



My health. My choices. My future.

Primary Clinician's Manual



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I. Primary Clinician Role

The Primary Clinician is a licensed mental health professional. The Team Leader or Outreach and Recruitment Coordinator can each serve in the role of Primary Clinician; and on most teams, each of these individuals will be Primary Clinician for a subgroup of clients.

The Primary Clinician is the primary resource for participants and their families. In that capacity, he/she provides emotional and practical support to the client and family, focuses on participant outreach, engagement, and retention; conducts needs assessments; provides psycho-education regarding first episode psychosis (FEP) and the goals of the OnTrackNY program; provides recovery coaching sessions that focus on skill building; engages in safety planning and wellness management planning with participants; and connects participants and families with the services and supports they need. As the team member who is most frequently the primary contact for participants and their families, the Primary Clinician is responsible for ongoing engagement, assessment, and relationship building with participants and their families. Having a point person on the team simplifies matters for participants and families. As participant and family needs are identified and goals established, the Primary Clinician draws on the expertise of the other team members and deploys the team's resources appropriately.

A. Providing Emotional and Practical Support

One of the key roles of the Primary Clinician is to assist participants and families in coping successfully with a first episode of psychosis. The period surrounding onset of psychotic symptoms is typically one of disequilibrium and substantial stress for the participant, family, and other members of his or her social network. The impact of disturbing psychiatric symptoms, combined with severe difficulties in functioning, sometimes preceded by a prodromal phase lasting months or years, make this period one of extreme vulnerability. Compounding the stress of dealing with symptoms and associated difficulties is uncertainty about the nature of the illness and what participants and their families can expect as the course of the episode evolves and the diagnosis clarifies.

While the need for emotional and practical support during this period is particularly acute, it is often difficult for participants and their families to engage effectively with treatment providers and to make optimal use of available services and supports. We anticipate that the integrated team approach of OnTrackNY programs will minimize some of the access and engagement challenges present in more typically fragmented systems of care. Nonetheless, ambivalence, anxiety, and stigma associated with psychiatric illness and treatment on the part of participants and their families will require attention by OnTrackNY teams in order to maximize the likelihood of participants' engagement with services.

Initially, participants and their families may need support in a variety of domains. These may include basic information on diagnosis, symptoms, course of illness, and treatment options; obtaining health insurance; applying for financial benefits; locating or maintaining stable housing;

minimizing the disruption of academic or employment activities; and resolving outstanding legal issues. Participants and their families also need encouragement and hope that, despite the difficult circumstances they face, recovery is a realistic expectation.

B. Creating a Durable Network of OnTrackNY Team Services and Community Supports

OnTrackNY offers coordinated services delivered by a specialized multidisciplinary team. The team will form a network to assist participants in achieving their goals. In addition, there may be many occasions when participants and families will need to be linked to service providers in the community. There are three general sets of community resources that participants and their families may need:

1. Mental Health or Clinical Services Not Provided by OnTrackNY Programs

Examples include extended trauma treatment for PTSD; inpatient substance abuse treatment; dialectical behavioral therapy; cognitive remediation.

2. Non-psychiatric Medical Services

Examples include primary care services; lab services; other medical appointments; substance use detoxification.

3. Peer or Community Support Resources

Examples include National Alliance on Mental Illness (NAMI); Alcoholics or Narcotics Anonymous (AA/NA); Al-Anon; Double Trouble; Depression and Bipolar Support Alliance.

In such cases, the Primary Clinician will actively assist the participant in contacting a provider or service and in following through on the contact. The exact nature of this assistance will differ for individual participants: some will require only a referral, while others may need help with making contact and/or getting to and from initial appointments. The goal is for OnTrackNY programs to provide most of the psychiatric/mental health intervention “in-house,” while at the same time assisting participants and families in becoming familiar with and eventually using natural supports in the community. Toward the end of the intervention, the team will assist participants and families in establishing links to other mental health services in the community. The Primary Clinician will coordinate these linkages to mental health and psychiatric professionals and will work with participants and their families to identify and select service options that are most appropriate.

C. Processes and Procedures

1. Referral and First Meeting

The enrollment process will be variable for each OnTrackNY client. Individuals will be referred from a range of sources. Hospital emergency rooms, inpatient units, outpatient clinics, school counseling

centers, private practitioners, and participants and families themselves are some examples of typical referral sources. It will be important to have a seamless transition from evaluation for eligibility to treatment. Factors that influence this process will be somewhat dependent on how the Team Leader organizes the outreach and enrollment process. This is further detailed in the outreach and enrollment manual. The first treatment meeting should include the Primary Clinician, the participant, his/her family members, and the team Psychiatrist. If necessary, the Primary Clinician can conduct the first meeting with the participant/family alone; in such cases, the Psychiatrist should meet with the participant/family within one week. Prior to the first meeting, the Primary Clinician should review relevant information from the client's evaluation and the referral process so that information does not need to be repeated.

The first meeting has several goals: to describe OnTrackNY and to explain what the team does; to establish rapport with the participant and his or her family; and to answer any questions that the participant or his/her family members may have. It is important to note that some participants may be hesitant to begin treatment, may be uneasy about seeking treatment in a mental health setting, or may just be ambivalent. Thus, for some participants it may take a few appointments before the first meeting actually takes place, especially if the participant is reluctant to come to a mental health setting. At this early stage in treatment, the Primary Clinician may need to show considerable creativity and be willing to go where the participant is or prefers to meet in order to make the connection with OnTrackNY as quickly as possible. In addition, it is important to try to get the participant to bring family members with him/her to the first meeting if at all possible. However, the Primary Clinician should schedule the meeting even if the participant is not willing to have family accompany him/her.

This first meeting is focused on allowing the participant to get to know the team. For some participants, this first meeting may be limited to hearing about team members and asking questions. While it is important to assess specific needs and to obtain information relevant to establishing a treatment plan, keep in mind that many participants and family members may be overwhelmed, upset, or otherwise unable or unwilling to move beyond rapport building in this first meeting. Good clinical skills for beginning relationships are key. There are a number of handouts that the Primary Clinician can provide at the first meeting: (1) What is Psychosis? (2) Recovery from Psychosis (3) How Can Family Members Help? (4) What is the Team? (see Appendix.) Handouts are especially useful in cases where participants or families want information but may be unable to focus or remember everything discussed in the meeting. Other participants may not want handouts. The Primary Clinician can use handouts if they will assist the participant and family, or may opt not to provide them to others who do not want a lot of written information. For some, handouts may be more useful once the Primary Clinician knows the participant better.

At the first meeting, the Primary Clinician may also introduce the participant to the Supported Employment and Education Specialist (SEES), and the Nurse. This is not the time for these team members to do assessments or in-depth planning about work/school/health. Instead, it is an introduction to all team members so that the participant knows who everyone is and their role on the team (See Appendix for Core Session 1: Introduction to the OnTrackNY Team). Given the

different time commitments and responsibilities of team members, the SEES, and Nurse may not always be available for the initial meeting.

2. Initial Treatment Planning

- **Collecting information**

The first step in creating the initial treatment plan is completing a comprehensive history and psychosocial needs assessment. This process will begin either at the first meeting following referral or soon after this meeting. Both the Primary Clinician and the Psychiatrist should meet with the participant to conduct the history and needs assessment. Here again, flexibility is key, and the Primary Clinician and Psychiatrist may have to meet separately with the participant to complete these activities rather than delay them. It is important to stress that a Shared Decision Making (SDM) approach will be used throughout the treatment planning process for both the psychosocial and psychopharmacological aspects of care. SDM as a key clinical concept underlying OnTrackNY is discussed in the OnTrackNY Team Manual.

The Primary Clinician starts by gathering a psychosocial history, conducting a needs assessment, screening for exposure to trauma and symptoms related to trauma exposure, and assessing risk and safety. To supplement the information provided by the participant, the Primary Clinician may collect information from previous treatment records, interviews with family members, and discussions with other members of the participant's support network including previous service providers and social network. As appropriate in relation to the participant's age, assent or consent should first be sought. While the Primary Clinician will do most of the history gathering, other team members can assist within their areas of specialty. For example, the Supported Education and Employment Specialist will usually meet with the participant to gather a detailed work and educational history.

The needs assessment follows the Critical Time Intervention framework discussed in the Team Manual and should include: (1) medication adherence and medical care; (2) supported education and employment; (3) family support and intervention; (4) fostering illness self-management and recovery; (5) social skills training, substance abuse treatment, coping skills training, and behavioral activation; (6) housing and income; (7) trauma-informed care; and (8) safety planning and suicide prevention. When conducting the needs assessment, the Primary Clinician must balance collecting factual information with engaging the participant in a recovery-oriented discussion in which the participant is heard and his/her choices and goals are validated. The needs assessment requires both short-term and long-term perspectives. Information gathered from the participant and family will have immediate implications for treatment foci. However, the needs assessment also involves processes that unfold over time as the members of the team work with and learn more about the participant.

To begin the needs assessment, the Primary Clinician will engage the participant in a discussion of the things that are important to the participant in his/her life, the strategies and supports that the participant finds helpful, and the participant's thoughts and ideas about how the team can help

and support him/her. These open-ended questions are critical to building a relationship, communicating support and understanding, and keeping the focus of the team and its efforts on working with the participant collaboratively. In addition, this style of interviewing is likely to provide the Primary Clinician with considerable information within the context of a free-flowing discussion. Three such questions will open the needs assessment:

- How has this (psychosis; experience; other word used by participant) interfered with the things that are important in your life (friends, family, responsibilities, school, work, independence, etc.)?
- What do you do that helps? ("When I get outside and walk, it gets my mind off the voices.")
- How can we be of help to you?

The goal is to use such open-ended questions to collect information in the different domains that are reflected on the Initial Psychosocial and Needs Assessment Form (see Appendix). As part of discussing needs with the participant, the primary clinician may introduce the participant to the possible behavioral treatment strategies and supports that the team can offer. For example, the Primary Clinician might discuss the possibility of utilizing recovery coaching strategies (e.g., social skills training, coping skills, behavioral activation, and substance abuse treatment as well as introduce the role of the Supported Education and Employment Specialist. That is, the participant should be educated generally about what the team offers and how the participant will work collaboratively with team members.

The Psychiatrist will assess the client's clinical status and to discuss his/her current medication treatment regimen as well as his/her psychiatric history and past experiences with psychiatric medications. If appropriate, family members will also participate in this discussion. Details of this procedure and forms used can be found in the OnTrackNY Team Psychiatrist Manual.

Initial sessions with participants should include careful assessment of safety. The role of the Primary Clinician in suicide prevention and safety planning is discussed below, and the OnTrackNY Team Manual includes comprehensive information on safety planning, including a safety plan template, for all team members.

- **Formulating and presenting the treatment plan**

The Primary Clinician and the Psychiatrist then present the psychosocial history, needs assessment, and medication assessment to the rest of the team at the team's next meeting. The team will begin discussing development of an initial treatment plan and possible interventions to help the participant achieve his or her goals. The Supported Education and Employment Specialist and Nurse are involved in the initial treatment planning as well, even though they may not have played an integral role in the initial needs assessment. The needs assessment will gather information on the domains addressed by the Supported Education and Employment Specialist and provide information about useful recovery coaching strategies that the Primary Clinician can include while working with the client (work, school, family needs, social and coping skills, substance abuse). These domains can be represented in the initial treatment plan.

The team will then meet with the participant and review the history, needs assessment, medication and health assessment, and recommendations. As noted below, this begins a process of shared decision making (SDM) that will guide decisions throughout the participant's involvement in the program.

The point is not to ask the participant to "rubber stamp" the team's initial recommendations – rather, these recommendations will help to begin the discussion. This meeting with the participant should be led by the primary clinician using a SDM approach to create the initial treatment plan, and SDM should be listed in the treatment plan itself as a strategy that will be used to discuss treatment-related decisions. The primary clinician will work collaboratively with the participant using SDM to select specific domains that will determine the primary foci for team members at the start of care. They will then identify relevant psychosocial interventions that should be included in the treatment plan based on the needs assessment. These initial domains will serve as a starting point to provide team members with a concrete plan used to guide their work and ensure that the interventions provided by each team member are highly focused. At the same time, as the participant spends more time in the program, these domains may change and be reflected in updated treatment plans. Selection of the areas to focus on in the initial treatment plan is simplified by the fact that some areas may not be applicable to all participants. For example, not all participants will have contact with family members or have problems with substance misuse. It is important to use an SDM framework for development of the initial treatment plan, and ensure that this process is inclusive of all potential domains of care so that the participant can truly select to focus on areas of most importance to him/her. For example, a participant may be most interested in working with the Supported Education and Employment Specialist on education and employment issues; this must be included in the initial treatment plan even if the Primary Clinician would prefer to focus on other domains at the start. The rationale for selection of these primary focus areas should be indicated in the treatment plan.

The Primary Clinician, the Psychiatrist and the participant should sign the initial treatment plan.

- **Developing a treatment schedule**

Following the initial treatment-planning meeting, a treatment schedule will be developed so that the participant and family members know when and how frequently they are to meet with team members. The frequency of contact will be highly individualized, with the expectation that clients may need a much higher frequency at first and may gradually reduce the frequency of contact over time.

Average Frequency of Contact

Primary Clinician & Psychiatrist:

Weekly for first month

Biweekly for months 2-6

Monthly beginning in month 7

Supported Education and Employment Specialist & Nurse:

Variable

- **Primary Clinician meetings with the participant**

Primary Clinician meetings with the participant are used to review how the participant is doing, progress toward treatment plan goals, delivery of recovery coaching interventions and any issues that the participant wants to address.

Meetings with the Primary Clinician may also include discussion of family issues and safety planning. Additional meetings that include the Primary Clinician, participant, and family members can be scheduled as needed. A schedule of meetings with other team members (Supported Education and Employment Specialist) will also be developed as needed. These meetings will vary by participant depending on each participant's needs assessment, treatment plan and treatment goals. That is, participants will differ on their involvement with the Supported Education and Employment Specialist and the types and number of recovery coaching sessions with the Primary Clinician. In addition, participants may elect to start these intervention components at different times – some may start working with the supported education and employment specialist immediately, while waiting to begin skills training and/or substance abuse treatment for a few weeks. Others may want to start all of these interventions right away. Still others may not need or wish to engage with supported education and employment services at all. So, the timing of meetings for the psychosocial interventions will be different for different participants.

- **Recovery coaching sessions**

Within the OnTrackNY model, recovery coaching interventions refer to cognitive behavioral based strategies that the clinician and participant can work on together as needed. These typically include social skills training, coping skills, substance abuse treatment, and behavioral activation. By including recovery coaching interventions as part of the core sessions delivered by the Primary Clinician (described below), the aim is that Primary Clinician assesses with each client whether any of these interventions will be useful for achieving recovery goals. This manual includes a suggested outline for introducing these topics to the client, determining if the client is amenable to doing this work, and starting the sessions. The Recovery Coaching Manual provides more in-depth guidance and examples that the Primary Clinician can use to delivery these interventions more comprehensively.

It is important to note that recovery coaching interventions be incorporated into the Primary Clinician sessions in a flexible manner and with the goal of addressing the immediate needs of the client. Although possible, it is not essential that the recovery coaching interventions be delivered in a highly structured manner. For example, one scenario is that the client presents with substance abuse, social skills deficits or significant negative symptoms and the Primary Clinician and client spend 10 sessions providing an in-depth and highly focused recovery intervention. Another very common scenario is that through discussing how the client is doing in general, the Primary Clinician and client discover that the client is experiencing significant anxiety. In this situation, it is appropriate to introduce coping strategies for managing anxiety and practicing relaxation strategies even if it is something that

has not been introduced before. Furthermore, it might prove to be beneficial to involve other team members (e.g., SEES) who may be working with the client in the community, and develop a plan for practicing the skills taught in session with the other team member in the community.

3. Other Activities at the Start of Treatment

- **Setting up a family meeting**

Families often play a significant role in the lives of the individuals with first episode psychosis (FEP). Families typically serve as the primary social contact and ongoing social network for persons with FEP, and a majority of persons with FEP are living with family members at the point when psychotic symptoms begin to emerge. As such, family members often have the role of the primary caregiver and advocate for their ill relative, providing ongoing emotional support, help in coping with symptoms, and practical assistance such as housing, transportation, and financial support. In addition, family members are often the ones to initiate and coordinate treatment as symptoms emerge or worsen.

Families may not fully understand the personality and behavior changes they observe in their relative or know how to access services available to help them. Moreover, observing these personality and behavior changes in a family member and experiencing their effects can be traumatic. Anxiety associated with concerns regarding the safety, health, and well-being of their relative is common. Feelings of grief, loss, and, at times, anger and frustration associated with the additional responsibilities placed on them and the challenges they face in attempting to support their relative are common as well. Family members struggle with the possibility that they may need to change their expectations concerning a relative's functioning, capacities, and future goals, while trying to find ways to help their relative cope with his/her own feelings of grief and loss associated with the effects of an illness (Drapalski, Leith, & Dixon, 2009). Another challenge is coping with the fluctuating insight that persons with FEP have regarding their illness, which can lead to limited adherence to treatment. As a result, families of persons with FEP often experience substantial distress.

The involvement of family members in the lives of persons with FEP, as well as the needs of these family members, underscores the importance of including families in the treatment of participants. Family members often spend considerably more time with the person with FEP than the provider does. Consequently, they often have information about their family member's current and past health, well-being, and functioning outside the treatment setting; potential stressors or triggers that may have been associated with the emergence of symptoms; and personal strengths which can prove invaluable to the provider in treatment planning. Moreover, families can support persons with FEP with their treatment and recovery goals in the community. However, a host of barriers to family involvement have been identified; recent work suggests the need for flexible family services that are specific to families' particular problems or questions at the time (Drapalski et al., 2008). Recognizing the importance of involving families in treatment, most multi-element treatment programs designed for persons with FEP have attempted to engage family members and have offered families services.

The OnTrackNY program recognizes the importance of family involvement and thus is designed to pay special attention to families and to engage family members in the treatment process as soon as treatment begins. In the OnTrackNY Team Manual, the importance of families is stressed, and strategies to be used by the team to reach out to and engage families at the start of treatment are highlighted. The Family Involvement Resources Manual provides further and more in-depth instruction regarding specific interventions to be used with participants and families around family-related goals.

The Primary Clinician will meet with the participant and family members to review the options for family interventions, discuss the family's needs and wishes regarding participating in family programming, and create a schedule that will be used to work with the family. This requires a discussion with the participant regarding his/her preferences and subsequent dialogue with family members. As we expect many individuals to be living with their families, significant family involvement with treatment is expected for most participants and required for minors. As part of this initiation of family interventions, the primary clinician should inform the participant and the family about the opportunity to attend the monthly family psycho-education groups and educate them about the brief family consultation component of the family intervention. Clinicians can utilize the Family Involvement Resources Manual to obtain guidance and materials for working with families.

- [Completing safety planning](#)

Developing a safety plan with participants and families is another key activity at the beginning of treatment. All participants will have a safety assessment during their initial contact with the primary clinician and will complete a safety plan (see Appendix) with the primary clinician. Those participants who are at high risk of suicide or self-harm (defined as those with a history of suicide attempts or self-harm or those who report suicidal ideation) will complete a safety plan in the same session as the safety assessment; those participants assessed at lower risk should have a safety plan completed within their first month of participation in the OnTrackNY program. Two strategies make up the safety planning intervention: safety planning, and attention to treating psychotic symptoms.

Safety planning is the first, short-term stage of intervention (to be conducted by the primary clinician), and antipsychotic medication change is the second, more long-term component (to be addressed by the psychiatrist). For more details, see the Safety Planning section in the Team Manual.

- [Screening for trauma exposure and trauma-related symptoms](#)

The primary clinician will ask every participant about exposure to traumatic events during his or her lifetime using a standardized instrument (see Appendix for PTSD Screening Questionnaire I). If the individual has experienced such event(s), trauma-related symptoms will also be assessed (see Appendix for PTSD Screening Questionnaire II). For those participants who have severe trauma-related symptoms, the primary clinician will discuss options for management of and treatment for such symptoms with him/her. One option for treatment includes the Brief Trauma Treatment

program, provided by the primary clinician. The program is a three-session relaxation training and psycho-education intervention that has been found to reduce PTSD symptoms in adults with serious mental illness and PTSD. For more details, see the Brief Trauma Treatment Program Manual.

- **Developing a wellness management plan**

The primary clinician will work with the participant to develop a wellness management plan (see Section 6, Wellness Management Planning, for details). Wellness management planning includes identification of early warning signs for symptom recurrence; relapse prevention strategies; activities that support recovery; activities that may interfere with recovery; and using personal strengths and resources effectively. This plan will be developed with the participant and, ideally, family members using an SDM approach and will be reviewed as part of the ongoing treatment plan review process occurring quarterly.

- **Activities for other team members at the start of treatment**

Near the start of treatment, the Supported Education and Employment Specialist will meet with the participant to describe what services he/she provides and to assess the participant's needs and goals in this area. Additionally, the Nurse will meet with the client to discuss health and wellness. The timing of these meetings will vary for different participants. As noted above, participants will differ on their involvement with supported education/ employment, health and wellness activities, skills training, and substance abuse treatment, and on when they elect to start these intervention components. It is important for each participant to be educated on the specific possible interventions offered by the various team members.

- **Core Sessions**

The Primary Clinician will offer up to ten core sessions to all clients, so that each individual has the opportunity to learn and think about these important issues. These core sessions are individual meetings reflect important subjects that the Primary Clinician should explore with all clients as a means of providing psycho-education, building engagement, understanding the client's cultural framework, emphasizing resiliency, identifying client's need for more focused interventions depending on established recovery goals, and discussing the time-limited nature of the intervention. Keep in mind that these core sessions will likely occur across several meetings with the participants.

1. Intro to the OnTrackNY program and team: Getting the most out of OnTrackNY
2. Early intervention and recovery: Managing my distress and troubling symptoms
3. Shared decision making around client goals
4. My cultural background and how it affects my understanding of my experience and my treatment choices
5. Identifying and using my personal strengths and social supports
6. Enhancing my social skills (Optional- offer to those who need to enhance social functioning)
7. Understanding how alcohol and drugs can affect my recovery (Optional-offer to those who are using alcohol and/or drugs)
8. Learning to manage difficult feelings or situations: Using coping skills and cognitive restructuring (Optional- offer to those experiencing depression, anxiety or other distressing emotions or symptoms)

9. Increasing engagement in the community through behavioral activation (Optional- offer to those who are experiencing negative symptoms)
10. Transition from OnTrackNY: Connecting with community supports and services

4. Ongoing Treatment

- **Delivery of interventions**

Treatment by all team members will be provided according to the manuals. Participants will generally come to the clinic for their regularly scheduled appointments, although the Primary Clinician may meet with individuals in the community as needed. This may also differ for work with the Supported Education and Employment Specialist when tasks related to work or school goals need to be done in the community; or when a team member is accompanying a participant to resolve a concrete-services or case management issue. Additionally, it is possible that some of the recovery coaching sessions with the Primary Clinician will occur in settings other than the office in order to support the practice of skills and generalization of knowledge for participants.

If the participant is satisfied with the schedule and how the interventions are being implemented, then the schedule will remain stable between treatment plan updates. At any time the participant can discuss with the Primary Clinician changes to the treatment schedule. Changes may include (but are not limited to) adding interventions (e.g., beginning skills training or substance abuse treatment); increasing frequency of meetings with the Primary Clinician; spending more time working with the Supported Education and Employment Specialist; increasing or decreasing work with family members. Participants who request a (non-crisis) appointment with the Primary Clinician, Psychiatrist, or Supported Education and Employment Specialist, will be seen as soon as possible.

- **Ongoing assessment and treatment planning**

Treatment planning is an ongoing process. As initial goals are reached, new goals will replace them on the treatment plan. Focus areas will change over the course of the intervention, with different focus areas identified at different points. Focus areas may also change with continued attention to and screening for safety and exposure to trauma. To reflect the changing nature of treatment goals, the treatment plan will be updated at least every three months or whenever a major change occurs. Treatment plans will be updated during a meeting between the Primary Clinician, the other team members, and the participant. That is, treatment plan updates should take place with the participant and all team members present if possible and if comfortable for the client. Family members may attend as well. As noted earlier, a good time to do treatment plan updates is following the weekly team meeting: team members will, if at all possible, reserve the hour following the weekly team meeting for treatment planning. Prior to this meeting, the treatment plan and any potential changes will have been discussed among team members. This discussion should focus on the participant's current goals, progress toward goals, whether goals are being met, what has worked and what hasn't worked, and whether new or revised goals are needed. The primary clinician will then present any thoughts or issues identified by the whole team to the participant and his/her family during the treatment plan update meeting.

The discussion between the team and the participant around updating the treatment plan will be participant-centered and should include several components:

- Review of each goal and discussion of progress toward each goal
- Elimination of goals that have been achieved, or revision of them in order to reflect both progress and work still to be done
- Identification of team members responsible for working with participant toward each goal
- Inclusion of new goals

The Primary Clinician will also check in with the participant regarding domains that have not been included in previous treatment plans to see whether the participant now wants to include these domains on the plan. For example, at the start of treatment, a participant may be wary about addressing issues related to substance abuse and may decline having substance use goals or recovery coaching strategies around substance abuse included on the initial treatment plan. At the treatment plan update meeting, the Primary Clinician will need to check in with the participant about his/her substance use and discuss the possibility of adding substance use goals to the treatment plan. Such a discussion will be done within an SDM framework in which the participant can discuss and weigh the benefits and drawbacks of addressing substance use within the treatment plan. All major treatment changes will be recorded on the treatment plan.

All treatment plan updates should be signed by the Primary Clinician, the Psychiatrist, and the participant.

- **Missed appointments, potential dropout, assertive outreach**

There is an expectation that participants will have a minimum of one contact per week with some member of the team during the first month of treatment. While this will most likely involve weekly contact with the primary clinician and the psychiatrist, it is possible that during some weeks, the contact may occur with other team members. When a participant misses an appointment, a team member should attempt to contact that participant within 24 hours to indicate that the appointment was missed and to reschedule the appointment or provide a reminder for any upcoming appointments that have already been scheduled. These reminder calls should not sound punitive in any way. The team member should convey that the participant was missed and that the team looks forward to seeing the participant soon, and should greet any information about the cause of the missed appointment with support and understanding. The team will deal with missed appointments by providing outreach, especially to those in danger of dropping out of the program. Outreach will be tailored to the participant and can include a range of strategies including calling the participant, contacting his or her family members, and making home visits.

- **Review of safety plan and wellness management plan**

In addition to ongoing review and revision of the safety plan and wellness management plan developed with participants, team members will remind participants and family members about the team's availability to work with participants/families during times of crises. During business hours, participants/family members should call the clinic: the Primary Clinician, or Psychiatrist will talk with

the participant/family member during the day. After business hours, the plan for contact with team members is as follows: The Primary Clinician will set up policies for evening coverage. The Primary Clinician will work with the team member on call who will assist participants/families in deciding how to manage a crisis, whether the crisis can be managed at home or will require emergency services, etc.

Participants and families should be provided with cards listing the team's contact numbers, including pager number, at intake, and this information should be reviewed with participants/ families periodically. If the on-call team member determines that emergency services or hospitalization is needed for a participant, the Psychiatrist will contact the hospital where the client will be taken to inform hospital staff and to provide history on the client. Different programs may manage the pager in different ways, but it is essential that participants and families have access to the team at all times.

- **Linkage with community and peer resources**

The team will develop a guide to community resources that participants may need or wish to access during their time with the team. An important goal of the team is to work with participants and their families to develop natural supports within the community. During the participant's time with the team, there may be many situations in which he or she wants or needs to be connected with other supports or services in the community. As noted previously, there are three general sets of community resources that may be needed by participants: mental health or clinical services not provided by the team; non- psychiatric medical services; and peer or community support resources. The nature of the team's assistance with these referrals will vary on a case-by-case basis, with some participants needing only contact information and others needing accompaniment to appointments/meetings.

5. Documentation

Each clinic will have its own process for record keeping and formatting progress notes. For OnTrackNY participants, all progress notes added to the case record should be clearly tied to the specific goals and focus areas outlined in the initial treatment plan and its updates.

The Primary Clinician should maintain the following materials in the office, accessible to all team members:

- Team contact numbers
- Participant (and support network) contact numbers
- Resource binder: A regularly-updated directory of commonly used community services and resources

To accommodate work in the field, the Primary Clinician should have the following materials in a portable format so that he or she will have access to them as needed:

- Blank chart forms
- Intake/assessment forms

- Treatment planning forms
- Consent for release of information forms
- Health Insurance Portability and Accountability Act (HIPAA) forms
- Progress note forms
- Checklist on SDM for participants
- Business cards (for participants, family, community providers/caregivers)
- Identification, cell phone, relevant contact numbers

6. Wellness Management Planning

The OnTrackNY program draws heavily on the concepts of the evidence-based practice of Illness Self-Management and Recovery. Recognizing illness symptoms and learning to manage them while pursuing life goals is a primary challenge for participants; accomplishing these tasks is central to the recovery process. OnTrackNY programs work with participants to learn signs of relapse and strategies for relapse prevention; to understand what helps and what does not help in staying well; and to identify and use strengths, supports, and coping skills effectively. Team members encourage participants to examine the link between mental and physical health, and to make healthy decisions about their lifestyles. The Primary Clinician works with participants to develop a tailored Wellness Management Plan (see Appendix) and revisits this plan with participants as part of ongoing treatment planning and review.

7. Transitioning Out of the OnTrackNY Program

Transitioning out of the OnTrackNY program is a critical phase in the treatment process. Clients typically stay with the ONTrackNY team for an average of 2 years. The transition planning process typically begins six months before discharge to ensure a smooth transition. Helping participants and their families to reassess their needs and preferences, and equipping them with knowledge about mental health services and the mental health care system, will help guide their selection of the most appropriate service options available. For many families, their experience of OnTrackNY will be very positive, with strong bonds forged between participants and their families, and the team. Families, who will typically not be experienced in navigating the mental health system, may be hesitant to move forward with community services, but they and their participant relatives will need to take steps to prepare for and to feel confident about transitioning to new treatment providers. The Primary Clinician plays a central role in the transition process by helping the participant and family to develop a plan for obtaining care in the community and to make that plan become a reality. The Primary Clinician also coordinates with other team members to ensure the plan is comprehensive, incorporating medication, school/work, and recovery goals.

Work with OnTrackNY is time-limited. The team must be cognizant of this and must convey it to participants and families. Transitioning to care in the community is a critical component of OnTrackNY and should be discussed early and often with participants and families so that they

recognize this as a goal – that is, transitioning from the team should be viewed as positive, meaningful, and something to work toward, rather than something to be dreaded or avoided.

Participants and families may have many worries and concerns about transitioning to community care. They will be familiar and comfortable with the ease with which they have been able to reach OnTrackNY staff, the flexibility of scheduling appointments, and the open communication with all team members. For many participants and families, relinquishing that dependable support will be frightening. Establishing relationships with new mental health care providers may seem overwhelming and risky. Participants and families need to know that they will be ready to take the step to community care because they will be properly prepared to navigate a world that is unfamiliar to them.

The following are areas in preparation for transition that the primary clinician should review with participants and their families:

a. Review of experience with the OnTrackNY program

At the start of the transition process, the primary clinician should plan a series of meetings with the participant and family to review their experience with OnTrackNY. This should involve a review of those services/supports provided by the team that were experienced as the most valued and those that were considered to be the least helpful, as well as those that participants and/or family members did not experience but that, in retrospect, they would have liked to have tried. This review should also include a look back at the initial needs assessment and treatment plan, to frame a discussion of progress from the beginning of treatment. The goal of this review is to identify services and supports that the participant would like to maintain as well as those they would like to initiate in the community.

b. Review of practical considerations that may impact community care options

Prior to formal transition planning, the primary clinician should have a good sense of the resources and services that are available in the community and should have information on these. To begin the transition planning process, the primary clinician should review with the participant and family a range of practical issues that may impact community care. These include, but are not limited to, insurance coverage for treatment and medications; location of services; clinician availability on evenings and weekends; ancillary support for families; and other contextual considerations. Review of these issues at the start of transition planning will educate and support the participant and family and help them better navigate the service system.

c. Development of a transition plan

The primary clinician will work with the participant and family to create a transition plan that will document goals and community services needed to achieve them. The Transition Plan (see Appendix) will help structure this discussion.

d. Utilizing recovery coaching interventions for focused work to enable participant to implement transition plan

The Primary Clinician works with the participant to develop a plan for receiving care in the community. The participant reviewing or practicing skills or activities with the Primary Clinician may strengthen implementation of this plan. For example, the participant may need to contact new treatment providers, ask questions about available services, or visit a clinic in the community. There may be cases where a participant does not feel comfortable doing these tasks, perhaps feeling nervous about meeting new people or encountering unfamiliar situations. The Primary Clinician can work with the participant to identify the social skills needed for these activities, practice/role play them in session, and help the participant develop and implement a plan to accomplish the tasks.

As work begins on the participant's transition plan, the Primary Clinician and participant can decide, using SDM, which of the activities below would be most helpful for the participant.

- **Identifying and reviewing tools in the toolbox**

During the time that the participant has been working with the team, he/she has developed a set of tools for solving problems, participating in shared decision making, coping with stress, managing symptoms, and interacting with others.

These skills may have developed naturally over time while the participant has been working with the team on recovery goals, or may have been learned through specific work utilizing recovery coaching interventions with the Primary Clinician. During this phase of treatment, the Primary Clinician and the participant can review what has worked well, what the participant does well or feels comfortable doing, what he/she would need to ask for help with, and who he/she would ask for help. These strategies should be written down and can be refined during this transition period. At the end of this phase, the participant should have a list of strategies or tools, when to use them, and when to ask for help.

- **Conducting skills check-up and honing skills for implementing transition plan**

The participant may be working with the Primary Clinician on a plan for receiving care in the community after leaving the OnTrackNY program. As noted above, the Primary Clinician may be able to specifically help the participant implement the plan by identifying needed skills, practicing them with the participant in sessions, and assisting the participant with carrying out the activities of the transition plan as appropriate.

- **Arranging community field trips**

As part of transition planning, the participant may need to visit new clinics, treatment providers, and other agencies that may be involved in his or her community care plan. The Primary Clinician can accompany the participant and assist him/her with navigating transportation routes, implementing social and/or coping skills in new environments, and providing support as the participant meets new people.

- **Helping the family prepare for transition**

The Primary Clinician can also assist the family during the transition to community care in various

ways. First, he or she can conduct a monthly family education group on transition (see Monthly Family Group materials in Family Resources Manual Appendix) – if there are several families coming up to or in the transition phase, the Primary Clinician may convene a special family group to discuss transition issues. Second, if a particular family needs extra assistance with planning for the transition, the Primary Clinician can do the above activities with participants and family members together. For example, the Primary Clinician may accompany the participant and family to visit a new agency in the community; or the may work with the participant and family to review effective communication and shared decision making skills so that when they are no longer meeting with the OnTrackNY program, the participant and family can continue to talk about treatment-, illness-, or recovery-related issues. This may involve writing up a plan for the family in the same way the that is done with the individual participant – a generic coping plan that the family can use for most situations, plus a specific plan for any particular situation that the family is predicting might be difficult to deal with or talk about together.

II. References and Recommended Readings

For a complete list of Recommended and Suggested Resources for Primary Clinicians, please consult the Center for Practice Innovation’s Learning Management System:

<http://practiceinnovations.org/>

III. Appendix

A. Primary Clinician Handouts



What is psychosis?

Psychosis occurs when a person loses contact with reality. The word “psychosis” scares some people, but it actually describes an experience that many people have. Three out of every 100 people experience psychosis at some time in their lives, and most of them recover.

What are the symptoms of psychosis?

Psychosis can affect the way a person thinks, feels, and acts. Some common symptoms of psychosis are:

- **Hallucinations can affect any of the five senses.** People experiencing psychosis might see, hear, taste, smell, or feel things that are not there, and they have difficulty believing that their senses are tricking them.
- **Delusions are false beliefs that people hold strongly, despite all evidence that their beliefs are not true.** For example, a person experiencing a delusion might believe she is being watched or followed.
- **Confused thinking occurs when a person’s thoughts don’t make sense.** His thoughts can be jumbled together, or they can be too fast or too slow. A person with confused thinking can have a hard time concentrating or remembering anything.
- **Changes in feelings can include quick changes in mood.** A person might also feel cut off from the rest of the world, or feel strange in some other way.
- **Behavior changes often result in a person not bathing, dressing, or otherwise caring for herself as usual.** Other behavior changes might involve behaviors that don’t make sense, such as laughing while someone else is talking about something sad.

What causes psychosis?

- Psychosis could have a number of different causes, and many researchers are working to understand why psychosis occurs. Some popular ideas are:
- **Biological:** Some people are more likely to develop psychosis because of their biology or their heredity. Many cases of psychosis have been linked to problems with neurotransmitters, or the chemical messengers that transmit impulses throughout a person’s brain and central nervous system. In addition, the relatives of people who experience psychosis are more likely to experience psychosis themselves.
- **Other factors:** A person’s first episode of psychosis can be triggered by stressful events or by drug use (especially use of marijuana, speed, or LSD).

What are the phases of psychosis?

Psychosis occurs in three predictable phases, but the length of each phase varies from person to person. These phases are:

- The prodromal phase is the early warning phase of psychosis, when a person experiences some mild symptoms and vague signs that something is not quite right.
- During the acute phase, a person clearly experiences one or more of the symptoms of psychosis.
- When a person reaches the recovery phase, he begins to feel like himself again. Different people experience the recovery phase differently. With effective treatment, many people who reach the recovery phase may never experience psychosis again.

How is psychosis treated?

Most people recover from psychosis, and many do so with the help of treatment. This treatment usually includes several parts:

- Learning treatment options and working with professionals to determine which options are right for you.
- Working with a mental health professional to practice ways to cope when things feel bad.
- Working with a doctor to determine how medications can help.
- Working with professionals who specialize in helping individuals learn to manage everything from relationships to jobs and school.

Recovery from psychosis

Three out of every 100 people experience psychosis at some time in their lives, and most of them recover. Recovery from psychosis results in some important life changes, and there are several things people can do to help themselves recover from psychosis.

What is it like to recover from psychosis?

Different people have different stories to tell about their recovery from psychosis. For example, some recover very quickly, while others only feel better after several months. With treatment, support and hard work people in recovery from psychosis can look forward to their lives improving in some important ways:

- **Symptom reduction:** People recovering from psychosis have fewer symptoms of psychosis, and those symptoms they do experience are less intense. That means these individuals are less likely to hallucinate (i.e., see, hear, taste, smell, or feel things that are not there), and they are less likely to have delusions (i.e., beliefs in things that are not true). These individuals also begin to think, feel, and act more like they did before they had psychosis.
- **Improved relationships:** People experiencing psychosis usually cannot relate to friends, family, and other significant people in their lives as they did before the psychosis. Once the psychosis begins to subside, though, they can begin to rebuild those relationships.
- **More connections with the outside world:** Perhaps because they have fewer symptoms to deal with – and more support from other people – people recovering from psychosis often can focus more time and energy on important personal goals like completing school, getting a good job, enjoying friends and family, and other things that make life fun and meaningful.

What helps people recover from psychosis?

The most important thing that helps people recover from psychosis is getting active. It may sound strange, but passively sitting around waiting for medicine and the professionals to cure you is usually not the way recovery happens! Most people who recover get active by:

- **Participating in treatment:** Active treatment participants partner with their treatment providers to learn all they can about their treatment options, such as medications and therapy. They keep their appointments with these providers and give the providers honest feedback about how treatment is working or not working for them.
- **Focus on personal goals:** Personal goals in work, school, or other areas of life can be strong motivators for people recovering from psychosis. If they are not immediately ready to resume all their previous activities, people recovering from psychosis can set smaller, more realistic goals that will help them make progress.

- **Finding needed support:** Friends, family, and other important people can provide important encouragement as people recover from psychosis. In addition, support groups for people who are recovering from psychosis can be important. In a support group you can find hope, friends, pride and proven strategies for getting well.
- **Taking care of yourself:** Recovering from psychosis is hard work, so people recovering from psychosis must make sure they take good care of themselves. This means they need good diets, plenty of exercise and sleep, and regular medical check-ups.
- **Taking an honest look at drug and alcohol use:** For some people, drug and alcohol use can trigger psychosis or make it worse. It can really help to take an honest look at your drug or alcohol use and ask yourself, “has it contributed to my psychosis?”
- **Keep your time structured:** Many people find that being bored is stressful. Just hanging around doing nothing is typically not helpful. Get busy and structure your day with activities such as school, work, volunteering, friends and exercise. Try to find the right balance between time alone and with time around people.

How can family members help?

What is psychosis?

Psychosis occurs when a person loses contact with reality. The word “psychosis” scares some people, but it actually describes an experience that many people have. Three out of every 100 people experience psychosis at some time in their lives, and most of them recover.

What causes psychosis?

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- Biological: Some people are more likely to develop psychosis because of their biology or their heredity. Many cases of psychosis have been linked to problems with neurotransmitters, or the chemical messengers that transmit impulses throughout a person’s brain and central nervous system. In addition, the relatives of people who experience psychosis are more likely to experience psychosis themselves.
- Other factors: A person’s first episode of psychosis can be triggered by stressful events or by drug use (especially use of marijuana, speed, or LSD).

What is the role of the family in recovery from psychosis?

Family members can be extremely important in the recovery process. The person may have difficulty in the early period with many things which used to be easy for them. When a person is recovering from their psychotic episode you can provide love, stability, understanding and reassurance, as well as help with practical issues. There are many ways that family members can help a person in recovery from psychosis. Family members can:

- Help the person with psychosis get to treatment appointments and work with their treatment team.
- Stay in regular contact with the treatment team.
- Advocate for the person with psychosis to get the support he/she needs.
- Learn about psychosis so you know what is happening.
- Assist with remembering and initiating appointments and activities.
- Observe and report symptoms the person with psychosis may not be aware of.
- Include the person with psychosis in family and social activities.
- Maintain a safe, positive, supportive atmosphere at home.
- Help with finances.
- Take care of yourself and get your questions answered.
- Understand the goals that your loved one has for recovery.
- Be patient.
- Attend family support groups in your area so learn how other families cope and support the recovery of loved ones.

What is OnTrackNY?

OnTrackNY is a program to help young people who are experiencing psychosis get effective treatment so that they can successfully reach their goals in life such as completing school, getting a good job, living independently and having rewarding relationships with friends.

What Does OnTrackNY Offer?

The goal of OnTrackNY is to provide hope and effective treatment so that young adults with psychosis can achieve their goals in life. Rather than working with just one mental health professional, we offer a collaborative team approach that relies on everyone's strengths and energy. The young adult with psychosis is a member of the team, along with the family and other mental health professionals. A team leader helps to keep everyone on the team working together toward the young adult's recovery. We use a "shared decision making" approach. That means that the young adult and the team work together to decide on the best treatment options. The treatment offered includes:

1. A comprehensive assessment of the young adult's personal recovery goals to inform and guide treatment.
2. Treatment and support from team members including a doctor, mental health professionals, and vocational specialists who have worked with people recovering from psychosis.
3. Counseling for family members focused on providing information about psychosis and teaching family members how to assist young people in their recovery.
4. Coaching from a vocational specialist with expertise in helping young people identify and reach their school and work goals.
5. Assistance with strategies for building healthy relationships and coping with problems in positive ways.
6. Treatment and support for drug or alcohol problems.

Consumer Shared Decision Making Card

(can be produced as a laminated card for the client to use to prompt SDM during meetings with the team)

Side 1:

Tips for Talking About Important Decisions with Your Treatment Provider

PREPARE before you see your provider. Write down your questions and concerns so you don't forget.

TELL providers what is most important to you. Answer their questions honestly. This helps them understand and respect what is important to you.

ASK for explanations or more information. When a provider offers a recommendation, ask them to explain WHY they think it is right for you. What are the benefits? What are the costs? What are the pros and cons?

SPEAK UP about your concerns and ask for options. For instance, if sexual side effects are of concern, it's okay to speak up and say you would like to find a medicine that does not have these side effects.

REMEMBER what was said. Write down what you and the provider agreed to.

FOLLOW-THROUGH with the decision you and the provider made. If you were not able to follow through, be honest about that. At the next appointment, report the good and the not-so-good results of your decision.

Side 2:

For all major decisions regarding your medications, treatment, school, work, family, and so on, ask yourself these questions:

When your provider gave you a recommendation, did they offer you one choice, or options to choose from?

Did your provider tell you about the pros and cons of each option?

Did you have a chance to ask your questions?

Did you have a chance to talk with important people like family before making your decision?

Did the provider listen to your opinion and what was important to you?

Did you have a say in what decision was right for you?

B. The Primary Clinician Core Sessions

Introducing the Core Sessions to Clients

Describe Core Sessions: *As clients come to the team, we have found that it's helpful to discuss some important topics. You and I will spend time together so that you can learn about the team and how we can work together. We'll also talk about some things that will be useful to you as you plan for your future. We have found that it's good to have these meetings early on as someone is first getting involved with the team, because the information and discussions we'll have can be useful as you plan your goals and think about how best to use the team to get to where you want to be.*

*As with everything that happens with the team, we want these meetings to be useful for you. So as we meet and talk, if topics come up that you aren't so interested in right now or if you'd like to spend more time on some than on others, that's fine. **We can be flexible so that the information you get is the information you want.***

At the end of these meetings, we will talk about how to use the information that you've learned in the rest of your work with the team.

Session 1: Introduction to the OnTrackNY program and team: Getting the most out of OnTrackNY

I. Introduction to Meeting and Rationale: The purpose of this meeting is to provide information about the OnTrackNY team. We have found that young people are eager to learn about these topics so they can better understand what they are experiencing. It can help to answer some questions you may have about what everyone on the team does and how they relate to you.

II. The OnTrackNY Team

There are many things that can help young people who have experienced unusual or troubling symptoms (psychosis). The OnTrackNY team includes several professionals who provide different treatments to help individuals achieve their recovery goals. Part of the job of the team is to collaborate with you to decide together what goals are important to you and which treatments seem best for you. Each person's goals are different and goals may change over time, so this will be an ongoing discussion.

The team offers a collaborative approach where each member of the team has certain strengths, knowledge, and expertise that they bring to the table. ***It's important to remember that you are a key part of this team.***

III. Members of the team (Note: include only as much detail as is useful to the individual)

- Team Leader
 - The Team Leader oversees all aspects of team, making sure that things are running smoothly and that you are getting quality treatment.
 - As part of keeping things running smoothly, the Team Leader coordinates everyone's schedule, talks with the heads of the agency, makes sure the team is reaching out to people, and assigns each participant to a Primary Clinician.
 - Sometimes Team Leaders also act as Primary Clinicians.
- Primary Clinician
 - The Primary Clinician works with you and your family to help identify treatment goals and develop a plan for getting them met.
 - You will meet one-on-one with me to discuss issues or problems you may be facing
 - I will also help you to coordinate all of your care.
 - I will connect you with resources provided by the team and in the community.
 - Recovery Coaching: It may be hard to think about this right now, but once you're feeling up to it, you and your family will start to think about what comes next and how to work towards goals like getting back to doing the things you want or like to do.
 - I can help you learn strategies and practice with skills that will help you in real-life situations.
 - We can also work on ways to improve your health.
- Psychiatrist
 - For many individuals, medications can be helpful in reducing symptoms and preventing

- symptoms that have almost or totally gone away from coming back.
 - The team psychiatrist works together with you, your family, and the team to help you make decisions about whether medication might be right for you and, if so, to find the medications that will be most helpful.
 - Medications commonly used for the treatment of the symptoms you've described include:
 - Medications that target symptoms like hearing voices or having unusual thoughts
 - Medications that can help with other symptoms like anxiety and depression
 - Medications that help manage side effects from other medications
 - The team psychiatrist also works with you to make sure that the medication you choose is working for you and to manage any side-effects you may have.
- Supported Education and Employment Specialist
 - Like other young people, your goals may include school or work.
 - The Supported Education and Employment Specialist works with you to:
 - Identify and clarify your educational and work-related goals.
 - Help you find a job/school that matches your interests.
 - Identify supports you may need to be successful and help to make sure those supports are in place.
 - Your plan will be unique for you based on your needs and preferences. For example, your plan might include help with transportation, working with a teacher or employer on your behalf, and helping you with your relationships with fellow students or co-workers.
- Nurse
 - The team nurse will work with you and the team psychiatrist to see how things are going with you in terms of your medication, any side effects you may be having, and how your health is.
- Outreach and Recruitment Coordinator
 - The Outreach and Recruitment Coordinator works to get the word out about the team and what we do, and will talk with you when you start the program to see whether the team is the right fit for you.
 - Sometimes Outreach and Recruitment Coordinators also act as Primary Clinicians.
- You
 - You work with the team to identify personal goals and steps needed to reach those goals.
 - You discuss your treatment options with the team and work with them to decide what services would be most helpful for you.
- Family Members and other supports
 - If you want your family or other people in your life involved, they will work with you and the team to find ways that they can support you.
 - You and the people you would like involved may also discuss which support services, if any, might be helpful.

IV. Time-Limited Services

The OnTrackNY team is starting to work with you at a time in life when you have started having

some difficult experiences. The goal of the program is to work with you as long as you need us, and then to support you in transitioning to other services and supports outside of the team. The average amount of time that young adults stay with our program is about two years, but we don't know what will be the right amount of time for you. We will return to the topic of transitioning to other services after you've been with the team some time.

V. Working Together with the Team

I hope you now feel like you understand who's on the team and what they do. Do you have any questions?

It's important to remember that the team is here to work with you. We will ask you a lot about your thoughts about how things are going for you as you work with us, and you will need to give your input and let us know what's going well and what could be better.

In one of our next meetings, we'll talk about how to be a part of the treatment discussions and decisions that are made and practice some skills for feeling comfortable getting your point across.

VI. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 2: Early intervention and recovery: Managing my distress and troubling symptoms

- I. Introduction to Meeting and Rationale:** The purpose of this meeting is to provide information about early intervention and recovery. Understanding what recovery is and how you want your recovery to go are important things that you will talk about with the OnTrackNY team. First, we'll talk some about some of the experiences you've had that have brought you to work with the team. Then, we'll talk about ways to think about recovery and your personal goals moving forward.

NOTE: Check in frequently with the client while delivering and discussing this information.

NOTE: Many young people may not think in terms of “psychosis” or find the term useful. It would be good to discuss their experiences with them and get an understanding of the language they use to refer to their experience of psychosis and/or what has led them to OnTrackNY.

II. Your experiences

As I've said, I want to start by talking about some of the experiences you've had that have brought you to work with the team. Tell me a bit about what was going on with you before you came here.

NOTE: Meet the client where he/she is at in terms of describing his/her experiences. Let him/her decide how much detail he/she provides. Use reflective listening to convey an understanding of the experience and feelings surrounding it. Summarize to make sure your understanding is accurate and give the client the chance to correct anything you have wrong. The goal of this is to learn how the client understands and describes his/her experience.

Please use the next paragraph as a guide, not as a verbatim script. The goal is to communicate to the client your interest in learning about his/her experiences, in his/her own words and then to structure a respectful, non-judgmental discussion to do so. The following questions are offered as examples – you may decide to use others as you see fit.

I appreciate your sharing your experience with me. The OnTrackNY team works with many young people who have had experiences that are similar to yours. People call these experiences by different names and refer to them in different ways. What have been some of the things you have heard so far, as they relate to why you are here? How do you feel about that? Is there another way of describing this that makes more sense to you? It is important to remember that the terms some people find helpful may not be a good description of other peoples' feelings and experiences.

NOTE: Presenting this material should not be a lecture. It should be a discussion. The PC should provide some information then ask for a reaction, understanding, etc. A good rule of thumb is for the PC to say 4- 6 sentences and then ask for the client's opinion, ask a question, etc.

NOTE: During these early stages of engagement, it is especially important to be mindful of the young person's experience of what may be happening and to adopt his/her language in the conversation. For example, you can start with:

"You've told me about several experiences you've had over the last several months that led you to come to the team – hearing voices and having beliefs that were hard to shake even though they seemed likely to be untrue. And, we talked about how it's been scary/confusing/ upsetting to have these experiences and not have anyone who could understand what you've been going through. One thing that we know from research is that these sorts of experiences are not so uncommon. Experiences that affect the way a person thinks, feels, and acts actually happen more often than you might think. Many people in our program have experienced this sort of thing.

NOTE: When considering whether to share and discuss parts of the next section, it is important to remember to gauge "where the person is at" before beginning psychoeducation using clinical jargon. Instead, this info may come later on.

III. What is Psychosis?

Psychosis involves difficulty telling the difference between what is real and what is not. Psychosis can affect the way a person thinks, feels, and acts and is experienced by approximately 3 out of every 100 people at some point in their lives. The first episode of psychosis typically occurs in a person's late teens or early twenties. Symptoms may start suddenly or develop gradually over time. Both men and women of every race, ethnicity, culture, and socioeconomic group have these experiences. Symptoms of psychosis are different from person to person and may even be different over time. Psychosis is treatable and most people recover. Discuss the young person's experience in greater depth here.

Common Symptoms of Psychosis

Hallucinations. Hallucinations cause people to hear, see, taste, or feel things that are not there. Hallucinations can seem very real. For that reason, people who experience hallucinations often have difficulty believing that they are not real. Examples of hallucinations include:

- Hearing noises or voices that others don't hear
- Seeing things that other don't see
- Having unusual sensations in one's body

Ask young person to share examples of any hallucinations he/she may have experienced.

Delusions. Delusions are beliefs that a person holds despite evidence that those beliefs are not true or accurate. Examples include:

- Believing that one is being watched or followed
- Believing that someone else is controlling one's thoughts
- Believing that others want to harm you
- Believing that things in the environment have a special meaning just for you

Ask young person if he/she can describe any beliefs or thoughts he/she may have had that may not be entirely accurate or where they may question the accuracy.

Confused thinking. One's thoughts, and the expression of those thoughts, don't connect together in a way that makes sense. Examples include:

- Thoughts can seem unclear
- Thoughts are jumbled together
- Thoughts are racing too fast or are coming too slow

Ask young person if he/she has had any difficulty expressing his or her thoughts. What has he/she noticed?

Changes in behavior. These can include:

- Spending more time alone.
- Having less interest in socializing with friends and family, going to work or school, or otherwise engaging in activities one used to enjoy.
- Not taking care of oneself as well as one used to (e.g., not bathing or dressing, may appear disheveled).
- Behaving in a way that doesn't seem to fit with the situation, such as laughing when talking about something sad or upsetting, or for no apparent reason.

Ask young person if he/she has noticed any changes in his/her behavior. What has he/she noticed?

Other symptoms that often go along with psychosis

- Depression: Low mood, sadness, less interest in activities
- Anxiety: Excessive fear or worry, feeling uncomfortable or anxious
- Mania: Elevated or irritable mood, heightened arousal or energy level

Highlight the fact that the individual may experience other symptoms that are either part of the psychosis (e.g. mania for someone with schizoaffective disorder) or a result of the symptoms (e.g. anxiety due to concerns about being followed; depression associated with life changes due to illness).

Phases of Psychosis [OPTIONAL – if young person asks about this information; as in other parts of this session, feel free to adapt language as appropriate]

Although each person's experience of psychosis is unique, typically an episode or period of psychosis involves 3 phases.

Prodromal phase. Early warning phase of psychosis. Individual starts to experience mild symptoms or vague signs that something is not quite right. Family members begin to notice unusual behavior or signs that something is not quite right. Early warning signs can include:

- Changes in sleep or appetite
- Changes in emotions (anxiety, depression, suspiciousness, irritability, depression)
- Problems in thinking (difficulty with concentration, memory, organizing thoughts)

- Changes in behavior (social withdrawal, decreased energy or motivation, difficulty functioning at work, home, school)

Ask individual if he/she can recall any early warning signs he/she may have experienced or observed. What was his/her understanding of it? What did he/she do?

Active phase. Individual is clearly experiencing symptoms of psychosis. Typically these include hallucinations and/or delusions but can also include disorganized thinking or behavior.

Recovery phase. Individual starts to feel like themselves again. Often associated with a decrease in symptoms and an increase in goal-directed activities. Each person experiences the recovery phase differently. The path taken to get to this phase can vary considerably from one person to another.

What Causes Psychosis? [OPTIONAL – if young person asks about this information; feel free to adapt language as appropriate]

PC: Ask young person what he/she thinks causes psychosis/mental illness. Anything that others have said or that they have heard others say? Discuss commonly held myths about the causes of psychosis and other mental illnesses such as that mental illness doesn't exist, caused by poor parenting, caused by being lazy or weak, caused by the devil, etc. and help to correct them by identifying them as myths. Emphasize the point that many of these myths develop as a way to explain behaviors that people didn't understand.

What We Know: Overview of Causes

a. Overview

- We are still working to fully understand why and how psychosis occurs.
- The development of psychosis appears to be influenced by a combination of biological/genetic, psychological, and environmental factors.
- Biological factors (genes) may make an individual more vulnerable to or have a greater risk for developing psychosis.
- Environmental factors (stressors) increase the likelihood that symptoms are expressed.

b. Biological factors (genes)

- Refers to the structure of the brain, chemicals in the brain, and genes that may make an individual more vulnerable to or have a greater risk for developing psychosis
- Biology
 - Psychosis is believed to be associated with an imbalance in chemicals in the brain called neurotransmitters.
 - Neurotransmitters are chemicals that transmit impulses or signals throughout the brain and central nervous system.
 - The neurotransmitter dopamine is associated with symptoms of psychosis.
 - Many medications work to correct this imbalance.
- Genes
 - Research suggests that some people may have a genetic predisposition to developing psychosis.

- People who experience psychosis are more likely to have a close relative who has experienced psychosis.

(Because development of the illness may be due in part to biological or genetic factors, family members may be concerned that they or other family members (e.g., children) may develop the illness. PCs should stress the fact that although having a relative may increase the likelihood that another family member may develop psychosis, it doesn't mean that a person will definitely develop an illness).

c. Psychological

- Personality, personal beliefs, thought, experiences, etc.

d. Environmental factors (stressors) can increase the likelihood that symptoms are expressed.

- Stressful events in the environment
 - Stressful events can increase an individual's vulnerability to psychosis.
 - High levels of stress can trigger the onset of symptoms or an increase in symptoms over time.
 - Stressful events can include a traumatic life event, a significant loss, increased responsibilities associated with school/work, or a physical illness.
- Substance use
 - Substance use can trigger the onset of symptoms or an increase in symptoms over time.
 - Drugs such as marijuana, speed or LSD are particularly likely to trigger symptoms.
 - However, substance use is generally not the underlying cause of psychosis.

PC: Some people with psychosis and/or their family members may think that substance use is the cause. PCs should emphasize that while substance may trigger symptoms, if the symptoms were just a result of substance use then they would go away once a person stopped using. Remember that people are looking for a sensible reason for the change they have experienced and substance use is frequently cited as a cause by both individuals and family.

IV. Recovery

Recovery is possible. The team is here to help you figure out how to progress in your recovery.

Note: Perhaps first ask some questions like: Have you ever heard of recovery? What do you think that it means?

Note: This can be a good place to watch some Recovery videos.

A. What is Recovery?

1) Description of recovery

- Recovery has been described as:
 - "...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles."

- “It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.”
- “...involves the development of new meaning and purpose in one’s life as one grows beyond the effects of mental illness.” (Anthony, 1993).
- Continuing with your life even though you still have symptoms. We believe that there are still many ways to continue to work towards your goals even though you may not be feeling well. Lots of people experience ups and downs with their symptoms and if they are engaged in their individual recoveries, figure out ways to adjust accordingly so that they’re not just waiting around for a cure before they can move ahead with their lives.

2) Recovery is different for each person

- Often involves:
 - A reduction in symptoms: fewer, less intense, or no hallucinations
 - Improved relationships: feel more comfortable around others, more interested and comfort interacting with others, spending time with friends and family
 - Connections with the outside world: engaged in work, school, volunteer activities, hobbies/other leisure or recreational activities
 - Focus on important personal life goals: more likely to make plans for the future, set goals and take steps towards reaching them

B. What Helps People in their Recovery from Psychosis?

*PCs should point out the fact that recovery is not the same thing as responding to treatment. While a majority of people have a substantial reduction in symptoms or remission of symptoms that is not always the case. **Although we can’t always control how we respond to treatment (e.g. medications), we do have control over other aspects of recovery.** There are many things that people can do in addition to typical treatment to help them learn ways to relate to and successfully manage one’s illness so that they are able to move forward in life.*

- Participation in treatment
 - Talking with providers about treatment options and working with providers to decide which treatments/services would be most helpful to you.
 - Attending appointments regularly.
 - Asking questions if there are things you don’t understand, feel haven’t been explained, or if there is information you would like to know.
 - Being honest with providers about whether treatment is working or not working. There are a number of treatment options to choose from if one does not seem to be working.
- Identifying and focusing on personal goals
 - Identifying what you would like to change or see different?
 - Is there something you would like to be doing that you are not doing now?
 - Working with providers to identify personal goals and what steps are necessary to reach those goals.
- Making use of supports

- Support network in the community
 - Family, friends, and other supportive people in their life
- Professionals
 - Treatment providers, school counselors, or other professionals
- Peers
 - Support groups for people with psychosis or for family members of people experiencing psychosis

V. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 3: Shared decision making around client goals

- I. Introduction to Meeting and Rationale:** The purpose of this meeting is to introduce the way that we plan and make decisions together. This is called “shared decision making” (SDM) and we use it to set goals that are meaningful to you. We’ll spend some time talking about what SDM means and how you will use it with the OnTrackNY team members. The SDM process insures that your voice is heard and your point of view is understood as we make decisions together.

NOTE: This is a useful meeting for family members too. Consider meeting with family members to cover this or doing this as part of a monthly family group.

NOTE TO PCs: To incorporate SDM into this meeting, ask yourself the following questions during a discussion: Are we clear and in agreement about the current issue, problem, or decision? Have we identified the relevant options? Do the young adult and I have all the information we need about this topic? Are we clear how the individual’s important values influence this decision? Is everyone who needs to be involved here? Have we clarified our preferences and any disagreements? If we disagree, have we negotiated a compromise? Have we put the plan in writing? As an example, consider a decision regarding disclosure in supported education. Does the young adult want to disclose information regarding her/his illness, disability, or needs for accommodations to a teacher? What are the options? For example, who would speak with the teacher? What exactly would be disclosed? What is the goal? What is most important to the young person in this situation – to avoid disclosure or to receive an accommodation? What are the advantages and disadvantages of disclosure and of requesting an accommodation? Does the individual need to speak with a girl/boyfriend, a parent, or a past teacher about this decision? What are the individual’s and the clinician’s preferences? Have the young adult and clinician negotiated a plan that both believe is ethical, realistic, and likely to meet their goals? Have they written down the specific plan for addressing this situation?

II. What is SDM and Why is it Important?

- We work on identifying things that you find important.
- SDM is an approach to setting goals that will help us make sure we talk about the things that are important to you and are within your values and preferences.
- It is important that you are heard when you are discussing your treatment and the things that are important to you. We will start this process now and it’s something you will get better and better at over time.
- Give SDM Pocket Card/Handout: Tips for Talking about Important Decisions with Providers (see Appendix).
- Ask client what s/he thinks about this approach. Why will it be important to use this approach?

III. SDM – How do we use it?

- **The client identifies issue/goal that is personally important.** This can include establishing goals of treatment, deciding whether or not to try out a particular component of

treatment or whether to include the family in a meeting, or to make a decision about changing medications. Start with the first issues/goals and then repeat with the second.

- **Options are outlined.** Following the above examples, establishing goals might begin with a list of common goals. The options regarding a family meeting might be to exclude the family, to include the family with a specific agreement to limit topics or sharing of information, or to include the family without limits on topics or information. The medication decision options might include staying with the same dose, increasing the dose, adding a side effect medication, changing medications, or “watchful waiting” and learning more about one’s symptoms before making decisions around medication use.
- **The pros and cons of each option are considered with information and educational materials provided as needed.** For example, they might consider the advantages and disadvantages of prioritizing employment, sharing an important meeting with family, or increasing a medication dose. In this process, the young person emphasizes her/his goals, values, or preferences; the clinician adds scientific information regarding likely outcomes, side effects, and/or unwanted medication effects (i.e., going with a neuroleptic that has a lesser chance of metabolic syndrome but a higher chance of TD).
- **The participants express their preferences.** For example, the individual ranks her/his top three goals in order and the professional does so also. Or each gives an opinion regarding the family meeting or the medication decision. The process can be conducted on paper or verbally.
- **Once areas of agreement and disagreement are clear, the participants negotiate compromises on areas of disagreement.** For example, they might identify different goals but agree to include each person’s top three goals on the treatment plan. If they disagree on including the family in a meeting, they might agree to meet without them in the next meeting and with them in the following meeting. Or they might disagree on increasing the medication and compromise on a plan to monitor symptoms and revisit the decision in one week.

NOTE TO PCs: A list of websites with printable or interactive decision aids can be found in the Center for Practice Innovation’s Learning Management System: <http://practiceinnovations.org/>

IV. Summary of today’s meeting

PC asks the consumer to identify some important points from today’s meeting. PC adds his/her perspective to this summary.

Session 4: My cultural background and how it affects my understanding of my experience and my treatment choices

I. Introduction to Meeting and Rationale: The purpose of this meeting is to talk about how your cultural and family background affects your understanding of your experience and the decisions that you make about your treatment. What is “culture”?

PC asks consumer what, if anything, this term means to her/him?

PC explains that:

- Culture is a way of describing the thoughts, languages, practices, beliefs, values, customs and traditions of social groups
- People often see themselves as belonging to a number of different cultures. For example, a person may have an African-American background (race), grow up in Haiti (ethnicity), follow the Catholic faith (religion), be a teenager (age), and be a recent immigrant to the U.S. (social).
- Some parts of your culture may be easy to recognize, such as skin culture or the language that you speak. Other parts of your cultural background are hard for others to know about you unless you choose to tell them. This includes:
 - Spiritual practices
 - Healing practices
 - Family customs
 - Types of food and drink that you like
 - Holiday celebrations
 - Values related to privacy and disclosing of personal information
 - Customs related to intimate relationships
 - Preferred ways of leisure or recreational activities
 - Sexual orientation
- People’s cultural traditions influence their ideas and feelings about many parts of life, including symptoms and treatment.

II. Why is understanding your cultural background important?

PC asks client why understanding your cultural background is important?

PC explains that:

- The connection to your cultural background will often influence:
- Your decisions about treatment
- How you feel about your problems and symptoms
- Your interest in seeking help
- Support available through community cultural connections

III. What does this have to do with you?

PC asks client if s/he can identify the cultures with which s/he identifies?

PC asks client if s/he is aware of how these cultures may influence his/her thoughts and feelings about problems, symptoms, and treatment.

PC asks client how her/his family background and family members' cultural experiences may influence his/her thoughts about problems, symptoms, and treatment.

PC asks client how her/his cultural background and community connections can support her/his recovery.

NOTE: The PC can use the questions in the Cultural Formulation Interview that is part of the DSM-V to also help guide this discussion.

IV. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 5: Identifying and using my personal strengths and social supports

I. Introduction to Meeting and Rationale: The purpose of this meeting is to talk about how your personal strengths and social supports can help with your recovery.

II. What are personal strengths and why are they important?

PC asks consumer what personal strengths s/he has.

PC explains that:

- Personal strengths are your skills, knowledge, talents, interests, values, personal qualities and physical characteristics that you can build on to help your recovery.
- When we are struggling with life problems, our strengths often help us to cope.
- Important point: it is not unusual for young people to believe that they do not have many personal strengths and to not recognize those that they do have. Just because they may not be aware of these personal strengths doesn't mean that others can't see them.
- Important point: it is not unusual for people who are experiencing symptoms or life problems to believe that they do not have many personal strengths and to not recognize those that they do have. Just because they may not be aware of these personal strengths doesn't mean that others can't see them.
- Knowing one's personal strengths can help with the recovery process.

III. What are social supports and why are they important?

PC asks consumer what personal supports s/he has. Who are the people that really make a difference in her/his life in a supportive, positive way?

PC explains that:

- Social supports are relationships that are rewarding, enriching, and helpful.
- Relationships can be considered supportive when both people trust and respect each other.
- Having social support means that you feel connected to and cared for by others.
- Sometimes even very caring relationships have problems. A supportive relationship can involve disagreements from time to time. In supportive relationships, disagreements are handled respectfully and can usually be resolved.
- Social support can come from many different kinds of people including family members, friends, peers, partners, coworkers, members of religious or spiritual groups, classmates, members of peer support groups, mental health practitioners, roommates, and neighbors.
- Social relationships are often an important part of people's lives and the quality of these relationships is a major factor in happiness.
- Social relationships play a very important role in recovery. People with mental health problems or symptoms often point to the importance of social supports in their recovery.

IV. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 6: Enhancing my social skills (Optional- offer to those who need to enhance social functioning)

I. Introduction to meeting and rationale: The purpose of this session is to discuss how increasing social competence can help with maintaining relationships and achieving goals.

II. Understanding and identifying any difficulties client has with social skills

PC works with the young person to identify any areas in his/her life that are proving to be most difficult to navigate or manage. PC should use open-ended questions and elicit information about the client's life and issues he/she is experiencing. Together, they can then start identifying if there are specific skills that could be taught to help establish and maintain social relationships, fulfill specific roles or get their needs met.

PC highlights that complex aspects of social skills are usually learned in adolescence or young adulthood and therefore it is normal that the client might benefit from learning and practicing certain techniques in session before they are applied to daily life.

As this discussion progresses, the PC responds to questions asked by the client and elicits their understanding and thoughts about engaging in social skills training.

PC provides examples of specific areas that might be important for young people. PC also provides examples of how other clients have engaged in social skills training in this program.

- a. Social networking
- b. Relating and Dating
- c. Expressing yourself
- d. Keeping cool

III. Next Steps

The PC and client discuss whether there is a benefit in providing working on this specific intervention that could help enhance social skills to help with achieving client's goals. The PC helps the client define a list of skills or areas that they would like to focus on during treatment.

NOTE: If a decision is made to proceed with social skills training, then the PC can use the recovery coaching manual to guide the delivery of the intervention.

IV. Summary of today's meeting

The PC asks the client to identify some important points from today's meeting and then adds his/her perspective to the summary.

Session 7: Understanding how alcohol and drugs can affect my recovery (Optional – offer to those who are using alcohol and/or drugs)

I. Introduction to Meeting and Rationale: The purpose of this meeting is to talk about the impact that using alcohol and/or drugs can have on a young person’s recovery. This meeting continues the discussion that began in the previous meeting.

II. Understanding the impact of alcohol and drugs on recovery.

PC asks consumer if s/he has any further thoughts or feelings about the part of discussion last meeting that focused on alcohol and drug use. PC responds to questions or issues raised by the consumer.

PC notes/acknowledges that alcohol and/or drug use are common among young people. PC asks consumer her/his observations and feelings about this.

PC presents the potential risks for young people in OnTrackNY who are using alcohol and drugs:

- More severe symptoms
- More frequent hospitalizations
- More frequent relapses
- Poorer functioning and satisfaction with life in the future
 - Greater chance of violence, homelessness, time in jail or prison, and suicide
 - Higher risk of medical problems including for some, HIV PC asks consumer her/his thoughts and feelings about these facts.

III. Personalizing the discussion – screening for alcohol and drug use

PC screens/assesses for alcohol and drug use.

IV. Next steps

PC explains that OnTrackNY offers support to young people concerning their alcohol and drug use and helps them to think through whether they’d like to make any changes such as cutting back (or even eliminating) use. The young person doesn’t need to have already made a decision to change in order to benefit from this support.

The PC explains that there is a recovery coach intervention that they can work on together to help with these issues – to help the consumer weigh the pros and cons of cutting back or eliminating use and if the consumer chooses to do so, to teach skills and provide other guidance so that s/he can accomplish this. The PC and consumer collaboratively decide if they want to devote time to this intervention.

NOTE: If a decision is made to proceed with substance abuse treatment, the PC can use the recovery coaching manual to guide the delivery of the intervention.

V. Summary of today’s meeting

PC asks the consumer to identify some important points from today’s meeting. PC adds his/her perspective to this summary.

Session 8: Learning to manage difficult feelings or situations: Using coping skills and cognitive restructuring (Optional- offer particularly to those experiencing depression, anxiety or other distressing emotions or symptoms)

I. Introduction to meeting and rationale: The purpose of this meeting is to discuss whether there are negative or distressing emotions that are particularly difficult for the client to manage.

II. What are coping skills?

PC and client discuss the nature of coping skills and how learning these strategies can prove to be helpful with managing emotions in a way that supports the achievement of client's goals.

PC asks the client what are some of the most common distressing or difficult feelings that they are experiencing? If the client is unable to label the feelings themselves then sometimes it is helpful to help them identify situations that make the client feel uncomfortable, sad, lonely, scared, or bored.

PC normalizes that we all experience situations that cause negative feelings or stress and additionally that everyone has ways of coping with these situations- both positive and negative coping strategies. At the same time, learning to cope in an effective ways allows people to feel better and also achieve personal goals.

III. Personalizing the discussion

PC asks client what are some of the current coping strategies that s/he currently uses and how these are working for the client. PC can then introduce the idea that there are specific coping strategies that have been found to be helpful with managing depression, anxiety, stress, anger, and negative thoughts. This can then lead to a discussion of coping skills that are taught in session might be beneficial.

- | | |
|-----------------------------------|----------------------------|
| a. Increasing pleasant activities | d. Changes in medication |
| b. Getting social support | e. Cognitive restructuring |
| c. Problem solving skills | f. Planning ahead |

IV. Next Steps

PC explains that OnTrackNY offers support to young people to help enhance coping skills and think through if there are better ways to manage negative feelings or thoughts. The PC explains that if the young person thinks it would be helpful, then they could spend some of their time together working on learning some of this strategies and experimenting using them in the client's daily life to determine if they are truly helpful. The PC and consumer engage in shared decision making and determine if they will devote time to this intervention.

NOTE: If a decision is made to proceed with the coping skills intervention, the PC can use the recovery coaching manual to guide the delivery of the intervention as this has examples and scripts for teaching several coping strategies.

V. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 9: Increasing engagement in the community through behavioral activation (Optional offer to those who are experiencing negative symptoms)

I. Introduction to meeting and rationale: The purpose of this meeting is to help the client understand how negative symptoms can be related to the client's inability to identify and engage in activities.

II. What are negative symptoms and how do they impact functioning?

PC provides psycho-education to client about the nature of negative symptoms in psychosis and how they can be related to decreased motivation and desire to do things on a daily basis. PC explains how sometimes part of having psychosis is feeling reduced pleasure, lowered drive and interest in one's environment, decreased interest in social interactions, an inability to fully express emotions, and sometimes diminished speech. PC then talks with the client to help identify if any of these symptoms have been present and ways that they may be interfering in goal achievement.

PC can provide some psycho-education about the relationship between thoughts/motivation and pleasure. For example, the PC can say "*we grow up thinking that in order to derive pleasure from an activity, we have to want to take part in it. However, many times, we do things even though we are not motivated in the moment only to later realize once we do it, that the activity was enjoyable. This is a typical error in thinking that most individual experience. Has this ever happened to you?*" The PC can also provide examples of this concept such as the relationship between motivation and exercise (e.g., level of motivation does not affect the benefits derived from exercise and most people usually feel good after they exercise even if they weren't excited to do it in the first place).

The PC can then spend time discussing how behavioral activation is one strategy that can help people get involved in things that may be interesting, fun or related to achieving personal goals. The PC can also provide examples of how other clients have benefitted from this intervention.

III. Next Steps

PC and client can engage in a discussion as to whether it makes sense to practice behavioral activation as part of their work together. If the client decides that this intervention is in line with his/her preferences and will be helpful towards helping him/her make progress towards their recovery goals then a plan should be made to include this as part of the treatment.

NOTE: If a decision is made to proceed with discussing and practicing behavioral activation, the PC can use the recovery coaching manual to guide the delivery of the intervention.

IV. Summary of today's meeting

PC asks the consumer to identify some important points from today's meeting. PC adds his/her perspective to this summary.

Session 10: Making connections beyond the FEP team: the transition process

I. Introduction to meeting and rationale:

We've worked together now for X years and you've been able to accomplish X, Y and Z (review with client his/her time with the team; encourage participation from the individual about what it was like when/he first started working with the team versus now). This may be a good time to start thinking about some next steps, of transitioning from our team to other treatment providers, and to think more about what other supports or resources you may want for the future.

II. What is the transition process and why is it important? The PC asks the client her/his thoughts about moving on from the team. What would this mean for the client? Why might it be important for him/her to move on from the team to different services and supports? The PC notes that there is no firm deadline but that the general plan would be to transition within the next six months or so.

PC notes that the transition process involves a series of steps that the client, together with his/her supports and the PC, will take to in order to celebrate the accomplishments of the client with the team and to identify and link to other supports in the community. It starts with reviewing the steps of the transition process, including:

Phase 1: Transition Planning (Engage clients in transition discussions, conduct assessment and develop a transition plan)

- Review strengths and progress towards goals achieved while on the team. (Can use Transition Planning Tool in Primary Clinician Manual)
- Discuss the client's vision of what success in the community would look like. Identify areas in need of attention during transition process (Can use Transition Planning Tool in Primary Clinician Manual)
- Discuss identified needs with other members of your OnTrackNY team (psychiatrist, nurse, supported education and employment specialist, recovery coach, etc.)

Phase 2: Linkage & Try-out (Build on and test client skills, prepare, strengthen and test existing supports, develop and test linkages with new supports)

- Explore options in the community for supports (services providers, family, friends, peer support, etc.)
- Build skills in areas where support is needed but the client would prefer independence to adding a new support
- Identify and contact specific services supports in the community (Use Resource and Referral Log in PC Manual)
- Create a transition plan that includes a clear timeline, identifies services and supports, provides a safety plan
- Share the transition plan with natural supports and team

Phase 3: Transfer of Care & Follow-up (Finalize transfer of care, monitor client progress following transition)

- Test the plan (meet new supports and share transition plan, gradually decrease involvement with team, transfer prescriptions, etc.)
- Celebrate accomplishments with the team and natural supports!
- Discharge and the official start of work with new services
- Follow-up with team

PC notes that there are benefits to engaging in a transition process:

- Your work with the team began at a time when you were struggling, but you've made great progress. Finding new services and supports is the next step in your ongoing recovery process.
- Change is difficult! Starting to talk about transition early on allows the client, supports, and the team to think carefully about their work together and what would be the best next step.
- You can make choices about what kind of support you would like and what you would like to do on your own.

PC asks the client how he/she feels about the transition process. Does he/she feel ready to begin the process (not the same as being ready for discharge!)? PC engages client around how transition serves to meet remaining goals and addresses clients' questions and concerns.

III. Next Steps

What will be the next step for the client and PC? PC follows the client's lead about readiness to begin the process. The next step could include scheduling a meeting with natural supports to introduce the idea of transition, or the next step could be to revisit the conversation in a month.

IV. Summary of today's meeting

PC asks the client to identify some important points from today's meeting. PC adds his/her perspective to the summary.

C. Initial Psychosocial and Needs Assessment

Initial Psychosocial and Needs Assessment

Participant Name: _____

Medical Record Number: _____

Date: _____

Date Shared with Team: _____

IDENTIFYING INFORMATION:

Age:	Gender:	Race/Ethnicity:	Marital Status:
Living Situation:		Sexual Orientation:	
Source (s) of Financial Support:			
Financial/Medical Benefits (in place and/or pending):			

BRIEF SOCIAL HISTORY:

Birthplace:
Raised By:
Family Composition:
Stressors in Current Family and/or Family Origin:
Pregnancy History:
Social Relationships (friends, significant others):
Hobbies/Interests:
Religion:
Community Involvement:
Legal Issues:

EDUCATION/EMPLOYMENT INFORMATION:

Currently Working or Attending School?	If Yes, Where?
If No, Most Recent School Attended or Job Held:	
Highest Grade Completed:	
Special Ed?	
Vocational Training?	

SUBSTANCE USE:

Alcohol?	If Yes, How Much?	Last Use:
Drugs?	If Yes, Type and Quantity:	
Last Use:		
Has Participant Sought Help for Alcohol or Drug Use?		
If Yes, When and Where:		

TRAUMA HISTORY:

Please see separate assessment for Trauma.
--

FAMILY INVOLVEMENT:

<input type="checkbox"/> Participant consents for family involvement; consent form on file.
<input type="checkbox"/> Participant is under age 18.
<input type="checkbox"/> Meeting with family to be scheduled.
Please see separate assessment for family involvement.

Please see Initial Psychiatric Evaluation for:

- History of Present Illness and Psychiatric History, including hospitalizations and previous treatment history;
- Family History of Psychiatric Illness, including family history of suicide;
- Suicide/Self-Harm Risk Assessment
- Violence Risk Assessment
- Physical Health Information, including current primary medical care provider
- Current Medications
- Mental Status Exam

SKILLS AND STRENGTHS:

What skills, abilities, and talents do you have? What are you good at?

What personal characteristics do you have that you feel good about?

What is a typical day like for you? What is your routine?

What do you do when you're going through a tough time? What helps?

Are there areas in which you would like to grow, change, or learn new skills? For example:

_____ Improving social skills

_____ Meeting new people/expanding social network

_____ Dating/relationship skills

_____ Being more assertive/standing up for yourself

_____ Learning healthy ways of coping with symptoms, depression, anxiety, strong emotions

_____ Anger management

_____ Improving physical health

_____ Finding rewarding ways to spend your time

_____ Other:

RECOVERY GOALS:

Do you have hopes and dreams for yourself and your family? What are they?

What is most important and meaningful to you in your life right now? (Family, friends, work/school responsibilities, health, faith, creativity, independence, etc.):

Do you know what you would like to accomplish over the next two or three months?

Over the next year?

Where do you see yourself in five years? Ten years?

RECOMMENDATIONS:

Issue	Describe Need	Plan	Other Info
Safety		<input type="checkbox"/> Create Safety Plan <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Financial/Housing		<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Family		<input type="checkbox"/> Schedule Family Meeting <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Medical		<input type="checkbox"/> Refer to Nurse <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Education Support		<input type="checkbox"/> Refer to Education/Employment Specialist	
Employment/Vocational Support		<input type="checkbox"/> Utilize Recovery Coaching Interventions <input type="checkbox"/> _____	
Social Skills/Social Support		<input type="checkbox"/> Utilize Recovery Coaching Interventions <input type="checkbox"/> _____	
Specific Coping Skills		<input type="checkbox"/> Utilize Recovery Coaching Interventions <input type="checkbox"/> _____	

Trauma		<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Legal		<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Other		<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	
Other		<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	

Notes: _____

Upcoming Appointment Dates: _____

Clinician Signature: _____ **Date:** _____

D. PTSD Screening Questionnaire I

PTSD Screening Questionnaire I

Client name and case number: _____ Unit Code: _____ Date: ___/___/___

Directions: We are trying to develop ways to help people understand traumatic experiences and how they may affect people's lives. We would like you to try to answer the following questions. We want to see if any of these things have happened to you. If you are not sure of an answer to a question, please make your best guess.

		No	Yes
1.	Were you involved in a motor vehicle accident for which you received medical attention or that badly injured or killed someone?	0	1
2.	Have you been involved in any other kind of accident where you or someone else was badly hurt (for example, a plane crash, an explosion or fire, or someone almost drowning)?	0	1
3.	Were you ever exposed to warfare or combat?	0	1
4.	Have you experienced the sudden and unexpected death of a close friend or loved one due to an accident, illness, suicide or murder?	0	1
5.	Have you been robbed or been present during a robbery where the robber(s) used or displayed a weapon?	0	1
6.	Have you ever been hit or beaten up and badly hurt by a stranger or by someone you didn't know very well?	0	1
7.	Have you seen a stranger (or someone you didn't know very well) attack or beat up someone and seriously injure or kill them?	0	1
8.	Has anyone threatened to kill you or seriously hurt you?	0	1
9.	While growing up, were you physically punished in a way that caused bruises, burns, cuts, or broken bones?	0	1
10.	Did you see or hear family fighting (such as any family member beating up or causing bruises, burns or cuts on another family member)?	0	1
11.	Have you ever been slapped, punched, kicked, beaten up, or otherwise physically hurt by your spouse (or former spouse), a boyfriend or girlfriend, or some other intimate partner?	0	1
12.	Before your 16th birthday, did anyone who was at least 5 years older than you touch or fondle your body in a sexual way or make you touch or fondle their body in a sexual way?	0	1
13.	Before your 16th birthday, did anyone close to your age touch your sexual parts or make you touch their sexual parts against your will?	0	1
14.	After your 16th birthday, did anyone touch your sexual parts or make you touch their sexual parts against your will?	0	1
15.	Has anyone stalked you, in other words, followed you or kept track of you causing you to feel scared or worried for your safety?	0	1
16.	Have you experienced or seen any other events that were life threatening, caused serious injury, or were highly disturbing or distressing (for example, being lost in the wilderness, kidnapped or held hostage, or seeing a mutilated body or body parts)?	0	1

E. PTSD Screening Questionnaire II

PTSD Screening Questionnaire II (PCL-5)

Client name and case number: _____ Unit Code: _____ Date: ___/___/___

The most distressing event you experienced was _____ and it happened on _____ (date).

For detailed information about the PCL-5, including scoring guidelines please go to:

<http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
A. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
B. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
C. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
D. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
E. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
F. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
G. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
H. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
I. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
J. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4

K. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
L. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
M. Feeling distant or cut off from other people?	0	1	2	3	4
N. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
O. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
P. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
Q. Being "super alert" or watchful or on guard?	0	1	2	3	4
R. Feeling jumpy or easily startled?	0	1	2	3	4
S. Having difficulty concentrating?	0	1	2	3	4
T. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr – Nation

F. Safety Plan

Step 1: **Warning signs:**

1. _____
2. _____
3. _____

Step 2: **Internal coping strategies: Things I can do to distract myself without contacting another person:**

1. _____
2. _____
3. _____

Step 3: **People who can help to distract me:**

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 4: **People I can ask for help:**

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: **Professionals or agencies I can contact during a crisis:**

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Local Hospital ED _____
Local Hospital ED Address/Phone _____
3. **Suicide Prevention Lifeline Phone: 1-800-273-TALK**

Step 6: **Making the environment safe:**

1. _____
2. _____
3. _____

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G. Wellness Management Plan

The purpose of this plan is to help me stay well and move forward in my recovery and in my life. It includes things I should do to stay well, and things I should avoid because they stand in the way of my recovery.

Things I can do that help me feel healthy, calm, and in control of my recovery each day:

1. _____
2. _____
3. _____
4. _____
5. _____

Things I should avoid because they make it harder for me to stay well:

1. _____
2. _____
3. _____
4. _____
5. _____

Relapse Prevention: Early warning signs that alert me to pay more attention to my health and wellness:

1. _____
2. _____
3. _____
4. _____

Strategies for managing early warning signs and preventing a crisis:

1. _____
2. _____
3. _____
4. _____

I. Transition Planning Tool

Client Name _____

Anticipated D/C Date: _____

What progress have I made in my time with the Team and what is my vision of success in the community? List goals the consumer and team have been working on in the areas below.

What progress has been made towards these goals? Which have been successfully achieved and which require additional work? For each domain, discuss the consumer's vision of what success in the community would look like. Identify areas in need of attention in the community.

	What progress has been made towards these goals?	Which have been successfully achieved and which require additional work?	What is my vision of what success in the community would look like?
Feeling better / Relief from symptoms			
Vocational/Educational			
Family Relationships and support			
Connections in the community			
Substance use / health issues			
Other			
Other			

What support might I want to support my vision of success in the community? Identify areas in need of attention in the community and OnTrackNYs, resources, links, interventions, and strategies needed to achieve success.

	What is my vision of what success in the community would look like?	OnTrackNYs or resources or links needed to achieve vision	Interventions or strategies needed to achieve vision
Feeling better / Relief from symptoms			
Vocational/Educational			
Family Relationships and support			
Connections in the community			
Substance use / health issues			
Other			
Other			

Team Members' Tasks:

Participant/Family Tasks:

What practical issues do I need to figure out and who can help me now and in the future?

Practical Issue	Who helps me with this now?	Who can help me with this in the future?
Insurance/Benefits/Entitlements		
Accommodations in work or school		
Other		

Team Members' Tasks:

Participant/Family Tasks:

J. Resources and Referral Log

Date									
									MH Clinic
									Private Psychiatrist
									Private Therapist
									CM/ICM/BCM
									Medical Clinic
									PROS
									Substance Use Treatment
									Supported Education/ Employment
									Self-Help
									Clubhouse
									Residential
									Other:
									Left Message
									Scheduled Appointment
									Program Rejected
									Wait Listed