

The NAVIGATE Team Members' Guide

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**A Part of the NIMH-Funded NAVIGATE Program for First Episode
Psychosis**

Clinician Manual

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The NAVIGATE Program for First Episode Psychosis Authorship of Manuals

NAVIGATE Psychopharmacological Treatment Manual

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NAVIGATE Psychosocial Treatment Manuals

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Chapter 1

An Introduction to the NAVIGATE Team Members' Guide

Please Read First:

NAVIGATE is a comprehensive intervention program for people who have experienced a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and recovery. More broadly, the NAVIGATE program helps consumers navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, on the job, at school, and in the social world. The NAVIGATE program includes four different treatments, each of which has a manual: NAVIGATE Psychopharmacological Treatment Manual, Supported Employment and Education, Individual Resiliency Training (IRT), and Family Education. There is also a Team Members' Guide that describes the overall NAVIGATE structure and how team members work together, and a manual for the Director of the NAVIGATE team.

The manual you are reading now describes the NAVIGATE structure and how team members work together.

Welcome to NAVIGATE! As a member of the NAVIGATE team, you will be participating in an exciting new program aimed at treating individuals with a first episode of psychosis in a comprehensive, specifically tailored program designed to improve the long-term outcome of schizophrenia-spectrum disorders. The NAVIGATE team includes the following 5 people:

- The *Director*, who also works with families as the *Family Education clinician*
- The *Prescriber*, who provides pharmacological treatment
- A *Supported Employment and Education specialist* who helps the client get back to school or work,
- Two *Individual Resiliency Training clinicians* who help clients understand their disorder and how to manage it, and develop resiliency skills for achieving their personal goals

The NAVIGATE team works collaboratively with the client, and family or other significant persons, to provide state-of-the-art treatment for first episode psychosis. As team members, you have both individual and shared responsibilities for instilling hope in people recovering from a first episode of psychosis, helping them establish and work towards personally meaningful goals, and providing the best treatment available for their illness in order for them to get back their lives.

As the NAVIGATE team, you will all work together to learn more about first episode psychosis and its treatment, and helping each individual find his or her own pathway to recovery. The goal of NAVIGATE is *recovery*, which is defined as helping the individual achieve optimal role functioning at school, work, social and leisure adjustment, self-care skills, and a sense of positive well-being and purpose. One of the most important ingredients for meeting these goals are your own personal beliefs, and your team's shared beliefs, about each person's ability to recover from a psychotic episode—to put it succinctly, your hope and belief in recovery. Your ability to work and learn together as a team, and to work with clients and other significant persons in their lives, is critical to your clients' ability to achieve recovery.

The *NAVIGATE Team Members' Guide* provides information that all team members need to know, including basic information about NAVIGATE, the rationale for developing the program, its core defining elements, and specific information about how the program works. The *Guide* begins by providing background information about schizophrenia and establishing the importance of developing effective treatments that could alter the long-term trajectory of the disorder. Research on the treatment of first episode psychosis in programs developed abroad is reviewed, as well as the limitations of applying those treatment models to the U.S. mental health service system. A rationale is then provided for the psychosocial component of treatment in the NAVIGATE, informed by the special needs of persons with a first episode of psychosis.

An overview of NAVIGATE is then provided, followed by logistics of staffing, role responsibilities, and meeting times. Then, information about the engagement of clients and families into treatment is provided. This is followed by consideration of the timing of implementing the different NAVIGATE services.

All members of the NAVIGATE team need to have a core set of clinical competencies. These competencies are described in Chapter 5 of this *Guide*. Next, in Chapter 6, guidelines are provided for conducting collaborative treatment planning and treatment reviews that include the client, family members, and other significant persons working alongside the NAVIGATE team. Such a collaborative approach to treatment ensures that all stakeholders are working together to improve the client's life.

Information about government-funded disability benefits programs, including the decision about whether or not to apply for such benefits, is an important issue facing many persons, and family members with a first episode of psychosis. All members of the NAVIGATE team need to be familiar with these issues. Team members will need to work collectively the client and family to make difficult decisions about applying for benefits. Issues related to applying for benefits are covered in Chapter 7 of the

How to Use the NAVIGATE Manuals

Detailed manuals exist for three of the psychosocial parts of NAVIGATE, including Individual Resiliency Training, the Family Education Program, and Supported Employment and Education. These manuals provide curriculum for clients and family members, as well as guidelines for clinicians. The manuals may seem overwhelming at first, but as you become familiar with them you will find them easy to use with first episode psychosis clients.

The purpose of the NAVIGATE training is to familiarize the clinician with the background and philosophy of each intervention, and how to find the critical information in each of the manuals. No one is expected to master all the material contained in each manual during the limited period of training available. The real learning in NAVIGATE takes place using the manual and materials in sessions with clients and family members, participating in NAVIGATE team meetings and supervision, as well as receiving feedback and answers to questions from expert consultants in each intervention.

As you learn about NAVIGATE and use one of the Interventions, it is perfectly okay to have your manual with you during sessions with the client. It is also desirable for you to be familiar with the session guidelines, handouts and worksheets in advance. Such preparation helps with a mutual learning process between the clinician, the client, and family members. Everyone has something important to teach the other, and shared learning experience will be helpful to working together on the client's goals.

Collaboration Is the Key to NAVIGATE

NAVIGATE provides a forum for professionals to work together with clients and families, with each individual adding their own expertise and experience. Learning in the NAVIGATE program is reciprocal, with clinicians learning from clients and families, and vice versa. Similarly, you can expect to learn from expert consultants while you learn NAVIGATE, just as they will be learning from you.

Each person who has had an episode of psychosis has to discover his or her own road to recovery. NAVIGATE is designed to provide tools to help individuals get onto their own pathways to recovery, and to navigate the challenges of their mental illness by choosing among a broad range of treatments for helping them achieve their goals. As you start in this learning experience, keep an open mind and expect to have your stereotypes of persons with a major mental illness challenged, and to be awakened by the unique needs and potential of persons with a first episode of psychosis and their families. Your awareness of each individual's capacity to become a productive member of society provides an important message to clients and family

members that having a mental illness does not prevent one from striving to reach one's goals and being valued by others for who they are and their contributions to their community.

We look forward to working with you on NAVIGATE, and learning alongside you as you work together as a team to help each person achieve their personal vision of recovery.

Chapter 2

Background and Rationale

NAVIGATE has been developed to provide the best treatment possible for individuals in their first episode of psychosis. The program was developed in response to the National Institute of Mental Health (NIMH), who requested that researchers develop and test interventions designed to improve the trajectory and prognosis of schizophrenia. This NIMH research program is called Recovery After an Initial Schizophrenia Episode, or RAISE. NAVIGATE was developed by a team of clinical researchers led by Dr. John Kane at the Zucker Hillside Hospital in New York and colleagues from institutions including Dartmouth Medical School, University of North Carolina at Chapel Hill, Harvard Medical School, Yale Medical School, University of Calgary, UCLA, and SUNY Downstate Medical Center.

The Long-term Disability of Schizophrenia

Schizophrenia is a major mental illness characterized by psychosis, negative symptoms (e.g., apathy, social withdrawal, anhedonia), and cognitive impairment. Depression and substance abuse commonly co-occur. These clients can have impaired functioning in the areas of work, school, parenting, self-care, independent living, interpersonal relationships, and leisure time.

Among adult psychiatric disorders, schizophrenia is the most disabling. Only 1% in the general population have schizophrenia, but over 30% of all spending for mental health treatment in the U.S. was accounted for by schizophrenia—about \$34 billion in 2001 (Mark et al., 2005). The high cost of treating schizophrenia is only one dimension of the impact of the illness, which has major effects on individuals, families, and society.

The toll of schizophrenia arising from premature death, family caregiving, unemployment, criminal justice costs, and physical and emotional distress is staggering (Samnaliev & Clark, 2008). According to the World Health Organization (Murray & Lopez, 1996), the combined economic and social costs of schizophrenia place it among the world's top ten causes of disability worldwide. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, and to reduce the global burden of the illness.

The Problem of First-Episode Psychosis Treatment

Many studies show that the greater the duration of time that a person with first episode of psychosis goes untreated, the more problems occur. For example, the longer the duration of untreated psychosis, the longer it takes to stabilize the psychotic symptoms, and the worse the person's overall functioning following symptom stabilization. Experts believe that early intervention could improve the quality of life and reduce the level of disability among people with schizophrenia.

Why Don't People with Schizophrenia Get Early Treatment?

On average, people endure new psychotic symptoms for many months, and sometimes even years before receiving any psychiatric treatment for their disorder (Häfner et al., 2003; Perkins et al., 2005). People may delay treatment due to the stigma of mental illness and schizophrenia (Corrigan, 2004; Judge et al., 2005). Other treatment providers, such as general practitioners, may not refer a person due to lack of awareness of the signs of psychosis. Family members are often aware that something is unusual is happening, but may not know that the changes are signs of a treatable mental illness. Family members also may be afraid to help their relative get treatment due to stigma or lack of understanding about the nature and treatment of the disorder. Rather than getting treatment, people with psychosis often end up in jail for their mental illness-related behaviors (Teplin, 1994; Teplin et al., 1996).

Problems with Early Treatment

Even when treatment for a first episode of psychosis is successfully started, people often have problems in treatment that is not attuned to their unique needs and goals. Treatment may be incomplete, including medication but no teaching of illness self-management skills (such as the prevention of relapses) or other skills training for living independently. When medication is provided, non-adherence is a major problem, which leads to increased relapse rates and more problems with daily functioning (Robinson et al., 1999).

Model Treatment Programs for First Episode Psychosis

Major advances in treatment programs have been made for persons with a first episode of psychosis. Thus far, all of the treatment development and research on model programs for first episode psychosis have occurred outside of the U.S., primarily in Australia, New Zealand, Europe, and Canada.

Research shows that programs designed for people with first episode psychosis lead to improvements in symptoms and functioning. For example, in an Australian treatment program (Early Psychosis Prevention Intervention Center: EPPIC), 65 individuals were treated and followed for 8 years after initial treatment (Mihalopoulos et al., 2009). At 8 years follow-up, people who received EPPIC treatment had lower levels

of symptoms, and were doing better than people who received standard public mental health services. Additionally, treatment of people in the specialized EPPIC program cost one-third as much as treatment for those in usual care because it was more effective.

Limitations of Treatment Models Developed Abroad for the U.S. Context

Some of the treatment programs that were developed abroad are not feasible to implement in the U.S., for several reasons.

First, the treatment programs developed abroad have usually been offered in systems where the entire population in a particular area is covered by a regional medical system that takes responsibility for the health of the population, allowing for the use of fully employed teams, outreach, and public education approaches. In contrast, the U.S. has fragmented treatment and payment systems, in which no single organization or service takes full responsibility for the treatment of people with psychosis. Also, all of the comprehensive treatment models for first episode psychosis have been provided in large cities that allow for use of a full time team. However, in the U.S., these services are usually provided by local community mental health centers (CMHCs) that serve smaller geographic catchment areas, such that staffing a first episode program presents different challenges.

Second, an important part of first episode psychosis programs developed abroad has been the use of a major public health campaign to educate the general population about psychosis and its treatment. These campaigns have been combined with outreach and education to people who are likely to have contact with individuals first experiencing psychotic symptoms, including school teachers, police, doctors, emergency room staff, and clergy. In the U.S., such major public education campaigns and outreach efforts are not a priority. In some ways, the U.S. system appears to focus more on preventing people from entering treatment until the symptoms are so bad that treatment is unavoidable, rather than trying to engage individuals with psychosis into treatment early in order to improve people's lives and prevent long-term disability.

In summary, NAVIGATE is a response to the need to develop a program for the comprehensive treatment of people with first episode of psychosis that can be implemented and funded within the current U.S. public health care system.

Conceptual Framework of NAVIGATE

Goals of NAVIGATE

The goal of NAVIGATE is *recovery*. In recent years the concept of recovery has taken on broad meanings that are personally important to mental health consumers. For example, according to Anthony (1993), "recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

New perspectives on recovery do not focus on the severity or persistence of psychiatric symptoms, but rather on the person's ability to experience a rewarding and meaningful life—even while the person may be managing or coping with existing symptoms. This way of thinking about recovery is consistent with models of *positive health*, which say that mental health is associated with leading a life of purpose and having quality connections with others (Ryff & Singer, 1998).

The *President's New Freedom Commission Report* (2003) has affirmed the pursuit of this type of recovery as a valid focus of treatment. According to the *Report*, "Recovery is the process in which people are able to live, work, learn, and participate fully in their communities." The Commission has also called for a transformation of the mental health system and argues for a system focusing on consumers and their families as partners. Treatment choice should be guided by a process of shared decision-making with recovery as the primary goal.

NAVIGATE embraces this newer view of recovery. Specifically, we define *recovery* in terms of:

- *Social/leisure functioning* (e.g., quality of social relationships, involvement in leisure activities, independent and self-care living skills)
- *Role functioning* (e.g., school, work, parenting)
- *Well-being* (e.g., self-esteem, hope, sense of purpose, enjoyment of life).

Impact of the Illness on Recovery Domains

People with schizophrenia have psychotic symptoms, negative symptoms, cognitive impairment, depression, and problems with substance abuse. *Psychotic symptoms* and *negative symptoms* are defining characteristics of schizophrenia. *Impaired cognitive functioning* can interfere with work, independent living, and social relationships (Green, 1996; McGurk & Mueser, 2004). Similar to cognitive impairment, *depression* is a common feature of schizophrenia, although not included in the diagnostic criteria. Depression may be the first sign of the illness before onset of psychotic symptoms (Häfner et al., 1999) and is one of the most persistent syndromes

over time (Häfner & an der Heiden, 2008). Furthermore, young persons who have had a first episode of psychosis are especially vulnerable to *suicidal ideation* and *suicide attempts* (Power, 2004). Finally, one-half of individuals with this disease develop substance use disorders (abuse or dependence), and thus substance abuse is included as part of schizophrenia.

All of the symptoms described above may be present in people with a first episode of psychosis. These symptoms have a negative impact on recovery, including social/leisure functioning, well-being, and role functioning. Therefore, one general approach to treatment is to indirectly improve recovery outcomes by directly targeting the psychiatric illness itself.

Illness Management

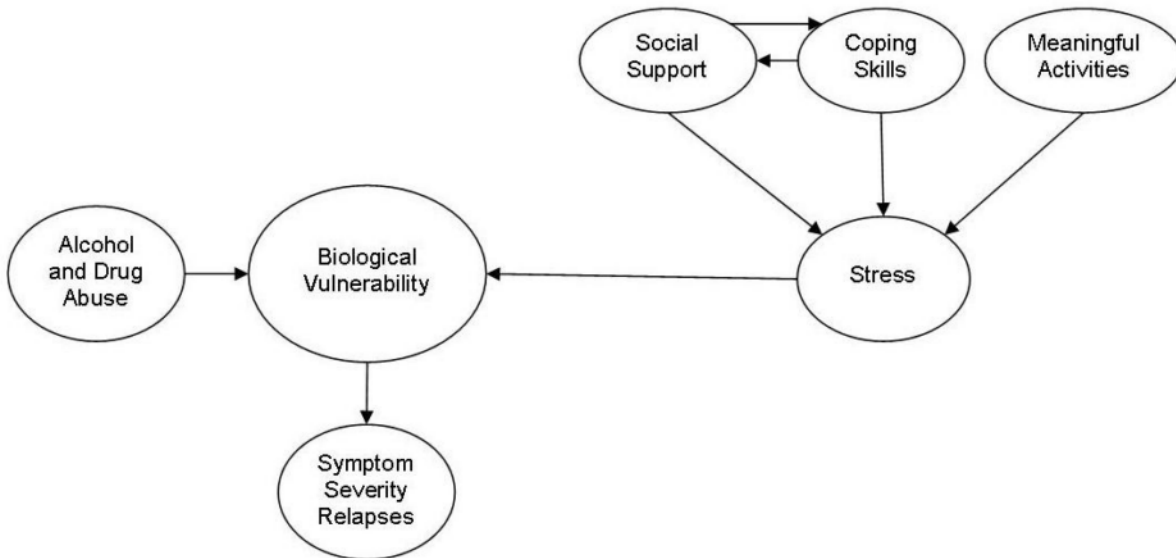
Illness management helps people achieve recovery by teaching and helping them control symptoms and prevent relapses so that they are better able to pursue their personal recovery goals. Illness management approaches to the treatment of schizophrenia derive from the stress-vulnerability model (Lieberman et al., 1986; Nuechterlein & Dawson, 1984; Zubin & Spring, 1977).

The Stress-Vulnerability Model. This model (see Figure 1) states that schizophrenia is caused by both psychological and biological vulnerabilities. *Biological vulnerabilities* are determined early on in life by genetic and early environmental influences. Once the vulnerability is established, the onset and course of the illness, including relapses and psychosocial functioning, is determined by both biological and psychosocial factors.

Stress, such as upsetting life events, can lead to relapses and worsening of functioning. However, *social support* can minimize the effects of stress on vulnerability, as can the individual's *coping skills* for dealing with stress and his or her involvement in meaningful activities.

Substance abuse is another important biological factor that can impact a person's vulnerability, leading to relapses of psychosis and hospitalizations.

Figure 1 - Stress Vulnerability Model



The principles of illness management based on the stress-vulnerability model are straightforward. The outcomes of schizophrenia can be improved through reducing biological vulnerability and stress, and by improving social support and coping skills.

Biological vulnerability can be reduced in two ways. First, *adherence to antipsychotic medications* can reduce biological vulnerability by changing the way nerve tracts in the brain function. Tracts that use the neurotransmitters dopamine and serotonin are believed to play a central role in causing the symptoms of schizophrenia, and these are improved by antipsychotic medications. Second, since substance abuse can worsen biological vulnerability, *substance abuse treatment* can also reduce this vulnerability.

Treatments that reduce stress in the environment, increase social support, or increase client coping can all reduce symptom severity and prevent relapses. Environmental stress in the family can be reduced by providing *family education* aimed at teaching the family about the nature and principles of treatment for schizophrenia, obtaining their support for the client's involvement in treatment, and learning low stress strategies for communication and solving problems together. Environmental stress can also be reduced by helping the client get involved in *meaningful activities that structure the person's time* without being overly demanding. *Client coping skills* can be bolstered in several ways, including providing clients information about schizophrenia and its treatment, and teaching them strategies for:

- managing stress
- monitoring symptoms

- preventing or minimizing symptom relapses
- coping with persistent symptoms
- using social skills to garner social support.

Psychiatric Rehabilitation

Treatment can also focus *directly* on helping people work towards recovery outcomes. Three psychiatric rehabilitation approaches are used in NAVIGATE to address the different parts of recovery and are shown in Figure 2. *Supported employment/education* targets improved *role functioning*, *social rehabilitation* targets *social and leisure functioning*, and *resiliency training* targets *personal well-being*. In addition, *family (and other social) support* can facilitate progress towards client goals.

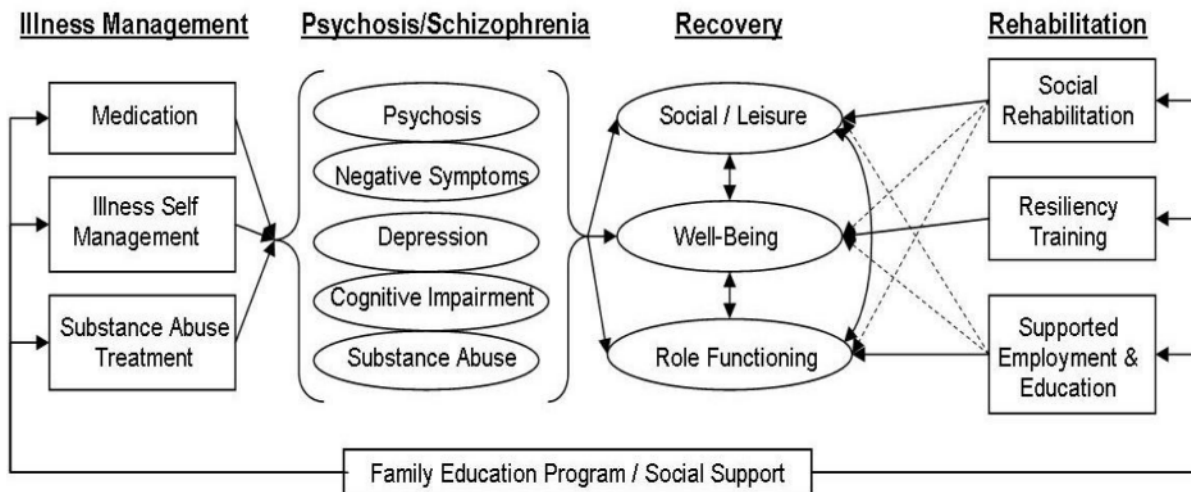
Supported Employment. This is the most effective approach for improving competitive employment outcomes in people with severe mental illness (Bond et al., 2008). A trained employment specialist provides individual services to all clients who have work as a goal. The goal is to find competitive work in community settings (not sheltered or transitional work) with a rapid job search (rather than long vocational assessments or prevocational training). The employment specialist pays attention to client preferences (e.g., type of job and decision about disclosure to employers), and provides follow-along supports after the client starts a job (rather than closing cases after the client obtains a job) (Becker & Drake, 2003). These principles of supported employment have also been used help people with recent first episode of psychosis with their educational goals (Killackey et al., 2008; Nuechterlein et al., 2008).

Social Rehabilitation or Skills Training Methods. Social rehabilitation methods help people develop better social, leisure, and independent living functioning (Kurtz & Mueser, 2008). Typical teaching methods to improve social skills include modeling, role playing, feedback, and practice of skills in session and in natural settings. People who develop psychosis often already have impaired social functioning. They may have lost friends following a psychotic episode. Efforts to help social adjustment can make a big difference and are included in comprehensive first episode programs (Falloon et al., 1998; Herrmann-Doig et al., 1993; Petersen et al., 2005).

Building Hope and Resilience. Clients value a sense of well-being, including positive emotions, self-esteem, hope, and a sense of purpose. Resilience, the ability to spring back from adverse life experiences (Neenan, 2009), is relevant when considering the life altering effect of a psychotic episode. The Individual Resiliency Training part of NAVIGATE emphasizes hope and resiliency. This is especially important for people with a first episode of psychosis, who may have a sense of hopelessness and loss of control (Perry, Taylor, & Shaw, 2007).

Family and Other Supports. Family, friends and others in a clients network can help the client with illness management and other types of rehabilitation or by providing direct assistance in attaining goals (Compton & Broussard, 2009; Mueser & Gingerich, 2006).

Figure 2 - Conceptual Model for Treatment of First Episode Psychosis



Special Issues for People with a First Episode of Psychosis

The development of NAVIGATE was informed by two special issues for people with first episode psychosis: getting back on their developmental track and processing the trauma of the onset of psychosis.

Getting Back on Track

The onset of psychosis knocks young people off of their developmental path (such as completing high school, going to college to become a professional, or parenting a young family). The longer the psychosis goes untreated, the more delay the individual may experience. People who have recently experienced a psychotic episode are acutely aware of their functional problems, which adds to feeling demoralized and hopeless (Birchwood et al. 1998; Lewine, 2005).

When planning treatment and setting goals, age and developmentally appropriate goals that are based on the individual's culture, family, and personal history should be identified. NAVIGATE clinicians work with clients to identify and address goals that are designed to support development. This focus helps to engage and retain clients in treatment because it maximizes the relevance of the program to their lives.

Processing the Trauma of Psychosis Experiences

People who have psychosis, such as frightening hallucinations and delusions, and have had aversive treatment experiences (such as involuntary hospitalization or being placed in physical restraints), frequently describe these experiences as traumatic (Williams-Keeler et al., 1994). These traumatic experiences can lead to distressing symptoms of posttraumatic stress disorder (PTSD), such as upsetting memories of psychotic symptoms or negative treatment experiences, avoidance of stimuli that remind the person of the events (including reluctance to take medication), and increased physiological arousal (Mueser et al., 2010). Furthermore, these events may trigger stigmatizing beliefs about mental illness that contribute to maladaptive functioning (Corrigan, 2004; Penn et al., 2005).

Clients and their relatives need the opportunity to process the experience of the psychosis in a family member and to become hopeful about the prospect of recovery (Jackson et al., 2009). NAVIGATE provides a forum for the client and family members to talk about the psychosis. Staff can correct inaccurate and stigmatizing beliefs about mental illness. The program also provides the opportunity to enhance their resiliency as they face the challenges before them. A sense of resiliency develops as the person develops and uses coping strategies. This process also allows clients and families to avoid developing maladaptive coping responses that may occur in the absence of specially designed treatment (e.g., withdrawal, resignation, or disengagement).

Chapter 3

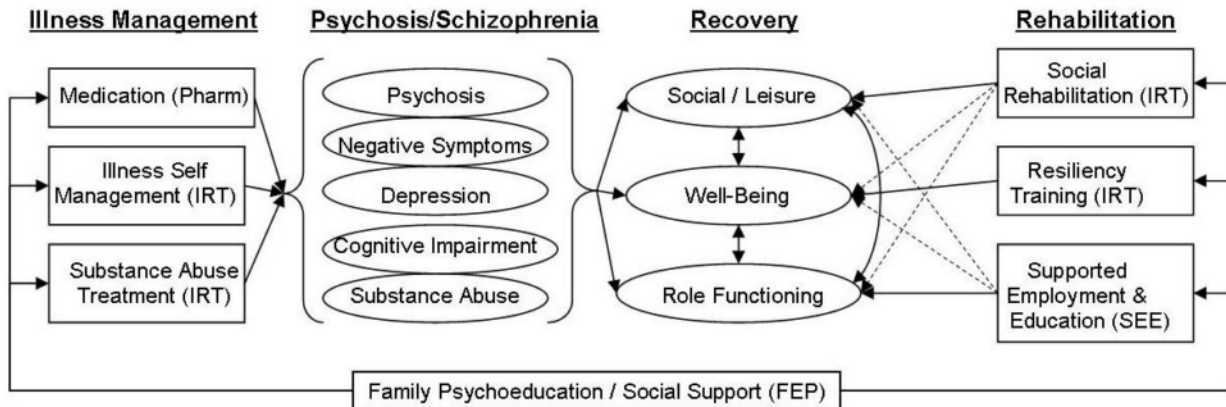
Overview of NAVIGATE

NAVIGATE is a comprehensive treatment program for people who have had a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and get their life back on track. More broadly, NAVIGATE helps clients navigate the road to recovery from an episode of psychosis, including getting back to functioning well at home, work, and in the social world.

NAVIGATE includes four different treatments. They are informed by special issues faced by persons with a first episode of psychosis and include the treatments in the conceptual model, as described in Chapter 2 and depicted in the Figure 1 below. These interventions include

- *Individualized Medication Treatment* aimed at reducing symptoms and preventing relapses in order to help people achieve their desired goals.
- *Family Education Program* aimed at
 - Teaching families about psychosis and its treatment.
 - Reducing relapses by encouraging medication adherence and monitoring early warning signs of relapse.
 - Supporting the client's work towards personal recovery goals.
 - Reducing family stress through improved communication and problem solving skills.
- *Individual Resiliency Training* aimed at
 - Helping clients achieve personal goals by teaching them about their disorder and its treatment.
 - Processing the experience of psychosis.
 - Reducing self-stigmatizing beliefs.
 - Helping them learn social and resiliency skills.
- *Supported Employment and Education* are aimed at
 - Helping clients to develop education and employment goals related to their career interests.
 - Specialists work with clients to help them obtain jobs or enroll in educational programs.
 - Follow along supports are provided for all clients who are employed or in school to help them be successful.

Figure 1 - Conceptual Model for the NAVIGATE Program



Abbreviation Key

IRT = Individual Resiliency Training
FEP = Family Education Program
SEE = Supported Employment and Education
Pharm = Pharmacological Treatment

NAVIGATE is typically staffed by five mental health professionals who work together as a team to provide the interventions. They work in a collaborative fashion with the client and family or other significant persons. The NAVIGATE team members include:

- The Director, who coordinates and leads the NAVIGATE team, and provides the Family Education Program
- The Prescriber, who provides Individualized Medication Treatment
- Two clinicians who provide Individualized Resiliency Training and case management
- The Supported Employment and Education specialist

In treatment planning, staff involve and respect the client and significant other persons, and work alongside the NAVIGATE team, and focusing on identifying and implementing to help client achieve their individual meaningful goals. The choice, timing, and intensity of the different interventions in NAVIGATE is determined jointly by the client, family (or other significant persons), and NAVIGATE team. Treatment planning and review meetings with the client occur regularly to choose services, monitor progress towards treatment goals, and modify treatment plans in order to be as responsive and helpful as possible.

The Two Phases of NAVIGATE

The provision of NAVIGATE services is divided into two phases, including the Engagement and Stabilization Phase, and the Recovery Phase.

1. Engagement and Stabilization Phase

This phase is expected to last one to two months, depending on the client's clinical status (i.e., acutely psychotic vs. remitted). The goals of the phase are to:

- Engage the client and family into treatment, including meeting staff members of the NAVIGATE treatment team.
- Initiate assessment, goal setting, and treatment planning.
- Initiate and adjust medication to reduce or stop acute symptoms.
- Address urgent basic needs (housing, medical, and legal).

Engaging client and his or her relatives in services is critical as soon as possible following the psychotic episode. The engagement of relatives is most likely to be successful during a time of crisis, when the family may be more open to acknowledging stress, expressing concerns, and receiving help from mental health professionals. Providing family education during the Engagement and Stabilization phase can immediately reduce some of the guilt, blame, or depression experienced by relatives, and enlist their long-term involvement in the client's treatment.

Engaging clients into NAVIGATE is facilitated by the early exploration of the client's goals for treatment, based on the individual's own preferences and values, and the assessment of areas of need. This work sets the stage for treatment planning. Staff first help clients identify and set client-centered treatment goals in the Engagement and Stabilization Phase and continue this process in the Recovery Phase. As clients meet different members of the NAVIGATE team and learn about their roles, they get orientated to the overall program, and get motivated to participate as they begin to understand how NAVIGATE helps people achieve their goals.

The use of medication is a key part of early treatment and is usually necessary to reduce or stop psychotic symptoms. Once psychotic symptoms are controlled or eliminated, clients can participate in treatment more fully and effectively. Pharmacological treatment often helps engage clients by reducing distressing symptoms as staff try to understand and work with the client to address his or her most prominent concerns.

Attending to urgent client needs such as housing, health, and legal issues can also help engage the client and family into the NAVIGATE program. As the IRT clinician addresses basic needs and develops a therapeutic relationship with the client, stress on

both the client and relatives or other significant persons can be reduced, reinforcing participation in NAVIGATE. Similarly, for many clients and significant others, the ability of the NAVIGATE team to resolve urgent client and/or family needs is a prerequisite for successful engagement into the program.

2. The Recovery Phase

The length of this phase varies depending upon each client's needs and progress towards personal goals. Most clients will remain active in NAVIGATE treatment for at least two years. Treatment planning and review meetings are held at least every six months with the NAVIGATE team, the client, and relatives (or significant other persons) to review progress, modify plans, or make new ones as needed.

The Recovery Phase includes the four different parts of NAVIGATE, each tailored to the individual client and relatives (or other natural supports): 1) Individualized Medication Management, 2) Family Education Program, 3) Supported Employment and Education, and 4) Individual Resiliency Training, which incorporates case management. These treatments are typically introduced during the Engagement and Stabilization Phase, and continued in the Recovery Phase. The frequency of sessions or meetings is tailored to the client's (and family members' or other significant persons') needs, goals, and preferences.

Individualized Medication Management focuses on use of antipsychotic medication to reduce or stop psychotic symptoms, and to prevent relapses while minimizing side effects. Other medications may be used to treat other symptoms, such as depression and anxiety.

There are four stages of the recovery framework for planning the Family Education Program (FEP): 1) managing the crisis, 2) stabilization and facilitating recovery, 3) consolidating the gains, and 3) prolonged recovery. Each stage has goals and interventions. The first stage occurs during the Engagement and Stabilization Phase and the other three stages occur during the Recovery Phase. FEP is usually delivered over 6-8 sessions, with more sessions provided when there are more problems, conflict, and stress.

Supported Employment and Education (SEE) begins as soon as it is possible. In some cases it may need to wait until after the client's acute symptoms have been stabilized. This service is provided to all clients who want to work, attend school, or both, regardless of the presence of ongoing symptoms. SEE services are continued as long as needed to support the client while they return to work or school.

Individual Resiliency Training (IRT) is provided by a clinician, usually on a weekly or biweekly basis. The focus of IRT is on helping clients achieve personal goals through developing their own personal resiliency, and learning relevant information and skills about how to manage their illness and improve their functioning. The curriculum in

IRT is taught on a modular basis, with all clients receiving a core set of Standard modules, including:

- Orientation
- Assessment/Initial Goal Setting
- Education about Psychosis
- Relapse Prevention Planning
- Processing the Psychotic Episode
- Developing Resiliency—Standard Sessions
- Building a Bridge to Your Goals

Additional modules can also be taught in IRT, based on the client's needs and goals, as determined by the client and clinician, with input from other NAVIGATE team members, relatives, and other significant persons. The other modules include:

- Dealing with Negative Feelings
- Coping with Symptoms
- Substance Use
- Having Fun and Developing Good Relationships
- Making Choices about Smoking
- Nutrition and Exercise
- Developing Resiliency—Individualized Sessions

Implementing NAVIGATE

More specific information about NAVIGATE that all team members need to know is provided in the following chapters of this NAVIGATE Team Members' Guide. In addition, further information is provided in the following manuals:

- Director's Manual
- Psychopharmacology Manual
- Family Education Program Manual
- Individual Resiliency Training Manual
- Supported Employment and Education Manual

Chapter 4

Logistics of Implementing NAVIGATE

This chapter addresses four issues about implementing NAVIGATE, including:

- The staffing and role responsibilities of NAVIGATE team members.
- Structural aspects of the program with respect to meeting times for the NAVIGATE team, supervision, and collaborative treatment planning and reviews.
- The timing of engagement of clients and families in treatment and provision of NAVIGATE interventions.

Staffing and Role Responsibilities of NAVIGATE Team Members

The staffing of the NAVIGATE team includes five individuals:

- The *NAVIGATE program Director* (M.A. level), who in most agencies also serves as the *Family Education Program clinician*
- The *Prescriber (or other qualified prescriber)*
- The *Supported Education and Employment specialist*
- *Two Individual Resiliency Training clinicians*

Each member of the NAVIGATE team has specific roles and responsibilities are outlined in Table 1 below, and described in more detail in the manuals for NAVIGATE. The rationale for the staffing is provided after the table.

Table 1: Roles and Responsibilities of the NAVIGATE Staff *

Roles and Responsibilities	Program Director*	Prescriber	Supported Employment & Education Specialist	Individual Resiliency Training Clinicians
Leads weekly NAVIGATE team meetings	X			
Participates in weekly NAVIGATE team meetings	X	X	X	X
Develops relationships with community referral sources	X			
Recruits, coordinates, screens referrals	X			
Engages clients & family members in program	X			
Reviews progress with agency director in recruitment and implementation of NAVIGATE on monthly or quarterly basis	X			
Conducts family assessments	X			
Leads collaborative treatment planning & review meeting with client/relatives, initially and then every 6 months	X			
Participates in collaborative treatment planning & review meeting with client/relatives, initially and then every 6 months	X	Optional	Optional	Optional
Provides Family Education Program (FEP)	X			
Supervises Supported Employment & Education (SEE) specialist weekly	X			
Supervises Individual Resiliency Training (IRT) clinicians weekly	X			
Conducts diagnostic & symptom assessments		X		
Provides pharmacological treatment		X		
Conducts employment & educational assessments			X	
Provides SEE			X	
Receives weekly supervision on SEE from Director			X	
Conducts psychosocial functioning assessments				X
Provides case management				X
Provides IRT				X
Receives weekly supervision on IRT from Director				X

*This table assumes that the NAVIGATE Director also serves as the Family Education clinician

The Director has the primary responsibility for managing the NAVIGATE program, including monitoring and improving quality of services. He or she is the single point of contact for the program. The Director screens and recruit clients and family members into the program. He or she works with individuals both inside the organization and in the community to ensure that people with first episode psychosis get referred to NAVIGATE.

The Director engages clients and relatives into the program and assesses family needs for the Family Education Program. Having the NAVIGATE Director provide the Family Education Program, while the Individual Resiliency Training clinicians work with

individual clients, makes it easier for the clinicians to maintain a working alliance with the client, while the Director attends to maintaining a working alliance with the overall family.

Finally, the NAVIGATE Director supervises the Individual Resiliency Training (IRT) clinicians and the Supported Employment and Education (SEE) specialist. If the SEE specialist receives supervision from an established supported employment program, then the specialist receives supervision from, the primary focus of the supervision by the Director is to ensure that SEE services are sensitive to issues of persons with a first episode of psychosis and addressing client educational goals. The Director works to make sure that SEE services are well coordinated with the other services provided in NAVIGATE. If the SEE specialist does not receive supervision from a supported employment program, the Director's supervision addresses the above points as well as ensuring that the specialist follows the principles of SEE outlined in the manual.

The multiple roles of the NAVIGATE Director could be provided by more than one individual. For example, a sixth clinically skilled person could provide any combination of FEP, supervision for the IRT clinicians and SEE specialist, and lead the collaborative treatment planning and review meetings with the client and family members, with the Director maintaining the overall coordinating role for the team. For another example, a sixth person could be included on the NAVIGATE team to provide FEP, while the Director provides supervision, leads collaborative treatment planning and review meetings, and supervises the FEP clinician. For the reasons described above, it is preferable to have different clinicians provide the IRT and FEP.

The Prescriber performs diagnostic assessments and elicits client preferences, goals, and values in order to guide the medication treatment. He or she assesses symptoms, collaborates with clients and relatives regarding pharmacological treatment, and participates in treatment planning and NAVIGATE team meetings.

A Supported Employment and Education (SEE) specialist is included on the NAVIGATE team to help clients seek and get work or further their education. Consistent with evidence-based supported employment (Bond et al., 2002), the SEE specialist's responsibilities are focused on working with clients to achieve their vocational or educational goals, and do not involve the SEE specialist providing clinical or case management services. The SEE specialists actively participate in regular NAVIGATE team meetings.

At treatment team meetings, the SEE specialist may bring important clinical issues related to the client's school or work functioning to the attention of the NAVIGATE team (e.g., symptoms, medication side effects, non-adherence to medication), which may be addressed by other members of the team. For example, the Prescriber may make changes in the client's medicines, an Individual Resiliency Training (IRT) clinician could teach the client how to better cope with symptoms, or the Director could work with the family to address problems with medication taking. The

SEE specialist then may implement and/or evaluate the effects of these interventions on school or work performance. The SEE specialist also helps clients develop strategies for overcoming or coping with cognitive difficulties that interfere with vocational or educational goals.

The Individual Resiliency Training (IRT) clinicians work with clients to help them set and achieve their personal recovery goals. They:

- Facilitate the development of clients' personal resiliency skills.
- Provide them with information about their psychiatric disorder and the principles of its treatment.
- Teach strategies for reducing distress and coping with symptoms.
- Help clients improve their social and leisure functioning.
- Prevent or address problems related to substance use or health (e.g., smoking, poor nutrition, sedentary lifestyle).

The IRT clinicians also provide case management, and participate in regular NAVIGATE team meetings.

At NAVIGATE team meetings the IRT clinicians update the other team members on the client's progress and difficulties in learning information and skills as the client works towards goals. The IRT clinicians strategize with other NAVIGATE team members to overcome obstacles. The IRT clinicians also help to address problems noted by other NAVIGATE team members. For example, the Prescriber might bring the problem of a client's suicidality or antipsychotic weight gain to the attention of the team, or the SEE specialist could note the effects of symptoms on the client's work or school functioning. Based on team consensus and discussion with the client, the IRT clinician could teach skills for reducing distress and coping with suicidal thinking, help the client improve his or her nutrition and exercise to minimize weight gain or lose weight, or help the client develop coping skills to deal with symptoms at work or school.

Structural Aspects of NAVIGATE

In order to function effectively, the NAVIGATE team is expected to meet regularly for specific activities. Three types of meetings are involved, including *NAVIGATE treatment team meetings, supervision meetings, and collaborative treatment planning and review meetings* (with the client and family or other significant persons). The frequency, duration, and nature of these meetings are summarized below.

NAVIGATE Team Meetings

- All of the members of the NAVIGATE team meet weekly to develop possible ideas for preliminary treatment plans for new clients, discuss and review progress towards treatment goals for established clients, and to identify and address other issues related to the clinical management of each client's disorder.
- NAVIGATE team meetings are led by the Director and last 30-60 minutes, depending on the number of clients in the program and the complexity of their treatment needs.
- As new clients are enrolled in the program, preliminary treatment planning meetings are held on a weekly basis as needed, as part of regular NAVIGATE team meetings. Information about these preliminary meetings is provided in Chapter 6 on Collaborative Treatment Planning in the NAVIGATE Team Members' Guide.

Supervision Meetings

- The NAVIGATE Director meets with the two IRT clinicians on a weekly basis for one hour to provide supervision for implementing the IRT intervention.
- Brief guidelines for supervision of IRT are provided in the Director's Manual, and more extended guidelines are in the IRT Manual.
- The NAVIGATE Director meets with the SEE specialist on a weekly basis for one hour to supervise the implementation of SEE and to ensure that the services are fully integrated with the other components of NAVIGATE.
- Brief guidelines for supervision of SEE are provided in the Director's Manual, and more extended guidelines are in the SEE Manual.

Collaborative Treatment Planning and Review Meetings

- Within one month of the client's enrollment in the NAVIGATE program, a one hour collaborative treatment planning meeting is held with the client, his or her

relatives or other significant persons (if applicable), the Director, and any other members of the NAVIGATE team who are involved in the treatment plan.

- Every six months after completing the initial collaborative treatment plan a collaborative treatment review and planning meeting is held with the client, his or her relatives or other significant persons, the Director, and any other members of the NAVIGATE team who have been or will be significantly involved in the treatment plan.
- Information about collaborative treatment planning and review meetings is provided in Chapter 6 on Collaborative Treatment Planning in the NAVIGATE Team Members' Guide.

Timing of Engagement of Clients and Families in Treatment and Provision of NAVIGATE Interventions

NAVIGATE provides a comprehensive array of services for persons who have experienced a recent episode of psychosis. The individual needs of clients and their family members (or other significant persons) vary from one person to the next, as may their willingness and motivation to participate. In order to avoid overwhelming the client and family during the Engagement and Stabilization Phase of NAVIGATE, while at the same time presenting them with options for engaging in the NAVIGATE interventions, it is crucial that the NAVIGATE team members are sensitive to the client's and family members' preferences regarding the extent and intensity of services they want to receive. In addition, because there is significant overlap in the curriculum taught in the Family Education Program and the Standard modules of the Individual Resiliency Training (IRT) intervention, guidelines are needed for how to teach this information when clients are involved in both interventions.

Engagement of Clients and Family Members in NAVIGATE

The Director will engage most client and family members (or other significant persons, hereafter referred to as "family members" or "relatives" for the sake of simplicity) into NAVIGATE. For clients who live with family members or have significant other, we recommend the following sequence of engagement steps:

1. The Director meets with the client to describe NAVIGATE, and enlists interest and willingness to participate in it (several meetings may be necessary). When the client expresses interest in NAVIGATE, the Director finds out about involved family members, and obtains permission to contact a key relative about the program.
2. The Director calls the key family member to briefly explain NAVIGATE and sets up a meeting with him or her and any other involved family members to discuss the

program in more detail. The Director meets with these family members to describe the NAVIGATE program, and enlist their willingness to participate in it.

3. The Director meets with the client and involved family members to provide a formal orientation to NAVIGATE, using the Orientation to the NAVIGATE Program handout in the FEP Manual (approx 20-30 min). The Director then explores the client's interest in participating in FEP sessions. If the client and family are interested, the Director schedules the first family session at a mutually agreeable date, preferably within one or two weeks of the Orientation meeting. If the client is not interested, the first FEP session is arranged with the relatives.
4. After reviewing the Orientation handout and arranging the first FEP session, the Director briefly introduces the client and relatives to the IRT clinician and SEE specialist (and Prescriber, if available). He or she sets up meetings with the IRT clinician, the Prescribers, and, if the client is interested, a meeting is set up with the SEE specialist, preferably in the community where most SEE services are provided.
5. After the client and family members have been introduced to the rest of the NAVIGATE team:
 - A. The Director meets with the relatives to begin the assessment for the FEP, and at the same time
 - B. The IRT clinician meets with the client to begin IRT, and agree on a desired frequency of initial meetings.

There are numerous acceptable variations to this sequence of engagement activities. For example:

- The family may contact the Director first, in which case Steps 1 and 2 are reversed.
- The Director (or other NAVIGATE team member) may meet the client and relatives together for the first time, in which case Steps 1 and 2 are combined.
- After the Orientation to NAVIGATE and meeting the NAVIGATE team members the client or relatives may be tired, so that meetings to begin FEP and IRT are set for a subsequent date (Step 5), preferably within a week or two of the Orientation meeting.
- If the client is highly symptomatic and still in the process of having his or her symptoms stabilized, the Director may arrange for the client to meet briefly with the IRT clinician, initiate FEP sessions with just the relatives, and postpone the first meeting with the SEE specialist.

- The client may initially feel discouraged or ambivalent about discussing what they want to accomplish related to employment or education, and may be reluctant to set up an appointment with the SEE specialist. The SEE specialist should be understanding of the client's ambivalence, while remaining hopeful. The SE specialist should explain that the purpose of the meeting is to get to know each other, and that the client does not have to agree to any work or school related plans at this point. If the client still doesn't want to meet with the SEE specialist, then the IRT clinician should explore work or school functioning later in the context of assessment and setting goals with the client.

When the client is engaged in NAVIGATE, but no family members are involved, the engagement process and initiation of NAVIGATE services follows a similar but simpler sequence than described above:

1. The Director meets with the client to describe NAVIGATE, and enlists interest and willingness to participate in it (several meetings may be necessary). When the client expresses interest in NAVIGATE, a meeting is set up to provide an orientation to the program.
2. The Director meets with the client to provide a formal orientation to the NAVIGATE program, using the Orientation to NAVIGATE handout in the IRT Manual (approx 20-30 min). This meeting can involve the IRT clinician, who will be working most intensively with the client.
3. After reviewing the Orientation handout, if the client has not yet met the IRT clinician, the Director briefly introduces the client to the IRT clinician and SEE specialist (and Prescriber, if available). If the client is interested and willing, a date to meet with the SEE specialist is arranged, preferably in the community.
4. After the client has been introduced to the rest of the NAVIGATE team, he or she meets with the IRT clinician to begin IRT, and agree on a desired frequency of initial meetings.

As described with engagement of the client when family members are involved, numerous acceptable variations in the engagement process are possible.

Client Involvement in Family Education Program (FEP)

Clients may vary in terms of how much they choose to be involved in the FEP, with three broad categories of involvement:

- The client is involved in all or nearly all FEP sessions
- The client participates in either part of the FEP sessions (e.g., either the first or last 20-30 minutes of each session) or in some sessions but not others

- The client participates in no FEP sessions

While it is the client's choice to participate in FEP sessions, the Director should encourage him or her to participate for several reasons. First, educating family members about the client's psychiatric disorder is often more effective when the client is present since he or she can provide personal examples of symptoms and effects of the illness on his or her life. This may serve as a "rallying point" around which the family can work together. Second, educating the client and family members together is more economical than providing education separately, which requires twice as much clinician time. Third, teaching the principles of treatment to the client and relatives together is more effective because it involves helping the family work together to address important issues, such as medication adherence and developing a relapse prevention plan. Fourth, working with the client and family together can often alert the FEP clinician to the presence of problems in communication and problem-solving that would otherwise be impossible to directly observe. Stressful communication and poor problem-solving skills evident in FEP sessions could then be addressed by providing the family with Modified Intensive Skills Training, focusing on communication and problem solving.

Overlapping Content Between FEP and IRT

Some clients attend FEP sessions along with their relatives, and others do not. Much of the educational material covered in FEP is the same as the material in the Standard modules of IRT. When the client is actively involved in FEP and attends some or all of the FEP sessions, IRT can be adapted to avoid overlap of educational information.

Adaptations to the provision of IRT for clients who are actively engaged in FEP involve using IRT sessions to briefly review any educational material covered in FEP, and to make up sessions of FEP that the client missed during individual IRT sessions. More specific information on these adaptations is provided in the IRT manual.

Chapter 5

Core Competencies of NAVIGATE Team Members

Core competencies are the basic skills necessary for all members of the NAVIGATE team. The following core competencies are part of the entire NAVIGATE program: shared decision-making, strengths and resiliency focus, motivational enhancement skills, psychoeducation teaching skills, cognitive-behavioral teaching skills, and collaboration with natural supports. These specific competencies are described below.

Shared Decision-Making

Shared decision-making means that treatment decisions are made by the client and clinician together, as partners, and based upon the client's desired goals. When family members or other significant persons are involved in the client's life and participate in NAVIGATE, they can also be involved in the decision-making process. Each partner contributes his or her own specialized knowledge and experience to making decisions, in contrast to traditional hierarchical decision-making in which "patients" are expected to passively follow the "doctor's orders."

An assumption of shared decision-making is that clients (and relatives) need critical information to make informed decisions, but that ultimately it is the client who decides on the treatment (Deegan et al., 2008). Involving and respecting the ability and right of clients to make their own treatment decisions recognizes the reality of where the choice lies. Clinicians who use this approach build the therapeutic relationship. Ignoring the person's desires or using coercion undermines the therapeutic relationship (Fenton, 2003).

In shared decision-making, treatment staff give evidence-based information about treatment that is individualized for the specific client the client gives information about his or her values, goals, and preferences. The two collaborators then discuss and negotiate a treatment plan that both believe is reasonable (Towle & Godolphin, 1999). This approach serves to empower the client and tear down internalized stigma (Corrigan, 2005). More information on the shared decision-making approach to treatment planning is described in Chapter 6 on Collaborative Treatment Planning.

Strengths and Resiliency Focus

NAVIGATE focuses on client strengths and resiliency. Resiliency means the ability to spring back from adverse life experiences. Traditionally, goal-setting in

psychiatric treatment and rehabilitation has been focused on the reduction or elimination of problems or deficits, such as symptoms, inappropriate behavior, or social withdrawal. For individuals who have already had many setbacks in their lives, the focus on deficits can worsen self-esteem.

When clinicians help clients to focus on their individual strengths and resiliency, clients and family become more aware of (and feel better about) their personal positive attributes. They become more aware of how they have previously used these abilities to cope with life challenges and achieve goals, and how they can use these attributes in the present and future. Focusing on strengths and resiliency not only makes people feel better about themselves and their efforts, but it helps clinicians tailor treatment to each individual and their family within their unique community.

A strengths-based approach is also consistent with positive psychology, which focuses on strengths and well-being, rather than limitations and negative emotions. This approach extends to reaching one's potential and deriving meaning from one's life, including self-acceptance, positive relations with others, and environmental mastery. People with a first episode of psychosis respond well to this focus on personal growth and developing meaning in life (Uzenoff et al., 2008).

Motivational Enhancement Skills

Motivation refers to the intention to follow-through with an action. Problems with sustaining motivation to follow through on desired plans and goals are one of the defining negative symptoms of schizophrenia ("avolition"). Low motivation is often present in people with a first episode of psychosis, and contributes to poor adherence to treatment and worse psychosocial functioning. Treatment providers can use specific techniques within all of the NAVIGATE services to help clients become more motivated.

Throughout NAVIGATE, one of the most basic approaches to enhancing the client's motivation to participate actively in treatment is the identification of personal goals. This includes helping clients to break down long-term goals into smaller and more manageable steps. Then, s/he explores how learning new information and skills (including about the treatment and management of one's psychiatric disorder) can help the client achieve his or her goals. Clinicians can use many other strategies for enhancing clients' motivation to become actively involved in their own treatment and make behavioral changes consistent with attaining their goals (Miller & Rollnick, 2002; Mueser et al., 2003). Some other examples of motivational enhancement include:

- Expressing empathy regarding the challenges the client faces.
- Supporting self-efficacy by instilling hope that the person is capable of making changes.

- Encouraging clients to think and dream about what they want out of their lives, and how they can achieve their goals.
- Reframing past challenges and setbacks as opportunities to identify personal strengths and survival skills that can be used in the future.
- Weighing the “pros” and “cons” of a health behavior (e.g., taking medication, using alcohol or drugs).
- Reinforcing “change talk” when the client is considering making a change that is consistent with treatment recommendations or his/her personal values and goals.
- “Rolling with resistance” instead of opposing it when the client is ambivalent about change, by affirming that ambivalence is normal. Clinicians can learn more about and address the client’s concerns about the anticipated change.

Psychoeducational Teaching Skills

Psychoeducation involves providing information about psychiatric disorders and their treatment to clients, family members, and other significant persons. Clients and their relatives need to understand what various treatment and rehabilitation options are and which are available in order to participate in the informed, shared decision-making that is the backbone of NAVIGATE.

Clinicians can use a variety of teaching strategies to help clients understand the information and to make it relevant to them. Common teaching strategies include:

- Presenting information verbally.
- Using and reviewing written handouts together.
- Asking questions to check understanding of information.
- Invite questions about the psychiatric disorder and its treatment.
- Asking clients for their experience related to the material.
- Adopting the language of the client and family to ensure that terms and concepts are understandable to them.
- Avoiding conflict by seeking common ground when there are disagreements between the clinician and client or family members, or between the client and family members, on topics such as diagnosis, symptoms, treatment experiences or the explanatory model for understanding psychosis.

Cognitive-Behavioral Therapy (CBT) Teaching Skills

A broad range of CBT approaches have been developed over the past several decades for both clinical and non-clinical populations (Bellack et al., 2004; Gingerich & Mueser, 2005; Kingdon & Turkington, 2004). Considering the most basic of all CBT skills, all NAVIGATE team members need to be able to use *positive verbal reinforcement* to encourage clients' participation in NAVIGATE, including setting personal goals, follow-through on home assignments and steps towards goals, following treatment recommendations, and active involvement in collaborative treatment planning and progress reviews.

NAVIGATE team members also need to know how to use *shaping*, or the reinforcement of successive approximations to a desired goal. This means that clinicians praise even tiny steps in the intended direction, whether it is steps towards the client's personal goal, improvements in symptom management, or involvement in making treatment decisions with the team.

In addition, there are many other CBT methods that work with first episode clients, including:

- **Skills training approaches** (e.g., modeling, role playing, positive and corrective feedback) to teach:
 - effective interpersonal skills (e.g., conversational skills, job interviewing, substance refusal, discussing medication issues with the Prescriber)
 - relaxation skills
 - skills for having fun
 - coping skills for persistent symptoms (e.g., hallucinations)
 - skills for coping with urges or cravings for alcohol or drugs
 - developing a relapse prevention plan to prevent psychosis
- **Cognitive restructuring** to change inaccurate or self-defeating thinking that leads to negative feelings, such as depression, suicidal thinking, anxiety, self-stigmatizing beliefs, and distress related to psychotic symptoms.
- **Teaching self-monitoring** to develop awareness of specific behaviors that may be targeted for change, such as smoking, eating, using alcohol or drugs, or talking to one's voices.
- **Conducting a functional or contextual analysis** in order to understand environmental or individual factors that contribute to or maintain behaviors of concern.
- **Behavioral tailoring** to incorporate new and more adaptive behaviors into the client's daily routine (e.g., taking medication) by developing natural environmental prompts for the behavior (e.g., placing the medication next to the coffee pot so s/he takes it after s/he gets up).

Clinicians need to use CBT to address skills and behaviors of specific interest to the client (Corrigan & Holmes, 1994). All of the NAVIGATE team members will do some CBT teaching. Basic knowledge of CBT teaching skills is critical to the overall success of the program.

Collaboration with Natural Supports

Natural supports are people who have a relationship and regular contact with the client who can help the client manage his or her psychiatric illness or make progress towards personal goals (Rapp & Goscha, 2006). Examples of natural supports include family members, friends, employers, and self-help group members.

Working with natural supports related to the client's treatment goals is important for several reasons. First, because of their regular contact with the client, natural supports are in an ideal position to help clients take steps towards personal goals or encourage them to follow up on treatment recommendations. Second, some natural supports may inadvertently undermine the client's treatment (e.g., discouraging taking medication), facilitate or encourage use of alcohol or drugs (e.g., indiscriminately give the client money that is spent on substances, using substances with the client), or interfere with progress towards goals (e.g., discouraging the client from returning to school or work because of fear that stress will provoke a relapse). Third, engaging natural supports can make new resources available to the client that would otherwise not have been tapped (e.g., a job lead, a useful suggestion, a potential role model). Work with natural supports also aims to help individuals repair relationships that may have been damaged during the prodromal period or acute episode of psychosis, in order to prevent a loss of supportive relationships.

Chapter 6

Collaborative Treatment Planning

Collaborative treatment planning is a process involving all of the members of the NAVIGATE team, working together with the client and family members or other significant persons. This type of treatment planning is necessary in order to ensure that all perspectives regarding a client's needs and desires are taken into account. Most importantly, the client's goals are honored and validated. Then all stakeholders have input into the treatment plan and are willing to support it. Two assumptions are key to this process (Adams & Grieder, 2005):

- Each client is viewed as a person of worth, and is respected as such.
- Each client has the right to self-determination, including the choosing of one's goals that are the focus of treatment.

After the initial treatment plan is made, regular treatment reviews are important in order to evaluate progress towards goals. Periodic assessments of progress (e.g., monthly) are done at NAVIGATE team meetings. However, collaborative treatment review meetings with the client (and family or other supportive persons) are also important. The client and team consider new approaches for goals for which limited progress has been made. They make plans to address new goals that have emerged over the course of treatment. They evaluate the need for continued treatment and plan for ending treatment when there is no more work to be done.

Scheduled Treatment Planning and Review Meetings

An initial treatment planning meeting including the NAVIGATE team, client, and family members, when they are involved, is generally held within one month of the client joining the program. Collaborative treatment review meetings are conducted at least once every six months, and more often when necessary (e.g., when there is clear lack of progress towards goals within just a few months of initiating the treatment plan). Review meetings also include the NAVIGATE team, client, and family members or significant others. Both treatment planning and review meetings focus on identifying client goals, client strengths, treatment needs, and methods for providing effective services to help clients achieve their goals.

Prior to a collaborative treatment planning meeting that includes the client and family members (or other significant persons), the NAVIGATE team has a preliminary meeting (during a regular team meeting) to share information and perspectives on the client's goals, psychosocial functioning, strengths, illness characteristics (e.g., symptoms), and family support. This meeting serves to identify proposed treatment

goals that the client appears likely to endorse, objectives related to those goals, and specific interventions designed to target those objectives.

Every six months after the initial treatment plan is completed, the team does a preliminary treatment plan review during their weekly team meeting, in anticipation of a treatment plan review with the client and his or her family. The different meetings involved in collaborative planning and reviewing progress towards treatment are summarized in Table 1 below.

Table 1: Meetings Related to Collaborative Treatment Planning and Reviews

Meeting	Team Members Present	When
Preparation for Collaborative Treatment Planning Meeting (approx. 20-30 min)	All NAVIGATE team members	3-4 weeks after client begins NAVIGATE, during weekly team meeting
Collaborative Treatment Planning Meeting (30-60 min)	NAVIGATE Director and most relevant team member(s), client, family members (or other supporters)	1 month after client begins NAVIGATE
Preparation for Collaborative Review Meeting (20-30 min)	All NAVIGATE team members	Prior to Collaborative Review Meeting, during weekly team meeting
Collaborative Review Meeting (30-60 min)	NAVIGATE Director and most relevant team member(s), client, family members (or other supporters)	Every 6 months after initial treatment plan has been developed

Assessment Domains

The domains of assessment can be divided into six broad areas, including:

- Recovery
- Psychopathology
- Illness management
- Health
- Family and other supports
- Basic living needs.

Each member of the NAVIGATE team is responsible for assessing specific areas of the client's functioning, with some areas assessed by more than one team member. Table 2 provides a list of different areas that are important to assess for treatment planning in persons with a first episode of psychosis, and which members of the NAVIGATE team are expected to have the most information about each area.

Table 2: NAVIGATE Assessments for Treatment Planning

Assessment Domains	NAVIGATE Team Members			
	IRT Clinician	Family Clinician	Prescriber	SEE Specialist
RECOVERY				
Client Goals	X	X	X	X
Strengths & Resiliency	X	X	X	X
Social - Leisure	X			
Work / School		X		X
Self-care / Independent Living	X	X		
Well - Being	X			
Spirituality	X			
PSYCHOPATHOLOGY				
Symptoms	X	X	X	
Substance Abuse	X	X	X	
Cognitive Functioning	X			X
Subjective Distress	X		X	
ILLNESS MANAGEMENT				
Medication Adherence	X	X	X	
Medication Side Effects			X	
Coping / Stress Management	X			
Relapse Prevention	X	X		
Knowledge of Illness	X	X		
HEALTH				
Weight	X		X	
Smoking	X		X	
Other			X	
FAMILY & OTHER SUPPORTS				
Family Relationships		X		
Relationships with Significant Others	X	X		
BASIC LIVING NEEDS				
Housing	X	X		
Finances	X	X		
Legal Problems	X			

With respect to the recovery domain, all NAVIGATE members elicit information from the client about his or her personal recovery goals or desired changes. Each person on the NAVIGATE team must develop a therapeutic relationship with the client, and establish goals that are the focus of collaborative work is an important bedrock for developing a strong working alliance (Horvath & Greenberg, 1989). In addition, because of the emphasis in NAVIGATE on identifying the individual strengths of each person and his or her family, as well as resiliency factors that could be further enhanced by participation in NAVIGATE, all team members are also expected to have information about the client's strengths and resiliency. Strengths and resiliency factors help clients achieve their personal goals.

The IRT clinicians usually have the most information about areas related to recovery, including social-leisure functioning, self-care and independent living, and well-being. The SEE specialist will usually have the most information on the client's work and school history and previous challenges, and the family clinician may have the most information about the client's self-care and independent living skills, as family members are often involved in helping the clients get their basic needs met. Family members may also have additional information about the client's work and school functioning and related strengths or interests.

In terms of psychopathology, both the Prescriber and IRT clinicians will usually have the most information about the client's symptoms and substance abuse. However, the family clinician may also have valuable information about symptoms and substance abuse that is based on input from family members. Similarly, the SEE specialist may have unique information about the client's symptoms based on observations made when working with the client towards his or her educational or work goals. Although formal cognitive assessment is not included as part of NAVIGATE, the SEE specialist has the most information about the client's cognitive functioning since strategies for evaluating cognitive difficulties contributing to work or school difficulties are included in the SEE manual. In addition, because the IRT clinician usually works most intensively with the client, using handouts, conducting role plays, and developing home practice assignments, that clinician may also have valuable information about the client's cognitive functioning, including his or her concentration, attention, and memory. The family clinician may also have information about the client's cognitive functioning, either from observations during family sessions or from family reports of cognitive difficulties.

Regarding illness management, the Prescriber, the IRT clinician, and the family clinician will all obtain information about the client's adherence to prescribed medication. The family clinician may have especially unique information because it comes from the family's perspective. Therefore, identifying clients who are not adherent to their prescribed medication, but who report to NAVIGATE team member that they take their medication, may be especially useful.

Medication side effects will be assessed mainly by the Prescriber, although they may be observed by any of the NAVIGATE team members. The client's coping strategies for dealing with symptoms and stress are determined primarily by the IRT clinician. The development of a relapse prevention plan is incorporated into both IRT

and the Family Education Program, and therefore clinicians implementing these services in NAVIGATE tend to have the best information regarding the client's ability to prevent relapses.

The client's health is a concern to all NAVIGATE team members, considering the high rate of smoking in schizophrenia-spectrum disorders (De Leon & Diaz, 2005), and the problem of weight gain associated with antipsychotic medications. Health functioning will be most specifically assessed by the Prescriber and the IRT clinician, as the interventions that each provide have the potential to impact those outcomes.

The quality, support, and strain in the client's family relationships will be assessed mainly by the family clinician, who will also evaluate the quality of relationships with other significant persons. The IRT clinician may also have additional information about the client's relationships with family members and other significant persons.

Although the grid provided in Table 2 indicates which members of the NAVIGATE team obtain specific types of assessment information, all team members have valuable information to contribute to the assessment of many of the different domains. This is especially true for treatment reviews, when each of the different team members may have spent significant amounts of time working with the client, and may have much more in-depth information about the client's functioning than they did in the beginning. For example, over the course of helping a client pursue his educational goals, the SEE specialist may develop knowledge about symptoms or medication side effects that are interfering with the client's ability to perform well in school. As another example, for some clients more family work may be done than individual IRT work, in which case the family clinician may learn more information about the client's social functioning, his or her well-being, and the person's ability to cope effectively with stress and symptoms. Treatment planning meetings provide the opportunity to share this information in order to develop and refine treatment goals as the client participates in NAVIGATE over time.

The Elements of a Treatment Plan

The core elements of a treatment plan include the client's individual goals, barriers to achieving each goal, objectives related to accomplishing each goal, client or family strengths and resiliency factors that can help achieve each objective, and interventions to achieve each objective.

Recovery goals are generally long-term and reflect the important accomplishments or changes the client would like to make in his or her life. Characteristics of good recovery goals include that they:

- Reflect client's hopes, wishes, aspirations, dreams, personal ambitions.
- Stated in client's own words.

- Are stated in positive terms (e.g., obtaining degree, improving relationship with parents) rather than negative terms (e.g., preventing relapses).
- Are personally meaningful to the client.

Barriers are anything that has interfered with the attainment of desired goals. Some barriers to achieving goals are typically related to the psychiatric illness, but others may not be. For example, psychiatric symptoms may have led to the client dropping out of high school and not being able to continue his or her studies, whereas the client's lack of knowledge about local GED programs could be a barrier to obtaining the desired degree.

Objectives are shorter-term steps towards achieving the client's goals. Objectives need to be specific and measurable to the extent possible, with a timeframe established for achieving each one. Objectives need to overcome any identified barriers to achieving the goal.

Client and family strengths and resiliency factors are identified that can help with the attainment of the objectives. A wide range of qualities and resources can be included as strengths and resiliency factors, including:

- Abilities, talents, hobbies
- Values, traditions
- Interests and hopes
- Resources and assets, such as money or skills
- Personal attributes, such as sense of humor, curiosity, determination, empathy, kindness, sensitivity to others, creativity, and adaptability
- Natural supports, such as family and friends

Interventions are then identified for helping clients achieve the stated objectives. For each intervention, a NAVIGATE team member is identified who is responsible for providing the intervention.

Developing a Preliminary Treatment Plan

Making a treatment plan that is truly collaborative, and involves input from all of the members of the NAVIGATE team, the client, and (when involved) family members or other significant persons requires time and coordination. An effective strategy is for the NAVIGATE team to first develop a preliminary treatment plan based on the assessments completed by each team member. Then, the team meets with the client (and family, etc.) to review the plan and make modifications as needed.

One NAVIGATE team member takes responsibility for developing a draft of the preliminary treatment plan. The most natural member of the team to do this would be the Director, but another team member could serve this purpose as well. When the NAVIGATE team members have completed their assessments, they provide a brief written summary to the team member who has been designated to develop the preliminary treatment plan. The “Client Assessments Information Worksheet” is useful for summarizing assessment information, and is included at the end of this chapter. The same worksheet is provided for all team members since any member could have useful information about any of the assessment domains.

Based on assessment information and input from the team, the Director (or other team member designated) develops a preliminary draft of the treatment plan, which is reviewed by the team at a weekly NAVIGATE meeting, and modified as needed. It will then be reviewed at the collaborative treatment planning meeting, as described below.

The Collaborative Treatment Planning Meeting

After a preliminary and tentative treatment plan has been developed, a meeting is scheduled with the client, family or other significant persons (if involved), and the NAVIGATE team. Not all NAVIGATE team members need to attend, but the presence of the Director and people who are most involved in treatment is ideal as they can answer questions the client or family may have about the recommended interventions.

The Director begins the meeting by thanking the client and family members for coming, and then gives out copies of the preliminary and tentative treatment plan to everyone, emphasizing that the final treatment plan will be driven by the client’s goals. The Director then walks the group through the plan, beginning with a review of the client’s recovery goals. The Director confirms with the clients that these goals are important. Barriers to achieving those goals are then briefly reviewed, followed by the objectives, and the rationale for each objective. Strengths and resiliency factors related to each objective are then reviewed, followed by a description of the recommended interventions. Questions are elicited and answered throughout the meeting, including providing more specific information about the interventions. The client may want changes to the treatment plan. These are discussed and added. When revisions are made to treatment plan, a revised copy is given to all of the participants, as well as all NAVIGATE team members, and everyone is thanked for their part in the process. Everyone is reminded that the treatment plan is a flexible document that will be modified based on changes in the client’s goals and progress.

Collaborative Follow-up Treatment Plan Reviews

Treatment plans are reviewed on a monthly basis to evaluate whether the interventions are being provided as planned, and to assess if the client appears to be benefiting from them. If there are problems implementing parts of the plan or if the client is not benefiting, the team discusses and problem-solves. If a major change in

the treatment plan is required, a new collaborative treatment plan is developed, using the same methods as the initial treatment plan.

Approximately six months after the initial treatment plan was developed, a second treatment plan review meeting is held. As with the initial treatment plan, NAVIGATE team members provide a brief written summary of the client's progress towards the objectives stated in the plan, any barriers, and any new objectives relevant to the client's goals. When new goals have been identified by the client, then they are also recorded. The person in charge of the plan puts this information into a draft of the treatment review, which summarizes progress towards the objectives, obstacles encountered, new objectives (if appropriate), new goals and associated objectives (if appropriate), and interventions recommended for achieving the objectives. The draft of this preliminary treatment review is then discussed with the NAVIGATE team, and modified as needed.

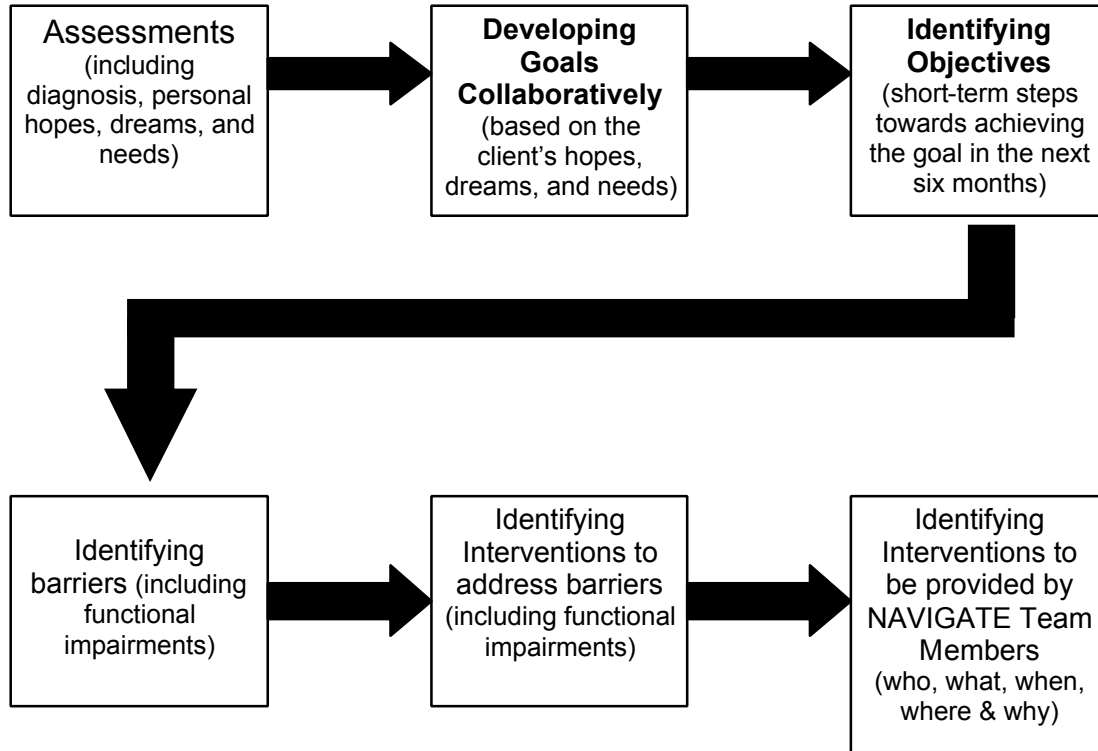
A second meeting is then set up with the NAVIGATE team, the client, and family members. The Director begins the meeting by thanking everyone for participating, and then briefly summarizes the original goals objectives and interventions in the plan. The client and family member are asked for their views on progress towards the goals and the client's involvement in the recommended interventions. The Director then gives out copies of the preliminary treatment review to the group. He or she goes over the views of the NAVIGATE team members about client progress, team recommendations for addressing objectives that have not yet been met, and their recommendations for new objectives and interventions for achieving them. Questions and concerns from the client and family members are discussed and added into a revised treatment review and given to everyone, including all NAVIGATE team members.

Addressing Medical Necessity

Many states require that all interventions in a treatment plan target impairments that are consistent with the person's mental health diagnosis—that is, they are justified based on "medical necessity." How can you use a person-centered approach to treatment planning while also meeting the medical necessity requirements?

As shown in Figure 1 below, the goals of treatment are life changes that the client wants to accomplish, expressed in his or her own words. The team's support of those goals ensures that the treatment planning process is person-centered and collaborative. The medical necessity requirement is met by making ensuring that all objectives clearly related to symptoms and impairments of the psychiatric disorder, and that recommended interventions target those symptoms and impairments to help clients achieve the objectives. When describing objectives that address illness-related problems, NAVIGATE team members should use language that is acceptable and understandable to the client and family.

Figure 1: Treatment Planning Flow Chart



Client Assessments Information Worksheet

Client: _____ Date Completed: _____

NAVIGATE Team Member(s) completing: _____

Date(s) of most recent session with client: _____

Instructions: Indicate assessment information for each of the following domains.

RECOVERY:

Client Goals: _____

Strengths & Resiliency: _____

Social / Leisure: _____

Work / School: _____

Self-care / Independent Living: _____

Well - Being: _____

Spirituality: _____

PSYCHOPATHOLOGY:

Symptoms: _____

Substance Abuse: _____

Cognitive Functioning: _____

Subjective Distress: _____

ILLNESS MANAGEMENT:

Medication Adherence: _____

Medication Side Effects: _____

Coping / Stress Management: _____

Relapse Prevention: _____

Knowledge of Illness: _____

HEALTH:

Weight: _____

Smoking: _____

Other: _____

FAMILY & OTHER SUPPORTS:

Family Relationships: _____

Relationships with Significant Others: _____

BASIC LIVING NEEDS:

Housing: _____

Finances: _____

Legal Problems: _____

Treatment Plan

Client: _____

Date: _____

Initial Treatment Plan

Follow-up Treatment Plan

Participants at Collaborative Treatment Planning Meeting

- Client
- Family Member(s) (specify whom: _____)
- Other Significant Person (specify whom: _____)
- NAVIGATE Director
- NAVIGATE Family Clinician if different from Director
- NAVIGATE Prescriber
- NAVIGATE IRT Clinician (specify whom: _____)
- NAVIGATE SEE Clinician
- Other NAVIGATE Team Member (specify whom: _____)

1. **Client Goal(s):** List long-term, personally meaningful goals for treatment in the client's own words.

A. _____

B. _____

C. _____

2. **Barriers to Goals:** For each goal identify any significant barriers to achieving the goal.

Barriers to Goal A: _____

Barriers to Goal B: _____

Barriers to Goal C: _____

3. **Objectives for Achieving Goal(s):** For each goal, list the objectives for achieving it. Address any significant barriers. Be as behaviorally specific as possible and indicate when the objective will be achieved.

Objective for Goal A

Target Date to Accomplish Goal A

a. _____

b. _____

c. _____

d. _____

e. _____

Objective for Goal B

Target Date to Accomplish Goal B

f. _____

g. _____

h. _____

i. _____

j. _____

Objective for Goal C

Target Date to Accomplish Goal C

k. _____

l. _____

m. _____

n. _____

o. _____

- 4. Strengths and Resiliency Factors:** List any client and family strengths or resiliency factors that can be used to achieve any of the objectives stated above. Consider personal attitudes, skills, knowledge and resources that the client or family have. Indicate which objective(s) the strength or resiliency factor may help achieve by writing the corresponding letter(s) from #3 above (a, b, c...).

Strength or Resiliency Factor:

Objective(s) (letters from #3)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- 5. Interventions:** Describe the specific interventions that will be used to achieve the objectives. Indicate who will provide the intervention, and which specific objective(s) it will address by writing the corresponding letter(s) from #3 above (a, b, c...).

Intervention:

Who will Provide:

Objective(s)

(letters from #3)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Treatment Plan Review

Client: _____

Date: _____

Participants at Collaborative Treatment Planning Meeting:

- Client
- Family Member(s) (specify whom: _____)
- Other Significant Person (specify whom: _____)
- NAVIGATE Director
- NAVIGATE Family Clinician if different from Director
- NAVIGATE Prescriber
- NAVIGATE IRT Clinician (specify whom: _____)
- NAVIGATE SEE Clinician
- Other NAVIGATE Team Member (specify whom: _____)

1. **Progress Towards Goals:** Indicate how much progress has been made towards each of the client's goals.

Goal A: _____

- Goal Accomplished Some Progress Little or no Progress

Is this still a goal: Yes No

Goal B: _____

- Goal Accomplished Some Progress Little or no Progress

Is this still a goal: Yes No

Goal C: _____

- Goal Accomplished Some Progress Little or no Progress

Is this still a goal: Yes No

2. **New Barriers:** for goals that have not been accomplished but are still goals, were any new barriers encountered that need to be addressed?

Barriers to Goal A: _____

Barriers to Goal B: _____

Barriers to Goal C: _____

3. **Progress towards Objectives:** For each objective related to each goal indicate how much progress was made.

Objective for Goal A

Progress Towards Objective

	Achieved	Some Progress	Little / No Progress	Dropped
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Objective for Goal B

Progress Towards Objective

	Achieved	Some Progress	Little / No Progress	Dropped
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Objective for Goal C

Progress Towards Objective

	Achieved	Some Progress	Little / No Progress	Dropped
k.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. New Strengths and Resiliency Factors: List any newly identified client and family strengths and resiliency factors that did help or could help achieve the objectives listed in #3 above.

Strength or Resiliency Factor:

Objective(s) (letters from #3)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Interventions: For each planned intervention indicate the success of the implementation.

Intervention:

Client Response

	Implemented Well	Worked Moderately Well	Worked Poorly	Not Implemented
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Proposed New Interventions: Describe any new interventions that have been suggested and will be used to achieve the objectives. Indicate who will provide the intervention, how often, and which specific objective(s) it will address by writing the corresponding letter(s) from #3 above (a, b, c...).

Proposed Interventions:	Who will Provide:	Objective(s): (letters from #3)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

New Client Goals

List any new goals that have been identified by the client that were not previously in the treatment plan

7. New Client Goal(s): List long-term, personally meaningful goals for treatment in the client's own words.

- A. _____
- B. _____
- C. _____

Chapter 7

Applying for Benefits

Decisions about whether a client should apply for benefits and which benefits to apply for are complex. Benefits can provide needed financial support and medical insurance, but can be psychologically discouraging and can reduce motivation to pursue education and vocational goals. Clients and family members need information to guide them in making a decision about whether or not to apply for benefits for the member with a first episode of psychosis.

All the NAVIGATE team members play a role in providing input and helping clients and their families with this decision process. For example, the family clinician can help by educating the client and family about some of the factors to consider as they make this decision. Because family members or the client may have strong, and perhaps even conflicting, beliefs about the meaning behind applying for disability benefits, it is important that the family clinician help everyone in the family to understand these differing perspectives.

For other examples, the SEE specialist may be helpful by discussing the pros and cons of applying for disability benefits and what advantages or disadvantages may exist as this decision relates to the client's work, education, and career goals. The IRT clinician may be helpful as he or she works with the client on the module *Education About Psychosis*. All the NAVIGATE team members may help the client and the family think about whether benefits will improve access to treatment services. Having a team meeting with the client and family members to discuss benefits and come to a shared decision about applying for benefits is very useful.

First-episode clients and families often have questions about public health benefits programs such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, and Medicaid. Whether a public health plan is better than private insurance for a particular individual is a personal decision for each person and family. Clinicians can ask the family and client questions to help to make this decision clearer to everyone involved. NAVIGATE staff need to be familiar with their state's eligibility requirements for public health plans and also with the appeal process, in the event that a client and his or her family disagree with a disability determination decision.

Private Health Insurance

Private health insurance coverage of mental health services varies from company to company and from state to state. Here are some key issues and questions to address about private insurance in order to help families decide whether to switch from their private insurance to public health plans (e.g., Medicare or Medicaid):

- **Parity Legislation:** With respect to insurance benefits, “parity” refers to whether psychiatric disorders and medical illnesses are treated equally. Parity means that appropriate treatments for each type of illness are covered. Be informed about recent legislation at the state and federal levels regarding mental health parity and private health insurance. Clinicians can help families and clients access reliable information about the federal Mental Health Parity and Addiction Equity Act, and other state laws mandating or regulating mental health benefits.
- **Allowed Mental Health Visits:** Private insurance companies often limit the number of mental health visits paid for by year. You need to find out how many mental health visits are permitted per year, and whether visits with the Prescriber count toward this limit. For example, some private insurers cap mental health visits between 12-20 visits per year. This cap does not provide enough visits for most clients recovering from a first episode of psychosis. Many insurance companies allow for more visits if they are given a strong reason.
- **Services Caps:** Private insurance plans may have a lifetime cap on some or all mental health services. If so, how much of the allocated amount has your client already used?
- **Management of Inpatient Benefits:** How stringently are the inpatient benefits managed by the private insurer? Some private insurance companies put pressure on the inpatient unit to discharge a client quickly, often before his or her symptoms have been stabilized and the person is ready to return to the community.
- **Allowed Intermediary Services:** Does the insurance company permit access to intermediary level of care services, such as intensive outpatient treatment, adolescent residential treatment, partial hospitalization, or visiting nurses association services?
- **Capitated Models:** Does the private insurer use a “capitated model” (i.e., a model in which the insurer receives a fixed amount of money for providing mental health services to individuals, rather than receiving money on a fee-for-service basis)? For example, a private insurance provider might require that an insured individual is hospitalized at a particular hospital. If there is capitation, how appropriate is that particular hospital for the client's age and diagnosis?
- **Continued Coverage on Parent's Policy:** If a client who is age 18 or older and *not* currently a full-time student elects to remain on a parent's private insurance, the following documentation may be needed:
 - Letter from treatment team supporting this retention on the basis that client is currently a “disabled adult”
 - Proof provided by client that he or she lives with the family

Social Security/Public Health Insurance

The [Social Security Disability](#) Insurance program (sometimes referred to as SSDI) pays benefits to individuals and certain family members if the person worked long enough and paid Social Security taxes. The [Supplemental Security Income](#) (SSI) program pays benefits to disabled adults and [children](#) who have limited income and resources. These programs have websites with information for clients.

As stated above, a key role for the NAVIGATE team is to assist family members in making a decision about applying for benefits, including those provided by or through Social Security. Clinicians should invite families and clients to read about benefits programs on the Internet or in pamphlets available at local Social Security offices. Also, a chapter and worksheet in the SEE Manual provides information about benefits programs and sources for more information, as well as a decision matrix tool to facilitate decision-making.

Here are some key issues and questions to address about public health plans in order to help clients and families decide whether to apply for these sorts of programs:

- **In general, what are the pros and cons** of applying to these sorts of programs related to helping the client to achieve his or her future goals and aspirations?
- **Eligibility Determination:** What is the eligibility determination process for each specific program? Who is available to help with this process? How will the program affect other people in the household who are receiving other types of benefits?
- **Client's Use of Benefits:** What will the money will be used for? Will the client need help with money management? Will the client need a representative payee to aid in responsible, healthy use of funds?
- **Personal Impact of Benefits Receipt:** What is the psychological impact of receiving benefits on the client? On the family? How might it affect the client's view of him/herself? How might it affect the family's view of the client?
- **Impact on Work/School:** What work incentive programs exist for each specific benefits program? What will the effect of the receipt of monthly benefits be on motivation to work or go to school? How might the client be able to balance part-time work and still maintain needed benefits?
- **Long-Term Benefits Reduction Plans:** What might be a reasonable, feasible plan for reduction (or withdrawal) of benefits in the future? Who is available to help create such a plan?

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