Coordinated Specialty Care (CSC) for First Episode Psychosis

What is the practice?

Coordinated specialty care (CSC) is an evidence-based model of early intervention for young adults experiencing first episode psychosis (FEP). The model is unique because it is team-based and multidisciplinary, collaborative, recovery-oriented, and emphasizes shared decision-making between the team and individuals experiencing FEP.

What outcomes does this practice produce?

The CSC-FEP approach is a shift away from more traditional models that are typically crisis-driven and lead to delays in treatment, lower quality of life, and higher individual and economic costs. In contrast, the CSC-FEP approach produces better clinical outcomes, lower treatment costs, and overall higher quality of life. Additionally, the approach aims to reduce the duration of untreated psychosis (DUP), as a shorter DUP is associated with better long-term clinical outcomes (Marshall et al., 2005).

Furthermore, The National Institute of Mental Health (NIMH) funded the Recovery After an Initial Schizophrenia Episode (RAISE) project to study CSC for young people experiencing FEP. The study found that people who engaged with CSC programs experienced greater improvement in their symptoms, stayed in treatment longer and were more likely to stay in school or working and connected socially than those who received standard mental health care.

Continued studies have demonstrated that individuals experiencing FEP engaged in CSC programs experience improvements in psychosis, depression, and other mood symptoms, as well as significant improvements in education, employment, and global functioning (Kane et al., 2016; Nossel et al., 2018; Srihari et al., 2015). Individual characteristics including race, ethnicity, and DUP can impact clinical and functional outcomes (Kane et al., 2016; Oluwoye et al., 2018).

What is the evidence for this practice?

Randomized controlled trials (Craig et al., 2004; Kane et al., 2016; Petersen et al., 2005; Srihari et al., 2015), historical control investigations (Fowler et al., 2009; McGorry et al., 1996; Mihalopoulos et al., 2009), naturalistic effectiveness studies (Calkins et al., 2020; Dixon et al., 2015; Kohler et al., 2020; Nossel et al., 2018; Smith et al., 2018; Uzenoff et al., 2012) and qualitative assessments (Daley et al., 2020) indicate that CSC services offered during or shortly after FEP are effective for improving clinical and functional outcomes among youth and young adults at risk for serious mental illness.

How is this practice implemented?

In what contexts is this practice implemented (e.g., schools, clinical)?

The CSC team is typically based in a community behavioral health agency, with most interventions delivered within the clinic, with supportive interventions also delivered within the community and home. For example, most CSC teams have a team member who takes the lead on employment and education services; much of their work is based in those very settings. Similarly, case managers may escort clients to appointments in the community, and facilitate engagement with needed social services.

What is the dosage of this practice (e.g., one-time training, six-week curriculum)?
CSC treatment programs in the RAISE initiative did not mandate a specific intensity or duration of services, but developed treatment plans based on the individual client's specific needs, goals, and pace of recovery. Across the United States, most CSC programs include a two-year timeframe for service delivery and individuals and families are offered weekly sessions, sometimes multiple depending on the number of service interventions they are involved in with the CSC team (e.g., individual therapy, family education, and supported employment and education).

How is the practice delivered (e.g., online, in-person)?
As described above, the CSC team employs a multidisciplinary approach to service delivery with supportive interventions occurring in clinic, community, and home settings as required. Most interventions are delivered in person, though phone-based services are fairly common, especially when engaging with natural supports and conducting case management services. Given the increase in delivery of telehealth services during the coronavirus disease 2019 pandemic, it is likely we may see more use of this modality as clinically appropriate.

What infrastructure or readiness is needed to implement this practice (e.g., capacity for data analysis, individual full-time equivalent [FTE])?
Successful implementation of CSC depends on assuring adequate coverage of key roles rather than achieving 1:1 correspondence between the number of providers and CSC service components. Essential functions include (1) overall team leadership and management and (2) competent delivery of core clinical services, including case management, psychotherapy, supported employment and education, family education and support, and pharmacotherapy/primary care coordination. The number of providers necessary to fill key roles may vary from site to site depending on the size of the FEP cohort served, the number of providers available, and the level of effort each provider devotes to the CSC program.

Here are some key components to consider:

- Consider the operational location of the team—will the team-based program operate and reside within an existing and established mental health clinic?
- Consider the geographic boundaries, including population density and service boundaries. For example, a population base of about 550,000 will have enough incident FEP cases to keep one FEP team filled at capacity given the team size and service durations proposed here, even with fairly conservative estimates about the number of such individuals who are identified and agree to be served.
- Each program should establish its eligibility criteria. The first critical decision around eligibility is determining a definition of early psychosis.
- A referral network is key for the success of the CSC program.
- Team human resources, training, and supervision.

For which population(s) can this practice be implemented?

For which population(s) is this best or promising practice (BPP) intended? Has it been adapted for diverse groups? If so, which ones?
CSC is intended primarily for youth, adolescents, and young adults experiencing FEP, typically between ages 15 and 25, with some programs extending to ages 35-40. Early intervention programs are designed to bridge existing services for these groups and eliminate gaps between child, adolescent, and adult mental health programs. In clinical trials, CSC has been restricted to persons with nonorganic, nonaffective psychotic disorders who have been ill for five years or less; empirical evidence regarding the effectiveness of CSC is greatest for persons who meet these criteria.

With which specific populations has this practice been successfully implemented?

See above description regarding the populations this practice has been successfully implemented for.

For which populations, if any, is this practice NOT a good fit?

Individuals ineligible for the CSC program (e.g., who do not meet FEP diagnostic criteria, or who have been ill for more than 5 years) should be referred to other mental health services.

Who can implement this practice?

What expertise is needed to implement the practice?

Training in evidence-based treatment for FEP occurs at two levels: (1) the overall philosophy of team-based care for FEP, and (2) specialized services that support the client's recovery. Each team member must master the overall theoretical framework of CSC treatment, including the recovery potential for individuals experiencing FEP and developmental issues specific to adolescents and young adults experiencing FEP. Other core competencies include: shared decision-making and person-centered care, strengths and resiliency focus, motivational enhancement skills, psychoeducational teaching skills, cultural responsivity, collaboration with natural supports, and application of measurement-based care. In addition, CSC staff members must understand common problems that cut across all service categories, such as difficulties in engaging the client and their family members, clients' vulnerability for developing substance use problems, and heightened risk of suicide during the early years of treatment.

What specific training or certification is required to implement the practice?

Specific training and certification depend on the team role. For example:

- Team Leader or Program Director, 1.0 FTE
  - An experienced master's level clinician who is trained in working with individuals experiencing FEP. They will be the primary contact person for clients and families and will spearhead efforts to engage clients in treatment.
- Supported Education and Employment Specialist, 1.0 FTE
  - A bachelor's level position; someone in this position should ideally have prior experience as a supported education or employment specialist. They will focus on assisting participants to continue, resume, or adapt their academic or vocational activities successfully, using the IPS (individual placement and support) model.
- Therapist or Recovery Coach, 0.5 to 1.0 FTE
  - An experienced master's level clinician who will help clients clarify goals, cope with stressful situations, interact more effectively with other people, and, in general, overcome barriers to their recovery.
- Outreach and Referral Specialist, 0.5 FTE (not on all CSC teams)
  - The designated individual(s) should be a master's level clinician (or possess a higher clinical degree) and the ability to identify primary psychosis and perform differential diagnoses for symptom profiles related to psychosis.
- Peer Specialist, 0.5 FTE
  - Peer specialists engage participants in services throughout treatment, to ensure that they have the information and resources they need to drive their treatment and to have an empowered voice in the treatment and planning process. Ideally, the peer specialist will be a young adult; however, any age will be considered for the position, as long as the individual understands youth culture and the ability to engage with young people as a peer. The peer specialist will also act as a cultural bridge between the language of the system and the participant and family, assisting them in navigating resources and in identifying needs and engaging with natural supports.
- Psychiatrist or Advanced Registered Nurse Practitioner (ARNP), 0.2 FTE

- Responsible for diagnosis, medical care needs, medication management, and acute management of suicidality and safety concerns. Medication management will be guided by a medication algorithm that provides information about evolving best practices. A shared decision-making framework will be used.

What costs are associated with delivering this practice?

Costs and financing for FEP services vary by locality and insurance source. In 2014, Congress appropriated funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the needs of individuals experiencing FEP. SAMHSA directed states to use 5% set aside from their Mental Health Block Grant (MHBG) to serve individuals experiencing FEP. In 2015, the set aside was increased to 10%. States also have the option to spend 20% of their MHBG funds on CSC-FEP by the end of two fiscal years in lieu of spending 10% each year.

These federal funds may be considered seed money to help begin CSC-FEP programs, while alternative or additional funds are essential to sustain the program over time. In some states, FEP services may be state supported via Medicaid waivers or other categorical funding. Overall, funding remains a challenge because key components of CSC-FEP services (e.g., peer support, supported employment education) are not typically covered by commercial health insurance or Medicaid plans. As a result, many states are actively working to develop a bundled Medicaid rate, with some states also exploring a similar rate through commercial insurance.

Research has shown that relative to other specialty medical services, the costs associated with CSC-FEP programs are modest. The annual cost difference between CSC-FEP and traditional programming is about approximately $3,674/year; this annual figure includes workforce development training costs (Rosenheck et al., 2016).

RAISE researchers have developed a publicly available decision support tool to determine the number of CSC teams needed to provide services in a given region, as well as the approximate cost of providing services (Humensky et al., 2013). The tool accounts for several variables, such as estimated incidence of FEP for a given catchment area, the percentage of eligible individuals who will actually enroll in the program, and the average duration of time an individual with FEP will receive services. The tool can help states select the CSC program configurations that best match local circumstances.

Learn more about the tool here:
https://pdfs.semanticscholar.org/6b4f/fe455508b8340f170ff3116077cee5564fb9.pdf

What costs and commitments are associated with becoming trained in this practice?

What is the cost associated with becoming trained?

Training costs for CSC-FEP vary widely, depending on the model implemented (e.g., NAVIGATE, OnTrack New York) and the training entity involved in training, and whether consultation and fidelity review are also part of the implementation support model. It is recommended that local trainers be enlisted in training and implementation support over time. If no local trainers exist, it is recommended that investments be made in train-the-trainer models that support local implementation and sustainability of these programs over time.

What is the time commitment associated with completing training?

The training time for each team member of the CSC team will depend on their role. Please see the section above, "What specific training or certification is required to implement the program." Generally, most team members should attend one to two days of CSC startup training that includes training related to CSC core competencies as well as team-based care. This is typically followed by one to two days of role- or intervention-specific training focused on skills training. Training should then be followed by at least monthly consultation and internal (agency-based) weekly supervision for all team members.

Are there recognized providers of training in this practice?

First episode specialty teams are composed of a group of professionals who have different but overlapping roles. CSC team members should be selected on the basis of credentials, clinical experience, affinity for recovery-oriented care, and respect for clients' independence and self-determination.

Seasoned clinicians are the preferred candidates for CSC roles, with emphasis on those clinicians who embrace the challenges of working with adolescents and young adults experiencing psychosis, are flexible regarding intervention approaches to engage clients and family members, and can tolerate uncertainty regarding clients' preferred recovery strategies.

Peers and those with lived experience have also been shown to be important resources for these programs given their ability to engage and support young people struggling with a psychotic disorder (Stavely et al., 2013).

Does the practice have an associated fidelity assessment?

Fidelity and outcome measures allow program planners and administrators to answer key questions around CSC program implementation such as:

- Are CSC team members implementing interventions as intended?
- Are providers delivering what was promised in the service contract?
- Have CSC services achieved desired clinical and functional outcomes for clients with FEP?

Given the different models of CSC, no one fidelity tool currently exists. There are currently steps being taken at a national level to solidify one program-level fidelity tool, but this will take some time to select and implement. Currently, one common program-level fidelity tool is the First Episode Psychosis Services Fidelity Scale-Revised (FEPS-FS-R; Addington, Noel, Landers, & Bond, 2020). There are also several intervention- or service-level fidelity scales that measure clinician practice (e.g., NAVIGATE Supported Employment and Education Fidelity Scale; Lynde, Gingerich, McGurk, & Mueser, 2020).

Absent a fidelity tool, some clinics or hospitals with CSC teams will document service contacts and clinical data via an electronic health record (EHR), allowing fidelity and outcome information to be obtained from electronic claims data or other automated reports. In the absence of an EHR, routine service logs may be used to inform many fidelity measures so long as they note the client and staff member involved, whether family members were present, and the location of the service (i.e., office versus community).

What resources or references are useful for understanding/implementing the practice?

New hires, or creative partnerships between agencies, may be necessary to acquire needed expertise, such as clinicians with supported employment and supported education skills. In addition, organizational restructuring, staff training, and ongoing consultation with FEP experts may be necessary to repurpose existing services and providers into an integrated, team-based CSC treatment program. Administrative changes may be needed to facilitate the integrated delivery of services, like protecting staff members' time for team meetings and providing ongoing supervision to assure fidelity to CSC principles. Finally, a variety of community outreach activities are necessary to stimulate and maintain referral pathways to the CSC program.

Where should you go for more information?

Information from this document was pulled from the following resources:

- Evidence-based treatments for first episode psychosis: Components of coordinated specialty care

- Bennett, M., Piscitelli, S., Goldman, H., Essock, S., & Dixon, L. *Coordinated specialty care for first episode psychosis: Manual II: Implementation*. National Institute of Mental Health.

- SMI Adviser Article: What components of coordinated specialty care (CSC) programs make this approach especially useful as a treatment for first episode psychosis (FEP)?

- Humensky, J. & Essock, D. S. (2013). State mental health policy: An interactive tool to estimate cost and resources for a first-episode psychosis initiative in New York state. *Psychiatric Services, 64*(9), 832-834. doi:10.1176/appi.ps.201300186

- Example CSC program in New York City.

- Search for Coordinated Specialty Care in:
  - MHTTC Training and Events Calendar: https://mhttcnetwork.org/centers/global-mhttc/training-and-events-calendar
  - MHTTC Product & Resources Catalog: https://mhttcnetwork.org/centers/global-mhttc/products-resources-catalog

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Lynde, D. W., Gingerich, S., McGurk, S. R., & Mueser, K. T. (2020) *NAVIGATE Supported Employment and Education (SEE) Manual*. Dartmouth Psychiatric Research Center.

Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P., & Croudace, T. (2005). Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: A systematic review. *Archives of General Psychiatry*. *62*(9), 975–983. doi:10.1001/archpsyc.62.9.975

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RAISE Early Treatment Program. *Schizophrenia Bulletin, 42*(4), 896-906. doi:10.1093/schbul/sbv224

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This Fact Sheet was created by:

Information from this document was sourced from the listed resources above. This document was compiled by **Amanda Lipp** from the Pacific Southwest MHTTC, Center for Applied Research Solutions (CARS) with contributions from Oladunni Oluwoye, PhD, Washington State University and Washington State University Center of Excellence in Early Psychosis and Maria Monroe-Devita, PhD, Washington State University Center of Excellence in Early Psychosis and the Northwest MHTTC at University of Washington.

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