PRACTICE GUIDELINES FOR OREGON EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)

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Guidelines for Oregon Early Assessment and Support Alliance Programs

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Introduction

The Oregon Health Authority prioritized the implementation of evidence-based best practices with the goal of minimizing disability associated with schizophrenia-related conditions. The following practice guidelines provide the framework for systemic change and service implementation. The goal is to provide intervention that maximizes speed and flexibility and minimizes barriers while utilizing a public health approach.

The Early Assessment and Support Alliance (EASA) is a systematic effort within Oregon to prevent early trauma and disability caused by schizophrenia-related conditions. The Mid-Valley Behavioral Care Network's Early Assessment and Support Team (EAST) first developed these guidelines in 2004. The program was based on the Australian Practice Guidelines for Early Psychosis (McGorry et al., 1998, 2010), and guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA) about multi-family psychoeducation, assertive community treatment, and supported employment (2008, 2009). In 2008 the guidelines were revised for statewide dissemination through EASA. The EASA model has been informed by McFarlane's *Family Aided Community Treatment* model (McFarlane, Stastny, & Deakins, 1992) as well as international practice guidelines (International Early Psychosis Association Writing Group, 2005) and British guidelines developed as part of the national Initiative to Reduce the Impact of Schizophrenia (IRIS) (http://www.iris-initiative.org.uk.). The 2011 guidelines are a culmination of international research, revisions in the Australian and international directives, feedback from EASA clinicians and participants, and emerging research from experts in the field of early psychosis.

According to the World Health Organization (WHO), schizophrenia, along with bipolar disorders and depressive disorders, is one of the ten leading causes of disability worldwide (2001). Schizophrenia is of particular concern because the typical age of onset occurs during the key developmental stage of adolescence or young adulthood. Onset at this stage, without early intervention, causes disability that often persists throughout the individual's life (Killackey & Jung, 2007). Indeed, research suggests that the early period of illness (the first two to five years) is a *critical period* (Nordentoft et al., 2008) that may impact the long-term level of disability. Symptoms associated with schizophrenia-related conditions can create rapid and devastating consequences for individuals, families and

communities. Access to appropriate treatment is critical to prevent unnecessary trauma, hospitalization, and disability.

The optimal treatment setting is the individual's community (Fitzgerald & Kulkarni, 1998). Thus, EASA works to prevent these consequences through community mobilization and education, early identification, proactive outreach and engagement, and evidence-based treatment and support.

The voices and needs of individual and family participants drive all services. EASA is designed as a transitional program. Services in the early phase should equip clients and their families to be effective self-advocates at both individual practice and systemic levels. The removal of barriers and accommodation of individual needs are priorities in this treatment model.

Culturally aware services are highly valued as essential to EASA's foundation. Services are delivered by and to a diverse representation of individuals and groups. EASA's clients and providers across the state represent a range of values, beliefs, identities, stages of life, and lifestyles. This is a dynamic and evolving element of service and requires ongoing dialogue, training, self-reflection, and systems improvement.

The EASA team is an important assessment and consultation resource for providers and individuals who do not specialize in differential diagnosis of psychotic illness. EASA prevents inappropriate early diagnosis and treatment by providing diagnostic training for providers. The EASA team provides consultation, support, and referrals to appropriate care. The majority of individuals identified by community sources will not have a schizophrenia-related condition; therefore EASA's role includes helping to connect these individuals with the most appropriate services for their needs.

Early intervention is a rapidly evolving field. The consensus of what constitutes *best practice* continues to develop with new research and experience. These guidelines will need to be periodically revisited and revised. Practitioners and administrators involved with this work will need to maintain awareness of new research and developments.

1. Systemic Infrastructure: *Successful implementation of early intervention requires significant system-level commitment and intervention in order to support improved practices. Directors, managers, and supervisors will maintain required elements of EASA network inclusion (see Appendix A) and practice, and are involved in ongoing evaluation to address systemic issues in a culturally-aware manner.*

Principles:

Early intervention requires systemic as well as practice improvements. Ongoing attention to system redesign is required.

a. Early intervention is part of a broader commitment to recovery-oriented system change. To be most effective, ongoing services are consistent with early intervention strategies.
b. Mid-managers and clinicians implementing early intervention programs are likely to encounter a range of policy, funding, procedural, and personnel system barriers to the implementation of improved practices. Executive management and policy leaders will need to support staff charged with implementation by identification and removal of these barriers wherever possible.
c. Services require a transdisciplinary approach with an adequate level of service intensity to respond to the acute and emerging needs of individuals referred, as well as the range of services they need.
d. The full range of services is provided in rural and remote areas as needed. Some services may need to be modified in order to meet the needs of rural residents and potential of limited resources.

Criteria/Strategies

1.1. Preferably, most individuals involved in early intervention services should be assigned to early intervention functions at least half-time. Full-time is ideal. When individuals have additional job responsibilities, those responsibilities should be carefully assessed to ensure the ability to coordinate with the EASA team and be flexible, responsive, and proactive in providing early intervention supports.

1.2. Staffing will be based on an assertive community treatment standard. Reduced caseload sizes are especially important for newer or more acute situations. Across the transdisciplinary team (as defined in 8.0), a staff to individual ratio of 1:10 or less is optimal.

1.3. The following treatment providers are considered essential to provide appropriate services:

a. Licensed Medical Provider (LMP) (Psychiatrist, Psychiatric Nurse Practitioner)
b. Nurse(s)
c. Master's Level Clinical/Case Management Staff (combines therapeutic and case management functions and can be provided by social workers, counselors etc.). Teams may also include Qualified Mental Health Associate (QMHA) case managers or skills trainers but they are not required
d. Occupational therapist(s)
e. Supported employment and education specialist(s)

1.4. There is recognition of the diverse communities within the geographic area and a commitment to provide culturally appropriate services.

a. Team members are prepared to serve the diverse needs of its community, recognizing the unique needs of local populations and actively exploring ways to reduce barriers to access.
b. All team members receive ongoing training and consultation about the impact of individual/family beliefs and practices and how these influence their perceptions, experiences, and needs.
c. Hiring practices take into consideration the linguistic and cultural diversity represented within the community being served.
d. Programs are encouraged to access informal and formal peer resources in EASA service delivery and transition. Peer resources can include individuals in recovery from similar conditions, as well as people from a relevant cultural or experiential background.

1.5. All team members will be trained and supported to serve youth under 18 and young adults, within the EASA age range of 15-25 (minimum).

a. Care is continuous across the age range and systems are integrated to accommodate transitioning through one system to the next.
b. Provision of care explores the values and needs of the youth and young adult individuals (i.e. texting and youth friendly work environment).

1.6. Implementation of early intervention requires attention to each of the following essential screening and engagement process elements:

a. education of all potential sources of referral within the existing mental health program in order to expedite appropriate access;
b. the EASA team is responsible for its own screening and intake process;
c. agency leaders participate in EASA Network agreements to ensure continuity and support for a highly mobile population. Examples of agreements include accepting individuals automatically who move into the county from another EASA County without re-screening or system barriers and providing cross-county services as appropriate, such as multi-family groups and workshops;
d. crisis coverage is available 24/7 and can be provided by crisis services outside of the EASA team. A strong linkage between crisis services and the early intervention program is established;
e. EASA maintains a clear identity of EASA within the parent agency (business card, letter head, business entrance, and website).

1.7. Implementation of early intervention requires attention to each of the following personnel practices: a. all staff working with EASA individuals complete required EASA orientation, training, credentialing (See appendix B) and fidelity (See appendix C); b. job descriptions, evaluation and agency credentialing procedures integrate early intervention responsibilities. c. agencies adjust productivity standards to address the need for additional outreach, joint sessions, coordination, extensive travel, and community education; d. the agency is flexible to adjust schedules to accommodate evening and weekend hours; e. agency clinical supervisors provide clinical supervision specific to early intervention practice.
1.8. Implementation of early intervention requires attention to each of the following service delivery and evaluation elements: a. The EASA team provides outpatient substance abuse treatment to individuals within scope of practice; b. The EASA team provides community-based and office-based interventions; c. agency standard procedures (front desk, scheduling, billing, etc.) may need to be reevaluated to ensure consistency with EASA practices; d. agency standard forms (mental health assessment, service plan, etc.) may need to be reevaluated to ensure consistency with EASA practices; e. an ongoing quality improvement process collects and responds to information about EASA fidelity, participant satisfaction, concerns and recommendations, and program outcomes.
1.9. Programs will need to pursue alternative forms of funding and bill a range of insurance. This may require clinicians to pursue clinical licensure.

2. Individual and Family/Primary Support System Participation In Decision Making:
Principles: Individuals and family/primary support system involved in service planning, delivery, monitoring, and evaluation seem to facilitate the development of ongoing services that are accessible and culturally appropriate for them and may result in more responsive treatment providers, better quality of care, and more empowered individuals and primary family/primary support system (McGorry et al., 2010).
Criteria/Strategies:
2.1 Involvement of individuals and families/primary support system include the following strategies: a. ensuring a clear and accessible feedback and complaints system with transparent resolution processes; b. conducting routine focus groups around EASA services; c. facilitating individual and family/primary support system representation on boards and committees; d. facilitating individual and family/primary support system in EASA team member hiring; e. facilitating individual and family/primary support system in development of treatment and activity groups. f. developing and /or linking with peer support programs.
2.2 Individual and family/primary support system will be recognized for their contribution to EASA service development including; a. payment for time and travel contributed; b. provision for supports to encourage participation including childcare, transportation etc.; c. provision of training for individual and family/primary support system to facilitate participation (e.g. meeting procedures, specific skills etc.); d. enabling development into more advanced roles.

3. At-Risk Focus: *Early intervention programs integrate information about early signs and risk factors into their education and treatment approach. Consideration of that which is culturally normative is integrated into how the at-risk experience is identified and/or treated.*
Principles: Schizophrenia-related conditions frequently have a gradual onset. The psychosis risk syndrome may indicate the earliest form of a psychotic disorder, or an at-risk mental state (McGlashan, Walsh, & Woods, 2010). Neurocognitive, sensory, perceptual, and affective changes, usually accompanied by a decline in functioning, characterize the at-risk mental state. Identifying, monitoring, and providing needs-based care during a potential at-risk mental state is optimal. The evidence regarding the effectiveness of specific interventions (therapy, medications, etc) remains preliminary. More data regarding the risk/benefits needs to be obtained (McGorry, et al., 2010). Statewide implementation in Oregon is focused on both first episode and at-risk services. Integrating current knowledge about the at-risk syndrome is important for the following reasons: a. The at-risk mental state is often when the most disabling symptoms develop, particularly those associated with cognitive changes. Early detection and response to these changes may prevent school drop-out and long–term functional disability. Suicide risk may also be higher in the at-risk state. Family conflict and emergence of substance abuse may also result. Additional assessment, monitoring and support for youth with at-risk symptoms may detect emerging symptoms and prevent much of the acuity of the initial emergence of psychosis. b. Later stage at-risk symptoms often are very similar to the acute form of illness. However, in the at-risk state, insight is typically retained, families are less impacted, individuals are often more likely to recognize the need for outside assistance, and non-pharmaceutical approaches may be more successful since the individual is better able to engage in interactive therapy. c. Since psychosis is a cyclical condition, a thorough understanding of early symptoms can help begin to develop a *relapse signature*, or predictable early signs of relapse.
Criteria/Strategies
3.1. When an individual has multiple risk factors for a schizophrenia-related condition, assessment and careful monitoring may help to reduce disability and prevent acute symptoms.
3.2. Psychosocial interventions are preferred during the at-risk state. Consideration of individual and family cultural values and norms as well as language needs will be incorporated into the delivery of these interventions.
3.3. The following are recommended treatment guidelines for the at-risk state: a. regularly monitor mental state and offer support;

b. treat specific syndromes and co-morbid symptoms using evidence-based treatments for symptoms present (e.g. CBT and/or exercise for anxiety and depression) and provide assistance for occupational and family stress;
c. provide psychoeducation;
d. provide family support and education;
e. inform individuals in a flexible, careful and clear way about risks for mental disorders;
f. antipsychotic medication usually is not indicated; exceptions should be considered when there is rapid deterioration. Consider omega-3 fatty acids for prevention or slowing transition to a schizophrenia-related condition (Amminger et al., 2010).

4. Community Education and Awareness: *A core element of early intervention services is a proactive and ongoing campaign to increase knowledge and reduce attitudinal barriers about schizophrenia-related conditions. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential.*

Principles:

Systematic community education is a critical element of early intervention. Goals of education include:

a. increase the awareness and skill level of likely referents to identify at-risk signs and facilitate ease of referrals;
b. increase community awareness of the existence and accessibility of early intervention services as a distinct element of the mental health system of care;
c. communicate a non-stigmatizing and hopeful message about the condition as treatable in which positive outcomes are expected with early intervention;
d. deliver information within appropriate and relevant cultural contexts.

Criteria/Strategies

4.1. EASA team time and funding capacity will be set aside in order to ensure that community education activities are not overshadowed by clinical demands.

4.2. Community education strategies will target specific groups rather than "the general public." Messages will be tailored to the particular values and interests of each group. Specific groups which will be targeted include medical primary care providers, school professionals, parents and others who come in contact with youth. Education of youth under 18 and young adults will also reduce stigma and facilitate referrals.

4.3. Communications about conditions should carry a positive, hopeful message about early recovery and should combat negative preconceptions and reflect current understandings.

4.4. Specific information about observable at-risk symptoms will be routinely included in order to facilitate early recognition.

4.5. Systematic efforts to reach out to smaller communities will be necessary in rural areas.

4.6. The EASA team will provide and track community education efforts.

5. Access and Screening: *EASA services are quickly accessible for people and their primary support systems who are at-risk or who are experiencing their first episode of schizophrenia-related conditions. Understanding barriers to access that may present based on issues of stigma and shame or cultural interpretations of initial onset is critical at this stage.*
Principles: A first presentation of a schizophrenia-related condition is often a psychiatric emergency. Rapid access to mental health services is of particular importance for these individuals and their primary support networks. As a general principle a partnership should be developed with primary support networks.
Criteria/Strategies
5.1. The early intervention program accepts referrals from a wide range of community members including professionals, lay individuals, families, primary support networks, and those who self-refer.
5.2. Initial contact with the referent is made within two (2) business days of the referral. A method for immediate response is in place for families in crisis who are not yet connected to mental health support.
5.3. The location of the initial screening is flexible to accommodate a place of convenience to the individual, either in the community or the office.
5.4. Initial contact is made with the family or support system within two (2) business days of the screening of the individual so that support, and psychoeducation can be provided and if necessary triage can occur if the individual is at high risk for harm to self, others, and/or hospitalization.
5.5. Contact and support is maintained with the family or support system if determined appropriate by the EASA screener, even if the individual is not yet ready to engage in the screening and/or EASA services.
5.6. The initial interview with the family and/or support system explores their level of knowledge of at-risk or psychotic symptoms and identifies their current needs.
5.7. If the individual is hospitalized during screening, a clinician from the EASA team reaches out to the family and/or primary support network and makes contact with the individual in the hospital prior to discharge. Whenever possible an EASA team member participates in hospital discharge planning.
5.8. Barriers to care are assessed during the screening process. Whenever possible individuals and their families are supported in addressing those barriers (i.e. transportation, legal issues, child care, and cultural and language issues, schedules, etc).
5.9. The referent and others involved in the referral process are notified of the outcome of the screening. If screened out the referent is provided with written feedback that includes clinical recommendations and resources.
5.10. An enrollment process is established that allows for the screening to occur without requiring the individual to complete or sign agency paperwork. Official enrollment occurs once the individual is determined to be appropriate for EASA and engagement is sufficient to allow for full informed consent. Documentation is kept during the screening process.

***6. Assessment and treatment planning**: Initial and ongoing comprehensive assessment and a regular review of progress is provided to all individuals enrolled. Consideration of that which is culturally preferred is integrated into the assessment and treatment planning process.*
Principles: All assessment and treatment planning takes place in the individual/support system's preferred environment and includes a focus on individual strengths. Any decision-making regarding treatment involves the individual and their support system whenever possible. Strengths Assessment procedures for individuals incorporate strategies to promote engagement and therapeutic alliance (Rapp & Goscha, 2006). The mental health assessment itself gathers information on phenomenology, primary and secondary symptoms, course and duration, at-risk symptoms, precipitants, relieving factors, explanatory model, effect of any treatment already tried, associated physical conditions, current and past substance use, family and individual history, the strengths of the individual and his/her family, their cultural beliefs and practices, premorbid functioning, and pathway to care (McGorry et al., 2010). Treatment planning is individually driven, reflects the individual's strengths and language, and is updated to reflect changes as they occur throughout the recovery process and when initiating transition into ongoing services.
Criteria/Strategies
6.1. A comprehensive culturally informed biopsychosocial assessment and strengths assessment with clinical recommendations and/or rule outs is completed.
6.2. A comprehensive risk assessment of unique risks for the individual is undertaken, to include; suicide, violence and victimization, disorganization, impulsivity, delusional content, and family conflict which might lead them to potentially harmful behavior. This also includes an assessment of the individual's potential to leave their usual residence or, if admitted, prematurely leave the hospital. A safety/crisis plan is completed and shared with relevant members of the individual's support network and clinical team.
6.3. The Licensed Medical Provider (LMP), nurse, and/or clinical team members facilitate completion of a comprehensive physical examination, including medical tests: CBC with differential; chemistry panel (with liver enzymes, electrolytes, BUN, Cr, calcium); urine drug screen; thyroid screen (TSH, T4). As appropriate, the physician may request urinalysis with microscopy, B-12 and folate and MRI or CT, and other tests/evaluations**.**
6.4. The EASA team and the individual and their support network meets to clarify needs and expectations, plan treatment, and review progress, and stages of treatment (see Appendix D) at the following junctures: a. initiation of the assessment process; b. after completion of assessment; c. every 90 days; d. when initiating transition out of EASA services (approximately 6 months to transition date).

6.5. Treatment planning is a dynamic process that includes: a. individually driven goals and objectives; b. strengths-based and in an individual's language; c. updated as changes occur and reflect the step-by-step recovery process; d. clearly measureable objectives; e. identified individual (staff, family, natural support, etc) responsible for assisting the individual with goal; f. clearly outlined time frames for completion of goals; g. transition goals and plans.
6.6. Assessment and treatment planning is culturally aware by: a. including interpreters and translations for the preferred language of individuals and their families; b. identifying appropriate location of these activities; c. use of relevant language and references; d. use of accessible communication styles; e. following individuals' values and preferences.

7. Family/Support System Partnership: *Family and support system involvement is an important contributor to a successful outcome. Family and support systems are defined in the broadest sense to be inclusive of members relevant to the individual's community.*
Principles: Generally individuals do better in many aspects of life with the inclusion of a support system (Onwumere, Bebbington, & Kuipers, 2011). The individual determines who is a member of their family and/or support system and when/how they will be included in the recovery process. It is important to clarify the individual's wishes regarding the involvement of the family in their recovery. In some instances, individuals in recovery do not want their families or support systems involved. The basis for this feeling is carefully explored. This does not preclude the team involving the family and support system in education and recovery within limits of confidentiality laws. The primary goals of family and support system partnership are: a. to develop a strong collaboration and shared understanding with family members; b. to tailor family/support system work to the needs, cultural values and norms of each system in order to empower the family/support system to cope, adjust to crisis and support wellness; c. to teach and model advocacy skills to families and support systems; d. to mitigate distress and/or trauma associated with the individual's condition; e. to mitigate distress and/or trauma associated with involvement in mental health systems;
Criteria/Strategies
7.1. Initial contact is made with the family or support system within 2 business days of the enrollment of the individual so that crisis intervention, support and psychoeducation can be provided. The EASA team is prepared to provide resources necessary to engage families or support systems in the most accessible and culturally sensitive manner (i.e. interpreters are available when communicating in different languages, verbal presentation of material if literacy is an issue, etc).
7.2. The initial interview with the family and/or support system explores their level of knowledge of at-risk and/or psychotic symptoms and identify their current needs. Family history and observations of the individual's behavior are an important part of the ongoing diagnostic process.
7.3. The family and support system is oriented to the transdisciplinary and transitional nature of the EASA team, what to expect in the short-term and long-term, resources for safety, coping and support, and what to do in a crisis.
7.4. Partnerships attend to: a. the impact on the family and support system; b. the impact on individual family members; c. the distinction between the individual and their condition; d. the interaction between the family and the course of the condition.
7.5. The family and support system is part of the ongoing review process, as specified under Guideline 6.4.

8. Transdisciplinary team: *The treatment team works together closely to maximize the benefit of each discipline, provide the individual and family with the most useful knowledge and support, share knowledge and experience to promote cultural awareness, and maintain an ability to cross disciplines when appropriate.*
Bruder (1994) describes this approach in more detail: "A transdisciplinary approach requires the team members to share roles and systematically cross discipline boundaries. The primary purpose of this approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give-and-take between all members on a regular, planned basis. Professionals from different disciplines teach, learn, and work together to accomplish a common set of intervention goals for an individual and her family. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline-specific characteristics. Assessment, intervention, and evaluation are carried out jointly by designated members of the team. This teamwork usually results in a decrease in the number of professionals who interact with the child on a daily basis" (p. 61). The primary goals of the team include: a. engage the individual and support system in a collaborative partnership; b. develop a shared explanatory model with the individual and support system; c. share information regarding cultural values or norms most relevant to individuals and their support systems to promote culturally informed services; d. facilitate individual choice; e. encourage active participation in multi-family groups and all aspects of treatment; f. provide the individual and support system with information and tools to identify and cope with symptoms; g. instill a perspective of hopefulness in the team and with/for the individual and support system; h. facilitate the individual's efforts toward completion of individual goals and developmental tasks; i. cross-train and coordinate well with each other and in the provision of treatment services; j. be proactive to encourage clinical excellence and value of all disciplines; k. routinely cross disciplines, within skill levels and appropriateness.
Criteria/Strategies
8.1. The team meets frequently (minimum of once each week) to review individual and support system needs and coordinate services. Each individual's services, strengths and goals are reviewed weekly.
8.2. Team members have ongoing contact relevant to the phase of care (See appendix D), recovery and the individual need.
8.3. Team meetings routinely include telling success stories.

8.4. Transfer of care within the team occurs as a planful, gradual process whenever possible. If transitions are due to individual personnel or agency changes, a careful, timely transition process includes:

a. notification to the individual by the original treating clinician if at all possible; if not, notification occurs to the individual by the clinical supervisor;
b. development of a transition plan with the individual;
c. offering a closure session with the original treating clinician if possible.

9. Psychoeducation: *Psychoeducation aims to develop a shared and increased understanding of the illness and recovery process for both the individual and the family/support system. Specific attention is given to cultural values and norms of an audience and broad accessibility to this information is essential.*
Principles: Psychoeducation may be delivered in a variety of modes, such as one to one, group sessions, or family/support system work, and workshops. Psychoeducation is an ongoing process and reflects research in the early intervention field. The material used for psychoeducation purposes is reviewed and updated regularly. Psychoeducation considers its audience and incorporates cultural reference points whenever possible.
Criteria/Strategies
9.1 Psychoeducation and support is provided for the family and support system on an initial, ongoing and as needed basis through both individual work and group programs.
9.2. The material used should be appropriate for early intervention, and additionally should reflect the individual's needs and take into account how the individual usually learns or absorbs new information. Frequently used materials are translated as needed, and reviewed for cultural appropriateness.
9.3. Content is provided in an accessible manner and in multiple forms (written, verbal, multiple languages etc.).
9.4. All EASA team members are responsible for ensuring the provision of psychoeducation.
9.5. All individuals have access to group programs and activities that provide education and the opportunity to discuss and assimilate information.
9.6. Psychoeducation explains: a. early intervention; b. the nature of the conditions; c. what to expect from EASA and the transition process; d. young adult development and identity; e. options available for treatment and recovery to maintain the least restrictive setting; f. the patterns and variable nature of recovery; g. the prospects for the future and what individuals in recovery and their supporters can do to influence this; h. success stories of others in similar situations who have achieved successful recovery; i. what agencies and partners will be involved in their treatment and how agency decisions are made; j. legal rights; k. specific strategies for symptom management, coping, and establishing appropriate accommodations; l. relapse prevention plans; m. how to select and work effectively with professionals; n. resources available to enhance recovery.

10. Counseling: *Counseling interventions are provided as part of ongoing treatment. Consideration of that which is culturally appropriate. is integrated into the counseling interventions.*
Principles: Supportive counseling plays a key role with individuals in early intervention and throughout treatment. Counseling uses evidence-based interventions tailored to the unique nature of the condition and complexity of the developmental stage. Counseling interventions may include but are not limited to: motivational interviewing, cognitive behavioral therapy (CBT), supportive and substance abuse treatment consistent with dual diagnosis best practice guidelines (SAMHSA, 2011, Nordentoft et al., 2006), case management, and community-based in vivo practices. Group interventions can be both efficient and effective in promoting recovery. Counselors assess needs for topic-specific groups available within or outside of the EASA program. Counselors promote involvement in groups to support individual goals. These approaches may all play a role in helping individuals adapt successfully to changed reality, master symptoms, and support the individual's progress toward developmentally appropriate goals. The EASA team makes every effort to support and advocate that the individual receiving care remain in the most integrated setting. A counselor is assigned to each individual and establishes a relationship with the family, introduces the individual to other team members, connects to appropriate therapeutic groups, and manages the ongoing assessment, treatment/discharge planning, and treatment coordination. The counselor acts as a clinical case manager, provides counseling, psychoeducation for the individual and family, family support, and community linkages and advocacy.
Criteria/Strategies
10.1. Specific counseling interventions are based on sound clinical judgment and consultation with the transdisciplinary team.
10.2. Specific objectives of counseling in early intervention: a. are strengths-based; b. implement harm reduction principles; c. form a therapeutic alliance with the individual; d. teach alternative strategies to deal with stressful situations; e. promote adaptation and recovery; f. protect and enhance self-esteem and self-efficacy; g. attend to stigma issues; h. support development of effective coping strategies; i. address trauma, grief, and loss experiences on individual and systemic levels; j. reduce secondary morbidity and comorbidity.
10.3. Counseling techniques demonstrate cultural awareness by: a. counselors proactively identifying their own cultural values, beliefs and assumptions in consultation and supervision, b. counselors seeking knowledge about cultural differences from appropriate individuals, c. including interpreters and translations for the preferred language of individuals and their families,

d. identifying appropriate location of these activities,
e. use of culturally relevant language and references,
f. use of accessible communication styles,
g. respecting values and preferences of individuals.

10.4. The following tools/techniques are used to meet specific counseling objectives:

a. ongoing use of the strengths-based assessment and treatment planning;
b. explore ways to reduce harm in the course of high risk behaviors;
c. educate regarding relapse prevention including use of Illness Management and Recovery (IMR) techniques (SAMHSA, 2009);
d. acknowledge and use of techniques to minimize the impact of traumatic occurrences;
e. feedback techniques such as the Session Rating Scale (Duncan & Miller, 2000);
f. utilize group formats;
g. teach advocacy;
h. promote social justice;
i. mitigate possible traumas associated with hospitalizations by accompanying the individual to the crisis service and letting people know what to expect.

11. Occupational Therapy: *Occupational therapy assessment and intervention supports individuals in maintaining engagement in everyday life to promote recovery. The diverse beliefs and values of the individual and his/her identity are respected in these interventions.*
Principles: "Occupational therapy is founded on an understanding that engaging in occupations structures everyday life and contributes to health and well-being" (American Occupational Therapy Association [AOTA], 2008, p. 628). Occupational therapy assessment and intervention supports individuals experiencing and/or recovering from psychosis and their families in successfully engaging in "desired or needed participation in home, school, workplace, and community life" (AOTA, 2008, p. 629). "Occupational therapy involves facilitating interactions among the individual, the environments or contexts, and the activities or occupations in order to help the individual reach the desired outcomes that support health and participation in life. Occupational therapy practitioners apply theory, evidence, knowledge, and skills regarding the therapeutic use of occupations to positively affect the individual's health, well-being, and life satisfaction." (AOTA, 2008, p. 647).
Criteria/Strategies
11.1. Occupational therapy services are dynamic and evolve in real time along with the individual's desires and needs.
11.2. The occupational therapist collaborates with the individual, individual's family/support system, and other clinicians to include information gained through the occupational therapy assessment in the development and implementation of the overall recovery plan.
11.3. The occupational therapist may provide direct intervention services to the individual and his/her family and will provide consultation to other team members when developing educational supports (individual education plans [IEPs] or 504 plans) and determining vocational supports/services.
11.4. Occupational therapy assessment and intervention focuses on the complex relationship of factors influencing the individual's ability to successfully engage in meaningful occupation. These factors include but are not limited to: a. areas of occupation the individual wants, needs, or is expected to engage in (i.e. activities of daily living; instrumental activities of daily living; rest and sleep; education; work; play; leisure; and social participation); b. individual factors (i.e. cultural values, beliefs, and spirituality; mental functions, sensory functions and pain; etc.); c. activity demands (i.e. objects and their properties; space demands; social demands; sequence and timing; required actions and performance skills; required body functions); d. performance skills (motor and praxis skills; sensory-perceptual skills; emotional regulation skills; cognitive skills; communication and social skills; e. performance patterns (habits; routines; rituals; roles).
11.5. The occupational therapist places special emphasis on sensory processing and sensory modulation techniques to help the individual to engage in meaningful occupations (Brown, Cromwell, Filion, Dunn, & Tollefson, 2002; Brown & Dunn, 2002; Champagne, Koomar, & Olson, 2010; Dunn, 2001; Kinnealey, Koenig, & Smith, 2011).

11.6. Occupational therapy techniques demonstrate cultural awareness by:

a. occupational therapists pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision;
b. occupational therapists seeking knowledge about cultural differences from appropriate individuals;
c. including interpreters and translations for the preferred language of individuals and their families;
d. identifying appropriate location of these activities;
e. use of culturally relevant language and references;
f. use of accessible communication styles.

12. Supported Employment/Education
Principles: There is an increasing recognition that specific educational and employment supports can enhance overall recovery for individuals (Rinaldi et al., 2010). The team includes vocational and education specialists who provide support to individuals in defining academic/vocational goals and entering and sustaining academic and/or vocational activities. The diverse beliefs and values of the individual and his/her identity are respected in these interventions.
Criteria/Strategies: 12.1. Specific Individual Placement and Support (IPS) model (Swanson & Becker, 2008) strategies and philosophy are utilized in assisting individuals in exploring, obtaining and maintaining employment and educational goals. The components of the model include: a. zero exclusion; all individuals who want to participate in employment and/or education are supported in this goal, regardless of severity of mental health or substance use/abuse symptoms, previous history, legal history and other perceived barriers; b. employment and educational services are fully integrated into the transdisciplinary model; c. competitive employment and educational opportunities are the goals; d. benefits planning is individualized as part of the employment and educational process; e. employment and educational opportunities are sought rapidly; f. ongoing follow along support is provided once the individual is employed or enrolled in school; g. individual preferences around employment and education are honored.
12.2. Supported employment/education techniques demonstrate cultural awareness by: a. supported employment/education specialists pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision; b. supported employment/education specialists seeking knowledge about cultural differences from appropriate individuals; c. including interpreters and translations for the preferred language of individuals and their families; d. identifying appropriate location of these activities; e. use of culturally relevant language and references; f. use of accessible communication styles; g. respecting values and preferences of individuals.

13. Psychopharmacological Interventions: *Psychopharmacological interventions are to be provided during the acute phase and for ongoing management of psychotic symptoms if appropriate and the individual chooses. Individuals in the at-risk state should be treated following guideline 3.0. The diverse beliefs and values of the individual and his/her identity are respected in these interventions.*
Principles: The aim of psychopharmacology in first-episode psychosis should be to maximize the therapeutic benefit for the individual while minimizing side effects. Close monitoring of symptoms, side effects, and adherence is essential. Use of non-pharmaceutical alternatives is preferred when appropriate.
Criteria/Strategies
13.1. Appointments with the licensed medical provider (LMP) occur within one week of acceptance into the EASA program unless not clinically indicated.
13.2. Novel antipsychotics are the first treatment of choice for acute psychotic symptoms (McGlashan, 2006). The rule is to start low and titrate up balancing both acute symptoms versus side effects. The dosage for the acute phase may not be the same dosage for the maintenance phase.
13.3. Individuals who are experiencing a comorbid manic syndrome may require a mood stabilizer.
13.4. Alternative strategies for achieving sedation are generally preferred to using neuroleptics. Pharmaceutical strategies may include: Trazodone, antihistamines, benzodiazepines, melatonin, or prescription strength sleep aid. For agitation, Trazodone, antihistamines, and benzodiazepines are preferred over increasing dosages of neuroleptics.
13.5. With the exception of the above, polypharmacy should be avoided, specifically the use of multiple neuroleptics.
13.6. The LMP will offer and allow for appointments with the family and/or the support system alone to provide psychoeducation around medical information and concerns with the permission from the individual.
13.7. EASA team members will attend LMP appointments as appropriate to coordinate and support integration of all services.
13.8. The LMP will continue to maintain contact with individuals who choose not to take or to discontinue medication, with the goals of building trust, encouraging the individual to make healthy choices, addressing objections and concerns to the use of medicines, and monitoring ongoing symptoms and safety. Communication with the family/support system is particularly important for those individuals who do not want to take medicine with a focus on maintaining safety, encouraging healthy empowerment of the individual, and supporting family coping.
13.9. Psychiatric visits should (normally) occur weekly during the initial crisis phase, and should occur at least monthly for most individuals. Most routine visits should last at least 30 minutes.
13.10. Many individuals will prefer to end antipsychotic medications after an initial trial for many reasons and some can do so successfully. Following clinical remission, an incremental decrease in the medication dose will be considered due to the data are too limited to assess the effects of initial antipsychotic medication treatment on outcomes for individuals with an early episode of schizophrenia. (Bola, Kao, & Soydan, 2011). Decreases in medication dosages should occur with close monitoring of symptoms, over many weeks with a view to cessation over a three to six month period. A relapse plan should be well-developed and agreed upon by

the individual, family/support system and coordinated with the EASA team.
13.11 Psychopharmacological techniques demonstrate cultural awareness by: a. LMPs pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision; b. LMPs seeking knowledge about cultural differences from appropriate individuals; c. including interpreters and translations for the preferred language of individuals and their families; d. identifying appropriate location of these activities; e. use of culturally relevant language and references; f. use of accessible communication styles; g. respecting values and preferences of individuals, with specific attention on the role/meaning of medication within the individual and family's/primary support system's cultural context.

14. Nursing Interventions. The aim of nursing in EASA is to augment the medical treatment and curb the historically poor health outcomes by coordinating with primary care providers, monitoring for side effects and general health issues, supporting medication assistance, and engaging with the transdisciplinary in addressing the risk factors. *The diverse beliefs and values of the individual and his/her identity are respected in these interventions.*

Principles:

There is an increase of awareness that individuals with mental and substance use disorders of all types including schizophrenia-related conditions die decades earlier than the general population, mostly due to preventable medical conditions such as diabetes, cardiovascular, respiratory, or infectious diseases (including HIV). Higher risk factors are due to:

a. high rates of smoking, substance use, obesity, and "unsafe" sexual practice;
b. poverty, social isolation, trauma, and incarceration;
c. a lack of coordination between behavioral and primary health care providers;
d. discrimination;
e. side effects from psychotropic medications; and
f. an overall lack of access to quality, culturally appropriate health care services (http://www.promoteacceptance.samhsa.gov/10by10).

Criteria/Strategies

14.1. The nurse provides ongoing physical assessment, coordination with primary care, careful monitoring of health status and side effects, and wellness support.

14.2. The nurse addresses individual and group wellness by offering health-related education and counseling such as

a. education on tobacco use and smoking cessation;
b. encouragement and support of exercise;
c. nutrition education;
d. education on healthy sleep hygiene;
e. education on pregnancy and safe sex behavior.

14.3. To support medication management the nurse will

a. meet with individuals at least monthly to review side effects, changes in medications, weight, waist circumference, blood pressure, BMI and AIMS and BARNES tests as indicated;
b. monitor availability of medication and connecting with Patient Assistance Programs or pharmaceutical representatives for samples, if necessary;
c. track and coordinating laboratory test completion with the primary medical provider;
d. administer injections to those prescribed depot medications;

e. coordinate with medical providers in acute situations (side effects, symptoms) when medication changes need to be made and following through with pharmacy and individuals on acquisition of changed medication; f. Monitor the use of over-the-counter medications and nutritional supplements.
14.4. The nurse coordinates information transfer with Primary Care Provider (notes, labs, medication regimes, etc.).
14.5. Nursing techniques demonstrate cultural awareness by: a. Nurses proactively identifying their own cultural values, beliefs, and assumptions in consultation and supervision; b. Nurses seeking knowledge about cultural differences from appropriate individuals; c. including interpreters and translations for the preferred language of individuals and their families; d. identifying appropriate location of these activities; e. use of culturally relevant language and references; f. use of accessible communication styles; g. respecting values and preferences of individuals, with specific attention on the role/meaning of health issues within the individual and family's/primary support system's cultural context.

15. Multi Family Groups:
Principles: Multi-family groups (MFG) are a preferred method of treatment for most individuals and their families/support system (McFarlane, 2002). Where MFGs are not available, single family groups can be offered following the same format. Fidelity to MFG standards in each of the key stages is critical: joining sessions, family workshop, and carefully structured initial and ongoing problem solving sessions.
Criteria/Strategies:
15.1. All MFG facilitators must achieve fidelity in MFG national evidence-based guidelines.
15.2. All EASA team members co-facilitating groups must complete MFG training.
15.3. EASA MFG facilitators receive specialized monthly supervision with review of recorded sessions until they complete the credentialing process.
15.4. Any trained member of the EASA team can co-facilitate MFG. Cross-discipline co-facilitation is encouraged.
15.5. Workshops are provided on a quarterly basis and include all team members.
15.6. MFG's and family workshops will be culturally aware by: a. including interpreters and translations for non-dominant speakers; b. identifying an appropriate time, day and location of group; c. using culturally relevant language and references; d. using accessible communication styles; e. respecting values and preferences of attendees; f. creating a welcoming environment that respects diversity of attendees.
15.7. Attendance is equally encouraged for individual and family members.
15.8. MFG's are offered at times and locations convenient for attendees. Food is available at groups (potluck, agency provided).

***16. Transition Planning**:*
Principles: Early intervention services are conceptualized as a transitional service and prepare the individual and family for long-term success. To support long-term recovery, transitions need to be carefully planned and implemented gradually. Transition planning includes the family and/or support system and is considered throughout all phases of care (see appendix D).
Criteria/Strategies
16.1. The program is described as time limited from the beginning, and the recovery plan addresses planning for transition from the inception of services.
16.2. EASA clinicians routinely utilize the EASA transition checklist and phase of treatment document throughout treatment (See appendixes D & E). A specific plan of transition is developed and shared with all team members at least 6 months prior to completion of two years of service.
16.3. Services within EASA focus on supporting a grounded, realistic positive view of the future. The EASA team in partnership with the individual and support system anticipates the time period at and after completion of EASA and what this will concretely look like. EASA team members make frequent use of success stories and invite participation by graduates/individuals in recovery in their interactions with individuals and family/support system members.
16.4. EASA team members facilitate the connection of individuals and family/primary supports to appropriate ongoing resources prior to discharge from EASA.
16.5. Transition techniques demonstrate cultural awareness by: a. The EASA team pro-actively identifying through consultation and clinical supervision how their own cultural values, beliefs and assumptions may influence transition. b. including interpreters and translations for the preferred language of individuals and their families/primary support in the transition process; c. use of culturally relevant language and references; d. use of accessible communication styles; e. respecting values and preferences of individuals when working on transitional supports.
16.6. Although EASA is a transitional service, it maintains an interest in the long-term well-being of individuals and families/support system who graduate. In order to maximize long-term success, EASA pursues the following strategies: a. provide individuals and family/primary support people with the information they need to be effective self-advocates at individual, agency and system levels; b. offer ongoing opportunities for graduates of EASA to return for educational workshops, support groups, and decision making committees; c. provide brief problem-solving support if needed ; d. request feedback for quality improvement/system development; e. offer consultation and training to professionals and individuals involved in ongoing care and support of EASA graduates;

f. integrate EASA graduates into community education and participant education activities.
16.7. Choice of transitional provider matters because of the importance of compatibility, mix of skills, and the need for a high level of trust and communication. Individuals and families/support systems should be informed from the outset, and it should be reinforced over time, that they have the choice of which clinician they work with, within the limitations of availability. Every effort should be made to accommodate individual and family/support system preferences in transition providers.

Glossary of Terms

At-risk mental state (ARMS): The period of time during which a person can be reliably identified as being at increased risk for the onset of psychosis compared with the general population. This period is sometimes referred to as the "prodrome", or the early stage of illness manifestation. However, ARMS is the preferred term because the prodrome can only be identified in retrospect after illness is diagnosed, and use of the term prior to diagnosis implies that the individual will inevitably meet the criteria for a psychotic illness. The At-risk mental state historically was called *high risk*. Yet this phrase fell out of favor because older studies used it in reference to those who had only genetic factors contributing to risk. The term *ultra-high risk,* which denotes both a genetic risk and functional decline is often used, but ARMS does not sound as ominous and is more accurate because most individuals scoring within the ARMS range have some form of diagnosable illness but do not go on to develop psychotic illness.

Clinical case management: A model in which functions often divided between a "therapist" and "case manager" are provided by the same individual. The clinical case manager may provide practical, hands-on support for tasks such as learning the bus system while also providing cognitive behavioral therapy or other clinical interventions.

Duration of untreated psychosis (DUP): The length of time from the point when an individual first begins to experience psychosis and the point when the person first receives treatment from a mental health clinician.

Early intervention: Specialized treatment provided during the ARMS or first episode of psychosis.

Early psychosis: Refers to a stage of illness that is either considered an at-risk stage of developing a major psychotic disorder or the first episode of a major psychotic disorder.

Family Aided Community Treatment (FACT): FACT integrates all components of a person with a psychotic condition's treatment under one coordinated system. The treatment includes: community based counseling and case management, employment and education support, medication management, occupational therapy, and family support and counseling. This integration of all components, including family support, reduces the likelihood of contradictions, collusion, and disagreements among those who are invested in the recovery of the individual (McFarlane, Stastny, & Deakins, 1992).

First episode of psychosis: The term is used to denote the first onset of full psychotic symptoms. During this period a specific diagnosis may not be clear, yet the individual is distressed or impaired by the clear presence of the symptoms.

Harm reduction principles: Focusing on reducing harmful behaviors or reducing their negative impact in situations where the individual is not currently receptive to ending the behaviors completely. Harm reduction techniques allow the individual to make substantive progress toward health in an honest relationship with the clinician.

In vivo principles: Using real-world situations or role playing for learning and mastery rather than didactic discussion.

Prodrome: The early stage of illness during which clear symptoms are manifest but not acute. The psychosis prodrome may be characterized by the onset of symptoms such as significant cognitive decline in areas such as olfaction and working memory, affective changes, and lower-level psychotic symptoms in which enough insight is preserved to allow for self-reflection. Prodrome is a retrospective concept and useful primarily for relapse planning to interrupt repeated cycles and community education about how illness typically progresses.

Psychoeducation: A central part of the treatment process in which the clinical team provides structured, didactic education to help the individual and family understand the illness, cope and develop needed skills, and deal effectively with the emotional impact. Psychoeducation can use a variety of formats, including individual, group, written, and multimedia.

Appendix A

Policy on Inclusion in the EASA Network, 11/1/11

The Early Assessment and Support Alliance (EASA) are committed to preventing unnecessary trauma and disability among young people who are showing early symptoms consistent with schizophrenia-related conditions. EASA uses a population-based public health approach: EASA engages a wide range of family, community, and system partners in rapid identification and effective support of youth with psychosis, and provides a network of skilled, specialty services to respond to teens and young adults with psychosis. EASA leadership, administration, and providers commit themselves to a rigorous process of training, credentialing, and system improvement. EASA provides early identification, outreach, rapid access, and targeted services, which empower young people and their families to pursue goals, focus on developmental needs, and develop strengths.

Local communities and agencies within Oregon wishing to develop EASA programs are encouraged to do so. In most cases, it will take a period of time and consultation to establish the needed infrastructure. In order to join the EASA Network and access ongoing state-funded consultation, supervision and training support, the following requirements must be met:

1) Senior leadership of the local provider and key local funders such as managed healthcare organizations must be familiar with the expectations of EASA and committed to integrating early psychosis intervention permanently into its infrastructure as a public health approach. Senior leadership includes executive and operational directors and management team responsible for children's services, adult services, crisis services and administration.

    a. This commitment includes a recognition and plan for providing access to the entire community regardless of insurance or ability to pay, even if this means grant writing or developing other fundraising plans to supplement existing funds.

    b. To be successful, the EASA agency, and youth-serving partners must be mobilized to identify teens and young adults showing early signs of psychosis, and to work collaboratively to provide the supports they need. The EASA agency takes a lead role in engaging these partners.

2) Specific staff must be assigned to the program and time set aside. They must be supported to participate in training, supervision and credentialing specific to EASA.

3) Senior leadership must periodically engage in state-level and local discussions and statewide EASA Network agreements.

4) Senior leadership must provide problem-solving support to remove barriers within and outside of the agency.

5) The program must be prepared to implement the following elements as defined in EASA practice guidelines:
    a. Criteria for access and transition following EASA minimum standards
    b. Community education
    c. Rapid response
    d. Outreach and engagement
    e. Comprehensive, age, and culturally-appropriate assessment and treatment emphasizing self-direction
    f. The local service should be organized around EASA practice guidelines, including a transdisciplinary team, Individualized Placement and Support, and Multi-Family psychoeducation.
    g. Data collection

The following services are available to all EASA sites, including those not receiving EASA-specific funds through the state:

1) Limited phone and face-to-face consultation, statewide group training, and consultation (by phone and in person)
2) EASA materials development and support
3) Site-specific training and on-site fidelity review
4) Gant-writing support and other site-specific consultation (may require an additional investment of local resources if the state has not funded it specifically)
5) Waivers and state-level policies associated with EASA will apply to local sites meeting the requirements for EASA

Appendix B

Credentialing Process

EASA Practice	Training Required	Supervision Required	Work Example
Understand Core Elements of EASA Practice Guidelines and Fidelity	2-day EASA Introduction Training	26 hours	Certificate of completion of training
Systemic Infrastructure	Supervisor must attend 1-day EASA supervisors training	None	A letter of support from county supervisor expressing provider and agency commitment to EASA practice guidelines
Community Education	Included in 2-day EASA introduction training	None	Video or live demonstration of presentation that includes core elements
Differential Diagnosis of Psychosis	Included in 2-day EASA introduction training, Structured Interview for Psychosis Risk Syndromes (SIPS) training, and 1-day differential diagnosis training	36 hours specific to differential diagnosis. The 26 hours of introduction training can apply toward this if differential diagnosis training was included during supervision	10 case presentations, review of 3 screenings or assessments. and completion of SIPS certification
Assessment and Treatment Planning	Included in 2-day EASA introduction training	Included in 26 hours of supervision	*Review (feedback & corrections) of 3 copies of the following: • Strengths Assessments • Risk Assessments • Relapse Prevention/Crisis Plans • Recovery Plans • Transition Plans
Trans-disciplinary team psychosocial practices	Included in 2-day EASA introduction training and completion of the following **trainings:	Included in 26 hours of supervision	Certificates of completion, Review of 1 video session demonstrating these skills, review of 3 feedback forms, and review of 3 FACT meetings

	• Motivational Interviewing • Client directed outcome informed therapy (e.g. Miller-Duncan) • Strength's Based Treatment Planning • Dual Diagnosis • CBT with psychosis • Working with adolescents		
Family Psychoeducation	2-day Family Psychoeducation training	15 hours specific to multi-family groups (MFG), which is not included in 26 hours of supervision	Fidelity review of the following: • 1 joining session • 1 MFG Workshop • 3 Problem-solving groups To receive credit fidelity must be at 80%
Individualized placement and support/Supported Employment/Education	Training specific to **IPS, **CIS and 2- day Introduction training	Included in 26 hours of supervision	Certificate of completion of training
Psychopharmacology	Included in 2-day EASA introduction training	Included in 26 hours of supervision	Completion of EASA medical knowledge exam with 80% or higher score
Data Collection and Evaluation	Training with MVBCN database staff	None	Demonstrated ability to complete the following processes for 5 clients: • Referral • Decision/Pathway to care • Intake • Screened out letter • Outcome review • Discharge outcome review

*If the required form is not part of the clinician's job, the clinician can meet this standard by reviewing completed forms with a certified EASA team member or trainer.

**Comparable trainings with similar content will be accepted.

All training and supervision must include elements of cultural competence including but not limited to:

1. self-reflection and responsibility around difference, power and privilege,
2. consideration of racial and cultural factors that may influence the individual's experience with EASA,
3. selective attention to cultural factors that may impact the individual's sociocultural experience (e.g. -etic vs. -emic factors),
4. using broaching to avoid defining the individual's race or culture as the primary source of concern, but rather to consider the individual in a cultural context and how race and culture *may* impact certain EASA related concerns.

Appendix C

Fidelity Checklist EASA sites must meet 80% of total score meet fidelity.

1.0 SYSTEMIC INFRASTRUCTURE.			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
1.1. Preferably, most individuals involved in early intervention services should be assigned to early intervention functions at least half-time. Full-time is ideal. When individuals have additional job responsibilities, those responsibilities should be carefully assessed to ensure the ability to coordinate with the early intervention team and be flexible, responsive, and proactive in providing early intervention supports.	EASA responsibilities are allocated adequate time (critical mass of 1/2 time to full-time staff preferred).	5- There is at least 1 FTE QMHP for each 25 projected caseload. Functions are consolidated into individual full-time positions to achieve critical mass, with a minimum of .2 FTE for rural areas. Clinical supervision focuses specifically on protecting availability of part-time staff. 4- There is at least 1 FTE QMHP for each 25 projected caseload. Functions are consolidated into positions of at least .75 FTE, with a minimum of .2 FTE for rural areas. Clinical supervision focuses specifically on protecting availability of part-time staff. 3- There is at least 1 FTE QMHP for each 25 projected caseload. Functions are consolidated into positions of at least .5 FTE, with a minimum of .2 FTE for rural areas. Clinical supervision focuses specifically on protecting availability of part-time staff. 2-There is at least 1 FTE QMHP for each 25 projected caseload. Functions are consolidated into positions of less than .5 FTE, with a minimum of .2 FTE for rural areas. Clinical supervision focuses specifically on protecting availability of part-time staff.	Population and caseload projection data, FTE list, senior management and team interview.

		1-There is less than 1 FTE QMHP for each 25 projected caseloads. Functions are consolidated into positions of less than .5 FTE, or .2 FTE for rural areas. Clinical supervision focuses on protecting availability of part-time staff.	
1.2. Staffing will be based on an assertive community treatment standard. Reduced caseload sizes are especially important for newer or more acute situations. Across the transdisciplinary team.	A team to individual ratio of 1:10 or less is optimal.	5- Team has individual: team FTE ratio of 1:10 or less (total FTE: total number clients). 4- Team has individual: team FTE ratio of more than 1:10 and less than 1:15. 3- More than 1:15 and less than 1:20 2- More than 1:20 and less than 1:25 1- 1:25 or more	Current caseload and current FTE.
1.3 Specific treatment providers are considered essential to provide appropriate early intervention services.	An EASA team consists of: a. Counselor/case manager (QMHP). b. Nurse. c. LMP. d. Occupational therapist. e. Supported employment/education.	5- Team includes all 5 of these functions. 4-Team includes 4 of these functions. Missing elements are identified and plan is in place for including them. 3-Team includes 3 of these functions. Missing elements are identified and plan is in place for including them. 2- Team includes 2 of these functions. 1- Team includes 1 of these functions.	Current staff list, senior management interview.
1.4. Recognition of the diverse communities within the geographic area and a commitment to provide culturally appropriate services;	EASA teams achieve culturally informed services with, a. Recognition of local diversity and needs, and active exploration of ways to reduce barriers to access. b. Ongoing training and consultation about the impact of	5- Team has plan and/or policy that addresses all 4 targets. 4- Team has plan and/or policy that addresses 3 targets. 3- Team has plan and/or policy that addresses 2 targets. 2- Team has plan and/or policy that addresses 1 target.	Data: population versus number served, interviews with supervisor and clinicians. Also a review of diversity plan/policy. Reviews to will look for evidence of: o Team awareness

	individual/family beliefs and practices and how these influence their perceptions, experiences, and needs. c. Hiring practices take into consideration the linguistic and cultural diversity represented within the community being served. d. Programs are encouraged to access informal and formal peer resources in EASA service delivery and transition. Peer resources can include individuals in recovery from similar conditions, as well as people from a relevant cultural or experiential background.	1-Evidence does not support any items.	of diversity of community compared to that of current EASA population and systematic plan to address gap. o Trainings and/or consultations available to team for specific diversity issues. o Job descriptions specifically addressing need for culturally informed team members. o Peer resource plans/practices that include attention to diversity of population.
1.5. All team members will be trained and supported to serve youth under 18 and young adults, within the EASA age range of 15-25 (minimum).	Both youth under 18 and young adults in EASA experience; a. Care is continuous across the age range and systems are integrated to accommodate transitioning through one system to the next. b. Provision of care explores the values and needs of the youth and young adult individuals (i.e. texting and	5- All team members serve youth under 18 and young adults; administrative systems are in place to support this; ongoing training is provided to maximize staff knowledge and skills and provision of care explores the values and needs of the youth and young adult individuals 4- All team members serve youth under 18 and young adults; administrative systems are being developed to support this; ongoing training is provided to maximize	Data: Age range served, interview with senior management, supervisors and team, records review of individuals transitioning into adulthood.

	youth friendly work environment).	staff knowledge and skills, but no or limited provision of care explores the values and needs of the youth and young adult individuals 3- Some team members are restricted in the age range they serve; but operate within the same team; ongoing training is provided to maximize staff knowledge and skills. 2- Team members are restricted in age range they serve. 1- Individuals of different ages are served by different teams.	
1.6 Early intervention programs follow specific screening and engagement practices in early intervention.	The EASA screening and engagement process includes: a. Education of all internal referents. b. Responsibility for own screening/intake. c. Leadership participation in EASA Network agreements. d. A Strong linkage to 24 hour crisis. e. A Clear identity within the County agency.	5- The EASA screening and engagement process includes all five recommended targets. 4- The EASA screening and engagement process includes four recommended targets. 3- The EASA screening and engagement process includes three recommended targets. 2- The EASA screening and engagement process includes two recommended targets. 1- The EASA screening and engagement process includes none of the recommended targets.	Phone call(s) to agency, County agency staff interviews, team and clinical supervisor interview.

1.7. Early intervention programs follow specific personnel practices in early intervention.	Personnel practices include: a. All staff have completed or are completing EASA orientation, training and credentialing. b. Job descriptions and evaluations reflecting EASA/early psychosis. c. Productivity standards are modified. d. Flexible schedules to accommodate. evenings/weekends are allowed. e. Clinical supervision is specific to early psychosis.	5- The EASA personnel practice process includes all five recommended targets. 4- The EASA personnel practice process includes four recommended targets. 3- The EASA personnel practice process includes three recommended targets. 2- The EASA personnel practice process includes two recommended targets. 1- The EASA personnel practice process includes none of the recommended targets.	
1.8. Early intervention programs follow specific service delivery and evaluation practices in early intervention.	Service delivery and evaluation include: a. Team provides substance abuse treatment. b. Services provided in the community. c. Agency standard procedures evaluated and altered as needed (i.e. front desk, scheduling, billing, etc.). d. Agency standard forms reevaluated and revised as needed. e. Active quality improvement process.	5- The EASA service delivery practice process includes all five recommended targets. 4- The EASA service delivery practice process includes four recommended targets. 3- The EASA service delivery practice process includes three recommended targets. 2- The EASA service delivery practice process includes two recommended targets. 1- The EASA service delivery practice process includes none of the recommended targets.	Team, clinical supervisor, senior management interview, review of procedures/ forms.

1.9. Pursuit of alternative forms of funding/billing.	There is an active pursuit of multiple funding sources.	5- EASA County actively pursues insurance and alternative funding 4- EASA County actively pursues insurance but not alternative funding 3- EASA County bills insurance where available, but does not actively pursue reimbursement. 2- EASA County bills Oregon Health Plan 1- Agency not billing other than EASA	Financial report, team, clinical supervisor, senior management interview.

2.0 INDIVIDUAL AND FAMILY/PRIMARY SUPPORT SYSTEM PARTICIPATION			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
2.1 & 2.2 Individuals and family/primary support system involved in service planning, delivery monitoring, and evaluation seem to facilitate the development of ongoing services that are accessible and culturally appropriate for them and may result in more responsive treatment providers, better quality of care, and more empowered individuals and primary family/primary support system	Involvement of individuals and families/primary support system include the following strategies: a. Ensuring a clear and accessible feedback and complaints system with transparent resolution processes. b. Conducting routine focus groups around EASA services. c. Facilitating individual and family/primary support system representation on boards and committees. d. Facilitating individual and family/primary support system in EASA team member hiring. e. Facilitating individual and family/primary support system in development of treatment and activity groups.	5- The EASA team has a plan/system in place to incorporate or is incorporating all seven targets. 4- The EASA team has a plan/system in place to incorporate or is incorporating five-six targets. 3- The EASA team has a plan/system in place to incorporate or is incorporating three-four targets 2- The EASA team has a plan/system in place to incorporate or is incorporating two targets. 1- The EASA team has a plan/system in place to incorporate or is incorporating at least one target.	EASA team, clinical supervisor interview, individual and family/primary support interview.

(McGorry et al., 2010).	f. Developing and /or linking with peer support programs. g. Formal recognition of family/primary support system contribution.		

3.0 AT-RISK FOCUS			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
3.1 & 3.2 Where an individual has multiple risk factors for schizophrenia related conditions, assessment careful monitoring, and appropriate treatment of the precursor symptoms may help to reduce disability and prevent acute symptoms.	EASA team members are trained in the assessment and subsequent tailored treatment of individuals in an at-risk state.	5- All EASA team members have been trained in the assessment and tailored treatment for individuals in an at-risk state. 4- At least half of EASA team members have been trained in the assessment and tailored treatment for individuals in an at-risk state. 3- Less than half of EASA team members have been trained in the assessment and tailored treatment for individuals in an at-risk state. 2- No EASA team members have been trained in the assessment and tailored treatment for individuals in an at-risk state, but are familiar with the guidelines. 1- The EASA Team is not familiar with the treatment and assessment guidelines around individuals with an at-risk state.	EASA team interview, certification.

3.3 Early intervention team members are following recommended treatment guidelines for the at-risk state.	The following are recommended treatment guidelines for the at-risk state a. Regularly monitor mental state and offer support. b. Treat specific syndromes and co-morbid symptoms using evidence based treatments for symptoms present (e.g. CBT and/or exercise for anxiety and depression) and provide assistance for occupational and family stress. c. Provide psychoeducation. d. Provide family support and education. e. Inform individuals in a flexible, careful and clear way about risks for mental disorders. f. Antipsychotic medication usually is not indicated; exceptions should be considered when there is rapid deterioration. Consider omega-3 fatty acids for prevention or slowing transition to a schizophrenia related condition (Amminger, et al. 2010).	5- The EASA team provides all six recommended treatment targets. 4- The EASA team provides four-five recommended treatment targets. 3- The EASA team provides two-three treatment targets. 2- The EASA team provides one recommended treatment targets. 1- The EASA team provides none of the recommended treatment targets. *To be scored in 3.3 there must be evidence of the above in at least half of the individuals whom the EASA team identifies as at-risk.	EASA team interview, chart review, EASA individual interview.

4.0 COMMUNITY EDUCATION AND AWARENESS			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
4.1	EASA teams have one or more	5- Two EASA team members set aside	Community education

Early intervention team time and funding capacity will be set aside in order to ensure that community education activities are not overshadowed by clinical demands.	individuals with time assigned to community education.	time to do community education on a routine basis. 4-At least one EASA team member sets aside time to do community education on a routine basis. 3- One EASA team member sets aside time to do community education on a routine basis, but it occurs infrequently. 2-No EASA team members set aside time to do community education on a routine basis, although community education is occurring. 1-Community education not occurring (less than 2 presentations/quarter)	tracking records, team interview.
4.2 & 4.6 Community education strategies will target specific groups rather than "the general public." Messages will be tailored to the particular values and interests of each group.	EASA Community education activities target specific groups with messages tailored to the group receiving the education. Recommended targeted groups include: a. Medical care providers. b. School professionals. c. Parents. d. Others that come in contact with youth.	5- A specific plan is being followed, tracked and fine-tuned for doing outreach to multiple groups. Goals and messages are identified for each group. 4-A specific plan is being followed, tracked and fine-tuned for doing outreach to multiple groups. Goals and messages are not clearly defined. 3- A specific plan is being followed, tracked and fine-tuned for doing outreach to at least two target groups. 2-Community education is occurring and being tracked without a plan. 1-Community education is not occurring (2x/quarter or less).	Community education by quarter, community education tracking records, team and supervisor interview.
4.3 & 4.4. Early intervention	EASA team members involved in community education understand the	5- Written materials and presentations include all five relevant targets.	Review of two presentations (with at

teams engage in community education to facilitate early recognition and a rapid referral.	materials and specific information covered. Communications about conditions should: a. Carry a positive, hopeful message about early recovery. b. Combat negative preconceptions. c. Reflect current understandings. d. Include specific information about observable at-risk symptoms to facilitate early recognition. e. Include relevant cultural information.	4- Written materials and presentations include at least four targets. 3- Written materials and presentations include at least three targets. 2- Written materials and presentations include at least two targets. 1- Written materials and presentations include only one target.	least one a real presentation) and written materials.
4.5 & 4.6 Early intervention teams systematic efforts to reach out to smaller communities.	EASA team community education plans and follow up activities reflect specific focus on rural areas.	5- The EASA team is systematically reaching out to educate rural parts of the region (i.e. towns with smaller populations and unincorporated areas), as reflected in community outreach plan and specific activities at least every month. 4- The EASA team is systematically reaching out to educate rural communities, as reflected in community outreach plan and specific activities at least every two months. 3- The EASA team has rural communities in its outreach plan, and conducts outreach to rural areas at least every three months 2- The EASA team has rural communities in its outreach plan but conducts outreach less than every three months 1- Rural communities are not included in outreach plan and outreach is not being done to these areas.	Review of community education log and community education plan.

		Total Points: _____ (Possible points:)	

5.0 ACCESS AND SCREENING			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
5.1 The Early intervention program will accept referrals from a wide range of community members including professionals, lay individuals, families, primary support networks, and those who self-refer.	Referrals are accepted from a wide range of referents and not primarily from the community mental health agency or the crisis/psychiatric/hospital system.	5- Over 50% of referrals come from a wide range of sources outside the community mental health agency or crisis system. 4- Less than 50% of referrals come from a wide range of sources outside the community mental health agency or crisis system. 3- Less than 40% of referrals come from a wide range of sources outside the community mental health agency or crisis system. 2- Less than 30% of referrals come from a wide range of sources outside the community mental health agency or crisis system. 1- Less than 20% of referrals come from a wide range of sources outside the community mental health agency or crisis system.	Referral records, EASA database.
5.2 Initial contact with referent will be made within 2 business days of the referral. A method for immediate response is in place for families in crisis who are not yet connected to mental health support.	A first presentation of suspected schizophrenia related condition is often a psychiatric emergency, rapid response and access to crisis resources is critical.	5- 90% of initial calls are returned within 2 business days. 4- 80% of initial calls are returned within 2 business days. 3- 70% of initial calls are returned within 2 business days. 2- 60% of initial calls are returned within 2 business days. 1-50% of initial calls are returned within 2 business days. *In order to be scored on 5.2 a method for immediate response must be in place for	Referral records, screening records, EASA database.

		families/support systems who are not yet connected to mental health support.	
5.3 The location of the initial screening is flexible to accommodate a place of convenience to the individual either in the community or the office.	Often is engagement is more successful in a place of convenience for the individual and their primary support system. When appropriate the initial screening will occur in a place of convenience.	5- 50% of initial screenings are done in locations other than the local mental health center. 4- More than 40% but less than 50% of initial screenings are done in locations other than the local mental health center. 3- More than 30% but of initial screenings are done in locations other than the local mental health center. 2- 10% to 29% of initial assessments are done in locations other than the local mental health center, 1- Less than 10% of initial assessments are done in the community outside of the mental health center.	Referral records, screening records, EASA database.
5.4, 5.5 & 5.6 Families and/or support system are often necessary for engagement and completion of the screening process.	The following elements are recommended for involving families and/or support system in the screening process; a. Initial contact is made with the family or support system within two (2) business days of the screening of the individual. b. Support and psychoeducation will be provided. c. If necessary triage can occur if the individual is at high risk for harm to self, others, and/or hospitalization. d. Contact and support will be maintained with family or support system if determined	5- The EASA team provides all 5of the recommended elements. 4- The EASA team provides 4 of the recommended elements. 3- The EASA team provides 3 of the recommended elements. 2- The EASA team provides 2 of the recommended elements. 1- The EASA team provides 1 of the recommended elements. *To be scored in 5.4-5.6 there must be evidence of the above in at least half of the individuals whom the EASA team has screened.	Referral records, screening records. family/support system interview, team interview.

	appropriate by EASA screener, even if the individual is not yet ready to engage in the screening and/or EASA services. e. The initial interview with the family and/or support system explores their level of knowledge of at-risk symptoms and identifies their current needs.		
5.7 & 5.8 If the individual is hospitalized during screening, a clinician from the early intervention team will reach out to the family and/or primary support network and make contact with the individual in the hospital prior to discharge. Whenever possible an early intervention team member will participate in hospital discharge planning. In addition Barriers to care will be assessed during the screening process. Whenever possible individuals and their families will	Barriers to completing screenings are identified and addressed.	5- The EASA team addresses necessary barriers to completing the screening process. 4- The EASA team addresses the hospital barrier by having team member(s) present and engaged in the discharge process and addresses most additional barriers. 3- The EASA team addresses the hospital barrier by having team member(s) present and engaged in the discharge process but is unable to address most of the additional barriers. 2- The EASA team is unable to address the hospital barrier but is able to address at least some of the additional barriers. 1- The EASA team is unable to address barriers to the screening process.	Screening records, individual and family/support system interview, team interview, clinical patterns of practice.

be supported in addressing those barriers (i.e. transportation, legal issues, child care, and cultural and language issues, schedules, etc.).			
5.9 & 5.10 The referent and others involved in the referral process are notified of the outcome of the screening. If screened out the referent will be provided with written feedback that will include clinical recommendations and resources. In addition, an enrollment process will be established that allows for the screening to occur without requiring the individual to complete or sign agency paperwork. Official enrollment occurs once the individual is determined to be appropriate for early intervention and engagement is	Referent notified of outcome of initial screening and there is an established process for documenting the engagement process and enrollment process.	5- The referral process is a collaborative process, with the EASA screener actively strategizing and discussing the referral with the referent. 90-100% of referents receive both a call and letter explaining the outcome of referral and there is a process for documentation of the engagement process and enrollment process. 4- The referral process is a collaborative process, with the EASA screener actively strategizing and discussing the referral with the referent. 90-100% of referents receive either a call or letter explaining outcome of referral and there is a process for documentation of the engagement process and enrollment process. 3- The referral process is a collaborative process, with the EASA screener actively strategizing and discussing the referral with the referent. 60-89% of referents receive either a call or letter explaining outcome of referral and there is a process for documentation of the engagement process and enrollment process. 2- Although the program actively collaborates with referents, there is not a system in place for notifying referents of	Screening records, referent interview, team interview.

sufficient to allow for full informed consent. Documentation is kept during the screening process.		the outcome of their referral, but there is a process for documentation of the engagement process and enrollment process 1- The program does not often collaborate with referents around referral strategies, and there is not a system in place for notifying referents of the outcome of their referral, but there is a process for documentation of the engagement process and enrollment process. * Scores are not based on practice prohibited by confidentiality laws.	
		Total Points: _____ (Possible points:)	

6.0 ASSESSMENT AND TREATMENT PLANNING			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
6.1 & 6.2 Comprehensive culturally-informed biopsychosocial assessment, risk assessment and subsequent crisis plan (if necessary) and strength's assessment with clinical recommendations and/or rule outs is completed.	EASA assessments demonstrate inclusion of: a. Phenomenology. b. Description of primary and secondary, comorbid signs & symptoms. c. Course and duration. d. At-risk symptoms. e. Precipitants. f. Relieving factors. g. Explanatory model. h. Effect of any treatment already tried. i. Associated physical	5- 13-16 elements are addressed and are included in an assessment format with most clients. 4- 12 elements are addressed in an assessment format and separate comprehensive risk and strength's assessments have been completed. 3- 9 of the elements are addressed in an assessment format and separate comprehensive risk and strength's assessments have been completed. 2- At least 9 elements are addressed in an assessment format but no separate risk and strength's assessment completed.	Chart review.

	conditions & health screening. j. Current and past substance use. k. Family and individual history. l. Cultural beliefs and practices. m. Premorbid and current functioning across life domains. n. Pathway to care. o. A separate comprehensive risk assessment. p. A separate comprehensive strength's assessment.	1- Less than 9 elements are addressed in an assessment and no separate risk and strength's assessment completed. *To be scored in 6.1 & 6.2 there must be evidence of the above in at least half of the individuals whom the EASA team has completed the initial assessment and have been active in EASA over 12 months. The elements do not have to be from a single assessment and are encouraged to be collected over time.	
6.3 The Licensed Medical Provider (LMP), nurse, and/or clinical team members facilitates completion of comprehensive lab and medical tests. .	Referral for exam and appropriate testing occurs at baseline and annually with the following tests as indicated by LMP: a. CBC with differential. b. Comprehensive metabolic panel (with liver enzymes, electrolytes, BUN, Cr, calcium). c. Urine drug screen. d. Thyroid screen (TSH, T4). e. As appropriate, the physician may request urinalysis with microscopy, B-12 and foliate and MRI or CT, and other tests/evaluations**.**	5- All indicated individuals are referred for tests; 90-100% receives most of the tests. 4- All indicated individuals are referred for tests; 80-89% receive most of them 3- All indicated individuals are referred for tests and 70-79%% receives most of them. 2- All indicated individuals are referred for tests and 60-69%% receives most of them. 1- All indicated individual are referred for tests; less than 50% receives most of them. *To be scored in 6.3 there must be evidence of the above in at least half of the individuals whom the EASA LMP has completed the initial assessment and been active in EASA for 12 months. If an individual was hospitalized and received labs those tests will meet criteria for the appropriate time frame.	Chart review.
6.4	Treatment and progress is reviewed	5- All 4 reviews occur involving both the	Chart review,

The early intervention team and the individual and their family/support system meets to clarify needs and expectations, plan treatment, and review progress, and stages of treatment (see Appendix D).	at the following junctures: a. Initiation of the assessment process. b. After completion of assessment. c. Every 90 days. d. When initiating transition out of EASA services (approximately 6 months to transition date.	individual and the family/support system. 4- 3 reviews occur involving both the individual and the family/support system. 3- 3 reviews occur but do not involve both the individual and the family/support system. 2- 2 reviews occur involving both the individual and the family/support system. 1- 2 reviews occur but do not involve both the individual and the family/support system. *To be scored in 6.4 there must be evidence of the above in at least half of the individuals whom the EASA team has been involved with for over 18 months. Scores are also not based on practice prohibited by confidentiality laws or on individuals/family or support system who were not willing or available to meet.	individual and family/support system interview.
6.5 Treatment planning in early intervention is a dynamic culturally aware process.	Treatment planning is a dynamic process that includes: a. Individually driven goals and objectives. b. Strengths based and in an individual's language. c. Updated as changes occur and reflect the step-by-step recovery process. d. Clearly measureable objectives. e. Identified individual (staff, family, natural support, etc.) responsible for assisting the individual	5- 90% or more of plans meet target. 4- 75-89% of plans meet target. 3- 50-74% of plans meet target. 2-25-49% of plans meet target. 1- Less than 25% of plans meet target.	Chart review, individual and family/support system interview.

	with goal. f. Clearly outlined time frames for completion of goals, transition goals and plans. g. Culturally aware.		
		Total Points: _____ (Possible Points:)	

7.0 FAMILY/SUPPORT SYSTEM PARTNERSHIP			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
7.1. Early intervention teams are prepared to provide resources necessary to engage families or support systems in the most accessible and culturally sensitive manner (i.e. interpreters are available when communicating in different languages, verbal presentation of material if literacy is an issue, etc.).	EASA team members make initial contact is made with the family or support system within two business days of the enrollment of the individual so that crisis intervention, support and psychoeducation can be provided.	5-Initial contact offering crisis intervention, support and psychoeducation occurs within 2 days for all applicable families/support systems; outreach specifically targets father figures and siblings as well as mothers. This practice occurs with 90% of applicable families/support systems. 4-Initial contact offering crisis intervention, support and psychoeducation occurs within 2 days for all families/support system; outreach specifically targets father figures and siblings as well as mothers. This practice occurs with 80% of applicable families/support systems. 3- Initial contact offering crisis intervention, support and psychoeducation occurs within 2 days for all families/support system; outreach specifically targets father figures and siblings as well as mothers. This practice occurs with 70% of applicable families/support systems. 2- Initial contact offering crisis	Chart review, family/support system interview, team interview.

		intervention, support and psychoeducation occurs within 2 days for all families/support system; outreach specifically targets father figures and siblings as well as mothers. This practice occurs with 60% of applicable families/support systems. 1- Initial contact offering crisis intervention, support and psychoeducation occurs within 2 days for all families/support system; outreach specifically targets father figures and siblings as well as mothers. This practice occurs with 50% of applicable families/support systems. * Scores are also not based on practice prohibited by confidentiality laws or on individuals/family or support system who were not willing or available to meet.	
7.2. An initial family interview in Early Intervention programs is conducted to ascertain family's level of knowledge of psychosis, impact on system, pathway to care and current needs.	EASA team members obtain direct family/support system history and observations of person's behavior as an important part of diagnostic process.	5- Family interviews addressing psychosis knowledge, needs, history and observations are central to 85% or more of assessments 4- Comprehensive family interviews addressing psychosis knowledge, needs, history and observations are central to 60-84% or more of assessments 3- Family interviews are central to 50-84% or more of assessments, but some content gaps are present 2- Family interviews are central to less than 50% or fewer of assessments 1- Family interviews are not done as part of assessment process for most individuals.	Chart review, family/support system interview, team interview.

		* Scores are also not based on practice prohibited by confidentiality laws or on individuals/family or support system whom were not willing or available to meet.	
7.3 The family and support system is oriented to the early intervention program.	EASA team members assure family and support systems are routinely oriented to : a. Transdisciplinary nature of EASA. b. Transitional process. c. What to expect in short-term. d. What to expect in long-term. (help to build positive vision) e. Resources for safety, coping and support. f. What to do in a crisis.	5- All 6 targets reviewed with new families/support system in an orientation to EASA. 4- 3 to 5 targets are reviewed with new families/support system in an orientation to EASA. 3- 1 to 2 targets are reviewed with new families/support system in an orientation to EASA. 2- Families/support system receive this information but not as part of an orientation to EASA. 1-Famlies/support system are not offered an orientation to EASA. *To be scored in 7.3 there must be evidence of the above in at least half of the individuals whom the EASA team has enrolled.	Chart review, family/support system interview, team interview, orientation documents.
7.4 Early intervention team view family/support systems as partners in the treatment program.	EASA family/support system partnerships attend to: a. Impact on family and support system b. Impact on individual family members. c. Distinction between individual and their condition. d. Interaction between the family and the course of the condition.	5- There is evidence that all 4 targets are met. 4- There is evidence that 3 targets are met. 3- There is evidence that 2 targets are met. 2- There is evidence that at least 1 target is met. 1-Family/support system partnerships are occurring but no evidence the targets are met. *To be scored in 7.4 there must be	Chart review, family/support system interview, team interview, educational handouts.

		evidence of the above in at least half of the individuals whom the EASA team has enrolled.	
		Total Points: _____ (Possible Points:)	

8.0 TRANSDISCIPLINARY TEAM			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
8.1, 8.2, & 8.3 The early identification team meets frequently (minimum of once each week) to review individual and support system needs in a transdisciplinary fashion.	All EASA team members meet weekly to cover the following: a. Coordination of EASA services relevant to the phase of care, recovery and individual need of each individual enrolled in EASA. b. Share success stories.	5- The EASA team has a pattern of practice consisting of a weekly review of all individuals including all team members and both targets are covered. 4- The EASA team has a pattern of practice consisting of a weekly review of all individuals including all team members, but both targets are not covered. 3- The EASA team has a pattern of practice consisting of a weekly review of all individuals but it does not include all team members. 2- The EASA team has a pattern of practice consisting of a weekly review occurs, but it does not does not cover all individuals. 1- The EASA team has a pattern of practice consisting of a review of all individuals that occurs less than weekly.	Team interview, observation of team meeting, team meeting notes.
8.4 Transfer of care within the early identification team occurs as a planful, gradual process whenever possible	If transitions are due to individual personnel or agency changes, a careful, timely transition process includes: a. Notification occurs to the individual by the original treating clinician if at all possible; if not,	5- When transfers occur all 3 targets are met. 4- When transfers occur at least 2 targets are met. 3- When transfers occur at least 1 target is met. 2- When transfers occur there is a plan but no targets are met.	Team interview, individual and family/support system interview, chart review.

	notification occurs to the individual by the clinical supervisor or designated team member. b. A transition plan is developed with the individual. c. A closure session with the original treating clinician is offered if at all possible.	1- When transfers occur no targets are met and no plan in place.	
		Total Points: _____ (Possible Points:)	

9.0 Psychoeducation			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
9.1, 9.2 & 9.3 Psychoeducation and support is provided for the family and support system on an initial, ongoing and as needed basis through both individual work and group programs.	The material used should be appropriate for early intervention, and additionally should reflect the individual's needs and take into account the following: a. How the individual learns or absorbs new information (e.g. cognitive challenges, level of stress, and insight into symptoms). b. Frequently used materials are translated as needed, and reviewed for cultural appropriateness. c. Content is provided in an accessible manner and in multiple forms (written,	5- Psychoeducation is provided in written and verbal formats, is translated as needed, is reviewed for cultural appropriateness and takes into account how the individual absorbs new information. 4- Psychoeducation is provided in written and verbal formats, is translated as needed and is reviewed for cultural appropriateness. 3- Psychoeducation is provided in written and verbal formats and is translated as needed. 2- Psychoeducation is provided in both written and verbal formats. 1- Psychoeducation is only provided verbally.	Chart review, family/support system interview, team interview, review of psychoeducation materials.

	verbal, multiple languages etc.).		
9.4 Early intervention team members are responsible for ensuring the provision of psychoeducation.	All EASA team members are providing psychoeducation.	5- All team members are providing psychoeducation. 4- 50% of team members are providing psychoeducation. 3- 25% of the team members are providing psychoeducation 2- At least 1 member is providing psychoeducation. 1- No team members are providing psychoeducation.	Team interview, individual and family/support system interview, team attendance at family psychoeducation workshops, chart review.
9.5 & 9.6 All individuals in early intervention programs have access to group programs and activities that provide education and the opportunity to discuss and assimilate information.	Psychoeducation (written or verbal) explains: a. Early intervention. b. The nature of the conditions. c. What to expect from EASA and the transition process. d. Young adult development and identity. e. Options available for treatment and recovery to maintain the least restrictive setting. f. The patterns and variable nature of recovery. g. The prospects for the future and what individuals in recovery and their supporters can	5- The team provides psychoeducation that covers 11-14 of the target areas in a group or individual format(s). 4- The team provides psychoeducation that covers 8-10 of the target areas in a group or individual format(s). 3- The team provides psychoeducation that covers 5-7 of the target areas in group or individual format. 2- The team provides psychoeducation that covers 3-4 of the target areas in group or individual format. 1- The team is not providing psychoeducation as defined by the EASA practice guidelines. *To be scored in 9.5 & 9.6 there must be evidence of the above in at least half of the individuals whom the EASA team has enrolled and are clinically appropriate to	Team interview, individual and family/support system interview, chart review, review of group and individual psychoeducational materials.

	do to influence this. h. Success stories of others in similar situations who have achieved successful recovery. i. What agencies and partners will be involved in their treatment and how agency decisions are made. j. Legal rights. k. Specific strategies for symptom management, coping, and establishing appropriate accommodations. l. Relapse prevention plans, m. How to select and work effectively with professionals. n. Resources available to enhance recovery.	receive psychoeducation.	
		Total Points: _____ (Possible Points:)	

10.0 COUNSELING			
ELEMENT	TARGET	HOW MEASURED?	SOURCE
10.1 & 10.2 Specific early intervention counseling interventions and objectives are based on sound clinical judgment and consultation with the transdisciplinary team	Objectives of EASA counseling include the following: a. Are strengths based. b. Implement harm reduction principles. c. Form a therapeutic alliance with the individual. d. Teach alternative strategies to deal with stressful	5- There is evidence that 9-10 objectives are addressed in counseling practice. 4- There is evidence that at least 8 objectives are addressed in counseling practice. 3- There is evidence that at least 6 objectives are addressed in counseling practice. 2- There is evidence that at least 4	Counselor interview, case presentations, chart review, individual and family/support system interview, clinical supervisor interview.

	situations. e. Promote adaptation and recovery. f. Protect and enhance self-esteem and self-efficacy. g. Attend to stigma issues. h. Support development of effective coping strategies. i. Address trauma, grief, and loss experiences on individual and systemic levels. j. Reduce secondary morbidity and comorbidity.	objectives are addressed in counseling practice. 1- There is evidence that at least 2 objectives are addressed in counseling practice.	
10.3 Early intervention counseling techniques demonstrate cultural awareness.	Cultural awareness in EASA counseling practice is demonstrated by: a. Counselors proactively identifying their own cultural values, beliefs and assumptions in consultation and supervision. b. Counselors seeking knowledge about cultural differences from appropriate individuals. c. Including interpreters and translations for the preferred language of individuals and their families. d. Identifying appropriate location of these activities. e. Use of culturally relevant language and references. f. Use of accessible	5- There is evidence that 6 targets are addressed in counseling practice. 4- There is evidence that at least 5 targets are addressed in counseling practice. 3- There is evidence that at least 3 targets are addressed in counseling practice. 2- There is evidence that at least 1 target is addressed in counseling practice. 1- There is no evidence that targets are being addressed in counseling practice.	Counselor interview, case Presentation, chart review, individual and family/support system interview, clinical supervisor interview.

	communication styles. g. Respecting values and preferences of individuals.		
10.4 Specific tools/techniques are used to meet specific counseling objectives in early intervention.	The following specific tools and interventions are used in EASA counseling practice: a. Ongoing use of the strengths based assessment and treatment planning. b. Explore ways to reduce harm in the course of high-risk behaviors. c. Educate regarding relapse prevention including use of Illness Management and Recovery (IMR) techniques (SAMHSA, 2009). d. Acknowledge and use of techniques to minimize the impact of traumatic occurrences. e. Feedback techniques such as the Session Rating Scale (Duncan & Miller, 2000). f. Utilize group formats. g. Teach advocacy. h. Promote social justice. i. Mitigate possible traumas associated with hospitalizations by accompanying the individual to the crisis service and letting people know what to expect.	5- There is evidence that all tools are utilized in counseling practice. 4- There is evidence that targets a, b, c, d & e and at least 3 others are utilized in counseling practice. 3- There is evidence that targets a, b, c, d & e and at least 2 others are utilized in counseling practice. 2- There is evidence that targets a, b, c, d & e and at least 1 other are utilized in counseling practice. 1- There is evidence that targets a, b, c, d & e are utilized in counseling practice. *Scores will be based on EASA individuals who are clinically appropriate for counseling.	Counselor interview, case presentation, chart review, individual and family/support system interview, clinical supervisors' interview.

		Total Points: _____ (Possible Points :)	

11.0 OCCUPATIONAL THERAPY			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
11.1, 11.2, 11.3 Early Intervention occupational therapy services are dynamic and evolve in real time along with the individual's desires and needs.	The EASA occupational therapist collaborates with the individual, individual's family, and other clinicians to include information gained through the occupational therapy assessment in the development and implementation of the overall recovery plan. The EASA occupational therapist may provide direct intervention services to the individual and his/her family and will provide consultation to other team members when developing educational supports (individual education plans [IEPs] or 504 plans) and determining vocational supports/services.	5-OT operates as a full member of the team, routinely collaborates and consults with team members, provides assessment and follow-up support to the majority of EASA clients, consistent with guidelines. 4-OT routinely collaborates and consults with team members but does not attend all meetings and/or provides assessment and follow-up support mostly consistent with guidelines. 3-OT is available on request but is not used routinely for the majority of clients and/or follows guidelines but not consistently. 2-OT is available on request but does not follow guidelines or is used/available only for a small minority of people. 1-No OT is available to the team at this time.	OT interview, individual and family/support system interview, team interview and chart review.
11.4 & 11.5 Early intervention occupational therapy assessment and intervention focuses on the complex relationship of factors influencing the individual's ability to successfully engage in meaningful occupation.	The following areas are assessed in EASA occupational therapy practice. a. Areas of occupation the individual wants, needs, or is expected to engage in (i.e. activities of daily living; instrumental activities of daily living; rest and sleep, education; work; play;	5- There is evidence that all 5 areas are assessed and a sensory measure utilized in OT practice. 4- There is evidence that a sensory measure utilized, area a. and 3 other areas are assessed in OT practice. 3- There is evidence that a sensory measure utilized, area a. and 2 other areas are assessed in OT practice. 2- There is evidence that a sensory measure utilized, area a. and 2 others are assessed in	OT interview, case presentation, individual and family/support system interview, team interview and chart review.

	leisure; and social participation). b. Individual factors (i.e. cultural values, beliefs, and spirituality; mental functions, sensory functions and pain; etc.). c. Activity demands (i.e. objects and their properties; space demands; social demands; sequence and timing; required actions and performance skills; required body functions). d. Performance skills (motor and praxis skills; sensory-perceptual skills; emotional regulation skills; cognitive skills; communication and social skills. e. Performance patterns (habits; routines; rituals; roles). The EASA occupational therapists also place special emphasis on sensory processing and sensory modulation techniques.	OT practice. 1- There is evidence that a sensory measure utilized, area a and 1 other are assessed in OT practice. *Areas of assessments may be completed by other qualified team members or outside consultants if an OT is not available on the team.	
11.6 Early intervention occupational therapy techniques demonstrate cultural awareness.	Cultural awareness in early EASA OT practice is demonstrated by: a. Occupational therapists pro-actively identifying their own cultural values, beliefs and assumptions in consultation and	5- There is evidence that 6 targets are addressed in OT practice. 4- There is evidence that at least 5 targets are addressed in OT practice. 3- There is evidence that at least 3 targets are addressed in OT practice. 2- There is evidence that at least 1 target is	OT interview, individual and family/support system interview, case presentation.

	supervision. b. Occupational therapists seeking knowledge about cultural differences from appropriate individuals. c. Including interpreters and translations for the preferred language of individuals and their families. d. Identifying appropriate location of these activities. e. Use of culturally relevant language and references. f. Use of accessible communication style. g. Respecting values and preferences of individuals.	addressed in OT practice. 1- There is no evidence that targets are being addressed in OT practice.	
		Total Points: _____ (Possible Points :)	

12.0 SUPPORTED EMPLOYMENT AND EDUCATION			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
12.1 Specific Individual Placement and Support (IPS) model (Swanson & Becker, 2008) strategies and philosophy are utilized in assisting individuals in exploring, obtaining and maintaining employment and educational goals.	The components of the model include; a. Zero exclusion; all individuals who want to participate in employment and/or education are supported in this goal regardless of severity of mental health or substance use/abuse symptoms, previous history, legal history and other perceived barriers. b. Employment and	5- The EASA site has an IPS fidelity score or self-report of 100 or over. 4- The EASA site has an IPS fidelity score or self-report of 90 or over. 3- The EASA site has an IPS fidelity score or self-report of 80 or over. 2- The EASA site has not yet completed an IPS fidelity review or self-report but is practicing IPS model. 1- The EASA site is not moving towards IPS fidelity.	Formal IPS fidelity report or self-report if not at full IPS implementation, supported employment/education specialist interview, individual and family/support system interview.

	educational services are fully integrated into the transdisciplinary model. c. Competitive employment and educational opportunities are the goals. d. Benefits planning is individualized as part of the employment and educational process. e. Employment and educational opportunities are sought rapidly. f. Ongoing follow along support is provided once the individual is employed or enrolled in school. g. Individual preferences around employment and education are honored.		
12.2 Early intervention supported employment/education techniques demonstrate cultural awareness.	Cultural awareness in EASA supported employment/education practice is demonstrated by: a. Supported employment/ education specialists pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision. b. Supported employment/education seeking knowledge about cultural differences from appropriate individuals.	5- There is evidence that all 6 targets are addressed in supported employment/education practice. 4- There is evidence that at least 5 targets are addressed in supported employment/education practice. 3- There is evidence that at least 3 targets are addressed in supported employment/education practice. 2- There is evidence that at least 1 target is addressed in supported employment/education practice. 1- There is no evidence that targets are being addressed in supported employment/education practice.	Employment/education specialist interview, individual and family/support system interview.

	c. Including interpreters and translations for the preferred language of individuals and their families. d. Identifying appropriate location of these activities. e. Use of culturally relevant language and references. f. Use of accessible communication style. g. Respecting values and preferences of individuals.		
		Total Points: _____ (Possible Points:)	

13.0 PSYCHOPHARMACOLOGICAL INTERVENTIONS			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
13.1 & 13.9 Appointments with the licensed medical provider (LMP) are offered rapidly and frequently.	Appointments with the LMP will occur: a. Within 1 week of enrollment into EASA. b. Occur weekly during an initial crisis phase of treatment. c. Occur monthly for most individuals enrolled.	5- The EASA LMP pattern of practice is consistent with all 3 targets being met. 4- The EASA LMP pattern of practice is consistent with 2 targets being met. 3- The EASA LMP pattern of practice is consistent with 1 target being met. 2- Individuals have scheduled appointments with the LMP but targets are not met as a pattern of practice. 1- Individuals do not have access to a LMP on the EASA team. *To be scored in 13.1 & 13.9 there must be evidence of the above in at least half of the individuals who consent to and are clinically appropriate for EASA LMP services.	Chart review, LMP interview, and individual and family/support system interview, scheduling system.
13.2, 13.3, 13.4,13.5 & 13.10	Psychopharmacological interventions include:	5- LMP is familiar with guidelines and follows them in 90% of EASA individuals	Chart review, LMP interview, and individual

Psychopharmacological interventions are specific to early intervention guidelines.	a. Novel antipsychotics are first treatment of choice for positive symptoms. b. Start low and titrate up weighing risks and benefits. c. Individuals with comorbid manic syndrome may require a mood stabilizer. d. Alternative to neuroleptics are used for achieving sedation and reducing agitation. e. With the exception of d, polypharmacy should be avoided, specifically the use of multiple neuroleptics. f. Decreases in medication should occur when an individual makes such a request. g. Following clinical remission, an incremental decrease in dose will be considered. h. In the cases of f & g decreases in medication should occur with close monitoring of symptoms, over many weeks with a view to cessation over a three to six month period and a relapse prevention plan should be well-developed and agreed upon by the individual,	prescribed medications. 4- LMP is familiar with guidelines and follows them in 75% of EASA individuals prescribed medications. 3- LMP is familiar with guidelines and follows them in 50% of EASA individuals prescribed medications. 2- LMP is familiar with the guidelines but follows them in less than 50% of EASA individuals 1- LMP is not familiar with the guidelines	and family/support system interview.

	family/support system and coordinated with the EASA team.		
13.6, 13.7 & 13.8 Appointments with the LMP allow for flexibility in modality of appointment to accommodate EASA individuals' choices, family/support system need for psychoeducation and coordination of care.	Appointments with the LMP will allow: a. Family/support system to attend alone to provide psychoeducation around medical information and concerns with the permission of the individual. b. EASA team members to attend as appropriate to coordinate and support integration of all services. c. Continue to maintain contact with individuals and their family/support system when the individual chooses to not take or discontinue medication.	5- The EASA LMP pattern of practice is consistent with all 3 targets being met. 4- The EASA LMP pattern of practice is consistent with 2 targets being met. 3- The EASA LMP pattern of practice is consistent with 1 target being met. 2- Individuals have scheduled appointments with the LMP but targets are not met. 1- Individuals do not have access to a LMP on the EASA team. *To be scored in 13.6, 13.7 & 13.8 there must be evidence of the above in at least half of the individuals who are enrolled in EASA	Chart review, LMP interview, and individual and family/support system interview.
13.11 Early intervention LMP practice demonstrate cultural awareness.	Cultural awareness in EASA LMP practice is demonstrated by: a. LMP's pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision. b. LMP's seeking knowledge about cultural differences from appropriate individuals;	5-There is evidence that 6 targets are addressed in LMP practice. 4- There is evidence that at least 5 targets are addressed in LMP practice. 3- There is evidence that at least 3 targets are addressed in LMP practice. 2- There is evidence that at least 1 target is addressed in LMP practice. 1- There is no evidence that targets are being addressed in LMP practice.	LMP interview, individual and family/support system interview.

	c. Including interpreters and translations for the preferred language of individuals and their families. d. Identifying appropriate location of these activities. e. Use of culturally relevant language and references. f. Use of accessible communication styles. g. Respecting values and preferences of individuals, with specific attention on the role/meaning of medication within the individual and family's/primary support system's cultural context.		
		Total Points: ___ (Possible Points:)	

14.0 NURSING INTERVENTIONS			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
14.1 & 14.2 The early intervention nurse provides ongoing wellness support**.**	The EASA nurse addresses individual and group wellness by offering health-related education and counseling such as: a. Education on tobacco use and smoking cessation. b. Encouragement and support of exercise. c. Nutrition education. d. Education on healthy sleep hygiene. e. Education on pregnancy and	5- All 5 of these functions are provided and tracked consistently by nurse on team. 4- All functions are being provided consistently by the team or in collaboration with a nurse not on the EASA team. 3- 3-4functions being provided consistently by the team or in collaboration with a nurse not on the EASA team. 2- No nurse on the team or collaborative partnership with nurse outside the team,	Nurse interview, individual and family/support system interview, chart review.

	safe sex behavior.	but functions provided and tracked with gaps identified and a plan in place to correct. 1- limited nursing on the team but functions are not provided or tracked.	
14.1,14. & 14.4 The early intervention nurse provides ongoing physical assessment, coordination with primary care, careful monitoring of health status and side effects.	To support medication management the EASA nurse will a. Meet with individuals at least monthly to review side effects, changes in medications, weight, waist circumference, blood pressure, BMI and AIMS and BARNES tests as indicated. b. Monitor availability of medication and connecting with Patient Assistance Programs or pharmaceutical representatives for samples, if necessary. c. Track and coordinating laboratory test completion with the primary medical provider. d. Administer injections to those prescribed depot medications. e. Coordinate with medical provider sin acute situations (side effects, symptoms) when medication changes need to be made and following through with pharmacy and individuals	5- Nurse consistently provides or oversees all 7 target areas. 4- All 7 target areas addressed but with limited nursing support. 3- 5-6 target areas addressed with limited or full nursing support. 2- 3-4 target areas addressed with limited or full nursing support. 1:-Fewer than 3 target areas addressed.	Nurse interview, individual and family/support system interview, chart review.

	on acquisition of changed medication. f. Monitor the use of over-the-counter medications and nutritional supplements. g. Coordinates information transfer with Primary Care Provider (notes, labs, medication regimes, etc.).		
14.6. Early intervention nursing techniques demonstrate cultural awareness.	Cultural awareness in EASA nursing practice is demonstrated by: a. Nurses pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision. b. Nurses seeking knowledge about cultural differences from appropriate individuals. c. Including interpreters and translations for the preferred language of individuals and their families; d. Identifying appropriate location of these activities. e. Use of culturally relevant language and references. f. Use of accessible communication style. g. Respecting values and preferences of individuals.	5- There is evidence that 6 targets are addressed in nursing practice. 4- There is evidence that at least 5 targets are addressed in nursing practice. 3- There is evidence that at least 3 targets are addressed in nursing practice. 2- There is evidence that at least 1 target is addressed in nursing practice. 1- There is no evidence that targets are being addressed in nursing practice.	Nurse interview, individual and family/support system interview, case presentation.

15.0 MULTI FAMILY GROUPS			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
15.1, 15.2,15.3 &15.4 MFG facilitators must engage in practice and supervision that meets national evidence-based guidelines.	EASA MFG facilitators meet national evidence-based guidelines by engaging in the following practices: a. Participating in video-taped fidelity reviews. b. Completion of MFG facilitator training. c. Monthly supervision specific to MFG. d. Multiple disciplines from the EASA team are co-facilitating MFGs.	5- All 4 targets are met by all MFG facilitators. 4- 3 of the targets are met by all MFG facilitators. 3- 2 of the targets are met by all MFG facilitators. 2- 1 of the targets is met by all MFG facilitators. 1- Not all MFG facilitators have reached at least 1 target area.	MFG consultation call notes, MFG facilitator interview.
15.5 & 15.6 MFG workshops are offered.	MFG workshops are: a. Offered on at least a quarterly basis. b. Include all EASA team members. c. Are culturally aware. d. Meet fidelity contents.	5- All 4 targets are met. 4- MFG workshops are offered on a quarterly basis, are culturally aware, meet fidelity contents but do not include all EASA team members. 3- MFG workshops are offered on a quarterly basis, are culturally aware, do not meet fidelity contents and do not include all EASA team members. 2- MFG workshops are offered on a quarterly basis, are not culturally aware, do not meet fidelity contents and do not include all EASA team members. 1- None of the targets are met. *If no new EASA individuals enroll during the quarter the EASA team would not have to complete a workshop during that quarter.	MFG consultation call notes, review of workshop materials, interview with MFG facilitators, individual and family/support system interview.
15.7	Multi-family groups (MFG) are a	5- 80% or more of individuals and/or	Chart review, database

Attendance is equally encouraged for individual and family members.	preferred method of treatment for most individuals and their families/support system (McFarlane, 2002). Where MFG's are not available, single family groups can be offered following the same format. Fidelity to MFG standards in each of the key stages is critical and will include: a. Joining sessions. b. MFG workshop. c. Carefully structured initial and ongoing problem solving sessions.	families/support system participate in both educational workshop and multi-family groups*. 4- 60% participate in both educational workshop and multi-family groups. 3- 40% participate in both educational workshop and multi-family groups. 2-20% participate in educational workshop and multi-family groups. 1- 10% participate in educational workshop and multi-family groups. *Single-family groups following multi-family structure count as MFG for this purpose, as does individual psychoeducational sessions as long as content meet MFG fidelity.	review.
15.8 MFGs are offered with attention to barriers.	MFGs are: a. At times that are convenient. b. Locations that are convenient for attendees. c. Food is available at groups (potluck, agency provided).	5- All 3 targets are met. 4- 2 targets are met. 3- 1 of the targets is met. 2- MFGs are available but no targets are met. 1- MFGs are not currently offered by the EASA Team.	Interview with MFG facilitators, individual and family/support system interview.
		Total Points: ____ (Possible Points:)	

16.0 Transition Planning			
ELEMENT	TARGET	HOW MEASURED?	SOURCES
16.1 The early intervention program is described as time limited from the	The EASA recovery plan reflects a transition plan at a minimum of 6 months prior to the individual's transition from EASA.	5- Communication and planning includes transitional focus from the beginning. 4-Communication and planning include transitional focus after 6 months.	Team interview, individual and support system interview, chart review.

beginning, and the recovery plan addresses planning for transition from the inception of services.		3-Communication and planning include transitional focus after 12 months. 2-Communication and planning include transitional focus after 18 months. 1- Communication and planning do not include transitional focus. *To be scored in 16.1 there must be evidence of the above in at least half of the individuals who are enrolled in EASA	
16.2 Early intervention clinicians routinely use the transition checklist and the phases of care document throughout treatment. A specific plan of transition is developed and completed at least 6 months prior to completion of two years of service.	EASA team members are utilizing the transition checklist and phases of care document throughout the individual's time in EASA.	5- Transition plans routinely address all areas in transition checklist. 4- Transition plans routinely address 8-9 areas from transition checklist. 3-Transition plans routinely address 7-8 areas of transition checklist. 2-Transition plans routinely address fewer than 7 areas on transition checklist. 1-Transition plans are not developed. *To be scored in 16.2 there must be evidence of the above in at least half of the individuals who within 6 months of transitioning from EASA.	Chart review, individual and support system interview, team interview.
16.3 Services within early intervention programs focus on supporting a grounded, realistic positive view of the future.	The EASA team in partnership with the individual and support system anticipates the time period at and after completion of EASA and what this will concretely look like. EASA team members make frequent use of success stories and invite participation by graduates/ individuals in recovery in their interactions with individuals and family/support	5- The program makes use of recovery stories throughout the treatment process, and offers opportunities to meet individuals/family/support system in recovery (e.g. graduation ceremony). 4-The program uses recovery stories throughout the treatment process, and provides occasional opportunities (2x a year) to meet individuals/family/support system in recovery. 3-The program uses recovery stories in	Team interview, individual and family/support system interview, review of flyers for events.

	system members.	the treatment process, and offers infrequent opportunities (1x a year) to meet individuals/family/support system in recovery. 2-The program uses recovery stories in the treatment process, but doesn't provide opportunities to meet people in recovery. 1-The program doesn't use recovery stories or opportunities to meet people in recovery.	
16.4 & 16.7 Choice of transitional provider from early intervention programs matters because of the importance of compatibility, mix of skills, and the need for a high level of trust and communication. The early intervention staff facilitates the connection of individuals and family/primary supports to appropriate ongoing resources prior to discharge from the program.	EASA team members while transitioning individuals and families/support system assure: a. Individuals/family/support systems are informed from the outset, and it should be reinforced over time. b. Individuals have the choice of which clinician they work with, within the limitations of availability. c. Every effort should be made to accommodate the family/support system preferences in transition providers. d. Team facilitates the connection of individuals and family/primary supports to appropriate ongoing resources prior to discharge from the	5- All 4 targets have been established prior to discharge with 90% or more individuals 4- All 4 targets connections have been established prior to discharge with 80-89% or more of individuals 3- All 4 targets have been established prior to discharge with 70-79% or more of individuals 2- All 4 targets have been established prior to discharge in 60% or more of individuals 1- All 4 targets have been established prior to discharge in less than 60% of individuals	Chart review, interview with individuals and families/support system.

	program.		
16.5 Early intervention transition techniques demonstrate cultural awareness.	The EASA team demonstrates cultural awareness in transitioning individuals by: f. Pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision that may influence transition. g. Including interpreters and translations for the preferred language of individuals and their families/primary support in the transition process. h. The use of culturally relevant language and references. i. The use of accessible communication styles. j. Respecting values and preferences of individuals when working on transitional supports.	5- There is evidence that all 5 targets are addressed in the transition process. 4- There is evidence that at least 4 targets are addressed in the transition process. 3- There is evidence that at least 3 targets are addressed in the transition process. 2- There is evidence that at least 2 targets are addressed in the transition process. 1- There is evidence that at least one target is addressed in the transition process.	Team interview, individual and family/support system interview, case presentation.
16.6 Although early intervention is a transitional service, it maintains an interest in the long-term well-being of individuals and families/support system who graduate.	In order to maximize long-term success, EASA pursues the following strategies: a. Provide individuals and family/primary support people with the information they need to be effective self-advocates at individual, agency and system levels.	5- There is evidence that all 6 targets are addressed in the post transition process. 4- There is evidence that at least 5 targets are addressed in the post transition process. 3- There is evidence that at least 4 targets are addressed in the post transition process. 2- There is evidence that at least 3 targets are addressed in the post transition	Team interview, interview with senior management, supervisors, graduate interview.

	b. Offer ongoing opportunities for graduates of EASA to return for educational workshops, support groups, and decision making committees. c. Provide brief problem-solving support if needed. d. Request feedback for quality improvement/system development. e. Offer consultation and training to professionals and individuals involved in ongoing care and support of EASA graduates. f. Integrate EASA graduates into community education and participant education activities	process. 1- There is evidence that at least 2 targets are addressed in the transition process.	
		Total Points: ____ (Possible Points:)	

Appendix D

PHASES OF CARE

The EASA clinical team works with people in five phases:

Phase 1 (up to 6 months): Assessment and stabilization

a. Outreach to individual and family/primary support system
b. Get to know the individual and family/primary support system
c. Provide comprehensive assessment
d. Complete needed medical tests (as soon as possible!)
e. Begin treatment for identified medical conditions, including psychosis and alcohol/drug dependency where feasible
f. Identify strengths, resources, needs and goals
g. Begin multi-family group process
h. Stabilize the situation: symptoms, economic situation, housing, relationships, school, work, etc.
i. Provide support and education to the individual and family/primary support system
j. Provide opportunities for peer involvement, physical fitness, etc.
k. Assess need for ongoing services from EASA

Phase 2 (approximately 6 months): Adaptation

a. Provide more extensive education to the individual and family/primary support system
b. Continue treatment with EASA Team
c. Address adaptation issues
d. Refine and test the relapse plan
e. Engage in alcohol and drug treatment if needed
f. Continue multi-family group process

g. Move forward proactively on living and/or vocational goals
h. Identify and establish necessary accommodations as needed at work or school
i. Identify and develop stable long-term economic and social support
j. Provide opportunities for peer involvement, physical fitness, etc.

Phase 3 (approximately 6 months): Consolidation

a. Continue multi-family group, vocation support and individual treatment
b. Continue to work toward personal goals
c. Develop a relapse prevention plan
d. Develop long-term plan

Phase 4 (approximately 6 months): Transition

a. Maintain contact with EASA Team
b. Continue multi-family group
c. Participate in individual and group opportunities
d. Establish ongoing treatment relationship and recovery plan

Phase 5: Post-graduation

a. Continue multi-family group (in some situations)
b. Continue with ongoing providers
c. Invitation to participate in events and mentoring
d. Invitation to participate in EASA planning/development activities
e. Periodic check-ins and problem solving as needed.

Appendix E

EASA TRANSITION CHECKLIST
Revised 11/27/2011
(Begin this process 6 months prior to graduation from EASA)

1. Individual has a written transition plan that reviews strengths and accomplishments to date, long-term and short-term goals, and a plan for achieving them.
    a. Career goals: school and work
    b. Family and relationships
    c. Housing and independent living
    d. Economic stability and insurance
    e. Transportation

2. The individual has connected with the ongoing supports and resources needed to accomplish their ongoing goals.

3. Individual has written relapse plan/advanced directive.
    a. Plan identifies early, intermediate and late warning signs
    b. Plan specifies actions to be taken by the individual and others when these signs occur
    c. Plan includes history of effective and ineffective interventions, and preferences about medications/ strategies
    d. Plan is realistic and has been tested.
    e. The individual has identified one or more key individuals to advocate in case of relapse
        i. Advocate has a copy of plan.

4. Appropriately qualified ongoing prescriber is identified (if necessary and/or desired).
    f. The individual has met and accepted the medical individual
    g. It is clear how the individual is going to pay for the medical care
    h. A copy of the individual's most recent assessment, medication history and relapse plan has been sent to prescriber

5. Ongoing counselor is identified (if necessary).
    i. A determination has been made of whether the individual needs/ wants an ongoing counselor
    j. Counselor is identified and individual has met, accepted counselor
    k. Counselor has treatment and medication history, assessments, relapse plan

l. It is clear how the individual is going to pay for services

5. The family/immediate support system is engaged with ongoing professional and self-help resources.

6. Access to medications has been established (if necessary).
   m. Individual has access to medications through insurance or other means
   n. Medications have been established through pharmaceutical assistance or other means for the next 3 months
   o. Individual knows how to secure future medications

8. Individual has completed treatment goals or has a clear path for completing them.
   -Goals have been reviewed and mutual agreement has been established that they have been met adequately
   -Specially focus on current and future career and educational goals
   -Provide resources for all goals not yet met or intended future goals

9. The individual has copies of key supportive documents (electronic or hard)
   -Medication history
   -Treatment summary
   -Resume
   -Relapse plan
   -Ongoing goals and service plan

10. Family members and/or other key support system members have been consulted regarding transition planning at the individual's level of consent.
   -Meeting has occurred & transition plan in place that all have agreed to
   -Family members and other key supporters have a copy of the relapse plan
   -Provide list of resources that may be necessary in the future (i.e. SSI, VRD)

11. Individual has completed discharge survey and permission to follow up established.

Listed below are general guidelines for decision making of early discharge (before the end of 2 years) once consultation and supervision discussions have concluded the following:

Relocation:
Moved out of county – 1 month after referral to new provider given reads choppy . If relocation is to a county with an EASA program, the current EASA team should obtain appropriate consents and releases to allow for exchange of verbal and written records. The new EASA County will offer services to the individual/family/primary support for the duration of the individual's remaining time with EASA.

Disengaged (despite extensive outreach attempts to individual and support system)
No Contact – 3 months after underutilizing services – 3 months

Choice: Transferred to more appropriate provider (such as long-term residential)

Diagnosis:
Any primary diagnosis other than Bipolar I Disorder with Psychotic Features, Schizophrenia or Schizoaffective Disorders

Symptoms of Psychosis:
No symptoms and off anti-psychotics for 6/9 months, achieving goals independently and client agrees with early discharge.

Early discharge will include engagement of individual and/or family/primary support system in transition planning to include Service Conclusion Summary with specific contact information for appropriate follow-up services including crisis planning based on apparent treatment needs at the time of last contact.

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