

First Episode Programs in Greater Context

Webinar 5: September 10, 2015

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Webinar Logistics

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Two blue arrows point from the text on the left to the "Use Telephone" radio button and the "Audio PIN" field in the screenshot.

Aims

- Explore the implementation of first episode programs in the wider system/state context including:
 - Financing
 - State and local systems
 - State and national resources
 - Organizational considerations



Implementing the 5% Block Grant Set Aside for First Episode Programs State Efforts and Technical Assistance Resources

**David Shern, Ph.D. with
Pat Shea, Kristin Neylon, Ted Lutterman, Robert Shaw and Mihran Kazandjian
National Association of State Mental Health Program Directors
NASMHPD Research Institute
September 10, 2015**



Disclosure Statement

- This work was supported by a contract from the Substance Abuse and Mental Health Services Administration.
- The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. Any references to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. Government or HHS.



Presentation Overview

- Introduction to the Block Grant Set Aside
- State implementation Efforts for the Set Aside
- NASMHPD/NRI Technical Assistance Resources
 - Environmental Scan
 - Webinar Series
 - Technical Assistance Publications
 - Outcome Measurement Summary



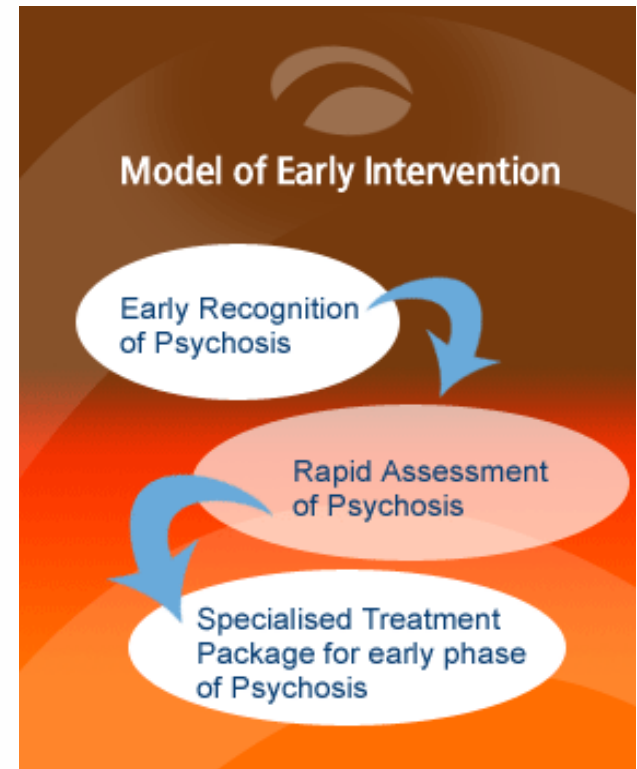
5% Set Aside for FEP

- The Fiscal Year 2014 SAMHSA included new funding and a new requirement within the Mental Health Block Grant (MHBG) that “States shall expend at least five percent of the amount each receives... to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.”

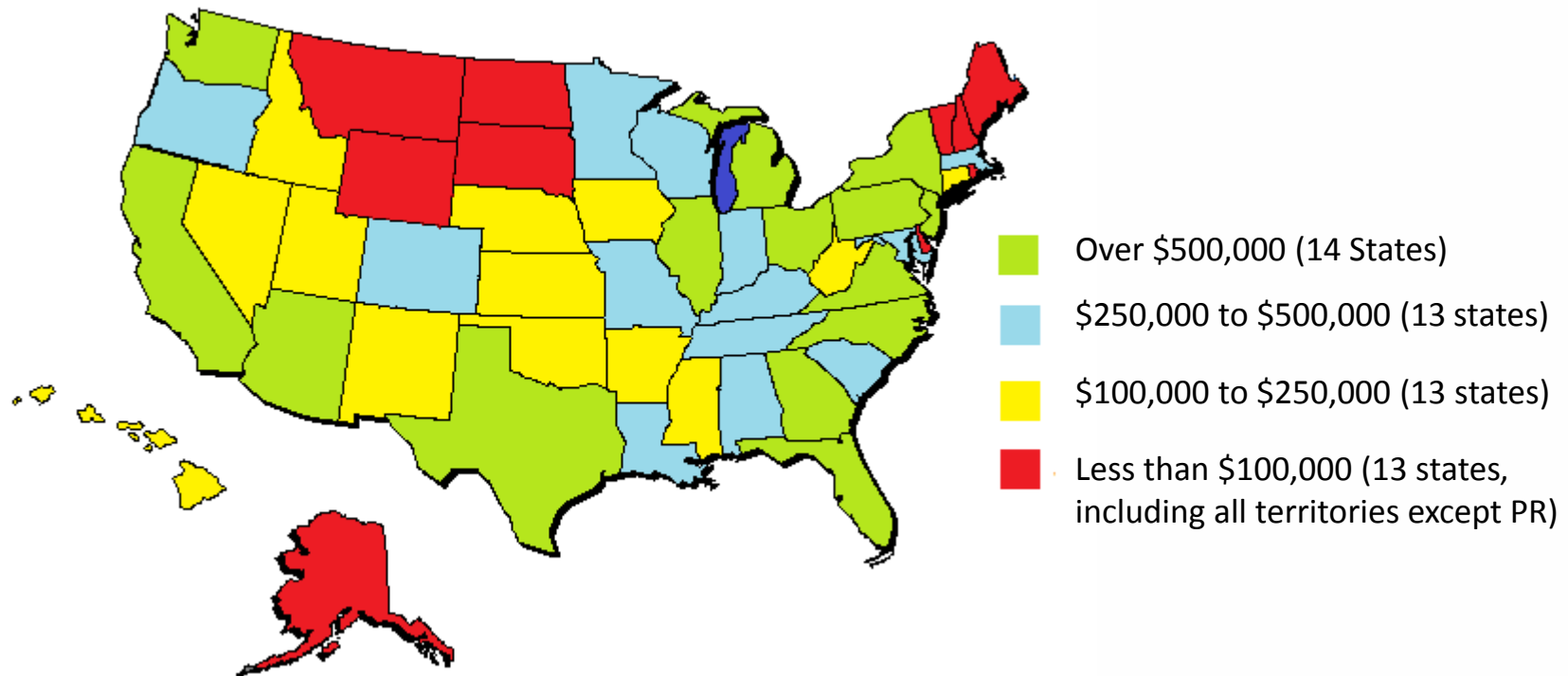


5% Set Aside Goal

- The set aside was intended to stimulate the development of programming for individuals in the early stages of their illness – prior to the development of disability. Funds were restricted to individuals with a first episode of serious mental illness.



MHBG State Allotments of the 5% Set-Aside



MHBG Set-Aside Funding ranged from \$3.1 million in CA to \$2,500 in Palau

Note, many states are providing additional State funds to support First Episode Programs

State/Territorial Implementation Strategies

- 7 implemented the RAISE Navigate Program – All are in the installation phase
- 11 implemented the On Track New York - Installation and program expansion
- 8 implemented the RAISE model unspecified – most in installation phase – 1 expanding services
- 15 implemented other Coordinated Specialty Care Programs (e.g Yale STEP, Oregon EASA)
- 9 are exploring programs for implementation
- 9 implemented EBP's for the population (e.g. Supported Employment, CBT, Family Psychoeducation)
- 2 states vary by county

States may be represented more than once if using multiple strategies



Technical Assistance Materials – The Environmental Scan

- Reviews a variety of programs and practices for early intervention with an emphasis on
 - Coordinated Specialty Care (CSC) models both domestic and international
 - Evidence based practices that are often included in CSC programs
- Selected additional resources includes
 - Organizational/Institutional resources (e.g. NIMH/SAMHSA)
 - Links to archived webinars of relevance
 - Selected peer reviewed articles on topics of interest
- Appendices providing more in depth information on selected programs.

<http://www.nasmhpd.org/sites/default/files/EnvironmentalScan2.10.2015.pdf>



Matrix A: Examples of Coordinated Care Models for Persons in Early Stages of Illness

Coordinated Specialty Care (CSC) as defined by the National Institute of Mental Health is a “team-based, multi-element approach to treating first episode psychosis^{4*}”. This section contains a selection of domestic and international CSCs aimed at treating first episodes of psychosis that occur as a result of a serious mental illnesses, including (but not limited to) schizophrenia, schizoaffective disorder, and schizophreniform disorder. This matrix is not intended to serve as an exhaustive listing of all of the individual CSC models or clinic sites across the globe, but rather to offer a representational sampling of programs utilizing this type of model. When available, eligibility criteria, treatment components, team staffing, and online resources are provided for each program (In the electronic version, web-links are embedded). Resources categorized under “Special Features” are developed by the program; other resources that are provided were developed by other sources, but are useful in implementing the CSC. Of course, a coordinated care approach is also beneficial to persons in early stages of other types of mental disorders beyond psychosis. At the end of this matrix, then, are examples of three integrated care program models that focus on mood disorders (one on bipolar, and two other on youth depression).

Program	Eligibility Criteria (May Vary by Treatment Location)	Treatment Components	Team Staffing (May Vary by Treatment Location)	Resources
<p>Sacramento EDAPT (SacEDAPT): Similar to EDAPT, SacEDAPT is a recovery-based treatment approach that provides for two years of services focusing on 1) reducing and managing symptoms, and 2) improving individuals’ ability to achieve success in independent roles. Gold standard assessments of clinical symptoms and psychosocial functioning are used to evaluate each client to determine appropriate diagnosis in order to guide treatment. This program is specifically designed for residents in Sacramento County, California, who receive Medi-Cal (California’s Medicaid program), or are uninsured or undocumented. [Note: program serves both FEP and high-risk populations]. Click Early Diagnosis and Preventive Treatment (EDAPT) & Sacramento EDAPT (SacEDAPT) for a more thorough description of this program.</p> <p>Program Established in 2011.</p> <p>Contact: Tara Niendam, Ph.D. Tel: 916-734-3090 / tniendam@ucdavis.edu http://earlypsychosis.ucdavis.edu/edapt Located at the Behavioral Health Center University of California Davis Medical Center 2230 Stockton, Blvd Sacramento, CA 95817</p>	<ul style="list-style-type: none"> • Ages 12-30 • Residents of Sacramento County • Non-affective and affective psychosis • Experienced symptoms in the past year • Have Medi-Cal or are uninsured and/or undocumented • Also serves prodromal clients 	<ul style="list-style-type: none"> • Medication Management • Individual/Family Psychoeducation and support • Multi-family groups • Supported Education • Supported Employment • Peer Support Groups • Family Support groups • Individual and Group Cognitive Behavioral Therapy • Substance Abuse Management Groups 	<ul style="list-style-type: none"> • Clinic Director • Director of Operations • Medical Director • Clinic Coordinator • Licensed Clinical Social Worker • Licensed Marriage and Family Therapist • Peer Advocate • Supported Education/ Employment Specialist 	<p>SPECIAL FEATURES:</p> <ul style="list-style-type: none"> • <i>For Professionals:</i> <ul style="list-style-type: none"> ◦ Fellowships, internships, and externships for professionals are available through the EDAPT program. • <i>Outreach and Screening Materials:</i> <ul style="list-style-type: none"> ◦ Online 21 Question Screening Survey ◦ Educational sessions for stakeholders and practitioners are available through the EDAPT program at UC Davis. ◦ How to access services <p>OUTCOME MEASURES/INSTRUMENTS:</p> <ul style="list-style-type: none"> • Change in clinical symptom severity is monitored using the following instruments: <ul style="list-style-type: none"> ◦ Global Functioning Scale – Social and Role ◦ CGI-SCH (Haro, 2008; Masand, O’Gorman, & Mandel, 2011) ◦ Columbia Suicide Severity Rating Scale (CSSRS) • Outcomes are also measured based on the following indicators: <ul style="list-style-type: none"> ◦ Participation in age-appropriate social



Evidence-Based Practice	Treatment Elements	Provider Requirements	Resources
<p>Cognitive Behavioral Therapy (CBT): CBT is a type of mental health psychotherapy where the counselor works with patients in a structured manner for a limited number of sessions. CBT helps patients become more aware of negative or inaccurate thinking so they can view their lives more clearly and respond to events more effectively. CBT can be helpful in treating mental disorders or illnesses by helping patients manage symptoms and prevent relapse, manage stress and emotions, improve communication and interpersonal relationships, overcome emotional trauma, cope with medical illnesses, and manage chronic physical symptoms. CBT can be used to treat depression, bipolar disorders, schizophrenia, and other serious mental illnesses. Source</p>	<ul style="list-style-type: none"> Based on the cognitive model of emotional response in which modifying thinking modifies emotional or other cognitive responses. Treatment is brief and time-limited, structured and directive; Requires a sound therapeutic relationship and is a collaborative effort between the therapist and the client. Requires active participation by the client in completing homework 	<p>Can be performed by a range of mental health professionals including psychiatrists, psychologists, social workers, nurses or licensed mental health therapists. Educational levels for certification listed below.</p> <p>The National Association of Cognitive Behavioral Therapists (NACBT) provides certification in CBT. NACBT offers four certification levels:</p> <ul style="list-style-type: none"> Diplomate in Cognitive Behavioral Therapy – The highest credential awarded by NACBT. Criteria required for certification (valid for 5 years): <ul style="list-style-type: none"> Masters or doctoral degree in psychology, counseling, social work, psychiatry, or related field from a regionally accredited university. Ten years of post-graduate experience at providing CBT. This experience must be verified. Three letters of recommendation from mental health professionals who are familiar with the applicant's cognitive behavioral skills. Successful completion of a certification program (all levels) in CBT that is recognized by NACBT, such as Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, or Cognitive Therapy. Certified Cognitive Behavioral Therapist – Criteria required for certification include (valid for 5 years): <ul style="list-style-type: none"> Masters or doctoral degree in psychology, counseling, social work, psychiatry, or related field from a regionally accredited university. Six years of post-graduate experience at providing CBT. This must be verified. Three letters of recommendation from mental health professionals who are familiar with the applicant's cognitive behavioral 	<p>FOR PATIENTS AND FAMILIES:</p> <ul style="list-style-type: none"> CBT Group Therapy Manual for both Providers and Patients (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided. CBT Open Group Member's Guidebook (Spanish Version): Workbook given to open group members to educate them about CBT group, highlight the connection between thoughts and mood, help patients better identify and manage thoughts (both harmful and helpful). CBT Closed Group Member's Guidebook (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided. CBT Individual Treatment Manual: Client's Guidebook (Spanish Version): Provides an overview of CBT and depression, and highlights the goals of the treatment plan. NAMI CBT Factsheet: Two-page factsheet that provides information about what CBT is, and when it is best used as a form of therapy. Cognitive Therapy Rating Scale: Allows the patient to provide feedback on the quality of the session. Related: Cognitive Therapy Rating Scale Manual. <p>FOR PROFESSIONALS:</p> <ul style="list-style-type: none"> A Therapist's Guide to Brief Cognitive Behavioral Therapy: This manual is designed for mental health practitioners looking to establish a solid foundation of CBT skills. Concepts contained in this manual detail the basic steps needed to provide CBT with the intent that users will feel increasingly comfortable conducting CBT. The manual is not designed for advanced CBT practitioners. CBT Group Therapy Manual for both Providers and Patients (Spanish Version): This manual provides ground rules for group therapy, a framework of CBT, what to expect in group therapy, and information about how thoughts affect moods. A daily mood scale and "homework" exercises are provided. CBT Manual for Non-CBT-Trained Professionals: Group Leader Introduction, Open Group Provider Manual (English), Open Group Provider Manual (Spanish) CBT Manual for Closed Group Leaders (Spanish Version): Provides tips to the Group Leader to ensure a successful session, including a list of supplies, goals, and processes.





Early Intervention in Psychosis: A Primer

Developed by Kate Hardy, Clin.Psych.D.;
Stanford University School of Medicine



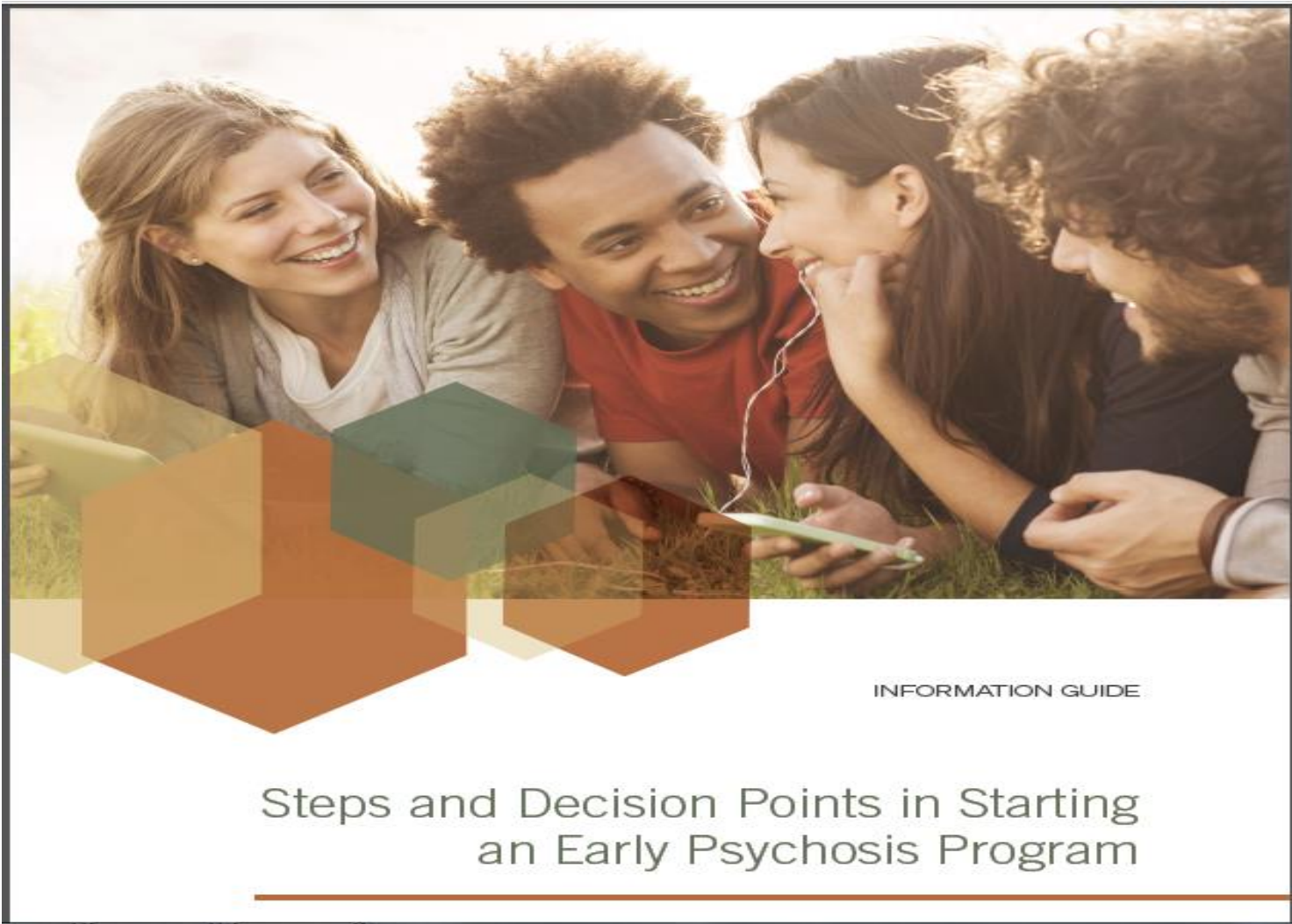


GUIDANCE MANUAL

Peer Involvement and Leadership
in Early Intervention in Psychosis
Services: From Planning to Peer
Support and Evaluation

Nev Jones, PhD, Stanford University





INFORMATION GUIDE

Steps and Decision Points in Starting an Early Psychosis Program

Tamara Sale, MA, of the EASA Center for Excellence at Portland State University,
with assistance from Shannon Blajeski





FACT SHEET

Building Upon Existing Programs and
Services to Meet the Needs of Persons
Experiencing a First Episode of Psychosis

Vicki L. Montesano, PhD; Associate Director, Best Practices
in Schizophrenia Treatment (BeST) Center and Lon C. Herman, M.A.; Director,
Best Practices in Schizophrenia Treatment (BeST) Center





FACT SHEET

Implementation of Coordinated Specialty Services for First Episode Psychosis in Rural and Frontier Communities¹

A.S. Crisanti, PhD, D. Altschul, PhD, L. Smart, PhD, and C. Bonham, MD; Division of Community Behavioral Health, Department of Psychiatry and Behavioral Sciences, University of New Mexico School of Medicine





ISSUE BRIEF

Supported Education for Persons Experiencing a First Episode of Psychosis

Deborah R. Becker, Sarah J. Swanson, Robert E. Drake, and Gary R. Bond
Dartmouth Psychiatric Research Center





Editorial team included Dr. David Shern and Dr. Robert Drake along with the Option Grid team at Dartmouth led by Dr. Glyn Elwyn and colleagues Dr. Manish Mishra and Ms. Arianna Blaine, Shern and Drake were joined by Drs. Pat Deegan, Lisa Dixon, Tony Lehman, Julie Kreyenbuhl and Will Torrey.

Assessing the Impact and Outcomes of FEP Programs

To Assist states and providers implementing FEP Programs to assess outcomes and impact, SAMHSA has sponsored several activities

- 4 Quarterly Webinars focusing on Outcomes
- NRI Report on What Outcome and Performance Measures early FEP Program have found most useful (report being completed Fall 2015)
- Collaboration with NIMH, ASPE, and PEPPNET Group (Prodromal and Early Psychosis Prevention Network)



Early Intervention Program Outcome Webinars

Four Quarterly Webinars to help States and Providers Learn from the experience of other Early Intervention Programs about what to measure and how to measure it:

[Copies of webinars are available online at: <http://www.nasmhpd.org/webinars>](http://www.nasmhpd.org/webinars)

1. Measuring the Impact of Early Intervention Programs for First Episode Psychosis: Experiences and Lessons Learned from Two States, Oregon and Maryland, December 16, 2014
2. Evidence Based Approaches to Systematic Fidelity Assessment for First Episode Programs, April 20, 2015
3. Practical Approaches to Measuring Fidelity in Coordinated Specialty Care for First Episode Psychosis, May 13, 2015
4. Methodological and Practical Issues in Population Based Programming for Persons with First Episode Psychosis: Incidence, Engagement, Penetration and Outreach Effectiveness, September 8, 2015





Strategies for Funding Coordinated Specialty Care Initiatives

- ❖ Mary F. Brunette, M.D.
- ❖ Howard H Goldman M.D. Ph.D.
- ❖ Thomas G. McGuire, Ph.D.

June 30, 2015



<http://www.nasmhpd.org/sites/default/files/June%2030%20PPT%20-%20All%20Presenters.pdf>



OTNY Implementation: Considerations Regarding How Organizational Issues Impact Addressing Performance Expectations

**Lisa Dixon, M.D.
Director, OnTrackNY, NYSPI
Professor of Psychiatry
Columbia University Medical Center**



Performance Expectations

- Based on collection of patient and team level data, largely from clinicians; stored and analyzed by OMH Performance, Measurement and Evaluation Unit.
- Data covers care processes and outcomes.
- Baseline, q 3month, and discharge forms for all clients completed at time of treatment planning.
- Q3 month information on team functioning submitted by team leader.



Performance Expectation Grid

Domain and Expectation	Operational -ization of Expectation	Source of Information
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Performance Expectations

- **Staffing.** Teams hire and maintain the required staff.

*Key Issues: How turnover, maternity leave are addressed

- **Caseload size.** Teams maintain a caseload that is small enough to allow for intensive and highly individualized services while, at the same time, serving as many clients as possible within these service demands.

*Key Issues: minimal problems; occasional push for too many too fast



Performance Expectations

- **Staff meets as a team.** These meetings are for strategic clinical thinking and reviewing the status and “next steps toward goals” for each person on the team’s caseload.
- *Key Issues: Environment of collaboration needed; time allowed; lack of overwhelming additional responsibilities



Performance Expectations

Domain and Expectation	Operationalization of Expectation
Admission occurs promptly; the time from inquiry about the program through eligibility determination and admission to the team is completed in a timely manner.	For at least 80% of individuals admitted to the program, the time from eligibility evaluation to admission is ≤ 1 week.
Teams act on referrals quickly and engage clients and families throughout the process from referral through admission.	Comment: Expectations around timeliness of the various components of the admission process are still evolving and will be informed by current performance across teams.

***Key Issues:** Orientation to community and connectivity to partners; maybe better in child and programs with clients who have greater disadvantage; sufficient staff time needed



Performance Expectations

Domain and Expectation	Operationalization of Expectation
Flexibility of Services. Services are provided in times and locations that promote engagement and retention of client.	<ul style="list-style-type: none">a. Team provides 24/7 coverageb. Policy is posted at the site in a location visible to clients/family members and distributed to each clientc. At least 10% of clients are seen in the community by at least one Team member at least once per quarter (exclude services provided by the Supported Education and Employment Specialist)d. Staff schedule shows the regular availability of office time outside of the regular work day for the scheduling of routine appointments.e. At least one family group each month meets outside the hours of 9-5 M-F.

***Key Issues: Agency policy and flexibility; recovery orientation; ability to address bureaucratic roadblocks**



Performance Expectations

Domain and Expectation	Operationalization of Expectation
<p>1. Psychotropic Medications. Pharmacotherapy is a core component of treatment. Because many clients with FEP are reluctant to try medication, teams work to develop trusting relationships and provide education about medication options and best practices for medication treatment for FEP so that clients are willing to try adequate trials of antipsychotic medications.</p>	<p>a. On the last day of the reporting period, antipsychotic medication was prescribed for at least 60% of clients.</p> <p>b. At least 75% of clients have had at least one trial of an antipsychotic medication prescribed for at least 4 continuous weeks within the recommended dosage range.</p> <p>...</p>

***Key Issues: Culture of respect, person-centeredness, recovery orientation, balance in medical leadership**



Performance Expectations

Domain and Expectation	Operationalization of Expectation
For clients prescribed antipsychotics, teams monitor weight change.	For at least 80% of clients prescribed an antipsychotic medication, weight is assessed at least quarterly.

***Key Issue: Orientation toward integrated care**



Performance Expectations

Domain and Expectation	Operationalization of Expectation
Clients who are using substances have their substance use addressed by their Primary Clinician.	Of clients whose substance use is seen as problematic by at least one member of the team (including the client), at least 50% of such clients are receiving treatment for substance by meeting with at least one OnTrackNY clinician during the quarter.

***Key Issue: Orientation toward substance abuse treatment, harm reduction**



Performance Expectations

Domain and Expectation	Operationalization of Expectation
SEES focuses exclusively on supported employment and supported education.	SEES primarily provide employment and education services. At least 90% of the SEES's time is devoted to assisting client in working on employment or education goals (vs. case management and crisis services, administrative duties, or other duties not directly related to employment or education).

***Key Issues: Respect for importance of this role beyond billing; understanding of role in recovery**



Performance Expectations

Domain and Expectation	Operationalization of Expectation
<p>Working with families. Team discusses with each client ways family might be involved in the client's treatment and determines each client's preferences and reassesses these preferences periodically. Team documents family's participation in treatment over time.</p>	<p>a. For all clients, Team has conversations regarding their preferences for family involvement as part of the admission process.</p> <p>b. For at least 50% of clients, at least one team member met with at least one member of the client's family each quarter.</p>

***Key Issue: Fears around HIPAA; discomfort with family; child world does better**



Summary

- Leadership and organizational culture influence ability to implement CSC programs in diverse ways
- Challenge to maximize “fit” while respecting agency culture



Leveraging Resources and Building Support: Learning from Oregon's Experience

Tamara Sale, MA

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Portland State University, Portland, Oregon

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September 10, 2015



Creating Shared Vision & Ownership



- How you define the problem(s) and vision determines the possible solutions
- Demonstrate broad reach, urgency, contrast between now and future, and potential impact
 - Generates understanding & commitment (especially when people with lived experience speak)
 - Creates flexibility in strategies for how we get there



Contrasts

AVAILABLE
ACCESSIBLE
AFFORDABLE

VERSUS

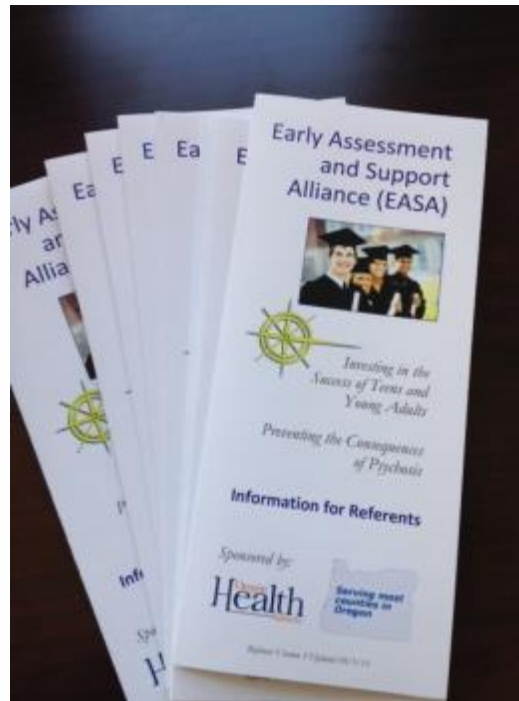
**ACCESS
DENIED**

- Education vs. people not knowing
- Rapid access vs. long delay
- Outreach & voluntary entry vs. involuntary traumatizing entry
- Support for developmental progress and career vs. push for disability
- Family education and support to keep families together vs. family burden & break-up
- Evidence-supported care vs. whatever happens to be available (usually not evidence-supported)
- Proactive approach to prevent hospitalizations and legal involvement vs. ongoing cycle of relapse
- Engagement of young people and families in system development vs. adversarial relationships
- Systemic problem solving vs. expensive ineffective strategies



Marketing

- Simple written materials with data & graphs
- Stories
- Clear and compelling messaging
- Ongoing relationships and investment



Health Care Reform: EASA's Genesis



- 1997 Oregon Medicaid health care reform created Mental Health Managed Care Organizations with flexibility & ability to reinvest in prevention/early intervention
- Mid-Valley Behavioral Care Network responsible for five original counties; reinvested Medicaid dollars for start-up
 - Sought private foundation and Federal Block Grant dollars to allow universal approach
 - Brought funders together to create sustainability strategy & build ownership over systemic solutions
 - Resulted in sharing of billing strategies, legislative appropriation, ongoing effort to align parity interpretations to include public mental health services (i.e. acceptance of agency licensure, requirements that comprehensive services for serious mental illness be covered)
- Created common name/materials, fidelity process, practice guidelines, cost analysis, etc.- allowed us to take unified approach
- Led to statewide effort; ongoing development
- Became core of young adult system effort



Sustainability Work Group



- Invited players who had authority and dollars
- Started with common understanding of what we were trying to fund
- Outlined payer scenarios and elements; identified what we could or couldn't pay for
- Prioritized non-Medicaid services at first
- Led to short-term and long-term strategies
 - Foundation grant applications; Federal Block Grant appropriation
 - Ongoing legislative appropriation (expanded later to include training & technical assistance)
 - Ongoing effort to integrate alternative payment methods into Coordinated Care Organizations
 - Ongoing effort to interpret parity rules to include team-based outpatient community-based mental health not available through private practitioners



National Opportunities

- Sharing resources
 - Regional efforts such Oregon/Washington and NY/Maryland
 - National learning collaboratives
 - Visiting each others' programs
 - Creating connections across people with similar roles
 - Sharing training costs & opportunities, capacity building
 - Developing web-based training including virtual coaching



Public Health Approach

- Incidence is predictable
- High cost borne by multiple players
- Current incentives to use the least effective, most reactive care
- Human & legal rights issue!



Role of People with Lived Experience



- Feedback and guidance to ensure accountability and relevance of your effort
- Most credible advocates for funding and broad support

Incremental Opportunism

- Start with what you can do
- Articulate the vision
- Aim for what you can't do yet
- Align with existing efforts



Short-Term Financing Strategies

- Expand priority definitions
- Tie to existing hospital diversion and health care reform efforts
- Maximize billing
- Apply for grant funding
- Break out practices to implement



Long-Term Financing Strategies

- Tie to high-traction efforts such as legislative priorities and court cases (Olmstead, etc.)
- Build champions by bringing them to the table, articulating shared vision, defining roles
- Work together with other sites & stakeholders to:
 - Advocate for meaningful insurance parity,
 - Build data,
 - Generate cost estimates,
 - Develop marketing strategies.



Cross-State Collaboration

- Sharing materials and program strategies
- Shared consultation, training & problem solving
- Developing web-based strategies
- Working toward a national vision & consistent system of care



Cross-State Collaboration

- National Association of State Mental Health Program Directors portal: <http://www.nasmhpd.org/content/early-intervention-psychosis-eip>
- Prodrome and Early Psychosis Network (PEPNET): <http://med.stanford.edu/peppnet/whoweare.html>
- National Psychosis Prevention Council: <http://psychosisprevention.org/>
- International Early Psychosis Association: www.iepa.org.au
- EASA: www.easacommunity.org
- Commonwealth programs: EPPIC <http://eppic.org.au/> , IRIS <http://www.iris-initiative.org.uk/>
- RAISE resources: <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-resources.shtml>
- Navigate (RAISE Early Tx Program manuals): www.navigateconsultants.org
- RAISE Connections/ OnTrack USA (implementation and treatment manuals): <http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx>



Discussion/Questions



Next Month

- **Evaluation/outcomes**
- **October 15 – 11am-1pm ET**



COP: Next Steps

- **Post webinar survey.**
- **September office hours with David, Lisa and Tamara**
 - Selections must be made by COB 9/17.



National Council for Behavioral Health Hill Day 2015



October 5-6, 2015
Washington, D.C.

