NAVIGATE Directors' Guide

April 2020 Revised Version

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DIRECTOR'S MANUAL FOR ENHANCED-NAVIGATE

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, 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 role of the director on the NAVIGATE team. The manual is a 2020 revision of the IRT manual originally developed for the RAISE-ETP study. The author of the original manual was Jean Addington. 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. In the Appendix to the introduction to this manual, you will find a list of the major revisions made in the 2020 revision of the Director Manual

INTRODUCTION AND OVERVIEW: ESTABLISHING NAVIGATE IN YOUR ORGANIZATION

This is a time of transformation in our understanding of how to enhance the recoveries of individuals diagnosed with a first episode of psychosis in the United States. A landmark study, the Recovery After an Initial Schizophrenia Episode (RAISE) Initiative, conducted with support from the National Institute of Mental Health (NIMH), tested an innovative team-based approach (called NAVIGATE) 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
- We named the usual care treatment "Community Care".
- In Community Care, clinicians provided whatever treatment they thought was best for each patient
- Patients were recruited from 21 different states in the United States

Over the first 2 years of treatment
- Patients who got Community Care treatment improved as one would expect to happen
  But
- NAVIGATE patients stayed in treatment longer and had more improvement in overall symptoms, depression and quality of life
- NAVIGATE patients were more likely to receive prescriptions that conformed to best practices and experienced less side effects than patients given 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 in the Appendix to this manual.

The NAVIGATE program is organized into four interventions: Medication Management, Individual Resiliency Training, Family Education, and Supported Employment and Education.   Each intervention has its own manual and materials, which were designed to be feasible in real-world settings and to make first episode psychosis treatment a viable option for community-based organizations.

In addition to the four interventions named above, each NAVIGATE team has a director. This manual is written to help the director in their role. The director will work with leaders of the organization to determine how best to set up the program within that organization. The director may be involved in hiring staff, locating space, developing a business plan, doing outreach and education, generating referrals, evaluating candidates for enrollment, and will conduct weekly team meetings and provide supervision to team members.

The director is responsible for implementing the NAVIGATE program within the organization. The director is often involved at all levels in that he or she will work with the overall agency director, NAVIGATE Trainers and Consultants, NAVIGATE team members, and other staff at the agency who are in a position to refer potential clients. The director will also work with the NAVIGATE team around multiple issues and will have ongoing contact with clients and family members.   It is advisable to develop written contracts with the agency leadership around specifics of the integration of the NAVIGATE program into the agency so that the structures are clear from the beginning and are available for future reference.

Each state has different public and private providers. The NAVIGATE director and agency director work together to develop a billing model and a plan for providing NAVIGATE services. This manual has been developed to act as guide for the director to ensure that they are aware of the primary issues and tasks that need to be addressed.   As can be seen in the Table of Contents, the manual is divided into 5 sections, each containing several short chapters. There is also an extensive Appendix section containing forms, worksheets and handouts that are helpful to NAVIGATE directors in their role.

I. Forming a NAVIGATE Team and Creating a Strong Foundation
II. Working with the Team
III. Supervising and Supporting Team Members
IV. Maintaining NAVIGATE Services
V. Appendix

CHAPTER 1: LOGISTICS OF GETTING STARTED

This chapter will describe important background information about the criteria for enrollment in NAVIGATE and the recommended staffing of a NAVIGATE team serving a full caseload, as well as address some of the practical tasks necessary to get the program up and running. This section attempts to address the common start-up issues for new teams. We recommend that you use the Director Start-up List in the appendix to make your own list so that you can think through all practical issues before you start.

RECOMMENDED CRITERIA FOR ENROLLING INDIVIDUALS IN NAVIGATE

NAVIGATE is based on the treatment program developed during the Recovery After a Schizophrenia Episode (RAISE) research initiative. The main results of the RAISE Early Treatment Program (RAISE ETP) can be found in the following article:

Kane, JM, Robinson DG, Schooler NR, et al. 2016. Comprehensive versus usual community care for first episode psychosis: Two-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*
Because the positive RAISE ETP results were obtained for persons who met specific enrollment criteria, NAVIGATE programs are encouraged to have the same or similar enrollment criteria, such as the following:

- Between the ages of 15-40
- Diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder
- Have received antipsychotic medications for less than one year

The following conditions are ruled out:
- Significant intellectual disability or autism
- Diagnoses of psychosis based on affective disorders (such as bipolar disorder or anxiety disorders) or personality disorders

RECOMMENDED STAFFING FOR A FULL NAVIGATE TEAM WITH A CASELOAD OF 25-30 CLIENTS

- Director: .5 FTE (often combined with family clinician role), a masters level clinician
- Family clinician: .5 FTE (often combined with director role), a masters level clinician
- Prescriber: .20 FTE, an M.D. or Nurse Practitioner or Physician's Assistant
- Individual Resiliency Trainer (IRT): 1.0 FTE, a masters level clinician
- Supported Employment and Education (SEE) specialist: 1.0 FTE, an individual with a bachelors level degree

Highly encouraged to be included as members of a NAVIGATE Team:
- Peer Specialist: .5 FTE, an individual with lived experience with mental health challenges
- Case Manager: .5 FTE, a person who meets the state and agency requirement to provide case management

THE ROLE OF THE NAVIGATE DIRECTOR

Organizations need to hire or designate a leader for the NAVIGATE program. Successful leaders have clinical and supervision skills, administrative skills, and authority to run a program within the organization.

The Director's administrative responsibilities may include: hiring team members, securing recommended training for team members, reaching out to in-house and community agencies to generate referrals, leading weekly team meetings, monitoring the programs faithfulness to the NAVIGATE model, monitoring client outcomes, and in some agencies, overseeing the team's financial responsibilities.

The director's clinical responsibilities usually include evaluating referrals to the program, supervising the clinical performance of the team, providing supervision and feedback to team members, monitoring clients' clinical status, and delivering some direct care to individuals and families. The majority of NAVIGATE Directors also fill the role of the Family Clinician. For a full caseload of

25-30 clients, this would mean a single person could be half-time director and half-time family clinician.

Ideally, a NAVIGATE director is a mid-level manager who has authority to suggest or make administrative changes within an agency. We suggest that the NAVIGATE director is a full-time employee of the agency and has at least half of their time applied to working with the NAVIGATE team in a director capacity. NAVIGATE directors should have a clinical master's degree or PhD degree, such as in social work, psychiatric rehabilitation, or psychology.

The NAVIGATE director should become familiar with all of the NAVIGATE manuals in order to effectively supervise team members and to coordinate the efforts of the team.

NAVIGATE IMPLEMENTATION TEAM

A small group of people often works together to do the activities needed to start a new service within an organization. This group, sometimes referred to as an "implementation team," can lead the process, develop a plan, and carry out the tasks described below.   The NAVIGATE implementation team may include the NAVIGATE Director, the agency director, a community support service administrative leader, an operations manager, a financial officer and a clinician who will work on the team.

The implementation team should plan to spend a few months becoming familiar with the treatment model, developing an implementation plan, and beginning to carry out the plan. The implementation plan should include: identifying funding for NAVIGATE treatment, working with funding sources to ensure a workable model, hiring or appointing staff to the team, training staff, developing a recruitment and referral system, identifying referral sources, deciding on outcomes reporting, aligning agency policies and paperwork with NAVIGATE, and reporting to the leaders of the organization. Implementation teams usually meet weekly to get the service up and running, and then monthly during the period of implementation. After 6 months of the NAVIGATE team being in operation, the implementation team may taper down to meet quarterly or merge with a larger administrative meeting within the organization.

The NAVIGATE director is usually the best person to ensure that the logistics of implementation are being adequately managed. It is not necessary that the logistics are identical to what is described below, but rather that everything below has been considered. Start-up tasks vary from site to site and include: determining number of clients that can be expected based on population of the catchment area, securing space, determining an agency-approved method for communication, staffing, risk management, and record management (See the startup checklist in the Appendix). We will cover some of these start-up tasks in more detail below.

A. It is important to calculate the number of first episode psychosis clients expected in your catchment area, based on the overall population in your geographical area. One way to determine this is by using the "First Episode Psychosis Program Calculator" contained in the article available at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300186. The full reference for this article is "State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State" in Psychiatric Services, September 1, 2013. Humensky, J; Dixon, L; Essock, S.
This article describes how it takes a population of about 500,000 to support a fully dedicated first episode psychosis team such as NAVIGATE, which is serving 25 to 30 clients.
Once you know how many clients you can estimate enrolling, you can determine the staffing requirements for your team. For example, if a small number of clients are expected you would not need a fully dedicated team, and would plan instead for a smaller team or a team whose members have only part of their time dedicated to the NAVIGATE team.

B. The need for space to house the team will be determined based on the number of clients that are expected to be enrolled and the number of staff that you expect to hire. It is ideal if the space is youth-friendly and has a pleasant waiting room.

C. Clear methods of communication need to exist within the NAVIGATE program and between the NAVIGATE program and other programs in the agency.

There are several options to consider for communication, such as having a cell phone dedicated to the NAVIGATE intervention, having a dedicated phone line, ensuring that the clinic's switchboard (or front desk) is aware of the NAVIGATE intervention, and considering an after-hours phone line. Alternate scenarios should be considered that are relevant for each potential setting. For example, is 24 hour coverage mandatory at your agency, or can programs only be available during office hours? If programs are only available during office hours, who does the team recommend for clients and families at other times, such as crisis phone numbers, emergency rooms, etc.?

E-mail is also helpful for team members to communicate between team members. Texting between team members is used by some teams. In addition, some agencies have secure methods for clients to communicate with staff via e-mail and texting. Each state and agency differs, however, in what is allowed for client – staff communication. You need to check with your agency about their regulations.

D. Determine your budget. The main factors to consider are the number of clients you expect to serve, the expenses you expect to incur (e.g., paying your staff, paying for space needed), how much income you expect from billing for services, and how much financial support you expect from the state. Keep in mind that each state's public insurance programs, such as Medicaid, vary in terms of which NAVIGATE services are billable. Also keep in mind that a portion of first episode clients are covered by private insurance. Like public insurance programs, private insurances vary in terms of which NAVIGATE services they reimburse for, how many visits they allow, and requirements for reimbursement. Make sure that you have explored all avenues for billing, including getting your agency listed for private insurance panels.

E. Determine how many clients your clinic can handle. The director needs to become aware of the options for client volume and the potential consequences on the agency's infrastructure. Issues to consider include:
1. The organization needs a flow of clients in order to be sustainable.
2. Recommendations for caseload volume will be site specific.
3. Target numbers for sustainability of the staff are addressed at start up.
4. Depending on the agency, determine how many clients will be enrolled in the program and the rate for adding new clients.
5. Appropriate numbers in caseloads for required productivity need to be in place. This means that the director has to project caseloads and accrual of clients. The director determines how many people will be in the program at certain intervals (i.e., how many clients do you expect at start-up, by 6 months, by 12 months, etc.).
6. Keep in mind that the program's caseload will build gradually. That is, at the beginning of the program, you may enroll a few clients per month, until developing a full caseload. Note that your NAVIGATE team members need to get experience in using the skills they have received in NAVIGATE training (e.g., IRT clinicians may need to practice helping clients learn practical facts about psychosis or to process the experience of having an episode) before you have a large number of clients. In that situation, if there are no agency restrictions, they can practice the skills they are learning with non-NAVIGATE clients.

F. Staffing
1. As mentioned above, the director needs to determine the number of clients that the NAVIGATE team is expecting. The director must also know the budget for implementing the program. These are the first steps towards determining how many staff members to hire and at what percentage of time (e.g., what FTE will each team member be?)
2. For staff members whose time is not 100% dedicated to NAVIGATE, the director determines how those staff members will divide their time between NAVIGATE and regular clinic duties.

3. For staff members whose time is not 100% dedicated to NAVIGATE, it is important to target the number of individuals or families they are expected to see. We suggest that this be documented in a contract.

4. In addition to the director role, staffing is allocated for the prescriber, Family clinician, Individual Resiliency Training (IRT) clinician, and Supported Employment/Education (SEE) specialist. We also encourage teams to include a peer specialist and a case manager, whose salaries also need to be factored in. Depending on the organization, there will be individuals with dual roles in NAVIGATE (e.g., usually the director is also the family clinician).

5. Keep in mind that staff requirements change over the course of time. For example, it takes a while to develop a full caseload, so staff time may be gradually increased, with fewer hours allocated at the time of the start of the program, since there are fewer clients.

6. Protected time should be established prior to starting up NAVIGATE. That is, the director should determine how the staff's time will be protected to work on the NAVIGATE role for which they were hired. It is very important that team members do not get pulled away to other duties. In the initial weeks, staff needs protected time to receive training, to participate in meetings to plan start-up and to practice what they are learning in training. In the later weeks and months, staff needs protected time to meet with clients and families and attend team meetings and other important meetings.

7. It is important to establish the number and frequency of meetings that will be required in both the early phase (when client numbers are fewer and more time is needed for startup planning) and then again at a later date once an acceptable quota of clients are enrolled. Developing a chart of projected meetings is helpful.

8. Community outreach and education should be started as soon as possible. Many potential referral sources are not aware of the symptoms of first episode psychosis and/or do not know where to find treatment. Chapter 2 provides suggestions on how to reach out to referral sources such as inpatient hospitals, emergency rooms,

outpatient programs, high schools, colleges, trade schools, and churches.   Getting referrals is very challenging when the community does not know that your program exists.

9. Develop a system for handling referrals. Is your criteria for entering the NAVIGATE program clearly articulated? Who will be the contact person for referrals? What information will they collect? Who will see potential clients? How will inappropriate referrals be referred to more appropriate services?

10. Keep in mind seasonal variations for staffing needs. For example, some programs have a high intake in November and December when college students may become aware that they are failing their courses, and in September and January when high school students start a new semester and have difficulties. Some sites with a large college population have lower intake in the summer when students have returned home. Also, keep in mind coverage for staff vacations and absences.

11. Make sure that NAVIGATE team members can attend clinical training and participate in supervision and consultation calls, as well as the weekly team meeting.

G. Starting a new team means developing **policies and procedures** that fit the activities of NAVIGATE. These will include many of the items reviewed above, such as admission criteria, discharge criteria, job descriptions, caseload size, hours of operation, location of services, record keeping, outcomes tracking, program and staff performance evaluation.

CHAPTER 2: OUTREACH AND EDUCATION

The primary goals of outreach and education are:
1. to increase the number of people in your community who can recognize first episode psychosis
2. to inform people that effective treatment exists to help individuals who experience first episode psychosis, the earlier the better
3. to increase referrals to the NAVIGATE program

Outreach and education will promote community awareness of the NAVIGATE treatment program and should be tailored to a wide variety of audiences. As the NAVIGATE program is getting started, the director usually dedicates five or more hours per week to outreach and education, and uses different methods (ranging from phone calls to informal presentations to formal presentation) to approach the community.

This chapter is designed to help directors make an outreach and education plan and to keep track of activities completed, contacts developed and follow up plans made.

A. Developing an Outreach and Education Plan (See Appendix) allows the director to:
    1. Plan where they will target their outreach and education efforts.
    2. Keep a record of the audiences they have reached.
    3. Provide a timeline for outreach and education activities.
    4. Plan for following up initial contacts.

B. The steps for planning outreach include:
    1. Developing a list of people and places to target. These include potential referral sources as well as public organizations. (See Appendix, Log of Contacts with Potential Referral Sources). Ensure pertinent contact information is added. Use this as the guide for education,

advertisements and for scheduling lectures, talks and brief presentations.

2. Developing a variety of presentations, ranging from a brief phone description of the NAVIGATE program to more formal presentations such as grand rounds. A template for contacting potential referral sources by phone and for providing follow-up to inquiries could be used. (See Appendix for an Example of Initial Phone Contact to Explain NAVIGATE).

3. Keeping a record of people and places that were contacted, the result of the contact, and the next steps planned (e.g., calling again in 1 week, scheduling a 15-minute presentation at the monthly social work department meeting, attending a treatment team meeting, etc.). Activities that are successful are noted as well as those that are not as successful. The contact sources are updated with respect to which ones were useful and which ones were less useful for recruitment. It will be important to find out which individual(s) may be most helpful in referring clients to NAVIGATE. For example, at the state psychiatric facility, it may be most helpful to work with the social worker or nurse who leads the discharge planning.

C. Identifying and prioritizing the target population for Outreach (See Log of Contacts with Potential Referral Sources in the Appendix).

1. The first priority of potential referral sources to contact contains those that are the most likely to refer first episode clients. This includes: inpatient psychiatric hospitals, emergency rooms, crisis teams, outpatient mental health clinics, and local chapter(s) of the National Alliance on Mental Illness (NAMI).

2. The second priority of potential referral sources to contact contains those that come into frequent contact with the age group most likely to develop first episode psychosis. This includes high schools, colleges, universities, transitional age youth services and trade schools. In addition, the criminal justice system often encounters

young people whose mental health symptoms have led to problems with the law.

3. The third priority of potential referral sources to contact includes public and community sites that allow information about the program to be conveyed to the general public. This includes: general medical practitioners, pediatricians, churches, synagogues, mosques, libraries, community centers, and recreation centers.

4. For each list, the most appropriate method of contact is determined.

D. Prepare materials to use.

1. The first step is to develop relevant fliers, brochures and posters to provide information about the first episode clinic.

2. The second step is to develop a range of other ways that the public can be informed about the NAVIGATE program, such as having an online presence, including a website that is likely to show up on an internet search. Hardcopy advertisements include: posters, public transit boards, flyers, business cards, mail-outs and newspaper postings. Verbal advertisements include newspaper stories and radio coverage.

3. The third step is to develop a range of presentations, such as an outline to use for short presentations at a staff meeting, a ppt to use at more formal presentations, and a list of short videos that can be used to illustrate important points about first episode psychosis and its treatment.

E. Distribute brochures and flyers by mail or e-mail to all of the potential referral sources. For example, inpatient hospitals, emergency rooms, crisis teams and mental health centers are key referral sources to whom you can mail out a brochure (or send an e-mail), followed by a personal call offering additional program information, and the opportunity to receive more material and/or a formal or informal presentation.

F. <u>All potential referral sources are contacted</u> so that they can be informed about the program. One strategy is as follows: after mailing out a brochure, a personal call is made. The primary purpose of the call is to find out if this is an appropriate referral source for first episode psychosis. The second purpose is to ensure that referral sources have as much information as possible in order to make appropriate referrals. It is important to be very clear about how and to whom to make a referral. (See Appendix for an example of the initial phone call to a potential referral source).

G. <u>Positive and negative responses to the outreach are documented</u> in the Outreach and Education plan, which should be updated each month.

H. <u>Key resources are asked if they would like a talk or presentation.</u> The resources most interested in having a talk or presentation often includes inpatient hospitals, emergency rooms, college counseling services, and crisis services. It is often helpful to ask a team member to accompany you as the director, such as the peer support specialist or the SEE specialist.
   1. The need for other talks comes from inquiries made about education and advertising outreach which will provide a list of potential sources for lectures/talks.
   2. Lectures/talks provide the audience with relevant information about early psychosis, first episode psychosis clients, and the NAVIGATE intervention; provide information about the referral process; and invite questions and comments from the audience.
   3. Relevant information: Each site produces its own presentation material. An example of a PowerPoint presentation is available from NAVIGATE trainers.
   4. Comments are used to evaluate the effectiveness of the lecture/talk and are added to the Outreach and Education Plan.
   5. Consider the possibility of holding a symposium that provides Continuing Education credits (such as CEUs or CMEs) on first episode treatment or collaborate with a group who would be interested in doing

such a symposium. A range of staff could then be invited, e.g., staff from all college counseling centers in locations with a high density of colleges.

I. <u>Acknowledge referral sources when they send a referral</u>. This can be helpful in sustaining communication with these sources and maintaining visibility of NAVIGATE as a viable referral option. This can be done in several ways:
    1. Ensure that sources get feedback on their referral.
    2. Let them know the outcome of the referral, whether the particular referral is appropriate or not. If the referral is not appropriate, it is helpful to the referral source to know the reason, so that more appropriate referrals can be made in the future.
    3. Thank the source for their referral regardless of suitability.

CHAPTER 3: ADMISSION CRITERIA AND REFERRALS

As described in Chapter 1, because the positive RAISE-ETP results were obtained for persons who met specific enrollment criteria, NAVIGATE programs are encouraged to have the same or very similar enrollment criteria, such as the following:

- Between the ages of 15-40
- Diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder
- Have received antipsychotic medications for less than one year

The following conditions are ruled out:
- Significant intellectual disability or autism or traumatic brain injury
- Symptoms of psychosis are related to diagnoses of affective disorders (such as bipolar disorder or anxiety disorders) or personality disorders

As described in Chapter 2, the director (and other team members) will do outreach and education activities in order to inform potential referral sources of the NAVIGATE program and introduce them to the enrollment criteria. Once referrals are received, it is important to design a streamlined approach to 1) process referrals, 2) make an initial assessment as to the suitability of the referral (for example, is the individual of the right age group? Are their symptoms consistent with a diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform? Do they have any conditions that are ruled out?) and 3) meet with clients who meet initial criteria and their family members for evaluation. Plans should also be made for how to refer out clients who do not meet criteria for NAVIGATE.

The following points may be helpful in developing systems of responding to referrals.

A. Referrals that arrive by standard mail, fax, electronic mail or phone should be directed to staff that are trained to identify relevant NAVIGATE referrals. Referrals should be followed up quickly.

B. The NAVIGATE director is usually the person who determines whether clients being referred meet NAVIGATE criteria. Sometimes the director needs to seek additional information from the referral source. The director contacts individuals and their family members to come in for an evaluation if the client appears to meet NAVIGATE criteria. Referrals who do not appear to meet criteria for NAVIGATE may need a referral to alternative services.

C. The agency and the NAVIGATE team should identify different ways referrals may be made (e.g., from professionals, directly from clients and families, internal and external sources). Each site will be different and will outline their own acceptable ways for receiving referrals.

D. The director usually works with the agency to develop guidelines on how to expedite the referral process for NAVIGATE relevant clients. Referrals should be received promptly by the director. The director, in turn, promptly reviews the referrals and gathers any additional information needed from the referral source. The director then makes an initial decision about whether the referral is appropriate and warrants an evaluation interview.

E. Potential NAVIGATE clients should not have to wait long for an evaluation once the referral is processed and they are determined to meet initial NAVIGATE criteria. NAVIGATE recommends that potential clients and their families be contacted for an evaluation within a week of their referral being received.

CHAPTER 4: FORMING THE TEAM

As mentioned in Chapter 1, The NAVIGATE team consists of:

- Director (usually also takes role of family clinician)
- Family Clinician (as noted above, usually also takes role of director)
- Prescriber (either a psychiatrist, nurse practitioner or physician's assistant)
- Individual Resiliency Training (IRT) Specialist
- Supported Employment and Education (SEE) Specialist
- Peer Specialist (highly recommended)
- Case Manager (highly recommended)

It is important to hire team members who are enthusiastic about working on this program and having the opportunity to increase early detection and treatment within this young population. It is desirable for team members to have some experience with working with psychosis and with working with this age group, but it is not always possible to locate staff with such expertise. It is important to keep in mind that staff members will also receive training to increase their skills in both these areas after they join the team.

A. Your site may decide to hire employees who already work for the organization and who may have dual roles in the organization. The director works with each staff member to make sure that their NAVIGATE time is protected and that they are able to carry out their NAVIGATE responsibilities.

B. Provide internal and external candidates with information and education about the NAVIGATE intervention in order to stimulate interest and to provide feedback about the initiative.

C. Identify individuals who have specific skill sets and an interest in early intervention. These are individuals either with relevant expertise, or those who have the potential to develop the required expertise relatively easily. In addition to usual clinician skills and qualities, clinicians who work with

young people experiencing a first episode of psychosis need the ability to be non-judgmental about the clients and their families. The clinicians need to understand the difficulties and challenges that the first episode clients and their families are experiencing. The clinicians also need to recognize that first episode clients are quite different from clients with a longer course of schizophrenia.

The clinicians need to convey hope that recovery is possible and that, despite having experienced psychosis, every individual has the potential to be resilient and lead a full, productive life.

D. It is important to clearly define each staff member's responsibilities and duties.

E. Take into account the diversity of first episode clients and encourage diverse candidates to apply for the position.

CHAPTER 5: LEADING THE TEAM

Once the team is hired, the director needs to contract for and schedule formal training for the team. Training consists of education for the whole team about first episode psychosis and recommendations for treatment, as well as training individual team members in their specific roles. Contact information for the NAVIGATE Training Coordinator can be found at navigateconsultants.org.

After the team has been trained, the director offers leadership and guidance to optimize how the team works together in the service of the individual's recovery and resilience. The director provides leadership in 4 major ways: building and maintaining team spirit, providing ongoing education about first episode psychosis, educating team members about strategies for addressing common challenges with this population, and encouraging the use of the shared decision-making model. More details are provided below.

A. Building and maintaining team spirit.
1. The team philosophy focuses on the best possible outcomes for first episode clients.
2. Work with team members to set realistic goals when working with first episode clients (e.g., it can take time for clients to develop a trusting relationship).
3. Help team members identify the progress the clients are making.
4. Increase team members' awareness of their contributions to clients' progress.
5. Celebrate milestones with the team, such as when the team has enrolled 10 clients, or when clients get jobs or go back to school.

B. Providing ongoing education about first episode psychosis and strategies for working effectively with this population.
1. Encourage staff to use non-stigmatizing language at all times. Use person-first language; for example, refer to "individuals who experience psychosis," rather than "psychotics" or "schizophrenics." Avoid technical

terminology and jargon that may not have a meaning for young clients and their families such as: somatic, avolition, anhedonia, etc. Language conducive to first episode clients includes fully explaining all complex clinical terms and the use of neutral terms to describe processes. It is also important to use normalizing language, which reduces anxiety and distress in first episode clients (e.g., "many young people experience symptoms of psychosis," "I have been told by other people with psychosis that…").

2. The client may already have preconceived attitudes about psychosis and/or mental health treatment. However, what is more likely is that they have not sought treatment before and do not have much sense of what treatment is all about. First episode clients often feel that early intervention (or any intervention) is not necessary and that their symptoms will just go away over time. This attitude can be altered by informing the client and their family about the importance of early intervention in delaying and/or preventing further symptoms and problems.

3. First episode clients often associate psychosis with an incurable illness and a life with no opportunities. An optimistic outlook by the treatment team and educating about the benefits of early intervention helps reduce this attitude. First episode clients should be informed of current knowledge about mental health disorders and their treatments and common myths should be dispelled.

4. First episode clients often hold attitudes about substance use that may be false (e.g.., substance use helps symptoms go away), inaccurate (e.g., taking a street drug one time has caused their ongoing problems with psychosis) and unproductive (e.g., antipsychotic medications are addictive).

C. Educating team members about strategies for common challenges in working with individuals with first episode psychosis

1. Individuals with first episode psychosis may appear guarded, mistrustful and reluctant to participate in the NAVIGATE program. Remain

optimistic and reinforce the clients' involvement in the shared decision-making model as a way of overcoming behavioral roadblocks. It is important to be patient and to engage the individual around their personal goals.

2. Individuals with first episode have had a variety of experiences that may contribute to their receptivity or lack of receptivity to working with the NAVIGATE team. For example, they may have had unpleasant experiences with schools or mental health services. One way to explore with first episode clients about past treatment experiences is to ask the following kinds of questions: What was helpful in previous treatment and what was not helpful? What did you like about previous treatment? What didn't you like about previous treatment?

3. Because of their symptoms, individuals with first episode are often unstructured or unorganized (e.g., they often forget or arrive late for appointments) and require a certain degree of flexibility by team members in order for the NAVIGATE intervention to be successful.

D. Encouraging the use of the shared decision-making model
1. The shared decision-making model combines the professionals' knowledge about psychosis with the clients' and family members' personal experience with psychosis.   The shared decision-making model uses input from the NAVIGATE team and from the first episode client and the family when planning treatment.

2. In NAVIGATE, treatment planning is based on: (i) the expertise of the treating clinician and/or treating team, (ii) information that is available in books and articles, especially those which are evidence based, and (iii) input from the client and family, who offer valuable information about what tends to work best for them, what they are prepared to do, their own knowledge and the context they are in. Client choice plays a major role in planning the different aspects of treatment. Input from the client's support system is also important.

CHAPTER 6: CONDUCTING TEAM MEETINGS

Team meetings are where decisions and planning will take place. Initially, when there are fewer clients, meetings can be used for planning and for reviewing training, including each intervention sharing with each other what they learned during their training.   There should always be the opportunity for review of all aspects of the NAVIGATE program at the team meeting. Team meetings are a vital component of the program.

A. Meetings are scheduled weekly and everyone is expected to attend. Team members will include: the director, IRT clinician(s), SEE specialist(s), family clinician(s), prescribers(s), peer specialist(s) and case manager(s). A meeting agenda, with action items, can be used to provide structure and efficient use of time. An example of a meeting agenda has been provided (See Appendix).

B. The meeting provides the opportunity to coordinate services and to pass along information to the NAVIGATE team members.

C. The goal is to keep the team on the same page regarding the client and family.   This may involve troubleshooting during team meetings about problems as they arise.

D. Each client should be briefly reviewed in each team meeting. If the caseload is high (e.g., over 20), it is acceptable to review half of the caseload each week.

E. The director leads the client review, beginning with a quick reminder of the client's personal goals, and then making sure that each team member's input is provided for each client. Time management is very important. Team members should be encouraged to state their input in a few sentences. When there is a crisis or urgent situation, of course, more time

may be needed for a particular client and for a particular intervention. A client-tracking form is provided in the Appendix as an example of a way to keep track of the input from team members during a team meeting.

F. Everyone on the team serves a vital role. It is important to push for each team member to attend the weekly team meetings, including the prescriber, even though their schedule may be challenging. Having access to the prescriber during team meetings helps the whole team be more effective. Being able to ask the prescriber questions about a client's medication is invaluable to the team members. And it is invaluable to the prescriber to be able to get input from the other team members about the client's goals, functioning, and concerns.

G. The director will find it helpful to keep track of which clients are receiving which services. For example, of the total number of active clients, how many are receiving IRT? SEE? Family? Peer Support? The percentage of clients being seen for each intervention should be greater than or equal to the percentage that were seen during the RAISE-ETP research. For example, during RAISE-ETP
    1. Family clinicians met about 75% of the relatives at some point while their loved one was in NAVIGATE and 68% had at least one family education session during the program. 46% attended at least 5 family education sessions in the first year.
    2. 68% of the NAVIGATE participants met with the SEE worker at least 3 times.
    3. 94.6% of NAVIGATE participants had one or more medication visits. Across all participants, the mean number of visits over the first 2 years per month was 0.55. Keep in mind that this data was derived from all participants and includes participants who dropped out of treatment.
    4. 99.5% of people in the NAVIGATE group had at least 1 IRT session. 90% of people in the NAVIGATE group had 3 or more IRT sessions

Therefore, based on the RAISE data, current NAVIGATE teams can expect about almost all of their clients to participate in medication visits, almost all of their clients to participate in IRT, 1/2 to 2/3 of the families to participate in Family Sessions, and 2/3 of their clients to participate in SEE sessions. If your team is not getting these levels of participation, it is important to problem-solve how the levels of participation can be increased.

H. It's important to monitor drop-out rates. The research shows that even with coordinated specialty care programs for first episode psychosis, a third to a half of clients will disengage before two years. We would like to see better rates of retention than this.
   When clients want to leave your program before two years, you need to explore the reasons. Some reasons for leaving the NAVIGATE program are a sign of recovery and resiliency, such as moving away because of getting a job or going back to school in a different location. Some reasons for leaving the program may indicate that the team needs to increase their efforts at engagement, as described in Chapter 8.
   When clients are leaving the program before graduation or when they graduate and transition to less intensive services, it is important to convey to them that the door is always open.

I. In addition to the weekly team meeting, a monthly meeting with the CEO and/or the agency director is held to update them on the NAVIGATE program as a whole (for example, number and source of referrals received, number of clients who are being served, number of clients who are currently working or in school) and to let them know about any problems for which that they need assistance. For example, there may be a problem with team members' protected time (such as being pulled away to other duties at the agency), or with space (such as being in danger of losing some of their office space), or with low numbers of referrals being received from other departments in the agency.

CHAPTER 7: CREATING A POSITIVE CLINICAL CLIMATE

To encourage young people to come for early treatment, we need to create a welcoming atmosphere. Here are some ideas:

A. Keep in mind that clients and families are in a vulnerable state, and may be sensitive to traditional mental health center waiting rooms, where there may be lots of clients waiting, almost all of whom will be older than the client, and often experiencing overt symptoms.   They may be also sensitive to a sense of confusion or chaos in traditional waiting rooms. Therefore, as much as possible, try to arrange for NAVIGATE clients to have a separate waiting area. If that is impossible, arrange to meet NAVIGATE clients as quickly as possible when they arrive in the waiting room and bring them back to the NAVIGATE offices.

B. First episode clients respond better to offices that are comfortable and cheerful, and which don't look bare and "institutional." If possible, get a fresh paint job for the offices, bring in colorful pillows and hang pleasant photos or prints on the walls.

C. Provide basic refreshments such as coffee and bottled water.

D. If clients and families are coming to the office for their first appointment, make sure they have good directions and if relevant, suggestions for parking options. Arrange to meet them at the front desk, arriving there before they do, so that they see a friendly welcoming face right away.

E. First episode clients and their family members will often hesitate to seek help if the clinic appears to be in a state of chaos. If the clinical atmosphere is crowded and chaotic, and attempts to change it are not successful, it should be disclosed to the client and family prior to the initial visit. This will avoid the "state of shock" that results when a first episode client encounters an unconventional or unknown environment.

F. Use person-first, recovery and resiliency-oriented language with clients and families at all times.

G. Be as accommodating as possible to clients' and family members' schedules and preferences. Make home visits available for IRT, family education, SEE, peer support, and case management. Establish evening hours at least one night a week to accommodate work or school schedules.

CHAPTER 8: USING THE WHOLE TEAM TO ENGAGE THE CLIENT AND FAMILY

The overall goal of the NAVIGATE program is that every client should get a chance to benefit from all the interventions. This does not mean that we force people to participate in everything. We just want to make sure they know as much as possible about all the interventions, and have a chance to meet face-to-face with the person providing it at least once or twice. This in keeping with shared decision-making. For example, how would clients know whether they want to participate in IRT if they don't know what it is, and how it might be helpful to them?

We also want to provide more than one opportunity to clients to start participating in an intervention. We revisit an intervention with the client to offer the opportunity again, even if the client initially declines. We recognize that people's situations change, their interests change, and their motivation to participate in a particular intervention may change. Therefore they may initially decline to participate in an intervention, but later decide that the intervention would be helpful.

This chapter will look at engagement at three different points in time: at the assessment meeting with the client and family; at the first meeting with the client and family after the client has been determined to meet enrollment criteria; and throughout the client's participation in NAVIGATE. This chapter will also address special issues for engagement in Family Education.

   A. Engagement at the assessment meeting with client and family
      1. The director is often the first and primary point of contact with the client and family. When you first meet with the client and family to determine eligibility for the program, many of the questions relate to the individual's symptoms, including the length of time the client has experienced them and their severity.

2. In addition, it is important to show that you care about the individual as a whole person, not just their symptoms. Ask about the client's interests, how they are spending their time, how they would like to be spending their time. How are things going with work or school? What are their current activities, plans, and aspirations for the future?

3. Explore with the individual what their primary concerns are, what they would like to have help with first. Clients have a wide variety of priorities. Some say they want help with relief from symptoms, others are more concerned about failing their classes, others are worried about financial or legal problems, and others are worried about their housing. When you show that you are interested in what worries them, it helps the engagement process. And if you are able to help with some of their concerns, or offer suggestions, it furthers the engagement process.

4. Also explore with the family what their primary concerns are, what they would like to have help with first. Like clients, families have a wide variety of priorities. In addition to concerns about their family member being evaluated for NAVIGATE, family members may be concerned about their other children or aging parents, or they may have financial problems.

5. Offer to help with the things you can reasonably do in your role, and suggest other resources (or make referrals) that can help the individual or the family.

6. Briefly describe the NAVIGATE program, taking care not to imply that the individual will definitely be eligible to enroll in NAVIGATE. You can use the NAVIGATE orientation sheet (see Appendix) as a guide, and if possible, point out how the different components of the program may be useful to address problems the client has been experiencing, including but not limited to their symptoms.

7. From the very first meeting, emphasize that people can be resilient to psychosis, and there are reasons to be hopeful about the future.

B. Engagement at the first meeting with the client and family after they have been determined to meet enrollment criteria

1. Prior to the meeting, arrange to have as many team members available as possible, so that there is a time for the client and family to briefly meet them. Meeting a team member might consist of you saying something like, "Let's just walk down the hall so you can meet the Family Clinician and Supported Employment and Education specialist." Or it might consist of you asking the team member to come down to your office for a quick "meet and greet."

2. Let the team members know that you would like each of them to set up a 20 minute meeting with the client and/or family in the next week or two, so each client gets a chance to find out more about the intervention, ask questions, and perhaps schedule their first full meeting.

3. Start your meeting with the client and family by sharing the good news that the client can be enrolled in the NAVIGATE program, and convey that you think the program will be very helpful to the client regarding the concerns they mentioned in the assessment meeting. Also convey that the program is designed to help family members, too. That is, we have a special family education program to help family members understand more about what the client has been going through, and how the whole family can work together.

4. Review the NAVIGATE program again, using the NAVIGATE Orientation Sheet in the Appendix. Your goal is to help the client and family see the value of each intervention and how it might specifically help them to participate in the interventions. Avoid saying things like "which intervention do you want to participate in?" This gives the message that we want them to choose among the interventions, rather than that we want them to have the advantage of each intervention.

5. Answer any questions the client or family may have.   Then say that you would like for them to have a chance to meet the team members. Let them know that you will be setting up a short (20-minute) meeting with the team members later in the week or next week, but that you would like to at least say "Hi" today. Then either walk down the hall to see the team members or ask them to come to your office, one at a time.

These meetings are meant to be very short "meet and greets" so that the client and family are not overwhelmed.

6. At the end of the meeting make sure that the client and family understand the next steps of participating in the program. It is helpful to write down a summary of these next steps, including appointment times, and names and phone #'s of the people with whom they are meeting.

C. Engagement throughout the client's participation in NAVIGATE

1. Clients often fluctuate in their engagement in NAVIGATE. It is not uncommon that a client will be very engaged and active in taking medication, attending their NAVIGATE appointments, and taking steps towards their goals—and then to rather suddenly disengage in one or more of these aspects of treatment. It is important to recognize that engagement is not just an issue when individuals are getting started in NAVIGATE. Engagement is an ongoing issue, and the director and all team members need to be alert to signs that an individual or a family is starting to be less engaged in treatment, and to help them get re-engaged.

2. As the director, during team meetings it is helpful to keep an eye on each client's participation in treatment and to help the whole team problem-solve when there seems to be a decline in engagement.

3. When there is a decline in engagement, there are many potential reasons, and it is important to explore on a case-by-case basis why a particular client is declining in engagement. Some of the common reasons for a decline in engagement include that the individual feels that

- Their needs are not getting met
- They are not making progress in goals that are important to them
- They are experiencing difficulties which are not being addressed
- They are finding it increasingly challenging to attend sessions, either because of the time, location, frequency, or problems with transportation

- They are experiencing fewer symptoms and no longer feel that they need treatment

4. Depending on the individual's reason for the decline in engagement, as director you can help the individual team members (and the team as a whole) explore what is keeping the individual from being engaged in treatment? What might be a natural opportunity or opening to increase their involvement? As director, you can also help problem-solve strategies the team can use to re-engage an individual. For example, if the client is finding it challenging to attend sessions, it may be preferable to schedule home visits. If the client no longer feels that they need treatment because of a decline in symptoms, it may be helpful to review the ways that treatment can help prevent symptoms returning. Also, if the individual does not see the value of treatment as it relates to symptoms, it may be helpful to focus more on the individual's goals and making progress towards them, which often remains very motivating to them.

5. As director, you may also be able to detect signs of disengagement in a particular intervention during supervision sessions with the IRT, the SEE, or the peer specialist. You can then problem-solve with the team member to develop strategies for re-engagement in that particular intervention.

D. Special issues for engagement in Family Education

1. 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 just more people telling me what to do").

2. 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).

3. 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.

4. Re-visit family involvement during team meetings, and help the whole team problem-solve on how to get the family involved. For example, a client who is reluctant to have their family involved might meet regularly with the IRT clinician. The IRT could suggest that the family clinician join them briefly during an IRT session to talk about the 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 five minutes to answer any questions or address any concerns the family member might have.

5. Look for additional strategies in the Family Education manual about engaging clients and family members in family education.

CHAPTER 9: CLINICAL SUPERVISION IN GENERAL

One of the key roles of the director is to provide weekly supervision of the IRT and SEE therapists. If the team has a peer specialist and a case manager, the director may be asked to supervise them, too, depending on the policy of the agency. (For example, some agencies may require case managers to be supervised by a case management supervisor.) If the director is not also the family clinician, the director will also provide supervision for the family clinician.

Some key issues of supervision are outlined below:

A. The supervision process is defined at the local site level. For example, some agencies have different requirements for their supervisors. This is dictated by the site and state licensing board.

B. The director will provide clinical supervision specific to the NAVIGATE intervention of the person that they are supervising.

C. If there is more than one team member providing an intervention, they can receive supervision together. For example, if there are two IRT's, they can receive supervision at the same time.

D. Supervision will target skill development.

E. Role-playing is encouraged during supervision.

CHAPTER 10: INDIVIDUAL RESILIENCY TRAINING (IRT) SUPERVISION

The Director of the NAVIGATE program provides weekly supervision to the Individual Resiliency Training (IRT) clinician. If there are two or more IRT clinicians, they can be supervised together.

A. The Director should familiarize themselves with IRT.
1.   The introductory chapter of the IRT manual provides a good overview of the intervention and should be read in advance of starting supervision.
2. After reading the introductory chapter, the director should read a module at a time, both the client handout and the clinical guidelines. Ideally the director should stay a module ahead of the supervisees.
3. The director should make use of the IRT demonstration videos, which can be found at navigateconsultants.org. The director can watch the video for each module prior to supervising that module and/or reserve time during supervision to watch the video together with the supervisees.

B. The tasks involved in providing supervision to the IRT clinicians include
1. Reviewing all clients receiving IRT.
2. Reviewing the progress that clients are making towards their personal goals.
3. Reviewing the strengths of each client related to their goals as well as the challenges they experience.
4. Ensuring that IRT services are fully integrated with other NAVIGATE services (i.e., IRT should be integrated with Individualized Medication Management, Supported Employment and Education, Family Education, Peer Support, and Case Management).
5. Helping IRT clinicians develop skills related to providing IRT.
6. Helping IRT clinicians problem-solve to develop strategies to address challenges they are experiencing in sessions with clients.
7. Providing IRT clinicians an opportunity to role play new skills.

C. The supervisor usually begins by asking a series of check-in questions when reviewing IRT clients, including the following:
    1. What IRT module is the client working on?
    2. What are the client's recovery and resiliency goals?
    3. What steps have been taken towards achieving the client's recovery and resiliency goals?
    4. What is the client's attendance rate?
    5. Are home assignments being completed?
    6. Are there any problems that currently need to be addressed?
    7. How is IRT being coordinated with other services in the NAVIGATE Program?

D. After the check-in and addressing any crisis situations, the supervisor and IRT clinicians collaboratively decide what is most helpful for the remaining time in supervision. The main options are:
    1. Planning for the next IRT module.
    2. Using Step-by-Step Problem Solving for a problem or challenge identified during the check-in, using the following steps when feasible:
        a. Defining the problem
        b. Eliciting possible strategies/solutions from the clinician(s)
        c. Evaluating strategies/solutions
        d. Clinician chooses strategy/solution to try
        e. Clinician makes a plan to try the strategy or solution
        f. Clinician plans to follow up on how the strategy/solution worked during the next supervision meeting
    3. Reviewing an IRT skill or clinical strategy for continuing the training of the clinician. Supervisors are encouraged to model new skills and to engage clinicians in role plays to practice the new skills during the supervision meetings

E. Supervision also provides an opportunity to address any challenges in engaging clients in IRT. For example, if the IRT clinician has only been able to engage a fraction of the clients on the team caseload, the supervisor can

explore barriers to engaging the clients and offer strategies to increase the rate of engagement.

F.   You will find more strategies for IRT supervision in the IRT manual.

CHAPTER 11. FAMILY EDUCATION SUPERVISION

If the Director of the NAVIGATE program is not themselves a Family Clinician, they provide weekly supervision to the Family clinician(s). Family supervision follows the same general steps as IRT supervision.   If there are two or more family clinicians, they can be supervised together.

    A. The Director should familiarize themselves with Family Education, using the Family Education manual.
   1. The introductory chapter of the Family manual provides a good overview of the intervention and should be read in advance of starting supervision.
   2. After reading the introductory chapter, the director should read a module at a time, both the client handout and the clinical guidelines. Ideally the director should stay at least a module ahead of the supervisees.

    B. The tasks involved in providing supervision to the Family Education clinician include
   1. Reviewing all clients whose families are receiving Family Education.
   2. Reviewing the progress that clients are making towards their personal goals (in IRT), and if family members have identified goals, reviewing the progress they have made.
   3. Reviewing the strengths of each family as well as the challenges they are experiencing.
   4. Ensuring that Family Education services are fully integrated with other NAVIGATE services (i.e., Family Education should be integrated with IRT, Medication Management, Supported Employment and Education, Peer Support, and Case Management).
   5. Helping Family clinicians develop skills related to providing family education.
   6. Helping Family clinicians problem-solve to develop strategies to address challenges they are experiencing in sessions with families

7. Providing Family clinicians an opportunity to role play new skills.

C. The supervisor usually begins by asking a series of check-in questions when reviewing all clients whose families are receiving Family Education.
   1. What educational module is the family working on?
   2. What is the client's recovery and resiliency goal(s)? Has the family identified goals? If so, what are they?
   3. What steps has the client taken towards achieving his or her recovery and resiliency goal(s)? If relevant, what steps has the family been taking towards their goals?
   4. What is the family's attendance rate?
   5. Are home assignments being completed?
   6. Are there any problems that currently need to be addressed?
   7. How is Family Education being coordinated with other services in the NAVIGATE Program?

D. After the check-in and addressing any crisis situations, the supervisor and Family Education clinician(s) collaboratively decide what is most helpful for the remaining time in supervision. The main options are:
   1. Planning for the next Family Education module.
   2. Using Step-by-Step Problem Solving for a problem or challenge identified during the check-in, using the following steps when feasible:
      • Defining the problem
      • Eliciting possible strategies/solutions from the clinician(s)
      • Evaluating strategies/solutions
      • Clinician chooses strategy/solution to try
      • Clinician makes a plan to try the strategy or solution
      • Clinician plans to follow up on how the strategy/solution worked during a supervision meeting in the next week or two
   3. Reviewing a Family Education skill or clinical strategy for continuing the training of the Family clinician. Supervisors are encouraged to model new skills and to engage clinicians in role plays to practice the new skills during the supervision meetings.

E. Supervision also provides an opportunity to address any challenges in engaging families in Family Education.   For example, if the Family clinician has only been able to engage a fraction of the families of the clients on the team caseload, the supervisor can explore barriers to engaging the other families and can offer strategies to increase the rate of engagement. See Chapter 8 for examples of strategies for using the whole team to engage families.

F. See the Family Education manual for additional strategies for Family Education supervision, and additional strategies for engaging the client and family and encouraging them to join Family Education sessions.

CHAPTER 12: Supported Employment and Education (SEE) Supervision

A. The director of the NAVIGATE program provides weekly supervision to the Supported Employment and Education (SEE) specialist. If there are two or more SEE specialists, they can be supervised together.

B. It is helpful to read Chapter 1 of the SEE manual, which provides an overview of the SEE model, prior to beginning supervision. The manual contains 11 chapters. It is helpful to read a chapter a week to acquaint yourself with the important components of SEE and to provide topics for supervision sessions.

C. The director should be especially aware of SEE principles and look for opportunities to reinforce these principles and for opportunities to address situations where the principles are not being followed. Here are the SEE principles:
   1. *All clients in the NAVIGATE program can participate in the SEE program*. Note that all clients should be introduced to the SEE specialist and have a chance for at least one or two meetings with the SEE specialist to learn more about the services; all clients who want to participate in SEE services can do so).
   2. *SEE and clinical services are integrated on the NAVIGATE team.*
   3. *SEE focuses on competitive work when work is the goal, and integrated education when school is the goal*.
   4. *SEE provides a comprehensive assessment* **(see the Career and Education Inventory in the SEE manual).**
   5. *Client's preferences are respected*. *S*ome clients may be interested in jobs and others in education; for those interested in jobs, they vary in the types of jobs they want; for those interested in education, they vary in the type of education they want; some clients want to disclose their mental illness to prospective employers or school personnel while others do not.

6. ***Benefits counseling is provided for those clients who are deciding on applying for federal or state benefits.*** The whole team can be involved in helping clients access accurate information and weigh the pros and cons of benefits. Many clients also benefit from talking to a designated benefits counselor at the agency or at the Social Security office or at the state office which handles benefits.

7. ***Rapid job or school search***. The general recommended timeframe for initiating the job search for clients who are interested in employment is that they are expected to begin having face-to-face contact with potential employers in their communities within 30 days of starting SEE services.

8. ***Follow along support should be provided after clients obtain work or enroll in school.*** By checking in regularly with the client about school or work, and being available for new job or school starts, the SEE specialist doesn't have to rely entirely on the client requesting his or her help.

   More details about the SEE principles and examples of how they are implemented can be found in the SEE manual.

D. SEE specialists who are members of a larger Supported Employment team may also receive supervision from the supervisor of that team.

E. The tasks involved in providing supervision to the SEE specialist include
   1. Reviewing all clients in SEE.
   2. Reviewing progress towards the SEE goals of each client.
   3. Reviewing the strengths and challenges of each client related to their SEE goals.
   4. Reviewing the current standing of each client in the program, including the phase of SEE services (i.e., engagement and assessment, goal development, employment or school search, follow-along supports).
   5. Ensuring that SEE services are fully integrated with other NAVIGATE services.
   6. Reviewing the SEE specialists' contacts with clients to make sure that needed services are provided in a timely manner, consistent with SEE principles, and in the most effective environments (e.g., the majority of

SEE services should be provided in the community not in the office; follow-along supports should be provided at or near the client's school or place of employment or in the community, such as a library or neighborhood coffee shop).

7. Accompanying SEE specialists into the field to further their SEE skills and provide feedback on those skills (e.g., the supervisor can go with SEE specialists when they are conducting a job development meeting or when they are exploring accommodations at a school).

8. Tracking and using client outcomes to set goals for improvements in SEE services (e.g., tracking how many clients are engaged in competitive employment and/or enrolled in school).

F. Supervision also provides an opportunity to address any challenges in engaging clients in SEE.   For example, if the SEE specialist has only been able to engage a fraction of the clients on the team caseload, the supervisor can explore barriers to engaging the other clients and can offer strategies to increase the rate of engagement.

G.   Regarding benefits and applying for them. 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 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 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.

H.   More suggestions for supervision of SEE specialists are provided in the SEE manual.

CHAPTER 13: PEER SPECIALIST SUPERVISION

As mentioned earlier in the manual, as NAVIGATE has evolved since the RAISE-ETP research, one of the really positive developments is that peer specialists are being added to NAVIGATE teams.

Peer specialist are extremely valuable members of the NAVIGATE team.   Their lived experience often permits them to establish healing relationships with individuals who may be hesitant about seeking mental health treatment, to be role models for individuals who feel hopeless about their situations, and to act as channels between professional staff members and individuals who have difficulty articulating their needs or concerns. They are also valuable leaders or co-leaders of a variety of groups and activities with clients. Peer specialists have significantly strengthened the effectiveness of many NAVIGATE teams.

Agencies vary on how supervision is provided to peer specialists. Some agencies and states have a peer specialist supervisor, and they provide supervision to all peer specialists at the agencies or in the state. Some agencies do not provide separate peer specialist supervision, in which case the NAVIGATE director should do so.

A. NAVIGATE believes strongly in the value of peer specialists on NAVIGATE teams. It may be helpful to the Director to be familiar with the variety of ways that peer specialists have been especially helpful on NAVIGATE teams. The following lists some examples, but there are additional ways that peer specialists can be helpful:
1. Sharing personal experiences to increase optimism and hope
2. Encouraging potential participants to join the program
3. Supporting completion of IRT and SEE assignments
4. Helping individuals work through issues around medication adherence
5. Modeling and supporting mental health recovery
6. Modeling and supporting substance use recovery

7. Helping individuals take steps towards their personal goals
8. Conducting or co-leading activity groups, such as groups centered on healthy living, yoga, artwork, community outings, music, and cooking
9. Assisting with case management and navigating complex systems
10. Providing outreach and aiding in recruitment
11. Teaching or reinforcing coping skills to manage symptoms and increase resiliency
12. Encouraging involvement in peer recovery groups.
13. Accompanying clients to visit schools, campuses, potential places of employment, or other locations they are interested in, to increase the client's comfort level
14. Sharing the peer perspective in team meetings

B. 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

C. To use the OnTrack Peer Manual most effectively, it is helpful to know the background of OnTrack and NAVIGATE. Both OnTrack and NAVIGATE are Coordinated Specialty Care (CSC) team models for the treatment of first episode psychosis. Both models were developed under the auspices of the RAISE (Recovery After an Initial Schizophrenia Episode) NIMH Initiative. Both models are recovery and resiliency-oriented and based on a shared decision-making model. The OnTrack Peer Manual is applicable to NAVIGATE peer support specialists.

Here are a few things to keep in mind for NAVIGATE providers who are reading and using the OnTrack Peer Manual:

1. The manual refers to the titles of team members on OnTrack. NAVIGATE is composed of a Director/Family Clinician, Prescriber,

Individual Resiliency Trainer (IRT), Supported Employment and Education Specialist (SEE), and often a peer specialist and a case manager. OnTrack is composed of an Outreach and Recruitment Coordinator, Team Leader, Prescriber, Nurse, Clinician, Recovery Coach, and Peer Specialist. The OnTrack Clinician and the OnTrack Recovery Coach work with individuals and families. This is similar to the services provided by the NAVIGATE IRT and NAVIGATE Family Clinician.

2. The manual refers to "T-MAP," which is a tool for individuals to better understand their own experiences and develop wellness tools. NAVIGATE does not include T-MAP as such, but many components of T-MAP are embedded in IRT and SEE.

CHAPTER 14: CASE MANAGEMENT SUPERVISION

As mentioned earlier in the manual, as NAVIGATE has evolved since the RAISE-ETP research, one of the positive developments is that case managers are being added to many NAVIGATE teams.

Case managers are extremely valuable members of the NAVIGATE team. They provide much needed information and assistance with resources such as housing, medical care, relevant financial benefits, transportation, clothing, and food.

Case managers often do not have need for supervision from the NAVIGATE Director. For example, there may be a case management department which provides supervision. There are several ways in which the Director could be helpful to the case managers, however, including the following:

A. Some case managers may not be familiar with psychosis and its symptoms. They may benefit from learning about it and being able to develop strategies for responding to clients who may be experiencing hallucinations or delusions or thought disorders. They may also benefit from learning about negative symptoms, and how they affect motivation, energy, and facial expressions.

B. Some case managers may be familiar with psychosis, but not with first episode psychosis. They may benefit from learning about the similarities and differences of working with people with first episode of psychosis, compared to those who have experienced psychosis for many years.

C. Case managers may be used to doing things FOR the clients on a repeated basis, rather than teaching them how to do things for themselves. It may be helpful to case managers to learn some practical strategies for teaching skills to NAVIGATE clients.

D. Case managers may benefit from learning more about the roles of the other NAVIGATE team members. For example, what does the client get in IRT? In SEE? In Family Education? In Peer Support? This knowledge will help case managers support the skills that clients are learning in these interventions, and even to help clients with home practice.

CHAPTER 15: WORKING WITH AGENCY LEADERSHIP

It is very important for the NAVIGATE Director to meet regularly with the leadership of the agency. The nature of the titles of the leadership in agencies varies, including CEO or Agency Director or Clinical Director. There are many ways for NAVIGATE directors to strengthen their partnership with agency leadership. We encourage NAVIGATE directors to:

A. Educate leaders about NAVIGATE and how the team works. Invite them to attend portions of the training, especially the overview.

B. Keep leaders informed of implementation successes (such as number of referrals received, number of clients enrolled, number of clients who are participating in work or school, etc.).

C. Keep leaders informed of implementation challenges (such as space problems, obstacles in getting referrals, pressure on the team's protected time). They can often help with solving problems.

D. Meet with agency leaders regularly, such as monthly. Even if the meeting is short (15 to 30 minutes), it is helpful for keeping the leadership up-to-date.

E. Invite agency leaders to a NAVIGATE team meeting so that they can see first-hand what the team does.

CHAPTER 16: DEALING WITH STAFF TURNOVER

Be prepared that there will be changes in staff while you are the Director of a NAVIGATE team.   It is important that all new staff members receive NAVIGATE-specific training to fill their role. In-person training is the most effective, and sometimes you may be able to locate such a training. For example, your state may be training a new team, and you could send new staff members to such a training. However, in the absence of in-person training opportunities, we have prepared some checklists for new IRTs, SEEs, Family Clinicians and Directors to get familiar with their roles. These checklists are provided in the Appendix.

CHAPTER 17: MONITORING CLIENT OUTCOMES

NAVIGATE recommends collecting information on client outcomes that would be expected to be impacted by participation in NAVIGATE. Some examples follow:

A. Participation in treatment (including how many sessions of each intervention are being attended, and how long the clients remain in treatment)

B. Participation in work or school activities

C. Reduction in psychotic symptoms

D. Reduction in depressive symptoms

E. Use of crisis services

F. Use of hospitalization

G. Involvement in the criminal justice system

H. Homelessness

I. Substance use

Some NAVIGATE teams also find it helpful to use the Illness Management and Recovery (IMR) Scales (both the client version of the scale and the clinician version of the scale) at baseline, quarterly during treatment, and at discharge. You can find copies of these scales in the Appendix to this manual.

CHAPTER 18: MONITORING FIDELITY TO NAVIGATE MODEL

It can be challenging to keep skills up after one has learned an evidence-based practice.   Over time, NAVIGATE team members often want to "add their own spin" to their work. Sometimes it is fine to make some adjustments when implementing NAVIGATE, at other times it can take away from the fidelity of the model.

Here are some ideas for addressing fidelity of implementation of services for Family Education, IRT, SEE, and the NAVIGATE team as a whole:

A. Monitoring the Quality of Family Education Sessions
   The "Family Education Fidelity Scale" is available as a tool to monitor fidelity to the intervention; both self-review and supervisor-review can be useful. The scale is included in the Family Education manual. The fidelity ratings cover the key ingredients of family work utilizing a 5 point scale from 1 = unsatisfactory to 5 = excellent.   The purpose of monitoring fidelity is to measure the extent to which family clinicians are implementing the treatment as intended by the model and to provide family clinicians with ongoing feedback about the implementation of the family work with clients.

   1. Family Clinician Self-Review
      One way to help Family Clinicians stay aligned with the NAVIGATE family education intervention is to use the Family Education Fidelity Scale to direct their work. This scale is included as an appendix to the Family Education manual. The scale includes the key components of the intervention, and reviewing the scale and the appropriate clinical guidelines *before* a session (even if they have done the session several times) often helps clinicians keep "on track." Particularly after a challenging session, it can be useful to review the fidelity scale and the guidelines again to determine if all the material was covered and if and how things diverted from the planned content. The Family Clinician can then do some self-reflection to determine if the diversion was needed

(for example, if there was an increase in symptoms or a medication crisis) or if greater effort to keep on the planned agenda could have been helpful.

2. Family Supervisor Review
Another strategy to address drift is for the supervisor to occasionally listen in on a family education session and use the Family Education Fidelity Scale to provide feedback to the provider. As mentioned above, this scale is available in the Family Education manual. Some supervisors find it easiest to just rotate in and join a session for each Family Clinician on a quarterly or biannual basis, while others ask the Family Clinician to record a session and the supervisor and clinician can then listen to the session together and both discuss and rate the session on the fidelity scale. Areas of concern can then be addressed. Of course, in the latter case, the participants would need to consent to the recording in advance. Feedback from listening to the family sessions and measuring fidelity can be used during supervision to help clinicians stay faithful to the model. The feedback also can help family clinicians identify clinician strengths as well as weaknesses, which can be addressed during supervision, leading to better client outcomes.

B. Monitoring the Quality of IRT Sessions
The "IRT Fidelity Scale" is available as a tool to monitor fidelity to the intervention; both self-review and supervisor-review can be useful. The scale is included in the IRT manual. The fidelity ratings cover the key ingredients of IRT, utilizing a 5-point scale from 1 = unsatisfactory to 5 = excellent. The purpose of monitoring fidelity is to measure the extent to which IRT clinicians are implementing the treatment as intended by the model and to provide IRT clinicians with ongoing feedback about the implementation of IRT.

1. IRT Clinician Self-Review
One way to help IRT clinicians to stay aligned with the IRT intervention is for the IRT clinician to use the IRT fidelity scale to direct their work. As mentioned above, this scale is included as an appendix to the IRT

manual. The scale includes the key components of the intervention, and reviewing the scale and the appropriate clinical guidelines *before* a session (even if they have done the session several times) often helps clinicians keep "on track." Particularly after a challenging session, it can be useful to review the fidelity scale and the guidelines again to determine if all the material was covered and if and how things diverted from the planned content. The IRT Clinician can then do some self-reflection to determine if the diversion was needed (for example, if there was an increase in symptoms or a medication crisis) or if greater effort to keep on the planned agenda could have been helpful.

2. <u>IRT Supervisor Review</u>
Another strategy to address drift is the supervisor to occasionally listen in on an IRT session and use the IRT Fidelity Scale to provide feedback to the IRT specialist. Some supervisors find it easiest to just rotate in and join a session for each IRT Clinician on a quarterly or biannual basis, while others ask the IRT Clinician to record a session and the supervisor and clinician can then listen to the session together and both discuss and rate the session on the fidelity scale. Areas of concern can then be addressed.   Of course, in the latter case, the participants would need to consent to the recording in advance. Feedback from listening to the IRT sessions and measuring fidelity can be used during supervision to help clinicians stay faithful to the model. The feedback also can help the supervisor identify clinician strengths as well as weaknesses, which can be addressed during supervision, leading to better client outcomes.

C. Monitoring the Implementation of SEE services
1. <u>SEE Specialist Self-Review</u>
One way to help SEE specialists stay aligned with the SEE intervention is for the SEE specialist to review the SEE principles and evaluate to what extent they are following these principles. The SEE principles are included in the SEE manual.

Reviewing the principles *before* a session often helps SEE specialists keep "on track." Particularly after a challenging session, it can be useful to review the principles again to determine if the principles were followed and if and how things diverted from the principles. The SEE specialist can then do some self-reflection to determine if the diversion was needed or if greater effort to follow the principles could have been helpful.

2. SEE Supervisor Review
Another strategy to address drift is for the supervisor to occasionally join the SEE specialist when they meet with a client or do job development or provide follow-along support. Feedback from accompanying the SEE specialist and evaluating how well the SEE principles were followed can be used during supervision to help SEE specialists stay faithful to the model. The feedback also can help the supervisor to identify strengths as well as weaknesses of the SEE specialist, which can be addressed during supervision, leading to better client outcomes.

3. Additional Ways to Address Fidelity in SEE
In addition to reviewing SEE principles and the extent to which the SEE specialist is following these principles, you can find several supervision and fidelity options in the SEE manual.

D. Monitoring the implementation of services by the NAVIGATE team as a whole
1. Participation Rates
The director will find it helpful to keep track of which clients are receiving which services. For example, of the total number of active clients, how many are receiving IRT? SEE? Family? Peer Support? Medication visits? Case management? The percentage of clients being seen for each intervention should be greater than or equal to the percentage that were seen during the RAISE-ETP research. For example, as mentioned in Chapter 6, during RAISE-ETP:

- Family clinicians met about 75% of the relatives at some point while their loved one was in NAVIGATE and 68% had at least one family education session during the program and 46% attended at least 5 family education sessions in the first year.
- 68% of the NAVIGATE participants met with the SEE worker at least 3 times.
- 94.6% of NAVIGATE participants had one or more medication visits. Across all participants, the mean number of visits over the first 2 years per month was 0.55. Keep in mind that this data was derived from all participants and includes participants who dropped out of treatment.
- 99.5% of people in the NAVIGATE group had at least 1 IRT session. 90% of people in the NAVIGATE group had 3 or more IRT sessions.

Therefore, based on the RAISE data, current NAVIGATE teams can expect about almost all of their clients to participate in medication visits, almost all of their clients to participate in IRT, ½ to 2/3 of the families to participate in Family Sessions, and 2/3 of their clients to participate in SEE sessions. If your team is not getting these levels of participation, it is important to problem-solve how their levels of participation can be increased.

2. <u>Drop Out Rates</u>
It's important to monitor drop-out rates. The research shows that even with coordinated specialty care programs for first episode psychosis, a third to a half of clients will disengage before two years. We would like to see better rates of retention than this.

When clients leave your program before two years, you need to explore the reasons. Some reasons for leaving the NAVIGATE program are a sign of recovery and resiliency, such as moving away because of getting a job or going back to school in a different location. Some reasons for leaving the program may indicate that the team needs to increase their efforts at engagement, as described in Chapter 8.

When clients are leaving the program before graduation or transition to less intensive services, it is important to convey to them that the door is always open.

Chapter 19: GRADUATION/TRANSITIONING TO LESS INTENSIVE SERVICES

NAVIGATE is based on RAISE-ETP, which offered a minimum of two years of treatment to first episode participants, but was not a formal study looking at randomly assigned lengths of treatment.   Therefore, we have some suggestions and guidelines for discharge procedures, but we cannot say that they are based on specific findings from the RAISE-ETP research. Also, NAVIGATE is a broad program which was not established in a single state or care system; we are limited in our capacity to dictate practices in the multiple states where the program is being implemented. Much depends on the resources and requirements available locally.

On the chart that follow, you will find some basic information about how NAVIGATE conceptualizes graduation (or transition to less intensive services):

Program length	NAVIGATE recommends a minimum of two to three years of treatment, but the program is not designed to last a specific length of time. Many participants stay longer, depending on local resources and clinical status. When local resources outside of NAVIGATE are plentiful and of good quality, discharge from NAVIGATE can often be at the two-year mark, but if local resources are limited, then there may be some advantages to continue clients' participation in NAVIGATE past the two year mark.
How to determine readiness to graduate	• NAVIGATE encourages that the team and the client and family collaborate to discuss graduation based on improved symptoms, functioning and goal achievement; an additional factor is that some agencies have a limited resources (such as limited capacity) to continue providing the program beyond a certain time period in order to best serve the needs of their community

How far in advance to begin discussions and planning	• NAVIGATE encourages teams to begin planning for transition to less intensive services from the very beginning of the client's enrollment, conveying to the client and family that NAVIGATE is a time-limited intervention. • The team begins to focus more specifically on discharge at approximately 18 months into their treatment in NAVIGATE, incorporating these discussions in scheduled collaborative treatment planning meetings and treatment review meetings (these meetings are expected to include the client and the family) • Client preference sometimes drives participants to leave the program prior to the minimum treatment offered—in our experience, this may because participants are doing well and want to pursue goals that make NAVIGATE participation impossible (like return to an out-of-state school where there is no CSC program available) or because there are they are doing poorly and refuse treatment. When clients inform the NAVIGATE team they are leaving the program early, the team is encouraged to coordinate discharge care as much as possible to attempt to get the most appropriate services for the client.
Specific activities done to facilitate/prepare	• NAVIGATE encourages teams to include discussion of graduation/discharge planning in all collaborative treatment planning meetings and treatment review meetings; during these meetings the team reviews how the client is participating in each of the interventions and what is still needed by the client to meet his/her goals; these meetings take place with client and family every 6 months (or more often if required by the agency). • We provide specific information on problem-solving around discharge planning in the Family Education Manual
How treatment approach supports eventual transition	• Final phase of treatment – prolonged recovery – prepares the client for transition • Each intervention supports transition by emphasizing learning information, strategies and skills that the client and family can take with them upon leaving the program
Post-discharge support	• Many, if not most, of NAVIGATE clients get discharged to the general clinic that hosts the NAVIGATE team and it is often possible for clients to work with the same staff members as when they were in NAVIGATE, although less intensively. For example, prescribers and case managers are usually part-time on the NAVIGATE team and employees of the host clinic, and they often continue to see NAVIGATE clients as part of their other roles at the clinic.

Regardless of their reason for leaving the NAVIGATE program, planful discharges are optimal. Each team member with whom the client is working (e.g., prescriber, IRT clinician, Family clinician, SEE specialist, case manager, and peer specialist) should work with the client to consolidate what they gained in their intervention and to make plans for continuing to move forward with their lives. Common focuses of helping clients prepare for transition from each intervention include:

- Summarizing the progress made by the client in the intervention
- Summarizing what the clients learned in the intervention
- Identifying strategies and skills they plan to continue using
- Planning how they can continue to take steps towards their goals

If feasible, the Director can put together the main points from each intervention into a single document that may be conceptualized as "NAVIGATE Takeaways."

More details about transitioning clients from each intervention can be found in the manuals of the interventions.

CHAPTER 20: OPTIONAL CHAPTER FOR INTEGRATING COGNITIVE ADAPTATION TRAINING (CAT) INTO TEAMS WHICH INCLUDE 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 COGNITIVE ADAPTATION TRAINING (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, and to interact with others. CAT uses customized supports set up 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 ones day, and engaging with others.

IS CAT A NEW TREATMENT?

CAT is not a new treatment. There are many studies over the past 20 years showing that CAT lowers rates of relapse, improves medication follow-through

and symptoms, and increases social and occupational functioning. CAT has been disseminated to 44 states and more than 10 countries. CAT is easy to learn and can be used by bachelor's or master's level staff.

WHY IS CAT BEING INCLUDED AS PART OF ESPRITO?

A. Many people with psychosis related to schizophrenia and schizoaffective disorders continue to struggle with recovery and do not have the outcomes they want.
B. CAT is a unique manual-driven treatment that works well to improve social and occupational functioning.
C. There are many individuals with first episode psychosis who are reluctant to get involved in Supported Education and Employment (SEE).
D. 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 in CAT 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.

WHO ON THE NAVIGATE TEAM WILL PROVIDE CAT?

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, peer specialist, or SEE specialist. The individual delivering CAT must have at least a bachelor's degree and must be able to make home visits and community visits 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.

HOW IS CAT USUALLY REIMBURSED?

CAT delivery is flexible, based upon the unique characteristics and specific billing requirements of the site. CAT will be delivered to the individuals enrolled in ESPRITO who belong to the groups described above. Case managers who can be reimbursed for home visits for psychosocial rehabilitation, skill-building, illness management and recovery (e.g., IMR) and medication education can typically bill for CAT services. SEE specialists may also be able to bill for CAT under current supported employment reimbursement mechanisms. In a current CAT study conducted at sites around the country we have learned that some sites can bill at a higher rate for CAT/psychosocial rehabilitation than they can for SEE. The ESPRITO Central Team will work with each site to determine who should be trained and who will provide CAT services.

HOW DOES CAT TRAINING WORK?

A. CAT training begins with an approximately 3-hour on-line course. This course provides the trainee with access to the CAT manual, video demonstrations, and a tool kit. The toolkit includes such things as examples of checklists, daily schedules, signs, supplies typically used, budgeting sheets, etc. For supervisors, there is an extra module on the supervision of CAT.

B. Following the 3-hour on-line training, trainees will participate in a total of a day and a half of webinar training, which includes practice in CAT application. The webinars will be led by the CAT expert team based in San Antonio and will be blocked to fit into the trainee's work schedule.

C. After the on-line training and webinars, case consultation is provided to the CAT specialists by phone or on-line. Case notes with photos of supports placed in the home and stripped of identifying information can be reviewed for fidelity.

HOW DOES THE TEAM IDENTIFY CLIENTS WHO MIGHT BENEFIT FROM CAT?

During team meetings, when reviewing clients, the team should be alert for signs that a client is either 1) 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 and Family clinician 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 is having 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 need to prompt the team on the first few clients, by asking, for example, "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.

The director may also want to focus some of their SEE supervision sessions (perhaps once a month or at least once a quarter) on reviewing clients whom the SEE is working with (or attempting to engage with) who are having problems identifying work or school goals or having problems succeeding at goals they have identified.

HOW DOES THE TEAM EDUCATE THE CLIENT AND FAMILY ABOUT CAT?

In the Appendix you will find an orientation sheet about CAT for individuals and an orientation sheet for families.

HOW DOES THE DIRECTOR HELP COORDINATE CAT SERVICES?

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, very little coordination is required. The SEE specialist will continue to provide input regularly during team meetings on 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, including some guidance to the CAT specialist about communicating regularly with the SEE specialist (both during and outside of team

meetings) and about the timing of shifting the focus of services to the SEE specialist. For example, if the client is referred to CAT because of problems with hygiene and time management, and makes significant progress in these areas, the CAT specialist may want to talk to the SEE specialist about transitioning back to SEE in order to help the client identify and follow up on potential job or employment 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.

WHAT IS AN EXAMPLE OF AN INDIVIDUAL WHO HAS RECEIVED CAT?

Jose was a 19-year-old male living with his father in a 2-bedroom apartment. Jose reported auditory hallucinations that were disturbing, and he would occasionally respond out loud to them. He was suspicious of individuals on the street and was certain they were watching him and talking about him. Jose spent his days inside the apartment sleeping or watching TV and smoking. He showered infrequently and appeared disheveled most days. His room was messy with spilled liquid and soiled clothing on the floor. His father, who worked two jobs, was angry that his son did nothing during the day. Jose left all of his dirty dishes and the father had little time to wash them, so they were stacked high in the sink.

The SEE specialist visited Jose to explore his interest in employment and/or education. Jose was willing to talk to the SEE specialist, but said that he didn't really have any goals related to employment or education. He gestured around his apartment and shrugged his shoulders. "It's hard to get my mind on work or school," he said. At the next team meeting, the SEE specialist consulted with the team, who agreed that Jose would be a good candidate for CAT. When the SEE specialist talked to Jose and his father about what CAT is and what it would entail, both were willing to have a CAT specialist visit the home.

The CAT specialist conducted assessments based on observations of Jose during the first month of home visits. During the environmental and functional assessment, it was determined that Jose was not taking his medication regularly based on pill counts and that he did not have many of the supplies needed to keep himself or his apartment clean. Jose's father stated that it was Jose's responsibility to purchase these items with money the father had given him, but Jose just spent his money on cigarettes. There was no soap in Jose's bathroom, no dish soap and only a ragged towel he was using to wash dishes.

In one of the first CAT interventions, the therapist provided a blank daily schedule and asked Jose to fill it out so that he could visually see how he spent his time. He was not aware of how little he did during a week, and the visual cue of his time spent was helpful. While he liked spending time lying down watching television, he was able to see that following the same schedule for the next year or next 5 years was not what he wanted. He worked with the CAT specialist to make a checklist of things that he would like to do every day. The list was initially short and included:

1. get out of the house at least every other day for a walk
2. get together with friends at least once a week
3. find a way to take medication every day

The CAT specialist helped Jose make a list of where he wanted to go when he got out of the house every other day, and went for a walk with him right away to try out going to his first choice, the local park a block away.

For his goal of getting together with friends, the CAT specialist helped Jose make a list of friends with common interests, and determined that the best way to contact them was by text. The CAT specialist then helped Jose compose a text before sending it to two of the people on his list.

The CAT specialist provided a pill box to help Jose to organize his medications. Together they determined that Jose would try putting the pillbox of his

medication next to the TV remote control, so that he would see it often. He also helped Jose set up a voice alarm to remind him of his goal of taking medication daily.

As Jose began to check off each task, he reported feeling a sense of accomplishment. His symptoms improved due to better medication follow-through. Jose added more tasks to the bottom of the list on his own, including taking a shower at least once a week and doing his laundry so that he would feel more comfortable when he got together with friends.

The CAT specialist provided Jose with bath soap, shampoo, laundry soap and a wheeling hamper. The CAT specialist then worked with Jose to help him plan when he would take a shower and helped him organize his bathroom so he would have easy access to the things he needed in order to take a shower. The specialist also helped him pack his dirty laundry and the laundry soap into the wheeling hamper and take it to the local laundry mat for the first time.

While at first Jose could identify no leisure activities he wanted to do, he had grown plants in high school. The CAT specialist was able to get soil, pots and seeds and he began to care for the plants. The CAT specialist then worked with Jose to identify longer term goals. In addition to enjoying growing plants, Jose said he also liked animals.

In exploring different possibilities for work, he expressed an interest to work at the animal shelter. He decided to establish himself at the shelter by first serving as a volunteer. The CAT specialist helped Jose think about the various types of jobs he was interested in.   The CAT specialist then met with Jose and the SEE specialist so that he could begin to identify positions that interested him and get help completing job applications.

The CAT specialist communicated with the NAVIGATE team weekly about the work with Jose. The CAT specialist continued to work with Jose for several weeks after he began working with the SEE specialist, and provided strategies and

materials for staying organized and remembering his appointments. He also helped Jose select clothing to wear for interviews and to organize his closet so he could easily find the clothes he was looking for.

APPENDIX 1:

Major Revisions Made to the Original Directors Manual in 2020

- 8 new chapters were added to the manual:

    13. Peer Specialist Supervision

    14. Case Management Supervision

    15. Working with Agency Leadership

    16. Dealing with Staff Turnover

    17. Monitoring Client Outcomes

    18. Monitoring Fidelity to NAVIGATE Model

    19. Graduation/Transitioning NAVIGATE Clients to Less Intensive Services

    20. Optional Chapter for Teams in ESPRITO Network: Integrating Cognitive Adaptation Training (CAT) Into Teams Which Include This Intervention

- 10 new documents were added to the appendix

- Publication List for RAISE-ETP

- Client Tracking Sheet for Team Meetings

- IRT Preparation List (for staff turnover)

- Family Clinician Preparation List (for staff turnover)

- SEE Specialist Preparation List (for staff turnover)

- Director Preparation List (for staff turnover)

- IMR Scale: Client Version

- IMR Scale: Clinician Version

- Optional (for ESPRITO teams): CAT Orientation Sheet for Individuals

- Optional (for ESPRITO teams): CAT Orientation Sheet for Families

Revisions were made in almost every original chapter to update them or add information or strategies for NAVIGATE Directors. On the following page there is a list of all the chapters in the NAVIGATE Director Manual 2020 Revision. New chapters are marked with an Asterisk.

Read First: Introduction and Overview to Navigate

Section I: Forming a NAVIGATE team and Creating a Strong Foundation

21. Logistics of Getting Started

22. Outreach and Education

23. Admission Criteria and Referrals

24. Forming the NAVIGATE team

Section II: Working with the Team

25. Leading the Team

26. Conducting Team Meetings

27. Creating a Positive Clinical Climate

28. Using the Whole Team to Engage the Client and Family

Section III. Supervising and Supporting Team Members

29. Clinical supervision in general

30. IRT Supervision

31. Family Supervision

32. SEE Supervision

33. Peer Specialist Supervision *

34. Case Management Supervision *

Section IV: Maintaining Your NAVIGATE Service

35. Working with Agency Leadership *

36. Dealing with Staff Turnover *

37. Monitoring Client Outcomes *

38. Monitoring Fidelity to NAVIGATE Model *

39. Graduation: Transitioning NAVIGATE Clients to Less Intensive Services *

20. Optional Chapter: Integrating Cognitive Adaptation Training (CAT) Into Teams Which Include This Intervention *

APPENDIX 2:

Publications Related to the RAISE-ETP Study on the NAVIGATE Program for Persons with a First Episode Psychosis

The list of publications contains the 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.

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2018

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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.

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2020

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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.

APPENDIX 3:
Director Start-Up List

__ Develop a business plan for operating the NAVIGATE Program

__ Develop an outreach and education plan to alert potential referral sources

__ Meet with agency leadership to establish support for the program, including guarantees of protected time to provide services

__ Arrange for regular meetings with CEO to give updates and engage in troubleshooting around challenges encountered by the program

__ Form an implementation team/advisory team that will meet regularly

__ Secure adequate space for meeting referrals, doing assessments, providing all interventions, and holding weekly team meetings

__ Secure computers, desks, telephones and business cards for NAVIGATE team members

__ Arrange for Information Technology (IT) support

__ Establish administrative and clerical staff support

__ Hire staff to provide the NAVIGATE interventions (prescriber, IRT Clinician(s), Family Clinician, SEE specialist, peer specialist, and case manager)

__ Determine how case management will be provided to clients (e.g., by a case manager on the NAVIGATE team, a case manager from outside the team, or by another member of the NAVIGATE team)

__ Get support for risk management, including security personnel, legal services and crisis response plans.

__ Plan for securely storing client information and sensitive data.

__ Set up meeting times for all meetings (e.g., weekly team meeting, IRT supervision, SEE supervision, Peer Support supervision, Case management supervision (depending on the policy of your agency and/or state), Director consultation call with NAVIGATE trainer (if being provided), meeting with

Agency director and/or CEO, meeting with Implementation and/or Advisory Team)

- Ensure that all team members have copies of the NAVIGATE Team Members' Guide as well as manuals and handouts to use in their interventions. (IRT, Family, Prescribers, Director, and SEE have designated NAVIGATE manuals. Peer specialists are encouraged to use the OnTrack Peer Specialist manual, and case managers are encouraged to consult with the case management supervision available at their agency)

APPENDIX 4:
Outreach and Education Plan

	Target Date	Date Completed	Notes (including important names and follow up plans)
Developing and obtaining marketing materials (such as brochures, posters and referral forms, business cards)			
Mailing or e-mailing brochures or information sheets			
Making list of potential referral sources			
Contacting referral sources at first level of priority			
Contacting referral sources at second level of priority			

Contacting referral sources at third level of priority			
Presentations at conferences			
Other Activities to Spread the Word about NAVIGATE			

APPENDIX 5:
Referral Contact Log

First level of priority of referral sources			
	Date contacted	**Notes**	**Follow up planned**
Inpatient Psychiatric Facilities			
Emergency Departments			
Crisis Services			
Outpatient Mental Health Services			
National Alliance on Mental Illness (NAMI) Chapters			

	Date contacted	Notes	Follow up planned

Second level of priority referral sources			
	Date contacted	**Notes**	**Follow up planned**
High Schools			
Community Colleges			
Colleges and Universities			
Trade Schools or Training Programs			

Places to Advertise and/or Offer Presentations			
	Date contacted	**Notes**	**Follow-up planned**
Churches, synagogues,			

mosques, and other religious groups			
Public Libraries and School Libraries			
Student Centers			
Community Centers			
Recreational Complexes (e.g., gyms, basketball courts)			
Other			

APPENDIX 6:
Initial Phone Contact Example

1. Introduce yourself as the Director of the NAVIGATE Program, and the agency or clinic you are associated with.

2. Explain that your program works with people who are experiencing a first episode of psychosis or who recently experienced one. Be prepared that the person you are contacting may not be familiar with psychosis.

3. Explain what a first episode of psychosis is and what people with a first episode usually present with, such as
   - Loss of contact with reality
   - Suspicion that others want to harm them
   - Hallucinations (hearing, seeing, smelling or feeling things which other do not)
   - Delusional thoughts or false beliefs
   - Grandiosity and elevated mood
   - Verbally or behaviorally disorganized

4. Our program works with individuals who have these symptoms even when they are not under the influence of a drug which can cause them, such as marijuana, meth, cocaine, alcohol, acid, ecstasy.

5. Inquire about whether the organization sees people who have some of these experiences (e.g., "Does your organization see people who may meet this description?" or "Does this sound like clients/students /parishioners you have seen before?")

6. Ask about the person's interest in receiving more information about your agency/clinic and the NAVIGATE program. What kind of material or presentation would be most useful for their organization (e.g., would they be

interested in an educational package, advertisement package, a short presentation or a lecture)?

7. Ask for information about where to send the material about NAVIGATE and/or who to contact to set up an in-person meeting or presentation.

APPENDIX 7:
Weekly Team Meeting Agenda Example

1. Start by asking the team to share examples of some positive things that have happened with clients and families over the past week. Elicit at least one example, preferably a few.

2. Brief update on recruitment and enrollment.

3. Review 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.

   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

APPENDIX 8:
Client Tracking Sheet

Client	Client's Goals	Prescriber Input	IRT Input	Family Input	SEE Input	Peer Specialist Input	Case Manager Input

APPENDIX 9:
Orientation Sheet for the NAVIGATE Program

This handout describes the NAVIGATE program, what it contains, and how it can help people stay on track with their lives.

- The NAVIGATE program is designed to help a person who has experienced an episode of psychosis.

- The program provides the person and their family the information, strategies and skills they need to help the person accomplish the things they want to accomplish in life.

- The NAVIGATE program involves a number of different interventions including medication management, resiliency training, help with work or school, and a family education and support program. Many NAVIGATE programs also include a peer support specialist and a case manager.

- These interventions have been shown to be effective in helping people get on with their lives.

- The NAVIGATE program is provided by a team that works together closely with the individual and their family.

The NAVIGATE Team

The team is led by the NAVIGATE Director, who helps coordinate all the following treatments:

Treatment	Provider	Aims
Medication Management	Psychiatrist or Nurse	• Monitor use of medication to reduce symptom distress
Family Education and Support	Family Clinician	• Provide information and skills to help relatives support their family member's resiliency
Individual Resiliency Training (IRT)	IRT Clinician	• Work with the person to help them make progress towards their goals and improve their functioning
Supported Employment and Education (SEE)	SEE Specialist	• Provide support and strategies to help people with work and school issues, such as getting or keeping a job or school enrollment

Many NAVIGATE teams also have one or both of the following interventions:

Treatment	Provider	Aims
Peer Support	Peer Support Specialist	• Share their lived experience with mental health challenges and their journey of recovery and resilience • Lead or co-lead groups and activities
Case management	Case manager	• Help people connect with community resources, such as transportation and housing

Below is a chart to write down the names of the people on the NAVIGATE team, their roles, and their contact information:

Role	Name	Contact Information
Director		
Psychiatrist or Nurse		
Family Clinician		
IRT Clinician		
SEE Clinician		
Peer Support Specialist		
Case Manager		

APPENDIX 10:

IRT CLINICIAN PREPARATION LIST

Goal of the IRT Preparation List: For new IRTs to learn as much as possible about NAVIGATE and the role of IRT when in-person training is not available.

Recommendations:

- Complete each activity on the checklist.
- Initial each activity as it is completed.
- Write at least one comment about something you learned from each activity
- Write at least one question that you had as you completed each activity.
- Meet with the NAVIGATE director to discuss what you have learned and get your questions answered.

A. **MATERIALS TO READ AND A VIDEO TO WATCH ABOUT FIRST EPISODE PSYCHOSIS AND THE NAVIGATE PROGRAM**
1. Familiarize yourself with NAVIGATE website and locate manuals: www.navigateconsultants.org

2. Read all of the Team Members' Guide from NAVIGATE website: www.navigateconsultants.org

    ___ Completed
    ___ Comments:
    ___ Questions:

3. Watch "Sometimes I'm Schizoaffective; All of the time I'm Human." Johnny Benjamin. 3 minute video on YouTube: https://www.youtube.com/watch?v=M3_hny4GFlY

    ___ Completed
    ___ Comments:
    ___ Questions:

B. READING AND VIDEO ACTIVITIES FOCUSED ON IRT ROLE

1. Read all of the Team Members' Guide from NAVIGATE website: www.navigateconsultants.org

    ___ Completed
    ___ Comments:
    ___ Questions:

2. Read Introduction chapter from the IRT manual

    ___ Completed
    ___ Comments:
    ___ Questions:

3. Watch "IRT Introduction" video and "Overview of an IRT Session" videos from NAVIGATE website

    ___ Completed
    ___ Comments:
    ___ Questions:

4. Read Module 1 from IRT manual (both clinician guidelines and client handout)

    ___ Completed
    ___ Comments:
    ___ Questions:

5. Watch IRT video for Module 1 from NAVIGATE website

    ___ Completed
    ___ Comments:
    ___ Questions:

6. Read module 2 from IRT manual (both clinician guidelines and client handout)

   ___ Completed
   ___ Comments:
   ___ Questions:

7. Complete the Strengths Test for yourself from Module 2

   ___ Completed
   ___ Comments:
   ___ Questions:

8. Watch IRT video for Module 2 from NAVIGATE website

   ___ Completed
   ___ Comments:
   ___ Questions:

9. Read Topic 1 of module 3 from IRT manual (clinician guidelines p. 107-115; and client handout, p 131 to 143)

   ___ Completed
   ___ Comments:
   ___ Questions:

10. Watch IRT video for Module 3 from NAVIGATE website

   ___ Completed
   ___ Comments:
   ___ Questions:

11. Continue to read IRT modules and watch the accompanying video until all are completed. The first 3 are important to get you started, but the remaining ones will help you get a good grasp of all the IRT modules.

__ Module 4
__ Module 5
__ Module 6
__ Module 7
__ Module 8
__ Module 9
__ Module 10
__ Module 11
__ Module 12
__ Module 13

C. **VIDEO ACTIVITIES TO HELP IRT CLINICIANS BECOME FAMILIAR WITH FIRST EPISODE PSYCHOSIS CLIENTS**
1. Recovery Stories on OnTrack website with examples of people who are working
   https://vimeopro.com/user23094934/voices-of-recovery/video/85828609
   https://vimeopro.com/user23094934/voices-of-recovery/video/85834373
   https://vimeopro.com/user23094934/voices-of-recovery/video/85834646

   ___ Completed
   ___ Comments:
   ___ Questions:

2. Recovery stories on OnTrack website with experiences of individuals who have completed their education. Each about 4 minutes.
   https://vimeopro.com/user23094934/voices-of-recovery/video/85740602
   https://vimeopro.com/user23094934/voices-of-recovery/video/85739637
   https://vimeopro.com/user23094934/voices-of-recovery/video/85741132

___ Completed

___ Comments:

___ Questions:

3. Examples of young people with first episode psychosis who are going to school or have completed school. Partners4StrongMinds.   About 15 minutes total.
https://www.youtube.com/channel/UCrM8Kxbl3OQaGVILepFOtUg

___ Completed

___ Comments:

___ Questions:

APPENDIX 11:

FAMILY CLINICIAN PREPARATION LIST

Goal of the Family Preparation List: For new Family Clinicians to learn as much as possible about NAVIGATE and the role of the Family Clinician when in-person training is not available.

Recommendations:

- Complete each activity on the checklist.
- Initial each activity as it is completed.
- Write at least one comment about something you learned from each activity
- Write at least one question that you had as you completed each activity.
- Meet with the NAVIGATE director to discuss what you have learned and get your questions answered.

A. **NAVIGATE MATERIALS TO READ FIRST AND A VIDEO TO WATCH ABOUT FIRST EPISODE PSYCHOSIS**
   1. Familiarize yourself with NAVIGATE website and locate manuals: www.navigateconsultants.org

   2. Read all of the Team Members' Guide from NAVIGATE website: www.navigateconsultants.org

      ___ Completed
      ___ Comments:
      ___ Questions:

   3. Watch "Sometimes I'm Schizoaffective; All of the time I'm Human." Johnny Benjamin. 3 minute video on YouTube.
      https://www.youtube.com/watch?v=M3_hny4GFlY

      ___ Completed
      ___ Comments:
      ___ Questions:

B. READING AND VIDEO ACTIVITIES FOCUSED ON FAMILY CLINICIAN ROLE

1. NASHPD webinar on the experience of families: **(about 1 hour 15 minutes)**
   https://www.nasmhpd.org/content/demystifying-psychosis-family-members-0

   ___ Completed
   ___ Comments:
   ___ Questions:

2. Watch First Episode Psychosis: A Primer. NASMHPD.   Total of 6 webinars of 20 minutes each. See links below.
   https://www.nasmhpd.org/content/early-intervention-psychosis-primer-0
   https://www.nasmhpd.org/content/demystifying-psychosis-family-members-0

   ___ Completed
   ___ Comments:
   ___ Questions:

4. Read Introduction chapter from the Family manual (p. 1-35)

   ___ Completed
   ___ Comments:
   ___ Questions:

5. Read Clinical Guidelines for the Family Engagement, Orientation and Assessment Phase (p 36 to 45).

   ___ Completed
   ___ Comments:
   ___ Questions:

6. Read Family Engagement, Orientation and Assessment Worksheets

___ Completed
___ Comments:
___ Questions:

7. Read Clinical Guidelines for "Just the Facts" Handouts (p. 46-65)

___ Completed
___ Comments:
___ Questions:

8. Read "Just the Facts" Participant Educational handouts (p. 86-180).

___ Completed
___ Comments:
___ Questions:

9. Watch videos of family experiences from OnTrack Website, each video is about 4 minutes.
https://vimeopro.com/user23094934/voices-of-recovery/video/85834900
https://vimeopro.com/user23094934/voices-of-recovery/video/85835336
https://vimeopro.com/user23094934/voices-of-recovery/video/85846092
https://vimeopro.com/user23094934/voices-of-recovery/video/85846322

___ Completed
___ Comments:
___ Questions:

C. VIDEO ACTIVITIES TO HELP FAMILY CLINICIANS BECOME FAMILIAR WITH FIRST EPISODE PSYCHOSIS CLIENTS

4. Recovery Stories on OnTrack website with examples of people who are working
https://vimeopro.com/user23094934/voices-of-recovery/video/85828609
https://vimeopro.com/user23094934/voices-of-recovery/video/85834373
https://vimeopro.com/user23094934/voices-of-recovery/video/85834646

___ Completed
___ Comments:
___ Questions:

5. Recovery stories on OnTrack website with experiences of individuals who have completed their education. Each about 4 minutes.
https://vimeopro.com/user23094934/voices-of-recovery/video/85740602
https://vimeopro.com/user23094934/voices-of-recovery/video/85739637
https://vimeopro.com/user23094934/voices-of-recovery/video/85741132

___ Completed
___ Comments:
___ Questions:

6. Examples of young people with first episode psychosis who are going to school or have completed school. Partners4StrongMinds.   About 15 minutes total.
https://www.youtube.com/channel/UCrM8Kxbl3OQaGVILepFOtUg

___ Completed
___ Comments:
___ Questions:

APPENDIX 12:

SEE PREPARATION LIST

Goal of the SEE Preparation List: For new SEEs to learn as much as possible about NAVIGATE and the SEE role when in-person training is not available.

Recommendations:
In the SEE manual, there is a section called "Learning SEE." This contains week-by-week checklists for 4 weeks of learning SEE. Keep track of when you complete each activity in "Learning SEE." Also write down questions and comments and share weekly with the NAVIGATE director.

IN ADDITION:

- Complete each activity on the following list.
- Initial each activity as it is completed.
- Write at least one comment about something you learned from each activity
- Write at least one question that you had as you completed each activity.
- Meet with the NAVIGATE director to discuss what you have learned and get your questions answered.

1. Read all of the Team Members' Guide from NAVIGATE website:
   www.navigateconsultants.org

   ___ Completed
   ___ Comments:
   ___ Questions:

2. Watch "Sometimes I'm Schizoaffective; All of the time I'm Human." Johnny Benjamin. 3 minute video.
   https://www.youtube.com/watch?v=M3_hny4GFlY

   ___ Completed
   ___ Comments:
   ___ Questions:

3. Watch Recovery Stories on the OnTrack website with examples of people who are working
   https://vimeopro.com/user23094934/voices-of-recovery/video/85828609
   https://vimeopro.com/user23094934/voices-of-recovery/video/85834373
   https://vimeopro.com/user23094934/voices-of-recovery/video/85834646

   ___ Completed
   ___ Comments:
   ___ Questions:

4. Watch Recovery Stories on the OnTrack website with experiences of individuals who have completed their education. Each about 4 minutes.
   https://vimeopro.com/user23094934/voices-of-recovery/video/85740602
   https://vimeopro.com/user23094934/voices-of-recovery/video/85739637
   https://vimeopro.com/user23094934/voices-of-recovery/video/85741132

   ___ Completed
   ___ Comments:
   ___ Questions:

5. Watch Examples of young people with first episode psychosis who are going to school or have completed school. About 15 minutes total.
   https://www.youtube.com/channel/UCrM8Kxbl3OQaGVILepFOtUg

   ___ Completed
   ___ Comments:
   ___ Questions:

Appendix 13:
DIRECTOR PREPARATION LIST

Goal of the Director Preparation List: For new directors to learn as much as possible about NAVIGATE and the role of the Director when in-person training is not available.

MOST IMPORTANT WEBSITE AND READING ACTIVITIES

1. Familiarize yourself with NAVIGATE website and locate manuals:
   www.navigateconsultants.org

2. Read the whole Team Members' Guide.

3. Read the whole Directors' Manual

4. Read the introduction to the Family Education manual.   Read at least one module (handout and clinical guidelines) from the manual.

5. Read introductory chapter to IRT manual. Read at least one module (handout and clinical guidelines) from the manual. Watch at least one IRT demonstration video from the website.

6. Read introductory chapter to SEE manual. Read at least one chapter (handout and clinical guidelines) from the manual.

7. Read introduction to The Quick Guide to NAVIGATE Psychopharmacological Treatment manual.

8. Read article on predicting the size of the team needed for a location, depending on their general population:
   http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300186

ADDITIONAL VIDEOS AND WEBINARS WHICH ARE HELPFUL TO NEW DIRECTORS:

1. First Episode Psychosis: A Primer. NASMHPD**.** Total of 6 webinars of 20 minutes each. See links below.
   https://www.nasmhpd.org/content/early-intervention-psychosis-primer-0
   https://www.nasmhpd.org/content/demystifying-psychosis-family-members-0

2. "Sometimes I'm Schizoaffective; All of the time I'm Human." Johnny Benjamin. This is a 3 minute video featuring a young person who has schizoaffective disorder. It helps to dispel misconceptions.
   https://www.youtube.com/watch?v=M3_hny4GFlY

3. Overview of NAVIGATE for Louisiana. Susan Gingerich. Some aspects of the presentation are specific to Louisiana, but many are general.   3 segments of about 55 minutes each.
   Part1:
   https://www.youtube.com/watch?v=wH6CMKJczkI&feature=youtu.be
   Part 2:
   https://www.youtube.com/watch?v=2NwImSXeGZ8&feature=youtu.be
   Part 3
   https://www.youtube.com/watch?v=z2OWkjVY2tk&feature=youtu.be

4. NASHPD webinar on working with families: **(1 hour 15 minutes)**
   Promoting Meaningful Family Involvement in Coordinated Specialty Care Programming for Persons with a First Episode of Psychosis

5. Family experience videos from OnTrack website. Each about 4 minutes
   https://vimeopro.com/user23094934/voices-of-recovery/video/85834900
   https://vimeopro.com/user23094934/voices-of-recovery/video/85835336
   https://vimeopro.com/user23094934/voices-of-recovery/video/85846092
   https://vimeopro.com/user23094934/voices-of-recovery/video/85846322

6. IRT Videos on NAVIGATE Website. Piper Meyer and David Penn. 15-20 minutes each. Review a few.

7. Review the Patient and Clinician questionnaires in the Prescriber manual.

8. Supported Education webinar. NASMHPD. 1 hour 25 minutes. See link below.
   [Supported Education as a Component of Coordinated Specialty Care for Persons with First Episode Psychosis](#)

9. *Mindmap.ct*
   http://mindmapct.org

   Is the website from a first episode treatment program in CT using a model called STEP. Their sites has some good information about symptoms of psychosis and the elements of treatment, which includes user-friendly language. Their site includes an on-line quiz that individuals can take to see if they might be experiencing psychosis.

   They have several short videos (about 7 minutes) including

   > *One from the point of view of clients:*
   > https://www.youtube.com/watch?v=OS6nLL0engk

   > *One from the point of view of a parent:*
   > https://www.youtube.com/watch?v=QrtLtKZvJRE

   > *One animated video that's educational about psychosis and treatment*
   > https://www.youtube.com/watch?v=VzqU3JiThXI&t=232s

10. Recovery Stories on OnTrack website with examples of young people who are working
    https://vimeopro.com/user23094934/voices-of-recovery/video/85828609
    https://vimeopro.com/user23094934/voices-of-recovery/video/85834373
    https://vimeopro.com/user23094934/voices-of-recovery/video/85834646

11. Recovery stories on OnTrack website with examples of individual who completed their education. Each about 4 minutes.
    https://vimeopro.com/user23094934/voices-of-recovery/video/85740602
    https://vimeopro.com/user23094934/voices-of-recovery/video/85739637
    https://vimeopro.com/user23094934/voices-of-recovery/video/85741132

12. Examples of young people with first episode psychosis who are going to school or have completed school. Partners4StrongMinds.   About 15 minutes total.
https://www.youtube.com/channel/UCrM8Kxbl3OQaGVILepFOtUg

APPENDIX 14:

Illness Management and Recovery Scale:

Client Self-Rating

To be completed at baseline and every three months.

Name or ID Number: _____   Date: _____

Please take a few minutes to fill out this survey. We are interested in the way things are for you, *so there is no right or wrong answer. If you are not sure about a question, just answer it as best as you can.*

Just circle the number of the answer that fits you best.

1. <u>Progress towards personal goals</u>: In the past 3 months, I have come up with…

1	2	3	4	5
<u>No</u> personal goals.	A personal goal, but have <u>not done anything</u> to finish my goal.	A personal goal and made it a <u>little way</u> toward finishing it.	A personal goal and have gotten <u>pretty far</u> in finishing my goal.	A personal goal and have <u>finished it</u>.

2. <u>Knowledge</u>: How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication?

1	2	3	4	5
Not very much.	A little.	Some	Quite a bit.	A great deal

3. <u>Involvement of family and friends in my mental health treatment</u>: How much are family members, friends, boyfriend/girlfriend, and other people who are important to you (outside your mental health agency) involved in your mental health treatment?

1	2	3	4	5
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time <u>and</u> they really help me with my mental health

4. <u>Contact with people outside of my family:</u> In a normal week, how many times do you talk to someone outside of your family (like a friend, co-worker, classmate, roommate, etc.)?

1	2	3	4	5
0 times/ week	1-2 times/ week	3-4 times/ week	6-7 times/ week	8 or more times/ week

5. <u>Time in structured roles</u>: How much time do you spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time do you spend in doing activities for or with another person that are expected of you? (This would not include self-care or personal home maintenance.)

1	2	3	4	5
2 hours or less/ week	3-5 hours/ week	6 to 15 hours/ week	16-30 hours/ week	More than 30 hours/ week

6. <u>Symptom distress</u>: How much do your symptoms bother you?

1	2	3	4	5
My symptoms *really* bother me *a lot*.	My symptoms bother me *quite a bit*.	My symptoms bother me *somewhat*.	My symptoms bother me *very little*.	My symptoms don't bother me *at all*.

7. <u>Impairment of functioning</u>: How much do your symptoms get in the way of you doing things that you would like to or need to do?

1	2	3	4	5
My symptoms *really* get in my way *a lot*.	My symptoms get in my way *quite a bit*.	My symptoms get in my way *somewhat*.	My symptoms get in my way *very little*.	My symptoms don't get in my way *at all.*

8. <u>Relapse prevention planning</u>: Which of the following would best describe what you know and what you have done in order not to have a relapse?

1	2	3	4	5
I don't know how to prevent relapses.	I know a little, but I haven't made a relapse prevention plan.	I know 1 or 2 things I can do, but I don't have a written plan	I have several things that I can do, but I don't have a written plan	I have a written plan that I have shared with others.

9. <u>Relapse of symptoms</u>: When is the last time you had a relapse of symptoms (that is, when your symptoms have gotten much worse)?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	I haven't had a relapse in the past year

10. <u>Psychiatric hospitalizations</u>: When is the last time you have been hospitalized for mental health or substance abuse reasons?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	I haven't been hospitalized in the past year

11. <u>Coping:</u> How well do feel like you are coping with your mental or emotional illness from day to day?

1	2	3	4	5
Not well at all	Not very well	Alright	Well	Very well

12. <u>Involvement with self-help activities</u>: How involved are you in consumer-run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

1	2	3	4	5
I don't know about any self-help activities.	I know about some self-help activities, but I'm not interested	I'm interested in self-help activities, but I have not participated in the past year	I participate in self-help activities occasionally.	I participate in self-help activities regularly.

13. <u>Using medication effectively</u>: (Don't answer this question if your doctor has not prescribed medication for you). How often do you take your medication as prescribed?

1	2	3	4	5
Never	Occasionally	About half the time.	Most of the time.	Every day.

14. <u>Functioning affected by alcohol use.</u> Drinking can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drinking get in the way of your functioning?

1	2	3	4	5
Alcohol use really gets in my way a lot	Alcohol use gets in my way quite a bit	Alcohol use gets in my way somewhat	Alcohol use gets in my way very little	Alcohol use is not a factor in my functioning

15. <u>Functioning affected by drug use.</u> Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drug use get in the way of your functioning?

1	2	3	4	5
Drug use really gets in my way a lot	Drug use gets in my way quite a bit	Drug use gets in my way somewhat	Drug use gets in my way very little	Drug use is not a factor in my functioning

APPENDIX 15:

Illness Management and Recovery Scale:

Clinician Rating

To be completed at baseline and every three months.

Clinician/Team Name: _____   Date: _____

Client Name or ID Number: _____

*Please take a few moments to fill out the following survey regarding your perception of your client's ability to manage her or his illness, as well as her or his progress toward recovery. We are interested in the way **you** feel about how things are going for your client, so please answer with your honest opinion. If you are not sure about an item, just answer as best as you can.*

Please circle the answer that fits your client the best.

1. Progress toward goals: In the past 3 months, s/he has come up with…

1	2	3	4	5
No personal goals	A personal goal, but has not done anything to finish the goal	A personal goal and made it a little way toward finishing it	A personal goal and has gotten pretty far in finishing the goal	A personal goal and has finished it

2. Knowledge: How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

1	2	3	4	5
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in his/her mental health treatment: How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her treatment?

1	2	3	4	5
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time and they really help with his/her mental health

4. <u>Contact with people outside of the family</u>: In a normal week, how many times does s/he talk to someone outside of her/his family (like a friend, co-worker, classmate, roommate, etc.)?

1	2	3	4	5
0 times/ week	1-2 times/ week	3-4 times/ week	6-7 times/ week	8 or more times/ week

5. <u>Time in structured roles</u>: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

1	2	3	4	5
2 hours or less/ week	3-5 hours/ week	6 to 15 hours/ week	16-30 hours/ week	More than 30 hours/ week

6. <u>Symptom distress</u>: How much do symptoms bother him/her?

1	2	3	4	5
Symptoms *really* bother him/her *a lot*	Symptoms bother him/her *quite a bit*	Symptoms bother him/her *somewhat*	Symptoms bother him/her *very little*	Symptoms don't bother him/her *at all*

7. <u>Impairment of functioning</u>: How much do symptoms get in the way of him/her doing things that s/he would like to do or needs to do?

1	2	3	4	5
Symptoms *really* get in her/his way *a lot*	Symptoms get in his/her way *quite a bit*	Symptoms get in his/her way *somewhat*	Symptoms get in his/her way *very little*	Symptoms don't get in his/her way *at all*

8. <u>Relapse prevention planning</u>: Which of the following would best describe what s/he knows and has done in order not to have a relapse?

1	2	3	4	5
Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written plan and has shared it with others

9. <u>Relapse of symptoms</u>: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year

10. <u>Psychiatric hospitalizations</u>: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

1	2	3	4	5
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year

11. <u>Coping:</u> How well do feel your client is coping with her/his mental or emotional illness from day to day?

1	2	3	4	5
Not well at all	Not very well	Alright	Well	Very well

12. <u>Involvement with self-help activities</u>: How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

1	2	3	4	5
Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly

13. <u>Using medication effectively</u>: (Don't answer this question if her/his doctor has not prescribed medication). How often does s/he take his/her medication as prescribed?

1	2	3	4	5
Never	Occasionally	About half the time	Most of the time	Every day

_____ Check here if the client is <u>not</u> prescribed psychiatric medications.

14. <u>Impairment of functioning through alcohol use</u>: Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty attending appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

1	2	3	4	5
Alcohol use *really* gets in her/his way *a lot*	Alcohol use gets in his/her way *quite a bit*	Alcohol use gets in his/her way *somewhat*	Alcohol use gets in his/her way *very little*	Alcohol use is *not a factor* in his/her functioning

15. <u>Impairment of functioning through drug use</u>: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty attending appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

1	2	3	4	5
Drug use *really* gets in her/his way *a lot*	Drug use gets in his/her way *quite a bit*	Drug use gets in his/her way *somewhat*	Drug use gets in his/her way *very little*	Drug use is *not a factor* in his/her functioning

APPENDIX 16:

Cognitive Adaptation Training (CAT) Orientation Sheet for Individuals

What is Cognitive Adaptation Training (CAT)?
- CAT is a treatment designed to help people develop strategies for problems they may have in remembering, organizing, planning, and paying attention.
- Having strategies for these problems helps people to be more independent, and to do other things they might be interested in, such as socializing, working, going to school or having fun.

What are some examples of typical activities that may take place in CAT?
- The CAT specialist will first spend time getting to know you and work with you to figure out what strategies would help you the most as an individual.
- The CAT specialist can help you in a variety of ways such as:
  - Determining what supplies you might need and helping you get them, like closet organizers, cleaning supplies, office supplies, pill boxes, clocks
  - Developing reminders like signs, calendars, cell phone alarms, post-it-notes
  - Creating checklists for daily or weekly activities
  - Helping you organize your room or closet or bathroom
  - Helping you develop leisure activities

Where do CAT sessions take place?
- At your home (with permission)
- At your workplace (with permission)
- At your school (with permission)
- In the community, such as at grocery stores or libraries

Who provides CAT?

- A member of your NAVIGATE team, such as the Supported Employment and Education (SEE) Specialist, the Individual Resiliency Trainer (IRT), the Case Manager or the Peer Specialist has received training in providing CAT.
- That team member will be the CAT specialist and will coordinate closely with the other NAVIGATE team members.

Who provides CAT on my NAVIGATE team?

_____

_____

APPENDIX 17:

Cognitive Adaptation Training (CAT) Orientation Sheet for Families

What is Cognitive Adaptation Training (CAT)?
- CAT is a treatment designed to help people develop strategies for problems they may have in remembering, organizing, planning, and paying attention.
- Having strategies for these problems helps people to be more independent, and to do other things they might be interested in, such as socializing, working, going to school or having fun.

What are some examples of typical activities that may take place in CAT?
- The CAT specialist will first spend time getting to know your family member and work with them to figure out what strategies would help them the most.
- The CAT specialist can help your family member in a variety of ways, such as:
  - Determining what supplies they might need and helping them get them, like closet organizers, cleaning supplies, office supplies, pill boxes, clocks
  - Developing reminders to put up in their room or in other parts of the house, like signs, calendars, cell phone alarms, post-it-notes
  - Creating checklists for daily or weekly activities
  - Helping them organize their room or closet or bathroom
  - Helping them develop leisure activities

Where do CAT sessions take place?
- At home (with permission)
- At the workplace (with permission)
- At the school (with permission)
- In the community, such as at grocery stores or libraries

Who provides CAT?

- A member of your NAVIGATE team, such as the Supported Employment and Education (SEE) Specialist, the Individual Resiliency Trainer (IRT), the Case Manager or the Peer Specialist has received training in providing CAT.
- That team member will be the CAT specialist and will coordinate closely with the other NAVIGATE team members.

Who provides CAT on your relative's NAVIGATE team?

_____

_____