Format of Educational Sessions in NAVIGATE

Scheduling

Sessions should be scheduled weekly or every other week, depending on the availability of the family. A routine schedule is optimal. We anticipate sessions will be 45-60 minutes in length.

Topics Covered

All participants should cover 8 topics—typically one per session, although some topics may benefit from more than one session. There is an optional 9th topic, "Basic Facts about Alcohol and Drugs" which is used if a client has a past or current substance use problem. The eight basic topics are:

- Facts about Psychosis
- Facts about Medication
- Facts about Coping with Stress
- Facts about Developing Resilience
- Relapse Prevention Planning
- Developing a Collaboration with Mental Health Professionals
- Effective Communication
- A Relative's Guide to Supporting Recovery from Psychosis

Session Format

All the educational sessions follow an agenda based on curriculum that has been prepared in advance, with the pace of teaching tailored to the individual needs of the client and relatives. The agenda involves:

- Greeting participants
- Setting the session agenda
- Asking about urgent issues
- Inquiring about client status (meds, IRT, symptoms)
- Following up on out-of-session assignments
- Introducing new topics
- Developing an out-of-session assignment (if appropriate)
- Deferred problem-solving

Sessions are usually 50 minutes, depending on content and family involvement. The information is summarized using visual aids, such as blackboards and handouts. The teaching format resembles a cross between a classroom, with the family clinician assuming the role of the teacher, and a discussion, with the family clinician acting as a facilitator. The conversation is guided by the family clinician so as to cover the curriculum as planned, while soliciting the experiences and understanding of

participants, their comments and questions, throughout the session.

In the educational sessions, the family clinician first provides a brief overview of the material to be covered that day. An interactive discussion centered on that topic follows, with an emphasis on helping the participants comprehend how the information applies to them. Handouts are given to each participant, and they are encouraged to review them prior to the next session. Non-urgent problems can be deferred to the end of the session.

Review Questions

One strategy for helping participants actively process educational information they have learned is for the family clinician to ask open-ended review questions after each topic area has been covered. These questions also provide valuable information to the family clinician about what the participant has learned and in which areas the client needs further education. A convenient time to ask these questions is at the end of completing a topic or at the beginning of a session in which a new educational topic will be taught. The Clinical Guidelines for each topic area has review questions that can be used.

Use of Educational Handouts

There are two basic approaches to the use of educational handouts in sessions devoted to teaching clients and families about a psychiatric disorder. One strategy is for the family clinician to give an educational handout to each participant at the beginning of the session and have him/her read the handout as the family clinician reviews and elaborates on the material. This method is best when the family clinician does not use other visual aids to summarize the material during the session (e.g., blackboard), and when the participant has good reading skills. A second method if for the family clinician to give the participants the handout at the end of the session and request that they review it as a homework assignment. This approach is preferable when the family clinician uses a blackboard during the session, as the handouts can be distracting. The family clinician can use either format, as tailored to the needs of the individual participants.

Each topic has a handout for participants and a clinical guideline handout that directs the family director/clinician to key points in the relevant handout. *Whenever you give resources to families, always check in after they have looked at them to be sure they have understood them in the way you intended*.

Session Materials

Prior to the session, the therapist should assure that all materials for the sessions are available—session materials (manual and *Clinical Guidelines* for the family clinician and a copy of the appropriate handouts for each participant), paper and pens/pencils, markers if a white board is being used. In addition, prior to the first session, a folder or

binder should be prepared for the family in which they can keep the educational handouts. The family is encouraged to bring the folder or binder to each session. *The clinician should make a copy of all completed forms for his/her records and later review.*

Complete Content Mastery is Not Required before Moving to the Next Topic

The content of each session is not necessarily fully assimilated by participants prior to moving on to the next topic. Therefore, it is often necessary to continue to look for opportunities to review older material when new topics are being discussed. For example, clients with substance use difficulties may improve up through the substance use sessions, but nevertheless still be at high risk for relapsing back into using substances following completion of the educational work. In subsequent meetings during the consultation and monthly-check-ins, it is important to routinely check in briefly about the client's substance use, his or her relapse prevention plan, and any other related issues that may need attention, such as symptoms that precipitate use. Similarly, if during a consultation session a relative starts complaining about how "lazy" or "unmotivated" a person in NAVIGATE is, it may be a good time to review the initial "Just the Facts-Psychosis" hand-out to highlight the impact of negative symptoms.

Education with Symptomatic Clients

Three kinds of client circumstances can make education especially challenging—when clients are too symptomatic to participate effectively in sessions, when clients are very withdrawn and uncommunicative, and/or when they deny then have an illness. These situations are quite common in the early phases of first episode psychosis.

In terms of managing participants who have a hard time participating because they are still agitated or confused, a number of strategies can be employed. Session length can be abbreviated, frequent (but simple) questions can be directed to the client to keep them on course, the family clinician can sit next to the client to orient him or her to what is on the board or written materials, and clients can be given permission to leave the session early or take a brief break if they wish. In the most severe cases, the initiation of the course of educational sessions can be deferred for a few weeks to see if the client becomes more able to concentrate.

It can also be challenging to work with clients who are very withdrawn and appear to have little to say. Often, this lack of speech may reflect preoccupation with internal stimuli—listening to voices, for example—or the slowed thinking and speech more typical of cognitive difficulties or negative symptoms. When conducting educational sessions with a person with this pattern of speech, it may be very hard to draw the client out and get his/her thoughts on the topic being discussed. Here, it is imperative that the family clinician slow the conversation down. Sitting close but across from the client so eye contact can be good may also help facilitate conversation. The director/clinician should direct occasional questions or comments to the client, and then be prepared for a period of silence while the client organizes his/her thoughts to

respond. It is sometimes tempting for the clinician or another family member to "fill in the gap" rather than wait for the person in NAVIGATE to speak, but it is very important to provide enough space and time that for the client to provide his/her input on the topic at hand. Sometimes clients are confused or frustrated by their own lack of thoughts and get in the habit of responding quickly and almost automatically with "I don't know" after almost any question is asked of them. The family clinician should try to get past the "I don't know" by encouraging a guess, or telling the client to take his/her time, or asking how others might answer the question. The goal here is to give the client the chance to begin to speak his/her own mind, even if it is hard, and to model ways the relatives can do this at home.

Some clients, especially when they are symptomatic, refuse to acknowledge a specific psychiatric disorder. In light of the cognitive limitations imposed by psychosis and the stigma associated with having a psychiatric illness, this is not surprising. There is little value in trying to persuade these clients of their specific diagnosis as this often only agitates them and erodes the therapeutic alliance. Instead, the family clinician has three options:

1. Many clients will acknowledge they are having "problems," "difficulties," or "emotional problems" even if they deny they have psychosis. In such cases, the family clinician can just mirror this language when talking about the specific client's experience and talk more generally about "people who have had psychosis" when conducting the education or using the handouts. If the client reiterates he/she has problems but does not have psychosis, the family clinician can just say, "We are talking about people who have problems like those you have experienced." Although this may seem awkward, this strategy actually works in many cases.

2. If the client is insistent he/she does not have any problems, the family clinician can still offer an abbreviated education component, emphasizing the stress-vulnerability model and recovery stories, but de-emphasizing "Facts about Psychosis" and medication information. These can be revisited when the client seems more open to them.

3. The client may agree to education for the family but decline to attend. Here, the family clinician proceeds with the material as planned and has an "open door" policy for the client.

Treatment Planning and the Consolidating Gains Phase

At this point, the family clinician will have a great deal of information about the client and his/her relatives, including the client's progress on goals and level of program participation, client and family strengths, levels of family conflict, and issues that may interfere with ongoing recovery. Prior to beginning the "Consolidating Gains" phase 3, the family clinician integrates the information learned so far with two objectives 1) treatment planning to address problems the family has identified for which they need

help—services may be provided by the family clinician or other members of the team as appropriative and 2) developing a recommended treatment plan for subsequent family work.

Many families will only need a modest level of services from this point, which would typically include monthly contact ("monthly check-ins") with the treatment team (in person or phone), invitations to the every 6 month treatment team meetings, and "as needed" consultation meetings as problems arise. However, a subset of families will likely benefit from more intensive work, such as modified behavioral family therapy (such as Modified Intensive Skills Training, or MIST, offered as part of the family program) or a referral for some other kind of services for a serious family problem (e.g. depression in a relative, domestic violence not related to symptoms). Indicators of a need for a more intensive level of services include 1) client not making progress on goals; 2) high levels of conflict in family; and 3) relative initiating frequent contact with clinic with many concerns about treatment and/or client. In considering whether to recommend a more intensive family program for these families, the family clinician should also take into account 1) their attendance and motivation during the educational sessions and 2) whether the indicators for a need for intensive services reflects an illness management problem or another problem which might be handled through another resource. If the problem seems illness related and the family has been attending sessions, then a recommendation for a course of modified behavioral family therapy is made. If the problem seems more related to a non-illness issue, the family can be referred to other resources for appropriate assistance.

Consolidating Gains Phase

By this point in the NAVIGATE program, the client will have been working with the treatment team for about four months, and the family clinician will have had time to learn which of the relapse risk factors are impinging on the client, and which protective factors are in place. The client is typically now participating in the IRT program and the situation is beginning to stabilize. At this point, the primary family work goals are to 1) incorporate knowledge into every day practice, 2) support the client's participation in the IRT program, 3) monitor relapse risk, and 4) develop realistic expectations for the client's short–term functioning. The family clinician will be learning of the client's progress through the IRT program staff, as well as having informal contact with the client, and will be making ongoing assessments on how well these objectives are being met.

If the situation is stable, the client is progressing and engaged in treatment, family conflict is moderate to low, and the relatives do not seem highly stressed, the family is offered a moderately intensive family intervention with the following components, which are discussed more fully below:

1. Formal monthly contact (monthly check-ins) with the family clinician, either through clinic meetings or planned phone calls; typically these sessions are face-to-face during the first year of participation in NAVIGATE, and then they

can be moved to phone contact for the length of the client's participation in the NAVIGATE program;

2. Invitations to the treatment team review meetings every 6 months for the client throughout the client's participation in the NAVIGATE program;

3. Encouragement to act as natural support persons for clients as they move through IRT;

4. Brief focused family consultation on an as needed basis throughout length of the client's participation in the NAVIGATE program.

If the situation is unstable, the client is not progressing and/or not engaged in treatment, and/or family conflict is high, the family clinician can recommend a course of modified behavioral family therapy, as described in Mueser and Glynn (Mueser and Glynn 1999).[1] The treatment includes five phases—(engagement, assessment, education, communication skills training, and problem-solving instruction). In NAVIGATE, the treatment is referred to as Modified Intensive Skills Training (MIST) and requires approximately six months, as some of the behavioral family therapy material overlaps with prior family work (e.g., engagement, education). Families offered the behavioral family therapy will also be invited to the treatment team meetings held every six months, concurrent with the behavioral family therapy, and will be offered family consultation meetings and discharge planning as discussed in the prolonged recovery phase after termination of the behavioral family therapy.

Monthly Check-Ins with the Family

It is critical for the client, relatives, and the treatment team to continue to be able to share information. Planned monthly contacts provide a forum for this information sharing, as well as providing an opportunity to see how the family is faring. It is preferable for the meetings to be held face-to-face during the first year, with both the relatives and the client participating; however, it is preferable to have the meeting on the phone rather than missing it for a month. After the first year, if the client is doing well, phone check-ins may suffice. Participants should be called two days in advance to remind them of the face-to-face meetings. Typical monthly contact meetings would last for 45 minutes. As the participants raise issues, the family clinician reviews educational material, gives advice and guidance, or problem-solves to resolve concerns. The family clinician also reminds families, as appropriate, that as clients progress through NAVIGATE, discharge to other treatment is a typical outcome and keeps the long-term focus on moving towards the client and family being as fully integrated into the "non-mental-health" community as possible.

[1] As behavioral family therapy is fully manualized in the Mueser and Glynn text, it will not be included in this manual, but instead the Mueser and Glynn text will be used as a supplement when needed.

Invitations to Join Every 6 Month Treatment Team Meetings

Every NAVIGATE client has a full treatment team progress review every 6 months. Both the client and relatives are invited to be part of the meeting, provided the client has consented to family involvement in care. The family clinician invites the family to attend during the family meeting prior to the team meeting, and endeavors to schedule the meetings at a time convenient for the family. He/she follows up with a reminder phone call two days before the meeting.

Encouragement to Act as Supporter for the Client's Participation in IRT

Generalization of skills is a critical element of the IRT program and one method to promote generalization is to have persons in the client's natural social network be available to practice skills and support their use in the client's everyday life. Relatives can be excellent support persons for the IRT program and the family clinician looks for opportunities to encourage their involvement whenever possible.

Brief Focused Family Consultation

During the consolidating gains phase of the NAVIGATE family program, most of the contact between the relatives and the family clinician will occur during the monthly check-in meetings. While many problems/issues can be resolved during these sessions, some problems may require more extended effort to address successfully. Examples of these kinds of issues might include 1) managing an incident of aggression in the home; 2) client's ongoing problems with substance use; or 3) helping the client prepare to go back to school. When the family clinician becomes aware of such an issue, he/she can offer the family a series of meetings wherein he/she can consult with the client and relatives about how to address the issue. These should not be conceptualized as traditional "family therapy" sessions as the family clinician is serving primarily as a consultant and resource to the family. Typically one to three 45 minute sessions are scheduled over a month's time, with both the family clinician and family members' assigned specified homework between sessions to progress on the problem. Families can access multiple courses of family consultation during their participation in the NAVIGATE family program on an as needed basis. They can either request the consultation or a member of the treatment team can suggest it might be useful.

Many families find that working to solve problems *in a systematic way* can lead to better outcomes. Families can learn to use a specific set of strategies to resolve problems and meet goals effectively. In the NAVIGATE family program, we often use this strategy as the foundation of family consultations. Two strategies are available to the clinician—problem-solving or decisional balances. Some situations are *problems to be solved* while some situations involve *making a decision* rather than solving a problem.

Families often find that following a specific structure for solving a problem can help to organize the members and keep them focused on the problem at hand. The

family clinician helps organize the family and structure the discussion to follow the steps of problem-solving using the consultation handout that is part of the NAVIGATE family materials. Using these steps had been shown to increase the likelihood that successful solutions will be found. The structured approach to solving problems in NAVIGATE follows six steps. The clinician works with family members and focuses on one step at a time.

The six steps are as follows:

- Discuss the problem or goal.
- Brainstorm at least three possible solutions.
- Briefly evaluate each solution.
- Choose the best solution.
- Plan the implementation.
- Review the implementation at the next consultation meeting; modify as needed.

Sometimes people are faced with complex situations that do not immediately lend themselves to the steps of problem solving. They require that a preliminary decision or choice be made before the initiation of problem solving. Typically, such decisions involve major lifestyle changes, such as whether the person in NAVIGATE should continue to live at home, enroll in school, begin using alcohol again, or tell friends about his/her recent problems with psychosis. To help make these difficult decisions, the clinician can introduce the task of conducting a *decisional balance.* A decisional balance involves learning steps similar to problem solving, including: (1) define the decision to be made; (2) generate a list of the advantages and disadvantages of one decision, and the advantages and disadvantages of another decision; (3) discuss the relative advantages and disadvantages; (4) select the best choice; (5) plan on how to implement the decision; and (6) follow up the plan at a later time. Everyone in the consultation should help give ideas for the decisional balance. Once a course of action has been chosen, a variety of problems or goals can often be identified, to be worked on one at a time, using the problem-solving strategy discussed above.

Content for the consultation can be structured using the consultation handout in the NAVIGATE Family binder.

Treatment Planning for the Prolonged Recovery Phase of Family Work in NAVIGATE

Clients often stay in the consolidating gains phase until a plan is made for their discharge from NAVIGATE, based on their overall level of improvement. This referral will typically be either to regular clinic care, to other community resources, or to the client's choice of physician (general or Psychiatrist). Some participants will have improved sufficiently to longer need specialty mental health care. A discharge plan is developed with the treatment team, client and family and then details reviewed in at least two consecutive meetings in the prolonged recovery phase.

Prolonged Recovery

Clients may be involved in NAVIGATE for a number of years, and the family will continue with monthly check-ins, invitations to treatment team meetings, and the availability of consultation during this period; typically, after the first year, most family contacts will be by phone, but the option for face-to-face meetings remains. A critical aspect of NAVIGATE is information sharing (with appropriate consents) among the client, relatives, and treatment team, all with an eye to supporting the client's recovery and reducing the family's burden. Many clients will make sufficient improvements in NAVIGATE and will transition out of the program at some point. The timing and transition will be a result of shared decision-making among all the relevant participants. At the point of transition, the family clinician plans at least two conjoint sessions with the client and relatives. The goals of these sessions are to review progress made in the program, review and refine the discharge plan, and to make referrals to any additional resources needed by the family. These sessions can replace the monthly meetings.

Treatment Planning Between the Two Discharge Planning Sessions

The family clinician reports to the team about any issues that arose as part of the first meeting and investigates referrals for any resources requested by the family.

Family Education Contact Sheets and Fidelity

Each session should be documented using the family education contact sheet (see Appendix). The purpose of the contact sheet is to help family clinicians and supervisors keep track of the participant's progress in treatment and the kinds of interventions that are provided (motivational, educational, or cognitive-behavioral), and whether or not the participants are completing home practice assignments. On site-supervisors may also find it useful to listen to tapes of the family sessions and provide feedback to clinicians on their adherence to the treatment model.

There is a fidelity scale available for the intervention, which supervisors and trainers may use to provide feedback (see appendix). The fidelity ratings cover the key ingredients of family work utilizing a 5 point scale from 1 = unsatisfactory to 5 = excellent. Ratings are based on listening to session audiotapes. 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. 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 assess weaknesses and strengths that can be addressed during supervision leading to better client outcomes.