

## Team Manual



### Primary Author and Editor:

Melanie Bennett, Ph.D University of Maryland School of Medicine  
And RAISE Connection Program Investigators

### NOTE:

CTI developed by Dan Herman, 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 and Center for Homelessness Prevention Studies

**OnTrackNY Team:** Rufina Lee, Ph.D., Liza Watkins, LMSW, Iruma Bello, Ph.D., Patricia Deegan, Ph.D., Sascha Altman DuBrul, MSW, Ilana Nossel, M.D., Lisa Dixon, M.D., M.P.H.

# Table of Contents

|      |   |    |
|------|---|----|
| I.   | Introduction .....  | 5  |
| A.   | Coming to Terms with a Diagnosis: The Individual's Challenge .....                      | 5  |
| B.   | Understanding FEP .....   | 7  |
| II.  | The OnTrackNY Treatment Team .....  | 8  |
| A.   | Overview of Team Members .....  | 8  |
| B.   | Summary of the Team Leader's Role and Responsibilities.....                             | 10 |
| C.   | Features of the Team .....  | 11 |
| III. | Clinical Concepts Underlying the Treatment Approach.....                                | 12 |
| A.   | Recovery .....  | 12 |
| B.   | Shared Decision-Making (SDM).....   | 14 |
| 1.   | Basic Steps in SDM.....   | 15 |
| 2.   | SDM as a Generic Process.....   | 16 |
| 3.   | SDM as a Structured Technique.....  | 17 |
| 4.   | Training in SDM .....   | 17 |
| 5.   | Medication Management as Illustration .....   | 17 |
| C.   | Active and Focused Treatment .....  | 17 |
| D.   | Flexible and Consistent Treatment .....   | 18 |
| E.   | Fostering Autonomy and Remaining Available .....  | 18 |
| F.   | Suicide Assessment and Prevention.....  | 18 |
| 1.   | Overview and Scope of Suicide Assessment and Prevention.....                            | 18 |
| 2.   | Definitions.....  | 19 |
| 3.   | Risk Factors for Suicide in Psychosis .....   | 19 |
| 4.   | Screening and Assessment of Suicide Risk.....   | 20 |
| 5.   | AIM Model: Assess, Intervene, and Monitor.....  | 21 |
| 6.   | Overall Team Framework for Addressing Suicidality .....                                 | 21 |
| 7.   | Triage of Suicidal Clients.....   | 22 |
| 8.   | Treatment Strategies.....   | 22 |
| 9.   | Clinical Example:.....  | 23 |
| 10.  | Utilizing the C-SSRS: .....   | 25 |
| 11.  | Safety Planning Intervention Overview.....  | 25 |
| 12.  | Approaching Safety Planning in the Context of FEP .....                                 | 26 |
| 13.  | Components of Safety Planning .....   | 26 |
| 14.  | Tailoring Safety Planning for FEP .....   | 29 |
| 15.  | Implementation/Adaptation of the Safety Plan for Special Populations and Settings ..... | 30 |
| 16.  | Link Between Safety Planning Intervention and Modifiable Risk Factors .....             | 31 |
| 17.  | Psychopharmacologic Intervention .....  | 32 |
| IV.  | Critical Time Intervention .....  | 32 |
| A.   | Key Components of CTI as Applied to OnTrackNY .....                                     | 32 |
| B.   | Guiding Strategies of CTI as Applied to OnTrackNY .....                                 | 33 |
| 1.   | Assertive Outreach and Ongoing Engagement .....   | 33 |
| 2.   | Needs Assessment .....  | 35 |

|  |    |
|--|----|
| 3. Time-Limited Approach.....  | 35 |
| C. Phases of CTI as Applied to OnTrackNY.....  | 36 |
| V. Focus Areas .....   | 45 |
| A. Medication Adherence and Medical Care.....  | 46 |
| B. Supported Education and Employment .....  | 47 |
| C. Family Support and Intervention.....  | 47 |
| D. Fostering Illness Self-Management and Recovery .....  | 47 |
| E. Social Skills Training, Substance Abuse Treatment, Coping Skills Training, and Behavioral Activation .....                                | 48 |
| F. Housing and Income.....   | 48 |
| G. Trauma Screening and Treatment.....   | 48 |
| H. Safety Planning and Suicide Prevention .....  | 49 |
| VI. Implementing OnTrackNY.....  | 50 |
| A. Human Resources and Hiring .....  | 50 |
| B. Resources.....  | 50 |
| C. Supervision and Compliance with Agency Rules .....  | 50 |
| VII. Team Process and Procedures .....   | 51 |
| A. Getting Started .....   | 51 |
| 1. Initial meetings.....   | 51 |
| 2. Treatment planning.....   | 51 |
| 3. Developing a treatment schedule .....   | 52 |
| B. Other Activities at the Start of Treatment .....  | 52 |
| 1. Meet the family.....  | 52 |
| 2. Screen and Assess for Suicidality Using the CSSRS and the OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool ..... | 53 |
| 3. Develop a wellness management plan .....  | 53 |
| 4. Meet all team members .....   | 53 |
| C. Ongoing Treatment .....   | 53 |
| 1. Delivery of interventions.....  | 53 |
| 2. Ongoing treatment planning .....  | 54 |
| 3. Ongoing outreach .....  | 54 |
| 4. Crisis planning and intervention.....   | 54 |
| 5. Linkage with community and peer resources .....   | 55 |
| 6. Documentation .....   | 55 |
| D. Termination .....   | 55 |
| VIII. Training and Supervision .....   | 56 |
| A. Training Activities.....  | 56 |
| B. Integrating Peer Specialists onto the Team: Challenges and Opportunities .....  | 56 |
| C. Supervision Activities .....  | 63 |
| 1. Overview of Types of Supervision.....   | 63 |
| 2. Supervision How-To's .....  | 66 |
| IX. References and Recommended Readings and Resources.....   | 68 |
| A. References Cited in Team Manual .....   | 68 |

|     |   |     |
|-----|---|-----|
| B.  | Recommended Introductory Training for All Staff .....                                     | 70  |
| 1.  | Pat Deegan's Introduction To FEP Videos: .....  | 70  |
| 2.  | CPI's Focus On Integrated Treatment Modules: (FIT) Stage-Wise Treatment .....             | 70  |
| 3.  | (Fit) Motivational Interviewing.....  | 71  |
| 4.  | (FIT) Cognitive Behavioral Therapy/Social Skills Training .....                           | 72  |
| 5.  | CPI's Safety Planning Modules.....  | 73  |
| 6.  | Highly Recommended Readings For All Team Members .....                                    | 73  |
| 7.  | Additional Suggested Readings And Resources For All Ontrackny Team Members .....          | 74  |
| X.  | Appendix .....  | 88  |
| A.  | Shared Decision Making (SDM) and Other Tools.....   | 88  |
| 1.  | Suicide Assessment and Prevention in First Episode Psychosis (FEP) Guidance Document .... | 89  |
| 2.  | OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool .....           | 94  |
| 3.  | Wellness Management Plan.....   | 99  |
| 4.  | Preparing to Talk About Symptoms.....   | 102 |
| 5.  | Surviving Stress.....   | 105 |
| 6.  | Stress Management.....  | 106 |
| 7.  | Psychiatric Medication and Me.....  | 107 |
| 8.  | Finding Personal Motivation to Use Medication.....  | 113 |
| 9.  | My Designated Observer.....   | 114 |
| 10. | Improving Concentration .....   | 116 |
| 11. | Family Involvement Decisional Balance Form.....   | 117 |
| 12. | Values Clarification Exercise .....   | 118 |
| 13. | Peer Specialist Supervision Checklist.....  | 120 |

## I. Introduction

The OnTrackNY Program Treatment Team 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 the team staff, the client, and sometimes the family. This manual describes the governing principles of the team, the team's activities, and approaches to treatment. 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. OnTrackNY 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 client in meeting age-appropriate life goals including returning to school, work and a meaningful 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 integrated throughout the person's involvement with the team, and all team members should be knowledgeable about these approaches.

The team strives to convey hope for recovery and views the person diagnosed with FEP as the central member of the team effort. Experience has shown that recovery depends on people moving beyond being passive recipients of care. People with diagnoses must actively collaborate with their treatment providers. Clients' life goals, aspirations and ambitions must drive treatment planning. The client 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 hallmarks 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 clients 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 individuals with FEP is to make sense of their 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 incident, and they 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 event that will affect them for the rest of their lives, and they 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 engage them in the program. Team members must not dismiss such questions and should not insist that the individual is in the beginning stages of 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 – contrary to 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 support, understanding, and an attitude that desired outcomes and recovery are possible.

- Don't tell people 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 people 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 that they 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 may have seen possibilities, not limitations. You may have felt powerful, if not invincible, as some young people do. You may have 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 the world, for example. Although it may seem contradictory, at the same time many adolescents are quite 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 that 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 their lives. It is absolutely normal to question a medical diagnosis and to grapple 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 his or her 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 he or she makes 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. People 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 experiences. 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 clients’ choice of treatment options, must understand that clients are wrestling with, trying on, and casting off the diagnosis. Trying to convince people 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) a 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 people as they come to terms with a new diagnosis is to help them formulate an understanding of “what the problem is” and “how to 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 counterterrorism sting,” a team member 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 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 primary clinician in particular, is to develop a trusting relationship with the client. The team must adopt the client’s metaphor of illness and language, and encourage exploration of goals in the context of the client’s changing understanding of what has happened.

## II. The OnTrackNY Treatment Team

The OnTrackNY Treatment Team operates as a collaborative unit for planning and decision making. The team includes individuals fulfilling the following roles: Team Leader, Outreach and Recruitment Coordinator, Primary Clinician, Psychiatrist (or Prescriber), Nurse, Supported Education and Employment (SEE) Specialist, and Peer Specialist. 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 client contact.

The TL is the communications hub of the team, ensuring all team members are kept informed of issues involving participants and their families. The TL monitors caseload size and coordinates program intakes and discharges. The TL facilitates meetings and provides training and supervision for the Outreach and Recruitment Coordinator, SEE specialist, and Primary Clinician. The TL is also the coordinator, negotiator and mediator for the team in terms of interfacing with staff in the host setting and manages issues related to office space, facilities, and supplies. Additionally, strong leadership from the TL is required to integrate Peer Specialists onto the team while safeguarding the unique role and contribution of peers to the team. Finally, the TL practices leadership and plays a key role in shaping a culture of respect on the team. OnTrackNY teams strive to be respectful of cultural, sexual and gender diversity.

### A. Overview of Team Members

**The Team Leader** oversees all aspects of team functioning and provides administrative and clinical oversight. The Team Leader coordinates the on-call schedule, interfaces with agency leadership, oversees the Outreach and Recruitment function, and assigns each client to a Primary Clinician. Team Leaders role model and guide the team in developing a culture of respect. The Team Leader also acts in the role of Primary Clinician for a subgroup of clients.

The Team Leader or Outreach and Recruitment Coordinator can each serve in the role of **Primary Clinician** and on most teams, each of these individuals will be the Primary Clinician for a subgroup of clients. The team member acting in the role of Primary Clinician will be the primary resource for the client and his family, coordinating an assessment of service needs, and working with the client to create a treatment plan within a shared decision-making framework. The client’s assigned Primary Clinician works closely with all members of the team in an integrated way develops a positive clinical relationship with the client early on and facilitates linkage with other community supports. The Primary Clinician delivers the Collaborative Approach to Recovery (CAR) intervention, which is comprised of assertive outreach and engagement strategies for clients and families, FEP and the goals of the team as a whole, case management, supportive psychotherapy and cognitive behavioral based psychotherapeutic interventions. This includes in vivo symptom management and relapse prevention techniques when



needed. As part of the CAR, the Primary Clinician is responsible for the assessment of suicidality and for delivering basic safety and crisis prevention planning.

After the initial engagement phase, the **Primary Clinician** discusses with all clients the need for and interest in illness management strategies, which consist of skills training/behavior change interventions. This will enable the client to get to know the various interventions the team can provide. After this discussion, some clients will opt to continue working on these strategies and others will not dependent on their values and preferences. We anticipate that some clients may want to wait to start strategies until needs that are more acute such as symptoms and basic functioning, are improved.

**The Team Prescriber** engages the patient 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 team Psychiatrist plays a key role in ongoing diagnosis.

**The SEE Specialist** takes the lead in assisting the client with employment and education goals. The SEE Specialist meets with all clients to assess work/school interests and assists clients in identifying and selecting options for school or work. At this point, some clients will opt to work with the SEE Specialist and others will not. In addition, the Primary Clinician can refer clients to the SEE Specialist. While not all clients will have work or educational goals, we anticipate that most clients will have such goals and so will work in some capacity with the SEE Specialist.

**The Team Nurse** works with the Psychiatrist to provide medication-monitoring, assessment of side effects, and wellness activities.

**The Outreach and Recruitment Coordinator** coordinates the outreach and recruitment activities for the team. He/she organizes and tracks presentations to publicize team activities, screens individuals referred to the program, and evaluates potential clients for eligibility.

**The Peer Specialist** uses his/her personal recovery story to instill hope, promote engagement and demonstrate goal attainment. Peer Specialists have a unique skill set that is different from that of clinicians. Specifically, peer staff are trained in the principles of mutuality and how to learn together with peers rather than “helping” peers. Peer Specialists are trained in a non-clinical worldview and have skills in supporting program participants if they are exploring alternate understandings of their distress and experiences. They are not junior clinicians and their unique perspective can help engage program participants and expand the power of the team to support the recovery of participants. Nevertheless, Peer Specialists are also trained to work collaboratively as an integral member of the team. They collaborate with the Outreach and Recruitment Coordinator to enhance outreach and engagement. Peer Specialists may provide practical and social supports to clients and families to help meet concrete needs. They work with the Primary Clinician to help individuals develop their own understanding of “what happened to me” and “how to get my life back on track.” Peer Specialists support participants in discovering and practicing self-care skills and might help to shape the team’s culture to more robustly practice person-centered, recovery-focused, strengths-based service delivery. All clients will be introduced to the Peer Specialist. However, the clients’ preferences will determine whether he/she works with the Peer Specialist.

## B. Summary of the Team Leader's Role and Responsibilities

The Team Leader is the overall supervisor of the OnTrackNY Initiative and is responsible for allocation of staff time to meet all of the responsibilities of the program, as well as for managing these activities in collaboration with the other team members. The Team Leader will be expected to:

- Lead the evolution of the culture of the team. Leadership involves actively promoting a culture where all team members feel valued and where hierarchy is minimized so that all team members feel safe in speaking up and contributing. Leadership involves cultivating a culture of respect on teams with particular attention to language and diversity.
- Monitor caseload size and coordinate program intakes and discharges
- As the communications hub of the team, ensure all team members are kept informed of relevant issues involving participants and their families
- Serve as Primary Clinician, or primary resource, for a number of OnTrackNY participants and their families, which is described in depth in the Collaborative Approach to Recovery Manual
- Assume some of the tasks associated with outreach and recruitment, which are described in depth in the Outreach and Recruitment Coordinator Manual
- Serve as the coordinator, negotiator and mediator for the team, in terms of interfacing with administrators and support staff in the host setting;
- Engage with and resolve matters between the team and the host agency, such as:
  - Hiring team members
  - Emphasizing smaller caseloads for the team
  - Providing services outside of the agency setting
  - Utilizing agency support staff to promote smooth team functioning
  - Negotiating the sharing of space
  - Advocating for resources to enhance program services;
- Provide opportunities for training and ongoing supervision of team members, which are described further below.

### Coordinating Key Activities of the OnTrackNY Program

There is a range of administrative needs that are relevant to coordinating activities of the OnTrackNY Team. These can be organized into several domains:

1. **Human resources and hiring.** Program administrators need to arrange for the hiring of staff. OnTrackNY sites have all been provided with sample job descriptions. All agency rules regarding evaluation and credentialing should be followed. If possible, it is most useful for the Team Leader to be involved in the hiring of the other team members.
2. **Resources.** The OnTrackNY Team serves a young population. It is important for the setting in which the team is located to appeal to young people, to be pleasant, inviting, and recovery-oriented. Space needs to be youth-friendly and, if possible, integrated into community or general health services, which may be seen as more inviting to individuals experiencing first episode psychosis (FEP), as well as their families. Additional resources may include money for petty cash to make small purchases to facilitate recovery-

oriented activities, transportation, etc. The team needs access to transportation for community visits and community services. Telephone, cell phone and computers should be provided according to agency policy.

3. **Personnel oversight and management tasks.** These include access to supervision for each of the program elements. Supervision for the Team Leader within the reporting structure is also necessary, in order to facilitate integrating the program into the overall agency structure. It is recommended that the Team Leader receive supervision with a clinician at least every two weeks and with a program administrator monthly. It is best for the psychiatrist to have access to expertise to assist with unique problems that may arise for OnTrackNY participants. In addition, the program administrator needs to establish back-up plans for coverage for the Team Leader and the psychiatrist, as well as emergency back-up coverage should the psychiatrist be unavailable.
4. **Conformance to agency regulations.** The Team Leader needs to ensure that OnTrackNY program elements are compatible with existing agency requirements. Suggested OnTrackNY forms should be compared and matched to required agency forms, so that redundancy can be eliminated to the extent possible.
5. **Clinical oversight and management tasks.** These include medical record management, registration and tracking, and census and visit tracking reports.
6. **Budgeting/reimbursement tasks.** These include billing, budget management, expense tracking, supply ordering, laboratory and pharmacy tracking and reimbursement.

All of these activities must be discussed collaboratively and constructively with the Team Leader, team members, and the host agency supporting the OnTrackNY team.

## C. Features of the Team

**Small caseloads.** The team will have small caseloads, consisting of 35 consumers or fewer, to ensure that team members have sufficient time to fully address all areas of intervention.

**Frequent team meetings.** The full team will meet once per week. At these meetings, the team will review all participants, discuss each team member's role in providing treatment, 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 and allow team members to check in with one another regarding the activities and goals of each in their areas of specialty. During team meetings, principles and practice are reinforced through review of current participants and ongoing training to improve clinical knowledge and skills. For instance, after an individual participant 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 supports, and taking a harm reduction approach to resolving problems.

**Staff Roles.** Referrals to the team come to the Team Leader, who assigns a Primary Clinician. The client's Primary Clinician then 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 client to plot an overall treatment plan to meet the individual's recovery goals.

### III. Clinical Concepts Underlying the Treatment Approach

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 good outcomes, 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 productive and satisfying lives. 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. OnTrackNY uses SAMHSA's working definition of recovery which states that "Recovery from mental disorders and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. "The therapeutic approach is strengths-based rather than focusing narrowly on symptoms and impairment and fosters hope. The emphasis is on what the service participant can and wants to do, rather than on limitations. Services are tailored to the client's changing preferences and needs over time.

Treatment decisions are guided by the client's cultural background, preferences, clinical status, specific challenges, and the phase of illness in which the treatment is occurring. Specifically, OnTrackNY focuses on SAMHSA's four dimensions that support a life in recovery:

1. **Health:** The OnTrackNY Team works with service participants and their families to make informed decisions to assist individuals in managing symptoms and to support physical and mental health. For example, the Prescriber and Nurse may work with the client to assess medication effects and side effects, while the Nurse and Primary Clinician may assist with the development and practice of wellness activities.
2. **Home:** In addition to providing pharmacologic and psychosocial treatment, OnTrackNY provides wrap-around supports, including assistance with practical needs. The team helps individuals and their families with concrete case management services including assistance with insurance, entitlements, and a stable and safe place to live.
3. **Purpose:** All members of the team work with the service participant in order to clarify and meet personal goals around work and/or school. The Primary Clinician will assist the service participant in establishing

goals and enacting a plan, and other team members will help the individual to carry out the plan. The SEE Specialist in particular will assist the participant as needed in finding work or resuming school and will continue to provide “follow along” supports to help the participant succeed at school and/or work. The Prescriber and participant will meet as frequently as needed (initially, often weekly) to assess possible medication side effects and their impact on work or school performance.

4. **Community:** The team is responsive to participants’ preferences regarding their desired level of interaction with family and friends. Simultaneously, the team also encourages the development of such relationships, including involvement in community groups that may foster support, friendship, and hope.

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 manage symptoms effectively and to 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 a first episode of psychosis. The work of the team is based on the notion of recovery, with interactions that will engage the client with respect, encourage client responsibility, and foster empowerment. The therapeutic stance is strengths- based rather than focusing exclusively on symptoms and impairment, and fosters hope. This is especially critical in working with individuals experiencing a first episode of psychosis. The emphasis will be on what the client 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 client 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, clients and family members may have some concerns. 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 be professional resistance to recovery approaches: “I’ve never seen a person diagnosed with schizophrenia who has recovered,” for example, or “In school they taught me this was a chronic illness.” Pat and Jacob Cohen’s notion of the “clinician’s illusion” can be helpful in explaining this perception that no one gets better (Cohen P & Cohen J, 1984): “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 clients 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 clients are more concerned with practical matters like resuming employment and independent housing. Clients often report that their views are neither elicited nor valued. Clinicians often express surprise when clients’ preferences are made explicit.

Shared decision making (SDM) is an approach to setting goals and making treatment decisions that enables clinicians and clients to clarify disagreements and to reach compromises. It emphasizes that the decision making process be guided by participants’ and families’ preferences. It is the role of the providers to ensure that the participants and families possess enough information about the scientific consensus regarding effectiveness of treatment approaches so that their preferences can truly be informed (Elwyn, et al., 2017). 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 client’s participation in and commitment to treatment, to enhance the professional’s understanding of the client’s values and preferences, and to strengthen the therapeutic alliance. SDM targets many factors associated with client 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, SDM asserts that the best decisions about treatment are made when individuals collaborate with treatment team members. In the SDM process there are two experts in the room: the team member is an expert in the science and practice of medicine, and the client is an expert in what matters in his or her life.

Numerous studies show that SDM improves the quality of decisions, clients’ 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 clients can be integrated with the recommendations of team members. As such, SDM is the standard therapeutic strategy employed in every component of the OnTrackNY 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 client 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 client preferences and values which may impact treatment decisions, and empower clients 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 clients and family members to identify goals, develop solutions to problems, make treatment choices, and revise treatment objectives over time. The following tools to support SDM can be found in the Appendix:

- "Psychiatric Medication and Me"
- "Preparing to Talk with Your Team"
- "Designated Observer"
- "Values Clarification for Family Involvement"
- "Family Involvement Decisional Balance Tool"

Clients will be taught SDM and advised to use it when making treatment related decisions so that they feel that they are an integral and dominant part of the decision making process. As part of their introduction to SDM, clients 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.

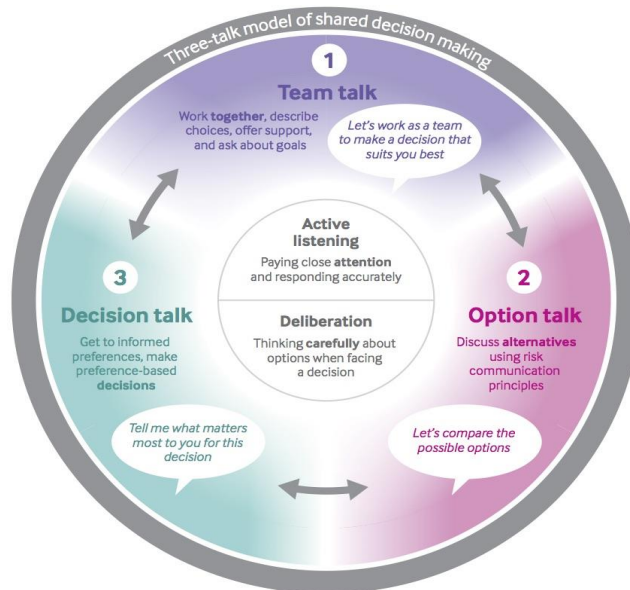
## 1. Basic Steps in SDM

SDM involves several basic steps that guide a conversation and are fluid and can sometimes be complex and recursive, therefore, it should not be thought of as a linear process that offers one final decision. 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 client (sometimes joined by family or friends) and the clinician (sometimes clinical team). Below are the steps for the Three-talk model of SDM as well as an info-graphic for the process. While carrying out the steps below, it is important that providers engage in active listening, which includes paying close attention and responding accurately during the process of SDM. Similarly, that they should engage in and promote a process of deliberation which entails thinking carefully about options when facing a decision (Elwyn, et al., 2017).

- **Step 1. Team Talk:** A framework is set for working together to describe choices, offer support and start defining goals. The client defines the problem or the decision to be made. For example, he/she agrees to establish goals of treatment, to decide whether or not to include family in a meeting, or to make a decision about changing medications. The message to the client is that everyone will work as a team to make a decision that best suits the client.
- **Step 2. Option Talk:** Options are outlined and in discussing the options, risk communication principles are used and tools are utilized to compare possible options in a deliberate manner. The pros and cons of each option are considered with information and educational materials provided as needed. 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. For each of these examples, they might consider the advantages and disadvantages. In this process, the client emphasizes her/his goals, values, or preferences; the clinician adds scientific information regarding likely outcomes, side effects, and/or unwanted medication effects (e.g., choosing a neuroleptic that has a lower chance of metabolic syndrome but a higher chance of TD).

- **Step 3. Decision Talk:** The participants express their preferences. Once areas of agreement and disagreement are clear, the team, including participants and family members, negotiate compromises on areas of disagreement and a preference-based decision is made. For example, the client 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. 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.



(Elwyn, et al., 2017)

## 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 client and I have all the information we need about this topic? Are we clear on how the client’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 client 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 client 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 client need to speak with a girlfriend, a parent, or a past teacher about this decision? What are the client's and the clinician's preferences? Have the client 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.

### **4. Training in SDM**

All members of the team will be trained in the principles and techniques of SDM. Clinicians are expected to use SDM as a general approach with clients and as a technique for making decisions regarding goals and treatments. Training will cover the three steps described above.

### **5. Medication Management as Illustration**

Learning to use medications as part of one's recovery 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 client make good decisions and achieve an optimal adjustment. Training focuses on specific techniques and considers in depth specific common scenarios: clients 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 time limited intervention period, the team must maintain an active and focused stance. "Active" means that the team is proactive in connecting with a client and his/her family, and providing the information needed for clients to consider all relevant treatment choices. For example, the Team Leader can actively reach out to clients 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 client and his or her system of supports is threatened. "Focused" refers to the team's effort to address intervention areas while also helping clients 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 client 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 clients 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 clients 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 clients 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 client and his or her family. At the beginning of the intervention, members of the team meet frequently with clients and are very involved in facilitating care. Team members must also work to develop a close rapport with clients at this stage. Over time, clients 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. Clients 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 client and family needs.

## **F. Suicide Assessment and Prevention**

### **1. Overview and Scope of Suicide Assessment and Prevention**

Individuals with FEP are at increased risk for suicide, and suicide prevention is a key goal of the OnTrackNY model. 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 with schizophrenia who report a suicide attempt made their first attempt after the onset of psychosis (Harkavy-Friedman et al., 1999). Between 4 and 10 percent of individuals with schizophrenia die by suicide (Caldwell et al., 1990; Inskip et al., 1998; Palmer et al., 2005) and the first 1-2 years following the onset of psychosis are a particularly high-risk period (Bornheimer et al., 2018; Castelein et al., 2015). Therefore, when treating individuals with first episode psychosis (FEP), there is an ongoing need for the assessment and management of suicide risk.

This manual describes a strategy for careful screening, assessment, and implementation of prevention strategies, including the safety planning intervention (Stanley and Brown, 2010) along with other strategies designed to reduce suicide risk in FEP.

## 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 was 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).
- **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.
- **Unintended self-harm:** Behaviors in the absence of suicidal intent (e.g., jumping off a building due to delusional beliefs about being able to fly, drinking bleach to cleanse oneself due to delusional beliefs about being dirty or having sinned). Differs from non-suicidal self-injurious behavior in that it is not intended to cause harm per se.

## 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). The OnTrackNY Suicide Assessment Tool (see appendix) lists both individual-specific and environmental risk factors, as well as protective factors, and indicates those, which are specific to individuals with FEP. Individuals with FEP 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 suicidal behavior, 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. Screening and Assessment of Suicide Risk

Use of a structured, systematic screening tool such as: The Columbia Suicide Severity Rating Scale (C-SSRS) (Posner, Brown et al, 2011), is an essential component of assessment and prevention in FEP. But screening is not enough. Individuals with FEP may be at elevated risk for suicide and unintended self-harm whether or not they endorse suicidal ideation or are flagged on an instrument such as the C-SSRS. For example, individuals may choose not to disclose suicidal ideation, or may be at risk for unintended self-harm behavior due to psychosis without suicidal intent. Therefore, it is critical to complete a comprehensive assessment to identify risk and protective factors for all participants in FEP services. We have developed a suicide and unintended self-harm assessment and prevention tool (found in the appendix), which can be directly used by your team, or adapted for your organization's electronic medical record system.

Once the initial assessment is completed at intake, team members should be on the lookout for changes that might indicate increased risk (i.e., increase in risk factors and/or decrease in protective factors), so that the person can be better engaged and supported during times of difficulty or crisis. Risk concerns can often be managed by helping individuals explore the meaning of what they are going through, thinking through alternatives to self-harm behaviors, and providing additional support within the CSC model. Peer support is critical to this process. Rarely teams may decide that acute risk is elevated to the point that an individual temporarily needs a higher level of care, such as hospitalization.



## 5. AIM Model: Assess, Intervene, and Monitor

The initial assessment should be conducted in a series of steps, based on the evidence-based AIM model (Assess, Intervene, and Monitor).

- Step 1: teams complete a structured screening for suicidal ideation and behaviors, such as the C-SSRS (see details below).
- Step 2: teams conduct a comprehensive assessment of individual and environmental risk and protective factors (see OnTrackNY suicide and unintended self-harm assessment and prevention tool in the appendix). This typically requires input from all team members, as participants may share different information with different people.
- Step 3: the primary clinician uses the information to make a summary assessment regarding risk and specifies whether the individual should be added to, remain on, or be removed from the elevated suicide and unintended self-harm risk monitoring list. This list is for the purpose of ensuring that enhanced monitoring and support is given to individuals who need it most.
- Step 4: the primary clinician works collaboratively with the rest of the team, the individual, and her/his family/supports to develop a plan to mitigate risk.
- Step 5: risk should be reviewed on an ongoing basis, depending on initial risk level and “warning signs” of increasing risk (i.e., changes to C-SSRS and/or to risk or protective factors).

## 6. Overall Team Framework for Addressing Suicidality

The primary clinician is generally the lead team member for risk assessment and prevention efforts, though all team members have a vital role to play. The psychiatric care provider (team prescriber) will also assess risk as part of the initial psychiatric evaluation and ongoing psychiatric management. All team members should participate in training regarding suicide and unintended self-harm in FEP and should report any warning signs of increased risk to the primary clinician (and/or team leader and psychiatric care provider). Although non-clinical team members (e.g., peer specialists and supported employment and education specialists (SEES) do not assess participants for suicide/unintended self-harm, they should receive training about different ways to think about and discuss these issues with participants and with the team. Risk assessment and prevention efforts should be discussed as a team, typically in team meeting, although urgent situations will warrant more immediate discussion and/or intervention.

Peer Specialists have a unique non-clinical role to play. Using the principles of mutuality and willingness to share and learn from each other, peer specialists can create a safe and accepting space for participants to talk about their feelings and thoughts. Peer Specialists are trained in alternate frameworks of understanding the experience of despair. For instance, “I feel unbearable shame.” “I can’t take being bullied or abused anymore.” “I am angry at so much injustice.” “I feel stuck and hopeless.” Peer Specialists are trained to talk to individuals about such feelings outside of a clinical framework. While assessment is a necessary aspect of care, having a team member who is explicitly not involved in assessment can provide a different kind of potentially life-saving support.

## 7. 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 (see below) should be invoked at this point for those reporting suicidal ideation or behavior, 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/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/suicide.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf)

## 8. Treatment Strategies

### **For all participants, particularly in the first 3 months of treatment:**

- Complete either the safety planning intervention or a wellness self-management plan (both described below), working collaboratively with the individual, and family, as appropriate.
  - The safety planning intervention is an evidence-based intervention for individuals with recent suicidal ideation or behavior. The safety planning intervention helps participants identify coping skills and supports. Although led by the primary clinician, any/all team members can assist with creating/ updating the safety plan, so it becomes a working document that individuals are willing to use and feel is helpful.
  - The wellness self-management plan is used with individuals who do not report suicidal ideation. It includes identifying strategies for maintaining wellness, coping skills, early warning signs, and a plan for managing relapse. Additionally, there are other tools which might be helpful, such as the OnTrackMaps, that the Peer Specialist can introduce and work collaboratively on with the participant.
- Provide psychoeducation about suicide and unintended self-harm risk and warning signs to the individual (and family, if appropriate) and review/update written safety or wellness self-management plan as needed. Ensure that this discussion happens in a person-centered, recovery-oriented way that helps the individual explore the meaning of what they are going through and think through alternatives to self-harm behaviors.
- Discuss access to lethal means and take steps to restrict access. Ask about access to firearms (or other weapons) and work with the individual and family/supports to ensure they are secured and not easily accessible in a crisis. Consider how much medication is supplied at one time and whether it may be appropriate to provide a more limited supply depending on the individual's risk and medication prescribed. The availability of potentially lethal medications or supplements (e.g., acetaminophen in the medicine cabinet) should also be asked about and addressed.
- Monitor risk frequently\*, including both screening for suicidal ideation and behavior, and reviewing pertinent risk and protective factors for the individual.

*\*Frequency of monitoring depends upon individual clinical circumstances. The suggested frequency for individuals at significant risk is at every session with a clinician. Risk level can change rapidly, so teams should have a low threshold for reconsidering risk.*

**The steps below should be taken as needed, depending upon individual circumstances:**

- Increase frequency of visits and increase assertive community outreach for individuals who have disengaged. Peer support services are critical to engaging and supporting individuals at elevated risk.
- Increase engagement of family or other community supports.
- Provide specific interventions to address modifiable risk factors and/or increase support, e.g., medication changes, evidence-based psychotherapy interventions, case management to meet basic needs, peer support services, substance use treatment, etc.
- Enhance protective factors, such as coping and problem-solving skills
- Consider transfer to a higher level of care for imminent risk when it is not possible to create a safe plan for outpatient care (e.g., psychiatric emergency department or hospitalization, partial hospitalization, crisis residence, etc.).

**Elevated Suicide and Unintended Self-Harm Risk Monitoring List**

- Maintaining a list of participants identified to be at elevated risk is a strategy for the team to flag those at highest risk and ensure that safety issues are adequately addressed for those participants, and that extra support is provided. The team may devote time in team meeting to discussing strategies for mitigating risk for those on this list or outside of team meeting as needed. Some teams hold a separate safety meeting to devote time as a team to identifying risk and protective factors and strategies for mitigating risk. The team may consider seeking consultation, within the agency and/or from OnTrackNY Central for individuals at particularly elevated risk.

## **9. Clinical Example:**

*Jose is a 20 year-old Latino man living with his mother and younger siblings. He reports a close relationship with his family and provides consent to involve his mother in treatment. Jose previously worked in a bowling alley, but has not worked in the past 3 months, and would like to find another job. He reports he has been hearing voices, but is reluctant to share the content. He denies feeling depressed, but reports feeling nervous and distressed by the voices. When asked about his sexual orientation, he reports that he is attracted to men, but has never discussed this with his family and fears he would be shunned by his extended family if they were to learn of his sexual attraction. He reports feelings of shame about his attraction to men, hearing voices, and his inability to financially contribute to his family. To cope with feelings of anxiety, distress and shame, he has been drinking alone every night. He has stopped seeing friends and spends most of his time in his room. He denies current or past thoughts of suicide. A C-SSRS was completed with Jose at intake, with no positive responses (step 1). After several meetings with his primary clinician, he reveals that the voices call him "dirty" and "disgusting." He denies hearing voices telling him to harm himself or others. He seems more anxious than usual and appears to be hearing voices during the session. He continues to deny suicidal thoughts, and a repeat C-SSRS is negative. He reveals that he has stopped his medication because he feels embarrassed to take it because someone might find out. The team uses a shared decision-making*

*process with Jose to discuss risks, benefits, and alternatives to medication and to help Jose consider his options. Jose is unwilling to consider restarting medication at this time.*

*The clinical team uses the OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool (step 2) and identifies the following risk and protective factors: recent increase in positive symptoms and recently stopped medication, anxiety/distress/shame, increased alcohol use, LGBTQ identity, unemployment, and social isolation. Protective factors include his connection to his family, safe living environment, and engagement with the team. Summarizing these factors (step 3), the team assesses that Jose is at elevated risk for suicide. Though he denies suicidal ideation or symptoms of depression and has no history of suicide attempts, he has a number of risk factors for suicide, as described above. The team discusses a plan to address modifiable risk factors and closely monitor Jose's risk (step 4). The team identifies the following strategies to support Jose and mitigate risk:*

### **Strategies for the Whole Team:**

1. Use compassionate listening to create a safe space where Jose can share how he is feeling and feel accepted and heard.
2. Share the team's concern of risk with Jose, conveying warmth and support. Elicit his feedback about the team's concern. Work collaboratively with Jose to determine which additional supports would be most helpful.
3. Continue to make peer support available and discuss with Jose whether he may want to try to reconnect with friends.
4. Let Jose know that the team supports and accepts him for who he is. Tell Jose that the team is there to support him regarding the complexity of how his sexual orientation might impact his relationship with his family. Offer to problem solve together different possibilities of how Jose might navigate these issues (e.g., speaking with his mother, identifying peer or mentor supports in the LGBTQ community, etc.). Let Jose know that the team can support him around these issues in whatever way and in whatever timeframe he chooses.

### **Strategies for Clinicians on the Team:**

1. Add Jose to the team's elevated suicide and unintended self-harm risk monitoring list.
2. Complete the wellness self-management plan with Jose and his mother (if Jose had suicidal ideation or behavior, team would use the safety planning intervention instead).
3. Provide psychoeducation to Jose and his mother about suicide and self-harm risk and warning signs. Discuss steps that Jose and/or his mother would take if Jose were to develop suicidal ideation, including contacting the team (ensure that Jose and his mother have the on-call number for after-hours contact) and if needed, going to the emergency room.
4. Discuss access to lethal means with Jose and his mother and take steps to restrict access, if applicable (e.g., if there were a gun or other weapon in the home).
5. Monitor risk at each appointment while also using compassionate listening so Jose continues to feel accepted and heard.
6. Maintain frequent contact with Jose and his mother. Plan for weekly appointments with the primary clinician, and 1-2 additional appointments or contacts each week (i.e., with the psychiatric care provider, SEES, and/or peer specialist).

7. Involve Jose's mother in the shared decision-making process regarding medication. Discuss how medication might help Jose with his goal of finding another job, as well as helping him with his anxiety and distress.
8. Help Jose identify, practice, and implement coping strategies that he can use when he is feeling anxious or distressed.
9. Address substance use: provide information about the role alcohol can play in suicide and self-harm risk, recommend to Jose that he consider reducing or eliminating his use of alcohol at this time, and assess Jose's readiness for change. Provide stage-based motivational treatment and use a harm reduction approach.
10. Re-assess risk at each follow up appointment for now, including the C-SSRS and a brief review of changes in risk/protective factors (step 5).

## 10. Utilizing the C-SSRS:

In order to determine the current level of suicide risk, standardized assessment tools are suggested: The Columbia Suicide Severity Rating Scale (C-SSRS) is used extensively in clinical and research settings around the world. It is designed to efficiently and accurately screen for suicidality through the use of a small number of questions that focus on the presence of suicidal ideation, the intensity of that ideation, and suicidal behavior. The Lifetime/Recent version allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior.

The "Since Last Visit" version of the scale assesses suicidality since the patient's last visit. This version is meant to assess patients who have completed at least one Lifetime/Recent C-SSRS assessment. The "Since Last Visit" version of the C-SSRS asks about any suicidal thoughts or behaviors the participant may have had since the last time you have administered the C-SSRS.

The Risk Assessment version of the scale provides a checklist for protective and risk factors for suicidality and assesses lifetime and past week suicidality. This version is meant to be used in an acute care setting. It is intended to help establish a person's immediate risk of suicide.

When acute suicide risk is indicated either by responses on the CSSR-S 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.

## 11. 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), if the participant reports suicidal ideation or behavior. Variants of this intervention are utilized in cognitive therapy and cognitive behavioral therapy for suicide prevention (Stanley et al., 2009). Consistent with the safety planning intervention and the spirit of integrating participant preferences, the Primary Clinician 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.

## 12. 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.

## 13. 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.



## **a. 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. 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 of 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 auditory hallucinations: 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 clinician (could be Primary Clinician, Team Leader, or Prescriber) must ask 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 on call should be contacted or the participant should seek a safe haven such as an emergency room.

## **b. 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 clinician 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 clinician will ask: "What might stand in the way of you thinking of these activities or doing them?" The clinician 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 clinician 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.

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

Together with the clinician, 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.

**d. 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 clinician 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.

**e. 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 clinician 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 clinician will discuss the participants' expectations when they contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so.

#### **f. 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 clinician 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.

### **14. 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 clinician 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 clinician 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 clinician 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 clinician 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 clinician, 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.

## 15. Implementation/Adaptation of the Safety Plan for Special Populations and Settings

After the safety plan has been completed, it is important to assess the participant's likelihood of using the safety plan. If the participant is reluctant or ambivalent about its use, the clinician 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 clinician 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 clinician should address the participant's feelings of hopelessness or negative outlook about the future owing to the illness and let the participant talk about his/her feelings about this rather than maintain a purely educational/problem-solving stance. Use of reflective listening can be especially helpful in allowing the

participant to express feelings about the plan and its place in his/her life. The clinician 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 clinician 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 Primary Clinician should expect to review it with participants at least quarterly.

## **16. 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 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.

## 17. 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. 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.

## IV. Critical Time Intervention

CTI provides the major organizing structure to the activities of the OnTrackNY. 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 OnTrackNY is conceptualized as the time following a first or early episode/s of psychosis. The goal of CTI within the OnTrackNY Program is to get clients linked with the team as a means to receive intensive treatment that supports clients' own goals for recovery.

### A. Key Components of CTI as Applied to OnTrackNY

There are several key components of CTI that are especially important to OnTrackNY.

1. **CTI within OnTrackNY includes ongoing assessment and treatment planning.** The team provides ongoing assessment and treatment planning that is focused on identifying and working toward recovery goals developed by clients and their families. Treatment plans are revised every three 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 client and the family are included whenever possible.
2. **CTI within OnTrackNY incorporates family involvement.** Family members can play an important role in providing ongoing support for clients experiencing FEP. The team works with families and other



interested sources of support (friends, peers, community members) to help the client 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 client and family develop a network that supports recovery.

3. **CTI within OnTrackNY recognizes client diversity.** 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 clients 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 members will receive training designed to ensure that their practices take these issues into account wherever possible.

## **B. Guiding Strategies of CTI as Applied to OnTrackNY**

There are several guiding strategies within CTI as applied to OnTrackNY. 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**

Clients are learning 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 to OnTrackNY involves using whatever strategies are needed in order to engage clients with the program. To this end, contact can be provided in the community or in the client's home environment rather than the office as a way to engage clients 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 client and family. Once a relationship has been established, it remains a critical task of CTI as it is applied within OnTrackNY to prevent clients from dropping out of care via assertive outreach and ongoing engagement efforts. The team aims to prevent loss of contact with clients by being flexible and finding an approach (or combination of approaches) that is acceptable to the client and his/her family. Being persistent is also essential in order to successfully locate and re-engage clients if they are lost to contact with services. This may involve concerted efforts to re-engage clients 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 clients 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 clients.

- **Primary Clinician is central contact person.** The Primary Clinician is the main treatment contact person. Having a single identified person gives clients and families someone with whom to develop a relationship and ask questions. Importantly, at the start of their work with the team, the client and/or the family will meet first with the Primary Clinician and the team psychiatrist together. Many

clients and families will be frightened and will want to be sure they have access to the psychiatrist. Together, the Primary Clinician and the psychiatrist will explain that they work together closely as a team and that the Primary Clinician will be the main contact and can always find the psychiatrist. The Primary Clinician will stay connected to the client and family throughout the two years of the program, although he/she does not have to be the main contact in cases where a client feels more connected to different team members. For example, if a client is working mostly with the SEE Specialist around work goals, then the SEE Specialist may have the most contact with this client 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.
- **Show sensitivity.** Be sensitive to how you interact with clients. 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 client may be nervous, wary, or may not want to see a health professional. Psychosis may distort clients' ability to process information. Overall, come to the process of meeting clients 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 client. Often family members want treatment more than the client. Where possible, get permission to talk to the family from the very beginning. For clients 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 clients 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 clients 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 clients 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. Clients should be asked, "What can we help with now that you are experiencing some relief from the psychosis?"
- **Convey hope and focus on clients' 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 clients around their own goals as a way to keep them connected to treatment. Clients' 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 people want help resuming a normal life.

- **Take into account the client's preference of meeting sites.** The long- term goal of the team is to provide services at the clinic. Initially, some clients might be more willing to meet at places in the community rather than at a treatment center. Assertive outreach may involve team members spending time in the community or in the client's home environment. For example, the Primary Clinician can meet the client for coffee, a meal or a walk around the neighborhood in order to make visits more comfortable for the client. The goal here is to foster a good relationship with the client and to address and work through any reservations or fears about coming to the clinic.
- **Nothing is permanent.** If the client 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, consider meeting with family if possible. Family members might have ideas about how to get clients into care.

## 2. Needs Assessment

One of the first tasks of CTI and so of the OnTrackNY program is to conduct a psychosocial needs assessment of the client 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 client's particular needs and circumstances. The Initial Psychosocial and Needs Assessment (found in the Collaborative Approach for Recovery Manual) is done by the Primary Clinician and the team psychiatrist. First, the goal of the needs assessment is to collect information on the client's history. This is done through discussion with the client, 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 client. 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 client and family members present, or done twice separately if the client wants to talk without family members present. Clinicians who work with clients with FEP have found that families and clients are generally in agreement in terms of the importance of the client resuming normal life, and improving in school, work, and social functioning. Second, in conducting the needs assessment, team members must balance collecting factual information with engaging with the client in a recovery-oriented discussion in which the client 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 client's life. Further modifications may result from continuing dialogue with the client 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 Primary Clinician in particular.

## 3. Time-Limited Approach

OnTrackNY is available to provide intensive services for approximately two years during which individuals are typically at their most vulnerable and not yet strongly connected to appropriate services. However, the intensity of involvement by the members of the treatment team, including the Primary Clinician, during this period can vary depending on changes in the level of need expressed by the client and his/her family. 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 any time after

completion of one year in the program and begins with the delivery of the Primary Clinician Core Session 10, “Transition from the OnTrackNY Team: Connecting with Community Services and Supports.” Coordinated by the Primary Clinician, this session will guide the timing of a more formal assessment using the Transition Planning Tool. The Transition Planning Tool considers input from all key stakeholders, including the client, his/her family, and other members of the OnTrackNY team. In short, the tool should be used to help determine whether the client is or is not in need of continued and ongoing assistance from the OnTrackNY program. While we anticipate that the specified two-year period of intensive services offered will be indicated for the majority of clients, we recognize that there is considerable uncertainty about the optimal duration of intensive services in FEP. For some participants, less than two years of service may be indicated. Likewise, a number of clients may benefit from more than two years of OnTrackNY services. We recommend, however, that 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 OnTrackNY

CTI is delivered within OnTrackNY 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.

| <b>Table 1: CTI Phases and Contributions Across the OnTrackNY Team</b> |  |   |   |
|--|--|---|---|
| <b>Phase</b>   | Phase 1:<br><br>Engagement with Team and Initial Needs Assessment  | Phase 2:<br><br>Ongoing Intervention and Monitoring   | Phase 3:<br><br>Identification of Future Needs and Services Transition  |
| <b>Timing</b>  | Months 1-3   | Months 4-18   | As per Core Session 7 and OnTrackNY Transition Planning Tool (used at any point during second year up to and including months 19-24)  |
| <b>Overall Purpose</b>   | <ol style="list-style-type: none"> <li>1. Develop a trusting relationship with client and family.</li> <li>2. Introduce client and family to team members.</li> <li>3. Complete needs assessment.</li> <li>4. Assess client’s understanding of “the problem.”</li> <li>5. Mediate and negotiate.</li> <li>6. Provide emotional and practical support.</li> <li>7. Negotiate stress in the</li> </ol> | <ol style="list-style-type: none"> <li>1. Provide interventions as appropriate. Regularly review and revise goals.</li> <li>2. Introduce idea of potential relapse and explore risk factors for relapse.</li> <li>3. Strengthen the support network.</li> <li>4. Continue to assist with supporting positive self-regard and managing stress in the environment.</li> <li>5. Maintain continuity of contact.</li> </ol> | <ol style="list-style-type: none"> <li>1. Assess transition considerations.</li> <li>2. Re-assess client’s needs, strengths, supports, and treatment preferences.</li> <li>3. Prepare for termination.</li> <li>4. Meet with client (both alone and with family) to mark end of the experience with OnTrackNY.</li> </ol> |

|                                     |  |   |   |
|-------------------------------------|--|---|---|
|                                     | <p>environment.</p> <ol style="list-style-type: none"> <li>8. Validate experience of stigma and support positive self-regard.</li> <li>9. Review and discuss goals.</li> </ol>   |   |   |
| <b>General Activities</b>           | <ol style="list-style-type: none"> <li>1. Obtain history.</li> <li>2. Meet with caregivers/family members.</li> <li>3. Complete safety planning.</li> <li>4. Engage family members and provide support.</li> <li>5. Make home visits.</li> <li>6. Accompany to community services as needed.</li> <li>7. Ensure adequate housing &amp; financial resources.</li> <li>8. Link clients with other members of the treatment team.</li> </ol>  | <ol style="list-style-type: none"> <li>1. Mediate conflicts.</li> <li>2. Help clients and family identify coping and relapse prevention strategies.</li> <li>3. Identify gaps and modify network as necessary.</li> <li>4. Regularly review and revise needs assessment and safety plan.</li> <li>5. Provide support of family via family component of treatment.</li> <li>6. Monitor client contact with other team members; revise as needed.</li> <li>7. Link with community resources as needed.</li> </ol> | <ol style="list-style-type: none"> <li>1. Begin transition process by identifying and addressing termination/transition needs and preferences.</li> <li>2. Coordinate assessment of further needs, preferences.</li> <li>3. Prepare for transition if indicated.</li> <li>4. Ensure support network and connection to service providers are safely in place.</li> <li>5. Plan for long-term goals.</li> <li>6. Hold transfer-of-care meetings as needed.</li> </ol> |
| <b>Primary Clinician Activities</b> | <ol style="list-style-type: none"> <li>1. Complete needs assessment.</li> <li>2. Review and discuss client's goals.</li> <li>3. Review Core Sessions.</li> <li>4. Introduce and discuss concept of shared decision making (Core Session 3).</li> <li>5. Develop treatment schedule.</li> <li>6. Assess needs and preferences regarding family involvement.</li> <li>7. Schedule family meeting.</li> <li>8. Formulate and present treatment plan.</li> <li>9. Assess safety and complete safety Planning.</li> <li>10. Screen for traumatic events and symptoms and plan for trauma treatment as appropriate</li> <li>11. Develop wellness plan</li> <li>12. Conduct assertive outreach as needed</li> </ol> | <ol style="list-style-type: none"> <li>1. Ongoing assessment, review and revision of client's and family's goals and needs.</li> </ol>  | <ol style="list-style-type: none"> <li>1. Begin transition process by identifying and addressing termination/transition needs and preferences (Core Session 7 and Transition Planning Tool).</li> <li>2. Coordinate assessment of further needs, preferences.</li> <li>3. Work with client to implement transition plan.</li> <li>4. Meet with client (both alone and with family) to mark transition from OnTrackNY.</li> </ol>                                    |

|   |  |  |  |
|---|--|--|--|
|   | <ul style="list-style-type: none"> <li>13. Provide case management as needed</li> <li>14. Obtain prior treatment records and consents for release of information as needed</li> </ul>  |  |  |
| <b>Collaborative Approach to Recovery (CAR) Activities Performed by the Primary Clinician</b> | <ul style="list-style-type: none"> <li>1. Assess role of Primary Clinician in assisting clients in attaining their goals; offer CBT based interventions</li> <li>2. Formal assessment of substance use/abuse if needed.</li> <li>3. Plan for sessions to address clients' identified needs.</li> </ul>   | <ul style="list-style-type: none"> <li>1. Assess readiness, needs, and goals:</li> <li>2. Social Skills Training (individual and group)</li> <li>3. Substance Abuse Treatment (individual and group)</li> <li>4. Coping Skills Training</li> <li>5. Behavioral Activation</li> <li>6. Psychoeducation</li> <li>7. Family Consults and Monthly Educational Groups</li> <li>8. Planning Sessions</li> <li>9. Supportive Sessions</li> </ul>  | <ul style="list-style-type: none"> <li>1. Assess readiness, needs, and goals.</li> <li>2. Identify and review the "tools in your toolbox."</li> <li>3. Review skills needed for implementing post OnTrackNY plan.</li> <li>4. Coping skills "check-up."</li> <li>5. Community "field trips" to other providers/resources</li> <li>6. Prepare the family for transition to care in the community.</li> <li>7. Planning Sessions.</li> </ul> |
| <b>Prescriber Activities</b>  | <ul style="list-style-type: none"> <li>1. Obtain comprehensive history of prior treatment with and response to psychiatric medications, including prior occurrence of side effects and specific concerns about medications.</li> <li>2. Evaluate extent of risk for non-adherence to treatment.</li> <li>3. Conduct baseline objective assessments of psychiatric symptoms (positive, negative, depressive) and antipsychotic side effects (e.g., metabolic, neurological).</li> <li>4. 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</li> </ul> | <ul style="list-style-type: none"> <li>1. Meet with the client approximately twice per month in months 3-6 and monthly thereafter, with the exact frequency of visits informed by clinical need.</li> <li>2. Continue to engage in shared decision-making with client (and family, if applicable) around need for and/or changes in antipsychotic treatment.</li> <li>3. Continue to discuss and provide printed educational materials on treatments recommended by OnTrackNY as well as other available treatments.</li> <li>4. For patients who accept antipsychotic treatment, periodically evaluate their objective symptom response development of side effect and make requisite changes in</li> </ul> |  |



|  |   |   |  |
|--|---|---|--|
|  | <p>medication treatment.</p> <ol style="list-style-type: none"> <li>5. For consumers who accept antipsychotic treatment, discuss and provide printed educational materials to patient (and family, if applicable) on treatments recommended by OnTrackNY as well as other available treatments.</li> <li>6. For consumers who decline antipsychotic treatment, engage in shared decision-making to develop a detailed plan for responding to recurrence of psychotic symptoms.</li> <li>7. Meet with client as needed. Frequency of visits is <u>highly individualized</u>. On average: at least weekly during the first month, and at least biweekly in the second month to facilitate intensive monitoring of response to and side effects from antipsychotic treatment.</li> <li>8. Participate with response and development of side effects and make requisite changes in treatment based on these assessments.</li> </ol> | <p>treatment based on these assessments.</p> <ol style="list-style-type: none"> <li>5. For clients 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.</li> <li>6. For consumers who accept antipsychotic treatment, periodically evaluate their adherence to treatment and make requisite changes based on these assessments.</li> <li>7. For consumers who decline antipsychotic treatment, continue to follow previously developed plan for responding to recurrences of psychotic symptoms.</li> <li>8. Engage in shared decision- making with client (and family, if applicable) to periodically re-visit decision to decline antipsychotic team in development of client's treatment plan, providing guidance around medical and psychiatric aspects of care and crisis intervention planning treatment.</li> <li>9. Serve as leader/provide oversight in management of crisis situations.</li> <li>10. Continue to participate with team in updating client's treatment plans, providing guidance around medical/psychiatric aspects of care and crisis intervention</li> </ol> |  |
|--|---|---|--|

|                                  |  |   |   |
|----------------------------------|--|---|---|
|                                  |  | planning.   |   |
| <b>SEE Specialist Activities</b> | <ol style="list-style-type: none"> <li>1. Meet with client to complete Career Profile.</li> <li>2. Develop a plan based on client choice and Career Profile.</li> <li>3. Determine if other vocational/educational resources are needed and refer to Vocational Rehabilitation Agency (VR) when applicable.</li> <li>4. Complete/revise resume if necessary.</li> <li>5. Obtain any school records/information if necessary.</li> <li>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</li> <li>7. Discuss disclosure risk and benefits.</li> <li>8. Begin job development and/or education activities.</li> <li>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 for items such as coping techniques, symptom alleviation, or addressing medication side effects.</li> <li>10. Help clients identify what natural supports will be helpful and assist them with developing those supports.</li> <li>11. Complete mock applications and interviews with clients who are not familiar with or comfortable with such activities.</li> </ol> | <ol style="list-style-type: none"> <li>1. SEE Specialist should meet or provide a service to each client at least once every week to two weeks, depending on client's needs.</li> <li>2. Follow through with goals and activities on the plan.</li> <li>3. When and where clients agree to disclosure, SEES should follow-up with employers of working clients once a month or as needed.</li> <li>4. Follow-up on any education activities as needed. Talk to professors and instructors if needed and with signed consent.</li> <li>5. Provide the needed follow-along supports to address any issues, concerns and celebrations.</li> <li>6. Engage with family and other natural supports when possible and needed (with consent).</li> <li>7. Review goals at six months and change/revise if necessary, or change/revise sooner if needed.</li> <li>8. Continue to meet with the team weekly.</li> <li>9. Continue to document and track information.</li> <li>10. Continue to meet with supervisor.</li> </ol> | <ol style="list-style-type: none"> <li>1. Each client will have different needs as they transition from OnTrackNY to other services.</li> <li>2. For individuals who are working, the SEES and the client should talk about the supports that have been most helpful and identify other agencies or resources 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.</li> <li>3. Connect with family members to ensure that they contribute to the transition plan, and provide them with community vocational/education resources, and education regarding special accommodations as they relates to work and school.</li> <li>4. Refer to local Vocational Rehabilitation Agency when applicable.</li> </ol> <p>All of the above applies to all clients transitioning out of OnTrackNY even if they did not access vocational/ educational services during phase one and two.</p> |

|                                   |  |  |  |
|-----------------------------------|--|--|--|
|                                   | <ol style="list-style-type: none"> <li>12. Meet with OnTrackNY team to ensure all are aware of vocational/educational activities weekly.</li> <li>13. Document all required information and complete all required SEE documentation forms. Track all job development contacts and education contacts. Track all job placements and education enrollments</li> <li>14. Supervision between Team Leader and SEE Specialist will take place every two weeks.</li> </ol> |  |  |
| <b>Peer Specialist Activities</b> | <ol style="list-style-type: none"> <li>1. Engage participants as they start working with the team (meeting with them at the hospital or at home).</li> <li>2. Forge a working alliance with participants and families.</li> <li>3. Describe the program to participants and families and how it might fit their preferences.</li> <li>4. Serve as the bridge between participant and rest of team when the individual is ambivalent about treatment.</li> </ol>      | <ol style="list-style-type: none"> <li>1. Build relationship with participants through the principles of connection, and mutuality.</li> <li>2. Discuss various ways to think about mental illness and make meaning of the experience to promote recovery.</li> <li>3. Support individuals as they navigate complex systems (e.g., school, housing, primary health care).</li> <li>4. Collaborate in the development of wellness tools and identifying strengths.</li> <li>5. Facilitate peer groups</li> <li>6. Collaborate with other team members to help with achieving goals.</li> <li>7. Work with families to provide support and provide additional perspectives.</li> </ol> | <ol style="list-style-type: none"> <li>1. Collaborate in the transition process with the rest of the team.</li> <li>2. Connect participants and families to local resources and community groups.</li> <li>3. Connect participants to the larger recovery community (in-person or web-based).</li> </ol> |

\* = offered to all clients

#### a. 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 (Core Session 1)** Clients and family members need to know all team members. Some clients 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. Delivery of the Core Sessions (see Collaborative Approach to Recovery Manual) will facilitate introduction to team members and key elements of the OnTrackNY approach.
2. **Build rapport and provide support.** Many things, large and small, are important in building rapport but a few stand out as critical. First, the team must always solicit the client'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 clients 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 clients or family members may initially refuse to use medication. The team must support clients and families as they make treatment decisions, be respectful when clients ask for additional information or change their minds about some aspects of the treatment plan, and provide practical support as needed within specific domains. For example, if a client is having difficulty obtaining a prescription for medication prescribed by the team psychiatrist, the psychiatrist may work with the Primary Clinician to resolve the problem. Practical support may be needed in many areas, including ensuring provision of adequate housing, securing financial resources, or helping clients get their needs met in the community. The Primary Clinician can also provide support by working with clients 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 using the recovery coaching strategies.
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 clients. It is important to remember that clients and family members will not always agree. Mediating conflicts between clients and family members will be an important role for the team. In addition, clients and families often have little or no experience with psychosis or the mental health system. Any previous contact with the mental health system may have resulted in ambiguous diagnoses and uncertain prognosis; thus clients and family members may have negative feelings towards mental health treatment and may have difficulty coping with the trauma of FEP. Families may need help adjusting their expectations so that they are able to convey hope for recovery, while clients 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 Primary Clinician and team psychiatrist, the ongoing review and evaluation of needs requires the involvement of all team members. There are some elements of needs assessment that involve collecting factual information from the client and the family and that must occur in a relatively short period of time so that the team can use this information when working with and supporting client. For example, all individuals will be screened for lifetime traumatic events and possible associated symptoms, and history of and current suicidality. There is also an element of needs assessment that is a process that unfolds over time as the members of the team and the client work with and learn about each other. Importantly, needs assessment must include identifying and highlighting clients' 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 client's goals and how they relate to those of the treatment team and family members, determining the order in which goals will be addressed, and reassessed over time.

## **b. 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 clients around their individual goals. Clients meet regularly with the team psychiatrist for issues related to medication use and unwanted effects. The client will work with the SEE Specialist on education/employment goals. The Primary Clinician will provide support and use recovery coaching strategies to will work with clients and families on family issues, communication, and problem solving. Importantly, the team will need to continue active engagement and outreach activities for some clients and families, especially those at risk of being lost to treatment. Phase 2 may represent a critical time for some clients with regard to decreased attendance and potential dropout. Some clients 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 hope that recovery is possible. It will be important for the team to locate clients 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 client's changing understanding of psychosis and its impact. In addition, it is important to discuss new goals and to re-emphasize goals that have been accomplished. Team members must also monitor achievements so that they can be re-addressed if needed. The team must work with clients and families to minimize stigma and stress in the 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 clients and families that ups and downs are to be expected, and that each "down" can be an experience that teaches and helps the client and family make progress 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 some 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 returns, 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.

Some of the most valuable things to be learned from a relapse are the factors that trigger relapse. These will differ for each individual, but identifying risk factors can help clients 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 mitigated. For example, if stress is a risk factor for relapse, and a client is going to have a stressful week related to studying for tests at school, the week can be planned out beforehand to schedule study time, identify stress-relieving activities, engage family members and other supports to help.

4. **Strengthen the support network.** The team helps the client to create or re-establish a social network, encourage communication and coordination between the client 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) and to provide basic educational information to family on psychosis, the recovery process, and early warning signs of symptom recurrence. Other activities that are relevant to the social network include identifying gaps in support and problem-solving as needed, identifying risks for housing loss and other adverse social outcomes, and helping the client to advocate for him/herself. In addition, the team always wants to be assisting the client and his/her family to develop natural supports in the community. The team will actively encourage the client and family to identify and connect with community resources. 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; inpatient substance abuse treatment, dialectical behavior therapy.
- Non-psychiatric medical services: examples include primary care services, lab services, or other medical appointments; substance use detoxification.
- Peer or community support resources: examples include National Alliance for Mental Illness (NAMI), Alcoholics/Narcotics Anonymous (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 client and family in linking to and using these resources. This can include the Primary Clinician following up with a referral source to check on a client's progress, accompanying the client to meetings or appointments in the community, or other active assistance as needed.

5. **Discuss transition readiness.** Although OnTrackNY 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. Core Session 7: "Transition from OnTrackNY Team: Connecting to Community Services and Supports" and the Transition Planning tool should be used to help determine whether the consumer is or is not in need to continued and ongoing assistance from the OnTrackNY program. While the use of the assessment and service planning tool is initiated by the Primary Clinician, feedback from all stakeholders including clients, their families, and the other team members, should be considered. If, after careful consideration of the information gleaned during this assessment, it is determined that the client is ready for transition, the OnTrackNY team should draw on the activities specified as part of Phase 3.



### **c. 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 client, and initiate effective support networks and plans for access to needed future services. The Transition Planning Tool and Resource and Referral Log should be used to help with these efforts.

Many clients 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 lasts for approximately two years, it is critical that discussion of and work toward transfer begin long before the two-year mark. The team, with activities led and coordinated by the Primary Clinician, will work together with clients and family members using SDM to determine the best options for care in the future. As noted above, the Transition Planning Tool will help guide these efforts. The team will help the client 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 client 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 client to complete create a transition plan. The transition plan should provide the client 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.

## **V. Focus Areas**

Clinical experience and research with persons with FEP point to several domains that are crucial in facilitating clients' recovery from an initial episode of psychosis: (1) medication adherence and 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 screening and treatment; 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 clients. For example, not all clients will have contact with family members or have problems with substance abuse. Furthermore, additional domains may be important for some clients. Importantly, focus areas may change over time.

The eight domains of CTI as applied within OnTrackNY 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 client. For example, in FEP, housing and income may be less of a focus for someone who lives in a stable situation with family members, but might be more important for someone who lacks

family financial and housing assistance. It is important to note that these areas represent objective areas of need that many clients will experience. However, the glue that holds everything together is the overarching importance of building a trusting relationship between the team and the client, and helping him or her 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. A frequent outcome of this decision is symptomatic relapse and subsequent difficulties in restarting medications. The team must educate clients about the recurring nature of psychosis, about health behaviors that lessen the risk for future episodes, and about how stress relates to relapse. The psychiatrist will be the primary member of the team focusing on medication options and adherence. It will be critical for the 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 nurse will assist in this area by helping the client manage any non- psychiatric medical care needs, particularly issues related to the metabolic side effects of antipsychotic medications. The client and the team must achieve a shared understanding of recovery goals and develop collaborative approaches to selecting and revising medication treatment approaches. The Appendix contains several tools to support this process:

- Preparing to Talk with Your Team
- Psychiatric Medication and Me
- Finding Personal Motivation
- Designated Observer

Learning to use psychiatric medication to support recovery is a journey often characterized by decisional conflict and uncertainty. For many, the journey includes moving from passively taking medicine to actively using it to support recovery. The role of the team 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 them incorporate the use of medicine into overall lifestyle.
3. Helping adjust self-concept to include ongoing use of medicine.
4. Building skills so that clients learn to advocate for themselves in the shared decision making process.
5. Validating the experience of stigma that is involved with using psychiatric medicine and helping clients minimize its impact.

6. Supporting clients' normal need to experiment with decreasing medication dosages, taking medication holidays, using complementary 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 model to be implemented by a dedicated Supported Education and Employment 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 SEE Specialist will conduct a more in-depth assessment and, where needed, collaborate with community providers who may be involved with the client's educational or vocational activities. While the SEE Specialist will be the main team member in charge of the SEE intervention, the Primary Clinician will assist with any relevant transitional activities that occur toward the end of the client's treatment with the team, such as helping to ensure that any necessary service linkages are in place and functioning. The Primary Clinician can also collaborate with the SEE Specialist on work-related social or coping skills as needed.

## **C. Family Support and Intervention**

CTI 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 Appendix contains several tools to support this process:

1. Family Involvement Decisional Balance
2. Values Clarification for Family Involvement

In addition, a Family Engagement and Needs Assessment can be found in the Primary Clinician Manual.

The Primary Clinician will work closely with clients' families, administering formal family-centered interventions as well as linking families to the rest of team for specialized work. The Primary Clinician will encourage family involvement in treatment planning, treatment decisions, and ongoing care and will 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 while pursuing life goals can be challenging for a person with a first episode of psychosis. Accomplishing these tasks is central to the recovery process. The team will help clients learn to identify signs of relapse and strategies for coping with symptoms of illness effectively. Each team member is involved in this process within his/her area of

specialization and assists the client in putting strategies to work in real-life situations. In addition to educating the client 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 client's setting his/her own life goals apart from the illness. (For example, see *Surviving Stress* in the Appendix, and the *Wellness Management Plan* in the Appendix of the *Primary Clinician Manual*.)

## **E. Social Skills Training, Substance Abuse Treatment, Coping Skills Training, and Behavioral Activation**

The Primary Clinician leads the assessment and delivery of recovery coaching strategies which consist of social and coping skills training, substance abuse treatment, and behavioral activation strategies. Social skills training and substance abuse treatment will be done individually and in groups where feasible.

The Primary Clinician will assist in assessing clients at the start of their involvement in OnTrackNY as to their need for and interest in these interventions, provide ongoing support to clients while providing these interventions, and assist in keeping clients engaged in and motivated to attend and participate in these interventions.

## **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, led by the Primary Clinician, to carefully assess and respond to threats to housing stability in order to prevent homelessness. In the case of loss of housing, the Primary Clinician will intervene quickly in the attempt to remedy such loss and to minimize discontinuities in access to treatment and other supports. Furthermore, the Primary Clinician 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 Primary Clinician might collaborate with the psychiatrist and nurse in situations where housing problems are due in part to substance abuse.

## **G. Trauma Screening and Treatment**

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 participants will be screened for trauma at intake, and at a second point after the client feels more comfortable with the team (see PTSD Screening Questionnaire I in Primary Clinician Manual).
3. If the participant has experienced a traumatic event, symptoms associated with the event will also be assessed (see PTSD Screening Questionnaire II in Primary Clinician Manual).
4. Participants whose symptoms associated with the trauma are severe or who meet criteria for PTSD will be offered the Brief PTSD Treatment program (see Brief PTSD Treatment Program Manual); or may opt to get further specialized PTSD care from an external provider/PTSD expert.
5. All interactions between the team and the participant will emphasize safety, choice, SDM, and lack of coercion.

A goal of the lifetime trauma screening is to assess previous or current trauma exposures; and screening for symptoms associated with the traumatic event is to assess the presence of PTSD symptoms. If symptoms of PTSD are present, the team will work with the participant to determine the best course of action for addressing the PTSD. The team will be trained to deliver the Brief PTSD Treatment program for individuals whose symptoms are pronounced enough to meet criteria for PTSD. The program is a three-session relaxation training and psychoeducation intervention that has been found to reduce PTSD symptoms in adults with serious mental illness and PTSD. The team will also develop a list of resources in the community for addressing trauma/PTSD, and a decision about making a referral to another provider must be made by the team and the participant together. It is important to note that, for many participants, inpatient settings can be re-traumatizing and that special care will often be needed if/when a participant is re-hospitalized during the two-year time in the program. In the case of current or ongoing violence or abuse, a safety plan will be created with the participant, 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; as many as 5-10% of individuals diagnosed with schizophrenia commit suicide. Details of the safety planning and suicide prevention strategies are described above.

## VI. Implementing OnTrackNY

### A. Human Resources and Hiring

Administrators need to arrange for hiring of staff. All agency rules regarding evaluation and credentialing should be followed. If possible, it is most useful to hire the Team Leader first, and for the Team Leader to then be involved in the hiring of the other team members.

### B. Resources

**Space.** The OnTrackNY team serves a young population. It is important for the setting in which the team is located to appeal to young people. Space needs to be youth-friendly and, if possible, integrated into community or general health services that may be seen as more inviting to clients with FEP and their families. The goal is to avoid providing settings that include large groups of individuals with more chronic illnesses. The team needs sufficient space to hold groups and team meetings as well as some space for private individual meetings. The space should be in an area that is easily accessible, either via public transportation or with parking.

**Off-site Services.** The program must have the option of providing off-site services. This may require access to a vehicle or public transportation.

**Medication Monitoring Needs.** The program must have access to a scale and blood pressure cuff and a convenient way to obtain laboratory tests, either on site or off site. Working out the logistics of labs and medication injections is critical and must be addressed at the start of implementation.

**Additional Resources.** Money for petty cash to use to make small purchases to facilitate recovery oriented activities, transportation, etc. should be included. Telephone, cell phone and computers should be provided according to agency policy.

### C. Supervision and Compliance with Agency Rules

Access to supervision for each of the program elements is important. In general, the Team Leader will provide supervision to each of the team members. Supervision for the Team Leader within the reporting structure is also necessary in order to facilitate integrating the program into the overall agency structure. Optimally, the Team Leader should have administrative supervision with a senior clinician at least every two weeks and monthly administrative supervision with the host setting's program director. Ideally, the team psychiatrist will have access to expertise to assist with unique problems that arise for FEP patients. Other personnel and management tasks include annual evaluations and time tracking for all OnTrackNY staff. In addition, the clinic administration needs to have back up plans for coverage for the Team Leader and the psychiatrist. Emergency back-up coverage is also necessary should the psychiatrist be unavailable.

The clinic administration needs to ensure that FEP program elements are compatible with existing agency requirements. Suggested FEP forms should be compared and matched against required agency forms so that redundancy can be eliminated to the extent possible. Medical record management, client registration



and tracking, evaluating clients' insurance to confirm coverage, and census and visit tracking reports need to be addressed. In addition, budgetary issues such as billing, budget management, expense tracking, supply ordering, laboratory pharmacy tracking and reimbursement must be considered in implementing the program.

## **VII. Team Process and Procedures**

Each team member has specific interventions and strategies that he/she brings to her work with clients in OnTrackNY. For detailed information on functions and procedures for each team member, please refer to each team member's manual. Below are processes and procedures that are relevant to all team members.

### **A. Getting Started**

#### **1. Initial meetings**

Participants are referred from a variety of sources. Wherever they come from, they may be new to treatment, scared or upset at the prospect of starting treatment, experiencing symptoms, and in other ways hesitant about or ambivalent toward treatment in a mental health setting. Many clients and family members will be overwhelmed and/or upset, the focus of all early contacts must be to allow the client and family to get to know the team, ask questions, and build rapport.

While it is important to assess specific needs and to obtain information relevant to the treatment plan, many clients 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 client to bring family members with him/her to initial meetings if possible. While initial meetings are generally focused on the client becoming acquainted with the Primary Clinician and team psychiatrist, the client should also be introduced to the other team members so that he or she knows who everyone is and their role on the team.

#### **2. Treatment planning**

The first step in creating the initial treatment plan is completing a comprehensive history and needs assessment. This process will begin either at the first meeting following referral or soon after. Both the Primary Clinician and the psychiatrist will meet with the client 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.

### 3. Developing a treatment schedule

Following the initial treatment planning meeting, a treatment schedule will be developed so that the client and family members know when they are to meet with team members and with what frequency. While the exact amount of contact will be highly individualized, the expectation is that the team will aspire to have a minimum frequency of contact with the client as follows:

| Minimum Frequency of Contact | Primary Clinician | SEE Specialist | Psychiatrist/Nurse | Peer Specialist |
|------------------------------|-------------------|----------------|--------------------|-----------------|
| Weekly for first month       | X                 | Variable       | X                  | Variable        |
| Bi-weekly for months 2-6     | X                 | Variable       | X                  | Variable        |
| Monthly beginning in month 7 | X                 | Variable       | X                  | Variable        |

Primary Clinician meetings with the client are used to cover Core Sessions (see Collaborative Approach for Recovery Manual), to review how he/she is doing, progress towards treatment plan goals, and any issues that the client wants to address. Meetings with the Primary Clinician can also include discussion of family issues and safety planning. Additional meetings that include the Primary Clinician, client, and family members can be scheduled as needed. A schedule of meetings with other team members will be developed as needed. These meetings will vary depending on each client's needs assessment, treatment plan, and treatment goals. That is, clients will differ in the frequency with which they meet with the Primary Clinician around illness management strategies, the SEE Specialist and the Peer Specialist. In addition, clients may elect to start these intervention components at different times – some may start with the SEE Specialist and the Peer 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. For the first month, the psychiatrist will meet with the client weekly to monitor symptom response and the occurrence of bothersome side effects. It is likely that more contact will be needed at the start of treatment, and that contacts will decrease in frequency over time as clients reach their goals and become more stable within their recovery.

## B. Other Activities at the Start of Treatment

### 1. 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 client regarding his/her preferences and subsequent dialogue with family members. As many clients live with family members, significant family involvement with treatment is expected for most clients and required for minors. As part of initiating family interventions, the Primary Clinician should introduce the client and family to the cognitive behavioral therapy based strategies discussed in the CAR Manual, and convey the

message that clients and their family members can be involved in the Brief Family Consultation and Monthly Educational Session components of the Family Intervention.

## **2. Screen and Assess for Suicidality Using the CSSRS and the OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool**

The Primary Clinician will screen for suicidal ideation and behavior using the CSSRS and then do a comprehensive assessment, using the OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool. They will then engage in safety planning or complete a wellness self management with the client as appropriate. This process is described in detail in this Team Manual. Briefly, all clients will have a suicide screening and assessment during their initial contact with their Primary Clinician. All clients with current or recent suicidal ideation or behavior will complete safety planning.

## **3. Develop a wellness management plan**

For individuals without suicidal thinking or behavior, the Primary Clinician will work with the individual to complete the wellness self-management (WSM) plan. These interventions are to help participants identify copings skills and supports to use when managing increased risk (see appendix).

## **4. Meet all team members**

Near the start of treatment, the SEE Specialist, Peer Specialist and Primary Clinician must meet with clients to describe the services they provide, and to assess the clients' needs and goals in their respective areas. The SEE Specialist will discuss supports around work and school, the Peer Specialist will discuss how they can support the client in their recovery journey, and the Primary Clinician will discuss the CAR intervention. The process for needs assessment and initial engagement for these team members can be found in their respective manuals. The timing of these meetings will vary for different clients. Although clients will differ in when they elect to start these intervention components, it is important for these team members to meet with all clients and educate them about their roles on the team.

# **C. Ongoing Treatment**

## **1. Delivery of interventions**

Treatment will be provided based on the manuals for each team member.

Clients will come to the clinic for their regularly scheduled appointments, although this may differ for work with the SEE specialist when services related to work or school goals need to be done in the community. If the client is satisfied with the schedule and how the interventions are being implemented, then the schedule will remain stable between treatment plan updates (see below).

## 2. Ongoing treatment planning

Treatment planning is an ongoing process that is headed by the Primary Clinician and 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 three months. Treatment plans will be updated during meetings between the Primary Clinician, the other team members, and the client. With the client's permission, family members are encouraged to attend. Specific procedures for the Primary Clinician and psychiatrist around treatment planning are provided in their respective manuals.

## 3. Ongoing outreach

There is an expectation that there will be at minimum one contact per week between some member of the team and the client during the first month of treatment. While this will most likely involve weekly contact with the Primary Clinician and psychiatrist, it is possible that some weeks the contact will occur with other team members. The team will address missed appointments by providing outreach, especially to those in danger of dropping out of the program. Outreach will be tailored to each client and family, but can include a range of strategies including contacting family members, phone calls, and home visits. When a client misses an appointment, a team member should attempt to contact that person within 24 hours to indicate that the appointment was missed and to 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 client was missed and that the team member looks forward to seeing the client soon, and should greet any information about the cause of the no-show with support and understanding.

## 4. Crisis planning and intervention

There are several components of the intervention that address planning for crises. For acute emergencies, a member of the team must be available at all times by phone or to meet with clients and family members. During business hours, clients should call the clinic and a team member will talk with the client as soon as possible that day. After business hours, a team member who is a licensed mental health professional should be available by pager or phone.

Whoever is on call will take the initial call from the client or family member, learn about the crisis, and problem solve with the client and/or his/her family members regarding 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 member on call will call the psychiatrist and have him/her call the client. In this way, the team members can provide background regarding the events of the crisis and not require the client or family member to repeat the information to different people.

Team members will also assist family members and clients in deciding how to manage a crisis, whether the crisis can be managed at home, or whether it will require hospitalization. The OnTrackNY team

should have relationships with several hospitals in the area that will be familiar with the program for ease in referring clients to ER services or hospitalization when needed. The team will provide clients and family members with contact numbers for them to call in a crisis. This will include providing the client and family members with wallet cards that list emergency numbers and a brief description about who to call at what time of day. Remember that the Wellness Self Management Plan is a useful tool for working on crisis planning with participants.

## 5. Linkage with community and peer resources

An important goal of the team is to work with clients and their families to develop natural supports within the community. During the time that the client 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 clients:

- Mental health or clinical services not provided by the team: examples include inpatient substance abuse treatment and 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 Primary Clinician will actively assist the client in contacting a new provider or service and in following through on that contact. The exact nature of this assistance will differ for individual clients – some will require only a referral, while others will ask for more help in contacting a resource or may want the team member to accompany him/her to the first or first several appointments/meetings.

## 6. Documentation

Each clinic will have its own process for record keeping and formatting progress notes. For clients working with the OnTrackNY 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 client/family contact numbers and a resource binder that serves as a directory of commonly used community services and resources.

## D. Termination

Involvement with the team will last approximately two years. During the last six months of treatment, the team must actively work toward planned transition of the relationship with the client, and initiate effective support networks and plans for access to needed future services in the community. The Transition Planning Tool can help guide these efforts. Transition will involve many challenges. Many clients 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. It is critical that the team begin discussion of and work toward transition long before transfer actually has to occur. 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 client within each area of specialty. An SDM approach is especially important when planning ongoing care, as this is a time when the client and his/her family need to drive planning and take ownership of decisions about the future.

## VIII. Training and Supervision

### A. Training Activities

Training for the OnTrackNY team includes two domains: team training and specialty training. Team training focuses on information and skills needed by all team members, as well as procedures that structure the team and guide the ways that team members work together and how tasks are assigned within the team. Specialty trainings are targeted and involve training on the skills and interventions required by that particular team member.

Training involves three components: (1) background readings, review of online training modules and associated discussion regarding lived experience of psychosis, (2) intensive in-person training, and (3) telephone/online training meetings specific to each program element/role. Team leaders are encouraged to be creative in their use of the online training modules. For instance, the video series titled “The Spirit of OnTrack” and “Shared Decision Making” are specially designed, rapid e-learning resources. Each video in the series is 8-12 minutes long and has a corresponding viewers’ guide that includes discussion questions and additional resources. Team leaders might consider showing one short video per month at a staff meeting and spending an additional ten minutes reviewing the discussion questions with the team.

### B. Integrating Peer Specialists onto the Team: Challenges and Opportunities

Peer Specialists are an emerging workforce in behavioral health. Peer Specialists are people with the lived experience of recovery after a diagnosis of mental illness. In addition to the wisdom they have gleaned through their experience, Peer Specialists have also fulfilled training and study requirements to earn certification. They must keep their certification up-to-date by fulfilling annual CEU requirements.

Peer Specialists are not junior clinicians. In fact, they are specifically trained to have a peer perspective, rather than a clinical perspective. However, there are also areas where the perspective and skill sets of all team members overlap. The chart below offers some examples of the differences between peer and clinical perspectives, and respective areas of overlap:

**Peer Specialist and Clinical Perspective**

| Peer Specialist Perspective  | Overlap   | Clinical Perspective   |
|--|---|--|
| Work is guided by the Principle of Mutuality defined as a focus on the connection between the Peer | Unconditional positive regard for the individual being served | Clinicians are in the role of helping and supporting participants with a focus on diagnosis, identification of strengths and treatment. There is |



|   |   |   |
|---|---|---|
| Specialist and the peer wherein there is reciprocity  |   | not an expectation of reciprocity in clinician/participation relationships.   |
| Focus on learning together rather than assessing or prescribing help  | A desire to support recovery and the young person's achievement of their human potential  | Focus on assessing and helping participants.  |
| Emphasis on sharing and exploring life experiences where both individuals share personal perspectives   | The importance of connection, finding common ground, and respect.   | Emphasis on exploring program participants' experiences, with less expectation for the clinician to share their personal experiences  |
| Might focus on the many ways to understand the experience of psychosis: bio-psycho-social; spiritual; cultural; psychosis as teacher; psychosis as a natural variation of human experience, etc.  | A commitment to support the young person in making meaning of their experience of psychosis   | The bio-psycho-social approach is the main framework for diagnosis and treatment while utilizing a cultural competency framework  |
| Do not participate in clinical decisions to use involuntary interventions such as involuntary commitment to a hospital; instead peer specialists might support participants during a hospitalization using the principles of mutuality  | Both clinicians and Peer Specialists recognize the importance of choice and self-determination in the recovery process.   | While struggling to balance the Duty to Care with the Dignity of Risk, clinicians have the power to use involuntary interventions such as involuntary commitment to a hospital to ensure safety |
| Trained to be advocates for and with participants. Advocacy may include speaking up about participant's needs and goals, or coaching participants in speaking for themselves. Advocacy may also include advocating for participant's legal rights, civil rights and human rights.   | Both clinicians and Peer Specialists strive to listen carefully to the needs and preferences, goals and aspirations of participants.  | Trained in recovery oriented practice which is strengths based, person-centered and aimed at supporting participants in achieving their unique goals.   |
| Peer Specialists are members of a socially devalued group often referred to as "the mentally ill." As such they are keenly attuned to stigma, dehumanizing practices, objectifying language, prejudice, discrimination and even offensive or traumatizing practices in mental health systems. As advocates, Peer Specialists will speak up if clinicians slip into language or practices that (often unintentionally) devalue participants or reinforce the status of socially devalued people. | Together, clinicians and Peer Specialists strive to create a culture of respect, not just within OnTrackNY teams, but throughout behavioral health systems and in the general public. | Clinicians who have not self-disclosed a personal psychiatric history, are not part of the socially devalued group known as the mentally ill.   |

Team leaders must take special care when integrating Peer Specialists onto the OnTrackNY team. There are several challenges. The first is there is only one Peer Specialist on the team. Not having other peer colleagues to share experiences with can be lonely and leave the Peer Specialist feeling isolated. Team leaders can address this challenge in a number of ways. First, ensure the Peer Specialist attends the monthly OnTrackNY Peer Specialist consultation call. Secondly, ensure the Peer Specialist attends all peer trainings. Third, consider allocating a budget for the Peer Specialist to attend national or regional peer conferences as well as connect with other Peer Specialists in the larger host agency if possible. And finally, make sure Peer Specialists are supported in getting CEU's for their annual re-certification.

A second challenge is leading the entire team through the culture shift that often occurs when Peer Specialists are integrated into multidisciplinary clinical teams. Pat Deegan (<https://www.patdeegan.com/blog/posts/peer-staff-disruptive-innovators>) has called Peer Specialists "disruptive innovators." The term disruptive innovator is not intended to imply that Peer Specialists come into the traditional mental health workplace with the intention to cause mischief and disruption. Rather, Deegan argues that by their very presence and different frame of reference (see Table 1), peer staff disrupt at least six common assumptions which underpin traditional clinical services. These potential disruptions may impact different OnTrackNY teams to differing degrees, depending on how the team is functioning. Team Leaders should be attentive to these possible issues as Peer Specialists are introduced to the team.

**Disruption #1 - Recovery is real:** Peer Specialists are the living proof that recovery is possible. By simply showing up, they overturn decades of clinical theory and training which taught that disorders such as schizophrenia are chronic conditions and the goal of clinicians should be to stabilize and maintain patients, rather than help them recover. Although OnTrackNY teams are recovery oriented and those who have been working with individuals with FEP for some time may have already embraced the idea of recovery based on witnessing the achievements that some program participants have attained, new providers, who haven't had this experience, may hold on to biases or myths about what is possible for each individual; it might be surprising to have a team member who has lived experience and is engaged in a fulfilling, meaningful and self-directed life. Disruption may result and is often expressed as a type of cognitive dissonance, as clinicians grapple with the implications of recovery oriented practice which withholds judgment about people's goals and aspirations, and try to reconcile this with how they have been trained in the past. Conversely, it can be expressed as annoyance at Peer Specialists for (in some cases) lacking formal education and/or clinical training.

**Disruption #2 - Sickness and health are not distinct domains of human experience:** There is a widely held assumption that wellness and sickness are separate domains. The sociologist Talcott Parsons has written extensively on this topic (Parsons, T. The Social System. Free Press, 1951). To this day, some institutional settings reflect this assumption. For instance, traditionally, there were bathrooms for the patients (the unwell) and those for the staff (the well); dining rooms for staff and separate ones for patients; state issued clothing for patients and status invoking uniforms for staff. All of these conventions helped draw a bright line between those who were well (staff) and those who were ill (patients). When Peer Specialists join an OnTrackNY team, they disrupt the assumption of categories because now one of the treatment team members is someone who in another setting might have been labeled as "sick." Peer Specialists are living proof there is a continuum, rather than a divide, between the

well and the unwell. Often this disruption is expressed when some team members begin questioning their status as a result of working alongside someone fulfilling a Peer Specialist role. For instance, a team member might be thinking: "I have a trauma history. I was in therapy. I use psychiatric medications. Am I a peer? Should I "out" myself as a peer? Am I in-the-closet because I have not disclosed my status as a person who has received MH services?" Again, Peer Specialists do not intend to create upheaval on the team. However, their very presence creates disruptions and the Team Leader must lead the team through the tension and opportunities that such disruptions afford. The opportunity here is for team members to explore their own story and the "why" of choosing to work with a population of people who are devalued by the larger culture within their particular role (e.g., as a clinician versus Peer Specialist). As team members explore their unique "story of why", and if they are willing to share with each other, it can create a deep bond among team members and protect against burnout.

**Disruption #3 – Peer Specialists can support the recovery of program participants:** Many studies have demonstrated peer staff can positively affect engagement, activation and health outcomes of peers diagnosed with mental illness and substance use disorders. With over 25,000 peer staff in the U.S. and 38 states having obtained a Medicaid waiver to allow peer staff to bill for services, there is no doubt peers are an emerging workforce in behavioral health. The very presence of peers on OnTrackNY teams disrupts the notion that help must be professionally mediated by licensed specialists. Team Leaders should be aware of how this disruption may be expressed. One of the ways is the team may not fully value the unique contribution of peer staff. Alternately, teams might subtly pressure peer staff to assimilate into clinical culture. This might take the form of telling Peer Specialists to stop "personalizing" issues, if they are passionately speaking up during a team meeting. Team Leaders can redirect this dynamic by focusing on the ways Peer Specialists and clinical staff can collaborate using their unique skills and experiences for the benefit of program participants.

**Disruption #4 - Peer Specialists are advocates:** We have already discussed how Peer Specialists do not adopt the clinical perspective. They strive to understand the clinical perspective, but are trained to view people and situations differently. Peer Specialists view part of their role to be advocates. They are trained to speak as advocates for legal rights, civil rights and human rights. They are also trained to support program participants in becoming self-advocates for their own needs and goals. Team leaders must understand that active advocacy for individual, legal, civil and human rights can cause strain and tension within the team. Teams are accustomed to thinking clinically. Peer staff are disruptive in as much as they are effective advocates and encourage the team to adopt a wider, more diverse view of a situation. Team members sometimes struggle with this wider perspective and the role of an advocate on the team. Team Leaders may notice that this can express itself as an assertion of hierarchy on the team (i.e., questioning the psychiatrist is insubordinate) or politely listening to the Peer Specialist and then moving on with the meeting as if he/she had not spoken. If the team leader can support the team in navigating the culture shift associated with this disruption, then the team will benefit from a wider lens that will enrich the understanding of the program participant's situation.

**Disruption #5 - Peer Specialists create role-conflict:** Peer Specialists remind team members that roles do not define us in our entirety. Most of us take great pride in our work (i.e., I am a doctor, I am a social worker, I am a Peer Specialist). But these are just one of many roles we inhabit. A doctor can be a patient. A social worker can be a client. A Peer Specialist can be a Town Councilor. Role conflict occurs

when there is incompatibility or tension between two or more roles in our lives. The presence of Peer Specialists can be disruptive for the team because it may introduce tension or conflict between the role of being a clinician and the new role of being a colleague/co-worker. This is especially true if one or more clinicians knew (or knew of) the Peer Specialist when they were in the role of patient/service recipient. Of course, in such situations, Peer Specialists will experience role conflict as well. During supervision, Team Leaders are encouraged to invite team members to talk about any role conflict they are experiencing. In some situations, it can be helpful for the clinician and Peer Specialist to have a frank conversation, openly acknowledging the tension associated with their respective role conflicts and committing themselves to working on developing a mutually respectful relationship as co-workers in the present. Another, more common way role strain expresses itself is through the language the team feels comfortable using before and after Peer Specialists join the team. Here's an example: Prior to Peer Specialists joining the team, clinicians in the room might be comfortable using terms like *decompensate, low functioning, high functioning, schizophrenic, co-dependent, poor prognosis, manipulative, attention seeking, help rejecting, non-compliant, poor insight, etc.* After a Peer Specialist joins the team, clinicians may feel uncomfortable using objectifying clinical-language-as-usual. So what language should the team use? That's a real learning opportunity for the team. These growing pains can be awkward and difficult, but with the Team Leader's help, the team can make a culture shift and find a more inclusive vocabulary for working together.

**Disruption #6 – Peer Specialists are members of a socially devalued group.** In our culture, people diagnosed with mental disorders have endured centuries of stigma, prejudice, discrimination, dehumanization, misguided social policy – from human warehousing to trans-institutionalization – violence and even death (lobotomy, refrigeration therapy, insulin coma, early morbidity/mortality, etc.). As members of this socially devalued group, Peer Specialists are acutely attuned to language or practices that dehumanize, objectify, or devalue program participants. They may object to or challenge clinical language or practices that, intentionally or unintentionally, devalue and objectify program participants on OnTrackNY teams. Words like low-functioning, high functioning, poor insight, manipulative, decompensating, etc. can be difficult for Peer Specialists to listen to. Team Leaders should be vigilant for signs of this culture shift. It is sometimes expressed as a deep resentment on the part of team members. They came to the work with hope and a deep desire to do something new and recovery oriented with young people experiencing FEP. They may resent being grouped with practices that have historically hurt people. They may concede that the wider behavioral health system has an uneven history, but the new OnTrackNY model is different. Team leaders can help during these transitions. Listening and respecting the experience of all team members is very important. Daring to raise these tensions, speak to them and invite all team members to speak is important. None of us is perfect and our systems of care are less perfect. We come to this work with the best of intentions. Once again, the opportunity here is for team members to explore their own story and the “why” of choosing to work with a population of people who are devalued by the larger culture. Team Leaders should encourage team members to explore their unique “story of why I chose this work.” If the team is willing to share their story-of-why with each other, it can create a deep bond of solidarity, combining the work of Peer Specialists and clinicians into a united and righteous effort to do what is right for those experiencing first episode psychosis.

Team Leaders must be aware of these growing pains. The team will go through some variation of these growing pains when a Peer Specialist joins. At first, the team will most probably embrace Peer Specialists

and welcome them onto the team. This is because, as individuals, the members of OnTrackNY teams are exemplary clinicians and deeply committed human beings. These are clinicians who are committed to person-centered care. They have stepped outside the “business-as-usual” mainstream. They have been brave and daring and visionary enough to dedicate themselves to helping young people in a new and ground-breaking way. Not only do they embrace recovery and hope and healing, they embrace the power of peer support as well. But change is not easy. It involves growing pains. Deep change is transformative. Deep change is uncomfortable and inconvenient. Deep change, transformation, is hard work.

Team leaders must help guide teams through the culture change and disruptions introduced by the inclusion of Peer Specialists on the team. After initial enthusiasm and embrace of peer staff, Team Leaders should expect the team to default to the status quo. The team most likely will, unwittingly and as a group, resist transformation. One of the common ways resistance surfaces is through micro-aggression. Micro-aggression is a term coined by the psychiatrist Chester Pierce in 1970, in his chapter “Offensive Mechanisms” in *The Black 70’s* (Ed. Barbour). Micro-aggression has been defined as,

*“Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights to the target person or group.”* (Sue, Capodilupo, Torino, et al. 2007)

Micro-aggressions are distinct from more traditional and overt forms of discrimination in that otherwise well-intentioned individuals can deliver them unconsciously, unaware of their potential harmful effects. The slow accumulation of micro-aggressions over a lifetime is in part what defines a marginalized experience, making explanation and communication with someone who does not share the same identity (in this case, the identity of being “mentally ill”) particularly difficult. The construct of micro-aggression has gained traction in recent years and is applied to other devalued groups, including people with disabilities. (<https://www.bustle.com/articles/186060-13-microaggressions-people-with-disabilities-face-on-a-daily-basis>; <https://www.patdeegan.com/blog/posts/mentalism-micro-aggression-and-peer-practitioner>).

Here are some real-world examples of micro-aggression directed at peer staff (Deegan, 1992), and as experienced by young adult Peer Specialists (Delman & Klodnick, 2016).

- A Team Leader had made arrangements for professional staff to have business cards. The cards were handed out, and there were no cards for the Peer Specialist on the team.
- When a peer staff member walks into the building, the traditional staff don't even say hello. They look down and pass by like the peer staff is not even there.
- A peer staff spoke up passionately during a team meeting because she felt that the client was being treated unfairly. Her supervisor told her she was being unprofessional for speaking up like that. The supervisor said the peer staff had to stop “personalizing the issue.”
- Peer staff felt uncomfortable when he or she heard another team member refer to clients as “riffraff.”
- Peer staff asks a question or offers a suggestion in a meeting and the other team member rolls their eyes and says they can discuss it later that day.

- Another team member made a comment expressing surprise that the peer staff could afford the type of car that he drives.

These are all examples of micro-aggressions that occur as teams are going through the growing pains of integrating the unique role of Peer Specialists onto the team. Team Leaders must not be idle in the face of micro-aggression and the team's systemic resistance to transformation. Instead, Team Leaders must lead the team through the tensions and strains of transformation. Transformation will not happen by itself. Team leaders must exercise leadership. They must avoid the extremes of being heavy handed and being too laid-back. Examples of a team leader becoming heavy handed might be to declare:

*"The words decompensate, low functioning, case, patient and chronic are never to be used on our team."*

This heavy handed approach will only drive resistance underground and make it more difficult to work with. It is much better to address resistance and growing pains in an open but focused manner. Team leaders will find success if they acknowledge that we are all growing and learning. No one is perfect and we all have room for improvement. We all make mistakes. Say out loud the team is undergoing a change. Invite team members to talk as a group and in individual supervision. Team Leaders can lead by validating the fact that the team is facing a change. Team Leaders can normalize the tension and strain as the team struggles with holding both the clinical and peer worldview. Team Leaders can encourage openness and a safe team environment in which to process and explore the challenge and opportunity of culture transformation.

In a similar way, ignoring the strains and tensions of team transformation can be problematic. An example might be the Team Leader avoids addressing micro-aggressions aimed at the Peer Specialist. Another example is leaving the Peer Specialist to work through micro-aggression as if it were an interpersonal issue. Micro-aggression is not simply an interpersonal issue or "bad blood" between two colleagues. Micro-aggressions are systemic resistance to transformative change that is disruptive of the status quo. Team Leaders are encouraged to deal with micro-aggression at a systemic level. One successful strategy is to announce that the team will be working together to discover language that is less objectifying and more inclusive. Put a jar and box of 25 cent tokens in the center of the table where the team meets. If a team member slips and uses overly objectifying language, have them put their initial on a token and drop it in the jar. For instance, if a team member (including the Peer Specialist) refers to a person as a "schizophrenic" or says refers to a participant as a case (e.g., "this is a difficult case"), have the team member initial the token and put it in the jar. At the end of the year, team members pay-up and the money can be used for a celebration with program participants.

If the supervisor notices micro-aggression, it is necessary to discuss it with the offending party in individual supervision. Again, the approach should not be heavy handed. Instead, the Team Leader should help the team member explore what's challenging about the culture shift. Think of the six types of disruptions outlined above. What, if any of these, are creating a challenge for the team member?

During routine supervision, Team Leaders should also encourage Peer Specialists to report any experience of micro-aggression or other areas of tension. The Team Leader should validate the pain, anger and confusion that occur when on the receiving end of micro-aggression. Help the Peer Specialist



not to internalize the experience. Reiterate how the team is in transition and how the Team Leader values the work of the Peer Specialist. Encourage the Peer Specialist to get support from other peers working on OnTrackNY teams. Never ask the Peer Specialist to take on the role of educating the team about micro-aggressions. An OnTrackNY Central trainer is more appropriate for that job.

## C. Supervision Activities

### 1. Overview of Types of Supervision

There are several types of supervision. The specific types of supervision that will be provided need to be carefully selected by each OnTrackNY team and the clinic in which it is embedded. Supervision can vary over time as teams become more experienced.

**Administrative supervision** involves oversight to ensure that the team is following the rules and procedures of the clinic in which it is embedded. The format, frequency, and emphasis of this supervision will need to be worked out on a team by team basis as clinic needs vary. Generally, the Team Leader will have weekly administrative supervision. Clinical supervision involves reviewing cases to ensure sound and competent clinical care. This will also vary by team depending on clinic rules and regulations.

**Clinical supervision** includes discussion of the specific activities and techniques the clinician is providing, periodic review of session notes, and identification of ways to improve or enhance clinical interactions.

**Clinical consultation** or conferences involve discussion of client's overall progress including all team members to maintain good clinical decision making. The Team Leader and psychiatrist each should identify an individual with credentials similar to their own within the clinic but outside of the team to meet with monthly who can provide this consultation.

**"Component" supervision** involves meetings of different team members across multiple teams. These will initially be led by the OnTrackNY trainer for each component and include regularly scheduled meetings of all individuals in each role across these multiple teams, such as regularly scheduled meetings of all the psychiatrists, all Primary Clinicians, etc. These meetings provide a forum in which those with similar roles on teams will be able to share materials, resources, and successes, as well as help in problem solving and creative thinking. These meetings may focus on:

**Team leader component supervision:** Discussion of participants, integrating clinic requirements (different forms and assessments), integration of the model as it pertains to all of the team leaders' roles and responsibilities, including the family work component.

**Psychiatrist component supervision:** Discussion of participants, problems encountered with the use of preferred medications, and strategies/approaches that have been found useful to help participants manage their illness.

**SEE Specialist component supervision:** Review of successes and challenges in job development, applying the model to supported education, creative ways to engage clients in job searches, how to coordinate and organize meetings with job sites, schools, etc.

**Primary Clinician supervision:** Review of areas being addressed (social skills training or substance abuse), challenges in teaching skills and supporting implementation outside the clinic, ways to build rapport and engagement, educating clients about the role of the recovery coaching strategies, how to use motivational enhancement strategies and shared decision making when approaching clinical problems with clients, and discussions regarding strategies for talking with young clients about planning for goals and using new skills in their lives.

**Family work component supervision:** Implementation of monthly family education groups and other family program components, engaging families, educating family members about psychosis, family work/issues not addressed during the regular supervision meetings.

**Peer Specialist Supervision:** Supervision of Peer Specialists can be challenging, especially when conducted by a non-Peer Specialist as will most often be the case in the OnTrackNY teams. The following guidelines will help the Team Leader be an effective supervisor for Peer Specialists:

1. Team Leaders should attend all trainings about the role and responsibilities of Peer Specialists. Knowledge of the unique, non-clinical role of Peer Specialists lays the groundwork for effective supervision.
2. Team Leaders are trained clinicians and Peer Specialists are individuals with the lived experience of recovery after being diagnosed with mental illness. (To be clear, any member of the team including the Team Leader might have experience with mental illness, but it is specifically the Peer Specialist's role to be open about it.) It is important for Team Leaders to avoid a clinical perspective on Peer Specialists during supervision. A frequently asked question is: "What should a supervisor do if they are noticing that the Peer Specialist is having symptoms while at work?" The answer is that the Team Leader must resist the slippery slope of speaking to the Peer Specialist about "symptoms" or personal mental health related issues. Instead, keep the focus squarely on job performance in relationship to the job description.
3. An effective supervisor of Peer Specialists is familiar with the Americans With Disabilities Act and the kinds of reasonable work accommodations that Peer Specialists may request. Examples of common accommodations include:
  - Flexible scheduling to allow for attending therapy appointments or the like
  - Modifying a Peer Specialist's office space to minimize noise or other distractions
  - Environmental shifts such as increased use of natural lighting
  - You can find more information about accommodations here:  
<https://www.dol.gov/odep/pubs/fact/psychiatric.htm>
  - Remember that a supervisor may not recommend an accommodation to an employee. Check with your Human Resources specialist for details about the ADA.

4. As with any employee, keep supervision strengths based. Help Peer Specialists identify strengths, address areas for growth, help them set professional goals and refine peer support skills such as advocacy and effective sharing of personal recovery stories.
5. Be familiar with all of the terms in the Peer Specialist job description (mutuality, advocacy, learning with, etc.). Be open and curious about learning new terms and concepts and use them as a guide when supervising.
6. During supervision be sure to invite the Peer Specialist to share their experience and observations of the culture shift happening on the team. Has the Peer Specialist experienced micro-aggression? Are they experiencing role strain? Are they feeling pressured to adopt the clinical worldview and language? Do they feel respected for bringing the unique peer perspective to the clinical team? Do they feel heard and respected by the team?
7. Just as with other employees, it is important for the supervisor to share any concerns about the Peer Specialist's job performance. Job performance expectations should be high for Peer Specialists just like with any team member.
8. One of the most challenging elements of being a Peer Specialist is being an advocate. Supervisors should be prepared to help Peer Specialists navigate their role as advocates. Some of the challenges that Supervisors can support Peer Specialists through include:
  - Learning how to act as an advocate and challenge team members without leaving them feeling berated or attacked
  - Learning how to advocate for a program participant in a situation that also brings up personal hurt or trauma. For instance, a Peer Specialist might be advocating for the team to reconsider an involuntary admission. During the discussion the Peer Specialist might recall their own traumatic experiences during involuntary admissions. In such situations a Peer Specialist might speak longer or more forcefully than usual. They might lose sight of the main goal the team is working toward or may find it tough to step back from the advocacy role after making their point.
9. Supervisors should be alert for signs that Peer Specialists are drifting from the peer role. It's important to share such observations with the Peer Specialist and invite them to share their perspectives. Here are some possible signs of drift:
  - Adopting clinical language and terms such as decompensating, high-functioning, manipulating, poor insight, triangulating, etc.
  - Reluctance to share lived experience with participants and families
  - Telling program participants what to do
  - Making decisions for program participants
  - Interpreting or attributing motive to a program participant's behavior either directly to the participant or when communicating with the team (verbally or in written notes) e.g., Harry is trying to divide the team; Segi is really being passive aggressive with me; or James has a symbiotic relationship with his mother.

**“Model” supervision** involves review of illustrative cases to ensure that the team is adhering to the underlying principles of mental health recovery, shared decision making, and critical time intervention. All members of the team participate in this monthly meeting. It can take the form of a team meeting in which a theme that runs across cases is discussed and specific cases are used to highlight examples. This

is also a good place to discuss issues – such as family involvement and how to work with families within the team – that are common to many cases. This would also be a good forum to bring in an expert in some area to review ideas and difficult cases.

## 2. Supervision How-To's

Supervision is important and should be a valued and supported part of clinical care. Supervision should be on a regular day and time that is good for all attendees and should be identified as an important part of the service of the team that should not be missed.

Good supervision takes planning. The Supervision Check List will help the Team Leader structure supervision with Peer Specialists. Additionally, each supervision meeting involving other team members should have a leader who is responsible for planning the content of the meeting, creating an agenda, distributing the agenda to the attendees, and writing the supervision note. For some types of supervision such as clinical supervision, the leader is generally the more senior person who is providing the supervision, such as the Team Leader. In other cases, the leader of the supervision meeting can be changed so that all members of the meeting are the leader at some point.

Each meeting should have a structure. Some sample structures for supervision meetings are as follows:

### **a. Clinical supervision, Team Leader and Primary Clinicians with a focus on CAR Intervention**

1. Review list of clients who are working on cognitive behavioral based strategies with the Primary Clinicians. Note clients who are nearing the end of their work with these strategies and provide a summary of status to the Team Leader.
2. Identify one or two clients to discuss in-depth. These could be clients that are progressing well and the Primary Clinician has ideas about additional work to be done, or clients that are challenging (poor engagement with the Primary Clinician, lack of progress, feeling stuck). The Primary Clinician should be prepared to provide a summary of these clients and identify the issue or challenge to discuss with the Team Leader.
3. Check in regarding groups (social skills, substance abuse treatment, family) that are led by the Primary Clinician and update on attendance, topics covered, and how these topics can be integrated into individual work.
4. Other skills training or illness management related issues/action plan to work on between supervision meetings.

### **b. Administrative supervision, Team Leader and Clinic Administrator**

1. Review all clients receiving services from the OnTrackNY team. Make sure all forms are complete for all clients or identify what's needed for whom and when it's due.
2. Discuss any administrative challenges that have taken place since the last meeting.
3. Check in regarding new clients or clients that will soon be discharged/transitioned to community care.
4. Other issues/action plan to work on between supervision meetings.

### **c. Model supervision, all Team Members present**

1. One team member is the leader of the meeting. This can rotate among team members.
2. The leader identifies an issue to discuss and provides a summary of the client(s) and the challenges to the model that it illustrates. These challenges are discussed and ways to respond according to the model are identified.
3. Discuss how each team member can contribute to working with this client in ways that are in line with the model.
4. Other issues/action plan to work on between supervision meetings.

## IX. References and Recommended Readings and Resources

### A. References Cited in Team Manual

- Brekke, J.S. et al. *Risks for Individuals with Schizophrenia Who Are Living in the Community*. Psychiatric Services, 2001.
- Cohen, P., and Cohen, J. *The Clinician's Illusion*. Archives of General Psychiatry, 1984.
- Davidson, L., Drake, R.E., Schmutte, T., et al. *Oil and Water or Oil and Vinegar? Evidence-Based Medicine Meets Recovery*. Community Mental Health Journal, 2009.
- Elwyn, G., Durand, M.A., Song, J., et al. A three-talk model for shared decision making: Multistage consultation process, *British Medical Journal*, 2017.
- Harkavy-Friedman, J.M., et al. *Suicidal Behavior in Schizophrenia: Characteristics of Individuals Who Had and Had Not Attempted Suicide*. American Journal of Psychiatry, 1999.
- Herman, D., Conover, S., Felix, A., Nakagawa, A., & Mills, D. *Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups*. Journal of Primary Prevention, 2007.
- Herman, D., Susser, E., Jandorf, L., Lavelle, J., & Bromet, E.J. *Homelessness among Individuals Hospitalized for the First Time with Psychotic Disorders: Findings from the Suffolk County Mental Health Project*. American Journal of Psychiatry, 1998.
- Kreyenbuhl, J., Nossel, I.R., & Dixon, L.B. *Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the Literature*. Schizophrenia Bulletin, 2009.
- Melle, I., et al. *Early Detection of the First Episode of Schizophrenia and Suicidal Behavior*. American Journal of Psychiatry, 2006.
- Neria, Y. et al. *Trauma Exposure and Posttraumatic Stress Disorder in Psychosis: Findings from a First-Admission Cohort*. Journal of Consulting and Clinical Psychology, 2002.
- Schomerus, G. et al. *Urban Residence, Victimhood and the Appraisal of Personal Safety in People with Schizophrenia*. Psychological Medicine, 2008.
- Shevlin, M., Dorahy, M.J., & Adamson, G. *Urban Residence, Victimhood and the Appraisal of Personal Safety in People with Schizophrenia*. American Journal of Psychiatry, 2007.
- Stanley, B., & Brown, G.K. *Safety Planning: An Intervention to Mitigate Suicide Risk*. Washington, D.C: Veterans Health Administration Publication, 2008.
- Susser, E. et al. *Preventing Recurrent Homelessness among Mentally Ill Men: A "Critical Time" Intervention after Discharge from a Shelter*. Journal of Public Health, 1997.



Whitley, R. *Cultural Competence, Evidence-Based Medicine, and Evidence-Based Practice*. Psychiatric Services, 2007.

## **B. Recommended Introductory Training for All Staff**

### **Center for Practice Innovations Modules, Webinars, and Videos in CPI Learning Management System:**

#### **1. Pat Deegan's Introduction To FEP Videos:**

In these videos, Patricia Deegan, Ph.D. discusses her experience of first episode psychosis and her recovery journey.

##### **a. Voices of Recovery Videos and Manual:**

These brief (approximately three minutes each) video clips provide a hopeful and inspiring message about recovery as told by young adults who have been diagnosed with serious mental illness and by family members. Topics include medications and side effects, working with the treatment team, symptom management, drugs and alcohol, and school and work.

##### **b. Shared Decision Making: 7-Part Series**

In this series of seven video clips (each 7-10 minutes), Patricia Deegan, Ph.D. introduces the concept of shared decision making, explains with concrete examples how it works, and focuses on its use with young individuals experiencing first episodes of psychosis.

#### **2. CPI's Focus On Integrated Treatment Modules: (FIT) Stage-Wise Treatment**

##### **a. Stage-Wise Treatment**

This is an introduction to the Stages of Change and the Stages of Treatment models—what they are, how they interact and the importance of providing interventions that work best for each stage. You will learn the four stages of treatment, the goal of each stage, the interventions that match the stage and how best to recognize your clients' stages of treatment.

##### **b. Early Stages of Change**

This is the second of four modules that discuss the stages of change, stages of treatment and stage-specific treatment interventions. This module concentrates on early change and stages of treatment. It begins with an overview of the Stages of Change and Stages of Treatment and how they are related. You will learn how to assess a client's stage of change accurately and how to use Motivational Interviewing as a primary tool in the early stages of treatment. The module then explores treatment interventions for each of the three early stages of change: pre- contemplation, contemplation and preparation. Real-life case studies illustrate interventions that are helpful during early stages of change.

### **c. Later Stages of Change**

This is the third of four modules that discuss the stages of change, stages of treatment and stage-specific treatment interventions. This module concentrates on later stages of change. It begins with a short review of the Stages of Change, lists the criteria for accurately assessing clients in these later stages and examines treatment interventions for each of two later stages (action and maintenance). Real-life case studies illustrate interventions that are helpful during later stages of change. You will also learn about treatment approaches for clients in multiple stages for different disorders; for example, contemplation of substance use and action for mental health issues.

### **d. Individual Interventions**

This module describes the use of individual interventions in the treatment of people with co-occurring disorders. You will learn about the advantages of individual treatment and the situations and clients where individual work would be the most appropriate. You will also learn about the need for building a safe environment balanced with structure and clear boundaries. The module covers strategies for developing the therapeutic relationship, especially the use of motivational interviewing skills such as asking open questions and using reflective listening statements. The last section of the module reviews how to use a stage-based approach in designing treatment plans for individual interventions, including criteria for assessing a client's stage of change and matching interventions appropriate for each stage. The module ends with a discussion of interventions particularly designed for clients in the early stages of treatment. These include providing outreach, practical assistance and clinical interventions.

## **3. (Fit) Motivational Interviewing**

### **a. Motivational Interviewing**

This is an introduction to motivational interviewing. You will learn about the benefits of using a motivational intervening approach, the spirit and the four principles of motivational interviewing including expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy. You will learn strategies for putting each principle into practice and for recognizing, eliciting and reinforcing client's change talk. You will have the benefit of seeing these strategies and skills demonstrated with real clients.

### **b. Motivational Interviewing II (Reflective listening and summarizing)**

The first module on Motivational Interviewing introduced the basics of this valuable technique. If you're not familiar with Motivational Interviewing, please review that module before you continue with this one. Motivational Interviewing is a client-centered, directive method for enhancing a client's own desire to change. Motivation comes from the client, based on his or her own values and goals. This module builds on these basics. You will learn four specific skills: open-ended questions, affirmations, reflective listening and summaries.

### **c. Motivational Interviewing III (Ambivalence as part of change)**

The first module on Motivational Interviewing introduced the basics of this valuable technique. If you're not familiar with Motivational Interviewing, please review that module before you continue with this one. In this module, you will learn about techniques to help people deal with their ambivalence. You'll learn how to use amplified reflection, double- sided reflection and managing resistance.

### **d. Motivational Interviewing and Harm Reduction**

The first module on Motivational Interviewing introduced the basics of this valuable technique. If you're not familiar with Motivational Interviewing, please review that module before you continue with this one. This module examines crisis management and harm reduction. You will learn when it's appropriate to use Motivational Interviewing for harm reduction, how to use it and the ethical issues around using Motivational Interviewing.

## **4. (FIT) Cognitive Behavioral Therapy/Social Skills Training**

### **a. CBT for Coping Skills and Problem-Solving**

This module is an overview of Cognitive Behavioral Therapy (CBT) and its application in treating both addiction and mental health symptoms. You will learn the basics of CBT for co- occurring disorders, the learning theories behind CBT, principles for implementing CBT, and strategies for using CBT in addiction counseling. The two fundamental components of CBT are conducting a functional analysis and teaching coping skills. You will learn how to use the functional analysis and the steps to teaching coping skills as well as how to apply CBT for problem solving and goal setting.

### **b. Social Skills Training**

Clients with co-occurring disorders often need help learning social skills. In this module, you will learn how you can teach clients by breaking skills into smaller steps and helping them practice new behaviors. You will also understand how social skills training can help people refuse drugs, avoid social isolation and develop healthier relationships. You will be able to download and use sample group curricula and printable lists of steps.

### **c. CPI's Individual Placement and Support (IPS) Model of Supported Education and Employment:**

This hour-long module is designed for practitioners, supervisors and program leaders who are involved in providing SEE services. It focuses on the importance of employment to persons diagnosed with a serious mental illness, the rationale for SEE, SEE fundamentals, core practitioner skills, and implementing SEE in NYS. It offers video clips of clients and practitioners, interactive exercises, and links to resources and web sites.

## 5. CPI's Safety Planning Modules

### a. Assessment of Suicidal Risk Using C-SSRS

The Columbia Suicide Severity Rating Scale (C-SSRS) was developed to assist practitioners and others to better identify people at suicide risk. This module introduces the C-SSRS, discusses its importance, and provides information about its structure. In addition, the learner is provided with detailed instructions concerning the administration of the scale.

### b. Safety Planning Intervention for Suicide Prevention

This module teaches the learner about the Safety Planning intervention developed by Dr. Barbara Stanley and Dr. Gregory Brown. This intervention is designed to help individuals who struggle with suicidal urges and thoughts to manage them so that safety is maintained.

### c. CPI's Wellness Self-Management Module:

This module covers the key concepts of illness self-management, including recognizing early warning signs of relapse, relapse prevention, and stress management.

## 6. Highly Recommended Readings for All Team Members

*(found in LMS)*

Six Articles on Key Concepts/Focus Areas:

### a. Topic: Engagement

Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. Kreyenbuhl, J., Nossel, I.R., & Dixon,

L.B. Schizophrenia Bulletin, 35(4), 696-703, 2009.

### b. Topic: Recovery Model and Implications for Treatment

Oil and water or oil and vinegar? Evidence-based medicine meets recovery. Davidson, L., Drake, R.E., Schmutte, T., et al. Community Mental Health Journal 45:323-332, 2009.

### c. Topic: Shared Decision Making

Shared decision making and medication management in the recovery process. Deegan, P.E., & Drake, R.E. Psychiatric Services, 57, 1636-1639, 2006.

#### **d. Topic: Suicide/Safety Planning**

**D(1):** Early detection of the first episode of schizophrenia and suicidal behavior. Melle, I., et al. American Journal of Psychiatry, 163: 800-804, 2006.

**D(2):** Safety planning: An intervention to mitigate suicide risk. Stanley, B., & Brown, G.K. Washington, D.C: Veterans Health Administration Publication, 2008.

#### **e. Topic: Trauma-Informed Care**

Trauma and psychosis: An analysis of the National Comorbidity Survey. Shevlin, M., Dorahy, M.J., & Adamson, G. American Journal of Psychiatry, 164(1), 166-169, 2007.

### **7. Additional Suggested Readings and Resources for All OntrackNY Team Members**

*(Available in LMS)*

#### **a. Topic: First Episode /Early Intervention & Treatment**

##### **Book:**

The First Episode of Psychosis: A Guide for Patients and their Families. Compton, M.T., & Broussard, B. (2009). New York: Oxford University Press.

##### **Articles:**

Addington, J. (2007). The Promise of Early Intervention. Early Intervention in Psychiatry, 1(4): 294-307.

Dixon, L.B., Dickerson, F.B., Bellack, A.S., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. Schizophrenia Bulletin, 36(1), 48-70.

Outram, S., Harris, G., et. al. (2014). Communicating a Schizophrenia Diagnosis to Patients and Families: A Qualitative Study of Mental Health Clinicians. Psychiatric Services, 65(4).

Penn, D.L., Waldheter, E.J., et. al. (2005). Psychosocial Treatments for First-Episode Psychosis: A Research Update. American Journal of Psychiatry, 162(12): 2220-2232.

##### **Links:**

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

National Institutes of Mental Health: Coordinated Specialty Care for First Episode Psychosis:  
<http://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-resources.shtml>



## **b. Topic: Co-Occurring Disorders**

### **Books:**

Mueser, K. T., Bennett, M. & Kushner, M. G. (1995). Epidemiology of substance use disorders among persons with chronic mental illnesses. In A. F. Lehman & L. B. Dixon (Eds.), *Double jeopardy: Chronic mental illness and substance use disorders*, Vol. 3, pp. 9-25. Longhorne, Pa: Harwood Academic Publishers.

### **Articles:**

Bradizza, C.M., Maisto, S.A., Vincent, P.C., Stasiewicz, P.R., Connors, G.J., & Mercer, N.D. (2009).

Predicting post-treatment-initiation alcohol use among clients with severe mental illness and alcohol use disorders. *Journal of Consulting and Clinical Psychology*, 77(96), 1147-1158.

Compton, M.T., Kelley, M.E., Ramsay, C.E., et al. (2007). Association of pre-onset cannabis, alcohol, and tobacco use with age of onset of prodrome and age of onset of psychosis in first-episode clients. *American Journal of Psychiatry*, 166(11), 1251-1257.

Drake, R.E., O'Neal, E.L., & Wallach, M.A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental illness and substance use disorders. *Journal of Substance Abuse Treatment*, 34(1), 123-138.

Mueser, K.T., Yarnold, P.R., Levinson, D.F., Singh, H., Bellack, A.S., Kee, K., Morrison, R.L., & Yadam, K.G. (1990). Prevalence of substance abuse in schizophrenia: Demographic and clinical correlates. *Schizophrenia Bulletin*, 16, 31-56.

Reiger, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse results for the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association*, 264, 2511-2518.

Whelan, G. (2007). Impact of severity of substance use disorder on symptomatic and functional outcome in young individuals with first-episode psychosis. *Journal of Clinical Psychiatry*, 68(5), 767-774.

### **Link:**

SAMHSA: <http://www.samhsa.gov/co-occurring/>

## **c. Topic: Critical Time Intervention**

### **Article:**

Herman, D., Conover, S., Felix, A., Nakagawa, A., & Mills, D. (2007). Critical time intervention: An empirically supported model for preventing homelessness in high risk groups. *Journal of Primary Prevention*, 28: 295-312.

## **d. Topic: Family Involvement/Support/Education/Interventions**

### **Articles:**

- Addington, J., McCleery, A., & Addington, D. (2005). Three-year outcome of family work in an early psychosis program. *Schizophrenia Research*, 79, 107-116.
- Drapalski, A.L., et al. (2008). The unmet needs of families of adults with serious mental illness and preferences regarding family services. *Psychiatric Services*, 59, 665-662.
- Drapalski, A.L., Leith, J., & Dixon, L. (2009). Involving families in the care of persons with schizophrenia and other serious mental illnesses: history, evidence, and recommendations. *Clinical Schizophrenia & Related Psychoses*, 3, 39-49.
- Fjell, A., et al. (2007). Multifamily group treatment in a program for patients with first-episode psychosis: experiences from the TIPS project. *Psychiatric Services*, 58, 171-173.
- Jeppesen, P., et al. (2005). Integrated treatment of first-episode psychosis: effect of treatment on family burden. *British Journal of Psychiatry*, 187, 85-90.
- Martens, L., & Addington, J. (2001). Psychological well-being of family members of individuals with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 36, 128-133.

### **Manual:**

- Glynn, S.M., Cohen, A.N., Murray-Swank, A., Drapalski, A., & Dixon, L. (2010). Family member provider outreach (FMPO) manual. Unpublished manual, VA Maryland Health Care System, Baltimore, MD.

## **e. Topic: Lived experience**

### **Books:**

- The Center Cannot Hold: My Journey Through Madness. Saks, E.R. (2007). New York: Hyperion.
- The Quiet Room: A Journey Out of the Torment of Madness. Schiller, L., & Bennett, A. (1994). New York: Warner Books.

### **Articles:**

- Addington, J., Coldham, E., Jones, B., Ko, T., & Addington, D. (2003). The first episode of psychosis: the experience of relatives. *Acta Psychiatrica Scandinavica*, 108, 285-289.
- Deegan, P.E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal*, 31(1), 62-69.
- Deegan, P. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 9(4), 11-19.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, 15(2), 197-200. Windell, D., Norman, R. & Malla, A. (2012). The Personal Meaning of Recovery Among Individuals Treated for a First Episode of Psychosis. *Psychiatric Services*, 63(6).

## **f. Topic: Medical Care**

### **Articles:**

American Diabetes Association. (2004). "Consensus development conference on antipsychotic drugs and obesity and diabetes." *Diabetes Care* 27(2): 596-601.

Buchanan, R. W., et al. (2010). "The 2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements." *Schizophr Bull* 36(1): 71-93.

Edward, K., Rasmussen, B. & Munro, I. (2010). Nursing Care of Clients Treated with Atypical Antipsychotics Who Have a Risk of Developing Metabolic Instability and/or Type 2 Diabetes. *Archives of Psychiatric Nursing* 24 (1): 46-53.

Freudenreich, O., Schulz, C. and Goff, D. (2009). "Initial medical work-up of first-episode psychosis: a conceptual review." *Early Intervention in Psychiatry* 3 (1): 10-18.

Marder, S. R., et al. (2004). "Physical health monitoring of patients with schizophrenia." *Am J Psychiatry* 161(8): 1334-1349.

Park, T., Usher, K., & Foster, K. (2011). Description of a Healthy Lifestyle Intervention for People with Serious Mental Illness Taking Second-Generation Antipsychotics. *International Journal of Mental Health Nursing* 20: 428-437.

## **g. Topic: Mental Health Law**

### **Link:**

Bazelon Center: <http://www.Bazelon.org/>

## **h. Topic: Peer Support/Community Integration**

### **Links:**

The Icarus Project: <http://www.theicarusproject.net/>

The Institute for Recovery and Community Integration: <http://www.mhrecovery.org/> Lived Experience Research Network: <http://www.lernetwork.org/>

National Empowerment Center: <http://www.power2u.org/index.html>

National Mental Health Consumers' Self Help Clearing House: <http://www.mhselfhelp.org/>

## **i. Topic: Psychopharmacology**

### **Articles:**

Meltzer, H.Y., et al. (2003). Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT). Archives of General Psychiatry, 60(1): 82-91. [Move from PC Section]

Raja, M. (2011). "Clozapine safety, 35 years later." Curr Drug Saf 6(3): 164-184.

### **Manual:**

New York State Office of Mental Health, Office of the Medical Director. Clozapine: A Manual for Clinicians, May 2012.

### **Online Module:**

"Considering Clozapine" consumer educational module: <http://practiceinnovations.org/>

### **Link:**

Evidence-Based Treatments: The Cochrane Reports: <http://www.cochrane.org/>

## **j. Topic: Relapse Prevention**

### **Articles:**

Alvarez-Jimenez, M., Parker, A., et. al. (2011). Preventing the Second Episode: A Systematic Review and Meta-Analysis of Psychosocial and Pharmacological Trials in First-Episode Psychosis. Schizophrenia Bulletin, 37(3): 619-630.

Robinson, D., Woerner, M.G., et. al. (1999). Predictors of Relapse Following Response from a First-Episode of Schizophrenia or Schizoaffective Disorder. Archives of General Psychiatry, 56: 241-247.

## **k. Topic: Recovery Model and Implications for Treatment**

### **Book:**

Davidson, L., Harding, C., Spaniol, L. (2005). Recovery from severe mental illnesses: Research evidence and implications for practice, Volume 1. Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences Boston University.

### **Articles:**

Bellack, A.S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophrenia Bulletin*, 32: 432-442.

Harding, C.M., & Zahniser, J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scand Supplement*, 384, 140-146.

**Links:**

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

Pat Deegan Associates/Common Ground: <https://www.patdeegan.com/>

Pat Deegan's Recovery Library: <https://www.recoverylibrary.com/>

SAMHSA's National Consensus Statement on Mental Health Recovery

<http://store.samhsa.gov/product/National-Consensus-Statement-on-Mental-Health-Recovery/SMA05-4129>

Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery to Practice:

<http://www.samhsa.gov/recoverytopractice/>

**I. Topic: Sexuality**

**Links:**

Deegan, P. 2001. Human Sexuality and Mental Illness: Consumer Viewpoints and Recovery Principals.

[http://beyachad.tripod.com/updates/doc-rtf/articles\\_sex.pdf](http://beyachad.tripod.com/updates/doc-rtf/articles_sex.pdf)

SAMHSA Resources: A Practitioners Resource Guide: Helping Families to Support their LGBT Children:

<http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS>

**m. Topic: Shared Decision Making**

**Article:**

Adams, J. R., & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal*, 42(1), 87-105.

Elwyn, G., Durand, M.A., Song, J., et al., (2017). A three-talk model for shared decision making: multistage consultation process. *British Medical Journal*, 359, j4891.

**Links:**

Dartmouth-Hitchcock Center: [http://patients.dartmouth-hitchcock.org/shared\\_decision\\_making.html](http://patients.dartmouth-hitchcock.org/shared_decision_making.html)

Mayo Clinic National Resource Center for Shared Decision Making: <http://shareddecisions.mayoclinic.org/>

News & progress in Shared Decision Making: <http://informedmedicaldecisions.org>

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

List of decision aids, links, and quality ratings of decision aids: <http://decisionaid.ohri.ca/AZlist/html>

Decision aid on antidepressants: <http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=10reports/?pageaction=displayproduct&productID=10>

Decision aid on whether to use medicine to help sleep:  
<http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=za1120>

Decision aid on whether to use medicine to quit smoking:  
<http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=zw1124&SECHWID=zw1124-Intro>

Decision aid for using medicine to treat PMS:  
<http://www.healthwise.net/cochranedecisionaid/Content/StdDocument.aspx?DOCHWID=aa45364&SECHWID=aa45364-Intro>

SAMHSA "Cool Tools": <http://mentalhealth.samhsa.gov/consumersurvivor/shared>

## **n. Topic: Social Skills**

### **Books:**

Mueser, K.T., & Bellack, A.S. (1998). Social skills and social functioning. In K.T. Mueser & N. Tarrier (Eds.), *Handbook of Social Functioning in Schizophrenia*. Needham Heights, MA: Allyn & Bacon (pp. 79-96).

Tenhula, W.N. & Bellack, A.S. (2008) *Social Skills Training*. In K. Mueser & D. Jeste (Eds.) *Clinical Handbook of Schizophrenia*. Guilford Press, New York.

### **Articles:**

Bellack, A.S. (2004). Skills training for people with severe mental illness. *Psychiatric Rehabilitation Journal*, 27, 375-391.

Bertrand, M.C., Sutton, H., Achim, A.M., Malla, A.K., & Lepage, M. (2007). Social cognitive impairments in first episode psychosis. *Schizophrenia Research*, 95(1-3), 124-133.

Horan, W.P., Subotnik, K.L., Snyder, K.S., & Nuechterlein, K.H. (2006). Do recent-onset schizophrenia patients experience a "social network crisis." *Psychiatry*, 69, 115-129.

Kurtz, M.M. & Mueser, K.T. (2008). Meta-analysis of controlled research on social skills training for schizophrenia. *Journal of Consulting and Clinical Psychology*, 76, 491-504.



Pilling, S., Bebbington, P., Kuipers, E., et al (2002). Psychological treatments in schizophrenia: II. Meta-analyses of randomized controlled trials and social skills training and cognitive remediation. *Psychological Medicine*, 32(5), 783-791.

Thorup, A., et al. (2006). Social network among young adults with first-episode schizophrenia spectrum disorders. *Social Psychiatry and Epidemiology*, 41, 761-770.

Tenhula, W.N. & Bellack, A.S. (2008) Social Skills Training. In K. Mueser & D. Jeste (Eds.) *Clinical Handbook of Schizophrenia*. Guilford Press, New York.

**Link:**

VA VISN5 MIRECC Social Skills Training Program:  
[http://www.mirecc.va.gov/visn5/training/social\\_skills.asp](http://www.mirecc.va.gov/visn5/training/social_skills.asp)

**o. Topic: Stigma**

**Article:**

Schulze, B. & Angermeyer, M. 2003. Subjective Experiences of Stigma: A Focus Group Study of Schizophrenic Patients, Their Relatives, and Mental Health Professionals. *Social Science & Medicine* 56: 299-312.

**p. Topic: Strengths Perspective**

**Book:**

Sullivan, W.P., & Rapp, C.A. (1994). Breaking away: The potential and promise of a strengths-based approach to social work practice. In R.G. Meinert, J.T. Pardeck, & W.P. Sullivan (Eds.), *Issues in social work: A critical analysis* (pp. 83-104). Westport, CT: Auburn House.

**Links:**

<http://www.personcenteredtreatmentplanning.com/>  
<http://www.socwel.ku.edu/mentalhealth/projects/Emerging/cm.shtml>

**q. Topic: Substance Abuse Treatment**

**Books:**

Bellack, A.S., Bennett, M.E., & Gearon, J.S. (2007). *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals*. NY: Taylor and Francis.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: The Guilford Press

### **Articles:**

Batki, S.L. (2007). Adapting motivational interviewing for comorbid schizophrenia and alcohol use disorders. *Clinical Psychology: Science and Practice*, 14, 39-57

Bellack, A.S., & Gearon, J.S. (1998). Substance abuse treatment for people with schizophrenia. *Addictive Behaviors*, 23(6), 749-766.

Bellack, A.S., & DiClemente, C.C. (1999). Treating substance abuse among clients with schizophrenia. *Psychiatric Services*, 50(1), 75-80.

### **Links:**

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

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

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

## **r. Topic: Suicide/Safety Planning**

### **Articles:**

Drake, R. E., Gates, C., Cotton, P.G., et al. (1984). Suicide among schizophrenics: who is at risk? *Journal of Nervous and Mental Disease*, 172, 613-617.

Harkavy-Friedman, J.M., et al. (1999). Suicidal behavior in schizophrenia: characteristics of individuals who had and had not attempted suicide. *American Journal of Psychiatry*, 156(8): 1276-1278.

Harkavy-Friedman, J.M., et al. (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations. *Journal of Clinical Psychiatry*, 64(8): 871-874.

Mamo, D.C. (2007). Managing suicidality in schizophrenia. *Canadian Journal of Psychiatry*, 52: 59-70.

## **s. Topic: Supervision**

### **Links:**

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

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

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

## **t. Topic: Supported Education and Employment**

### **Books/Manuals:**

Becker, D., & Drake, R. A Working Life for People with Severe Mental Illness. New York: Oxford Press, 2003.

Drake, R.E., Bond, G.R., & Becker, D.R. Individual Placement and Support: An Evidence-Based Approach to Supported Employment. New York: Oxford University Press, 2012.

Employment Resource Book

### **Articles:**

Killackey, E. J., Jackson, H. J., & McGorry, P. D. (2008). Vocational intervention in first-episode psychosis: Individual Placement and Support versus treatment as usual. *British Journal of Psychiatry*, 193, 114-120.

Nuechterlein, K. H., Subotnik, K. L., Turner, L. R., Ventura, J., Becker, D. R., & Drake, R. E. (2008). Individual placement and support for individuals with recent-onset schizophrenia: integrating supported education and supported employment. *Psychiatr Rehabil J*, 31(4), 340-349.

### **Links:**

Advocates for Children: <http://www.advocatesforchildren.org/>

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

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

University of Washington: Academic Accommodations for Students with Psychiatric Disabilities: <http://www.washington.edu/doit/Brochures/PDF/psych.pdf>

## **u. Topic: Trauma-Informed Care Articles:**

Carey, K.B., Leontieva, L., Dimmock, J., Maisto, S.A., & Gearon, J.S., Kaltman, S.I., Brown C., & Bellack, A.S. (2003). Traumatic life events and PTSD among women with substance use disorders and schizophrenia. *Psychiatric Services*, 54(4), 523- 528.

Morrison, A.P., Frame, L., & Larkin, W. (2003). Relationship between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology*, 42 (Pt 4), 331-353.

Neria, Y. et al. (2002). Trauma exposure and posttraumatic stress disorder in psychosis: Findings from a first-admission cohort. *Journal of Consulting and Clinical Psychology*, 70(1), 246-251.

Varese, F. et al. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38(4): 661-671.

**Link:**

SAMHSA TIP Sheet: <http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

**v. Topic: Wellness Self-Management**

**Manual:**

Wellness Self-Management Personal Workbook

**Journals:**

Early Intervention in Psychiatry [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1751-7893](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1751-7893)

Psychosis: Psychological, Social, and Integrative Approaches  
[www.tandfonline.com/loi/rpsy20#sthash.cDrEY2oH.dpuf](http://www.tandfonline.com/loi/rpsy20#sthash.cDrEY2oH.dpuf)

Associations, Organizations, and Informational Websites: Active Minds – College Students and Mental Health: <http://www.activeminds.org/about/our-story>

The Brain & Behavior Research Foundation/NARSAD: <http://bbrfoundation.org/>

BringChange2Mind (Anti-Stigma): <http://bringchange2mind.org/>

Hearing Voices Network: <http://www.hearingvoicesusa.org/>

International Early Psychosis Association: <http://iepa.org.au/>

International Society for Psychosocial and Social Approaches to Psychosis: <http://www.isps.org/>

National Alliance on Mental Illness: <http://www.nami.org/>

National Institute of Mental Health: <http://www.nimh.nih.gov/index.shtml>

Psychiatric Rehabilitation Association: <http://www.uspra.org/about-pra>

Psychosis Sucks: Website of Fraser Early Intervention Program in Canada:  
<http://www.psychosissucks.ca/>

Schizophrenia.Com General Information: <http://www.schizophrenia.com>

Schizophrenia Research Forum: <http://www.schizophreniaforum.org/>

Substance Abuse and Mental Health Services Administration: <http://www.samhsa.gov/>

## **w. Other U.S. First-Episode Programs:**

### **California**

San Francisco and Surrounding Areas: Prevention and Recovery in Early Psychosis:  
<http://prepwellness.org/>

### **Connecticut**

New Haven, CT: Yale University School of Medicine STEP Program:  
<http://www.step.yale.edu/psychosis/firstepisode.aspx>

### **Illinois**

Chicago, IL: University of Illinois at Chicago First Episode Psychosis Program: <http://www.psych.uic.edu/>

### **Maine**

Portland, ME: Maine Medical Center: Portland Early Identification & Referral Service (PIER):  
[http://www.mmc.org/pier\\_body.cfm?id=2094](http://www.mmc.org/pier_body.cfm?id=2094)

### **Maryland**

Baltimore, MD: Early Psychosis Intervention Clinic at Johns Hopkins Bayview Medical Center:  
[http://www.hopkinsmedicine.org/psychiatry/specialty\\_areas/schizophrenia/patient\\_information/treatment\\_services/early\\_psychosis.html](http://www.hopkinsmedicine.org/psychiatry/specialty_areas/schizophrenia/patient_information/treatment_services/early_psychosis.html)

Baltimore, MD: University of Maryland School of Medicine First Episode Clinic:  
[http://www.mprc.umaryland.edu/NRP/fec\\_clinic.asp](http://www.mprc.umaryland.edu/NRP/fec_clinic.asp)

### **Massachusetts**

Boston, MA: Beth Israel Deaconess Medical Center PREP Program: <http://www.bidmc.org/Centers-and-Departments/Departments/Psychiatry/The-Prevention-and-Recovery-in-Early-Psychosis---PREP/Program-Information.aspx>

Boston, MA: Mass. General First-Episode and Early Psychosis Program:  
<http://www.massgeneral.org/schizophrenia/services/treatmentprograms.aspx?id=1571>

### **Michigan**

Wayne State University Psychiatric Center: Services for the Treatment of Early Psychosis (STEP):  
<http://prognosis.med.wayne.edu/article/new-schizophrenia-program-focuses-on-those-in-early-stages-of-illness>

## **Minnesota**

Minneapolis, MN: University of Minnesota Medical Center:  
<http://www.uofmmmedicalcenter.org/Specialties/Behavioralhealth/FirstEpisodePsychosis/>

## **New York**

OnTrackNY Program Sites:

Brooklyn, NY: Kings County Hospital: <http://www.nyc.gov/html/hhc/html/news/press-release-20140506-kchc-mental-health-adolescents.shtml>

Long Island, NY: North Shore/Long Island Jewish Medical Center:  
<http://www.northshorelij.com/hospitals/treatment/early-treatment-program>

New York, NY: New York State Psychiatric Institute: <http://nyspi.org/nyspi/patients-and-families/ontrack-ny-connections-program>

Westchester, NY: Mental Health Association of Westchester:  
<http://www.mhawestchester.org/html/ontrackny1.html>

## **Other New York Programs:**

New York, NY: Parachute NYC: <http://www.nyc.gov/html/doh/html/mental/parachute.shtml>

## **North Carolina**

Carrboro, NC: University of North Carolina Outreach and Support Intervention Services (OASIS):  
<http://www.med.unc.edu/psych/cecmh/patient-client-information/oasis>

## **Ohio**

Northeast Ohio Medical University Best Practices in Schizophrenia Treatment Center: FIRST Programs:  
<http://www.neomed.edu/academics/bestcenter/bestpracticefirstepisodepsychosis>

## **Oregon**

Early Assessment and Support Alliance (Various Counties):  
<http://www.oregon.gov/oha/amh/Pages/easa.aspx>

## **Texas**

Dallas, TX: University of Texas-Southwest Medical Center First Episode Psychosis Program:  
<http://www.utsouthwestern.edu/education/medical-school/departments/psychiatry/research/clinical/fepp/index.html>





## **X. Appendix**

### **A. Shared Decision Making (SDM) and Other Tools**

- 1. OnTrackNY Suicide and Unintended Self Harm Guidance Document**
- 2. OnTrackNY Suicide and Unintended Self Harm Assessment and Prevention Tool**
- 3. Wellness Self-Management Plan**
- 4. Preparing to Talk about Symptoms**
- 5. Surviving Stress**
- 6. Psychiatric Medication and Me**
- 7. Finding Personal Motivation to Use Medication**
- 8. My Designated Observer**
- 9. Improving Concentration**
- 10. Family Involvement Decisional Balance Form**
- 11. Values Clarification Exercise**

## 1. Suicide Assessment and Prevention in First Episode Psychosis (FEP) Guidance Document

Individuals with FEP are at high risk for suicide, and suicide prevention is a key goal of Coordinated Specialty Care (CSC) for early psychosis.

We also include assessment and prevention of unintended self-harm, which may occur in the context of psychosis, impulse control challenges, or substance use. This differs from non-suicidal self-injurious behavior in that it is not intended to cause harm per se. However, unintended self-harm can place individuals at increased risk of serious injury or death. See examples below.

### Examples of unintended self-harm behavior in the absence of suicidal intent:

1. Jumping off a building due to delusional beliefs about being able to fly.
2. Drinking bleach to cleanse oneself due to delusional beliefs about being dirty or having sinned.
3. Cutting oneself due to believing that one has a recording device implanted.
4. Walking into traffic due to disorganization.

Hope permeates all activities of the team and is powerful in

helping individuals see beyond despair, toward their future. The language we use and the dignity with which we treat participants, supporting their dreams and aspirations, are part of the overarching framework of prevention and are central to the work of the team. Despite the team's best efforts to convey hope, individuals may nonetheless develop suicidal thoughts or unintended self-harm behaviors.

Use of a structured, systematic screening tool such as the C-SSRS, is an essential component of assessment and prevention in FEP. But screening is not enough. Individuals with FEP may be

at elevated risk for suicide and unintended self-harm whether or not they endorse suicidal ideation or are flagged on an instrument such as the C-SSRS. For example, individuals may choose not to disclose suicidal ideation, or may be at risk for unintended self-harm behavior due to psychosis without suicidal intent. Therefore, it is critical to complete a comprehensive assessment to identify risk and protective factors for all participants in FEP services. We have developed a suicide and unintended self-harm assessment and prevention tool, which can be directly used by your team, or adapted for your organization's electronic medical record system.

Once the initial assessment is completed at intake, team members should be on the lookout for changes that might indicate increased risk (i.e., increase in risk factors and/or decrease in protective factors), so that the person can be better engaged and supported during times of difficulty or crisis. Risk concerns can often be managed by helping individuals explore the meaning of what they are going through, thinking through alternatives to self-harm behaviors, and providing additional support within the CSC

### Suicide Risk in FEP

- Fifteen percent of people who die by suicide are psychotic at the time of death.
- Between 4 and 10 percent of individuals with schizophrenia die by suicide.
- The risk of suicide for individuals with FEP is 3 times higher than that of older adults with schizophrenia.
- The first 2 years following the onset of psychosis are a particularly high-risk period.

model. Peer support is critical to this process. Rarely teams may decide that acute risk is elevated to the point that an individual temporarily needs a higher level of care, such as hospitalization.

The initial assessment should be conducted in a series of steps, based on the evidence-based AIM model (Assess, Intervene, and Monitor). In step 1, teams complete a structured screening for suicidal ideation and behaviors, such as the C-SSRS. In step 2, teams conduct a comprehensive assessment of individual and environmental risk and protective factors (see OnTrackNY suicide and unintended self-harm assessment and prevention tool). This typically requires input from all team members, as participants may share different information with different people. In step 3, the primary clinician uses the information to make a summary assessment regarding risk and specifies whether the individual should be added to, remain on, or be removed from the elevated suicide and unintended self-harm risk monitoring list. This list is for the purpose of ensuring that enhanced monitoring and support is given to individuals who need it most. In step 4, the primary clinician works collaboratively with the rest of the team, the individual, and her/his family/supports to develop a plan to mitigate risk. Finally, in step 5, risk should be reviewed on an ongoing basis, depending on initial risk level and “warning signs” of increasing risk (i.e., changes to C-SSRS and/or to risk or protective factors).

- Step 1: Structured screening
- Step 2: Assessment
- Step 3: Summary risk assessment
- Step 4: Planning to mitigate risk
- Step 5: Monitoring risk over time

The primary clinician is generally the lead team member for risk assessment and prevention efforts, though all team members have a vital role to play. The psychiatric care provider (team prescriber) will also assess risk as part of the initial psychiatric evaluation and ongoing psychiatric management. All team members should participate in training regarding suicide and unintended self-harm in FEP and should report any warning signs of increased risk to the primary clinician (and/or team leader and psychiatric care provider). Although non-clinical team members (e.g., peer specialists and supported employment and education specialists (SEES)) do not assess participants for suicide/unintended self-harm, they should receive training about different ways to think about and discuss these issues with participants and with the team. Risk assessment and prevention efforts should be discussed as a team, typically in team meeting, although urgent situations will warrant more immediate discussion and/or intervention.

Peer Specialists have a unique non-clinical role to play. Using the principles of mutuality and willingness to share and learn from each other, peer specialists can create a safe and accepting space for participants to talk about their feelings and thoughts. Peer specialists are trained in alternate frameworks of understanding the experience of despair. For instance, *I feel unbearable shame. I can't take being bullied or abused anymore. I am angry at so much*

*injustice. I feel stuck and hopeless.* Peer Specialist are trained to talk to individuals about such feelings outside of a clinical framework. While assessment is a necessary aspect of care, having a team member who is explicitly not involved in assessment can provide a different kind of potentially life-saving support.

#### Unique Contribution of Peer Specialists

1. A non-clinical role
2. Do not assess peers
3. Create safe space for sharing and learning from each other
4. Peers are trained in discussing with participants non-medical frameworks for understanding the wish to die

**For all participants, particularly in the first 3 months of treatment:**

- Complete either the safety planning intervention or a wellness self-management plan, working collaboratively with the individual, and family, as appropriate.
  - The safety planning intervention is an evidence-based intervention for individuals with recent suicidal ideation or behavior. The safety planning intervention helps participants identify coping skills and supports. Although led by the primary clinician, any/all team members can assist with creating/ updating the safety plan, so it becomes a working document that individuals are willing to use and feel is helpful.
  - The wellness self-management plan is used with individuals who do not report suicidal ideation. It includes identifying strategies for maintaining wellness, coping skills, early warning signs, and a plan for managing relapse. Additionally, there are other tools which might be helpful, such as the OnTrackMaps, that the Peer Specialist can introduce and work collaboratively on with the participant.
- Provide psychoeducation about suicide and unintended self-harm risk and warning signs to the individual (and family, if appropriate) and review/update written safety or wellness self-management plan as needed. Ensure that this discussion happens in a person-centered, recovery-oriented way that helps the individual explore the meaning of what they are going through and think through alternatives to self-harm behaviors.
- Discuss access to lethal means and take steps to restrict access. Ask about access to firearms (or other weapons) and work with the individual and family/supports to ensure they are secured and not easily accessible in a crisis. Consider how much medication is supplied at one time and whether it may be appropriate to provide a more limited supply depending on the individual's risk and medication prescribed. The availability of potentially lethal medications or supplements (e.g., acetaminophen in the medicine cabinet) should also be asked about and addressed.
- Monitor risk frequently\*, including both screening for suicidal ideation and behavior, and reviewing pertinent risk and protective factors for the individual.

*\*Frequency of monitoring depends upon individual clinical circumstances. The suggested frequency for individuals at significant risk is at every session with a clinician. Risk level can change rapidly, so teams should have a low threshold for reconsidering risk.*

**The steps below should be taken as needed, depending upon individual circumstances:**

- Increase frequency of visits and increase assertive community outreach for individuals who have disengaged. Peer support services are critical to engaging and supporting individuals at elevated risk.
- Increase engagement of family or other community supports.
- Provide specific interventions to address modifiable risk factors and/or increase support, e.g., medication changes, evidence-based psychotherapy interventions, case management to meet basic needs, peer support services, substance use treatment, etc.
- Enhance protective factors, such as coping and problem-solving skills
- Consider transfer to a higher level of care for imminent risk when it is not possible to create a safe plan for outpatient care (e.g., psychiatric emergency department or hospitalization, partial hospitalization, crisis residence, etc.).

**Elevated Suicide and Unintended Self-Harm Risk Monitoring List**

Maintaining a list of participants identified to be at elevated risk is a strategy for the team to flag those at highest risk and ensure that safety issues are adequately addressed for those participants, and that extra support is provided. The team may devote time in team meeting to discussing strategies for mitigating

risk for those on this list or outside of team meeting as needed. Some teams hold a separate safety meeting to devote time as a team to identifying risk and protective factors and strategies for mitigating risk. The team may consider seeking consultation, within the agency and/or from OnTrackNY Central for individuals at particularly elevated risk.

### **Clinical Example**

*Jose is a 20 year-old Latino man living with his mother and younger siblings. He reports a close relationship with his family and provides consent to involve his mother in treatment. Jose previously worked in a bowling alley, but has not worked in the past 3 months, and would like to find another job. He reports he has been hearing voices, but is reluctant to share the content. He denies feeling depressed, but reports feeling nervous and distressed by the voices. When asked about his sexual orientation, he reports that he is attracted to men, but has never discussed this with his family and fears he would be shunned by his extended family if they were to learn of his sexual attraction. He reports feelings of shame about his attraction to men, hearing voices, and his inability to financially contribute to his family. To cope with feelings of anxiety, distress and shame, he has been drinking alone every night. He has stopped seeing friends and spends most of his time in his room. He denies current or past thoughts of suicide. A C-SSRS was completed with Jose at intake, with no positive responses (step 1). After several meetings with his primary clinician, he reveals that the voices call him "dirty" and "disgusting." He denies hearing voices telling him to harm himself or others. He seems more anxious than usual and appears to be hearing voices during the session. He continues to deny suicidal thoughts, and a repeat C-SSRS is negative. He reveals that he has stopped his medication because he feels embarrassed to take it because someone might find out. The team uses a shared decision-making process with Jose to discuss risks, benefits, and alternatives to medication and to help Jose consider his options. Jose is unwilling to consider restarting medication at this time.*

*The clinical team uses the OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool (step 2) and identifies the following risk and protective factors: recent increase in positive symptoms and recently stopped medication, anxiety/distress/shame, increased alcohol use, LGBTQ identity, unemployment, and social isolation. Protective factors include his connection to his family, safe living environment, and engagement with the team. Summarizing these factors (step 3), the team assesses that Jose is at elevated risk for suicide. Though he denies suicidal ideation or symptoms of depression and has no history of suicide attempts, he has a number of risk factors for suicide, as described above. The team discusses a plan to address modifiable risk factors and closely monitor Jose's risk (step 4). The team identifies the following strategies to support Jose and mitigate risk:*

#### **Strategies for the Whole Team:**

1. Use compassionate listening to create a safe space where Jose can share how he is feeling and feel accepted and heard.
2. Share the team's concern of risk with Jose, conveying warmth and support. Elicit his feedback about the team's concern. Work collaboratively with Jose to determine which additional supports would be most helpful.



3. Continue to make peer support available and discuss with Jose whether he may want to try to reconnect with friends.
4. Let Jose know that the team supports and accepts him for who he is. Tell Jose that the team is there to support him regarding the complexity of how his sexual orientation might impact his relationship with his family. Offer to problem solve together different possibilities of how Jose might navigate these issues (e.g., speaking with his mother, identifying peer or mentor supports in the LGBTQ community, etc.). Let Jose know that the team can support him around these issues in whatever way and in whatever timeframe he chooses.

### **Strategies for Clinicians on the Team:**

5. Add Jose to the team's elevated suicide and unintended self-harm risk monitoring list.
6. Complete the wellness self-management plan with Jose and his mother (if Jose had suicidal ideation or behavior, team would use the safety planning intervention instead).
7. Provide psychoeducation to Jose and his mother about suicide and self-harm risk and warning signs. Discuss steps that Jose and/or his mother would take if Jose were to develop suicidal ideation, including contacting the team (ensure that Jose and his mother have the on-call number for after-hours contact) and if needed, going to the emergency room.
8. Discuss access to lethal means with Jose and his mother and take steps to restrict access, if applicable (e.g., if there were a gun or other weapon in the home).
9. Monitor risk at each appointment while also using compassionate listening so Jose continues to feel accepted and heard.
10. Maintain frequent contact with Jose and his mother. Plan for weekly appointments with the primary clinician, and 1-2 additional appointments or contacts each week (i.e., with the psychiatric care provider, SEES, and/or peer specialist).
11. Involve Jose's mother in the shared decision-making process regarding medication. Discuss how medication might help Jose with his goal of finding another job, as well as helping him with his anxiety and distress.
12. Help Jose identify, practice, and implement coping strategies that he can use when he is feeling anxious or distressed.
13. Address substance use: provide information about the role alcohol can play in suicide and self-harm risk, recommend to Jose that he consider reducing or eliminating his use of alcohol at this time, and assess Jose's readiness for change. Provide stage-based motivational treatment and use a harm reduction approach.
14. Re-assess risk at each follow up appointment for now, including the C-SSRS and a brief review of changes in risk/protective factors (step 5).

## **2. OnTrackNY Suicide and Unintended Self-Harm Assessment and Prevention Tool**

Step 1: Structured screening, such as C-SSRS (initial and follow-up versions).

Step 2: Please check off relevant risk and protective factors (items are generally listed in order of importance, and **bold** items are specific to first episode psychosis (FEP) population). Include input from all team members.

| <b><u>Individual-specific Risk Factors</u></b>   | <b><u>Environmental Risk Factors</u></b>  |
|--|---|
| <p><u>Proximal:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Recent suicide attempt or non-suicidal self-injurious behavior</li> <li><input type="checkbox"/> Recent suicidal ideation (e.g., reported on C-SSRS)</li> <li><input type="checkbox"/> Recent psychiatric hospital or ED discharge</li> <li><input type="checkbox"/> <b>Within first 3 months of outpatient treatment or recent disengagement from outpatient treatment</b></li> <li><input type="checkbox"/> Recent impulsive or aggressive behavior</li> <li><input type="checkbox"/> <b>Recent command auditory hallucinations</b></li> <li><input type="checkbox"/> <b>Ongoing or recent increase in positive symptoms (e.g., AH, paranoia)</b></li> <li><input type="checkbox"/> <b>Ongoing or recent increase in disorganization</b></li> <li><input type="checkbox"/> Ongoing or recent increase in mood (especially depressive) or severe anxiety symptoms</li> <li><input type="checkbox"/> <b>Hopelessness (e.g., can manifest as “insight” into illness, causing demoralization)</b></li> <li><input type="checkbox"/> Recent increase in social isolation or withdrawal</li> <li><input type="checkbox"/> On-going or recent increase in substance use</li> <li><input type="checkbox"/> Refusal or inability to safety plan</li> <li><input type="checkbox"/> Recent or impending loss(es) and/or significant negative event(s) (financial, relationship, occupational, legal, etc.)</li> <li><input type="checkbox"/> Recent or ongoing social rejection, bullying, or victimization</li> <li><input type="checkbox"/> Recent akathisia or agitation</li> <li><input type="checkbox"/> Other:</li> </ul> <p><u>Distal:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Previous suicide attempt or non-suicidal self-injurious behavior</li> <li><input type="checkbox"/> Mood or personality d/o (e.g., depressive, bipolar, borderline personality d/o)</li> <li><input type="checkbox"/> Traumatic brain injury</li> <li><input type="checkbox"/> Family history of suicide or suicidal behavior</li> <li><input type="checkbox"/> History of sexual and physical abuse, neglect, or domestic violence</li> <li><input type="checkbox"/> <b>Poorer pre-morbid functioning or significant decline in functioning after psychosis onset</b></li> <li><input type="checkbox"/> <b>Duration of untreated psychosis longer than 6 months</b></li> <li><input type="checkbox"/> <b>Early onset psychosis (&lt;18 years old)</b></li> <li><input type="checkbox"/> LGBTQ+</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Lives alone</li> <li><input type="checkbox"/> Family stress/instability</li> <li><input type="checkbox"/> Current or pending homelessness/unstable housing</li> <li><input type="checkbox"/> Recent or pending incarceration</li> <li><input type="checkbox"/> Recent thoughts about or attempts to access lethal means (e.g., firearms, highly toxic medications or other substances, bridges or high buildings, materials for hanging/asphyxiation, etc.)</li> <li><input type="checkbox"/> Other:</li> </ul> |

|  |  |
|--|--|
| <input type="checkbox"/> Other:  |  |
| <p><b><u>Individual-specific Protective Factors</u></b></p> <input type="checkbox"/> <b>Reality testing intact</b><br><input type="checkbox"/> Positive coping and/or problem-solving skills<br><input type="checkbox"/> Expression of hope for the future<br><input type="checkbox"/> Identification of reasons for living<br><input type="checkbox"/> Sense of responsibility to family, pets, or others<br><input type="checkbox"/> Engaged in work or school<br><input type="checkbox"/> Fear of death or dying<br><input type="checkbox"/> Cultural, spiritual, and/or moral attitudes against suicide<br><input type="checkbox"/> Positive current therapeutic relationship(s)<br><input type="checkbox"/> Adherence with medications<br><input type="checkbox"/> Other: | <p><b><u>Environmental Protective Factors</u></b></p> <input type="checkbox"/> Access to supportive clinical interventions and outreach<br><input type="checkbox"/> Supportive social network or family<br><input type="checkbox"/> Lives with family<br><input type="checkbox"/> Other: |

Step 3: Using the information from the suicide ideation/behavior screen (e.g., C-SSRS) and all relevant risk and protective factors, make a summary assessment regarding risk and decide whether the individual needs to be added to, remain on, or be removed from the elevated suicide and unintended self-harm risk monitoring list. This is an individualized clinical judgment, based on specific knowledge of the individual and input from all team members. At least *during the first 3 months of treatment*, many individuals with FEP may be at increased risk, so teams should have a lower threshold for placing individuals on the elevated suicide and unintended self-harm risk monitoring list early in treatment, until they get to know them better:

- ☐ Add to elevated suicide and unintended self-harm risk monitoring list
- ☐ Remain on elevated suicide and unintended self-harm risk monitoring list
- ☐ Remove from elevated suicide and unintended self-harm risk monitoring list

Taking the most pertinent risk and protective factors for the individual into account, please summarize your risk assessment and justify the decision related to elevated suicide and unintended self-harm risk monitoring status:

---



---



---



---

Step 4: Please work collaboratively with the other team members, the individual, and family/supports to come up with a plan to decrease suicide and unintended self-harm risk, and document in the medical record. This plan may include any combination of the following (check box next to each item being added to plan at this time):



**For all participants, particularly in the first 3 months of treatment:**

- ☐ For individuals with explicit recent suicidal thinking or behavior, complete the safety planning intervention. For individuals without suicidal thinking or behavior, complete the wellness self-management (WSM) plan. These interventions are to help participants identify copings skills and supports to use when managing increased risk. While the primary clinician typically takes the lead, any/all team members can assist with creating and updating the safety/WSM plan, so that it is a working document that individuals are willing to use and feel is helpful.
- ☐ Provide psychoeducation about suicide and unintended self-harm risk and warning signs to the individual (and family, if appropriate) and review/update written safety/WSM plan as needed.
- ☐ Discuss access to lethal means, and take steps to restrict access. Ask about access to firearms (or other weapons) in the home, and work with the individual and family/supports to ensure that they are secured and not easily accessible in a crisis. Consider how much medication is supplied at one time and whether it may be appropriate to provide a more limited supply depending on the individual's risk and medication prescribed. Consider over-the-counter medications or supplements as well (e.g., acetaminophen in the medicine cabinet).
- ☐ Monitor suicide and unintended self-harm risk frequently\*, including both screening for suicidal ideation/behavior and reviewing pertinent risk and protective factors for the individual.

**The steps below should be taken as needed, depending upon individual circumstances. While some of these interventions could benefit anyone, they should be prioritized for individuals on the elevated suicide and unintended self-harm risk monitoring list:**

- ☐ Increase frequency of visits for individuals engaged in care, and increase community outreach for individuals who have disengaged.
- ☐ Increase engagement of family or other community supports.
- ☐ Provide specific interventions to mitigate risk factors and/or increase support, e.g., medication changes, evidence-based psychotherapy interventions, case management to meet basic needs, peer support services, substance use treatment, etc.
- ☐ Enhance protective factors, such as coping and problem-solving skills
- ☐ Consider transfer to a higher level of care for imminent risk when it is not possible to create a safe plan as an outpatient (e.g., psychiatric emergency department or hospitalization, partial hospitalization, crisis residence, etc.).

Step 5: Monitor risk over time. Frequency of monitoring/re-assessment depends upon individual clinical circumstances, including elevated suicide and unintended self-harm risk monitoring status. In general, the suggested frequency for individuals at significant risk is at every session with a clinician. However, please remember that risk level can change rapidly in the FEP population, so teams should be aware of potential changes in risk and protective factors, and have a low threshold for conducting formal re-assessment of suicide and unintended self-harm risk.



### 3. Wellness Management Plan

#### a. Background

The OnTrackNY program draws heavily on the concepts of the evidence-based practice of Illness Self-Management and Recovery. Recognizing illness symptoms and learning to manage them while pursuing life goals is a primary challenge for participants; accomplishing these tasks is central to the recovery process. OnTrackNY programs work with participants to learn signs of relapse and strategies for relapse prevention and managing crises; to understand what helps and what does not help in staying well; and to identify and use strengths, supports, and coping skills effectively. Team members encourage participants to examine the link between mental and physical health, and to make healthy decisions about their lifestyles. The primary clinician works with participants to develop a tailored Wellness Management Plan and revisits this plan with participants as part of ongoing treatment planning and review.

#### b. Wellness Management Plan

The purpose of this plan is to help me stay well and move forward in my recovery and in my life. It includes things I should do to stay well, and things I should avoid because they stand in the way of my recovery. This plan is meant to help me identify strategies to effectively navigate difficult situations that may arise and help my supports understand what I might find helpful during difficult times.

##### **Strategies for Staying Well**

Things I can do that help me feel healthy, calm, and in control of my recovery each day (people, places, activities), including things that I can add to my current routine even if I am not doing them now (e.g., regular exercise, eating nutritious foods, getting enough sleep, medicine, social activities):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Things I should avoid because they make it harder for me to stay well (people, places, things):

1. \_\_\_\_\_

2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### **Relapse Prevention**

Early warning signs that alert me to pay more attention to my health and wellness. These might include changes in my thinking, mood, way I act, or in the things I do. These types of thoughts, feelings and behaviors are the ones that make me upset, cause me difficulty in completing important daily activities, and prevent me from achieving my goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Strategies for managing early warning signs and preventing a crisis. These are the strategies I can use to cope with these early warning signs:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Action Steps: Specific steps I will take to implement and start using my coping skills (things I might do, skills I might try, people I might reach out to for help):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

4. \_\_\_\_\_

**Managing a Relapse:**

People I want involved to help me if I experience a relapse or crisis and how best to contact them:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Things that need to be taken care of when I experience a relapse/crisis:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

- Ways in which I want each person involved and who should do what:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

-

## 4. Preparing to Talk About Symptoms

We can't always get all the time we want with our doctor, therapist or other team members. Use this form to help prepare for the things you want to discuss with your team.

**Step 1:** What is a symptom? Symptoms are things like extreme worries or fears, or intrusive thoughts. Most often symptoms are indicators that something in our life needs tending to. Symptoms are like a red flag that grab our attention and call us to action. Perhaps we need to avoid certain situations. Perhaps we need to improve our self-care. Perhaps we need to have a good cry, deal with some anger or get extra help from our team.

**Describe the experience or symptom that is bothering you or feels the most important to talk about with team members.**

**Step 2:** Fill in the chart below:

|  | Yes | No | Not Sure | Not Applicable |
|--|-----|----|----------|----------------|
| Does the issue/symptom you wrote above, affect:              |     |    |          |                |
| My relationships or friendships? How?                        |     |    |          |                |
| My ability to work? How?                                     |     |    |          |                |
| My ability to live where I want to live? How?                |     |    |          |                |
| My ability to take care of myself? How?                      |     |    |          |                |
| My ability to do the things I enjoy in life? How?            |     |    |          |                |
| My ability to fulfill my responsibilities to my family? How? |     |    |          |                |
| My ability to be the person I want to be in life? How?       |     |    |          |                |
| My self-esteem? How?   |     |    |          |                |
| My health? How?  |     |    |          |                |
| My safety or the safety of others? How?                      |     |    |          |                |
| Other things not listed above? How?                          |     |    |          |                |

**Step 3:** Is the symptom you described above one you can put up with for a while or do you want to try to do something about it? (check one)

- ☐ YES, I want to do something about it.
- ☐ NO, I can live with this symptom.
- ☐ I can live with this symptom but others around me find it disruptive so I feel I have to do something about it.
- ☐ I don't know. I want to explore my options.
- ☐ I can live with this symptom; and even though others find it too disturbing, I do not want help to change or eliminate this symptom at this time. The consequences of my choice may be (use the section below):

What might happen if I choose to do nothing for a while?

**Step 4:** Has anything other than medication ever helped in the past with this issue/symptom? Examples might be exercise, therapy, staying busy, talking to a friend, lifting weights or cutting down on coffee. Things other than medication that have helped:

**Step 5:** In the past, have any medications helped you with this issue/symptom?

If you answered "YES", what is the name of the medication and how was it helpful?

☐ Yes

☐ No

**We all experience stress.** It's so normal it's almost invisible. The good news is that there are many ways to tame the stress monster. The first step is to recognize it. Then you can learn to master it. Experiment with these tips to see which ones work for you. And remember, you can always work with your Recovery Coach to identify other ways to deal with stress.

**Sidestep avoidable stressors:** You can find ways to avoid a lot of stressful situations. For example, if shopping with your partner stresses you, then agree not to shop together. If the noise at work increases your stress, negotiate with your boss about wearing headphones to help manage the stress.

**Find the right time for major life changes:** If you plan on getting a job, dating again, and moving out on your own all at the same time, you are in for a lot of stress. Plan major changes in your life in a way that you can take a 'breather' in between. Taking breaks between big events can really help.

### **Try other things**

**Develop a positive attitude:** Preventing stress is easier when you have a positive attitude. Even if you can't control a situation you're in, you can be in control of your attitude about the situation.

**Exercise:** Exercising is a good way to reduce stress. Start by getting more active each day and see if you can work up to exercising regularly a few times a week.



*Feeling overwhelmed is normal, but there are work arounds.*



*Meditation or being still helps some people prepare for the day.*

**Eat and sleep well:** Getting a good night's sleep and eating nutritious meals will help you be healthy. And when you're healthy, you'll be less stressed.

**Reward yourself:** When you overcome a challenge, give yourself a reward! You can take a break and relax, or download that song you've been wanting.



## 6. Stress Management

### When You Stay in Charge

*You can't prevent all stress. It's important to have a management plan. This is you being your own best back-up.*

**CREATE A LIST OF WHAT YOU DO, OR WHAT YOU WILL DO, TO TAKE CHARGE OF THE STRESS IN YOUR LIFE.**

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Visualize expected events:** Take time to imagine an upcoming event. Picture what it will look and feel like. Think about what you want to say and do. Then when the event happens, you will have had some practice and feel more confident.

**Have a back-up plan:** Does it look like you are going to lose your job or fail a class? Do you have a major money concern? Imagine how this will impact your life and create a back-up plan that will help you be safe. Who can help?

What do you need the most?

**Relax with deep breathing:** If you're feeling really stressed, slowly take a deep breath and hold it for a couple of beats. Then exhale, really slowly. 1-2-3-4-5. Repeat. Deep breathing helps many people relax.

**Ask for help:** Ask for help if you have to do something that feels overwhelming. Grab a buddy. Take a friend. Strategize with your Recovery Coach. Most people will be happy to help out.

**Relax by clearing your mind:** Take a break in a quiet place and invite your mind to relax by focusing on one peaceful image or thought.

What image will you use? Relax your muscles: Stress causes your muscles to get tense.

Tightening and then relaxing different muscles is one way of relaxing them. Notice what happens when you tighten a muscle - say in your forearm - for a few seconds, and then relax it slowly. Feel the difference.

**Relax with stretching and exercising:** Stretching can be done anywhere and anytime. And exercise, like taking a walk, is also a great way to stretch muscles and get you thinking about different things.

**Think positively:** When faced with a difficult situation, put things into perspective. Ask yourself "What does this situation mean in the grand scheme of things? Is it really such a big problem?"

**Practice calmness:** Plan to listen to some quiet music for a few minutes each day; take a long bath or shower; some people find prayer or meditation helpful. It might take a little while to get quieted down. Stick with it.

## 7. Psychiatric Medication and Me

Psychiatric medicines can be helpful to our recovery. However, sometimes psychiatric medications can alter our sense of who we are. For instance, you might be a naturally talkative person, but some medications may make you feel more quiet and withdrawn. This worksheet will help you and your team understand what's unique about you. Together, you'll be able to determine if the medications you may take would be truly helpful in supporting YOU in your recovery. Here are some exercises to get you started:

### a. How I See Myself

In the list below, circle the words you honestly think describe you when you are feeling well. Add your own words in the spaces provided. Then answer the questions that follow:

|                                |                                |                         |                              |
|--------------------------------|--------------------------------|-------------------------|------------------------------|
| EASY GOING                     | LIKE TO PARTY                  | ENERGETIC               | LIKE TO SLEEP IN LATE        |
| TALKATIVE                      | OUTGOING                       | THOUGHTFUL              | PROCRASTINATOR               |
| ANGRY                          | CONFIDENT                      | LAZY                    | NOT VERY EMOTIONAL           |
| GET PUSHED AROUND              | NEEDY                          | CREATIVE                | EASILY BORED                 |
| LIKE HOW I LOOK                | INDEPENDENT                    | ACTIVE                  | SHY                          |
| CRY EASILY                     | RESERVED                       | TRUST PEOPLE            | LONER                        |
| EXTROVERTED                    | LIKE TO STAY UP LATE           | INTROVERTED             | LIKE IT QUIET                |
| SENSITIVE, BUT DON'T SHOW IT   | STUBBORN                       | NIGHT OWL               | DON'T LIKE CROWDS            |
| GET IN PEOPLE'S FACE           | SENSITIVE AND SHOW MY FEELINGS | DON'T LIKE HOW I LOOK   | DON'T CARE WHAT OTHERS SAY   |
| BASICALLY THINK LIFE IS HARD   | WANT TO BE LIKED               | LIKE PHYSICAL ACTIVIITY | BASICALLY THINK LIFE IS GOOD |
| EARLY BIRD                     | BAD TEMPERED                   | SLOPPY                  | GOOD APPETITE                |
| DON'T TRUST PEOPLE             | QUIET TYPE                     | BOOKWORM                | LIKE IT LOUD                 |
| OTHER WORDS THAT DESCRIBE YOU? |                                |                         |                              |

|   |  |                                     |  |
|---|--|-------------------------------------|--|
| <b>a. What do you enjoy doing?</b>  |  |                                     |  |
|   |  |                                     |  |
| <b>b. What is your energy like when you are feeling well?</b>   |  |                                     |  |
| High Energy <input type="checkbox"/>  | Medium Energy <input type="checkbox"/> | Low Energy <input type="checkbox"/> |  |
| <b>c. Which statement(s) is true for you when you are feeling most like yourself?</b>   |  |                                     |  |
| <input type="checkbox"/> I almost always get tired in the mid-afternoon but bounce back in the evening<br><input type="checkbox"/> I have the most energy in the morning<br><input type="checkbox"/> I have the most energy in the evening<br><input type="checkbox"/> Other: _____   |  |                                     |  |
| <b>d. I am a morning person:</b>  | Yes <input type="checkbox"/>           | No <input type="checkbox"/>         |  |
| <b>e. I am a night owl:</b>   | Yes <input type="checkbox"/>           | No <input type="checkbox"/>         |  |
| <b>f. I like to take naps in the daytime:</b>   | Yes <input type="checkbox"/>           | No <input type="checkbox"/>         |  |
| <b>g. When I am feeling well I usually sleep about _____ hours a night.</b>   |  |                                     |  |
| <b>h. When you are feeling like your normal self, where would you place yourself on this continuum?</b>   |  |                                     |  |
| <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Solitary and Quiet</span> <span>Outgoing and Social</span> </div>   |  |                                     |  |
| <b>i. In terms of how much you usually talk when you are feeling well, how would you describe yourself:</b>   |  |                                     |  |
| <input type="checkbox"/> Very talkative, love to chat<br><input type="checkbox"/> I'm moderate. I like to talk but usually not for a long time<br><input type="checkbox"/> I'm the quiet type. I'm more a listener than a talker.<br><input type="checkbox"/> I keep to myself. I might answer people's questions but rarely begin conversations. |  |                                     |  |
| <b>j. I am shy:</b>   | Yes <input type="checkbox"/>           | No <input type="checkbox"/>         |  |
| <b>k. What are some of the things that you really like about yourself?</b>  |  |                                     |  |

## b. Room for Improvement

No one is perfect! We all have areas where we would like to grow and improve. Below is a list of things that others have said they would like to change about themselves. Circle the ones that you would like to change about yourself. Use the blank boxes to fill in your own examples of things you'd like to change about yourself:

|                         |                                 |                               |                         |                          |
|-------------------------|---------------------------------|-------------------------------|-------------------------|--------------------------|
| BE MORE ACTIVE          | BE MORE RELIABLE                | BE MORE GENEROUS              | GET THINGS DONE ON TIME | BE MORE SELF-DISCIPLINED |
| CONTROL MY TEMPER       | BE MORE GRATEFUL                | BE A GOOD LISTENER            | AVOID GOSSIP            | BE MORE HONEST           |
| THINK BEFORE I ACT      | STOP COMPARING MYSELF TO OTHERS | BE SATISFIED WITH WHAT I HAVE | STICK WITH THINGS       | STOP PUTTING MYSELF DOWN |
| TRUST OTHERS MORE       | PUSH THROUGH MY SHYNESS         | LET GO OF GRUDGES             | BE MORE PATIENT         | WORRY LESS               |
| HAVE A BRIGHTER OUTLOOK | TAKE MORE RISKS                 | SPEAK UP                      | STAY IN TOUCH           | ACCEPT RESPONSIBILITY    |
| OTHER WAYS TO IMPROVE   |                                 |                               |                         |                          |

**If you could change two things about yourself, what would the new you be like?**

1.

2.

**c. Part C**

Now that you have answered these questions, take a moment to look over what you wrote. In the space provided below, write a short summary of what you are like when you are feeling well, thinking about the answers you gave above. Remember, nobody is perfect! Include the good and not-so-good aspects of yourself in your description.

**A Description of Me When I Am Doing Well:**

*(Use more paper if you want)*

Your description of yourself when you are feeling well is important because it describes YOU! You are a unique and valuable individual. It is important to let your psychiatrist – actually, everyone on your team - know what you are like as an individual. Consider reading your description of yourself to your psychiatrist. Together you can work to insure that psychiatric medications support the things that make you unique and support you getting the life you want.

**1. What are your hopes about what medication will do for you?**

|  |
|--|
|  |
| <b>2. What are your fears about how medication might change you?</b>         |
|  |
| <b>3. Does the medication seem to be having effects that you like?</b>       |
|  |
| <b>4. Does the medication seem to be having effects that you don't like?</b> |
|  |

**Take care of your symptoms so that you can be YOU!**



## 8. Finding Personal Motivation to Use Medication



Our family may urge us to take medication to help our mental health. Our team may encourage us to try medication. A judge may want us to take mental health medication. This can feel annoying until we discover our own personal motivation to use medication to help support our recovery. **Why do you (or don't you) use medication to support your mental health?** This worksheet will help you explore what might motivate you to use mental health medication.

**Step 1: What are some of the problems or symptoms that brought you to the clinic?**

**Step 2: List 3 things that the problems or symptoms are keeping you from doing or that you really would like to be able to do like "play soccer again" or "go to school" or "get back with my girlfriend."**

1.

2.

3.

**Step 3: Review your list in Step 2. Each of the things you listed can become a Personal Motivator. Next, add your Personal Motivators to the blank in each sentence below.**

Example: I am using this medicine so that I can be close to my girlfriend.

**1. I am using this medicine so that (add your personal motivator)**

**2. I am using this medicine so that**

**3. I am using this medicine so that**

**Option:** Get a pair of scissors, and cut out your Personal Motivators listed in Step 3. Tape your Personal Motivators to your medicine bottles. Each time you take your medicine, you'll be reminded of your reason – your motivation - for taking the medicine. Good luck!

## 9. My Designated Observer

|  |   |   |
|--|---|---|
| <p><b>Why a Designated Observer?</b></p> <p>Sometimes it's helpful to have another person tell us if we seem different than we usually do, especially if we're trying a new medication, stopping a medication, or making changes to our medication.</p> <p>The person listed below is my Designated Observer. He/She will help me evaluate the changes I am making to my medications.</p> <p><b>My Designated Observer is:</b></p> <hr/> <p><b>I'm choosing this person because:</b></p> | <p><b>About the changes</b></p> <p>The change I'm making is:</p><br><br><br><br><br><p>The change started on:</p><br><br><br><br><br> | <div data-bbox="1084 262 1398 472" data-label="Image"> </div> <p><b>Observers can help me see:</b></p> <ul style="list-style-type: none"> <li>• How I'm interacting with others.</li> <li>• How I am fulfilling my responsibilities</li> <li>• If my attitude or personality or seems different.</li> <li>• If my symptoms are changing.</li> <li>• If there are changes in my sense of humor or mood.</li> </ul> <p><b>INSTRUCTION:</b> This worksheet should be filled out by the person selecting a Designated Observer.</p> |
| <div data-bbox="180 1339 561 1583" data-label="Text"> <p>ob·serv·er (/ əb'zərvər/)<br/> Noun: A person who watches or notices something.<br/> Synonyms: watcher, spectator or spotter.</p> </div>  | <p>My Reason for making the change is:</p><br><br><br><br><br><p>As a result of the change I hope that:</p><br><br><br><br><br>       |   |



Dear Designated Observer, in the table below, please indicate if it seems to you like I'm taking my medication, if I'm doing a wellness activity, and if I seem to be using drugs or alcohol. Also, please rate my symptoms and describe any side-effects you think you observe. I've drawn a line through any columns I don't want you to rate. Thanks for helping me learn more about how this medicine works for me.

| <b>Date</b> | <b>Seems Like I'm Taking Medication?</b>                    | <b>Seems Like I'm Doing A Wellness Activity</b>             | <b>Seems Like I'm Using Drugs or Alcohol?</b>               | <b>Seems Like My Symptoms Are Changing?</b>                 | <b>Seems Like I'm Having Side Effects?</b>                  |
|-------------|---|---|---|---|---|
|             | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: |
|             | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: |
|             | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: | Check if Yes: <input type="checkbox"/><br>If yes, describe: |

Weekly Summary/overall comments:

## 10. Improving Concentration

If you are **experiencing** difficulty with concentration, you are not alone. Below are some tips from people who have taken steps to improve their concentration. You might want to try these suggestions to see if one or more helps you.

1. Break up tasks into smaller parts: One way to practice your concentration skills is to break tasks down into smaller parts. For instance, if you want to read a book but find your mind wandering, focus on reading one paragraph at a time rather than trying to read a whole chapter or the whole book. In time, you will find it easier to get through a paragraph without getting distracted. Then you can focus on completing two paragraphs, etc.



### **What task can you break down into smaller tasks to practice your concentration skills?**

2. Create an environment that supports concentration: At an amusement park it can be very hard to concentrate! The situation or environment we are in affects our ability to focus. When you need to concentrate create an environment that minimizes distractions. You might want to try some of these steps:
  - Plan my own quiet corner away from distractions. Use a bookcase to create a wall. Shut a door.
  - Clean or organize my space.
  - Before focused concentration, take care of basic physical needs such as feeling hungry.
  - Be rested and relaxed before beginning. Get a good night's sleep.
  - Gather supplies before beginning. This will limit interruptions.
3. Try the "Five More" rule: When it's hard to concentrate some of us find the "Five More" is really helpful. If you are in the middle of a task and are tempted to give up - do just FIVE MORE. Read FIVE MORE pages, finish FIVE MORE math problems, work FIVE MORE minutes, wait FIVE MORE minutes. Continuing to concentrate when your brain is tired is the key to S-T-R-E-T-C-H-I-N-G your attention span and building mental endurance.

### **Read this or say out loud:**

When I feel like I can't concentrate anymore and I am bothered by this, I will use the "Five More" rule. This will help me focus for longer and longer and I will see that I'm being successful

4. Writing down directions: Difficulty with concentration can make it challenging to follow directions. When this happens you can ask for directions or instructions to be given one step at a time. You can also make a list of each step that is required and check things off one-by-one. This will help with concentration and focus.

☐ Yes, I can ask that instructions or directions be given one step at a time.

- ☐ Yes, I can make a list of each step that is required and check things off one-by-one.

## **11. Family Involvement Decisional Balance Form**

### **a. Good Outcomes from Having Family More Involved in Care:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

(Examples: relatives might feel calmer if they know the doctor, might be able to manage medication better, relatives might be able to help me more if I have a symptom flare-up, relatives might be able to help me reach some of my goals)

### **b. Challenges with Having Family More Involved in Care**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

(Examples: might risk privacy, might feel too controlled, might lead to more fights)

## 12. Values Clarification Exercise

The goal of this exercise is to help participants clarify their personal values and how they relate to family involvement in care, through the use of the values clarification exercise. The team leader first provides three pieces of paper labeled "Very Important," "Moderately Important," and "Little or No Importance" at the top. Participants are given the list of values cards and asked to sort them into three piles (very important, moderately important, little or no importance). These values cards include concrete issues of interest to most persons (e.g., "getting along with my family") and those of special relevance to persons with serious psychiatric illnesses (e.g. "staying out of the hospital," "keeping symptoms to a low level," "not embarrassing myself in public"). If a participant says "I don't know," the team leader prompts with, "Make your best guess." If this does not help the participant make a choice, the team leader can make a "Do Not Know" category.

"I want to understand what is really important to you in life. Here is a set of life values cards. They describe experiences and values that are important to some people but not to others. Would you please read each one and then put in the pile which reflects how important that value is personally, to you?"

After all the cards are sorted, the team leader then takes the pile of most importance and discusses how family might be related to each value by asking the participant:

"How do you think your family being involved in your care and getting more support might be related to (this value)?"

### Life Values for the Cards

- Living independently in my own apartment or house
- Paying my bills
- Getting along with my family
- Having a fun social life
- Having friends
- Being self-sufficient
- Meeting new people
- Having a partner
- Dating
- Staying out of the hospital
- Feeling proud of myself
- Having nice clothes
- Having a nice car
- Not embarrassing myself in public
- Having something productive to do with my time
- Having extra money
- Keeping my symptoms to a low level
- Having a hobby
- Helping others
- Making others who care about me proud

- Recovering from my mental/emotional problems
- Reducing stress
- Having a strong religious/spiritual life
- Being in good physical health
- Creativity
- Going to school
- Working

Important values and their relation to family involvement are noted on a separate sheet of paper by the team leader. Values that are inconsistent with family involvement are discussed with the client. For example, the client may value “being self-sufficient” and believe that family involvement in care may conflict with this goal. The team leader helps the client resolve the discrepancy between the value and family involvement. For example, in the situation just mentioned, the provider would ask the participant if he/she has known of self-sufficient individuals (perhaps friends or relatives) who still consult with others about health decisions.

*This exercise is from the Family Member Provider Outreach Manual:*

Glynn, S.M., Cohen, A.N., Murray-Swank, A., Drapalski, A., Dixon, L. (2010). Family Member Provider Outreach (FMPO) Manual. Unpublished manual, VA Maryland Health Care System, Baltimore, MD.



### 13. Peer Specialist Supervision Checklist

The Team Leader (supervisor) can use this checklist to structure supervision of the Peer Specialist and to support performance of key job responsibilities. Remember, the Peer Specialist is not a clinician. The Peer Specialist has the challenge of working within an OnTrackNY team, while simultaneously working and speaking from a peer perspective.

#### Remaining Peer

- ☐ When working with program participants, the Peer Specialist keeps the focus on learning together, rather than assessing problems and prescribing help.
- ☐ The Peer Specialist is skilled in sharing relevant personal experiences in-the-service-of supporting program participants' recovery/wellness/self-discovery.
- ☐ The Peer Specialist seeks to understand program participants' evolving understanding of "what happened to me" which often involves non-traditional, non-clinical meaning making.
- ☐ Peer Specialist's program notes and verbal communication to the team are peer-centric and do not include overtly clinical language. Specifically, communication does not include common clinical idioms (e.g. schizophrenia, low functioning, manipulative, decompensating, suicidal, etc.) and does not attribute motive to behavior (triangulating, manipulative, help seeking-rejecting, etc.).
- ☐ Peer Specialist mentoring, training, conferences, publications, web-forums, etc. are being accessed.
- ☐ Check for signs of "drift" from the role of Peer Specialist:
- ☐ Adopting clinical language and terms such as decompensating, high-functioning, etc.
- ☐ Reluctance to share lived experience with participants and families
- ☐ Telling/advising program participants what to do
- ☐ Making decisions for program participants

#### Influencing Team Culture

- ☐ The Peer Specialist and Team Leader are working together to promote a recovery oriented, inclusive, youth-friendly culture of respect on the team.
- ☐ The Peer Specialist is not being "siloe" as the only voice of recovery/wellness/self-discovery on the team.
- ☐ Ask about the Peer Specialist's impressions/observations of the culture shift that is occurring on the team.
- ☐ Ask about the Peer Specialist's experience of micro-aggression and role strain on the team.
- ☐ Ask if Peer Specialist's opinions or dissensions are given equal weight in decision-making?
- ☐ (If applicable) Ask if Peer Specialist feels free to express diverse cultural/ethnic and socioeconomic identities, sexual orientation/gender identification, and experiences respect from other team members.

#### Team Communication

- ☐ Speaks up during team meetings in an effort to respectfully present non-clinical perspectives and understandings. For instance, at times he/she may speak from human rights, feminist or social justice perspectives.
- ☐ Demonstrates the ability to communicate the peer framework respectfully to the team both verbally and in writing.
- ☐ Works collaboratively with other team members as needed to help participants achieve goals.

### **Outreach/Engagement/Bridge Building**

- ☐ Facilitates connection with participants.
- ☐ Facilitates connection with family members.
- ☐ Collaborates with ORC to promote community awareness of OnTrackNY services (e.g. ERs, high schools, etc.).
- ☐ Serves as a bridge between the team and participant/families when necessary.

### **Relationship Building**

- ☐ Develops authentic relationships with program participants and/or families.
- ☐ Shares personal experiences with participants and families.
- ☐ Role models recovery/healing/self-discovery for program participants and families.

### **Embraces Creative Narratives**

- ☐ Is open and willing to follow program participants' evolving understanding of the meaning of "what happened to me".

### **Advocacy**

- ☐ Invites program participants to attend meetings to advocate for their interests.
- ☐ Rehearses and helps program participants to prepare for self-advocacy.
- ☐ Advocates by encouraging team members to use SDM, and highlighting people's civil and legal rights.
- ☐ Speaks up at team meetings to advocate for alternative, non-clinical understandings of the experience of psychosis and recovery/wellness/self-discovery.

### **Co-Creating Support and Wellness Tools**

- ☐ Has mapped community resources, peer resources and natural supports available to all citizens in the community including program participants.
- ☐ Has assisted program participants in developing a wellness toolkit.

