Coordinated specialty care sets itself apart from ACT with two key differences: (1) CSC targets a specific and younger population (those aged 15-25) who have recently been diagnosed and (2) CSC sets expectations for a time-limited treatment of 2-3 years (Heinssen, Goldstein & Azrin, 2014).

To be accepted into a CSC program for treatment related to first episode psychosis, the recommended inclusion criteria listed by the National Alliance on Mental Illness (NAMI) is as follows:

- **Age range:** 15-25 years
- **Diagnosis:** schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, psychosis not otherwise specified (NOS)
- **Duration of psychotic symptoms:** >1 week and <2 years
- **Ability to speak and understand English**
- **Anticipated availability to participate in programming for 1 year**
- **NAMI also included a list of exclusion criteria which include:**
  - Other diagnoses associated with psychosis
  - Substance-induced disorder
  - Psychotic affective disorder (e.g., major depressive or manic episode with psychotic features)
  - Psychotic disorder due to a general medical condition
  - Medical conditions that impair function independent of psychosis
  - Intellectual disability

An essential characteristic of coordinated specialty care is its collaborative and recovery-oriented approach (Heinssen, Goldstein & Azrin, 2014). All members of the treatment team work together toward a common goal.
Coordinated specialty care programs tend to possess four to six team members, all sharing a caseload of 30-35 clients. Each team member is thoroughly trained in the principles of phase-specific care designed precisely for treating clients affected by FEP (Heinssen, Goldstein & Azrin, 2014). Teams may also opt to include a team member with lived experience of psychosis, as these individuals can directly relate to consumers and create a more welcoming environment for incoming clients.

An important aspect of CSC teams is the frequent communication that takes place among all professional participants. Weekly meetings serve several purposes including: focusing on all client’s recovery goals and needs, increasing team confidence, and improving program reliability (Heinssen, Goldstein & Azrin, 2014). Frequent contact is beneficial in keeping all providers informed of client treatment concerns and recovery progress.

There are six key roles that must be attended to when developing a CSC team. These roles include: team leadership, case management, supported employment and education (SEE), psychotherapy, family education and support, and lastly, pharmacotherapy and primary care coordination.

Several programs across the United States use the basic framework of CSC to implement early intervention programs for the treatment of first episode psychosis. Programs may slightly differ from one another but certain core characteristics remain such as being team-based, multi-element, collaborative and recovery-oriented. Figure 1 briefly discusses the four main programs functioning across the country, including the model providing consultation to Kentucky: the Early Assessment and Support Alliance (EASA).

The EASA Model
In the early 2000’s, several countries gathered to create the International Early psychosis Association. The intent was to create a forum where countries could share their program ideals and knowledge regarding early psychosis. One major outcome of this meeting was the development of the foundation of early psychosis intervention strategies. Support for early interventions for FEP began to spread internationally, eventually making its way to the United States. Oregon is a pioneer in the field with a well-established system in place to treat clients experiencing psychosis.

Oregon’s Early Assessment and Support Alliance (EASA) was created by the Mid-Valley Behavioral Care Network, an intergovernmental mental health managed care organization in charge of publicly funded mental health services under the Oregon Health plan. EASA started providing community level early psychosis interventions in 2001, and was the first systematic integration of population-wide early psychosis intervention to the public mental health system in the United States (Sale & Blajeski, 2015). As of 2007, EASA has been implemented statewide using specific practice guidelines and has begun the process of fidelity and evaluation.

EASAs’s mission is to “Keep young people with the early signs of psychosis on their normal life paths by building community awareness and offering easily accessible, effective treatment and support.” The program has set itself apart from other early intervention teams by focusing on early detection and community education while incorporating multidisciplinary professionals and using evidence-based practice. The program seeks to support individuals experiencing FEP as they complete their education, enter adult roles and employment options, live in a safe and positive environment, and participate in healthy social groups while promoting positive well-being. Participation in an EASA program requires the following:

- Ages 12 – 25;
- Experienced FEP within the last 12 months; or
- Experiencing early at-risk symptoms of psychosis

Kentucky’s Involvement
The need for early interventions is evidenced by the facts listed in Figure 2. In previous years, Kentucky has seen more than 900 individuals enter psychiatric facilities to treat schizophrenia or related illnesses. Kentucky saw a need to develop special programs dedicated to early interventions for FEP, which might also allow Kentuckians to receive the best treatment available while remaining in their communities. Kentucky’s Department for Behavioral Health, Developmental and Intellectual Disabilities responded by traveling to Oregon to gain further insight as to how the EASA model provided quality community care for first episode psychosis. KDBHDID was impressed by Oregon’s system and chose EASA developers as consultants for CSC start-up sites in Kentucky.

Kentucky’s start-up sites are located in two regional community health centers: Mountain Comprehensive Care Center and Cumberland River Behavioral Health. The MCCCC area encompasses Prestonsburg and surrounding counties, while the CRBH services Corbin and contiguous counties.

The programs based in Kentucky have yet to develop a name and currently use Early

The Facts (Figure 2)
- Psychotic disorders affect about 1% of the US population over 18 years old
- There are 3 million adults living in Kentucky
- About 30,000 Kentuckians will be affected with a psychotic disorder this year
- In 2013, 918 young adults with schizophrenia or a related illness entered Kentucky’s adult psychiatric facilities

Number of Young Adults by Hospital:
- Appalachian Regional Hospital: 168
- Central State Hospital: 237
- Eastern State Hospital: 294
- Western State Hospital: 219
- Total: 918
A mobile outreach approach is adopted which differs greatly from traditional care modalities. This method allows the program to reach out to clients in a variety of settings to provide the essential care necessary for recovery. It is also beneficial for the program to allow for a 24-hour on-call service for those clients who may be experiencing crisis situations.

The structure of CSC teams allows for the acute care during and following the event of FEP. Clients have frequent contact with all team members concerning their care. Team members also maintain frequent communication among each other to ensure all members are up-to-date on treatment and recovery goals. The previously discussed mobile outreach and on-call personnel provide the consumer with the attentiveness necessary to handle emergencies.

Programs differ on the continuity of care following FEP with some programs limiting their time to 2 years, while others recommend 5 years (Heinssen, Goldstein & Azrin, 2014). EASA participants progress through 5 phases with the last two phases focusing on future planning. Phase 4 highlights transition and Phase 5 collaborates with clients post-graduation. For more information on all phases visit: www.easacommunity.org/ea -sa -services

Fidelity monitoring should answer 3 key questions concerning CSC implementation:
1. Are CSC team members implementing interventions as intended?
2. Are providers delivering what was promised in the service contract?
3. Have CSC services achieved desired clinical and functional outcomes for clients?
(Heinssen, Goldstein & Azrin, 2014)

Interventions for First Episode Psychosis as an interim descriptor. Eventually it is the program’s wish to speak with young people and their families to discuss name possibilities. This conjoint effort will result in a title that appeals to a younger population.

Treating first episode psychosis using a CSC framework in Kentucky is an up and coming venture and the programs are in the earliest stages of development. Funding to start-up sites began in July 2015 but neither site will begin to provide services until January 2016. A six month period was set aside so planning and training could take place, along with community conversation to inform potential stakeholders about the program’s goals and services.

Throughout this six month period the basic components of CSC in Kentucky have been cultivated, closely following guidelines developed by EASA. Figure 3 discusses these components in more detail. These key elements are essential for any program to operate smoothly and Kentucky has carefully included each component in the program design. Operation only occurs if each program is staffed by the appropriate personnel. Key roles for CSC programming in Kentucky is further discussed in Figure 4. Kentucky will ensure each role is successfully fulfilled before accepting clients into treatment.

Involving the community in the process is one of the most effective ways to provide quality care for first episode psychosis. A key component of CSC programming is engaging with the community. It is realized early on that if the programs are to be successful, the community must understand the program objectives. Kentucky has already made great strides in connecting programs with the community.

**KENTUCKY UPDATES 2015 Planning Year**
- All CMHCs have designated at least one child services and one adult services key contact for Early Interventions for First Episode Psychosis Programming for their region.
- Stakeholder planning meetings were held regarding implementation of CSC.
- DBHID selected two CMHCs as start-up sites (Mountain Comprehensive Care Center and Cumberland River Behavioral Health).
- The two start-up sites were allowed six (6) months of planning.
- Tamara Sale and Dr. Ryan Melton at EASA will provide overall technical assistance to Kentucky concerning the implementation of CSC. RA1SE and OnTrack NY will also be used as consultants on an as needed basis.
- Dr. Cathy Batscha from UofL will provide technical assistance around clinical issues for this population.

**2016 Implementation Year**
- Meetings held in September 2015 introduced community partners to CSC and provided training to program staff on CBT for psychosis.
- DBHID/IPOP will generate a report through existing data collection efforts that will begin to capture data related to youth and young adults with, or at risk of FEP.
- DBHID will provide technical assistance, training and ongoing support to the two start-up sites. Additional statewide trainings and support will also be held for the remaining regions in order to ensure success.
At this stage of development, Kentucky has developed multiple community partnerships and created an implementation team. Stakeholder planning meetings were held regarding implementation and in September of 2015, community partners were introduced to coordinated specialty care. Upon introduction to CSC, an overview of CBT for psychosis was provided to each program's staff. Additionally, all community mental health centers have designated at least one child services and one adult services key contact in their region to connect potential clients to early interventions for FEP.

An early success has been Kentucky’s ability to provide thorough education to CMHC’s regarding early interventions and its benefits. The programs’ wish is to reach out not only to CMHC’s but also to those living in the community to provide quality education concerning first episode psychosis. The desired outcome of community education efforts is to greatly reduce the stigma surrounding mental illness.

Ultimately, Kentucky plans to see early interventions for first episode psychosis spread across the state. Individuals have been busy laying the necessary groundwork to expand coordinated specialty care for FEP beyond the initial start-up sites. Currently, Kentucky is targeting to achieve state-wide implementation within six years.

REFERENCES


Want Additional Information?

Helpful Sites:

- The National Alliance on Mental Illness discusses first episode psychosis in more detail: https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Psychosis/First-Episode-Psychosis
- For additional material on the RAISE research project, visit the National Institute of Mental Health website. Link to informational RAISE page: http://www.nimh.nih.gov/health/topics/schizophrenia/raise-questions-and-answers.shtml
- Visit the Early Assessment & Support Alliance website to gain further insight into the model providing consultation to Kentucky programs: http://www.easacomunity.org/

### TEAM MEMBER ROLES (FIGURE 4)

<table>
<thead>
<tr>
<th>PROJECT LEADERSHIP</th>
<th>Leaders should be experienced and able to provide ongoing guidance to other team members. Major tasks include managing team functions and coordinating key services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTREACH SPECIALIST</td>
<td>These specialists are the community’s link to the program providing services. Specialists maintain connections within the community so individuals may be referred to treatment for FEP.</td>
</tr>
<tr>
<td>CASE MANAGEMENT</td>
<td>Case managers maintain frequent contact with clients and family members. Case managers remain flexible, meeting a client in his/her environment if needed. Tasks include: assisting the client in problem solving, offering practical solutions to problems, and coordinating social services.</td>
</tr>
<tr>
<td>SUPPORTED EMPLOYMENT &amp; EDUCATION (SEE)</td>
<td>SEE employees meet with clients to determine the client’s educational and employment goals. If the client expresses an interest, the SEE specialist strives for rapid placement for the client.</td>
</tr>
<tr>
<td>PSYCHOTHERAPY</td>
<td>Emphasis is placed on resilience training, illness and wellness management, and the development of general coping skills.</td>
</tr>
<tr>
<td>FAMILY EDUCATION &amp; SUPPORT</td>
<td>Aims to teach relatives or alternative support systems about psychosis and its treatment. Those in a client’s life are then more capable to aide in the client’s recovery.</td>
</tr>
<tr>
<td>PHARMACOTHERAPY &amp; PRIMARY CARE COORDINATION</td>
<td>Evidence-based pharmacologic approaches guide medication selection and dosing for first episode psychosis. Providers pay close attention to cardiometabolic risk factors and maintain close contact with primary care providers (Heinssen, Goldstein &amp; Azrin, 2014).</td>
</tr>
<tr>
<td>PEER SUPPORT</td>
<td>Peer support is fulfilled by individuals who have personally experienced psychosis. These individuals can offer their wisdom to newcomers and create a sense of understanding and hope.</td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY</td>
<td>Assist clients to identify and improve cognitive and sensory issues. Occupational therapists break down tasks, pinpoint adjustments and develop routines (Sale &amp; Blajeski, 2015).</td>
</tr>
</tbody>
</table>

The Institute for Excellence in Behavioral Health is a contracted initiative of the Department for Behavioral Health, Developmental and Intellectual Disabilities in partnership with the Training Resource Center at Eastern Kentucky University.