

Early Psychosis Program Implementation in California: Overview of Coordinated Specialty Care (CSC)

Tara Niendam, Ph.D.

Assistant Professor, UC Davis Department of Psychiatry
Director of Operations, UC Davis Early Psychosis Programs
(EDAPT & SacEDAPT Clinics)

Objectives

- Provide an overview of Coordinated Specialty Care (CSC) within the US
- Provide overview of psychosocial treatment options, including therapeutic interventions and additional supports such as Family/Peer Advocate and Supported Education/Employment
- Provide suggestions for program implementation

US Models of Coordinated Specialty Care (CSC)

- RAISE, EASA, PIER, EDAPT, PREP...
- All are variations on coordinated specialty care with some nuances for the target population
 - Both CHR and First episode
 - Ages served
 - Other criteria?
 - Substance dependence, IQ<70, County of residence, Uninsured, Undocumented...

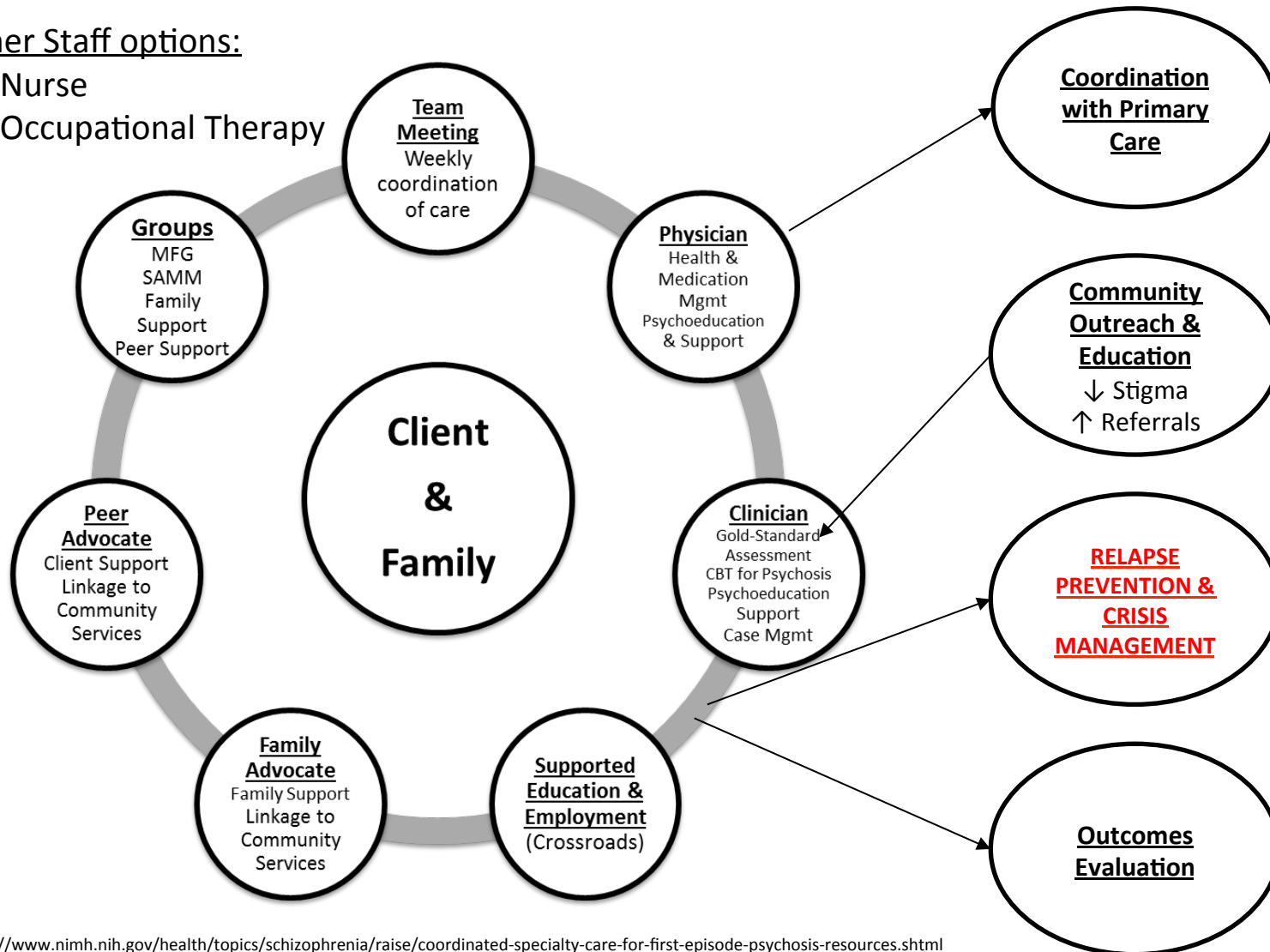
Heinssen, R., A. Goldstein, and S. Azrin, *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care*. 2014: National Institutes of Mental Health.

http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

Coordinated Specialty Care Model

Other Staff options:

- Nurse
- Occupational Therapy



Outreach

- Focus on “points of first contact” for mental health services in your community
 - Community mental health
 - Emergency rooms, Crisis centers, hospitals
 - Schools, colleges
 - Primary Care
 - Jails, Probation, Police
 - Community organizations, social services agencies
 - Social Media
- Goals = Increase knowledge of early signs and symptoms, awareness of your program (rapid referrals), reduce stigma
- Ongoing process – you MUST keep doing this to keep referrals coming in

Identification & Assessment

- Screening process by trained staff to determine preliminary eligibility
 - Respond quickly
 - Over the phone OR in person
 - May include valid screening measure (PQ-B, Loewy et al., 2011)



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EDAPT Screening Survey

If you or a loved one are experiencing any of the symptoms identified on this website but are unsure whether our clinical services are right for you, please take this 21-question Screening Survey. Your answers cannot be linked to you or your computer, but will provide you an immediate recommendation about whether you should contact EDAPT or SacEDAPT for a comprehensive assessment.

If your score indicates that you do not need to call our clinic, you will receive information and referrals to other organizations and services which will be most appropriate for you. Of course, you are always welcome to call or email us regardless of your results.

1. Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?

No Yes

[Next](#)

Available at Earlypsychosis.ucdavis.edu

Identification & Assessment

- Comprehensive Evaluation
 - Semi-structured assessment of psychosis, mood, trauma, and substance use symptoms:
 - First Episode: Structure Clinical Interview for DSM (SCID, First et al., 2002)
 - High Risk: Structured Interview for Prodromal Syndromes (SIPS; McGlashan et al., 2001)
 - When did psychosis start/worsen and impact functioning?
 - Include collateral information! Engage family/support persons now!

Identification & Assessment

- Comprehensive Evaluation
 - Thorough History: Prenatal/Perinatal, Developmental, Medical, Prior Treatment, Family Mental Illness, Social Functioning, Role Functioning, Cognition (IQ), Trauma
 - When did things change?
 - Risk Factors: Relapse/hospitalization, Suicide, Violence, Housing stability, Running Away, etc
 - Other relevant psychosocial factors: Support, Finances, etc.

Treatment Plan

- Recovery is possible (vs. disability)!
 - Recovery is not the absence of symptoms, but the improved management of distress
 - Primary goal = return the client to their baseline functioning and support development of meaningful roles and goals
- What are the client's goals?
 - May not be mental health related...
 - OK to focus on what motivates them so you can engage them in care
 - Strengths based
- How can support persons be included in treatment and supported to help client achieve their goals?
- What components of your treatment should they participate in to achieve their goals?

Interdisciplinary Team-based Approach

- Weekly Team Meetings = Core Piece of the model!
 - Review cases, treatment recommendations, consensus diagnosis
- Clinician or case manager assigned to each client
 - Provide psychoeducation, therapy, crisis support
- Psychiatric support
 - Assigned to each client, available regular appts AND crisis appts, part of the team, available for consultation and coordination (co-located)
 - Monitor medications, refer for labs, coordinate care with other medical practitioners
- Support to maintain academic or vocational functioning
 - Supported Education & Employment
- Support and psychoeducation for family
 - Via groups or individually
 - Peer and Family Advocates

Team Leadership & Support

- Program Manager or Director
 - Oversees program, works with county on contract and budget
 - May do outreach or educational presentations
- Team Leader
 - Daily oversight, supervision of staff to ensure fidelity, may provide direct care
 - Ensures quality and timeliness of services
 - Oversees outcomes data collection
- Clerical support
 - Initial engagement, phone screens
 - Manage scheduling, records, labs, etc to support the staff and clients
 - Don't under budget here!!
- **All are part of the team!**

Psychosocial Interventions

- Medications do not target the full range of symptoms
- Individuals need support with building skills to improve or return to social/role functioning, even once symptoms have remitted
- Psychosocial Interventions are targeted at helping the individual manage stressors to avoid relapse and learn coping skills to manage any residual symptoms

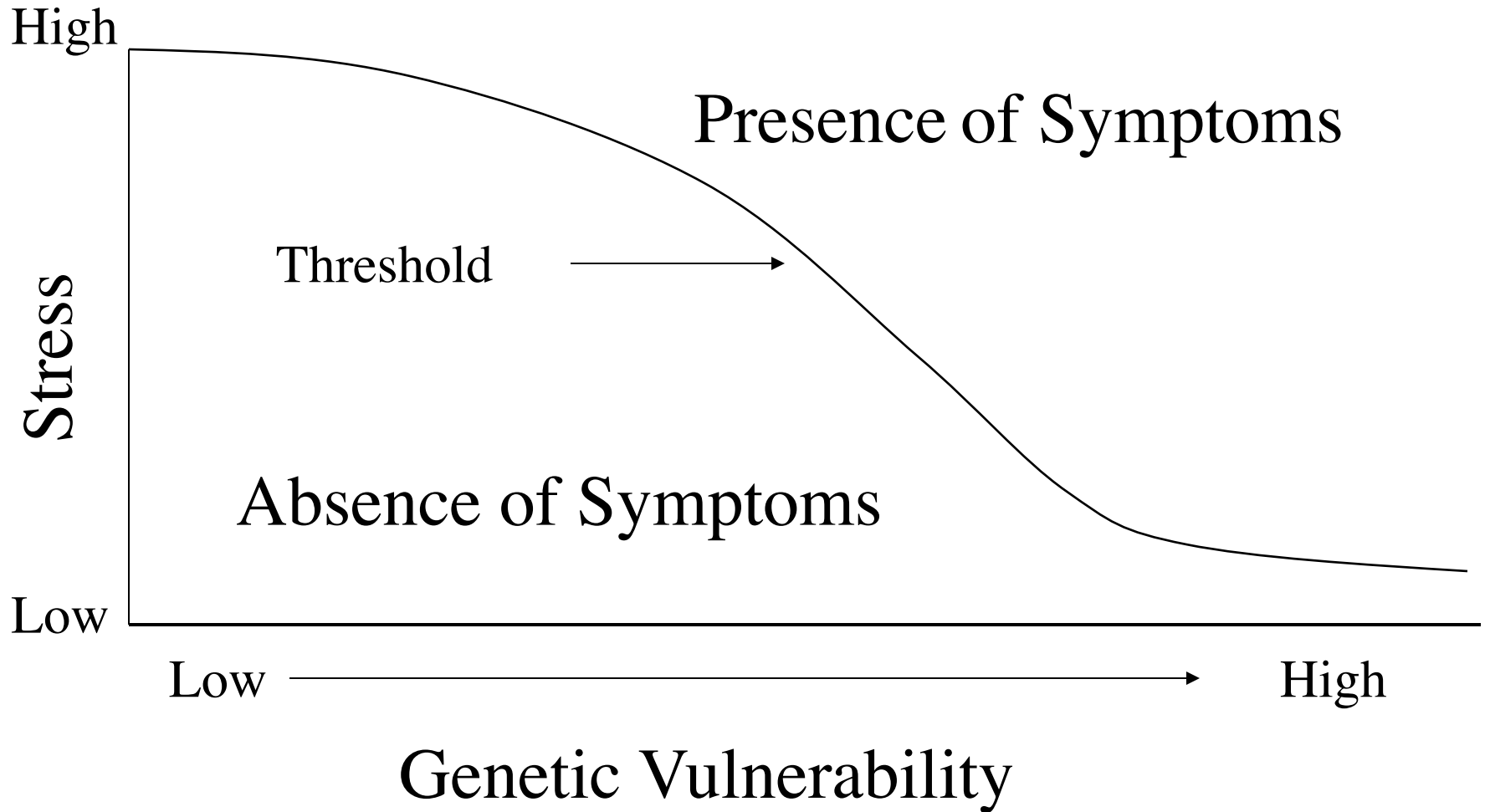
Engagement in Treatment

- Review assessment results, current risk factors
 - Psychoeducation on diagnosis
 - Safety Planning
 - Lay the foundation for treatment
- Describe treatment approach
 - Why should they engage in what you are offering?
 - Important of family/collateral engagement

Importance of Family Involvement

- Enhanced support system for recovery
 - Family provide significant support to individuals in the early stages of psychosis
- Improved communication – how are things really going?
- Increased engagement in treatment
- Need to ensure family is there for the long term

Vulnerability-Stress Model



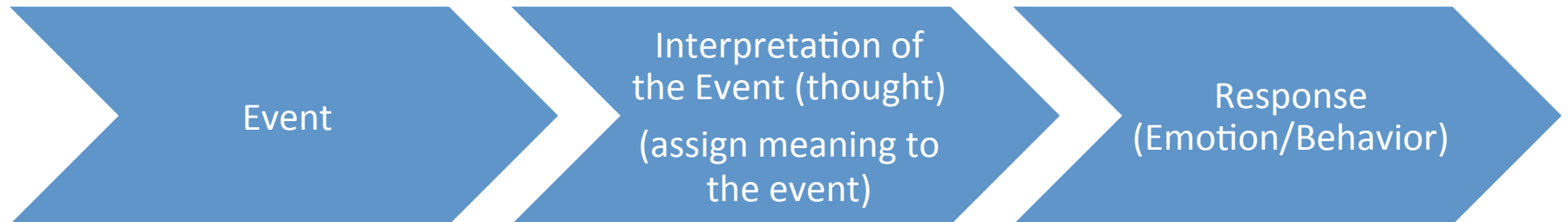
Individualized Interventions

Cognitive Behavioral Therapy for Psychosis (CBTp)

- CBT for psychosis has been studied in over 40 randomized controlled trials and various meta-analyses since the 1990's (Lecomte, et.al., 2014)
- CBT for psychosis is effective, demonstrating acceptable effect sizes, and that it should be delivered routinely as part of a treatment package offered to people with schizophrenia (Morrison and Barratt, 2010).

Cognitive Behavioral Therapy for Psychosis (CBTp)

- Cognitive Model: It is the *interpretation* of an experience that causes the distress, not the experience itself.



Cognitive Behavior Therapy

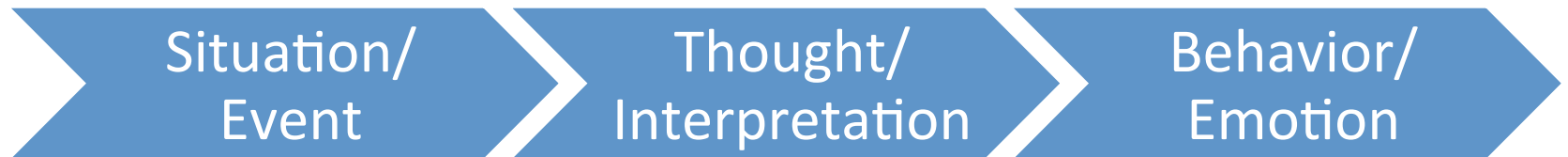
- People respond differently to similar situations based on how they are thinking about the situation
- CBT teaches people to observe their thinking, evaluate it for accuracy and impact, and change inaccurate thoughts in effort to reduce distress

Cognitive Behavior Therapy

- Psychotic thoughts vs. depressed thoughts vs. anxious thoughts...what's the difference?
- Psychosis=distorted/false beliefs, misinterpretations of the environment
- Psychotic experiences are culturally unacceptable interpretations of experience
 - Panic Disorder: “my heart is beating quickly, my breathing is accelerated, I must be dying”
 - Psychosis: “my heart is beating quickly, the government planted a chip in me”
 - Anorexia: “I’m too fat, I can’t eat, food is making me fat”
 - Psychosis: “My food is poisoned therefore I can’t eat it”
 - Social Anxiety: “Others are looking at me and laughing”
 - Psychosis: “Others are looking at me and going to hurt me”

Cognitive Behavior Therapy

- Conceptualize the psychotic symptom as the “situation/event”
 - Situation/Event: hearing voices
 - Thoughts: interpretation of voices and/or their content; negative automatic belief about voices
 - Emotion: fear, anxiety
 - Behaviors: response to voices



Cognitive Techniques

- CATCH IT:
 - identify automatic thoughts (content of symptom) and **interpretations** of the symptom and the resulting feelings & behaviors
 - evaluate level of conviction and impact on behavior, use SUDS to measure distress level of the “thought”
- CHECK IT:
 - evaluate accuracy of the thought
 - identify patterns of distortion
 - evidence for and against
- CHANGE IT:
 - generate alternate interpretations
 - more realistic beliefs/interpretations
 - normalize

Cognitive Techniques

- Goal may not be to remove distorted belief entirely
 - Simply telling person that they are wrong will not change the belief
 - Reduction of conviction can be very helpful
- Examine alternate explanations for the intrusion/experience and see how each explanation effects conviction level and level of distress (use SUDS to measure each time)

Group Treatment Approaches

- Multi-Family Group Therapy (MFGT)
- Family Support Group (FSG)
- Substance Abuse Management Group (SAM)
- Peer Symptom Management Group
- Expressive Arts Group

Multifamily Group Therapy

- Originally developed in the 1960's, adapted by William McFarlane in the 80's
 - High “expressed emotion” in the home is consistently associated with relapse.
- Goal is enhance problem solving, improve communication and reduce distress/conflict in environment
 - REDUCE Criticism, Hostility, Emotional Over-involvement
 - Increase Warmth and Positive Regard
- Main Stages of MFGT program
 - 1) Conducting an educational workshop about psychosis for families
 - 2) Joining (i.e., building rapport/alliance) among individual patients and families
 - 3) Problem-solving focused groups attended by both patients and families

MFGT is delivered by two clinicians to groups of 5-8 families over a 2-year period.

Multifamily Group Therapy

- MFG Goals: gain knowledge of psychosis and learn skills (problem solving, communication and stress management), reduce isolation
- Leads to improved illness course and outcomes through:
 - Families benefit from each other's experiences in solving problems
 - Increasing social network size and support,
- Across a number of clinical trials, MFG has been shown to decrease relapse and re-hospitalization among patients with schizophrenia and to improve family well-being over the 2-year treatment period (McFarlane et al., 2003).

Family Support Group

- Designed to provide psychoeducation and support to family members of the client
 - Helps them understand symptoms (vs. developmental processes, other disorders)
 - Helps them monitor symptoms at home and teaches them how to respond (ex: do not directly challenge delusions)
 - Helps them gain support for supporting the client at home
 - Problem solving facilitation/orientation

Substance Abuse Management Group

- Based on SacPORT Substance Abuse Management Module (SAMM)
- Harm reduction/recovery oriented model
- Learn about biological impact of substance use (psychoeducation)
- Learn more effective coping strategies (behavioral and problem solving oriented group)

Peer Symptom Management Group

- Skills based group
- Identify symptoms
- Reduce and manage stressors
- Build social skills
- Learn about healthy habits related to diet, sleep, etc.
- Gain peer support

Expressive Arts Group

- Non-verbal, artistic expression of stressors, symptoms and distress
 - Music, writing, visual art, dance
- Gain social skills
- Gain peer support
- Learn symptom management through building healthy coping skills

Supported Education/Employment

- Returning to work or school is often a key wellness goal for our clients
- SEE services are an integral component of mental health treatment rather than a separate service (Crowther et al., 2001)
- Services are based on client's preferences and choices
 - Assessment of goals
 - Education about skills needed to reach goals
 - Guidance in obtaining support/skill development
- Serves as the liason between team and other services (work, school)
 - Employment → Coaching on resume. Volunteer to build job skills THEN apply for jobs
 - Education → Support via 504 or IEP THEN return to regular setting

Peer/Family Support

- Direct services targeting mental health & functioning treatment goals provided by
 - *Peer: individual with lived experience with the illness*
 - *Family: have a family member who is a consumer with the illness*
- Integrated part of the team at all levels
- Assessment of needs at the beginning of treatment
- Supports treatment goals – problem solving, communication, social skills.
 - Co-leads groups (FSG, MFG)
- Shares story – provides hope
- Assists in accessing benefits and services in the community
- Supports during transition to ongoing care at end of 2 yrs in program

How do we start a program?

- What are the truly CORE components?
 - A multi-disciplinary team
 - Need at least a clinician, psychiatric care, and support staff
 - Training in assessment and treatment (CBTp, MFG)
 - Someone who can supervise you/consult in an ongoing way
 - Outreach to community → need to be ready when referrals come in
 - Can add other components as you build a census
 - Make sure you have cross-training and coverage!
 - Ok to share staff with other programs, BUT they have to be able to function in the team and respond to crises

Sale, T. and S. Blajeski, Steps and Decision Points in Starting an Early Psychosis Program. 2015: NASMHPD Publications.

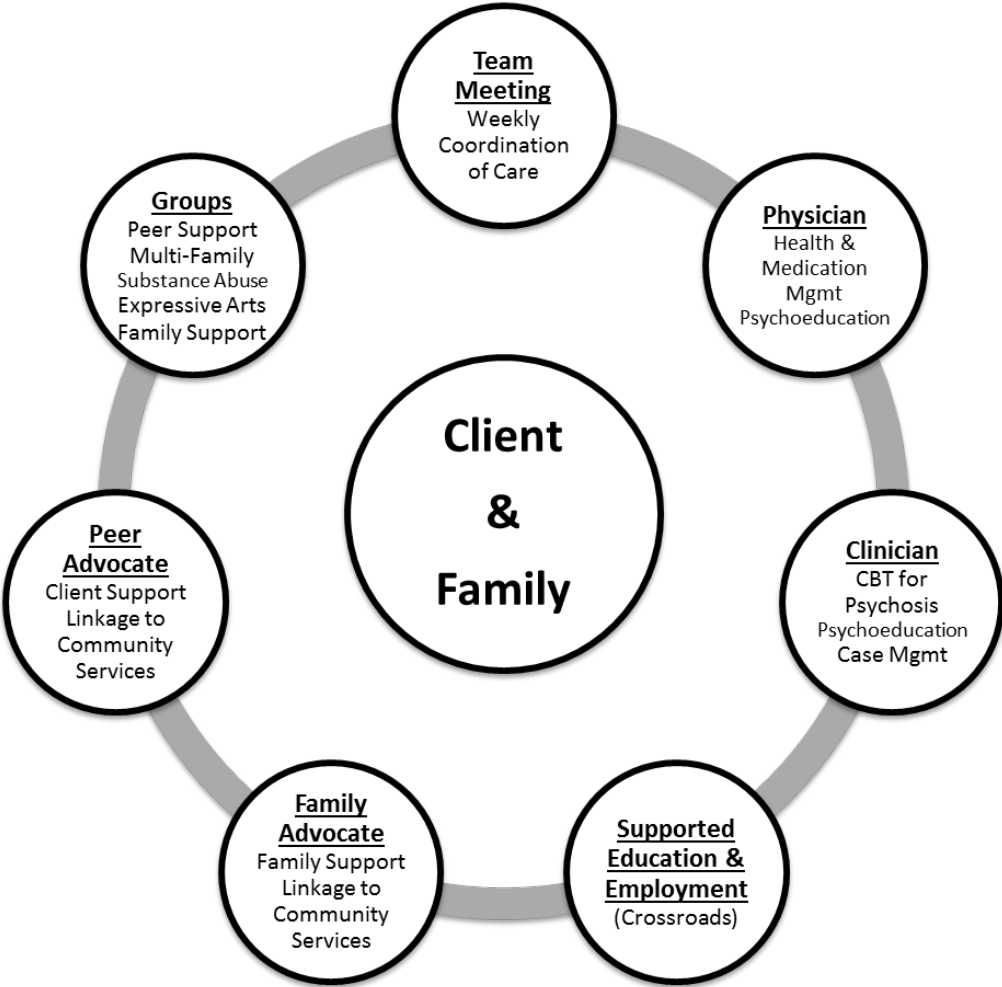
http://www.nasmhpd.org/sites/default/files/KeyDecisionPointsGuide_0.pdf

SacEDAPT

Coordinated
Specialty Care

Treatment Approach

The Model in Action



Vignette

Beginning of Treatment

- Anna is a 17 year old Asian woman completes the initial assessment process which included both clinical and MD intakes. Her initial diagnosis is Psychosis NOS with onset of psychotic symptoms 6 months ago.
- Anna lives with her parents, two younger brothers, and paternal grandmother in a rented house. Her parents report increased stress and tension at home since Anna started experiencing symptoms. They share that they are unfamiliar with mental health diagnoses and do not have any prior experience of seeking mental health services. They are worried about Anna's ability to recover and return to her daily activities, as well as her potential to have a job in the future.
 - *Clinical team reviews case, determines eligibility for services.*
 - *A primary clinician and MD are assigned to the case*
 - *Clinic Coordinator reaches out to schedule appointments with the team*

Vignette

- Anna experiences:
 - Auditory hallucinations: Anna has reported she hears a male voice that is critical and comments negatively about her choices. She has been observed responding to this voice by family and friends; this greatly disturbs them and embarrasses Anna. Some friends are starting to avoid her.
 - Negative symptoms including anhedonia and avolition: Anna has begun isolating herself in her room and avoiding interactions with family and friends.
- *Clinician meets with Anna and her family for welcome session: provides feedback on the assessment results, psychoeducation about psychosis symptoms, and the SacEDAPT treatment model. Anna and family members are encouraged to participate in groups and return for a follow up in 1 week.*
- *Clinician works with Anna and her family to develop treatment plan*
- *Psychiatrist meets with Anna and her family to develop medication treatment plan*
- *Family Advocate (FA) reviews the client's clinical assessment and her treatment goals in preparation for meeting her and her family*

Vignette

- Once an “A” student, Anna’s grades have been progressively falling this year and she is now in danger of failing several classes. She is at risk of not graduating on time from high school. She struggles to stay organized and has difficulty completing assignments. Education is highly valued by Anna’s family so this situation is causing much distress at home.
 - *Clinician introduces the family to the clinic’s Supported Education services*
 - *Supported Education Specialist (SES) reaches out to Anna’s parents to schedule a needs assessment*
 - *FA reaches out to Anna’s parents to schedule family needs assessment. Shares lived experience as a mother whose daughter had a similar experience and provides encouragement that things will get better. Identifies other areas where family needs support.*

Vignette

- In the past year, Anna has been hospitalized twice for danger to self, which was prompted by her responding to directives from her auditory hallucinations. This experience was very traumatic for the family:
 - ✓ They were shocked that their daughter would think about harming herself
 - ✓ They had difficulty coordinating care between the hospital and Anna's outpatient provider
 - ✓ They did not fully understand the explanation of treatment provided by Anna's psychiatrist in the hospital
 - ✓ Anna was uncooperative and tried to leave the hospital, which required the use of restraints
- *Clinician systematically evaluates DTS/DTO and develops a safety plan with Anna and her family, including how to call police if needed.*
- *Psychiatrist reviews Anna's current medications to determine if they are adequately controlling her symptoms.*

Vignette

- Family Advocate meets with family, introduces role, and then assesses their needs.
 - Family identifies strong ties to their ethnic community. Anna's parents share how grandmother is having trouble understanding Anna's experience as a mental illness due to a cultural belief in the spirit world. Grandmother is more open to Anna receiving treatment after a spiritual cleansing ritual performed by a shaman failed to improve her well-being.
 - Anna's parents have many questions about psychosis and concerns about medication. They have an interest in also pursuing herbal remedies and other non-Western treatments.
- *FA gets a sense of what additional psychoeducation would be helpful so this can be discussed by the team. FA makes a note to also provide materials in grandmother's native language.*
- *FA makes a note to inform the psychiatrist about the family's concern about medication and interest in non-Western approaches to encourage open communication.*

Vignette

- Family Advocate meets with family, introduces role, and then assesses their needs.
 - Anna's mother lost her job six months ago and is having trouble finding work. Computer skills would increase her chances of finding employment.
 - *FA identifies possible linkage to no-cost computer literacy program and resume workshop available through a local organization.*
 - Anna's father has a steady job at a warehouse. However, the family is starting to worry about paying rent and their bills. They are worried about having to file for bankruptcy.
 - *FA offers linkage to benefits, e.g. Cal Fresh, SSI, to help supplement the family's income. FA identifies ways to reduce bills via money-saving programs, e.g. CA Life Line program, SMUD and PG&E utility assistance programs.*
 - *FA suggests possible need for referral for no-cost legal advice on bankruptcy.*

Vignette

- Anna's family members are struggling to deal with the change in her behaviors at home. One sibling is angry that Anna doesn't have to do chores anymore; the other sibling is confused and afraid when Anna responds to her voices. This has caused conflict amongst the siblings and the parents are having difficulty setting boundaries and communicating effectively.
- Regular conversations now seem to escalate into arguments. Anna's parents are worried because the constant arguing is upsetting Anna. They have observed her crying on several occasions because she feels badly for affecting her family.
 - *Clinician encourages all family members to come to session to problem solve and work on communication. Clinician provides psychoeducation about stress and its role in increasing symptoms.*
 - *Clinician encourages participation in Multi-family group and Family Support group*

Vignette

- The family is interested in getting support for communication but unsure about attending group. They state they don't want other people to know about their problems and are a "private" family.
 - *Clinician invites FA to the next session to share lived experience in Multi-Family Group.*
 - *FA works to understand their concerns and normalize the fear and worry associated with attending group therapy. FA shares personal accounts and attempts to help the family in understanding potential benefits, despite the discomfort they might initially feel. FA shares how the group is a welcoming and understanding environment.*
 - *FA and Anna's clinician discuss how to help the family learn to respond to Anna's symptoms and current level of functioning.*

Vignette

Hospitalization

- Anna is hospitalized again for danger to self. She has stopped taking her medication. Family reported that she tried to hurt herself with a knife, the police were called, and she was transported to the hospital.
 - *Clinic Coordinator reaches out to hospital social worker to facilitate coordination of care. Asks for hospital to coordinate medication changes with Psychiatrist.*
 - *FA reaches out to the family: 1) identifies need to review the hospitalization experience with the family and offer support, 2) FA provides collateral support to the family by reviewing their rights and options during the hospitalization, including how to communicate with hospital staff, 3) FA offers to attend discharge planning meeting to advocate/support the family*

Vignette

Resumption of Outpatient Treatment

- Anna and her parents are welcomed to the SacEDAPT program by Anna's assigned clinician and psychiatrist.
 - *Clinic Coordinator ensures all hospital records and labs are obtained and available for the team*
- The psychiatrist wants to restart Anna on antipsychotic medication and invites FA to join the session. The psychiatrist discusses the use of herbal remedies with Anna's parents and provides feedback on possible interactions. Anna is somewhat reluctant to try the new medications given the possible side effects. Her parents are not comfortable with Anna starting medication.
 - *FA shares her lived experience facing a similar decision*
 - *FA encourages Anna and her parents to discuss their concerns further with her psychiatrist*
- After reviewing the pro's and con's further with the psychiatrist, Anna, with the support of her parents, decides to complete a trial of the medication to see if there will be potential benefits.

Vignette

Clinician Appointment

- Stress at home and concerns about Anna's performance in school dominates her therapy sessions. Anna feels too tired and stressed to attend and has been refusing to go to school. She often isolates in her room at home, saying she "can't do anything right!"
 - *Clinician asks FA and SES to reach out to Anna and her family.*
 - *The FA works with Anna's parents to help them understand how setting small goals and offering praise will give Anna a sense of pride and accomplishment for tasks she is able to complete.*
 - *The SES supports Anna's parents in connecting with her school to help her obtain an IEP for academic support.*

Vignette

Team Meeting

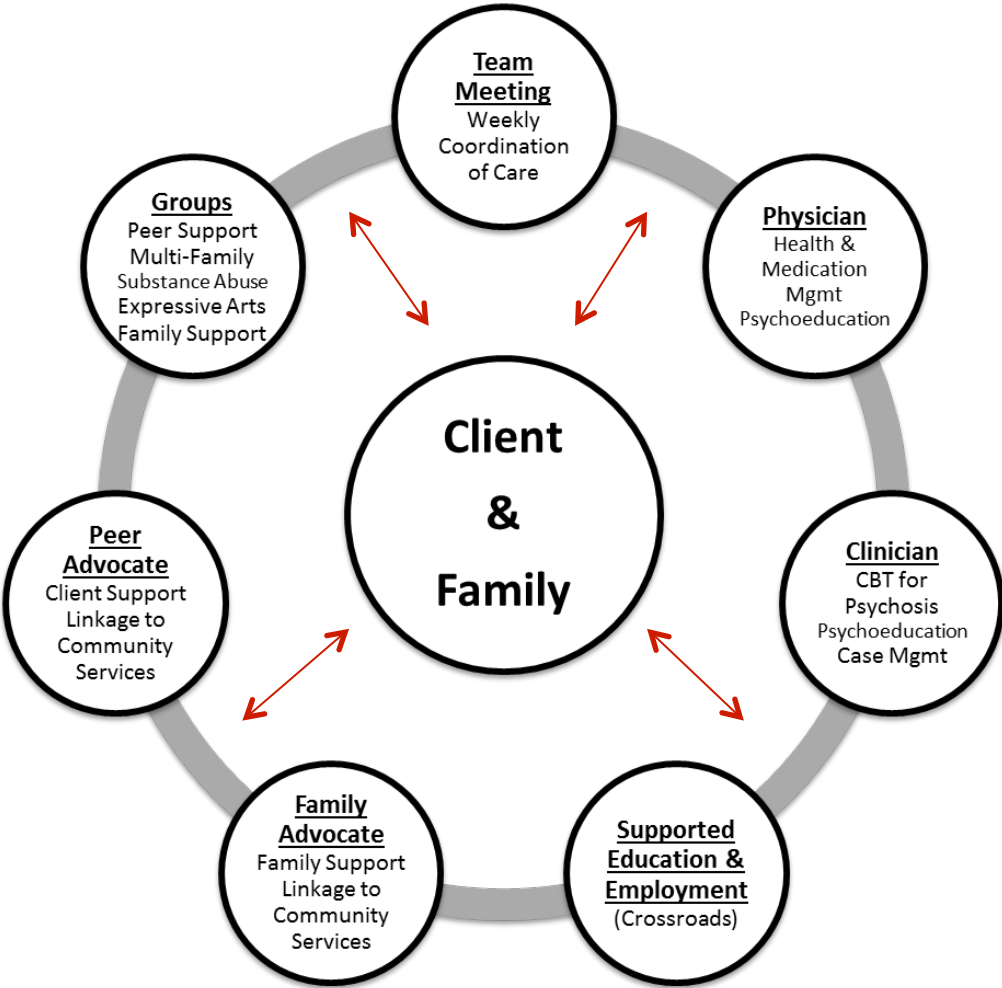
- Anna's clinician reports that Anna's family is now participating in Multi-Family Group to help with communication and boundary setting at home. Last week this group worked on helping Anna's family reestablish structure at home and brainstormed ideas; the family selected creating a chore chart.
- Psychiatrist reports that Anna's symptoms seem to be reducing on a low dose of Risperdal.
- Supported education reports that she is scheduled to attend the IEP with the family the following week.
 - *The clinician asks FA to check in with the family on their progress at home.*
 - *FA calls Anna's parents to ask how the chore chart is working, discusses their challenges with getting started, and offers encouragement to keep going.*

SacEDAPT

Coordinated
Specialty Care

Treatment Approach

The Model in Action



References & Resources

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More References & Resources

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Upcoming Webinar

SAMHSA/CMHS Webinar – *New Resource Materials on Addressing First Episode Psychosis: Product Overview*

Tuesday, November 15, 2016, 2:00-3:30pm Eastern Time

Register at:

[https://jbsinternational.webex.com/jbsinternational/
onstage/g.php?
MTID=e8e8f5d4370c3bd91e22a94a44ccb1706](https://jbsinternational.webex.com/jbsinternational/onstage/g.php?MTID=e8e8f5d4370c3bd91e22a94a44ccb1706)

Upcoming Webinar

**BHCOE Webinar- *Managing First Episodes of Psychosis
The Role of Medications***

Thursday, December 15, 2016, 11:00-12:00pm PST

Register at:

[http://uc-d.adobeconnect.com/bhcoewebinar4/event/
event_info.html](http://uc-d.adobeconnect.com/bhcoewebinar4/event/event_info.html)

Suggested Videos

- Implementing Early Treatment of Psychosis: RAISE Connection
 - <https://www.youtube.com/watch?v=zNnP1qZJnVI>
- Dr. Aaron Beck: Cognitive Behavioral Therapy for Schizophrenia
 - <https://www.youtube.com/watch?v=bpPoJnFjisY>
- Cognitive Restructuring in Schizophrenia
 - <https://www.youtube.com/watch?v=JG0w1lg3eyA>
- CBT Treatment Goals for Schizophrenia
 - <https://www.youtube.com/watch?v=eosGflfle3c>

QUESTIONS??