



ISSUE BRIEF

Workforce Development In Coordinated Specialty Care Programs

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INTRODUCTION

THE EVOLUTION OF COORDINATED SPECIALTY CARE

Schizophrenia is one of the most disabling and costly of all illnesses (Murray & Lopez, 1997; Walker, McGee, & Druss, 2015). It affects roughly 1% of the population, with onset occurring most typically at the developmentally important period between 15-25 years of age (McGrath, Saha, Chant, & Welham, 2008). The past few decades have seen a surge of programmatic efforts to intervene intensively as soon as possible after the onset of psychotic symptoms, and there is mounting evidence that this yields superior outcomes compared to usual treatment.

Multiple randomized clinical trials have demonstrated that multi-component team-based services, now referred to as Coordinated Specialty Care (CSC), lead to a greater reduction in symptoms and amount of time psychiatrically hospitalized, and to improved vocational outcomes and quality of life (Craig et al., 2004; Grawe, Falloon, Widen, & Skogvoll, 2006; Kane et al., 2016; Nordentoft, Rasmussen, Melau, Hjorthoj, & Thorup, 2014; Secher et al., 2014; Srihari et al., 2015). Research also has demonstrated that reducing the duration of untreated psychosis (DUP) results in better long-term outcomes, such as higher rates of recovery and independent living at 10-year follow-up (Hegelstad et al., 2012).

As this evidence began to accumulate, model CSC programs evolved, testing specific interventions and service delivery methods. Early studies took place in Europe and Australia, and then began to occur in the U.S. The first randomized clinical trial of a U.S. public sector based service, Specialized Treatment Early in Psychosis (STEP) (Srihari et al., 2015), was followed by a large cluster randomized trial, Recovery After an Initial Schizophrenia Episode (RAISE), demonstrating feasibility and effectiveness of widespread implementation (Kane et al., 2016). Both of these studies were funded by the National Institutes of Health (NIH), demonstrated superior outcomes to usual care in the U.S., and signaled a growing federal interest and commitment to early intervention.

Availability of CSC in this country grew from an initial handful at academic centers, to statewide implementation projects (e.g., California, New York, and Oregon), and then to a surge in the number of sites following the RAISE initiative. Beginning in 2014, Congress added new funds to the mental health block grant and required that these new funds (5% of the block grant) be used to support early intervention programs. Additional funds and a 10% set aside for these programs followed in FY 2016. From just 12 CSC community clinics in 2008, there were an estimated 162 programs in implementation or full operation in 2016. A total of 46 states had plans to maintain, expand, or implement at least 1 CSC program, with a projected total of 213 programs in operation or under development (NASMHPD, 2016).



WORKFORCE CHALLENGES IN BEHAVIORAL HEALTH

There are longstanding and very substantive concerns about the behavioral health workforce in the U.S. and abroad (Smith & Jury, 2017). The recurring themes focus on the difficulty recruiting qualified individuals to fill positions within the mental health and addiction treatment systems; achieving diversity within the workforce that matches the diverse populations receiving services; retaining individuals once hired and dealing with the negative impact of high levels of staff turnover; achieving competence within the workforce through effective education, training, and supervision on best practices; developing skilled supervisors, managers, and leaders; broadening the workforce to include persons in recovery and family members as formal care providers; and enabling all health and social service providers to meet the needs of individuals with behavioral health conditions through integrated approaches to care (Hoge, Stuart, Morris et al., 2013; SAMHSA, 2009). These and other issues have been the focus of concern and attention among the states as they strive to ensure access to quality care (Hoge, Wolf, Migdole, Cannata, & Gregory, 2016).

As Coordinated Specialty Care has grown in the United States, there has been increased attention to the workforce challenges related to operating these programs. A set of recurring questions has emerged: What are the workforce competencies required for this work? What are the best strategies for recruiting, selecting, and retaining individuals most qualified to do the work? What are the recommended approaches to orientation, training, continued professional development, and supervision of CSC staff?

PROJECT GOAL

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to support the creation of a wide range of informational resources related to early intervention in psychosis; the development of these products is coordinated by the National Association of State Mental Health Program Directors (NASMHPD). The goal of the project described in this Brief was to gather information from experts in the field on recommended best practices for addressing workforce challenges in CSC programs.

NASMHPD engaged the Annapolis Coalition on the Behavioral Health Workforce to manage this project. The Annapolis Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the workforce in the mental health and addiction sectors (<http://annapoliscoalition.org>). For the past 15 years it has provided technical assistance on workforce issues to federal and state agencies, non-profit organizations, and foundations.

A few comments on the issue of language are in order. There are many different names used to refer to the types of services that are the focus of this Issue Brief, including Coordinated Specialty Care, Early Intervention, and First Episode Psychosis (FEP) Services. The term *Coordinated Specialty Care* or its abbreviation, CSC, will be used throughout this document.

The term *worker* is used to refer to all individuals who staff these programs, recognizing that some of the roles and competencies will differ between individuals from differing disciplines. Workers include: recent graduates who are entering the workforce for the first time; seasoned professionals who have experience in behavioral health prior to employment in a CSC; peers in recovery; and trainees in professional or other educational programs. The term *workforce development* is used to refer to efforts to recruit, select, retain, train, supervise, and improve the performance of individuals working in CSC programs.

METHOD

The primary sources of information for this project were the expert opinions of nine carefully selected respondents. A respondent was defined as one or two individuals affiliated with the same organization who had substantial knowledge about developing and managing Coordinated Specialty Care services. The number of respondents was limited to nine in order to comply with the Federal Office of Management and Budget rules regarding data collection methods.

Within the constraints of this sample size, respondents were chosen to reflect the broad range of healthcare settings within the U.S. They represented a variety of geographic regions, urban and rural locations, private and public institutions, and academic and non-academic centers. Respondents from relatively new programs and from well-established programs were among those interviewed in order to capture differing experiences in staff recruitment, training, and retention. Also included were representatives from CSCs with formal training rotations for students in professional programs (e.g., psychiatric residents, psychology doctoral interns), and those with extensive experience consulting, training, or providing technical assistance to new or developing CSC programs.

Respondents were interviewed by phone for up to 90 minutes using a semi-structured protocol. The interviews were conducted by an experienced clinical director of a CSC program and were recorded. Respondents were first asked to identify the main workforce challenges in CSCs. Subsequent questions probed for respondents' recommendations regarding: worker competencies, recruitment and selection, orientation, continuing professional development, supervision, retention, and the inclusion of trainees. Toward the end of the interview, respondents were asked to comment on how workforce challenges vary by type of worker (e.g., trainee, new graduate, experienced worker, peer, etc.) and to recommend relevant workforce related resources.

Written summaries of each interview were produced. The comments of all respondents to a specific question (e.g., required competencies) were incorporated into a single document and reviewed by the project team to first identify and then summarize the prominent themes. After review by NASMHPD, the draft Issue Brief was circulated to all respondents for their review and comments, which informed this final report.

While there was considerable agreement among respondents, there were areas in which opinions differed. Some of these differences are noted in the findings. Each respondent

discussed many, but not all, of the numerous of topics mentioned in this Issue Brief. Therefore, the reader should not conclude that all respondents endorsed each and every recommendation or conclusion that appears below.

What follows are the findings and recommendations by topic and a brief conclusion. A list of additional resources relevant to workforce development in CSC can be found at the end of this Issue Brief.

FINDINGS & RECOMMENDATIONS

I. COMPETENCIES

The concept of “competencies” generally refers to knowledge, skills, and attitudes. Respondents were asked to identify competencies required for providing CSC services that staff members might not have obtained during their professional education or prior work experience. The responses highlighted core competencies in behavioral health that respondents considered extremely important in CSC, as well as competencies that they considered somewhat unique to CSC.

There does not appear to be an existing, comprehensive, and widely recognized set of published competencies for this work. However, there are numerous resources that explicitly or implicitly identify some competencies. These include training manuals for CSC models of care (e.g. RAISE Treatment Manuals, <https://raiseetp.org/StudyManuals/index.cfm>); a fidelity scale (First Episode Psychosis Services Fidelity Scale [FEPS-FS 1.0], (Addington et al., 2016); consensus guidelines; and various publications (Heinssen, Goldstein, & Azrin, 2014; Pollard, Cahill, & Srihari, 2016). While CSC is still developing, many of the respondents seemed to agree that there is a widely recognized set of best practices for this specialty and that workers require competencies to deliver these practices.

The vast majority of competencies identified by respondents were for workers involved in the direct provision of services to clients and families. It was frequently noted that not all competencies are required by each worker given the team approach to care and the likelihood of specialization within the team, based in part on discipline. It was also noted that some workers have important skills by virtue of their personal characteristics (e.g., interpersonal abilities), while many other skills have been acquired through training and experience.

Below are the competencies identified by respondents. These are organized into the categories of foundational knowledge, interpersonal abilities, screening and assessment, and intervention. In the few cases in which a competency was linked to a specific type of worker, the worker type is noted in parentheses. Following the competency list for direct care staff are comments about competencies for peer staff and program managers, and a discussion of the unique aspects of competencies for CSC practice. While considerable information about CSC competencies are offered below, the lists are not intended to be comprehensive or definitive since they are based on recommendations from a limited number of respondents.

Competencies for Direct Care Staff

Foundational Knowledge

Be knowledgeable about the development of adolescents, transition age youth, and young adults. Development of independent living skills, adult identity formation, career ambitions, and romantic and other social relationships are key tasks for this age range. CSC workers need to understand these developmental tasks in order to assist clients in acquiring social, vocational, and daily living skills, and conduct psychotherapeutic work around identity. In CSC services, workers must be knowledgeable about typical development in order to recognize and intervene when development is being impacted by illness and to minimize the possibility that the expected challenges during the course of development will be regarded as abnormal.

Remain current on the literature regarding early stages of psychosis and its treatment. The professional literature on psychosis and CSC approaches to service delivery is rapidly expanding. Worker knowledge of this literature is essential for practice and often can be used to reassure clients and family members. All team members should be familiar with recovery outcomes in CSC and concepts of resilience. At least one team member, typically the team leader, must keep current on the latest findings regarding etiology, pathophysiology, concurrent challenges and comorbidities, treatment approaches and interventions.

Interpersonal Abilities

Display strong abilities to communicate clearly, with sensitivity and tact. Young persons suffering from psychosis are often struggling with paranoia, internalized stigma, and difficulties with attention and focus. Clients and their families are also likely to be in distress and in need of information and reassurance. CSC workers must communicate about diagnosis, treatment, and prognosis at an appropriate pace and in a manner that takes into account the educational level, cultural context, and receptivity of clients and families to new and, at times, troubling information.

Convey hope and optimism, while remaining vigilant for symptoms and signs of risk. A primary task of CSC workers is to instill hope in clients and families and to counter their negative perceptions of psychosis and its potential impact on the client's future. While remaining positive, CSC workers need to simultaneously be aware that this phase of illness presents the highest risk of suicide, violence toward others, and psychiatric relapse compared to later phases in the course of illness. They must continue to emphasize client goals and functional recovery, while monitoring for early warning signs of relapse and risk of harm to self or others. CSC workers recognize that clients' presentations in the early stages of illness likely represents "seeing them at their worst" and does not necessarily reflect their potential to succeed.

Demonstrate comfort and flexibility in interacting with clients, families, and other caregivers. CSC workers function in complex interpersonal environments that involve a client and family in distress, multiple coworkers, and providers from other agencies. Workers must be able to maintain poise when faced with intense emotional expression, conflict, and bizarre ideation or behavior. They need to be skilled in adapting to rapidly shifting tasks and interactions as they strive to reduce client and family distress, avoid power struggles, and remain focused on the ultimate goals of treatment.

Effectively engage clients and families into treatment. There are many potential barriers to engagement during a first episode of psychosis, including: client and family lack of information about and acknowledgment of illness; negative attitudes about mental illness; personal priorities that don't include mental health treatment; and fears about treatments, such as involuntary commitment. Since this is a critical period in the course of illness, skilled workers must place a high value on engagement. They should be: creative in their engagement efforts; adept at maintaining a non-judgmental and non-punitive stance toward client and family behaviors; tolerant of client and family ambivalence about or absences from treatment (e.g., clients who do not show are not immediately discharged); flexible in conducting engagement activities in settings preferred by the clients or in inpatient settings when rehospitalized; and focused on individual client priorities and interests, which may range from focus on symptom relief to support in school or recreational activities.

Develop and maintain a trusting therapeutic alliance with clients and their families. Effective workers in CSC services respect clients and families as essential members of the treatment team. They attempt to foster a working relationship based on open communication, cooperation, and meaningful participation. Workers should be straightforward and empathic in their interactions, validate client and family experiences, and utilize shared decision-making approaches.

Adapt the approach to the diverse characteristics of clients and families. CSC programs typically serve a heterogeneous population, within which the lives of individual clients and families are influenced by their racial, ethnic, cultural, and gender identities, and socioeconomic status. Based on knowledge of client and family characteristics, workers must individualize care, even within structured interventions. This includes adapting to the communication styles of clients and families and to their concepts of illness, treatment and recovery.



Function effectively as a member of a team. CSC services use an interdisciplinary team-based care delivery model that brings together diverse perspectives from talented co-workers to enrich formulations, treatment planning, and comprehensive interventions. CSC workers must be able to function in a team, communicating information to others readily and often, participating in team meetings to jointly plan and coordinate care, and consulting with others around issues such as risk.

Collaborate with staff in other programs, community agencies, schools, and the criminal justice system. Individuals early in the course of a serious mental illness typically benefit from comprehensive services provided by multiple professionals. The CSC worker should develop a broad range of professional relationships with community providers, as well as skills in communication and collaboration in the delivery of care. Similar skills are essential in coordinating with high school and university personnel to facilitate entry or re-entry of clients into educational programs. Since it is common for clients in CSC programs to have criminal justice involvement, workers should be skilled in collaborating with professionals in that system, such as probation officers, police Crisis Intervention Teams (CIT), and jail diversion staff. Selected workers on the team should also be competent in teaching health, social service, educational, and criminal justice professionals, and community members to recognize early warning signs of psychosis and to refer individuals with such signs to CSC services.

Manage conflict between others, including clients and families. The typical conflicts between parents and youth at this developmental stage are often accentuated by a serious illness, by differences of opinion about its cause and treatment, and by concerns about the ability of the client to continue to move toward independence. Disagreement can also occur between staff on the team or among community providers involved in delivery of care. Workers in CSCs should be skilled in managing conflict by facilitating communication between individuals who are at odds, de-escalating situations when tensions run high, problem-solving, and brokering compromise.

Screening & Assessment

Detect, screen, and differentially diagnose relevant mental health, substance use, and medical conditions. CSC programs strive to differentiate between primary, affective, substance induced, and organic psychoses, and clinical high risk versus active psychosis. There also are a multitude of possible comorbidities and psychosocial factors to consider that may contribute to the clinical presentation and need to be addressed in treatment. CSC workers tasked with screening and assessment must be capable of screening for target inclusion criteria and conducting thorough assessments that examine biological, psychological, and psychosocial factors. Given the early phase of illness, workers must be skilled in an ongoing process of assessment and differential diagnosis as the clinical picture unfolds over time.



Embrace diagnostic uncertainty. There is considerable diagnostic ambiguity in the early stages of psychosis and many potential diagnostic rule-outs that can only be resolved over time. CSC workers must develop a level of comfort with and acceptance of this uncertainty. They also must clarify the ongoing assessment plan, communicate the uncertainty openly with clients and families, educate them about the potential diagnoses, and address misperceptions they may have about the inevitability of disability and other inaccurate stereotypes regarding psychosis.

Conduct brief screens and assessments of client risk to self or others. There is a relatively high risk during this phase of illness. Therefore, CSC workers must engage in regular monitoring for warning signs of risk to self or others, inability to engage in basic self-care, and for relapse into active psychosis.

Conduct neuropsychological assessment with a focus on the cognitive symptoms of psychosis. The cognitive symptoms of psychosis often persist and have a significant impact on functioning long after positive symptoms have remitted. Ideally, a neuropsychologist, knowledgeable about adolescent and young adult development is available as a member of the CSC team or as a consultant to the team. This professional should be skilled in differential diagnosis, assessment of the areas of cognition typically affected in psychosis, measurement of the impact of medication on cognition, and in offering recommendations for compensatory strategies, accommodations, and cognitive remediation. (neuropsychologist)

Intervention

Embrace recovery oriented practices in delivering CSC. Prognosis is improved with early intervention for psychosis, and engagement into treatment is greatly facilitated by prioritizing client preferences. Effective CSC workers focus on the goals identified by the client, which may often relate to social, occupational, and educational functioning, rather than simply on symptom remission. The worker should also use person-centered and shared decision-making approaches to care.

Employ interventions appropriate for the phase of illness and stage of treatment. The CSC worker adjusts treatment for phase of illness, emphasizing engagement, assessment, stabilization, and safety planning during the initial acute phase; shifting to psychoeducation, skills training, medication management, and help with work, health, and school goals during the reintegration or maintenance phase; and ultimately focusing on independent community living.

Implement evidence-based interventions and best practices. Diverse treatments are used in CSC programs. Therefore, workers should be able to provide many of the interventions listed below. They must be able to adhere to a model while remaining flexible and adjusting services to the needs of clients.

- Motivational enhancement therapy (MET)
- Motivational interviewing (MI)
- Cognitive behavioral therapy for psychosis, relapse prevention, substance use, and other disorders



- Social skills training
- Psychoeducation
- Supported employment and education (supported employment/education specialist)
- Cognitive enhancement and remediation
- Harm reduction
- Group therapies
- Individual resilience training
- Medications
- Trauma informed care

Collaborate and intervene with families using evidence-based practices. Positive affect in the family environment may protect against psychiatric relapse for FEP clients (Lee, Barrowclough, & Lobban, 2014). Family members of young people in the early stages of psychotic illness typically experience significant distress and caregiver burden. With support and psychoeducation, families can be enlisted as valuable members of the treatment team. Workers in CSCs must be capable of gathering history and observations from family members, providing support and education regarding illness to reduce negative attributions, improving communication within families, and engaging them in problem solving without blaming or stigmatizing. Specific skill in delivering family interventions is recommended, such as CBT for Relapse Prevention, Behavioral Family Therapy (BFT), Multifamily Group Psychoeducation and Support (MFG), and Family Focused Therapy (FFT).

Support client and family access to age-appropriate educational and community resources. Due to the heterogeneity of populations served in CSCs and the diversity of their psychosocial needs, workers should be able to find and connect clients and families to appropriate resources in their area. These include clinical, medical, legal, social and educational services. The ability to connect a client to educational services and participate in development of a 504 Plan or Individualized Education Plan (IEP) is particularly important.

Formulate safety plans. Workers in CSCs must be able to maintain a therapeutic alliance, minimize coercion, and maximize client time spent in the community. Unless risk of harm to self or others appears imminent, the worker must be skilled at using options other than involuntary psychiatric hospitalization, such as increasing frequency of outpatient visits, conducting home or community-based visits, arranging respite care, engaging the client's support system in monitoring health and safety, assisting the client in developing more immediate coping strategies, and ensuring removal of potential means of harm. The worker is able to clarify with clients and families the conditions under which they should access emergency services and the procedures for gaining such access.

Intervene assertively in times of heightened risk or crisis. Clients may experience acute psychotic episodes that include disorganization or suicidal or homicidal ideation that pose a risk to the client, family, or community. The CSC worker must be capable of

detecting an increase in symptoms or a decline in functioning; meeting frequently with clients during these times, whether in the office or community; communicating clearly and openly about the assessment of risk; making timely decisions; and taking assertive action when necessary. The worker respects the client's rights, offers choices when choice is possible, and follows the principles of procedural justice.

Prescribe and manage medications using guidelines and best practices designed for CSC. Clients in early stages of psychosis are relatively new to treatment, likely less tolerant of medication side effects, and may respond to lower doses. Due to developmental stage and differing interpretations of the cause of and remedies for mental health problems, they also are often reluctant to take medication. CSC prescribers use their knowledge of these factors to guide their working relationship with the client and to shape their prescribing practice. They assess the meaning of medications to clients and families, address misperceptions, communicate that medications will not necessarily be prescribed indefinitely, and use shared decision-making and motivational approaches to increase adherence. They routinely monitor for side effects and quickly intervene around increases in cardiovascular risk through actions such as changing medications or engaging clients in health-related interventions. (psychiatrists, nurses with prescriptive authority, physician assistants).

Monitor and measure outcome. Tracking outcomes is a key task in many CSC programs for clinical reasons, such as monitoring client progress, and for programmatic purposes, such as evaluating the effectiveness of the CSC program as a whole. The CSC worker must be adept at monitoring and measuring symptoms, substance use, health behaviors and health status, work and school functioning, time engaged in treatment, and service utilization. The worker must also be able to use the resulting data to inform the planning and delivery of care.

Use technology to deliver services. The relatively low incidence of new cases of psychosis makes it difficult in less populated areas to justify a local specialty clinic. Clients and families also can be reluctant to come to a clinic due to stigma or a lack of a perceived need for mental healthcare. In these situations, CSC workers are able to use technology, such as telehealth applications and secure videoconferencing, to deliver interventions remotely to clients and families and to foster collaboration among team members and other providers who are in different physical locations. Use of technology, such as texting and health monitoring apps, is also developmentally appropriate for transition age youth and may facilitate engagement.



Competencies for Peer Staff

Multiple respondents expressed the value of including peer staff on CSC teams; however, there was little description of specific competencies and an acknowledgment that this area is in early stages of development. There is now a Peer Specialist Manual developed by OnTrackNY that is publicly available (see Resources section), and a related job description that identifies responsibilities. These responsibilities, which essentially capture peer competencies in CSC, have been adapted and included here with permission (OnTrackNY, 2017).

Outreach/engagement/bridge building. Facilitate engagement with CSC teams by: forging strong connections with clients and families; undertaking outreach activities designed to promote community awareness of CSC services; encouraging help-seeking; and at times serving as a bridge between team members and clients when they experience ambivalence about treatment.

Relationship building. Develop authentic, meaningful relationships with clients and families through empathy, sharing experiences, listening, and collaborating with genuine curiosity and interest.

Embracing creative narratives. Understand, share and discuss multiple frameworks for understanding life experiences such as psychosis with clients and the rest of the CSC team. Intentionally use language in the service of listening to understand and make space for complex personal stories of recovery and resilience.

Advocacy. Advocate with and for clients both in the larger community and on the team.

Co-creating support and wellness tools. Collaborate with clients to clarify their personal visions and develop their wellness toolkit. Along with other team members, support clients in strengthening their self-awareness, building life skills, and connecting to resources and community outside of the CSC team.

Influencing team culture. Influence the team culture by advocating for clients, promoting a youth friendly approach and encouraging the use of recovery-oriented language. Work actively within the team itself to help build an environment that operates from a belief

in the human potential to grow and an understanding of human diversity.

Team communication. Maintain open and frequent communication with the team, including reporting safety and other concerns to the team. Keep notes on visits with clients as required by the provider agency. In the spirit of peer support, co-collaborate on reporting with the client.



Competencies for Program Managers

Occasionally, respondents mentioned competencies that were relevant to individuals who were in leadership roles rather than the provision of direct care. Though these were not the focus of the interviews, multiple aspects of program manager competence were highlighted.

Advocate for reasonable productivity standards. There are aspects of care considered essential to CSC that may suppress typical measures of productivity. These include flexible schedules for workers so that they can respond rapidly to changing client needs and caseload maximums that may be lower than other outpatient services. There is an understandable pressure and pragmatic need to generate revenue in most systems of care. However, the program manager must be able educate agency leaders about the CSC approach and evidence-base on CSC effectiveness, as well as the program's value in a local system of care, to advocate for productivity standards that permit adherence to the CSC model.

Manage resources to facilitate rapid access to services. There is ample evidence that delaying care early in the course of illness has a negative impact on outcomes in psychosis. Within the program, managers must proactively manage resources to prevent waitlists and respond rapidly to potential crises. They work with their team to prioritize timely admissions, initial engagement, and crisis management by routinely considering adequate levels of service for existing clients, transitioning to appropriate community services those who were determined by longitudinal assessment not to meet program criteria, and leveraging other human resources (e.g., clerical staff) to reduce tasks unrelated to direct care. Program managers may implement strategies that allow flexible allocation of resources, such as one CSC program's use of a daily morning "huddle" during which primary clinicians and the program manager meet briefly to discuss and triage new referrals and potential crises.

Insure effective delivery of CSC and adherence to the model. Program managers work to protect time in CSC workers' schedules for flexible client scheduling, coordination of care, continuing professional development, and supervision. They must keep current with the emerging literature on the characteristics, development, and treatment of FEP, and disseminate this knowledge to the rest of the team. Program managers should monitor their team's fidelity to CSC best practices and analyze key outcomes on variables such as positive symptom remission, vocational engagement, re-hospitalization, weight gain, and smoking. They must be able to adjust service delivery, adding or changing interventions offered or improving fidelity to a treatment if outcomes are not on par with those achieved nationally.

Unique Aspects of CSC Competencies

At first glance, most of the competencies identified above appear to be common to what many experts would consider optimal for any behavioral health worker, not just those in a CSC program. Many respondents lamented lack of breadth and depth of competencies among new graduates of professional schools hired by CSC programs for their first job, and among experienced clinicians recruited from other types of programs. Consistent with literature around the lag between validation of a practice as evidence-based and its widespread adoption, the respondents also bemoaned the fact that the provision of best practices appears to be far from common in many behavioral health programs. Thus, achieving actual competence among workers in the areas identified above and ensuring that the workers routinely use these competencies in the daily delivery of CSC services becomes a top workforce development priority.

Despite the fact that many of the competencies identified above are relatively generic, there were a number of areas in which the competencies seemed somewhat unique for CSC workers, usually because of their critical importance to this work and the differences involved in employing these competencies with clients and families in the midst of a first episode of psychosis. Below is a discussion of those areas.

Assertive and Community Engagement

While assertive engagement is a component of a number of other treatment models, such as Assertive Community Treatment (ACT), it is not the predominant practice in behavioral health. In contrast to usual community treatment, in which the focus is principally on clients who attend appointments, the worker in a CSC program must be capable of actively reaching out to clients who are reluctant to participate in treatment. Offering care only to those clients with significant motivation and a capacity to keep scheduled appointments is insufficient to meet the needs of the first episode psychosis population. While most treatment programs do not consider a person to be a client until they have attended and completed an intake appointment, the CSC worker must routinely assume some level of

responsibility for an individual after their initial screening. The worker relies on the assumption that, for this population, the process of engagement into treatment is as important as the delivery of treatment.

The engagement competencies of a CSC worker involve an approach that is inviting and persuasive, but is low pressure and non-coercive. It emphasizes tolerance of no-shows, open access scheduling, and meeting in non-office locations when preferred. Visiting potential clients while on an inpatient unit is a common practice. The worker strives to fully understand the client's experiences of illness, while also expressing curiosity about the client's non-clinical interests. The worker also exhibits competencies as a coach to the family and other persons in the client's support system, guiding them on how to encourage the client to access and utilize care.



The worker uses multiple methods of contact with the potential client and family, including phone calls, texts, and letters. Skilled in communication, the worker conveys a desire to collaborate with the client on his or her goals, emphasizing how the CSC program can assist with meeting those goals and attempting to allay fears or concerns about receiving treatment. When the possibility of engagement seems in question, the worker is skilled in brainstorming alternative approaches with a supervisor, program manager, and other team members as they strive to ensure that all available strategies have been exhausted.

Differential Diagnosis is an Ongoing Activity

In usual and customary behavioral health treatment, diagnosis is typically derived from an initial, often one-time evaluation at admission and is infrequently revisited. Over the course of treatment, diagnoses may be carried over from one treatment episode to the next, without significant re-examination.

For a first episode population, there is significant diagnostic ambiguity in the early stage of psychosis as symptoms emerge and pathophysiology unfolds. The worker in a CSC program must be capable of engaging in assessment and differential diagnosis as ongoing processes that extend well beyond intake and over the entire course of care. The worker considers diagnoses as provisional and as hypotheses to be tested over time as he or she observes changes in the clinical presentation and requests medical and neuropsychological assessments, when warranted, to rule out various etiologies.

The CSC worker regularly reviews the diagnostic formulation in team meetings, through consultations with a physician or advanced practice nurse, and by examining laboratory results and other test findings. He or she incorporates new data into the diagnostic process as the therapeutic alliance is strengthened and the client becomes more comfortable with disclosing additional information. The worker functions as a keen observer of the interplay between the passage of time and fluctuations in symptoms, noting whether remission occurs in the absence of substance use or if psychosis is present only in the context of acute mood episodes. When the diagnosis is determined to be something other than what is targeted by the CSC program, the worker facilitates referral to more appropriate treatment; for example, intensive substance abuse services or specialized medical care, to adequately treat the underlying cause of psychosis.

Providing Developmentally Responsive Services

The first episode of psychosis typically occurs in midst of the critical developmental period of adolescence and young adulthood and can impact all major spheres of functioning. While issues of development do tend to receive attention from most behavioral health professionals treating individuals in this age range, the issues become so much more critical when psychosis is impacting diverse areas of functioning.

It is critical that the CSC worker be knowledgeable about the developmental characteristics and tasks associated with this age range in order set realistic goals, tailor treatments, connect the clients with resources appropriate to their developmental stage, and assist them in managing the challenges to normal development posed by psychosis. The worker must be knowledgeable about and competent in navigating the child-serving and adult-serving systems, and able to help the client navigate the gap between them.

At a practical level, the CSC worker offers later day appointments to accommodate adolescent and young adult sleep patterns and school schedules. Appointments may be set initially through conversation with clients and their families, but shift over time to scheduling directly with clients and helping them devise reminder strategies and transportation solutions. Issues such as peer relationships and efforts at transitioning toward independence are explicitly raised in the course of treatment. The CSC worker is skilled at coaching parents on supporting clients' efforts at independence and is also able to work with schools and universities to negotiate reasonable accommodations. Prescribers in CSCs are knowledgeable of the difference in prescribing guidelines between adolescent and adult populations, and they prescribe accordingly. They may help clients shift from family oversight of medication adherence to managing their medications more independently through the use of reminders, pill boxes, and visiting nurse services.

Working Intensively with Families

Even though family involvement when treating persons with schizophrenia is recommended by experts (e.g., Schizophrenia PORT) and of demonstrated effectiveness through outcomes research (e.g., McFarlane, 2016), the frequency with which it occurs is fairly low (e.g., Glynn, 2012). While a small percentage of families in usual treatment for schizophrenia may receive family intervention, the worker in a CSC program must routinely involve the majority of families, offering psychoeducation, skills training, and evidence-based family interventions. Since individuals with a first episode of psychosis often live with their families or are reliant on support from them, the CSC worker seeks to maximize their support, facilitate communication and problem-solving, increase positive affect in the family environment, help set limits when necessary, and minimize family caregiver burden.



Workers routinely coach families on how to foster the client's engagement in services. They also teach them how to monitor and observe significant changes in behavior or symptoms. Due to the need for confidentiality and the goal for the client to achieve independence, separate clinicians may be provided for the client and for family members with clear communications to each about how confidential information will be protected and when information will be shared. CSC workers understand the differing roles of families depending on the age and developmental level of the client.

Taking a Population Health Approach

Behavioral health systems that respond only to those who request and actively participate in treatment do not adequately address the problem of psychosis in their community.

The CSC worker actively contributes to efforts to enlist professionals within local agencies and from the community to be part of a referral network engaged in the early detection of psychosis. They conduct community outreach and professional education activities, focusing on the early warning signs of psychosis, the importance of early intervention, and the referral process for CSC. The skilled worker engages in case finding, going far beyond the more common practices of engagement and treatment.

II. RECRUITMENT AND SELECTION

Respondents had numerous suggestions regarding the issues of recruitment and selection of CSC workers. However, it was noted that workers are, at times, simply assigned by the host organization, with little, if any, input from the CSC leadership. These dynamics are often driven by human resource policies and procedures and negotiated arrangements with unions regarding workers' rights based on seniority.

While it is common to think about recruitment and selection based on individual qualifications, respondents emphasized the importance of a team perspective in the selection process. Ideally, all workers would possess each of the competencies identified above. However, it is more realistic to hire individuals who complement existing team members so that, as a whole, all desired abilities are contained within the team. The hiring of a new worker is simply not done in a vacuum.

The other context to consider is the community being served. Optimally, a team reflects the diversity of that community, especially since research suggests that engagement in behavioral health services is facilitated when similar racial and cultural characteristics are shared between workers and clients (Chao, Steffen, & Heiby, 2012). Proficiency in the predominant language of the community among at least some of the team members is also highly desirable. Thus, the formula for recruitment and selection considers the applicant's qualifications for CSC work, the extent to which his or her skills would complement those of existing team members, and the potential contribution of the applicant to ensuring diversity within the team. The latter issue must be considered within the constraints of federal and state laws and regulations and the human resource policies of the host agency.

Selection Criteria

Prior Training & Work Experience

It is easy to conjure up visions of the ideal CSC worker, but difficult to discern the actual qualifications of an applicant. The most practical and measurable selection criteria offered by respondents involved prior training and work experience. Few, if any, applicants will have training and work experience specific to CSC. However, prior training and work experience in the following were considered highly relevant:

Psychosis. Prior training and especially prior work experience in the treatment of individuals with psychosis were considered highly desirable. However, multiple respondents noted that extensive experience with psychosis, especially in long-term inpatient units or in other settings that emphasize "chronic care," could be disadvantageous if such experiences had fostered among the applicant a pessimism about recovery and a custodial, as opposed to recovery-oriented, approach to care. It was recommended that the beliefs and attitudes of candidates with long work histories involving serious mental illness be reviewed carefully.



Evidence-based practices. Respondents noted the benefit of hiring candidates who have formal training in evidence-based practices that are relevant to CSC programs and experience in their application. Those practices are identified above in the section on competencies.

Child and adolescent services. Formal training and experience in the assessment and treatment of children and adolescents was frequently identified by respondents as an asset in a CSC position, particularly if it involved: high acuity and high risk; intensive levels of care; comprehensive services; or juvenile justice involvement. Applicants with such backgrounds were considered most likely to be knowledgeable and savvy about networks of care and to have skills that would be transferable to working with young adults in CSC programs. The caveat offered with this recommendation was that many workers who have been employed in the child and adolescent behavioral health system do not have significant experience with psychosis.

Experience working with families. The importance of an ability to work closely with families has been documented above. Therefore, prior training and experience with family collaboration and intervention was considered a desirable characteristic among applicants. It was noted that candidates whose work history has been predominantly with adult populations are less likely to have extensive experience working with families than those whose work has been focused on child and adolescent populations.

Competence

Recommendations about selection were invariably linked to applicants' competencies, since the challenge in recruitment is to find individuals who have, or can easily develop, the competencies needed to do this work. Most respondents emphasized the importance of competencies that are derived, to some extent, from personal qualities that make an individual particularly suited to CSC work. These are described in detail in the *Interpersonal Abilities* section of the competency section above. Determining applicants' competencies in other areas, including foundational knowledge, screening and assessment, and intervention, was considered important by respondents, but received somewhat less attention, given the possibility of training workers in these areas.

Recruitment Strategies

In order to obtain the most appropriate candidates, a respondent suggested that job postings and advertisements be as descriptive as possible about the nature of the work, desired skills, and prior work experience. These should also note that training will be provided, once hired, so as not to needlessly discourage applications from good candidates who might otherwise falsely conclude that they need expertise in CSC to apply.



Respondents routinely mentioned the challenge of determining whether applicants possess desired competencies prior to being hired. A number of specific strategies were recommended, though none were unique to CSC recruitment.

- The formal interview is a classic selection technique. Interviews by multiple team members or a group interview by the team was a suggested strategy. Respondents offered numerous interview questions for consideration. These included asking candidates to:
 - Share their views on the possibilities of recovery from psychosis;
 - Talk about a past high risk or stressful situation they encountered and describe how it was managed;
 - Discuss how they would react to a situation in which a client who is highly symptomatic wants to return to work;
 - Describe a mistake that they made and how they responded.
- The use during an interview of a role-play about a “therapeutic scenario” was recommended by one respondent as a strategy for getting a sense of how an applicant might respond to a potential situation in a CSC program.
- Including persons in recovery on a selection panel was recommended for gauging candidates’ comfort in interacting with individuals with severe mental illnesses and obtaining views of the candidate from the perspective of those who have likely used services. The desirability and challenge of compensating persons in recovery for their participation was noted.
- Having applicants visit team meetings was suggested as one strategy for providing a realistic preview of the work to aid candidates in judging whether employment on a CSC team would be of interest.

Through interviews, reviews of application materials, and conversations with those providing references for candidates, respondents suggested looking for evidence of true “zeal” or “passion” about recovery-oriented work with young adults who have psychosis.

Estimating Recruitment Needs

Shifting focus from the individual worker to the program level, respondents suggested that managers can use the incidence rate for first episode psychosis and census data on the number of transition age youth in the community to determine the approximate number of potential clients in the catchment area. For an example, review the interactive tool used by New York State’s Office of Mental Health to estimate staffing needs (Humensky, Dixon, & Essock, 2013). Setting aspirational goals regarding the portion of this population the CSC will be able to detect and engage, and estimating caseload size for each worker, can then yield an estimate of the number of workers that will be required to staff a CSC program once fully operational. Since the pace at which clients



will be identified and admitted to the CSC is difficult to predict, one recommended start-up strategy was to hire the total number of workers needed prior to having a full census and then deploying the unused staff time for case finding and development of referral networks in the community.

III. ORIENTATION, TRAINING & PROFESSIONAL DEVELOPMENT

Orientation and Initial Training

With dedicated federal block grant funding and increased state financial support, new CSCs are being established and existing programs are often expanding, leading to workforce recruitment and training needs. Established CSC programs also have recruitment needs as a result of worker turnover. The approach to orientation and training differs between new versus established programs.

In new programs, orientation and initial training can occur with all CSC workers simultaneously. However, it is challenging to solidify newly acquired skills when there are few clients available for experiential learning. Staff downtime in new programs can be used creatively to extend and intensify initial training, develop referral networks, and conduct outreach. Respondents cautioned that in agencies where there is pressure to “lend” unscheduled CSC worker time to other programs to reduce non-billable hours, it may be difficult to reclaim the CSC workers’ time as the CSC program census increases.

Orientation and initial training is less efficient when an established program is focusing on a single new employee. However, opportunities to shadow existing workers and to “learn by doing” with existing clients are major advantages. Whenever training a small number of workers, respondents suggested organizing shared training activities among multiple CSC programs or sites.

Stages of Training and Professional Development

The respondents identified a sequence of steps in the training and professional development process, which include: establishing expectations; assessment of workers’ skills; education; practical experience; and monitoring of performance.

Establishing Expectations

Program managers or team leaders are advised to establish expectations for workers early in their training. This begins by educating new hires about the collaborative, multidisciplinary nature of CSC practice and their specific roles within the team. Expectations are set regarding the need for flexibility in fulfilling assigned responsibilities and for ongoing learning. New workers are encouraged to focus on awareness of their reactions to clients and the work, and to observe reactions among other team members. They benefit from encouragement that their existing behavioral health skill sets can be applied to CSC work. Program leaders, supervisors, and other members of the team ideally model the expected behaviors.



Assessment of Worker Strengths and Learning Needs

Respondents recommended using multiple methods to understand a new worker's competencies and areas in which training and support are particularly needed. These methods included: discussion with the worker, observation of his or her professional behavior, and requesting that the worker complete a self-assessment. CSC leaders are advised to evaluate new CSC workers' understanding and acceptance of recovery-oriented principles and practices and to remain vigilant for the presence of any stigmatizing or other negative attitudes toward clients, families, and psychosis. Program leaders should pay particular attention to the comfort of new CSC workers' in working within a multidisciplinary team.

Education

Training can be provided by CSC program leaders, experienced team members, or outside consultants. Respondents recommended the use of multiple methods to keep training stimulating and to accommodate various learning styles. These included: in person training, online training, watching and discussing videos, reviewing manuals, assignment and discussion of readings, role playing and simulation of client and team interactions, pre- and post-tests, and meeting with other CSC workers to discuss their roles and experiences. New CSC workers can be provided a checklist outlining materials to review and tasks to complete as part of orientation. It may be prudent to manage the duration and intensity of initial training, so as not to overwhelm a new employee. Reviewing each of the competencies described earlier in this Issue Brief also was recommended, with the provision of training on selected competencies when needed.

With respect to educational content, new CSC workers benefit from understanding the context in which they are practicing. Initial training optimally includes an overview of the history of early intervention with psychosis; the origins of CSC internationally; growth of these programs in the U.S., including the significance of RAISE; and the development of the CSC program at which the worker is employed. New workers in CSC should be educated about the evidence base for the model they are to deliver; particularly, clinical trials demonstrating effectiveness and efficacy of team based interventions (e.g., LEO, OPUS, STEP, RAISE). It can be helpful to contrast the effectiveness of CSC with the less positive outcomes and more pessimistic outlook of historical approaches. Workers should be educated in the objectives of CSC, which include changing systems so that engagement in treatment occurs early and distress related to prolonged illness, declines in functioning, and needless trauma experienced during efforts to obtain care are minimized.

Initial training should provide the new CSC worker with a solid foundation about psychosis. Recommended topics include prevalence and incidence, etiology, symptoms, the diathesis-stress model, the impact of high levels of expressed emotion, common comorbidities such as anxiety, and complicating issues such as criminal justice involvement. New hires without extensive experience with psychosis may need to learn strategies for remaining calm and maintaining a clear focus when interacting with actively psychotic individuals. Trainers should address common myths and misperceptions about serious mental illness, psychosis and CSC programs. For example, they must convey two facts that workers must understand and use simultaneously to inform their efforts with

clients. The first is that persons with psychosis do not have significantly higher rates of violence than the general population and are more likely to be the victims of violence than to engage in it. The second is that, at the same time, rates of violence toward self or other are highest during the first episode, especially if the person is untreated.

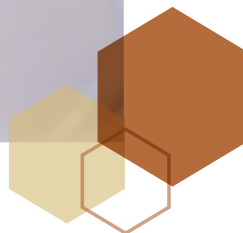
Training should include an overview of adolescent and young adult development, particularly for those staff members whose background is primarily in adult mental health (see, for example, Capparelli, et al, 2016). New CSC workers optimally learn about typical developmental tasks and challenges, as well as the threats to development posed by serious mental illness. Generally, they also need instruction in working with the educational system for clients who require accommodations (e.g., special education and Section 504).

New CSC workers must be trained in the manualized treatments that they will deliver, as well as the strategies for flexibly implementing these structured interventions and addressing client priorities and preferences. This is particularly important for workers who have not been previously trained in EBPs.

Guidance should be provided on working within an interdisciplinary team and on the roles of the various disciplines. One respondent described a creative strategy for training an all-new staff together. It involves creating a table of the team members' roles, asking workers to discuss their roles with each other, and developing a grid or "roadmap" from these conversations about how the various team members could collaborate.

New hires should receive information about the characteristics of the geographic areas served, including safety of neighborhoods in which CSC workers may deliver services or conduct community outreach. Programs should orient new workers to attitudes

about the CSC program within in the host institution, as well as common perceptions of the CSC program and host institution within the community. By understanding these perceptions, workers will be better prepared to navigate interactions with other professionals and community members.



Training in the administrative aspects of the work, such as the medical records system, is obviously required. Many CSC programs utilize other forms of technology with which workers must become proficient or be able to train clients to use. Examples provided by respondents include smart phones, tablets, telehealth devices, and applications for tracking goals, mood, and wellness. Training in telehealth approaches may be particularly important for CSC workers in rural and frontier areas (Cristanti, et al 2015).

Experience

Multiple respondents emphasized hands on experience working with clients within the CSC program as the most valuable learning tool. New CSC workers consolidate didactic learning by delivering services and then revisiting discussions about CSC core values, models and techniques. In some CSC programs, new workers first engage in observational learning by shadowing other staff before taking on direct care responsibilities. The observation period may vary in length, with one respondent recommending a minimum of two weeks and another suggesting a duration tailored to the needs of each worker.

Monitoring Performance

As CSC workers gain experience with clients, the respondents emphasized the importance of monitoring the attitudes and skills as exhibited in the daily work. One recommendation focused on watching for demeaning attitudes or behaviors among new CSC workers toward clients or toward staff with less advanced degrees.

Continuing Professional Development

Respondents noted that there is now an abundance of training resources available to CSCs, such as manuals, videos, books, workshops, conferences and consultants. However, one respondent lamented the lack of funding for staff to travel to educational events. At least one relevant conference, IEPA Early Intervention in Mental Health, has made its proceedings available online at no cost (<https://iepa.org.au/iepa10/>). Please see the “Resources” section below for a list of suggested training websites and materials.

Multiple respondents described the importance of protecting CSC workers’ time for continuing education activities. Respondents suggested that leadership of CSC programs create ongoing and varied training opportunities for their staff to maintain worker interest and competency. Since each CSC worker brings a unique background of experience and strengths, individualizing the continuing education plan to the extent possible was also suggested. One respondent recommended that CSC programs host educational activities for CE credit that are open to the community in order to improve the program’s referral and treatment network. Another respondent’s CSC program offers an annual one-day, foundation-sponsored conference, in which all program staff members are encouraged to participate, often as presenters. Professionals from the region are also invited.

As with the initial training and orientation period, there are a variety of suggested methods for ongoing education. Clinical team meetings can be used as a venue for modeling, teaching, and learning. At least one CSC uses team meetings once a month for “themed” rounds highlighting a CSC value, principle, practice approach, or clinical or professional development challenge. Respondents also suggested the use of monthly clinical case

conferences where a client is interviewed or presented in detail and discussed. If CSC programs are housed in agencies that also have psychosis risk clinics, step down programs for CSC graduates, young adult teams, or that are located near other CSC programs, the respondents suggested joint efforts by these programs to organize and share educational resources. Journal clubs have been used to share new research or empirically driven treatment guidelines and CSC programs have lobbied their host institutions to invite Grand Rounds speakers who have expertise in early psychosis.

Other strategies suggested by respondents include using existing CSC workers as in house educators in a “train the trainer” model, as well as having more experienced workers mentor team members who have less experience. Assigning CSC workers various leadership or management roles has been used as a strategy to increase their skills and demonstrate mastery in new areas. Expert consultants can provide state-of-the-art continuing education. Since learning is often best solidified through application, one suggested strategy is to arrange for periodic follow-up calls for workers with the consultants to discuss successes and challenges.

Finally, incentives to actively participate in ongoing education were suggested by multiple respondents. Offering continuing education credits is a common practice. Another recommended strategy involves negotiating within the host institution for continuing education time to count toward measures of productivity, making participation an “easier sell” to workers. One CSC offers financial rewards in the form of an increase in pay for each EBP in which workers are trained and become competent. This accomplishment by the worker, when achieved, is also formally recognized within the team.

Educational and Certification Reform

The recommendations above focus on orientation, training, and professional development *within* a CSC program. However, there were also calls for broader change in our educational systems. In terms of curriculum, it was recommended that educational programs and degrees be developed that are relevant to CSC services, such as the masters program in *Early Intervention in Psychosis* at Kings College London.

Requirements from the Accreditation Council for Graduate Medical Education (ACGME), which guide education in psychiatry, could be revised to require that residents specializing in child and adolescent populations gain exposure to CSC programs, and that those specializing in adult populations receive some training in working with adolescents between the ages of 16-18 and their families. There was a similar call for other disciplines to offer specialized training and certification in this area of work as well as inclusion of knowledge of early intervention in licensure requirements. Other respondents suggested annual national or regional continuing education meetings or conferences.



IV. SUPERVISION

Respondents emphasized the essential nature of high quality, consistently delivered supervision in CSC. One took the position that “supervision of a clinician may be *more* important than the skills of the clinician” based on observations of skilled clinicians who floundered in a CSC program in the absence of good supervision.

In addition to regularly scheduled individual supervision, it was noted that work is supervised or directed through other means within CSC programs. There is frequent consultation between supervisors and supervisees and communication between members of the treatment team. Group supervision, team meetings and clinical rounds are other forums in which oversight and direction of workers takes place. These group formats provide unique opportunities for collaborative brainstorming, modeling, and vicarious learning.

The Importance of Supervisor Training

Respondents noted that supervisors must have training in this role and in how to supervise effectively. They must be very knowledgeable about the policies and procedures of the host agency and, at times, play a “buffering role” between the supervisee and the agency. Knowledge about the population being served and skill in CSC EBPs is also essential. Supervisors must be trained to manage risk through the activities of the workers they supervise.

Supervisor skills are so important because modeling is one of the main ways in which a supervisor influences worker behavior. A good supervisor models appropriate attitudes; language; interactions with clients, families, team members, and the community; and reactions to challenging issues such as client suicidality, relapse, or homicidal ideation.

The Focus of Supervision

From the perspective of the respondents, supervisors should orient workers on how to participate in supervision effectively. The sessions are then used to reinforce and further explore the issues and topics covered in orientation and initial training. Supervision is ideally strengths-based in focus, while tending to areas of needed improvement. This strengths-based focus is ideally applied to improving supervisees’ performance and guiding the supervisee’s approach to CSC clients.

The respondents discussed a tension that supervisors often have to address as workers try to adhere closely to manualized interventions, while striving to remain person-centered and responsive to a client’s needs. For example, if the CSC is empirically testing a particular approach or intervention, CSC workers who have many years of experience may need to be guided by the supervisor to adhere to a manual rather than their usual approach. On the other hand, workers may need to be reminded of limitations of rigidly following the manual and of the need to tailor treatment to the client.

Respondents advised that clinical and administrative issues must both be addressed in supervision. They cautioned against administrative issues, such as billable hours, paperwork, and productivity, dominating supervision time and crowding out important

clinical matters. Respondents suggested maintaining a balance in supervision among: quick updates on clients; discussions of problems or challenging cases; and reviews of cases in which things are going well. They noted that discussion of successes often receives too little emphasis.

Supervisors were advised by respondents to work with supervisees to encourage self-examination and self-reflection. In order to be maximally effective, workers need to develop awareness of their own biases, their preferred ways of learning, and their approach to clinical work. It is particularly important in CSC programs that supervisors focus on issues of stigma toward people with SMI since clients and families in the midst of a first episode are dealing so acutely with their own reactions and the reactions of others to the troubling signs of mental illness.



Respondents described the fundamental supervisory task of helping workers formulate “what to do and why.” They recommended that supervisors continually tie discussions of clinical decision-making and technique to CSC principles and practices, such as early intervention, risk reduction, and recovery-oriented team-based responses.

In working with a first episode population, supervisors are constantly focused on risk. They guide workers’ activities in conducting careful risk assessments and ensure that risk is being continually monitored. Supervisory discussions should center on the level of risk; decisions about whether it is clinically acceptable; the strategies to mitigate it; and how, as a worker, to manage the uncertainty and anxiety surrounding it. Workers are encouraged not to “sit with risk alone,” but to

proactively discuss safety concerns with other team members and together formulate an assessment and plan. They are supported by supervisors in simultaneously holding recovery oriented optimism, being mindful of increased risk in this phase of illness, and in tolerating the discomfort that can accompany respecting a client’s rights to make decisions, such as to discontinue medication. Supervisors provide guidance on applying procedural justice in a calm, assertive manner when risk is imminent and involuntary hospitalization is necessary. When adverse events occur, increased support is provided to workers; a forum is provided to debrief, process, and review the incident; and supervisors monitor workers’ reactions to negative experiences.

At times, teaching occurs in supervision. The types of content respondents suggested included community resources relevant to a client’s need (e.g., psychosis knowledgeable primary care providers), new findings in the emerging literature, or literature specific to a client’s treatment.

Evaluation

Multiple respondents discussed the importance of evaluation and feedback. They recommended the 360-degree feedback technique in which those who work with a supervisor or supervisee complete anonymous evaluations of his/her performance, which is then summarized and provided to the individual as feedback. Those completing the evaluations may include supervisors, co-workers, support staff, clients, and family members. The use of self-appraisals or self-assessments was also recommended. Lastly, supervisors were advised to request direct feedback from their supervisees about the supervision provided and how it could be improved.

V. RETENTION

Many respondents described worker turnover as a significant challenge within the behavioral health field in general and one of the largest workforce challenges for managers of CSC programs. They stressed the particular difficulty in retaining workers in rural settings and the challenges of finding and keeping occupational therapists, prescribers, and nurses. While workers may opt for other behavioral health jobs, respondents lamented that they occasionally leave the behavioral health field altogether due to constant funding uncertainties and burnout.

When a CSC worker resigns, the tremendous investment of time spent recruiting, orienting, and training that individual is lost. Clients and family members, many of whom are already difficult to engage, can be negatively affected by the departure of a staff member who has begun to work with them. These transitions become periods of higher risk for clients due to the loss of a therapeutic relationship and the staff shortage that may occur while a replacement is found and brought on board.

Potential Causes of Turnover

Given that CSC is relatively new and not yet common, workers are unlikely to have prior experience in or familiarity with delivering such services. Therefore, it can be difficult to determine if CSC will be a good fit for the worker until he or she gains some experience with the job. For example, some workers may discover that delivering structured EBPs clashes with their preferred mode of practice. Others may find that they never become comfortable providing treatment in the community. Respondents also noted that the inconsistency with which clients engage in treatment can be a particular source of job frustration. Workers often take this personally, feel demoralized, or blame themselves for not being more effective. The strain of worrying about high-risk clients, especially those who do not engage, also takes its toll.

Respondents held differing opinions with respect to the impact of worker pay on turnover. Those that discussed this issue agreed that CSC workers should be paid a reasonable and competitive salary. However, some did not think that salaries significantly affected staff turnover, while others were adamant that higher salaries lead to greater retention. The combination of poor pay and the stress of CSC work were cited as a formula for dissatisfaction. Another respondent cited a CSC program in which competitive salaries were offered, but were insufficient to prevent turnover.

Staff morale can be undermined by the tenuous financial support for the program, which can result from uncertainty about the renewal of grants, challenges obtaining reimbursement for services, and threats to funding due to a low census and levels of staff productivity.

Retention Strategies

Fortunately, respondents provided a number of suggestions for increasing the retention of CSC workers, the first of which focused on employee recruitment and selection. They recommended favoring applicants with historical ties to the local area who are more likely to want to remain in the community over the long term. Such candidates are also likely to have local work experience and familiarity with the existing system of care. The use of federal or state loan repayment programs was also suggested as a strategy to entice and retain workers for CSC in underserved areas.

Once hired, the provision of good supervision was considered of the highest priority in terms of supporting and retaining workers. The optimal characteristics of that supervision have been described above. From the perspective of retention, ready access to a supportive supervisor in times of crisis was considered essential, as well as an emphasis in supervision on worker self-care.

Many respondents emphasized the importance of the work environment to employee retention. They noted the key role of program leadership in establishing the culture and “tone” for the team. Positive, supportive, warm, and welcoming social environments foster team morale and staff retention. The use of humor was recognized as something that can be of particular value. An environment in which difficult issues can be discussed openly and there is “open door” access to program leaders was recommended as well.

One respondent discussed the importance of addressing the physical work environment. This was perceived as something that is too often overlooked but can have a significant impact on worker morale. Support of any kind that is offered by the host agency to the CSC program was viewed as demonstrating an organizational culture that is welcoming of the team, boosting morale and hopefully retention.

Efforts at team building were also suggested. These include more formal team building exercises and informal social events, such as going out to dinner. One respondent noted that, while informal social events are not mandatory, they do allow workers to get to know one another on a more personal level and will often be requested by staff members if these have not occurred for some time.

With respect to frustrations about client engagement, respondents recommended educating and continually reassuring workers that this is common in first episode populations and a challenge across all CSC programs. Staff members may benefit from support in brainstorming creative engagement strategies and from working with clients in community settings where worker-client interactions may be less formal, less strained, and more comfortable for the client.

Respondents encouraged CSC managers to be transparent about funding issues, since the sense of the tenuousness of funding may lead some workers to always “have one foot out the door.” It was suggested that it is preferable to share information on funding status, timelines for specific funding sources, and prospects for the future rather than letting workers wonder and worry uninformed.

There were several suggestions about the value of creating a supportive learning environment. Workers are more likely to be satisfied if they are respected as professionals, have ongoing educational options to develop and refine their skills, can be recognized for their achievements, and have opportunities for advancement.

A final recommendation to promote retention related to offering workers opportunities to assume some responsibility and ownership for an element of the program. For example, one CSC program has engaged more experienced workers to train other staff, conduct fidelity reviews, and participate in program development. Another CSC has designated qualified workers as the “lead” on an intervention of particular interest to them. Typical responsibilities in this role include client recruitment, coordination of specialized staff training, and serving as a staff resource. These opportunities allow workers to carve out a niche within the program, develop a sense of mastery in a specialized area, and exercise their creativity.

VI. WORKING WITH TRAINEES

Respondents were asked about the inclusion of trainees in CSC programs. They expressed mixed opinions, describing multiple challenges, as well as advantages. In general, respondents discussed the need for balance between providing valuable training experiences that will ultimately grow the workforce and benefit the field, while not disrupting care or unduly taxing a program’s limited resources with a training and supervision burden. Some CSC programs, particularly those without an academic center affiliation, do not host trainees.

Challenges

In some academic centers, trainees are “placed” on the CSC team without being selected by or having a preference for that team. If the trainee did not seek out the CSC placement, he or she may be more likely to lack enthusiasm and have attitudes that compromise their involvement.

Junior trainees can be a particular challenge if they are novice clinicians with little practical experience. Most trainees have had limited exposure to individuals with psychosis and to the diverse medical and psychosocial interventions for treating these conditions since there are relatively few clinical placements and research labs that offer relevant training. In addition to requiring orientation and training about CSC, students may need more extensive training in foundational knowledge and skills, more time shadowing experienced workers, and greater amounts of supervision.

A respondent highlighted the multiple financial challenges of incorporating trainees in a CSC team. These include funding trainee stipends; lost productivity among workers assigned training tasks; and lost revenue when services provided by trainees are ineligible

for reimbursement. The need for supervisors or other workers to re-interview clients and double check trainee assessments, formulations, and clinical decisions were other sources of inefficiency and cost.

Multiple respondents, including those who had supervised trainees with active caseloads in other settings, discussed their discomfort in assigning trainees direct care responsibilities in a CSC program, especially a primary clinician role. Their concerns focused on the need for direct care providers to be highly skilled in risk assessment and management, and very knowledgeable about community resources. There was also concern about the impact on clients of trainee turnover when in direct care roles.

Advantages

Despite the multitude of challenges, many CSC programs do include trainees in their programs. Most respondents acknowledged an obligation to contribute to the development of the future workforce in general and to the CSC workforce in particular. Some viewed it as a way of “spreading the word” about this novel model of care.

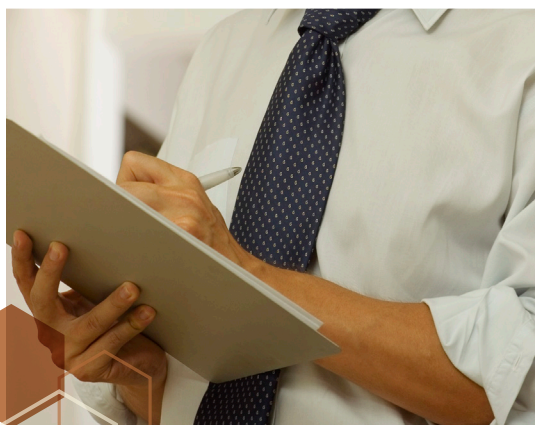
With respect to the CSC team, the value of trainees in “keeping everybody on their toes” was mentioned. Their presence, and their questions about what is to be done and why, require that the staff must be able to provide a rationale for the work with clients. One respondent stated that one does not really “know” something until one teaches it. Therefore, the presence of trainees can prompt CSC staff members to clarify their own thinking about the work.

Trainees are also valued because they do share in some of the work burden, assuming responsibilities that would otherwise fall to permanent workers. One respondent observed that clients often seem to enjoy working with trainees and express the belief that they are helping with the training mission. Trainees may be closer in age to clients than most workers, which may facilitate engagement and provide the team with an additional “youth perspective.”

Strategies

There is a compelling rationale for accepting more advanced trainees with some relevant prior experience about psychosis for longer training rotations so that they can contribute to the team once orientation and skill development has occurred. Longer rotations also minimize disruptive transitions in caregivers for the clients. It was recommended that placement on a CSC team should not be a trainee’s first clinical placement. One program, for example, accepts psychiatric residents who are in their 3rd or higher year of training, psychology graduate students in their 4th or higher year of training, and social work students in their final year of training.

While trainees optimally go through the same orientation and training process as other CSC staff, it is imperative to address their knowledge and skill deficits about psychosis, and myths



about serious mental illness. Respondents noted that trainees often need considerable reassurance about their own safety. The challenge for supervisors is to be mindful of risk and take reasonable safety precautions without creating excessive fears about the dangerousness of clients.

One respondent noted that trainees have to have some meaningful role in service delivery in order to value the placement. At minimum, trainees can observe assessment and treatment and participate in clinical discussions and educational events. Some respondents recommended that trainees shadow experienced CSC workers or collaborate with them as co-therapists. Sharing a caseload and co-facilitating group or family interventions allows the more experienced CSC worker to directly model skills and observe the trainee's interactions with clients and families, providing support or intervention when necessary. For psychology trainees, one additional way to make a contribution to the team is by conducting psychological or neuropsychological testing.

Multiple respondents suggested that trainees be assigned to time-limited interventions due to the short-term duration of their involvement. They advised preparing clients and families in advance for the brief nature of the relationship with trainees.

More than one respondent emphasized the importance of selecting as mentors for the trainees those CSC workers who enjoy that role, and see the value in training future CSC workers and disseminating the model. These workers must have time built into their schedules to provide proper training and supervision. The value of good supervision was repeatedly mentioned, with one CSC program's host institution requiring that the supervisor actually be present in the room for the trainee's sessions with clients. Though time consuming and initially uncomfortable, direct observation is an excellent teaching method that generates invaluable material for supervision sessions.

CONCLUSION

Many of the respondents described their participation in this process as a useful exercise, prompting them to reflect on their approach to workforce issues in CSC and to make their current workforce practices more explicit. This is, perhaps, an apt metaphor for the field of Coordinated Specialty Care more generally. Having grown substantially in both sophistication and size, it is an appropriate time in the evolution of this field to identify and make more explicit the workforce development practices that can support and sustain early identification of, and intervention with, individuals experiencing psychosis. The notion of sharing ideas among CSC programs regarding best practices in workforce development was met with considerable enthusiasm.

Participants also acknowledged that the evidence base on CSC is still growing. There are differing opinions about which practices are essential in a comprehensive effort at early intervention. This means that identification of best practices regarding workforce competencies, recruitment, selection, and training will be debated as well. Nonetheless,

almost every respondent agreed that there are a set of widely accepted evidence-based interventions and best practices for this work that can be used as a foundation to shape the field's approach to workforce development.

As in all areas of behavioral health, there are concerns about the ongoing struggle to adequately fund CSC programs and the impact of financial constraints on productivity demands, worker stress, and burnout. At the state and federal level, ongoing advocacy efforts were recommended to secure improved funding structures (e.g., case rates) and funding levels to support programs and workers in delivering this cost-effective form of care.

In many ways, the workforce best practices described in this Issue Brief are designed to ensure that CSC clients benefit from the type of optimal screening, engagement, assessment, and intervention from a person-centered and recovery-oriented perspective that every client with a behavioral health condition should receive. Unfortunately, usual and customary care often falls far short of these standards. To a large extent, the first workforce task of the leadership of CSC programs is to help workers develop competencies that ideally might have been acquired in graduate education programs or through prior work experience. The second workforce task for leaders is to structure and manage a CSC program to ensure that these competencies are used routinely in daily practice and delivered through effective collaborations that are grounded in a multidisciplinary team.

Beyond the drive to train and supervise workers to provide the highest possible quality of care, there are number of tasks that, in combination, define the unique workforce competencies required to deliver effective CSC services. The first involves skill in the process of flexible, creative, and assertive engagement, in which engagement in treatment is considered as important as the treatment itself. The second requires expertise in the process of ongoing differential diagnosis, in which the worker constantly seeks and remains open to new data, and considers all diagnoses and formulations as hypotheses to be tested over time. The third focuses on the capability to provide services that are thoroughly informed by knowledge of adolescent and young adult development and are adjusted to developmental stage. And the fourth involves expertise in working intensely with families to engage and educate them, promote their support of the client and the treatment process, guide their response to crises, and help them foster the independence of their loved one.

While differences among disciplines in CSC roles and competencies were occasionally mentioned, these did not emerge as a prime focus in the interviews. Notably, the involvement of peers in workforce roles remains an emerging focus, with few CSC programs including them despite their prominence in workforce roles in other behavioral health programs nationwide. There appears to be broad enthusiasm for their inclusion and recognition of a need for a programmatic effort to define peer roles, competencies, and training for this work. With respect to selection



of peers, a history of personal experience with psychosis was suggested as a potentially key criterion. Beyond education in peer support practices, the importance of peers receiving training in adolescent development, identity issues, and social relationships also was suggested.

The core competencies for CSC workers involving service delivery fall squarely within the realm of behavioral health. In contrast, the vital work of developing early detection campaigns that reach health and social service providers and the public requires knowledge and skills that typically fall outside of behavioral health. There is widespread recognition that reducing the duration of untreated psychosis through such outreach must be a major goal of CSC. Therefore, collaboration with marketing and communication experts and adopting and adapting their techniques and strategies must be an ongoing part of CSC workforce development.

Throughout all of the discussions with the experts who contributed to this project, there was recognition that jobs in a CSC program involve challenging, high-risk work that is simultaneously rewarding. It promises meaningful impact on the trajectory of serious illness, both for a single individual and for the rates of recovery among the young adult population. This, it was argued, should be a key message in efforts to recruit and retain talented and creative workers to this field.



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ADDITIONAL RESOURCES

IEPA Early Intervention in Mental Health

<https://iepa.org.au>

Kings College London, Early Intervention in Psychosis MSc degree program

<http://www.kcl.ac.uk/study/postgraduate/taught-courses/early-intervention-in-psychosis-msc.aspx>

NASMHPD Training on Resources Available

<https://www.nasmhpd.org/content/new-informational-resources-addressing-first-episode-psychosis-product-overview>

OnTrackNY Manuals and Other Resources

<http://ontrackny.org/Resources>

PEPPNET Resources

<https://med.stanford.edu/peppnet/resources.html>

RAISE Manuals

<https://raiseetp.org/studymanuals/index.cfm>

<http://navigateconsultants.org/materials/>

Recovery Stories

<https://vimeo.com/user23094934/voices-of-recovery>

SAMHSA Recovery to Practice

<https://www.samhsa.gov/recovery-to-practice>

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