Individual Resiliency Training (IRT)

Lead authors: David L. Penn, Piper S. Meyer, and Jennifer D. Gottlieb

Contributing authors, in alphabetical order: Cori Cather, Susan Gingerich, Kim T. Mueser, and Sylvia Saade

A Part of the NAVIGATE Program for First Episode Psychosis

Clinician Manual

April 1st, 2014

These manuals were part of a project that was supported by the National Institute of Mental Health under award number HHSN271200900019C.The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health.

The NAVIGATE Program for First Episode Psychosis
Authorship of Manuals

NAVIGATE Psychopharmacological Treatment Manual

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

NAVIGATE Psychosocial Treatment Manuals

Overall General Editors: Kim T. Mueser and Susan Gingerich
Project Coordinator for Manuals: Karen A. Sullivan

Directors Manual
Lead author: Jean Addington

Individual Resiliency Training (IRT) Manual
Lead authors: David L. Penn, Piper S. Meyer, and Jennifer D. Gottlieb
Contributing authors, in alphabetical order: Cori Cather, Susan Gingerich, Kim T. Mueser, and Sylvia Saade

Supported Employment and Education (SEE) Manual
Lead author: David W. Lynde
Contributing authors, in alphabetical order: Susan Gingerich, Susan R. McGurk, and Kim T. Mueser

Family Education Program (FEP) Manual
Lead author: Shirley M. Glynn
Contributing authors, in alphabetical order: Cori Cather, Susan Gingerich, Jennifer D. Gottlieb, Piper S. Meyer, Kim T. Mueser, and David L. Penn

NAVIGATE Team Members' Guide
Lead authors: Kim T. Mueser and Susan Gingerich
Contributing authors, in alphabetical order: Jean Addington, Mary F. Brunette, Cori Cather, Jennifer D. Gottlieb, David W. Lynde, and David L. Penn

Please Read First:

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

The manual you are reading now describes the NAVIGATE Individual Resiliency Training (IRT) Program and how to implement it.

INTRODUCTION TO IRT: OVERVIEW, LOGISTICS, AND IMPLEMENTATION

This manual describes Individual Resiliency Training (IRT), a psychosocial treatment for individuals recovering from an initial episode of psychosis that is part of the larger, team-based NAVIGATE program. Due to the fact that the recovery rate following an initial psychotic episode is variable, IRT addresses multiple domains of impairment, any of which can contribute to future relapse and/or poor long-term outcome. These domains are: 1) illness self-management; 2) substance use; 3) residual and/or emerging symptoms; 4) trauma and PTSD; 5) health; and 6) functional difficulties. In addition, IRT focuses on client strengths and resiliency factors, including both how to capitalize on them and make them stronger in order to help clients meet their personal goals and overcome their problems.

In the following section we provide an overview of IRT and the logistics of providing it. We then discuss clinical issues that may arise during the implementation of IRT. Clinicians are referred to the NAVIGATE Team Members' Guide for background and a description of the NAVIGATE program. In addition, the NAVIGATE Team Members' Guide describes core competencies required by all clinicians on the NAVIGATE team, as well as information about collaborative treatment planning and issues related to applying for disability benefits in persons who have recently experienced a first episode of psychosis.

Overview of IRT

What is IRT?

IRT is a modular-based intervention for individuals recovering from a first episode of non-affective psychosis. Its primary aims are to promote recovery by identifying client

strengths and resiliency factors, enhancing illness management, teaching skills to facilitate functional recovery (and to achieve and maintain personal wellness).

Fourteen modules comprise IRT:

Outline of IRT

Module	Standard or Individualized?
1. Orientation	Standard
2. Assessment/Initial Goal Setting	Standard
3. Education about Psychosis	Standard
4. Relapse Prevention Planning	Standard
5. Processing the Psychotic Episode	Standard
6. Developing Resiliency-Standard Sessions	Standard
7. Building a Bridge to Your Goals	Standard
8. Dealing with Negative Feelings	Individualized
9. Coping with Symptoms	Individualized
10. Substance Use	Individualized
11. Having Fun and Developing Good Relationships	Individualized
12. Making Choices about Smoking	Individualized
13. Nutrition and Exercise	Individualized
14. Developing Resiliency-Individualized Sessions	Individualized

The recommended flow of IRT is described below.

All clients should receive the first seven modules, as they represent the foundation of individual treatment for first episode psychosis. After these modules, progress should be formally evaluated, and based on collaborative decision-making, the direction of the next step in the IRT program is determined. For example, for clients with current substance use problems, the Substance Use module will be pursued. Some clients may have several problem areas that they want to address. For example, a client who continues to experience auditory hallucinations, lacks friends, and is dealing with significant weight gain might choose to work with his or her IRT clinician on the "Coping with Symptoms," "Having Fun and Developing Good Relationships," and "Nutrition and Exercise" modules. In essence, the client and clinician jointly determine which problem areas are creating obstacles to recovery (and personal wellness) and use the IRT program as a means to addressing them.

In the next section, we provide a thumbnail sketch of IRT. A more detailed description of IRT and the interventions that comprise them are provided in the clinical guidelines and handouts for each module. We refer to the initial seven modules as "standard modules" and the remaining modules, collaboratively selected based on the individual's goals, problems, and areas of concern, as "individualized modules."

Module #1: Orientation (1-2 sessions)

The Orientation module is designed to familiarize clients and their relatives (or other supporters) with the NAVIGATE program and with IRT. For this reason, it is ideal if the client and family can meet together with the IRT clinician in the orientation session. The IRT clinician and Family Education Program clinician may want to meet jointly with the client and relatives to orient them together and may also want to use the orientation session as an opportunity to introduce them to other NAVIGATE staff, such as the Supported Employment and Education specialist.

The Orientation module has the following goals: 1) provide information about the different components of the NAVIGATE program, IRT, and an overview of the topics in IRT; 2) set positive expectations for active participation in IRT; 3) address immediate concerns from client and relatives; and 4) teach relaxed breathing as a strategy for clients and relatives who are feeling anxious, stressed, or overwhelmed. This module serves to orient the client to the NAVIGATE program, in general, and to the IRT program, in particular. At this point, the clinician provides basic information about session logistics (frequency, duration, involvement of relatives or other supportive individuals), the content of IRT (i.e., the standard and individualized modules), and if necessary, addresses any family/client needs (e.g., via problem solving). It is also important to set expectations regarding attendance, home practice, and the client's role in being an active participant in the IRT process. It is also during the orientation that background information is obtained from the client and relatives in terms of the problems that brought them into treatment. Finally, for clients and relatives who feel overwhelmed by the illness or even the treatment process, relaxed breathing is taught.

Module #2: Assessment/Initial Goal Setting (2-4 sessions)

The goals of this module are to: 1) help client to define what recovery means to him or her; 2) define resiliency and help client think about his or her resilient qualities; 3) assess client strengths and areas for improvement; 4) review the steps of setting a goal; and 5) help the client set a long-term meaningful goal that is broken down into 1 to 3 short-term goals.

This module helps the client get oriented to what recovery is and to the concept of resilience. The client is asked to consider the concept of resilience and how he or she defines it. The goal is to instill hope and have the client realize that resilience is a characteristic that can help him or her overcome an initial psychotic episode.

A few sessions are then devoted to assessment of client strengths. We have included both structured assessment measures (e.g. the Brief Strengths Test) as well as unstructured assessments (e.g., open-ended questions) to elicit information from the client.

The heart of IRT is the setting and pursuing of personally meaningful goals. Therefore, we spend a few sessions helping clients identify long-term goals, and break down these goals into shorter-term goals. To aid in this process, we have provided a goal-planning sheet (to track progress on goals). As some clients may not be ready to set goals at this point, we

revisit goal setting/tracking at the end of the standard module set (in Module #7, Building a Bridge to Your Goals).

Module #3: Education about Psychosis (7-11 sessions)

The Education about Psychosis module is designed to teach clients and their relatives (or other supporters) basic information about psychosis and the principles of its treatment. For this reason, it is ideal if the client and relatives can meet together for educational sessions with the Family Education Program (FEP) clinician. If possible, the FEP clinician will provide the bulk of the education to both relatives and clients concurrently. However, if there are no relatives available or if they choose not to participate, the IRT clinician will be the principle provider of education about psychosis to the client. In some situations, the client and relatives may attend FEP sessions together, but the client may also need to process the information independently with the IRT clinician. Or the client may miss some FEP sessions, and the IRT clinician can help him or her to catch up.

The goals of the Education about Psychosis module are to: 1) elicit information about the client's and relatives' understanding of symptoms, causes, course, medications, and the impact of stress on his or her life; 2) provide psychoeducation that addresses gaps in the client's and relative's knowledge about psychosis, substance use, medication, and strategies to cope with stress; and 3) discuss strategies to build resilience. Education about Psychosis should facilitate informed decision-making by clients, help them to develop strategies to foster medication adherence, and contribute to their understanding of how stress can affect symptoms. The client is also taught a variety of relaxation techniques for managing stress.

In addition to basic education about psychosis, this module revisits the concept of resilience. The client is asked to define resilience in his or her own words and to consider how resilience can be incorporated into his or her treatment. Finally, the client is introduced to "resiliency stories," which refer to difficult experiences that people have been able to overcome, and the client's own resilience in the face of challenges is explored. Such stories help clients to discover resilient qualities within themselves, how these qualities have enabled them deal with problems in the past, and how they may help them overcome the challenges they currently face.

Module #4: Relapse Prevention Planning (2-4 sessions)

The Relapse Prevention Planning module is designed to teach clients and their relatives (or other supporters) basic information about relapses and how to prevent them. For this reason, it is ideal if the client and relatives can meet together for Relapse Prevention Planning sessions with the FEP clinician. If possible, the FEP clinician will provide the bulk of the education about this topic to both relatives and clients concurrently. However, if there are no relatives available or if they choose not to participate, the IRT clinician will be the principal provider of education about relapse prevention to the client. In some situations, the client and relatives may attend FEP sessions together, but the client may also need to process the information independently with the IRT clinician. Or the client may miss some FEP sessions, and the IRT clinician can help him or her to catch up.

This module has two primary goals: 1) provide information on the factors that contribute to set backs or relapses, such as early warning signs and triggers; and 2) help the client develop and implement a relapse prevention plan.

Relapse is defined with the client and he or she is introduced to the idea that relapses can be prevented, which in turn, can facilitate progress towards personal goals. In addition, common early warning signs of relapse are defined and described and the concept of relapse triggers is introduced. The relationship between early warning signs and triggers is explored in preparation for developing a relapse prevention plan. Finally, clients are walked through the steps of completing their own personal relapse prevention plan, in collaboration with supportive people in their life.

Module #5: Processing the Psychotic Episode (3-5 sessions)

The goals of this module are to: 1) help the client process the psychotic episode—that is, to understand how it has affected his or her life; 2) help the client identify positive coping strategies used and resiliency demonstrated during this period; 3) help the client identify and challenge self-stigmatizing beliefs about the experience of psychosis; and 4) develop a positive attitude towards facing life's challenges ahead.

As this is a sensitive area for many clients, this module begins with talking with the client about how to discuss the topic of his or her psychotic episode, as well as the pace of this discussion. For clients who are reticent to discuss their experience, personal accounts of other individuals with first episode psychosis are reviewed and discussed. Clients are encouraged to "tell their story" and to create a narrative that helps them process all aspects of their psychotic episode (i.e., precursors, triggers, and effects of the episode).

In order to better understand some of the ways that self-stigmatization may contribute to the client's distress, symptoms, and problems in social functioning, the second half of this module involves the assessment and challenging of commonly-endorsed beliefs related to self-stigma that people sometimes develop following a first episode of psychosis. Self-stigmatizing beliefs are assessed using a brief standardized questionnaire before and after the psychotic episode has been processed to evaluate change. For those clients who continue to endorse stigmatizing beliefs, a brief introduction to and practice of cognitive restructuring is provided. At the end of the module, if self-stigmatizing beliefs continue to be present and cause distress, the clinician encourages the client to continue onto the individualized module Dealing with Negative Feelings (#8) for further work with cognitive restructuring.

Module #6: Developing Resiliency--Standard Sessions (3-4 sessions)

This module has the following goals: 1) to provide information about resiliency and help client identify with the resiliency process; and 2) to help the client build resiliency through using strengths and paying attention to the good things that happen.

This module is broken down into two sections that include topics for both the standard sessions and the individualized sessions. In the standard resiliency sessions, the following three topics will be covered with all clients: "Exploring your Resilience," "Using Your Strengths," and "Finding the Good Things Each Day." During the standard sessions, the process of developing resiliency is reviewed. In addition, the client is helped to identify personal qualities that he or she sees as resilient and reviews personal resiliency stories. The client is asked to review the top character strengths that represent him or her the most, which were originally identified in the Assessment/goal setting module. By finding new ways to use their strengths in their daily life, clients can learn to capitalize on their strengths more in different situations. In the home assignment follow-up, clients reflect on how it felt to use their strengths and how they may use their strengths more often in the future.

The client is also introduced to strategies for paying attention to the good things that happen in his or her life. This is designed to help clients' notice, pay more attention to, and remember positive events that occur throughout their day. Clients also are prompted to think about why good things happen to them and who is responsible for the good things that happen.

Module #7: Building a Bridge to Your Goals (2-3 sessions)

This module has the following goals: 1) help the client identify a personal goal (if one was not been set earlier) or review the goal that was set in Module 2; 2) review progress towards his or her goal and make modifications if necessary; and 3) help the client decide whether he or she will continue in treatment, and if so, which individualized modules she or he will follow.

This module provides a structure to use collaborative decision-making to help the client decide how to proceed in his or her treatment. The clinician discusses the client's progress towards goals, barriers the client has faced or could potentially face when working towards goals, strengths, and helpful strategies from the standard modules. The clinician also works with the client to identify areas of functioning or distress that the client can address in the Individualized modules. At the end of the module, the clinician helps the client develop a Personalized Treatment Plan in which the client decides what modules he or she wants to learn, and the next steps in making progress towards his or her goal(s).

Module #8: Dealing with Negative Feelings (7-12 sessions)

This module has two general goals: 1) teach the skill of cognitive restructuring (CR) as a self-management tool to help the client deal with negative feelings; and 2) help the client use this skill to deal with negative feelings (such as depression and anxiety), including negative feelings related to self-stigmatizing beliefs, psychotic symptoms, non-psychotic symptoms, suicidal thinking and behavior, and PTSD symptoms. Incorporated within the self-management model for conducting cognitive restructuring is a step-by-step approach to developing "action plans" for addressing problems in which a careful evaluation of the client's concerns indicates that they have realistic basis.

In this module, the clinician provides information about different areas of emotional distress and specific approaches to targeting and decreasing emotional distress (i.e., cognitive restructuring). The client is first taught about the relationship between thoughts and feelings (i.e., emotional responses to different situations are mediated by the person's thoughts or beliefs about those situations, themselves, other people, and the world in general). Clients are then taught how to recognize when they are engaging in "Common Styles of Thinking," or common, inaccurate ways that people reach conclusions that lead to negative feelings (such as catastrophizing" or "all-or-nothing thinking"), and how to examine, challenge, and change these beliefs. Teaching clients how to recognize and change Common Styles of Thinking serves as an introduction to the skill of cognitive restructuring, and provides a basis for beginning to practice the skill for dealing with negative feelings.

The client is then taught the "5 Steps of Cognitive Restructuring (CR)," which is a step-by-step approach to dealing with and resolving any negative feeling. Negative feelings based on thoughts or beliefs that are judged to be inaccurate after a close examination of the evidence are modified, leading to a reduction in the negative feeling. Negative feelings based on thoughts that are judged to be accurate are followed up by developing an action plan for dealing with and resolving the problem situation. The client is given opportunities to practice the 5 Steps of CR in session and at home. Clients are encouraged to continue to use the 5 Steps of CR on a regular basis as a self-management tool for dealing with negative feelings.

The 5 Steps of CR are used to address negative feelings that the client has. This includes negative feelings related to specific persistent symptoms, including depression, suicidal thinking or behavior, anxiety, paranoia, auditory hallucinations, posttraumatic stress disorder (PTSD) due to either the experience of the psychotic episode and upsetting treatment experiences, or due to lifetime traumatic experiences (e.g., sexual abuse or assault, sudden and unexpected loss of a loved one), and self-stigmatizing beliefs that have persisted despite completing the Processing the Psychotic Episode module.

Module #9: Coping with Symptoms (2-4 sessions for each symptom selected)

This module has the following goals, to: 1) assist clients in identifying persistent symptoms that interfere with activities or their enjoyment of life; 2) help the client identify the symptoms that interfere the most, and select relevant handouts to address these symptoms; 3) assist the client in selecting coping strategies that he or she is most interested in learning; 4) teach coping strategies in sessions, using modeling and role playing whenever possible; and 5) assist clients in practicing coping strategies in their own environment, using home practice assignments, and, in some instances, conducting sessions at off-site locations.

This module is recommended for clients who experience persistent symptoms that interfere with activities, goals, or enjoyment, but who do not report significant distress, or for clients who have completed the "Dealing with Negative Feelings" module and have learned the 5 Steps of CR model of cognitive restructuring, but continue to experience significant distress from specific symptoms. The symptoms that are addressed in this module include depression, anxiety, hallucinations, sleep problems, low stamina and energy, and worrisome or troubling thoughts (e.g., thoughts related to paranoid ideation or delusions of reference). A range of coping strategies is taught for each symptom, including such strategies as relaxation techniques, cognitive restructuring, distraction, exercise, and mindfulness. Clients are encouraged to learn to use at least two coping strategies for each of their targeted symptoms.

Module #10: Substance Use (11-20 sessions)

This module does not require that the client be motivated to become sober—only that he or she is willing to talk about substance use and to explore its effects. The module is recommended for clients whose substance use has resulted in significant problems, such as precipitating symptoms, problems in social or role functioning (e.g., school, work), money problems, legal problems, family conflict, or victimization. In addition, because clients with a

first episode of psychosis are vulnerable to developing a substance use disorder, the module is recommended for clients who use substances regularly but have not yet developed a clear substance abuse problem. The goals of this module are to: 1) provide basic information about substances, common reasons for using, and negative effects of substances on psychosis and personal goals; 2) enhance motivation to reduce or stop using substances; 3) teach skills for managing urges to use substances, coping with symptoms that precipitate substance use, and dealing with social situations involving substances; and 4) develop a personal substance abuse relapse prevention plan.

In this module, clinicians provide an open and accepting atmosphere for clients to discuss substance use and whether or not the client is comfortable sharing that information with his or her family. In addition, information is provided about the effects of using different psychoactive substances, common reasons for using substances, and negative effects of using substances. Clients are also asked to share their experiences with using substances. Next, clients are engaged in a decisional balance to weigh the advantages and disadvantages of using vs. not using substances in order to increase the person's motivation to quit or cut down substance use. Clients are taught strategies to increase social support for not using substances and skills for avoiding use in high risk situations. Lastly, for clients who have achieved abstinence, the clinician helps the client develop a substance abuse relapse prevention plan.

Module #11: Having Fun and Developing Good Relationships (composed of three sub-modules: Having Fun [3-6 sessions], Connecting with People [5-9 sessions] and Improving Relationships [5-9 sessions])

This module is recommended for clients who are looking for fun activities and experiences and/or who would like to form new connections with people or improve current relationships. The goals of this module are to: 1) help the client renew old fun activities and develop new fun activities; 2) get the most enjoyment out of fun activities by learning how to appreciate the "3 Stages of Fun"; 3) connect with people by contacting old friends and meeting new people; 4) improve the quality of relationships by developing skills to better understand other people, communicate more effectively, manage disclosure, and understand social cues.

This module is broken into 3 sub-modules: Having Fun, Connecting with People and Improving Relationships. The Introduction to the module provides an overview of the sub-modules and includes questions designed to help the client decide which sub-modules he or she would like to work on and in what order. Clients can choose one, two, or all three of the sub-modules, which can be done in any order. If a clear preference does not emerge for which sub-module to start on, Having Fun is recommended as the one to begin with. Helping clients renew old interests and develop new ones often provides natural social opportunities to meet people with similar interests. By working on increasing the fun in the their life, clients often encounter new social situations that they are motivated to be successful in. This can lead to moving from the Having Fun sub-module to one or both of the two other sub-modules, which focus more directly on social relationships.

In all three sub-modules, there is a strong emphasis on actively practicing skills, using methods such as role plays in and out of the session to help clients get familiar with the skills, and helping clients understand the relevance in their life and feel more comfortable using the skills.

Module #12: Making Choices about Smoking (2-4 sessions)

This module walks clients through the steps of identifying their personal benefits and concerns about smoking and quitting. Concerns about quitting are normalized and suggestions are provided for coping with these concerns throughout the handouts. Clients are presented with information about available treatment options. The clinician then helps clients take stock of their willingness to make changes to their smoking behavior. Clients who are willing then work with the clinician collaboratively to develop a plan for tobacco reduction or abstinence.

Module #13: Nutrition and Exercise (2-4 sessions)

This module provides a rationale for and identifies skills to improve nutrition and increase exercise. Concerns about changing diet and increasing activity level are addressed and some possible solutions identified. Clients are presented with information about specific ways of increasing activity and improving diet. The clinician then helps the client take stock of his willingness to make changes to his eating and exercise behavior. Clients who are willing then work with the clinician to collaboratively develop a plan for making some changes in diet and activity level.

Module #14: Developing Resiliency--Individualized Sessions (2-10 sessions)

This module helps clients learn additional skills to build resiliency with the following goals: 1) learn strategies to build positive emotions and facilitate resiliency; and 2) help the client build resiliency through the skills of gratitude, savoring, active/constructive communication, and practicing acts of kindness.

In addition to information about resiliency and its characteristics, there are a variety of exercises in this module. These exercises (e.g., a gratitude visit; savoring; practicing acts of kindness) are meant to increase positive mood, well-being, and a sense of purpose, factors which should facilitate recovery and strengthen resilience. Such exercises may also help clients “get back on track” in terms of helping them achieve important personal goals.

This module can be used either as a stand-alone module or as a source of single resiliency exercises that can be integrated into the first session or two of each of the individualized modules chosen by the client. In Module #7, clinicians should discuss with the client his or her preference for resiliency exercises available in the individualized Developing Resiliency module. When clients have chosen to complete one or more individualized modules they should also complete one resiliency exercise at the beginning of each module. For example, if a client chooses to complete the “Substance Use” module, he or she would be encouraged to do a resiliency exercise of his or her choice at the beginning of that

module. If the client chooses not to complete any of the individualized modules, he or she has the option of doing Developing Resiliency as an individualized stand-alone module, including the opportunity to do all of the resiliency exercises.

Logistics

Implementing the Modules: Topics and Clinical Guidelines

As described later in this manual, each module includes a set of "topics", which are summarized in handouts and reviewed/discussed with the client in session, and a corresponding set of "clinical guidelines", which provide instructions for the clinician on the administration of a given topic area.

Topics provide basic information about a specific subject within a module (e.g., "Basic Facts about Alcohol and Drugs" is a topic in the Substance Use module), as well as checklists for the client to complete, worksheets (such as the 5 Steps of Cognitive Restructuring worksheet found in the Dealing with Negative Feelings module), standard assessment measures as well as home practice options. Thus, for each topic area, there is a handout, which includes text, worksheets, checklists, home practice options, etc. Review and use of these handouts in session may vary depending on the clinician's and client's style and circumstances. For example, you can take turns reading a handout aloud with the client, or you can summarize sections for the client and have him or her review the handout as a home assignment. In addition, there are summary points for review that are both in boxes and at the end of the handouts, and questions throughout each handout designed to facilitate discussion as it is reviewed. You do not have to use handout materials in every session, although with most clients they are useful. Some clients with very poor reading skills may find the handouts daunting, and clinicians can teach the information using the handout as a guide for himself or herself.

The clinical guidelines provide instructions and tips on how to teach the client the information and skills in a given module. For example, the Education about Psychosis module covers four different topics: 1) What is psychosis? 2) Medications for Psychosis; 3) Coping with Stress; and 4) Strategies to Build Resilience. The clinical guidelines begin with a listing of the general goals for this module, followed by a listing of the four topic areas, an overview of the session structure, general teaching strategies, and instructions. This is meant to orient the clinician to the module in general. Then, clinical guidelines are provided for each topic area, covering the following information: A) overview of the topic area; B) goals for that topic area; C) materials needed (e.g. what handouts are needed for that topic area); D) suggested pacing of the sessions (broken down into a "slow" and "medium" pace); E) teaching strategies (e.g., connecting information to the client's goal); F) tips for common problems; G) suggestions for evaluating gains; and H) a summary table that clinicians can use to remind themselves of the goals for that topic and therapeutic techniques to help meet them (including suggested probe questions).

We strongly suggest that you read both the handouts and guidelines prior to the session, although it is fine to have the clinical guidelines in front of you during the session as a reminder.

Session Frequency and Duration

You should expect the client to take approximately 4-6 months to complete the seven IRT standard modules, depending on the frequency of sessions and the learning pace of the client. Each IRT session should be approximately 45-60 minutes (depending on client functioning, motivation, etc), with sessions preferably conducted on a weekly or biweekly basis. However, if scheduling less frequent sessions is critical to keeping the client engaged in IRT, you are encouraged to accommodate to the client's preferences.

Depending on client need, goals, and motivation, one or more of the individualized IRT modules may be taught, which differ in length. Clients may also vary in their motivation for treatment and ability to process information at different points in their illness. Thus, both the frequency of sessions and duration of time that IRT is provided will vary considerably between clients, with some participating in the program for up to two years. IRT does not impose a fixed number of sessions or time limit on treatment, but rather leaves this open as a matter to be determined collaboratively between you, the client, family members, and the other members of the NAVIGATE team.

The goals of each module are not necessarily fully achieved when the module is completed. Therefore, it is often necessary to continue working with the client on practicing skills taught in the module, or reviewing progress towards goals relevant to that module, even after moving onto a new IRT module. For example, clients with substance use difficulties may improve during the substance use module, but nevertheless still be at high risk for relapsing back into using substances following completion of this module. In order to minimize the chances of such a relapse, it is important to routinely check in about the client's substance use, his or her relapse prevention plan, and any other related issues that may need attention, such as symptoms that precipitate use. If ongoing difficulty persists or re-emerges, it may be necessary to re-visit earlier therapeutic techniques and strategies, as alluded to earlier in this section. Clearly, the clinician should always attend to issues that are in the best interest of the client when they arise.

For another example, teaching skills such as cognitive restructuring (Dealing with Negative Feelings module), coping skills (Coping with Symptoms module), and interpersonal skills (Having Fun and Developing Good Relationships module) often requires extended practice and honing of the skill over time for clients to develop real competence. Practice of targeted skills naturally takes place when you are teaching the material in a particular module, but this practice can be continued for a few minutes in each session even after you move onto another module. Thus, it is important to be aware that learning the requisite skills covered in a particular module may require ongoing practice after the module has been completed.

One challenge for you, the client and the NAVIGATE treatment team is deciding when to end treatment. Of course, if clients have completed the standard modules and the individualized modules of their choice, have met their goals (which should be tracked weekly), and are satisfied with their progress, then this would be a natural stopping point. For clients who continue to work on goals, have persistent or emerging problems to address after completing the standard modules and individualized modules of their choice, then you and the clients will collaboratively determine which areas to address, which modules to review, and which additional individualized modules that might be helpful.

Location of Sessions

IRT is not merely an office-based treatment. As an IRT clinician, you will need to liaise with other important individuals in the client's life, including members of the NAVIGATE treatment team and family members and other "indigenous supporters" (with the client's permission; see below for procedures). In addition, a number of the areas addressed by IRT modules, such as Coping with Symptoms, and Having Fun and Developing Good Relationships, may only be effectively targeted via activities conducted outside of the office, such as *in vivo* exercises (e.g., having the client practice a particular social skill with a friend or family member). The ultimate goal of any intervention, including IRT, is that the skills learned in-session generalize to the rest of the client's life and have positive lasting impacts.

Session Organization

Typically, the IRT session is structured in the following manner:

- Greeting and check-in, including any ongoing areas of difficulty (e.g., substance use)
- Setting of an agenda
- Reviewing previous session
- Reviewing home practice
- Following up on goals
- Covering new material or reviewing material as needed, taking advantage of opportunities to role play and practice skills
- Asking client to summarize and provide feedback about the session
- Developing a new home practice assignment and identifying ways that indigenous supporters can assist

As noted in the first step of the session structure, you should briefly check in regarding any significant problem areas for the client, such as weight gain, substance use or medication non-adherence (regardless of current treatment phase). If any pressing concerns emerge, it may be necessary to include those as agenda items (see below).

The setting of an agenda involves you and the client setting up a plan for what will be worked on in the session. Although this is done in a collaborative manner, it is your job to make sure that the agenda addresses issues related to the client's goals. Generally, the first agenda items are reviewing the past session and completion of the home practice assignment, as this helps the client understand that home practice is a critical component of

treatment. Also, this helps to connect work conducted in the previous session with the current session. It's also helpful at this time to review progress towards goals because this is a key component of treatment that needs to be followed up on a regular basis.

Both you and the client cover the remaining agenda items in order of importance as identified. Note that you need to be very responsive to "emergency" agenda items by addressing them immediately if they clearly represent a crisis. "*Indeed, you should always prioritize pressing concerns that the client may bring in."* However, for clients who regularly present with a "crisis of the week," it is important that you demonstrate understanding of the client's concerns, while adopting a problem-focused approach to prevent the session from becoming derailed. An example of such an approach is provided below:

Clinician: It's good to see you. How are you? How have things been going since we last talked?
Client: My psychiatrist wants to increase my medication. She won't ever listen to me. She just treats me like a nut. What does she care? I'm just a number to her. Those meds make me really sleepy, I can't do my job, I can't stay awake…
Clinician: You sound really upset. I wonder…
Client: (interrupting) I am upset, she just wants to hold me back. She's trying to make money for the drug companies.
Clinician: So, you feel like your doctor doesn't have your best interests in mind when it comes to your medication? Well, is it fair to say that this should be a top agenda item today, maybe after we cover your home practice and progress towards your goal?

After new material is discussed in session, you and the client should collaboratively determine an appropriate home practice assignment, and should also try to identify ways that the client's indigenous supporter(s) may assist over the coming week. The session should end with you checking in with the client to get his or her perspective on how the session went. Also, we strongly recommend asking clients, particularly those with attention problems, to share what they got out of the session. It may be helpful for you to jot down a few notes based on the client's recollection of the main points of the session (in the client's own words) that can be referred to by the client between sessions.

Home Practice

Home practice is an essential part of IRT, and is something that you need to attend to in every session. There are two major reasons why home practice is a critical component of treatment. First, it builds in generalization of skills from the session to the client's social environment. For example, a client who has difficulty initiating conversations may work with the clinician in-session on developing appropriate social skills. Home practice then allows the client to practice starting conversations in situations that he or she encounters in daily life. Second, there is empirical support for the use of home practice. Kazantzis et al. (2000) conducted a meta-analysis (i.e., a statistical review and summary of many studies), and found that home practice assignment and compliance had a moderate impact on treatment

outcome. In other words, clients who completed home practice were more likely to improve following treatment than clients who did not complete home practice.

Suggested home practice assignments are provided in most handouts. For example, in the Relapse Prevention Planning module, the client is asked to consider practicing one strategy to help him or her cope with the early warning signs of a relapse. Other home practice assignments might involve completing a checklist (e.g., The Triggers of Relapse Checklist found in the same module) either alone or with a family member or friend. No matter what the assignment, it is important that the home practice assignment be developed collaboratively (even if it is an assignment not listed on the handout) and that the client sees a benefit for doing the home practice. Clients are more motivated to complete home practice assignments that have clear relevance to their lives and current situations (e.g., a client with a goal of getting a job develops a home assignment to practice a coping strategy dealing with low stamina and energy that he or she can use while working).

You should be prepared for times when the client does not complete the assignment. Do not assume that the client doesn't want to complete it. Rather, you need to assess what prevented the client from doing the assignment. Potential challenges to home practice assignment completion includes:

- Client did not understand the assignment
- Client lost the assignment
- Client was not comfortable with practicing his or her new skills outside the session
- Client did not have the opportunity to do the assignment
- The assignment was too complex or difficult
- There was inadequate opportunity to practice the skills needed for the assignment in session
- The client forgot to do the assignment
- The client did not see how the assignment could be helpful in his or her situation or attainment of goals

If poor follow-though on home assignments is a persistent problem, you need to ask the client why. If the client has trouble coming up with an answer, develop a hypothesis of why the client does not complete home practice assignments, and then problem solve with the client to rectify this problem. In other words, what are the factors that are contributing to and maintaining home practice non-adherence? Make sure that you provide sufficient praise to the client upon completing the assignments. The most effective praise is specific, genuine, and not patronizing. Positive feedback makes the client feel good for completing the project, but can also help the client identify how he or she felt when using the skill outside of the session. For clients who have significant cognitive difficulties, or persistent symptoms, poor follow-though on homework may be related to difficulties with memory or being easily distracted. Working to involve the client's natural supports, such as family members, in helping the client follow through on home assignments in IRT is often an effective strategy for compensating for cognitive or symptom problems that interfere with completion of home assignments.

Coordinating IRT with the Family Education Program

NAVIGATE is a comprehensive team-based intervention, and it is important to coordinate IRT with the other components of the program: Family Education Program (FEP), Supported Employment and Education (SEE), and Medication Management. Coordination with FEP is especially important, because it is recommended that Module 1 (Orientation), Module 3 (Education about Psychosis) and Module 4 (Relapse Prevention) be done in joint sessions with clients and their relatives (or other supporters). If possible, the FEP clinician will conduct joint sessions for these modules, using handouts from the FEP manual, which were designed to be applicable to both relatives and clients. Joint sessions will usually be conducted by the FEP clinician alone, but the IRT clinician could also co-facilitate one or more sessions.

It may not always be feasible for the FEP clinician to provide joint sessions with relatives and clients, for a variety of reasons such as the following: no relatives are available, relatives are available but the client does not give permission for their involvement, relatives are available but cannot attend sessions, the client is unwilling or unable to attend joint sessions. In such situations, the IRT clinician will provide Module 3 and Module 4 to the client in IRT sessions. Also, the client may benefit from reviewing and processing the information independently in IRT sessions after attending joint sessions. Finally, in some instances, the client may miss some FEP sessions, and the IRT clinician can help him or her to catch up.

After completing Module 4 (Relapse Prevention Planning), there is no more substantial overlap between the curriculum in IRT and FEP. The IRT clinician will continue to meet with the client, and provide the FEP clinician and other members of the NAVIGATE periodic updates on the client progress, and how relatives can continue to provide support to the client and help him or her make progress towards goals. Some additional FEP sessions that focus on educational topics such as effective communication and developing a collaborating relationship with professionals may continue to involve the client. In addition, depending on the client's and family's needs, FEP sessions including the client may continue to be provided to the family to address high levels of stress and tension by providing training in communication and problem solving skills using in-session practice and home assignments, or family consultation may be provided to address specific concerns on an as-needed basis. In such cases, similar to the role of the IRT clinician, the FEP clinician regularly updates the NAVIGATE team on progress in the family work, and explores with the team how IRT and SEE can complement or facilitate the goals of FEP. Over the course of IRT, relatives may join sessions as requested by the client. For example, the client might choose to ask relatives to sit in on some portions of Module 2 (assessment/goal setting) sessions so that they are informed of his or her goals and how they can be helpful. Or the client might ask relatives to join some sessions of Module 5 (Processing the Psychotic Episode) to share their experiences.

Case Management

One of the challenges of doing IRT is coordinating it with case management. This issue can be addressed in a few ways: 1) Dividing the session into IRT and case management components. This can occur when a client brings in a crisis, such as being in danger of losing his or her apartment, and needs to address this problem. In that case, you might spend half of your time on case management issues, and the remaining on the IRT topic. 2) Integrating IRT into case management. For example, in the aforementioned example, you could prompt the client to use relevant skills learned in IRT to ask for help from his or her family. In essence, situations that arise during case management can be used as a "natural laboratory" to reinforce and practice skills learned during IRT.

Miscellaneous Clinical Elements in IRT

1. Collaboration with Natural Supports

Natural supports are non-mental health professionals who by virtue of their relationship and regular contact with the client are potentially in a position to help that person manage his or her psychiatric illness or make progress towards personal goals. Examples of natural supports include family members, friends, employers, self-help group members, and other members of a community organization. We consider these natural supports a type of "indigenous supporter;" that is, an individual in the client's home, work or community environment who can help the client pursue their goals. For example, because of their contact with clients in "real world" settings, natural supports are often in an ideal position to support illness self-management behaviors and steps towards goals. In addition, engaging natural supports can help the clinician make new resources available to the client that would otherwise not have been tapped (e.g., a job lead).

While clients are not required to have indigenous supporters, they are highly encouraged to identify somebody who can serve in this role. This approach of enlisting external assistance and support has also been encouraged in other treatment approaches for individuals with schizophrenia and other severe mental illnesses (e.g., Illness Management and Recovery and Integrated Treatment for Dual Disorders; Gingerich & Mueser, 2010; Mueser et al., 2003).

There are a number of individuals who can be included as indigenous supporters during IRT:

- Family members
- Spouse
- Boyfriend/girlfriend
- Roommate(s)
- Friends

It is ideal to enlist the assistance of an individual who either lives with, or is in close regular contact with, the client. For most clients, family members will probably be ideal candidates. The clinician should obtain the client's written permission to contact any potential indigenous supporter before doing so.

There are many ways that indigenous supporters can be involved in treatment. An indigenous supporter may:

- Review handouts and other material from IRT with the client
- Assist the client with home practice assignments
- Help the client practice a new skill or reinforce one that the client uses spontaneously
- Help the client with practical assistance, such as transportation or locating resources
- Take an active role in helping the client achieve goals
- Take an active role in the client's relapse prevention plan
- Stay informed about the progress of IRT through regular contact with the clinician and/or the NAVIGATE team

2. Suicide Risk and Prevention in Early Psychosis

Approximately 5-10% of people with schizophrenia will commit suicide. Further, there is a particularly high risk of suicidality among individuals recovering from their first episode of psychosis. At least 50% of individuals with first episode psychosis have experienced suicidal thoughts and approximately 25% have made a suicide attempt by the time of first contact with treatment services (Power, 2004). Indeed, while the acute phase of the illness represents a risky period regarding suicidality, it is the early recovery phase following remission of psychotic symptoms when most suicides actually occur. Individuals during this phase are beginning to experience the psychological and social impact of the illness, and many are likely to experience "post-psychotic depression" (Birchwood et al., 2000). Depression and suicidal ideation is especially common among individuals who feel engulfed and trapped by their illness, and who become hopeless about the future, predicting a loss of social status and limited potential for improvement (Birchwood, 2003). Specifically, suicide risk in early psychosis is highest during the following periods:

- During emerging psychosis (i.e., prodromal phase)
- Immediately prior to hospitalization and immediately following discharge
- Several months following symptom remission (early recovery period)
- After first relapse (i.e., when realization occurs that illness is recurrent)

Given the heightened risk of suicide following a first episode of psychosis, you are strongly encouraged to consider all IRT clients as being "high risk" and to regularly monitor their clients for suicide risk. Risk factors for suicide in early psychosis include:

- Male gender
- Single
- Unemployed

- Suicidal ideation and/or previous suicide attempt(s)
- Good premorbid functioning with high personal expectations
- High premorbid IQ
- Good insight
- Depression and/or hopelessness
- Substance abuse
- Large degree of illness-related deterioration
- Command hallucinations
- Grandiose or persecutory delusions (may result in self-destructive behavior)
- Family history of suicide

Additional factors that may increase the risk of suicidality include:

- Recent loss of social support
- Isolation/reduced supervision
- Treatment non-adherence
- Environmental stress/conflict (e.g., family conflict or criticism)

You should be mindful of the above risk factors, and identify clients who may be at increased risk of suicide. On the NAVIGATE team, the psychiatrist routinely assesses for suicidal ideation. Family members may also bring information about their relative's suicidal thinking to their family clinician on the NAVIGATE team, and thus you may know that this is a significant clinical issue from your work on the team. If a client expresses suicidal thoughts to you, in order to evaluate it further obtain the following information: "frequency of thoughts", "presence of active intent and plan", "lethality and availability/feasibility of the plan", and "potential obstacles to implementation of the plan". If clients express active suicidal ideation, hospitalization may be required. If clients express suicidal thoughts without active intent (e.g., "I'd be better off dead"), ensure that they are willing to contract for safety and be certain that they will be closely monitored. **In any case, the presence of any suicidal ideation in clients must be communicated immediately to the rest of the NAVIGATE team**. If a client is actively suicidal and other healthcare providers are unavailable, you should contact his or her local emergency department and ask for the psychiatrist or crisis worker on call. You should document in the client's chart: all risk assessment and safety plans, all supervision and consultative contacts, all contacts with outside providers, current disposition of client, and any other action taken on behalf of the client.

After attending to the steps described above, you should try to engage clients who experience suicidal ideation in Module 8 (Dealing with Negative Feelings), Module 9 (Coping with Symptoms), or both. Module 8 teaches cognitive restructuring as a self-management skill reducing negative feelings, which can be especially helpful in addressing mood-related symptoms, including suicidal thinking, depression, anxiety, paranoia, distress related to hallucinations, PTSD, or self-stigmatizing beliefs. This module also includes assessment measures for tracking the effects of teaching cognitive restructuring on reducing symptoms that are associated with suicidality, including hopelessness, depression, anxiety, PTSD symptoms, and self-stigmatizing beliefs. Module 9 is aimed at teaching a range of coping strategies for dealing with persistent symptoms, including depression, anxiety, hallucinations,

and delusions, all of which can be related to suicidal thinking (coping strategies for other symptoms are taught as well, including sleeping difficulties and lack of stamina or energy). Those symptoms that are most strongly associated with the client's suicidal thinking can be targeted for teaching coping strategies.

Although Modules 8 and 9 are Individualized IRT modules, and not Standard modules, they can be taught at any point that suicidal thinking is recognized as a significant symptom that must be addressed immediately, even before the Standard modules have been completed. There are two general approaches to addressing suicidal thinking using Modules 8 or 9 during the provision of the Standard modules. First, you can devote part of each Standard module session that you are working on to teaching information and skills from Module 8 or 9 (e.g., 15 or 20 minutes). Second, you can temporarily suspend work on the Standard modules in order to focus exclusively on Module 8 or 9 in order to maximize the intensity of your focus on the suicidal thinking.

There are a number of other ways that you can minimize suicide risk or address emerging suicidality in clients. One fundamental way is to assure that clients are continually engaged with treatment services. Other specific strategies include: boosting self-esteem, fostering hope, and training clients in problem-solving, interpersonal effectiveness, distress tolerance, and emotion regulation skills.

For additional information on suicide risk assessment and prevention in early psychosis, consult the following references:

- Power, P. (2004). Suicide prevention in early psychosis. In J. Gleeson & P.D. McGorry (Eds.), *Psychological interventions in early psychosis: A treatment handbook* (pp. 175-189). Chichester, England: John Wiley & Sons.

- Clinical materials available from EPPIC at http://www.eppic.org.au/
  - Case management handbook (EPPIC, 2001, pp. 63-66)
  - Managing the acute phase of early psychosis (ORYGEN Youth Health, 2004, pp. 32-34)

3. Flexibility

IRT is intended to be flexible, both in terms of the areas it targets as well as in terms of treatment frequency, intensity, and duration. We have built this flexibility into the treatment so as to be able to best address the heterogeneity of first episode psychosis. In addition, we realize that for many NAVIGATE clients, this will be their first exposure to mental health treatment. Thus, their motivation to engage in treatment may wax and wane, requiring IRT to be delivered in a manner that meets the client where he or she is at (e.g. weekly; biweekly; monthly). We feel that it is paramount to continually engage, and re-engage clients in treatment (while they are in need of services), which ultimately should facilitate recovery and reduce the likelihood of relapse.

At times, the client's needs may necessitate providing IRT modules out of order, as described above for individuals experiencing significant suicidal ideation. For another example, if a client experiences distressing symptoms such as hallucinations or delusions, it is most helpful to shift as soon as possible to Module 8 (Dealing with Negative Feelings) to learn cognitive restructuring or to Module 9 (Coping with Symptoms) to learn further coping strategies. As another example, if a client experiences problems with weight gain, he or she could be guided to Module 13 (Nutrition and Exercise), which provides strategies for nutrition and exercise. After a few sessions learning some of the strategies in Module 13, the IRT clinician could shift back to the other IRT modules, but check in for a few minutes every session with the client on progress and troubleshoot any difficulties he or she is experiencing in the area of weight.

Flexibility in the delivery of IRT increases its effectiveness and is helpful in reducing the likelihood of clients dropping out of treatment. As different agencies might have different protocols for dealing with client drop-outs (or poor or intermittent attendance), we feel that being flexible in the delivery of IRT is something that should cut across most settings in helping keep clients engaged in treatment.

4. Clinical Supervision

For the most effective IRT implementation, weekly group supervision for one hour is recommended for all clinicians involved in IRT. It is important that supervision time be protected for clinicians (i.e., that participation in supervision be considered as a part of any productivity quotas or expectations placed on clinicians) in order to ensure their active involvement. Supervision should support clinicians' continued IRT work, and help them problem solve challenges that can arise with clients as well as with the agency. These weekly clinical supervision meetings can also help sustain the practice of IRT after the initial training and implementation. IRT clinical supervision will help with the following:

1) Monitoring the delivery of IRT to clients
2) Providing feedback about the implementation of IRT within the agency
3) Providing opportunities for clinicians to practice IRT skills
4) Increasing competence with these skills
5) Offering clinicians support while implementing IRT

Clinical supervision is most helpful when there is a specific structure that guides the meetings. After individual IRT sessions have begun, there is a simple structure that the IRT supervisor can follow during clinical supervision. First, the IRT supervisor conducts a brief check-in with clinicians about the current status of IRT individual cases. As part of the check-in, the IRT supervisor generally asks a series of seven questions to update progress in IRT, identify problems early, and track the implementation of IRT. The check-in questions include:

1) What module is the client working on?
2) What is the client's recovery goal(s)?
3) What steps have been taken towards achieving the recovery goal(s)?
4) What is the client's attendance rate?

5) Are home assignments being completed?
6) Are there any problems that currently need to be addressed?
7) How is IRT being coordinated with other elements of the NAVIGATE program (e.g., Family Education, Supported Employment and Education, and Psychiatry)?

After answering these questions with clinicians, IRT supervisors have four different options for the remainder of the clinical supervision session:

1. Planning for the next module with clinicians
2. Problem solving or giving suggestions for a problem or challenge identified during the check-in
3. Asking a clinician to give a case presentation
4. Reviewing an IRT skill or strategy for advanced training

The IRT supervisor can help clinicians plan for the next module by reviewing the goals of the module, discussing the motivational, educational, and cognitive-behavioral teaching strategies that could be used during that module, brainstorming ideas for home assignments, and linking the goals of the module to the client's recovery goal.

A second option involves problem-solving a challenge that was identified during the check-in. All of the clinicians are encouraged to offer suggestions for solutions, and the supervisor can suggest role-playing one of the strategies as a practice. Supervisors often use the following steps for problem solving during IRT supervision:

1. Defining the problem or challenge
2. Eliciting possible strategies/solutions from all clinicians
3. Evaluating strategies/solutions
4. IRT clinician chooses strategy/solution (or combination) to try
5. IRT clinician makes a specific plan to try out the strategy or solution
6. IRT clinician plans to follow up how the strategy/solution worked in supervision in the next week or two

As a third option, the IRT supervisor can ask a clinician to review a case presentation, usually focused on a client who is having difficulty making progress towards recovery. In this situation, it is important for the clinician presenting the case to provide some background information about the client, including the client's recovery goal(s) and any progress made towards recovery, IRT modules that have been completed, examples of motivational, educational, and cognitive-behavioral teaching strategies that the clinician has used, examples of home assignments, and one or two specific issues with which the clinician needs assistance. Problem solving can be used to address the issues identified by the clinician, with the supervisor and other clinicians offering suggestions for solutions.

The fourth possibility is to use the clinical supervision time for continued training. The purpose of the training can be to focus on a specific teaching strategy, module, or component of IRT such as setting goals, developing home assignments, or teaching advanced IRT skills. The IRT supervisor begins by reviewing how and when to use a skill or strategy, models how to use it, has the clinicians practice how to use it, and provides feedback. This process

mirrors the use of role-plays to practice skills in IRT. For example, if reviewing how to develop home assignments during the session, the IRT supervisor would start by asking what difficulties clinicians have had and how clinicians are currently developing home assignments. The IRT supervisor reviews additional strategies for helping clients to come up with home assignments and then models in a role-play how he or she would use one or more of these strategies in a session. The supervisor then elicits the clinicians' feedback at the end of the role play. The clinicians then pair up and practice developing home assignments and make a plan to try the strategy that they practiced with an individual client over the next week or two.

In addition to the structure for IRT supervision suggested above, there are some strategies that supervisors can use to engage clinicians in the supervision process and assess clinical competence with IRT. When discussing IRT cases, whether during the brief check-in or during a case presentation, the IRT supervisor should involve all clinicians in problem solving. This creates an active process and promotes the learning and sharing of ideas among IRT clinicians. The focus of the discussion should always return to the client's recovery goal by linking the goal to information and skills throughout the modules. As IRT supervisors provide additional training during clinical supervision, they have opportunities to observe the skills of their clinicians when practicing skills during supervision and asking them to demonstrate in role plays the skills that they used with their clients. It is also extremely helpful for supervisors to listen to sessions that have been recorded to see how clinicians are using the IRT skills in practice.

5. IRT Contact Sheets and Fidelity

Each session should be documented using the IRT contact sheet (see Appendix 1). The purpose of the contact sheet is to help IRT clinicians and supervisors keep track of the client's progress in treatment and the kinds of interventions that are provided (motivational, educational, or cognitive-behavioral), and whether or not the client is completing home practice assignments.

IRT clinicians can tape a number of IRT sessions in order to monitor treatment fidelity. Supervisors can listen to the tapes, provide ratings based on the IRT fidelity scale (see Appendix 2), and provide feedback to the IRT clinician.

The fidelity ratings are based upon the key ingredients of IRT, which include items such as setting an agenda, goal setting and follow-up, developing and reviewing of home assignments, use of motivational enhancement and educational strategies, cognitive restructuring, and taking a recovery/resiliency focus. The fidelity scale uses a 5 point scale from 1 = unsatisfactory to 5 = excellent. The purpose of monitoring fidelity is to measure the extent to which IRT clinicians are implementing the treatment as intended by the model and to provide IRT clinicians with ongoing feedback about the implementation of IRT with their clients. Feedback from listening to the IRT sessions and measuring fidelity can be used during supervision to help clinicians stay faithful to the model. The feedback also can help IRT clinicians assess weaknesses and strengths that can be addressed during supervision leading to better client outcomes.