NAVIGATE Team Members' Guide

April 2020 Revised Version

This manual is the 2020 revision of the Team Members' Guide originally developed for the RAISE-ETP study, funded by NIMH. Kim Mueser and Susan Gingerich are the authors of the original Team Members' Guide. Susan Gingerich is the author of this 2020 revision. The revision updates the original material to reflect 1) new scientific discoveries since the original manual was written, 2) experience providing NAVIGATE treatment in the RAISE-ETP study, and 3) experience of clinics providing NAVIGATE treatment in a wide range of real-world settings. At the end of Chapter 1, An Introduction to the NAVIGATE Team Members' Guide, you will find a list of the major revisions made in the Team Members' Guide 2020 revision.

Authorship of all Manuals for the NAVIGATE Program for First Episode Psychosis

Psychopharmacological Treatment Manual (now entitled "The Quick Guide to NAVIGATE Psychopharmacological Treatment")

The original manual was written by a committee chaired by Delbert G. Robinson, M.D. Christoph U. Correll, M.D., Ben Kurian, M.D., Alexander L. Miller, M.D., Ronny Pipes, M.A. and Nina R. Schooler, Ph.D. contributed to the scientific content of the Manual and the COMPASS Computer Decision Support System. Preston Park, MCSD led the programming team and Patricia Marcy, R.N. and Cristina Gomes Gonzalez, CCRP provided administrative support. The author of the revision of 2020 is Delbert G. Robinson, M.D.

Director Manual

The original manual was written by Jean Addington. The author of the revision of 2020 is Susan Gingerich.

Individual Resiliency Training (IRT) Manual

The original manual was written by David L. Penn and Piper S. Meyer-Kalos, and Jen D. Gottlieb, with contributing authors (in alphabetical order): Cori Cather, Susan Gingerich, Kim T. Mueser, and Sylvia Saade. The author of the revision of 2020 is Piper Meyer-Kalos.

Supported Employment and Education (SEE) Manual

The original manual was written by David W. Lynde, with contributing authors (in alphabetical order): Susan Gingerich, Susan R. McGurk, and Kim T. Mueser. The author of the 2020 addendum is Shirley Glynn.

Family Education Manual

The original manual was written by Shirley M. Glynn, with contributing authors (in alphabetical order): Cori Cather, Susan Gingerich, Jennifer D. Gottlieb, Piper S. Meyer, Kim T. Mueser, and David L. Penn. The authors of the revision of 2020 are Shirley Glynn and Susan Gingerich.

NAVIGATE Team Members' Guide

The original manual was written by Kim T. Mueser and Susan Gingerich, with contributing authors (in alphabetical order): Jean Addington, Mary F. Brunette, Cori Cather, Jennifer D. Gottlieb, David W. Lynde, and David L. Penn. The author of the revision of 2020 is Susan Gingerich.

Table of Contents

NAVIGATE Team Members' Guide

Chapter 1: An Introduction to the NAVIGATE Team Members' Guide 5
- How to Use the NAVIGATE Manuals 7
- Collaboration Is the Key to NAVIGATE 8
- Revisions in the 2020 Version of the Team Members' Guide 8

Chapter 2: Background and Rationale 9
- The Long-term Disability of Schizophrenia 9
- The Challenge of First-Episode Psychosis Treatment 9
- History of Treatment Programs for First Episode Psychosis 10
- Results of the RAISE-ETP Research Project 11
- Conceptual Framework of NAVIGATE 12
- The Stress-Vulnerability Model 13
- Special Issues for People with a First Episode of Psychosis 16
- References for the RAISE-ETP Study on the NAVIGATE Programs for Persons with a First Episode Psychosis 17

Chapter 3: Overview of NAVIGATE 20
- The Two Phases of NAVIGATE 22
- Implementing NAVIGATE 25

Chapter 4: Logistics of Implementing NAVIGATE 26
- Staffing and Role Responsibilities of NAVIGATE Team Members 26
- The Structure of NAVIGATE 30
- Timing of Engagement of Clients and Families in Treatment and Provision of NAVIGATE Interventions 31

Chapter 5: Core Competencies of NAVIGATE Team Members 35
- Shared Decision-Making 35
- Strengths and Resiliency Focus 35
- Motivational Enhancement Skills 36
- Psychoeducational Teaching Skills 37
- Cognitive-Behavioral Therapy (CBT) Teaching Skills 37

Collaboration with Natural Supports ... 38
Chapter 6: Collaborative Treatment Planning ... 40
Assessments ... 41
The Elements of a Treatment Plan ... 43
Developing a Preliminary Treatment Plan ... 44
The Collaborative Treatment Planning Meeting ... 45
Collaborative Treatment Plan Reviews ... 46
Addressing Medical Necessity ... 47
Client Assessments Worksheet ... 48
Treatment Plan ... 51
Treatment Plan Review ... 54
Chapter 7: Applying for Benefits ... 58
Private Health Insurance ... 59
Social Security/Public Health Insurance ... 60
Chapter 8: Optional Chapter for Understanding the Role of Cognitive Adaptation Training (CAT) on Teams Which Includes This Intervention ... 61
References for the Team Members' Guide ... 63

Chapter 1: An Introduction to the NAVIGATE Team Members' Guide

Please Read First:

NAVIGATE is a comprehensive treatment program for people who have experienced a first episode of non-affective psychosis. Treatment is provided by a coordinated specialty care (CSC) team, which helps people work toward personal goals and recovery. More broadly, the NAVIGATE program helps clients 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 social situations.

The NAVIGATE team includes the following members: Director, Family Clinician, Prescriber, Supported Employment and Education (SEE) Specialist, and Individual Resiliency Training (IRT) Clinician. Many teams also include a Peer Support Specialist and a Case manager. The RAISE-ETP research study comparing NAVIGATE with standard care found advantages for NAVIGATE treatment in quality of life, symptom levels and participation in work and school (Kane, et al, 2016).

The manual you are now reading describes the NAVIGATE structure and how the team works together. The manual is a 2020 revision of the Team Members Guide originally developed for the RAISE-ETP study. The authors of the original manual were Kim Mueser and Susan Gingerich. The author of this revision is Susan Gingerich. The revision updates the original material to reflect 1) new scientific discoveries since the original manual was written, 2) experience providing NAVIGATE treatment in the RAISE-ETP study, and 3) experience of clinics providing NAVIGATE treatment in a wide range of real-world settings. At the end of Chapter 1, An Introduction to the NAVIGATE Team Members' Guide, you will find a list of the major revisions made in the 2020 revision of the Team Members' Guide.

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 roles:

- Director
- Family Clinician
- Prescriber
- Supported Employment and Education Specialist
- Individual Resilience Training Clinician

In addition, many NAVIGATE teams include the following roles:

- Peer Support Specialist
- Case Manager

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 on track with their lives.

As the NAVIGATE team, you will all work together to learn more about first episode psychosis and its treatment, and effective ways to help each individual find their own pathway to recovery. The goal of NAVIGATE is *recovery and resiliency*, which is defined as helping the individual achieve optimal role functioning at school, work, social activities, leisure activities, and self-care skills, and to develop 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 and be resilient from a psychotic episode—to put it succinctly, your hope and belief in a positive future for the individual. Your ability to work and learn together as a team, and to work with clients and significant persons in their lives, is critical to your clients' ability to achieve recovery and resiliency.

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-spectrum disorders (schizophrenia, schizoaffective disorder and schizophreniform disorder) and establishing the importance of developing effective treatments that could alter the long-term trajectory of these disorders.

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 components of

treatment in the NAVIGATE, informed by the special needs of persons with a first episode of psychosis. In addition, a brief review of the research of RAISE-ETP (Recovery of an Initial Schizophrenia Episode-Early Treatment Program) is provided, which compared NAVIGATE treatment to community care treatment.

An overview of NAVIGATE is then provided, followed by logistics of staffing, role responsibilities, and meetings. 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, as well as NAVIGATE team members. 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 with a first episode of psychosis and their family members. All members of the NAVIGATE team need to be familiar with these issues. Team members will need to work collaboratively with 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 *NAVIGATE Team Members' Guide*.

The Guide ends with an optional chapter on understanding the role of Cognitive Adaptation Training (CAT) on teams which include this intervention. Cognitive Adaptation Training (CAT) is an intervention that is offered to NAVIGATE Teams which are members of the ESPRITO Network. ESPRITO stands for Early-Phase Schizophrenia Practice-Based Research to Improve Treatment Outcomes. If your NAVIGATE team is part of the ESPRITO Network, please read this chapter about CAT.

How to Use the NAVIGATE Manuals

Detailed manuals exist for three of the psychosocial interventions of NAVIGATE, including Individual Resiliency Training (IRT), the Family Education Program, and Supported Employment and Education (SEE). These manuals provide curriculum for clients and family members, as well as guidelines for clinicians. There are also manuals for the Director and for the Prescriber. 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.

In-person training is recommended for NAVIGATE teams. More information about training can be found by contacting the NAVIGATE Training Coordinator, whose contact information is available at the NAVIGATE website, navigateconsultants.org.

The purpose of the NAVIGATE manuals is to familiarize the team members with the background and philosophy of each intervention, and to provide the critical tools to implement each component. No one is expected to master all the material contained in each manual at once. The real learning in NAVIGATE takes place by 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 the 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 and resiliency. NAVIGATE is designed to provide tools to help individuals find their own pathways, and to navigate the challenges of psychosis by choosing among a broad range of treatments and strategies 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 psychosis challenged. 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 psychosis 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.

Revisions in the 2020 Version of the Team Members' Guide

As mentioned earlier in this chapter, the revisions in the Team Members' Guide reflect 1) new scientific discoveries since the original manual was written, 2) experience providing NAVIGATE treatment in the RAISE-ETP study, and 3) experience of clinics providing NAVIGATE. Some of the major revisions made include:

- **i.** Adding throughout the manual, information about the roles of Peer Support Specialists and Case Managers, who serve a vital function on many NAVIGATE teams.
- **ii.** Including in Chapter 2 a summary of the RAISE-ETP research results that support the use of NAVIGATE
- **iii.** Adding to Chapter 2 a list of the publications related to the RAISE-ETP research results
- **iv.** Explicating the process of collaborative treatment planning and review in Chapter 6
- **v.** Providing more guidance in Chapter 7 on the team approach to responding to client's interest in applying for benefits
- **vi.** Adding Chapter 8, an optional chapter on the Cognitive Adaptation Training (CAT) Intervention, for teams which may be providing the CAT intervention as part of their participation in the ESPRITO Network

Chapter 2: Background and Rationale

NAVIGATE was 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), which requested that researchers develop and test interventions designed to improve the trajectory and prognosis of schizophrenia in the U.S. The NIMH research program was 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 with schizophrenia spectrum diagnoses. Clients with schizophrenia spectrum disorders can have challenges 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 striking (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 Challenge 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 Receive 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 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 the treatment they need, people with psychosis unfortunately 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 when the treatment is not attuned to their unique needs and goals. Also treatment may be incomplete, including medication but no teaching of illness self-management skills (such as the prevention of relapses) and no skills training for improving their functioning and quality of life. 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).

History of Treatment Programs for First Episode Psychosis

Major advances in treatment programs have been made for persons with a first episode of psychosis. Until the RAISE research initiative, all of the treatment development and research on model programs for first episode psychosis 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 programs prior to the RAISE research initiative had been provided in large cities that allowed for use of a full-time team. However, in the U.S., mental health services are usually provided by local community mental health centers (CMHCs) that often serve smaller geographic catchment areas, such that staffing a first episode program presents 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 have not been not a priority. In some ways, the U.S. system appeared in the past to focus more on preventing people from entering treatment until the symptoms were so bad that treatment was unavoidable, rather than trying to engage individuals with psychosis into treatment early in order to improve their lives and prevent long-term disability.

In summary, NAVIGATE is the result of 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.

Results of the RAISE-ETP Research Project

The Recovery After an Initial Schizophrenia Episode (RAISE) Initiative, conducted with support from the National Institute of Mental Health (NIMH), tested the team-based NAVIGATE approach with participants having a first episode of psychosis. Seventeen mental health sites in the U.S., including urban, suburban, and rural settings, and serving people from diverse ethnic and cultural backgrounds, provided NAVIGATE during the RAISE-Early Treatment Program (RAISE-ETP) research. Over the next two years, in comparison to usual care, NAVIGATE showed many advantages. Below is a brief summary of the RAISE-ETP research:

- The RAISE-ETP study compared NAVIGATE with usual care treatment with 404 first episode patients
- The usual care treatment was named “Community Care”
- In Community Care, clinicians provided whatever treatment they thought was best for each patient
- Clients were recruited from 21 different states in the United States

<u>Over the first 2 years of treatment</u>

- Clients who received Community Care treatment improved as one would expect to happen

  But

- NAVIGATE clients stayed in treatment longer and had more improvement in overall symptoms, depression and quality of life
- NAVIGATE clients were more likely to receive prescriptions that conformed to best practices and experienced less side effects than clients who got Community Care treatment.

To learn more about the results of the RAISE-ETP research project, you can find a list of publications up to March 2020 at the end of this chapter.

Conceptual Framework of NAVIGATE

Goals of NAVIGATE

The goal of NAVIGATE is *recovery and resiliency*. In recent years the concept of recovery and resiliency has taken on broad meanings that are personally important to mental health clients. 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 and resiliency 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 and resiliency 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) affirmed the pursuit of this type of recovery and resiliency 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 also called for a transformation of the mental health system and argued for a system focusing on clients and their families as partners. Treatment choice should be guided by a process of shared decision-making with recovery and resiliency as the primary goal.

NAVIGATE embraces this view of recovery and resiliency. Specifically, we define recovery and resiliency 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 and Resiliency Domains

People with schizophrenia have psychotic symptoms, negative symptoms, cognitive impairment, and often experience challenges with depression and substance abuse. *Psychotic symptoms* and *negative symptoms* are defining characteristics of schizophrenia. *Problems with cognitive functioning* can interfere with work, independent living, and social relationships (Green, 1996; McGurk & Mueser, 2004). Similar to cognitive problems, *depression* is a common feature of schizophrenia, although not included in the diagnostic criteria. Depression may be the first sign of the illness before the 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 illness develop substance use disorders (abuse or dependence).
All of the symptoms and challenges described above may be present in people with a first episode of psychosis. These symptoms have a negative impact on recovery and resiliency, including social/leisure functioning, well-being, and role functioning. Therefore, one general approach to treatment is to indirectly improve recovery and resiliency outcomes by directly targeting the psychiatric illness itself.

Illness Management

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

The Stress-Vulnerability Model

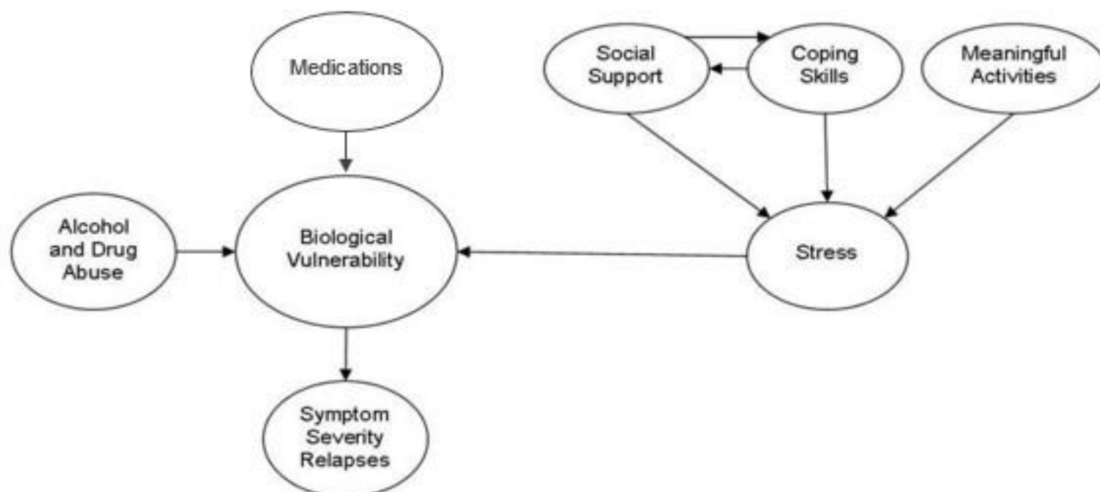
This model (see Figure 1) states that schizophrenia is caused by both psychological and biological vulnerabilities. *Biological vulnerabilities* are determined early on in life by genetic and early environmental influences. Recent research has also shown that *certain characteristics of society*—poverty, membership in some (but not all) immigrant groups and ethnicities, urbanization—all appear to increase the risk of schizophrenia (Morgan & 2010; Pérez-Álvarez et al, 2016). These are sometimes called "social determinants" of health. Similarly, we know that *certain personal experiences*, including negative childhood events and lifetime trauma exposure, as well as substance use, also are associated with increased risk of psychosis and schizophrenia (Bentall e al, 2012: Hunt et al, 2018).

It is important to emphasize that we are describing risk factors and that many individuals experience these risk factors but do not develop psychosis. It is also important to remember that once the vulnerability is established, the onset and course of the illness, including relapses and psychosocial functioning, are 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 use of *coping skills* and their 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 indicate that the outcomes of schizophrenia can be improved through reducing biological vulnerability and stress, and by improving social support, coping skills, and involvement in meaningful activities.

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 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 also 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 communicating 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 with information about schizophrenia and its treatment, and teaching them strategies for:

- Managing stress
- Monitoring symptoms
- Preventing or minimizing symptom relapses
- Coping with symptoms
- Using social skills to garner social support.

Psychiatric Rehabilitation

Treatment can also focus *directly* on helping people work towards recovery and resiliency outcomes. Three psychiatric rehabilitation approaches are used in NAVIGATE to address different parts of recovery and resiliency. These approaches 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.

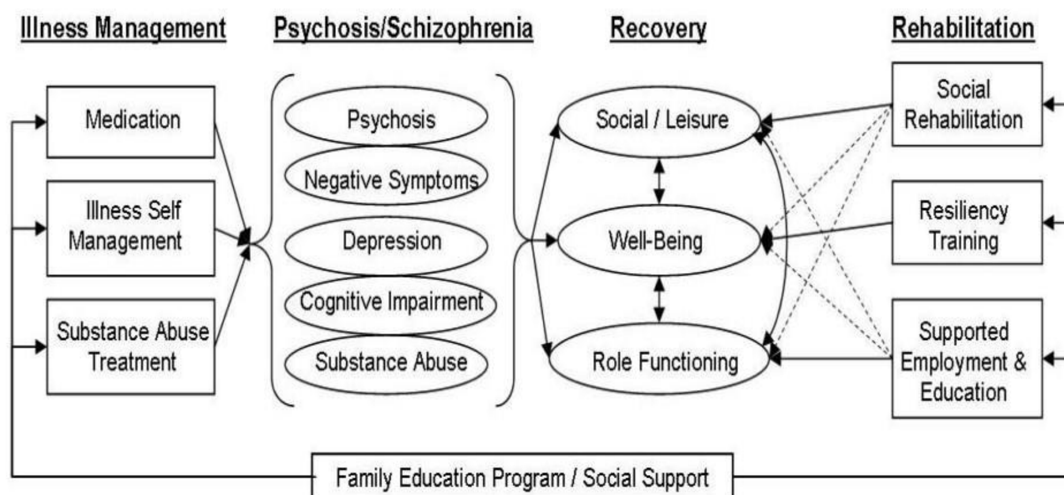
Supported Employment. This is the most effective approach for improving competitive employment outcomes in people with severe mental illness (Bond et al., 2008). A trained employment specialist provides individual services to all clients who have work as a goal. The goal is to find competitive work in 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 have impaired social functioning and 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 Natural Supports. Family, friends and others in a client's network can provide vital social support. In addition, they 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 can knock young people off of their developmental path (such as completing high school, going to college, getting their first job, developing intimate relationships, 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, 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 need the opportunity to process the experience of the psychosis and to become hopeful about the prospect of recovery (Jackson et al., 2009). The whole NAVIGATE program provides a forum for the client to talk about the psychosis, and the team can correct inaccurate and stigmatizing beliefs. The program also provides the opportunity to enhance clients' 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 to avoid developing maladaptive coping responses that may occur in the absence of specially designed treatment (e.g., withdrawal, resignation, or disengagement). There is a specific module called "Processing the Psychotic Episode" in the IRT manual.

References for the RAISE-ETP Study on the NAVIGATE Programs for Persons with a First Episode Psychosis

The list of publications below contains publications employing data from the RAISE-ETP study and covers the period up to March 2020. They are in chronological order. The authors include individuals who were part of the study team and also individuals not affiliated with the study.

Please note the NAVIGATE Training Website, where all NAVIGATE manuals can be downloaded for free: http://navigateconsultants.org

2014

Correll, C. U., Robinson, D. G., Schooler, N. R., Brunette, M. F., Mueser, K. T., Rosenheck, R. A., Marcy, P., Addington, J., Estroff, S. E., Robinson, J., Penn, D. L., Azrin, S., Goldstein, A., Severe, J., Heinssen, R. K., & Kane, J. M. (2014). Cardiometabolic risk in patients with first-episode schizophrenia spectrum disorders: Baseline results from the RAISE-ETP study. *JAMA Psychiatry, 71*, 1350-63.

2015

Addington, J., Heinssen, R. K., Robinson, D. G., Schooler, N. R., Marcy, P., Brunette, M. F., Correll, C. U., Estroff, S. E., Mueser, K. T., Penn, D. L., Robinson, J. A., Rosenheck, R. A., Azrin, S. T., Goldstein, A. B., Severe, J., & Kane, J. M. (2015). Duration of untreated psychosis in community treatment settings in the United States. *Psychiatric Services, 66*, 753–56.

Kane, J. M., Robinson, D. G., Schooler, N. R., Marcy, P., Correll, C. U., Brunette, M. F., Mueser, K. T., Rosenheck, R. A., Addington, J., Estroff, S. E., Robinson, J., Penn, D. L., & Severe, J. (2015). The RAISE Early Treatment Program: Background rationale and study design. *Journal of Clinical Psychiatry, 76*, 240–46.

Meyer-Kalos, P., Gottlieb, J. D., Penn, D. L., Mueser, K. T., & Gingerich, S. (2015). Individual Resiliency Training (IRT): An early intervention approach to enhance well-being in persons with first episode psychosis. *Psychiatric Annals, 45*, 554-60.

Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Gingerich, S., Glynn, S. M., Lynde, D. W., Gottlieb, J. D., Meyer-Kalos, P., Cather, C., McGurk, S. R., Saade, S., Robinson, D. G., Schooler, N. R., Rosenheck, R. A., & Kane, J. M. (2015). The NAVIGATE program for first episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services, 66*, 680-90.

Robinson, D. G., Schooler, N. R., John, M., Correll, C. U., Marcy, P., Addington, J., Brunette, M. F., Estroff, S. E., Mueser, K. T., Penn, D. L., Robinson, J., Rosenheck, R. A., Severe, J., Goldstein, A., Azrin, S., Heinssen, R. K., & Kane, J. M. (2015). Prescription practices in the treatment of first episode schizophrenia-spectrum disorders: Data from the National RAISE-ETP Study. *American Journal of Psychiatry, 172*, 237-48.

2016

Kane, J. M., Robinson, D. E., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Lynde, D. W., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Pipes, R., Kurian, B. T., Miller, A. L., Azrin, S. T., Goldstein, A. B., Severe, J. B., Lin, H., Majnu, J., & Heinssen, R. K. (2016). Comprehensive versus usual care for first episode psychosis: Two-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*, 362-72.

Rosenheck, R. A., Leslie, D., Sint, K., Lin, H., Robinson, D. E., Schooler, N. R., Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Rupp, A., Schoenbaum, M., & Kane, J. M. (2016). Cost-effectiveness of

comprehensive, integrated care for first episode psychosis in the NIMH RAISE Early Treatment Program. *Schizophrenia Bulletin, 42*, 896-906.

2017

Browne, J., Penn, D. L., Meyer-Kalos, P., Mueser, K. T., Estroff, S. E., Brunette, M. F., Correll, C. U., Robinson, J., Rosenheck, R. A., Schooler, N. R., Robinson, D. G., Addington, J., Marcy, P., & Kane, J. M. (2017). Psychological well-being and mental health recovery in the NIMH RAISE Early Treatment Program. *Schizophrenia Research, 185*, 167-72.

Rosenheck, R. A., Estroff, S. E., Sint, K., Lin, H., Mueser, K. T., Robinson, D. E., Schooler, N. R., Marcy, P., & Kane, J. M. (2017). Incomes and outcomes: Social Security Disability benefits in first episode psychosis. *American Journal of Psychiatry*, *174*, 886-94.

Rosenheck, R. A., Mueser, K. T., Sint, K., Lin, H., Lynde, D. W., Glynn, S. M., Robinson, D. E., Schooler, N. R., Marcy, P., Mohamed, S., & Kane, J. M. (2017). Supported employment and education in comprehensive, integrated care for first episode psychosis: Effects on work, school, and disability income. *Schizophrenia Research, 182*, 120-8.

2018

Browne, J., Edwards, A. N., Penn, D. L., Meyer-Kalos, P. S., Gottlieb, J. D., Julian, P., Ludwig, K., Mueser, K. T., & Kane, J. M. (2018). Factor structure of therapist fidelity to individual resiliency training in the Recovery After an Initial Schizophrenia Episode Early Treatment Program. *Early Intervention in Psychiatry*, *12*, 1052-63.

Browne, J., Penn, D. L., Estroff, S. E., Ludwig, K., Merritt, C., Meyer-Kalos, P., Mueser, K. T., Gottlieb, J. D., & Kane, J. M. (2018). Character strengths of individuals with first episode psychosis in individual resiliency training. *Schizophrenia Research*, *195*, 448-54.

Brunette, M. F., Mueser, K. T., Babbin, S., Meyer-Kalos, P., Rosenheck, R., Correll, C. U., Cather, C., Robinson, D. E., Schooler, N. R., Penn, D. L., Addington, J., Estroff, S. E., Gottlieb, J. D., Glynn, S. M., Marcy, P., Robinson, J., & Kane, J. M. (2018). Demographic and clinical correlates of substance use disorders in first episode psychosis. *Schizophrenia Research, 194*, 4-12.

Cather, C., Brunette, M. F., Mueser, K. T., Babbin, S. F., Rosenheck, R., Correll, C. U., & Meyer-Kalos, P. (2018). Impact of comprehensive treatment for first episode psychosis on substance use outcomes: A randomized controlled trial. *Psychiatry Research, 268*, 303-11.

Fulford, D., Piskulic, D., Addington, J., Kane, J. M., Schooler, N.R., & Mueser, K. T. (2018). Prospective relationships between motivation and functioning in the recovery after an initial episode of schizophrenia. *Schizophrenia Bulletin*, *44*, 369-77.

Glynn, S. M., Gingerich, S., Meyer-Kalos, P., Mueser, K. T., Chan-Golston, A., Sugar, C. A., Schooler, N. R., Rosenheck, R., & Kane, J. M. (2018). Family burden in the US RAISE-ETP program: Treatment effects and predictors. *Schizophrenia Bulletin, 44*, S320.

Nagendra, A., Schooler, N. R., Kane, J. M., Robinson, D. G., Mueser, K. T., Estroff, S. E., Addington, J., Marcy, P., & Penn, D. L. (2018). Demographic, psychosocial, clinical, and neurocognitive baseline characteristics of black Americans in the RAISE-ETP study. *Schizophrenia Research, 193*, 64-8.

Oluwoye, O., Stiles, B., Monroe-DeVita, M., Chwasiak, L., McClellan, J. M., Dyck, D. G., Cabassa, L. J., & McDonell, M. G. (2018). Racial-ethnic disparities in first-episode psychosis treatment outcomes from the RAISE-ETP study. *Psychiatric Services, 69*, 1138-45.

Robinson, D. G., Schooler, N. R., Correll, C. U., John, M., Kurian, B. T., Marcy, P., Miller, A. L., Pipes, R., Trivedi, M. H., & Kane, J. M. (2018). Psychopharmacological treatment in the RAISE-ETP study: Outcomes of a manual and computer decision support system based intervention. *American Journal of Psychiatry, 175*, 169-79.

Sint, K., Rosenheck, R., Robinson, D. E., Schooler, N. R., Marcy, P., Kane, J. M., Mueser, K. T., & Lin, H. (2018). Accounting for group differences in study retention in a randomized trial of specialized treatment for first episode psychosis. *Schizophrenia Research*, *195*, 481-7.

2019

Alcover, K. C., Oluwoye, O., Kriegel, L., McPherson, S., & McDonell, M. G. (2019). Impact of first episode psychosis treatment on heavy cannabis use: Secondary analysis on RAISE-ETP study (letter to editor). *Schizophrenia Research, 211*, 86-7.

Browne, J., Bass, E., Mueser, K. T., Meyer-Kalos, P., Gottlieb, J. D., Estroff, S. E., & Penn, D. L. (2019). Client predictors of the therapeutic alliance in individual resiliency training for first episode psychosis. *Schizophrenia Research*, *204*, 385-90.

Browne, J., Mueser, K. T., Meyer-Kalos, P., Gottlieb, J. D., Estroff, S. E., & Penn, D. L. (2019). The therapeutic alliance in individual resiliency training for first episode psychosis: Relationship with treatment outcomes and therapy participation. *Journal of Consulting and Clinical Psychology*, *87*, 734-44.

Fulford, D., Meyer-Kalos, P., & Mueser, K. T. (2019). An active ingredient for motivation enhancement? The importance of addressing personally meaningful goals in comprehensive care for first-episode psychosis. *Schizophrenia Bulletin, 45*, S357.

Hardy, K. V., Landa, Y., Meyer-Kalos, P., & Mueser, K. T. (2019). Psychotherapeutic interventions for early psychosis. In K. V. Hardy, J. S. Ballon, D. L. Noordsy & S. Adelsheim (Eds.), *Intervening Early in Psychosis: A Team Approach* (pp. 211-39). Washington, DC: American Psychiatric Publishing.

Mueser, K. T., Meyer-Kalos, P., Glynn, S. M., Lynde, D. W., Robinson, D. E., Gingerich, S., Penn, D. L., Cather, C., Gottlieb, J. D., Marcy, P., Wiseman, J. L., Potretzke, S., Brunette, M. F., Schooler, N. R., Addington, J., Rosenheck, R. A., Estroff, S. E., & Kane, J. M. (2019). Implementation and fidelity assessment of the NAVIGATE treatment program for first episode psychosis in a multi-site study. *Schizophrenia Research*, *204*, 271-81.

Nuttall, A. K., Thakkar, K. N., Luo, X., Mueser, K. T., Glynn, S. M., Achtyes, E. D., & Kane, J. M. (2019). Longitudinal associations of family burden and patient quality of life in the context of first-episode schizophrenia in the RAISE-ETP study. *Psychiatry Research, 276*, 60-8.

Oluwoye, O., Monroe-DeVita, M., Burduli, E., Chwastiak, L., McPherson, S., McClellan, J. M., & McDonell, M. G. (2019). Impact of tobacco, alcohol and cannabis use on treatment outcomes among patients experiencing first episode psychosis: Data from the national RAISE-ETP study. *Early Intervention in Psychiatry, 13*, 142- 46.

Robinson, D. E., Schooler, N. R., Rosenheck, R. A., Lin, H., Sint, K., Kane, J. M., & Marcy, P. (2019). Predictors of hospitalization of individuals with first-episode psychosis: Data from a 2-year follow-up of the RAISE-ETP. *Psychiatric Services*, *70*, 369-77.

2020

DeTore, N. R., Gottlieb, J. D., & Mueser, K. T. (2020 Ahead of Print). Prevalence and correlates of PTSD in first episode psychosis: Findings from the RAISE-ETP study. *Psychological Services*.

Mueser, K. T., DeTore, N. R., Kredlow Acunzo, M. A., Bourgeois, M. L., Penn, D. L., & Hintz, K. (2020). Clinical and demographic correlates of stigma in first episode psychosis: The impact of duration of untreated psychosis. *Acta Psychiatrica Scandinavica*, *141*, 157-66.

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 and resiliency from an episode of psychosis, including getting back to functioning well at home, at work, and in the social world.

NAVIGATE includes four different treatment interventions. 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 Figure 1 below. These treatment interventions are:

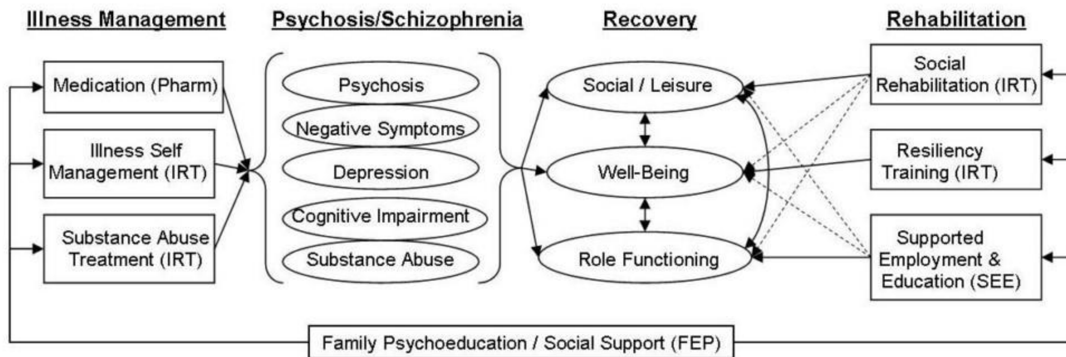
- *Medication Treatment* aimed at reducing symptoms and preventing relapses in order to help people achieve their desired goals

- *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 (IRT)* aimed at
  - Helping clients identify and use their personal strengths
  - 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 skills and resiliency skills.

- *Supported Employment and Education (SEE)* aimed at
  - Helping clients to develop education and employment goals related to their career interests.
  - Working with clients to help them obtain jobs or enroll in educational programs.
  - Providing follow along supports 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 staffed by 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
- The Family Clinician, who provides the Family Education Program
- The Prescriber, who provides Medication Treatment
- The IRT clinician(s) who provides Individual Resiliency Training
- The Supported Employment and Education (SEE) specialist, who helps clients identify and pursue work and school goals

In addition, many NAVIGATE teams include the following roles:

- The Peer Support Specialist, who has lived experience with mental health challenges and provides hope and encouragement to clients and sometimes leads or co-leads groups, such as support groups or activity groups
- The Case Manager, who provides case management, which often includes assistance in accessing housing, transportation, and other community resources

The choice, timing, and intensity of the different interventions in NAVIGATE is determined jointly by the client, family (or other significant persons), and the NAVIGATE team. Collaborative treatment planning meetings and treatment review meetings with the client and family 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: the Engagement and Stabilization Phase, and the Recovery/Resiliency Phase.

Engagement and Stabilization Phase

This phase is expected to last one to two months, depending on the client's clinical status (i.e., whether the client is experiencing acute symptoms of psychosis or the symptoms are remitted). The goals of this phase are to:

- Engage the client and family into treatment, including meeting members of the NAVIGATE team and having short (20 minute) meetings with each if possible
- Initiate assessment, goal-setting, and treatment planning.
- Initiate and adjust medication to treat symptoms
- Address urgent basic needs (such as housing, medical problems, and legal issues).

Engaging the clients and their 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 start to reduce some of the guilt, blame, or depression experienced by relatives, and enlist their long-term involvement in the client's treatment.

Engaging a client 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/Resiliency Phase. As clients meet different members of the NAVIGATE team and learn about their roles, they get oriented 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 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 them to address their 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 team 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.

If a peer support specialist is part of the team, it is extremely helpful for them to connect with clients in the Engagement and Stabilization Phase. Clients appreciate the opportunity to

talk to someone who has experienced mental health challenges, since they are often feeling alone in their experiences. The peer support specialist helps the clients be more hopeful about their future.

The Recovery/Resiliency 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. Collaborative treatment planning meetings, including the client and relatives or other significant persons, and NAVIGATE team members, are held at the beginning of treatment, and collaborative treatment review meetings (again including the client and relatives or other significant persons) occur at least every six months.

The Recovery/Resiliency Phase includes providing the interventions of NAVIGATE, each tailored to the individual client and relatives (or other natural supports): 1) Individualized Medication Management, 2) Family Education 3) Supported Employment and Education, 4) Individual Resiliency Training, 5) Case management (provided either by a case manager or another member of the NAVIGATE team such as the IRT clinician), and 6) Peer Support (if available). These interventions are typically introduced during the Engagement and Stabilization Phase, and continued in the Recovery/Resiliency Phase. The frequency of sessions or meetings is tailored to the client's (and family members' or other significant persons') needs, goals, and preferences.

NAVIGATE encourages the teams to offer all the interventions to clients and families, but does not require them to participate in everything. However, without being offered the interventions, and educated about what benefit the interventions might have, it is difficult for clients and families to make informed decisions about participating. Therefore, we suggest that all clients have a good exposure to all the interventions.

Individualized Medication Management focuses on the use of antipsychotic medication to reduce or stop psychotic symptoms, and to prevent relapses. Medication management in NAVIGATE also emphasizes minimizing side effects. On a case-by-case basis, a few clients may also benefit from medications in addition to antipsychotics, to treat other symptoms, such as depression and anxiety. Prescribing more than one medication for psychiatric symptoms is done very cautiously in NAVIGATE.

Family Education helps the family understand more about psychosis and its treatment and to develop strategies for coping with stress and communicating effectively. Family Education usually begins in the engagement and stabilization phase and continues for several weeks into the recovery/resiliency phase. It is usually delivered over 12-14 sessions, on a weekly or every-other-week basis, with more sessions provided when there are more problems, conflict, and stress. There are 10 modules in the Family Education curriculum:

- Facts about Psychosis
- Facts about Medication
- Facts about Coping with Stress
- Facts about Alcohol and Drugs
- Facts about Healthy Lifestyles

- Developing Resiliency
- Effective Communication
- Developing a Plan to Stay Well
- Developing Collaboration with Mental Health Professionals.
- A Relative's Guide to Supporting Recovery from Psychosis

Supported Employment and Education (SEE) begins as soon as it is possible, although in some cases it may need to wait until after the client's acute symptoms have been stabilized. Even if clients do not identify that they want to work or attend school, it is important for them to have at least one or two meetings with the SEE specialist so that they are aware of the supports available and can explore their interests. The SEE specialist works with interested clients regardless of the presence of ongoing symptoms or substance use. 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 the IRT clinician, usually on a weekly or every-other-week 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 symptoms 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 (including identifying personal strengths) and Goal-Setting
- Education about Psychosis
- Healthy Lifestyles
- Developing a Plan to Stay Well
- Processing the Psychotic Episode
- Developing Resiliency—Standard Sessions
- Building a Bridge to Your Goals

Additional Individualized 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 Individualized modules include:

- Dealing with Negative Feelings
- Coping with Symptoms
- Substance Use
- Having Fun and Developing Good Relationships
- Developing Resiliency—Individualized Sessions

Implementing NAVIGATE

Information about implementing specific NAVIGATE interventions is provided in the following manuals:

- Director's Manual
- The Quick Guide to NAVIGATE Psychopharmacological Treatment
- Family Education Program Manual
- Individual Resiliency Training (IRT) Manual
- Supported Employment and Education (SEE) Manual

NAVIGATE does not have a separate manual for peer specialists. However, we recommend the OnTrack peer specialist manual, which can be downloaded at the following link:

http://ontrackny.org/Portals/1/Files/Resources/Peer%20Specialist%20Manual%20Final%202_17.17.pdf?ver=2017-04-04-063602-080

Because case management tends to be a role that varies by state and by agency, NAVIGATE does not have a separate manual for case managers. As part of their role, case managers should have access to (or create) a notebook of resources that clients commonly need, such as housing, medical care, financial benefits, transportation, clothing, and food.

Chapter 4: Logistics of Implementing NAVIGATE

This chapter addresses three basic issues about implementing NAVIGATE, including:

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

Staffing and Role Responsibilities of NAVIGATE Team Members

The members of the NAVIGATE team include the following:

- The NAVIGATE Director (the same person often serves as the Family Education Clinician; e.g., ½ of their time is devoted to the role of director, ½ of their time is devoted to their role as family clinician)
- Family Education clinician) (as noted above, the same person often serves as the Director)
- The Prescriber (psychiatrist or nurse practitioner or physician's assistant)
- The Supported Education and Employment (SEE) specialist
- Individual Resiliency Training (IRT) clinician(s)

Many teams also include the following members:

- Peer Support Specialist
- Case Manager

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

Table 1: Roles and Responsibilities of the NAVIGATE Staff *

Roles and Responsibilities	Director/ Family Clinician*	Pre-scriber	SEE Specialist	IRT Training Clinicians	Peer Specialist **	Case Manager **
Leads weekly NAVIGATE team meetings	X					
Participates in weekly NAVIGATE team meetings	X	X	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 meetings 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**	**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	Some-times	X				
Provides pharmacological treatment, including ≥ monthly app'ts		X				
Conducts employment & educational assessments			X			
Provides SEE services			X			
Receives weekly supervision on SEE from Director			X			
Conducts psychosocial functioning assessments and strengths assessment	X			X		
Provides case management and may receive supervision from director				**If no case Manager X**	X	
Provides peer support and may receive supervision from director						X
Provides IRT				X		
Receives weekly supervision on IRT from Director				X		

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

**This table recognizes that some teams have peer support specialists and case managers whereas others do not.

The Director has the primary responsibility for managing the NAVIGATE program, including recruitment, assessment for enrollment, and monitoring and improving the quality of services. Directors are usually the primary point of contact for the program. Directors screen and recruit clients and family members into the program. They work with staff both inside the organization and in the wider community to ensure that people with first episode psychosis get referred to NAVIGATE.

The Director engages clients who meet criteria and their relatives into the program. Having the NAVIGATE Director provide the Family Education Program makes it easier for the IRT clinician 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, and in some instance supervises the peer specialist and the case manager. If the SEE specialist receives supervision from an established supported employment program, then 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, an additional clinically skilled person could be added to the team to provide any combination of Family Education, supervision for the IRT clinicians and SEE specialist, and lead the collaborative treatment planning and treatment review meetings with the client and family members, with the Director maintaining the overall coordinating role for the team. For another example, an additional clinically skilled person could be included on the NAVIGATE team to provide Family Education, while the Director provides supervision, leads collaborative treatment planning and review meetings, and supervises the Family clinician. For the reasons described earlier in this section, 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. Prescribers assess symptoms and side effects, collaborate with clients and relatives regarding pharmacological treatment, and participate in treatment planning and weekly NAVIGATE team meetings. The prescriber follows the medication guidelines and assessment strategies recommended in The Quick Guide to NAVIGATE Psychopharmacological Treatment, including using the Client Questionnaire and Prescriber Questionnaires at each meeting with the client.

The 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, in response to SEE input, the Prescriber may make changes in the client's medicines, an IRT clinician could teach the client how to better cope with symptoms, or the Family clinician could work with the family to address challenges with the client remembering to take medication. 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) clinician(s) works with clients to help them set and achieve their personal recovery goals. IRTs:

- Help clients identify their personal strengths
- Help clients identify personal goals and break them down into manageable steps
- Help clients develop or enhance their 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).

If there is no case manager on the team, the IRT clinicians may also provide case management.

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 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 stress or help the client improve his or her nutrition and exercise to reduce weight gain, or help the client develop coping skills to deal with symptoms at work or school.

The Peer Support Specialist has lived experience with mental health challenges and provides hope and encouragement to clients and sometimes leads or co-leads groups, such as support groups or activity groups.

The Case Manager provides case management, which often includes assistance in accessing housing, transportation, and other community resources

The Structure 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 team meetings*, *supervision meetings*, *and collaborative treatment planning and review meetings* (with the client and family or other significant persons present). The frequency, duration, and nature of these meetings are summarized below.

NAVIGATE Team Meetings

- All members of the NAVIGATE team meet weekly.
- NAVIGATE team meetings are led by the Director and usually last 60 minutes, depending on the number of clients in the program and the complexity of their treatment needs. The recommended agenda for a team meeting is:

    1. Team shares examples of some positive things that have happened with clients and families over the past week.
    2. Brief update on recruitment and enrollment.
    3. Review of each enrolled client, starting with a quick reminder of the client's goal(s) and then a brief report from each team member. During review, identify challenges and make plans to address them, including who does what and when. Each team member gives input on their work with the client and/or family, such as:

        A. Prescriber: medication issues, side effects, and symptom management
        B. Family Education Clinician: family engagement and involvement, what module they are covering in Family Education, any issues or concerns
        C. IRT Clinician(s): individual engagement and involvement, what module they are covering in IRT, any issues or concerns
        D. SEE Specialist: individual engagement and involvement, what stage they are at with SEE (such as doing the Career Inventory, identifying goals, job or school search, application process, employed or in school, follow-along supports), any issues or concerns
        E. Peer specialist: individual engagement and involvement, activities they are doing with the client, any issues or concerns
        F. Case Manager: individual engagement and involvement, case management activities they are doing with the client, any issues or concerns

    4. As each client is brought up for review, it is noted when their initial treatment planning meeting or their next treatment review meeting is scheduled. If they are due soon for such a meeting, preliminary planning is done during the team meeting to prepare. A preliminary or "penciled-in" plan is made for use during the treatment planning or review meeting itself. More information is provided about preliminary planning for treatment planning or treatment review meetings in Chapter 6.

Supervision Meetings

- The NAVIGATE Director meets with the IRT clinician(s) on a weekly basis for one hour to provide supervision for implementing the IRT intervention. If there is more than one IRT clinician, they can receive supervision together.

- 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.

- Depending on the guidelines and requirements of the agency, peer support specialists and case managers also receive weekly supervision with the Director. Brief guidelines are provided in the Director's 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 or will be significantly involved in the client's treatment. It is not required that every team member attend.

- 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.

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, coordination is needed between the Family Clinician and the IRT clinician 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 the overall NAVIGATE program. For clients who live with family members or with a partner or significant other, we recommend the following sequence of engagement steps:

1. The Director meets with the client and family for an initial assessment to find out if the client meets the criteria of the NAVIGATE program and to schedule an appointment with the person who conducts the diagnostic assessment (often the prescriber). In the process of this first meeting, the director briefly describes NAVIGATE and what is provided in the program.

2. When the client has been determined to meet NAVIGATE criteria, the director has another meeting with the client and family, and describes NAVIGATE in more detail. The directors usually uses the Orientation to the NAVIGATE Program handout. At that time the director enlists interest and willingness to participate in the NAVIGATE program. The director usually tries to arrange a brief “meet and greet” with each team member.

3. At the “meet-and-greet” meeting, the team member can set up a 20-minute initial appointment with the client to further explain their intervention and how it might be helpful to the client.

4. After the client and family members have been introduced to the rest of the NAVIGATE team and have met with the individual team members for a 20-minute appointment:

    A. If the client and relatives agree, the family clinician meets individually with them to get to know them better and assess their needs, followed by sessions where the family meets together. The client is encouraged to attend these family sessions.

    AND

    B. If the client agrees, the IRT clinician meets with the client to begin IRT sessions, and together they agree on a desired frequency of initial meetings.

    C. Very often the client benefits from meeting with the Peer Specialist very early in their treatment. And if they have case management needs, it may be important to set up an appointment with the Case Manager early on.

5. After the client begins the family sessions and the IRT sessions, they are encouraged to start meeting with the SEE specialist if they haven’t already.

NOTE: 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. During symptom stabilization they often find it beneficial to meet with the Peer Specialist, who can provide hope and encouragement from their own lived experience. Or they may find it helpful to meet with the case manager, who can assist with locating resources such as housing, transportation, or food.

Client Involvement in Family Education Program (FEP)

Sometimes clients will say that they do not want their family to participate in their treatment. There are multiple potential reasons for this reaction, such as wanting to be independent of their families (e.g., "I can handle this on my own") or not wanting to "bother" their families ("they are too busy to come to any appointments") or having a history of conflict with their families ("they don't want to be involved with me") or having a misunderstanding about what family education sessions are about ("family meetings would be about people criticizing me and telling me what to do").

When a client expresses reluctance to have their family involved it is important to be curious about their point of view and their concerns, to dispel any misunderstandings about family education sessions, and to help the client to consider the possible advantages of their family being involved (e.g., the family might understand better what the client has been going through; meeting together might help reduce conflict; coming to family meetings might help everyone get on the same page and support each other).

Sometimes families will say that they do not want to be involved in family education sessions. There are multiple potential reasons for this reaction. Similar to the suggestions above, it is important to be curious about their point of view and their concerns, to dispel any misunderstandings about family education sessions, and to help them consider the possible advantages of joining family sessions.

When clients and/or families have not agreed to participate in family education sessions it is important to re-visit this topic during team meetings, and the team can help problem-solve about how to get the family involved. For example, a client who is reluctant to have their family involved might be meeting regularly with the IRT clinician. The IRT clinician could suggest that the family clinician join them briefly during an IRT session to talk about the Family Education program and answer any questions the client may have. As another example, a family member who is reluctant to be involved in family education might regularly accompany the client to medication appointments. The prescriber might broach the subject with the family member and even suggest that the family clinician join them for a few minutes to answer any questions or address any concerns the family member might have.

Clients may agree to have their family attend family sessions, but will vary in terms of how much they choose to be involved in the sessions themselves, with three broad categories of involvement:

- The client may be involved in all or nearly all Family Education sessions
- The client may participate in only some Family Education sessions or may join only part of the session (e.g., either the first or last 20-30 minutes of the session)
- The client may participate in no Family Education sessions

While it is the client's and family's choice to participate in Family Education sessions, the Director and the rest of the team should encourage them 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 they can provide personal examples of symptoms and effects of the illness on their life. This may serve as a "rallying point" around which the family can work together.

Second, 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.

Third, working with the client and family together can alert the Family Clinician to strengths within the family that they otherwise would not have been aware of, or it can alert the Family Clinician to the presence of problems in communication and problem-solving that would otherwise be impossible to observe.

Finally, if clients and family members learn about psychosis together and become comfortable in talking about it together, this will help them continue to communicate about it in their home environment. For example, if the client and family are used to talking about the symptom of hearing voices, if the client begins to have auditory hallucinations, the client is more likely to share that information with family members and the family members are more likely to have a calm and sympathetic response. Together they may be able to reach out more effectively to the treatment team.

Overlapping Content between Family Education and Individual Resiliency Training

As noted above, some clients attend Family sessions along with their relatives, and others do not. When the client is actively involved in Family Education and attends some or all of the family sessions, IRT can be adapted to avoid overlap of educational information. As noted earlier, much of the educational material covered in Family Education covers similar topic as the material in the Standard modules of IRT.

Adaptations to the provision of IRT for clients who are actively engaged in Family Education involve using IRT sessions to briefly review any educational material covered in Family Education and to “fill in” any additional information on the topics that is provided in IRT modules. Or if the IRT sessions are covering a topic before it is covered in the Family Education sessions, the Family sessions can briefly review the educational material covered in IRT and “fill in” any additional information on the topic that is provided in the Family Education module.

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, psychoeducational teaching skills, cognitive-behavioral teaching skills, and collaboration with natural supports. These competencies are described below.

Shared Decision-Making

Shared decision-making means that treatment decisions are made by the client and clinician(s) 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 in the process contributes their 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. Clinicians who ignore the person's desires or use coercion undermine the therapeutic relationship (Fenton, 2003).

In shared decision-making, treatment providers give evidence-based information about treatment and 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 break 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 illness-related problems or "deficits," such as symptoms, inappropriate behavior, or social withdrawal. For individuals who have already had many setbacks in their lives, the traditional focus can worsen self-esteem.

When clinicians help clients and family 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 consistent with positive psychology, which focuses on strengths and well-being, rather than on limitations and negative emotions. The strengths-based approach also lends to developing strategies for reaching one's potential and deriving meaning from one's life, including self-acceptance, positive relationships 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

Motivational Interviewing (MI) is a person-centered approach to helping individuals who are ambivalent about making decisions or making changes in their lives. It was developed by Miller and Rollnick (Miller and Rollnick, 2013) and has been widely adopted in settings providing treatment to people with challenges in many areas, including mental health, substance use, physical health, involvement with the criminal justice system, school, nutrition, and weight management. We highly encourage you to take advantage of training opportunities in motivational interviewing. Information about training and other aspects of motivational interviewing can be found on the website: https://motivationalinterviewing.org/

Motivation refers to the intention and determination 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 lack of adherence to treatment and problems with psychosocial functioning. Treatment providers can use specific motivational 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 clinicians helping clients to break down long-term goals into smaller goals (objectives) and more manageable steps. Then, the clinicians can explore how learning new information and skills (including skills about the treatment and management of one's psychiatric disorder) can help the client achieve their goals.

In addition to the strategy of helping clients connect information, strategies and skills to their goals (e.g., asking "how might this help you make progress towards your goal?"), 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., what are the advantages and disadvantages of taking medication or getting regular exercise or avoiding alcohol and drugs?).

- Reinforcing “change talk” when the client is considering making a change that is consistent with treatment recommendations or with their personal values and goals.

- “Rolling with reluctance” instead of opposing it when the client is ambivalent about change, by affirming that ambivalence is normal. Instead of arguing with the client’s point of view, clinicians can explore the client’s ambivalence and learn more about their point of view. This helps the clinician more effectively address the client’s concerns about an 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 the nature of various treatment options and which options 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 taught during NAVIGATE and to make this information relevant to them as individuals. Common teaching strategies include:

- Breaking down large pieces of information into smaller “chunks.”

- Using and reviewing written handouts together or summarizing the content of handouts in a conversational way.

- Asking questions to check understanding of information.

- Inviting 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).

Positive verbal reinforcement is often considered to be the most basic and powerful of all CBT skills. Therefore all NAVIGATE team members need to be able to use *positive verbal reinforcement* to encourage clients' participation in NAVIGATE, including setting personal goals, following through on home assignments, taking steps towards goals, following treatment recommendations, and active involvement in collaborative treatment planning and treatment 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 very small steps in the intended direction, such as taking 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 are effective with first episode clients, including:

- **Skills training approaches** (e.g., modeling, role playing, feedback, and home practice) to teach:
  - social skills (e.g., conversation skills, job interviewing, substance refusal, discussing medication issues with the Prescriber)
  - relaxation skills
  - skills for having fun
  - coping skills for symptoms (e.g., hallucinations)
  - skills for coping with urges or cravings for alcohol or drugs
  - developing a Relapse Prevention Plan (often called A Wellness Plan) to prevent return of symptoms of 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, overeating, using alcohol or drugs.

- **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 the client is visually prompted to take it in the morning when they routinely make a pot of coffee).

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" refers to people who have a relationship and regular contact with the client who can help the client manage their 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., by discouraging taking medication), facilitate or encourage the use of alcohol or drugs (e.g., by indiscriminately giving the client money that is spent on substances or 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 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 an 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 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. It is important that 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.

Periodic assessments of progress on the treatment plan (e.g., monthly) are done at NAVIGATE team meetings. However, formal collaborative treatment review meetings with the client (and family or other supportive persons) every six months are also important. The client, the supportive people in the client's life, and the 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 if indicated, plan how to transition the client to less intensive services.

Scheduled Treatment Planning Meetings and Treatment Plan Review Meetings

An initial treatment planning meeting including NAVIGATE team members, the client, and family members (and/or other supportive people) 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). Treatment review meetings include the NAVIGATE team, client, and family members or significant others. Both treatment planning and treatment 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 the first collaborative treatment planning meeting, the NAVIGATE team has a preliminary meeting (may be part of a regular team meeting) to share information and perspectives on the client's goals, 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. The initial draft of the treatment plan is referred to as a "preliminary treatment plan" or "penciled-in treatment plan," since it is subject to change during the actual treatment planning meeting.

Every six months after the first treatment plan is completed, the team does a preliminary treatment plan review during their weekly team meeting, in anticipation of a treatment plan review meeting 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. 15 to 20 min) during regular team meeting to develop a preliminary plan	All NAVIGATE team members	About 3 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 Treatment Review Meeting (approx.15-20 min), during regular team meeting to develop a preliminary plan for the treatment review meeting	All NAVIGATE team members	Prior to Collaborative Treatment Review Meeting, during weekly team meeting
Collaborative Treatment 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

Assessments

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

- Recovery and resiliency
- Mental health (including symptoms and functioning)
- Illness management
- Physical 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. The IRT, Family Education, and SEE interventions each have assessment tools. IRT has the Brief Strengths Test, Satisfaction with Areas of My Life, Stressful Events Screening Questionnaire, and the CRAFFT substance use screening.

Family Education has the Individual Family Member Interview, and SEE has the Career Inventory. The prescriber does a standard diagnostic assessment and in addition does the Prescriber Questionnaire after reviewing the results of the Patient Self-Report Questionnaire. The Peer Specialist and Case Manager may have their own assessment tools, depending on their state or their agency.

In the process of assessing the client for their own interventions, some team members gather additional helpful information which can be useful in the collaborative treatment planning process.

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 Spec.	Peer Support Spec.	Case manager
RECOVERY AND RESILIENCY						
Client Goals	X	X	X	X	X	X
Strengths & Resiliency	X	X	X	X	X	X
Social - Leisure	X				X	
Work / School		X		X	X	
Self- care / Independent Living	X	X			X	X
Well - Being	X				X	
Spirituality	X				X	
MENTAL HEALTH						
Symptoms	X	X	X			
Substance Abuse	X	X	X			
Cognitive Functioning	X		X	X		
Subjective Distress	X		X		X	
ILLNESS MANAGEMENT						
Medication Adherence	X	X	X			
Medication Side Effects			X			
Coping / Stress Management	X				X	
Relapse Prevention	X	X				
Knowledge of Illness	X	X				
PHYSICAL HEALTH						
Weight	X	X	X			

Smoking	X	X	X			
Other health issues			X			
FAMILY & OTHER SUPPORTS						
Family Relationships	X	X			X	
Relationships with Significant Others	X	X			X	
BASIC LIVING NEEDS						
Housing	X	X				X
Finances	X	X				X
Legal Problems	X	X				X

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 plan 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.

As an example of how the team members may have more in-depth information in a variety of areas, over the course of helping a client pursue their 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, the family clinician may learn helpful information about the client's social functioning, their well-being, and their ability to cope effectively with stress and symptoms. As another example, the peer support specialist may become aware of the client's desire to live independently. Treatment review 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 recovery and resiliency goals
- Barriers to achieving each goal
- Objectives related to accomplishing each goal
- Client and family strengths and resiliency factors that can help achieve each objective
- Interventions for helping the client achieve their objectives

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

- Reflect the client's hopes, wishes, aspirations, dreams, personal ambitions.
- Are stated in the client's own words.
- Are stated in positive terms (e.g., obtaining degree, improving relationship with parents) rather than negative terms (e.g., stop fighting with parents).
- Are personally meaningful to the client.

Barriers are anything that has interfered with or is expected to interfere 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 been a barrier to clients completing high school, whereas clients' lack of knowledge about local GED programs (a barrier that is not symptom-related) could also be interfering with getting their diploma or certificate.

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 factor in how 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 skills or money
- Personal attributes, such as determination, 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.

An example of a blank treatment plan is provided at the end of this chapter.

Developing a Preliminary Treatment Plan

Making a treatment plan that is truly collaborative and that involves input from all of the members of the NAVIGATE team, the client, and family members requires time and coordination. As mentioned earlier, 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 usually 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 Worksheet is useful for providing a brief written summary of each team member's assessment information. A blank copy of this worksheet is included at the end of this chapter. A copy of the same worksheet is provided for all team members to complete, since any member could have useful information about any of the assessment domains. It is expected that team members will probably not fill out all categories of the worksheet, since they each have different interactions with the client and gather different assessment information.

Based on assessment information and input from the team, the Director (or other team member designated) develops a preliminary draft of the treatment plan (sometimes referred to as a "penciled-in plan") which is reviewed by the team at a weekly NAVIGATE meeting, and modified as needed. As mentioned earlier, there is an example of a blank treatment plan at the end of this chapter which can be used for the preliminary plan. The preliminary plan will then be reviewed at the collaborative treatment planning meeting, as described below.

The Collaborative Treatment Planning Meeting

After a preliminary treatment plan has been developed, a meeting is scheduled with the client, family members and the NAVIGATE team to work together collaboratively to develop a treatment plan with the client. Not all NAVIGATE team members need to attend, but the presence of the Director and the team members who are most involved in treatment is ideal as they can answer questions the client or family may have about the recommended interventions.

1. The Director begins the meeting by thanking the client and family members for coming, and then gives out copies of the preliminary treatment plan to everyone, emphasizing that the final treatment plan will be driven by the client's goals.

2. The Director then walks the group through the plan, beginning with a review of the client's goals. The Director confirms with the clients that these goals are important to them.

3. Barriers to achieving those goals are then briefly reviewed

4. Objectives are developed for each goal.

5. Strengths and resiliency factors related to each objective are then reviewed

6. Interventions are listed to achieve each objective, including who will provide each intervention.

7. When the treatment plan is completed, reflecting input from the client and family, everyone in attendance is thanked for their participation and contributions, and copies of the final plan are given to each person.

Questions are elicited and answered throughout the meeting, including providing more specific information about the interventions. Keep in mind that the client or family members may want changes to the preliminary treatment plan. These are discussed and added. 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 Treatment Plan Reviews

Approximately six months after the initial treatment plan was developed, a second meeting is scheduled to review and revise the treatment plan as needed. The client and family members are invited. Not all NAVIGATE team members need to attend, but the presence of the Director and the team members who are most involved in treatment is ideal because they can answer questions the client or family may have about the recommended interventions.

To develop a preliminary Treatment Plan Review, NAVIGATE team members provide a brief written summary to the Director (or other team member in charge of the Treatment Plan Review for the client) of the following:

1. Client's progress towards the goals identified in the current plan
2. New barriers (if any) to the goals
3. New strengths and resiliency factors (if any)
4. Progress towards objectives identified in the current plan
5. Assessment of success of planned interventions in the current plan
6. New objectives (if any)
7. New goals identified by the client (if any)

Using a blank Treatment Plan Review (see the example provided at the end of this chapter), the team member in charge of developing the plan summarizes the information provided by the team members and drafts a preliminary treatment plan review. The preliminary treatment plan review is then discussed with the NAVIGATE team and modified as needed. This is often done during the weekly team meeting.

Members of the NAVIGATE team, the client, and family members attend the Treatment Plan Review meeting. The Director begins the meeting by thanking everyone for coming, 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 plan review to the group. The Director 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 and gets input from the client and family members.

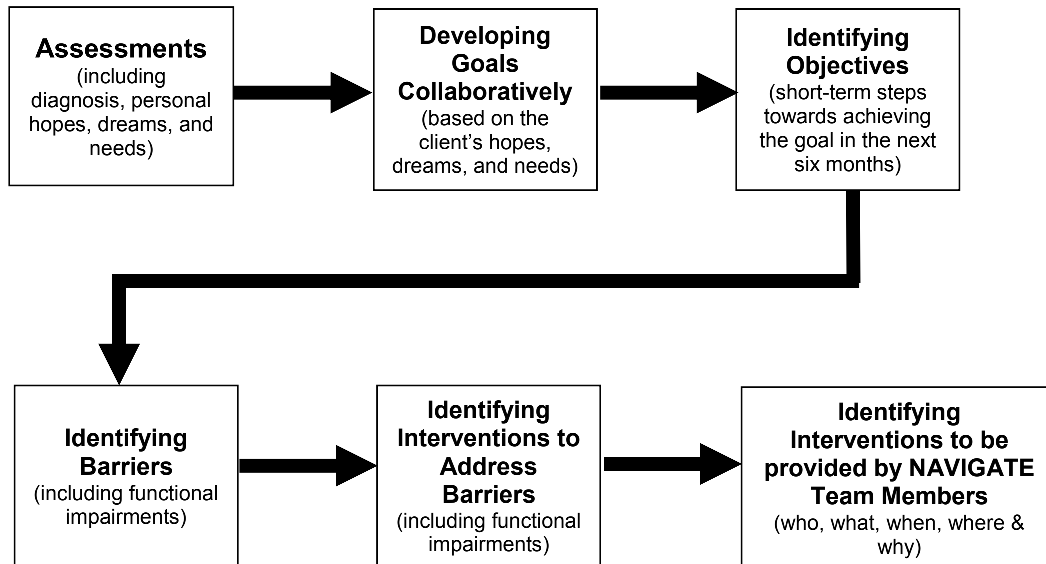
Keep in mind that questions are elicited and answered throughout the meeting. The client or family members may want changes to the preliminary Treatment Plan Review. Questions and concerns from the client and family members are discussed and added into a revised treatment plan review and given to everyone in attendance.

Addressing Medical Necessity

Many states require that all interventions in a treatment plan must target impairments that are consistent with the person's mental health diagnosis—that is, the interventions in the treatment plan are justified based on "medical necessity." It is important to 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 their 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 sure that all objectives are 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 Worksheet

Client: ______________________________ **Date:** _____________________

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: ____

____

Mental Health: ____

____

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(s) (specify whom: ___________________)

☐ NAVIGATE Director

☐ NAVIGATE Family Clinician if different from Director

☐ NAVIGATE Prescriber

☐ NAVIGATE IRT Clinician

☐ NAVIGATE SEE Clinician

☐ Peer Specialist

☐ Case Manager

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.

Objectives for Goal A	**Target Date to Accomplish Goal A**
a. ______________________	______________________
b. ______________________	______________________
c. ______________________	______________________
d. ______________________	______________________
e. ______________________	______________________

Objectives for Goal B	**Target Date to Accomplish Goal B**
a. ______________________	______________________
b. ______________________	______________________
c. ______________________	______________________
d. ______________________	______________________
e. ______________________	______________________

Objectives for Goal C	**Target Date to Accomplish Goal C**
a. ______________________	______________________
b. ______________________	______________________
c. ______________________	______________________
d. ______________________	______________________
e. ______________________	______________________

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

☐ NAVIGATE SEE Clinician

☐ Peer Support Specialist

☐ Case Manager

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.

Objectives for Goal A	**Progress Towards Objective**			
	Achieved	Some Progress	Little/ No Progress	Dropped
a. ______________	☐	☐	☐	☐
b. ______________	☐	☐	☐	☐
c. ______________	☐	☐	☐	☐
d. ______________	☐	☐	☐	☐
e. ______________	☐	☐	☐	☐

Objectives for Goal B	**Progress Towards Objective**			
	Achieved	Some Progress	Little/ No Progress	Dropped
a. ______________	☐	☐	☐	☐
b. ______________	☐	☐	☐	☐
c. ______________	☐	☐	☐	☐
d. ______________	☐	☐	☐	☐
e. ______________	☐	☐	☐	☐

Objectives for Goal C	**Progress Towards Objective**			
	Achieved	Some Progress	Little/ No Progress	Dropped
a. ______________	☐	☐	☐	☐
b. ______________	☐	☐	☐	☐
c. ______________	☐	☐	☐	☐
d. ______________	☐	☐	☐	☐
e. ______________	☐	☐	☐	☐

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
___________________________	☐	☐	☐	☐
___________________________	☐	☐	☐	☐
___________________________	☐	☐	☐	☐
___________________________	☐	☐	☐	☐
___________________________	☐	☐	☐	☐

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 the individual's motivation to pursue educational 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. The NAVIGATE team can be an important source of information on benefits, and can help the client and family explore the pro's and con's of applying for benefits.

It is important to keep in mind that a core tenant of the NAVIGATE program is that recovery and resiliency from an initial psychotic episode is possible, and that prolonged disability is NOT a foregone conclusion. However, it is not known at program entry who will be able to fully recover their functioning and the timeframe for that recovery. It is also not known at program entry who might need some kind of disability support. Therefore, a general discussion of benefits programs for psychiatric disability is well within the scope of the offering of the NAVIGATE program.

The original SEE manual suggested that the SEE specialist be the primary resource for clients in the process of deciding to apply for initial benefits. In the ten years since the original manual was written, the NAVIGATE trainers' thinking about the issue has changed, and we now encourage another member of the NAVIGATE team (such as the case manager or IRT or Director) or another resource person to assume primary responsibility for leading the discussion on the initial application for benefits as well as overseeing the process if the NAVIGATE client does decide to apply for disability benefits. It is very complicated for SEE specialists to encourage NAVIGATE clients to commit to work or school goals while they are simultaneously helping them apply for disability benefits.

The criteria for being eligible for benefits from the Social Security Administration (SSA) and the process for applying for benefits frequently change. If the client and family are interested in applying for benefits, and need information about eligibility and the application process, we recommend that the client and family meet with a Benefits Specialist (sometimes called a Benefits Counselor or a Claims Specialist) at the Social Security office for the most up-to-date information.

All the NAVIGATE team members can play a role in providing input and helping clients and their families with the decision process about benefits. 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 disability benefits, it is important that the family clinician help everyone in the family to understand these differing perspectives. As another example, 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. Having a team meeting with the client and family members to discuss benefits and come to a shared decision about applying for benefits can be very useful.

Private Health Insurance

First-episode clients and families may have private insurance and 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 decision that some clients and families may need to make. Clinicians can help the family and client identify the pro's and con's of this decision. It is helpful for the NAVIGATE staff to be familiar with their state's eligibility requirements for public health plans and how to access the services of a Benefits Specialist (as mentioned earlier in this chapter).

It is important to keep in mind that 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:** 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 in a given year. The client or family should be directed 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. Some 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:** It is important to know how stringently the inpatient benefits are managed by the private insurer. Some private insurance companies put pressure on the inpatient unit to discharge a client quickly, often before their symptoms have been stabilized and before 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 there is a fixed amount of money for providing mental health services to individuals, rather than a variable amount of 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:** Private insurance policies have an age limit and other criteria that must be met for individuals to be still covered under their parent's policy.

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. Also, as mentioned earlier in this chapter, we recommend that the client and family meet with a Benefits Specialist (sometimes called a Benefits Counselor or a Claims Specialist) at the Social Security office for the most up-to-date information.

Team members should encourage interested families and clients to meet with a Benefits Specialist, and to read about benefits programs on the internet or in pamphlets available at local Social Security offices. Also, there is more information about the pro's and con's of receiving benefits in the SEE manual.
.
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 Social Security programs related to helping the client to achieve their 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 themselves? 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 the person's motivation to work or go to school? How might the client be able to balance part-time work and still maintain benefits?

Chapter 8: Optional Chapter for Understanding the Role of Cognitive Adaptation Training (CAT) on Teams Which Includes This Intervention

Important Background: Cognitive Adaptation Training (CAT) is an intervention that is offered to NAVIGATE Teams which are members of the ESPRITO Network. ESPRITO stands for Early-Phase Schizophrenia Practice-Based Research to Improve Treatment Outcomes. If your NAVIGATE team is part of the ESPRITO Network, please read this chapter about CAT. If your NAVIGATE team is not part of the ESPRITO Network, but is interested in CAT, you can find information about CAT training at the International Center of Excellence for Evidence-Based Practices website, at the following link: iceebp.com. You can click on “Cognitive Adaptation Training.”

What is CAT?

CAT is an evidence-based psychosocial treatment designed to help people develop strategies for problems they may have in remembering, organizing, planning, and paying attention. These kinds of problems often interfere with people’s ability to perform independent living tasks, to work, to attend school, and to interact with others. CAT uses customized supports set up, with permission, on visits to a person’s home or work or school environment. Supports include things like signs, alarms, pill containers, checklists, apps, text messages, and the organization of belongings. These supports are designed to ensure that the therapy is there when the CAT therapist is not. By repetitive use of supports, CAT can lead to habit-formation for tasks like taking medication regularly, showering, cleaning up after oneself, completing work tasks, scheduling one’s day, and engaging with others.

Who will provide CAT on the NAVIGATE Team?

If your team is part of ESPRITO, the central ESPRITO team will arrange to train one or more individuals at your site to deliver CAT. This person could be a case manager, SEE specialist, peer specialist or IRT clinician. The individual delivering CAT must have at least a bachelor’s degree and must be able to make home visits and community visits that can be reimbursed by existing mechanisms. Team members selected to provide CAT must be available to participate in training and supervision. The training will be provided on-line and does not require the CAT Trainee to travel to in-person training.

Which NAVIGATE clients will benefit from CAT services?

CAT will be used to help two groups of individuals in ESPRITO NAVIGATE programs.

1. Clients who are reluctant to express that they have a work or school goal.
   These clients are often not engaged in any productive activity. These clients may benefit from attention to improving everyday functioning as a gateway into work and school goals.

2. Clients who express work and school goals, but who need extra support to be successful in SEE.
   These individuals may be struggling at work or school or may have had unsatisfactory terminations. CAT supports may help the individual either retain current employment or school enrollment, or to prevent problems in their next job or school attempt.

How will CAT candidates be identified?

During team meetings, when reviewing clients, the team should be alert for signs that a client is either 1) is not engaging in any productive activity and/or is having difficulty identifying work or school goals or 2) trying to pursue work or school goals but having difficulty succeeding. This kind of information is most often provided by the SEE, but the IRT, Family clinician, peer specialist and case manager may also notice signs. For example, the IRT Clinician may notice that the client has difficulty getting to IRT appointments on time, and during sessions has problems keeping their belongings organized or locating items that they planned to bring to the session. The Family clinician may hear from the family that the client has difficulty showering or wearing clean clothes or finds it challenging to do tasks that require more than one step.

At least once a month, one of the weekly team meetings should include a routine review of clients in terms of whether or not they might benefit from CAT. For example, in going through the usual routine of reviewing each client and getting input from each team member, the director can include the question, “What do we know about this client in terms of whether they might benefit from CAT?” The director may prompt the team by asking questions such as, “Is this client having problems in remembering, organizing, planning, and paying attention? Is this client having a hard time identifying work or school goals? Or has this client identified work and school goals but is having problems in succeeding at these goals?” Also, during treatment planning meetings, the team should be attentive to the possibility of adding CAT services when a client is having cognitive difficulties.

How will CAT services be integrated as part of the team approach?

Coordinating CAT services depends a great deal on who is trained in CAT on your team. If the SEE specialist is the team member trained in CAT, they will continue to provide input regularly during team meetings on the client’s progress, both in CAT and in SEE, and can shift easily between the two interventions, or can blend the two interventions.

If the team member trained in CAT is not the SEE specialist, more coordination may be needed. For example, the CAT specialist may need to communicate regularly with the SEE specialist (both during and outside of team meetings) and coordinate timing of shifting the focus of services to the SEE specialist. For example, the SEE may refer a client to CAT because of problems with hygiene and time management. If the client makes significant progress in these areas and now wants to look for work, the CAT specialist should talk to the SEE specialist about transitioning back to SEE in order to help the client identify and follow up on potential job interests. This kind of conversation may be most efficient on a one-to-one basis with the CAT specialist and the SEE specialist, or it may be most efficient during a team meeting, depending on the complexity of the client’s cognitive challenges.

More information about CAT can be found in the CAT Guide for NAVIGATE Teams.

References for the Team Members' Guide

Adams, N., & Grieder, D. M. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Inc.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*, 1123.

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

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (2004). *Social Skills Training for Schizophrenia: A Step-by-Step Guide* (Second ed.). New York: Guilford Press.

Birchwood, M., Todd, P., & Jackson, C. (1998). Early intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry, 172 (Supplement 33)*, 5359.

Bond, G. R., Campbell, K., Evans, L. J., Gervey, R., Pascaris, A., Tice, S., Del Bene, D., & Revell, G. (2002). A scale to measure quality of supported employment for persons with severe mental illness. *Journal of Vocational Rehabilitation, 17*, 239250.

Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal, 31*, 280-290.

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

Corrigan, P. W. (2004). Don't call me nuts: An international perspective on the stigma of mental illness. *Acta Psychiatrica Scandinavica, 109*, 403-404.

Corrigan, P. W. (Ed.). (2005). *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*. Washington, DC: American Psychological Association.

Corrigan, P. W., & Holmes, E. P. (1994). Patient identification of "Street Skills" for a psychosocial training module. *Hospital and Community Psychiatry, 45*, 273-276.

de Leon, J., & Diaz, F. J. (2005). A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophrenia Research, 76*, 135-157.

Deegan, P. E., Rapp, C. A., Holter, M., & Riefer, M. (2008). Best practices: a program to support shared decision making in an outpatient psychiatric medication clinic. *Psychiatric Services, 59*, 603-605.

Falloon, I. R. H., Coverdale, J. H., Laidlaw, T. M., Merry, S., Kydd, R. R., & Morosini, P. (1998). Early intervention for schizophrenic disorders: Implementing optimal treatment strategies in routine clinical services. *British Journal of Psychiatry, 172*(Suppl. 33), 33-38.

Fenton, W. S. (2003). Shared decision making: A model for the physician-patient relationship in the 21st century? *Acta Psychiatrica Scandinavica, 107*, 401-402.

Gingerich, S., & Mueser, K. T. (2005). Illness management and recovery. In R. E. Drake & M. R. Merrens & D. W. Lynde (Eds.), *Evidence-Based Mental Health Practice: A Textbook* (pp. 395-424). New York: Norton.

Gingerich, S. & Mueser, K.T. (2011). *Illness Management and Recovery: Personalized Skills and Strategies for Those with Mental Illness.* Hazelden Publications.

Green, M. F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? *American Journal of Psychiatry, 153*, 321-330.

Häfner, H., & an der Heiden, W. (2008). Course and outcome. In K. T. Mueser & D. V. Jeste (Eds.), *Clinical Handbook of Schizophrenia* (pp. 100-113). New York: Guilford Press.

Häfner, H., Löffler, W., Maurer, K., Hambrecht, M., & an der Heiden, W. (1999). Depression, negative symptoms, social stagnation and social decline in the early course of schizophrenia. *Acta Psychiatrica Scandinavica, 100*, 105-118.

Häfner, H., Maurer, K., Löffler, W., an der Heiden, W., Hambrecht, M., & SchultzeLutter, F. (2003). Modeling the early course of schizophrenia. *Schizophrenia Bulletin, 29*, 325-340.

Herrmann-Doig, T., Maude, D., & Edwards, J. (1993). *Systematic Treatment of Persistent Psychosis: A Psychological Approach to Facilitating Recovery in Young People with First-Episode Psychosis*. London: Martin Dunitz.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Jackson, C., Trower, P., Reid, I., Smith, J., Hall, M., Townend, M., Barton, K., Jones, J., Ross, K., Russell, R., Newton, E., Dunn, G., & Birchwood, M. (2009). Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms. *Behaviour and Research Therapy, 47*, 454-462.

Judge, A., Perkins, D. O., Nieri, J., & Penn, D. L. (2005). Pathways to care in first episode psychosis: A pilot study on help-seeking precipitants and barriers to care. *Journal of Mental Health, 14*, 465-469.

Kane, J. M., Robinson, D. E., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Lynde, D. W., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Pipes, R., Kurian, B. T., Miller, A. L., Azrin, S. T., Goldstein, A. B., Severe, J. B., Lin, H., Majnu, J., & Heinssen, R. K. (2016). Comprehensive versus usual care for first episode psychosis: Two-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*, 362-72

Killackey, E., Jackson, H. J., & McGorry, P. D. (2008). Vocational intervention in firstepisode psychosis: A randomised controlled trial of individual placement and support versus treatment as usual. *British Journal of Psychiatry, 193*, 114-120.

Kingdon, D. G., & Turkington, D. (2004). *Cognitive Therapy of Schizophrenia*. New York: Guilford Press.

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

Lewine, R. R. J. (2005). Social class of origin, lost potential, and hopelessness in schizophrenia. *Schizophrenia Research, 76*, 329-335.

Liberman, R. P., Mueser, K. T., Wallace, C. J., Jacobs, H. E., Eckman, T., & Massel, H. K. (1986). Training skills in the psychiatrically disabled: Learning coping and competence. *Schizophrenia Bulletin, 12*, 631-647.

Mark, T., Coffey, R., Vandivort-Warren, R., Harwood, H., & King, E. (2005). U.S. Spending For Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs, Jan-Jun Suppl Web Exclusives*, W5-133-W135-142.

McGurk, S. R., & Mueser, K. T. (2004). Cognitive functioning, symptoms, and work in supported employment: A review and heuristic model. *Schizophrenia Research, 70*, 147-174.

Mihalopoulos, C., Harris, M., Henry, L., Harrigan, S., & McGorry, P. (2009). Is early intervention in psychosis cost-effective over the long term? *Schizophrenia Bulletin, 35*, 909-918.

Miller, W. R., & Rollnick, S. (Eds.). (2012). *Motivational Interviewing: Helping People Change* (3rd ed.). New York: Guilford Press.

Mueser, K. T., & Gingerich, S. (2006). *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*. New York: Guilford Press.

Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research, 116*, 217-227.
Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Press.
Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard University Press.
Neenan, M. (2009). *Developing Resilience: A Cognitive-Behavioural Approach*. London: Routledge.
Nuechterlein, K. H., & Dawson, M. E. (1984). A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin, 10*, 300-312.
Nuechterlein, K. H., Subotnik, K. L., Turner, L. R., Ventura, J., Becker, D. R., & Drake, R. E. (2008). Individual placement and support for individuals with recent-onset schizophrenia: Integrating supported education and supported employment. *Psychiatric Rehabilitation Journal, 31*, 340-349.
Penn, D. L., Waldheter, E. J., Mueser, K. T., Perkins, D. O., & Lieberman, J. A. (2005). Psychosocial treatment for first episode psychosis: A research update. *American Journal of Psychiatry, 162*, 2220-2232.
Perkins, D. O., Gu, H., Boteva, K., & Lieberman, J. A. (2005). Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: A critical review and meta-analysis. *American Journal of Psychiatry, 162*, 17851804.
Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health, 16*, 781-793.
Petersen, L., Jeppesen, P., Thorup, A., Abel, M. B., Ohlenschlager, J., Christensen, T. O., Krarup, G., Jorgensen, P., & Nordentoft, M. (2005). A randomized, multicenter trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *British Medical Journal, 331*, 602-609.
Power, P. (2004). Suicide prevention in early psychosis. In J. Gleeson & P. D. McGorry (Eds.), *Psychological Interventions in Early Psychosis: A Treatment Handbook* (pp. 175-190). Chichester, England: John Wiley & Sons.
President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America: Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Substance Abuse and Mental Health Services Administration.
Rapp, C. A., & Goscha, R. J. (2006). *The Strengths Model: Case Management with People with Psychiatric Disabilities* (Second ed.). New York: Oxford University Press.
Robinson, D., Woerner, M. G., Alvir, J. M., Bilder, R., Goldman, R., Geisler, S., Koreen, A., Sheitman, B., Chakos, M., Mayerhoff, D., & Lieberman, J. A. (1999). Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry, 56*, 241-247.
Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1-28.
Samnaliev, M., & Clark, R. E. (2008). The economics of schizophrenia. In K. T. Mueser & D. V. Jeste (Eds.), *Clinical Handbook of Schizophrenia* (pp. 507-515). New York: Guilford Press.
Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health, 84*, 290-293.
Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women. I. Pretrial jail detainees. *Archives of General Psychiatry, 53*, 505-512.

Towle, A., & Godolphin, W. (1999). Framework for teaching and learning informed shared decision making. *British Medical Journal, 319*, 766-771.

Uzenoff, S. R., Perkins, D. O., Hamer, R. M., Wiesen, C. A., & Penn, D. L. (2008). A preliminary trial of adherence-coping-education (ACE) therapy for early psychosis. *Journal of Nervous and Mental Disease, 196*, 572-575.

Williams-Keeler, L., Milliken, H., & Jones, B. (1994). Psychosis as precipitating trauma for PTSD: A treatment strategy. *American Journal of Orthopsychiatry, 64*, 493498.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology, 86*, 103-126.