Practice Guidelines

KY Department for Behavioral Health, Developmental and Intellectual Disabilities
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EASA
Early Assessment & Support Alliance

OVERVIEW

The KY Department for Behavioral Health, Developmental and Intellectual Disabilities, Division of Behavioral Health is dedicated to supporting the state's effort to significantly increase access to specialized evidence-based services and supports, including outreach services, to youth and young adults (15-30 years old) with, or at risk of, early psychosis symptoms and their families. The youth/young adults and initial start-up site providers have chosen the name iHOPE (Helping Others Pursue Excellence) to identify the Coordinated Specialty Care Programs in Kentucky.

Each year in Kentucky, a significant number of youth and young adults with schizophrenia or other related illnesses are admitted to a psychiatric facility. With a peak onset occurring between 15-25 years of age, psychotic disorders such as schizophrenia can significantly disrupt a young person's social, academic, and vocational development and initiate a course of accumulating disability. Young people who are experiencing first episode psychosis and their families, are often frightened and confused, and struggle to understand what is happening to them (Heinssen, Goldstein and Azrin, 2014).

COORDINATED SPECIALTY CARE (CSC) is a team-based model that is offered during or shortly after the first episode of psychosis and is effective for improving clinical and functional outcomes. Research has shown that team based early psychosis treatment programs that ensure rapid access to care, represent worthwhile treatment models for improving symptoms. They can reduce relapse episodes and psychiatric hospitalizations and preventing deterioration and disability among individuals affected by psychosis (Heinssen, Goldstein and Azrin, 2014). These programs are already well established in Australia, Canada, and the United Kingdom.

The **KEY COMPONENTS OF CSC** include the following and are aimed at bridging gaps between child, adolescent, and adult behavioral health services and are highly coordinated with physical health care:

- Project leadership,
- Outreach services,
- Medication management with low doses of atypical antipsychotic medications,
- Peer support services,
- Case management,
- Cognitive behavioral therapy,
- Family education and support,
- Employment and education support, and
- Occupational therapy.

KEY PROGRAMS in the US that use a CSC MODEL for INDIVIDUALS with FIRST EPISODE PSYCHOSIS:

- **Early Assessment and Support Alliance (EASA) (Oregon):**
    - The first statewide effort in the United States to provide systematic early psychosis intervention for adolescents and young adults.
    - There are established EASA programs or programs being implemented in licensed public mental health centers in all of Oregon's 36 counties.
- **RAISE (Recovery After an Initial Schizophrenia Episode) Early Treatment Program:**
    - CSC programs in 17 community clinics located in urban, suburban, and rural settings across the United States.
- **RAISE Connection:**
    - CSC programs in New York City, New York and Baltimore, Maryland.
    - Each team consists of four staff members (2.7 full-time equivalent [FTE] employees) for a target caseload of 25 clients. A licensed clinician serves as full-time team leader.
- **OnTrackNY (Yonkers, NY):**
    - The RAISE Connection program model was modified to increase flexibility and to allow for staff time to do CSC outreach and evaluations for eligibility.
    - CSC teams serve between 30-35 clients and require two FTE licensed staff members who cover 4 roles: team leader, recovery coach, primary care manager, and outreach and recruitment coordinator. The team leader must be full-time.

Kentucky has received approval from the Early Assessment and Support Alliance (EASA) Program to utilize their practice guidelines as a template for Kentucky's guidelines.

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 originally based on the Australian Practice Guidelines for Early Psychosis (McGorry et al., 1998, 2010). Guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA) evidenced based practices of multi-family psychoeducation, assertive community treatment, and supported employment (2008, 2009) were added later. 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 2013 EASA Guidelines used as a template for Kentucky's iHOPE Practice Guidelines is 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. These 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.

iHOPE PHILOSOPHY OF CARE

The voices and needs of individual and family participants drive all services. iHOPE is designed as a transitional program. Services in the early phase should equip young people 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 iHOPE's foundation. Services are delivered by and to a diverse representation of individuals and groups. Young people receiving services through iHOPE, their family members, and providers across the state represent a range of values, beliefs, identities, stages of life, and lifestyles. Creating culturally aware services is a dynamic and evolving element of service and requires ongoing dialogue, training, self-reflection, and systems improvement.

The iHOPE team is an important assessment and consultation resource for providers and individuals who do not specialize in differential diagnosis of psychotic illness. iHOPE prevents inappropriate early diagnosis and treatment by providing diagnostic training for providers. The iHOPE 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 iHOPE's role includes helping to connect these individuals with the most appropriate services for their needs.

The optimal treatment setting is the individual's community (Fitzgerald & Kulkarni, 1998). The iHOPE team provides this support through community mobilization and education, early identification, proactive outreach and engagement, and evidence-based treatment and support.

DEFINITIONS

Young person/young people: Youth and young adults between the ages of 15-30 years old with, or at risk of early psychosis symptoms.

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 "psychosis risk syndrome", or the early stage of illness manifestation. However, ARMS is the preferred term because the risk for psychosis 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 ARMS 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.

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 behavioral 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 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.

Psychosis risk syndrome: The early stage of illness during which clear symptoms are manifest but not acute. The psychosis risk syndrome 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. Psychosis risk syndrome 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.

Social Justice Allies: Social justice allies are defined as members of privileged social groups who consciously work to end forms of systemic oppression (Broido, 2000).

Support System/Person(s): Support systems/person(s) are defined in the broadest sense to be inclusive of members relevant to the individual's community.

Psychotic disorders: Disorders, as identified in the DSM 5, that include psychosis within the listed categories of symptoms such as schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, other specified schizophrenia spectrum and other psychotic disorder, or unspecified schizophrenia spectrum and other psychotic disorder.

iHOPE PRACTICE GUIDELINES

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 iHOPE practice guidelines, 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 staff 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 iHOPE team and be flexible, responsive, and proactive in providing early intervention supports.

1.2. Staffing will be based on a more intensive 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 young person ratio of 1:10 or less is optimal.

1.3. The following treatment providers are considered essential to provide appropriate services. Individual services are based on the interests and needs of the young person:

   a. Program Director
   b. Prescriber (Psychiatrist, Psychiatric Nurse Practitioner)
   c. Master's Level Clinician
   d. Targeted Case Management
   e. Peer Support Specialist(s)
   f. Supported employment and education specialist(s)
   g. Occupational therapist(s) must be available either in the program or contracted outside of the program.
   h. Collaboration with Primary Care Physician/Nurse

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 iHOPE 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 and young adults, within the iHOPE age range of 15-30 years old (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 adults (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 behavioral health program in order to expedite appropriate

access;
  b. The iHOPE team is responsible for its own screening and intake process;
  c. Agency leaders participate in iHOPE interagency 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 iHOPE Program 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 iHOPE team. A strong linkage between crisis services and the early intervention program is established;
  e. iHOPE maintains a clear identity of iHOPE within the parent agency (business card, letter head, business entrance, website and other forms of social media).

1.7. Implementation of early intervention requires attention to each of the following personnel practices:
  a. All staff working with individuals in iHOPE complete required iHOPE orientation and training per DBH expectations;
  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 iHOPE team provides outpatient substance use disorder treatment to individuals within their scope of practice;
  b. The iHOPE team provides community-based and office-based interventions depending on the interests/needs of the young person;
  c. Agency standard procedures (front desk, scheduling, billing, etc.) may need to be reevaluated to ensure consistency with iHOPE practices;
  d. agency standard forms (behavioral health assessment, service plan, etc.) may need to be reevaluated to ensure consistency with iHOPE practices;
  e. An ongoing quality improvement process collects and responds to information about 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:

Young people 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 young people and families/primary support persons can include the following strategies (this is not an all inclusive list):

a. Ensuring a clear and accessible feedback and complaints process with transparent resolution processes;
b. Conducting routine focus groups around iHOPE services;
c. Ensuring representation on boards and committees;
d. Ensuring participation in iHOPE team member hiring;
e. Ensuring participation in the development of treatment and activity groups;
f. Ensuring the close collaboration with peer support programs.

2.2 Young people and family/primary support persons will be recognized for their contribution to iHOPE service development including;

a. Payment for time and travel contributed;
b. Provision for supports to encourage participation including childcare, transportation etc.;
c. Provision of specialized training to support and empower participation in above listed activities under 2.1 (e.g. training on meeting procedures, specific skills etc.);
d. Enabling development into more advanced roles.

3. Psychosis Risk Syndrome 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 psychosis 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 Kentucky is focused on early interventions for first episode and psychosis risk syndrome. Integrating current knowledge about the psychosis risk syndrome is important for the following reasons:

a. This 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 psychosis risk symptoms often are very similar to the acute form of illness. However, in the psychosis-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 to the young person;

b. Treat specific syndromes and co-morbid symptoms using evidence-based treatments for symptoms present (e.g. cognitive behavioral therapy 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 behavioral health 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 psychosis 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 behavioral 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. iHOPE 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, hospital staff, law enforcement, parents and others who come in contact with youth. Education of youth under 18 and young adults will also reduce stigma and facilitate referrals. Strategies such as Mental Health First Aid/Youth Mental Health First Aid Training will be used to support this effort.

4.3. Communications about conditions should carry a positive, hopeful message about early recovery, core elements of treatment, how to refer to iHOPE and should combat negative preconceptions and reflect current understandings of first episode psychosis.

4.4. Specific information about observable psychosis 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 iHOPE team will provide and track community education efforts.

5. Access and Screening Process: *iHOPE services are quickly accessible for young 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 behavioral health services is of particular importance for young people and their primary support networks. As a general principle a partnership should be developed with primary support networks. The priority population is 15-30 year olds who have had a first episode of psychosis within the last year. Youth between 14-15 years old will be considered for admission if the young person is deemed at high risk for residential services if intervention is not provided by iHOPE.

Criteria/Strategies

5.1. iHOPE 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 behavioral health support.

5.3. The location of the initial screening is flexible to accommodate a place of convenience to the young person, 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 young person so that support and psychoeducation can be provided and if necessary triage can occur if the young person is at high risk for harm to self, others, and/or hospitalization.

5.5. Contact and support is maintained with the family and/or support system if determined appropriate by the iHOPE screener, even if the young person is not yet ready to engage in the screening and/or iHOPE services.

5.6. The initial interview with the family and/or support system explores their level of knowledge of psychosis risk or psychotic symptoms and identifies their current needs.

5.7. If the young person is hospitalized during screening, a clinician from the iHOPE 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 iHOPE team member participates in hospital discharge planning.

5.8. Barriers to care are assessed during the screening process. Whenever possible young people and their families are supported in addressing those barriers (i.e. transportation, legal issues, child care, 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 and the young person/family/support person is provided with a warm hand-off to more appropriate services/supports (connection with a staff person within the more appropriate program or service and potentially meeting together with that staff person and the young person/family).

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 iHOPE 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 young people 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 young person/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 young people incorporate strategies to promote engagement and therapeutic alliance (Rapp & Goscha, 2006). The behavioral health assessment itself gathers information on the young person and the family's and/or support system's experience over time, primary and secondary symptoms, course and duration, psychosis 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 young person and his/her support system, their cultural beliefs and practices, premorbid functioning, and pathway to care (McGorry et al., 2010).

Treatment planning is individually driven, reflects the young person's strengths and own words and is updated to reflect changes as they occur throughout the recovery process and when initiating transition into ongoing services.

Substance Use Issues: About half of young people with a first episode of psychosis presently have or have had substance use issues in their past. (Archie, et al, 2007). If a young person with first episode psychosis continues to use alcohol and other drugs while in treatment, there is an "increased symptoms, adjustment difficulties, the ability to follow through with person centered treatment, relapses, and hospitalizations. Thus substance use disorders constitute a major risk factor for these clients." (Wisdom, Manuel, & Drake, 2011). "The diagnostic distinction between a substance-induced psychosis and a primary psychosis that co-occurs with drug use is relevant in planning for appropriate treatment. The issues of assessment and treatment planning are particularly important in the early stages of psychotic disorder, because this is a time when the symptom picture is often unclear and a proper match of diagnosis with treatment may be critically important for outcome." (Caton, Samet, & Haset, 2000).

Criteria/Strategies

6.1. A comprehensive culturally informed biopsychosocial assessment and strengths assessment with clinical recommendations and/or rule outs is completed. (for example: the DSM 5 Cultural Formulation Interview)

6.2. A comprehensive risk assessment of unique risks for the young person is undertaken, to include; suicide, violence and victimization, disorganization, impulsivity, delusional content, substance use issues, and family conflict which might lead them to potentially harmful behavior. This also includes an assessment of the young person'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 young person's support network and clinical team.

6.3. The prescriber, 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); fasting blood glucose, and lipids at initiation of antipsychotic medications and annually there after. As appropriate, the physician may request urinalysis with microscopy, B-12 and folate and MRI or CT, and other tests/evaluations**.**

6.4. The iHOPE team and the young person and their support network meets to clarify needs and expectations, plan treatment, and review progress, and stages of treatment at the following junctures:

a. Initiation of the assessment process;
b. After completion of assessment;
c. Every 90 days or sooner if treatment needs dictate and level of care changes or there is a change in the young person's condition;
d. When initiating transition out of iHOPE services (approximately 6 months to transition date).

6.5. Treatment planning is a person-centered process that includes:

a. Individually driven goals and objectives;
b. Strengths-based and in a young person's language;
c. Updated as changes occur and reflect the step-by-step recovery process;
d. Clearly measureable objectives;
e. Identified support person (staff, family, natural support, etc) responsible for assisting the young person with goal;
f. Clearly outlined time frames for completion of goals and objectives;
g. Transition goals and plans discussed at the beginning of treatment and throughout treatment process.

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. Respecting young person’s values and preferences.
f. Respecting youth culture.

6.7. It is expected that a thorough assessment will be completed that is informed by a well-defined differential diagnosis protocol that includes a Structured Clinical Interview for DSM Disorders (SCID) level of assessment along with American Society for Addiction Medicine (ASAM) criteria if indicated (see Principles related to “Substance Use Issues” above).

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 young person 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 young person'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 young person's condition;

Criteria/Strategies

7.1. Initial contact is made with the family or support system early in Phase 1 of treatment for the young person so that crisis intervention, support and psychoeducation can be provided. The iHOPE team routinely reaches out to parental figures and siblings who may not be part of the initial referral to provide support and educations and reduce family or support system conflict. The iHOPE 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 identifies their current needs. Family history and observations of the young person'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 iHOPE 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 young person and the behavioral health issues;
  d. The interaction between the family and the course of the behavioral health issues.

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 young person 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.*

Principles:

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 young person and support person(s) in a collaborative partnership;
b. Develop a shared explanatory model with the young person and support person(s);
c. Share information regarding cultural values or norms most relevant to young people 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 young person and support person(s) with information and tools to identify and cope with symptoms;
g. Instill a perspective of hopefulness in the team and with/for the young person and support person(s);
h. Facilitate the young person's efforts toward completion of their 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 the needs of the young person and their support person(s) and coordinate services. Each young person's services, strengths and goals are reviewed weekly.

8.2. Team members have ongoing contact relevant to the phase of care, recovery and the young person's 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 young person 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 young person; 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 young person 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, family/support system work, and/or 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 young person and 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 young person's needs and take into account how the young person 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 iHOPE team members are responsible for ensuring the provision of psychoeducation.

9.5. All young people 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 ihope 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. Individual/Group Behavioral Health Therapy: *Therapy interventions are provided as part of ongoing treatment. Consideration of that which is culturally appropriate is integrated into the counseling interventions.*

Principles:

Supportive behavioral health therapy plays a key role with individuals in early intervention and throughout treatment. Therapy uses evidence-based interventions tailored to the unique nature of the condition and complexity of the developmental stage. Therapy interventions may include but are not limited to: motivational interviewing, cognitive behavioral therapy (CBT), supportive and substance use disorder treatment consistent with dual diagnosis best practice guidelines (SAMHSA, 2011, Nordentoft et al., 2006), and community-based in vivo practices. Group interventions can be both efficient and effective in promoting recovery. Therapists assess needs for topic-specific groups available within or outside of the iHOPE program. Therapists 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 iHOPE team makes every effort to support and advocate that the young person remain in the most integrated setting.

A therapist is assigned to each young person and establishes a relationship with the family, introduces the young person to other team members, connects to appropriate therapeutic groups, and manages the ongoing assessment, treatment/discharge planning, and treatment coordination. The therapist acts as primary clinician, provides therapy, psychoeducation for the young person and family, and family support.

Criteria/Strategies

10.1. Specific therapy interventions are based on sound clinical judgment and consultation with the transdisciplinary team.

10.2. iHOPE therapy:

- a. Is strengths-based;
- b. Implements harm reduction principles;
- c. Forms a therapeutic alliance with the young person;
- d. Teaches alternative strategies to deal with stressful situations;
- e. Promotes adaptation and recovery;
- f. Protects and enhances self-esteem and self-efficacy;
- g. Attends to stigma issues;
- h. Supports development of effective coping strategies;
- i. Addresses trauma, grief, and loss experiences on individual and systemic levels;
- j. Reduces secondary morbidity and comorbidity.

10.3. Therapy techniques demonstrate cultural awareness by:

- a. Therapists proactively identifying their own cultural values, beliefs and assumptions in consultation and supervision;

b. Therapists seeking knowledge about cultural differences from appropriate content experts;
c. Including interpreters and translations for the preferred language of the young person and their family;
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 the young person;
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

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

a. Ongoing use of trauma-informed practices
b. Ongoing use of the strengths-based assessment and treatment planning;
c. Feedback techniques such as the session rating scale (duncan & miller, 2000);
d. Utilize harm reduction techniques.;
e. Educate regarding relapse prevention including use of illness management and recovery (imr) techniques (samhsa, 2009);
f. Acknowledge and use of techniques to minimize the impact of traumatic occurrences;
g. Utilize group formats;
h. Mitigate possible traumas associated with hospitalizations by accompanying the young person to the crisis service and letting people know what to expect;
i. Teach advocacy and promote social justice.

11. Occupational Therapy: *Occupational therapy assessment and intervention supports young people in maintaining engagement in everyday life to promote recovery. The diverse beliefs and values of the young person and his/her identity are respected in these interventions. It is expected that Occupational Therapy is available within the iHOPE Program* ***or*** *through contract with another program.*

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 young person’s desires and needs.

11.2. The occupational therapist collaborates with the young person, their family/support system, and other team members 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 young person and their 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 young person’s ability to successfully engage in meaningful occupation. These factors include but are not limited to:

a. Areas of occupation the young person 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 young person 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 content experts;
c. Including interpreters and translations for the preferred language of the young person and their family;
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 the young person;
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

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 the young person in defining academic/vocational goals and entering and sustaining academic and/or vocational activities. The diverse beliefs and values of the young person 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 behavioral health 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 content experts;
c. Including interpreters and translations for the preferred language of the young person and their family;
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 the young person.
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

13. Prescribers: *Prescriber interventions are to be provided during the acute phase and for ongoing management of psychotic symptoms if appropriate and the young person chooses. Young people in the at-risk state should be treated following guideline 3.0. The diverse beliefs and values of the young person 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 young person 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 prescriber occur within one week of acceptance into the iHOPE program unless not clinically indicated.

13.2. Novel antipsychotics vs. typical antipsychotics are the first medical treatment of choice for acute positive 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. Young people 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 prescriber will offer and allow for appointments with the family and/or the support system alone, with the permission from the young person, to provide psychoeducation around medical information and concerns.

13.7. iHOPE team members will attend prescriber appointments as appropriate to coordinate and support integration of all services.

13.8. The prescriber will continue to maintain contact with young people who choose not to take or to discontinue medication, with the goals of building trust, encouraging the young person 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 young people who do not want to take medicine with a focus on maintaining safety, encouraging healthy empowerment of the young person, 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 young people in iHOPE. Most routine visits should last at least 30 minutes.

13.10. The young person may 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 young person, family/support system and coordinated with the iHOPE team.

13.11 Prescribers demonstrate cultural awareness by:

a. Pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision;
b. Seeking knowledge about cultural differences from content experts;
c. Including interpreters and translations for the preferred language of the young person and their family;
d. Identifying appropriate location of these activities;
e. The use of culturally relevant language and references;
f. The use of accessible communication styles;
g. Respecting values and preferences of the young person, with specific attention on the role/meaning of medication within the young person’s and family’s/primary support system’s cultural context.
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

14. Purposeful Coordination with Primary Care Physician/Nurse. The aim of purposeful coordination with the primary care physician/Nurse 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 young person 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;
f. An overall lack of access to quality, culturally appropriate health care services.

Criteria/Strategies

14.1. The iHOPE Team establishes a purposeful collaboration with the young person's primary care physician (PCP)/nurse at the beginning of admission and throughout treatment in the iHOPE Program. PCP/nursing strategies will include the items listed below in 14.2 – 14.6.

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

14.3. The PCP/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.

14.4. To support medication management the PCP/nurse will

a. Meet with the young person 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.

14.5. If nurse is an internal part of the internal iHOPE team, the nurse coordinates information transfer with Primary Care Provider (notes, labs, medication regimes, etc.).

14.6. PCP/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 content experts;
c. Including interpreters and translations for the preferred language of young people 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 young person and family's/primary support system's cultural context.
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

15. Multi-Family Groups: *Multi-Family Group (MFG) treatment is an evidence-based intervention for treating persons with severe mental illness, particularly schizophrenia, and their families. It combines psychoeducation and behavioral family therapy in a multiple-family group format. The expectation is that by increasing the social network of individuals and families with similar challenges, families will receive support from each other's experiences in solving problems, and therefore improved outcomes can more easily be seen. This model has been shown to lower hospitalization and relapse rates among individuals with schizophrenia and improve family well-being over the course of treatment. (Stuart and Schlosser, 2009).*

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. There are four stages of MFG: 1) joining (i.e., building rapport/alliance) among the individual/family members; 2) conducting an educational workshop about schizophrenia for families; 3) relapse prevention through problem-solving groups attended by both individuals and families; 4) and vocational and social skills support. MFG is delivered by two clinicians to groups of 5-8 families over a 2-year period.

Criteria/Strategies:

15.1. All MFG facilitators must achieve fidelity in MFG national evidence-based guidelines.

15.2. All iHOPE team members co-facilitating groups must complete MFG training.

15.3. Any trained member of the iHOPE team can co-facilitate MFG. Cross-discipline co-facilitation is encouraged.

15.4. Workshops are provided on a quarterly basis and include all team members.

15.5. MFGs 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;
g. Respecting youth culture.
h. Respecting geographic cultural variances (rural culture/Appalachian culture)

15.6. Attendance is equally encouraged for the young person and family members.
15.7. MFGs are offered at times and locations convenient for attendees. Food is available at groups (potluck, agency provided).

16. *Peer Support*: *Peer Support Specialists are a necessary component to support the ongoing wellness of individuals experiencing behavioral health issues. Young people in particular report identifying more easily with others who have been through similar situations and are now in recovery. Peer Support is vital bridge to engaging young people in their own recovery and support services.*

Principles:

Peer Support, an evidence-based practice, is defined as social and emotional support that is provided by persons having a behavioral health condition to others sharing a similar behavioral health condition in order to bring about a desired social or personal change. All peer specialists are individuals with mental illnesses and/or substance use disorders who are or were receiving behavioral health services and who self-identify as such. The support that is given and received is developed around principles of respect, shared responsibility and mutual agreement of what is helpful.

Criteria/Strategies:

16.1. A Peer Support Service is a structured and scheduled therapeutic activity with an individual or group provided by a trained, self-identified consumer of behavioral health services. A Peer Specialist guides individuals toward the identification and achievement of specific goals defined by the individual and specified in the Individual Treatment/Recovery Plan.

This service is supervised by a credentialed professional who assures that all services rendered by a Peer Specialist are provided in accordance with the service standards, pertinent statutes and regulations, and within accepted standards of clinical practice.

16.2. The Peer Support Service is provided by self-identified consumers of behavioral health services - people who have been diagnosed with a mental illness and/or substance use disorders and have successfully demonstrated their own efforts at self-directed recovery - and who have been hired by the community mental health center, state operated facility or other provider approved by the Department for Medicaid Services. The job of a PSS is not to replace current clinical behavioral health staff but to offer additional and/or alternative options to help peers in their efforts to recover.

16.3. Peer Support Specialists (PSS) are required to complete a 30 hour training program and passed a test in order to become Medicaid billable.

16.4. The components of Peer Support include:

a. Providing individual or group recovery education and support.
b. Independent living skills training and support to enhance housing stability.
c. Assisting the young person in developing a Wellness and/or Crisis Plan to avoid/shorten future psychiatric hospitalization.
d. Assisting the young person in developing an Advance Directive for Mental Health Treatment.

e. Assisting the young person in exploring needs, hopes and aspirations, and set specific recovery-oriented goals/objectives.
f. Problem solving activities with the young person.
g. Individual or group activities focusing on identifying and decreasing negative self- talk.
h. Assisting the young person in identifying skills and supports needed to accomplish individualized goals.
i. Providing outreach to individuals, either for those who have dropped out of treatment or those who have not yet engaged in treatment services.
j. Instilling hope for personal recovery.

16.5. Peer support techniques demonstrate cultural awareness by:
a. Pro-actively identifying their own cultural values, beliefs and assumptions in consultation and supervision;
b. Seeking knowledge about cultural differences from appropriate content experts;
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 the young person.
h. Respecting youth culture
i. Respecting geographic cultural variances (rural culture/Appalachian culture)

17. *Targeted Case Management*: *Case management provides support to young people by assisting the individual in gaining access to needed medical, social, educational, or other needed services and supports.*

Principles:

Successful treatment of individuals with first episode psychosis often requires a high degree of coordinated care which is effectively delivered using case management as a component of care. Individuals who experience a first episode of psychosis often need assistance with practical problems such as obtaining medical care, managing money, securing transportation, navigating the criminal justice system, and obtaining stable housing. (Heinssen, Goldstein, Azrin; 2014).

Criteria/Strategies:

17.1. Specific case management practices are based on sound judgment and consultation with the transdisciplinary team.

17.2. iHOPE case management:

a. Is strengths-based;
b. Implements harm reduction principles;
c. Forms a therapeutic alliance with the young person;
d. Teaches alternative strategies to deal with stressful situations;
e. Promotes adaptation and recovery;
f. Protects and enhances self-esteem and self-efficacy;
g. Attends to stigma issues;
h. Supports development of effective coping strategies;
i. Addresses trauma, grief, and loss experiences on individual and systemic levels;
j. Reduces secondary morbidity and comorbidity.

17.3. Case managers demonstrate cultural awareness by:

a. Case managers proactively identifying their own cultural values, beliefs and assumptions in consultation and supervision;
b. Case managers seeking knowledge about cultural differences from appropriate content experts;
c. Including interpreters and translations for the preferred language of the young person and their family;
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 the young person;
h. Respecting youth culture;
i. Respecting geographic cultural variances (rural culture/Appalachian culture).

18. 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.

Criteria/Strategies

18.1. The program is described as time limited from the beginning, and the recovery plan addresses planning for transition from the inception of services.

18.2. iHOPE team members routinely use the transition checklist and phase of treatment document throughout treatment. A specific plan of transition is developed in collaboration with the young person and shared with all team members at least 6 months prior to anticipated graduation from program.

18.3. Services within iHOPE focus on supporting a grounded, realistic positive view of the future. The iHOPE team in partnership with the young person and support person(s) anticipates the time period at and after completion of iHOPE and what this will concretely look like. iHOPE team members make frequent use of success stories and invite participation by graduates/individuals in recovery in their interactions with young people and family/support system members.

18.4. iHOPE team members facilitate the connection of young people and family/primary supports to appropriate ongoing resources prior to discharge from iHOPE.

18.5. Transition techniques demonstrate cultural awareness by:

a. The iHope 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 the young person and their family/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 the young person when working on transitional supports;
f. Respecting youth culture;
g. Respecting geographic cultural variances (rural culture/Appalachian culture).

18.6. Although iHOPE is a transitional service, it maintains an interest in the long-term well-being of the young person and families/support system who graduate. In order to maximize long-term success, iHOPE pursues the following strategies:

a. It provides the young person and family/primary support person(s) with the information they need to be effective self-advocates at individual, agency and system levels;
b. It offers ongoing opportunities for graduates of iHope to return for educational workshops, support groups, and decision making committees;
c. it provides brief problem-solving support if needed ;
d. The program requests feedback for quality improvement/system development;
e. It offers consultation and training to professionals and individuals involved in ongoing care and support of iHope graduates;
f. It integrates iHope graduates into community education and participant education activities.

18.7. 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. Young people 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.

Appendix A

FIVE PHASES OF CARE

The iHOPE Team works with young people throughout 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 young person and their 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 iHOPE

Phase 2 (approximately 6 months): Adaptation

a. Provide more extensive education to the young person and their family/primary support system
b. Continue treatment with iHOPE 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 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 iHOPE 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 iHOPE planning/development activities
e. Periodic check-ins and problem solving as needed.

Appendix B

TRANSITION CHECKLIST

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(Begin this process 6 months prior to graduation from iHOPE)

1. The young person 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 young person has connected with the ongoing supports and resources needed to accomplish their ongoing goals.

3. The young person has written relapse plan/advanced directive.
    a. Plan identifies early, intermediate and late warning signs for relapse
    b. Plan specifies actions to be taken by the young person and others when relapse 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).
    a. The young person has met and accepted the medical provider
    b. It is clear how the young person is going to pay for the medical care
    c. A copy of the young person’s most recent assessment, medication history and relapse plan has been sent to prescriber

5. Ongoing Therapist is identified (if necessary).
    a. A determination has been made of whether the young person needs/wants an ongoing therapy
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  b. Therapist is identified and the young person has met and accepted counselor
  c. Therapist has treatment and medication history, assessments, relapse plan
  d. It is clear how the young person 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).
   a. The young person has access to medications through insurance or other means
   b. Medications have been established through pharmaceutical assistance or other means for the next 3 months
   c. The young person knows how to secure future medications

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

9. The young person has copies of key supportive documents (electronic or hard).
   a. Medication history
   b. Treatment summary
   c. Resume
   d. Relapse plan
   e. 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.
   a. Meeting has occurred & transition plan in place that all have agreed to
   b. Family members and other key supporters have a copy of the relapse plan
   c. Provide list of resources that may be necessary in the future

11. The young person has completed discharge survey and permission to follow up established.

EARLY DISCHARGE

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

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

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)

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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