



A collaborative for the early identification and treatment of mental illness with psychosis



## **Maryland Early Intervention Program (EIP) Team Manual**

**Developed by the RAISE Connection Program Research Team**

Components of this manual focused on CTI are based on work done by Dan Herman, D.S.W, M.S., Sarah Conover, M.P.H., and Ezra Susser, M.D., Dr.PH  
New York State Psychiatric Institute;  
Department of Epidemiology and Center for Homelessness Prevention Studies,  
Columbia University Mailman School of Public Health  
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Team Manual  
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## I. Introduction

The Maryland Early Intervention Program is a multidisciplinary unit that works collaboratively with the individual diagnosed with first episode psychosis (FEP) to achieve recovery goals. The team is made up of a Team Leader, a Team Psychiatrist, an IPS Specialist, a Recovery Coach, the consumer, and sometimes the family. This manual describes the governing principles of the team, the team's activities, and approaches to treatment engagement and assertive outreach. The overall structure of the team described rests upon the phases and activities of the Critical Time Intervention (CTI) model that is adapted for individuals experiencing FEP. The Early Intervention Program acknowledges that the first episode of psychosis may represent a turning point, a critical time in the life of individuals, and that by intervening appropriately, the outcome of this critical time can be optimized to assist the consumer in meeting age-appropriate life goals including return to school, work and a full life in society. The CTI model de-emphasizes the notion of chronicity and posits recovery as the expected outcome for people. Hence the CTI model has stages and is time-limited. The approaches specified in this manual are not done separately but are integrated, and all members of the team are educated about these strategies.

The team strives to convey hope for recovery and views the person diagnosed with FEP as the central member of the team effort. At first this may seem counter intuitive. Many mental health clinicians have been trained to see the person with a diagnosis as "the problem", not part of the solution. However, experience has shown that recovery depends on people moving beyond being passive spectators and recipients of care. People with diagnoses must actively collaborate with their treatment team. Consumers' life goals, aspirations and ambitions must drive treatment planning. The consumer must have a voice and a choice in deciding what treatment is best, and what good treatment outcomes are. Symptom reduction is not enough. Functional recovery goals such as return to school, work, and community are the hallmark of effective, recovery-oriented services.

First and foremost, psychosis is a human experience. Beneath the turmoil and confusion, fear and uncertainties, is a young person just like any other. The job of the team is to engage the energy, youth, hope, promise and human potential of the young person and to support him/her in achieving life goals. The fact that consumers working with the team will be experiencing psychosis for the first time highlights the need for members of the treatment team to have an understanding of the existential struggle that the individual is facing. “Who am I” is a question that all young people face. “Who am I and who can I become now that I have a diagnosis of psychosis”, is the more complicated question facing our young people.

### **A. Coming to Terms with a Diagnosis: The Individual’s Challenge**

One of the most difficult issues for an individual with FEP is to make sense of this experience and to figure out how this experience fits into their understanding of themselves and their goals. Most are not yet ready to take on the persona of one who is “mentally ill”, and they struggle with questions about the first episode, why it happened, and whether it is something that is truly going to affect them and their lives. They often question whether the psychotic experience was a one-time phase, and search for possible causes - such as being stressed out, smoking too much marijuana, or lack of sleep – that can be relatively easily addressed. At a broader level, individuals with FEP are asking themselves whether this experience represents a life-changing and goal-changing experience that will affect them for the rest of their lives and are hoping that it does not. This is a true struggle for many individuals, who are trying to understand their experience and are asking whether they have an illness that will impact them for their entire lives.

It is critical that team members understand that individuals with FEP initially view the FEP experience in this way. It is important to accept these questions as expected and valid. This existential struggle does not represent a lack of insight. It is the healthy, resilient part of the person that is struggling to make sense of the experience of psychosis and its meaning for the future. Before the team can deliver interventions, they must acknowledge and understand



these questions as the most basic way to build a connection, work with individuals and to engage them in the program. Team members must not dismiss such questions or attempt to educate consumers and their families in an effort to dispel their hopes and beliefs. Team members should not try to prove that the individual is beginning what will develop into a severe psychiatric illness that will persist forever. Such messages convey hopelessness – that this is a chronic illness from which there is no recovery – that goes against the notion of recovery that the team seeks to impart and that can impact an individual’s desire to engage at all with the team and program. *We do not* want to communicate a sense of pessimism and hopelessness. *We do* want to convey an atmosphere of support and understanding and an attitude that desired outcomes and recovery are possible.

- Don’t tell a person they will be ill for the rest of their lives. Do tell them they you are there to help them move forward with their lives and to achieve their goals.
- Don’t tell a person that they will have to take medicine for the rest of their lives. Do tell them that many people find that psychiatric medicine can help manage symptoms so one can get on with what’s important and fun in life.

Think back to when you were an adolescent or young adult. At that time, when you looked toward your future, you saw possibilities, not limitations. You felt powerful, if not invincible, as most young people do. “Vulnerability” was a word that was not in your vocabulary. You had big dreams for yourself: to be a rock star, to be an athlete, to be a teacher or carpenter, to join the military, to raise a family, to go to college, to fall in love, to make a difference in this world, etc. Although it may seem contradictory, at the same time most adolescents are incredibly insecure. They are afraid that if people knew what they were really like, everyone would hate and shun them. They are afraid that they are not as skilled and competent as their peers and they will be discovered as such.

Now imagine having a psychotic episode in the midst of your adolescence or young adulthood. How would you make sense of that experience? How would you answer the

question, “Why did this happen to me?” Certainly you would experience shock and disbelief at having been hospitalized and diagnosed. Most probably you would ask yourself:

Was the psychosis just a phase I went through?

Will it happen again?

Did it happen because I partied too much in the month before the psychosis?

Did it happen because I was studying too hard for exams and didn’t get enough sleep?

Maybe psychosis was a type of calling to a religious vocation as described by many saints and sages through the ages.

Maybe the psychosis happened because I was dumped by my boyfriend/girlfriend and I’ll rebound in time.

Maybe I’m really okay and they just got the diagnosis wrong. Misdiagnosis is prevalent in psychiatry and other medical specialties.

Maybe this experience confirms all my worst fears about how bad a person I am and how unlikely it is that I will succeed.

Maybe I have a mild case and it will pass if I just stop smoking pot.

All people who are diagnosed with serious disorders and illnesses, whether diabetes, cancer, HIV, epilepsy, asthma or first episode psychosis, struggle to come to terms with the diagnosis and what it means for one’s life. It is absolutely normal to question a medical diagnosis and to quite literally wrestle with it. Diagnoses live in textbooks. The task of the person with the diagnosis is to make sense of it in the context and meaning of one’s life. That takes time. Most people emerge from their first or second or third hospitalization and continue to wrestle with the meaning that the diagnosis has for them and their future. It is an evolutionary process that unfolds over years, if not decades.

## **B. Understanding FEP**

One of the most important things that the team can do is to “walk with a person” as they make the journey of coming to terms with a diagnosis of FEP. This means that team members

will educate and teach and offer options, but they cannot make decisions for individuals diagnosed with FEP, who might be considered potential consumers of mental health services. Consumers will listen and learn, and make decisions the best they know how. They will try and fail and try again. They will make mistakes, take risks and learn from their mistakes. In the disability community, this is often referred to as the dignity of risk and the right to failure. Of course, people have the right to succeed as well. But success often is predicated on learning from failures. Team members, while providing interventions and guiding consumers' choice of treatment options, must understand that consumers are wrestling with, trying on, and casting off, the diagnosis. Trying to convince a person of their diagnosis is not helpful. Helping them learn about the diagnosis and how it fits, and does not fit, their experience, is helpful. Insisting that a person "gain insight" is not helpful. Helping a person reflect on events leading up to re-hospitalization in order to learn from them is helpful. Forcing a person to "accept the diagnosis" is not helpful. Showing people examples of others who are leading full and meaningful lives with (and in spite of) the diagnosis, is helpful. Teaching a person what the diagnosis means is only part of the solution. Teaching people how they can manage the disorder and achieve personal life goals in spite of the diagnosis is the key to supporting individuals' recovery.

One of the keys to walking with a person as they wrestle with a new diagnosis is to help them formulate an understanding of "what the problem is" and "how I can be a part of the solution". How does the person understand "the problem"? How can the person prevent "the problem" from happening again? If the person says, "The reason I ended up in the hospital is because the FBI is spying on me as part of their counter terrorism sting", the Team Leader can say, "What can YOU DO to get a handle on that situation? What can YOU DO to avoid going to the hospital next time?" If a person says that they are genetically and biologically predisposed to psychosis and that's what leads to hospitalization, the Team Leader can ask, "What can YOU DO to avoid going to the hospital next time?" What seems to matter in recovery is not how individuals understand their diagnosis, but how their understanding of what the problem is

empowers them to do something about it. The major task for the team, and the Team Leader in particular, is to develop a trusting relationship with the consumer. The team must adopt the consumer's metaphor of illness and language, and encourage exploration of goals in the context of the consumer's changing understanding of what has happened.

## **II. The Early Intervention Program Treatment Team**

The Early Intervention Program Treatment Team operates as a collaborative unit for planning and decision making. The team includes a full-time Team Leader, a part-time Team Psychiatrist, a full-time Individual Placement and Support (IPS) Specialist, and a half-time Recovery Coach. When there is a vacancy on the team, it should be filled within 30 days in order to ensure that the team can maintain a high level of consumer contact.

### **A. Overview of Team Members**

The Team Leader is the primary resource for the consumer and his family, coordinating an assessment of service needs, and working with the consumer to create the treatment plan within a shared decision-making framework. The Team Leader works closely with all members of the team in a closely integrated way, and develops a positive clinical relationship with the consumer early on and facilitates linkage with other treatment services and community supports. The Team Leader also provides family outreach and general psychoeducation to family members about FEP and the goals of the team as a whole. The Team Leader provides the consumer with *in vivo* management and relapse prevention techniques when needed. Finally, the Team Leader is responsible for the assessment of suicidality and for delivering basic safety and crisis planning.

The Team Psychiatrist engages the consumer in shared decision making about medication and the next steps in medication treatment. The Team Psychiatrist also plays a key role during episodes of crisis and provides ongoing assistance and support for coping with relapses. In addition, the psychiatrist plays a key role in ongoing diagnosis. In order to document

consumers' meetings with the psychiatrist, the psychiatrist must complete the "Psychiatrist Visit Log" following each visit with the consumer. Visits to be logged include those for needs assessment, treatment planning and revising, and regular medication meetings.

The IPS Specialist takes the lead in assisting the consumer with employment and education goals. After the initial engagement phase, the IPS Specialist meets with all consumers to assess work/school interests and assist consumers in identifying and selecting options for school or work. At this point, some consumers will opt to work with the IPS Specialist and others will not. In addition, consumers can be referred by the Team Leader. While not all consumers will have work or educational goals, we anticipate that most consumers will have such goals and so will work in some capacity with the IPS Specialist.

The Recovery Coach works with consumers in the delivery of the social and coping skills training, substance abuse treatment, and behavioral activation, as well as to implement Brief Family Consultations and Monthly Family Meetings. After the initial engagement phase, the Recovery Coach meets with all consumers and completes an informal assessment of the need for and interest in skills training/behavior change interventions. Some consumers will opt to participate in these interventions and others will not. Consumers can also be referred to the Recovery Coach by the Team Leader. We anticipate that many consumers may want to wait to start work with the Recovery Coach until more acute needs such as symptoms and basic functioning are improved.

## **B. Features of the team**

**1. Small caseloads.** The team will have small caseloads, consisting of 25 consumers or less, to ensure that team members have sufficient time to fully address all areas of intervention. The small caseload also will enable the Team Leader to develop and nurture a trusting relationship with the consumer, and perform activities outside of the clinic setting, such as home visits and community outreach activities, as needed, particularly during the earlier phases of the intervention.

**2. Frequent team meetings.** The full team will meet once per week. At these meetings, the team will review cases, discuss each team member's role in the case, 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, as well as provide time for the Team Leader to check in with each team member regarding the activities and goals of each in their areas of specialty. During team meetings, principles and practice 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, techniques to use when negotiating with community providers, and taking a harm reduction approach to resolving problems.

The team should also save the hour following the weekly team meeting for treatment planning or updating with consumers. When an initial treatment plan or an update is to be discussed with consumers, the goal is to have all team members present. Scheduling time for treatment planning meetings following the weekly team meeting ensures that all team members can be present.

Aside from team meetings, the Team Leader will meet with the IPS Specialist and Recovery Coach regularly throughout the week. These meetings will involve sharing information on consumers' goals and progress, as well as be an opportunity for the Team Leader to provide fieldbased supervision to the IPS Specialist and the Recovery Coach.

**3. Staff Roles.** Referrals to the team come to the Team Leader. The Team Leader coordinates the initial Team activities, including initial assessment (see below for components of initial assessment) and initial treatment planning. Based on the assessment, and in full consultation with the client, the team will engage in shared decision making with the consumer to plot an overall treatment plan to meet the individual's expressed recovery goals. Team members will focus predominantly on their assigned roles. They may cover for each other occasionally.

### **III. Clinical Concepts Underlying the Treatment Team**

The overall therapeutic stance assumed by the team can be described as supportive and educational. Team members operate under the following broad principles.

#### **A. Recovery**

Schizophrenia and most other forms of serious mental illness (SMI) have traditionally been viewed as chronic conditions with poor outcomes. This pessimistic view has begun to change, as a series of long term outcome studies have demonstrated that the course is more variable both across and within individuals, and that many people meeting strict diagnostic criteria have very good outcomes, often without maintenance medication. There are now upwards of 20 contemporary trials of the long term outcome of schizophrenia. Studies vary in specific criteria, measures, samples, and time frame, but overall some 50% of people with careful research diagnoses appear to have a good outcome, with substantial reduction of symptoms, and good quality of life and role function over extended periods of time. At the same time, there has been a growing consumer movement among people with SMI that has challenged both the traditional negative perspective on course of illness and the assumptions that people with the illness should not be expected to lead a productive and satisfying life. These two forces, new data and consumer voices, have contributed to a social and political change that has begun to have an impact on public attitudes and patterns of service delivery, including criteria for reimbursement, and relationships between providers and consumers. A central focus in this evolution is the concept of recovery.

Recovery, from the consumer perspective, is a process that occurs over time in a non-linear fashion. This is reflected in a definition developed by Substance Abuse Mental Health Services Administration (SAMHSA): Mental health recovery is a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full human potential or “personhood.” Ten characteristics of recovery and recovery-oriented services were also identified by SAMHSA:

1. Self-direction, 2. Individualized and Person-Centered, 3. Empowerment, 4. Holistic, 5. Non-Linear, 6. Strengths-Based, 7. Peer Support, 8. Respect, 9. Responsibility, 10. Hope. The SAMHSA definition has become the standard for the field. It has been adopted by the Veterans Health Administration and several state mental health systems, and will guide future SAMHSA funding programs. Others have made the distinction between recovery “from” an illness (i.e. disease is no longer present) to recovery “in” the illness, which emphasizes “learning how to live a safe, dignified, full, and self-determined life, at times in the face of the enduring symptoms of a serious mental illness” (Davidson et al., 2005, p. 324) and may be more relevant for many people for whom mental illness will be an ongoing condition.

It is important to remember that recovery does not necessarily mean that one is symptom free or “cured”. Rather, recovery for many means learning to effectively manage symptoms and utilize wellness strategies in order to achieve the things that matter in life: love, work and community contribution. People in recovery often use mental health and peer support services continuously or intermittently to support recovery throughout the lifespan. We view recovery as an essential component of our therapeutic stance for individuals experiencing their first episode of psychosis. The work of the team is based on the notion of recovery, with interactions that will engage the consumer with respect, encourage consumer responsibility, and foster empowerment. The therapeutic stance is strengths-based rather than focusing exclusively on symptoms and impairment, and will foster hope. This is especially critical in working with individuals experiencing their first episode of psychosis. The emphasis will be on what the consumer can do and would like to do, rather than on what he or she cannot do. Care will be tailored to the needs of each individual at any given time rather than one size fits all, as has historically been common in many treatment programs. Decisions about which treatments will be provided will consider consumer preference, clinical status, specific impairments, and the phase of illness in which the treatment is occurring.

While the philosophy of the team emphasizes recovery as defined above, consumers and family members might have some resistance to the idea of recovery as they understand



it. For instance, some family members may fear that a recovery approach means that mental health systems will withdraw service eligibility after a person is “in recovery” and that they will be left with no support. Sensitivity to this fear and reassurance that services will be ongoing can help families be more accepting of the recovery approach. There can also professional resistance to recovery approaches: “I’ve never seen a person diagnosed with schizophrenia who has recovered” or “In school they taught me this was a chronic illness”. Courtenay Harding’s notion of the “clinician’s illusion” can be helpful explaining this perception that no one gets better (Harding & Zahniser, 1994): “The ‘illusion’ occurs when clinicians repeatedly see the few most severely ill in their caseloads as ‘typical’ when, in fact, such patients represent a small proportion of the actual possible spectrum. Recent worldwide studies have investigated the assumption of downward course and all have found wide heterogeneity in the very long term outcome (over 2 decades) for schizophrenia, despite differences in diagnostic criteria used (e.g. 7-14). However, notwithstanding the criticisms of diagnostic differences (valid or not), all of these studies have come to the same conclusions. The longer investigators follow an identified intact cohort (whether probands were in or out of treatment), the more pronounced the picture of increasing heterogeneity and improvement in function. These studies have consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases” (p. 140). In order to work effectively, all Team members must understand that recovery is possible.

## **B. Shared Decision-Making (SDM)**

Mental health clinicians and consumers often disagree regarding the goals of treatment and regarding specific treatment decisions. For example, mental health professionals are often more concerned with symptoms and illness management, while consumers are more concerned with practical matters like resuming employment and independent housing. Consumers often report that their views are neither elicited nor valued. Clinicians often express surprise when consumers’ preferences are made explicit.

Shared decision making (SDM) is an approach to setting goals and making treatment decisions that enables clinicians and consumers to clarify disagreements and to reach compromises. SDM relies on techniques such as decision aids, discussion of options, decisional balance exercises, comparing parallel ratings, and negotiating compromises. It aims to increase knowledge, to increase the consumer's participation in and commitment to treatment, to enhance the professional's understanding of the consumer's values and preferences, and to strengthen the therapeutic alliance. SDM targets many factors associated with consumer satisfaction and identified barriers and facilitators of treatment utilization. SDM challenges traditional assumptions that the team member always knows what is best for an individual. Instead, shared decision making asserts that the best decisions about treatment are made when individuals collaborate with treatment team members. In the shared decision making process there are two experts in the room: the team member is an expert in the science and practice of medicine, and the consumer is an expert in what matters in his or her life.

Numerous studies show that SDM improves the quality of decisions, consumers' satisfaction, and the treatment alliance. In evidence-based practice in general medical care, SDM is associated with greater knowledge of health conditions and treatments, better treatment adherence and engagement, better health outcomes, and greater satisfaction with care. Studies using SDM approaches with individuals with schizophrenia suggest that participation in the decision-making process is feasible and that individuals can make rational, informed decisions regarding their treatment. Controlled trials of SDM in mental health settings, including studies of individuals with schizophrenia, show positive results (Kreyenbuhl, Nossel, & Dixon, 2009).

SDM provides a useful framework within which the preferences of consumers can be integrated with the recommendations of team members. As such, SDM is the standard therapeutic strategy employed in every component of the Early Intervention Program Treatment Team, and all team members must understand SDM and practice it in their own domain of intervention. As implemented by the team, SDM is a collaborative process in which the

consumer and the team member share knowledge and information and actively participate in treatment decisions, resulting in an agreement on a preferred treatment approach. The role of the team member in this process is to educate the consumer concerning available, evidence-based treatments, acknowledge and help clarify consumer preferences and values which may impact treatment decisions, and empower consumers to take an active role in the decision-making process.

All team members will be trained in SDM, and SDM will be used as team members work together with consumers and family members to identify goals, develop solutions to problems, make treatment choices, and revise treatment objectives over time. Consumers will be taught SDM and advised to use it when making treatment related decisions so that consumers feel that they are an integral and dominant part of the decision making process. As part of their training, consumers will be provided with a SDM wallet card that lists the steps of SDM and encouraged to review it during meetings with team members. The team uses SDM both as a general approach to discussions and as a specific set of techniques for important decisions.

**1. Basic Steps in SDM.** SDM involves several basic steps. These are sometimes insinuated into clinical discussions and sometimes used explicitly with decision aids and documentation for each step. The participants in SDM are the consumer (sometimes joined by family or friends) and the clinician (sometimes clinical team).

**Step 1. The consumer defines the problem or the decision to be made.** For example, they agree to establish goals of treatment, to decide whether or not to include the family in a meeting, or to make a decision about changing medications.

**Step 2. Options are outlined.** Following the above examples, establishing goals might begin with a list of common goals. The options regarding a family meeting might be to exclude the family, to include the family with a specific agreement to limit topics or sharing of information, or to include the family without limits on topics or information. The medication decision options might include staying with the same dose, increasing the dose, adding a side effect medication,

changing medications, or “watchful waiting” and learning more about one’s symptoms before making decisions around medication use.

**Step 3. The pros and cons of each option are considered with information and educational materials provided as needed.** For example, they might consider the advantages and disadvantages of prioritizing employment, sharing an important meeting with family, or increasing a medication dose. In this process, the consumer emphasizes her/his goals, values, or preferences; the clinician adds scientific information regarding likely outcomes, side effects, and/or unwanted medication effects (i.e., going with a neuroleptic that has a lesser chance of metabolic syndrome but a higher chance of TD).

**Step 4. The participants express their preferences.** For example, the consumer ranks her/his top three goals in order and the professional does so also. Or each gives an opinion regarding the family meeting or the medication decision. The process can be conducted on paper or verbally.

**Step 5. Once areas of agreement and disagreement are clear, the participants negotiate compromises on areas of disagreement.** For example, they might identify different goals but agree to include each person’s top three goals on the treatment plan. If they disagree on including the family in a meeting, they might agree to meet without them in the next meeting and with them in the following meeting. Or they might disagree on increasing the medication and compromise on a plan to monitor symptoms and revisit the decision in one week.

**2. SDM as a generic process.** Team members incorporate SDM principles as a general process by asking themselves the following questions during a discussion: Are we clear and in agreement about the current issue, problem, or decision? Have we identified the relevant options? Do the consumer and I have all the information we need about this topic? Are we clear how the consumer’s important values influence this decision? Is everyone who needs to be involved here? Have we clarified our preferences and any disagreements? If we disagree, have we negotiated a compromise? Have we put the plan in writing?

As an example, consider a decision regarding disclosure in supported education. Does the consumer want to disclose information regarding her/his illness, disability, or needs for accommodations to a teacher? What are the options? For example, who would speak with the teacher? What exactly would be disclosed? What is the goal? What is most important to the consumer in this situation – to avoid disclosure or to receive an accommodation? What are the advantages and disadvantages of disclosure and of requesting an accommodation? Does the consumer need to speak with a girl friend, a parent, or a past teacher about this decision? What are the consumer's and the clinician's preferences? Have the consumer and clinician negotiated a plan that both believe is ethical, realistic, and likely to meet their goals? Have they written down the specific plan for addressing this situation?

**3. SDM as a structured technique.** SDM can also be used in a more formal fashion, as described above in Section B. Team members use SDM in this structured fashion to determine treatment goals, to select treatments that match specific goals, and to make some important decisions regarding treatment. As a structured technique, SDM involves using specific forms for education, for decisions aids, and for documenting steps in the process.

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/consumersurvivor/shared.asp> - includes SAMHSA “Cool Tools”

**4. Training in SDM.** All members of the team will be trained in the principles and techniques of SDM. Training will include readings, discussions, demonstrations, and role-playing. Clinicians are expected to use SDM as a general approach with consumers and as a technique for making decisions regarding goals and treatments. Training will cover the five steps described above.

In teaching these steps, trainers will start with common examples and will proceed to examples that can be difficult or contentious. Training will include specific decision aids and specific techniques. Decision aids can be used for setting goals and for selecting interventions to reach an important goal. For example, a decision aid can be used to obtain accurate information, clarify values, consider pros and cons, and express preferences in relation to searching for a job, applying for disability, attending Alcoholics Anonymous, sharing personal information with family, or reducing the dose of a medication.

In training exercises, we will cover decisions that will affect each of the team members. Because they work as a team, they need to understand how each member approaches key decisions.

**5. Medication management as illustration.** Learning to use medications as part of one's recovery plan is an important area of SDM. People with FEP specify their important goals and their reasons for using medications. Recognizing the need for medications and coping with side effects are difficult processes. Education, support, and alliance are critical issues.

The team uses standardized educational materials, SDM techniques, and a working relationship to help each consumer make good decisions and achieve an optimal adjustment. Training focuses on specific techniques and considers in depth specific common scenarios: consumers who do not believe they have an illness, initial choice of medications, involving family in medication decisions, non-responsiveness to medications, dealing with side effects, decisions to stop medications, and the effects of alcohol and other drugs on medications.

### **C. Active and Focused Treatment**

In order to maximize their effectiveness during the relatively brief intervention period, the team must maintain an active and focused stance. “Active” means that the team is proactive in connecting with a consumer and his/her family, and providing the information needed for consumers to consider all relevant treatment choices. For example, the Team Leader can actively reach out to consumers at home and in other places in their environment as needed to promote engagement with the team. This proactive approach continues throughout the initial phase of engagement and comes into play at any subsequent point at which the connection between the consumer and his or her system of supports is threatened. “Focus” refers to the team’s effort to both address intervention areas while also helping consumers and family members partner with community providers for future treatment needs.

### **D. Flexible and Consistent Treatment**

For the team to be both flexible and consistent may seem contradictory, however both clinical stances are very important. Flexibility allows the team to respond sensitively and practically to a myriad of situations. For example, a particular feature of the team may seem well suited to a consumer at first, but may ultimately prove impractical or undesirable when the time comes to put it into action. Flexibility permits the team to adjust the plan accordingly. Flexibility also allows the team to respond to consumers on an as-needed basis when circumstances dictate. Flexibility is a companion to ongoing needs assessment, which takes into account changing individual needs and contexts. Team members must be flexible and treat the consumers with whom they work differently depending on each individual’s particular constellation of strengths and difficulties. Consistency is the complement of flexibility. It is important for consumers to feel that team members are consistent as people and professionals. As professionals, Team members must be trusted to remember their appointments, arrive on time, listen during a meeting, explain things in an understandable way, and behave reliably over the course of their many interactions. As people, team members must be consistently supportive, empathic, and trustworthy.

## **E. Fostering Autonomy and Remaining Available**

The team must try to strike a balance between being responsive and encouraging independence on the part of the consumer and his or her caretakers. At the beginning of the intervention, members of the team, especially the Team Leader, meet frequently with consumers and are very involved in facilitating care. Team members must also work to develop a close rapport with consumers at this stage. Over time, consumers and family members assume increasing responsibility for their care or find resources in the community that can help them where and when they need it. Consumers and families move along a continuum of support: sometimes they may need more autonomy in order to grow; other times, they may need greater support to maintain psychological or material stability. The team must titrate the degree of support they provide according to consumer and family needs.

## **F. In-Depth Safety Planning**

**1. Overview and Scope of Safety Planning.** Previous research has demonstrated that individuals with psychosis report suicidal behavior early in the course of illness (Melle et al., 2006) and that at least 80% of individuals who report a suicide attempt made their first attempt after the onset of psychosis (Harkavy-Friedman et al., 1999). Therefore, when treating individuals with first episode psychosis (FEP), there is an ongoing need for the assessment and management of suicidal behavior and ideation. This ongoing process relies on sound clinical judgment informed by research findings.

This manual describes an approach to identifying and managing individuals with FEP who are at elevated risk for suicide (e.g., participants who have made suicide attempts in the past, or those with current suicidal ideation) through acute periods where they are experiencing current increased risk (e.g., marked rise in suicide ideation, increased hopelessness or depression). We provide a method of obtaining a full history of previous suicidal behavior and current self-reported suicidal behavior and ideation and appropriate interventions to help manage risk. It is important to remember that this information is not intended to substitute for clinician judgment in the evaluation and treatment of suicide risk. Instead, its goal is to provide guidance to clinicians



to supplement their management of these participants in the hope that participant safety can be enhanced while using hospitalizations only when absolutely necessary.

Risk assessments and two interventions are conducted: safety planning intervention and immediate attention to treating psychotic symptoms, since increased or recurrent psychosis are often critical risk factors for suicidal behavior. This manual describes a strategy in which careful assessment, triage, and implementation of the safety planning intervention (Stanley and Brown, 2010) along with dosage adjustment, switching or addition of antipsychotic medication designed to reduce suicide risk in FEP, are employed. In addition, pharmacologic and psychosocial approaches that target modifiable factors known to increase suicide risk (e.g., current substance use, impulsivity, heightened feelings of hopelessness) ought to be considered, but describing the treatment approaches to these symptoms is beyond the scope of this manual.

**2. Definitions.** The following definitions apply to terms used in this manual:

**Suicide attempt:** A potentially self-injurious behavior, associated with at least some intent to die as a result of the act. Evidence that the individual intended to kill him/herself can be explicit or inferred from the behavior or circumstance. A suicide attempt may or may not result in actual injury.

**Interrupted attempt:** A potentially self-injurious behavior with suicidal intent that would have resulted in an attempt except that: someone else prevented the behavior (e.g., suicidal individual had pills in hand and about to swallow them when someone walked into the room and stopped the individual from ingesting the pills; or the suicidal individual reconsidered and stopped himself/herself before making the attempt (e.g., the individual went to a bridge to jump in a suicide attempt but decided not to and went home).

**Suicidal ideation:** Passive thoughts about wanting to be dead (i.e., wish to die or wish to go to sleep and not wake up) or active thoughts about killing oneself (i.e., actively thinking about killing self or considering a method or plan).

**Elevated risk of suicide:** Lifetime history of a suicide attempt or history of an interrupted suicide attempt or current suicide ideation as indicated by a positive response ( $\geq 3$ ) to HASS-I or HASS-II critical items listed in Section IV-A.3.

**Acute risk of suicide:** Immediate current increase in suicide risk as evidenced by individual reporting serious suicidal ideation, especially in the presence of a suicide plan and/or suicide intent. This determination is made by conducting further evaluation of positive responses on the critical items from HASS-I listed in Section IV-A.3.

**3. Risk factors for suicide in psychosis.** Risk factors for suicide in psychosis are somewhat different from those found in other conditions (Caldwell & Gottesman, 1990; Drake

et al., 1984; Harkavy-Friedman et al., 1999). It is important to remember that the majority of individuals with FEP are relatively young and male. They are faced with a frightening and isolating experience and may not feel in control of their behavior. Factors such as feelings of isolation, hopelessness and fear of recurring or further mental deterioration may be present. Their problem-solving abilities when faced with stressful life changes, such as loss of relationships, need for ongoing treatment, and hospital discharge planning may be challenged, and symptoms such as behavioral and cognitive disorganization can impair judgment and behavioral control. In addition, past suicide attempts, aggression, impulsiveness and substance use can also interfere with adaptive functioning and increase risk for suicidal behavior.

Hopelessness about the future and the fear that FEP may be the start of a long and chronic illness – without any information or education regarding the empirically-based evidence that recovery is possible – are especially important initial risk factors. Drake et al. (1984) identified the non-psychotic, depressed phase of the illness as particularly high-risk, especially for some young patients with chronic and relapsing illness, good educational backgrounds, high performance expectations, painful awareness of illness, fears of further mental disintegration, suicidal ideation, and hopelessness about the future. Mamo (2007) reported that the key danger signs are depression, despair, and hopelessness in recent-onset participants, especially those with higher cognitive functioning and higher educational attainment. Individuals with less successful pre-morbid functioning may lack problem-solving skills and be at increased risk as well.

It is important to consider the unique aspects of psychosis, especially FEP, when using the safety planning intervention. This intervention is based on a straightforward approach to preventing self harm, with an emphasis on engaging in a discussion about this topic early in the treatment process and having a plan available to implement, if needed. While such an approach is very useful for those who will talk about self harm and suicide, clinical experience suggests that there are others with psychosis who may also engage in suicidal behavior. For example,

clinical experience with individuals with schizophrenia suggests that those who engage in suicidal behavior may become hopeless after some major loss or stress, such as a relapse of illness, may withdraw from treatment when they leave the hospital, and may commit suicide using a very lethal attempt (such as jumping off a building or under a train) without talking to anyone or reaching out to anyone. Therefore, ongoing clinical attention to suicidality and sound clinical judgment are crucial. Also, heightened monitoring of suicidality when hopelessness and/or major stresses and losses occur is indicated. This suggests that the overall approach to suicide prevention is for the members of the treatment team to stay closely connected to the participant, to work diligently to prevent withdrawal from treatment, and to constantly model and address hope and connectedness.

**4. Assessment of suicidal behavior.** In order to determine the current level of suicide risk, standardized assessment tools are suggested: The HASS-Demo, which gathers information about the individual's history of suicidal ideation and attempts; the HASS-I, which surveys suicide ideation and behavior for the past two weeks; and the HASS-II, which surveys lifetime ideation and behavior except for the past two weeks. They will be administered at study entry, and the HASS-I will be administered when there is concern about recent suicidal ideation or behavior. These instruments have been chosen because they allow for a brief self-report format for assessing suicidal behavior and have been used with hundreds of individuals with psychotic disorders. The HASS-I has demonstrated sensitivity to change from hospital admission to discharge (Harkavy-Friedman, 2009). The HASS-I and II are 22-item self-report questionnaires that ask about suicidal ideation and behavior. Items are rated on a five-point Likert scale (range: 0 = never to 4 = daily) and assess experience with specific behaviors.

After the HASS-I is administered, the information obtained is used by the clinician to determine any indication for management of suicidal ideation or behavior. Any non-substance related item that specifies active suicidal behavior (i.e., items 3, 7, 8, 10, 11, 12, 16, 17, 19, 20,

22) scored above 1 should be followed up with further questioning. Critical items from HASS-I that trigger further evaluation:

- Item 3. Had ideas about killing yourself?
- Item 7. Been in high places and felt like jumping?
- Item 8. Thought about ways to kill yourself?
- Item 10. Gotten so discouraged that you thought about ending your life?
- Item 11. Felt like running into traffic?
- Item 12. Had a plan of how you would kill yourself?
- Item 16. Thought about killing yourself but did not try to do it?
- Item 17. Tried to kill yourself?
- Item 19. Talked to someone about killing yourself?
- Item 20. Had a plan to kill yourself, started to do it and then stopped at the last moment?
- Item 22. Heard a voice(s) telling you to kill yourself?

Participants suspected to be at risk for suicide as determined by the HASS-I will be asked the following questions by a clinician: (1) You mentioned that during the past two weeks you experienced ...; do you have a desire to kill yourself that you think you might act on? (2) Do you have a plan for killing yourself and do you intend to carry the plan out? Participants reporting a moderate to severe level of suicide intent as indicated by these items (score of 3 or greater) or during a clinical interview will be provided with an increased level of clinical assessment and appropriate intervention.

**Elevated suicide risk** is determined by assessing past history of suicidal behavior. It is important to gather information about the type of behavior (ideas, attempts), the frequency, planfulness, persistence of suicidal ideation, the medical damage of previous attempts, the strength of the intent to die and the circumstances surrounding suicidal behavior (Harkavy-Friedman & Nelson, 1997). The HASS-Demo is used to facilitate this assessment along with the HASS-I and HASS-II. The HASS-I can be re-administered any time there is concern about the presence of suicidal behavior.

**Acute suicide risk** triggers further clinical evaluation and should include an assessment of current suicidal ideation including frequency, persistence and planfulness. It is also important to assess the person's psychotic behavior (type, frequency, awareness and attitude toward symptoms, and strategies for managing psychotic symptoms). Assessing the presence

of command auditory hallucinations and how the person manages them is also important (Harkavy-Friedman et al., 2003). Since being bothered by psychotic symptoms is one of the main reasons reported for suicidal behavior (Harkavy-Friedman et al., 1999) medications and their effectiveness can play a role regarding the presence of suicidal behavior, making it important to assess type, dose, efficacy, side effects, and need for adjunctive medications such as anti-depressants over the course of treatment. Finally, it is important to assess co-morbid depression (Harkavy-Friedman et al., 2004) and substance use along with recent stressors.

When **acute suicide risk** is indicated either by responses on the HASS or during clinical treatment, it is important to provide a safe haven, whether that involves the family, support network or hospitalization. In an acute situation when safety planning is not enough, it is important to maintain constant observation of the person, remove and restrict access to means and assist the person through the acute high-risk period. Reduction of suicidal behavior will include stabilizing psychotic, depressive or other symptoms while limiting medication side effects. Using the safety plan, it will be important to mobilize and support social networks.

**5. Triage of suicidal clients.** Once a risk assessment is completed, the clinician must determine the appropriate level of care for the participant. In particular, the clinician must first determine whether immediate emergency intervention is required. The clinician must then determine which of three usual options is indicated: hospitalization (either voluntary or involuntary); increased monitoring (e.g., increased contact by phone and/or in person with the clinician and, if this is decided as appropriate, the type and frequency of this contact); or continued treatment at current level of care. In addition, the safety planning intervention should be invoked at this point, particularly for those participants who will be maintained on an outpatient basis. If the participant is hospitalized, the intervention should be done at discharge so that it can be used going forward. The American Psychiatric Association has developed useful guidelines on the assessment and treatment of suicidal patients to which clinicians should refer for guidance: <http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1663420#112155>

## **6. Safety planning intervention overview (adapted from Stanley & Brown, 2010).**

The safety planning intervention will be completed following suicide risk assessment (cf. American Psychiatric Association, 2003) and administration of the HASS-Demo, -I and -II, if the participant has been evaluated as at elevated risk for suicide. Variants of this intervention are utilized in cognitive therapy and cognitive behavioral therapy for suicide prevention (Stanley et al., 2009). During risk assessment, an account of the events that transpired before, during, and after the most recent suicidal crisis is obtained by the team leader using the HASS-Demo and HASS-I. This description will include any activating events, and the participant's reactions to these events. Such a description will assist in the identification of warning signs to be included in the safety plan as well as the identification of specific activities that may be used to alleviate a crisis. Consistent with the safety planning intervention and the spirit of integrating participant preferences, the team leader and participant develop the safety plan together. Safety plans will be brief, will use an easy-to-read format, will use the participant's own words, and will be given to the participant and maintained in the his or her clinical record.

**7. Approaching safety planning in the context of FEP.** It is important to remember that while many participants with FEP will be engaging in treatment and meeting with the treatment team, they are simultaneously experiencing a critical struggle to understand FEP, to put it into some sort of context that they can understand, to process the impact FEP might have on their lives, and to maintain hope that everything will eventually turn out well. Safety planning – with its focus on potentially frightening topics such as self harm and suicide – may be an extremely difficult activity for individuals with FEP to face. It is critical that team members understand that participants with FEP may initially view the FEP experience – and the need for safety planning – as frightening. Most participants, however, will find safety planning comforting as it will help them to manage difficult thoughts and feelings and to outline a plan of action for them. The goal of safety planning is one of planning ahead and being prepared for something that can, but doesn't always, happen. A good analogy to use is that of planning for other potential emergencies (e.g., doing fire drills with the hope that a fire will not occur).

It is important to acknowledge that fear of being involuntarily hospitalized for reporting suicidal impulses can be a major disincentive to reporting such impulses. Safety planning can be a tool that can help minimize the need for hospitalizations. Participants may learn to disguise intent and underreport in order to avoid involuntary commitment. It is important to explicitly discuss the grounds for invoking involuntary measures and to emphasize that involuntary hospitalization is only used as a way to protect the participant until the acute suicidal risk has passed. The participant must know that discussing suicidal ideation is not, in and of itself, grounds for involuntary hospitalization. Involuntary measures, especially when invoked “by surprise,” can undermine the alliance with the participant. If there is a non-negotiable zone with regard to intent to self harm, that needs to be clarified well in advance so it does not come as a surprise. The stance related to acting to protect a participant when he or she is a danger to himself or herself comes from the clinician’s goal of helping the participant with FEP pass through periods of high risk rather than supporting self-destructive behavior. We know that periods of high risk do pass and getting through them is the challenge.

**8. Components of Safety Planning.** The basic components of safety planning include (1) recognizing warning signs that are proximal to an impending suicidal crisis; (2) identifying and employing internal coping strategies without contacting another person; (3) socializing with family members or others who may offer support as well as distraction from the crisis; (4) contacting family members or friends who may help to resolve a crisis; (5) contacting mental health professionals or agencies; and (6) reducing the potential for use of lethal means.

Participants are instructed first to recognize when they are in crisis and then to follow each step as outlined in the plan. If following the instructions outlined in the first step fails to decrease the level of suicide risk, then the next step is followed, and so forth.

**Step 1: Recognizing warning signs.** The first step in developing the safety plan involves the recognition of the signs that immediately precede a suicide crisis that are integrated

into a list on the safety plan. The HASS-Demo will help to identify risky circumstances. These warning signs can include thoughts, images, thinking styles, mood, or behavior. Participants learn to identify and pay attention to their warning signs. Questions such as: “How will you know when the safety plan should be used?” will help participants identify these signs. In addition, participants list experiences noted to be concurrent with the time they begin to think about suicide or feel distress. These warning signs are listed on the safety plan in the participants’ own words, such as “feeling irritable,” “feeling down,” “worrying a lot,” “feeling hopeless,” “having relationship problems,” or “thinking that I cannot take it anymore.” Similarly, problematic behaviors can be listed that are typically associated with suicidality such as “spending a lot time by myself,” “avoiding other people,” “not doing activities that I usually do,” or “using drugs.”

Additional warning signs that may affect people with psychosis include feeling overwhelmed by their illness and feeling that recovery is not possible, and having hallucinations, including command, negative voices telling him or her to harm or kill him/herself. Some participants may experience voices telling them that they are worthless and deserve to die, and/or commanding them to do something potentially harmful (e.g., get a gun, go to the top of a tall building) or to commit suicide (e.g., shoot or jump). Knowing to report the emergence of these types of voices/thoughts is a key to knowing early warning signs of suicide in FEP. The team leader must query about these sorts of voices in the initial safety planning meeting. If the participant feels under control of command auditory hallucinations and unable to resist them, the clinician should be contacted or the participant should seek a safe haven such as an emergency room.

**Step 2: Using internal coping strategies.** After identifying signs and circumstances associated with a suicidal crisis, participants list activities that they could do without needing to contact other people. Such activities function as a way for participants to distract themselves from the crisis and prevent suicide ideation from escalating. Examples of coping strategies include going for a walk, listening to inspirational music, going online, taking a shower, playing



with a pet, exercising, engaging in a hobby, reading, or doing chores. Activities that serve as “strong” distractions vary from person to person and, therefore, the participant should be an active participant in generating ideas. As a therapeutic strategy, it is useful to have participants try to cope on their own with suicidal ideation, even if it is just for a brief time. Participants may be asked, “What can you do, on your own, if you get suicidal again, to help yourself not to act on your thoughts or urges?” After internal coping strategies have been generated, the clinician should obtain specific feedback. For example, the team leader can ask, “How likely do you think you would be able to do this during a time of crisis?” If participants express doubt about their ability to implement a specific step on the safety plan, then the team leader will ask: “What might stand in the way of you thinking of these activities or doing them?” The team leader will use a collaborative, problem-solving approach to ensure that potential roadblocks to using these strategies are addressed and/or that alternative coping strategies are identified. If participants still remain unconvinced that they can apply a particular strategy during a crisis, other strategies should be developed. The team leader will help participants identify a few of these strategies that they would use in order of priority; the strategies that are the easiest to do or most likely to be effective are prioritized at the top of the list.

**Step 3: Using socialization to distract from the crisis and to obtain support.**

Together with the team leader, participants will identify safe, non-triggering social settings and key people who may be able to help if internal coping strategies do not reduce suicidal ideation. When contacting others, participants may or may not inform them that they are experiencing a crisis and are in need of help. Socializing with friends or family members without explicitly informing them of their suicidal state may assist in distracting participants from suicidal thoughts, or help them to feel connected with others and thus, alleviate the suicidal crisis. Participants are specifically instructed to reach out to these individuals if engaging in the activities in the second step does not resolve the crisis. It is key to list several people, in case participants cannot reach the first person on the list. The list of individuals who may be contacted is prioritized, and phone numbers are included. In addition, the participant identifies safe social settings such as a

local coffee shop, house of worship, library or AA meeting, if appropriate, to serve this function, especially if the participant has a limited social circle. Finally, it is important to identify and note specific reasons for living that can serve to mitigate suicidal behavior.

**Step 4: Contacting family members or friends who may offer help to resolve a crisis.** This step involves planning for action to be implemented when internal coping strategies or socializing with others does not alleviate the crisis. Participants may choose to inform family members or friends that they are experiencing a suicidal crisis. However, given the complexity of deciding if participants should or should not disclose to others that they are thinking about suicide, the team leader and participant should work collaboratively to formulate an optimal plan. This will include weighing the pros and cons of disclosing their suicidal state to a person who may offer support. Thus, participants may choose to enlist individuals who may help to distract themselves as indicated in Step 3, as well as individuals who will assist in managing a suicidal crisis as indicated in Step 4. For both of these steps, participants should be asked about the likelihood that they would contact these individuals and to identify potential obstacles and ways to overcome them.

In developing safety plans with participants with FEP, many of whom will be late adolescents, it may be important to identify key adults to participate in the plan. Adolescents will determine which family members or other responsible adults are more likely to have a calming and effective coping influence. Some family members, particularly those with whom the adolescent has frequent conflicts, may not be good candidates to enlist to participate in the safety plan. Family members can also be coached to help the participant use the safety plan. In addition, special care must be taken when helping the participant identify individuals other than family members who may offer support and distraction from the suicidal crisis.

These first four steps have the added benefit of helping the participants develop self-efficacy, which in turn helps the participants feel less vulnerable as they develop some sense of mastery over their feelings/crises.

**Step 5: Contacting professionals and agencies.** The fifth step consists of generating the telephone numbers and/or locations of professionals who can assist in a time of crisis. Participants are instructed to contact a professional or agency if the previous steps (i.e., internal coping strategies, contacting friends or family members) are not effective in resolving the crisis. As with the other steps of the safety plan, the list of professionals or agencies may be prioritized. The safety plan will include the name and phone number of the team leader and the team pager number. However, the safety plan should also include other professionals who can be reached, especially during non-business hours. Specifically, contact information for a local 24-hour hotline should be listed, as well as other local or national support services that handle emergency calls (such as the Suicide Prevention Lifeline: 800-273-TALK). Participants may be reluctant to disclose suicidality to professionals for fear of being hospitalized. The team leader will discuss the participants' expectations when they contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so.

**Step 6: Reducing the potential for use of lethal means.** The risk for suicide is amplified when there is a readily available lethal method. Thus, a key component in a safety plan involves limiting access to any potential lethal means. This may include safely storing medication, implementing gun safety procedures, or restricting access to knives. For methods with low lethality, the team leader will ask participants to remove or restrict their access to these methods themselves. The urgency and importance of removing access is more pronounced when the lethal weapon is a firearm. The optimal plan is for the highly lethal method to be removed and stored by a designated, responsible person – usually a family member or close friend, or even the police (Simon, 2007). Of note, removal of a lethal method does not guarantee participant safety because participants may decide to use another method. If participants report any other methods or specific plans for suicide, then these means should also be secured or removed. Specific behaviors for making the participants' environment safer should be noted on the safety plan.

**9. Tailoring Safety Planning for FEP.** There are several ways in which development of the safety plan must be tailored for FEP:

**Involve family members.** Family members should be involved in the development of the safety plan. Family involvement is important for several reasons. Family members can help with concrete ideas to use in the safety plan, especially when the participant is symptomatic and may be unable to suggest practical coping strategies that can be used to maintain safety. Family members can also serve as contacts who can watch for concerning signs such as increased isolation, depression and substance use and alert the treatment team of changes in mood that might precede attempts at self harm. Family members should be allies in identifying external messages of hopelessness and chronicity, whether via a drug company advertisement, a Hollywood movie, a TV ad or newspaper article. They should discuss exposure to these messages, particularly when the person with FEP was present, and openly identify to the participant the message as lacking support from scientific studies on recovery. In addition, because research shows an increased risk for suicide in individuals with high expectations for achievement, these expectations must be addressed, and the team leader should work to enlist family members to express to the participant their understanding of the illness and their acceptance that expectations may need to change, either temporarily or permanently. The family member can communicate to the participant that his/her family understands why the participant is having difficulty and that the family does not hold the participant responsible.

**Awareness of warning signs in FEP.** Be sure to include warning signs that are frequently found in FEP, including isolation, feelings of hopelessness, and withdrawing from family/treatment. These have been found to precipitate suicides in people with psychosis (see Overview). Also, as stated earlier, assess the potential presence of psychotic symptoms such as command auditory hallucinations that may impact suicidal thinking. An increase in psychotic symptoms may be a trigger for suicidal behavior, especially since an increase in psychotic symptoms can heighten fears and feelings of hopelessness. Alcohol and other substance use, as well as recent loss, are also potential triggers.

**Consult with the team.** The team leader should consult with the treatment team to determine when participants should be encouraged or coached to follow their safety plan and when a higher level of observation or other external precaution should be implemented. In consultation with the treatment team, the team leader should include the length of time the participant should spend on each step of the plan before moving to the next step. It is important to determine how long to wait for Steps 2-4 to work before progressing to and enacting Step 5. In FEP, a higher level of intervention should be considered fairly quickly, especially at the beginning of treatment when the participant may have had little experience using the safety plan and coping on his/her own with suicidal thoughts and feelings. When the plan is first developed, the team leader may opt to set time limits on each step so that the participant goes from Step 2 to Step 4 quickly. As the participant progresses in treatment and gains coping skills, the plan can be revised to include longer amounts of time to use Steps 2-4 before seeking professional assistance. The plan should include information on when the participant should go immediately to Step 5, or building in what could be termed a definition of “imminent risk.” While this should be discussed between the participant and the team leader, the plan should include certain signs, such as persistent suicidal thoughts or a formed plan for self harm, that require immediate attention by the treatment team or other professionals.

**10. Implementation/Adaptation of the Safety Plan for Special Populations and Settings.** After the safety plan has been completed, it is important to assess the participants’ likelihood of using the safety plan. If the participant is reluctant or ambivalent about its use, the team leader needs to work with the participant to identify and modify negative beliefs, feelings, or assumptions about using the safety plan. This can involve a discussion about what it means to the participant to have a safety plan and his/her feelings around discussing safety with other people during a high-risk time. While educating the participant about the need to have a safety plan and the importance of the plan as part of comprehensive treatment for FEP, the team leader should also pay attention to the participant’s feelings about the plan. That is,

the participant may understand the reason and need for the plan, but might feel anxiety or fear due to having an illness that might involve self harm. The team leader should address the participants' feelings of hopelessness or negative outlook about the future owing to the illness and let the participants talk about their feelings about this rather than maintain a purely educational/problem-solving stance. Use of reflective listening can be especially helpful in allowing participants to express their feelings about the plan and its place in their life.

The team leader should be prepared to address psychotic symptoms such as delusions or paranoia that may impede a participant from using the safety plan. For example, paranoia may keep a participant from informing family members about safety issues and elevated risk. The assessment of whether or not the participant will actually use the strategies on the list should include discussion of what to do when the participant is symptomatic, such as having a family member either assist in implementing the safety plan or contacting the treatment team or other professionals if the participant is too symptomatic to do so. The team leader should also determine if there are particular situations in which the participant would find it difficult to use the plan – such as when the participant has been doing well for a while, or when the participant is at work or school or with friends and not with family members – and then problem-solve so that the participant feels comfortable using the safety plan no matter what the circumstance.

Once the participant indicates a willingness to use the safety plan during a crisis, the original document is given to him/her to take home and a copy is kept in the medical record. The team will also discuss where the safety plan will be kept and how it will be retrieved during a crisis. The format of the safety plan may be adapted depending upon the needs of the participant. However, regardless of format, the most important feature of the safety plan is that it is readily accessible and easy to use.

Safety plans will be revised during subsequent visits as new coping skills are learned, as the participant's social network is expanded or as clinical or environmental conditions change. In addition, as functioning improves in one area, a participant may experience more stress or

challenge in another area. For example, after the initial crisis that brings the participant into treatment is resolved and the participant is stabilized on medication, he/she may just be starting to contend with the realities of living with psychosis and the notion that this illness must be managed for the foreseeable future. Thus the safety plan may need to be revised to include new triggers for suicidal ideation and behavior. At the same time, it is helpful to revisit coping strategies to determine if changes should be made. While there is no set schedule for revising the safety plan, the team leader should expect to review it at least quarterly.

#### **11. Link between Safety Planning Intervention and Modifiable Risk Factors.**

The safety planning intervention should be accompanied by use of additional strategies that address the major risk factors for suicide in FEP. Especially important are continued attention to treatment of depression and stress. In addition, other modifiable risk factors associated with suicide and safety, including substance abuse, social isolation, hopelessness, and anxiety, should be addressed. These factors may be listed on the safety plan as warning signs, and professional treatment or other forms of support for these conditions should be sought. For example, if substance abuse is a warning sign of suicide, Steps 3 or 4 may involve talking with a professional or seeking assistance as a way to cope with an early warning sign for suicide. Most importantly, interventions directly targeting the problem behavior should be considered and discussed with the participant.

A significant modifiable risk is staff conveying messages that can be perceived as indicating hopelessness to participants and their families (e.g., you will have to stay on this medicine for the rest of your life; you have to postpone your life goals until you are well enough to pursue them; you have to get well first, then reach for the stars; you have to avoid stress; you can't go to work until your symptoms are ameliorated). Emphasizing hopefulness and stressing the possibility of recovery is helpful in mitigating suicidal feelings and helpful in engaging participants in the development and use of the safety plan. Identifying the core problem that feels unsolvable and developing alternate strategies for problem-solving may also facilitate

safety planning. Also, it is important to emphasize to participants that periods of hopelessness and suicidal states have an ebb and flow and will pass, especially when helpful steps are taken. It is also helpful to let participants know that the suicidal moment is an intensified experience when it feels that suicide will resolve the problems they are experiencing. The clinician's role is to maintain the stance that alternative, more effective strategies will be beneficial in both the short- and long-term.

**12. Psychopharmacologic Intervention.** Based on the well-established fact that increased or recurrent psychosis (and the fear and hopelessness that treatment professionals often communicate to those who develop it) is a risk factor for suicide, a key component of the safety planning intervention will be to maximize antipsychotic treatment. Given the INTERSEPT data, we recommend that individuals who are clinically judged to be at high risk for suicidal behavior be considered for treatment with clozapine or for augmentation of their current antipsychotic regimen by either increasing the dose or switching to another antipsychotic. Appropriate psychopharmacologic intervention as part of suicide prevention must be addressed by the treatment team – especially the psychiatrist – during the initial development of the safety plan. A considerable body of literature has demonstrated that treatment with antipsychotic medications, of any type, has been associated with decreased suicidal behavior in individuals with psychotic illness.

**13. Training on Suicide Risk Assessment and the Safety Planning Intervention.** Training of the team leader, psychiatrist and recovery coach will include identification and assessment of risk factors; identification and assessment of protective factors; and review of potential intervention modalities for acutely suicidal individuals. Such interventions will include, but not be limited to, the safety planning intervention as described above; increased monitoring; medication strategies; and psychiatric hospitalization, which is considered a measure of last resort. A detailed description of the process of safety planning with case examples will be included. A didactic approach coupled with role play are essential features of the training.



Samples of safety plans developed with suicidal individuals will be reviewed in the training. Periodic review of safety planning will be conducted to ensure fidelity to the procedure.

#### **IV. Critical Time Intervention and the Early Intervention Program**

CTI provides the major organizing structure to the activities of the Early Intervention Program Treatment Team. Critical Time Intervention (CTI) is a time-limited psychosocial model designed to enhance continuity of support for persons with serious mental illness during critical periods. Originally developed and tested with individuals during the transition from shelters to community housing, CTI has since been applied during other critical periods, such as the months following discharge from inpatient psychiatric treatment. CTI aims to provide emotional and practical support and strengthen the individual's long-term ties to services, family, and friends during the critical period. A number of studies, including several randomized trials, have demonstrated the effectiveness of the model (Herman et al., 2007; Susser et al., 1997). The critical time in the Early Intervention Program is conceptualized as the time following a first or early episode/s of psychosis. The goal of CTI within the Early Intervention Program is to get consumers linked with the team as a means to receive intensive treatment that supports consumers' own goals for recovery.

##### **A. Key Components of CTI as applied to the Early Intervention Team**

There are several key components of CTI that are especially important to the Early Intervention Team.

**1. CTI within the Early Intervention Team includes ongoing assessment and treatment planning.** The Team provides ongoing assessment and treatment planning that is focused on identifying and working towards recovery goals developed by consumers and their families. Treatment plans are revised every six months to allow for regular discussion and reassessment of goals and services based upon differing levels and types of need at different points in time. The consumer and the family are included whenever possible.

**2. CTI within the Early Intervention Team incorporates family involvement.** Family members can play an important role in providing ongoing support for consumers experiencing FEP. The team works with families and other interested sources of support (friends, peers, community members) to help the consumer cope, achieve their goals, and maintain a positive outlook about the future. As noted previously, the team also provides connections to community resources so that the consumer and family develop a network that supports recovery.

**3. CTI within the Early Intervention Team recognizes consumer diversity.** Consumer variability - in age, ethnic and cultural background, etc – impacts the ways in which services are offered to meet the needs and priorities of specific ethnic and cultural groups. For example, key psychosocial developmental issues typically faced by late adolescents and young adults must be taken into account. Chief among these is the need for young adults to show differentiation and independence from family while running up against the limitations imposed by psychiatric symptoms. Relatedly, a growing body of research suggests that consumers and their families are more likely to participate in and benefit from services that are organized and delivered in a culturally competent fashion. Characteristics of such an approach include respect for service recipients' "ethnocultural beliefs, values, attitudes and conventions" (Whitley, 2007). Team Leaders will receive training designed to ensure that their practices take these issues into account wherever possible.

## **B. Guiding Strategies of CTI as applied to the Early Intervention Team**

There are several guiding strategies within CTI as applied to the Early Intervention Team. These include: (1) Assertive outreach and ongoing engagement, (2) Ongoing *in vivo* assessment, and (3) A time-limited approach.

**1. Assertive outreach and ongoing engagement.** Consumers are getting introduced to what psychosis is, thinking about how it will affect them now and in the future, and having complex feelings about treatment and what it means for their lives. CTI as applied within the Early Intervention Program involves using whatever strategies are needed in order to engage

consumers with the program. To this end, contact can be provided in the community or in the consumer's home environment rather than the office as a way to engage consumers in the short-term. The goal is to promote engagement with the team with services provided in the clinic over the long term. It requires that the team be willing to begin by addressing the most pressing concerns expressed by the consumer and relevant caretakers. Once a relationship has been established, it remains a critical task of CTI as it is applied within the Early Intervention Program to prevent consumers from dropping out of care via assertive outreach and ongoing engagement efforts. The team, lead by the Team Leader, aims to prevent loss of contact with consumers by being flexible and finding an approach (or combination of approaches) that is acceptable to the consumer and his/her family. Being persistent is also essential in order to successfully locate and re-engage consumers if they are lost to contact with services. This may involve concerted efforts to re-engage consumers who do not adhere to treatment plans or move to locations, such as shelters or correctional facilities that are unconventional for traditional mental health outreach efforts. Finally, the team must balance these assertive outreach efforts with respect for the legitimate preferences of consumers who may elect not to continue to participate in treatment. The following are specific strategies for treatment engagement and outreach to be used by the team both at the beginning and throughout their work with consumers.

**Team Leader is central contact person.** The Team Leader is the main contact person throughout the early phase of treatment. Having a single identified person gives consumers and families someone with whom to develop a relationship and ask questions. Importantly, at the start of their work with the team, the consumer and/or the family will meet first with the Team Leader and the Team Psychiatrist together. Many consumers and families will be frightened and will want to be sure they have access to the psychiatrist. Together, the Team Leader and the Team Psychiatrist will explain that they work together closely as a team and that the Team Leader will be the main contact and can always find the psychiatrist. The Team Leader will stay

connected to the consumer and family throughout the two years of the program, although he/she does not have to be the main contact in cases where a consumer feels more connected to a different team members. For example, if a consumer is working mostly with the IPS Specialist around work goals, then the IPS Specialist may have the most contact with this consumer of all team members.

**Time between screening/assessment and start of treatment is brief.** The time period between screening/assessment and start of treatment should be brief. In addition, engagement and assessment should occur concurrently. McGorry's group explains that repeated assessment by different components of the service hampers engagement (ORYGEN Youth Health, 2004). Gather information gradually, while fostering a close relationship. Introduce key players who will take part in working with the consumer to define and work towards recovery goals.

**Show sensitivity.** Be sensitive to how you interact with consumers. Use appropriate body language, especially with a consumer who is experiencing paranoia or fearful suspiciousness (e.g. sit side-by-side, avoid too much eye contact, allow personal space). Recognize that the consumer may be nervous, wary, or may not want to see a health professional. Psychosis may distort consumers' ability to process information. Overall, come to the process of meeting consumers with an understanding that at first the most important thing is establishing trust and rapport. An additional way to show sensitivity is to provide simple, clear and coherent information; a structured and predictable environment; and tolerant, non-demanding, supportive relationships with the treatment team. Carefully explain procedures involved in assessments. No matter how disorganized a person may appear, always explain procedures and next steps in a straightforward, plain-English fashion.

**Family involvement.** Have the family attend the first treatment appointment if possible and approved by the consumer. Often family members want treatment more than the consumer. Where possible, get permission to talk to the family from the very beginning. For consumers who are reluctant to have their family involved in their care, explain why family involvement is

beneficial in the treatment of psychosis. Importantly, as family involvement begins, the team must establish the terms of confidentiality and its limits. This will differ by age. Minors will have more limits on confidentiality and less ability to keep family members from being involved in their treatment. Older consumers will have more room to negotiate the role of family members in treatment, and the team will need to help determine how confidentiality will be maintained in such situations.

**Provide “instrumental help” and review needs regularly.** Help consumers and families with practical tasks they identify as important. Examples include help obtaining benefits, transportation, housing, or other services. This can be a way to show consumers and family members the benefits of treatment. In addition, these issues may be seen as more or equally important to the service recipients as formal treatment or may impede access to treatment. CTI includes regular needs assessments that will be done at the start of treatment and then reviewed and revised at regular intervals. Consumers should be asked, “What can we help with now that you are experiencing some relief from the psychosis?”

**Convey hope and focus on consumers’ goals.** The team must convey the message that “I believe you can be one of the ones to recover.” Conveying hope for recovery and belief in the individual’s resilience is foundational to engagement. Moreover, hope is powerful medicine. Engage consumers around their own goals as a way to keep them connected to treatment. Consumers’ most important goal will typically be “resuming normal life” with activities such as education/employment. If needed, change the focus from treatment/illness to a return to school/job. Most consumers want help resuming a normal life.

**Take into account the consumer’s preference of meeting sites.** The long-term goal of the team is to provide services at the clinic. Initially, or for those who are not coming to the clinic regularly, consumers might be more willing to meet at places in the community rather than at a treatment center. Assertive outreach may involve the Team Leader spending time in the community or in the consumer’s home environment in the short-term. For example, the Team

Leader can meet the consumer for coffee, a meal or a walk around the neighborhood in order to make visits seem more social. The goal here is to foster a good relationship with the consumer, and to address and work through any reservations or fears about coming to the clinic.

**Nothing is permanent.** If the consumer is reluctant to engage, don't close the door. Revisit and see if things have changed: "I understand this is how you feel this week. Let's check back in next week and let's see how you feel then." In this situation, meet with family. Family members might have ideas about how to get consumers into care.

**2. Needs assessment.** One of the first tasks in CTI and so of the Early Intervention Program Team is to conduct a psychosocial needs assessment of the consumer and his or her environment. A careful assessment of needs (including strengths) ensures that the scope of the intervention will be individually tailored to the consumer's particular needs and circumstances. The needs assessment is done by the Team Leader and the Team Psychiatrist. While complete processes and procedures for the needs assessment are provided in the Team Leader and Team Psychiatrist Manuals, there are some key features that are important to highlight here due to their relevance to the entire team. First, the goal of the needs assessment is to collect information on the consumer's history. This is done through discussion with the consumer, as well as through use of other sources of information such as interviews with family members and school records. Inclusion of family members is especially important. FEP impacts families in many ways and families will have needs that are connected to the concerns and needs of the consumer. In addition, sometimes the consumer is not thinking clearly and cannot fully engage in the needs assessment. Because of these factors, the needs assessment can be done with the consumer and family members present, or done twice separately if the consumer wants to talk without family members present. Clinicians who work with consumers with FEP have found that families and consumers are generally in agreement in terms of the importance of the consumer resuming normal life, and improving in school, work, social functioning. Second, in conducting the needs assessment, team members must balance collecting factual information

with engaging with the consumer in a recovery-oriented discussion in which the consumer is heard and his/her choices and goals are validated. Third, needs assessment is an ongoing process. Over time, modifications will be made to the information based on data gathered from documents and interviews of other people in the consumer's life. Further modifications may result from continuing dialogue with the consumer and members of his or her support network, who will likely reveal more as a stronger rapport develops with the team in general and the Team Leader in particular.

**3. Time-limited approach.** The Early Intervention Program Team is available to provide intensive services for up to a two-year period during which individuals are typically at their most vulnerable and not yet strongly connected to appropriate services and caregivers. However, the intensity of involvement by the members of the treatment team, including the Team Leader, during this period can vary depending on changes in the level of need expressed by the consumer and his/her caregivers. The two-year period is divided into three phases (described below), each of which emphasizes specific goals and activities. Of note, the third phase may be initiated anytime after completion of one year in the program as indicated in reference to findings/plans generated using the Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool. Coordinated by the Team Leader, this tool helps guide an assessment that considers input from all key stakeholders, including the consumer, his/her family, and the other members of the Early Intervention Program Team. In short, the tool should be used to help determine whether the consumer is or is not in need of continued and ongoing assistance from the Early Intervention Program. While we anticipate that the specified two-year period of intensive services offered by the Early Intervention Program will be indicated for the majority of consumers, we recognize that there is considerable uncertainty about the optimal duration of intensive services in FEP. For a minority of participants (for a variety of reasons), less than two years of Early Intervention Program service may be indicated. We recommend however, that consideration of early transition (defined as

anytime during the second year prior to the specified end of the two-year expected tenure) be considered carefully and executed on a limited basis.

### **C. Phases of CTI as applied to the Early Intervention Program**

CTI is delivered within the Early Intervention Program in three phases over two years. Table 1 summarizes these phases and the timing, duration, purpose, and activities associated with each phase. The tasks associated with each phase are described in greater detail below. Specific activities for team members are provided in the separate team member manuals.

#### **Phase 1: Engagement with Team and Initial Needs Assessment**

During Phase 1, engagement with the team is critical. Specific activities that support strong engagement include the following.

**1. Introduce the team.** Consumers and family members need to know all team members. Some consumers will want to meet all team members right away, while others will prefer to meet new team members more gradually. Team members can introduce themselves slowly over time.

**2. Build rapport and provide support.** Many things, large and small, are an important part of building rapport but a few stand out as critical. First, the team must always solicit the consumer's view of what's going on. Coming to terms with any diagnosis is a process, and the team needs to be involved respectfully in that process. As progress or setbacks occurs, the understanding of "what the problem is" will undergo revisions in light of the experience. This is all part of the process of coming to terms with a diagnosis. Some consumers and families will need basic educational information regarding psychosis, the recovery process, and treatment options. Others will come in with definite ideas in mind about how they want their treatment to unfold. For example, some consumers or family members may initially refuse to use medication. The team must support consumers and caregivers as they make treatment decisions, be respectful when the consumers asks for additional information or changes his/her mind about some aspect of the treatment plan, and provide practical support as needed within their specific



domain. For example, if a consumer is having difficulty obtaining a prescription for medication prescribed by the Team Psychiatrist, the psychiatrist may work with the Team Leader to resolve the problem. Practical support may be needed in many areas, including ensuring provision of adequate housing, securing financial resources, or helping consumers get their needs met in the community. Recovery coaches can provide support by working with a consumer to learn and practice effective skills for coping with stressful situations and communication skills for use in expressing feelings as a way to reduce environmental stress.

**3. Involve families.** Developing a trusting and collaborative relationship with family members is critical to engagement. The team involves family members in recovery planning and supporting the consumer. It is important to remember that consumers and family members will not always agree. Mediating conflicts between consumers and family members will be an important role for the team. In addition, consumers and families often have little or no experience with psychosis or the mental health system. Any contact with the mental health system may have resulted in ambiguous diagnoses and uncertain prognosis; thus consumers and family members may have negative feelings towards mental health treatment and may have issues surrounding the lack of coping with the trauma of FEP. Families may need help adjusting their expectations so that they are able to convey hope for recovery, while consumers may need help restoring self-confidence following their experience with psychosis and treatment.

**4. Conduct needs assessment.** The needs assessment will reflect an ongoing process of discussion and collection of information. While this process is initially headed up by the Team Leader and Team Psychiatrist, the ongoing review and evaluation of needs requires the involvement of all team members. There is an element of needs assessment that involves collecting factual information from the consumer and the family and must occur in a relatively short period of time so that the team can use this information when working with and supporting consumers. There is also an element of needs assessment that is a process that unfolds over time as the members of the Team and the consumer work with and learn about each other. Importantly, needs assessment must include identifying and highlighting a consumer's

strengths, and team members must remember to ask about and build on strengths as they begin work in their individual domains. Importantly, a key aspect of the needs assessment is discussion of the consumer's goals and how these related to those of the treatment team and family members, determining the order in which goals will be addressed, and reassessing goals over time.

## **Phase 2: Ongoing Intervention and Monitoring**

During Phase 2, the team provides intensive intervention in their respective domains and works together to coordinate care, goals, and progress. Specific activities included in Phase 2 are described below.

**1. Provide interventions.** All team members work with consumers around their individual goals. Consumers meet regularly with the Team Psychiatrist for issues related to medication use and unwanted effects. The consumer will work with the IPS Specialist on education/employment goals. The Team Leader and the Recovery Coach will work with consumers and families on family issues, communication, and problem solving. Importantly, the team will need to continue active engagement and outreach activities for some consumers and families, especially with consumers at risk of being lost to treatment. Phase 2 may represent a critical time for some consumers with regards to decreased attendance and potential dropout out. Some consumers may feel better and may not want to continue in treatment, while others may not be feeling much better or see much improvement and may give up that recovery is possible. It will be important for the team to locate consumers who have been missing treatment appointments and work to re-engage them.

**2. Regularly review and revise goals.** Goals may change over time and in response to the consumers' changing understanding of psychosis and its impact. In addition, it is important to discuss new goals and to re-emphasizing goals that have been accomplished. Team members must also monitor achievements so that they can be re-addressed if needed. The team must also work with consumers and families to minimize stigma and stress in environment, to foster hope that problems can be overcome, and to convey that recovery is possible.

**3. Explore risk factors for relapse.** The team must educate consumers and families that ups and downs are to be expected, and that each “down” can be an experience that teaches and helps the consumer and family get further on in recovery. An important concept here is the difference between “breaking down” and “breaking through” that is experienced by those who have lived with psychosis. The idea here is that most individuals experiencing early episodes of psychosis go back to the hospital in the process of recovery. In the beginning, the individual feels like each time he/she goes back, he/she has failed or “gotten sick again” or had another “breakdown”. But slowly, over time, the individual will realize that each time he/she returns to the hospital or gets symptomatic again and has to adjust medications, it is not necessarily a failure. The individual learns that he/she is not going back to the beginning each time, but rather is “spiraling up and out” as he/she learns through experience to manage the disorder. There’s an old AA story that illustrates this concept of “relapse” within recovery:

*I was walking down the street, came to a hole in the sidewalk and fell in. I was walking down the street, came to a hole in the sidewalk, tried to jump over it and fell in. I was walking down the street again, came to a hole in the sidewalk, and walked around it.*

This is what is meant by learning from experience. Relapse need not be a failure or a breakdown or a return to point zero. Within a recovery orientation, relapse can be another step forward. It can be a breakthrough, not just a breakdown.

One of the most valuable things to be learned from a relapse are the factors that trigger relapse. These will differ for different consumers, but identifying risk factors can help consumers and families plan their daily activities with an eye to being in situations that are not high risk. In addition, when risk factors are identified, they can be planned for and thought through. For example, if stress is a risk factor for relapse, and a consumer is going to have a stressful week related to studying for tests at school, the week can be planned out beforehand so that study time is schedule, stress relieving activities are identified, and family members are engaged and told what they can do to help.

**Table 1: CTI Phases and Contributions Across the Early Intervention Team**

Phase	Phase 1: Engagement with Team and Initial Needs Assessment	Phase 2: Ongoing Intervention and Monitoring	Phase 3: Identification of Future Needs and Services Transition
<b>Timing</b>	Months 1-2	Months 3-22	As per the "Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool" (used at any point during second year up to and including months 23-24)
<b>Overall Purpose</b>	<ol style="list-style-type: none"> <li>Develop a trusting relationship with consumer and family.</li> <li>Introduce consumer and family to team members.</li> <li>Complete needs assessment.</li> <li>Assess consumer's understanding of "the problem".</li> <li>Mediate and negotiate.</li> <li>Provide emotional and practical support.</li> <li>Negotiate stress in the environment.</li> <li>Validate stigma and support positive self-regard.</li> <li>Review and discuss goals</li> </ol>	<ol style="list-style-type: none"> <li>Provide interventions as appropriate.</li> <li>Regularly review and revise goals.</li> <li>Introduce idea of potential relapse and explore risk factors for relapse.</li> <li>Strengthen the support network.</li> <li>Continue to assist with supporting positive self-regard and managing stress in the environment.</li> <li>Maintain continuity of contact.</li> </ol>	<ol style="list-style-type: none"> <li>Assess transition considerations.</li> <li>Re-assess consumers' needs, strengths, and support/treatment preferences.</li> <li>Prepare for termination.</li> <li>Meet with consumer (both alone and with family) to mark end of the experience with the Early Intervention Program.</li> </ol>
<b>General Activities</b>	<ol style="list-style-type: none"> <li>Obtain history</li> <li>Meet with caregivers/family members</li> <li>Complete safety planning</li> <li>Engage family members and provide support</li> <li>Make home visits</li> <li>Accompany to community services as needed</li> <li>Ensure adequate housing &amp; financial resources</li> <li>Link consumer with other members of the treatment team</li> </ol>	<ol style="list-style-type: none"> <li>Mediate conflicts</li> <li>Help consumer and family identify coping and relapse prevention strategies</li> <li>Identify gaps and modify network as necessary</li> <li>Regularly review and revise needs assessment and safety plan</li> <li>Provide support of family via family component of treatment</li> <li>Monitor consumer contact with other team members; revise as needed</li> <li>Link with community resources as needed</li> </ol>	<ol style="list-style-type: none"> <li>Begin transition process by identifying and addressing termination/transition needs and preferences.</li> <li>Coordinate assessment of further needs, preferences.</li> <li>Prepare for transition if indicated</li> <li>Ensure support network and connection to service providers are safely in place</li> <li>Plan for long-term goals- Hold transfer-of-care meetings as needed</li> </ol>
<b>Team Leader Activities</b>	<ol style="list-style-type: none"> <li>Complete needs assessment</li> <li>Review and discuss consumers' goals</li> <li>Introduce and discuss concept of Shared Decision Making</li> <li>Develop treatment schedule</li> <li>Assess needs and preferences regarding family involvement</li> <li>Schedule family meeting</li> <li>Formulate and present treatment plan</li> </ol>	<p>Ongoing assessment, review and revision of consumers' and families' goals and needs.</p>	<ol style="list-style-type: none"> <li>Begin transition process by identifying and addressing termination/transition needs and preferences</li> <li>Coordinate assessment of further needs, preferences</li> <li>Refer consumer to Recovery Coach for focused work to implement transition plan</li> <li>Meet with consumer (both alone and with family) to mark transition from Early</li> </ol>

<p><b>Psychiatrist Activities</b></p>	<p>8. Complete safety planning 9. Develop wellness plan 10. Conduct assertive outreach as needed 11. Provide case management as needed 12. Obtain prior treatment records and consents for release of information as needed</p> <p>1. Obtain comprehensive history of prior treatment with and response to psychiatric medications, including prior occurrence of side effects and specific concerns about medications. Evaluate extent of risk for non-adherence to treatment. 2. Conduct baseline objective assessments of psychiatric symptoms (positive, negative, depressive) and antipsychotic side effects (e.g., metabolic, neurological). 3. Introduce concept of shared decision-making around medication treatment; provide education about medications for psychosis (and ancillary psychiatric symptoms, if applicable), including risks/benefits of antipsychotic medication treatment. 4. For patients who accept antipsychotic treatment, discuss and provide printed educational materials to patient (and family, if applicable) on treatments recommended by the Early Intervention Program as well as other available treatments. 5. For patients who decline antipsychotic treatment, engage in shared decision-making to develop a detailed plan for responding to recurrence of psychotic symptoms. 6. Meet with patient at least two times and up to 4 times during the first month, and twice in the second month to facilitate intensive monitoring of response to and side effects from antipsychotic treatment. 7. Participate with team in development of patients' treatment plans, providing particular guidance around medical and psychiatric aspects of care and crisis intervention planning.</p>	<p>1. Meet with the patient approximately twice in months 3 -6 and monthly thereafter, with the exact frequency of visits being informed by clinical need. 2. Continue to engage in shared decision-making with patient (and family, if applicable) around need for and/or changes in antipsychotic treatment. 3. Continue to discuss and provide printed educational materials on treatments recommended by the Early Intervention Program as well as other available treatments. 4. For patients who accept antipsychotic treatment, periodically evaluate their objective symptom response and development of side effects and make requisite changes in treatment based on these assessments. 5. For patients who accept antipsychotic treatment, periodically evaluate their subjective response to treatment, including experience with side effects and other concerns, and make requisite changes in treatment based on these assessments. 6. For patients who accept antipsychotic treatment, periodically evaluate their adherence to treatment and make requisite changes based on these assessments. 7. For patients who decline antipsychotic treatment, continue to follow previously developed plan for responding to recurrences of psychotic symptoms. Engage in shared decision-making with patient (and family, if applicable) to periodically re-visit decision to decline antipsychotic treatment. 8. Serve as leader/provide oversight to</p>	<p>Intervention Program.</p> <p>1. Refer to and use the "Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool" to identify and address termination/transition needs and preferences. 2. Oversee the evaluation of potential risks that may arise during the transition period and the development of a safety plan to manage these risks. 3. If applicable, ensure that patient has adequate supply of medications until psychiatric care has been transferred.</p>
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	<p>9. Continue to participate with team in management of crisis situations. updating participants' treatment plans, providing particular guidance around medical/psychiatric aspects of care and crisis intervention planning.</p>		
<p>Each client will have different needs as they transition from the Early Intervention Program Team to other services. For individuals who are working, the IPSS and the client should talk about the supports that have been most helpful and identify other agencies or resource that can provide the same level of support. They should also identify what natural supports have been helpful and available and develop a plan to continue those supports. Connect with family members to ensure that they contribute to the transition plan, and provide them with community vocational/educational resources, and education regarding special accommodations as it relates to work and school. Refer to the Vocational Rehabilitation Agency when applicable.</p> <p>All of the above applies to all clients transitioning out of the Early Intervention Program even if they did not access vocational/educational services during phase one and two.</p>	<p>1. IPS Specialist (IPSS) should meet or provide a service to each client at least once every week to two weeks, depending on clients needs. 2. Follow through with goals and activities on the plan. 3. When and where there is disclosure IPSS should follow-up with employers of working consumers once a month or as needed. 4. Follow-up on any education activities as needed. Talk to professors and instructors if needed and with signed consent. 5. Provide the needed follow-along supports to address any issues, concerns and celebrations. 6. Engage with family and other natural supports when possible and needed (with consent). 7. Review goals at six months and change/revise if necessary, or change/revise sooner if needed 8. Continue to meet with the team weekly. 9. Continue to document and track information. 10. Continue to have supervision</p>	<p>1. Meet with client to complete Career Profile. 2. Develop a plan based on client choice and Career Profile. 3. Determine if other vocational/educational resources are needed and refer to Vocational Rehabilitation Agency (VR) when applicable. 4. Complete/revise resume if necessary. 5. Obtain any school records/information if necessary. 6. Meet with family members to collaborate on vocational/educational activities and discuss goals. Also engage with family member for current and future support, and educate families on possible accommodations around school and work. 7. Discuss disclosure risk and benefits. 8. Begin job development and/or education activities. 9. For clients who are already working and/or in an education program determine what supports will be helpful. Outline the supports needed on the plan. Items such as coping techniques, working through symptoms, or addressing medication side effects. 10. Help clients identify what natural supports will be helpful and assist them with developing those supports. 11. Complete mock applications and interviews with clients who are not familiar with or comfortable with such activities. 12. Meet with Early Intervention Program team to ensure all are aware of vocational/educational activities weekly. 13. Document all required information and complete all required IPS documentation forms. Track all job development contacts and education contacts. Track all job placements and education enrollments 14. Supervision between Team Leader and IPS</p>	<p><b>IPS Specialist Activities</b></p>



<b>Recovery Coach Activities</b>	<p>Specialist will take place every two weeks.</p> <ol style="list-style-type: none"> <li>Referral to RC to meet and discuss what RC has to offer as part of the Early Intervention Program*</li> <li>Assessing Readiness, Needs, and Goals</li> <li>Formal assessment of substance use/abuse if required. Follow up on info form SCID.</li> <li>Introductory Sessions</li> <li>Planning Sessions</li> </ol>	<ol style="list-style-type: none"> <li>Assess readiness, needs, and goals (Individual and group)</li> <li>Substance Abuse Treatment (Individual and group)</li> <li>Coping Skills Training</li> <li>Behavioral Activation</li> <li>Psycho-education</li> <li>Family Consults and Monthly Educational Groups</li> <li>Planning Sessions</li> <li>Supportive Sessions</li> <li>- Case Management as needed</li> </ol>	<ol style="list-style-type: none"> <li>Referral to RC to meet and discuss what RC has to offer in Phase 3*</li> <li>Assess readiness, needs, and goals</li> <li>Identify and review the "tools in your toolbox" Skills for implementing post-Early Intervention Program plan</li> <li>Coping skills "check-up"</li> <li>Community "field trips"</li> <li>Prepare the family for transition to care in the community</li> <li>Planning Sessions</li> <li>Case Management as needed</li> </ol>
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\* = offered to all clients

**4. Strengthen the support network.** The team *helps* the consumer to create or re-establish a social network, encourage communication and coordination between the consumer and his/her support network (family, friends). Another important task is to help the family become advocates (e.g., learn how to gain access to services); provide basic educational information to family re: psychosis, recovery process and early warning signs. Other activities that are relevant to the social network include identifying gaps in support and problem solve as needed, identifying risks for housing loss and other adverse social outcomes, and helping the consumer to advocate for him/her self. In addition, the team always wants to be assisting the consumer and his/her family to develop natural supports in the community. 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 NAMI, AA/NA, Double Trouble, Depression and Bipolar Support Alliance.

Use of community resources is linked to goals in the treatment plan, and the team not only identifies resources and makes referrals, but also actively assists the consumer 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 consumer's progress, the Recovery Coach accompanying the consumer to meetings or appointments in the community, or other active assistance as needed.

**5. Discuss transition readiness.** Although the Early Intervention Program is designed to provide two years of intensive services and supports, it should be anticipated that some consumers will be ready for transition out of the program prior to completing a full two years.



The Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool should be used to help determine whether the consumer is or is not in need to continued and ongoing assistance from the Early Intervention Program. While this assessment and service planning tool is initiated by the Team Leader, feedback from all stakeholders including consumers, their families and the other team members should be considered. If after careful and full consideration of the information gleaned during this assessment, it is determined that the consumer is ready for transition, the Early Intervention Team should draw on the activities specified as part of Phase 3.

### **Phase 3: Identification of Future Needs and Services Transition**

During Phase 3, the team must actively work toward planned termination of the relationship with the consumer, and initiate effective support networks and plans for access to needed future services. The Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool should be used to help with these efforts. Many consumers and family members will have developed a strong attachment to the team and may be reluctant to discuss termination. Some may not want to end the relationship and may wish that it could continue. While involvement with the team is limited to two years, it is critical that discussion of and work towards transfer begin long before the 2-year mark. The team, with activities lead and coordinated by the Team, Leader, will work together with consumers and family members using SDM to determine the best options for care in the future. As noted above, the Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool will help guide these efforts. The team will help the consumer and family identify needed care in the community and create a support network that covers all needed areas of continuing care. Suggested activities during this phase include: Review of work done with all team members; discussion of successes in that work; identification and specification of supportive relationships and resources in the community that can be accessed in the future; initiation and use of consumer and family groups focused on issues of transition and termination, identification of community based services and supports, and review of benefits and consideration of future

costs and insurance issues. All team members should also work with the consumer to complete a Transition Plan. Described in greater detail below, this plan is designed to provide the consumer with a resource he/she can take away and use to guide selection of future supports/ services. The plan can also be used to review tools and strategies to aid with ongoing illness and wellness management associated with sustaining one's engagement in his/her own recovery. Of note, it is important for all members of the treatment team to be aware to not set up a disincentive here, i.e., as I get better, my "reward" is losing the people I care about and who care about me.

## **V. Focus Areas**

Clinical experience and research with persons with FEP point to several domains that are seen as crucial in facilitating consumers' recovery from an initial episode of psychosis: (1) medication adherence & medical care; (2) supported education and employment; (3) family support and intervention; (4) fostering illness self-management and recovery; (5) social skills training, substance abuse treatment, coping skills training, and behavioral activation; (6) housing & income; (7) trauma-informed care; and (8) suicide prevention. These domains should be addressed and monitored over the two years of the intervention. To start, all domains will be assessed as part of the initial needs assessment in order to determine the two or three that will become the primary foci of efforts by the team at any given time, depending on the needs and circumstances of the consumer. This is to ensure that the work of the treatment team in general remains highly focused. Some areas may not be applicable to all consumers. For example, not all consumers will have contact with family members or have problems with substance abuse. Furthermore, additional domains may be important for some consumers. Importantly, focus areas may change time.

The eight domains of CTI as applied within the Early Intervention Program are described below. The order in which these are presented does not reflect their order of importance – the order

of importance of the different focus areas will vary by consumer. For example, in FEP, housing and income may be less of a focus for a consumer who lives in a stable situation with family members, but might be more important for another consumer who is lacking in family financial and housing assistance. It is important to note that these areas represent objective areas of need that many consumers will experience. However, the glue that holds everything together is the overarching importance of building a trusting relationship among the Team Leader, the team, and the consumer, and helping the consumer to understand and master the management of the psychotic experience using personal and professional resources. These tasks pervade each of the following CTI focus areas, and serve as the foundation that supports any work or improvement in these areas. That is, there must be a trusting, supportive, and empathic relationship as the basis for CTI. A summary of each domain is provided below. Specific information for implementation is provided in the individual team member manuals.

#### **A. Medication adherence and medical care**

Maintaining adherence to medications is a major challenge with newly ill people, who tend to conceptualize psychotic episodes within an infectious disease model of illness and treatment. As they recover from a first episode and achieve remission of symptoms, many individuals discontinue medication, particularly if they are experiencing bothersome side effects. The usual outcome for this decision is symptomatic relapse and subsequent difficulties in restarting medications. As part of CTI within the Early Intervention Program, the team, lead by the Team Leader and Psychiatrist, must educate consumers about the recurring nature of psychosis, about health behaviors that lessen the risk for future episodes, and about how stress relates to relapse. The Team Psychiatrist will be the primary member of the team focusing on medication options and adherence. It will be critical for the team psychiatrist to adopt a shared decision making framework for all of the discussions around medication options, and to maintain this framework as a way to discuss medication preferences and goals throughout the team experience. The Team Leader will assist in this area by helping the consumer to manage any

non-psychiatric medical care needs, particularly issues related to the metabolic side effects of antipsychotic medications. The consumer and the team must achieve a shared understanding of recovery goals and develop collaborative approaches to selecting and revising medication treatment approaches.

Learning to use psychiatric medication to support recovery is a journey often characterized by decisional conflict and decisional uncertainty. For many, the journey includes moving from passively *taking* medicine to actively *using* it to support recovery. The role of the Team leader and psychiatrist is to accompany and support people on this journey by:

1. Helping them navigate the complex benefits and trade-offs of the medicine
2. Helping people incorporate the use of medicine into overall lifestyle
3. Helping adjust self-concept to include ongoing use of medicine
4. Building skills so that people learn to effectively advocate for themselves in the shared decision making process
5. Validating the stigma that is involved with using psychiatric medicine and helping people do practical problem solving to minimize its impact
6. Supporting peoples' normal need to experiment with decreasing meds, taking medication holidays, using complimentary and holistic approaches and developing cognitive behavioral strategies for managing symptoms.

## **B. Supported education and employment**

Helping persons who have experienced an initial psychotic episode return to school or work is a key step in helping them resume their social and developmental tasks and, ultimately, recovering from their illness. The team will rely on an Individual Placement and Support (IPS) model to be implemented by dedicated IPS Specialist who is an integral member of the team. As a first step, the initial needs assessment will include some assessment of work and school history and goals. The IPS Specialist will conduct more in-depth assessment and, where needed, collaborate with community providers who may be involved with the consumer's

educational or vocational activities. While the IPS Specialist will be the main Team member in charge of the IPS intervention, the Team Leader will assist with any relevant transitional activities that occur toward the end of the consumer's treatment by the team, such as helping to ensure that any necessary service linkages are in place and functioning. The Recovery Coach can collaborate with the IPS Specialist on work-related social or coping skills as needed.

### **C. Family support and intervention**

CTI within the Early Intervention Program includes assessment of and attention to family needs and goals. The team offers a variety of services designed to meet the individualized needs and preferences of the families of participants. Efforts will be made to include families in all aspects of treatment. This will include initial outreach and engagement efforts and a detailed assessment of the consumer and family needs. The Team Leader will work closely with consumers' families, administering formal family-centered interventions as well as linking families to the rest of team for specialized work. The Team Leader will encourage family involvement in treatment planning, treatment decisions, and ongoing care and assist family members in forging a collaborative relationship with the treatment team. In addition, families will be offered more formal family services, including brief education, family consultation, and family psychoeducation.

### **D. Fostering illness self-management and recovery**

Recognizing illness symptoms and learning to manage them at the same time as pursuing life goals are challenging for the person with a first episode of psychosis. Accomplishing these tasks is central to the recovery process. The team will help consumers learn to identify signs of relapse and strategies for coping with symptoms of illness in a timely and successful way. Each team member is involved in this process within his/her area of specialization and assists the consumer in putting strategies to work in real-life situations. In addition to educating the consumer about psychosis, medications, and signs of symptom exacerbation, the team introduces the concept of recovery and brings to life the recovery model by facilitating the consumer's setting his/her own life goals apart from the illness.

### **E. Social skills training, substance abuse treatment coping skills training, and behavioral activation**

The Recovery Coach leads the assessment and delivery of social and coping skill training, substance abuse treatment, and behavioral activation strategies. Social skill training and substance abuse treatment will be done individually and in groups where feasible. The Team Leader will assist in assessing consumers at the start of their involvement in the Early Intervention Program as to their need for and interest in these interventions, provide ongoing support to consumers as these interventions are provided, and assist in keeping consumers engaged in and motivated to attend and participate in work with the Recovery Coach.

### **F. Housing and income**

Residential instability and homelessness are common among persons with mental illness and are associated with interruptions in access to care, victimization, and increased morbidity and mortality. Research demonstrates that homelessness is not confined to persons with long-term illness. For instance, a large epidemiologic study of persons with FEP in a suburban county found that fifteen percent had experienced at least one lifetime episode of homelessness before or within two years of their initial hospitalization and that most of these episodes preceded their first hospital stay (Herman, 1998). Thus an important focus area of CTI is housing. It will be important for the team, lead by the Team Leader, to carefully assess and respond to threats to housing stability in order to prevent homelessness. In the case of loss of housing, the Team Leader will intervene quickly in the attempt to remedy such loss and to minimize discontinuities in access to treatment and other supports. Furthermore, the Team Leader will also attempt to ensure that the consumer has access to adequate income, particularly in cases in which he or she is no longer living with the family of origin. Other members of the team will assist in housing related issues as needed. For example, the Recovery Coach collaborate in cases where housing problems are due in part to substance abuse.

## **G. Trauma-informed care**

The multi-faceted association between trauma and psychosis has been increasingly well documented and recognized as an important issue in the provision of services to persons with severe mental illness. Epidemiologic research demonstrates that exposure to traumatic events, including abuse during childhood, are common in persons with psychosis (Shevlin, 2007). It has also been shown that psychosis appears to place people at elevated risk of exposure to traumatic events including violent victimization (Brekke, 2001; Schomerus 2008). Finally, a growing number of first-person accounts suggest that the experience of psychosis itself may be perceived as traumatic (Morrison, 2003). Although the impact of exposure to traumatic events can vary widely, a recent epidemiologic study found that the prevalence of PTSD in persons with first episode psychosis was 14% (Neria et. al.2002).

These findings confirm the need for members of the team to take into account trauma and its impact on consumers with FEP. The team will provide trauma-informed care, which includes the following:

1. All members of the team will be educated about the prevalence and effects of trauma in FEP
2. All consumers will be screened for trauma
3. All interactions between the team and the consumer will emphasize safety, choice, SDM, and lack of coercion
4. All consumers will have a clear crisis plan
5. Consumers with PTSD symptoms will be referred to expert PTSD care.

A goal of the needs assessment is to carefully assess previous or current trauma exposures and the possible presence of PTSD symptoms. If symptoms of PTSD are present, the team will work with the consumer to determine the best course of action for addressing the PTSD. The goal here is for the team to provide trauma-informed care for FEP, but a typical treatment team will likely not have the expertise to treat trauma/PTSD. The Team Leader will

develop a list of resources in the community for addressing trauma/PTSD, and a decision about making a referral must be made by the team and the consumer together. It is important to note that, for many consumers, inpatient settings can be re-traumatizing and that special care will often be needed if/when a consumer is re-hospitalized during the 2-year time in the program. In the case of current or ongoing violence or abuse, a safety plan will be created with the consumer, and any Tarasoff protections made as indicated. Social and coping skills training may also address ways in which consumers may increase their capacity to avoid victimization. In our clinical experience with persons with FEP, we occasionally see trauma emerge as a key concern early in the treatment process. More commonly, however, the need for treatment for traumatic exposures tends to emerge later when the immediate impact of the psychosis onset has attenuated.

#### **H. Safety Planning and Suicide Prevention**

Suicidal behavior is a common complication of psychotic disorders and as many as 5-10% of individuals diagnosed with schizophrenia die by their own hand. Oftentimes the suicidal behaviors seen early in the process of diagnosis and treatment and likely related to the hopelessness that is conveyed to people during their first exposure to treatment (i.e., you have a disease and you will have to take medicines for the rest of your life). This prognosis of doom and chronicity, paired with the mandate to take medications that can have noxious side effects for the rest of one's life, can instill feelings of hopelessness: "Why bother living, if I can't really live, but can only be "ill" for the rest of my life. Many suicides and suicide attempts occur early in the course of illness and suicidal behavior has been found to be reduced after initial contact for treatment of psychosis (Melle et al., 2006). This highlights the need for early assessment of suicidal behavior for individuals with FEP and the importance of intervention for lowering suicidal behavior in this high-risk group as an integral component of the recovery model and giving a message of hope for recovery.

Our goal is to implement an immediate and simple approach to suicidal behavior, leaving



hospitalization as a last resort. Two strategies make up the Safety Planning Intervention: safety planning and immediate attention to treating psychotic symptoms. Safety planning is the first, short-term stage of intervention (detailed in the Team Leader manual), and antipsychotic medication change is the second, more long-term component (to be addressed by the Team Psychiatrist). First, safety plans will be developed following suicide risk assessment. The basic components of safety planning include (a) recognizing warning signs that are proximal to an impending suicidal crisis; (b) identifying and employing internal coping strategies without contacting another person; (c) socializing with family members or others who may offer support as well as distraction from the crisis; (d) contacting family members or friends who may help to resolve a crisis; (e) contacting mental health professionals or agencies; and (f) reducing the potential for use of lethal means. Consumers are instructed first to recognize when they are in crisis and then to follow each step as outlined in the plan. If following the instructions outlined in the first step fails to decrease the level of suicide risk, then the next step is followed, and so forth. After the safety plan has been developed, the Team Leader will assess the patients' likelihood to use the safety plan as a whole and discuss where the safety plan will be kept and how it will be retrieved during a crisis.

## **VI. Team Process and Procedures**

Each team member has specific interventions and strategies that he/she brings to her work with consumers in the Early Intervention Program. For detailed information on functions and procedures for each team member, it is necessary to review each Team Member Manual. Below are processes and procedures that are relevant to all team members.

### **A. Getting Started**

**Initial Meetings.** Consumers are referred to the Early Intervention Team from a variety of sources. Wherever they come from, young consumers may be new to treatment, scared or upset at the prospect of starting treatment, experiencing symptoms, and in other ways hesitant to or ambivalent towards treatment at a mental health setting. Many consumers and family

members will be overwhelmed and/or upset. These feelings are understandable. The focus of all early contacts must be to allow the consumer to get to know the team, ask questions, and build rapport. While it is important to assess specific needs and get information relevant to the treatment plan (see Team Leader and Psychiatrist Manuals for a full description of the needs assessment process), many consumers and family members will be overwhelmed, upset, or otherwise unable or unwilling to move beyond rapport building and question answering in the early meetings. Good clinical skills for beginning the relationship are key. At this early stage, some creativity may be needed to encourage treatment engagement. If needed, team members should go wherever the consumer is or prefers to meet as rapidly as possible to make the connection. Others, especially those who are referred from mental health clinics, may already be willing to come to the clinic for these early meetings. In addition, it is important to try to get the consumer to bring family members with him/her to initial meetings if possible. While initial meetings are generally focused on the consumer becoming acquainted with the Team Leader and Team Psychiatrist, the consumer should also be introduced to the IPS Specialist and the Recovery Coach so that the consumer knows who everyone is and their role on the team.

**Treatment Planning.** The first step in creating the initial treatment plan is completing a comprehensive history and psychosocial needs assessment. This process will begin either at the first meeting following referral or soon after. Both the Team Leader and the Team Psychiatrist will meet with the consumer to conduct the history and needs assessment. It is important to stress that a SDM approach will be used throughout the treatment planning process for both the psychosocial and psychopharmacological aspects of care. Details of the needs assessment process can be found in the Team Leader and Team Psychiatrist Manuals.

**Developing a Treatment Schedule.** Following the initial treatment planning meeting, a treatment schedule will be developed so that the consumer and family members know when they are to meet with Team members and with what frequency. While the exact amount of

contact will be individualized, the expectation is that the team will aspire to have a minimum frequency of contact with the consumer as follows:

Minimum Frequency of Contact	Team Leader	IPS Specialist, Recovery Coach	Psychiatrist
Weekly for first month	X	variable	If possible
Bi-weekly for months 2-6	X	variable	X
Monthly beginning in month 7	X	variable	X

Team Leader meetings with the consumer are used to review how the consumer is doing, progress towards treatment plan goals, and any issues that the consumer wants to address. Meetings with the Team Leader can also include discussion of family issues and safety planning. Additional meetings that include the Team Leader, consumer, and family members can be scheduled as needed. A schedule of meetings with other team members (Recovery Coach, IPS Specialist) will be developed as needed. These meetings will vary by consumer depending on each consumer’s needs assessment, treatment plan, and treatment goals. That is, consumers will differ in the frequency with which they meet with the Recovery Coach and the IPS Specialist. In addition, consumers may elect to start these intervention components at different times – some may start with the IPS Specialist immediately, while waiting to begin social skills training and substance abuse treatment for a few weeks. Others may want to start all of these interventions right away. In terms of meetings with the team psychiatrist, for the first month, the psychiatrist will meet with the participant weekly to monitor symptom response and the occurrence of bothersome side effects. Length of time in the intervention is also a factor. It is likely that more contact will be needed at the start of treatment, and contacts will decrease over time as goals are reached and consumers are getting more stable within their recovery.

**B. Other activities at the start of treatment**

**Meet the family.** Meeting with family members is critical. Family members need to learn about the family intervention component of the team, discuss the family’s needs and wants regarding participating in family programming, and create a family treatment schedule. This requires a discussion with the consumer regarding his/her preferences and subsequent

dialogue with family members. As many consumers live with family members, significant family involvement with treatment is expected for most consumers and required for minors. As part of this start-up of family interventions, the Team Leader should introduce the consumer and the family to the Recovery Coach, who can then take the lead in getting consumers and their family members involved in Family Workshops, Brief Family Consultation, and Monthly Educational Session components of the Family Intervention.

**Complete safety planning.** The Team Leader will complete Safety Planning with the consumer. This process is described in detail in the Team Leader Manual. Briefly, all consumers will have a safety assessment during their initial contact with the Team Leader. All consumers who are high risk of suicide or self harm (defined as those with a prior history of suicide or self harm or those who report frequent suicidal ideation) will complete Safety Planning with the Team Leader.

**Develop a wellness management plan.** The Team Leader will work with the consumer to a Wellness Management Plan to help the consumer and his/her family cope with any kinds of crisis (mental illness, substance abuse, self-harm, etc). This process is described in detail in the Team Leader Manual. Briefly, information in the Wellness Management Plan will include: (1) early warning signs, (2) what to do when early warning signs occur, (3) how to judge when you need to call a professional, (4) which professional to call under what circumstances, (5) how to problem solve during a crisis, (6) ways to avoid hospitalization, (7) plan for what to do if you are feeling unsafe, (8) how consumers will get to the hospital if they refuse to go on their own.

**Meet all team members.** Near the start of treatment, the IPS Specialist and the Recovery Coach must introduce themselves to the consumer, meet with the consumer to describe what services they provide, and assess the consumer's needs and goals in their respective areas. The process for needs assessment for these team members can be found in their respective manuals. The timing of these meetings will vary for different consumers. Although consumers will differ on when they elect to start these intervention components, it is important for these team members to meet with consumers and educate them about their roles on the team.

## C. Ongoing Treatment

**Delivery of interventions.** Treatment will be provided based on the manuals for each team member. Consumers will come to the clinic at their regularly scheduled appointments, although this may differ for work with the IPS specialist when work related to work or school goals needs to be done in the community. If the consumer is satisfied with the schedule and how the interventions are being implemented, then the schedule will remain stable between treatment plan updates (see below). At any time the consumer can discuss with the Team Leader changes to the treatment schedule. Changes can include (but are not limited to) adding interventions (e.g. beginning SST or SA treatment), increasing weekly meetings with the Team Leader, spending more time working with the IPS specialist, increasing or decreasing work with family members. Consumers who request an appointment (non-crisis) with the Team Leader, Team Psychiatrist, IPS Specialist, or Recovery Coach will be seen as soon as possible.

**Ongoing treatment planning.** Treatment planning is an ongoing process that is headed by the Team Leader and Team Psychiatrist. As initial goals are reached, new goals will replace them on the treatment plan. Focus areas will change over the course of the intervention, with different focus areas being chosen at different points. To reflect the changing nature of treatment goals, the treatment plan will be updated every 3 months or whenever a major change occurs. Treatment plans will be updated during meetings between the Team Leader, the other team members, and the consumer. Family members may attend. Specific procedures for the Team Leader and Team Psychiatrist around treatment planning are provided in their respective manuals.

**Ongoing outreach.** There is an expectation that there will be at minimum one contact per week between some member of the team and the consumer during the first month of treatment. While this will most likely involve weekly contact with the Team Leader and Team Psychiatrist, it is possible that some weeks the contact will occur with other Team members. The team will deal with missed appointments by providing outreach, especially to those in danger

of dropping out of the program. Outreach will be tailored to the consumer, but can include a range of strategies including contacting family members, phone calls to consumers, and home visits. When a consumer misses an appointment, a team member should attempt to contact that consumer within 24 hours to indicate that the consumer was missed and reschedule the appointment or provide a reminder for any upcoming appointments that have already been scheduled. These reminder calls should not sound punitive in any way. The team member should convey that the consumer was missed, that the team member looks forward to seeing the consumer soon, and greet any information about the cause of the no-show with support and understanding.

**Crisis planning and intervention.** There are several components of the intervention that address planning for crises, including safety planning (done by the Team Leader) which focuses on developing a plan to implement if a crisis should occur in the future. For acute emergencies, a member of the team must be available at all times by phone or to meet with consumers and family members. During business hours, consumers will call the clinic and the Team Leader or Recovery Coach will talk to the consumer within the day. After business hours, the Team Leader and Recovery Coach share responsibility for carrying a beeper. Due to his/her status as the head of the team and a full time employee, the Team Leader carries the beeper two weeks for every week it is carried by the Recovery Coach. Due to the focused nature of his/her work with the consumer, the IPS Specialist does not carry the beeper.

Whoever is on call will take the initial call from the consumer, learn about the crisis, and problem solve with the consumer and/or his/her family members around the best next step. The on-call team member will triage calls to the Team Psychiatrist as needed (in cases in which the crisis involves medication, medication side effects, or other issues related to an immediate medical emergency). In such cases, the Team Leader or Recovery Coach will call the Team Psychiatrist and have him/her call the consumer. In this way the team members can provide background regarding the events of the crisis and not require the consumer or family member to repeat the information to different people.

Team members will also assist family members and consumers in deciding how to manage a crisis, whether the crisis can be managed at home, or whether it will require hospitalization. The Early Intervention Program Team should have relationships with several hospitals in the area that will be familiar with the program for ease in referring consumers to if ER services or hospitalization when needed. The team will provide consumers and family members contact numbers for them to call in a crisis. This will include providing the consumer and family members with wallet cards that list emergency numbers and a brief description who to call at what time of day. The Team Leader and the Team Psychiatrist will both have beepers; one will be available for crisis calls at all times. When the Team Leader or Team Psychiatrist received a phone call from a consumer or family member, he/she will quickly assess whether the crisis can be dealt with locally (at the clinic during clinic hours; at home if after hours) or whether consumer needs to go to the hospital. If a determination is made the ER services or hospitalization is needed, the Team Psychiatrist will call the hospital to inform them.

**Linkage with community and peer resources.** An important goal of the team is to work with consumers and their families to develop natural supports within the community. During the time that the consumer is involved with the team, there will be many occasions in which connections will be needed with service providers in the community. There are three general sets of community resources that will be needed for many consumers:

- 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 NAMI, AA/NA, Double Trouble, Depression and Bipolar Support Alliance.

In such cases, the Team Leader will actively assist the consumer in contacting a new provider

or service and in following through on that contact. The exact nature of this assistance will differ for individual consumers – some will require only a referral while others will ask for more help in contacting a resource or want the team member to accompany him/her to the first or first several appointments/meetings.

**Documentation.** Each clinic will have its own process for record keeping and formatting progress notes. For consumers working with the Early Intervention Program Team, progress notes added to the case record should be clearly tied to specific goals and focus areas outlined in the initial treatment plan and its updates. The Team Leader should maintain a set of materials in the office, accessible to all team members that includes team and consumer/family contact numbers and a resource binder that serves as a directory of commonly used community services and resources.

**Use of checklists for treatment adherence.** The team will use checklists to ensure that team members follow basic procedures in the administration of different elements of the intervention. These are more completely described in the manual for each member. For example, the Team leader will use a checklist to screen every consumer for suicidal ideation/behavior and follow up positive screens with suicide assessment and planning. The Recovery Coach will use a checklist during each social skills training meeting to ensure that all components of skills training were accomplished. Such in-session check-lists will guide clinical thinking and guide development of progress notes for that service.

#### **D. Termination**

Involvement with the team will last approximately 2 years. During the last 6 months of treatment, the team must actively work toward planned termination of the relationship with the consumer, and initiate effective support networks and plans for access to needed future services in the community. The Assessment Considerations to Inform Early Transition and Early Intervention-Team Termination Planning Tool can help guide these efforts. Termination will involve many challenges. Many consumers will have developed a strong attachment to their



team and may be reluctant to discuss transfer of care issues and planning. Some may not want to end the relationship and may wish that it could continue. While involvement with the team is limited to two years, it is critical that the team, lead by the Team Leader, begin discussion of and work towards transfer long before transfer actually has to occur. The Team Leader and the consumer will work together, using SDM, to figure out the best options for care after involvement with the team has ended. The main tasks for the team include ensuring that the support network is safely in place and that it covers all needed areas of continuing care. All members of the team will assist in this area by helping to determine the best community care for a consumer within each area of specialty, and assisting the Team Leader in connected with agencies and providers in the community. An SDM approach is especially important when planning ongoing care, as this is a time when the consumer and his/her family need to drive planning and take ownership of decisions about the future.

### **E. Issues of Safety and Safety Planning**

All participants have a safety assessment during their initial contact with the Team Leader and will complete safety planning with the Team Leader. Participants who are at high-risk of suicide or self-harm (defined as those with a history of suicide attempts or self-harm or those who report frequent suicidal ideation) will complete a safety plan in the same session as the safety assessment; those participants assessed at lower risk should have a safety plan completed within their first month of participation in the Early Intervention Program. As noted above, there are two components to the safety planning intervention: completion of the safety planning document and attention to treating psychotic symptoms. Safety planning is the first, short-term stage of intervention (to be conducted by the team leader), and antipsychotic medication change is the second, more long-term component (to be addressed by the psychiatrist).

While the Team Leader and the Psychiatrist are involved in formal safety planning, all team members can talk with participants about safety issues as needed. For example, the IPS specialist or the Recovery Coach might see a participant during a week that he/she is not

scheduled to see the Team Leader. In such cases, one of these team members may need to check in with the participant about safety (if the participant is high risk for safety) or if he/she discloses problems or thoughts around safety and self harm. As another example, the Recovery Coach carries the team beeper regularly and so may be involved in safety issues and crisis management. Thus it is critical that all team members know safety planning, know which participants are high-risk and need to be asked about safety, and what processes are in place for each participant around safety.

## **VII. Training and Supervision**

### **A. Overview**

The Early Intervention Program includes three sets of professionals: Expert Clinicians, State-Level Trainers, and Team Clinicians. The Expert Clinicians developed the program elements of the intervention, with separate experts for the Team Leader, IPS, Recovery Coach, Family, and Psychopharmacology elements of the program. In addition, they determined specific roles and functions for each team member and adapted interventions for clients experiencing a first episode of psychosis. The State-Level Trainers are professionals with extensive experience training direct front-line clinicians in evidence-based interventions that are comparable to Early Intervention Program elements, but had not specifically worked with first episode populations. Team Clinicians work directly with individuals with FEP and implement the program elements.

At the start of the project, the Expert Clinicians were responsible for developing and implementing all training and supervision activities. The State-Level Trainers shadowed the Expert Clinicians in order to learn the program elements themselves (when needed), and to learn how to apply the program elements to first episode clients, with the goal of providing on the ground support to clinicians on behalf of the expert supervisors (who were largely available only by phone). In so doing, State-Level Trainers would acquire the additional expertise needed for them to be able to train clinicians on the program elements and eventually take over all

training and supervision tasks. A transition of training and supervision tasks from Expert Clinicians to State-Level Trainers was planned for the second half of the project.

## **B. Training Activities**

**1. Components of Training Provided to All Team members.** Training as provided by the Expert Clinicians involved three components: (1) background readings and associated discussion regarding lived experience of psychosis, (2) intensive in-person training, (3) and telephone training meetings specific to each program element. First, all Early Intervention Program clinicians were provided with background readings in the lived experience of psychosis, as well as readings on topics that were important across program elements, including Shared Decision Making, Psychopharmacology, and Safety Planning (see Table 1 for a list of readings that were provided to all Team Clinicians). In training phone calls (see below for a description), readings were discussed in order to ensure that all participants had exposure to the unique challenges of those experiencing first episode psychosis and their families and understood the commitment of the Early Intervention Program to having consumer and family input into their treatment and goals.

Second, all Expert Clinicians, State-Level Trainers, and Team Clinicians attended a 2-day intensive in-person training on August 16-17, 2010. The first day of the training included a discussion of first episode psychosis, treatment, and recovery (lead by Bob Drake and Pat Deegan), followed by an overview of intervention principles and clinical concepts. Clinical vignettes were presented to demonstrate correct and incorrect ways to complete a needs assessment with a young adult consumer and his family member, and discussion around the vignette included all participants as a way to identify the important administrative and personal aspects of the needs assessment process. Day 1 also included an overview of all intervention components and key principles, including CTI, working with youth, trauma informed care, psychopharmacology, support employment/education, working with families, social skills training and substance abuse treatment, safety planning, and prevention planning. The second

day of the training included breakout sessions by program element. Team Leaders met with their set of Expert Clinicians (Lin Sikich, Amy Drapalski, Greg Brown, Jason Shiffman) and reviewed in more detail domains including how to be a team leader, Critical Time Intervention, working with families, safety planning, and prevention planning. The IPS Clinicians met with their set of Expert Clinicians (Debbie Becker, Sarah Swanson) to review the background and implementation of Supported Employment and Education. The Recovery Coaches met with their Expert Clinicians (Alan Bellack, Melanie Bennett) to learn about social Skills training and substance abuse treatment. Psychiatrists met with their Expert Clinicians (Bob Buchanan, Joe McEvoy, Julie Kreyenbuhl, Tom Smith) to review the antipsychotic treatment algorithms for the project. Following these individual team member meetings, the group reconvened and together reviewed a needs assessment summary, with Expert Clinicians addressing relevant considerations and issues specific to their program element, as well as to discuss how to engage the consumers in moving forward with treatment planning and delivery of related supports and services. Finally, the clinical teams met together to discuss another needs assessment summary, with a focus on detailing how they would address the relevant needs and issues. This was followed by a discussion with the full group that included mock team meetings with opportunities to practice/discuss how to coordinate/sequence/prioritize the various treatments and services and engage the consumer and his family in the development of a full and integrated treatment plan.

Third, Expert Clinicians held telephone training meetings specific to each program element. Personnel involved in the psychosocial program elements (Team Leader Group, Supported Employment and Education Group, Recovery Coach Group) had weekly calls, while those involved in the Psychiatrist Group held telephone meetings every two weeks.

**2. Components of Training Specific to Program Components.** The following sections detail the specific training activities for each program element group.

Team Leader Group Training. Team leaders received two training sessions with Pat Deegan about shared decision making and recovery focus. Other Team Leader trainings,

including working with families and principles of recovery, were mostly provided by Lin Sikich, Bob Drake, and Amy Drapalski.

Psychiatrist Group Training. Hour-long training calls for the psychiatrists were held twice monthly and were facilitated by the Expert Clinicians (Bob Buchanan, Joe McEvoy, Julie Kreyenbuhl, Tom Smith) and Peer Expert (Pat Deegan). One call was devoted to a training session on shared decision-making and recovery focus conducted by Pat Deegan. The psychiatrists were also polled regarding their needs and interest in special psychopharmacology topics. There were three special topics identified and discussed in subsequent calls: (1) the use of metformin to treat antipsychotic-induced weight gain; (2) the diagnosis and treatment of antipsychotic-induced sexual side effects; and (3) the costs and benefits of antipsychotic-switching for the treatment of metabolic side effects. The Expert Clinicians solicited experts in these topic areas from outside the Early Intervention Program to conduct these trainings.

Supported Employment and Education Group Training. IPS specialists and their supervisors read the IPS manual, participated in the Dartmouth IPS supported employment online course, and were given copies of Supported Employment: A Practical Guide. The IPS Expert Trainer visited each of the programs to demonstrate and relationship building with employers and to watch supervisors and employment specialists make contacts with employers.

Recovery Coach Group Training. Training calls for the Recovery Coaches were run weekly by Melanie Bennett. These calls involved discussion of readings, review of intervention elements, and practical application and role-playing of the interventions. First, Recovery Coaches were provided with additional background readings on motivational interviewing, social skills training, substance abuse treatment, and shared decision making as it relates to substance abuse treatment. Early calls involved reviewing the important points of these topics as they relate to first episode psychosis, working with young adults, and engaging individuals with treatment. In addition, we discussed the role of the Recovery Coach, how she was integrated within the team, how she used her time in the context of the 50% time commitment, how she would interact with other team members to get referrals from the team and report back

to the team on client progress. Second, training calls involved a review a how to do social skills training and substance abuse treatment as outlined in the treatment manual. We reviewed the manuals thoroughly, discussed hypothetical clients, and did role playing of entire social skills training and substance abuse treatment sessions. In addition, Recovery Coaches brought questions to the calls and these were discussed and answered.

### **C. Supervision Activities**

**1. Overview of supervision.** As cases began to accrue, activities shifted away from a focus on training and towards a focus on on-going case review and clinical supervision. With the exception of the family work, supervision has been done separately by program component, with regular supervision telephone calls for each group. The following sections detail the specific activities of supervision calls for each program element group.

**2. Supervision activities specific to program components.** The following sections detail the specific supervision activities for each program element group.

Team Leader Group Supervision Telephone Calls. As cases accrued, the weekly Team Leader phone calls included discussion of cases as well as worked on integrating model requirements (different forms and assessments) into local clinical operations. This call included discussion of cases and integration of the model as it pertained to all of the team leaders' roles and responsibilities, including the family work component, and as such involved the team leader and family work experts and state trainers.

Psychiatrist Group Supervision Telephone Calls. As the number of clients in the Early Intervention Program grew, the twice monthly training calls for psychiatrists moderated by the Expert Clinicians switched to a discussion of selected cases. In general, these calls provided an opportunity to discuss difficult cases, problems encountered with the implementation of preferred medications, and strategies/approaches that have been found useful to help participants manage their illness and psychotropic medications.

Supported Employment and Education Group Supervision Telephone Calls. The IPS supervisor had twice monthly phone calls with employment specialists and one of the team

leaders. State IPS trainers have visited each of the programs to conduct employer contacts with the employment specialists.

Recovery Coach Group Supervision Telephone Calls. As clients started to enroll in the program, the Recovery Coach call transitioned to a focus on supervision of cases. For the first 4-5 months, this call was weekly, and the slow pace of recruitment allowed for a thorough discussion of each case each week. Specifically, each Recovery Coach would provide an update of each case or a summary of any new cases. For existing cases, the Recovery Coach would review what area was being addressed in her meeting with the client (social skills training or substance abuse), how the client was doing in general (mood, functioning) and with learning the skill, and whether any homework was done or any situation encountered since the previous meeting that allowed the client to use the skill or strategy that was planned. For new clients, discussion centered on ways to build rapport and engagement, educate clients about the role of the Recovery Coach, and plan with the client (using motivational enhancement strategies and shared decision making) goals and areas to work on together. As the supervisor, Dr. Bennett would advise the Recovery Coach s in implementing SST and SA, how to adapt to individual needs, and how to use motivational enhancement strategies and shared decision making when approaching clinical problems with clients. Calls also involved discussions regarding strategies for talking with young clients about planning for goals and using new skills in their lives.

Family Work Group Supervision Telephone Calls. Starting in August 2011, the family specialist began holding an additional monthly call for the Team Leaders and Recovery Coaches which specifically focused on family work, including the implementation of the monthly family education groups and other family program components, as well as providing supervision around any family work/issues not addressed during the regular Team Leader telephone call. Regular supervision around family work continued to be provided during the Team Leader supervision telephone call as well.





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