EARLY PSYCHOSIS INTERVENTIONS IN NORTH CAROLINA
EPI-NC

First Episode Psychosis Coordinated Specialty Care Fidelity Guidelines

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Program Implementation Guidelines

1. Program Admission Criteria

Rationale: The mandate of Coordinated Specialty Care (CSC) programs for early psychosis is to serve adolescents and young adults during their first several years post psychosis-onset, a "critical window" where CSC programs have demonstrated improved functional outcomes and reduced likelihood of a disabling course[1]. Premorbid to psychosis, cognitive deficits and impairments in social function may be evident in childhood. Similar deficits in cognitive and social function also occur in developmental disorders. Because of this overlap, persons with a developmental disorder are allowed as long as the developmental disorder severity is mild and the developmental disorder itself is not the primary focus of treatment.

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
• **Between the ages 15-30*** • **Onset first episode psychosis within three years OR previous program participant appropriate for program readmission** • **DSM 5 psychotic disorder diagnosis*:** ○ **schizophrenia** ○ **schizoaffective** ○ **schizophreniform** ○ **brief psychotic disorder** ○ **unspecified schizophrenia spectrum and other psychotic disorder** ○ **bipolar disorder with psychotic feature (where psychosis is a prominent feature)** • **No significant developmental disorder (e.g., moderate to severe intellectual developmental disorder or level 2 or level 3 autism spectrum disorder). Mild intellectual developmental disorder (IQ > 70) or level 1 autism spectrum disorder allowed.**	• Less than 80% of admissions meet criteria.	• Between 80% to 95% of admissions meet the criteria.	• More than 95% of admissions meet criteria.	• Admission form

*It is acceptable to admit a person for a diagnostic evaluation period where there is diagnostic uncertainty. Examples include:

- A person with borderline personality disorder may experience transient, self-limiting auditory hallucinations and paranoia when stressed, that may initially be difficult to differentiate from psychosis related to schizophrenia-spectrum disorders[2].
- It may be difficult to distinguish intrusive thoughts due to OCD from thought insertion, or compulsive behaviors from repetitive behaviors related to delusions[3]. Note that about 10-20% of persons with schizophrenia may also meet criteria for OCD and persons with OCD have increased risk of later developing schizophrenia[4].
- Psychosis may be due to Intoxication with cannabinoids, stimulants, and other substances. Substance-induced psychosis clears soon after the drug is cleared from the body. However, it may be difficult to determine the relationship between the substance and psychosis in persons who use drugs daily.

2. Engagement Strategies

Rationale: The CSC treatment model emphasizes strategies to enhance program engagement. The NAVIGATE and other early psychosis CSC fidelity scales require less than two weeks between the initial referral and the program intake appointment, as "Patients who experience a first episode of psychosis require urgent or emergent care." Furthermore, delays between referral and initial intake may interfere with initial engagement in the program. With usual treatment approaches disengagement rates are high and are associated with poor outcomes[5], thus CSC programs emphasizes the importance of active engagement strategies*. Strategies promoting engagement include use of a collaborative approach based on shared decision-making, and an appreciation of personal, relational, and cultural factors.

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
Intake appointment scheduled within 2 weeks of referral.	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Referral form • Admission form
Appropriate referrals attend intake evaluation.	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Referral form • Admission form
The program uses active engagement strategies to minimize loss to follow-up.	• More than 50% of clients are lost to follow-up. • Program does not routinely address barriers to participation for most clients*.	• Between 30%-50% of clients are lost to follow-up. • Program routinely addresses barriers to program. participation*.	• Less than 30% of clients are lost to follow-up. • Program routinely addresses barriers to program participation*.	• Discharge form
Clients report CSC Team uses a collaborative approach**	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Program Feedback Form

*For example, address participant declining engagement with appropriate psychotherapy techniques (e.g., motivational interviewing), identify and address barriers to accessing care (e.g., transportation, financial issues) and/or provide community-based care, offer family members counseling around engagement even if client refuses treatment
**Client perception of a collaborative approach include: Client agrees that "I, not staff, decided my treatment goals", that "Staff helped me obtain the information I needed so that I could take charge of managing my illness", "Staff told me what side effects to watch out for", "I felt comfortable asking questions about my treatment and medication", that the medical provider made efforts to "help you understand your health issues", "listen to the things that matter most to you about your health issues", "include what matters most to you in choosing what to do next"

3. Multidisciplinary Team Approach

Rationale: Regular team meetings attended by all providers are essential to multidisciplinary care. Team meetings are held weekly. The team meeting agenda includes reviews of **new admission**, **clinical crises**, **complex cases,** and **termination of services**. The clinical status and treatment plan for every client needs to be reviewed at least quarterly. Regarding termination of services, while CSC programs are time limited by design, long-term studies find that gains in functional recovery are diminished or lost with strict time limits to CSC services (e.g., 2-3 years)[1]. Ultimately, the decision for the program to initiate end of services and referral to other providers is based on clinical factors and in collaboration with the client and their family. General guidelines for program-initiated discharges include that a client has achieved their individual recovery/illness management goals[6] or, for clients with a severe disabling course, that they can benefit from programs targeting chronic disabling mental disorders. See footnote* for factors that may be considered.

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
All providers attend team meetings and participate when one of their clients is discussed.	• Team does not formerly meet. Clients may be discussed by team members informally by email, phone, or in-person.	• Some team members attend team meetings sporadically.	• Team includes all providers.	• Team Lead report • Team Meeting Tracking Form
The team meets weekly.		• The team meets regularly but not weekly.	• Team meets weekly.	
New admissions, clinical crises, complex cases, and discharges are discussed at team meetings.	• The team agenda doesn't include these items.	• The team agenda includes some, but not all, of these items.	• The team agenda includes all these items.	• Team Meeting Tracking Form
The team reviews and discusses the clinical status and treatment plan of client	• Criteria met for less than half of clients.	• Criteria met for 50-90% of clients.	• Criteria met for more than 90% of clients.	• Quarterly Clinical Review • Team Meeting Tracking Form

4. Service Delivery

Rationale: Intensity of treatment is individualized to best meet the client's and their family member's needs. The CSC treatment model includes frequent clinical encounters provided by a multidisciplinary team, especially during the first six months of program involvement, to enhance engagement, engender trust with providers, and provide clients and their family members with enhanced support as they learn about psychosis and psychosis recovery. Reduced frequency of services may indicate issues with program engagement or that the client may be achieving their individual recovery/illness management goals. Most clients voice a preference for family member involvement[7] and family member involvement may promote engagement[8].

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
Individual Therapy • **Minimum frequency**[1] ○ **First 3 months: weekly therapy (minimum of 8 sessions over weeks 1-13)** ○ **3-24 months: monthly therapy (minimum of 21 sessions)** ○ **> 24 months**: criteria in development	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Service delivery form
Family Therapy: • **Family members involved in treatment** • **Minimum frequency**[2]**: Families receive 9 family sessions (individual or multifamily group) within the first year.**	• <50% of families have at least one contact with a team member each year • Criteria met for less than half of clients.	• 50%-89% of families have at least one contact with a team member • Criteria met for 50-75% of clients.	• >90% of families have at least one contact with a team member • Criteria met for more than 75% of clients.	• Service delivery form
Medical Management: • **Minimum frequency:** ○ **first 3 months: every 1-2 weeks, (8 visits over weeks 1-13).** ○ **3-24 months: monthly (21 visits over months 4-24).** ○ **after 24 months: quarterly (4 visits per year).** • **Safety monitoring minimum frequency:** ○ **lipids, HgA1C, obtained within first three months of program admission (may include values recorded in medical record within previous year) and then annually.** ○ **vitals (BP, height, weight) obtained within first three months of program admission and then every three months.**	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Service delivery form

Supported Employment & Education: • **Services are provided to all clients who indicate an interest.** • **Services are offered to all clients on program admission (no exclusion criteria such as job readiness factors, substance use, symptoms, history of violent behavior, cognitive impairments, treatment non-adherence, personal presentation, or other factors).** • **For clients not previously engaged with SEE specialist, services are offered on a quarterly basis.** • **SEES engaged in at least 3 community visits per month[4].**	• Services are not routinely offered to all clients. • Services provided to <25% of clients.	• Services routinely offered to all clients. • Services provided to 25%-50% of clients.	• Services routinely offered to all clients. • Services provided to ≥50% of clients.	• Service delivery form • Quarterly review form • SEEs climate/culture survey
Peer Support: • **Services are provided to all clients who indicate an interest.** • **Services are offered to all clients on program admission.** • **For clients not previously engaged with a Peer Support Specialist, services are offered on a quarterly basis.** • **PSS engaged in at least 3 community visits per month[5].**	• Services are not routinely offered to all clients. • Services provided to <25% of clients.	• Services routinely offered to all clients • Services provided to 25%-50% of clients	• Services routinely offered to all clients. • Services provided to ≥50% of clients.	• Service delivery form • Quarterly review form • PSS climate/culture survey
Case Management Standard: • **Services are offered to all clients on program admission.**	• Services are not routinely offered to all clients. • Services provided to <10% of clients.	• Services routinely offered to all clients • Services provided to 10%-25% of clients	• Services routinely offered to all clients. • Services provided to ≥25% of clients.	• Service Delivery form • Quarterly Review

[1]Individual Therapy, services should be evidence-based. During the first year of treatment, clients should receive a minimum of 6 sessions of Individual Resiliency Training (IRT). Based on client needs and preferences, other evidence-based therapies may be used following IRT, including but not exclusive: Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Social Skills Training, etc.

[2]Individual Family Therapy should follow the NAVIGATE manual and Multifamily Group Therapy should follow EPI-NC guidelines.

Case Management Services:

[3]Medical management services should follow evidence-based treatment guidelines for schizophrenia and FEP-specific treatment guidelines.

[4]Supported Employment and Education and Support services should follow the NC-CSC guidelines.

[5]Peer Support Specialist services should follow the NC-CSC guidelines

5. Wellness (Relapse Prevention) Plans

Rationale: Psychosis relapse often derails social and vocational recovery and is associated with development of treatment resistance. Compared to routine care, CSC programs reduce psychosis relapse rates[9]. Successful illness management involves a client developing an understanding of their personal risk factors for relapse and utilizing strategies that mitigate relapse risk.

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
Utilizes the IRT Wellness Plan module or a similar structured tool for relapse prevention planning.	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	• Relapse prevention form
Conducts initial relapse prevention planning session within the first year of program participation.	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	
After the first year, conducts wellness/relapse prevention plan review at minimum annually. *	• Criteria met for less than half of clients.	• Criteria met for 50-75% of clients.	• Criteria met for more than 75% of clients.	

*Additional reviews may be done as clinically indicated, for example following a relapse, or when there is a major change in routine, such as when starting a job, moving into an independent living situation.)

6. Fidelity Monitoring

Rationale: Maintaining fidelity to core components of CSC programs is key to producing the improved clinical outcomes of CSC over routine clinical management of early psychosis.

Criteria	Below Standard	Approaching Standard	Meets Standard	How Measured
Program completes data collection forms at baseline and then quarterly.	• Less than 60% of baseline forms collected. • Less than 50% of follow-up visit forms collected	• Between 60%-89% of baseline forms collected • Between 50%-74% of follow-up visit forms collected.	• At least 90% of baseline forms collected. • At least 75% of follow-up forms were collected.	• Database: missing data report
Team members review annual program fidelity report and discuss program strengths and areas that may need to be addressed	• Team members do not participate in review of annual program fidelity report.	• Some but not all team members participate in review of annual program fidelity report	• All team members participate in review of annual program fidelity report and develop strategies to address areas where standards are not met. • All team members are informed and discuss program fidelity reports.	• Annual fidelity review

Organizational Resources

7. Program Facilities Rationale: CSC programs require resources and administrative support to provide services.				
Criteria	**Below Standard**	**Approaching Standard**	**Meets Standard**	**How Measured**
• Private offices available for individual psychotherapy, family psychotherapy, and medical management services • Office-based services provided in a centralized location. • Administrative infrastructure provides adequate support for scheduling, reminders, medical record documentation and client billing • Facilities and staff for routine assessment of height, weight, and blood pressure • Access to phlebotomy and laboratory services (safety labs, urine drug testing) • Access to facilities to administer of long-acting injectable medications • Clinics offer access to services in the community or via telehealth • 24/7 crisis coverage (If another entity provides services an agreement is in place that describes procedures for communication between the entity and the program.)	• Less than 75% (<6) of criteria are met.	• 75-85% (6 to 7) of criteria are met.	• All criteria met.	• Team Lead report

8. Multidisciplinary Team Staffing

Rationale: A multidisciplinary treatment team with relatively low client-to-provider ratios is an essential feature of CSC services. The following FTE recommendations are based on recommendations from other first episode CSC programs' fidelity rating documents, and from the experiences of NC CSC programs over the past seven years. A team serves about 45 clients.

Role	Qualifications	Major Roles	FTE/45 clients	How Measured

Team Lead	Licensed Therapist	• Maintain program fidelity
		  ○ Administrative leadership
		  ○ Clinical supervision of staff
		• Community outreach
			.3	Team Lead report

Program Intake	Licensed Therapist	• Screen referrals (e.g. for program admission criteria) • Initial program intake meeting with client and family	.1 .1	
Family Therapist	Licensed Therapist	• Individual family therapy • Multifamily group therapy	.5	
Individual Therapist	Licensed Therapist	• Individual therapy • Group therapy	1	
Supported Employment and Education Specialist	IPS Certified	• Supported employment interventions • Supported education interventions • Benefits counseling (WIPA)	1	
Peer Support Specialist	Lived experience	• Client recovery support	1.0	
Digital Support Specialist: Fidelity and outcomes	N/A	• Ensure data related to fidelity and outcomes is collected and entered into the database.	0.1	
Medical Management	Licensed MD/DO/NP/LPN	• Diagnostic assessment • Medication management • Health promotion/preventative health management	0.70	
Case Management/Care Coordination	As determined by Site	• Case management services are available to clients.	0.1-0.5	

*The FEP CSC model requires all team members to perform nonbillable services. These include weekly team meetings (~1 hour/week). All Team members spend another 1-2 hours on care coordination (discussions outside of team meetings with team members and clinicians outside of the team). The Team lead has an additional .3 FTE for administrative purposes. There is an additional .1 FTE for screening clients for possible program participation.

9. Staff Training and Certification

Rationale: First episode psychosis interventions differ from routine clinical care. Providers need to be skilled in delivery of interventions that address the unique needs of clients and their families during the early stages of recovery from a psychotic disorder.

Staff Role	Below Standard	Approaching Standard	Meets Standard	How Measured
Individual Therapist	• No therapist trained in early psychosis therapy approaches	• At least one therapist trained and certified to deliver Individual Resiliency Training (IRT)*. • All therapists participate in ongoing continuing education relevant to early psychosis	• All therapists are trained and certified to deliver Individual Resiliency Training (IRT)*. • Providers attend and participate in EPI-NC consultation calls related to this role.	• EPI-NC onboarding records • IRT certification • EPI-NC onboarding records • EPI-NC consultation call records
Family Therapist	• No therapist trained in NAVIGATE model of family therapy	• At least one therapist trained on NAVIGATE family therapy model.	• All family therapists trained on NAVIGATE family therapy model • The provider attends and participates in monthly EPI-NC calls related to this role.	• EPI-NC onboarding records • EPI-NC monthly consultation call records
Medical	• The provider has not participated in onboarding training and is not certified to prescribe clozapine.	• The provider has participated in onboarding training for recent onset psychosis. • The provider is certified to use clozapine.	• Meets “Approaching Standard “criteria. • The provider participates in ongoing continuing education relevant to early psychosis • The provider attends and participates in monthly EPI-NC calls related to this role.	• EPI-NC onboarding records • EPI-NC consultation call records
Supported Employment and Education	• The provider is not trained in Individualized Placement and Support (IPS) services,	• The provider is trained in Individualized Placement and Support (IPS) services but has no training specific to early psychosis.	• The provider is trained in Individualized Placement and Support (IPS) services. • The provider has additional training relevant to early psychosis. • The provider attends and participates in bimonthly EPI-NC calls related to this role.	• Team Lead report • EPI-NC onboarding records • EPI-NC consultation call records
Peer Support	• No certification for Peer Support Specialist.		• Certification • Trained on utilization of Horyzons • Providers attend and participate in	• Team Lead report • EPI-NC onboarding

			monthly EPI-NC calls related to this role.	records • EPI-NC consultation call records
Digital Support: Fidelity and outcomes			• Participated in Digital Support onboarding • Completed both Digital Support and REDCap training • Attends and participates in monthly meetings	• EPI-NC onboarding records • EPI-NC consultation call records
*Certified on standard and individualized IRT modules - ratings of 3 or higher on overall quality of sessions on at least 4 recorded IRT sessions - 2 standard and 2 individualized modules				

Appendix

Notes on Fidelity

1. Fidelity guidelines are being developed for:
    a. Team meeting structure
    b. Community outreach
    c. Formalizing treatment teams developing QI initiative to address areas related to Fidelity.
    d. Developing best practice recommendations for engagement strategies.
2. In addition to the guidelines provided here, CSC Programs should follow evidenced-based treatment guidelines for schizophrenia.
3. CSC clinics in North Carolina have a slightly more constricted range of ages served than other fidelity model specifications in the US (i.e., 15 to 30). Research suggests most clients who experience their first episode of psychosis are between the ages of 15 to 30, with a decline in incidence rates after age 30. In addition, the needs of individuals who first experience a psychotic episode in adolescence or young adulthood may benefit most from the types of programming and wrap-around services provided by CSC clinics in North Carolina. For example, individuals who experience psychosis for the first time at midlife have unique needs that might be better addressed in a different treatment setting.
4. The purpose of the EPI-NC network is to expand access to care and provide resources for young people experiencing psychosis across the state. As such, it is an expectation that CSC programs offer services that align with the needs and preferences of clients and their supporters. Although some programs facilitate access to care by mandating community visits, CSC programs in NC can flexibly accommodate their clients by offering a variety of care approaches (e.g., appointments in the community, telehealth sessions, crisis support, and/or private offices for medical management and psychotherapy).
5. The presentation and impact of psychosis can vary significantly from one client to another. As such, early intervention in psychosis services aim to provide a full range of pharmacological, psychosocial, occupational, and educational interventions for people with psychosis. Along these lines, EPI-NC programs are encouraged to use evidence-based approaches to medication management, psychotherapy, and supported employment and education services. These services can include but are not limited to Navigate interventions such as Individual Resiliency Training and Family Psychoeducation. The purpose of this flexibility is to allow for inclusive and individualized treatment based on the client's strengths, needs, and recovery goals.

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