Early Assessment and Support Alliance (EASA) Practice Guidelines and Fidelity Assessment Tool (2026)

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The EASA Practice Guidelines and Fidelity Assessment Tool (2026) format was developed collaboratively by the EASA Center for Excellence and the Human Services Implementation Lab at Portland State University. *For more information and/or a no-cost electronic copy of the full instrument, visit www.easacommunity.org or https://hsimplementationlab.org/*.

Recommended Citation: Sage, M., Cellarius, K., Simmons, A. (2026) Early Assessment and Support Alliance (EASA) Practice Guidelines and Fidelity Assessment Tool. Portland, OR: EASA Center for Excellence

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EASA Center for Excellence (C4E)

With support from Oregon Health & Science University (OHSU), Portland State University (PSU), and the Oregon Health Authority (OHA), the EASA Center for Excellence (C4E) at the OHSU-PSU School of Public Health is an internationally recognized training, consultation, technical assistance, and research organization for early psychosis intervention programs statewide in Oregon, as well as across the United States. The EASA Center for Excellence and EASA programs were designed to facilitate the evolution of mental health systems into systems that empower and center the voices of individuals and their family members and supports, integrating proactive, resiliency-based person-centered approaches[1]. The EASA Center for Excellence is a transdisciplinary team of individuals from diverse disciplines and personal and professional backgrounds, knowledge, and experience in the early psychosis intervention field. The EASA Center for Excellence envisions a society—from the largest systems of care to individuals' unique support networks—that values the lived experience and perspectives of every person, and is able to mobilize quickly and effectively to meet the needs of individuals who are experiencing symptoms of psychosis or who are at-risk for developing psychosis. The EASA Center for Excellence centers the voices, perspectives, knowledge, and experiences of early psychosis intervention participants and graduates, their family members and supports. We honor each unique contribution that continues to inform improvements in early psychosis intervention care in communities across the United States.

The EASA Center for Excellence and EASA programs seek to center quality and practice improvement for diverse community groups through data collection rather than aspiring to a model that centers mental health care outcomes that align with Western medical model values and outcome measures. The EASA Center for Excellence is actively working to integrate OHA's Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation or Gender Identity (SOGI) standards[2], national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare[3], and utilization of qualitative and quantitative data to increase accountability with and to continue to improve care in the communities served by early psychosis intervention programs in Oregon and nationally. Assessing program successes and areas for growth across categories will rely on a decolonized understanding of data and the gathering, interpretation, and application of understanding that data[4]. This involves disaggregating data across intersectional categories and using methods that honor storytelling, narratives, and other forms of sharing experience and knowledge across diverse community members and groups.

Introduction

The Oregon Health Authority has prioritized the implementation of evidence-based best practices in early psychosis intervention for schizophrenia spectrum disorders and bipolar disorder with psychosis in the state of Oregon since the beginning of statewide expansion in 2008[5]. Oregon was the first state in the United States to implement early psychosis intervention care in community mental health settings in 2001. Oregon's model of care was based on Australian early psychosis intervention guidelines and evolved over time to integrate a combination of evidence-based practices disseminated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and international early psychosis intervention practice guidelines[6] [7]. Statewide expansion of early psychosis intervention programming in Oregon began in 2008 and included individuals identified as being at risk for developing psychosis using structured assessment tools[8]. Statewide expansion was funded by the Oregon legislature as a result of state level advocacy by EASA participants and graduates and their family members and supports. EASA is a systematic effort to provide holistic, proactive, developmentally informed, strengths-based transdisciplinary care for individuals at risk for developing psychosis and individuals who are experiencing or who have experienced a first episode of psychosis in the past year[9].

Early psychosis intervention care is designed to reduce the duration of untreated psychosis (DUP) in youth and young adults experiencing their first episode of psychosis. Reducing DUP by identifying individuals with signs of psychosis as early as possible leads to significant improvements in clinical and functional outcomes[10]. Early identification and treatment of individuals experiencing a first episode of psychosis has been shown to prevent high acuity, reduce suicidality[11], improve clinical and functional outcomes, and support them in staying on their typical life paths[12]. Coordinated Specialty Care, or CSC, is recognized in the United States as the standard of care for individuals experiencing their first episode of psychosis[13]. CSC includes several key components: individual and family therapy, case management, supported employment and education, medication management, and family psychoeducation and support[14]. The EASA model includes key CSC components and integrates peer support, Occupational Therapy, elements of Assertive Community Treatment (ACT) guided by McFarlane's Family-Aided ACT model, structured family psychoeducation based on the Anderson-McFarlane model, Cognitive Behavioral Therapy (CBT) for psychosis, Motivational Interviewing and harm reduction approaches, emerging practices, practice-based evidence, and lived experience literature[15]. The EASA practice guidelines were revised in 2008 for statewide dissemination, and two sections were added, one on systemic infrastructure and one on transition planning. An updated version of the EASA practice guidelines that included a section on participatory decision making and new language related to cultural competency was published in 2013[16]. Versions of the 2013 EASA Practice Guidelines have been adapted and implemented by early psychosis intervention programs across the United States.

The EASA Practice Guidelines and Fidelity Assessment Tool (2026) are an updated iteration of Oregon's early psychosis intervention model. They are designed to guide community mental health organizations and their early psychosis intervention teams in designing approaches and interventions in ways that fit the developmental, cultural and spiritual identities of individuals, their family members, and support systems. They center individual, family, and community cultural and spiritual identities, healing rituals, beliefs, values, and practices as integrated, core elements of healing and resiliency in early psychosis intervention care. They are intended to be utilized as a guiding framework for systemic change, service implementation, and ongoing quality and practice improvements to care and are designed to inform organizational and program development, training, consultation, fidelity reviews, and therapeutic healing approaches and practices. They are a culmination of national and international research, input and feedback from early psychosis intervention participants, graduates, family members and support systems, early psychosis intervention team members, supervisors, and leaders in community mental health throughout Oregon and nationally.

Culturally Responsive, Trauma-Informed Early Psychosis Intervention Care

Integration of cultural, racial, ethnic, and spiritual identities of individuals, their family, and their supports is critical in early psychosis intervention care[17]. Research examining social determinants of health highlights a pattern of racial disparities in risk factors for psychosis, pathways to care, access to care and lack of appropriate treatment resources that meet the cultural needs of populations served[18]. Refugees, asylees, and immigrant populations are shown to be at higher risk for developing psychosis and racial/ethnic discrimination is associated with the prevalence of experiences and symptoms of psychosis[19]. Mental health is defined as a social construct based on belief systems about illness[20]. Cultural beliefs and values impact what is defined as a problem, the understanding of the problem, and which solutions are considered desirable[21]. However, CSC programs in the United States have not established clear guidelines for tailoring engagement and treatment based on culturally rooted perspectives, values, and beliefs with diverse populations[22]. One clear example of this is the absence of deliberate, systematic integration of culturally responsive engagement, assessment, and treatment with respect to implementation and provision of early psychosis intervention services in Tribal communities in Oregon or nationally. This is despite research demonstrating that approximately 70% of American Indian/Alaska Natives in the United States utilize traditional healers and/or traditional healing practices in their care[23].

Historical and structural racism have ongoing impacts on communities of color, including mental health disparities, poverty, and housing discrimination[24]. SAMHSA recommends that all behavioral healthcare settings implement trauma-informed approaches into care, outlining six principles of a trauma-informed approach: (1) safety, (2) trustworthiness & transparency, (3) peer support, (4)collaboration & mutuality, (5) empowerment, voice, & choice, and (6) cultural, historical & gender issues[25]. Attending to trauma induced by systemic oppression, colonization, present-day, historical, and transgenerational harm is integral to healing and recovery[26]. The necessity of addressing racial trauma, a form of race-based stress, has been recognized as a critical aspect of holistic, culturally responsive mental health care[27]. A recent study examining rates of Post-traumatic Stress Disorder (PTSD) in individuals experiencing a first episode of psychosis found that approximately 80% of participants reported at least one traumatic event in their lifetime[28]. The study noted a significant correlation between a diagnosis of PTSD, more severe depression, stigma, and DUP[29]. Research demonstrates that individuals who experience trauma are at increased level of vulnerability for developing symptoms of psychosis, symptom severity, and prevalence[30]. Trauma has been found to significantly impact conversion to psychosis among individuals identified as at risk for developing psychosis[31]. A current gap exists in early psychosis intervention programming related to consistent and deliberate integration of trauma informed care and trauma specific interventions[32].

Early psychosis intervention care plays an essential role in supporting individuals in building and fortifying healthy connections to self and community as they form their identities, make meaning of their experiences, and navigate the challenges and opportunities of becoming interdependent as well as the realities of stigma and discrimination[33]. Mental health research and treatment have primarily focused on removing pathologies and has not deliberately recognized or supported individual/family/community relationships to cultural, racial, ethnic and spiritual identities as essential aspects in healing and recovery[34]. However, research has shown promising results related to the relationship between religion, spirituality and mental health in holistic, person-centered care for individuals with mental health disorders[35]. Research specific to individuals diagnosed with psychosis, schizophrenia spectrum disorders, and bipolar disorder has shown that integration of spirituality and religion into care help facilitate culturally relevant coping skills and healing[36].

Early psychosis intervention programs are tasked with providing care that values individuals as those who negotiate and make sense of mental health challenges and as unique contributors, community members, leaders, and knowledge carriers who bring forward their history and present-day experiences offering guidance and hope for the future. The systemic nature of building, designing, and sustaining empowering mental health treatment involves the entire community of care through the utilization of trauma-informed approaches with staff, participants, graduates, family members, and their supports.

EASA Fidelity Assessment Scale Snapshot

Fidelity Assessment Scale:

1=Organization has **not yet demonstrated awareness** for the need for this component
2=Organization has **demonstrated awareness**, but work on this component has not yet begun
3=Organization is **actively working to implement** component
4=Component is **in place**, but it is not yet sustainable or monitored
5= Component is **sustainably in place and monitored** for continuous quality and practice improvement

EASA Domains & Program Components	Score	EASA Domains & Program Components	Score
DOMAIN #1: SYSTEMIC INFRASTRUCTURE & PROGRAM DEVELOPMENT		**DOMAIN #4: CORE PRACTICES (continued)**	
1.1 Population Served		**4.6 Community-Based Services**	
1.2 Transdisciplinary Team Approach		**4.7 Engagement & Retention**	
1.3 Staffing to Ensure Adequate Frequency & Intensity of Service		**4.8 Comprehensive Assessment Process**	
1.4 Low Participant to Staff Ratio		**4.9 Treatment Planning**	
1.5 Service Accessibility		**4.10 Evidence-Based Practices**	
1.6 Program Sustainability		**4.11 Integrated Treatment for Co-Occurring Disorders (COD)**	
1.7 Collaboration & Power Sharing		**4.12 Maintaining Engagement during Psychiatric Hospitalizations**	
1.8 Quality & Practice Improvement		**4.13 Transfer of Care Due to Staff Changes**	
DOMAIN #2: COMMUNITY EDUCATION & OUTREACH		**4.14 Transition Planning**	
2.1 Program Visibility		**DOMAIN #5: TRANSDISCIPLINARY TEAM ROLES**	
2.2 Community Education & Outreach to Promote Early Identification		**5.1 Team Lead/Supervisor**	
2.3 Targeted Messaging		**5.2 Case Manager**	
2.4 Outreach & Education with Staff in Educational Settings		**5.3 Clinician**	
2.5 Outreach & Education with Primary Care and Medical Providers		**5.4 Peer Support Specialist**	
DOMAIN #3: FAMILY & SUPPORT SYSTEM ENGAGEMENT & PSYCHOEDUCATION		**5.5 Occupational Therapist**	
3.1 Orientation to Care		**5.6 Psychiatric Care Provider**	
3.2 Trauma-Informed, Culturally Responsive Care		**5.7 Nurse**	
3.3 Family & Support System Engagement & Partnership		**5.8 Supported Education Specialist**	
3.4 Structured Family Psychoeducation (FPE)		**5.9 Supported Employment Specialist**	
DOMAIN #4: CORE PRACTICES		**DOMAIN #6: STAFF TRAINING AND SUPPORT**	
4.1 Rapid Access		**6.1 Inclusive Hiring & Onboarding Process**	
4.2 Screening		**6.2 Early Psychosis Intervention Orientation**	
4.3 Crisis Response		**6.3 Early Psychosis Intervention Training and Consultation**	
4.4 Enrollment		**6.4 Ongoing Education & Support**	
4.5 Weekly Team Meeting		**6.5 Trauma Informed Workforce Wellness**	
		OVERALL AVERAGE SCORE	

DOMAIN #1: SYSTEMIC INFRASTRUCTURE & PROGRAM DEVELOPMENT

Effective early psychosis intervention care requires significant, ongoing commitment to systemic program development and practice and quality improvement to support wellness and positive functional and clinical outcomes among individuals who are showing early symptoms consistent with clinical high risk for psychosis or first episode psychosis[37]. Early psychosis intervention services are provided by a team of highly qualified and trained professionals that provide and expand upon the full range of specialized Coordinated Specialty Care (CSC) core service components[38]. Early psychosis intervention programs utilize a transdisciplinary approach with an adequate level of service intensity to respond flexibly and proactively to the acute and non-acute needs of participants as well as the range of services they need. Rural, urban and frontier catchment areas/counties are defined according to state and federal definitions[39] [40] [41]Early psychosis intervention staffing is based on assertive community treatment standards. A recent UK study noted the increased effectiveness of smaller care coordinator caseloads in improving secondary outcomes and reducing rates of relapse in individuals receiving early psychosis intervention care[42] [43]Reduced caseload sizes are especially important for newer or more acute situations. The importance of small caseloads and coordinated, transdisciplinary team care is highlighted in the literature on successful implementation of early psychosis intervention care[44]. A systematic review of early psychosis intervention programming emphasized the role of funding and organizational structure factors, in addition to service and staff factors, that impact successful implementation of early psychosis intervention care[45].

1.1 Population Served	Rating	1	2	3	4	5
The early psychosis intervention program serves youth and young adults, age 12-30; who meet criteria for clinical high risk for psychosis, schizophrenia spectrum disorder or bipolar disorder with psychosis; whose symptoms (1) developed or were diagnosed within the past 12 months and (2) symptoms are not known to be caused by substance use*, trauma, major depression or another medical condition. Individuals brought in under Clinical High Risk for psychosis meet criteria for one of the three progressive Psychosis Risk Syndromes based on Structured Clinical Interview for Psychosis Risk Syndrome (SIPS) assessment completed by a trained and certified SIPS interviewer. The program may accept individuals into the program who have been experiencing symptoms of psychosis for longer than 12 months based on clinical fit and program capacity on a case-by-case basis. In addition, the program may accept individuals for whom diagnosis is unclear in order to address their needs and ensure rapid access to care without delays. *Current research demonstrates that cannabis use in certain individuals can increase the risk of them developing a primary thought disorder. Teams are encouraged to bring individuals whose diagnostic presentation is unclear into the program for further assessment while also providing treatment and to consult with their supervisor and EASA C4E staff for assistance with differential diagnosis.		Team is unaware of specific eligibility criteria.	Team is aware of eligibility criteria but does not follow it.	Team follows the eligibility criteria; however, program does not accept individuals for whom diagnosis is unclear.	Program meets population need based on incidence rate of schizophrenia spectrum disorders for youth and young adults per local data and census[46] [47] .The incidence rate of schizophrenia is estimated to be approximately 16 per 100,000 per year[48].	All of the above, plus, team reviews enrollments regularly for continued appropriateness and to ensure that all eligible youth in the catchment area are being identified.

1.2. Transdisciplinary Team Approach	Rating	1	2	3	4	5
All team roles and tasks are fully integrated into individualized transdisciplinary care including counseling, case management, family support, peer support, licensed medical provider, occupational therapy, nursing, substance use, supported employment, supported education, and supervision.		Team is unaware of the need for transdisciplinary staffing nor for working collaboratively across disciplines.	Team is aware of the need but does not prioritize transdisciplinary staffing or collaboration.	Team roles and tasks are integrated, but two or more of the roles have been absent for three months or more and no other team member(s) have taken on those tasks within their scope of practice.	Team uses informal & formal feedback informed techniques w/ participants, family members, & support system. If a role is not represented on the team, other team member(s) are supported with training, consultation and supervision to take on those tasks within their scope of practice.	All of the above plus team roles are fully staffed. Functional and clinical outcomes are routinely tracked.

1.3. Staffing to Ensure Adequate Frequency & Intensity of Service	Rating	1	2	3	4	5
All team members in early psychosis intervention programs in counties/catchment areas designated as urban utilizing state and federal definitions are assigned at least 0.5 dedicated FTE to the program with the exception of nursing and psychiatric care provider positions. Full- time FTE is preferable. All team members in counties designated as rural or frontier utilizing state and federal definitions are assigned at least 0.3 dedicated FTE to the program with the exception of nursing and psychiatric care positions, with at least 0.5 FTE being preferable. Team members cannot be assigned to work in more than 2 programs including the early psychosis intervention program. Full-time (1.0 FTE) QMHPs who also provide care coordination have a maximum of 20 participants including their caseload outside of the early psychosis intervention program. Job descriptions for all positions are specific to the early intervention program with dedicated FTE.		Agency is unaware of the amount of staffing needed to ensure adequate frequency & intensity of service.	Agency is aware of the amount of staffing needed but has not strategized how to fully staff the team.	Agency is working to fully staff the team; however, some positions lack adequate FTE &/or are assigned to work in more than 2 programs including the early psychosis intervention program. Job descriptions for some of the team positions are specific to early intervention with designated FTE.	Team is fully staffed with the designated adequate FTE & are assigned to work in no more than 2 programs. Full-time QMHPs that also provide care coordination have a maximum of 20 participants including their caseload outside of the early psychosis intervention program.	All of the above, plus job descriptions for all positions are specific to the early intervention program with dedicated FTE. There is a plan to backfill vacancies with other agency staff until there is a permanent replacement for that position.

1.4. Low Participant to Staff Ratio	Rating	1	2	3	4	5
The team maintains a low participant to staff ratio not to exceed 10 participants per 1.0 FTE across the transdisciplinary team as defined in 1.2 Transdisciplinary Team Approach, which includes all direct service staff except for the psychiatric care provider and nursing roles. This ratio does not include other administrative staff such as the program assistant or other managers assigned to provide administrative oversight to the team except in cases where they also provide direct services (such as completing screenings, carrying a caseload and/or covering caseloads if staff are on leave or clinical positions are open, co-facilitating groups, etc.). Staffing accounts for blended roles. Program must have minimum 0.75 total dedicated FTE across team roles excluding psychiatric care provider and nursing roles.		Agency is unaware of the need to maintain a low participant to staff ratio.	Agency is aware of the need to maintain a low participant to staff ratio, but does not track it as defined &/or does not work to achieve it. Program has 0.39 total dedicated FTE or less across team roles excluding psychiatric care provider and nursing roles.	Agency is working to maintain a low participant to staff ratio, but the ratio continues to exceed the recommended 10 participants per 1.0 FTE. Program has 0.40-.59 total dedicated FTE across team roles excluding psychiatric care provider and nursing roles.	Team is fully staffed with the designated adequate FTE & are assigned to work in no more than 2 programs. Program has 0.60-.74 total dedicated FTE across team roles excluding psychiatric care provider and nursing roles.	All of the above, plus program has 0.75 total dedicated FTE or more across team roles excluding psychiatric care provider and nursing roles.

1.5 Service Accessibility	Rating	1	2	3	4	5
Agency standard procedures (front desk practices, scheduling, intake and enrollment procedures, treatment expectations, discharge timeline) have been evaluated and modified as needed to align with best practices and meet individualized needs of participants and their family members and support system. Agency standard forms (mental health or behavioral health assessment, risk assessment, treatment plans, wellness plans, etc.) have been evaluated and modified as needed to align with early psychosis intervention best practices. Early intervention services are offered to all participants who meet eligibility criteria regardless of insurance or ability to pay. Agency policy and fiscal agreement practices are modified to ensure access to services, including offering sliding fee scales and waiving co-pays and/or co-insurance.		Team is unaware of the need to evaluate and modify policies, procedures, or forms to align with best practices and meet individualized needs of participants, family members and/or support system.	Team is aware of the need but has not yet begun a review of their policies, procedures, or forms and does not offer early intervention services to all participants regardless of insurance or ability to pay.	A review has begun and/or some revisions have been made, but the process is not yet complete.	A review has been completed and revisions have been made, but there is no plan to gather feedback on those revisions. Program offers early intervention services to all participants regardless of insurance or ability to pay.	All of the above, plus all relevant policies, procedures, and forms have been reviewed and modified to ensure access to services, including offering sliding fee scales and waiving co-pays and/or co-insurance. A plan for soliciting feedback on agency standard procedures and practices at least once/quarter is in place and changes are made as a result of that feedback.

1.6 Program Sustainability	Rating	1	2	3	4	5
The program is sustained through diversified funding sources, including acceptance and full utilization of private and public insurance. Grant and supplemental funding are only utilized for non-billable services, such as community education & outreach and service elements not covered by insurance. Agency leadership, state staff, and EASA Center for Excellence leadership collaborate to address gaps in service and support teams in maximizing billing for all covered services.		The program is unaware of the need to diversify funding sources or optimize billing for all covered services.	The program is aware of the need to diversify and maximize funding sources, however, it has not yet done so.	The program is working toward diversifying funding, sources, but more work is needed. If one or more funding sources are lost, the program will need to cut staffing and/or might not continue.	The program is sustained through diversified funding sources, but more work could be done to maximize billing.	All of the above, plus agency leadership, state staff, and EASA C4E leadership collaborate to address gaps in funding and support teams in maximizing billing.

1.7 Collaboration & Power Sharing	Rating	1	2	3	4	5
Current and former participants, family members and supports are seen as partners and are invited and encouraged to provide formal and informal feedback on program as well as to join hiring panels, agency committees, boards, advocacy groups, and activities that inform and shape agency policies, practices, and procedures. Participants are compensated for their time and contributions. Barriers to participate are addressed by team and agency leadership.		The program is unaware of the need to involve participants, family members, and supports in all areas of programming, engagement, services planning, and quality and practice improvement.	The program is aware of the need to involve participants, family members, and supports in all program areas, but has not yet done so.	Participants, family members, and supports are involved in some, but not all areas of program planning, implementation & improvement, including program visibility & accessibility, pathways to care; physical space, hiring & staffing decisions, community education & outreach, material development, program activities & groups.	Participants, family members, and supports are involved in <u>all</u> identified areas of program planning, implementation & improvement, but feedback is not always sought and barriers to participation are not addressed.	All of the above plus individuals are recognized and compensated for their time & contributions by the program or agency. Individuals with lived experience in EASA serve on agency advisory committees or boards, hiring panels, agency board of directors, and/or quality improvement committees. Participants, family members, and supports are encouraged to join state-level advocacy groups & committees. Feedback is solicited at least once/quarter through focus groups and/or surveys . Barriers to participation are addressed by team and agency leadership.

Metrics*: Types of individuals involved in program planning & implementation*: ☐Participants, ☐Graduates, ☐Family Members, ☐Supports, ☐None
Areas with participant, family members, and support involvement in planning & implementation: ☐program visibility & accessibility, ☐pathways to care; ☐physical space, ☐hiring & staffing decisions, ☐community education & outreach, ☐material development, ☐program activities & groups, ☐None
Document examples:

1.8 Quality & Practice Improvement	Rating	1	2	3	4	5
Agency leadership, supervisors, & program staff collaborate to create and implement an active Quality and Practice Improvement (QPI) plan with goals and strategies that integrate clear measurable objectives related to the program.		The program is unaware of the need to create and implement an active Quality and Practice Improvement (QPI) plan.	The program is aware of the need for a QPI plan, but development has not yet begun.	A QPI plan has been developed and approved by leadership, but all components are not yet in place and/or it is not being implemented as written. Participants, family members, supports, & early psychosis intervention team members provide feedback on some, but not all program areas including program visibility & accessibility, pathways to care; physical space, hiring & staffing decisions, community education & outreach, material development, & program activities & groups.	Program participates in fidelity reviews at minimum every 2 years. The QPI plan integrates the site's most recent fidelity review report and recommendations, integration of program data, and feedback and recommendations from participants, family members, and supports. The QPI plan includes decision-making, evaluation, and follow-through to ensure plan objectives are met. Participants, family members, supports and program staff are involved in evaluating all identified areas.	All of the above and QPI plan is reviewed at least quarterly by agency leadership and team, and actions are taken as a result of each review. State staff & EASA Center for Excellence team collaborate with agency leadership to address system-level barriers & advocate for improvement.

DOMAIN #2: COMMUNITY EDUCATION & OUTREACH

Reducing the duration of untreated psychosis requires a population-based public health approach to increase mental health literacy among communities[49]. Community education and outreach in early psychosis intervention is a proactive, ongoing structured effort designed to increase knowledge and awareness about early signs and symptoms of psychosis, communicate program eligibility criteria, and ensure community members know how to refer individuals to the program. Early identification and treatment in early psychosis intervention have been shown to improve primary and secondary outcomes, prevent crisis system involvement and reduce hospitalizations, improve symptoms, and significantly reduce suicide risk[50]. Community members play key roles in recognizing early signs and facilitating timely referrals. Community education and outreach facilitate early identification and rapid access to care while strengthening community partnerships and addressing stigma. It is critical that agency leadership and local teams understand the individuals, groups, and cultures, and values represented in each community they present to and engage with; the types of experiences (positive and negative) that they have had; informal and formal leaders in each community; and an understanding of how the different individuals, groups, and cultures view psychosis and psychosis-related conditions. Community members (for example, school staff, cultural brokers, and primary care physicians) are key in identifying and referring youth who may meet criteria for early intervention as early as possible in order to reduce the duration of untreated psychosis.

2.1. Program Visibility	**Rating**	**1**	**2**	**3**	**4**	**5**
The program has a clear, separate identity within their community mental health agency or county that includes (1) signage inside & outside the building with program name and EASA statewide logo, (2) brochures in the lobby, (3) a presence on the agency website that describes the program, its eligibility criteria, the referral process, and a link to the statewide website, and (4) a social media presence.		The program is unaware that it may be hard to find the program due to a lack of visibility within the agency.	The program is aware that it lacks visibility within the agency and may be hard to find, however, work on creating presence has not yet begun or is stalled.	The program is actively working on creating a presence, but components are either missing or inadequate (no dedicated referral line, signage is not prominent, etc.)	All four components of a visible EASA program are in place, however, reviewing and updating the materials occurs at a frequency less than quarterly.	All four components are in place and pathway to care information is gathered at screening. Community education and outreach (CEO) strategic plan is updated quarterly to reflect pathway to care information for targeted outreach.

2.2 Community Education & Outreach Strategic Plan to Promote Early Identification	Rating	1	2	3	4	5
The Community Education and Outreach (CEO) Strategic Plan focuses on building and maintaining collaborative relationships with a diverse range of community leaders, members, and partners. It includes: (a) targeted outreach that integrates pathway to care data and (b) specific audiences for outreach, goals for the outreach specific to each audience, who the team will reach out to, which team member will reach out and when, and methods for tracking and refining plan and (c) The plan targets the following audiences, prioritizing groups and catchment areas that have not been referring to the program, or where relationships need further relationship building and development: (1) internal agency staff, (2) crisis response, (3) hospitals and emergency departments, (4) educational systems (middle schools, high schools, GED programs, universities, trade schools, community colleges), (5) youth & young adults ages 12-30, (6) families, support systems, & social supports, (7) primary care providers, (8) entities representing underrepresented or marginalized populations, spiritual/religious communities, and smaller communities within the catchment area. (d) Frequency of contact based on geography, establishing referent relationship with smaller communities and community members and groups that historically do and do not have these relationships with MH agency.		The program is unaware of the need to create and implement a Community Education and Outreach (CEO) Strategic Plan to promote early identification & engagement.	The program is aware of the need for CEO strategic plan but develop-ment has not yet begun.	A CEO strategic plan has been developed in collaboration with agency leadership, but all components are not yet in place and/or it is not being implemented as written. Some, but not all audiences, prioritizing groups and catchment areas that have not been referring to the program, or where relationships need further relationship building and development are included.	The CEO strategic plan addresses all audiences, prioritizing groups and catchment areas and integrates pathway to care data. One assigned person coordinates the activities across the full team. All team members are involved in community education and outreach events and activities, which occur at least 3x/month or 12x/quarter across the team. Specific outreach goals for each audience include who the team will reach out to, which team member will reach out and when.	All of the above, plus the plan is tracked and regularly refined. CEO activities are routinely included in supervisory discussions to ensure they are not overshadowed by clinical demands. Plan is reviewed by full team & supervisor at least quarterly & includes feedback from participants, family members, and supports & staff from target communities. State staff, agency leadership, & EASA C4E team collaborate to address system-level barriers to implementation of CEO Strategic Plan & advocate for improvement.

2.3 Targeted Messaging	Rating	1	2	3	4	5
Outreach activities and events include tailored messaging and lived experience examples aimed at increasing awareness, skill level and referrals from the target audience. All CEO messaging includes (1) accurate information from current research and practice about early signs and symptoms of psychosis and clinical high risk, (2) positive, hopeful focus on resilience & likelihood of positive outcomes, (3) Information that challenges misconceptions and reduces public and self-stigma, (4) core program elements and referral processes. Participants, family members, and supports are involved in helping design messaging for target audiences and are compensated for their time.		The program is unaware of what to include in targeted messaging to individuals and community groups.	The program is aware of what to include in targeted messaging, but materials have not been developed, and staff have not been trained.	Materials with targeted messages have been developed and some, but not all staff have been trained -or- staff have been trained but are not yet experienced or comfortable with providing the messaging.	All staff are trained and comfortable providing tailored messaging and materials to specific audiences. Specific target audiences have been assigned to staff based on their expertise and experience with the population-specific messaging.	All of the above, plus outreach efforts and changes in referral counts by group are tracked. Feedback on messaging is collected from target audiences, and messaging and materials are modified as needed. Participants, family members, and supports are involved in designing messaging for target audiences and are compensated for their time.

2.4 Outreach & Education with Staff in Educational Settings	Rating	1	2	3	4	5
The team has relationships with various staff across local educational settings (middle schools, high schools, GED programs, universities, trade schools, community colleges) that include: (1) community education and outreach events and activities that provide information about signs and symptoms of psychosis, eligibility criteria, how to refer, and positive, hopeful messaging, (2) rapid access for all referrals, and (3) consultation and collaboration with school staff during screening and for enrolled participants.		The team is unaware of the need to have relationships with staff across multiple types of educational settings in their catchment area.	The team is aware of the need but has not yet included outreach to staff in educational settings in their CEO strategic plan and does not have regular contact with more than 1-2 educational settings in their catchment area.	Educational settings are included in the team's CEO strategic plan, and the team has begun making contact, however there are still multiple schools/educational settings with which they have not made contact.	The team has relationships with multiple local educational settings; however, some participants are not supported due to inconsistent communication and/ or relationships. If school staff leave, relationships may be lost.	Program is visible and known by the majority of school settings in the catchment area. The team collaborates proactively with schools and educational settings that participants attend. There is a plan in place to maintain relationships even if a key school staff person leaves.

2.5 Outreach & Education with Primary Care & Medical Providers	Rating	1	2	3	4	5
The team has relationships with primary care providers and medical providers across local medical settings that include: (1) community education and outreach events and activities that provide information about signs and symptoms of psychosis, eligibility criteria, how to refer, and positive, hopeful messaging, (2) rapid access for all referrals, and (3) consultation and collaboration with medical staff during screening and for enrolled participants.		The team is unaware of the need to have relationships with staff across multiple types of medical settings in their catchment area.	The team is aware of the need but has not yet included outreach to medical providers in their CEO strategic plan and does not have regular contact with more than 1-2 medical settings in their catchment area.	Medical providers are included in the team's CEO strategic plan, and the team has begun making contact, however, there are still multiple medical provider settings with which the team has not made contact.	The team has relationships with staff across multiple local medical provider settings; however, some participants are not supported due to inconsistent communication and/ or relationships. If medical staff leave, relationships may be lost.	Program is visible and known by the majority of medical provider settings in the catchment area. The team collaborates proactively with primary care providers and medical staff where participants receive medical care. There is a plan in place to maintain relationships even if key medical staff leave.

DOMAIN #3: FAMILY & SUPPORT SYSTEM ENGAGEMENT & PSYCHOEDUCATION

Family and support system involvement and structured psychoeducation in early psychosis intervention care is a key contributor to short and long-term outcomes for individuals as well as their family members and support system[51] [52] [53]. Family and support system involvement and partnership in care is communicated as essential from first contact. Early psychosis intervention care encourages engagement with and involvement of all family members and support system with permission of the participant. Family members and support system are seen as essential partners with the participant and the early psychosis intervention team, and their knowledge, values, and perspectives are an integral part of trauma-informed, culturally responsive early psychosis intervention care. Family members from "ethnoracially minoritized and low socioeconomic backgrounds are significantly less likely than non-Latinx white and high socioeconomic families to be involved in CSC"[54]. High fidelity CSC programs are associated with higher participant retention and stronger family engagement, with programs that proactively recommend family services as a standard of care and provide benefits counseling demonstrating the strongest family engagement[55]. The early psychosis intervention team routinely offers participants, family members and their support system structured family psychoeducation interventions as a standard practice. The terms family and support system are defined broadly to include people that the participant relies on for support and considers their family of choice. If a participant is unable to identify family members or primary support system that they would like to involve, the early intervention team explores with them the people in their lives who could become involved as support system for them, for example, friends, roommates, coaches, partners, extended family members, or spiritual healers. Involvement of family members and supports is first discussed during screening and is revisited throughout treatment to adapt and accommodate the changing needs of the participant, family members, and support system.

3.1 Orientation to Care	Rating	1	2	3	4	5
Early psychosis intervention participants, family members and supports receive formal orientation to the program within one week of enrollment. Scheduling and location of orientation is flexible based on the needs of the participant, family members, & supports. Orientation activities include but are not limited to: (1) introduction to all team members and their roles on the team, (2) a psychiatric appointment offered within 7 business days of enrollment regardless of whether or not they are currently taking medications or want to take medications, (3) provision & explanation of written orientation & psychoeducation materials tailored to individual, family member, and/or support system values, beliefs, perspectives, needs, preferred language, and literacy level. These written materials include: (i) family guidelines, (ii) an introduction to team and their roles, (iii) crisis plan and resources, (iv) confidentiality, rights, and grievance policy, (v) information about communication, (vi) role of family and support system in treatment, (vii) information about symptoms & diagnosis, coping strategies, and opportunities for additional support, (viii) culturally-responsive crisis intervention support and resources, and (ix) other relevant local resources. The early intervention program is described as a time-limited program from the very beginning of treatment and throughout treatment. Transition from the program is communicated as a flexible, adaptable process that integrates the needs of the participant, family members, and supports.		The program is unaware of the need for participants, family members and support system to receive a formal orientation to the program upon enrollment.	The program is aware of the need for a formal orientation, but one has not been developed and/or it does not follow best practices.	A standardized orientation process that follows best practices has been developed, but it is not yet being implemented consistently for all new participants, family members and supports.	A standardized orientation process that follows best practices is implemented consistently across all participants, family members and supports.	All of the above, plus situations where individuals did not receive an orientation upon enrollment are systematically reviewed in individual and group supervision. Feedback on the orientation process is collected from those who received it and changes are made as a result.

3.2 Trauma-Informed, Culturally Responsive Care	Rating	1	2	3	4	5
Team deliberately and routinely explores participant, family members & supports' beliefs, values, & perspectives on health, wellness, illness, and healing beginning with screening through transition from care. Cultural formulation is actively integrated from the first contact and throughout treatment in all interactions with the individual, family and their community. Team members actively seek to understand the individual and family history, cultural and spiritual values and practices and sources of resilience, strength, and support. The assessment process is an ongoing, dynamic process throughout treatment and deliberately gathers and integrates information about identity as integral to a participant's healing, recovery, and overall wellbeing. Experiences of discrimination, stigma, negative attitudes of others, and institutionalized discrimination are addressed in culturally responsive, trauma-informed ways throughout assessment and treatment. The team limits the number of times a participant is asked to share information about difficult or traumatic symptoms or experiences during the screening and/or assessment process and throughout treatment.		The team is unaware of the need to be trauma and culturally responsive.	The team is aware of the need to be trauma and culturally responsive, however, they have not been trained and are unsure of how to go about it.	Staff have been trained in trauma-informed care and culturally responsive engagement and assessment techniques, though they are not practiced by all staff or with all participants.	Trauma-informed and culturally responsive engagement and assessment techniques are implemented as designed by most team members.	All of the above, plus all agency staff are knowledgeable about the program & trained in trauma informed care. Emerging signs of participant or family/supports disengagement are quickly identified and addressed. Any participants who have discharged prior to completing treatment in the past 12 months did not disengage from care due to staff turnover.

3.3. Family & Support System Engagement & Partnership	Rating	1	2	3	4	5
Initial contact is made with all identified family members & support system immediately upon entry to the program and includes: (1) crisis intervention, (2) immediate case management support for urgent, practical needs with attention to social determinants of health, (3) an exploration of their level of knowledge & interpretation of symptoms, (4) education, (5) solicitation of information regarding participant & family history and observations of the participant's developmental progression, development of symptoms, and changes in functioning and/or behaviors using the Family Input Form or other tool, and (6) orientation to the program, the transdisciplinary and transitional nature of services, what to expect in the short-term and long-term, resources for safety, coping and support, how to define a crisis and what to do in case of a crisis. Throughout the program (with participant permission): (7) the family is routinely involved in sessions where assessment results are shared and treatment goals/ treatment progress is discussed, (8) the team routinely reaches out to parents, caregivers, siblings, and other support system who may not have been part of the initial referral to provide support and education and to reduce family and/or support system conflict, and (9) team members model advocacy skills, attend to their needs, address & mitigate distress and/or trauma associated with the individual's condition, involvement in mental health, crisis, and/or law enforcement interactions. The agency where the program is located is a welcoming, accessible, youth & young adult friendly physical environment that integrates décor & artwork that has been created or selected by participants, family members, & supports.		The team is unaware of the need to engage family members or supports as partners in care.	The team is aware of the need to engage family members or supports as partners in care, however, they are unsure of what it entails and/or how to go about it.	There is a system and workflow around family member & support engagement that meets best practices. However, they are not followed by all staff or with all identified family members and supports.	Family and support engagement and partnership is conducted in a manner that meets best practices by most team members.	All of the above, plus emerging needs or signs of disengagement or misunderstandings about the condition are quickly noticed and addressed. Situations where family members and supports were not initially engaged during enrollment are systematically reviewed. Agency where program is located provides a youth & young adult friendly environment that integrates décor & artwork that has been created or selected by participants, family members & supports. Feedback on family & support engagement and partnership is gathered, and changes are made as a result.

3.4 Structured Family Psychoeducation (FPE)	Rating	1	2	3	4	5
All participants, family members & supports are offered routine structured family psychoeducation by trained early psychosis intervention team members that includes: (1) joining sessions that include an introduction and review of family guidelines and cover joining session core content, (2) educational workshop covering but not limited to, (i) current information about clinical high risk for psychosis, first episode psychosis and bipolar disorder with psychosis that is targeted to workshop attendees and covers a wide range of explanations for these experiences, (ii) review of family guidelines (iii) integration of lived experience, (iv) information on typical adolescent and young adult development and distinction from symptoms, (v) typical family responses, (vi) communication & coping skills, (vii) what treatment looks like (transdisciplinary team approach focusing on wellness and recovery, overview of medications) (viii) structure of single-family interventions (SFI) and multi-family groups (MFG) and what to expect in group 1, group 2, and ongoing problem-solving sessions, and (3) structured single-family intervention (SFI) or multi-family group (MFG) problem solving sessions offered 2x/month in person and/or virtually. FPE interventions include additional topics, engagement, or supports tailored to meet individual needs, values and norms in support of wellness and recovery. The location, time, and date of FPE interventions are flexible based on the needs of the participants. Food is provided by the program/agency for in-person SFI, MFG, and educational workshops. Agency policy permits participation in MFG post-graduation as well as participation in their local catchment area if participant moves to a different catchment area, and all participants, family members, & supports are informed of this policy.		The team is unaware of the need to provide structured family psycho-education.	The team is aware of the need to provide structured family psycho-education, however, no team members are trained in FPE.	There is a system and workflow around structured family psychoeducation that meets EASA best practices. However, the schedule is not predictable or shared with all participants, family members and supports. Individual psychoeducation may not be integrated into routine interactions by staff.	Structured family psychoeducation in individual and group formats is regularly provided by trained team members. FPE sessions are consistent and predictable and shared with all participants, family members and supports. Team members participate in routine FPE consultation.	All of the above, plus situations where family and supports do not engage in FPE are systematically reviewed. Feedback on psychoeducation is gathered, and changes are made as a result.

DOMAIN #4: CORE PRACTICES

Evidence-based core activities in CSC programs include the following key components: case management, service coordination, family psychoeducation and support, cognitive or behavioral therapy, medication management, supported employment and education (SEE), small caseloads, routine team meetings, assertive outreach for engagement, and community-based care[56]. In addition, early psychosis invention programs must be rapidly accessible, teams must complete their own screenings, and programs must have a strong link to crisis services[57] [58]. Deliberate and careful attention to participant engagement and retention is critical from the first contact. Programs should routinely assess the impact of staff turnover on participant engagement and retention. Core practices include individualized ongoing assessment, treatment planning, and transition planning processes based on the needs, values, and preferences of the participant and their family members and supports. Care is extended beyond two years when clinically indicated to ensure the best long-term outcomes for participants and their family members and supports[59].

4.1 Rapid Access	Rating	1	2	3	4	5
Access to the program is facilitated by a streamlined referral and intake process that includes (1) a *No Wrong Door* referral policy with dedicated program referral line, (2) initial contact with referent, participant, family members, & supports & information about access to 24-hour crisis services within 2 business days of referral, (3) an eligibility determination is made within 14 calendar days of referral, (4) an intake appointment is offered within 7 calendar days of determining eligibility, and (5) program does not have a waitlist for screening or intake. If a program starts a waitlist, they are required to notify OHA and EASA C4E within 2 business days to problem solve barriers to access. Program accepts referrals and transfers from other early psychosis intervention programs without requiring additional screening or assessment to determine program eligibility. Cross-catchment services for participants who move are facilitated proactively to ensure continuity of care.		Rapid engagement is not prioritized or tracked, and the program is unaware of the importance of rapid access for youth and young adults experiencing early symptoms of psychosis.	The program is aware of the importance of rapid access to care, but a workflow that ensures rapid access for every potential participant has not been developed. Program is unaware of the policy to notify EASA C4E and OHA within 2 business days of needing a waitlist to problem solve barriers to access.	Referrals are accepted from a wide range of community members including professionals, community members, individuals, family members, primary support networks, and those who self-refer. At least 50% of referrals come from outside the crisis system and the community mental health agency where the program is located. Transfers from other early psychosis intervention programs are accepted w/o re-screening for eligibility. The program meets the access to care timeline for fewer than 80% of referents.	All of the above, plus the program meets the access to care timeline for at least 80% of participants and has no waitlist. Program has a dedicated referral line that is checked at least once/daily during business hours and includes information on how to access after-hours crisis services. Cross-catchment services for participants who move are facilitated proactively to ensure continuity of care. However, there is no backup plan to address staff turnover or leave.	The program meets the access to care timeline for at least 90% of participants and has no waitlist. The agency has identified a therapist and psychiatric care provider trained in early psychosis intervention to provide clinical care to participants, their family members & supports in the event of staff turnover or leave.

4.2 Screening	Rating	1	2	3	4	5
(1) Screening process and location are flexible and based on the needs of the individual, family members & supports. (2) Outreach may occur over an extended period of time as needed to engage individuals referred to the program without requiring an individual to complete or sign agency paperwork. (3) Documentation is kept during the screening process. (4) All eligibility screenings are completed by a Master's level or higher QMHP[1] trained in early psychosis intervention screening and assessment, including certification in SIPS and SCID[2]. (5) At least two trained and certified SIPS assessors are available to conduct screenings. (6) A method for immediate response and triage is in place for individuals in crisis or at high risk for harm or hospitalization who are not connected to mental health support. (7) Exploration of values, beliefs, and perspectives, including use of Cultural Formulation Interview (CFI), exploration of family and support strengths, values, and needs, and psychoeducation and resources tailored to those strengths, values, and needs are provided during screening. (8) The team actively works to initiate and complete screening process with individuals who are in the hospital prior to discharge whenever possible. The team coordinates closely with hospital staff regarding services and discharge planning to ensure a smooth transition. (9) Individuals who do not meet criteria for the program are connected to appropriate care by early psychosis intervention team and consultation to new provider(s) is offered by local early psychosis intervention team. (10) Verbal and written information (email and/or letter) regarding screening results and outcome is provided to the referent, participant, family members & supports (with participant permission) and documented in electronic health record system, including clinical recommendations, crisis information, resources, & appeal process.		The program is unaware of the need for a standardized screening process.	The program is aware of the need for a standardized screening process, but they have not been developed and/or they do not follow EASA best practices.	A standardized screening process that follows EASA best practices have been developed and approved by leadership, but it is not yet being implemented consistently.	A standardized screening process that follows EASA best practices is implemented consistently across all participants.	All of the above, plus situations where participants were not screened according to the workflow or were screened out, are systematically reviewed in individual and group supervision. Feedback on the screening process is collected from participants and changes are made as a result.

[1] Qualified Mental Health Professional (QMHP)

[2] Structured Interview for Psychosis Risk Syndrome (SIPS); Structured Clinical Interview for the DSM-V (SCID)

4.3 Crisis Response	Rating	1	2	3	4	5
Early psychosis intervention teams provide or help facilitate urgent appointments in participants' homes or communities to avoid the need for accessing emergency department care or hospitalization whenever possible. All individuals who are referred to or enrolled in early psychosis intervention care are provided written and verbal information on crisis services and when and how to access them. There is a strong, clear linkage between crisis services and the early psychosis intervention team.		Crisis services are not provided and/or the team is unaware of the need to provide services that avoid the need for accessing emergency department care or hospitalization.	The program is aware of the need for crisis response services, however, there is no systematic plan for providing them.	The team provides or helps facilitate some, but not all urgent appointments in participants' homes or communities to avoid the need for accessing emergency department care or hospitalization. Not all individuals are provided written and verbal information on crisis services. Local crisis services may not be aware of or linked to the early psychosis intervention team.	There is a strong, clear linkage between crisis services & the team. If crisis services are provided outside of the team, crisis staff have access to program records, crisis & relapse prevention/wellness plans & communicate with the team any information regarding contact with participants, family members & supports the next business day.	All of the above, plus crisis services are reviewed by the full team & supervisor at least quarterly & includes feedback from participants, family members & supports, first responders and emergency departments. State staff, agency leadership, & EASA C4E team collaborate to address system-level barriers to crisis services & advocate for improvement.

4.4 Enrollment	Rating	1	2	3	4	5
Official enrollment in the program occurs once the individual is determined to meet criteria for the program and engagement is sufficient to allow for full informed consent. Participants, family members & their supports receive orientation to the program, information on their rights, grievance and complaints process, crisis information and resources, and feedback opportunities upon entry into the program.		The program is unaware of the need for standardized enrollment policies.	The program is aware of the need for standardized enrollment policies, but they have not been developed and/or they do not follow EASA best practices.	A standardized enrollment policy and workflow that follow best practices have been developed and approved by leadership, however, they are not yet being implemented consistently.	A standardized enrollment policy and workflow that follow EASA best practices is implemented consistently across all participants.	All of the above, plus situations where participant meets eligibility criteria and does not enroll in program are systematically reviewed in individual and group supervision. Feedback on the enrollment process is collected from participants and changes are made as a result.

4.5 Weekly Team Meeting	Rating	1	2	3	4	5
Team meetings occur weekly (virtually, in person, or hybrid), utilize the EASA Team Meeting Template (or another template that covers all team meeting core components included in the EASA Team Meeting Template) and include all team members involved in care. Team meetings routinely coordinate engagement and care for all participants in the program. Treatment coordination focuses on concrete, specific planning that builds on the strengths, goals, values, and cultural and spiritual needs of all participants, family members, and support system. Team meetings focus on coordination and consultation across all team members using strengths-based, resiliency focused language and celebrating successes. If clinical disagreements arise during a team meeting, areas of increased risk for participant arise, participant disengagement or risk of disengagement are identified, and/or further consultation and coordination is needed a plan is created and put into place for the team to address these needs in a timely manner. Teams who do not have current participants meet weekly to discuss referrals, community outreach and education, and program development.		Team is unaware of the need to (1) meet at least weekly to coordinate care, (2) to have all team members participate, and/or (3) to review each participant during that meeting.	Team is aware of the purpose and format of the weekly team meeting, but it does not occur regularly, all members are rarely present and/or all participants are rarely reviewed during each meeting.	The team meets at least weekly, all members are always present (with rare exceptions) & all participants are reviewed each time, however coordination fails to focus on strengths, success stories, concrete goals of all participants, their family members, & support system.	Meetings focus on coordination & consultation across all team members using strengths-based, resiliency focused language that celebrates successes. If clinical disagreements arise, areas of increased risk, risk of participant disengagement or participant disengagement are identified a plan is put into place to address them in a timely manner. Teams that do not have current participants or have not had current participants in the past 6 months meet weekly.	All of the above, plus the team reviews progress on plans made during past meetings and adjusts them as needed. Records of past meetings are kept and easily accessible by all team members.

4.6 Community-Based Services	Rating	1	2	3	4	5
The team offers the majority of services in the community to provide the opportunity for engagement and skill building in the community. The team prioritizes participant, family members, & supports preference for where services take place. The team is trained and skilled in providing community-based services. Team has full agency leadership support in providing community-based services, which includes modifying or eliminating productivity standards for staff.		Team and agency leadership are unaware of the need and purpose for providing the majority of services in the community, rather than in-office.	Team and agency leadership are aware of the need and purpose for providing the majority of services in the community, but it is not prioritized.	Less than 65% of face-to-face contacts are offered in the community.	65 - 74% of face-to-face contacts are offered in the community. Productivity standards are modified but not eliminated.	At least 75% of total face-to- face contacts are offered in the community. The percentage of community-based contacts is tracked per participant, and changes are made if needed. Productivity standards are eliminated for staff.

4.7. Engagement and Retention	Rating	1	2	3	4	5
The team uses specific culturally responsive, trauma-informed engagement techniques (i.e., narrative storytelling) to engage and partner with participants, family members, and supports & center their lived experience and personal stories. The team systematically collaborates with participants, family members & supports to facilitate the learning of specific skills and knowledge areas related to Clinical High Risk for psychosis (CHRp) and/or first episode psychosis that support their involvement, including treatment planning & wellness & relapse prevention planning with participant consent. All information and materials (written and verbal) are provided in the participant and family members' preferred language and literacy level, including alternate formats as needed.		The team is unaware of the need for culturally responsive, trauma-informed engagement techniques.	The team is aware of the need for culturally responsive, trauma-informed engagement techniques, but they are unsure of what that entails. The techniques being used may only resonate with a specific demographic and not others. Engagement and retention rates may be low as a result.	The team has begun using culturally responsive, trauma-informed engagement techniques for a diverse set of participants, family members & supports, including using the Cultural Formulation Interview (CFI) to guide discussion, build rapport and center involvement of family members and support system on a routine basis, but more could be done.	All of the above, plus materials are available in multiple formats & languages, and family members & supports are involved in treatment including treatment planning & wellness & relapse prevention planning with participant consent.	All of the above, plus program data reflects an increase in retention and engagement in care and treatment of participants from baseline. Team reviews all instances of participant disengagement in weekly team meetings, consultation, and individual and group supervision to evaluate practices, barriers, and make changes based on this information.

4.8. Comprehensive Assessment Process	Rating	1	2	3	4	5
Team members collaborate with participants, family members & supports to complete a flexible assessment process over time, postponing items that may pose a barrier to engagement. Assessment in early psychosis intervention care is an ongoing, dynamic process that takes place throughout treatment and includes (1) The EASA Comprehensive Risk Assessment and strengths assessment/narrative/values card-sort completed as soon as possible after enrollment unless completion is a barrier to engagement. Additional assessments include: (2) a Structured Clinical Interview for the DSM-5 (SCID) for individuals ages 18+, when clinically indicated (Not required to determine program eligibility), (3) a Structured Interview for Psychosis Risk Screening (SIPS) is required for those brought in under Clinical High Risk for psychosis & includes monitoring of SOPS[3] scores, and (4) Cultural Formulation Interview (CFI). The comprehensive assessment also includes: (5) participant, family member & supports beliefs, values, & perspectives on health, wellness, illness, and healing, experiences of discrimination, stigma, negative attitudes of others, and institutionalized discrimination, (6) personal identity as integral to a participant's healing, recovery, and overall wellbeing, (7) a strengths narrative, assessment or values card-sort, (8) sensory and cognitive functioning (9) medical/health status including a comprehensive physical exam w/recommended lab tests including metabolic functioning, and (10) developmentally tailored employment and education status/goals (career profile and assessments).		The program is unaware of the need for a standardized assessment process.	The program is aware of the need for a standardized assessment process, but they have not been developed and/or they do not follow EASA best practices.	A standardized assessment process that follows EASA best practices has been developed and approved by leadership, but it is not yet being implemented consistently.	A standardized assessment process that follows EASA best practices is implemented consistently across all participants. Assessment is an ongoing, dynamic process that is paced based on individual needs. The process centers the lived experience of the participant and integrates transdisciplinary team clinical judgment and professional knowledge.	All of the above, plus situations where participants were not assessed according to the standard process are systematically reviewed in individual and group supervision and consultation. Feedback on the assessment process is collected from participants, family members, & supports and changes are made as a result.

[3] Scale of Prodromal Symptoms (SOPS) scores are tracked every 90-120 days using clinical judgment and current best practices

4.9 Treatment Planning	Rating	1	2	3	4	5
Treatment planning is a collaborative process with participants and family members & supports with participant consent. Treatment planning is a dynamic process that centers shared decision making approaches. Treatment planning is informed by ongoing assessment and centers participant strengths, values, needs, and resources. Interventions and outcomes include family members & supports with participant consent. Interventions and outcomes are reflected on the treatment plan and reviewed with all parties at 90-day intervals through transition.		The program is unaware of the need for a collaborative, strengths-based treatment planning process that is repeated every 90 days or more frequently as clinically indicated.	The program is aware of the need for a collaborative, strengths-based treatment planning process, but they do not have a systematic process that follows EASA best practices.	A collaborative treatment planning process that follows EASA best practices has been developed and approved by leadership, but it is not yet being implemented consistently.	A collaborative treatment planning process that utilizes shared-decision making approaches and follows EASA best practices is implemented consistently across all participants. The treatment planning process centers the lived experience of the participant and integrates transdisciplinary team clinical judgment and professional knowledge.	All of the above, plus feedback on the treatment planning process is collected from participants, family members, & supports and changes are made as a result.

4.10 Evidence-Based Practices	Rating	1	2	3	4	5
The team uses evidence-based practices (EBPs) and interventions and emerging knowledge tailored to the unique nature of the condition and complexity of the developmental stage. Interventions are provided in individual and group settings and may include but are not limited to: (1) Structured Family Psychoeducation, (2) Shared-Decision Making Approaches, (3) Motivational interviewing, (4) Cognitive Behavioral Therapy (CBT), (5) Cognitive remediation, (6) Co-occurring Disorder treatment, (7) Trauma-focused treatment, (8) Supported Education, (9) Supported Employment, and (10) Feedback Informed Treatment using participant rated outcome measures.		The program is unaware of the need to use evidence-based interventions and emerging knowledge tailored to the unique nature of the condition and complexity of the developmental stage.	The program is aware of the need to use evidence-based interventions and emerging knowledge, but few, if any, are currently used.	The program has a list of evidence-based interventions that it provides, and it is posted on the website and in brochures. The interventions are provided, but they are not all provided with fidelity to those models and/or some participants who need specific services are not getting them. Additional training in EBPs is needed.	All listed EBPS are available, staff are trained & EBPs are provided with fidelity to the model. All participants are receiving EBPs tailored to their condition and developmental stage. Program materials list the evidence-based interventions provided by the team.	All of the above, plus fidelity to EBPs and discussion of emerging best practices is a regular topic during supervision and planning meetings. Informal and formal feedback using participant rated outcome measures is sought routinely from program participants, and treatment plans are adjusted as needed.

4.11. Integrated Treatment for Co-Occurring Disorders (COD)	Rating	1	2	3	4	5
Substance use/misuse is addressed by the entire team in alignment with integrated treatment for co-occurring disorders (COD) that includes: (1) screening and assessment for interactions between mental health conditions and COD; (2) support for harm reduction; (3) application of stages of change readiness in treatment; (4) Shared Decision-Making approaches, (5) motivational interviewing; & (6) cognitive-behavioral therapy (CBT) principles.		No COD services are provided and/or the program is unaware of the need for COD services.	The program is aware of the need for COD services, but substance use is not yet systematically addressed by the team according to COD best practices.	Some, but not all aspects of COD treatment are available, but it is not in alignment with best practices &/or not everyone who needs it is receiving it.	The team assumes responsibility for providing integrated treatment for COD. There is little need for participants to access COD services outside of the team. Core services include systematic and integrated screening and assessment and interventions. Services are tailored for early stages of change readiness (outreach, motivational interviewing) & later stages (CBT, relapse prevention).	All of the above, plus discussion of COD services, including harm reduction & medication, is a regular topic during team meetings, treatment planning & cross-training events. Feedback on COD treatment is sought from program participants, & services are adjusted as needed.

4.12 Maintaining Engagement during Psychiatric Hospitalizations	Rating	1	2	3	4	5
The team is closely involved in psychiatric hospitalizations and discharges. This includes activating a crisis plan to employ alternative strategies to prevent hospitalization, assessment of need for hospitalization, & support w/voluntary and involuntary admissions, contact with participant during their hospital stay, support and education for family members & supports during hospitalization, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge including medications and community disposition (e.g., housing, service planning).		The program is unaware of the need to be involved in psychiatric hospitalizations and discharges.	The program is aware of the need to be involved in psychiatric hospitalizations and discharges, but a plan for maintaining engagement has not yet been developed.	A plan has been developed and approved by leadership, however, not all of the components are in place and/or it is not being implemented as written. Some, but not all participants receive engagement services while hospitalized and/or at intake or discharge.	The plan is fully in place. All participants have contact from the team during their hospital stay, support and education for family members & supports is provided during hospital stay, collaboration with hospital staff & coordination around discharge including medications and community disposition (e.g., housing, service planning) is provided.	All of the above, plus psychiatric admissions and discharges are tracked and regularly reviewed to see how they could have been avoided.

4.13 Transfer of Care Due to Staff Changes	Rating	1	2	3	4	5
Transfers of care due to staff changes within the team occur as a planful, gradual process whenever possible. The transferring team member (preferred), team lead, clinical supervisor or designated team member notifies the participant. The participant, family members, & their supports collaborate in making decisions about how to best support the transition of care between providers with attention paid to continuing engagement and goal setting during this period.		The team is unaware of the need for planful, gradual transitions in care due to staff turnover.	The team is aware of the need for planful, gradual transitions but a workflow has not yet been developed or documented.	A transition workflow has been developed and is in use, but the procedure does not occur as designed for every participant.	The transition workflow is implemented as designed by most team members; however, implementation can be inconsistent and feedback is not sought from participants, family members, & their supports. Disengagement may occur as a result.	All of the above, plus emerging signs of disengagement during the transition period are quickly noticed and followed up on. Any participants who have discharged prior to completing treatment in the past 12 months did not disengage from care due to staff turnover.

4.14 Transition Planning	Rating	1	2	3	4	5
The transition process is a collaborative, individualized process guided by the values, needs and priorities of the participants, family members & supports that utilizes culturally responsive, trauma informed approaches and practices. Transition planning engages all involved parties in decision-making about holistic, long-term resources and support systems. It is individualized to ensure that participants succeed in a way that fits for them across life domains. Transition from early psychosis intervention care is a time of increased risk for suicide and an increase or recurrence of symptoms. To sustain long and short-term outcomes early psychosis intervention programs are encouraged to extend care beyond 2 years[60].		The team is unaware of the need for a gradual, flexible transition process, nor of the need to inform participants, family members & supports that the services are transitional in nature. Services may be offered for less than two years.	The team is aware of the need for a gradual, flexible transition process, but a workflow has not yet been developed or documented. Individuals are offered at least 2 years of early psychosis intervention care.	A transition workflow exists that includes (1) discussing the transitional nature of the program from the very beginning, (2) using the EASA transition checklist beginning 6 months prior to every planned discharge, and (3) psychoeducation for participants, family members & supports that addresses the risk for relapse of symptoms & suicidality. (4) Transition planning is discussed regularly in team meetings and individual and group supervision. (5) The program has a referral network of providers who offer person-centered, resiliency-oriented care. However, identified resources could be more comprehensive and some participants may be discharged before successful connections have been solidified. Follow-up check-ins are not routinely occurring.	Participants, family members & supports know what to expect from standard outpatient services if they choose to enroll. Participants have a relapse prevention or wellness plan that has been tested, modified, and finalized with all involved parties, as well as with new providers, prior to discharge with participant consent. Graduations are celebrated as important achievements. Follow-up check-ins occur to support post-program continuity. Program provides support after graduation without having to re-enroll in services and permits graduates & their family members & supports to contact team for brief problem solving and follow-up.	Program extends care beyond 2 years when clinically indicated with participant, family members & support consent. Barriers to successful transition planning are addressed on a team, agency, & systemic level. Participants, family members & supports are encouraged to participate in agency, local, and state level quality and practice improvement activities, community education and outreach, and leadership opportunities post-graduation.

DOMAIN #5: TRANSDISCIPLINARY TEAM ROLES

Early psychosis intervention team members share roles and cross discipline boundaries within their scope of practice to "pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided."[61]. Transdisciplinary care differs from multidisciplinary care in that in transdisciplinary care all team members share ideas and collaborate to create integrated and comprehensive treatment goals and interventions, rather than each team member using their own expertise to develop individual treatment goals and interventions. In effective transdisciplinary team care all team members must have adequate FTE to perform the tasks for their role, attend weekly team meetings, and work closely with other team members across disciplines and roles to collaborate and coordinate care[62].

5.1 Team Lead/Supervisor	**Rating**	**1**	**2**	**3**	**4**	**5**
The team has a team lead/supervisor who: (1) attends weekly team meetings and ensures close coordination of care across the team, (2) serves as point person for inquiries and consultations about the program, (3) provides culturally responsive and trauma informed training, education, individual clinical supervision, group supervision, crisis response, and support for the team, (4) routinely participates in early psychosis intervention training and consultation, (5) oversees data collection and practice and quality improvement activities for the program, (6) serves as a liaison in collaboration with community organizations and agencies, (7) ensures transfer of care due to staff changes within the team occurs as a planful, gradual process whenever possible, (8) may carry a small caseload and/or co-facilitate multi-family groups and other groups as needed. *If the Team Lead role is not filled other members on the team are supported and trained to complete associated Team Lead tasks within their scope of practice.*		The person fulfilling this role is unaware of the tasks that a Team Lead typically performs.	Team Lead is aware of the tasks that a Team Lead typically performs, however, they do not have adequate FTE to complete those tasks. Team lead meets minimum qualifications.	Team Lead has adequate FTE to perform all but two of the tasks. Team lead meets minimum qualifications.	Team Lead has adequate FTE, performs all but one of the tasks, and meets all qualifications necessary for the job, but does not have a clinical license.	Team Lead has adequate FTE, performs all of the tasks, and meets all qualifications necessary for the job, including having a clinical license.

5.2 Case Manager	Rating	1	2	3	4	5
Case management services provide support to participants to assist them in accessing housing, medical, social, educational and other resources, support system, and services. All team members providing case management services (1) attend weekly team meetings & (2) work closely with team members to coordinate care. (3) Case management services include but are not limited to (i) engagement, (ii) bridging, (iii) crisis management (iv) coordination, (v) referrals, (vi) advocacy and empowerment, & (vii) psychoeducation and problem-solving. *If a case manager role is not filled, other members on the team are trained and supported to complete associated tasks within their scope of practice.*		There is no one in the case manager role on the team or the person(s) in this role is unaware of the tasks that an early psychosis intervention case manager typically performs.	Case managers are aware of the tasks that case managers typically perform, but do not have adequate FTE or training to complete those tasks. Case manager meets minimum training & qualifications.	Case managers meet minimum qualifications. The person(s) in this role meets <u>some, but not all,</u> of the case management needs of participants due to either limited FTE or lack of specialized training.	Case managers have appropriate training and allocated FTE to provide the needed amount and areas of case management to any participant, however, their services might not be documented in the treatment plan or tracked. Case managers provide coordination, consultation and cross-training to other team members. Case managers empower participants using person-centered, culturally responsive, trauma-informed practices and approaches.	Case managers have adequate FTE to provide the needed amount and areas of case management to any participant. Case management services are documented in the treatment plan, and tracked. Case managers have all the training and qualifications necessary for the job.

5.3 Clinician	Rating	1	2	3	4	5
The team has clinician(s) who: (1) attend weekly meetings, (2) work closely with team members to coordinate care, (3) provide counseling interventions in individual and group settings, including but not limited to: (i) motivational interviewing, (ii) Cognitive Behavioral Therapy (CBT), (iii) cognitive remediation and/or cognitive enhancement techniques, (iv) co-occurring disorder treatment, (v) trauma-focused treatment, and (vi) psychoeducation and problem-solving. *All agencies must have an identified clinician outside of the early psychosis intervention team who is trained and supported to fulfill the tasks of the role if the position becomes vacant.*		There is no one in the clinician role or the clinician(s) are unaware of the tasks that an early psychosis intervention clinician typically performs.	Clinician(s) are aware of the tasks that clinicians typically perform; however, they do not have adequate FTE to complete those tasks. All clinician(s) meet minimum qualifications.	All clinician(s) meet minimum qualifications. The person(s) in this role meets <u>some, but not all,</u> of the counseling needs of participants due to either limited FTE or lack of specialized training.	All clinician(s) have adequate FTE to perform all of the tasks, and meet all qualifications necessary for the job, however, they do not have a clinical license. Consultation and cross training for other team members is provided. Clinician(s) empower participants using person-centered, culturally responsive, trauma-informed practices and approaches.	Clinician(s) have adequate FTE, perform all of the tasks, and meet all qualifications necessary for the job. Clinician(s) have clinical licenses.

5.4 Peer Support Specialist	Rating	1	2	3	4	5
The team has a Peer Support Specialist who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, (3) provides services that encourage participants to be self-determined in their treatment and recovery and reflect the participant's values, priorities, and perspectives without attempting to interpret or modify them. Peer support services in early psychosis intervention are not clinical services in the traditional sense. Peer Support Specialists do not engage in diagnostic processes or treatment decision making although they may assist participants in the formulation of their treatment goals. Peer Support Specialists support participants to understand the program and the treatment process, encourage participants to articulate their hopes, values, and concerns, and represent participant perspectives in team meetings. Peer Support Specialists may attend participant appointments at their request with the goal of supporting them in their own self-advocacy. Peer support services reflect resilience-oriented, person-centered core competencies. Peer support services are often community-based to build rapport, engagement, and trust. The idea that both the Peer Support Specialist and the participant can grow from sharing experiences is encouraged and supported by the full team and agency leadership. *If the Peer Support Specialist role is not filled other members on the team are trained and supported to complete associated tasks within their scope of practice.*		There is no one in the peer support specialist role or the peer support specialist is unaware of the tasks that an early psychosis intervention peer support specialist typically performs.	Peer support specialist is aware of the tasks that peer support specialists typically perform; however, they do not have adequate FTE to complete those tasks. Peer support specialist meets minimum qualifications.	Peer support specialist meets minimum qualifications. The person in this role meets some, but not all, of the peer support needs of participants due to either limited FTE or lack of specialized training.	Peer support specialist has enough FTE to perform all of the tasks and meet all qualifications necessary for the job. Consultation and cross training for other team members is provided. PSS empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	Peer support specialist has adequate FTE, performs all of the tasks, and meets all of the qualifications necessary for the job.

5.5 Occupational Therapist	Rating	1	2	3	4	5
The team has an occupational therapist who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, & (3) conducts assessments & develops interventions that address the following areas that a participant wants, needs, or is expected to engage in, including activities of daily living (ADLs); instrumental activities of daily living (IADLs), health management (for example, medication routines, symptom monitoring, relapse prevention and wellness planning, rest and sleep, education, work, play, leisure, & social participation that the participant wants, needs, or is expected to engage in. Occupational therapists integrate personal and participant factors into care. Personal factors include the participant's background and lived experience that are not a part of a health condition (for example, age, cultural and spiritual identity, gender identity, education, roles, and lifestyle). Participant factors include values, beliefs, spirituality, body functions (including cognitive, emotional, and sensory functions), and body structures that influence participation in daily life. Occupational therapists provide assessment and intervention for activity demands using interventions that include analysis of activity demands such as relevance and meaning, objects and their properties, environmental and social demands, sequencing and timing, required actions, performance skills, and required body functions and structures, performance skills (motor skills, process skills, and social interaction skills necessary for participation in meaningful occupations) and performance patterns (supporting development and re-establishment of habits, routines, rituals, and roles that foster stability, identity development, growth, and recovery). Occupational therapists assess and address environmental factors including physical, social, cultural, institutional, and virtual environments that influence participation and engagement in meaningful occupations. *If the OT role is not filled other members on the team are trained and supported to complete associated OT tasks within their scope of practice.*		There is no one in the Occupational Therapist (OT) role on the team or the person in this role is unaware of the tasks that an OT typically performs.	The OT is aware of the tasks that an OT typically performs, however, they do not have enough FTE or training to complete those tasks. OT meets minimum qualifications.	The OT meets minimum qualifications and knows the psychosocial interventions shown to provide significant improvements in occupational and social functioning for youth and young adults at risk for developing or experiencing a first episode of psychosis. The person in this role meets <u>some, but not all,</u> of the OT needs of participants due to either limited FTE or lack of specialized training.	The OT role has adequate training and allocated FTE to provide the needed amount and all areas of OT to participants, however, their services might not be documented in the treatment plan or tracked. The OT provides coordination, consultation and cross-training to other team members. The OT empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	The OT role has adequate FTE to provide the needed amount and areas of OT to participants, their services are documented in the treatment plan and tracked. The OT meets all qualifications necessary for the job.

5.6 Psychiatric Care Provider	Rating	1	2	3	4	5
The team has a psychiatric care provider who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, & (3) is available to meet with new participants within 7 business days of admission, (4) engages in regular consultation, including monthly EASA+Med meetings, (5) plays a role in initial evaluations and diagnostic discussions, (6) offers weekly 30+ minute visits for participants early in psychosis recovery and a minimum of monthly 30+ minutes visits thereafter, (7) keeps participant life details in mind between appointments for continuity of care, (8) offers urgent appointments to be responsive to participant needs & prevent hospitalization, (9) collaborates with other team members, including nursing staff, to systemically measure and track medication adherence, side-effects (utilizing tools such as the Glasgow Antipsychotic Side-Effect Scale, Automatic Involuntary Movement Scale, Barnes Akathisia Scale, or Extrapyramidal Symptom Rating Scale), substance use, and routine medical and mental health progress (tracking and monitoring suicide and harm risks, vitals, and labs as warranted) and ensures that mental health is integrated with medical/whole person health, (10) clearly articulates psychiatric medication treatment targets consistent with participant goals, values, and needs while keeping in mind unique risk profiles given the participant's diagnosis and life circumstances, (11) offers treatment of co-occurring disorders consistent with evidence-based best practices, (12) utilizes shared-decision making approaches to consider treatment with clozapine or long-acting injectables, (13) strives for low-dose monotherapy whenever possible in addressing psychosis, (14) is aware of withdrawal phenomena and actively measures desired effects and tracks emergence or re-emergence of symptoms in collaboration with participants, family members, supports, and the team whenever cross-titration, taper, or discontinuation strategies are pursued. *All agencies must have an identified psychiatric care provider outside of the early psychosis intervention team who is trained and supported to fulfill the tasks of the role if the position becomes vacant.*		There is no one in the psychiatric care provider role on the team or the person in this role is unaware of the tasks that an early psychosis intervention psychiatric care provider typically performs.	The psychiatric care provider is aware of the tasks that a psychiatric care provider typically performs, however, they do not have enough FTE or training to complete those tasks. The psychiatric care provider meets minimum qualifications.	The psychiatric care provider meets minimum qualifications and tasks that a psychiatric care provider typically performs. The person in this role meets <u>some, but not all,</u> of the psychiatric care needs of participants due to either limited FTE or lack of specialized training. Consultation and cross training for other team members is limited.	The psychiatric care provider has enough training and allocated FTE to provide the needed psychiatric care to any participant who needs it, but the tracking of suicide risk, vitals & side effects and involvement in wellness/relapse prevention planning and treatment planning may be limited. Consultation and cross training for other team members is provided. Psychiatric care provider empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	The psychiatric care provider has enough training and allocated FTE to provide the needed psychiatric care to all participants, their services are documented in the treatment plan, and tracked. The psychiatric care provider meets all clinical qualifications necessary for the job, utilizes specific side-effect tracking tools, tracks and monitors suicide and harm risks, vitals, and labs as warranted, is involved in wellness/relapse prevention planning and treatment planning, and collaborates with the team and participant, family members in all aspects of care.

5.7 Nurse	Rating	1	2	3	4	5
The team has a nurse who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, (3) completes an initial nursing assessment upon acceptance to the program and a mini assessment every 3-6 months as needed, (4) meets with participants at least monthly to support medication management or when participant is seen by the psychiatric care provider to review side effects and changes in medications, (5) attends psychiatric care appointments with participant permission, (6) monitors weight, waist circumference and BMI when clinically indicated, monitors vital signs, and conducts an AIMS test and Barnes Akathisia Rating during each assessment, (7) addresses participant wellness by providing health-related education and counseling[4], (8) monitors medication access & connects participants with Patient Assistance Programs or pharmaceutical representatives for samples when needed, (9) supports taking medications according to provider instructions, including coordinating with other team members to provide pill minders, bubble packs, &/or medication deliveries, (10) assists in obtaining or changing primary care providers, (11) coordinates with team members to assist in exploring insurance options if needed, (12) tracks and coordinates laboratory test completion the PCP and MH provider, (13) administers injections, (14) ensures medications are ordered and administered according to psychiatric care provider instructions, (15) coordinates with psychiatric care providers in acute situations (side effects, symptoms) when medication changes need to be made, (16) follows through with pharmacy and participants to ensure medications are changed, (17) monitors the use of OTC medications and nutritional supplements, coordinates information transfer with PCPs (notes, labs, medication regimes)[5]. *If the nurse role is not filled other members on the team are trained and supported to complete associated tasks within their scope of practice.*		There is no nurse or the nurse is unaware of the tasks that a nurse working in early psychosis intervention care typically performs.	The person in the nursing role is aware of the tasks that a nurse typically performs, however, they do not have adequate FTE or training to complete those tasks. Nurse meets minimum qualifications.	Nurse has adequate FTE to perform some but not all of the tasks. Nurse meets minimum qualifications. Consultation and cross training for other team members is limited.	Nurse has an RN, enough training and allocated FTE to provide the needed care to all participants, but record keeping and coordination with external providers is limited. Consultation and cross training for other team members is provided. Nurse empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	Nurse has adequate FTE, performs all of the tasks, and meets all qualifications necessary for the job, including having an RN.

[4] Education is provided in individual and/or group formats on (I) tobacco use & smoking cessation, (ii) physical movement/activities, (iii) nutrition & food security, (iv) sleep hygiene, (v) pregnancy & sexual health.

[5] *If the Nurse role is not filled by an RN:* LPNs or MAs working within the scope of their practice or those w/a delegation from an RN or MD/DO may be utilized in the absence of an RN for items 3-16 with the following exceptions: (6) Health monitoring: Only LPN and MA are able to monitor weight, waist circumference, vital signs, and BMI, (7) Wellness: to be determined by comfort level of LPN or MA and medical team, (9) LPNs, but not MA's, can assess ability to take medications according to provider instructions.

5.8 Supported Education Specialist	Rating	1	2	3	4	5
The team has a supported education (SEd) specialist who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, (3) provides initial educational engagement immediately after expressing interest in educational pursuits or supports (Rapid Services), (4) uses shared decision making to center services around personal preferences, strengths & needs specific to education, (5) addresses 5 key areas: (i) disclosure, (ii) accommodations (Primary/secondary level: 504 & Special Education. Postsecondary level: Disability Services), (iii) family involvement and support in educational goals, (iv) benefits counseling (scholarships, grants, financial aid, (v) follow along supports and skills (study skills, organization, planning), (6) explores enrollment and career options (incl selecting classes, identifying educational supports & resources), (7) coordinates with other team members to actively build and maintain relationships with school and academic systems with a focus on participant preference, including (i) joining with participants in community-based educational activities in the community alongside team members & (ii) at least monthly contact with school staff (school counselor, disability counselor, program director, nurse, IEP/504 meetings). **Zero Exclusion:** <u>All</u> individuals who express interest in education services, without exception, are offered access to educational services. *Role may be shared with Supported Employment Specialist if adequate training and dedicated FTE for both roles are available. If Supported Education (SEd) role is not filled other members on the team are trained and supported to complete associated tasks within their scope of practice.*		There is no one in the SEd Specialist role on the team or the person in this role is unaware of the tasks that an early psychosis intervention SEd Specialist typically performs.	The SEd Specialist is aware of the tasks that an early psychosis intervention SEd Specialist typically performs, however, they do not have adequate FTE or training to complete those tasks. SEd Specialist meets minimum qualifications.	The SEd Specialist meets minimum qualifications meets <u>some, but not all,</u> of the SEd needs of participants due to either limited FTE or lack of specialized training. Every participant is informed of educational services at intake and throughout their time in the program regardless of initial stated preferences.	The SEd Specialist has enough training and allocated FTE to provide the needed amount and areas of SEd to any participant who needs it, however, their services might not be documented in the treatment plan or tracked. The SEd Specialist provides coordination, consultation and cross-training to other team members. SEd empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	The SEd Specialist has adequate FTE to provide the needed amount and areas of SEd to any participant. SEd services are evidence-based & tailored to youth & young adult developmental stages & needs, & services are documented in the treatment plan and tracked. The SEd Specialist has all qualifications necessary for the job.

5.9 Supported Employment Specialist	Rating	1	2	3	4	5
The team has a supported employment (SE) specialist who: (1) attends weekly meetings, (2) works closely with team members to coordinate care, (3) provides initial employment assessment immediately after expressing interest in employment pursuits or supports (Rapid Job Engagement), (4) uses shared decision making to center services around personal preferences, strengths & needs specific to employment, (5) addresses 5 key areas: (i) career profile, (ii) disclosure/accommodations, (iii) family involvement and support in employment goals, (iv) benefits counseling (figuring out what benefits they have, skill building regarding reporting work experience to benefits), (v) follow along supports and skills (job coaching, resume, interview skills, how to leave a job), (6) provides competitive job options & strategies to build work experience, incl internships & volunteer experience to strength knowledge of diverse job fields, (7) assists with career exploration (shadowing, informational interviews with people in fields of interest, Oregon Career Information System resources, (8) collaborates with and provides connection to Voc Rehab, (9) coordinates with other team members to actively build and maintain relationships with potential future employers with a focus on participant preference, including (i) joining with participants in community-based job development activities in the community alongside team members & (ii) at least 1 employer contact per week (job development, interview skills, job application). **Zero Exclusion**: <u>All</u> individuals who express interest in employment services, without exception, are offered access to them. *Role may be shared with Supported Education (SEd) Specialist if adequate training and dedicated FTE for both roles are available. If Supported Employment (SE) role is not filled other members on the team are trained and supported to complete associated tasks within their scope of practice.*		There is no one in the SE Specialist role on the team or the person in this role is unaware of the tasks that a SE Specialist typically performs.	The SE Specialist is aware of the tasks that a SE Specialist typically performs, however, they do not have adequate FTE or training to complete those tasks. SE Specialist meets minimum qualifications.	The SE Specialist meets minimum qualifications and meets <u>some, but not all,</u> of the SE needs of participants due to either limited FTE or lack of specialized training. Every participant is informed of SE services at intake and throughout their time in the program regardless of initial stated preferences.	The SE Specialist has enough training and allocated FTE to provide the needed amount and areas of SE to any participant who needs it, but their services might not be documented in the treatment plan or tracked. The SE Specialist provides coordination, consultation and cross-training to other team members. SE empowers participants using person-centered, culturally responsive, trauma-informed practices and approaches.	The SE Specialist has adequate FTE to provide the needed amount and areas of SE to any participant. SE services are evidence-based & tailored to youth & young adult developmental stages & needs, & services are documented in the treatment plan and tracked. The SE Specialist has all qualifications necessary for the job.

DOMAIN #6: STAFF TRAINING & SUPPORT

Successful and sustainable early psychosis intervention programs are located within agencies that prioritize the utilization of trauma-informed approaches with staff, including inclusive hiring and onboarding practices. Early psychosis intervention team members are highly trained individuals who demonstrate specialized core aptitudes and skills[63]. Agency leadership supports all early psychosis intervention team members in completing specialized orientation as well as initial and ongoing training, consultation, education, and supervision specific to their role within the early psychosis intervention team. Agency leadership routinely collects and reviews feedback from staff and makes changes as a result of that feedback.

6.1 Inclusive Hiring & Onboarding Process	Rating	1	2	3	4	5
The agency has written policies committed to recruiting and retaining staff who reflect the communities they serve. Screening, hiring and onboarding are designed to promote a culture of collaboration and power sharing by involving individuals with lived experience (participants, graduates, family members & supports) in the hiring and orientation processes for the early psychosis intervention program. Their involvement includes participation in the hiring committee that reviews applicants, drafts interview questions, conducts interviews and makes hiring decisions. The hiring process assesses each applicant's goodness of fit for participants, family members & the team, knowledge of early psychosis intervention and the role that trauma and culture play in participant and family member engagement, healing, and recovery. EASA team lead or administrator notifies EASA C4E of any staff changes within 14 calendar days of a team member leaving or joining their team using the EASA Staff Change Form.		The program has not yet demonstrated awareness of the need to develop a hiring and onboarding process that includes individuals with lived experience in a meaningful way.	The program is aware of the need to review hiring and onboarding processes but plans to do so have not yet been made. A role for individuals with lived experience has not yet been identified.	An inclusive hiring and onboarding process has been developed that follows EASA best practices, but some components are missing or it is inconsistently followed.	The program consistently follows their hiring and onboarding plan, it involves individuals with lived experience in meaningful ways. Onboarding includes a review of the early psychosis intervention model and the role that trauma and culture play in participant and family member engagement, healing and recovery.	Hiring and onboarding plan is sustainably in place. Feedback on the process is collected and cumulatively reviewed at least annually and changes are made, if appropriate. Team lead or administrator notifies EASA C4E of any staff changes within 14 calendar days of a team member leaving or joining their team using the EASA Staff Change Form.

6.2 Early Psychosis Intervention Orientation	Rating	1	2	3	4	5
Early psychosis intervention orientation includes: (1) receiving clear written information about program goals and tasks and responsibilities specific to their position upon hiring; (2) shadowing other team members on their team, in their catchment area, and/or other catchment areas before working 1:1 with participants and family members; (3) attending joint appointments with other team members; and (4) being observed by clinical supervisor and given feedback on strengths, challenges, and identifying areas for improvement/additional training, consultation, and support.		The program has not yet demonstrated awareness of the need for orienting new staff to early psychosis intervention and the early psychosis intervention model.	The program is aware of the need to orient new staff, but a systematic plan for doing so has not yet been developed.	An orientation plan is in place that includes the 4 recommended components, but less than 80% of staff have received the plan as written or completion is not tracked.	An orientation plan is in place and 80-99% of team members have completed all four components of the plan as written.	All of the above, plus 100% of team members have completed the orientation within 60 days of joining the team. Orientation completion is tracked and easily accessible. Observation & feedback by clinical supervisor is repeated as needed, and at least annually. If needed, different training modules &/or job shadowing activities are repeated.

6.3 Early Psychosis Intervention Training and Consultation	Rating	1	2	3	4	5
All team members are trained and supported to serve individuals under and over 18. Within 90 days of hiring, all team members complete: (1) full EASA Introductory module series prior to providing direct care to participants; (2) Differential Diagnosis modules or live training day 1 and Differential Diagnosis training modules and Day 2 live training session (all Master's level clinicians completing screenings &/or behavioral health assessments); (3) Structured Interview for Psychosis Risk Syndrome (SIPS) training and pass certification (all Master's level clinicians completing screenings and/or behavioral health assessments); (4) Family Psychoeducation (FPE) modules and live training session, (5) activation of 360Learning account to participate in trainings and ongoing consultation in regional, role-based, and FPE consultation calls.		The program has not yet demonstrated awareness of the need for ongoing supports to promote competence and confidence around Trauma-Informed Care.	The program is aware of the need to provide ongoing training and consultation to ensure implementation of best practices including a focus on engagement, and community outreach, however, opportunities may not yet be available to all staff. Training participation is not tracked.	The program has a professional development plan that includes educational and practice opportunities for each staff role to ensure they are (1) done at a reasonable pace, (2) role specific, and (3) performed throughout the job cycle, but fewer than 80% have completed full set of recommended trainings.	80-99% of team members have completed full set of trainings. Ongoing training and consultation, including evidence-based and emerging best practices for outreach, engagement and services, is paired with practice opportunities, and is role specific. Trauma informed care and culturally responsive care are ongoing topics. It may take more than 90 days for team members to complete the full set of trainings. Skill levels and training outcomes may not yet be fully evaluated.	100% of team members have completed full set of trainings and participate in ongoing consultation calls. Ongoing training and practice opportunities are available, sustainable and established throughout the job cycle. EASA Center for Excellence evaluates training and consultation outcomes and feedback at least once/quarter and changes are made as a result.

6.4 Ongoing Education & Support	Rating	1	2	3	4	5
Training is paired with educational opportunities that promote competence (knowledge) and confidence (skill) to provide evidence-based early psychosis intervention services, engagement, and community outreach using planful culturally responsive and trauma-informed engagement and retention strategies. This learning is (1) done at a reasonable pace, (2) role specific, and (3) performed throughout the job cycle (ask "who needs to know what by when?"). Routine clinical supervision & active participation in EASA C4E regional, role-based, and FPE consultation calls are ongoing. Clinical supervision is specific to early psychosis intervention and includes discussions of ongoing skill development and support.		The program has not yet demonstrated awareness of the need for ongoing supports to promote competence and confidence specific to trauma-informed and culturally responsive care in early psychosis intervention.	The program is aware of the need to support ongoing clinical supervision and educational opportunities specific to early psychosis intervention care, engagement, and community outreach, however, staff are not supported with adequate time to participate.	The program has a professional development plan that includes educational and practice opportunities for each staff role to ensure they are (1) done at a reasonable pace, (2) role specific, and (3) performed throughout the job cycle. Fewer than 80% of team members have participated in an EASA C4E training and/or attended at least 4 consultation calls in the past six months.	Ongoing training and consultation, including evidence-based and emerging best practices for outreach, engagement and services, is paired with practice opportunities, and is role specific. Trauma-Informed and culturally responsive care in early psychosis intervention are ongoing topics. 80-99% of team members have participated in an EASA C4E training and/or attended at least 4 consultation calls in the past six months. Skill levels and training outcomes may not yet be fully evaluated.	Ongoing training and practice opportunities are available, sustainable and established throughout the job cycle (e.g. EASA C4E consultation calls, trainings, learning collaboratives). Outcomes are evaluated. 100% of team members have participated in an EASA C4E training and/or participated in at least 4 consultation calls in the past six months. EASA Center for Excellence evaluates training and consultation outcomes and feedback at least once/quarter and changes are made as a result.

6.5 Trauma Informed Workforce Wellness	Rating	1	2	3	4	5
Workforce wellness is (1) culturally responsive, (2) systematically addressed, (3) inclusive, (4) used by staff, (5) addresses burnout and toxic stress, and (6) is positively received by staff. Team members are offered choices regarding factors that affect their daily work (schedule, flextime, office setup/décor) whenever possible. Choices are offered within clear guidelines regarding work responsibilities and tasks. Relationships take precedence over policy and product. Clinical supervision is role-specific, trauma-informed and culturally responsive, occurs regularly and provides support around employee care/wellness, job satisfaction, vicarious traumatization, and burnout.		Neither the program nor the parent agency has demonstrated awareness of the need to support workforce wellness to prevent burnout and staff turnover.	The program is aware of value of supporting the wellness of their workforce, however, they have not yet developed a plan to address it.	The team is reviewing the causes of staff stress/ burnout & is developing a plan to address it. Staff input is being gathered. A wellness team is in place, preferably at the agency level, which includes service users, providers, leadership and interdisciplinary staff.	A workforce wellness plan is in place that includes policies, procedures, practices, activities, services, and social & physical environments. Staff are aware of one or more wellness activities, but funding and leadership support are limited. If key staff leave, the culture of workforce wellness may not continue. Routine team building activities occur that promote positive team culture, prevent burnout, & retain diverse, skilled team members.	Workforce wellness is codified in policies, procedures, practices, activities, services, and social and physical environments and is supported as its own stand-alone initiative. Funds are not diverted to support other efforts. Staff report that the workplace is inclusive, that wellness activities occur regularly and are a positive experience. Feedback on the quality of workforce wellness is utilized and responded to by the team lead and/or agency leadership. The team has a staff turnover rate of less than 30% over past year.

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