotherapist(s): Licensed or license-eligible MA or PhD level clinician |
| Medication Management & Health Promotion | Prescription & monitoring of medication and support/promotion of goals related to physical health | Prescriber: Licensed psychiatrist and/or nurse practitioner |
| Family Support | Ongoing inclusion of family members in care, including psychoeducation and potential family-focused therapeutic interventions | Shared effort across team |
| Supported Education & Employment (SEE) | Specialized support in meeting goals related to work and/or school | SEE Specialist: Minimum Bachelor's level SEE specialist |
| Case Management | Comprehensive support in addressing practical problems such as housing, transportation, legal involvement, finances, and medical care | Case Manager: Minimum Bachelor's level case manager |

It has been our philosophy to meet providers interested in FEP work "where they are" rather than insisting that they have all the service elements in place within their program before welcoming FEP clients. This might mean starting with the basic elements of individual and family psychosocial intervention, while partnering with a prescriber and employment support service outside the team. Although the ideal of CSC is to *coordinate* as many elements as possible within a single coherent multidisciplinary team, the philosophy articulated in the pages above can be implemented in partnership with external collaborators. For a more detailed workbook on how to start thinking about coordinating service elements, see the "FEP Self-Assessment Tool" in Appendix I.

## Team Leadership & Coordination

Sustaining an effective and collaborative mental health team requires leadership with a clear vision of care goals and the ability to coordinate services to achieve these goals. The team leader oversees administrative functions (ex. budgeting, staffing), supervises therapists and SEE staff, leads team meetings, manages program evaluation data, and directs overall clinic flow. A qualified team leader has a minimum Master's level clinical degree, is located on-site, and has a clear commitment to the principles of care outlined previously.

Strong team leadership is a core element of FEP care given the multidisciplinary nature of these programs. In particular, regular (weekly or biweekly) team meetings provide opportunities for staff addressing different aspects of care to coordinate treatment for each patient, a critical step to maintain high-quality integrated care. In these meetings, under the direction of the team leader, team members review new admissions and the status of each FEP patient. Discussion focuses on each team member's role in the patient's care, and reviews progress towards treatment goals. Acuity changes are noted and responded to that day with a specific plan incorporating the individual's own preferences and identified self-management practices. The goal is to work with the individual to identify changes in symptoms and functioning early on so that life-disrupting emergencies can be avoided.

## Individual Psychotherapy

Individual psychotherapy has three main functions in FEP treatment. First, it is an essential tool to promote recovery in functioning and symptomology. Second, it addresses and prevents comorbid conditions that impair progress towards an individual's recovery goals (ex. substance use, anxiety, trauma). Third, it provides a means to follow a patient's presentation over time and to offer ongoing psychoeducation to patients and families.

Developing a therapeutic alliance and providing psychoeducation are critical first steps in individual psychotherapy. Building rapport is essential to psychotherapy, as a therapist must work collaboratively with the patient to identify, explore, and replace maladaptive thinking that leads to distress. Psychoeducation, in the context of supportive therapy, can offer relief and the best possible environment for making decisions about accepting treatment and moving towards recovery (Dixon et al., 2010; Pekkala & Merinder, 2002). In general, individuals must be closely monitored and provided with education about issues related to their illness. With gentle support, sensitive attention to grief and mourning, and appropriate problem solving, individuals can work towards finding meaning in their experience and cope with the losses engendered by their illness. Other practices such as CBT for psychosis, cognitive remediation, behavioral exposure and/or activation, and social

skills training can be offered in the context of individual psychotherapy as well, depending on the individualized treatment plan.

Each client in a FEP program should have an assigned therapist, from whom they receive care coordination and individual psychotherapy. A qualified psychotherapist is a licensed or license-eligible Master's- or Doctoral-level clinician, is located on-site (or attends team meetings, if they work at a satellite location), and actively provides evidence-based interventions. Therapists should meet with at least 80% of their clients monthly, with other visits scheduled at a frequency determined by mutually agreed-upon individual treatment goals. In addition to individual clinic-based care, therapists should attend at least three days of FEP-specific training each year and engage in community work (ex. off-site meetings with clients). Psychoeducation should be provided to patients, as well as to caregivers or other groups as indicated, covering a range of FEP-related topics (Dixon et al., 2010).

**A note on therapeutic groups:**

Many FEP programs opt to offer psychoeducation, CBT, substance use treatment, social skills training, cognitive remediation and enhancement, and other therapeutic interventions in groups rather than individual therapy.

Both approaches can work well. The decision to opt for groups vs. individual therapy or telehealth versus face-to-face services will depend on a range of local and logistical factors, as well as client treatment preferences.

## Medication Management & Health Promotion

Within the context of FEP care, psychopharmacology is a team sport involving clients, families, prescribers, and other members of the interdisciplinary treatment team. As many young people may be reluctant to start or stay on medication, FEP staff must first develop trusting relationships and provide education about medication options such that young people are willing to adhere to recommendations. The use of medication involves complex decision-making and requires an active partnership between the patient and the prescriber. Shared decision-making offers a framework to address the complexities of these choices with an emphasis on the unique concerns, values, and life circumstances of the person served and the advantages and disadvantages of medications based on empirical evidence (Barry & Edgman-Levitan, 2012). The goal is to find and administer the lowest effective doses to minimize side effects. First episode patients may require lower doses of medication relative to those with established chronic disorders; see Dr. Keshavan's slide set on psychomarmcologic treatment in FEP for an excellent review. Treatment for other co-occurring conditions such as substance use disorders, depression and anxiety, and non-psychiatric conditions may also need to be considered.

A licensed psychiatrist or nurse practitioner should meet with clients within their first six months of enrollment and monitor side effects of any medication at least twice annually using structured assessment tools. Dosing of antipsychotic medication should fall within best practice guidelines for second-generation antipsychotic medications (APMs) and between 300-600 chlorpromazine equivalent for first-generation APMs. If there is an inadequate response to two trials of APMs (equivalent to 10mg of Haldol, and over a 3-month period), clozapine is recommended (Gardner et al., 2010). Each client should have an assigned provider, even if they are not currently accepting medications. Client to full-time prescriber ratios should be 125:1 or less (Heinssen et al., 2014).

In addition to providing mental health interventions, prescribers also take the lead on attending to patients' physical health. Comorbid medical illnesses are common in those seeking care for early

psychosis (Chang et al., 2010; Gardner-Sood et al., 2015; Stubbs et al., 2016), and the use of many psychiatric medications can increase risk of developing a medical comorbidity, particularly in relation to cardiometabolic complications (Heald, 2010; Stahl et al., 2009; Tschoner et al., 2007). FEP teams should strive to provide education on health and wellness, maintain contact with primary care clinicians (PCPs) and other providers, coordinate services for clients receiving long-acting injected medications (LAIs), and monitor lab results. Assessment of factors that contribute to metabolic syndrome (BMI, blood pressure, cholesterol, triglycerides, and glucose) should occur at least every six months.

Although the prescriber exercises leadership in monitoring patients' health and educating other team members about physical health concerns, the aim is to incorporate physical wellness as an important piece of the "whole person care" culture across the treatment team. Possible programs concomitant with these goals include exercise or athletic groups, support for local athletic opportunities such as training for a 5k race, facilitated access to dental care, and cooking and nutrition classes.

## Family Support

There is strong evidence that familial involvement in FEP care is associated with improved treatment outcomes (Camacho-Gomez & Castellvi, 2020). With permission from the young adult receiving treatment, a parent, caregiver, or other identified family member should be involved both in the initial assessment and in ongoing care. While this might seem obvious for providers who routinely serve pediatric populations, FEP services should aim to include family or the client's preferred social supports even for clients 18 and over. Typically, a primary clinician meets with the whole family about once each month to help the patient share progress, to provide support and psychoeducation, and to augment intra-family communication and problem-solving skills. Family members can find comfort and support in information that helps put their experience with psychosis into perspective.

Further support may be provided in the form of multi-family groups (MFG). MFG include 3-5 families and their affected relatives. The treatment involves an introductory, day-long psychoeducational workshop followed by a bi-weekly, structured group that helps youth and families discuss solutions to problems and work toward specific goals (McFarlane, 2016). Other family intervention models that have been used in the early psychosis population include the NAVIGATE family education model and the Open Dialogue Network model. Team should strive to balance evidence-based psychoeducation with cultural competence and humility when delivering family support and education.

Importantly, the inclusion of a family member, while desirable, cannot be a requirement or eligibility criteria for FEP treatment. In practice, such requirements only serve to screen out the most marginalized and vulnerable patients. It also bears clarification that, in all sections discussed here, the word "family" is by no means limited to genetic or child-rearing relatives. The goal of family treatment is to engage and improve natural social support which could take the form of parents, siblings, partners, or friends.

## Supported Employment & Education (SEE)

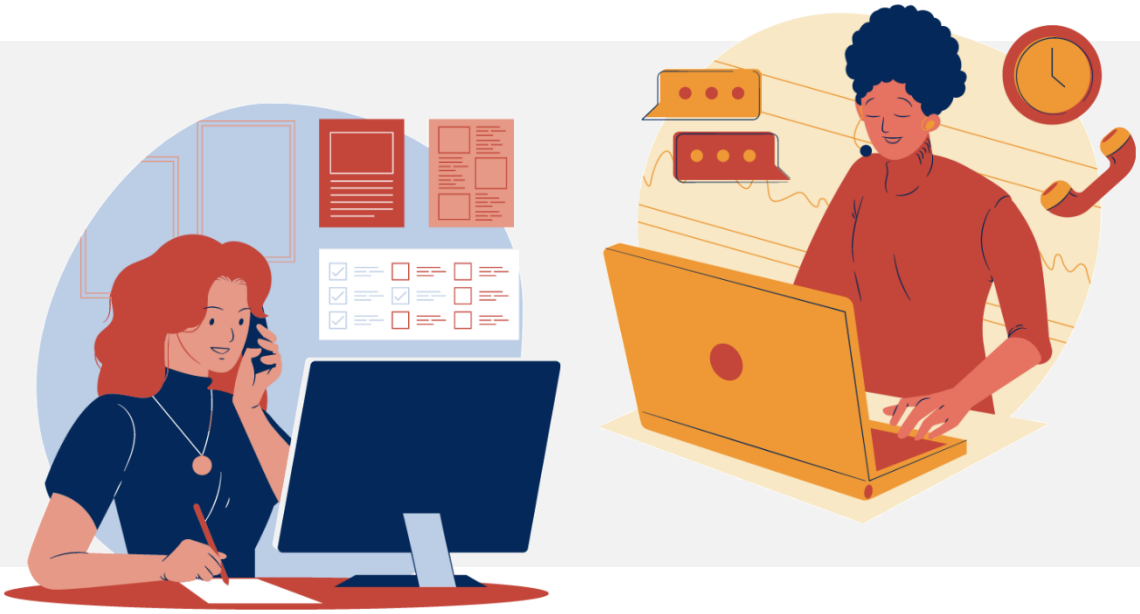
Progress towards goals related to work and/or school is key to rehabilitation in FEP care (Mueser et al., 2016). Employment and education contribute significantly to quality of life for young adults, and to long-term stability following graduation from care (Bond et al., 2001). The SEE specialist is a vocational generalist who provides 1) work-related services to help FEP clients find and maintain employment in the community, and 2) educational supports to help individuals pursue education necessary to secure a desired vocation. A SEE specialist has at minimum a bachelor's degree and is involved in all phases of FEP care, including intake, engagement, assessment, job or school placement, ongoing support throughout employment or education, and transition-related assistance.

Specific responsibilities of the SEE specialist will depend on the case conceptualization for each client in their program. However, it is recommended that these supports follow an evidence-based structure such as Individual Placement and Support (IPS) (Bond, 1998). SEE support should have a highly visible presence in a program's promotional materials and have active support from program leadership. Job or school searches should begin as early as possible following an individual's intake in the clinic. Such searches should focus on competitive employment and cannot be restricted to clients on the basis of time, diagnosis, symptom profile, housing status, legal involvement, or level of disability (similar to the IPS principle of Zero Exclusion). Another core part of a SEE work is community engagement. In some models, SEE specialists are encouraged to spend the majority of their working hours outside of the clinical setting; for instance, developing relationships with local high schools, colleges, and employers and working with clients to advocate for themselves at school and work to obtain needed accommodations.

## Case Management

Following the aforementioned principle of whole-patient care, treatment must recognize and address the fact that psychosis is not the only problem in a young person's life— that, in fact, other problems may be more pressing than the presenting psychotic symptoms and may exacerbate the severity of these symptoms. Without acknowledging practical problems such as housing, transportation, financial management, legal involvement, and medical care, we minimize the effectiveness of care as it exists in the context of a person's overall wellbeing.

Each client in a FEP program should have an assigned staff contact for needs related to case management. The case manager has at minimum a bachelor's degree and oversees that appropriate appointments are made with team members and other agencies in accordance with the client's treatment plan. The case manager assists clients with administrative and social needs, including but not limited to housing, finances, legal concerns, primary care services, and basic living skills. In many programs, individual therapists also assist with case management needs, but ideally, these responsibilities would be delegated to another full-time team member.



# FEP Program Procedures

## Evidence-Based "Processes"

The previous section describes the service elements that are necessary for a CSC program. Programs may wish to train staff to deliver specific evidence-based practices (EBPs) such as the NAVIGATE model of CSC, motivational interviewing, cognitive behavioral therapy for psychosis (CBT-P), cognitive remediation, or IPS. EBPs should be selected and deployed with clients' input and individualized treatment plan in mind. In other words, EBPs are valuable tools in a clinician's toolkit but do not substitute for a conceptualization-based treatment plan.

Evidence-based practice is best delivered in an organizational context that supports such practices, which we can call "evidence-based process." Process here refers to establishing clinical culture that emphasizes transparency, continuous quality improvement, and a commitment to honoring the tenets of the CSC model. These include processes for admitting new clients to the clinical service, assessing important clinical and functional domains, obtaining training and supervision in specific EBPs, and managing discharge and transitions when clients move on from the FEP program.

## Intake & Eligibility

This is one of the most challenge issues for FEP programs to manage: whom to admit for care and on what schedule. Programs must dynamically set defined eligibility criteria that includes eligible diagnoses, duration of psychosis, comorbidities, and prior treatment (see Table 2) – while still maintaining some tolerance for inevitable uncertainty and working quickly to engage reluctant clients and families in care. There is nothing easy about pulling this off!

Recommended practices include documenting all referrals systematically and electronically; obtaining and reviewing relevant medical records; conducting a semi-structured evaluation or consultation before officially admitting clients for FEP services; reviewing difficult eligibility considerations in multidisciplinary team meetings; actively considering how cultural and racial biases may be impacting eligibility decisions; and striving to meet clients quickly, within that "golden hour" opportunity of motivation for treatment.

Table 2. Eligibility Considerations for FEP Treatment

| *Domain* | *Eligibility Considerations* |
|---|---|
| Diagnosis | • Affective psychoses – many programs do include individuals with bipolar disorder with psychotic features.<br>• Possible substance-induced psychoses – although CSC is not intended for treatment of substance-induced psychoses, many clients whose initial psychosis occurred under the influence find that the psychosis is persistent. In other words, what first appeared as a substance-induced psychosis turns out to be a primary psychosis. In many cases, time will tell.<br>• Clients with history of developmental disorder (e.g. Autism Spectrum Disorder) or traumatic brain injury – these are common exclusion criteria but represent a wide spectrum of clinical presentations. |
| Age | • Psychosis onset typically occurs between ages 15-30 (Kessler et al., 2007; Thorup et al., 2007); however, earlier onset is possible. Can your agency treat minors? How low can you go? |
| Duration of Psychosis | • Evidence shows that CSC treatment is most impactful within the first 1.5 years of psychosis (Kane et al., 2016), but this is impractical for most programs, especially new ones. Programs might consider being more inclusive at first (e.g. accepting clients who are within first 3 years of illness) and narrowing that threshold over time depending on volume of referrals. |
| Comorbid Conditions | • Common comorbid conditions include substance use disorders, mood and anxiety disorders, and trauma/stress disorders. These are not usually used as exclusion criteria, unless there is a clear and acute need for substance detox. |
| Prior Treatment | • It is unusual for programs to exclude potential clients on the basis of prior treatment (e.g., prior exposure to antipsychotic medications or prior CSC enrollment) unless they are doing a clinical trial of some sort. |

## Assessment & Measurement-Based Care

All clients should receive a comprehensive biopsychosocial assessment that yields both a working diagnosis and a conceptualization of factors contributing to the illness that could be targets for intervention. The assessment should be conducted by an experienced masters- or doctoral-level clinician and should synthesize information about the onset and course of psychotic symptoms, changes in functioning and behavior, developmental history (including important stressors or traumatic events), individual and family psychiatric history, medical history, review of current psychiatric symptoms, risk factors for harm to self or others, and strengths. This information can come from the client directly, their family, and medical records as relevant.

Additionally, clinicians should use structured assessments to measure functional domains that are expected to change in response to treatment. This should include social and occupational functioning, severity of psychiatric symptoms (hallucinations, delusions, depression, anxiety, etc.), psychosocial needs (e.g., access to adequate housing), frequency/severity of substance use, re-hospitalization, metabolic health, and acuity of suicide risk. (See **www.mapnet.online/measures**

for structured assessments currently utilized by Massachusetts programs, which have been harmonized with national initiatives to study treatment outcomes from FEP programs).

The goal of conducting structured assessments at regular intervals (preferably every 6 months) is primarily clinical: to see whether progress has been made in treatment, much the same way that a cardiologist monitors blood pressure and cholesterol in each patient. Assessment results should be discussed within the interdisciplinary team to inform treatment plans and also shared sensitively with clients themselves. For example, a clinician could say, "When you first came into treatment, you had the goal of returning to work, but I'm realizing we haven't made much progress on that. What do you think should be the next step?"

A secondary goal of these assessments is that they enable a culture of continuous data-driven quality improvement. The use of a fidelity scale such as the First-Episode Psychosis Services Fidelity Scale (FEPS-FS) allows programs to measure adherence to evidence-based practices (Addington et al., 2016). Programs can analyze what percentage of clients are meeting defined quality benchmarks in accordance with the FEPS-FS and design initiatives to improve their own performance. For instance, a team might aim for 75% of clients to avoid re-hospitalization within the first year of treatment and monitor whether they are able to achieve that goal. Assessments are also vital for documenting and working to eliminate racial and ethnic disparities in treatment outcomes and service utilization. In the broader scope, depending on a clinic's relationship to research or government stakeholders, programs may opt to share data in a non-identifiable way with state- or national-level stakeholders to monitor treatment outcomes and advocate for funding or policy changes.

## Training & Supervision

CSC programs should have opportunities to participate in specialized FEP training, ideally within the context of a learning community of others with shared interests. Staff should learn about the vulnerability-stress model of psychosis development (Nuechterlein & Dawson, 1984) and be familiar with research on the causes of psychosis. Training in specific practices should be conceptualized within a continuous quality improvement framework with specific goals in mind. For instance, a program that wishes to improve psychoeducation offerings for families could train in facilitating multi-family psychoeducation groups; a program that wants to reduce substance use among clients could train in motivational interviewing; and a program that aims to boost workforce participation might choose to train staff in the individualized placement and support model.

Training for all of these practices is best delivered in the context of ongoing supervision to support implementation and address barriers that arise. Further, training delivered within a learning collaborative model offers the additional benefit of developing a community of mutual support and consultation. Several learning opportunities exist in context of national and regional initiatives (i.e. PEPPNET, MHTTC, MAPNET), and need to be made available to FEP providers.

## Discharge & Transitions

Careful attention must be paid to clients' transitions out of an FEP program. There is no evidence-based or agreed-upon period of time after which a patient should be discharged from FEP care; in fact, a rapid time-limited transfer of care has been shown to diminish the benefits of early intervention (Bertelsen et al., 2008; Gafoor et al., 2010). For practical purposes, however, programs often adopt a practice of systematically moving toward discharge after a pre-determined period of treatment (ex. 2 years). Patients should not be discharged simply for poor engagement. No-shows are expected in this population and should not be used alone as justification to discharge an actively ill client. The decision to transition out of care is ideally a collaborative one between a patient and their clinical team. Discharge is warranted if the patient has achieved their treatment goals, is no longer eligible (ex. moved out of area), or has requested other treatment. In the case of disengagement, multiple efforts should be made to assess the client's progress, identify areas of need, and facilitate a transition to a level of care that is acceptable to the client based on their self-identified recovery goals.

A difficult and often unspoken aspect of FEP care is that programs need to discharge clients in order to accept new ones. In other words, discharge procedures are a critical step, and often a critical barrier, to reducing population-level treatment delays for psychosis. This transition is tricky, particularly for the majority of clients who will require some level of ongoing specialized care in a system that is much less organized and accessible than the world of FEP treatment. While this is universally challenging, the following steps have been suggested to facilitate care transitions:

1. **Have a working protocol in place to guide discharge**. A set of standard operating procedures can limit confusion in times of transition, which is important to maintain continuity of care. Staff should be aware of this protocol as a facet of overall clinic operations.
2. **Provide a referral letter/letter of discharge**. Whenever possible, communicate the discharge plan formally in writing for both the client and clinic's records. Clinicians should discuss the prospect of discharge with clients and ensure that they are aware of—and able to follow— the discharge plan.
3. **Provide a warm handoff whenever possible**. Clients may be particularly concerned by the uncertainty of starting treatment with an unfamiliar provider. Direct clinician-to-clinician communication can help the FEP provider to ease this transition, and to build a degree of familiarity between the client and the new provider. Having a period of overlap between the discharging and accepting clinicians can be helpful where possible.
4. **Form relationships with external community providers**. Clinicians may be hesitant to discharge a client to an unfamiliar clinician whose knowledge of psychosis is unclear, or who may be an inappropriate fit for their client's level of need. To address this concern, it is useful to have a list of trusted community partners who are comfortable and able to help clients step down from more intensive FEP care.
5. **Use peer support to offer continuity during transitions**. When presented with a loss of structure, clients can struggle to adhere to post-FEP treatment recommendations. Programs with peer support available may consider involving a peer specialist to facilitate successful transitions for young people leaving the program.

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## Appendix I. FEP Self-Assessment Tool (ie. Goal Setting Tool)

# Massachusetts FEP CSC Program Self-Assessment Tool

1. Applicant Organization
   Contact Person:

   Mailing address:

   Email address:

   Phone number:

2. FEP CSC Program
   FEP CSC Site Address:

   FEP CSC Program Contact Person:

   Mailing address:

   Email address:

   Phone number:

3. Status of FEP CSC Program at this site
   Indicate if you have a FEP CSC program currently or if you plan to establish a FEP CSC program at this site

   ___ Current program

   ___ Planned program

4. Current FEP services at this site
   4.1 (***if applicable***) How long have you had a formal First Episode Psychosis (FEP) program (years)?

   4.2 What are the eligibility criteria for participation in your current or planned FEP CSC program (include any criteria related to age, diagnosis, or duration of illness, etc.)

4.3 How many people do you currently serve who would be eligible to participate in FEP CSC?

4.4 What are the ages of the people do you currently serve who would be eligible to participate in FEP CSC?

| *Age Range* | *FEP program currently* |
|---|---|
| Under age 15 | |
| 15-18 | |
| 19-25 | |
| 26+ | |
| Total: | |

4.5 Describe the people you serve currently with regard to gender, race, and ethnicity.

4.6 What are the geographic areas that comprise the communities that you serve?

4.7 What are the cultural, linguistic and other needs of the communities that you serve and how do you address the needs of these communities?

4.8 Referral sources
Please identify your most common referral sources:

4.9 Where and what community-based education and recruitment activities do you offer (e.g. PCP practices, college health centers, high schools, etc.)?

## 5. FEP CSC Program -- Team Operations

### 5.1 Program Facilities

Please describe what 'space' is available to the FEP CSC program, e.g. dedicated milieu space, group room, etc.

### 5.2 Current staff FEP experience

Describe the experience staff at this site currently have with providing outpatient services for youth and young adults newly experiencing psychosis

5.3 Core FEP team roles

For each role listed, please indicate how this role is or will be fulfilled. In the space below this chart, please provide details on how you use other resources, e.g. volunteers, trainees, other community organizations, to fulfil these roles.

| | *Current staff member (name, credentials, FTE allocated to role)* | *To be hired staff member (FTE allocated to the role)* | *Available through volunteers, trainees, partnering with other organizations** | *Unavailable at this time* |
|---|---|---|---|---|
| Team Leader | ○ | ○ | ○ | ○ |
| Prescriber | ○ | ○ | ○ | ○ |
| Psychologist (assessment and program evaluation) | ○ | ○ | ○ | ○ |
| Individual Therapist | ○ | ○ | ○ | ○ |
| Family Therapist | ○ | ○ | ○ | ○ |
| Peer specialist | ○ | ○ | ○ | ○ |
| Nurse | ○ | ○ | ○ | ○ |
| Substance Abuse Specialist | ○ | ○ | ○ | ○ |
| Employment specialist | ○ | ○ | ○ | ○ |
| Education specialist | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ |

** Please describe how you use other resources, e.g. volunteers, trainees, other community organizations, to fulfil the roles above:*

## 5.4 FEP Team Services offered

Please indicate what FEP CSC service components you have currently implemented or plan to implement within your FEP CSC program and to what degree you are able to offer them through the FEP team or in collaboration with other community resources.

In the space below this table, please describe what you are able to partially offer through your FEP program and how you collaborate with community resources to deliver the services below.

| | *Fully available through your current or planned FEP program* | *Partially available through your FEP program** | *Available through collaborations with other service providers** | *Not available* |
|---|---|---|---|---|
| Individual Psychotherapy | ○ | ○ | ○ | ○ |
| Care coordination | ○ | ○ | ○ | ○ |
| Group Psychotherapy | ○ | ○ | ○ | ○ |
| Supported Employment | ○ | ○ | ○ | ○ |
| Supported Education | ○ | ○ | ○ | ○ |
| Psychoeducation (young adult focused) | ○ | ○ | ○ | ○ |
| Psychoeducation (family focused) | ○ | ○ | ○ | ○ |
| Family Therapy – Individual Families | ○ | ○ | ○ | ○ |
| Family Therapy – Multi-family Group | ○ | ○ | ○ | ○ |
| Peer Support Services | ○ | ○ | ○ | ○ |
| Health and Wellness | ○ | ○ | ○ | ○ |
| Psychopharmacology | ○ | ○ | ○ | ○ |
| Substance Use | ○ | ○ | ○ | ○ |
| Assessment (cognitive, functioning, psychosocial) | ○ | ○ | ○ | ○ |
| Community Outreach | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ |

**For those services you are able to partially offer through your FEP program, please provide details of how/what you are able to provide and how you collaborate with community resources to deliver the services above:*

**Please describe any plans that you have to enhance your ability to deliver these services through partnerships, contracts, or other funding sources:*

5.5 **Multidisciplinary Treatment team meetings**

Please indicate the frequency with which the Multi-disciplinary team meets regularly to conduct case review

| *More than once a week* | *Weekly* | *Every other week* | *Monthly* | *No regular schedule* | *No team meetings* |
|---|---|---|---|---|---|

5.6 **Staff Supervision & Training**

Please indicate the frequency with which individual team members receive regular supervision for their FEP team work.

| *More than once a week* | *Weekly* | *Every other week* | *Monthly* | *No regular schedule* | *No team meetings* |
|---|---|---|---|---|---|

Please indicate your current training priorities:

| | ***Proportion of Staff with some exposure*** *1=none; 2=some; 3=most; 4=all* | ***Current Training priority*** *1=now; 2=next 1-2 yrs; 3=2+ years; 4=Already addressed* |
|---|---|---|
| Core Principles in First Episode Psychosis *(Recovery-oriented, trauma-informed, person-centered, shared decision making, developmentally informed, phase-specific)* | _____ | _____ |
| Addressing vulnerability to Substance Abuse among young adults with psychosis | _____ | _____ |
| Suicide Risk assessment and prevention for young adults with psychosis | _____ | _____ |
| Psychopharmacology for young adults with psychosis | _____ | _____ |
| Individual treatment for young adults with psychosis | _____ | _____ |
| Family treatment for young adults with psychosis | _____ | _____ |
| Cultural competence | _____ | _____ |
| Integrating Peer Services | _____ | _____ |
| Other | _____ | _____ |

** Please describe what training areas your program has expertise that you can share with the learning community:*

## 5.7 Evidence Based Practices

For each EBP listed below, please indicate whether this EBP is currently offered through your FEP team and/or agency and what opportunities staff have had to learn about the EBP. Use the scale defined here and indicate all that apply for each EBP.

0 = Not currently available
1 = Staff have had a one-time training;
2 = Staff participated in on-going training and supervision/consultation;
3 = There are on-site, certified trainers in this EBP;
4 = Practitioners of the EBP participate in fidelity monitoring

NOTE: You are welcome to list additional EBPs provided through your FEP team as well.

| *Evidence Based Practices* | *FEP team offers* | *Agency offers* |
|---|---|---|
| 1. Motivational Interviewing | ○ | ○ |
| 2. CBT for Psychosis | ○ | ○ |
| 3. MacFarlane Multi-family group | ○ | ○ |
| 4. Open Dialogues | ○ | ○ |
| 5. Individual Resiliency Training | ○ | ○ |
| 6. Individual Placement and Support | ○ | ○ |
| 7. Cognitive Enhancement Treatment | ○ | ○ |
| 8. Acceptance and Commitment Therapy | ○ | ○ |
| 9. Dialectical Behavior Therapy | ○ | ○ |
| 10. Other: (List below) | | |
| | ○ | ○ |
| | ○ | ○ |
| | ○ | ○ |
| | ○ | ○ |

## 5.8 Describe whether and how you currently monitor and assess fidelity to EBPs

6. FEP team Continuous Quality Improvement

6.1 Please describe how you currently evaluate the effectiveness of your program. List all assessment measures you utilize and how often they are administered, e.g. at admission, every 6 months, annually, at discharge.

6.2 Describe how you currently obtain and incorporate feedback from young adults and their families.

7. FEP Program Development Planning

7.1 Summarize the strengths and needs of your program.

7.2 Describe your FEP Program development goals and plan for the next 2 years

# Appendix II. Fidelity Assessment Scale

**MAPNET Coordinated Specialty Care (CSC) Fidelity Scale**

Adapted from PA CSC Program Fidelity Scale

mapnet

| **Section 1: Program Structure** | | | |
|---|---|---|---|
| # | Item | Description of Measure | Scoring |
| 1 | Program Length | Program offers services for:<br>a) Specified period (as reflected in program policies and promotional materials)<br>b) Specified period (as reflected by 10 most recent discharges) | 0 = <6 months<br>1 = 6 months<br>2 = 1 year<br>3 = 2 years or more |
| 2 | Inclusion/Exclusion | Evidence based inclusion/exclusion criteria are consistently defined for:<br>a) Onset of psychosis*<br>b) Diagnosis<br>c) Age<br>d) Catchment<br>e) Insurance | 1 point each<br>*Critical item: total score = 0 if a is undefined |
| 3 | Caseload | Client to therapist target ratio of 20:1 (calculated by the number of full time licensed therapists divided by the total clients enrolled at the time of fidelity rating) | Current caseload per therapist:<br>0 = 60+<br>1 = 51-60<br>2 = 41-50<br>3 = 31-40<br>4 = 21-30<br>5 = 20 or less |
| 4 (A) | Multidisciplinary Team Meetings | Interdisciplinary team meetings focus on case review, including referrals, admissions & discharges, status updates, complex cases. | Meetings are held:<br>0 = never<br>1 = quarterly<br>2 = monthly<br>3 = twice/month<br>4 = weekly<br>5 = weekly plus case conferences |
| 4 (B) | Team Meeting Attendance | Each team member attends at least 75% of scheduled meetings | 0 = no<br>1 = yes |
| 5 | Crisis and Safety | Program does the following to manage crises:<br>a) A 24/7 crisis service is available<br>b) Clients are provided contact details for crisis service<br>c) Incidents are documented<br>d) Structured tools are used to assess risks | 1 point each |

**MAPNET Coordinated Specialty Care (CSC) Fidelity Scale**
Adapted from PA CSC Program Fidelity Scale

mapnet

| Section 2: Program Staff Roles and Responsibilities | | | |
|---|---|---|---|
| # | Item | Description of Measure | Scoring |
| 6 | Team Leader/Program Director | Minimum MA level clinician located on-site* and conducts (or delegates) specified services:<br>a) Administrative functions (staff performance goals, budgeting)<br>b) Supervision to therapists & SEE staff at least 2x/month<br>c) Leading team meetings<br>d) Managing program evaluation data<br>e) Management of clinic flow | 1 point each<br>*Critical item: total score = 0 if position filled by non-licensed or off-site staff |
| 7 | Pharmacotherapy | Licensed psychiatry or NP* located on-site (or, if satellite, attends team meetings) and provides specified services:<br>a) Caseload does not exceed 125 per 1 FTE<br>b) Each client has an assigned prescriber<br>c) Prescriber meets with >80% of clients monthly during 1st 6 months of enrollment<br>d) Antipsychotic medication dosing (for at least 80% of clients) is within government approved guidelines for 2nd-generation APMs and between 300-600 chlorpromazine equiv. for 1st-generation APMs<br>e) Clozapine prescribed if inadequate response to 2 trials of APMs (equivalent to 10 mg Haldol, and over a 3-month period)<br>f) Side effects for >80% of clients assessed at least every 6 months using structured assessment tools | 1 point each<br>*Critical item: total score = 0 if position filled by non-licensed staff or if caseload exceeds 125 per FTE |
| 8 | Individual Therapy | Licensed or license-eligible MA or PhD level clinician* located on-site (or, if satellite, attends team meetings) and actively provides evidence-based interventions, including:<br>a) Each client has an assigned therapist<br>b) Meets with >80% of clients weekly<br>c) Attends at least 3 days of FEP-specific training annually<br>d) Does work in the community (i.e., off-site meetings with clients) | 1 point each<br>*Critical item: total score = 0 if position filled by non-licensed or license-eligible staff |
| 9 | Physical Health & Wellness Promotion | Licensed nurse or other medical professional* located on-site (or, if satellite, attends team meetings) and provides services including:<br>a) Provides education on health and wellness to clients and families<br>b) Maintains contact with PCP and other providers as needed<br>c) Administers medications including LAI's<br>d) Monitors lab results and vitals (specifically measures of metabolic syndrome) at least every 6 months for 80% of clients | 1 point each<br>*Critical item: total score = 0 if position filled by non-qualified staff |

| | | | |
|---|---|---|---|
| 10 | Supported Education and Employment | Minimum bachelor's level* SEE specialist is on-site (or, if satellite, attends team meetings) and provides specific services including:<br>a) The SEE Specialist is a vocational generalist, performing all phases of employment/education services, incl. intake, engagement, assessment, placement, ongoing support, and transition-assistance.<br>b) 65% or more of the SEE Specialist's time is spent in the community.<br>c) The program practices Zero Exclusion, such that no client is excluded from SEE Services who expresses an interest in employment or education; service is not contingent on clinical approval nor adherence to eligibility criteria or other treatment plan activities.<br>d) The agency includes a focus on employment and education, such that support for employment and education is evident in the program's promotional materials/website; forms used by a variety of staff; staff job descriptions; and is supported by agency leadership.<br>e) Job/Education search begins quickly (within 30 days of initial meeting)<br>f) Individualized and Time-Unlimited Supports are made available throughout the process (incl. benefits planning)<br>g) The SEE Specialist exclusively seeks competitive Employment (incl. paying internships) and/or mainstream educational placements | 1 point each<br>*Critical item: total score = 0 if position filled by non-qualified staff |
| 11 | Case Management | Minimum bachelor's level* case manager is on-site (or, if satellite, attends team meetings) and provides specific services including:<br>a) Each client has assigned staff for CM needs<br>b) Sees that appropriate appointments are made with other team members and/or agencies in collaboration with client and with reference to treatment plan<br>c) Assists client with administrative and social needs (housing, finances, legal, primary care, basic living skills, etc.)<br>d) Position is not delegated to another full-time team member | 1 point each<br>*Critical item: total score = 0 if position filled by non-qualified staff |
| 12 | Peer Support | Peer Support Specialist located on-site (or, if satellite, attends team meetings*) and provides specific services to assist and support clients' goals including:<br>a) Receives regular training and supervision on skills (i.e., daily living, job readiness, communication, and goal setting).<br>b) Offers to meet with clients in the community.<br>c) Makes contact within 30 days of entry to the program.<br>d) Supports clients toward achievement of their short-term and long-term goals (i.e., daily living, job readiness, communication, and healthy living).<br>e) Included in the treatment plan discussion, and Peer Support is included as an intervention in client treatment plans. | 1 point each<br>*Critical item: total score = 0 if position unfilled or not included in team meetings |

**MAPNET Coordinated Specialty Care (CSC) Fidelity Scale**
Adapted from PA CSC Program Fidelity Scale

mapnet

| **Process and Clinical Flow** | | | |
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| # | Item | Description of Measure | Scoring |
| 13 | Admission | Intake process includes a comprehensive bio-psycho-social assessment of:<br>a) Course and onset of psychotic symptoms<br>b) Changes in functioning/behavior<br>c) Individual and family psychiatric history<br>d) Medical history<br>e) Co-morbid disorders<br>f) Risk behaviors (including suicide)<br>g) Strengths | 1 point each |
| 14 | Engagement | Service promotes engagement and retention of clients, e.g.:<br>a) Services are flexible with times and locations<br>b) Social groups and/or peer support available<br>c) Shared decision making documented for all services<br>d) Inviting, age appropriate environment<br>e) Staff are in contact with other providers/agencies during crises to ensure continuity of care and re-engagement | 1 point each |
| 15 | Family/Caregiver Involvement | Inclusion and participation of family/caregiver such that at least 80% of client-identified families:<br>a) Are involved in initial assessment<br>b) Have treatment involvement assessed and documented<br>c) Are contacted at least quarterly by one or more team member<br>d) Have family/multi-family therapy participation documented at least quarterly<br>e) ROI for family-team contact is signed and on file | 1 point each |
| 16 | Ongoing Assessment | Comprehensive assessment completed at least every six months and includes:<br>a) Educational and occupational functioning<br>b) Social functioning<br>c) Symptoms<br>d) Psychosocial needs (housing, financial, etc.)<br>e) Substance use<br>f) Suicide/risk<br>g) Feedback is offered to client (and, if relevant, family) | 1 point each |
| 17 | Quality Improvement | The team seeks to monitor and improve the quality of services by:<br>a) Soliciting and reviewing feedback from clients and families (e.g., via the “CSQ”)<br>b) Setting team-based QI goals at least once per year | 1 point each |

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| 18 | Cultural Responsiveness | The team practices Cultural Responsiveness by acknowledging and discussing the client's cultural environment (e.g., race, ethnicity, religion, sexual orientation, gender identity, SES, etc.) and social environment (e.g., social media, technological exposure/engagement) by:<br>a) Inquiring about each client's cultural background and identity, and considering/discussing the relevance to treatment during intake<br>b) Using non-biased, inclusive language to assess clients' gender and sexual identity<br>c) Using professional translators to communicate with non-English speaking clients and family members | 1 point each |
| 19 | Treatment Planning | Individualized treatment plans are created and documented with the client after initial assessment and:<br>a) Are updated at least every 6 months<br>b) Identify needs and goals, including vocational/educational goals<br>c) Identify service preferences (pharmacotherapy, SEE, substance abuse services, weight mgmt. assistance, etc.)<br>d) Outline a plan of action<br>e) Assess previous plans for areas of improvement<br>f) Client is involved in treatment plan creation and review<br>g) Plans receive multidisciplinary input and review (e.g., during team meetings) | 1 point each |
| 20 | Outreach | Accurate information about the program is available:<br>a) On brochures and/or program website*<br>b) Program information is accurate on FEP-TAC website<br>c) Program responds to outreach requests by sending up to date information, making in-person site visits, or collaborating with FEP-TAC team to ensure community providers receive needed materials/information | 1 point each<br>*Critical item: total score = 0 if (a) = 0 |
| 21 | Psychoeducation | Psychoeducation is provided:<br>a) For clients*<br>b) For families/caregivers<br>c) In groups to encourage support<br>d) Through formal sessions occurring at least 4 times annually<br>e) Covers a range of FEP-related topics | 1 point each<br>*Critical item: total score = 0 if (a) = 0 |
| 22 | Discharge | a) Clients are discharged from the program if (1) they have completed the determined program length; (2) they are no longer eligible (e.g., moved out of area, received disqualifying diagnosis); or (3) client has disengaged or requested other treatment*<br>b) A working protocol is in place for handling discharge<br>c) When possible a referral letter/letter of discharge is provided to client<br>d) A warm handoff (direct clinician-to-clinician communication) is made to appropriate provider<br>e) Staff are aware of discharge protocols | 1 point each<br>*Critical item: total score = 0 if program discharges for other reasons |

## Appendix III. Sample Treatment Plan for a New Client

### Case Conceptualization

RJ is a 22-year old man with schizoaffective disorder and ongoing cannabis use. He identifies as Black and Latino with strong family ties both locally and in the Dominican Republic. He first experienced psychosis in spring of last year, in the context of heavy cannabis use and a stressful romantic break up that also led to depressed mood. He was hospitalized 3 times before initiating outpatient treatment in the FEP program, all in the context of heavy cannabis use and erratic behavior. RJ's symptoms of psychosis include hearing the voice of god, believing that others can read his mind, feeling guilty about negative thoughts which he believes others can access, and feeling that he is being watched even when alone. He endorses some symptoms of depression including low mood, poor appetite, anhedonia, and disrupted sleep. He resides with his parents, who are quite worried about his mental state and his unusual behavior. For instance, RJ's mother notes that he has covered the windows of his bedroom with newspaper and sometimes refuses to emerge even to use the bathroom. RJ is unemployed and his prevailing goal is to find a job.

### Goal 1: RJ would like to find a job.

Intervention: RJ will meet with the SEE specialist weekly, either via telehealth or in person. They will brainstorm jobs that would be a good fit. The SEE specialist will provide help as relevant with searching for jobs, preparing applications, and advocating for any needed accommodations.

### Goal 2: RJ would like to be able to cope better with the stress of being around other people, whom he believes have access to his "negative thoughts."

Intervention 1: RJ will meet weekly with an individual therapist, who will provide CBT-informed psychotherapy with the goal of managing RJ's anxiety when he is around other people. The therapist will use motivational interviewing to inquire about the relationship between RJ's cannabis use and his stress level. Reducing cannabis use is not a goal that RJ has identified at this time.

Intervention 2: RJ's parents will meet monthly with the FEP family therapist to learn how they can support RJ's goal of being less isolated. This may involve learning about RJ's diagnosis and the potential impact of ongoing cannabis use, and making communication very low-stress while RJ recovers from this episode of illness.

### Goal 3: RJ would like to have higher quality and more regular sleep.

Intervention 1: RJ will meet with a FEP team prescriber for a medication consult. The FEP team will regularly assess the severity of his sleep disturbance, positive symptoms, and depression. Every effort will be made to prescribe medication that is indicated for RJ's difficulties and consistent with his preferences. The prescriber will solicit and discuss any reluctance or ambivalence about medications with RJ. The prescriber will monitor closely for side effects.

Intervention 2: RJ's individual therapist will provide psychoeducation about sleep hygiene practices and encourage him to set small goals supporting better sleep, such as spending time outside of his bedroom every day.