HEALTH AND HUMAN SERVICES COMMISSION GRANT AGREEMENT, CONTRACT NO. HHS001329300014 UNDER THE MENTAL HEALTH COORDINATED SPECIALTY CARE GRANT PROGRAM

The parties to this agreement ("Grant Agreement" or "Contract") are **HEALTH AND HUMAN SERVICES COMMISSION** ("System Agency" or "HHSC"), a pass-through entity, and MHMR of Tarrant County ("Grantee"), having its principal office at **3840 Hulen Tower North** (each a "Party" and collectively the "Parties").

I. PURPOSE

The purpose of this Grant Agreement is to provide Coordinated Specialty Care (CSC) services for individuals who are between 15 to 30 years of age and are in the early stages of a primary psychotic disorder in the service area.

II. LEGAL AUTHORITY

This Grant Agreement is entered into pursuant to Subparts I and III, B, Title XIX, Public Health Service Act (42 USC Section 300x, et seq.), 45 CFR Part 96, Texas Health and Safety Code Section 533.034.

III. DURATION

This Grant Agreement is effective on September 1, 2023 and expires on **August 31, 2025**, unless renewed, extended, or terminated pursuant to the terms and conditions of the Contract. System Agency, at its sole discretion, may extend this Contract for any period(s) of time, provided the Contract term, including all extensions or renewals, does not exceed 5 years.

IV. STATEMENT OF WORK

The Statement of Work to which Grantee is bound is incorporated into and made a part of this Grant Agreement for all purposes and included as **ATTACHMENT A, STATEMENT OF WORK (VERSION 1)**.

V. BUDGET AND INDIRECT COST RATE

The total amount of this Grant Agreement will not exceed **$850,000.00**. Grantee is not required to provide matching funds.

The total not-to-exceed amount includes the following:

Total Federal Funds: **$850,000.00**
Total State Funds: $0.00

All expenditures under the Grant Agreement will be in accordance with **ATTACHMENT B, BUDGET AND INVOICE SUBMISSION REQUIREMENTS (VERSION 1)**.

Indirect Cost Rate: The Grantee's acknowledged or approved Indirect Cost Rate (ICR) is contained within **ATTACHMENT B,** and the ICR Acknowledgement Letter – Ten Percent De Minimis is attached to this Contract and incorporated as **ATTACHMENT J**. Grantee must have an approved or acknowledged indirect cost rate in order to recover indirect costs.

If the System Agency approves or acknowledges an updated indirect cost rate, the Grant Agreement will be amended to incorporate the new rate (and the new indirect cost rate letter, if applicable) and the budget revised accordingly.

VI. REPORTING REQUIREMENTS

Grantee shall submit reports as outlined in **ATTACHMENT A, STATEMENT OF WORK (VERSION 1).**

VII. CONTRACT REPRESENTATIVES

The following will act as the representative authorized to administer activities under this Grant Agreement on behalf of their respective Party.

System Agency	**Grantee**
Jason Graves	Susan Garnett
Health and Human Services Commission	MHMR of Tarrant County
4601 W. Guadalupe St., Mail Code 2058	3840 Hulen Tower North
Austin, Texas 78751	Fort Worth, Texas 76107
jason.graves@hhs.texas.gov	**ceo@mhmrtc.org**

VIII. NOTICE REQUIREMENTS

A. All notices given by Grantee shall be in writing, include the Grant Agreement contract number, comply with all terms and conditions of the Grant Agreement, and be delivered to the System Agency's Contract Representative identified above.
B. Grantee shall send legal notices to System Agency at the address below and provide a copy to the System Agency's Contract Representative:

Health and Human Services Commission
Attn: Office of Chief Counsel
4601 W. Guadalupe, Mail Code 1100
Austin, Texas 78751

C. Notices given by System Agency to Grantee may be emailed, mailed or sent by common carrier. Email notices shall be deemed delivered when sent by System Agency. Notices sent by mail shall be deemed delivered when deposited by the System Agency in the United States mail, postage paid, certified, return receipt requested. Notices sent by common carrier shall be deemed delivered

when deposited by the System Agency with a common carrier, overnight, signature required. Legal Notice to System Agency must not be submitted by email.

D. Notices given by Grantee to System Agency shall be deemed delivered when received by System Agency.

E. Either Party may change its Contract Representative or Legal Notice contact by providing written notice to the other Party.

IX. FEDERAL AWARD INFORMATION

A. **GRANTEE'S UNIQUE ENTITY IDENTIFIER] IS: LJ9ENHUAKHV3**

B. **Federal funding under this Grant Agreement is a subaward under the following federal awards.**

C. **Federal Award Identification Number (FAIN):** B09SM087345

1. Assistance Listings Title, Number, and Dollar Amount:
   Block Grants for Community Mental Health Services – 93.958 – $65,049,659.00
2. Federal Award Date: 02/23/2023
3. Federal Award Period: 10/01/2022 – 09/30/2024
4. Name of Federal Awarding Agency: Substance Abuse and Mental Health Services Administration (SAMHSA)
5. Federal Award Project Description: Block Grants for Community Mental Health Services
6. Awarding Official Contact Information: Wendy Pang, Grants Management Specialist-Center for Mental Health Services, wendy.pang@samhsa.hhs.gov, (240)276-1419
7. Total Amount of Federal Funds Awarded to System Agency: $65,049,659.00
8. Amount of Funds Awarded to Grantee: $850,000.00
9. Identification of Whether the Award is for Research and Development: No

X. SUPPLEMENTAL CONDITIONS

Except as otherwise revised, modified or supplemented in this Article X, the HHS Contract Affirmations Version 2.2 (referred herein as "Attachment C"), controls.

SECTION 55, FEDERAL OCCUPATIONAL SAFETY AND HEALTH LAW, is revised and restated as follows:

As applicable, Contractor represents and warrants that all articles and services shall meet or exceed the safety standards established and promulgated under the Federal Occupational Safety and Health Act of 1970, as amended (29 U.S.C. Chapter 15).

XI. CONTRACT DOCUMENTS

The following documents are incorporated by reference and made a part of this Grant Agreement for all purposes.

ATTACHMENT A	**STATEMENT OF WORK (VERSION 1)**
ATTACHMENT A-1	**CSC MANUAL II: IMPLEMENTATION**

ATTACHMENT A-2	**CLINICAL DIAGNOSTIC ELIGIBILITY EARLY ONSET PROGRAM**
ATTACHMENT A-3	**CSC MANUAL I: OUTREACH AND RECRUITMENT**
ATTACHMENT A-4	**ACUTE CARE MEDICAL HISTORY FORM**
ATTACHMENT A-5	**EARLY ONSET DATA DEFINITIONS**
ATTACHMENT A-6	**SECURITY ADMINISTRATOR ATTESTATION & AUTHORIZED USERS LIST**
ATTACHMENT A-7	**CSC HOUSING SUPPORTS CHECKLIST**
ATTACHMENT A-8	**HOUSING SUPPORT GUIDANCE**
ATTACHMENT A-9	**ONTRACKNY FIDELITY PROTOCOL**
ATTACHMENT B	**BUDGET AND INVOICE SUBMISSION REQUIREMENTS (VERSION 1)**
ATTACHMENT C	**HHS CONTRACT AFFIRMATIONS VERSION 2.2**
ATTACHMENT D	**HHS UNIFORM TERMS AND CONDITIONS -- GRANT VERSION 3.2**
ATTACHMENT E	**DATA USE AGREEMENT (COMMUNITY CENTER VERSION 8.5)**
ATTACHMENT F	**ADDITIONAL PROVISIONS -- GRANT VERSION 1.0**
ATTACHMENT G	**FEDERAL ASSURANCES**
ATTACHMENT H	**CERTIFICATE REGARDING LOBBYING**
ATTACHMENT I	**FFATA CERTIFICATION FORM**
ATTACHMENT J	**INDIRECT COST RATE ACKNOWLEDGEMENT LETTER – TEN PERCENT DE MINIMIS**

In the event of conflict, ambiguity or inconsistency between the terms and conditions set forth in the document that comprise this Contract, and any amendments hereto, the controlling documents shall be this Signature Document, then the remaining documents in the following order of precedence:

ATTACHMENT E	**DATA USE AGREEMENT (COMMUNITY CENTER VERSION 8.5)**
ATTACHMENT C	**HHS CONTRACT AFFIRMATIONS VERSION 2.2**
ATTACHMENT D	**HHS UNIFORM TERMS AND CONDITIONS -- GRANT VERSION 3.2**
ATTACHMENT F	**ADDITIONAL PROVISIONS -- GRANT VERSION 1.0**
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ATTACHMENT G	**FEDERAL ASSURANCES**
ATTACHMENT H	**CERTIFICATE REGARDING LOBBYING**
ATTACHMENT I	**FFATA CERTIFICATION FORM**

XII. SIGNATURE AUTHORITY

Each Party represents and warrants that the person executing this Grant Agreement on its behalf has full power and authority to enter into this Grant Agreement. Any services or work performed by Grantee before this Grant Agreement is effective or after it ceases to be effective are performed at the sole risk of Grantee.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE FOR HHSC GRANT AGREEMENT, HHSC CONTRACT NO. HHS001329300014

HEALTH AND HUMAN SERVICES COMMISSION

DocuSigned by:
Sonja Gaines
147CCA4134D941B...

Signature

Sonja Gaines

Deputy Executive Commissioner

Date of Signature: September 8, 2023

MHMR OF TARRANT COUNTY

DocuSigned by:
Susan Garnett
A5786F7A2A0E45B...

Signature

Susan Garnett

CEO

Date of Signature: September 8, 2023

Attachment A
Statement of Work (Version 1)

SECTION I: GRANTEE RESPONSIBILITIES

A. TARGET POPULATION

Grantee shall provide Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) services for individuals who are between 15 to 30 years of age, regardless of the age of the individual at onset and meet the criteria for a psychotic disorder from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). These diagnoses for psychosis are listed in *Attachment A-2, Clinical Diagnostic Eligibility-Early Onset Program*, of the Contract.

B. PROGRAM REQUIREMENTS

1. Grantee shall implement a CSC-FEP program for early psychosis identification and service provision in accordance with *Attachment A-3, CSC-FEP Manual I: Outreach and Recruitment,* and *Attachment A-1, CSC-FEP Manual II: Implementation*, of the Contract.
2. Grantee shall establish a client medical record in accordance with internal client admission standards and procedures.
3. Grantee shall establish dedicated CSC-FEP Team(s).
4. Grantee shall provide a Certified Peer Provider in accordance with the standards defined in Texas Administrative Code (TAC), Title 26, Part 1, Chapter 301.
5. Grantee shall provide a Certified Family Partner in accordance with the standards defined in TAC, Title 26, Part 1, Chapter 301, who is available to meet with families of all clients who are enrolled in the CSC-FEP program. This includes family members of children and family members (with signed consent) of adult individuals enrolled in the CSC-FEP Program.
6. CSC-FEP Service Provisions are contained in the fidelity standards for assessment Coordinated Specialty Care in *Attachment A-9, On Track NY Fidelity Assessment Protocol*, of the Contract.
7. Grantee shall assign one or more staff responsibility for tracking policy updates posted on System Agency's identified platform and disseminating information within the organization to ensure contractor stays informed and continues to receive updated information.
8. Grantee shall provide an average of 5 contacts of CSC-FEP services per month for the first 12 months an individual is enrolled in the CSC-FEP program. The service period begins when an individual is enrolled in the CSC-FEP program and applies to the first 12 months the individual receives services, even if those 12 months are not contiguous).
9. Within 30 calendar days of the Contract Effective Date, Grantee shall develop and submit to System Agency a CSC-FEP Implementation Plan that includes:
    a. For each team member: the name, position, credential, and percentage of Full Time Equivalent (FTE);

b. Methods to address staff vacancies during the Contract term, including continuation of services while on-boarding is completed for new staff;
c. A timeline for annual *Attachment A-9*, of the Contract, which is an outcome assessment tool that evaluates the quality of the treatment and how much it complies with the treatment model design; and
d. If the Grantee or Grantee's CSC-FEP team has not completed in initial training associated with CSC-FEP and consistent with the requirements outlined in Section I(D)(1) and immediately preceding the Contract Effective Date, then Grantee shall submit implementation timeline containing benchmarks identifying:
    i. Date by which the CSC-FEP Team will be in place and have completed the two-day initial team training and at least 3 strategies that will be implemented to provide services;
    ii. When is it estimated that services will begin for the CSC-FEP enrolled individuals; and
    iii. What barriers are anticipated for service provision and strategies planned for community outreach and engagement.

C. STAFFING

1. Some of the staff roles may be combined when appropriate. However, the Certified Family Partner and the Certified Peer Specialist roles cannot be combined.
2. Grantee shall staff the CSC-FEP team exclusively with personnel essential to the team roles described in *Attachment A-1* and *Attachment A-3,* which must include the following team members:
    a. Team Lead who is a Licensed Professional of the Healing Arts (LPHA);
    b. Supportive Employment and Education Specialist (SEES), as described at ipsworks.org but certification through ipsworks.org is not required;
    c. Licensed Counselor if counseling is not provided by the Team Lead;
    d. Case Manager or Skills Trainer;
    e. Certified Peer Specialist;
    f. Certified Family Partner who is available for all enrolled in CSC-FEP; and
    g. Psychiatrist, Psychiatric Advanced Practice Nurse, or Physician Assistant.
3. Grantee must receive System Agency's prior written approval for any deviation to its staffing plan or credentialing standards, with the exception of medical staff.
4. Grantee shall employ at least 3.0 FTE per CSC-FEP team excluding the amount of time for the Psychiatrist, Psychiatric Advanced Practice Nurse, or Physician Assistant dedicated solely to the CSC-FEP program. The Team Lead or CSC-FEP Clinical Program Supervisor must be a full-time employee.
5. In areas with a mental health workforce shortage, Grantee may request alternate staff credentials be considered to fill the roles of the team. Any deviation from Sections I(C)(2)(a-f) must receive the prior written approval of System Agency.
6. Grantee shall not alter the quantity or quality of services due to staff vacancies. If CSC-FEP Team members leave their position, Grantee shall notify System Agency of the vacancy within 15 business days and the plan to ensure that those duties are fully executed by qualified staff until any vacancy is filled. Grantee shall make every attempt to fill all vacancies within 30 calendar days.

D. TRAINING AND EVIDENCE-BASED CURRICULUM

1. Grantee, in its first year of the CSC-FEP program, shall use a System Agency-approved subcontractor experienced in CSC-FEP training to provide training to all initial CSC-FEP staff regarding evidence-based practices for an initial 2-day training of Grantee staff. This initial training must be recorded. This initial 2-day training must be completed before individuals can be admitted and served in the CSC-FEP program. The training organization must have and make available subject matter experts who can provide technical assistance and education to CSC-FEP staff.
2. Grantee with established CSC-FEP programs shall provide ongoing training to ensure team members are trained in the most recent evidence-based practices. Grantee shall maintain records of the CSC-FEP team members' training, and ongoing training must include any of the topics below:
   a. Introduction to Coordinated Specialty Care;
   b. Shared Decision Making;
   c. Psychopharmacology of CSC-FEP;
   d. Working with families of children enrolled in CSC-FEP;
   e. Working with families of adults enrolled in CSC-FEP;
   f. IPS/ SEES in CSC-FEP;
   g. The Primary Clinician Role: Psychotherapy, Support and Case Management;
   h. Skills Building;
   i. Texas Special Education rules and regulations;
   j. Illness Management and Recovery;
   k. Co-Occurring substance use treatment including harm reduction;
   l. Cognitive Behavioral Therapy for psychosis (CBT-p);
   m. Trauma-Focused Cognitive Behavioral Therapy;
   n. Preparing Adolescents for Young Adulthood;
   o. Transition Age Youth;
   p. Family Psychoeducation;
   q. Other Substance Abuse Mental Health Services Administration (SAMHSA) evidence-based practices deemed appropriate by System Agency for the CSC-FEP program; and
   r. Cultural Competency.
3. Grantee shall ensure that all CSC-FEP team members maintain the necessary training and licensure required by law to practice their profession (e.g., professional certifications or licensures).

E. RECRUITING, ADMITTING, AND OUTREACH

1. Within 90 days of the Contract Effective Date, Grantee shall have a caseload of no more than 30 enrolled individuals per CSC-FEP team.
2. Grantee shall serve a minimum of 20 individuals per team.
3. Grantee shall complete the Adults Uniform Assessment or Child and Adolescent Uniform Assessment at intake within 7 calendar days of referral. Grantee shall

update assessments as indicated in the Texas Resilience and Recovery Utilization Management Guidelines -- Child and Adolescent Services and Texas Resilience and Recovery Utilization Management Utilization Management Guidelines – Adult Services, as applicable, (collectively "Utilization Management Guidelines") available at: https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual, which is incorporated into this Contract by reference. Enrolled individuals shall receive assessments in accordance with standards set forth in the 26 TAC Rule 301.353 (Provider Responsibilities for Treatment Planning and Service Authorization).

4. Grantee shall ensure that there is a Mental Health Needs Assessment and documentation to ensure that the client's story includes strengths and needs in the following areas:
   a. Housing;
   b. Employment;
   c. Education;
   d. Social Support;
   e. Finances;
   f. Basic Living Skills;
   g. Primary Care Access;
   h. Social Skills;
   i. Family Support;
   j. Past Trauma; and
   k. Legal issues, especially in the past year.
5. Grantee shall maintain, and make available to System Agency, an Outreach and Recruitment Plan in accordance with *Attachment 3, CSC-FEP Manual I: Outreach and Recruitment*, of the Contract. The Recruitment Plan must include written policies and procedures that outline program admission criteria and ensure that the CSC-FEP program caseload remains between 20 and 30 individuals per CSC-FEP team. For example, outreach and client recruitment activities may include organizing community education events on early psychosis, networking with hospitals and educational organizations, and coordinating with other facilities to identify candidates for the CSC-FEP program.
6. Grantee shall serve individuals in the community as outlined in the Utilization Management Guidelines as applicable.
7. Grantee shall build rapport and provide education about medication options and best practices to enrolled individuals for medication treatment for CSC-FEP so that enrolled individuals are willing to consider taking psychotropic medication including antipsychotic medications, to the extent clinically appropriate.
8. Each enrolled individual will have documentation to include the following:
   a. Individual's name,
   b. Medical history by Primary care provider,
   c. CSC-FEP program admission date,
   d. Primary care referral or linkage date,
   e. Date of first appointment with Primary Care Physician, and
   f. Subsequent primary care and specialty care appointment dates.

9. Grantee shall transition individuals from the CSC-FEP program to the most appropriate level of care if an individual becomes ineligible for the program.

F. SERVICE PROVISION

1. Grantee shall ensure that all enrolled individuals who are interested have access to Individual Placement and Support Services (IPS) regardless of readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, or personal presentation.
2. Grantee's IPS or SEES Specialist shall assist enrolled individuals in pursuing permanent competitive jobs and academic opportunities in mainstream, integrated educational settings. Acceptable jobs include seasonal jobs and temporary jobs that are part of the labor market.
3. Grantee shall provide a 24/7 phone access for enrolled individuals and their families to use when a crisis occurs. Grantee shall provide in-person crisis support through an established Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA) to help connect individuals to necessary resources, including medical backup.
4. As required in the applicable Utilization Management Guidelines, Grantee shall regularly assess all individuals during intake for suicide risk and thereafter proactively monitor suicide risk throughout treatment and whenever safety concerns arise. Safety Plans must be developed and implemented by CSC-FEP program staff for individuals identified by the staff to be a safety risk within 24 hours. Grantee shall use System Agency-approved risk assessment tools and file in the client's chart. Safety Plans must be made available to System Agency upon request.
5. As defined in the applicable Utilization Management Guidelines, Grantee shall develop a Recovery Plan during the admission process and every 90 calendar days thereafter. Grantee shall comply with Recovery Plan requirements in accordance with Texas Administrative Code, Title 26, Part 1, Chapter 306, Subchapter F, Mental Health Rehabilitative Services Rule 306.311 (relating to Service Authorization and Recovery Plan).
6. Grantee's CSC-FEP team shall periodically discuss with each enrolled individual his or her preferences for family involvement.
7. Grantee shall ensure that the length of stay in the CSC-FEP program for any individual does not exceed 36 months.
8. Grantee's CSC-FEP program shall document efforts to support clients in meeting basic needs by directing clients to community support resources and helping individuals complete the required steps to access available resources.
9. Grantee's CSC-FEP program resources may be used to support client's basic needs if these resources are not available in the community, documented in the recovery plan, and in compliance with providers' policies and procedures and the Contract requirements.
10. Prior to spending Contract funds to assist enrolled CSC-FEP individuals with housing expenses, Grantee shall submit a request to System Agency using *Attachment A-7, Housing Supports Checklist,* of the Contract and for System Agency written approval. Grantee shall utilize *Attachment A-8, Housing Support*

Guidance, of the Contract for guidance in providing support to enrolled CSC-FEP individuals for housing expenses or needs.

G. DATA SUBMISSION AND REPORTING

1. Grantee shall use the procedure codes in the current version of the Mental Health Service Array in CMBHS, Grantee shall report service delivery data in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW). The Mental Health Service Array (Information Mental Health Service Array Combined) is located in the MBOW folder in the Consumer Analysis (CA) General Warehouse Information Specifications subfolder. If Grantee does not have access to MBOW, request for access must be submitted to System Agency.
2. Grantee shall submit data through CMBHS at: https://cmbhs.dshs.state.tx.us/cmbhs/WebPages/Default.aspx or Grantee shall submit batch data, if applicable, in accordance with the Utilization Management Guidelines.
3. A Quarterly Data Reporting Form will be available to the Grantee from the HHSC CSC-FEP staff after the Contract is executed.
4. Grantee shall complete the Quarterly Data Reporting Form, and submit the completed form to mhcontracts@hhsc.state.tx.us, FEP@hhs.texas.gov, with copy to the System Agency Contract Representative. The form is due on a quarterly basis each state fiscal year in accordance with the due dates listed below, but if the due date falls on a holiday or weekend then form is due on or by the next business day:
   a. September 15;
   b. December 15;
   c. March 15; and
   d. June 15.
5. Grantee shall complete Quarterly Data Reporting Form with guidance from *Attachment A-5, Early Onset Data Definitions*, of the Contract.
6. System Agency will gather outcome and target data from MBOW on a quarterly basis and cross-reference it with the quarterly data submission from Grantee. MBOW will be the official source for data once it is submitted.

H. SUBAWARD MONITORING

Grantee shall monitor the activities of any subcontractor or subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with applicable statutes, regulations, and the terms and conditions of the subaward, and that subaward performance goals are achieved.

I. CLINICAL MANAGEMENT FOR BEHAVIORAL HEALTH SERVICES (CMBHS)

1. Grantee shall ensure that it has appropriate internet access and a reasonable number of computers of sufficient capability to use CMBHS.
2. Grantee shall notify System Agency immediately if a security violation is detected, or if Grantee has any reason to suspect that the security or integrity of CMBHS data has been or may be compromised in any way. Grantee is required to update records on a daily basis to reflect any changes in CMBHS user account status.

3. Grantee shall ensure that adequate internal controls, security, and oversight are established for the approval and electronic transfer of information regarding payments and reporting requirements. Grantee shall ensure that the electronic payment requests and reports transmitted contain true, accurate, and complete information.
4. System Agency may limit or deny Grantee access to CMBHS at any time, at its sole discretion, and Grantee will not incur any liability for failure to meet any Contract requirements resulting from such limited or denied access.
5. Grantee shall use the following CMBHS components and functionality, in accordance with System Agency instructions:
   a. Staff Member;
   b. User Profiles;
   c. Assign Roles; and
   d. Enrolled individuals Profile.
6. Grantee's network monitoring must include contracting or providing troubleshooting or assistance with Grantee-owned Wide Area Networks (WANs), Local Area Networks (LANs), router switches, network hubs or other equipment and Internet Service Provider (ISP). Grantee is responsible for maintaining local procedures to end-users and is responsible for data backup, data restoration, and contingency planning functions for all local data. Grantee shall:
   a. Create, delete, and modify end-user LAN-based accounts;
   b. Change or reset user local passwords as necessary;
   c. Administer security additions and changes and deletions for CMBHS;
   d. Install, maintain, monitor, and support Grantee LANs and WANs; and
   e. Select, purchase service from, and monitor performance of its ISP.
7. System Agency will provide support for CMBHS including problem tracking and problem resolution. System Agency will provide telephone numbers for Grantee to access assistance for CMBHS related problem resolution. System Agency will provide initial CMBHS training which Grantee is required to attend. Grantee shall provide subsequent ongoing end-user training, as needed.
8. Grantee shall designate a security administrator and a back-up security administrator. The security administrator is required to implement and maintain a system for management of user accounts and/or user roles to ensure that all the CMBHS user accounts are current. Grantee shall develop and maintain a written security policy that ensures adequate system security and protection of confidential information to prevent unauthorized disclosure and to respond to, notify individuals of, and mitigate any unauthorized use or disclosure of confidential information. Grantee shall fulfill the following requirements:
   a. Using *Attachment A-6*, *Security Administrator Attestation & Authorized Users List,* of the Contract, Grantee shall submit a signed list of authorized user information and the name, phone number, and email address of the primary and secondary security administrators, to provide the names of employees and contracted laborers authorized to have access to secure data. Grantee shall submit *Attachment A-6* by email to mhcontracts@hhsc.state.tx.us and to the System Agency Contract Representative and no later September 15 and March

15 of each fiscal year. Grantee shall ensure that access to CMBHS is restricted to authorized users only.

b. If any changes are made to the designated security administrator or the back-up security administrator, Grantee shall notify System Agency within 10 business days by submitting an updated *Attachment A-6*. System Agency will, within 24 hours of the notification, remove access to users who are no longer authorized to have access to secure data.

SECTION II. SYSTEM AGENCY RESPONSIBILITIES

System Agency will provide consultation to Grantee in the review, assessment, and development of the CSC-FEP program, by:

1. Scheduling monthly meetings, at minimum, with Grantee through coordination calls to assess Grantee's technical assistance needs and to monitor status of the CSC-FEP program development.
2. Providing timely review and input of goals and objectives.
3. Providing subject matter expertise and guidance on relevant data, programs, research and best practices.
4. Providing active input with information and resources that can help to support the activities of the Grantee.
5. Providing input and review of Grantee Quarterly Data Reporting Form, which is subject to System Agency review and approval.

SECTION III: PERFORMANCE MEASURES

A. Within 30 calendar days of the Contract Effective Date, Grantee shall submit the Implementation Plan described in Section I(B)(9).
B. Grantee shall submit all required data and reports in accordance with the instructions outlined in Section I(G).
C. Grantee shall conduct an annual Fidelity Assessment. This information is subject to System Agency review at any time throughout the term of the Contract.
D. Grantee shall submit a Staff Roster as part of the Quarterly Data Report, which must include the following:
    1. Name;
    2. Credentials;
    3. Amount of full time equivalent (FTE) budgeted;
    4. Name of Position;
    5. Team role(s);
    6. Phone number; and
    7. Email address.
E. Grantee shall adhere to the following performance measures:
    1. CSC-FEP team caseload does not exceed a 12:1 ratio;
    2. An Outreach and Recruitment Plan as specified in Section I(E);
    3. Documentation through individual's electronic health record that at least 80% of enrolled individuals met with a psychiatrist, psychiatric advanced practice nurse, or physician assistant at least once per quarter beyond the initial session to review

medication effectiveness and side effects. Grantee shall record symptoms and side effects of medication in a manner that facilitates monitoring of an enrolled individual's changes over time. This documentation is subject to System Agency review at any time throughout the term of the Contract. Upon System Agency's request, Grantee shall submit this documentation within 5 calendar days.

F. System Agency will monitor Grantee's performance of the requirements set forth under the Statement of Work, budget and invoicing requirements, and compliance with the Contract terms and conditions. Upon request from System Agency, the Grantee shall revise any performance measures to System Agency's satisfaction and in accordance with the requirements under the Contract.
G. Grantee shall submit, as instructed, all required reports, documentation, and other information, including any pertaining to performance measures, by email to mhcontracts@hhsc.state.tx.us, FEP@hhs.texas.gov and System Agency Contract Representative.
H. If System Agency determines, based on Grantee performance monitoring, that System Agency requires documentation or additional information, then Grantee shall submit documentation or information using the following methods as requested by System Agency:
    1. If by mail, then Grantee shall submit to the following address:
    Health and Human Services Commission
    Mental Health Contracts Management Unit
    P. O. Box 149347
    Austin, TX 78714-9347
    2. If by overnight mail, then Grantee shall submit to the following address:
    Health and Human Services Commission
    Mental Health Contracts Management Unit (Mail Code 2058)
    909 West 45th Street, Bldg. 552
    Austin, TX 78751
    3. If by fax, then Grantee shall send using the following number: (512) 467-5476.

SECTION IV: FUNDING

A. Grantee shall establish and maintain an independent accounting system that is available for the purpose of audit and identifies the source and application of funds provided under this Contract and original source documentation substantiating costs are specifically and solely allocable to this Contract and are traceable from the transaction to the general ledger.
B. Grantee shall expend 50% of the total grant funds no later than March 1 of each state fiscal year. If census of CSC-FEP program is lower than expected and if 50% of the funding has not been spent by March 1 of the state fiscal year, Grantee shall immediately direct the unspent funds towards one of the following CSC-FEP activities:
    1. Community outreach and education;
    2. Additional CSC-FEP training; or
    3. Other CSC-FEP activities as authorized by System Agency.
C. System Agency, at its sole discretion, may adjust the funding amount of the Contract based on performance measures, outcome measures, waitlist, or other criteria determined

by System Agency. Additionally, contingent upon availability of funds System Agency may implement an alternative reimbursement methodology using the original rates set forth in the Contract or rates effective at the time of such revision.

D. The estimated state fiscal year funding amount may either be ratified or amended at the sole discretion of the System Agency, based on changes in appropriations, budget cuts, transfer of funds between programs or agencies, amendment of the Texas General Appropriations Act, agency consolidation, or any other disruption of current funding for this Contract.

Coordinated Specialty Care for First Episode Psychosis

Manual II: Implementation

National Institute of Mental Health

RAISE
Recovery After an Initial Schizophrenia Episode
A Research Project of the NIMH

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Disclaimer:
The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of HHS.

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Table of Contents

I. Introduction

This manual is designed to guide implementation of a team-based program to serve individuals who are experiencing emerging psychosis within an existing mental health clinic (MHC). It provides information on administrative issues that must be discussed and resolved between the team and the clinic, such as hiring team members, managing team caseloads, providing services outside of the clinic setting, using the clinic's support staff for smooth team functioning, and sharing space and resources. Other critical implementation issues involve training and ongoing supervision of team members, ways to measure fidelity to the team model, and how to build supervision and fidelity assessment into ongoing practice within the clinic.

The recommendations and resources provided in this manual are derived from the experiences of the Recovery After an Initial Schizophrenia Episode Implementation and Evaluation Study (RAISE-IES). RAISE-IES was funded by the National Institute of Mental Health (NIMH) to develop tools that would support the implementation of Coordinated Specialty Care (CSC) programs designed to provide early intervention services for people with non-affective psychoses. The Connection Program represents an example of a CSC program recommended for first episode psychosis (FEP), and was the clinical intervention developed and evaluated in RAISE-IES. This manual is based on the experience of creating and implementing CSC programs in New York, New York and Baltimore, Maryland. Two Connection Teams were formed, one in each city. Per the CSC treatment model, and as will be further discussed throughout this manual, teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach. Throughout this document, we may refer to these team members in our examples of implementation. Keep in mind that teams in other locations, under different circumstances, may have different staffing configurations. These particular titles and associated training plans may not apply. They can, however, serve as useful guides for how to construct new programs.

Experience with creating and implementing these two Connection Teams illustrates the many opportunities that arise from embedding such a team within a larger MHC in terms of administration, resource sharing, and collaborations among staff members. The manual is intended to convey general concepts, providing examples from two program implementations: The RAISE Connection Program and OnTrackNY. OnTrackNY represents an extension and adaptation of RAISE Connection and is also a CSC model currently being implemented in four locations throughout New York.

II. Administrative Issues in Implementation

Section Tools

- ✓ ***Appendix 1: Getting Started Checklist***
- ✓ ***Appendix 2: RAISE Connection Program Eligibility Criteria***
- ✓ ***Appendix 3: Sample Job Descriptions for Team Hires***

This section describes a number of issues that need to be considered when implementing a team-based CSC program that serves individuals who are experiencing emerging psychosis. A checklist of these issues is provided in *Appendix 1*.

A. Program Structure and Services

An early consideration is the operational location of the team—will the team-based program operate and reside within an existing and established MHC, or will it be established as a separate organization and/or in a separate location? Advantages of the former include the opportunity for efficiencies within a shared infrastructure. Advantages of the latter include the possible opportunity to be more flexible and less stigmatizing for individuals who might avoid community mental health programs entirely. A related question is whether there will be a single team that functions on its own or a collection of teams that network to provide services to a broader area. In the case of related or collaborating teams, some efforts (e.g., training, developing an outreach and referral network, and performing outreach and recruitment) may be performed centrally to share costs. The single vs. multiple team issue will also influence the development of a referral network. Establishing a network for a single team will generally require efforts targeted to a specific area and/or set of referral sources, whereas creating a network of referral sources for a linked set of teams would require strategies to blanket outreach across large areas.

B. Geographic Boundaries

Two important issues related to geographic boundaries are population density and service boundaries. A population base of about 550,000 will have enough incident FEP cases to keep one FEP team filled at capacity given the team size and service durations proposed here, even with fairly conservative estimates about the number of such individuals who are identified and agree to be served.[1] The report by Humensky et al.[1] includes an interactive spreadsheet tool to estimate the number of teams that a given area can support and the associated cost given user-specified values for relevant variables (e.g., fraction of incident cases approached). When deciding whether the population density is sufficient to support one or more teams, the service boundaries need to be determined for each team operating in the area. Since part of the team's mission is to provide at least some services in the field, it is important to consider setting service boundaries that are reachable and will not require excessive time for travel when team members provide services in the community. Availability of public transportation is an important

[1] Humensky JL, Dixon LB, Essock SE. An interactive tool to estimate costs and resources for a first episode psychosis initiative in New York State. *Psychiatric Services*, 2013; 64 (9):832–834.

consideration, as is how accustomed to travel the potential population is. If the program will provide supported education or employment, the Individual Placement and Support (IPS) Specialist will make visits to community locations that need to be within reach of the young people and families served. As a rule of thumb, new teams should consider accepting clients living one-half hour from the clinic if education and employment services are offered. Without education and employment services, consider accepting clients no more than 45 minutes away from the team location.

C. Types of Clients Who Will Receive Services

Each program should establish its eligibility criteria. The first critical decision around eligibility is determining a definition of early psychosis. This includes not only how long an individual can have had psychotic symptoms, but what constitutes psychotic symptoms. Each team also needs to determine whether they will include individuals with diagnoses associated with psychosis, such as psychosis due to a medical condition, substance-induced psychosis, or mood disorders with psychotic features. Finally, the team needs to decide if there are any diagnoses that would exclude an individual from admission, such as developmental delays, pervasive developmental disorders, oppositional defiant disorder, or substance abuse and/or dependence disorders.

Other domains to consider when determining eligibility for team services include:

- Age range
- Comorbid medication conditions
- Comorbid trauma
- Housing instability
- Legal problems or prisoner status
- Cultural diversity and need for culturally sensitive services
- Primary language other than English
- Insurance status

The eligibility criteria used for the Connection Program are listed in *Appendix 2*, along with the rationale for each. Service eligibility was determined prior to admission. If, after admission, the team obtained new information that indicated that the individual was not eligible for the CSC program, the team continued providing services.

D. Connection with State and Surrounding Partners

It is important for a first-episode specialty care program to link with other programs in the community that may be needed in the course of a young person's care. For example, emergency care services, inpatient substance abuse treatment programs, and other services are not provided by the CSC but may need to be accessed by clients. It is critical that CSC programs and their clinicians connect and develop relationships with these other services during the set-up phase, so that these services may be easily accessed in a crisis situation. To ensure smooth transitions, the partnerships need to be in place and ready for use.

E. Determine Funding/Operating Budget

Funding for FEP services will vary by locality and insurance source. In some states, FEP services may be state supported via Medicaid waivers or other categorical funding. For a detailed discussion of approaches to financing interventions for FEP, see: http://aspe.hhs.gov/daltcp/reports/2012/EarlyInt.pdf . Budget issues that need consideration for FEP programs are similar to those of any other clinic-based program: identification of payment sources, billing, budget management, expense tracking, supply ordering, and laboratory and pharmacy tracking and reimbursement.

F. Establish a Referral Network

A referral network is key for the success of the CSC program. Establishing a referral network has many components that are summarized in *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*. Once established, the referral network needs ongoing management – referral sources contacted regularly, contact information updated, etc. The team or mental health center will also need to track referrals and outreach activities. Strategies for this are provided in detail in the *Outreach and Recruitment Manual*.

G. Application of Clinic Procedures to the Team

There are a range of procedural issues that are relevant to setting up a CSC team within an existing MHC.

1. ***Human Resources and Hiring.*** Administrators are responsible for hiring staff. Sample job descriptions are provided in *Appendix 3*. All agency rules regarding evaluation and credentialing should be followed. If possible, hire the Team Leader first so that the Team Leader can be involved in the hiring of the other team members.

2. ***Resources.*** Resources needed include space, computers, office equipment, and other transportation funds.

    - Setting. Issues pertaining to the setting and space for services (including the capacity to provide services outside of the clinic) need to be addressed between the team and the clinic administrators at the start. Early psychosis intervention teams serve a young population. The setting in which the team is located needs to appeal to young clients. The setting should be pleasant, inviting, and recovery-oriented. Integrating the service into community or general health services would be preferred. The team needs sufficient space to hold groups and team meetings as well as some space for private individual meetings. The space should, if possible, be in an area that is easily accessible, either via public transportation and/or with parking. There also needs to be the option of providing services outside of the clinic.

- Computer Access. It is important for all team members to have computer access in a large enough space to also accommodate clients and their families. During sessions or meetings, team members may use computers to access resources, direct clients and families to services, assist with job searches, and watch videos or view other treatment-consistent content. Ideally, team members would have access to a laptop computer that could be used in different locations and shared among team members.

- Medical Equipment. Basic medical equipment needed to dispense and monitor medication should be available so that clients can work with the Team Psychiatrist on site at regular appointments. This equipment includes a scale and blood pressure cuff, as well as a way of obtaining labs, either on site or off site. Working out the logistics of labs and injections is critical and must be addressed at the start of program implementation.

- Additional Resources. Programs should also have access to money for petty cash. These funds would be used to make small purchases such as refreshments, snacks, reading material, or cab fare. The team also needs access to transportation for community visits and to provide access to community services. This could include a car depending on the community. Telephones, cell phones, and computers should be provided according to agency policy.

3. ***Programmatic Oversight and Management.*** These tasks include supervision, consultation, back-up coverage, and other administrative management duties. All of these issues must be addressed collaboratively and constructively between the team and the MHC.

- Supervision. Access to supervision for each of the team members is a critical consideration. Supervision for the Team Leader within the reporting structure is also necessary to facilitate integrating the program into the overall agency structure. Ideally, the Team Leader should have administrative supervision with the clinic coordinator at least every 2 weeks, and monthly supervision with the clinic's program director. Optimal there would be an Individual Placement and Support Supervisor in the agency or available to the program.

- Consultation. Access to expert consultation and/or peer supervision, especially for the Team Psychiatrist, is also important. At the beginning of the program, it would be optimal for the physician to have access to consultative expertise to assist with unique problems that arise for FEP patients.

- Back-up Coverage. The clinic administration needs to have back-up plans for coverage for the Team Leader and the Team Psychiatrist in the event that either is out for a scheduled absence. Emergency back-up coverage is also necessary if the physician is not available.

- Management Duties. Other personnel and management tasks can include annual evaluations for the Team Leader and time tracking for all team members. The Team Leader presumably evaluates all team members. Psychiatrist evaluation should be done

according to program policy.

4. ***Adherence to/Compliance with clinic regulations.*** The Clinic Administration must ensure that FEP program elements are compatible with existing agency requirements. Suggested FEP forms should be compared and matched to required agency forms so that redundancy can be eliminated.

5. ***Clinical oversight and management tasks.*** These include medical records management, patient registration and tracking, evaluation of clients' insurance to confirm coverage, and census and visit tracking reports.

H. Staffing Requirements

First episode specialty teams are comprised of a group of professionals who have different but overlapping roles. At minimum, teams should have a main leader or coordinator who is responsible for the client's overall treatment plan and programming. In addition, each client should have a team member who provides in-depth individual and family support, suicide prevention planning and crisis management, and assistance with access to community resources and supports. This can be the Team Leader or primary clinician. Case management can also be provided, if needed, by the designated primary clinician or by another team member. Each team should have a psychiatrist or prescriber who works with clients on issues of medication, management, wellness, and side effects. Teams should also have a Supported Employment Specialist to work with clients on re-entry to school or work, as well as team members who can work with clients on goals that require social or coping skills training and attention to substance use. Each team must have someone dedicated to establishing and maintaining a referral network and evaluating potential clients as described in the *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*.

Team members should have dedicated time for their team-related work. This is especially important for team members who are not 100% full-time equivalent (FTE). If someone's time is divided between the CSC team and other responsibilities, steps should be taken to ensure that their team time is preserved and differentiated from their other clinic-related responsibilities.

RAISE Connection Program Teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach. The Team Leader and IPS specialist were full-time clinicians, whereas the Recovery Coach and the Psychiatrist were part-time at 50% and 20% effort, respectively. Teams in other locations and under different circumstances may have alternate staffing configurations, so these particular titles may not apply. For example, OnTrackNY Teams have two full time equivalent staff covering the Team Leader, Primary Clinician, Recovery Coach and Outreach Coordinator roles. A full-time IPS specialist, 0.3 FTE prescriber, and 0.2 FTE nurse round out the team.

I. Team Features

There are specific aspects of CSC team functioning that are recommended in order to ensure program success:

1. ***Small Caseloads.*** The team should have small caseloads, consisting of 25–30 clients or less, to ensure that team members have sufficient time to fully address all areas of intervention. The small caseload will also enable team members to develop and nurture a trusting relationship with the client and allow the team member time to perform activities outside of the clinic setting, such as home visits and community outreach, as needed. This flexibility is particularly important during the earlier phases of intervention and engagement.

2. ***Frequent Team Meetings.*** The whole team should plan to meet once per week. At these meetings, the team will review the status of each client, discuss each team member's role in the client's care, and review progress towards treatment goals. Team meetings should model respect, recovery, and shared decision-making. These meetings give team members the opportunity to inform and be informed by one another. They also provide time for the Team Leader to "check in" with each team member regarding the activities and goals of each respective specialty. During team meetings, the principles and practices of CSC care are reinforced through review of current cases and ongoing training to improve clinical knowledge and skills. For instance, after a case is presented, the team may provide feedback on such issues as making the transition to the next phase of care, negotiating with community providers, and taking a harm-reduction approach to resolving problems.

   The team should save the hour following the weekly team meeting for treatment planning or updating with clients. When an initial treatment plan or an update is discussed with clients, the goal is to have all team members present. Scheduling time for treatment planning meetings following the weekly team meeting is an easy way of ensuring that all team members will be present.

   Section IV: Supervision provides a detailed discussion of team meetings for the purpose of supervision.

3. ***Central Point of Referral.*** As discussed in *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*, referrals to the team should come to a staff member dedicated to outreach and referral activities. This may be a staff member on the team (Outreach and Referral Specialist), or a group of staff members on an outreach and referral team. All advertising about the FEP program should list appropriate contact information. A central referral process that involves a dedicated referral line staff makes calling and contacting the team an easy process for clients, families, community providers, and other potential referral sources.

4. ***Coordinating Entry to the Program.*** The person receiving referrals should work with the team to coordinate the initial team activities, including intake assessment and preliminary treatment planning. Based on the assessment, the team will engage in shared decision making with the client to plot an overall treatment plan to meet the individual's expressed

recovery goals; treatment planning is conducted in full consultation with the client. Clients' capacity and interest in formal goal setting and making decisions can fluctuate throughout the course of treatment; preference and comfort with the decision-making role should be regularly explored. For the RAISE Connection Program Teams in Maryland and New York, the Team Leader coordinated a young person's entry to the program after the Outreach and Referral Specialist identified them as eligible.

5. ***Working as a Team in a Shared Decision Making Framework.*** Although the CSC team works collaboratively in the treatment of a client, a client may only be working with one or two clinicians at any point in time. At a minimum, all clients should work with the Team Leader (or assigned primary clinician for programs with others serving in the primary role) and the Team Psychiatrist. Even clients who are not interested in taking medication should meet with the psychiatrist to learn about medication options, set goals regarding when a medication trial may be warranted, and establish a relationship with the psychiatrist in case his/her feelings about medication change. Working with other members of the team is not mandatory but strongly encouraged, and it is expected that these working relationships may change over time.

Case Narrative 1: Introduction to Team Members and Gradual Engagement with Different Team Components

The Connection Program Team uses treatment planning to help new clients learn about the different aspects of the program and decide, within a framework of Shared Decision Making, which components they wanted to use and when. For example, at program entry, one new client may be most interested in a trial of medication, and not be ready to work on skills training or employment. Another new client may be very interested in getting back to work or school, but less interested in medication or family work. A third might be willing to work on decreasing his/her substance use in order to benefit most from medication and prepare for an eventual job search. Getting started with the team is flexible such that what is most important to the client and his/her family can be addressed first, and components can be added later as clients feel better, revise their goals, and look to the future.

Although team members may cover for each other occasionally (e.g., the Team Leader may see a client and work on employment related goals if the employment specialist is not available one day), each team member specializes in his/her component of the intervention. If a team wants to be structured to be able to accommodate overlapping roles, it is important to hire people with common skill sets so that tasks can be shared across team members. As discussed in *Section III: Training,* role flexibility is also the reason why cross-team training is important; the team members should be trained in all components they will be expected to cover clinically. For example, *Maryland and New York Connection Teams were comprised of a Team Leader, a Team Psychiatrist, an Individualized Placement and Support (IPS) Specialist, and a Recovery Coach; these staff members largely focused on their individual areas of expertise and there was little overlapping of roles.*

While the RAISE Connection Program had little overlap in roles, new teams in other locations with different circumstances, may have alternate staffing configurations and be

structured to have more flexibility in sharing roles. OnTrackNY, is now being implemented in four locations in New York. *OnTrackNY teams will be made up of a Team Leader, a Primary Clinician, a Team Psychiatrist, an IPS Specialist, a Recovery Coach, a Team Nurse, and an Outreach and Referral Specialist. In this structure, the individuals serving as the Recovery Coach or Outreach and Referral Specialist can also serve in the Primary Clinician role.*

6. ***Connecting with Community Partners.*** The team helps the client create or re-establish a social network within and beyond the family. School and work provide other opportunities to establish and grow natural supports. Some clients need help connecting with resources to avoid housing loss or other adverse social outcomes. The team works with the client and family to develop advocacy skills.

   Use of community resources is directly linked to goals in the treatment plan. The role of the team members is to not only identify resources and make referrals, but actively assist the client and family in linking to and using these resources. This can include the Team Leader following up with a referral source to check on a client's progress, the Recovery Coach accompanying the client to meetings or appointments in the community, or other active assistance as needed. Identifying community resources will be actively encouraged and assisted by the team.

   There are several areas in which resources in the community may be sought:

   - Mental Health or Clinical Services Not Provided by the Team: examples include cognitive behavioral treatment for depression, anxiety disorders, or PTSD; inpatient substance abuse treatment; dialectical behavior therapy

   - Non-Psychiatric Medical Services: examples include primary care services, lab services, or other medical appointments; substance use detoxification

   - Peer or Community Support Resources: examples include National Alliance on Mental Illness (NAMI), Alcoholics Anonymous/ Narcotics Anonymous (AA/NA, Double Trouble, and the Depression and Bipolar Support Alliance. Consumer organizations, such as On Our Own Wellness and Recovery Centers, are also important resources for clients and families.

   It is also important to assist clients in re-connecting with their communities around activities that are social and pleasurable. These may be activities that consumers do with their families, friends, or alone.

Case Narrative 2: Ways to Re-Engage with the Community.

It is important to remember that clients with early psychosis are young people and an important component of their recovery is doing things they enjoy with other young people. The Team helped clients access social supports and engage or re-engage with their communities in line with their treatment goals. Clients looking to make new friends might participate in the team's social skills group, meet with the RC in the community to practice these skills, and then plan a community activity to do on his/her own in order to put these skills into practice. Clients were encouraged by team members to engage in community activities they found enjoyable or that would allow them to try out new skills gradually and prior to having to use them in an important situation. For example, one client had, before his hospitalization, enjoyed playing basketball at college with his friends. The team worked with him to identify places he could play basketball now that he was living at home, people he could ask to play ball with him, and times during the week when he could get a game together. Another client was distressed by the weight gain she experienced due to her medication and told the team that she wanted to start exercising. The team helped her talk to her brother about taking her to a gym; assisted her in signing up for a gym membership; and provided support, encouragement, and praise as she began to swim at the gym several times per week. The team helped another client who wrote poetry to find locations in the community where he could listen to poetry; he eventually presented some of his own work. In all of these examples, the team helped consumers engage with people, activities, and community settings in ways that were positive and in line with their recovery goals.

III. Training

Section Tools:

- ✓ ***Appendix 4: Background Readings and Resources – Team***
- ✓ ***Appendix 5:Background Readings and Resources – Recovery Coach Training***
- ✓ ***Appendix 6: Background Readings and Resources – Supported Employment and Education***
- ✓ ***Appendix 7. Vignettes to Use in Team Training***
- ✓ ***Appendix 8. Scripts for Training Role Plays***
- ✓ ***Appendix 9: Slides and Forms to Use for Team Training Topics***

A. Training Overview

As has been emphasized throughout this manual, developing a CSC program to serve individuals with emerging psychosis will be influenced by the clinic in which the team is going to function and by the needs and resources of that clinic. This means that not all teams will be exactly the same, though all will be implementing the same underlying principles of CSC care. Training should be tailored to the specific needs of the clinic and team staff. This section provides an overview of training approaches for the team members in clinical roles. Training considerations for those responsible for outreach and recruitment can be found in the *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*.

Team member training encompasses two domains: Team Training and Specialty Training. Team Training focuses on information and skills needed by all team members, including the overall program philosophy and principles of the CSC program and the procedures that structure the team and guide the ways that team members work together and assign tasks within the team. Specialty Trainings are targeted to the responsibilities of each team member; these trainings focus on the skills and interventions required by particular team members to effectively deliver their assigned component(s). A program should decide up front how much flexibility there will be in role assignments. If there is greater flexibility, team members should be 'cross-trained' to competency in the various specialized areas in which they will be expected to serve.

Background readings and discussions are useful for all team members. More intensive in-person or in some cases on-line training is also needed. The amount of time devoted to training is influenced by the background and previous training/experience of team members. *In training the RAISE Connection Program Teams in Maryland and New York, initial in-person training lasted for 2 days and included presentations on the model supporting the work of the team, didactic presentations on the different components of the team, and exercises designed to illustrate clinical activities and ways for the team to work together to understand clients, their needs, and how these impact treatment planning.*

An important consideration is who should provide training as outlined in this section. New FEP teams need to identify the experts and resources in their communities and within the larger community of FEP treatment development. This manual includes a range of written and online resources. New teams should plan to reach out to national experts, local community

organizations and providers, and existing teams for assistance in accomplishing the training. Information can be found on the NIMH RAISE website (http://www.nimh.nih.gov/raise) or from the RAISE intervention program developers.

B. Team Training (Training the Team as a Whole)

1. Background Readings and Discussions

a) Readings. All team clinicians should be provided with background readings on FEP and the lived experience of psychosis, and topics that are important across program elements. The cross-cutting topics include: shared decision making, trauma-informed care, the recovery model, and suicide/safety planning. A list of background readings and resources is provided in *Appendices 4–6*. An experienced trainer or facilitator should lead discussions of the readings so that team members learn about and understand the unique challenges experienced by individuals experiencing an FEP and their families. In addition, readings should emphasize the importance of incorporating client and family input into treatment and goals and the strategies for how to interact with and include families in decision making while respecting the preferences of the young adult.

b) Online resources. In addition to readings, many online resources provide valuable information in different formats and allow team members to practice or learn new content and skills (See *Appendices 4–6*). The Voices of Recovery video series, developed for the RAISE project, can be found at the following link: http://practiceinnovations.org/ConsumersandFamilies/ViewAllContent/tabid/232/Default.aspx. A manual that provides guidance as to how the videos may be used for staff training, as well a discussion for how to use with clients and families is available at http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx.

c) Additional Perspectives in Training.

- Peers. Including peers or a consumer-professional who understand both receiving and providing services can provide an invaluable perspective to training. Peer/consumer knowledge of the subjective experience of psychosis and treatment is a critical perspective to represent in training. Existing resources on peer experience, such as those provided online or newly created materials to address this topic, can be key adjuncts to care.

- Family. The importance of understanding the perspective of family members who are often central in the lives of individuals experiencing psychosis cannot be overstated. Trainings should include family members or a family–professional who can communicate to staff how the family might be experiencing the situation and who understands the impact of accepting the changes and challenges taking place with their loved one. NAMI presentations and trainings might also be helpful for staff training.

2. Intensive, In-Person Activities

The purpose of the in-person, whole-team training activities is to present a thorough review of information that is key to understanding the team approach and to introduce and practice the concept of "team-ness" to the team members. In-person training sessions allow for presentation of material that is relevant to the team as a whole, and then for breakout sessions to present material by component.

The informational and didactic components of training should include:

- Topics relevant to the CSC conceptual model:
  - ✓ first episode psychosis
  - ✓ critical time intervention
  - ✓ mental health recovery
  - ✓ working with youth
  - ✓ shared decision making
  - ✓ trauma informed care
  - ✓ safety planning
  - ✓ person-centered treatment planning

- Topics relevant to the components of the team:
  - ✓ psychopharmacology
  - ✓ supported employment and education
  - ✓ working with families
  - ✓ social skills training and substance abuse treatment
  - ✓ relapse prevention planning

- A review of functional procedures of the team:
  - ✓ team member roles
  - ✓ small caseloads
  - ✓ frequent team meetings
  - ✓ progress notes and documentation of team activities
  - ✓ after hours roles and responsibilities

- A thorough review of the timing of team activities:
  - ✓ initial referral and treatment planning
  - ✓ a history and needs assessment done collaboratively by the Team Leader and the Team Psychiatrist
  - ✓ development and implementation of the initial treatment plan
  - ✓ Team Leader activities at the start of treatment (e.g., set up a family meeting; complete safety planning, develop a relapse prevention and crisis plan)
  - ✓ activities for other team members at the start of treatment (e.g., IPS Specialist and the Skills Trainer must introduce themselves to the client, meet with the client to describe what services they provide, and assess the client's needs and goals in their respective areas)
  - ✓ ongoing treatment

- ✓ issues around missed appointments/potential dropout/assertive outreach
- ✓ transition
- ✓ linking with community and peer resources

Forms to use for many of these topics are available in *Appendix 9*.

The experiential/practice components of the training should include:

- **Clinical Vignettes** (see samples in *Appendix 7*) can be used to stimulate discussion among the team members, asking them to identify the important administrative and personal aspects of the needs assessment process and determine how to address the relevant needs and issues.

- **Role Playing Situations** (see samples in *Appendix 8)* can illustrate key clinical concepts and activities relevant for new team members.

- **Mock Team Meetings** are also useful to practice/discuss how to coordinate, sequence, and prioritize the various treatments and services and engage a client and family in developing a full and integrated treatment plan. Materials including clinical vignettes and scripts for role plays are provided in *Appendix 9*.

C. Ongoing Training for the Team

Ongoing training is essential. Training key intervention components such as shared decision making, motivational enhancement, critical time intervention, and safety planning should be repeated regularly to make sure knowledge and skills stay fresh. Ongoing training can take the form of in-person expert training, reviewing and role-playing situations to get continued practice, or finding relevant (training experiences in the team's geographic area. Hospitals, colleges, universities, and other research institutions are excellent resources – the team should explore these settings, meet people doing related work, and get on listservs and mailing lists so that they will be aware of any training opportunities. The team will be faced with new experiences and situations each day; making ongoing training a priority will help prepare team members for new treatment issues when they arise. Team members should keep a list of areas they feel additional training is needed and work with MHC staff to link with training opportunities in these areas.

D. Specialty Training (Training Components of the Team)

Specialty training focuses on specific team roles. The in-person or intensive component is enhanced and more efficient when more than one team is being trained.

1. Background Readings and Discussion.

All team members should be provided with background readings on topics related to their specialty area. A list of background readings and resources relevant to different team members

is provided in *Appendices 4–6*. Team members should share what they learn with each other—this both reinforces new learning and also helps team members inform each other about their areas of expertise.

2. Intensive, In-Person Activities.

As noted above, in-person trainings allow for in-depth presentation of material. As part of a team-wide, in-person training, time should be allocated to breakout sessions to present material that is relevant and specific to each team member. These breakout sessions allow all Team Leaders, Psychiatrists, IPS Specialists, Recovery Coaches, and other team members to learn and practice topics and interventions that are specifically relevant to their areas of focus. Below is a brief listing of the topic areas to cover for each clinical role. These breakdowns reflect the division of roles and responsibilities used in the RAISE Connection Program.

- *Team Leaders*
  - ✓ How to be a Team Leader
  - ✓ Critical time intervention
  - ✓ Working with families
  - ✓ Safety planning
  - ✓ Relapse prevention planning

- *Team Prescriber*
  - ✓ Antipsychotic treatment schedules
  - ✓ Side effect monitoring
  - ✓ Linkage to primary care
  - ✓ Smoking cessation

- *Supported Employment/Education Specialists*
  - ✓ Background and implementation of supported employment and education

- *Recovery Coaches (see Appendix 5 for resources and readings)*
  - ✓ Treatment interventions and strategies – e.g., social skills training, substance abuse treatment
  - ✓ Coping skills
  - ✓ Helping clients become more active and master the skills needed to engage in different activities
  - ✓ Strategies for support and engagement activities

E. Training for Team Members

Ongoing training for team members in their areas of specialty is important. Team members should connect with community and state sources of support such as learning collaboratives, listservs, and interest groups, and should link with other FEP teams both locally and nationally. It is relatively easy to reach out to others doing FEP treatment, supported employment and education, family psycho-education, and behavioral family interventions, etc. Each team member

should keep a list of areas in which they feel they need additional training and work with MHC staff to locate training opportunities in these areas.

IV. Supervision

Section Tools:

- ✓ ***Appendix 10. Sample Forms for Supervision Notes***
- ✓ ***Appendix 11. Resources for Supervision***

A. Types of Supervision

CSC programs require several types of supervision. How supervision is handled may be contingent on where the program is located and the rules of the clinic in which the CSC program may be embedded. The following supervision is recommended:

1. ***Administrative Supervision*** involves oversight to ensure that the FEP team is following the rules and procedures of the clinic in which it is embedded. The format, frequency, and emphasis of this supervision will need to be worked out on a team-by-team basis as clinic needs vary. Generally, the individual who is leading the team will receive administrative supervision from someone within the clinic administration and then pass along information and monitor the rest of the team regarding issues such as changes in clinic policy or larger programmatic issues that impact the CSC team. *In the NIMH RAISE Connection Program, the Team Leader met weekly with the Clinic Coordinator and monthly with the clinic Program Director.*

2. ***Clinical Supervision*** involves reviewing clients' status to ensure sound and competent clinical care. The amount of clinical supervision will also vary by team depending on clinic rules and regulations. Supervision is distinct from team meetings, in which all members of the team meet, report on their work with an individual, and plan continued work towards goals; team meetings may often include the client and/or family member/s. In contrast, clinical supervision includes discussion of the specific activities and techniques the clinician is providing, periodic review of session tapes or notes, and identification of ways to improve or enhance clinical interactions. *In the RAISE Connection Program, the Team Leader conducted clinical supervision every other week with both the Recovery Coach and the Supported Employment Specialist.*

3. ***Clinical Consultation*** involves discussion of individual clients with someone outside of the team to maintain good clinical decision-making. The Team Leader and the psychiatrist each should identify an individual with similar credentials within the clinic but outside of the team to provide this consultation in monthly meetings.

4. ***"Component" Supervision*** can bring together team members across multiple teams. If there are multiple teams in a region or state, a creative addition to supervision would be to have a regular meeting of all the team members (e.g., a meeting of all of the Recovery Coaches, or supported employment/education providers). These meetings can provide a forum in which those with similar roles on teams would be able to share materials, resources, and successes, as well as help in problem solving and creative thinking. This mode of supervision is especially well-suited to issues related to family involvement as team members can discuss ways to engage families in care and give each other new ideas in this area. *For example, in the RAISE Connection Programs in New York and Maryland, Team Leaders from the two states met via conference call for component supervision, as did the Psychiatrists, Recovery Coaches, and IPS Specialists. These conferences occurred about once a month and were facilitated initially by national experts and then by local training teams.*

   The experience of the RAISE Connection Program generated suggested topics for component supervision meetings:

- Team Leader Component Supervision**:**
  - ✓ Case discussion
  - ✓ Integrating clinic requirements into care (e.g., clinic specific forms and assessments)
  - ✓ Integrating the model throughout all of the Team Leader roles and responsibilities, including the family component.

- Psychiatrist Component Supervision:
  - ✓ Case discussion
  - ✓ Problems encountered with the implementation of preferred medications
  - ✓ Strategies /approaches that have been found useful to help participants manage their illness and psychotropic medications.

- IPS Specialist Component Supervision:
  - ✓ Review of work and employment status of each client
  - ✓ Successes and challenges in job development
  - ✓ Applying the model to supported education
  - ✓ Creative ways to engage clients in job searches
  - ✓ How to coordinate and organize meetings with job sites, schools, etc.

- Recovery Coach Component Supervision:
  - ✓ Review areas being addressed (social skills training or substance abuse)
  - ✓ Challenges in teaching skills and supporting implementation outside the clinic
  - ✓ Ways to build rapport and engagement,
  - ✓ Educating clients about the role of the Recovery Coach
  - ✓ How to use motivational enhancement strategies and shared decision making when approaching clinical problems with clients
  - ✓ Discussions regarding strategies for talking with young clients about planning for goals and using new skills in their lives.

- Family Work Component Supervision:
  - ✓ implementation of monthly family education groups and other family program components
  - ✓ Engaging families
  - ✓ Educating family members about psychosis
  - ✓ Family work/issues not addressed during the regular supervision meetings.

5. ***Supervision in the Team-based Model****:* In the same way that training has team- and role-based components, supervision also requires both perspectives. Supervision in the team-based model involves all team members and focuses on whether the team is working together in accordance with the model. Model supervision involves client reviews or reviews of specific topics to ensure that the team is adhering to the underlying principles of mental health recovery, shared decision making, and critical time intervention. All members of the team participate in this monthly meeting. It can take the form of a team meeting in which a theme that runs across the care of different clients is discussed. This is also a good place to discuss issues that are common to many clients, such as how to address trauma or how to work with families within the team.

If all types of supervision are needed, decisions must be made about who will provide them and how to manage the amount of supervision so that there is not an excess of meetings. It will be up to the team and the clinic to decide how best to use supervision time to cover the needs of the team.

B. Ways to Deliver Supervision

Supervision can be done in person or on the phone. It is recommended that administrative and clinical supervision be done in person, and that the medical records for the clients being discussed be available during the meeting. This allows for review of records to make sure that forms are properly completed in a timely manner. Clinical consultation and model supervision can be done in person or on the phone. A plan for each should be developed and provided to attendees prior to the meeting. For clinical consultation, the Team Leader or the Team Psychiatrist should list one to two clients to discuss with the consultant, provide a brief write-up on the background of the case and the issues for which consultation is sought. For model supervision, each team member should be assigned a date to prepare a clinical case or several cases that illustrate an issue. A write-up of the case(s) should be provided to all attendees prior to the meeting.

While supervision can be done by telephone or in person, experience suggests that some in-person time is necessary and beneficial. The team and the clinic can decide the exact ratio of phone to in-person meetings. Some types of supervision—especially if it is component supervision shared among multiple teams—may be suited to the telephone. For example, "model" supervision could be shared among multiple teams, done over the phone or via video conference. The discussion could involve teams sharing common patterns or themes they see among clients and share how to address these while adhering to the model.

C. Supervision How-To's

Supervision is an important part of clinical care. Supervision should be on a regular day and time that is good for all attendees and should be identified as an important part of the service of the team.

Good supervision takes planning. As noted above, each supervision meeting should have a leader who is responsible for planning the content of the meeting, creating an agenda, distributing the agenda to attendees, writing the supervision note, and recording attendance and what was discussed. A sample form for supervision notes is provided in *Appendix 10*. For some types of supervision (e.g., clinical), the leader of the meeting is generally the more senior person (e.g., Team Leader). In other cases, the leader of the supervision meeting can be alternated so that all members of the meeting are the leader at some point.

The following are some sample structures for supervision meetings:

Clinical Supervision, Team Leader/Recovery Coach

1. Review list of clients who are working with the Recovery Coach. Note clients who are nearing the end of their work with the Recovery Coach and provide a status summary to the Team Leader. Assign new cases to Recovery Coach; Team Leader can provide a summary of the case and a reason for the referral to the Recovery Coach.

2. Identify one or two clients to discuss in-depth. These could be cases that are progressing well and the Recovery Coach has ideas about additional work to be done, or cases that are challenging (e.g., poor engagement with Recovery Coach, lack of progress, feeling stuck). The Recovery Coach should be prepared to provide a summary of these cases and identify the issue or challenge to discuss with the Team Leader.

3. Check in regarding groups (e.g., social skills, substance abuse treatment, family) that are led by the Recovery Coach and update on attendance, topics covered, and how these topics can be integrated into individual work.

4. Other issues/action plan to work on between supervision meetings.

Administrative Supervision, Team Leader and Clinic Administrator

1. Review all clients receiving services from the Team. Make sure all forms are complete for all clients or identify what's needed for whom and when it's due.

2. Discuss any administrative challenges that have taken place since the last meeting.

3. Check in regarding new cases or cases that will soon be discharged/transitioned to community care.

4. Other issues/action plan to work on between supervision meetings.

Model Supervision, All Team Members Present

1. One team member is the leader of the meeting. This can rotate among team members.

2. The leader identifies an issue or client whose care is challenging for discussion and provides a care summary. These challenges are discussed and possible responses are identified according to the treatment model.

3. Discuss how each team member can contribute to this case in ways that are in line with the model.

4. Other issues/action plan to work on between supervision meetings.

A list of resources for supervision is provided in *Appendix 11*.

V. Fidelity

Section Tools:

- ✓ ***Appendix 12: Resources for Fidelity***

Fidelity measures are important because they provide valuable information to three stakeholder groups:

- Payers want to know if they are getting what they are paying for
- Trainers/supervisors want to know whether clinical staff are implementing the interventions as intended over time
- Clients/families want to know if the services they are investing their time/effort/finances in are up to par and can reasonably be expected to promote the outcomes they care about (school/work/friends/health)

A practical approach to fidelity is recommended, with measures drawn from information that is typically readily available in routine practice settings implementing the CSC program as described. Fidelity measures should support and draw from routine clinical operations.

Optimal fidelity measures are those that are good proxies for the components of the intervention that they are measuring. For example, a core expectation for the intervention is that antipsychotic medications are a central part of treatment for almost everyone. Hence, associated fidelity measures would examine the proportion of clients prescribed an antipsychotic and the proportion who had had an adequate trial on an antipsychotic, where "adequate" was specified clearly enough to be measured objectively. Routine service logs will support many fidelity measures so long as they note for each contact the client, staff involved, whether family was present, and the location of the service (office versus community). The presence of routine clinical forms such as those included in this manual to support the intervention can be used to document that those components of the intervention occurred. For example, if a program expectation is that safety is assessed at intake, then the presence of such a completed safety-assessment form at intake signifies that such an assessment was completed. Routine medication records and associated laboratory orders provide information necessary to assess fidelity to the psychopharmacology components of the intervention. *Appendix 12* provides, for each intervention component, core expectations and how they may be operationalized.

Most clinics or hospitals housing an FEP team will have staff record service contacts via an electronic record. All will have electronic claims records. Many also will have electronic health records for each client that will contain information such as weight, medications prescribed, and various symptom check lists. Whenever possible, fidelity data should be obtained from claims data and other electronic sources to minimize the data collection/compilation burden on clinical and administrative staff. As a fallback, payers can specify the data an FEP program is required to submit, and those submissions can be verified via site visits. *The RAISE Connection Program Teams in Maryland and New York were part of a research project operating in two very different sites and relied on abstracting information from specified locations in the project's required clinical forms maintained in clients' charts and entry of that data into a centralized database built for this study. Designing, building, debugging, and implementing such a chart abstraction*

system is cumbersome for short-term use, but is a feasible approach when abstraction from electronic claims is not an option.

Appendix List

Appendix 1: Getting Started Checklist

Getting Started Checklist:

	Activity
☑	Identify program structure and services
☑	Determine geographic boundaries
☑	Define clinic population and eligibility criteria
☑	Connect with state and surrounding partners
☑	Establish funding / operating budget
☑	Establish a referral network
☑	Apply clinic procedures to the team
☑	Establish programmatic oversight rules
☑	Assess staffing requirements
☑	Develop standards for team functioning
☑	Develop training plan

Appendix 2: Inclusion and Exclusion Criteria Used in the RAISE Connection Program

Inclusion Criteria: All Should Be Met

1. Age range: 15–35 years (Maryland 15–35; New York 16–35)
2. Diagnosis: schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, psychosis not otherwise specified (NOS)
3. Duration of psychotic symptoms > 1 week and < 2 years
4. Ability to speak and understand English
5. Anticipated availability to attend the clinic for 1 year

Exclusion Criteria: None Should Be Met

1. Other diagnoses associated with psychosis:
    - Substance-induced psychotic disorder
    - Psychotic affective disorder (e.g., major depressive or manic episode with psychotic features)
    - Psychotic disorder due to a general medical condition
2. Medical conditions that impair function independent of psychosis
3. Intellectual disability

Inclusion Criteria 1: Age range 15–35 years (Maryland 15–35; New York 16–35)**.** Treatment at each specialty clinic will be informed by the developmental stage of its clients. Each clinic will need to select the age range for services, and then ensure that the team is appropriately trained to meet the psychosocial treatment needs of that population. This is particularly true for IPS services, because educational and vocation needs can vary widely for different age groups. Recovery groups could also be targeted for developmental stages or goals, such as transitional aged youth or college groups.

Inclusion Criteria 2: Diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, psychosis not otherwise specified (NOS), or brief psychotic disorder. In the case of the Connection Program, the clinic served individuals who were in the early stages of a primary psychotic disorder. The interventions were selected and staff trained specifically for individuals experiencing these symptoms. Other clinics may consider expanding to include individuals experiencing mood-or substance-induced psychosis.

Inclusion Criteria 3: Duration of psychotic symptoms > 1 week and < 2 years. A wide variety of methods exist for defining the start of psychotic symptoms. For the Connection Program, the ORS evaluated the date of each of the earliest symptoms. Many individuals experience transient, attenuated symptoms of psychosis without ever developing psychosis. For an individual to be eligible for the Connection Program, the potential clients' symptoms were evaluated for

- the level of their symptom intensity (frequency),
- the impact on their behavior, and
- whether the individual experiences a reduced awareness that their unusual

perceptual experiences and/or unusual beliefs are symptoms.

Date of onset should be determined for each symptom. In the Connection Program, the earliest date of onset was used to calculate the duration of psychotic symptoms. Psychotic symptoms include:

- Delusions of reference—belief that others are taking special notice of them, talking about them, references on TV, reading material, etc.
- Persecutory delusions—belief that he or she is being attacked, harassed, persecuted, or conspired against
- Grandiose delusions—belief that he or she possesses special powers, exaggerated importance (rich or famous), or relationship to a deity
- Somatic delusions—belief that his or her body is grossly distorted; change or disturbance in appearance or functioning
- Other (religious, guilt, jealousy)—unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful, or belief that he or she is in a relationship with someone famous
- Mind control (insertion/withdrawal)—belief that thoughts and/or actions are under the control of an external force. Individual may experience thoughts being placed into head and/or thoughts being taken out of his or her head.
- Thought broadcasting—belief that others can hear their thoughts or read his or her mind
- Hallucinations: auditory, visual, tactile, olfactory, and/or gustatory

A reduced awareness that a person's unusual perceptual experiences and/or unusual beliefs are symptoms must be present (e.g., a belief held with conviction despite evidence to the contrary). Additionally, either impact on behavior and/or intensity (symptoms occur at least intermittently or a preoccupation with belief) must be evident.

Other specialty clinics may use different criteria to determine the duration of psychotic symptoms. Examples include date of first antipsychotic medications prescribed for psychosis, or date of first psychiatric hospitalization due to psychosis. A date of onset can also be determined by subjective terms through a discussion between the ORS and the Senior Clinician.

Inclusion Criteria 4: Ability to speak and understand English. Language inclusion criteria should be determined based on the available services at each specialty clinic site. The Connection Program staff did not have bilingual staff members or available interpreters. For specialty clinics serving clients speaking other languages, this criteria item should be revised accordingly. If the service-seeker was a minor, the Connection Program required that at least one

parent/guardian could discuss and approve participation in English. Specialty clinics will need to communicate with parents/guardians about treatment and provide psycho-education to families. Consider carefully the languages and fluency levels that your clinic will require for parents/guardian attending the program to ensure that collaborative decision making can occur with parents/guardians as well as with the minor service-seekers.

Exclusion Criteria: None Should Be Met

Like the inclusion criteria, the Connection Program exclusion criteria were created based on the types of individuals that the clinic intended to serve and the available services at the program. Some individuals were experiencing symptoms and illnesses beyond the scope of the teams' specialized training. Other individuals were experiencing psychotic symptoms caused by illnesses other than a primary psychotic illness.

Substance-Induced Psychosis.

- Type of substance and usual pattern of use
- Focus on alcohol, sedatives, hypnotics, and/or anxiolytics
- Focus on periods of significant increase or decrease in relation to onset of psychotic symptoms
- Qualifying psychotic symptoms must be present in the absence of substance intoxication and/or withdrawal

Affective Psychosis. Individuals experiencing affective psychosis were not included. This included individuals experiencing either a major depressive episode or a manic episode with psychotic features. Individuals with mood symptoms and substance abuse were accepted; however, these individuals experienced prominent psychosis, in the absence of any mood symptoms. Services for primary mood, substance use, or medical illnesses are substantively different from those with primary psychotic disorders. Other specialty clinics include individuals with mood- or substance-induced psychosis, and each clinic will need to choose parameters for psychosis substance and mood.

a) Presence of Mood Symptoms (Based on DSM-IV) (Focus on temporal relationship between mood symptoms and onset of psychotic symptoms)
    - Major Depressive Episode: Five or more of the following symptoms with impact on functioning for a period of 2 weeks or greater (1 or 2 must be present)
        1) Depressed mood most of the day or nearly every day
        2) Markedly diminished loss of interest in activities previously enjoyed
        3) Significant weight change (loss or gain)
        4) Insomnia nearly every day
        5) Psychomotor agitation or retardation nearly every day
        6) Fatigue or loss of energy
        7) Feelings of worthlessness or excessive guilt
        8) Diminished ability to concentrate or indecisiveness
        9) Suicidal ideation and/or suicidal attempt
    - Mania: Persistently expansive or irritable mood, plus three or more of the

following symptoms within a distinct period (at least 1 week)
1) Inflated self-esteem or grandiosity
2) Decreased need for sleep
3) Pressured speech
4) Flight of ideas/racing thoughts
5) Distractibility
6) Increase in goal-directed activity or psychomotor agitation
7) Excessive engagement in pleasurable risk-taking behaviors

- Qualifying psychotic symptoms must be present and primary with an absence of mood symptoms for at least 2 weeks.

Psychosis Due to a General Medical Condition

- Prominent psychotic symptoms due to the direct physiological effects of a general medical condition
- General Medical Conditions include: neurological conditions (including traumatic brain injuries), endocrine conditions, metabolic conditions, autoimmune disorders with central nervous system involvement

Medical Conditions that Impair Function Independent of Psychosis

As defined by disability necessitating the person to be on or to apply for Supplemental Security Income [SSI], Social Security Disability Insurance [SSDI], workers compensation, veterans disability, or similar benefits.

Intellectual Disability

Operationalized as an IQ below 70 for the intervention, but we recommend raising this to exclude borderline intellectual functioning (IQ below 85).

Appendix 3: Sample Job Descriptions for Team Hires

At full capacity, the team's caseload would be 30 clients. Clients will receive services for 2 years. Training will be provided to all staff members working with individuals experiencing their first episode of psychosis and in the specific treatments that will be provided.

1. Team Leader, 1.0 FTE
   An experienced Master's level clinician who is trained in working with individuals experiencing FEP. He or she will be the primary contact person for clients and families and will spearhead efforts to engage clients in treatment. The Team Leader's primary goals are to build a positive relationship with participants and assist them in developing their abilities for illness self-management. The Team Leader will work with participants using a shared decision-making process to develop and modify treatment plans. The Team Leader will provide support, education, consultation, and basic services to participants and their families. With younger individuals, work with families will be more prominent since they play a pivotal role in the individuals' lives during adolescence and the first years of adulthood. The Team Leader will monitor, oversee, and supervise the team-based process.

2. Supported Education and Employment Specialist, 1.0 FTE
   A Bachelor's level position; someone in this position should ideally have prior experience as a supported education or employment specialist. He or she will focus on assisting participants to continue, resume, or adapt their academic or vocational activities successfully, using the IPS (individual placement and support) model.

3. Recovery Coach, 0.5 FTE
   An experienced Master's level clinician who will help clients clarify goals, cope with stressful situations, interact more effectively with other people, and in general, overcome barriers to their recovery. This is done within a framework that is empowering and cultivates peer support through the use of structured behavioral interventions aimed at learning new skills and supporting behavior change, including social skills training, substance abuse treatment, behavioral activation, coping skills training, and psycho-education.

4. Outreach and Referral Specialist, 0.5 FTE
   The designated individual(s) should be a Master's level clinician (or possess a higher clinical degree) and the ability to identify primary psychosis and perform differential diagnoses for symptom profiles related to psychosis. A program may choose to identify persons within the clinical team to lead outreach and recruitment activities, or establish a separate team of individuals who will only be responsible for such activities.

5. Psychiatrist, 0.2 FTE
   He or she will be responsible for diagnosis, medical care needs, medication management, and acute management of suicidality and safety concerns. Medication management will be guided by a medication algorithm that provides information about evolving best practices. A shared decision-making framework will be used.

Appendix 4: Background Readings and Resources - Team

National Alliance on Mental Illness (NAMI)
Information on First Episode of Psychosis
http://www.nami.org/template.cfm?section=First_Episode

Substance Abuse and Mental Health Services Administration (SAMHSA)
Recovery to Practice
http://www.samhsa.gov/recoverytopractice/

Choices in Recovery
http://www.choicesinrecovery.com/

Shared Decision Making
http://patients.dartmouth-hitchcock.org/shared_decision_making.html

Lived Experience:

Addington J, Coldham E, Jones B, et al. (2003). The first episode of psychosis: the experience of relatives. *Acta PsychiatrScand*, 108, 285–289.

Compton MT and Broussard B. (2009). *The First Episode of Psychosis: A Guide for Patients and their Families.* NY: Oxford University Press.

Deegan, PE (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatr Rehabil J*, 31(1), 62–69.

Deegan, P. (1988). Recovery: the lived experience of rehabilitation. *Psychosoc Rehabil J,* 9(4), 11–19.

Leete, E. (1989). How I perceive and manage my illness. *Schizophr Bull*, 15(2), 197–200.

Saks, ER (2007). *The Center Cannot Hold: My Journal Through Madness.* New York: Hyperion.

Schiller L, and Bennett A. (1994). *The Quiet Room: A Journey Out of the Torment of Madness.* NY: Warner Books.

Peers/Community:

The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities
http://tucollaborative.org/index.html

The Institute for Recovery and Community Integration
http://www.mhrecovery.org/

Recovery Model and Implications for Treatment:

Bellack AS. (2006). Scientific and client models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophr Bull*, 32: 432–442.

Davidson L, Drake RE, Schmutte T, et al.(2009). Oil and water or oil and vinegar? Evidence-based medicine meets recovery. *Community Ment Health J*, 45:323-332.

Davidson L, Harding C, Spaniol L, eds. (2005). *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice.* Volume 1. Center for Psychiatric Rehabilitation Sargent College of Health and Rehabilitation Sciences Boston University.

Harding CM, and Zahniser JH. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatr Scand Suppl*, 384, 140–146.

Kreyenbuhl J, Nossel IR, and Dixon LB. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *SchizophrBull*35(4), 696–703.

Melle I, Johannesen JO, Friis S, et al. (2006). Early detection of the first episode of schizophrenia and suicidal behavior. *Am J Psychiatry*, 163(5), 800–804.

Trauma-Informed Care:

Morrison AP, Frame L, and Larkin W. (2003). Relationships between trauma and psychosis: A review and integration. *Br J Clin Psychol*, 42 (Pt 4), 331–353.

Neria Y, Bromet EJ, Sievers S, et al. (2002). Trauma exposure and posttraumatic stress disorder in psychosis: Findings from a first-admission cohort. *J ConsultClinPsychol*, 70(1), 246–251.

ShevlinM, DorahyMJ, and Adamson G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *Am J Psychiatry*, 164(1), 166–169.

Voices of Recovery videos
http://practiceinnovations.org/ConsumersandFamilies/ViewAllContent/tabid/232/Default.aspx

http://www.theannainstitute.org/TSA-ADULTS.htm

http://www.ptsd.va.gov/index.asp

Shared Decision Making:

Adams J R, and Drake R E. (2006). Shared decision-making and evidence-based practice. *Comm Ment Health J*, 42(1), 87–105.

Deegan PE, and Drake RE. (2006). Shared decision making and medication management in the recovery process. *Psychiatr Serv*, 57, 16361639.

Examples of decision aids in the public domain can be found at the following sites:

- http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=10 – decision aid on antidepressants
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=za1120 - decision aid on whether to use medicine to help sleep
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=zw1124&SECHWID=zw1124-Intro - decision aid on whether to use medicine to quit smoking
- http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=aa45364&SECHWID=aa45364-Intro - decision aid for using medicine to treat PMS
- http://mentalhealth.samhsa.gov/clientsurvivor/shared.asp - includes SAMHSA "Cool Tools"

Suicide / Safety Planning:

CaldwellCB, and Gottesman JI. (1990). Schizophrenics kill themselves too: A review of risk factors for suicide. *SchizophrBull*16(4): 571–589.

Drake R E, Gates C, Cotton PG, et al. *(*1984). Suicide among schizophrenics: who is at risk? *J Nerv MentDis,* 172*,* 613–617.

Harkavy-FriedmanJM and NelsonEA (1997). Assessment and intervention for the suicidal patient with schizophrenia. *Psychiatr Q*, 68(4): 361–375.

Harkavy-Friedman JM, Restifo K, Malaspina D, et al. (1999). Suicidal behavior in schizophrenia: characteristics of individuals who had and had not attempted suicide. *Am J Psychiatry*, 156(8): 1276–1278.

Harkavy-Friedman, JM,Kimhy D, Nelson, EA, et al. . (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations. *J Clin Psychiatry*, 64(8): 871–874.

Harkavy-Friedman JM, Nelson EA, Vernarde DF, et al. (2004). Suicidal behavior in schizophrenia and schizoaffective disorder: examining the role of depression. *Suicide Life-ThreatBehav*, 34(1): 66–76.

Mamo DC. (2007). Managing suicidality in schizophrenia. *Can J Psychiatry*, 52: 59–70.

Melle I, Johannesen JO, Friis S, et al. (2006). Early detection of the first episode of schizophrenia and suicidal behavior. *Am J Psychiatry*, 163: 800–804.

Stanley B andBrown GK. (2008). *Safety planning: An intervention to mitigate suicide risk.* Washington, D.C: Veterans Health Administration Publication.

Stanley B, Brown F, Brent D, et al. (2009). Cognitive behavior therapy for suicide prevention (CBT-SP): treatment model, feasibility and acceptability. *JAmn AcadChild AdolescPsychiatry*, 48(10): 1005–1013.

Appendix 5: Background Readings and Resources - Recovery Coach Training

VA VISN5 MIRECC Social Skills Training Program
http://www.mirecc.va.gov/visn5/training/social_skills.asp

The Institute for Recovery and Community Integration
http://www.mhrecovery.org/

Motivational Interviewing
http://www.motivationalinterview.org/

SAMHSA – Co-occurring Disorders
http://www.samhsa.gov/co-occurring/

Person Centered Planning / Strengths Based Care
http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instructionmanual2-3-10.pdf

Stages of Change
http://www.aafp.org/afp/2000/0301/p1409.html

Substance Abuse Treatment Resources
http://casaa.unm.edu/

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Appendix 6: Background Readings and Resources - Supported Employment and Education

Supported Employment

Dartmouth IPS Supported Employment Center
http://www.dartmouth.edu/~ips/

SAMHSA
http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

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Appendix 7: Vignettes to Use in Team Training

Note: The goal in using vignettes is to demonstrate correct and incorrect ways of completing a needs assessment with a young adult client and his or her family member. Discussion of the vignette included all team members as a way to identify the important administrative and personal aspects of the needs assessment process.

Vignette 1: Addressing Various Treatment Foci

Context/Details:

1) Review the summary of the needs assessment. The team as a whole can address relevant considerations and issues relevant to their work as a team, as well as how they would engage the client in moving forward with treatment planning and delivery of related supports and services.

2) Next each break-out team can meet separately to discuss how they would address the relevant needs and issues summarized in the assessment summary.

First group:	Psychiatry and Medication Specialists
Second group:	IPS team
Third group:	RCs
Fourth group:	Team Leaders (with consideration of range of treatment foci including family, trauma, safety planning, housing/income, wellness self-management, etc.)

3) Next the full group will re-assemble for a "mock" team meeting. Participants will be charged with discussing how to coordinate/sequence/prioritize the various treatments and services and engage the client in the development of a full and integrated treatment plan. We also use this as a learning opportunity to discuss the challenges of working as a team.

Summary of Needs Assessment:

A 23-year-old woman was referred to the RAISE Connection Team at discharge from a 2-week hospitalization for treatment of her first psychotic episode. She completed her first round of meetings with various team members and the following information was collected as part of her initial needs assessment. Consideration of this "report" should be discussed from the perspective of each team so that each team can focus on and explore what services it has to offer and how they might be presented to the client and his/her family.

Medication: The client had a favorable therapeutic response to oral risperidone and received an injection of risperidone micorspheres (Risperdal CONSTA) 25 mg IM just before discharge. At her first team meeting, the client reported that she has been sleeping well, that the voices are greatly diminished and no longer intrusive, and that she feels safe again. However, she reported concern about weight gain and stated that she was distressed by this. She also expressed concern that she is pregnant because her menstrual period has not occurred this month; she denies recent sexual activity.

Wellness Management: The client is concerned about recent weight can and also expressed interest in getting fit and learning how to eat better. She also noted that she would like to learn more about stress management.

Education and Employment: The client has a GED. She reported an interest in considering going

to a local community college. She also noted that she is tired of not having much money and expressed interest in getting a job. She has only had a few part-time jobs and expressed anxiety about the prospect of entering the job market.

Family Support: Client lives with her mom and step-dad. She has no siblings and reports having no friends. She sees her biological father only about once or twice a year.

Housing and Income: Client lives with her mom and step-dad but reports that she is not happy there and that her step-dad "creeps her out." She has no health insurance and no source of income. Her biological father, who lives out of state, provides her with intermittent financial support.

Substance Abuse: Client smokes 2 packs of cigarettes a day. She reports feeling ambivalent about quitting. She knows she "should" but is not sure she's ready or able to.

Trauma: Client has hinted she may have been sexually abused as a child. She is unwilling to discuss this but has referenced "bad" experiences that leave her feeling freaked out about getting involved with anyone sexually. She also witnessed a stabbing in her neighborhood when she was 13 and says that she prefers to hang at home because it's safer than dealing with her neighborhood.

Safety: Client was actively suicidal at the time of her hospitalization. She currently notes that she no longer is pre-occupied with wanting to end her life and that she only intermittently has thoughts about hurting herself. She says that she has no current plans to hurt herself.

Vignette 2: How to Engage the Full Team and Client in Coordinated Treatment Planning

Context/Details:

1) Review the summary of the needs assessment. The team as a whole can address considerations and issues relevant to their work as a team, as well as how they would engage the client in moving forward with coordinated treatment planning and delivery of related supports and services.

2) Next each break-out team can meet separately to discuss how they would address the relevant needs and issues summarized in the assessment summary.

First group:	Psychiatry and Medication Specialists
Second group:	IPS team
Third group:	RCs
Fourth group:	Team Leaders (with consideration of range of treatment foci including family, trauma, safety planning, housing/income, wellness self-management, etc.)

3) Next the full group will re-assemble for a "mock" team meeting. Participants will be charged with discussing how to coordinate/sequence/prioritize the various treatments and services and engage the client in the development of a full and integrated treatment plan. We also use this as a learning opportunity to discuss the challenges of working as a team.

Summary of Needs Assessment

An 18-year-old male was referred to the Connection Team by the psychologist embedded in his inner-city public high school, where he was struggling to complete his junior year. He lives with his grandmother and two half-siblings. He and his grandmother have already met with the Team Leader and Team Psychiatrist but both have been reluctant to meet with the other team members.

Medication: After 4 4-week trials each of perphenazine (up to 16 mg. daily at which coarse EPSE were apparent) and risperidone (up to 6 mg daily at which he appeared slightly akinetic and complained of sexual dysfunction), this young man continues to be preoccupied with voices that were a central feature of his first psychotic break 2 months ago without any abatement in frequency and intensity. Of note, his biological mother (who is currently incarcerated) and his grandmother both have Type II diabetes mellitus.

Wellness Management: The client is overweight, has a very poor diet, and is generally inactive. He reports significant difficulties with sleep. Although he huffed glue regularly for several years and reported a history of poly-substance use, he reports that he has not used any substances for the past 6 months. He also has moderate to severe asthma.

Education and Employment: The client repeated the third grade and has a long history of learning disabilities. His current IEP provides access to a school counselor and additional

educational services. He has been having difficulty in school this current year and has missed several days. He reports that he hates school and would like to drop-out. He has never held a paying job.

Family Support: Client lives with his grandmother and two half siblings (ages 16 and 11). His grandmother works full time as nurses' aide with a rotating day-evening work schedule. The client's mother is currently in jail.

Substance Abuse: As noted, the client acknowledged that he huffed glue regularly for several years and reported a history of poly-substance use. He reports that he has not used any substances (other than cigarettes) for the past 6 months. The client smokes about a pack of cigarettes a day.

Trauma: Client was removed from his mother's care by Child Protective Services at age 4 secondary to investigated reports of neglect and physical abuse. He lived in one or two foster care placements until moving in with grandmother where he has remained for the past 10 years.

Safety: Client reports hearing command hallucinations to hurt himself. Although he says he is able to ignore these demands and that he is not suicidal, he reports feeling concerned that the voices will get stronger and more powerful as he gets older.

Vignettes Related to Psychopharmacology for Team Psychiatrist Training

Psychopharm Vignette 1: A 23-year-old woman is referred to the Connection Team at discharge from a two week hospitalization for treatment of her first psychotic episode. She had a favorable therapeutic response to oral risperidone and received an injection of risperidone microspheres (Risperdal CONSTA) 25 mg IM just before discharge. When you first meet her in clinic, she and her family report that she has been sleeping well, that voices are rare and not intrusive, and that she feels safe again. However, she reports that she has gained weight and that her clothes have become too tight. She also expresses concern that she is pregnant because her menstrual period has not occurred this month; she denies sexual activity.

Issues to discuss: Prolactin, long-acting injected med, birth control, convincing patient/family to consider a switch in medications

Psychopharm Vignette 2: After 4 week trials each of perphenazine (up to 16 mg daily at which coarse EPSE were apparent) and risperidone (up to 6 mg daily at which he appeared slightly akinetic and complained of sexual dysfunction), this 18-year-old man continues to be preoccupied with voices that were a central feature of his first psychotic break 2 months ago. He has been unable to engage with vocational and social programming. You consider trials of olanzapine, and later clozapine, if the olanzapine fails. His mother has Type II diabetes mellitus.

Issues to discuss: Metformin (preemptive or reactive), fish oil, exercise

Psychopharm Vignette 3: A 22-year-old man with first episode psychosis and ongoing abuse of marijuana and alcohol remains unable to engage in programming despite being assured antipsychotic treatment with a long-acting injected medication. He repeatedly fights with his step-father and has made two suicide attempts. He has not engaged in substance use treatment despite numerous attempts

Issues to discuss: Hospitalization, clozapine

Psychopharm Vignette 4: A 19-year-old woman responded favorably to oral fluphenazine during a hospitalization for her first psychotic episode. At discharge, she was given an injection of fluphenazine decanoate 25 mg IM. At her first visit, she is akinetic and has clear cog-wheeling. Her family report she sleeps 18 hours per day. They want her taken off this “poison.”

Issues to discuss: sensible dosing, rapid interventions—aripiprazole, family: all meds can be toxic if dosed incorrectly

Appendix 8: Scripts for Training Role Plays

Note: Role plays contain scripts for encounters done "well" and done "poorly." It is recommended that the poor example be done first, with the discussion focused on what made it poor. This should be followed by the done "well" example and discussion of what was improved and how the interaction was more consistent with the principles of the recovery model, shared decision making, and compassionate interacting with young people with FEP.

Role Play 1: Young Adult, First Meeting with Team Leader for Initial Needs Assessment

Context/Details: John is a 22-year-old single man who was working full time as a front desk clerk for a hotel until 4 months ago, when he started showing increasing signs of psychosis. He had never been a very outgoing person, but he was able to interact appropriately with hotel guests until about a year ago. His job involved answering the phones, taking reservations, greeting and checking in guests, fielding customer service complaints, and assisting with luggage. He sometimes had difficulty dealing with guests complaints, especially when the guest was angry. His supervisor had to step in on occasion to help, but she was happy with his work until about a year ago.

About a year ago, John became more sensitive about customer complaints at the hotel and sometimes felt that the customers were blaming him personally for problems they were having with their rooms. He thought that perhaps he was not concentrating as well as he had in the past, and felt this might be contributing to mistakes he sometimes made in assigning rooms and working on billing for hotel charges. However, John increasingly felt that customers were being unreasonable in their complaints. He started trying to avoid those customers who he thought were troublemakers. This caused additional trouble when these customers complained to his supervisor. She tried to work with John to help him improve his interactions with customers.
About 4 months ago, John started believing that some hotel customers were deliberately trying to trick him into making mistakes on their hotel bills, which they would then blame on him and ask him to correct. John started hearing an accusatory voice talking to him while he worked at the hotel, which he attributed to hotel customers who were trying to influence his mind and get him fired. Then the voices started occurring when John was at home as well, so John got increasingly upset. John called the police to report that some guests at the hotel were working together to force him to make errors on the job and get him fired. John was then hospitalized for his paranoid delusions and auditory hallucinations.

John was referred to the Connection Team for eligibility screening. He still thinks that customers at the hotel were the main cause of his problems. He is aware, however, that his concentration has been poor and that he has been very upset with the things that have been happening to him. John has been given antipsychotic medication, but he is not sure that it is doing him any good and wonders whether he needs to continue taking it. He would just like to put the whole period behind him and get back to work as soon as possible.

Role play that models the encounter "done poorly":

> Team Leader: Thanks for coming in today to meet with me. I want to use our time today to complete a needs assessment so that I can put your treatment plan together. I apologize in advance for the number of questions I'm going to ask, but we've got to get through this full assessment today (hold up papers). Ok let's get started. I see from your intake form that you were hospitalized 4 months ago. Can you tell me why you were hospitalized.
>
> John: I was having concerns about my job. I was only in the hospital for a few days, though.

Team Leader: That's good. Do you remember what medications you were taking when you left the hospital?

John: Yes. They started me on something called Respira something

Team Leader: Riperidone?

John: Yeah, that's it.

Team Leader: Are you still taking that medicine.

John: Yes…well sort of. I mean, I'm not sure if I really need it.

Team Leader: Sounds like medication compliance is something that we should put on your treatment plan. I will let your psychiatrist know so you can talk to her about why taking medicine is so important. I can also work with you to helpwith your medication compliance.

John: Uh, ok. I really don't think I want to take the medicine though. I don't think I need it. Do you think I can stop taking it?

Team Leader: Well…. I can't really answer that question. Again, I know that you will be meeting your psychiatrist soon, so I suggest you discuss that issue with her. OK. Great. Now back to your last hospitalization. What symptoms were you experiencing at that time.

John: Well, I was really having trouble at work.

Team Leader: That's right you mentioned that. Were you having any specific symptoms that were making it difficult for you at work? For example, was your mood a problem, or were you having any unusual thoughts or concerns, or feeling very distracted, things like that.

John: I was having a hard time dealing with difficult guests at the hotel where I work. Still a lot of stuff going on there but I'm hoping that it will get better soon.

Team Leader: OK. Since you are going to be meeting with the psychiatrist too, so you can talk more about specific symptoms when you meet with her. Ok. Great, now the next set of questions is about substance abuse. Are you using drugs or alcohol?

John: I smoke marijuana sometimes.

Team Leader: How often?

John: A couple of times a week. Usually just at night before I go to bed.

Team Leader: Any other substances?

John: No.

Team Leader: Do you smoke cigarettes?

John: Yes.

Team Leader: How much do you smoke?

John: About a pack a day.

Team Leader: Ok. We don't have time today, but it sounds like we may want to focus on helping you with your smoking both cigarettes and marijuana. I know that these substances can interfere with one's life and of course as you know they both present significant health risks too.

I can also tell you about various resources and treatments to help with smoking cessation next time we meet. OK. Let's see (while turning pages) Let's move on. Next, I'd like to ask about your educational background. How far did you get in school?

John: I graduated from high school. I also took some classes at Washington County Community College.

Team Leader: That's great. What are your goals regarding your education?

John: Well, I don't know.

Team Leader: That's OK. Next time we meet we can talk more about this and get a feel for your ideas about this. OK…regarding employment, you mentioned that you work the front desk at the Marriott Courtyard in Washingtonville.

John: That's right.

Team Leader: Great. How long have you been working there?

John: About a year now.

Team Leader: That's great. I do know, however, that you said things have been difficult at work for you lately. I'm sure we will talk more about this as we get to know each other. Part of learning how to live with mental illness is learning how it will challenge you at work and in your relationships, etc. As you learn more about living with your illness we can work together to help you make sure that you're prepared to deal with these challenges.

(NOTE FROM FACILITATOR)…."Alright, we're now going to fast forward and re-join this

meeting right before it wraps up."

Team Leader: Terrific. I apologize again for moving across so many topics but I wanted to make sure that we completed the assessment. You were very helpful. I feel I learned about you and look forward to working with you!

Facilitated Discussion re: what was missing/done poorly:

This should include review/application of intervention principles/clinical concepts etc. (SDM, recovery-oriented, active/focused Stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Role play that models the encounter done "well":

Team Leader: Hello (reach out to shake client's hand). Very nice to meet you in person. OK, as I mentioned what I hope to do today is learn more about how things are going for you and how we can be of help to you.

John: OK.

Team Leader: Great. OK. You talked a lot about your job when we spoke briefly on the phone. Sounds like work is a big and important part of your life right now.

John: I guess so. Although it's stressing me out and really hoping I don't get fired.

Team Leader: OK let's start there. Help me understand how the stress has interfered with things at work.

John: Well. I've been having trouble with hotel guests. I get angry all the time cause they're deliberately trying to make my job harder and get me fired.

Team Leader: Tell me more about feeling angry and how that affects your job.

John: I get so angry that I get confused and have trouble concentrating and my thoughts start racing and I get all pre-occupied.

Team Leader: Those sound like they would make any job difficult. I guess step one is to decide if those are problems you want to address right now.

John: Well I don't want to lose my job.

Team Leader: I hear that. That sounds like a clear goal. Let's talk about what things might be helpful in working on this goal.

John: OK. How do we do that.

Team Leader: Well, we can start by talking about options and then review what the pros and cons are for those options. For example, medication is one option. We can also figure out together who else you'd like to have involved in making decisions and what your preferences are so that you can identify how you'd like to proceed.

John: I'm not sure I want to take medication at all. I'm currently taking those pills they started me on when I was in the hospital and I'm gaining all this weight and not sure I even really need 'em, let alone what I'm taking them for.

Team Leader: You don't need to make any decisions today. Does sound like you want to explore this further, though. Also sounds like you may have some questions, concerns or want more information. I know that you are going to be meeting with the psychiatrist soon so we can talk more at our next meeting about how to prepare for that meeting and what to expect so that you can be fully involved in making decisions about medication.

John: OK.

Team Leader: Great. I also want to make sure we spend some time talking about what you've been doing or used to do to help deal with the stress you've been talking about.

John: You're not gonna wanna hear this, but smoking a joint before going to bed helps and smoking cigarettes also helps me chill out.

Team Leader: That's helpful to know, thanks. Any down sides or concerns you have about smoking a joint or smoking cigarettes.

John: Well, in addition to the money, the pot does sometimes make me kinda paranoid.

Team Leader: Ok. So just like with all things there are going to be pros and cons to discuss for this too. Are you OK keeping this on our agenda as something to check in on?

John: Well. I guess. Although I am not feeling ready to quit.

Team Leader: OK. I hear that. Thanks for permission to check back in with you though.

John: Whatever.

Team Leader: OK in addition to identifying things you want to work on, I want to make sure we also make time to talk about what your life goals are and how you can best work toward reaching those goals.

John: Well, if I don't shape up, I'm gonna lose my job. I'm also scared that things are going to get worse. I don't even understand why this is getting worse.

Team Leader: I hear that you're stressed about that. I also hear that you have a lot of questions. That's very normal. Part of our journey is making sense of how our lives

unfold. I look forward to exploring those questions with you and offer assistance to help you move forward with you goals and achieve the full and rich life that you deserve. I know we need to end for today, but thanks for getting started with me. As we move forward know that I and others on the team will be available to meet with you to help you stay connected to your goals and the services we have available here. We are also available to help you identify and choose what you'd like to work on, and get the supports you need to. Again, thanks for coming today.

Facilitated Discussion re: what was done well: This should include review/application of intervention principles/clinical concepts etc. (e.g., Shared Decision Making , recovery-oriented, active/focused stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Role Play 2: Follow-up Meeting with a Teenager and Team Leader to Formulate/Develop Treatment Foci/Goals

Context/Details: Max is a 16-year-old 10th grade boy who was recently discharged from the hospital where he had been admitted for suicidal ideation and substance abuse after a 3 week hospitalization. Although he stated that he was abusing multiple substances, his urine tox screen was negative and also had been negative when he was hospitalized 2 months previously for similar complaints. His parents noted that he has become increasingly withdrawn over the past two years and now only interacts with a few friends. He has always been hard to motivate to do schoolwork, but his grades slipped from mostly B's to C's and D's over the past year. Last summer he worked as an assistant at a drama camp for elementary age kids and enjoyed it, but he did not apply this year. He did not run track this year, but thinks he might continue cross country in the fall.

During his evaluation, he admitted to almost constantly feeling like his mind was arguing with itself, hearing an old woman talking to him saying what a bad person he is, feeling someone standing behind him, and seeing odd light trails that others do not see. He notes that he is concerned that people in the government and in his neighborhood are monitoring him and want to put him in jail. He feels that if he stays in the house with the curtains closed and lights off it will be harder for them to catch him. He also changes his email frequently and avoids talking on the phone to make it harder to catch him. He sometimes gets messages from the TV. He reports recent suicidal thoughts but has no current plan. He denies homicidality but does not know what he would need to do if the neighbors or government entered his house. He reports that it has been hard to pay attention in school with his head arguing and that he is not sure that he will pass some of his classes.

At the time of his recent discharge, he was not able to identify any activities that he was sure he would enjoy. He was open to the idea of trying the drama class again. He continued to hear the woman especially late at night or when he was alone for an extended period of time, but knew others thought she was not real. He knew others thought the government was not interested in him but was not sure they would really know and continued to be concerned about this. He still preferred to be alone and continued to maintain that he had been abusing drugs.

Client and his mother return after 3 weeks for another team meeting. In the meantime, they have met with the Team Leader three times once in the family home, with the psychiatrist once and with the supported education worker once. The supported education worker has observed the client at school and obtained additional information from school staff. Skills specialist has not had any separate meetings with client or his family.

The Team Leader notes that the client seems to get upset when his mother, father, or brother express concern about him by clenching his fists or looking down at the floor. He does seem to be relaxed when the family dog sits by him or he is listening to music. He also seems more agitated when news shows or talk shows are on TV. She has gone over the shared decision making card with him and his parents. His parents have told the Team Leader that he can be very irritable if they ask about his homework or try to get him to sit with them after dinner. They also note that he is eating a lot and his clothes are getting tight. At times he seems very anxious and

preoccupied, and occasionally, he will talk quietly to himself but they are unsure what he is saying. Max's brother notes that Max is being teased at school, and Max reports that other students comment on his weight gain and untidy appearance. Other kids accuse him of using drugs, and most kids who are in classes with him seem to be afraid of him.

The supported education worker notes that the client currently is failing one class and has C's and D's in the others. His first period teacher (English) said he frequently puts his head down on the desk and appears to be asleep. He is not contributing to discussions in that class or in world history. If pushed in class, he begins muttering to himself or clenching his fists. He is also having trouble turning in homework and has particular trouble in geometry with understanding what to do or what formulas to use. He eats by himself in an isolated hallway. He will sometimes go watch people on the track after school. He reports difficulty paying attention in school, with his arguing head and that he is not sure that he will pass some of his classes.

He notes that he continues to hear the woman especially late at night or when he is alone for an extended period of time, but knows she is not real. He knows others think the government is not interested in him but is not sure how they would really know and continues to be concerned about this. He still prefers to be alone and continues to maintain that he had been abusing drugs.

He has been taking his risperidone, but has noted some sleepiness that makes school harder. He is worried about his weight.

Role play that models the encounter "done poorly":

> **Team Leader:** Welcome to the meeting. You are really lucky that everyone could come. We wanted to see how things were going and what else needs to be done. You know everyone here don't you?
>
> **Max:** Uh, I guess so?
>
> **Mother:** I don't remember everyone's names and I don't think I know the person on your left.
>
> **Team Leader:** Oh don't worry about remembering everyone's names. We know this is a stressful time for you. This is Sue, the skill trainer. Now let's see how things are going. Max, do you have any things that you especially want to work on?
>
> **Max:** Not really.
>
> **Team Leader:** Ok, Max are you having any thoughts about hurting yourself or someone else now?
>
> **Max:** Not really.
>
> **Mother:** But his brother did tell me that some of the kids were afraid of him.

Team Leader: Are you afraid of him and have you had any complaints from school staff?

Mom: No, but he does ball his fists up sometimes.

Team Leader: Max, would you tell someone if you were really feeling like hurting someone.

Max: Probably.

Team Leader: Good. Then it probably isn't a concern. Probably just their lack of awareness about schizophrenia. How are your symptoms Max?

Max: They seem a little bit better but I'm still having problems at school.

Psychiatrist: That is great. Are you having any stiffness, any restlessness?

Max: No.

Mother: He is eating a lot.

Psychiatrist: Don't worry. We can add a side effect medicine called metformin that I'll call in. And you should encourage him to eat more fruits. Any other concerns?

Max: Uhh, nah.

Team Leader: OK, are you doing things with friends or doing any things you enjoy.

Max: I talked to some guys on the track team the other day and that was ok. I like to play my games.

Team Leader: Great. Keep working on that. Ok. Now let's hear what the education specialist has to say about school.

IPS: Well, I've observed Max at school and talked to his teachers. They all seem very willing to help him but feel like he has to do his part. Max, they are concerned that you aren't turning in a lot of your work. Can you try to do better with that? I think it would really help you to use a planner to keep track of your assignments. Will you try that?

Max: I am trying. I already use a planner, but I keep losing it. It is really hard for me to pay attention sometimes because of the arguments and the noise.

IPS: We can have you sit in the front of the class so you won't get so distracted. We'll have to set up an IEP meeting. I know you are failing geometry, so I'll get you a tutor for that. The other thing the teachers brought up was your muttering under your breath and being more fidgety at times. I know that it is hard to do what adults ask you to do, but

you really have to or you'll be suspended. Can you try to be more respectful?

Max: I guess so, mumbles, "I am respectful, it's the other people who aren't."

Team Leader: Let's see what's left. No issues with family support, money, trauma or substance use so I guess we're done. Does anyone want to add anything or have any comments? OK, well see you in 2-3 weeks. We'll call to set something up. Thanks. Bye.

Facilitated Discussion re: What was Missing/Done Poorly:

This should include review/application of intervention principles/clinical concepts etc. (e.g., SDM, recovery-oriented, active/focused stance, use of open-ended explorations, flexibility and consistency, autonomy/availability).

Consideration of intervention components reviewed during previous session (including supported employment/education, social skills training/substance abuse, medication adherence, family support, etc.)

Role Play that Models the Encounter Done "Well":

Team Leader: Welcome to the meeting. Thank you all for coming. Helping Max get back to his usual self is going to take all of us working together as a team. We especially need your input Max and Mrs. Brown. The rest of us are here to help you understand what has happened with Max's thoughts and feelings and to help you figure out ways to make things work out better for him. We each have different experiences and skills that can be helpful to young people in situations like Max's, but everyone is unique and we need the two of you to tell us what is important to you and what you want to do. I know you have met most of the people here, but I wanted to have us all go around and introduce ourselves again and tell you a little bit about what we can help you figure out.
Team goes around and introduce themselves and briefly describes the kinds of services they can provide and the kinds of problems they can help with.

Team Leader: This meeting is really to make sure we are going in the right directions and that you two don't have any other things that you want to work on right now or that other people on the team haven't noticed things that it might be helpful to consider. Max, how do you think things have been going the last few weeks?

Max: Uh, I don't know. It has been hard going back to school and everybody gets on my case all the time. But my brain isn't arguing with itself as much and I'm not hearing that mean lady as much.

Team Leader: It's great to hear that your symptoms are a bit better, but sounds like you wish things were better with school and people getting on your case. Would you rather talk about school or people getting on your case first.

Max: I don't know. I guess school. There isn't a lot of time left in the semester and I am

afraid I'm going to flunk out.

Team Leader: Can you help us understand more about what has been hard at school?

Max: I feel like people are looking at me and talking about me and I just want them to shut up.

Team Leader: That can be a really uncomfortable feeling. When does that happen?

Max: It happens a lot in class and there are these three guys who keep bothering me during lunch. They keep calling me a druggie and a zombie.

Team Leader: Do you have any ideas why those guys are saying that?

Max: No.

Mom: Your brother had mentioned that you often talk about using drugs at school. I know that you still talk about it at home sometimes. Do you think that has anything to do with it?

Max: I don't know.

IPS: I noticed that you often put your head down in class and don't very often talk unless you are upset and talking under your breath.

Max: It's when I am upset that people start looking at me and talking about me in class. They act like I am going to hurt them.

IPS: You can look a bit scary then because you also often make your hands into fists. Maybe we could help you figure out a different way to deal with being upset. Would you like that?

Max: Yeah. But it would be even better if people quit upsetting me by getting on my case. I try to stay awake but in the morning it is really hard. Sometimes it is just too much with my head arguing with itself and the teacher talking or asking why I don't say something or didn't turn in my work. When that happens I just try to tune everything out, if I try to keep up with the teacher I think my head will explode.

IPS: It sounds like there are lots of things going on at school. Let me see if I understand what you have said so far. You are worried about your grades. There is a problem with being sleepy in the morning. There are still problems with your head arguing that make it hard to pay attention. There are problems with people pushing you to hard. There are problems with people looking at you and talking with you that might have something to do with talking about using drugs or looking scary when you are upset. Is there anything I misunderstood or anything else going on at school that you want to tell us about.

Max: I guess that's it. I just don't feel like there is anyone there who cares or understands.

IPS: I think there are several things that might help. Do you want us to tell you the things that we can think of first and then you can choose how you want to approach it or do you want to tell us what's most important to try to fix right now?

Max: Ugh. I don't know.

Psychiatrist: I think it sounds like we need to do some fine-tuning with your medicine so you aren't so sleepy in the morning and so you have more relief from the arguing. There might be other things that are bugging you about your medicine too.

Mother: I'm worried about his weight and Max keeps saying he's getting fat.

Psychiatrist: That is a very real concern, thanks for letting me know about it. Let's talk more about the medicine in a bit. Right now let's hear from the rest of the team and see what ideas they have for improving things at school.

RC: You mentioned you didn't feel like there was anyone you could talk to at school? Are you having a hard time reconnecting with your friends or were you thinking more of a teacher or counselor?

Max: Both I guess. I tried saying hi to a few guys from the track team, but didn't know what to say next . . . I was afraid they'd think I was weird too . . . guess I'm just more comfortable being by myself.

RC: We could probably work together on some strategies for reconnecting if you'd like. I could also help you see if there are things that you are doing that you might not even be aware of that make you look different or put people off. Kind of like the mumbling.

Max: Maybe.

RC: I could also help with the drug use issues. I'm not real clear what you are thinking about that – it sounds like you really don't want people calling you a druggie. Just let me or Team Leader know when you want to deal with that.

IPS: Sometimes we can set up systems at school to try to help with hard classes or getting too much information at once or even things like homework or somebody to talk to when you're upset. We usually start with you and me and your Mom brainstorming about things that might help, then have a meeting at school with your principal and teachers to help them understand what's going on and get their ideas for helpful things. Would you be open to working together like that?

Max: Yeah.

Team Leader: Great we'll set up a time to do that. I was wondering if there are any times when you are feeling stressed that you have any thoughts about hurting yourself or hurting someone else?

Max: Not really.

Mother: But his brother did tell me that some of the kids were afraid of him and sometimes at home it is a little bit scary when he balls up his fists and is talking to himself.

Team Leader: Max, can you help us understand what you are thinking and feeling at those times?

Max: I just want to be left alone. I don't want to hurt anyone although sometimes I think people are trying to set me off so the government has an excuse to come get me. I don't want people to be afraid and I definitely don't want the government involved.

Team Leader: It sounds like you really want to find a way to get some space but don't want people to be afraid. Is that something that we could help you work on – finding a way to get space when you need it so you don't feel like people are pressuring you? Sounds like we'll need a system at home and at school.

Max: Yeah, that would be good.

Team Leader: So we've agreed to work on adjusting your medicine so you aren't so sleepy or hungry and so it works better, to work on some ways for you to get space when you need it and to not get so upset or look scary, and ways to work on helping you succeed in your classes and have people, both kids and grownups, who you can talk to at school. We can make some decisions about the medicine right after this meeting, and set up a time with the education specialist and later with your school in the next few days. You and I can work on ways for you to get space so you don't feel under so much pressure from people. Maybe we can also identify some things that will help you know when you are starting to feel pressured before it gets too bad or things that almost always lead to feeling pressured. The skills trainer can also work with you on reconnecting to people. Are there other things that you are concerned about right now Max? Or any things you have questions about?

Max: No, this seems like a lot for now.

Team Leader: Mrs. Brown, are there any other concerns that you have that we should address now, before we stop today?

Mother: No, I think we have set out the most urgent things. Can we set up the appointments with you and education specialist now?

Team Leader: Why don't you, I, and education specialist do that now while Max talks to

the psychiatrist by himself for a few minutes. We'll also plan to get back together as a whole team in 3-4 weeks to see how things are going. Thank you everybody for coming. I think we've made a good start to helping Max get to where he wants to be. Max thanks so much for helping us all figure out the things we can help you with. You did a great job.

Facilitated Discussion re: What was done well:

This should include review/application of intervention principles/clinical concepts etc. (Shared Decision Making, Recovery-oriented, Active/Focused Stance, use of open-ended explorations, Flexibility and Consistency, Autonomy/Availability).

Appendix 9: Forms to Use for Team Training Topics

- ✓ Client Shared Decision Making Card

- ✓ General Educational Handouts for Clients and Families:
  - ➢ What is the Connection Team
  - ➢ What is Psychosis
  - ➢ Role of the Family
  - ➢ Recovery from Psychosis

Client Shared Decision Making Card

The text below may be used to produce a laminated card for clients to have in order to prompt them to engage in shared decision making during meetings with the team.

Side 1:

Tips for Talking About Important Decisions with Your Treatment Provider

☐ **PREPARE** before you see your provider. Write down your questions and concerns so you don't forget.

☐ **TELL** providers what is most important to you. Answer their questions honestly. This helps them understand and respect what is important to you.

☐ **ASK** for explanations or more information. When a provider offers a recommendation, ask them to explain WHY they think it is right for you. What are the benefits? What are the costs? What are the pros and cons?

☐ **SPEAK UP** about your concerns and ask for options. For instance, if sexual side effects are of concern, it's okay to speak up and say you would like to find a medicine that does not have these side effects.

☐ **REMEMBER** what was said. Write down what you and the provider agreed to.

☐ **FOLLOW THROUGH** with the decision you and the provider made. If you were not able to follow-through, be honest about that. At the next appointment, report the good and the not-so-good results of your decision.

Side 2:

For all major decisions regarding your medications, treatment, school, work, family, and so on, ask yourself these questions:

☐ When your provider gave you a recommendation, did they offer you onechoice, or options to choose from?
☐ Did your provider tell you about the pros and cons of each option?
☐ Did you have a chance to ask your questions?
☐ Did you have a chance to talk with important people like family before making your decision?
☐ Did the provider listen to your opinion and what was important to you?
☐ Did you have a say in what decision was right for you?

The Connection Team
Helping People Live Their Best Lives

What Is the Connection Team?

The Connection Team is a program to help young people who are experiencing psychosis get effective treatment so they can successfully reach their goals in life such as completing school, getting a good job, living independently, and having rewarding relationships with friends.

What Does the Connection Team Offer?

The goal of the Connection Team is to provide hope and effective treatment so that young adults with psychosis can achieve their goals in life. Rather than working with just one mental health professional, we offer a collaborative team approach that relies on everyone's strengths and energy. The young adult with psychosis is a member of the team, along with the family when possible and other mental health professionals. A Team Leader helps to keep everyone on the team working together toward the young adult's recovery. We use a "shared decision making" approach. That means that the young adult and the Team work together to decide on the best treatment options. The treatment offered includes:

1. Comprehensive assessment of the young adult's personal recovery goals to inform and guide treatment.

2. Treatment and support from team members, including a doctor, mental health professionals, and vocational specialists who have worked with people recovering from psychosis.

3. Counseling and educational support for family members focused on providing information about psychosis and teaching family members how to assist young people in their recovery.

4. Coaching from a vocational specialist with expertise in helping young people identify and reach their school and work goals.

5. Assistance with strategies for building healthy relationships and coping with problems in positive ways.

6. Treatment and support for drug or alcohol problems.

The RAISE Connection Program:
Helping people live their best lives

What Is Psychosis?

Psychosis occurs when a person loses contact with reality. The word "psychosis" scares some people, but it actually describes an experience that many people have. Three out of every 100 people experience psychosis at some time in their lives, and most of them recover.

What Are the Symptoms of Psychosis?

Psychosis can affect the way a person thinks, feels, and acts. Some common symptoms of psychosis are:

- ***Hallucinations*** can affect any of the five senses. People experiencing psychosis might see, hear, taste, smell, or feel things that are not there, and they have difficulty believing that their senses are tricking them.
- ***Delusions*** are false beliefs that people hold strongly, despite all evidence that their beliefs are not true. For example, a person experiencing a delusion might believe she is being watched or followed.
- ***Confused thinking*** occurs when a person's thoughts don't make sense. His or her thoughts can be jumbled together, or they can be too fast or too slow. A person with confused thinking can have a hard time concentrating or remembering anything.
- ***Changes in feelings*** can include quick changes in mood. A person might also feel cut off from the rest of the world, or feel strange in some other way.
- ***Behavior changes*** often result in a person not bathing, dressing, or otherwise caring for him- or herself as usual. Other behavior changes might involve behaviors that don't make sense, such as laughing while someone else is talking about something sad.

What Causes Psychosis?

Psychosis could have a number of different causes, and many researchers are working to understand why psychosis occurs. Some popular ideas are:

- ***Biological:*** Some people are more likely to develop psychosis because of their biology or their heredity. Many cases of psychosis have been linked to problems with neurotransmitters, the chemical messengers that transmit impulses throughout a person's brain and central nervous system. In addition, the relatives of people who experience psychosis are more likely to experience psychosis themselves.
- ***Other factors:*** A person's first episode of psychosis can be triggered by stressful events or by drug use (especially use of marijuana, speed, or LSD).

What Are the Phases of Psychosis?

Psychosis occurs in three predictable phases, but the length of each phase varies from person to person. These phases are:

1. The ***prodromal phase*** is the early warning phase of psychosis, when a person experiences some mild symptoms and vague signs that something is not quite right.
2. During the ***acute phase,*** a person clearly experiences one or more of the symptoms of psychosis.
3. A person reaching the ***recovery phase,*** he begins to feel like him- or herself again. Different people experience the recovery phase differently. With effective treatment, many people who reach the recovery phase may never experience psychosis again.

How Is Psychosis Treated?

Most people recover from psychosis, and many do so with the help of treatment. This treatment usually includes several parts:

- Learning treatment options and working with professionals to determine which options are right for you.
- Working with a mental health professional to practice ways to cope when things feel bad.
- Working with a doctor to determine how medications can help.
- Working with professionals who specialize in helping individuals learn to manage everything from relationships to jobs and school.

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Helping people live their best lives

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- ***Other factors:*** A person's first episode of psychosis can be triggered by stressful events or by drug use (especially use of marijuana, speed, or LSD).

What Is the Role of the Family in Recovery From Psychosis?

Family members can be extremely important in the recovery process. The person may have difficulty in the early period with many things which used to be easy for them. When a person is recovering from their psychotic episode you can provide love, stability, understanding and reassurance, as well as help with practical issues. There are many ways that family members can help a person in recovery from psychosis. Family members can:

- Help the person with psychosis get to treatment appointments and work with their treatment team.
- Stay in regular contact with the treatment team.
- Advocate for the person with psychosis to get the support he/she needs.
- Learn about psychosis so you know what is happening.
- Assist with remembering and initiating appointments and activities.
- Observe and report symptoms the person with psychosis may not be aware of.
- Include the person with psychosis in family and social activities.
- Maintain a safe, positive, supportive atmosphere at home.
- Help with finances.
- Take care of yourself and get your questions answered.
- Understand the goals that your loved one has for recovery.
- Be patient.
- Attend family support groups in your area to learn how other families cope and support the recovery of loved ones.

The RAISE Connection Program:
Helping people live their best lives

Recovery From Psychosis

Three out of every 100 people experience psychosis at some time in their lives, and most of them recover. Recovery from psychosis results in some important life changes, and there are several things people can do to help themselves .

What Is It Like to Recover From Psychosis?

Different people have different stories to tell about their recovery from psychosis. For example, some recover very quickly, while others feel better after several months. With treatment, support, and hard work, people in recovery from psychosis can look forward to their lives improving in some important ways:

- ***Symptom reduction:*** People recovering from psychosis have fewer symptoms of psychosis, and the symptoms they do experience are less intense. That means these individuals are less likely to hallucinate (i.e., see, hear, taste, smell, or feel things that are not there), and they are less likely to have delusions (i.e., beliefs in things that are not true). These individuals also begin to think, feel, and act more like they did before they had psychosis.

- ***Improved relationships:*** People experiencing psychosis usually cannot relate to friends, family, and other significant people in their lives as they did before psychosis. Once the psychosis begins to subside, though, they can begin to rebuild those relationships.

- ***More connections with outside world:*** Perhaps because they have fewer symptoms to deal with – and more support from other people—people recovering from psychosis often can focus more time and energy on important personal goals like completing school, getting a good job, enjoying friends and family, and other things that make life fun and meaningful.

What Helps People Recover From Psychosis?

The most important thing that helps people recover from psychosis is *getting active*. It may sound strange, but passively sitting around waiting for medicine and the professionals to cure you is usually *not* the way recovery happens! Most people who recover *get active* by:

- ***Participating in treatment:*** Active treatment participants partner with their treatment providers to learn all they can about their treatment options, such as medications and therapy. They keep their appointments with these providers, and give the providers honest feedback about how treatment is working or not working for them.

- ***Focus on personal goals:*** Personal goals in work, school, or other areas of life can be strong motivators for people recovering from psychosis. If they are not immediately

ready to resume all their previous activities, people recovering from psychosis can set smaller, more realistic goals that will help them make progress.

- ***Finding support:*** Friends, family, and other important people can provide important encouragement as people recover from psychosis. In addition, support groups for people who are recovering from psychosis can be important. In a support group you can find hope, friends, pride and proven strategies for getting well.

- ***Taking care of yourself:*** Recovering from psychosis is hard work, so people recovering from psychosis must make sure they take good care of themselves. This means they need good diets, plenty of exercise and sleep, and regular medical check-ups.

- ***Taking an honest look at drug and alcohol use:*** For some people, drug and alcohol use can trigger psychosis or make it worse. It can really help to take an honest look at one's drug or alcohol use and ask , "has it contributed to my psychosis?"

- ***Keeping your time structured:*** Many people find that being bored is stressful. Just hanging around doing nothing is typically not helpful. Get busy and structure your day with activities such as school, work, volunteering, friends and exercise. Try to find the right balance between time alone and time with people.

Appendix 10: Sample Forms for Supervision Notes

Supervision Note

Date: _____

Type of meeting:
- Administrative supervision
- Clinical supervision
- Clinical consultation
- Component supervision
- Model supervision

Team members present:
- Team Leader
- Psychiatrist
- Recovery Coach
- IPS Specialist
- Clinic Administrator
- Program Director
- Other: _____

Meeting Leader: _____

Attendance (please check):

Name	Name
Name	Name
Name	Name
Name	Name
Name	Name
Name	Name

Issues Discussed:

Plans/actions for next meeting:

Appendix 11: Resources for Supervision

Association of Psychology Postdoctoral and Internship Centers
http://www.appic.org/Training-Resources/Resources#Supervision

Mental Health Evidence Based Practice Project
http://www.socialwork.buffalo.edu/ebp/supervision/index.htm

SAMHSA
http://toolkit.ahpnet.com/Dealing-with-Stress-in-the-Workplace/Impact-of-Stress-on-Retention/Want-to-Reduce-Stress-and-Burnout-in-Behavioral-He/Mentoring-and-Clinical-Supervision-Programs.aspx

Slide sets and other resources for Clinical Supervision: A Competency-based Approach by Carol Falender, Ph.D.
http://www.cfalender.com/

Azar S A. (2000). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: A cognitive behavioral approach to supervision. *J Clin Psychol*, 56(5), 643–663.

Edwards D, Burnard P, Hannigan B, et al. (2005). Clinical supervision and burnout: The influences of clinical supervision for community mental health nurses. *J ClinNurs*, 15(8), 1007–1015.

Torrey WC, Drake, RE, Dixon L, et al. (2001). Implementing evidence-based practices for persons with severe mental illness. *Psychiatr Serv*, 52(1), 45–50.

Triantafillou N. (1997). A solution-focused approach to mental health supervision. *J Syst* Ther, 16(4), 305–328.

Mental Health Self Help (and other) Resources

FINDING RESOURCES LOCALLY

The three agencies / projects below are resource centers in our area to help people connect to a wide variety of health, human services, self-help and other resources. Useful for clinicians, clients, families etc.

Maryland Community Services Locator:www.mdcsl.org
Searchable directory of health, human services, self help and other community resources across the state.
Available to anyone who can access the website. See handout flier

Dial 2-1-1:www.211metrodc.org
Anyone can literally dial 2-1-1 any day on any phone (like dialing 311 for city services or 911 for emergency) to get connected to operators who can help them find social services in DC, Northern VA and parts of MD.
The website also has a searchable directory like MDCSL
See the bottom of the site's front page for additional regional resource centers to call for help as well.

Baltimore Crisis Response, Inc (BCRI): www.bcresponse.org
Hotline: 410-433-5175 or 410-752-2272
Office: 410-433-5255

NATIONAL SELF-HELP RESOURCE WEBSITES

American Self Help Group Clearing House:http://www.mentalhelp.net/selfhelp/
Self-Help Group Sourcebook Online – look up groups on many topics, US and international. Very good links to related resources

National Self Help Clearing House:http://www.selfhelpweb.org/index html (???) or 212-817-1822
"to facilitate access to self-help groups and increase the awareness of the importance of mutual support"

National Mental Health Consumers Self Help Clearing House:http://www.mhselfhelp.org/
Info source and technical assistance for mental health consumer self-help organizations and individuals

Center for Community Support and Research, WSU:http://www.ccsr.wichita.edu
Broad center re strengthening community organizations with a long history and deep relationship with self help groups. Many good resources re self help research and capacity-building.

MH SELF HELP LOCALLY

Also see National Resources, below

On Our Own of Maryland, Inc:www.onourownmd.org
Wide array of self help and advocacy programs and support groups across the state for people with mental illnesses
List of affiliates across Maryland: http://www.onourownmd.org/affiliates.html
State office: 410-646-0262 or 800-704-0262

Depression and Bipolar Support Alliance www.dbsalliance.org
National contacts to find local groups: 800-826-3632 or chapters@dbsalliance.org
To find local chapters and support groups:
http://www.dbsalliance.org/site/PageServer?pagename=support_findsupport

Recovery International, Inc.:http://www.lowselfhelpsystems.org/index.asp
"self-help mental health organization founded in 1937, sponsors weekly group peer-led meetings in nearly 600 communities around the world, as well as telephone and Internet-based meetings.." (312) 337-5661 or inquiries@recovery-inc.org
To find a Maryland meeting: http://www.lowselfhelpsystems.org/meetings/meetings-per-city.asp

Alcoholics Anonymous, Baltimore area:http://baltimoreaa.org or 410 663-1922
Provides contacts for local meetings and 24hr phone support

Narcotics Anonymous, MD:http://www freestatena.org or 1-800-317-3222
Provides contacts for local meetings and 24hr phone support

MD Coalition of Families for Children's Mental Health:http://www mdcoalition.org/
"dedicated to improving services for children with mental health needs and their families, and building a network of information and support for families across Maryland"
Statewide office: 410.730.8267 or 1.888.607.3637
Baltimore office: 410.235.6340 or 1.888.607.3637

Parents Place of Maryland:http://www.ppmd.org/
410-768-9100 or info@ppmd.org "peer support for parents of children with all disabilities"

Jewish Coalition Against Sexual Abuse and Assault: http://www.theawarenesscenter.org/networkinggroups.html info@theawarenesscenter.org or 443-857-5560 support groups and information

Autism Society of America – Baltimore Chesapeake Chapter:
http://www.bcc-asa.org/BCCASAMeeting.htm or questions@bcc-asa.org or 410-655-7933
support groups and information for parents of children with autism spectrum, for siblings, and for adults with autism spectrum

NAMI Maryland:http://md nami.org/
410-863-0470 or helpline:800-467-0075 or namimd@nami.org
Information, support, skill classes, education programs and other resources for family members of people with mental illnesses and clients themselves. Local chapters in every county:
http://md nami.org/aboutus/aboutus_affiliates htm

MH SELF HELP NATIONAL RESOURCES

National Empowerment Center:www.power2u.org
800-769-3728 or info4@power2u.org
wide array of high quality consumer-created resources, trainings, self-help packages, strategies and links

Emotions Anonymous:http://www.emotionsanonymous.org/
"a twelve-step organization… composed of people who come together in weekly meetings for the purpose of working toward recovery from emotional difficulties…the only requirement for membership is a desire to become well emotionally." Many meetings online, but also in person. To find local meetings: (651) 647-9712 or infodf3498fjsd@emotionsanonymous.org

GROW, Inc:www.growinamerica.org
"an international mental health movement with a network of member-run support groups in the USA, Australia, New Zealand and Ireland. GROW in America is fully developed in Illinois and New Jersey. It also has a small core of groups in Rhode Island. *GROW is organized, friendly help.* It is based on mutual-help groups, friendship, leadership and mutual education. People come to GROW with diverse problems in living, such as mental health issues, emotional troubles, or difficulty coping with grief, loneliness, anxiety or stress…"

OTHER

Example of in print self help resources (domestic violence):
http://resources.baltimorecountymd.gov/Documents/Women/selfhelp2005.pdf

Suicide Hotlines, (various organizations centralized service):
http://www.suicide.org/suicide-hotlines.htm

Appendix 12: Resources for Fidelity

Recommended Performance Measures/Fidelity Requirements for First Episode Psychosis Programs

Based on Experience with the RAISE Connection Program's Standards and Practices
(January 29, 2013)

Performance Expectations for the Team's Structure and Functioning

Program Component and Associated Expectations	Operationalization of Expectations
Staffing. Teams hire and maintain the required staff.	1.0 FTE Team Leader who is a licensed clinician 1.0 FTE IPS Specialist 0.5 FTE Skills Trainer who is a licensed clinician 0.2 FTE Psychiatrist Vacancies are filled within 30 days
Caseload size. Teams maintain a caseload that is small enough to allow for intensive and highly individualized services while, at the same time, serving as many clients as possible within these service demands.	Caseload does not exceed 30
Staff meet as a team. These meetings are for strategic clinical thinking and reviewing the status and "next steps toward goals" for each person on the team's caseload.	Full team meets at least weekly.
Intake occurs promptly.	Intake occurs within 1 week of referral.
At least one member of the team is available 24/7.	Team has on-call system for after-hours availability and service logs show that any given month includes services on nights and weekends.
Outreach. Teams see clients in the field as needed.	At least 10% of participants have at least one visit in the community with the Team Leader, psychiatrist, and/or recovery coach.

Program Component and Associated Expectations	Operationalization of Expectations
Safety assessment. All clients assessed for suicide risk and safety plans are formulated and implemented for those determined to be at risk.	The HASS Demo or equivalent screening tool is completed with every participant at intake and whenever concerns about possible suicide are raised. For those who meet or exceed the specified threshold indicating a risk of suicide, a safety plan developed the same day of the screening is included in the chart. Is this given to the individual and the family so they will be able to act according to the plan?
Discharge. The team provides a critical time intervention rather than a source of services for people well along in their recovery. Clients transition from the team to routine services as soon as clinically appropriate. The team follows up with discharged clients and with post-discharge providers as appropriate to help assure a smooth transition to routine community services.	Median and average length of stay with Connection Team of all participants to be calculated at the end of each quarter. Mean length of stay for discharged clients will not exceed 30 months. Individual length of stay for any participant will not exceed 36 months. At least 90% of participants plan for discharge with Team (as opposed to leaving precipitously). Discharge planning begins at least XXX months prior to the discharge date. At least 90% percent of discharged participants attend their first appointment with a mental health service provider within 30 days of discharge.

Performance Expectations for the Psychopharmacology Intervention

Domain and Expectation	Operationalization of Expectations
Psychotropic Medications. Pharmacotherapy is a core component of treatment. Because many clients with FEP are reluctant to try medication, teams work to develop trusting relationships and provide education about medication options and best practices for medication treatment for FEP so that clients are willing to try antipsychotic medications.	Antipsychotic medication is prescribed for at least 60% of patients on the team at any given time. At least 75% of patients have had at least one trial of an antipsychotic medication prescribed for at least 4 weeks within the recommended dosage range.
Assessment of medication effects. Psychiatrist and client regularly review medication effectiveness and side effects.	At least quarterly, psychiatrist and client review medications. Psychiatrist records symptoms and side effects using standardized assessment scales in a manner that facilitates monitoring changes over time.

Domain and Expectation	Operationalization of Expectations
	Weight gain of over 1 BMI prompts consideration of a change (in medication, dosage, or behavioral intervention).
Assessment of weight.	Weight is assessed monthly.
Assessment of fasting glucose/HbA1c and lipids.	Assessment of fasting glucose/HbA1c and lipids conducted at intake, 2 months after, and then annually. Schedule repeated if new antipsychotic started.

Performance Expectations for Services by the Recovery Coach or Equivalent Clinician

Domain and Expectation	Operationalization of Expectations
Recovery Coach provides flexible, motivational interventions. Recovery Coach works with clients and families, supporting resiliency and skill building in illness management and recovery treatment and treatment for substance use.	Recovery Coach's service logs indicate the provision of both group and individual sessions in illness management and recovery. At least 75% of patients participate in at least one session provided by the Recovery Coach. At least 25% of clients have one or more family members participate (whether or not client is present) in at least one session provided by the Recovery Coach. Recovery Coach's service logs indicate the provision of substance abuse treatment to at least 25% of clients.

Performance Expectations for the Family Intervention

Domain and Expectation	Operationalization of Expectations
Working with families. Team discusses with each client ways family might be involved in the client's treatment and determines each client's preferences and reassesses these preferences periodically. Team documents family's participation in treatment over time.	Team has conversation with all participants regarding their preferences for family involvement as part of intake and at least quarterly thereafter. Service logs note when family member is present. Service logs indicate that, in any given quarter, at least 50% of clients have one or more family members meeting with a member of the team at least once.

Performance Expectations for the Individual Placement and Support (IPS) Specialist

Domain and Expectation	Operationalization of Expectations
IPS specialist focuses exclusively on supported employment and supported education.	IPS specialists provide only employment and education services. Service logs indicate that less than 10% of the IPS specialist's time is devoted to case management and crisis services, administrative duties, or other duties not directly related to employment or education.
Team Leader provides intensive, outcome-based supervision	Team Leader conducts biweekly IPS supervision to review client situations and identify new strategies and ideas to help clients in their work lives. IPS records document at least 2 such meetings per month. Team Leader reviews employer contact logs with IPS specialist at least twice per month and helps IPS specialist think of plans to follow up with employers and teachers/instructors. IPS records document at least 2 such meetings per month. Team Leader reviews current client outcomes with IPS specialist and sets goals to improve program performance at least quarterly, with a monthly review. Team maintains a list of performance goals and associated performance over time.
Zero exclusion criteria. All clients interested have access to IPS regardless of readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation.	IPS specialist has met with at least 90% of clients at least once. Current case load of IPS specialist includes individuals actively using substances (unless the very unlikely situation exists wherein no clients on the team are abusing drugs/alcohol).
Competitive jobs and mainstream education promptly pursued. IPS specialists help clients pursue permanent competitive jobs and academic opportunities in mainstream, integrated educational settings. Acceptable jobs include seasonal jobs and temporary jobs that are part of the community's regular labor market.	Team monitors rates of being in school or employed and at least 50% of clients are either in school pursuing a degree or competitively employed.
Individualized follow-along supports. IPS specialist helps client problem solve work/school issues, based on a job/education support plan. The IPS specialist assists the client to seek out and benefit from natural supports (e.g., tutoring services, coworkers, family, etc.). Support is based on client preferences, work history, needs, and demands of the work/school environment. At client's request, IPS specialist provides employer supports or intervenes at an academic institution (e.g., educational information, job accommodations). The	At least 80% of the time, there is at least one visit with the IPS specialist between the job/academic start and end dates. If there exists at least one face-to-face meeting by the IPS worker during the client's job tenure/time in school, then the standard of follow along supports has been met. If there is no such service, then the standard hasn't been met. If the job/school lasted only one day, omit from the computing of this measure.

Domain and Expectation	Operationalization of Expectations
IPS specialist promotes career development, assisting clients in the pursuit of education and training, more desirable jobs and more preferred job duties. Most contact is face-to-face.	At least 50% of IPS specialist's time is in community settings (outside the mental health center), devoted to engagement, employer and educational institution contacts, providing follow-along support, etc.

Attachment A-2

Clinical Diagnostic Eligibility Early Onset Program

The service takes clients aged between 15 and 30 years of age who are experiencing their first episode of psychosis and within two years of the diagnosis date of a qualifying diagnosis (one of the diagnoses below).

DSM-5		Schizophrenia
ICD-10	F20.0	Paranoid schizophrenia
ICD-9	295.30	Paranoid type schizophrenia
DSM-5		Schizophrenia
ICD-10	F20.1	Disorganized schizophrenia
ICD-9	295.10	Disorganized type schizophrenia, unspecified
DSM-5		Schizophrenia
ICD-10	F20.2	Catatonic schizophrenia
ICD-9	295.20	Catatonic type schizophrenia, unspecified
DSM-5		Schizophrenia
ICD-10	F20.3	Undifferentiated schizophrenia
ICD-9	295.90	Unspecified schizophrenia, unspecified
DSM-5		Schizophreniform disorder
ICD-10	F20.81	Schizophreniform disorder
ICD-9	295.40	Schizophreniform disorder, unspecified
DSM-5		Schizophrenia
ICD-10	F20.89	Other schizophrenia
ICD-9	295.80	Other specified types of schizophrenia, unspecified
DSM-5		Schizophrenia
ICD-10	F20.9	Schizophrenia, unspecified
ICD-9	295.90	Unspecified schizophrenia, unspecified
DSM-5		Schizotypal personality disorder
ICD-10	F21	Schizotypal disorder
ICD-9	301.22	Schizotypal personality disorder
DSM-5		Delusional disorder
ICD-10	F22	Delusional disorder
ICD-9	297.0	Paranoid state, simple
ICD-9	297.1	Delusional disorder
ICD-9	297.2	Paraphrenia
DSM-5		Brief psychotic disorder
ICD-10	F23	Brief psychotic disorder
ICD-9	298.3	Acute paranoid reaction
ICD-9	298.4	Psychogenic paranoid psychosis
ICD-9	298.8	Other and unspecified reactive psychosis
DSM-5		Schizoaffective disorder, bipolar type
ICD-10	F25.0	Schizoaffective disorder, bipolar type
ICD-9	295.70	Schizoaffective disorder, unspecified
DSM-5		Schizoaffective disorder, depressive type

ICD-10	F25.1	Schizoaffective disorder, depressive type
ICD-9	295.70	Schizoaffective disorder, unspecified
DSM-5		Other specified schizophrenia spectrum and other psychotic disorders
ICD-10	F28	Other psychotic disorder not due to a substance or known physiological condition
ICD-9	298.9	Unspecified psychosis
DSM-5		Unspecified schizophrenia spectrum and other psychotic disorder
ICD-10	F29	Unspecified psychosis not due to a substance or known physiological condition
ICD-9	298.9	Unspecified psychosis
DSM-5		
ICD-10	F30.2	Manic episode, severe with psychotic symptoms
ICD-9	296.04	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior
DSM-5		Bipolar I disorder, Current or most recent episode manic, with psychotic features
ICD-10	F31.2	Bipolar disorder, current episode manic severe with psychotic features
ICD-9	296.44	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior
DSM-5		Bipolar I disorder, Current or most recent episode depressed, with psychotic features
ICD-10	F31.5	Bipolar I disorder, Current episode depressed, severe, with psychotic features
ICD-9	296.54	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior
DSM-5		
ICD-10	F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
ICD-9	296.64	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior
DSM-5		Major depressive disorder, single episode, with psychotic features
ICD-10	F32.3	Major depressive disorder, single episode, severe with psychotic features
ICD-9	296.24	Major depressive affective disorder, single episode, severe, specified as with psychotic behavior
ICD-9	298.0	Depressive type psychosis
DSM-5		Major depressive disorder, recurrent episode, with psychotic features
ICD-10	F33.3	Major depressive disorder, recurrent, severe, with psychotic symptoms
ICD-9	296.34	Major depressive affective disorder, recurrent episode, severe, specified as with psychotic behavior
ICD-9	298.0	Depressive type psychosis

Coordinated Specialty Care for First Episode Psychosis

Manual I: Outreach and Recruitment

National Institute of Mental Health

RAISE
Recovery After an Initial Schizophrenia Episode
A Research Project of the NIMH

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Table of Contents

I. Introduction

The low incidence of schizophrenia (3 in 10,000 / year; WHO, 2012), coupled with complex differential diagnosis (White, Anjum & Schultz, 2006), make it particularly difficult to identify individuals experiencing early psychosis. Engaging individuals in appropriate treatment is further complicated by the individuals' and family members' unique and culturally-derived definition of these experiences (Bergner, Leiner, Carter, et al, 2008), their often negative perceptions about mental health services (Compton, Esterberg, Druss, et al, 2006), difficulties in cognitive processing caused by the illness that may affect the process of obtaining and storing knowledge (Beck, 2009), and stigma associated with acknowledgement of mental illness by individuals and families.

When developing an early intervention specialty clinic, it is essential to develop a structure that systematically disseminates information about the program and can facilitate a successful referral and enrollment process. This manual describes methods for outreach, steps to establishing a referral network, and guidance on evaluating and admitting individuals to a specialty clinic. Individuals partaking in such activities will be referred to in this manual as outreach and referral specialists (ORS) or as the outreach and referral team (O&R team). The O&R role is critical to the success of Coordinated Specialty Care (CSC) programs, as the ORS is typically the first point of contact a potential client may have with CSC care and play a central role in engagement. This engagement process must embody a vision of recovery and hope that communicates the program's person-centered focus, as opposed to an illness-focused approach. As will be emphasized throughout the manual, language is central to this goal. The language used by ORS should mirror that of the potential client and convey new meanings of treatment which emphasize recovery and hope.

The recommendations and resources provided in this manual are derived from the experiences of the Recovery After an Initial Schizophrenia Episode Implementation and Evaluation Study (RAISE-IES). RAISE-IES was funded by the National Institute of Mental Health (NIMH) to, in part, develop tools that would support the implementation of programs designed to provide early intervention services for people with non-affective psychoses. The Connection Program was the clinical intervention developed and evaluated in RAISE-IES. RAISE Connection Program represents an example of a CSC program recommended for first episode psychosis. This manual provides examples of practical tools and materials that can be used for outreach and referral activities as well as case narratives that highlight the experiences of RAISE-IES. Throughout the manual, 'Section Tools' are highlighted, pointing to appendices with relevant tools and information.

Note: The RAISE Connection Program was part of a research study. As a result, some of the language and procedures that are embedded in these tools would need to be modified for usual clinical practice.

II. Establishing and Equipping the Outreach and Referral Team

The CSC Team Leader or Program Director should designate one or more individuals who will oversee the outreach and referral (O&R) process for the program. As part of O&R, these individuals will also be responsible for initial assessments of the potential client's eligibility for the program. The designated individual(s) should be a master's level clinician (or possess a higher clinical degree) with the ability to identify primary psychosis and perform differential diagnoses for symptom profiles related to psychosis. A program may choose to identify persons within the clinical team to lead outreach and recruitment activities, or establish a separate team of individuals who will only be responsible for such activities. If outreach staff members are not part of the clinical team, they should be trained in the core concepts of the program (as outlined in the companion manual, *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation*.)

While this manual focuses on the O&R activities of team members, it is also useful to have access to senior agency leadership who may facilitate outreach and/or recruitment by strategic networking and presentations, as appropriate. For example, a senior administrator may establish contacts across organizations with other administrators within the community.

A. Training and Supervision

Section Tools:

- ✓ ***Examples of strengths-based language can be found in Appendix 1.***

1. Key Concepts in O&R Training.

The list below provides a general overview of the key concepts O&R team members should be familiar with before they begin their activities. Recommended readings may be found in the companion manual, *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation.*

- Program Components: O&R team members should have an understanding of all team roles and functions, services offered, and the general model.

- Insurance and Financial Matters: O&R team members should know the program's pre-determined payment structure to suitably inform providers, service seekers, and family members. Examples include: if certain services are fully covered at no cost; if medications are covered; if any insurance is accepted; and/or if there are options for an income-based sliding scale.

- Psychoeducation: O&R team members must be familiar with the concepts and the general literature regarding schizophrenia including early warning signs, impact on functioning, and the importance of early intervention.

- Presentations: O&R team members require training in how to give presentations to

various audiences. The audience may include physicians, mental health professionals, school counselors, and other professionals (e.g., police, religious authorities, etc.) Presentations may also be given at different venues in the health sector and the community.

- Evaluation: As they may be conducting eligibility evaluations/engaging in pre-screening activities, O&R team members should: understand symptoms associated with psychosis, mood disorders, and substance use disorders; know how to diagnose primary psychotic disorders and be familiar with differential diagnoses; be able to identify the onset of prodromal symptoms; and become accustomed to determining date of onset of psychosis.

- Safety and emergencies: O&R team members must be knowledgeable about emergency procedures implemented by the agency housing the specialty clinic, as well as procedures set in place within the team (e.g., contacting senior clinician in a crisis, etc.)

- Reporting requirements: O&R team members must fully understand required responses to suspected child abuse and homicidal thoughts as mandated by law.

2. ***Language.*** Person-centered language is an important tool for outreach and early engagement. Examples of recovery-oriented and strengths-based language are included in Appendix 1. When speaking with potential clients or family members, avoid using diagnostic terms (e.g., schizophrenia, delusional disorder) unless specifically discussing diagnoses—use the same language that potential clients or family members use when describing their experiences. O&R team members represent the first contact a potential client has with the CSC program and team. For successful engagement, it is essential that their language and approach emphasize messages of recovery and highlight a person-centered approach to treatment.

3. ***Supervision***. When the clinic is first established, the O&R team will need clinical supervision to review incoming referrals and address any barriers encountered as staff attempt to establish rapport with potential clients or families. Backup supervision should be available by a senior clinician to provide assistance in addressing safety concerns and complex situations. The independence of the ORS should increase with time and experience.

B. Creating Materials and Outreach Tools

Section Tools:

- ✓ ***Examples of brochures and flyers used for outreach during the RAISE Connection Program are provided in Appendices 2 and 3.***

Prior to the initiation of outreach and recruitment activities, it is helpful for the program to develop materials that help communicate information about the CSC program and serve as entry points for potential clients, family members, and other service providers to learn about and contact program staff.

- ***Website:*** The website should be easy to navigate and can include sub-sections for clinicians, consumers, and family members. In addition to including contact information and directions to the clinic, the program may also choose to include an inquiry form on the website, which would allow interested parties to submit requests for information about the program. The website should be kept up to date, and have an appealing look.

- ***Centralized Phone Line:*** The program should establish one phone number for all referral calls. This number can be routed to various outreach team members to answer calls on a rotating basis. Toll-free lines that automatically email transcribed messages to a centralized, secure email address may be an effective way to receive and respond to referral inquiries in a timely fashion.

- ***Brochures and flyers:*** Two types of brochures and/or flyers should be created: one to meet the needs of consumers and family members, and another to target providers. Each should include a brief introduction to the specialty clinic along with an overview of admission criteria and relevant contact information. The provider brochure can incorporate knowledge from previous research to highlight the need for early intervention, using clinical terminology to describe consumers. The consumer and family brochures should speak to the overall goals of the program and briefly describe specific program activities. Materials for consumers and family members should not use diagnostic language. Creating electronic versions are that can be easily shared via email is also helpful.

- ***Supplies:*** As budgets allow, purchasing items such as pens or notepads with the program name to distribute may serve as helpful reminders to referral sources.

The O&R team can work with external branding agencies to develop materials that distribute information about the new early intervention specialty program to providers, service seekers, and family members. All written information made available to the public (non-provider) should use appropriate, person-centered language to describe the program without using medical/diagnostic terms.

III. Establishing and Maintaining a Referral Network

Before creating the referral network, several characteristics of the specialty program should be identified so that the outreach team can convey this information to potential referral sources. These program characteristics include levels of program services, geographic boundaries for services, financial structure, and clinic admission criteria. When establishing the network, also consider characteristics of state-specific regulations and local mental health agency structures. For example, it is important to be informed regarding criteria for involuntary status; confidentiality regulations and standards for working with minors; and accessibility of different levels of care that are provided by state hospitals, general psychiatric units, partial hospital and/or day treatment programs, respite care, peer services, outpatient services, and private practice offices. Additionally, the O&R team should be knowledgeable about financial and insurance systems within the state.

Section Tools:

- ✓ ***A flip chart, letters, and newsletter articles can be found in Appendices 5, 17, and 18.***
- ✓ ***Guidelines for creating an Outreach Tracking System and a template can be found in Appendices 12 and 13.***

A. Communications Strategies

Outreach activities should encompass efforts that will facilitate connections to specialty clinics as early in the individual's illness as possible. The O&R team must expand these efforts beyond institutions, to reach the larger community. Understanding the cultural norms of residents in the area surrounding the clinic can be beneficial to reaching a larger audience and engaging individuals in early intervention services. In addition to using various materials and tools as previously described, the following methods can also be used to communicate information about the specialty clinic:

- ***Presentations:*** Presentations about the program and its services should be customized to separately target consumers, families, and mental health professionals using terms that are meaningful to them. Presentations should provide some education about first episode psychosis (e.g., etiology, effects of illness, impacts on functioning, etc.), and why early intervention is thought to be important. Flip charts of presentations serve as a visual tool to facilitate discussion during small staff presentations and/or to use during initial meetings with potential clients and families.

- ***Newsletters:*** A new specialty clinic may choose to write an article specifically for newsletters. The O&R team may approach existing organizations (who already circulate news briefs to their listservs) to include the article in their newsletter.

- ***Host Websites:*** Reach out to larger institutions that provide resources on their websites and request that information about the new specialty clinic be placed on their host website. Examples include: Schizophrenia.com; local NAMI website; and the website for the host agency of which the clinic is a part (e.g., larger hospital or university

system).

- ***Social Media:*** Social media and the internet can be used in a variety of ways. The target audience may consist of anyone who may benefit from receiving user-friendly information. The specialty clinic may choose to distribute academically oriented research articles, information on current affairs as it relates to psychosis and early intervention, blog posts highlighting specific topics of interest, etc. Whether using Facebook, Twitter, or other social media outlets, the specialty clinic's objective should be to disseminate information to the public and offer general resources when appropriate.

B. Outreach Tracking System

The O&R team should implement and maintain systems to track all the outreach activities and referrals. Tracking allows for an evaluation of the impact and staff time required for different activities. This can be designed as a database (i.e., using a program such as Access), or through the use of Excel spreadsheets. Elements that should be included in the outreach tracking system include:

- Organization/Agency Name
- Specific units/departments
- Names of particular agency contacts and relevant contact information
- Tracking outreach: date/name/type of activity (presentation, email, etc.) and plans for follow up

C. Referral Network and Outreach Activities

The O&R team should identify the potential referring organizations within the clinic's geographic boundaries. Any local organizations that may encounter potential clients should be included in this original list. All relevant information for such organizations should be stored in the Outreach Tracking System.

O&R team members should conduct initial outreach activities using both top-down and bottom-up tactics, approaching both executive administrators and staff providing direct services at potential referring institutions. Whether the initial contact occurs via administrators or front-line staff, the outreach staff should attempt to inform staff at all levels about the clinic services.

Establishing rapport with referral organizations occurs in three stages: Orientation, Uptake, and Optimization. During the Orientation stage, the outreach team focuses on establishing initial contact with the referral source and orienting key staff members to the specialty clinic program and services. The Uptake stage describes the period of time when initial referrals are received by the specialty clinic. Open communication with referral sources ensures that initial referrals occur successfully and the referral process is working. Any impediments in the referral process may cause a referral source to stop sending referrals. The third stage, Optimization, describes the process used to maintain a stream of referrals. This stage ensures that ongoing communication

occurs to identify regular referral personnel and orient new personal to the specialty program.

D. Outreach Process: When, How, and How Much

- Start introductory outreach activities prior to the launch of the new program. Organizations and individuals should be notified once the program can begin considering new referrals and offering screening and intake appointments.

- Determine level of outreach

  - *Mailings only:* Send letters or emails describing the clinic services and referral instructions on a scheduled basis. Mailings may include a supply of flyers and brochures. "*Meet and greet" sites*: Target a selected number of clinicians and sites for once/twice-yearly visits from the outreach team and presentations about the study.

  - *"Enriched outreach" sites:* Visit high-yield referral sites on a regular basis to develop a familiar and collegial relationship with the site clinical staff.

- Work with high-volume referral sources to establish customized procedures to facilitate referrals. Consider facilitating potential client screening and referral through mechanisms such as regular attendance at staff meetings or by monitoring electronic medical records when possible.

- Identify organizations that are sending fewer referrals than anticipated. Additional contact may be required to provide further training and/or to identify and remove any barriers. Maintaining regular contact also allows opportunities to present to new staff and re-orient existing staff about program services, admission criteria, and the referral process.

- Expand the referral network slowly to ensure that the clinic can adequately respond to most referrals.

Case Narrative 1: Like Speaks to Like: The Importance of Outreach Within Disciplines

Whenever possible during the implementation study, a psychiatrist and social worker would give presentations as a team. Having both a psychiatrist and a social worker present was beneficial throughout the course of the presentation. While a psychiatrist was able to provide more in-depth information from a medical perspective, a social worker was able to provide greater detail about key psycho-social components. Presentations would often start with the psychiatrist speaking about the onset and course of psychotic disorders, an overview of currently available treatments, and the importance of early intervention. The social worker would follow up with a description of the comprehensive services offered by the RAISE Connection Program, along with guidelines for making a referral. The overall nature of the presentation consistently blended research and clinical concepts. When appropriate, presenters integrated a mental health systems perspective to provide a bigger picture about health care

services and costs in the state. Because audiences were mostly composed of psychiatrists, psychologists, and social workers, each with varying interests, having a psychiatrist and social worker present provided a platform for a discussion that engaged persons from all of these disciplines.

Case Narrative 2: Combining Education with Outreach

The Connection Program Team Leader contacted an inpatient unit at a community hospital and described the clinical research service. The inpatient team wanted to hear more and invited the Connection Team representatives to a staff meeting. The outreach staff told the inpatient leadership that a Connection Team senior psychiatrist would attend the meeting and provide an overview of the project and its relevance to the hospital's work. The hospital leadership agreed to schedule the visit for a staff meeting that had a brief agenda, to allow for an overview of first episode psychosis, the Connection Team services, and open discussion.

The staff meeting was informal and attended by a mix of psychiatrists, social workers, and nurses. It began with a 15-minute presentation by the RAISE Connection Program senior psychiatrist covering:

- *The emerging focus on prevention and early intervention throughout mental health;*
- *The needs of adolescents and young adults with first episode psychosis for education and employment support;*
- *The potential to limit disability in this population with comprehensive early intervention*
- *The importance of engaging families and support persons in the care of these individuals.*

Open discussion followed with hospital staff members describing patients with first episode psychosis and the difficulties they experience with treatment and follow-up. The Connection Team senior psychiatrist acknowledged the hospital staff experiences and reinforced the above principles. The Connection Team outreach staff followed with a detailed but brief (5-minute) description of the services provided by the Connection Team. The hospital staff was enthusiastic and gave further examples of how these services could meet the needs of selected patients. The meeting ended with the Connection Team outreach staff providing written and verbal information regarding eligibility and contact information. The Connection Team senior psychiatrist offered to provide a grand rounds presentation on first episode psychosis if the hospital wished in the future, and also suggested a follow-up visit to the staff meeting within 3 to 6 months.

Case Narrative 3: Information Dispersion: Exponential Return on Outreach Efforts

The outreach and recruitment committee initially anticipated the use of different modalities to announce the start of the Connection Program. In addition to conducting outreach via presentations, emails, letters, and phone calls, the committee collaborated with media specialists to establish other methods of advertising. Together we designed a poster intended to be placed in several subway stations and/or bus stops; and also created an advertisement to be placed in local newspapers. In addition to printed advertisements, the committee sought to use digital advertising through social media websites. Subsequent to the initial recruiting period, the outreach and recruitment committee learned that many providers were hearing about the program either directly from presentations or from other colleagues. The committee soon learned that emails and flyers were being passed to several other organizations and providers, including those we had not made a connection with directly. With the success of receiving numerous referrals, the committee conclusively determined that the use of formal advertising was not necessary at this time.

E. Description of Outreach by Institution Type

1. Key Concepts for Mental health Facilities (e.g., Psychiatric Inpatient Units; Emergency Rooms; Crisis Response Teams; Outpatient Clinics):

- Presentations given at inpatient units should be offered on a regular basis. The objective is to cater to the needs of providers who often develop disposition plans with short notice. The O&R team should offer to visit regularly even if only for the purpose of checking in during team meetings. During visits, the O&R team should: encourage providers to call the team as early as possible about a potential new client; emphasize that the ORS can come to the unit to meet with the potential client and family members prior to discharge; offer to be a resource in case the potential client does not meet admissions criteria following an evaluation.

- Some hospital systems may have a centralized referral call center which anyone seeking services may call to inquire about the services offered within that institution. It is important for the O&R team to connect with staff within such referral call center systems. Staff fielding calls should be given adequate information about the specialty clinic and admission criteria.

- Emergency room outreach activities should focus on making the referral process easier—set up systems collaboratively from the start to help ensure a streamlined process.

- Presentations and check-ins with mobile crisis teams, partial hospitalization programs, and other outpatient clinics may happen less regularly. ORS staff members should inform outpatient providers that should a potential client be deemed admissible, a transfer of care would need to take place around the time of intake into the specialty clinic.

- All facilities should be provided with written materials designed for consumers and families to be placed in waiting rooms and/or distributed as providers see fit.

Case Narrative 4: Electronic Medical Record Reviews

Two challenges in establishing a potentially high yield referral source are timely identification and referral for individuals experiencing first episode of psychosis (FEP). Staff members of the referring organization require training to identify individuals experiencing FEP, and many sources, such as inpatient units, require rapid referrals for discharge planning. Outreach staff leveraged electronic medical record technology to expedite identification of individuals experiencing FEP and their referral to the Connection Program.

The outreach team identified a large local hospital as a potentially high yield referral source. Existing chart reviews were already being conducted to approach individuals for research, and the Connection Program team developed procedures to facilitate client referrals to the CSC program. A designated chart reviewer who was employed by the Hospital Center received a list of medical record numbers for current patients based on age and diagnosis, including Brief Psychotic Episode, Psychosis NOS,

Schizophreniform, Bipolar I with Psychotic Features, Major Depression with Psychotic Features, Delusional Disorder, and Schizophrenia. The chart reviewer examined admission and psychiatric treatment history in detail to determine whether this individual appeared to be experiencing FEP. When the outreach staff identified an individual who may be eligible for the Connection Program, they sent an email to the attending psychiatrist, social worker, and discharge coordinator indicating that an individual on their caseload may be eligible for the Connection Program and providing the medical record number of the potential client. The outreach team received a copy of these emails, and an outreach team member would contact the treatment team to offer an onsite presentation of services for the individual and their family members.

This process not only allowed the outreach team to target their efforts towards specific individuals experiencing FEP, but it served to identify which healthcare professionals regularly encountered individuals experiencing FEP in their practice. Once potentially high yield healthcare professionals were identified, the outreach team could provide presentations about available services and offer in service education. This strategy offered the Connection Program as a potential solution for discharge planning and established a collaborative relationship with the referral source.

Case Narrative 5: Concerns About "Stealing" Patients

Program presentations were met with suspicion by some clinicians who were concerned that the program was attempting to "steal" patients from their clinic. The O&R Team addressed these concerns in several ways. First, they emphasized that they were not interested in having individuals change service providers if it was not clinically appropriate. For example, if the potential clients were doing well in their current care, it may not be clinically appropriate for them to come to the Connection Program at this time. Second, the services available through the Connection Program were reviewed, with the emphasis that additional services would be available to the potential clients and their families. Services such as employment assistance, case management, and family psychoeducation were unlikely to be available to their clients outside of the Connection Program. Third, the O&R team emphasized the importance of engaging individuals with early psychosis in treatment and with the level of community outreach available through the Connection Program. Fifth, the O&R team emphasized that early psychosis is a low incidence condition. The actual number of individuals eligible for these specialized services would represent a very small portion of the providers' entire caseload. Finally, the O&R team continued to affirm the clinician's judgment about whether or not the Connection Program was a good fit for the client. The result was that when most clinicians understood the full range of services available at the Connection Program, they were pleased to offer the program to their client as a treatment alternative.

Some clinicians, particularly private practice psychiatrists, hoped to retain clinical care of their client and refer the potential client to the Connection Program for therapy, case management, supported employment/education services, and recovery coaching. Similarly, family members may request that existing providers maintain treatment while an individual participates in the Connection Program. Fully integrated, comprehensive care through the Connection Program team provides many treatment advantages. Therefore, the Connection Program model requires that participating individuals receive available services (e.g., psychiatry, therapy) from the Connection Program team. This may have business implications to some practitioners; however, the client benefits of the integrated treatment model may often result in referrals even in these cases.

2. Key Concepts for Colleges and Schools:

- Presentations at colleges should target college counseling centers and student disability offices that may both serve as gatekeepers to more intensive services. Material should be customized to address the kind of encounters these professionals may have with potential clients (i.e., educating them about early warning signs as they relate to functioning and performance in school).

- Presentations at high school and state education systems also require focus on the kind of encounters teachers and guidance counselors may have with high school students. Given the large number of schools, O&R team members can encourage administrators to pass on introductory information about early intervention services to officials at local schools. Interested parties can receive more focused presentations targeting a group of educators and/or counselors within their school or district.

- Outreach may be directed towards local medical, nursing, psychology, and social work schools. Students of these disciplines often circulate among multiple service providers and may facilitate further dissemination of information.

3. Other Potential Sites for Outreach

- Professional, Family, and Consumer Organizations. These organizations are often contacted by persons seeking support or additional services. ORS staff members need not provide specific details about the program's eligibility criteria and/or referral process; rather, emphasize that the CSC program can be presented as a resource to individuals and families who are seeking treatment for symptoms that are characteristic of psychosis.

- Research studies conducting ongoing schizophrenia and/or other related research. While evaluating study participants, researchers at such programs may learn that the individual may be in need of further clinical services. In such cases, the CSC program may be a resource.

- Existing FEP and prodromal clinics. While conducting outreach, ORS staff members should highlight the potential for a reciprocal relationship. For example, re-directing callers to other FEP or prodromal clinics if the potential client is eligible, or if the CSC reaches capacity.

- General practitioners. Based on interest level, customize presentations to meet the needs of a general practitioner. For example, it may be necessary to provide more detailed psychoeducation regarding early warning signs, symptoms, clinical acuity; how to approach the subject of treatment with his or her patients and family members, etc.

- Places of worship, substance abuse programs, social service programs, or criminal justice systems. Professionals at these institutions would benefit from a more nuanced outreach strategy aimed at helping them interact appropriately with the persons they encounter within their roles.

Case Narrative 6: Differences Between Medical and Non-medical Outreach

Outreach to clinical settings (e.g., hospitals, mental health clinics) differed from outreach to non-clinical settings (e.g., colleges/schools, community groups). Clinicians wanted information about treatment options for their patients and were also interested in opportunities for clinical consultation regarding complex cases. Clinicians and clinical leaders were interested in opportunities for continuing education and were open to scheduling grand rounds or staff conferences. In contrast, outreach efforts to non-clinical settings were tailored to the characteristics of the program. For example, school counseling centers were not interested in learning about psychotic disorders (more than one college counseling program emphasized that their students did not have such disorders). Community-based advocacy or organizer groups were also keenly aware of stigma associated with serious mental illness. Outreach to these groups focused on how the Connection team could be a resource to assist their students/residents/family members to accomplish shared goals, such as educational, work, or other goals that may improve quality of life.

F. Outreach to Complex Organizations

Administrative Services Organizations. Start with presentations to state and local level directors, and learn how to approach distributing information across the state's mental health network. Subsequent outreach can be delivered as appropriate. If any state or local agencies offer mental health referrals to families or clients, the specialty clinic can be included on these agencies' resource lists. Poster presentations at conferences sponsored by the state or local mental health associations can also be used to reach a wide variety of providers and identify new potential referral sources.

Affiliated HMOs. Working with Health Maintenance Organizations (HMOs) adds a third party to the referral process (i.e., the HMO care manager). The outreach staff should keep two goals in mind: 1.) provide enough tools to the care managers who will facilitate referrals of individuals involved in care management programs, and 2.) learn how information can be disseminated by the HMO throughout its provider network so that providers can initiate referrals independent of the HMO care manager. Many HMOs are large entities with numerous public and private sector contracts, and outreach staff may need to make initial contacts with HMO regional directors or other senior leaders to obtain approvals to work with care manager teams.

During presentations with care managers, it is important to convey how the outreach team can facilitate this process for care managers and providers. Outreach team members should work collaboratively with care managers to streamline the process of identifying individuals in need of services, and sufficiently linking them to services. We recommend monthly calls with area administrators and care managers to develop a system to simplify the process, and to address any challenges that may arise.

Case Narrative 7: Establishing a Relationship with HMOs and Working with Care Managers

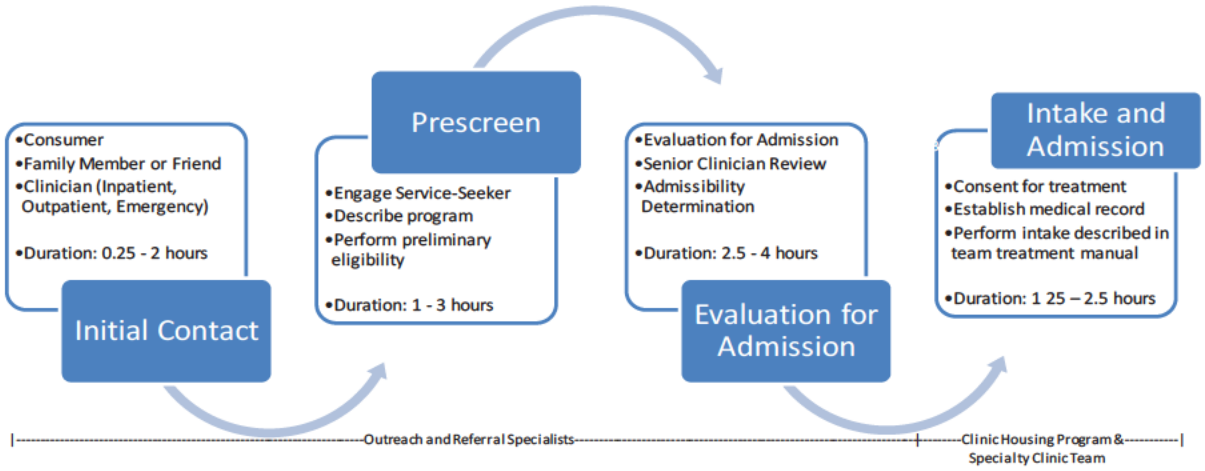
In New York, the outreach team along with a senior clinician had the opportunity of piloting a collaboration with a local Behavioral Health Organization (BHO). BHOs are managed by larger health maintenance organizations, and target behavioral health services. During initial contacts by the senior psychiatrist to a BHO regional director, information about the Connection Program was provided, including knowledge about specific services and the kinds of people who would be referred to the program. Subsequently, it was agreed upon to have monthly check-in phone calls. A social worker from the outreach team also joined these monthly calls. During this process, the two members of the Connection Program and the BHO regional director began planning for ways to get care managers involved in the process. Once the regional director had sufficient information about the program, the proposed collaboration between this BHO and the Connection Program was shared with a local area director. The plan was to then give a presentation to local area directors, and meet with direct care managers to provide detailed information about the program and walk them through the process of making a referral. A one-page flyer was created for care managers to refer to as a quick guide to know when to call outreach and enrollment staff. This flyer would be helpful as a reference when care managers receive calls from hospitals or other service providers looking for a resource for the admitted patient.

IV. Client Screening, Evaluation, and Admission

Client screening, evaluation, and admission encompass the identification, early engagement, evaluation for admission, and clinic admission of individuals experiencing early psychosis.

Potential clients entering the specialty clinic pass through four stages: 1) Initial Contact, 2) Prescreening, 3) Evaluation for Admission, and 4) Intake and Admission. Figure 1 provides an overview of each step. While the figure provides time estimates, the ORS Team should always be aware that potential clients and family members may require additional time prior to making decisions for a variety of reasons. Remain mindful of the importance of allowing potential clients to move at their own pace when making decisions. The ORS team can offer support by being available to answer questions and encouraging potential clients to remain in contact. During the screening and evaluation period, it is important for the ORS to not act as a primary clinician and to appropriately convey that the potential client is not in treatment at the specialty clinic.

Figure 1: Outreach, Referral, and Admission Overview



Section Tools:

- ✓ ***Diagrams and templates for referral screening and evaluation forms can be found in Appendices 6-9.***
- ✓ ***Sample Flip Chart (for providing psychoeducation) can be found in Appendix 5.***
- ✓ ***Guidelines for creating a Potential Client Tracking System and a template can be found in Appendices 12 and 14.***
- ✓ ***A sample resource list and referring out diagram can be found in Appendices 10 and 11.***

A. Creating Procedures and Tools for Referral and Evaluation

Prior to conducting evaluations for admission, procedures and tools should be established to help track and collect information regarding potential clients. It is also important to have available resources and procedures for managing individuals who are not eligible for the CSC program.

- **Potential Client Tracking System (PCTS).** Systems for keeping track of all referrals received should be implemented and maintained by the O&R team. The PCTS can be designed as a database (i.e., using a program such as Access), or Excel spreadsheets. At a minimum, the system should include:

  - Date of referral
  - Name of person calling and relationship to potential client
  - Name of organization
  - Outcome of referral (Screening/Evaluation in Progress; Intake; Referred Out-Not eligible; No Response/Refused; Referred Out-Waitlist)
  - Multiple rows (with space for dates) to reflect multiple contacts for the same service seeker

- **Resources List (for Re-directing Individuals and Emergent Situations):**
  - Area emergency resources, including Lifenet phone numbers
  - For clinics and programs, include the following information:
    - Organization name and relevant specific programs within organization
    - Location, contact phone numbers, and names of specific people with whom a relationship has been established
    - Population served, including age range and conditions treated
    - Insurance requirements and fees
    - Catchment area requirements
    - Services offered (e.g., individual, medication management, groups, vocational services, etc.)
    - Referral/Intake process (include any forms the program may require to be completed)

- **Referral Screening Packet.** Screening packets should be developed and maintained by the O&R team. Referral screening forms should highlight key demographic and clinical information received during initial contacts. A comprehensive referral screening form can be used to inform the eligibility evaluation.

- **Evaluation Form/Narrative.** An evaluation form will clearly identify the factors that lead to admissibility or inadmissibility. A program may also choose to capture information regarding an individual's pathway to care from the time of onset to the date of enrollment in an early intervention clinic. Questions eliciting such information can be asked and noted on the evaluation form. For persons eligible for enrollment, using an evaluation narrative is recommended to provide descriptions and context related to factors leading to admissibility, including history of hospitalizations,

substance use, and any other information the ORS feels appropriate to note. Such a narrative can be helpful for other team members to read prior to meeting the potential client.

- **Waitlist Procedure.** Whether or not the specialty clinic will maintain a waitlist should be pre-determined and should integrate the host agency's policies. If a waitlist is maintained, the following should be used as a guideline:
    - Inform the potential client about the waitlist, and provide a potential date for evaluation based on anticipated openings.
    - Encourage the potential client or family member to seek interim services, and provide sufficient referrals. Encourage individuals to remain in contact periodically to check for openings.
    - Contact potential clients based on date of referral once the clinic is able to offer evaluations. If the potential client has already established care and needs are being met, refrain from disrupting treatment.
- **Safety Procedures.** See Section II.A: *Training and Supervision*

B. Directing Flow of Referrals

Incoming referrals may go in one of two directions: meeting with the ORS for an evaluation or being redirected elsewhere. The ORS team member will have to redirect referrals for the following situations: 1) the ORS immediately learns that the potential client is not appropriate for the program or the individual declines to proceed further, 2) the clinic is at capacity, and/or 3) an emergent situation is apparent. For all other referrals, an evaluation should be considered.

1. Emergent Situations

During initial contacts with a potential client or family member, if an emergent situation is apparent, the ORS should proceed cautiously. Ideally, the individual may be encouraged to contact their current service provider for further assessment/guidance. If the individual is not currently in care with another mental health professional**,** the ORS must use their clinical judgment and redirect the individual appropriately. This may include providing information to the nearest emergency room, or advising the caller to contact emergency services. At minimum, the ORS should provide any additional information for local mobile crisis teams and/or crisis centers.

2. Redirecting Referrals

The ORS team may learn that a potential client does not meet criteria for admission during initial contacts, prescreening, or upon completing an evaluation. Information about alternative treatment providers should be provided whenever possible.

Providing alternative referrals entails knowledge of the potential client, such as diagnostic information, insurance and financial ability, pertinent demographics, and geographic location. The ORS also needs to have a basic understanding of programs in the area, their requirements, and their referral process. If the ORS identifies a need for alternative referrals during the screening process, it is helpful to capture any supplemental information that could lead to a more appropriate referral. For example, if the ORS learns that a young potential client is not interested in treatment but is struggling with high school courses, or would like to apply to college, it may be valuable to identify a program that may offer education and employment support in addition to clinical treatment. The ORS staff should make efforts to facilitate introductions as appropriate while providing alternative referrals to callers. This helps maintain connections with area providers for the referral network. For potential clients and family members, this practice may help make their transition between agencies more seamless. Some factors to consider when making referrals include:

- *Level of Care Needed*: Inpatient, residential or long-term care, partial hospitalization or continuing day treatment programs, individual outpatient (psychiatrist and other mental health professionals)

- *Insurance/Financial Ability*: Does the potential client have insurance? Does he or she have out of network benefits? Do the potential client and/or family members have the means to pay for services out of pocket?

- *Geographic/Location Needs*: Does the potential client need services close to home/work/school? Can he or she travel independently?

- *Specialty Programs*: Are there clinics or programs in the area that address the potential client's diagnostic features (i.e., substance use programs, anxiety disorder clinics, etc.)

- *Supportive Services*: Consider what you have learned about the potential client, and what is important to him or her. Might they benefit from any of the following: Education and employment services, social skills building, groups, targeted treatment (i.e., cognitive-remediation)

C. Stages of Referral and Evaluation

1. Initial Contact

The goals of initial contacts are to: a) establish/maintain rapport; b) describe key elements of clinic services c) identify decision makers and supports (e.g., potential client alone, potential client with parent/guardian; other family or supports); d) determine the potential client's level of interest; and e) proceed with prescreening or redirect as indicated.

- **Self-Referral.** Self-referrals occur when potential clients, their friends, or their family members learn about the specialty clinic on their own through a variety of sources, and initiate the first phone call to the specialty clinic. Initial calls by adults seeking services for themselves can be addressed accordingly (see goals of initial contact above). Some precautions need to be taken when speaking with minors, parents of minors or adults, and others who may be calling on a client's behalf. In these situations it is important for the ORS team member to provide information about the program, while refraining from asking many questions about the individual seeking services. O&R team members should try to connect with the client as early as possible, and decisions about evaluation appointments should be made in collaboration with the potential client and other persons involved in their care. Parents or legal guardians must be present for meetings with minors.

- **Clinician Referral.** Clinicians referring clients include providers, school counselors, and other health professionals. Initial contacts with clinicians should largely follow the same goals described above, with the following additional guidelines:

    - Review all available relevant records. The ORS should try to gain additional contextual information (regarding important events and symptoms), and discuss any aspects of the potential client's history that may need further clarification.

    - If concerns arise regarding admissibility to the CSC program, the ORS should identify concerns with the provider, and make a plan for alternative referrals.

    - Whenever possible, encourage a meeting with the potential client prior to a formal intake evaluation appointment, and encourage clinicians to join a portion of such meetings.

    - The ORS should inform the referring clinicians that transition of clinical care does not occur upon referral; rather, transfer of care is coordinated between the CSC team and the referring clinician *after* the client has enrolled in the program. The precise timing of transfer of clinical care needs clear communication so that both the referring clinician and the CSC team know which provider should be collaborating with the individual on their treatment decisions at any given time.

2. Prescreening

Prescreening potential clients consists of providing psychoeducation and appropriately describing services offered by the CSC team. Prescreening may occur naturally during the initial contacts by phone, in-person meetings prior to the evaluation, or just before the evaluation itself.

The goals of prescreening are to: a) establish/maintain rapport with the potential client; b) describe key elements of CSC services; c) review the program admission criteria with the potential client and his or her supports; d) determine the potential client interest; and e) briefly ascertain whether the individual meets criteria for admission and determine next steps (conduct an evaluation or refer out). The goal of successful prescreening is to decrease the number of individuals referred for full evaluation who are unlikely to meet program eligibility requirements. If admission seems likely, the ORS should begin coordinating next steps for possible intake with the clinical team.

Providing psychoeducation. It is important to provide some degree of education about first episode psychosis and why early intervention is thought to be important. Individuals and families are often in crisis during the early stages of engagement and/or may have difficulty understanding the depth of what it means to have psychosis and what recovery may entail. Connecting the topics covered in psychoeducation to what is important to individuals and families may facilitate early engagement by placing program services into context with the potential client's needs. For example, if a younger client would like to return to school, discuss the supported education services offered. Consider using a flip chart (with relevant information and visual graphics) that may facilitate discussion about FEP and early intervention services.

Describing the specialty clinic services. The ORS should briefly describe the CSC program services to interested individuals using plain, non-medical language, preferably the language that the potential clients use to describe their experiences.

The presentation of specialty program services should be personalized, integrating information acquired previously, the potential client's level of understanding regarding treatment, and his or her interest in learning more about specific services. The following should be used as a guide but can be adapted for each CSC program:

- Describe the program as being designed to provide comprehensive care for individuals who have recently had unusual or disturbing experiences. Highlight that the program is founded on recovery-oriented principles, and is designed to help adolescents and young adults reach their optimal level of functioning.

- Provide brief descriptions of all team members. Try to use examples to describe how each team member can help (e.g., focusing on an Individual Placement and Support (IPS) role if potential client is having trouble going back to school, or describing social skills training if the individual is describing withdrawal/isolation).

- Psychiatrist: Medication management
- Team Leader (TL): Clinician who provides supportive therapy and coordination of care
- Recovery Coach: Clinician who provides skills training and substance abuse counseling, if indicated
- Education and Employment Specialist: Professional who provides services based on an IPS model
- Outreach and Referral Specialist: Clinician who will coordinate initial evaluations.

- Other factors to emphasize:
  - Number and types of visits and services vary based on treatment needs and can change over time depending on what clients and family members find helpful.
  - Services are provided based on a shared-decision making model (e.g., the team will collaborate with service seekers to develop treatment plans).
  - If a particular service is not directly provided by the local team, advise the potential client that the team can help link potential clients with services in the community.

3. Evaluation for Admission.

The ORS conducts evaluations for admission in person with the potential client. Once the ORS gathers sufficient information to determine admissibility, the ORS discusses the potential client with a designated senior clinician or follows the protocol designed by the early intervention program for making final admission determinations. During the process, the ORS team member or the senior clinician may request additional information to facilitate admission determination (such as medical records or corroborative information from family members/primary supports).

Evaluation for admission interviews can take place at the specialty clinic or at another site mutually agreeable to the potential clients and the ORS. Regardless of the location, the evaluation for admission should take place in a private and quiet room where the potential client will feel comfortable answering personal questions. If the potential client is a minor, he or she should attend this meeting with a parent or guardian so that the parent or guardian can give written permission for the evaluation for admission; the evaluation, however, should be conducted without the parent or guardian present.

To minimize evaluation burden, the ORS team should make the evaluation as brief as possible, while obtaining key information to inform admission determination. Focus on the clinic admission criteria while listening to the potential client and establishing rapport. Determining a diagnosis and initiating treatment are not the goals of the evaluation. This evaluation should inform decisions on whether the specialty clinic services fit the potential client's needs. This activity should not be confused with an intake, although information obtained during this evaluation may be used at intake. There are three steps involved in the evaluation process: obtaining releases of information and family contact forms, the evaluation itself, and a determination for care.

Step 1: Obtaining the Release of Information and Family Contact Forms. Releases should be obtained as early as feasible, based on the clinical judgment of the ORS. Convey to the potential client that although it is not mandatory to provide consent to obtain previous records or speak to family members, it can be helpful in case the ORS are not able to fully clarify what was happening; in turn, this additional information will be helpful in determining whether the program will fit his or her needs.

Step 2: Evaluation Process. Admission determinations should occur within 24 hours from the time of evaluation. To reduce the burden on the potential client, the ORS should keep in mind that the purpose of the evaluation is not to make an *exact* diagnosis; rather, it is to obtain enough information to determine whether the individual meets all admission criteria for the program. The ORS should review the Referral Screening Form (See *Appendix 7*) along with available medical records prior to the evaluation, and focus on areas of uncertainty (i.e., confirming qualifying symptoms of psychosis and clarifying substance use and mood symptoms). Once the evaluation is complete, the ORS can complete the Evaluation Form (See *Appendix 8*).

Potential client evaluations for admission can be done using an evaluation form or a tool such as the Structured Clinical Interview for DSM (SCID). Given the challenges of determining the onset of psychotic symptoms as well as the differential diagnosis between affective and non-affective disorders with psychosis, a systematic approach such as using the SCID is highly recommended. The SCID can be modified to fit the diagnostic criteria for CSC programs. For example, the RAISE Connection program used the "SCID modified for RAISE Connection," or SCID-RV, which was developed by modifying the SCID-IV to include criteria from the Symptom Onset of Psychosis Scale. The SCID-RV establishes the presence of psychotic symptoms, date of onset, and whether the symptoms are attributable to drugs or medical conditions. The mood disorders module is included to identify when psychosis is due to a depression or manic episode meeting full affective syndrome criteria (as opposed to those with sub-threshold depressive symptoms). The SCID- RV has guidelines for determining the presence of psychosis (a rating of "3") that were adapted from the definition of psychosis in the Structured Interview for Prodromal Syndromes (SIPS rating scale).

Considerable training can be required to conduct a SCID interview, depending on the experience and skill set of the individual who is administering it. Review of the case examples of the differences between prodromal symptoms and criterion psychotic symptoms is helpful. Interviewers should observe several SCID interviews and then have a chance to practice while being observed. As the SCID has been modified for DSM-V and continues to be updated,

programs wishing to use the SCID should contact the American Psychiatric Association or Michael First, M.D., at Columbia University Medical Center (Mbf2@columbia.edu) for more information.

During the evaluation, frame events using a timeline. The timeline can be completed with the potential client and can be a useful tool in obtaining information about significant events. Examples of events to identify on a timeline include: Important life events (e.g., graduations, moving, jobs, etc.); previous treatment/hospitalizations; date of onset; course of substance use, if applicable; notable mood symptoms, if applicable.

The section below describes expected components of the admission evaluation and specifies the admission criteria used for the Connection Program. This list should be adapted to the admission criteria for a new specialty clinic.

a) History. Gain an understanding of the potential client's overall life history (i.e., school/work history, noting any gradual decline in functioning when applicable).

b) Previous hospitalizations and/or treatment for psychiatric symptoms or conditions. Note that some programs limit the total duration of exposure to antipsychotic medications as part of inclusion criteria. The evaluation process must be part of obtaining detailed information about previous treatment.

c) Symptoms of psychosis and related indicators. For each of the potential client's symptoms, investigate:

- The level of their symptom intensity (frequency),
- The impact on their behavior, and
- Whether the individual experiences a reduced awareness that their unusual perceptual experiences and/or delusions are symptoms: that is, they believe their delusions to be real despite the contrary.

Additionally, symptoms must have an impact on behavior and/or they must be intense enough that they occur at least intermittently or the client is preoccupied with them. Date of onset should be determined for each symptom. Symptoms to investigate include:

- Delusions of reference—belief that others are taking special notice of them or talking about him or her; belief that references to the person are being made on TV or in reading material.

- Persecutory delusions—belief that he or she is being attacked, harassed, persecuted, or conspired against.

- Grandiose delusions—belief that he or she possesses special powers, exaggerated importance (rich or famous), or relationship with a deity.

- Somatic beliefs—belief that his or her body is grossly distorted or that there has

been a change or disturbance in appearance or functioning.

- Other unusual delusions—for example, unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful (jealousy), or belief that he or she is in a relationship with someone famous.

- Mind control (insertion/withdrawal)—belief that thoughts and/or actions are under the control of an external force. Individual may complain of thoughts being placed into head and/or thoughts being taken out of their head.

- Thought broadcasting—belief that others can hear their thoughts or read their mind.

- Sensory experiences that are not shared by others (as above). Can include any sensory modality: auditory, visual, tactile, olfactory, and/or gustatory.

d) Substance use. Determine:

- Which substances are being used and the usual pattern of use.

- Whether alcohol, sedatives, hypnotics, and/or anxiolytics and the periods of significant increase or decrease coincide with onset of symptoms of psychosis.

- Qualifying symptoms of psychosis must be present in the absence of substance intoxication and/or withdrawal

e) Presence of mood symptoms (focus on temporal relationship between mood symptoms and onset of symptoms of psychosis)

- Major Depressive Episode—five or more of the following symptoms with impact on functioning for a period of 2 weeks or greater (1 or 2 must be present):

  1) Depressed mood most of the day, nearly every day
  2) Markedly diminished loss of interest in activities that are usually enjoyable
  3) Significant weight change (loss or gain)
  4) Insomnia nearly every day
  5) Increase in action or movement (psychomotor agitation) or decrease in action or movement (psychomotor retardation) nearly every day
  6) Fatigue or loss of energy
  7) Feelings of worthlessness or excessive guilt
  8) Diminished ability to concentrate or indecisiveness
  9) Suicidal ideation and/or suicidal attempt

- Mania—persistently expansive or irritable mood, plus three or more of the following symptoms with a distinct period (at least 1 week):

  1) Inflated self-esteem or grandiosity
  2) Decreased need for sleep
  3) Pressured speech
  4) Flight of ideas/racing thoughts
  5) Distractibility
  6) Increase in goal-directed activity or increase in action or movement (a.k.a. psychomotor agitation)
  7) Excessive engagement in pleasurable risk-taking behaviors

- Qualifying symptoms of psychosis must be present and primary with an absence of mood symptoms for at least 2 weeks.

f) General medical condition (exclusion criterion)

- Indicate any prominent symptoms of psychosis due to the direct physiological effects of a general medical condition, including neurological conditions (including traumatic brain injuries), endocrine conditions, metabolic conditions, autoimmune disorders with central nervous system involvement.

g) Duration of psychotic symptoms

- The rules for determining date of onset should be specified within the evaluation protocol. CSCs can establish their own rules regarding eligibility; the RAISE Connection Program required psychosis to be present for greater than one week and less than 2 years.

Step 3: Final Determination and Next Steps. Given the challenges of making accurate diagnoses of individuals who are early in psychosis, programs should have a supervisory strategy that takes staff experience and expertise into account. One possibility is that for the first 6 months of the program, the ORS reviews all cases, including those that appear more straightforward, with a senior clinician. When the senior clinician is satisfied that the ORS is making accurate determinations of straightforward cases, the senior clinician can empower the ORS to make independent decisions. At that point, the senior clinician should discuss and provide evidence for that judgment with program leadership. Alternatively, the senior clinician can also decide to review all cases with the ORS.

Admission determinations should be made as quickly as possible, ideally within 24 hours following the evaluation. If determining admissibility is delayed due to the need to obtain more information, communicate this appropriately to the potential client, family members, and providers. In extreme circumstances, reviewing an individual's evaluation may be delayed; however, this process should not extend beyond 1 week following evaluation.

If the potential client meets admission criteria, the ORS must inform the potential client, family

members, and any providers involved in care. At this time, the ORS should also be prepared to offer options for a clinical intake appointment and to facilitate introductions as appropriate.

If the potential client does not meet admission criteria, the ORS should inform the potential client, family members, and providers involved in care. When speaking with potential clients and family members convey that the program is not a good fit and that services attained elsewhere may be more appropriate. This conversation should be had with utmost sensitivity. Connections to other resources must be facilitated appropriately. See *Section IV.B.2: Redirecting Referrals.*

4. Intake and Admission

Notably, conducting an intake is not necessarily the responsibility of an ORS, unless the program assigns that role to the ORS. If the individual coming in for services has not already met the clinical team, the ORS should facilitate such introductions prior to the intake appointment. Additionally, the ORS must convey any information that may be helpful for the clinical team to know about the newly admitted individual (i.e., tips for engagement, special circumstances, any challenges that may have come up during the evaluation process). The ORS should also ensure that the clinical team has the following information:

- Evaluation Form
- Evaluation Narrative
- Relevant contact information for potential clients, family members/primary supports, and providers
- Any medical records obtained during evaluation

Case Narrative 8: Balancing Intake Workload

The Connection Program found that sometimes, several weeks would pass where no potential clients were ready for admission to the program. Other weeks, two to three individuals would require intake appointments. The rate of potential client admissions may need to be balanced based on potential client treatment needs and staff availability.

New FEP clients often require intensive services, and the team may be unable to receive multiple new consumers within the same week. The clinical team felt comfortable with one admission per week. Two admissions per week were a stretch, but they could be performed, especially if there were no admissions in the prior week.

The team found it helpful to orchestrate potential client admissions to manage the flow of clients into the clinic based on each potential client's needs. For example, a potential client being discharged from inpatient treatment to the program may take admission priority over potential clients coming from existing outpatient treatment. Individuals in existing outpatient treatment may be able to delay their admission by extending outpatient treatment.

In Maryland, the team offered a regular, weekly intake day to facilitate coordinating intake flow with the ORS. The ORS could then schedule admissible potential clients for admission as slots were available. The ORS could also work with the referrers and the potential clients to set realistic expectations about intake dates who were already in existing treatment.

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Appendix	Title	Content and Purpose
1	Person-Centered Language	Examples of person-centered, recovery-oriented language for use in ORS training.
2	Potential Client Brochure	Brief introduction about the Connection Program, describes what participation may entail and speaks to overall goals of the program.
3	Family Flyer	Brief introduction about the Connection Program, describes what participation may entail and speaks to overall goals of the program to family members.
4	Sample Potential Client Contact Form	A form completed by the potential client to initiate contact with the specialty clinic.
5	Flip Chart Sample	Provides information about what symptoms may appear, what is happening in the brain, why early engagement is important. Describes the early intervention program and its services.
6	Sample Screening and Redirecting Referral Diagram	An alternate sample diagram describing the process of determining whether or not an individual meets clinic admission criteria, and offering suggestions for external referral sources based on results.
7	Referral Screening Packet	A packet containing a cover sheet and the referral screening worksheet.
8	Evaluation Form	A form that documents the results of an evaluation for admission. Filed with the medical records.
9	Evaluation Narrative	A narrative to be written by the ORS and delivered to the team. Provides a summary of information collected during the prescreening and evaluation processes.
10	Resources List Template	A template for collecting information on local referral sources. Helpful for constructing alternate referral sources and emergency contacts for the ORS fielding incoming referrals.
11	Redirecting Referrals Diagram	A diagram of factors to consider when redirecting referrals, such as level of care, insurance, geographic location, available specialty clinics, and types of services required.
12	Establishing Outreach and Potential Client Tracking Systems	A document outlining system considerations, recommended data collection, and suggested reporting features for a Referral Network Outreach Tracking System and Service Seeker Tracking System.
13	Outreach Tracking Template	A template for a simple outreach tracking log.
14	Referral Tracking Template	A template for a simple potential client referral tracking log.

Item	Material	Content and Purpose
15	Commonly Used Substances	A list of illicit substances that can be reviewed with the service seeker when performing evaluations to determine whether substance use is concurrent with onset of symptoms of psychosis.
16	Psychosis Associated with General Medical Conditions	A list of medical conditions that may be associated with symptoms of psychosis that can be reviewed with the potential client when performing evaluations to assist in screening whether a general medical condition may have precipitated symptoms of psychosis.
17	Blast Letter to Providers (sample)	Sample blast email to providers to announce program services.
18	Brief for the Maryland Coalition of Families for Children's Mental Health Newsletter	Sample article for the Maryland Coalition newsletter.

Appendix 1. Person-Centered Language

The Glass Half Empty…The Glass Half Full	
Deficit-based Language	**Strengths-based, Recovery-oriented Alternative**
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following…
An addict/junkie	**A person diagnosed with an addiction that experiences the following…
Clinical Case Manager	Recovery Coach/Recovery Guide (*I'm not a case, and you're not my manager!*)
Front-line staff/in the trenches	Direct care/support staff providing compassionate care
Substance abuse/abuser	Person with an addiction to substances; substance use interferes with person's life
Suffering from	Working to recover from; experiencing; living with
Treatment Team	Recovery Team, Recovery Support System
LMHA Local Mental Health AUTHORITY	Recovery and Wellness Center
High-functioning vs. Low Functioning	Person's symptoms interfere with their relationship (e.g., work habits, etc.) in the following way…
Acting-out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups/mutual aid groups
Unrealistic	Person has high expectations for self and recovery
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis; does not agree that they have a mental illness pre-contemplative stage of recovery
Weaknesses	Barriers to change; needs
Unmotivated	Person is not interested in what the system has to offer; interests and motivating incentives unclear; preferred options not available

Deficit-based Language	**Strengths-based, Recovery-oriented Alternative**
Resistant	Not open to… Chooses not to…Has own ideas…
Clinical decompensation, relapse, failure	Person is re-experiencing symptoms of illness/addiction; an opportunity to develop and/or apply coping skills and to draw meaning from managing an adverse event: Re-occurrence
Maintaining clinical stability/abstinence	Promoting and sustaining recovery
Untreated alcoholics	People not yet in recovery; pre-contemplative/contemplative stage of recovery
Prevent suicide	Promote life
Puts self/recovery at risk	Takes chances to grow and experience new things
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; beginning to think for oneself
Minimize risk	Maximize growth
Consumer (in addictions community)	Person in recovery, person working on recovery
Patient (in mental health community)	Individual, consumer, person receiving services
Treatment works	Individual, consumer, person receiving services
Treatment system	Recovery Community
Discharged to aftercare	Connected to long-term recovery management
Enable	Empower the individual through empathy, emotional authenticity, and encouragement
Frequent Flyer	Takes advantage of services and supports as necessary
Dangerous	Specify behavior
Manipulative	Resourceful; really trying to get help
Entitled	Aware of one’s rights
DTO/DTS/GD	Describe behaviors that render one danger to self/others, etc.

Deficit-based Language	**Strengths-based, Recovery-oriented Alternative**
Baseline	What a person looks like when they are doing well
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
Grandiose	Has high hopes and expectations of self
User of the system	Resourceful; good self-advocate

Content of table derived from the following sources:
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HEALTH AND HUMAN SERVICES
Contract Number HHS001329300014
Attachment C CONTRACT AFFIRMATIONS

For purposes of these Contract Affirmations, HHS includes both the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). System Agency refers to HHSC, DSHS, or both, that will be a party to this Contract. These Contract Affirmations apply to all Contractors and Grantees (referred to as "Contractor") regardless of their business form (e.g., individual, partnership, corporation).

By entering into this Contract, Contractor affirms, without exception, understands, and agrees to comply with the following items through the life of the Contract:

1. Contractor represents and warrants that these Contract Affirmations apply to Contractor and all of Contractor's principals, officers, directors, shareholders, partners, owners, agents, employees, subcontractors, independent contractors, and any other representatives who may provide services under, who have a financial interest in, or otherwise are interested in this Contract and any related Solicitation.

2. Complete and Accurate Information

Contractor represents and warrants that all statements and information provided to HHS are current, complete, and accurate. This includes all statements and information in this Contract and any related Solicitation Response.

3. Public Information Act

Contractor understands that HHS will comply with the Texas Public Information Act (Chapter 552 of the Texas Government Code) as interpreted by judicial rulings and opinions of the Attorney General of the State of Texas. Information, documentation, and other material prepared and submitted in connection with this Contract or any related Solicitation may be subject to public disclosure pursuant to the Texas Public Information Act. In accordance with Section 2252.907 of the Texas Government Code, Contractor is required to make any information created or exchanged with the State pursuant to the Contract, and not otherwise excepted from disclosure under the Texas Public Information Act, available in a format that is accessible by the public at no additional charge to the State.

4. Contracting Information Requirements

Contractor represents and warrants that it will comply with the requirements of Section 552.372(a) of the Texas Government Code. Except as provided by Section 552.374(c) of the Texas Government Code, the requirements of Subchapter J (Additional Provisions Related to Contracting Information), Chapter 552 of the Government Code, may apply to the Contract and the Contractor agrees that the Contract can be terminated if the Contractor knowingly or intentionally fails to comply with a requirement of that subchapter.

5. Assignment

A. Contractor shall not assign its rights under the Contract or delegate the performance of its duties under the Contract without prior written approval from System Agency. Any attempted assignment in violation of this provision is void and without effect.

B. Contractor understands and agrees the System Agency may in one or more transactions assign, pledge, or transfer the Contract. Upon receipt of System Agency's notice of assignment, pledge, or transfer, Contractor shall cooperate with System Agency in giving effect to such assignment, pledge, or transfer, at no cost to System Agency or to the recipient entity.

6. Terms and Conditions

Contractor accepts the Solicitation terms and conditions unless specifically noted by exceptions advanced in the form and manner directed in the Solicitation, if any, under which this Contract was awarded. Contractor agrees that all exceptions to the Solicitation, as well as terms and conditions advanced by Contractor that differ in any manner from HHS' terms and conditions, if any, are rejected unless expressly accepted by System Agency in writing.

7. HHS Right to Use

Contractor agrees that HHS has the right to use, produce, and distribute copies of and to disclose to HHS employees, agents, and contractors and other governmental entities all or part of this Contract or any related Solicitation Response as HHS deems necessary to complete the procurement process or comply with state or federal laws.

8. Release from Liability

Contractor generally releases from liability and waives all claims against any party providing information about the Contractor at the request of System Agency.

9. Dealings with Public Servants

Contractor has not given, has not offered to give, and does not intend to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with this Contract or any related Solicitation, or related Solicitation Response.

10. Financial Participation Prohibited

Under Section 2155.004, Texas Government Code (relating to financial participation in preparing solicitations), Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

11. Prior Disaster Relief Contract Violation

Under Sections 2155.006 and 2261.053 of the Texas Government Code (relating to convictions and penalties regarding Hurricane Rita, Hurricane Katrina, and other disasters), the Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive this Contract

and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

12. Child Support Obligation

Under Section 231.006(d) of the Texas Family Code regarding child support, Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive the specified payment and acknowledges that the Contract may be terminated and payment may be withheld if this certification is inaccurate. If the certification is shown to be false, Contractor may be liable for additional costs and damages set out in 231.006(f).

13. Suspension and Debarment

Contractor certifies that it and its principals are not suspended or debarred from doing business with the state or federal government as listed on the *State of Texas Debarred Vendor List* maintained by the Texas Comptroller of Public Accounts and the *System for Award Management (SAM*) maintained by the General Services Administration. This certification is made pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376, and any relevant regulations promulgated by the Department or Agency funding this project. This provision shall be included in its entirety in Contractor's subcontracts, if any, if payment in whole or in part is from federal funds.

14. Excluded Parties

Contractor certifies that it is not listed in the prohibited vendors list authorized by Executive Order 13224, *"Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism,"* published by the United States Department of the Treasury, Office of Foreign Assets Control.'

15. Foreign Terrorist Organizations

Contractor represents and warrants that it is not engaged in business with Iran, Sudan, or a foreign terrorist organization, as prohibited by Section 2252.152 of the Texas Government Code.

16. Executive Head of a State Agency

In accordance with Section 669.003 of the Texas Government Code, relating to contracting with the executive head of a state agency, Contractor certifies that it is not (1) the executive head of an HHS agency, (2) a person who at any time during the four years before the date of this Contract was the executive head of an HHS agency, or (3) a person who employs a current or former executive head of an HHS agency.

17. Human Trafficking Prohibition

Under Section 2155.0061 of the Texas Government Code, Contractor certifies that the individual or business entity named in this Contract is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

18. Franchise Tax Status

Contractor represents and warrants that it is not currently delinquent in the payment of any franchise taxes owed the State of Texas under Chapter 171 of the Texas Tax Code.

19. Debts and Delinquencies

Contractor agrees that any payments due under this Contract shall be applied towards any debt or delinquency that is owed to the State of Texas.

20. Lobbying Prohibition

Contractor represents and warrants that payments to Contractor and Contractor's receipt of appropriated or other funds under this Contract or any related Solicitation are not prohibited by Sections 556.005, 556.0055, or 556.008 of the Texas Government Code (relating to use of appropriated money or state funds to employ or pay lobbyists, lobbying expenses, or influence legislation).

21. Buy Texas

Contractor agrees to comply with Section 2155.4441 of the Texas Government Code, requiring the purchase of products and materials produced in the State of Texas in performing service contracts.

22. Disaster Recovery Plan

Contractor agrees that upon request of System Agency, Contractor shall provide copies of its most recent business continuity and disaster recovery plans.

23. Computer Equipment Recycling Program

If this Contract is for the purchase or lease of computer equipment, then Contractor certifies that it is in compliance with Subchapter Y, Chapter 361 of the Texas Health and Safety Code related to the Computer Equipment Recycling Program and the Texas Commission on Environmental Quality rules in 30 TAC Chapter 328.

24. Television Equipment Recycling Program

If this Contract is for the purchase or lease of covered television equipment, then Contractor certifies that it is compliance with Subchapter Z, Chapter 361 of the Texas Health and Safety Code related to the Television Equipment Recycling Program.

25. Cybersecurity Training

A. Contractor represents and warrants that it will comply with the requirements of Section 2054.5192 of the Texas Government Code relating to cybersecurity training and required verification of completion of the training program.

B. Contractor represents and warrants that if Contractor or Subcontractors, officers, or employees of Contractor have access to any state computer system or database, the Contractor, Subcontractors, officers, and employees of Contractor shall complete cybersecurity training pursuant to and in accordance with Government Code, Section 2054.5192.

26. Restricted Employment for Certain State Personnel

Contractor acknowledges that, pursuant to Section 572.069 of the Texas Government Code, a former state officer or employee of a state agency who during the period of state service or employment participated on behalf of a state agency in a procurement or contract negotiation involving Contractor may not accept employment from Contractor before the second anniversary of the date the Contract is signed or the procurement is terminated or withdrawn.

27. No Conflicts of Interest

A. Contractor represents and warrants that it has no actual or potential conflicts of interest in providing the requested goods or services to System Agency under this Contract or any related Solicitation and that Contractor's provision of the requested goods and/or services under this Contract and any related Solicitation will not constitute an actual or potential conflict of interest or reasonably create an appearance of impropriety.

B. Contractor agrees that, if after execution of the Contract, Contractor discovers or is made aware of a Conflict of Interest, Contractor will immediately and fully disclose such interest in writing to System Agency. In addition, Contractor will promptly and fully disclose any relationship that might be perceived or represented as a conflict after its discovery by Contractor or by System Agency as a potential conflict. System Agency reserves the right to make a final determination regarding the existence of Conflicts of Interest, and Contractor agrees to abide by System Agency's decision.

28. Fraud, Waste, and Abuse

Contractor understands that HHS does not tolerate any type of fraud, waste, or abuse. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. Pursuant to Texas Government Code, Section 321.022, if the administrative head of a department or entity that is subject to audit by the state auditor has reasonable cause to believe that money received from the state by the department or entity or by a client or contractor of the department or entity may have been lost, misappropriated, or misused, or that other fraudulent or unlawful conduct has occurred in relation to the operation of the department or entity, the administrative head shall report the reason and basis for the belief to the Texas State Auditor's Office (SAO). All employees or contractors who have reasonable cause to believe that fraud, waste, or abuse has occurred (including misconduct by any HHS employee, Grantee officer, agent, employee, or subcontractor that would constitute fraud, waste, or abuse) are required to immediately report the questioned activity to the Health and Human Services Commission's Office of Inspector General. Contractor agrees to comply with all applicable laws, rules, regulations, and System Agency policies regarding fraud, waste, and abuse including, but not limited to, HHS Circular C-027.

A report to the SAO must be made through one of the following avenues:

- SAO Toll Free Hotline: 1-800-TX-AUDIT
- SAO website: http://sao.fraud.state.tx.us/

All reports made to the OIG must be made through one of the following avenues:

- OIG Toll Free Hotline 1-800-436-6184
- OIG Website: ReportTexasFraud.com
- Internal Affairs Email: InternalAffairsReferral@hhsc.state.tx.us
- OIG Hotline Email: OIGFraudHotline@hhsc.state.tx.us.
- OIG Mailing Address: Office of Inspector General
  Attn: Fraud Hotline
  MC 1300
  P.O. Box 85200
  Austin, Texas 78708-5200

29. Antitrust

The undersigned affirms under penalty of perjury of the laws of the State of Texas that:

A. in connection with this Contract and any related Solicitation Response, neither I nor any representative of the Contractor has violated any provision of the Texas Free Enterprise and Antitrust Act, Tex. Bus. & Comm. Code Chapter 15;

B. in connection with this Contract and any related Solicitation Response, neither I nor any representative of the Contractor has violated any federal antitrust law; and

C. neither I nor any representative of the Contractor has directly or indirectly communicated any of the contents of this Contract and any related Solicitation Response to a competitor of the Contractor or any other company, corporation, firm, partnership or individual engaged in the same line of business as the Contractor.

30. Legal and Regulatory Actions

Contractor represents and warrants that it is not aware of and has received no notice of any court or governmental agency proceeding, investigation, or other action pending or threatened against Contractor or any of the individuals or entities included in numbered paragraph 1 of these Contract Affirmations within the five (5) calendar years immediately preceding execution of this Contract or the submission of any related Solicitation Response that would or could impair Contractor's performance under this Contract, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into this Contract. If Contractor is unable to make the preceding representation and warranty, then Contractor instead represents and warrants that it has provided to System Agency a complete, detailed disclosure of any such court or governmental agency proceeding, investigation, or other action that would or could impair Contractor's performance under this Contract, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into this Contract. In addition, Contractor acknowledges this is a continuing disclosure requirement. Contractor represents and warrants that Contractor shall notify System Agency in writing within five (5) business days of any changes to the representations or warranties in this clause and understands that failure to so timely update System Agency shall constitute breach of contract and may result in immediate contract termination.

31. No Felony Criminal Convictions

Contractor represents that neither Contractor nor any of its employees, agents, or representatives, including any subcontractors and employees, agents, or representative of such subcontractors, have been convicted of a felony criminal offense or that if such a conviction has occurred Contractor has fully advised System Agency in writing of the facts and circumstances surrounding the convictions.

32. Unfair Business Practices

Contractor represents and warrants that it has not been the subject of allegations of Deceptive Trade Practices violations under Chapter 17 of the Texas Business and Commerce Code, or allegations of any unfair business practice in any administrative hearing or court suit and that Contractor has not been found to be liable for such practices in such proceedings. Contractor certifies that it has no officers who have served as officers of other entities who have been the subject of allegations of Deceptive Trade Practices violations or allegations of any unfair business practices in an administrative hearing or court suit and that such officers have not been found to be liable for such practices in such proceedings**.**

33. Entities that Boycott Israel

Contractor represents and warrants that (1) it does not, and shall not for the duration of the Contract, boycott Israel or (2) the verification required by Section 2271.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

34. E-Verify

Contractor certifies that for contracts for services, Contractor shall utilize the U.S. Department of Homeland Security's E-Verify system during the term of this Contract to determine the eligibility of:

1. all persons employed by Contractor to perform duties within Texas; and
2. all persons, including subcontractors, assigned by Contractor to perform work pursuant to this Contract within the United States of America.

35. Former Agency Employees – Certain Contracts

If this Contract is an employment contract, a professional services contract under Chapter 2254 of the Texas Government Code, or a consulting services contract under Chapter 2254 of the Texas Government Code, in accordance with Section 2252.901 of the Texas Government Code, Contractor represents and warrants that neither Contractor nor any of Contractor's employees including, but not limited to, those authorized to provide services under the Contract, were former employees of an HHS Agency during the twelve (12) month period immediately prior to the date of the execution of the Contract.

36. Disclosure of Prior State Employment – Consulting Services

If this Contract is for consulting services,

A. In accordance with Section 2254.033 of the Texas Government Code, a Contractor providing consulting services who has been employed by, or employs an individual who has been employed by, System Agency or another State of Texas agency at any time during the two years preceding the submission of Contractor's offer to provide services must disclose the following information in its offer to provide services. Contractor hereby certifies that this information was provided and remains true, correct, and complete:

1. Name of individual(s) (Contractor or employee(s));
2. Status;
3. The nature of the previous employment with HHSC or the other State of Texas agency;
4. The date the employment was terminated and the reason for the termination; and
5. The annual rate of compensation for the employment at the time of its termination.

B. If no information was provided in response to Section A above, Contractor certifies that neither Contractor nor any individual employed by Contractor was employed by System Agency or any other State of Texas agency at any time during the two years preceding the submission of Contractor's offer to provide services.

37. Abortion Funding Limitation

Contractor understands, acknowledges, and agrees that, pursuant to Article IX of the General Appropriations Act (the Act), to the extent allowed by federal and state law, money appropriated by the Texas Legislature may not be distributed to any individual or entity that, during the period for which funds are appropriated under the Act:

1. performs an abortion procedure that is not reimbursable under the state's Medicaid program;
2. is commonly owned, managed, or controlled by an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program; or
3. is a franchise or affiliate of an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program.

The provision does not apply to a hospital licensed under Chapter 241, Health and Safety Code, or an office exempt under Section 245.004(2), Health and Safety Code. Contractor represents and warrants that it is not ineligible, nor will it be ineligible during the term of this Contract, to receive appropriated funding pursuant to Article IX.

38. Funding Eligibility

Contractor understands, acknowledges, and agrees that, pursuant to Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code, except as exempted under that Chapter, HHSC cannot contract with an abortion provider or an affiliate of an abortion provider. Contractor certifies that it is not ineligible to contract with HHSC under the terms of Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code.

39. Prohibition on Certain Telecommunications and Video Surveillance Services or Equipment (2 CFR 200.216)

Contractor certifies that the individual or business entity named in this Response or Contract is not ineligible to receive the specified Contract or funding pursuant to 2 CFR 200.216.

40. COVID-19 Vaccine Passports

Pursuant to Texas Health and Safety Code, Section 161.0085(c), Contractor certifies that it does not require its customers to provide any documentation certifying the customer's COVID-19 vaccination or post-transmission recovery on entry to, to gain access to, or to receive service from the Contractor's business. Contractor acknowledges that such a vaccine or recovery requirement would make Contractor ineligible for a state-funded contract.

41. Entities that Boycott Energy Companies

In accordance with Senate Bill 13, Acts 2021, 87th Leg., R.S., pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies boycotting certain energy companies), Contractor represents and warrants that: (1) it does not, and will not for the duration of the Contract, boycott energy companies or (2) the verification required by Section 2274.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

42. Entities that Discriminate Against Firearm and Ammunition Industries

In accordance with Senate Bill 19, Acts 2021, 87th Leg., R.S., pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies that discriminate against firearm and ammunition industries), Contractor verifies that: (1) it does not, and will not for the duration of the Contract, have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association or (2) the verification required by Section 2274.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

43. Security Controls for State Agency Data

In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.138, Contractor understands, acknowledges, and agrees that if, pursuant to this Contract, Contractor is or will be authorized to access, transmit, use, or store data for System Agency, Contractor is required to meet the security controls the System Agency determines are proportionate with System Agency's risk under the Contract based on the sensitivity of System Agency's data and that Contractor must periodically provide to System Agency evidence that Contractor meets the security controls required under the Contract.

44. Cloud Computing State Risk and Authorization Management Program (TX-RAMP)

In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.0593, Contractor acknowledges and agrees that, if providing cloud computing services for System Agency, Contractor must comply with the requirements of the state risk and authorization management program and that System Agency may not enter or renew a contract with Contractor to purchase cloud computing services for the agency that are subject to the state risk and authorization management program unless Contractor demonstrates compliance with program requirements. If providing cloud computing services for System Agency that are subject to the state risk and authorization management program, Contractor certifies it will maintain program compliance and certification throughout the term of the Contract.

45. Office of Inspector General Investigative Findings Expert Review

In accordance with Senate Bill 799, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 531.102(m-1)(2) is applicable to this Contract, Contractor affirms that it possesses the necessary occupational licenses and experience.

46. Contract for Professional Services of Physicians, Optometrists, and Registered Nurses

In accordance with Senate Bill 799, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 2254.008(a)(2) is applicable to this Contract, Contractor affirms that it possesses the necessary occupational licenses and experience.

47. Foreign-Owned Companies in Connection with Critical Infrastructure

If Texas Government Code, Section 2274.0102(a)(1) (relating to prohibition on contracts with certain foreign-owned companies in connection with critical infrastructure) is applicable to this Contract, pursuant to Government Code Section 2274.0102, Contractor certifies that neither it nor its parent company, nor any affiliate of Contractor or its parent company, is: (1) majority owned or controlled by citizens or governmental entities of China, Iran, North Korea, Russia, or any other country designated by the Governor under Government Code Section 2274.0103, or (2) headquartered in any of those countries.

48. Critical Infrastructure Subcontracts

For purposes of this Paragraph, the designated countries are China, Iran, North Korea, Russia, and any countries lawfully designated by the Governor as a threat to critical infrastructure. Pursuant to Section 113.002 of the Business and Commerce Code, Contractor shall not enter into a subcontract that will provide direct or remote access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business and Commerce Code, in this state, other than access specifically allowed for product warranty and support purposes to any subcontractor unless (i) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is majority owned or controlled by citizens or governmental entities of a designated country; and (ii) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is headquartered in a designated country. Contractor will notify the System Agency before entering into any subcontract that will provide direct or remote

access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business & Commerce Code, in this state.

49. Enforcement of Certain Federal Firearms Laws Prohibited

In accordance with House Bill 957, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 2.101 is applicable to Contractor, Contractor certifies that it is not ineligible to receive state grant funds pursuant to Texas Government Code, Section 2.103.

50. Prohibition on Abortions

Contractor understands, acknowledges, and agrees that, pursuant to Article II of the General Appropriations Act, (1) no funds shall be used to pay the direct or indirect costs (including marketing, overhead, rent, phones, and utilities) of abortion procedures provided by contractors of HHSC; and (2) no funds appropriated for Medicaid Family Planning, Healthy Texas Women Program, or the Family Planning Program shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures. Contractor represents and warrants that it is not ineligible, nor will it be ineligible during the term of this Contract, to receive appropriated funding pursuant to Article II.

51. False Representation

Contractor understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Contractor is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of this Contract.

52. False Statements

Contractor represents and warrants that all statements and information prepared and submitted by Contractor in this Contract and any related Solicitation Response are current, complete, true, and accurate. Contractor acknowledges any false statement or material misrepresentation made by Contractor during the performance of this Contract or any related Solicitation is a material breach of contract and may void this Contract. Further, Contractor understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Contractor is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of this Contract.

53. Permits and License

Contractor represents and warrants that it will comply with all applicable laws and maintain all permits and licenses required by applicable city, county, state, and federal rules, regulations, statutes, codes, and other laws that pertain to this Contract.

54. Equal Employment Opportunity

Contractor represents and warrants its compliance with all applicable duly enacted state and federal laws governing equal employment opportunities.

55. Federal Occupational Safety and Health Law

Contractor represents and warrants that all articles and services shall meet or exceed the safety standards established and promulgated under the Federal Occupational Safety and Health Act of 1970, as amended (29 U.S.C. Chapter 15).

56. Signature Authority

Contractor represents and warrants that the individual signing this Contract Affirmations document is authorized to sign on behalf of Contractor and to bind the Contractor.

Signature Page Follows

Authorized representative on behalf of Contractor must complete and sign the following:

My Health My Resources of Tarrant County

Legal Name of Contractor

MHMR of Tarrant County

Assumed Business Name of Contractor, if applicable (d/b/a or 'doing business as')

Texas County(s) for Assumed Business Name (d/b/a or 'doing business as')
Attach Assumed Name Certificate(s) filed with the Texas Secretary of State and Assumed Name Certificate(s), if any, for each Texas County Where Assumed Name Certificate(s) has been filed.

DocuSigned by:
Susan Garnett
A5786F7A2A0E45B...

Signature of Authorized Representative

September 8, 2023

Date Signed

Susan Garnett

Printed Name of Authorized Representative First, Middle Name or Initial, and Last Name

CEO

Title of Authorized Representative

3840 Hulen St

Physical Street Address

Fort Worth, TX 76107

City, State, Zip Code

Mailing Address, if different

City, State, Zip Code

817-569-4300

Phone Number

Fax Number

ceo@mhmrtc.org

02-033-3597

Email Address

DUNS Number

susan.garnett@mhmrtc.org

1757129456

Federal Employer Identification Number

Texas Identification Number (TIN)

30119759329

751249456

Texas Franchise Tax Number

Texas Secretary of State Filing Number

LJ9ENHUAKHV3

SAM.gov Unique Entity Identifier (UEI)

Attachment D

TEXAS
Health and Human Services

Health and Human Services (HHS)

Uniform Terms and Conditions - Grant

Version 3.2

Published and Effective – July 2022

Responsible Office: Chief Counsel

ABOUT THIS DOCUMENT

In this document, Grantees (also referred to in this document as subrecipients or contractors) will find requirements and conditions applicable to grant funds administered and passed-through by both the Texas Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). These requirements and conditions are incorporated into the Grant Agreement through acceptance by Grantee of any funding award by HHSC or DSHS.

The terms and conditions in this document are in addition to all requirements listed in the RFA, if any, under which applications for this grant award are accepted, as well as all applicable federal and state laws and regulations. Applicable federal and state laws and regulations may include, but are not limited to: 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards; requirements of the entity that awarded the funds to HHS; Chapter 783 of the Texas Government Code; Texas Comptroller of Public Accounts' agency rules (including Uniform Grant and Contract Standards set forth in Title 34, Part 1, Chapter 20, Subchapter E, Division 4 of the Texas Administrative Code); the Texas Grant Management Standards (TxGMS) developed by the Texas Comptroller of Public Accounts; and the Funding Announcement, Solicitation, or other instrument/documentation under which HHS was awarded funds. HHS, in its sole discretion, reserves the right to add requirements, terms, or conditions.

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ARTICLE I. DEFINITIONS AND INTERPRETIVE PROVISIONS

1.1 DEFINITIONS

As used in this Grant Agreement, unless a different definition is specified, or the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Amendment" means a written agreement, signed by the Parties, which documents changes to the Grant Agreement.

"Contract" or "Grant Agreement" means the agreement entered into by the Parties, including the Signature Document, these Uniform Terms and Conditions, along with any attachments and amendments that may be issued by the System Agency.

"Deliverables" means the goods, services, and work product, including all reports and project documentation, required to be provided by Grantee to the System Agency.

"DSHS" means the Department of State Health Services.

"Effective Date" means the date on which the Grant Agreement takes effect.

"Federal Fiscal Year" means the period beginning October 1 and ending September 30 each year, which is the annual accounting period for the United States government.

"GAAP" means Generally Accepted Accounting Principles.

"GASB" means the Governmental Accounting Standards Board.

"Grantee" means the Party receiving funds under this Grant Agreement. May also be referred to as "subrecipient" or "contractor" in this document.

"HHSC" means the Texas Health and Human Services Commission.

"Health and Human Services" or "HHS" includes HHSC and DSHS.

"Intellectual Property Rights" means the worldwide proprietary rights or interests, including patent, copyright, trade secret, and trademark rights, as such right may be evidenced by or embodied in:

i. any idea, design, concept, personality right, method, process, technique, apparatus, invention, discovery, or improvement;
ii. any work of authorship, including any compilation, computer code, website or web page design, literary work, pictorial work, or graphic work;
iii. any trademark, service mark, trade dress, trade name, branding, or other indicia of source or origin;
iv. domain name registrations; and
v. any other proprietary or similar rights. The Intellectual Property Rights of a Party include all worldwide proprietary rights or interests that the Party may have acquired by assignment, by exclusive license, or by license with the right to grant sublicenses.

"Parties" means the System Agency and Grantee, collectively.

"Party" means either the System Agency or Grantee, individually.

"Project" means specific activities of the Grantee that are supported by funds provided under this Grant Agreement.

"Signature Document" means the document executed by all Parties for this Grant Agreement.

"Solicitation," "Funding Announcement" or "Request for Applications (RFA)" means the document (including all exhibits, attachments, and published addenda), issued by the System Agency under which applications for grant funds were requested, which is incorporated by reference in the Grant Agreement for all purposes in its entirety.

"Solicitation Response" or "Application" means Grantee's full and complete Solicitation response (including any attachments and addenda), which is incorporated by reference in the Grant Agreement for all purposes in its entirety.

"State Fiscal Year" means the period beginning September 1 and ending August 31 each year, which is the annual accounting period for the State of Texas.

"State of Texas *Textravel*" means the Texas Comptroller of Public Accounts' state travel rules, policies, and guidelines.

"Statement of Work" means the description of activities Grantee must perform to complete the Project, as specified in the Grant Agreement and as may be amended.

"System Agency" means HHSC or DSHS, as applicable.

"Work Product" means any and all works, including work papers, notes, materials, approaches, designs, specifications, systems, innovations, improvements, inventions, software, programs, source code, documentation, training materials, audio or audiovisual recordings, methodologies, concepts, studies, reports, whether finished or unfinished, and whether or not included in the deliverables, that are developed, produced, generated or provided by Grantee in connection with Grantee's performance of its duties under the Grant Agreement or through use of any funding provided under this Grant Agreement.

"Texas Grant Management Standards" or "TxGMS" means uniform grant and contract administration procedures, developed under the authority of Chapter 783 of the Texas Government Code, to promote the efficient use of public funds in local government and in programs requiring cooperation among local, state, and federal agencies. Under this Grant Agreement, TxGMS applies to Grantee except as otherwise provided by applicable law or directed by System Agency. Additionally, except as otherwise provided by applicable law, in the event of a conflict between TxGMS and applicable federal or state law, federal law prevails over state law and state law prevails over TxGMS.

1.2 INTERPRETIVE PROVISIONS

A. The meanings of defined terms include the singular and plural forms.
B. The words "hereof," "herein," "hereunder," and similar words refer to this Grant Agreement as a whole and not to any particular provision, section, attachment, or schedule of this Grant Agreement unless otherwise specified.
C. The term "including" is not limiting and means "including without limitation" and, unless otherwise expressly provided in this Grant Agreement, (i) references to contracts

(including this Grant Agreement) and other contractual instruments shall be deemed to include all subsequent Amendments and other modifications, but only to the extent that such Amendments and other modifications are not prohibited by the terms of this Grant Agreement, and (ii) references to any statute or regulation are to be construed as including all statutory and regulatory provisions consolidating, amending, replacing, supplementing, or interpreting the statute or regulation.

D. Any references to agreements, contracts, statutes, or administrative rules or regulations in the Grant Agreement are references to these documents as amended, modified, or supplemented during the term of the Grant Agreement.
E. The captions and headings of this Grant Agreement are for convenience of reference only and do not affect the interpretation of this Grant Agreement.
F. All attachments, including those incorporated by reference, and any Amendments are considered part of the terms of this Grant Agreement.
G. This Grant Agreement may use several different limitations, regulations, or policies to regulate the same or similar matters. All such limitations, regulations, and policies are cumulative.
H. Unless otherwise expressly provided, reference to any action of the System Agency or by the System Agency by way of consent, approval, or waiver will be deemed modified by the phrase "in its sole discretion."
I. Time is of the essence in this Grant Agreement.
J. Prior to execution of the Grant Agreement, Grantee must notify System Agency's designated contact in writing of any ambiguity, conflict, discrepancy, omission, or other error. If Grantee fails to notify the System Agency designated contact of any ambiguity, conflict, discrepancy, omission or other error in the Grant Agreement prior to Grantee's execution of the Grant Agreement, Grantee:
    i. Shall have waived any claim of error or ambiguity in the Grant Agreement; and
    ii. Shall not contest the interpretation by the System Agency of such provision(s).

No grantee will be entitled to additional reimbursement, relief, or time by reason of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error or its later correction.

ARTICLE II. PAYMENT PROVISIONS

2.1 Prompt Payment

Payment shall be made in accordance with Chapter 2251 of the Texas Government Code, commonly known as the Texas Prompt Payment Act. Chapter 2251 of the Texas Government Code shall govern remittance of payment and remedies for late payment and non-payment.

2.2 Taxes

Grantee represents and warrants that it shall pay all taxes or similar amounts resulting from the Grant Agreement, including, but not limited to, any federal, State, or local income, sales or excise taxes of Grantee or its employees. System Agency shall not be liable for any taxes resulting from the Grant Agreement.

2.3 Ancillary and Travel Expenses

A. Except as otherwise provided in the Grant Agreement, no ancillary expenses incurred by the Grantee in connection with its provision of the services or deliverables will be reimbursed by the System Agency. Ancillary expenses include, but are not limited to, costs associated with transportation, delivery, and insurance for each deliverable.

B. Except as otherwise provided in the Grant Agreement, when the reimbursement of travel expenses is authorized by the Grant Agreement, all such expenses will be reimbursed in accordance with the rates set by the Texas Comptroller's *Textravel* guidelines, which can currently be accessed at: https://fmx.cpa.texas.gov/fmx/travel/textravel/.

2.4 Billing

Unless otherwise provided in the Grant Agreement, Grantee shall bill the System Agency in accordance with the Grant Agreement. Unless otherwise specified in the Grant Agreement, Grantee shall submit requests for reimbursement or payment monthly by the last business day of the month following the month in which expenses were incurred or services provided. Grantee shall maintain all documentation that substantiates invoices and make the documentation available to the System Agency upon request.

2.5 Use of Funds

Grantee shall expend funds under this Grant Agreement only for approved services and for reasonable and allowable expenses directly related to those services.

2.6 Use for Match Prohibited

Grantee shall not use funds provided under this Grant Agreement for matching purposes in securing other funding without the written approval of the System Agency.

2.7 Program Income

Program income refers to gross income directly generated by a supporting activity during the period of performance. Unless otherwise required under the Grant Agreement, Grantee shall use Program Income, as provided in TxGMS, to further the Project, and Grantee shall spend the Program Income on the Project. Grantee shall identify and report Program Income in accordance with the Grant Agreement, applicable law, and any programmatic guidance. Grantee shall expend Program Income during the Grant Agreement term, when earned, and may not carry Program Income forward to any succeeding term. Grantee shall refund Program Income to the System Agency if the Program Income is not expended in the term in which it is earned. The System Agency may base future funding levels, in part, upon Grantee's proficiency in identifying, billing, collecting, and reporting Program Income, and in using Program Income for the purposes and under the conditions specified in this Grant Agreement.

2.8 Nonsupplanting

Grant funds must be used to supplement existing, new or corresponding programming and related activities. Grant funds may not be used to supplant (replace) existing funds that have been appropriated, allocated, or disbursed for the same purpose. System Agency may conduct Grant monitoring or audits may be conducted to review, among other things, Grantee's compliance with this provision.

2.9 Indirect Cost Rates

The System Agency may acknowledge an indirect cost rate for Grantees that is utilized for all applicable Grant Agreements. For subrecipients receiving federal funds, indirect cost rates will be determined in accordance with applicable law including, but not limited to, 2 CFR 200.414(f). For recipients receiving state funds, indirect costs will be determined in accordance with applicable law including, but not limited to, TxGMS. Grantees funded with blended federal and state funding will be subject to both state and federal requirements when determining indirect costs. In the event of a conflict between TxGMS and applicable federal law or regulation, the provisions of federal law or regulation will apply. Grantee will provide any necessary financial documents to determine the indirect cost rate in accordance with the Uniform Grant Guidance (UGG) and TxGMS.

ARTICLE III. STATE AND FEDERAL FUNDING

3.1 Excess Obligations Prohibited

This Grant Agreement is subject to termination or cancellation, without penalty to System Agency, either in whole or in part, subject to the availability and actual receipt by System Agency of state or federal funds. System Agency is a state agency whose authority and appropriations are subject to actions of the Texas Legislature. If System Agency becomes subject to a legislative change, revocation of statutory authority, or lack of appropriated funds that would render either System Agency's or Grantee's delivery or performance under the Grant Agreement impossible or unnecessary, the Grant Agreement will be terminated or cancelled and be deemed null and void. In the event of a termination or cancellation under this Section, System Agency will not be liable to Grantee for any damages that are caused or associated with such termination or cancellation, and System Agency will not be required to give prior notice. Additionally, System Agency will not be liable to Grantee for any remaining unpaid funds under this Grant Agreement at time of termination.

3.2 No Debt Against the State

This Grant Agreement will not be construed as creating any debt by or on behalf of the State of Texas.

3.3 Debts and Delinquencies

Grantee agrees that any payments due under the Grant Agreement shall be directly applied towards eliminating any debt or delinquency it has to the State of Texas including, but not limited to, delinquent taxes, delinquent student loan payments, and delinquent child support during the entirety of the Grant Agreement term.

3.4 Refunds and Overpayments

A. At its sole discretion, the System Agency may (i) withhold all or part of any payments to Grantee to offset overpayments, unallowable or ineligible costs made to the Grantee, or if any required financial status report(s) is not submitted by the due date(s); or (ii) require Grantee to promptly refund or credit - within thirty (30) calendar days of written notice – to System Agency any funds erroneously paid by System Agency which are not expressly authorized under the Grant Agreement.

B. "Overpayments" as used in this Section include payments (i) made by the System Agency that exceed the maximum allowable rates; (ii) that are not allowed under applicable laws, rules, or regulations; or (iii) that are otherwise inconsistent with this Grant Agreement, including any unapproved expenditures. Grantee understands and agrees that it shall be liable to the System Agency for any costs disallowed pursuant to financial and compliance audit(s) of funds received under this Grant Agreement. Grantee further understands and agrees that reimbursement of such disallowed costs shall be paid by Grantee from funds which were not provided or otherwise made available to Grantee under this Grant Agreement.

ARTICLE IV. ALLOWABLE COSTS AND AUDIT REQUIREMENTS

4.1 Allowable Costs

A. Allowable Costs are restricted to costs that are authorized under Texas Uniform Grant Management Standards (TxGMS) and applicable state and federal rules and laws. This Grant Agreement is subject to all applicable requirements of TxGMS, including the criteria for Allowable Costs. Additional federal requirements apply if this Grant Agreement is funded, in whole or in part, with federal funds.

B. System Agency will reimburse Grantee for actual, allowable, and allocable costs incurred by Grantee in performing the Project, provided the costs are sufficiently documented. Grantee must have incurred a cost prior to claiming reimbursement and within the applicable term to be eligible for reimbursement under this Grant Agreement. At its sole discretion, the System Agency will determine whether costs submitted by Grantee are allowable and eligible for reimbursement. The System Agency may take repayment (recoup) from remaining funds available under this Grant Agreement in amounts necessary to fulfill Grantee's repayment obligations. Grantee and all payments received by Grantee under this Grant Agreement are subject to applicable cost principles, audit requirements, and administrative requirements including applicable provisions under 2 CFR 200, 48 CFR Part 31, and TxGMS.

C. OMB Circulars will be applied with the modifications prescribed by TxGMS with effect given to whichever provision imposes the more stringent requirement in the event of a conflict.

4.2 Audits and Financial Statements

A. Audits

i. Grantee understands and agrees that Grantee is subject to any and all applicable audit requirements found in state or federal law or regulation or added by this Grant Agreement

ii. HHS Single Audit Unit will notify Grantee to complete the Single Audit Determination Form. If Grantee fails to complete the form within thirty (30) calendar days after receipt of notice, Grantee maybe subject to sanctions and remedies for non-compliance.

iii. If Grantee, within Grantee's fiscal year, expends at least SEVEN HUNDRED FIFTY THOUSAND DOLLARS ($750,000) in federal funds awarded, Grantee shall have a single audit or program-specific audit in accordance with 2 CFR 200. The federal

threshold amount includes federal funds passed through by way of state agency awards.

iv. If Grantee, within Grantee's fiscal year, expends at least SEVEN HUNDRED FIFTY THOUSAND DOLLARS ($750,000) in state funds awarded, Grantee shall have a single audit or program-specific audit in accordance with TxGMS. The audit must be conducted by an independent certified public accountant and in accordance with 2 CFR 200, Government Auditing Standards, and TxGMS.

v. For-profit Grantees whose expenditures meet or exceed the federal or state expenditure thresholds stated above shall follow the guidelines in 2 CFR 200 or TxGMS, as applicable, for their program-specific audits.

vi. Each Grantee required to obtain a single audit must competitively re-procure single audit services once every six years. Grantee shall procure audit services in compliance with this section, state procurement procedures, as well as with applicable provisions of 2 CFR 200 and TxGMS.

B. Financial Statements.

Each Grantee that does not meet the expenditure threshold for a single audit or program-specific audit, must provide financial statements for the audit period.

4.3 Submission of Audits and Financial Statements

A. Audits.

Due the earlier of 30 days after receipt of the independent certified public accountant's report or nine months after the end of the fiscal year, Grantee shall submit one electronic copy of the single audit or program-specific audit to the System Agency via:

i. HHS portal at https://hhsportal.hhs.state.tx.us/heartwebextr/hhscSau or,

ii. Email to: single_audit_report@hhsc.state.tx.us.

B. Financial Statements.

Due no later than nine months after the Grantee's fiscal year-end, Grantees not required to submit an audit, shall submit one electronic copy of their financial statements via:

i. HHS portal at https://hhsportal.hhs.state.tx.us/heartwebextr/hhscSau; or,

ii. Email to: single_audit_report@hhsc.state.tx.us.

ARTICLE V. WARRANTY, AFFIRMATIONS, ASSURANCES AND CERTIFICATIONS

5.1 Warranty

Grantee warrants that all work under this Grant Agreement shall be completed in a manner consistent with standards under the terms of this Grant Agreement, in the applicable trade, profession, or industry; shall conform to or exceed the specifications set forth in the Grant Agreement; and all deliverables shall be fit for ordinary use, of good quality, and with no material defects. If System Agency, in its sole discretion, determines Grantee has failed to complete work timely or to perform satisfactorily under conditions required by this Grant Agreement, the System Agency may require Grantee, at its sole expense, to:

i. Repair or replace all defective or damaged work;

ii. Refund any payment Grantee received from System Agency for all defective or damaged work and, in conjunction therewith, require Grantee to accept the return of such work; and,

iii. Take necessary action to ensure that Grantee's future performance and work conform to the Grant Agreement requirements.

5.2 General Affirmations

Grantee certifies that, to the extent affirmations are incorporated into the Grant Agreement, the Grantee has reviewed the affirmations and that Grantee is in compliance with all requirements.

5.3 Federal Assurances

Grantee further certifies that, to the extent federal assurances are incorporated into the Grant Agreement, the Grantee has reviewed the federal assurances and that Grantee is in compliance with all requirements.

5.4 Federal Certifications

Grantee further certifies that, to the extent federal certifications are incorporated into the Grant Agreement, the Grantee has reviewed the federal certifications and that Grantee is in compliance with all requirements. In addition, Grantee certifies that it is in compliance with all applicable federal laws, rules, and regulations, as they may pertain to this Grant Agreement.

5.5 State Assurances

Except to the extent of any conflict under applicable law or requirements or guidelines of any federal awarding agency from which funding for this Grant Agreement originated, the Grantee must comply with the applicable state assurances included within the TxGMS which are incorporated here by reference.

ARTICLE VI. INTELLECTUAL PROPERTY

6.1 Ownership of Work Product

A. All right, title, and interest in the Work Product, including all Intellectual Property Rights therein, is exclusively owned by System Agency. Grantee and Grantee's employees will have no rights in or ownership of the Work Product or any other property of System Agency.

B. Any and all Work Product that is copyrightable under United States copyright law is deemed to be "work made for hire" owned by System Agency, as provided by Title 17 of the United States Code. To the extent that Work Product does not qualify as a "work made for hire" under applicable federal law, Grantee hereby irrevocably assigns and transfers to System Agency, its successors and assigns, the entire right, title, and interest in and to the Work Product, including any and all Intellectual Property Rights embodied therein or associated therewith, and in and to all works based upon, derived from, or incorporating the Work Product, and in and to all income, royalties, damages, claims and payments now or hereafter due or payable with respect thereto, and in and to all causes of action, either in law or in equity for past, present or future infringement based on the copyrights, and in and to all rights corresponding to the foregoing.

C. Grantee agrees to execute all papers and to perform such other acts as System Agency may deem necessary to secure for System Agency or its designee the rights herein assigned.

D. In the event that Grantee has any rights in and to the Work Product that cannot be assigned to System Agency, Grantee hereby grants to System Agency an exclusive, worldwide, royalty-free, transferable, irrevocable, and perpetual license, with the right to sublicense, to reproduce, distribute, modify, create derivative works of, publicly perform and publicly display, make, have made, use, sell and offer for sale the Work Product and any products developed by practicing such rights.
E. The foregoing does not apply to Incorporated Pre-existing Works or Third Party IP that are incorporated in the Work Product by Grantee. Grantee shall provide System Agency access during normal business hours to all Grantee materials, premises, and computer files containing the Work Product.

6.2 Grantee's Pre-Existing Works

A. To the extent that Grantee incorporates into the Work Product any works of Grantee that were created by Grantee or that Grantee acquired rights in prior to the Effective Date of this Grant Agreement ("**Incorporated Pre-existing Works**"), Grantee retains ownership of such Incorporated Pre-existing Works.
B. Grantee hereby grants to System Agency an irrevocable, perpetual, non-exclusive, royalty-free, transferable, worldwide right and license, with the right to sublicense, to use, reproduce, modify, copy, create derivative works of, publish, publicly perform and display, sell, offer to sell, make and have made, the Incorporated Pre-existing Works, in any medium, with or without the associated Work Product.
C. Grantee represents, warrants, and covenants to System Agency that Grantee has all necessary right and authority to grant the foregoing license in the Incorporated Pre-existing Works to System Agency.

6.3 Third Party IP

A. To the extent that any Third Party IP is included or incorporated in the Work Product by Grantee, Grantee hereby grants to System Agency, or shall obtain from the applicable third party for System Agency's benefit, the irrevocable, perpetual, non-exclusive, worldwide, royalty-free right and license, for System Agency's internal business or governmental purposes only, to use, reproduce, display, perform, distribute copies of, and prepare derivative works based upon such Third Party IP and any derivative works thereof embodied in or delivered to System Agency in conjunction with the Work Product, and to authorize others to do any or all of the foregoing.
B. Grantee shall obtain System Agency's advance written approval prior to incorporating any Third Party IP into the Work Product, and Grantee shall notify System Agency on delivery of the Work Product if such materials include any Third Party IP.
C. Grantee shall provide System Agency all supporting documentation demonstrating Grantee's compliance with this Section 6.3, including without limitation documentation indicating a third party's written approval for Grantee to use any Third Party IP that may be incorporated in the Work Product.

6.4 Agreements with Employees and Subcontractors

Grantee shall have written, binding agreements with its employees and subcontractors that include provisions sufficient to give effect to and enable Grantee's compliance with Grantee's obligations under this Article VI, Intellectual Property.

6.5 Delivery upon Termination or Expiration

No later than the first calendar day after the termination or expiration of the Grant Agreement or upon System Agency's request, Grantee shall deliver to System Agency all completed, or partially completed, Work Product, including any Incorporated Pre-existing Works, and any and all versions thereof. Grantee's failure to timely deliver such Work Product is a material breach of the Grant Agreement. Grantee will not retain any copies of the Work Product or any documentation or other products or results of Grantee's activities under the Grant Agreement without the prior written consent of System Agency.

6.6 Survival

The provisions and obligations of this Article survive any termination or expiration of the Grant Agreement.

6.7 System Agency Data

A. As between the Parties, all data and information acquired, accessed, or made available to Grantee by, through, or on behalf of System Agency or System Agency contractors, including all electronic data generated, processed, transmitted, or stored by Grantee in the course of providing data processing services in connection with Grantee's performance hereunder (the "System Agency Data"), is owned solely by System Agency.
B. Grantee has no right or license to use, analyze, aggregate, transmit, create derivatives of, copy, disclose, or process the System Agency Data except as required for Grantee to fulfill its obligations under the Grant Agreement or as authorized in advance in writing by System Agency.
C. For the avoidance of doubt, Grantee is expressly prohibited from using, and from permitting any third party to use, System Agency Data for marketing, research, or other non-governmental or commercial purposes, without the prior written consent of System Agency.
D. Grantee shall make System Agency Data available to System Agency, including to System Agency's designated vendors, as directed in writing by System Agency. The foregoing shall be at no cost to System Agency.
E. Furthermore, the proprietary nature of Grantee's systems that process, store, collect, and/or transmit the System Agency Data shall not excuse Grantee's performance of its obligations hereunder.

ARTICLE VII. PROPERTY

7.1 Use of State Property

A. Grantee is prohibited from using State Property for any purpose other than performing Services authorized under the Grant Agreement.
B. State Property includes, but is not limited to, System Agency's office space, identification badges, System Agency information technology equipment and networks (*e.g.,* laptops, portable printers, cell phones, iPads or tablets, external hard drives, data storage devices, any System Agency-issued software, and the System Agency Virtual Private Network (VPN client)), and any other resources of System Agency.

C. Grantee shall not remove State Property from the continental United States. In addition, Grantee may not use any computing device to access System Agency's network or e-mail while outside of the continental United States.
D. Grantee shall not perform any maintenance services on State Property unless the Grant Agreement expressly authorizes such Services.
E. During the time that State Property is in the possession of Grantee, Grantee shall be responsible for:
   i. all repair and replacement charges incurred by State Agency that are associated with loss of State Property or damage beyond normal wear and tear, and
   ii. all charges attributable to Grantee's use of State Property that exceeds the Grant Agreement scope. Grantee shall fully reimburse such charges to System Agency within ten (10) calendar days of Grantee's receipt of System Agency's notice of amount due. Use of State Property for a purpose not authorized by the Grant Agreement shall constitute breach of contract and may result in termination of the Grant Agreement and the pursuit of other remedies available to System Agency under contract, at law, or in equity.

7.2 Damage to State Property

A. In the event of loss, destruction, or damage to any System Agency or State of Texas owned, leased, or occupied property or equipment by Grantee or Grantee's employees, agents, Subcontractors, or suppliers, Grantee shall be liable to System Agency and the State of Texas for the full cost of repair, reconstruction, or replacement of the lost, destroyed, or damaged property.
B. Grantee shall notify System Agency of the loss, destruction, or damage of equipment or property within one (1) business day. Grantee shall reimburse System Agency and the State of Texas for such property damage within ten (10) calendar days after Grantee's receipt of System Agency's notice of amount due.

7.3 Property Rights upon Termination or Expiration of Contract

In the event the Grant Agreement is terminated for any reason or expires, State Property remains the property of the System Agency and must be returned to the System Agency by the earlier of the end date of the Grant Agreement or upon System Agency's request.

7.4 Equipment and Property

A. The Grantee must ensure equipment with a per-unit cost of $5,000 or greater purchased with grant funds under this award is used solely for the purpose of this Grant or is properly pro-rated for use under this Grant. Grantee must have control systems to prevent loss, damage, or theft of property funded under this Grant. Grantee shall maintain equipment management and inventory procedures for equipment, whether acquired in part or whole with grant funds, until disposition occurs.
B. When equipment acquired by Grantee under this Grant Agreement is no longer needed for the original project or for other activities currently supported by System Agency, the Grantee must properly dispose of the equipment pursuant to 2 CFR and/or TxGMS, as applicable. Upon termination of this Grant Agreement, use and disposal of equipment by the Grantee shall conform with TxGMS requirements.
C. Grantee shall initiate the purchase of all equipment approved in writing by the System Agency in accordance with the schedule approved by System Agency, as applicable.

Failure to timely initiate the purchase of equipment may result in the loss of availability of funds for the purchase of equipment. Requests to purchase previously approved equipment after the first quarter in the Grant Agreement must be submitted to the assigned System Agency contract manager.

D. Controlled Assets include firearms, regardless of the acquisition cost, and the following assets with an acquisition cost of $500 or more, but less than $5,000: desktop and laptop computers (including notebooks, tablets and similar devices), non-portable printers and copiers, emergency management equipment, communication devices and systems, medical and laboratory equipment, and media equipment. Controlled Assets are considered supplies.

E. System Agency funds must not be used to purchase buildings or real property without prior written approval from System Agency. Any costs related to the initial acquisition of the buildings or real property are not allowable without written pre-approval.

ARTICLE VIII. RECORD RETENTION, AUDIT, AND CONFIDENTIALITY

8.1 Record Maintenance and Retention

A. Grantee shall keep and maintain under GAAP or GASB, as applicable, full, true, and complete records necessary to fully disclose to the System Agency, the Texas State Auditor's Office, the United States Government, and their authorized representatives sufficient information to determine compliance with the terms and conditions of this Grant Agreement and all state and federal rules, regulations, and statutes.

B. Grantee shall maintain and retain legible copies of this Grant Agreement and all records relating to the performance of the Grant Agreement, including supporting fiscal documents adequate to ensure that claims for grant funds are in accordance with applicable State of Texas requirements. These records shall be maintained and retained by the Grantee for a minimum of seven (7) years after the Grant Agreement expiration date or seven (7) years after all audits, claims, litigation or disputes involving the Grant Agreement are resolved, whichever is later.

8.2 Agency's Right to Audit

A. Grantee shall make available at reasonable times and upon reasonable notice, and for reasonable periods, work papers, reports, books, records, supporting documents kept current by Grantee pertaining to the Grant Agreement for purposes of inspecting, monitoring, auditing, or evaluating by System Agency and the State of Texas.

B. In addition to any right of access arising by operation of law, Grantee and any of Grantee's affiliate or subsidiary organizations, or Subcontractors shall permit the System Agency or any of its duly authorized representatives, as well as duly authorized federal, state or local authorities, unrestricted access to and the right to examine any site where business is conducted or services are performed, and all records, which includes but is not limited to financial, client and patient records, books, papers or documents related to this Grant Agreement. If the Grant Agreement includes federal funds, federal agencies that shall have a right of access to records as described in this section include: the federal agency providing the funds, the Comptroller General of the United States, the General Accounting Office, the Office of the Inspector General, and any of their authorized

representatives. In addition, agencies of the State of Texas that shall have a right of access to records as described in this section include: the System Agency, HHS's contracted examiners, the State Auditor's Office, the Office of the Texas Attorney General, and any successor agencies. Each of these entities may be a duly authorized authority.

C. If deemed necessary by the System Agency or any duly authorized authority, for the purpose of investigation or hearing, Grantee shall produce original documents related to this Grant Agreement.
D. The System Agency and any duly authorized authority shall have the right to audit billings both before and after payment, and all documentation that substantiates the billings.
E. Grantee shall include this provision concerning the right of access to, and examination of, sites and information related to this Grant Agreement in any Subcontract it awards.

8.3 Response/Compliance with Audit or Inspection Findings

A. Grantee must act to ensure its and its Subcontractors' compliance with all corrections necessary to address any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle, or any other deficiency identified in any audit, review, or inspection of the Grant Agreement and the services and Deliverables provided. Any such correction will be at Grantee's or its Subcontractor's sole expense. Whether Grantee's action corrects the noncompliance shall be solely the decision of the System Agency.
B. As part of the services, Grantee must provide to HHS upon request a copy of those portions of Grantee's and its Subcontractors' internal audit reports relating to the services and Deliverables provided to the State under the Grant Agreement.

8.4 State Auditor's Right to Audit

The state auditor may conduct an audit or investigation of any entity receiving funds from the state directly under the Grant Agreement or indirectly through a subcontract under the Grant Agreement. The acceptance of funds directly under the Grant Agreement or indirectly through a subcontract under the Grant Agreement acts as acceptance of the authority of the state auditor, under the direction of the legislative audit committee, to conduct an audit or investigation in connection with those funds. Under the direction of the legislative audit committee, an entity that is the subject of an audit or investigation by the state auditor must provide the state auditor with access to any information the state auditor considers relevant to the investigation or audit.

8.5 Confidentiality

Grantee shall maintain as confidential and shall not disclose to third parties without System Agency's prior written consent, any System Agency information including but not limited to System Agency's business activities, practices, systems, conditions and services. This section will survive termination or expiration of this Grant Agreement. This requirement must be included in all subcontracts awarded by Grantee.

ARTICLE IX. GRANT REMEDIES, TERMINATION AND PROHIBITED ACTIVITIES

9.1 Remedies

A. To ensure Grantee's full performance of the Grant Agreement and compliance with applicable law, System Agency reserves the right to hold Grantee accountable for breach of contract or substandard performance and may take remedial or corrective actions, including, but not limited to the following:
   i. temporarily withholding cash disbursements or reimbursements pending correction of the deficiency;
   ii. disallowing or denying use of funds for the activity or action deemed not to be in compliance;
   iii. disallowing claims for reimbursement that may require a partial or whole return of previous payments or reimbursements;
   iv. suspending all or part of the Grant Agreement;
   v. requiring the Grantee to take specific actions in order to remain in compliance with the Grant Agreement;
   vi. recouping payments made by the System Agency to the Grantee found to be in error;
   vii. suspending, limiting, or placing conditions on the Grantee's continued performance of the Project;
   viii. prohibiting the Grantee from receiving additional funds for other grant programs administered by the System Agency until satisfactory compliance resolution is obtained;
   ix. withholding release of new grant agreements; and
   x. imposing any other remedies, sanctions or penalties authorized under this Grant Agreement or permitted by federal or state statute, law, regulation or rule.

B. Unless expressly authorized by System Agency, Grantee may not be entitled to reimbursement for expenses incurred while the Grant Agreement is suspended.

C. No action taken by System Agency in exercising remedies or imposing sanctions will constitute or operate as a waiver of any other rights or remedies available to System Agency under the Grant Agreement or pursuant to law. Additionally, no action taken by System Agency in exercising remedies or imposing sanctions will constitute or operate as an acceptance, waiver, or cure of Grantee's breach. Unless expressly authorized by System Agency, Grantee may not be entitled to reimbursement for expenses incurred while the Grant Agreement is suspended or after termination.

9.2 Termination for Convenience

The System Agency may terminate the Grant Agreement, in whole or in part, at any time when, in its sole discretion, the System Agency determines that termination is in the best interests of the State of Texas. The termination will be effective on the date specified in the System Agency's notice of termination.

9.3 Termination for Cause

A. Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, the System Agency may terminate the Grant Agreement, in whole or in part, upon either of the following conditions:

i. **Material Breach**
The System Agency may terminate the Grant Agreement, in whole or in part, if the System Agency determines, in its sole discretion, that Grantee has materially breached the Grant Agreement or has failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction, whether or not such violation prevents or substantially impairs performance of Grantee's duties under the Grant Agreement. Grantee's misrepresentation in any aspect including, but not limited to, of Grantee's Solicitation Application, if any, or Grantee's addition to the SAM exclusion list (identification in SAM as an excluded entity) may also constitute a material breach of the Grant Agreement.

ii. **Failure to Maintain Financial Viability**
The System Agency may terminate the Grant Agreement if the System Agency, in its sole discretion, determines that Grantee no longer maintains the financial viability required to complete the services and deliverables, or otherwise fully perform its responsibilities under the Grant Agreement.

B. System Agency will specify the effective date of such termination in the notice to Grantee. If no effective date is specified, the Grant Agreement will terminate on the date of the notification.

9.4 Grantee Responsibility for System Agency's Termination Costs

If the System Agency terminates the Grant Agreement for cause, the Grantee shall be responsible to the System Agency for all costs incurred by the System Agency and the State of Texas to replace the Grantee. These costs include, but are not limited to, the costs of procuring a substitute grantee and the cost of any claim or litigation attributable to Grantee's failure to perform any work in accordance with the terms of the Grant Agreement.

9.5 Inherently Religious Activities

Grantee may not use grant funding to engage in inherently religious activities, such as proselytizing, scripture study, or worship. Grantees may engage in inherently religious activities; however, these activities must be separate in time or location from the grant-funded program. Moreover, grantees must not compel program beneficiaries to participate in inherently religious activities. These requirements apply to all grantees, not just faith-based organizations.

9.6 Political Activities

Grant funds cannot be used for the following activities:

A. Grantees and their relevant sub-grantees or subcontractors are prohibited from using grant funds directly or indirectly for political purposes, including lobbying, advocating for legislation, campaigning for, endorsing, contributing to, or otherwise supporting political candidates or parties, and voter registration campaigns. Grantees may use private, or non-System Agency money or contributions for political purposes but may not charge to, or be reimbursed from, System Agency contracts or grants for the costs of such activities.

B. Grant-funded employees may not use official authority or influence to achieve any political purpose and grant funds cannot be used for the salary, benefits, or any other compensation of an elected official.

C. Grant funds may not be used to employ, in any capacity, a person who is required by Chapter 305 of the Texas Government Code to register as a lobbyist. Additionally, grant funds cannot be used to pay membership dues to an organization that partially or wholly pays the salary of a person who is required by Chapter 305 of the Texas Government Code to register as a lobbyist.
D. As applicable, Grantee will comply with 31 USC § 1352, relating to the limitation on use of appropriated funds to influence certain Federal contracting and financial transactions.

ARTICLE X. INDEMNITY

10.1 General Indemnity

A. GRANTEE SHALL DEFEND, INDEMNIFY AND HOLD HARMLESS THE STATE OF TEXAS AND SYSTEM AGENCY, AND/OR THEIR OFFICERS, AGENTS, EMPLOYEES, REPRESENTATIVES, CONTRACTORS, ASSIGNEES, AND/OR DESIGNEES FROM ANY AND ALL LIABILITY, ACTIONS, CLAIMS, DEMANDS, OR SUITS, AND ALL RELATED COSTS, ATTORNEYS' FEES, AND EXPENSES ARISING OUT OF OR RESULTING FROM ANY ACTS OR OMISSIONS OF GRANTEE OR ITS AGENTS, EMPLOYEES, SUBCONTRACTORS, ORDER FULFILLERS, OR SUPPLIERS OF SUBCONTRACTORS IN THE EXECUTION OR PERFORMANCE OF THE GRANT AGREEMENT AND ANY PURCHASE ORDERS ISSUED UNDER THE GRANT AGREEMENT.

B. THIS PARAGRAPH IS NOT INTENDED TO AND WILL NOT BE CONSTRUED TO REQUIRE GRANTEE TO INDEMNIFY OR HOLD HARMLESS THE STATE OR THE SYSTEM AGENCY FOR ANY CLAIMS OR LIABILITIES RESULTING FROM THE NEGLIGENT ACTS OR OMISSIONS OF THE SYSTEM AGENCY OR ITS EMPLOYEES.

C. For the avoidance of doubt, System Agency shall not indemnify Grantee or any other entity under the Grant Agreement.

10.2 Intellectual Property

GRANTEE SHALL DEFEND, INDEMNIFY, AND HOLD HARMLESS THE SYSTEM AGENCY AND THE STATE OF TEXAS FROM AND AGAINST ANY AND ALL CLAIMS, VIOLATIONS, MISAPPROPRIATIONS, OR INFRINGEMENT OF ANY PATENT, TRADEMARK, COPYRIGHT, TRADE SECRET, OR OTHER INTELLECTUAL PROPERTY RIGHTS AND/OR OTHER INTANGIBLE PROPERTY, PUBLICITY OR PRIVACY RIGHTS, AND/OR IN CONNECTION WITH OR ARISING FROM:

i. THE PERFORMANCE OR ACTIONS OF GRANTEE PURSUANT TO THIS GRANT AGREEMENT;
ii. ANY DELIVERABLE, WORK PRODUCT, CONFIGURED SERVICE OR OTHER SERVICE PROVIDED HEREUNDER; AND/OR
iii. SYSTEM AGENCY'S AND/OR GRANTEE'S USE OF OR ACQUISITION OF ANY REQUESTED SERVICES OR OTHER ITEMS PROVIDED TO SYSTEM AGENCY BY GRANTEE OR OTHERWISE TO WHICH SYSTEM

AGENCY HAS ACCESS AS A RESULT OF GRANTEE'S PERFORMANCE UNDER THE GRANT AGREEMENT.

10.3 Additional Indemnity Provisions

A. GRANTEE AND SYSTEM AGENCY AGREE TO FURNISH TIMELY WRITTEN NOTICE TO EACH OTHER OF ANY INDEMNITY CLAIM. GRANTEE SHALL BE LIABLE TO PAY ALL COSTS OF DEFENSE, INCLUDING ATTORNEYS' FEES.

B. THE DEFENSE SHALL BE COORDINATED BY THE GRANTEE WITH THE OFFICE OF THE TEXAS ATTORNEY GENERAL WHEN TEXAS STATE AGENCIES ARE NAMED DEFENDANTS IN ANY LAWSUIT AND GRANTEE MAY NOT AGREE TO ANY SETTLEMENT WITHOUT FIRST OBTAINING THE CONCURRENCE FROM THE OFFICE OF THE TEXAS ATTORNEY GENERAL.

C. GRANTEE SHALL REIMBURSE SYSTEM AGENCY AND THE STATE OF TEXAS FOR ANY CLAIMS, DAMAGES, COSTS, EXPENSES OR OTHER AMOUNTS, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS' FEES AND COURT COSTS, ARISING FROM ANY SUCH CLAIM. IF THE SYSTEM AGENCY DETERMINES THAT A CONFLICT EXISTS BETWEEN ITS INTERESTS AND THOSE OF GRANTEE OR IF SYSTEM AGENCY IS REQUIRED BY APPLICABLE LAW TO SELECT SEPARATE COUNSEL, SYSTEM AGENCY WILL BE PERMITTED TO SELECT SEPARATE COUNSEL AND GRANTEE SHALL PAY ALL REASONABLE COSTS OF SYSTEM AGENCY'S COUNSEL.

ARTICLE XI. GENERAL PROVISIONS

11.1 Amendments

Except as otherwise expressly provided, the Grant Agreement may only be amended by a written Amendment executed by both Parties.

11.2 No Quantity Guarantees

The System Agency makes no guarantee of volume or usage of work under this Grant Agreement. All work requested may be on an irregular and as needed basis throughout the Grant Agreement term.

11.3 Child Abuse Reporting Requirements

A. Grantees shall comply with child abuse and neglect reporting requirements in Texas Family Code Chapter 261. This section is in addition to and does not supersede any other legal obligation of the Grantee to report child abuse.

B. Grantee shall use the Texas Abuse Hotline Website located at https://www.txabusehotline.org/Login/Default.aspx as required by the System Agency. Grantee shall retain reporting documentation on site and make it available for inspection by the System Agency.

11.4 Certification of Meeting or Exceeding Tobacco-Free Workplace Policy Minimum Standards

A. Grantee certifies that it has adopted and enforces a Tobacco-Free Workplace Policy that meets or exceeds all of the following minimum standards of:
   i. Prohibiting the use of all forms of tobacco products, including but not limited to cigarettes, cigars, pipes, water pipes (hookah), bidis, kreteks, electronic cigarettes, smokeless tobacco, snuff and chewing tobacco;
   ii. Designating the property to which this Policy applies as a "designated area," which must at least comprise all buildings and structures where activities funded under this Grant Agreement are taking place, as well as Grantee owned, leased, or controlled sidewalks, parking lots, walkways, and attached parking structures immediately adjacent to this designated area;
   iii. Applying to all employees and visitors in this designated area; and
   iv. Providing for or referring its employees to tobacco use cessation services.

B. If Grantee cannot meet these minimum standards, it must obtain a waiver from the System Agency.

11.5 Insurance and Bonds

Unless otherwise specified in this Contract, Grantee shall acquire and maintain, for the duration of this Contract, insurance coverage necessary to ensure proper fulfillment of this Contract and potential liabilities thereunder with financially sound and reputable insurers licensed by the Texas Department of Insurance, in the type and amount customarily carried within the industry as determined by the System Agency. Grantee shall provide evidence of insurance as required under this Contract, including a schedule of coverage or underwriter's schedules establishing to the satisfaction of the System Agency the nature and extent of coverage granted by each such policy, upon request by the System Agency. In the event that any policy is determined by the System Agency to be deficient to comply with the terms of this Contract, Grantee shall secure such additional policies or coverage as the System Agency may reasonably request or that are required by law or regulation. If coverage expires during the term of this Contract, Grantee must produce renewal certificates for each type of coverage. In addition, if required by System Agency, Grantee must obtain and have on file a blanket fidelity bond that indemnifies System Agency against the loss or theft of any grant funds, including applicable matching funds. The fidelity bond must cover the entirety of the grant term and any subsequent renewals. The failure of Grantee to comply with these requirements may subject Grantee to remedial or corrective actions detailed in section 10.1, General Indemnity, above.

These and all other insurance requirements under the Grant apply to both Grantee and its Subcontractors, if any. Grantee is responsible for ensuring its Subcontractors' compliance with all requirements.

11.6 Limitation on Authority

A. Grantee shall not have any authority to act for or on behalf of the System Agency or the State of Texas except as expressly provided for in the Grant Agreement; no other authority, power, or use is granted or implied. Grantee may not incur any debt,

obligation, expense, or liability of any kind on behalf of System Agency or the State of Texas.

B. Grantee may not rely upon implied authority and is not granted authority under the Grant Agreement to:
   i. Make public policy on behalf of the System Agency;
   ii. Promulgate, amend, or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of a System Agency program; or
   iii. Unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of the System Agency regarding System Agency programs or the Grant Agreement. However, upon System Agency request and with reasonable notice from System Agency to the Grantee, the Grantee shall assist the System Agency in communications and negotiations regarding the Work under the Grant Agreement with state and federal governments.

11.7 Change in Laws and Compliance with Laws

Grantee shall comply with all laws, regulations, requirements and guidelines applicable to a Grantee providing services and products required by the Grant Agreement to the State of Texas, as these laws, regulations, requirements and guidelines currently exist and as amended throughout the term of the Grant Agreement. Notwithstanding Section 11.1, Amendments, above, System Agency reserves the right, in its sole discretion, to unilaterally amend the Grant Agreement to incorporate any modifications necessary for System Agency's compliance, as an agency of the State of Texas, with all applicable state and federal laws, regulations, requirements and guidelines.

11.8 Subcontractors

Grantee may not subcontract any or all of the Work and/or obligations under the Grant Agreement without prior written approval of the System Agency. Subcontracts, if any, entered into by the Grantee shall be in writing and be subject to the requirements of the Grant Agreement. Should Grantee subcontract any of the services required in the Grant Agreement, Grantee expressly understands and acknowledges System Agency is in no manner liable to any subcontractor(s) of Grantee. In no event shall this provision relieve Grantee of the responsibility for ensuring that the services performed under all subcontracts are rendered in compliance with the Grant Agreement.

11.9 Permitting and Licensure

At Grantee's sole expense, Grantee shall procure and maintain for the duration of this Grant Agreement any state, county, city, or federal license, authorization, insurance, waiver, permit, qualification or certification required by statute, ordinance, law, or regulation to be held by Grantee to provide the goods or services required by this Grant Agreement. Grantee shall be responsible for payment of all taxes, assessments, fees, premiums, permits, and licenses required by law. Grantee shall be responsible for payment of any such government obligations not paid by its Subcontractors during performance of this Grant Agreement.

11.10 Independent Contractor

Grantee and Grantee's employees, representatives, agents, Subcontractors, suppliers, and third-party service providers shall serve as independent contractors in providing the services

under the Grant Agreement. Neither Grantee nor System Agency is an agent of the other and neither may make any commitments on the other party's behalf. The Grantee is not a "governmental body" solely by virtue of this Grant Agreement or receipt of grant funds under this Grant Agreement. Grantee shall have no claim against System Agency for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. The Grant Agreement shall not create any joint venture, partnership, agency, or employment relationship between Grantee and System Agency.

11.11 Governing Law and Venue

The Grant Agreement shall be governed by and construed in accordance with the laws of the State of Texas, without regard to the conflicts of law provisions. The venue of any suit arising under the Grant Agreement is fixed in any court of competent jurisdiction of Travis County, Texas, unless the specific venue is otherwise identified in a statute which directly names or otherwise identifies its applicability to the System Agency.

11.12 Severability

If any provision contained in this Grant Agreement is held to be unenforceable by a court of law or equity, such construction will not affect the legality, validity, or enforceability of any other provision or provisions of this Grant Agreement. It is the intent and agreement of the Parties this Grant Agreement shall be deemed amended by modifying such provision to the extent necessary to render it valid, legal and enforceable while preserving its intent or, if such modification is not possible, by substituting another provision that is valid, legal and enforceable and that achieves the same objective. All other provisions of this Grant Agreement will continue in full force and effect.

11.13 Survivability

Expiration or termination of the Grant Agreement for any reason does not release Grantee from any liability or obligation set forth in the Grant Agreement that is expressly stated to survive any such expiration or termination, that by its nature would be intended to be applicable following any such expiration or termination, or that is necessary to fulfill the essential purpose of the Grant Agreement, including without limitation the provisions regarding return of grant funds, audit requirements, records retention, public information, warranty, indemnification, confidentiality, and rights and remedies upon termination.

11.14 Force Majeure

Neither Grantee nor System Agency shall be liable to the other for any delay in, or failure of performance, of any requirement included in the Grant Agreement caused by force majeure. The existence of such causes of delay or failure shall extend the period of performance until after the causes of delay or failure have been removed provided the non-performing party exercises all reasonable due diligence to perform. Force majeure is defined as acts of God, war, fires, explosions, hurricanes, floods, failure of transportation, or other causes that are beyond the reasonable control of either party and that by exercise of due foresight such party could not reasonably have been expected to avoid, and which, by the exercise of all reasonable due diligence, such party is unable to overcome.

11.15 No Implied Waiver of Provisions

The failure of the System Agency to object to or to take affirmative action with respect to any conduct of the Grantee which is in violation or breach of the terms of the Grant Agreement shall not be construed as a waiver of the violation or breach, or of any future violation or breach.

11.16 Funding Disclaimers and Labeling

A. Grantee shall not use System Agency's name or refer to System Agency directly or indirectly in any media appearance, public service announcement, or disclosure relating to this Grant Agreement including any promotional material without first obtaining written consent from System Agency. The foregoing prohibition includes, without limitation, the placement of banners, pop-up ads, or other advertisements promoting Grantee's or a third party's products, services, workshops, trainings, or other commercial offerings on any website portal or internet-based service or software application hosted or managed by Grantee. This does not limit the Grantee's responsibility to comply with obligations related to the Texas Public Information Act or Texas Open Meetings Act.

B. In general, no publication (including websites, reports, projects, etc.) may convey System Agency's recognition or endorsement of the Grantee's project without prior written approval from System Agency. Publications funded in part or wholly by HHS grant funding must include a statement that "HHS and neither any of its components operate, control, are responsible for, or necessarily endorse, this publication (including, without limitation, its content, technical infrastructure, and policies, and any services or tools provided)" at HHS's request.

11.17 Media Releases

A. Grantee shall not use System Agency's name, logo, or other likeness in any press release, marketing material or other announcement without System Agency's prior written approval. System Agency does not endorse any vendor, commodity, or service. Grantee is not authorized to make or participate in any media releases or public announcements pertaining to this Grant Agreement or the Services to which they relate without System Agency's prior written consent, and then only in accordance with explicit written instruction from System Agency.

B. Grantee may publish, at its sole expense, results of Grantee performance under the Grant Agreement with the System Agency's prior review and approval, which the System Agency may exercise at its sole discretion. Any publication (written, visual, or sound) will acknowledge the support received from the System Agency and any Federal agency, as appropriate.

11.18 Prohibition on Non-Compete Restrictions

Grantee shall not require any employees or Subcontractors to agree to any conditions, such as non-compete clauses or other contractual arrangements, that would limit or restrict such persons or entities from employment or contracting with the State of Texas.

11.19 Sovereign Immunity

Nothing in the Grant Agreement will be construed as a waiver of the System Agency's or the State's sovereign immunity. This Grant Agreement shall not constitute or be construed as a waiver of any of the privileges, rights, defenses, remedies, or immunities available to the

System Agency or the State of Texas. The failure to enforce, or any delay in the enforcement, of any privileges, rights, defenses, remedies, or immunities available to the System Agency or the State of Texas under the Grant Agreement or under applicable law shall not constitute a waiver of such privileges, rights, defenses, remedies, or immunities or be considered as a basis for estoppel. System Agency does not waive any privileges, rights, defenses, or immunities available to System Agency by entering into the Grant Agreement or by its conduct prior to or subsequent to entering into the Grant Agreement.

11.20 Entire Contract and Modification

The Grant Agreement constitutes the entire agreement of the Parties and is intended as a complete and exclusive statement of the promises, representations, negotiations, discussions, and other agreements that may have been made in connection with the subject matter hereof. Any additional or conflicting terms in any future document incorporated into the Grant Agreement will be harmonized with this Grant Agreement to the extent possible.

11.21 Counterparts

This Grant Agreement may be executed in any number of counterparts, each of which will be an original, and all such counterparts will together constitute but one and the same Grant Agreement.

11.22 Proper Authority

Each Party represents and warrants that the person executing this Grant Agreement on its behalf has full power and authority to enter into this Grant Agreement.

11.23 E-Verify Program

Grantee certifies that it utilizes and will continue to utilize the U.S. Department of Homeland Security's E-Verify system to determine the eligibility of:

A. all persons employed to perform duties within Texas during the term of the Grant Agreement; and
B. all persons, (including subcontractors) assigned by the Grantee to perform work pursuant to the Grant Agreement within the United States of America.

11.24 Civil Rights

A. Grantee agrees to comply with state and federal anti-discrimination laws, including:
   i. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
   ii. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
   iii. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
   iv. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
   v. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
   vi. Food and Nutrition Act of 2008 (7 U.S.C. §2011 et seq.); and
   vii. The System Agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Grant Agreement.
B. Grantee agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from

participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

C. Grantee agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. State and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Grantee agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.
D. Grantee agrees to post applicable civil rights posters in areas open to the public informing clients of their civil rights and including contact information for the HHS Civil Rights Office. The posters are available on the HHS website at: https://hhs.texas.gov/about-hhs/your-rights/civil-rights-office/civil-rights-posters.
E. Grantee agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.
F. Upon request, Grantee shall provide HHSC's Civil Rights Office with copies of the Grantee's civil rights policies and procedures.
G. Grantee must notify HHSC's Civil Rights Office of any complaints of discrimination received relating to its performance under this Grant Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office
701 W. 51st Street, Mail CodeW206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
Fax: (512) 438-5885
Email: HHSCivilRightsOffice@hhsc.state.tx.us.

11.25 Enterprise Information Management Standards

Grantee shall conform to HHS standards for data management as described by the policies of the HHS Office of Data, Analytics, and Performance. These include, but are not limited to, standards for documentation and communication of data models, metadata, and other data definition methods that are required by HHS for ongoing data governance, strategic portfolio analysis, interoperability planning, and valuation of HHS System data assets.

11.26 Disclosure of Litigation

A. The Grantee must disclose in writing to the contract manager assigned to this Grant Agreement any material civil or criminal litigation or indictment either threatened or

ATTACHMENT G

View Burden Statement

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
DocuSigned by: Susan Garnett A5786F7A2A0E45B...	CEO
APPLICANT ORGANIZATION	DATE SUBMITTED
MHMR of Tarrant County	September 8, 2023

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CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION

MHMR of Tarrant County

* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Prefix: | * First Name: Susan | Middle Name:

* Last Name: Garnett | Suffix:

* Title: CEO

* SIGNATURE: DocuSigned by: Susan Garnett A5786F7A2A0E45B...

* DATE: September 8, 2023