NAVIGATE Individual Resiliency Training Manual

APRIL 2020 REVISED VERSION

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 individual strengths and resiliency factors, including both how to capitalize on them and make them stronger in order to help individuals 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. The diagnoses covered by IRT includes schizophrenia, schizoaffective disorder, and schizophreniform. Its primary aims are to promote recovery by identifying individual strengths and resiliency factors, enhancing illness management, and teaching skills to facilitate functional recovery (and to achieve and maintain personal wellness).

13 comprise IRT, eight of which are recommended as standard modules which should be provided to all individuals participating in IRT. See the chart below.

Outline of IRT

Module	Standard or Individualized?
1. Orientation	Standard
2. Assessment/Initial Goal Setting	Standard
3. Education about Psychosis	Standard
4. Healthy Lifestyles	Standard
5. Developing a Wellness Plan	Standard

6. Processing the Psychotic Episode	Standard
7. Developing Resiliency-Standard Sessions	Standard
8. Building a Bridge to Your Goals	Standard
9. Dealing with Negative Feelings	Individualized
10. Coping with Symptoms	Individualized
11. Substance Use	Individualized
12. Having Fun and Developing Good Relationships	Individualized
13. Developing Resiliency-Individualized Sessions	Individualized

Since the individuals with psychosis and their family members need to know similar information, IRT and Family Education cover similar topics. The overlap of similar information in these topics is helpful because both the individual and supportive persons in treatment receive the same information about psychosis and schizophrenia and the NAVIGATE team members have some flexibility on where the person receives this education. This means that there is sometimes an “overlap” of some the modules in IRT and the modules in Family Education. Here is a chart of the Family Education Modules:

Although it is helpful to know about the overlap between IRT and Family Education, the focus of this manual is on IRT, so the recommended flow of IRT will now be described below.

All individuals should receive the first eight 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 individuals with current substance use problems, the Substance Use module will be pursued. Some individuals may have several problem areas that they want to address. For example, a person who continues to experience auditory hallucinations and lacks friends, might choose to work with an IRT clinician on the “Coping with Symptoms” and “Having Fun and Developing Good Relationships” modules. In essence, the person and clinician jointly determine which problem areas are creating obstacles to personal wellness and use the IRT program as a means to addressing them. Overall, IRT works well if the modules are provided in the order they are listed. However, IRT is designed to be flexible. The IRT clinician can choose to go out of order on the modules if a significant need arises. For example, if a person is struggling with severe symptoms, the IRT clinician can go out of order and introduce Module 10, Coping with Symptoms, in order to give the person the opportunity to get some relief from the symptoms they are experiencing. Of if a person has just experienced a return of symptoms and/or a hospitalization, it would be beneficial to develop a wellness plan, covered in Module 5, as soon as possible.

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 eight 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 individuals and their relatives (or other supporters) with the NAVIGATE program and with IRT. For this reason, it is ideal if the person and family can meet together with the IRT clinician in the IRT orientation session. The IRT clinician and Family Education Program clinician may want to meet jointly with the person 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 or the peer specialist.

The Orientation module has the following goals: 1) provide information about the different components of the NAVIGATE program (focusing mostly on IRT), and provide an overview of the topics in IRT; 2) set positive expectations for active participation in IRT; 3) address immediate concerns from the individual and relatives; and 4) teach relaxed breathing as a strategy for individuals and relatives who are feeling anxious, stressed, or overwhelmed. This module serves to orient the person 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/individual needs (e.g., via problem solving). It is also important to set expectations regarding attendance, home practice, and the person's role in being an active participant in the IRT process. It is also during the orientation that background information is obtained from the person and relatives in terms of the problems that brought them into treatment. Finally, for individuals and relatives who feel overwhelmed by the illness or even the treatment process, relaxed breathing is taught. Relaxed breathing can then be used as needed in other IRT sessions.

Module #2: Assessment/Initial Goal Setting (2-5 sessions)

The goals of this module are to: 1) help the person to define what wellness or "getting their life back on track" means to them; 2) define resiliency and help the person think about their resilient qualities; 3) assess personal strengths and identify areas of their life that they may want to improve; and 4) help the person set a long-term meaningful goal that is broken down into 1 to 3 short-term goals.

This module helps the person define what wellness or getting back on track looks like for them and to orient them to the concept of resilience. The person is asked to consider the concept of resilience and how they define it. The goal is to instill hope and have the person realize that resilience is a characteristic that can help them overcome an initial psychotic episode.

We have included both structured assessment measures (e.g. the Brief Strengths Test and assessments for trauma and substance use) as well as unstructured assessments (e.g., open-ended questions) to elicit information from the person.

The heart of IRT is the setting and pursuing of personally meaningful goals. Therefore, in session individuals 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). IRT clinicians refer to the completed goal-planning sheet throughout IRT in order to support the person in achieving their goals. IRT clinicians will also revisit the goal setting/tracking process at the end of the standard module set (in Module #8, Building a Bridge to Your Goals).

Module #3: Education about Psychosis (9-13 sessions)

The Education about Psychosis module is designed to teach individuals and their relatives (or other supporters) basic information about psychosis, substance use, and the principles of its treatment. For this reason, it can be helpful if the person and relatives can meet together for educational sessions with the Family Education Program (FEP) clinician. If possible, the FEP clinician could provide the bulk of the education to both relatives and individuals concurrently. When individuals receive this information with their family members there can be less confusion and it allows the IRT clinician to follow-up in the next IRT session to review what the person learned and answer any specific questions that the person may not have wanted to ask with family members present. However, if there are no relatives available or if relatives choose not to participate, the IRT clinician can be the principle provider of education about psychosis to the person. In some situations, the person and relatives may attend FEP sessions together, but the person may also need to process the information independently with the IRT clinician. Or the person may miss some FEP sessions, and the IRT clinician can help them to catch up.

The goals of the Education about Psychosis module are to: 1) elicit information about the person's and relatives' understanding of symptoms, causes, course, substance use problems, interactions between substance use and psychosis, medications, and the impact of stress on their life; 2) provide psychoeducation that addresses gaps in the person's and relative's knowledge about psychosis, substance use, medication, and strategies to cope with stress; and 3) discuss some basic strategies to build resilience. In addition, information is provided about the effects of using different psychoactive substances (such as alcohol and street drugs), common reasons for using substances, and negative effects of using substances. Individuals are also asked to share their experiences with using substances.

If an individual has substance use problems, the Education about Psychosis can be the first opportunity for the IRT clinician to have more in depth discussions about the severity and frequency of substance use along with the reasons that people use substances. As substance use is discussed, it can be helpful to consider how Module 11-Substance Use could be helpful. There are helpful strategies included in the Substance Use module to address the common reasons that people use substances and use behavioral experiments to try out changes to substance use. The IRT clinician should discuss reviewing the substance use module with the individual as part of reviewing these topics in the Education about Psychosis module.

The Education about Psychosis module should facilitate informed decision-making by individuals, help them to develop strategies to foster medication adherence, and contribute to

their understanding of how substance use and stress can affect symptoms. The person is also taught a variety of relaxation techniques for managing stress.

In addition to basic education about psychosis and substance use, this module revisits the concept of resilience. The person is asked to define resilience in their own words and to consider how resilience can be incorporated into their treatment. Finally, the person is introduced to “resiliency stories,” which refer to difficult experiences that people have been able to overcome, and the person’s own resilience in the face of challenges is explored. Such stories help individuals 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: Healthy Lifestyles (5-8 sessions)

This module provides information and skills to build a healthy lifestyle. It focuses on helping individuals improve nutrition, exercise, and sleep as well as exploring steps to cut down or quit smoking. Concerns about changing diet and increasing activity level are addressed and some possible solutions identified. Individuals are presented with information about specific ways of increasing activity, improving diet, and improving sleep habits. People who are willing to make changes can collaboratively develop a plan for making some changes in diet, activity level, and sleep.

In addition, people are provided with information about smoking, including helping people identify the pro’s and con’s of smoking, and the pro’s and con’s of quitting. Concerns about quitting are normalized and suggestions are provided for coping with these concerns throughout the handouts. Individuals are presented with information about available treatment options for stopping or reducing their smoking. Individuals who are willing to make a change in smoking work with the clinician collaboratively to develop a plan for tobacco reduction or abstinence.

Module #5: Developing a Wellness Plan (2-3 sessions)

The Developing a Wellness Plan module is designed to teach individuals and their relatives (or other supporters) basic information about the return of symptoms and how to prevent symptoms from returning. For this reason, it is ideal if the person and relatives can meet together for Developing a Wellness Plan sessions with the FEP clinician. If possible, the FEP clinician will provide the bulk of the education about this topic to both relatives and individuals 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 person. In some situations, the person and relatives may attend FEP sessions together, but the person may also need to process the information independently with the IRT clinician. Or the person may miss some FEP sessions, and the IRT clinician can help them to catch up.

This module has two primary goals: 1) provide information on the common causes of symptoms returning, how to identify early warning signs, and how to respond to early warning signs, and 2) help the person develop and implement a Wellness Plan.

Individuals and family members are introduced to the idea that symptom return can be prevented, which in turn, can facilitate progress towards personal goals. Individuals work collaboratively with the IRT clinician to develop a 3-part Wellness Plan. In Part 1, individuals are introduced to the three common causes of symptoms returning which are stopping medication, using alcohol or drugs, and difficulty managing high levels of stress and they identify ways to prevent the common causes of symptoms returning. In Part 2, common early warning signs are defined and described. In Part 3, individuals identify action steps to respond to early warning signs. Finally, individuals are walked through the steps of sharing and practicing their Wellness Plan, in collaboration with supportive people in their life.

Module #6: Processing the Psychotic Episode (3-5 sessions)

The goals of this module are to: 1) help the person process the psychotic episode—that is, to help them "tell their story" and help them sort out aspects of their experience when they first had symptoms or when they were first hospitalized that may have been confusing or upsetting; 2) help the person identify positive coping strategies used and resiliency demonstrated during this period; 3) help the person 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 people, this module begins with talking with the person about how to talking about their psychotic episode may be helpful to them, what will be covered in the module topic of their psychotic episode, and the pacing of the module which can match the individual needs. Because people are often reticent to discuss their experience, personal accounts of other individuals with first episode psychosis are reviewed and discussed. Individuals 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 person'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. For example, people may believe that they are to blame for what happened or that they cannot be trusted because of what happened. Self-stigmatizing beliefs are assessed using a brief standardized questionnaire before and after the psychotic episode has been processed to evaluate change. For those individuals 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 person to continue onto the individualized module Dealing with Negative Feelings (#9) for further work with cognitive restructuring.

Module #7: Developing Resiliency--Standard Sessions (3-4 sessions)

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

This module is broken down into two sections that include topics for the standard sessions and the individualized sessions. In the standard resiliency sessions, the following four topics will be covered with all individuals: “Exploring your Resilience,” “Good Things,” “Savoring,” and “Mindfulness.” During the standard sessions, the process of developing resiliency is reviewed. In addition, the person identifies personal qualities that they see as resilient and reviews personal resiliency stories. The person is asked to review the top character strengths that represent them the most, which were originally identified in the Assessment/goal setting module.

The person is also introduced to strategies for paying attention to the good things that happen in their life, strategies for savoring, and learning strategies to practice mindfulness. These activities are designed to help people notice, pay more attention to, and remember positive events that occur throughout their day.

Module #8: Building a Bridge to Your Goals (2-3 sessions)

This module has the following goals: 1) help the person 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 their goal and make modifications if necessary; and 3) help the person decide whether they will continue regular IRT sessions and if so, which individualized modules they would find helpful.

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

Module #9: 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 person deal with negative feelings; and 2) help the person 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 indicates that the person’s concerns have a realistic basis.

In this module, the clinician provides information about different areas of emotional distress and specific approaches to targeting and decreasing emotional distress, called cognitive restructuring. The person 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). Individuals 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 individuals 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 person is then taught the "5 Steps of Cognitive Restructuring (CR)," which is a step-by-step approach to dealing with and resolving negative feelings. 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 person is given opportunities to practice the 5 Steps of CR in session and at home. Individuals 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 person 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 other traumatic experiences in their life (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 #10: Coping with Symptoms (2-4 sessions for each symptom selected)

This module has the following goals, to: 1) assist individuals in identifying symptoms that interfere with activities or their enjoyment of life; 2) help the person identify the symptoms that interfere the most, and select relevant handouts to address these symptoms; 3) assist the person in selecting coping strategies that they are most interested in learning; 4) teach coping strategies in sessions, using modeling and role playing whenever possible; and 5) assist individuals 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 individuals who experience distressing symptoms that interfere with activities, goals, or enjoyment, or for individuals 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. Individuals are encouraged to learn to use at least two coping strategies for each of their targeted symptoms.

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

In the Education about Psychosis module, individuals will learn basic information about substance use and the negative effects it has for people with psychosis. The Substance Use module is recommended for individuals who need more help in examining their substance use and more support in making decisions about whether they want to quit or cut down and in learning some strategies for doing so. This module does not require that the person be motivated to become sober—only that they are willing to talk about substance use and to explore its effects. The module is recommended for individuals 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 individuals with a first episode of psychosis are vulnerable to developing a substance use disorder, the module is recommended for individuals who use substances regularly but have not yet developed a clear substance abuse problem. The goals of this module are to: 1) enhance motivation to reduce or stop using substances; 2) teach skills for managing urges to use substances, coping with symptoms that precipitate substance use, and dealing with social situations involving substances; and 3) develop a personal prevention plan for those individuals who want to cut down or stop using substances.

In this module, clinicians provide an open and accepting atmosphere for individuals to discuss substance use and whether or not the person is comfortable sharing that information with their family. Individuals learn skills to overcome the common reasons that people use substances and can practice these skills using behavioral experiments. Individuals are taught strategies to increase social support, deal with negative feelings, cope with cravings, and deal with boredom. Lastly, as mentioned above, for individuals who are interested in cutting down or stopping substance use, the clinician helps the person develop a plan to stay on track with cutting down or stopping substance use.

Module #12: 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 individuals 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 person 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 person decide which sub-modules they would like to work on and in what order. Individuals 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 individuals 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, individuals 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 individuals get familiar with the skills, and helping individuals understand the relevance in their life and feel more comfortable using the skills.

Module #13: Developing Resiliency--Individualized Sessions (2-10 sessions)

This module helps individuals learn additional skills to build resiliency with the following goals: 1) learn strategies to build positive emotions and facilitate resiliency; and 2) help the person build resiliency through the skills of gratitude, 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 individuals “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 each person. In the Developing Resiliency standard module, clinicians should discuss with the person their preference for resiliency exercises available in the individualized Developing Resiliency module. When individuals 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 person chooses to complete the “Substance Use” module, they would be encouraged to do a resiliency exercise of their choice at the beginning of that module. If the person chooses not to complete any of the individualized modules, they have 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 in more detail later in this manual, each module includes a set of “topics”, which are summarized in handouts and reviewed/discussed with the person 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, as well as checklists for the person to complete, worksheets 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 person’s style and circumstances. For example, you can take turns reading a handout aloud with the person, or you can summarize sections for the person in the session and have them review the written handout at home as needed. 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 the actual handouts in every session, although with most individuals they are useful. Some individuals with very poor reading skills may find the handouts daunting, and clinicians can teach the information in a conversational style, using the handout as a guide for themselves.

The clinical guidelines provide instructions and tips on how to teach the individual the information and skills in a given module. For example, the Education about Psychosis module covers six different topics: 1) What is psychosis? 2) Basic Facts about Alcohol and Drugs 3) Substance Use and Psychosis 4) Medications for Psychosis; 5) Coping with Stress; and 6) Strategies to Build Resilience. The clinical guidelines begin with a listing of the general goals for this module, followed by a listing of the six topic areas. 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 person’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 with the individual, 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 an individual to take approximately 4-6 months to complete the standard IRT sessions and 6-12 months to complete all IRT sessions, depending on the frequency of

sessions and the learning pace of the person. Each IRT session should be approximately 45-60 minutes (depending on individual's functioning, motivation, etc.), with sessions preferably conducted weekly or once every 2 weeks. However, if scheduling less frequent sessions is critical to keeping the person engaged in IRT, you are encouraged to accommodate to the person's preferences.

Depending on individual need, goals, and motivation, one or more of the individualized IRT modules may be taught, which differ in length. People 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 people, 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 person, 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 person 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, people 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 person's substance use, their 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 person 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 people 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 person and the NAVIGATE treatment team is deciding when to end treatment. Of course, if people 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 people 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 individual 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. For example, if a person is unwilling to come to the agency, they may be willing to have you come to their home. Or if the person's symptoms interfere with them going out of the home (e.g., paranoia) but they may be comfortable with sessions in the home. In cases where symptoms are interfering with ability to leave the home, the IRT home visits would likely center on learning coping strategies for those symptoms so they are interfering less with the person's activities and functioning.

As an IRT clinician, you will need to liaise with other important individuals in the person's life, including members of the NAVIGATE treatment team and family members and other "indigenous supporters" (with the person'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 person 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 person's life and have positive lasting impacts.

Session Organization

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

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

As noted in the first step of the session structure, you should briefly check in regarding any significant problem areas for the person, 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 individual 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 person's concerns and to their goals. Generally, the first agenda items are reviewing the past session and completion of the home practice assignment, as this helps the person 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 individual 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 person may bring in.* However, for people who regularly present with a "crisis of the week," it is important that you demonstrate understanding of the person'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?
Individual: 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…
Individual: (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 individual should collaboratively determine an appropriate home practice assignment, and should also try to identify ways that the person's indigenous supporter(s) may assist with the assignment over the coming week. The session should end with you checking in with the person to get their perspective on how the session went. Also, we strongly recommend asking people, particularly those with attention problems, to share what they got out of the session.

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 helps the person generalize skills from the session to their social environment. For example, a person who has difficulty initiating conversations may work with the clinician in-session on developing appropriate social skills. Home practice then allows the person to practice starting conversations in situations that they encounter 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 completion of assignments had a moderate impact on treatment outcome. In other words, people who completed home practice were more likely to improve following treatment than people who did not complete home practice.

Suggested home practice assignments are provided in most handouts. For example, in the Developing a Wellness Plan module, the person is asked to consider practicing one strategy to help them cope with the early warning signs of a relapse. Other home practice assignments might involve completing a checklist 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 person sees a benefit for doing the home practice. People are more motivated to complete home practice assignments that have clear relevance to their lives and current situations (e.g., a person with a goal of getting a job develops a home assignment to practice a coping strategy dealing with low stamina and energy that they can use while working).

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

- Person did not understand the assignment
- Person lost the assignment
- Person was not comfortable with practicing their new skills outside the session
- Person 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 person forgot to do the assignment
- The person did not see how the assignment could be helpful in their situation or attainment of goals

If poor follow-though on home assignments is a persistent problem, you need to explore this with the person. If the person has trouble coming up with potential reasons that following through on homework is a problem, develop a hypothesis of why the person does not complete home practice assignments, and then problem solve with the person 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 individual upon completing the assignments. The most effective praise is specific, genuine, and not patronizing. Positive feedback makes the person feel good for completing the home practice, but can also encourage them and build motivation to use the skill outside of the session. For people 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 person's natural supports, such as family members, in helping the person 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, as was noted earlier in this introduction, its content frequently overlaps with the content of IRT. It is also important to coordinate with IRT because it is recommended that Module 1 (Orientation), Module 3 (Education about Psychosis) and Module 5 (Developing a Wellness Plan) of IRT be done in joint sessions with individuals 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 individuals. 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 the individual, for a variety of reasons such as the following: no relatives are available, relatives are available but the person does not give permission for their involvement, relatives are available but cannot attend sessions, the person is unwilling or unable to attend joint sessions. In such situations, the IRT clinician will provide Module 1, 3 and Module 5 to the person in IRT sessions. Also, the person may benefit from reviewing and processing the information independently in IRT sessions after attending joint sessions. Finally, in some instances, the person may miss some FEP sessions, and the IRT clinician can help them to catch up.

Case Management

Many NAVIGATE teams include a case manager. However, if teams do not include a separate person to do case management, other team members, including IRT clinicians, may be providing case management in addition to their intervention. If you are doing IRT and case management with individuals, you may find it challenging to fit both activities into your sessions. This issue can be addressed in a few ways: 1) Dividing the session into IRT and case management components. This can occur when a person brings in a crisis, such as being in danger of losing their 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. If you use this strategy, it is recommended to do the IRT topic in the first part of the session and case management in the second part. 2) Integrating IRT into case management. In essence, situations that arise during case management can be used as a "natural laboratory" to reinforce and practice skills learned during IRT. 3) Scheduling separate IRT sessions and case management sessions as needed. For individuals who have case management needs that are a priority or have several case management needs that need to be addressed.

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 person are potentially in a position to help that person manage their 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. These natural supports are often called "indigenous supporters" because they are people in the person's natural environment, such as their home, community, work place or school who can help the person pursue their goals. Because of their contact with individuals 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 person that would otherwise not have been tapped (e.g., a job lead).

While individuals 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 (Gingerich & Mueser, 2010) and Integrated Treatment for Dual Disorders (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
- Teacher or school counselor
- Leader or member of their religious group

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

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

- Review handouts and other material from IRT with the person
- Assist the person with home practice assignments
- Help the person practice a new skill learned in IRT or reinforce one that the person uses spontaneously
- Help the person with practical assistance, such as transportation or locating resources
- Take an active role in helping the person achieve goals
- Take an active role in the person's plan for staying well
- 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 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 individuals as being “high risk” and to regularly monitor their risk for suicide. 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
- Depression and/or hopelessness
- Substance abuse
- 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)

We recommend the Columbia Suicide Severity Rating Scale to assess for suicide risk. There are different versions of the scale for younger adolescents for parents or family members to use that you can find on the following website: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

Here is an example of the screener questions that can be asked at the beginning of an IRT session:

Columbia Suicide Severity Rating Scale
Since Last Contact – Self-Report

	Since Last Contact	
Please answer questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts of killing yourself?		
If YES, answer all questions 3, 4, 5, and 6. **If NO, skip directly to question 6.**		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself? (As opposed to you have the thoughts, but you definitely would not act on them?)		
5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you intend to carry out your plan?		
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *(For example: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)*		

Scoring:
Severity of Ideation Subscale - consists of 5 questions that reflect five types of ideation of increasing severity:

- A positive answer to Question 4 or 5 indicating presence of ideation with at least some intent to die in the past one month indicates a severe risk and clear need for further evaluation and clinical management (e.g., triggers immediate referral to mental health services and patient safety precautions).

4 – Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (e.g., I would hang myself [method] and I can't guarantee that I won't do it [intent]).

5 – Active Suicidal Ideation with Specific Plan and Intent (e.g., tomorrow at 1:00pm when I know no one will be home [plan], I am going to [intent] take a handful of Tylenol that I have in my medicine cabinet).

Suicidal Behavior Subscale - includes questions about 4 suicidal behaviors and non-suicidal self-injurious behavior.

- Presence of ANY suicidal behavior (suicide attempt, interrupted attempt, aborted attempt and preparatory behavior) in the past 3 months indicates a severe risk and clear need for further evaluation and clinical management (e.g., triggers immediate referral to mental health services and patient safety precautions)

***Note:** *Endorsement of other questions on the scale could also indicate a need for further evaluation or clinical management depending on population or context, however a positive answer to Question 4 or 5 in the past month or any behavior in the past 3 months indicate the most severely emergent clinical situation.*

You should be mindful of the above risk factors, and identify individuals 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 person 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 individuals express active suicidal ideation, hospitalization may be required. If individuals 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 individuals must be communicated immediately to the rest of the NAVIGATE team**. If a person is actively suicidal and other healthcare providers are unavailable, you should contact their local emergency department and ask for the psychiatrist or crisis worker on call. You should document in the person's chart: all risk assessment and safety plans, all supervision and consultative contacts, all contacts with outside providers, current disposition of person, and any other action taken on behalf of the individual.

After attending to the steps described above, you should try to engage individuals who experience suicidal ideation in Module 9 (Dealing with Negative Feelings), Module 10 (Coping with Symptoms), or both. Module 9 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 10 is aimed at teaching a range of coping strategies for dealing with 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 person's suicidal thinking can be targeted for teaching coping strategies.

Although Modules 9 and 10 are Individualized IRT modules, and not Standard modules, they can be taught at any point that suicidal thinking is recognized. Suicidal thinking is 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 9 or 10 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 9 or 10 (e.g., 15 or 20 minutes). Second, you can temporarily suspend work on the Standard modules in order to focus exclusively on Module 9 or 10 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 individuals. One fundamental way is to assure that individuals are continually engaged with treatment services. Other specific strategies include: boosting self-esteem, fostering hope, and training individuals 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:

Ventriglio, A., Gentile, A., Bonfitto, I., Stella, E., Mari, M., Steardo, L., & Bellomo, A. (2016). Suicide in the early stage of schizophrenia. Frontiers in psychiatry, 7, 116. https://www.frontiersin.org/articles/10.3389/fpsyt.2016.00116

- Columbia Suicide Severity website with training, scales, and resources: http://cssrs.columbia.edu
- 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 individuals, 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 person where they are at (e.g. weekly; biweekly; monthly). We feel that it is paramount to continually engage and re-engage individuals in treatment (while they are in need of services), which ultimately should facilitate recovery and reduce the likelihood of relapse.

At times, the person's needs may necessitate providing IRT modules out of order, as described above for individuals experiencing significant suicidal ideation. For another example, if a person experiences distressing symptoms such as hallucinations or delusions, it is most helpful to shift as soon as possible to Module 9 (Dealing with Negative Feelings) to learn cognitive restructuring or to Module 10 (Coping with Symptoms) to learn behavioral coping strategies for specific symptoms. As another example, if a person experiences problems with weight gain, they could be guided to Module 4 (Healthy Lifestyles), which provides strategies for nutrition and exercise. After a few sessions learning some of the strategies in Module 4, the IRT clinician could shift back to the other IRT modules, but check in for a few minutes every session with the person on progress and troubleshoot any difficulties they are experiencing in the area of weight.

Flexibility in the delivery of IRT increases its effectiveness and is helpful in reducing the likelihood of individuals dropping out of treatment. As different agencies might have different protocols for dealing with dropouts (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 individuals 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 individuals 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 individuals
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. Status of IRT individual cases includes how many NAVIGATE individuals is the IRT clinician currently seeing in sessions. As part of the check-in, the IRT supervisor generally asks a series of seven questions to update on the individual's progress in IRT, identify problems early, and track the implementation of IRT. The check-in questions include:

1. What module is the individual working on?
2. What is the person's wellness goal(s)?

3. What steps have been taken towards achieving the recovery goal(s)?
4. What is the person'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, Case Management, Supported Employment and Education, Peer Support, and Medication Management)?

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(s) that the clinicians will be doing with the individual(s)
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

In the first option, 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 person's recovery goal.

A second option involves problem-solving a challenge that was identified during the check-in. All of the clinicians in the supervision session 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. Define the problem or challenge (everyone participates)
2. Elicit possible strategies/solutions from all clinicians (everyone participates)
3. Evaluate strategies/solutions, identifying pro's and con's of each solution (everyone participates)
4. Choose the best strategy/solution (or combination) to try (done by clinician whose case this is)
5. Make a specific plan to try out the strategy or solution (done by clinician whose case this is)
6. Plan to follow up how the strategy/solution worked in supervision in the next week or two (done by clinician whose case this is)

As a third option, the IRT supervisor can ask a clinician to do a case presentation, usually focused on a person 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 person, including the person's wellness 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 such as eliciting the narrative in the Processing the Episode module or teaching the 5 steps of cognitive restructuring. The IRT supervisor begins by reviewing how and when to use a skill or strategy, models how to use it, asks the clinicians to practice using it in a role-play, 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 individuals to come up with home assignments and then models in a role-play how they 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 in role plays and make a plan to try the strategy that they practiced with an individual 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 person's wellness 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 individuals. It is also extremely helpful for supervisors to listen to IRT 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 person's progress in treatment and the kinds of interventions that are provided (motivational, educational, or cognitive-behavioral), and whether or not the person 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 home assignments,

using 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. 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 outcomes.

6. Clinician Resources

Additional resources for clinicians can be found in Appendix 3. These include more detailed resources related to first episode psychosis and the therapeutic techniques comprising IRT (e.g. cognitive behavioral therapy).