



My health. My choices. My future.

# Recovery Coach Manual



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## I. Introduction

### A. The Recovery Coach (RC) within the OnTrackNY Program Model

The goal of OnTrackNY is to get consumers linked with the team as a means to receive intensive treatment that supports consumers' own goals for recovery. The clinical concepts underlying the program include a recovery orientation, the use of shared decision making, an active/focused stance throughout treatment, providers who are flexible and consistent, and a process that fosters autonomy yet allows clients to remain connected with a team. The phases of the program include engagement/initial assessment, ongoing intervention/monitoring/reassessment of need, and transfer of care/planning for future needs/services.

There are several focal areas: medication adherence, medical care, supported education/employment, family support, behavioral interventions (including social and coping skills training and substance abuse treatment), housing/income, trauma-informed care, and safety planning/suicide prevention.

**As a member of the treatment team, the RC will be involved to varying degrees in all of these domains, but is the leader of the team in the domain of behavioral interventions and takes an especially active role in the family support domain.** It is important to note that, depending on the OnTrackNY team's staffing configuration, the individual that serves as the Recovery Coach may be a full time or half time member of the OnTrackNY team. Also, this individual may serve in other role(s) such as Primary Clinician and Outreach and Recruitment Coordinator. The Team Leader insures that the individual who serves as Recovery Coach is fully involved and integrated into all team functions. This allows for thoughtful referrals and timely updates about the RC's work with clients.

OnTrackNY clients work with their Primary Clinicians to establish personally meaningful recovery goals, through the treatment planning process and participation in core sessions with the Primary Clinician. The services provided by the Recovery Coach will help many clients to accomplish these goals. The services provided by the Recovery Coach are:

- Social skills training
- Substance abuse treatment
- Coping skills training
- Behavioral activation
- Family psychoeducational groups
- Family consultation

Once goals are set through the treatment planning process, a referral to the Recovery Coach will occur as appropriate. If helpful, the OnTrackNY client's first meeting (or set of meetings) with the RC can be held jointly with the PC, to insure clear communication and maximize the client's comfort.

This manual will explain the different RC activities in detail and provide outlines for specific intervention sessions.

## B. Clinical Foundations of the Recovery Coach Role

The role of the RC is to help clients overcome barriers to their recovery. This is done through the use of structured behavioral interventions aimed at learning new skills and supporting behavior change.

Work with the RC is flexible. The RC receives client referrals from the Primary Clinician. At first, the RC will get to know the client and utilize clinical assessment to determine their level of social functioning and substance use via a shared decision making (SDM) framework. As the overall orientation of the OnTrackNY Team is SDM, the RC will work collaboratively with the Primary Clinician and clients to determine when these interventions are needed and can be most helpful. Participants who decide, in connection with their Primary Clinician, that any of these domains requires additional attention, will meet regularly with the RC to address goals in these areas. Others may opt not to work with the RC initially, but may request this at a later date as goals change and new challenges are faced. Still others will prefer not to work with the RC at all, as their goals focus specifically on medication or work issues. The decision to work with the RC or not is likely to change over the two years of contact, and some individuals will move in and out of this work periodically. Thus the RC is available to accept referrals over time as problems manifest themselves.

### 1. Strengths-Based Care

**Strengths Based Case Management** was developed by Charles Rapp of the University of Kansas (Sullivan & Rapp, 1994; Weick, Rapp, Sullivan & Kisthardt, 1989). The philosophy of this model – that individuals with mental health disorders have “meaningful and important life goals and draw upon both personal and environmental strengths to achieve them” – is a critical foundation for the work of the RC. Strengths-based care includes several core principles, chief among them that the care provider and the client utilize and support an individual’s strengths as they work towards identifying and achieving personal recovery goals. There have been nine published studies on Strengths Based Case Management in mental health, and all have demonstrated positive outcomes such as decreased rates of hospitalization and improved employment outcomes, as well as in improved quality of life for people with psychiatric disabilities. While many of the activities of the RC involve skills training, the underlying focus is on how an individual can use his/her strengths and learn skills for augmenting these strengths to create a meaningful recovery. For more information on Strengths Based Case Management, the RC can consult the following websites:

<http://www.socwel.ku.edu/mentalhealth/projects/Emerging/cm.shtml>

[http://www.maaclink.org/index.php?option=com\\_content&view=article&id=17&Itemid=18](http://www.maaclink.org/index.php?option=com_content&view=article&id=17&Itemid=18)

### 2. Motivational Enhancement

The primary therapeutic strategy for RCs is motivational enhancement. It is critical that the RC convey empathy, hope and optimism, provide treatment choices for clients, meet clients where they are, and support clients’ own strengths and hopes for change. The overall tone provided by the RC

and the clinical skills that are used to engage clients and work with them towards their goals are based on motivational interviewing (Miller & Rollnick, 1991, 2002). Overall, MI includes a set of strategies that help clients identify and move towards their goals. It is collaborative – the clinician and the client work together to identify reasons for change and changes that are needed. MI recognizes that the client has autonomy and so must decide what actions are best for him/her. Importantly, MI involves an active clinician helping to steer discussion and highlight the client’s language that is in support of change. While these ideas are described in later sections of the manual that address substance abuse treatment, it is important to highlight motivational enhancement strategies that are relevant to all of the RC’s work.

First, it is critical to understand the stages of change and Prochaska and DiClementi’s Transtheoretical Model (TTM) to conceptualize motivation throughout the RC’s work. The RC will work with clients to make changes, try new things, and learn new skills – all require motivation to learn and implement. Not all clients will want to change or try new things right away. RCs need to assess stage of change when working with clients (pre- contemplation, contemplation, preparation, action, or maintenance) and tailor their work and approach accordingly. From this perspective, empathy is critical – the RC must try to understand the client’s feelings and perspectives without judging, criticizing, or blaming. A good strategy is to listen and reflect. Do not try to solve the problem. Try to understand the client’s experience. In addition, RCs must always remember that ambivalence is a normal part of the change process. Reluctance or unwillingness to change, especially at the start of treatment, is to be expected. Clients may take a long time to commit to the idea of change, and even when they have expressed some commitment, this may wax and wane over time and may be more related to the threat of punishment than to their actual treatment goals or future plans. Gains will be made and lost. It is important to measure success in small units and to support success, however small it may be. Often at the start of treatment, clinicians are ready to help someone change (from a stage of change viewpoint, clinicians are in the action stage) and clients are not thinking about or are ambivalent about change (in precontemplation or contemplation stages of change) and are not ready to act. This disconnect is often a central reason why clinicians and clients don’t make progress in terms of discussing and understanding substance use, its consequences, and the client’s goals. Make sure to discuss ambivalence and start where the client is, rather than jump into action. Discussing ambivalence as part of a shared decision making process around substance use goals is an ideal way to both educate a client and for a clinician to learn about why that client is ambivalent about change. Finally, self-efficacy is critically important. Many people fail to attempt change because they do not believe they can succeed. Helping a client develop self-efficacy is key to that client being able to try something new or make a change.

### 3. Shared Decision Making (SDM)

Details on the background and implementation of SDM are provided in the Team Manual. While the details are not repeated here, it is important to highlight the importance of using SDM to the work of the RCs. In brief, SDM is a collaborative process in which the client and the team member share knowledge and information and actively participate in treatment decisions, resulting in an agreement on a preferred treatment approach. The role of the RC in this process is to educate the client concerning available, evidence-based treatments, acknowledge and help clarify client preferences



and values which may impact treatment decisions, and empower clients to take an active role in the decision-making process. This framework is especially important to the work of the RC, who will often help clients learn new skills, change behaviors, or try new activities. In all of these cases, the client must work with the RC to discuss options and decide how to proceed.

## II. Recovery Coach Sessions

### A. Content of Sessions

The RC will provide the following structured interventions: Social Skills Training, Substance Abuse treatment, Behavioral Activation, and Coping Skills Training. Social Skills Training involves helping clients learn to talk and interact with others more comfortably and effectively. Coping Skills Training involves teaching clients strategies for coping with difficult feelings or situations in order to decrease stress in their lives, such as coping with anxiety or depression. Behavioral Activation focuses on helping clients identify pleasant activities in the community and do these activities as a way to decrease isolation and depression. Substance abuse treatment is indicated for clients with problem use of or dependence on alcohol or other drugs. In the sections that follow there are detailed instructions for how to administer these interventions within the OnTrackNY Program.

### B. Location of Sessions

The RC can work individually with clients in the office, at their homes, or in the community. Some clients will have a preferred location, while others will benefit from a combination of locations. In addition, the location of the work may change over time. For example, a client who is working with the RC on behavioral activation aimed at trying new activities in the community might meet with the RC at the clinic office to identify preferred pleasurable activities and gather information about them, and eventually be accompanied by the RC to try one of these activities in the community. A client who does not prefer to engage with the RC in the office might choose that the RC visit him/her at home in order to begin the process of building rapport. Over time, as rapport is established and priority goals selected, the meetings may change to take place at the office. The key here is flexibility and allowing the RC to have options in working with clients.

Groups and family education meetings would most likely take place at the office. However, there would be a role for holding some group or family education sessions in the community. For example, clients attending a social skills group may benefit from a meeting with the RC at a coffee shop to practice skills they are learning in the group. Or a family education group may decide to go together to attend a community event highlighting a topic or individual of interest and relevance to FEP.

### C. Types of Session

The RC can work with clients in individual sessions, groups, or family education meetings. We anticipate that most work with the RC will be done in individual sessions that focus on learning new skills that may help a person reach his/her goals. However, groups and family education meetings can supplement individual sessions. For example, a client who is working with the RC on social skills training will often benefit from attending a social skills training group in which several clients come

together to learn and practice skills. This work could also be the topic of a family education meeting in order to educate family members about the work that clients do with the RC and alert them to the new skills clients are learning and starting to use in their lives. The similar intersect of individual and group sessions may be useful for clients pursuing substance abuse treatment with the RC – individual sessions complemented by substance abuse treatment groups may allow a client the benefits of focused work and peer support that can be helpful as one works to build a drug-free social support network.

#### D. Use of Recovery Videos

An important resource for RCs to make use of is the OnTrackNY Program Recovery Videos (see OnTrackNY Program Recovery Videos Instruction Manual for Clinical Staff in CPI Learning Management System (LMS) for details). These 24 brief video clips feature individuals telling their stories about who they are and what has been helpful in managing their psychotic disorder. These are real people telling their real stories. Four of the clips are by parents, describing how they have helped their child and how they have helped themselves be able to help their child. Each clip lasts about three minutes. You'll meet people who are single, married, in school, working, hanging out with old and new friends, and living healthy lives. The manual contains descriptions of each video clip as well as questions for discussion.

There are many possible ways to incorporate these videos into RC work with clients. Some are listed here:

1. Use videos of family members at the start of the discussion/support section of the Monthly Family Groups. Select a video that corresponds to the topic of the group for that meeting. Show the video as a lead-in to the discussion/support section of the group as a way to get participants thinking and generate discussion.
2. Use videos to bring up a topic that the client may not want to talk about. For example, many clients do not want to talk about their substance use. Selecting a video clip that addresses substance use and its impact on someone with psychosis can be a useful way to approach a difficult topic.
3. Use videos to illustrate the stages of change. Select a video clip in which the individual describes past feelings of not wanting to change or not seeing that a change was needed and how this changed for the individual into considering a change and then making a change.
4. For someone who is depressed, anxious, or hopeless, the videos can illustrate the possibility of recovery. For someone who is having trouble being motivated or engaging in community activities, the videos can illustrate the benefits of trying some activities or pursuing some connection with the community.
5. Young clients are often used to watching content and learning things on-line. This may be a comfortable way for some clients to learn about something - they may enjoy watching a video with the RC as a way to spend time gathering information or learning about something (rather than always talking together).

### III. RC Assessment Activities

Clients begin their work with the RC after having established personally meaningful goals with the Primary Clinician through the treatment planning process. The RC will be thoroughly knowledgeable



about the assessments completed and the treatment planning that has occurred. In order to help focus her/his work with the client, the RC may collect additional assessment information that builds upon the information already known. This is similar to the IPS specialist’s use of the Career Profile assessment early in working with referred clients.

Following the initial few sessions, the Recovery Coach should have gathered sufficient information to be able to talk with the client about their work together and begin intervention in one of the Recovery Coach domains.

It is important to remember that client readiness to change is critical in identifying treatment goals. Clients come to treatment with a range of concerns, some of which are more important to them than others. There are several key principles of motivational enhancement that are critical when determining where to start work with the Recovery Coach.

1. Meet the client where he/she is “at.”
2. The client must voice reasons for change.
3. The responsibility for change resides with the client.
4. Empathy is key to work on change.
5. The Recovery Coach can provide clear advice on how to change.
6. Provide a menu of treatment strategies and options.
7. Convey that change is possible.

The table below shows ways that client stage of change influence the choice of treatment strategy

### Matching Stages of Change with Intervention Strategies

Stage of change	Treatment goals	Strategies
“I don’t see a need to change.”	<p>Establish working alliance.</p> <p>Discuss impact of the behavior on the client’s life now and in the future.</p> <p>Create doubt that behavior is “harmless”.</p>	<ol style="list-style-type: none"> <li>1. Outreach/relationship building.               <ul style="list-style-type: none"> <li>• Discuss client’s own strengths and goals. What is client interested and willing to work on?</li> </ul> </li> <li>2. Motivational Enhancement Strategies (* = especially important)               <ul style="list-style-type: none"> <li>• Express Empathy *</li> <li>• Develop Discrepancy</li> <li>• Roll with Resistance (avoid arguing) *</li> <li>• Support Self-Efficacy (client is responsible for change)</li> </ul> </li> </ol> <p>Expressing empathy and rolling with resistance are especially important. Precontemplators have been told that what they are doing is wrong and they are bad or weak because they haven’t changed or have had difficulty in making change last. They may feel anger or shame. They may have been through previous treatment and felt it wasn’t helpful. Empathy is critical to reducing anger and feeling understood</p>

Stage of change	Treatment goals	Strategies
		<p>and in conveying that the Recovery Coach is a person who wants to help the client achieve his/her own goals. Rolling with resistance is key – contemplators have been told repeatedly that they need to change and they generally don't want to hear another person explain the ways in which they are bad or wrong or weak. They may be angry at having to talk about their behavior to yet another person.</p> <p>3. Educate significant others to enhance their skills in supporting client commitment to change.</p> <ul style="list-style-type: none"> <li>• Meet interested family members. Find out their thoughts and goals about behavior and change.</li> <li>• Introduce Recovery Coach role on team.</li> </ul>
<p><b>Contemplation</b></p> <p>"I know I should change but there are things about the behavior I like."</p>	<p>Explain ambivalence.</p> <p>Help clients recognize and weigh the negative aspects of behavior so scale tips toward change.</p> <p>Highlight extrinsic motivators for change.</p> <p>Help client discover intrinsic motivators for change.</p>	<p>1. Continued outreach/relationship building. 2. Motivational Enhancement Strategies (* = especially important)</p> <ul style="list-style-type: none"> <li>• Express Empathy</li> <li>• Develop Discrepancy *</li> <li>• Roll with Resistance (avoid arguing)</li> <li>• Support Self-Efficacy (client is responsible for change)</li> </ul> <p>Developing discrepancy is especially important. Contemplators are ambivalent and feel two ways about their behavior. Discrepancy is the vehicle by which the client will recognize the need to change. The Recovery Coach should not make the argument for change. This must come from the client. Use tools such as pros/cons list, decisional balance, readiness scales, and functional analysis to identify reasons for change and ways to accomplish goals without problem behavior.</p> <p>3. Continued discussion with significant others to enhance their skills in supporting client commitment to change.</p> <ul style="list-style-type: none"> <li>• Keep in touch with family members. Get their points of view on client's behavior and thoughts on change. Teach family members ways to support client's ideas about change.</li> </ul>
<p><b>Preparation</b></p> <p>"I'm ready to try to change but I don't know how."</p>	<p>Strengthen commitment to change.</p> <p>Help client develop self-efficacy.</p> <p>Identify potential</p>	<p>1. Continued outreach/relationship building. 2. Motivational Enhancement Strategies</p> <ul style="list-style-type: none"> <li>• Express Empathy</li> <li>• Develop Discrepancy</li> <li>• Roll with Resistance (avoid arguing)</li> <li>• Support Self-Efficacy (client is responsible for change) *</li> </ul>

Stage of change	Treatment goals	Strategies
	change strategies; learn and practice strategies that client believes he/she can implement.	<p>Supporting self-efficacy is especially important because in order to make a change, the client must believe that he/she can actually change.</p> <ol style="list-style-type: none"> <li>3. Goal-setting - The process of talking about &amp; setting goals strengthens commitment to change.</li> <li>4. Practical skills training related to goals. <ul style="list-style-type: none"> <li>• What does client need to learn?</li> <li>• Identify which parts of the Recovery Coach manual fit with the skills they client needs to learn.</li> </ul> </li> <li>5. Link with community resources and identify social support. <ul style="list-style-type: none"> <li>• Client is not on his/her own.</li> <li>• Who can they access for what types of support?</li> <li>• Identify community resources that can help.</li> </ul> </li> </ol>
<p><b>Action</b></p> <p>“I’m ready to try to change. I am worried change will be difficult.”</p>	<p>Carry out change strategies.</p> <p>Provide support and encouragement to maintain gains achieved.</p> <p>Reduce ambivalence in transitions from thought to action.</p>	<ol style="list-style-type: none"> <li>1. Continued outreach/relationship building.</li> <li>2. Motivational Enhancement Strategies (* = especially important) <ul style="list-style-type: none"> <li>• Express Empathy *</li> <li>• Develop Discrepancy</li> <li>• Roll with Resistance (avoid arguing)</li> <li>• Support Self-Efficacy (client is responsible for change) *</li> </ul> <p>Expressing empathy and supporting self-efficacy are especially important because making changes is very difficult (and many in the client’s life won’t realize this) and over time self-efficacy and motivation to change can wane.</p> </li> <li>3. Continued discussion with significant others to enhance their skills in supporting client commitment to change. <ul style="list-style-type: none"> <li>• How is change going according to family members?</li> <li>• What can family members do to support change?</li> </ul> </li> <li>4. Practical skills training related to goals: coping skills, general problem solving, relapse prevention. Highlight that relapse to previous behavior is possible and happens to anyone trying to make a change.</li> <li>5. Continue to link with community resources and identify social support.</li> <li>6. Identify ways to reinforce change <ul style="list-style-type: none"> <li>• Track positive changes, generate ideas for self- rewards, support a realistic view of</li> </ul> </li> </ol>

Stage of change	Treatment goals	Strategies
<p><b>Maintenance</b></p> <p>“I’m keeping up with my behavior change. It’s still not easy.”</p>	<p>Continue to practice skills and apply them to new situations.</p> <p>Plan for coping with high risk situations.</p> <p>Discuss having time for fun in life.</p>	<p>change through small steps, assist the client in finding new reinforcers.</p> <ol style="list-style-type: none"> <li>1. Continued outreach/relationship building</li> <li>2. Motivational Enhancement Strategies (* = especially important) <ul style="list-style-type: none"> <li>• Express Empathy *</li> <li>• Develop Discrepancy</li> <li>• Roll with Resistance (avoid arguing)</li> <li>• Support Self-Efficacy (client is responsible for change) *</li> </ul> </li> </ol> <p>Expressing empathy and supporting self-efficacy are especially important because making changes is very difficult (and many in the client’s life won’t realize this) and over time self-efficacy and motivation to change can wane.</p> <ol style="list-style-type: none"> <li>3. Continued discussion with significant others to enhance their skills in supporting client commitment to change.</li> <li>4. Continued use of skills training related to goals: coping skills, general problem solving, relapse prevention.</li> <li>5. Link with community resources, identify social support.</li> <li>6. Identify and try new activities and sources of pleasure. Discuss lifestyle changes that will support maintenance of behavior change.</li> </ol>
<p><b>Relapse</b></p>	<p>Help client re-enter the change process.</p>	<ol style="list-style-type: none"> <li>1. Continued outreach/relationship building. Highlight that relapse to previous behavior is possible and happens to anyone trying to make a change.</li> <li>2. Motivational Enhancement Strategies (* = especially important) <ul style="list-style-type: none"> <li>• Express empathy *</li> <li>• Develop Discrepancy</li> <li>• Roll with Resistance (avoid arguing) *</li> <li>• Support Self-Efficacy (client is responsible for change) *</li> </ul> </li> </ol> <p>Expressing empathy and supporting self-efficacy are especially important because making changes is very difficult (and many in the client’s life won’t realize this). Self-efficacy can drop dramatically during relapse. Client may return to feelings of anger and shame, so rolling with resistance is also important here.</p> <ol style="list-style-type: none"> <li>3. Continued discussion with significant others to</li> </ol>

Stage of change	Treatment goals	Strategies
		<p>enhance their skills in supporting client commitment to change.</p> <ul style="list-style-type: none"> <li>• Help family members understand that changes were positive and that relapse is common and a way to learn.</li> </ul> <p>4. Continued use of skills training related to goals: coping skills, general problem solving, relapse prevention.</p> <p>5. Continued link with community resources and identify social support.</p>

## IV. Social Skills Training

### A. Background

Social skills are interpersonal behaviors that are normative and/or socially sanctioned. They include such things as dress and behavior codes, rules about what to say and not to say, and stylistic guidelines about the expression of affect, social reinforcement, interpersonal distance, etc. Many individuals with psychotic disorders such as schizophrenia show marked deficits in social skills. Whether these deficits are due to individuals never having learned social skills or losing skills once learned due to illness onset and length of illness, these deficits make it difficult for many individuals with these disorders to establish and maintain social relationships, fulfill social roles (e.g., worker, spouse), or to have their needs met. There are different types of social skills deficits: (1) not knowing how to perform social skills appropriately (due to lack of learning as a child or lack of practice during critical developmental stages); (2) not using social skills that are in one's repertoire when they are called for (due to factors such as symptoms, negative affective states such as anxiety and stress, and neurocognitive deficits in memory and attention); and (3) when appropriate behavior is undermined by socially inappropriate behavior. As will be discussed further below, a major goal of both the social skills training and the substance abuse training provided by the OnTrackNY program is to enhance a sense of self-efficacy so clients will feel empowered to use their skills.

Social competence can be conceptualized in the context of the social skills model. In this model, "social skills" entail three component skills: (1) social perception, or receiving skills; (2) social cognition, or processing skills; and (3) behavioral response, or expressive skills. Social perception is the ability to accurately read or decode social inputs, including accurate detection of affect cues, such as facial expressions and nuances of voice, gesture, and body posture, as well as verbal content and contextual information. Social cognition (also referred to as social problem solving) involves effective analysis of the social stimulus, integration of current information with historical information, and planning of an effective response. Behavioral response or expressive skills include the ability to generate effective verbal content, to speak with appropriate paralinguistic characteristics, and to use suitable nonverbal behaviors such as facial expression, gestures, and posture. Effective social behavior requires the smooth integration of these three component processes so as to meet the demands of the specific social situation.

The term "skill" is used to emphasize that social competence is based on a set of learned abilities. Many elemental aspects of social skills, such as sharing and turn taking, are learned in childhood, while more complex aspects of social skills, such as dating and job interview skills, are generally acquired in adolescence and young adulthood. Some elements of social competence, such as the perception of facial expressions of affect, may be genetically hard-wired. Nevertheless, research suggests that virtually all social behaviors can be modified by experience or training. Effective social functioning is hypothesized to rely upon three circumstances: (1) individuals know how to perform appropriately; (2) they use skills in their repertoire when they are called for, and (3) they avoid socially inappropriate behaviors that undermine appropriate behavior.



Some research suggests that some people with schizophrenia have difficulty acquiring key social skills. Some children who later develop schizophrenia in adulthood have been found to have subtle attention deficits in childhood that may interfere with the development of social relationships and the acquisition of basic social skills. Second, schizophrenia often strikes first in late adolescence or young adulthood, a critical period for mastery of adult social roles and skills, such as dating and sexual behaviors, work related skills, and the ability to form and maintain adult relationships. Too often, individuals with schizophrenia gradually develop isolated lives, punctuated by periods in psychiatric hospitals or in community residences. Such events remove people from their “normal” peer group, provide few opportunities to engage in age appropriate social roles, and may limit primary social contacts to mental health staff. Under such circumstances people with schizophrenia do not have the opportunity to acquire and practice appropriate adult roles. Moreover, skills mastered earlier in life may be lost due to disuse or inappropriateness during periods of illness exacerbation. Successive failure experiences also reduce self-efficacy, making people less likely to use skills in their repertoire. Additionally, prolonged periods of institutionalization and the segregation of people with psychiatric disabilities from mainstream community life (through exclusion and stigma), can reinforce the role of being a “mental patient” and make it hard to access opportunities to learn age appropriate social skills.

Social skills training (SST) is one vehicle for improving social skills. SST is a structured behavioral intervention based on social learning principles. It emphasizes the role of behavioral rehearsal in skill development rather than relying on discussion. SST is a voluntary program that many adolescents and young adults choose to participate in. It should not be confused with the relatively unfocused social groups that linger on in day-treatment programs with captive audiences. Rather, successful SST is engaging and immediately useful to participants.

## B. Social Skills Training in First Episode Psychosis

Social skills deficits also impact individuals with FEP. Studies of individuals with FEP suggest difficulty in several domains of social functioning, including peer, family, and work/school relationships. Such findings illustrate the importance of social functioning and addressing deficits in this area in fully treating an individual with FEP. One of the major goals of the OnTrackNY program is to help clients maintain or re-establish normative social relationships and to prevent progressive social withdrawal and isolation. SST is the key intervention designed to achieve this goal, and hence should be made available to all participants.

SST is particularly well suited to work with individuals who have experienced a first episode. The structure of training is flexible and oriented to the stylistic preferences of adolescents and young adults. The training groups are active and engaging, and deal with teaching practical skills and solving contemporaneous problems in living, not abstract discussion or advice giving. They make extensive use of humor, mutual support, and encouragement. The content of training is tailored to the specific needs of this cohort, including dating, safe sex, developing and sustaining friendships, and social interactions at school and work. The emphasis is on current needs and goals of participants. Importantly, SST served as the basis of the OPUS treatment trial in Denmark, one of the largest and most effective first episode trials to date. As was the case in OPUS, SST as part of

OnTrackNY permits inclusion of an interrelated set of skills- based strategies (including substance abuse treatment) based on the needs and preferences of the particular group. This will also allow groups to accommodate to the diagnostically and developmentally heterogeneous population recruited for our program.

SST is supported by an extensive literature and is widely regarded as an evidence-based practice (e.g., it is included in the 2009 Schizophrenia Patient Outcomes Research Team (PORT) recommendations (Dixon et al., 2010). First, SST is not an intervention that reduces symptoms or prevents relapse. SST might affect these domains indirectly, by helping an individual acquire skills that help to reduce social problems that would otherwise cause sufficient stress to precipitate exacerbations of symptoms. Rather, SST is a targeted treatment that can help a person achieve important social outcomes when applied in conjunction with other critical interventions (e.g., pharmacotherapy, case management, substance abuse treatment, supported employment/supported education and environmental supports (e.g., housing). Second, SST is effective in increasing the use of specific social behaviors and improving functioning in the specific domains that are the primary focus of the treatment. SST techniques have become a standard component of many interventions that help people cope with difficult social situations (e.g., refusing street drugs, negotiating with a potential sexual partner to use condoms, employment). Third, SST appears to have a positive effect on satisfaction and self-efficacy. Individuals with social skills deficits feel more self-confident in social situations after participating in SST.

### C. Domains of SST

The underlying premise of SST is that improved social functioning can be achieved by teaching effective social skills, and the key to skills training is behavioral rehearsal. While SST may involve some discussion of social issues, sessions are primarily devoted to teaching and rehearsal, not discussion. The primary vehicle for behavioral rehearsal in SST is role play of simulated conversations. The trainer first describes how to perform the skill and then models the behavior. After identifying a relevant social situation in which the skill might be used, the participant engages in a role play with the trainer and other participants. The trainer provides feedback and positive reinforcement, followed by suggestions for how the response can be even better. SST can take place in small groups (6-8 participants) or one-on-one. In the case of group delivery, groups should not exceed 6-8 participants so that all participants have ample opportunity for behavioral rehearsal (i.e. role playing) in each session. When provided individually, the RC and the client will have plenty of time to devote to behavioral rehearsal of different situations. Behavioral rehearsal in SST has two functions. First, rehearsal is essential to develop adequate behavioral competence (skills). Second, successful rehearsal in the group helps develop confidence or self-efficacy, which is essential to enable the individual to try out new skills in the community.

SST is organized around content areas or curriculum units. When engaging the client the clinician develops collaborative goals re: social interactions, such as learning skills needed to develop dating relationships, to succeed on job interviews, or to negotiate issues with parents. SST is then focused on addressing these goals. Training is organized around curriculum units analogous to a class, with a limited number of sessions and a lesson plan for each session. The client can take a class again or

receive supplementary sessions as needed, as well as enrolling in a subsequent class on a different topic. Notably, SST is delivered in a time-limited fashion targeted on collaborative goals.

The OnTrackNY program will target four domains of social skills: (1) Communication skills (“Social Networking”); (2) Friendship and dating skills (“Relating and Dating”); (3) Assertiveness skills (“Expressing Yourself”); and (4) Conflict management skills (“Keeping Cool”).

1. **Communication skills (“Social Networking”).** Conversation skills are necessary for engaging in general social interactions. Skills in this domain involve starting conversations, maintaining conversations, ending conversations, and getting your point across.
2. **Friendship and dating skills (“Relating and Dating”).** These skills are a critical part of re-engaging with friends and family following FEP. Skills in this domain include: talking generally about the experience of FEP, talking to friends and family about FEP, expressing positive feelings, asking someone for a date, finding common interests, and expressing affection. It is important to note that all participants will work with the Primary Clinician on issues related to disclosing information and feelings about first episode psychosis. Some specific topics that will be addressed by the Primary Clinician will include whether and how to talk to others about FEP, what information to disclose to whom, and how to make decisions about what to tell to different people. At the beginning of FEP, clients often don’t know what to say about what’s going on with them or where they have been. Different people ask them questions and they don’t know how to respond. How to respond to such questions is part of the way that participants will come to have an understanding of FEP and will need to be addressed at the start of and over the course the intervention. The Primary Clinician, as the team member who will work most closely with the client, will have an ongoing discussion about these issues with the client. However, there will be cases in which a client may require more assistance with practicing ways to talk with people about these issues, especially with people who are not close friends or family members. As part of SST, the RC will have the option of addressing these topics as they relate to the client’s good social functioning and feeling comfortable around other people. Thus topics such as “talking generally about the experience of FEP” and “talking to friends and family about FEP” are included as part of SST in order to provide additional practice with these skills in every day situations.
3. **Assertiveness skills (“Expressing Yourself”).** An important component of sound social functioning is expressing one’s feelings and refusing to do things that one does not want to do. Assertiveness skills that will be targeted by OnTrackNY includes expressing negative feelings, making requests, refusing requests, and making complaints. Other modules in this unit will support Individual Placement and Support (IPS) by teaching social skills that are needed to be effective in school and at work, including problem solving (with an emphasis on interacting with employers and teachers), asking for help, maintaining social relationships, and dealing with problem situations.
4. **Conflict management skills (“Keeping Cool”).** Conflict management skills are used to manage situations in which people hold different opinions or have different needs.. These skills are especially important for individuals with FEP to use when interacting with family members. Skills in this domain include compromise and negotiation, disagreeing with someone without arguing, leaving stressful situations, anger management, responding to complaints, and general problem solving.

## D. SST Session Outlines

The skills described here provide the basics for accomplishing the social task (e.g., starting a conversation). These basic skills are generally useful for introducing the skill domain, and are suitable for very impaired clients. However, they will be too simple for many FEP participants. A key feature of SST is that both the skill level and content of training can be tailored to the needs and abilities of participants. Hence, the trainer can and should quickly move to more ecologically valid training that is suitable for the participant's skill level as soon as possible. For example, a young FEP participant who has a peer group and is having difficulty re-establishing connections after a hospitalization will not need much if any focus on starting and ending conversations, but may need to focus more on how to discuss the illness and how to slow down conversations to facilitate cognitive processing. Conversely, someone who never had good social skills and has been isolated for some time during an extended prodromal phase of illness may require training on core skills. Further, in both cases, rehearsal of simple skills may be helpful in enhancing self-efficacy and increasing the person's willingness to engage in the target behavior in the community.

The skills described below represent likely targets for a majority of participants. Some skills (e.g., how to discuss illness, safe sex and avoidance of unwanted sex) will be applicable for most, while others (e.g., refusing unwanted sex) may only be applicable to a select subgroup. Moreover, it is to be expected that participants will bring other, more idiosyncratic interpersonal problems to sessions that require different skills or substantive variations of those skills described below. Per above, SST is quite flexible and dynamic, and new or modified skill training units can be developed to insure the relevance of the training to the needs and goals of the FEP person. Thus, the list and descriptions below should be viewed as a starting point rather than as a definitive treatment protocol.

### 1. Social Networking Skills

#### #1: Starting Conversations

**RATIONALE:** There are many situations when you want to start a conversation with another person. This may be someone you know or someone you have never met but would like to get to know. Sometimes people feel shy about starting a conversation. We find that things go more smoothly when you keep specific steps in mind.

#### **STEPS OF THE SKILL:**

1. Choose the right time and place.
2. Introduce yourself or greet the person you wish to talk with.
3. Make small talk (i.e. talk about the weather or sports)
4. Judge if the other person is listening and wants to talk.

#### **SCENES TO USE IN ROLE PLAYS:**

1. A new person is starting in your class or at your job.
2. You are waiting in line with other people at a store or at school.
3. You are at a family gathering.

4. You are sitting with another person at lunch.
5. You are meeting someone for the first time.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Steps 1 and 4 require the client to make a judgment regarding what are the appropriate time and place to begin a discussion, as well as whether the person being addressed is interested in participating. It is important for the RC to spend time assisting the client with the identification of social cues they can look for when making such judgments.
2. Clients may not be familiar with what constitutes "small talk" (step 3). The RC may want to generate a list of topics that can be used for making small talk.

## #2: Maintaining Conversations

**RATIONALE:** Sometimes you may want to go further than a brief conversation; you may want to talk longer with someone because you like the person or are interested in what is being said. Often, people don't know how to keep a conversation going, or they feel uncomfortable. One way to keep a conversation going is by asking questions.

### **STEPS OF THE SKILL:**

1. Greet the person.
2. Ask a question about something you would like to know about.
3. Judge if the person is listening and is interested in pursuing the conversation.

### **SCENES TO USE IN ROLE PLAYS:**

1. Watching a TV program with another person who also seems to enjoy the program.
2. Seeing your roommate after he or she has spent a day with his or her family.
3. Having a cup of coffee or soda with a friend.
4. Sharing a chore (such as cleaning up after dinner) with someone.
5. Talking to someone at your job or school.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Clients may have difficulty determining what kinds of questions are socially appropriate to ask in different situations. The RC can use the role play scenes to help clients identify socially appropriate questions to ask in various situations. For example, the RC can ask clients to generate a list of questions that would be appropriate to ask a friend with whom they are having coffee before role playing the scene so that they have some options to choose from.
2. The RC needs to distinguish "general" questions from those that are more specific. Providing the group with examples of the two types of questions will be useful.
3. The RC may need to assist members with the identification of social cues required in Step 4.

## #3: Ending Conversations

**RATIONALE:** Conversations don't go on forever. Sooner or later someone must end the conversation. Many times it may be up to you to end the conversation. There are many reasons for ending a

conversation, including running out of time, needing to go somewhere else, or running out of things to say. You can end conversations more smoothly if you keep certain steps in mind.

**STEPS OF THE SKILL:**

1. Wait until the other person has finished speaking.
2. Use a nonverbal gesture such as glancing away or looking at your watch.
3. Make a closing comment such as “Well, I really must be going now.”
4. Say, “Good-bye.”

**SCENES TO USE IN ROLE PLAYS:**

1. Talking about a TV show with someone, but it becomes time for you to leave to meet someone for dinner.
2. Finishing lunch with another person and you have to get home.
3. Talking with a friend before work/school starts.
4. Talking with a person you don’t know well and you run out of things to say.
5. Talking with a friend during breakfast, and it’s time to go to work.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Clients may not be aware of how the use of nonverbal gestures can either help make a social interaction run more smoothly or make it more awkward. A brief group discussion regarding how to utilize nonverbal gestures can be quite helpful. If a client still does not understand how to use nonverbal gestures, skip Step 2 and go to Step 3.

**#4: Getting Your Point Across**

RATIONALE: There are times when we all have something that we want to talk about or explain to others. Being able to get your point across in a clear and concise manner is an important component of effective communication. It makes it easier for others to understand and respond to what you are saying.

**STEPS OF THE SKILL:**

1. Decide on the main point you want to get across.
2. Speak in short sentences and stay on the topic.
3. Pause to let the other person speak or ask questions.
4. Answer any questions.

**SCENES TO USE IN ROLE PLAYS:**

1. You tell a friend the best place to buy a pair of sneakers.
2. You talk with your roommate about how you would like to divide up chores in the apartment.
3. You suggest to a family member a place you would like to go on an outing.
4. You explain to your Primary Clinician that you want to make some changes in your treatment goals.



## **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. The RC can discuss with clients the importance of staying calm and speaking in a clear voice that is not too loud or too soft when trying to make a point. For example, the RC can discuss how it is more likely that a person will not be listened to when he or she is yelling and agitated. Therefore in order to be understood, it is often important to be in reasonable control of one's feelings.
2. It is important to note cultural differences that may be relevant to getting one's point across. There may be cultural differences in how people talk to one another, whether or not they assertively state their ideas, and in expectations about how people of different ages behave with and toward one another. The RC should ask clients if and how their culture would play into this skill and work with the client to tailor the steps to their needs.

## **2. Relating and Dating**

### **#1: Talking generally about the experience of your mental health**

Rationale: There may be occasions when people ask you about what's been going on with you or how you are and you want to tell them something about what you have been experiencing in your recovery. You will need to figure out who you want to talk to about your recovery and in what situations you feel comfortable disclosing personal information about your mental health. Sometimes you may want to share a lot of information with someone who you trust and is supportive. Many times you may feel comfortable telling someone you had a very stressful period, but not want to go into details. The following steps can be used in a situation in which you want to tell a brief amount to the person you are talking with, but you don't want to spend a lot of time on it or disclose too many details.

#### **STEPS OF THE SKILL:**

1. Tell the individual the information you want to disclose about your mental health needs and recovery.
2. Speak in short sentences and stay on the topic.
3. Pause to let the other person speak or ask questions.
4. Tell the person you are doing better now and/or change the topic (e.g., ask a general question or introduce a new topic for discussion)

#### **SCENES TO USE IN ROLE PLAYS:**

1. You see a family member whom you haven't seen in a while and the family member mentions that another relative (your mother, father, sibling) told them you were "going through some things."
2. You were out of school for a while due to some mental health or emotional distress. You are getting ready to go back to school and a friend asks you why you have been out of school.

#### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. The RC, in conjunction with the primary clinician, should talk with clients about what information they want to disclose and to whom. The goal of this skill is to give the client a framework for talking about their mental health needs and informing people about it when he/she is ready and wants to do this. The RC and primary clinician want to make sure that this topic is discussed in advance of a situation in which disclosure may be needed so that the client can be prepared. For example, does

the client feel comfortable using a diagnostic term (e.g., I have schizophrenia) or does he or she prefer to talk about it in the abstract (e.g., I have been having trouble concentrating and organizing my thinking).

2. There will be many times when the client will not want to disclose any information to a person who is asking. The RC should help the client identify the situations in which he/she would not want to disclose any information (i.e. the person asking is not a close friend or relative, the setting is not right, the client just doesn't want to talk about it) and practice a response for such a situation (e.g., I had some health problems, but things are better now). In this context, the RC will want to help the client formulate a response when they don't really want to provide much information. In such cases, the RC and client can develop a response that the client feels comfortable with. This response may involve omitting information or being somewhat untruthful. The pros and cons of not being truthful should be discussed. It is important to remember that all people are untruthful sometimes (either by leaving out information or not providing information that they don't want to disclose) and that in some situations in which they are being asked personal questions, clients can opt to do this too.

## #2: Talking to friends and family about your mental health

Rationale: There will be times when you want to disclose information about your mental health and recovery to people who are close to you. You will need to decide who you want to disclose to and what information or feelings you want to talk about. The following steps are for use in situations in which you want to talk about your mental health with someone.

### **STEPS OF THE SKILL:**

1. Make eye contact.
2. Disclose the information or feelings you want to talk about.
3. Follow up with clarification if needed.
4. Answer any questions.

### **SCENES TO USE IN ROLE PLAYS:**

1. You are talking to your best friend and you want to share about your mental health needs and recovery.
2. You want your parents to understand what the experience with mental health challenges has been like for you.
3. You want to talk to your boyfriend/girlfriend about what experiencing mental health challenges has been like for you, to ask for his/her support, or to tell him/her what you need from them.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. The RC, in conjunction with the Primary Clinician, should talk with clients about what information they want to disclose and to whom. The goal of this skill is to give the client a framework for talking about their mental health and recovery and informing people about it when he/she is ready and wants to do this. The RC and Primary Clinician want to make sure that this topic is discussed in advance of a situation in which disclosure may be needed so that the client can be prepared.

**RATIONALE:** When people have encountered a series of difficulties, they tend to focus on the problems around them and forget to notice the positive things that other people do. Noticing positive things helps to increase a person's sense of belonging and sense of being able to do things well. Also, a person who knows he or she is doing something well is more likely to repeat what he or she has done to please others.

**STEPS OF THE SKILL:**

1. Look at the person.
2. Tell the person exactly what it was that pleased you.
3. Tell them how it made you feel.

**SCENES TO USE IN ROLE PLAYS:**

1. A family member has cooked a meal you enjoyed.
2. A friend helped you out with a problem.
3. A family member woke you up so that you would be on time for an appointment.
4. A family member gave you a ride to an outside appointment.
5. A co-worker at your new job ate lunch with you.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

Sometimes clients may protest that it is not necessary to say positive things because people already know when they are doing something nice. The RC can remind clients that everyone likes it when someone has appreciated something that he or she has done.

**#4: Asking someone for a date**

**RATIONALE:** There are times when you may find yourself attracted to another person; it could be someone you have just met or perhaps someone you already know. In either case, you may want to pursue dating that person. We have found that it is a little easier to ask someone for a date if you follow the steps listed below.

**STEPS OF THE SKILL:**

1. Choose an appropriate person to ask.
2. Suggest an activity to do together.
3. Listen to the person's response and do one of the following:
  - a. If the person responds positively to your suggestion choose a day and time to get together. Be willing to compromise.
  - b. If the person indicates that he or she is not interested in going out on a date, thank the person for being honest with you.

**SCENES TO USE IN ROLE PLAYS:**

1. There is a new person at your work/school whom you would like to get to know.
2. You discover that you have a lot in common with a person at work and decide to ask him/her out.
3. There is a person with whom you volunteer that you would like to get to know.

4. You are at a party at a friend's house, and you meet someone whom you would like to ask out.
5. You decide to ask your new neighbor out on a date.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Some clients may have difficulty identifying appropriate people to date. The RC should spend time before practicing the skill helping clients identify what are some important factors to consider when choosing a potential date. For instance, clients can ask themselves questions such as "How well do I know the person?"; "Is this person available to date or is he or she involved in a relationship?"; "Is this someone who is not allowed to date me?" (e.g., a staff member is off limits); "What things do I have in common with this person?"
2. The RC needs to remind clients that there is always the chance that the person they are asking may refuse their invitation. It is therefore important to be prepared for that possibility. Strategies for handling a possible rejection should be identified, such as remaining calm and not getting angry at the person. Also, clients can always talk to a friend or someone they trust afterwards and share their feelings about the incident.

**#5: Finding common interests**

RATIONALE: One of the best ways to meet new people or develop friendships is to learn something about others. At the same time, sharing something about yourself also encourages the development of new relationships. Talking to another person about common interests that you may have is an easy and enjoyable way to learn more about each other.

**STEPS OF THE SKILL:**

1. Introduce yourself or greet the person you want to talk with.
2. Ask the person about what activities or hobbies he or she enjoys doing.
3. Tell the person about what activities or hobbies you enjoy doing.
4. Try to find a common interest.

**SCENES TO USE IN ROLE PLAYS:**

1. You want to get to know the new person at work/school.
2. You and your roommate want to do some activity together, but you do not know what each other likes.
3. You are interested in getting reacquainted with a family member who has just moved back into the area.
4. You are having lunch with a person you just met on your new job.
5. You are at a party and meet someone you would like to get to know better.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

After clients have spent several sessions role playing this skill and feel relatively comfortable with it, group leaders can change the format of the group to one that is less structured. The RC can choose a topic to discuss relating to common interests and then facilitate the discussion. Members seem better able to talk about subjects that are related to things that happened before the onset of their

illness. Topics that are particularly popular include favorite TV programs watched when a kid, games that you played as a kid, and music that you used to listen to when you were younger.

## #6: Expressing affection

**RATIONALE:** There are times when you may find that you like someone very much and want to let that person know how you feel. Letting someone know that you care about him or her can seem awkward or even a little scary. We have found that following these few steps can help to make expressing affection go a little more smoothly.

### **STEPS OF THE SKILL:**

1. Choose a person whom you are fond of.
2. Pick a time and place where you can be with the person in private.
3. Express affection using a warm and caring voice tone and/or offering a warm physical gesture.
4. Tell the person why you feel this way.

### **SCENES TO USE IN ROLE PLAYS:**

1. You have just finished a date with a person whom you like very much.
2. You have been dating someone exclusively for a while and you want to tell them how you feel about them.
3. It is your grandmother's birthday, and you want to let her know how important she is to you.
4. It is Valentine's Day, and you just received flowers from a person you have dated a few times.
5. You want to let a friend know how much he or she means to you.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. The RC should point out at the beginning of group that this skill focuses on the expression of verbal affection. However, group leaders should use this skill as an opportunity to have a frank discussion about the physical expression of affection as well. Step three offers the opportunity to have this discussion.
2. This skill requires that a client be able to identify which people are appropriate to express affection to. It will be helpful for group leaders to discuss with members how to decide who is and is not an appropriate choice to express affection to.
3. The RC should remind clients that even when they choose an appropriate person to express affection to, their gesture may not be well received. It will be useful for group leaders to help members identify clues to look for that may indicate that the other person is uncomfortable and how to respond in those instances

## #7 (Optional): Refusing unwanted sexual advances

**NOTE:** This skill is especially applicable to a client who has been or may soon become sexually active. This skill is important to learn at any age but may be less relevant to a minor who has not been active. In the case of a minor, the RC may need to make parents aware that this content is being discussed. The RC should discuss this with the treatment team.

**RATIONALE:** Nobody should ever feel pressured into having sex when he or she does not want to. Sometimes people may feel pressured by someone they have just met, or perhaps by someone they know well or are currently dating. It is important to be able to make your feelings clearly known in a firm and direct manner.

**STEPS OF THE SKILL:**

1. Using a firm voice, tell the person that you are not interested in having sex.
2. Depending on your relationship with that person, explain why you feel that way.
3. If the person does not listen and continues to pressure you, leave the situation.

**SCENES TO USE IN ROLE PLAYS:**

1. A person you have just met wants to have sex with you.
2. A person that you have been dating for the last month pressures you to have sex. You like this person a lot but are not yet comfortable with the idea of becoming sexually involved.
3. Your partner that you are living with wants to have sex, but you are not feeling the same way at the moment.
4. A person you work with has helped you out and now tells you that you owe him. He or she starts pressuring you to have sex.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

Before practicing this skill, the RC should have a discussion with a client about the importance of never being pressured into doing something that you do not want to do. The RC can remind clients that if a person truly cares about him/her that person will respect their decision without putting them down. Some clients will have a difficult time distinguishing between what is real and what is not real. It is very important for the RC to frequently remind members that this is just a role play and then talk about why it is important to practice this skill. If a client seems to have a difficult time distinguishing between the two, then the role play should be stopped and be replaced by a general discussion about strategies for handling pressure to engage in sexual activity.

**#8 (Optional): Requesting that a partner use a condom**

**NOTE:** This skill is important to learn at any age but may be less relevant to a minor who has not been active. In the case of a minor, the RC may need to make parents aware that this content is being discussed. The RC should discuss this with the treatment team.

**RATIONALE:** When engaging in sexual activity, it is important to protect yourself from contracting sexually transmitted diseases. Requesting that your partner use a condom is one way to significantly reduce your risk of contracting a sexually transmitted disease. It is also one important way to reduce the chances of an unwanted pregnancy.

**STEPS OF THE SKILL:**

1. Choose a time and place where you and your partner can talk in private.
2. Tell your partner that you would like to make sure that a condom is used.
3. Explain your reasons for making the request.



4. If he/she refuses, tell him/her that you will not engage in any sexual activity with him/her until a condom is used.

#### **SCENES TO USE IN ROLE PLAYS:**

1. You want to have sex with a person you just met.
2. You want to have sex with a person whom you have been dating for the last month.
3. You want to have sex with a person whom you have been dating regularly for the last year.

#### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. It will be useful for the RC to remind members that this request is best made before engaging in sexual activity. It is also better not to wait until the moment before they are about to engage in intercourse to make the request.
2. Some clients will have a difficult time distinguishing between what is real and what is not real. It is very important for the RC to frequently remind clients that it is just a role play and then talk about why it is important to practice this skill. If a client seems to have a difficult time distinguishing between the two, then the role play should be stopped and replaced by a general discussion about strategies for requesting that a partner wear a condom.

### **#9 (Optional): Refusing pressure to engage in high-risk sexual behavior**

NOTE: This skill is especially applicable to a client who has been or may soon become sexually active. This skill is important to learn at any age but may be less relevant to a minor who has not been active. In the case of a minor, the RC may need to make parents aware that this content is being discussed. The RC should discuss this with the treatment team.

RATIONALE: Engaging in high-risk sexual behavior can have serious consequences. High-risk sexual activity greatly increasing your chances of contracting sexually transmitted diseases, including AIDS. Knowing how to refuse pressure to engage in high-risk sexual activities is one important step toward taking care of yourself and your health.

#### **STEPS OF THE SKILL:**

1. Tell your partner that you will not engage in the high-risk sexual activity.
2. Explain your reason for refusing to do so.
3. If you still want to engage in sex, suggest a different sexual activity that is safer.
4. If the person continues to pressure you, tell him or her that you need to leave.

#### **SCENES TO USE IN ROLE PLAYS:**

1. A person you have just met wants you to engage in a high-risk sexual activity.
2. A person you have been dating for about a month and like a lot pressures you to engage in a high-risk sexual activity. You want to have sex with this person but are not willing to put yourself at risk by giving in to his or her request.
3. Your partner, whom you have been involved with for over a year, thinks it might be fun try something new to spice up your sex lives. Unfortunately, what he or she has in mind is considered to be a high-risk sexual activity.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Before practicing this skill, the RC should have the client generate a list of sexual behaviors that are considered to be high-risk for contracting STDs, especially AIDS (refer to the Appendix for a list). The RC will also need to have a discussion about how people contract AIDS and other STDs, and he/she may also need to dispel any myths surrounding the transmission of these diseases as well as myths about who is likely to carry these diseases.
2. Some clients have a difficult time distinguishing between what is real and what is not real. It is very important for the RC to frequently remind such clients that this is just a role-play and then talk about why it is important to practice this skill. If a client seems to have a difficult time distinguishing between the two, then the role play should be stopped and then replaced by a general discussion about high-risk sexual behaviors.

## **3. Expressing Yourself**

### **#1: Expressing unpleasant feelings**

**RATIONALE:** Even when people do their best to please each other, there will be times when things are displeasing or unpleasant. It is only natural in the course of living with other people and going to programs with other people that unpleasant feelings arise. Examples of unpleasant feelings are anger, sadness, anxiety, concern, or worry. How people express their feelings can help to prevent arguments and more bad feelings. It is helpful to keep certain things in mind when expressing an unpleasant feeling.

#### **STEPS OF THE SKILL:**

1. Look at the person. Speak calmly and firmly.
2. Say exactly what the other person did that upset you.
3. Tell the person how it made you feel.
4. Suggest how the person might prevent this from happening in the future.

#### **SCENES TO USE IN ROLE PLAYS:**

1. Your roommate left dirty clothes in the living room.
2. A professional missed an appointment with you.
3. You are worried when your roommate is out later than expected.
4. Your family canceled a weekend visit.
5. Your friend was late meeting you for lunch.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

This skill requires that clients identify an unpleasant feeling (Step 3). However, not all clients will be able to do this. It is helpful in the first session of teaching this skill to generate a list of unpleasant feelings. The list can be written on a flip chart and placed where it can be seen when clients are role playing

### **#2: Making requests**

**RATIONALE:** In anyone's life, situations come up where it is necessary to ask another person to do something or to change his or her behavior. A request that is heard as a demand or as nagging usually does not make the other person want to follow through with the request. Making a request in a positive way, however, is usually less stressful and is more likely to lead to the request being met. There are no guarantees, of course, but a request usually goes better if you keep in mind the following points.

**STEPS OF THE SKILL:**

1. Look at the person.
2. Say exactly what you would like the person to do.
3. Tell the person how it would make you feel.

In making your request, use phrases like:

1. "I would like you to\_\_\_\_\_."
2. "I would really appreciate it if you would do\_\_\_\_\_."
3. "It's very important to me that you help me with\_\_\_\_\_."

**SCENES TO USE IN ROLE PLAYS:**

1. Ask someone to go to lunch with you.
2. Ask someone to help you with a chore or an errand.
3. Request an appointment with you counselor to talk about a problem.
4. Ask your friend to borrow his or her DVD or ipod.
5. Ask someone at work/school to turn down his or her radio.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. It is important to tailor this skill so that the individuals who learn quickly do not get bored. Therefore, it is helpful to elicit specific situations where a client may have wanted to make a request but was unable to.
2. For other clients who may be experiencing greater difficulty learning a skill, it is helpful to suggest just one phrase, such as "I would appreciate it if you would\_\_\_\_\_", to use when making a request.
3. Remind clients that although a request made in this manner is most likely to lead to receiving the request, it does not guarantee that the request will be granted.

**#3: Refusing requests**

**RATIONALE:** We can't always do what other people ask us to do. We may be too busy, or not feel capable, or may believe that what is being asked is unreasonable. If we refuse in a rude or gruff manner, it can make for hurt feelings or anger. On the other hand, if we are not clear about refusing or if we speak in a hesitant way, it might lead to a misunderstanding or argument.

**STEPS OF THE SKILL:**

1. Look at the person. Speak firmly and calmly.
2. Tell the person you cannot do what he or she asked. Use a phrase such as "I'm sorry but I cannot\_\_\_\_\_."

3. Give a reason if it seems necessary.

### **SCENES TO USE IN ROLE PLAYS:**

1. Your treatment provider asks to meet with you at 3:00 P.M., but you already have an appointment.
2. A friend asks you to go to a basketball game, but you don't like basketball.
3. Your roommate asks you to pick up some groceries, but you're feeling tired.
4. A friend asks you to lend him or her money, but you are broke.
5. A family member asks you to help prepare dinner, but you have plans to watch a special TV show.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. It is important for the RC to remind clients that there are some situations when a request is made of them where refusing would be inappropriate, such as when a staff person asks the client to follow a safety rule.
2. There are also instances when refusing a request may result in some harm to the client. Situations such as the client refusing to take medication or go to the doctor need to be handled delicately because the consequences can be severe. In these instances, it may be helpful to encourage clients to use the skill Compromise and Negotiation instead of Refusing Requests.

## **#4: Making complaints**

**RATIONALE:** A number of unpleasant situations can be avoided by expressing yourself clearly and making requests in a positive way. However, situations often come up where something displeasing does happen. At those times you need to make a complaint. Making a complaint usually works best if you can also suggest a solution.

### **STEPS OF THE SKILL:**

1. Look at the person. Speak firmly and calmly.
2. State your complaint. Be specific about what the situation is.
3. Tell the person how the problem might be solved.

### **SCENES TO USE IN ROLE PLAYS:**

1. You lose money in the vending machine.
2. Someone interrupts you when you are speaking.
3. You order a cheeseburger, but the waitress brings a plain hamburger.
4. You buy a bus pass, and the clerk gives you the wrong change.
5. Someone in a nonsmoking area lights up a cigarette.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. This skill requires that a client be able to identify possible solutions before stating a complaint. The RC should encourage clients to brainstorm possible solutions before a role play is practiced so that the participants have an idea of what solution they will propose ahead of time.
2. The RC can remind members that this is the best way to make a complaint, but there are no guarantees that the solution they suggest will be carried out.

## #5: Responding to complaints or criticism that you do not agree with

**RATIONALE:** As careful and considerate as you might try to be, there will be times when someone has to make a complaint to you. For instance, you accidentally bump into someone or you forget an appointment. If you get upset when someone complains to you, it only makes the situation worse. Following the steps of the skill will help you respond in a calm manner.

### **STEPS OF THE SKILL:**

1. Look at the person and remain calm.
2. Listen to the complaint, keeping an open mind.
3. Repeat back what the person said.
4. Accept responsibility and apologize (or compromise) if necessary.

### **SCENES TO USE IN ROLE PLAYS:**

1. Someone complains to you that you interrupted them.
2. Someone complains to you that you lit up a cigarette on the bus.
3. Your school counselor complains that you are late for your appointment.
4. Your roommate complains that your music is too loud.
5. A family member says that you are not working hard enough on your school work.
6. A friend says your outfit is unattractive.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

There may be some clients who have a difficult time remaining calm while listening to a complaint being lodged against them. Therefore, it may be helpful for the RC to discuss strategies for managing angry feelings. For example, taking a time-out or counting to 10 may be useful strategies to employ in certain situations.

## #6 (Optional): Asking for help or support

**RATIONALE:** There will be times when you, like everyone, need some help, clarification, or support from someone else. It can be hard to ask for help, especially if you are the type of person that tries to do things on his/her own. Having a few easy steps to follow can help you feel better about asking for help.

### **STEPS OF THE SKILL:**

1. Find a quiet time to talk and look at the person.
2. Explain the situation in 1-2 sentences.
3. Ask for help. Be specific about that you would like them to do.
4. Listen to their answer and thank them.

### **SCENES TO USE IN ROLE PLAYS:**

1. You are finding some school work very hard to understand and you want to ask a friend/your sibling/the teacher to explain it to you.
2. A family member has asked you to do something and you're not sure how to do it.
3. You want to talk to your boyfriend/girlfriend about feeling stressed out.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Asking for help can be difficult for some people. The RC and the client should discuss why asking for help can be positive and who to ask for what types of help.

### **#7 (Optional): Responding to gossip/negative comments**

RATIONALE: Returning to work or school after FEP, you may face people who want to know what happened to you or who are talking to each other about what they think happened to you. This may be especially relevant to those people who you don't want to talk to about your experiences; such people may make negative comments. The goal here is to have some response or way to address these comments. Some family members may also make negative comments.

### **STEPS OF THE SKILL:**

1. Find a time to talk one-on-one with the person; look at the person and speak calmly.
2. State what you heard that is bothering you. Be brief and specific.
3. Ask the person to stop talking about you.

### **SCENES TO USE IN ROLE PLAYS:**

1. You are at a family gathering and you hear a relative comment that you have been "out of it" for a while.
2. Your friend tells you that other people at school are spreading rumors about you.
3. You overheard some coworkers talking about your missing work for a few weeks.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. A client may not want to confront someone at work or school. The RC and the client should develop a plan that includes talking to other people about any concerns, such as a teacher or administrator at school or a boss at work or a parent in the case of other family members.

## **4. Keeping Cool**

### **#1: Compromise and negotiation**

RATIONALE: Often, people find that they disagree with each other, even when they want to do something together. At these times, it is helpful to work out a compromise. In a compromise, each person usually gets some of what he or she wants, but usually has to give up something. The goal is to reach a solution that is acceptable to all involved.

### **STEPS OF THE SKILL:**

1. Explain your viewpoint briefly.
2. Listen to the other person's viewpoint.
3. Repeat the other person's viewpoint.
4. Suggest a compromise.



**SCENES TO USE IN ROLE PLAYS:**

1. You want to go to lunch with your friend and get pizza. He/she does not want pizza that day.
2. A treatment provider asks you to schedule an appointment for 2:00 P.M. on Wednesday. You have other plans at that time.
3. You and your friend want to go see a movie. You want to see an action movie, and your friend wants to see a comedy.
4. In planning to go out with a friend, he/she suggests bowling. You would rather go out to eat.
5. You want to visit your family next weekend. They have other plans.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

Not all clients will understand what it means to negotiate and come to a compromise. Therefore, it is important that the RC spend time explaining these concepts before beginning a role play. For example, to negotiate something, both parties have to state what it is that they want to get out of the interaction. Once all the wishes have been listed, both parties must review the list and decide upon a compromise. A compromise usually occurs when both parties get some of what they wanted.

**#2: Disagreeing with someone without arguing**

**RATIONALE:** Not everyone we come in contact with will agree with all of our ideas or opinions, just as we do not agree with all of theirs.

Disagreeing with another person's opinion does not have to lead to bad feelings or an argument. In fact, life would be boring if everyone had the same ideas. When you disagree with another person's opinion, things often go more smoothly if you keep certain things in mind.

**STEPS OF THE SKILL:**

1. Briefly state your point of view.
2. Listen to the other person's opinion without interrupting.
3. If you do not agree with the other person's opinion, simply say that it is okay to disagree.
4. End the conversation or move on to another topic.

**SCENES TO USE IN ROLE PLAYS:**

1. You and a friend have a different opinion about a movie you just saw.
2. You and your roommate have a different opinion about which musical group is better.
3. You and a family member have a different opinion about how to celebrate your birthday.
4. You and a treatment provider disagree about what has been the most helpful thing in getting you a job.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

It is important to emphasize that this skill is designed to be used in situations where there are no significant consequences for having a different opinion. In situations where there may be more serious consequences, such as disagreeing with a doctor's opinion about using medication, the skill Compromise and Negotiation should be employed. There may also be situations where any kind of disagreement may cause a strong or even violent reaction, such as encountering a political or

religious extremist. In these situations, Leaving Stressful Situations may be a more appropriate skill to use.

### #3: Leaving stressful situations

**RATIONALE:** There are times when we find ourselves in situations that we consider stressful. For instance, when others criticize us or when we do something that another does not like. Often, remaining in situations that are stressful only makes us feel worse and at times may even aggravate the situation. Many times, leaving until you have calmed down and then dealing with it afterwards is the most productive way of managing the stressful situation.

#### **STEPS OF THE SKILL:**

1. Evaluate whether the situation is stressful (i.e., tune in to your thoughts, feelings, and physical sensations).
2. Tell the other person that the situation is stressful and that you must leave.
3. If there is a conflict, tell the person that you will discuss it with him or her at another time.
4. Leave the situation.

#### **SCENES TO USE IN ROLE PLAYS:**

1. A relative has falsely accused you of stealing \$10.00.
2. A friend is angry because you won't go to a bar with him or her.
3. A relative is upset because he or she found drugs in your room.
4. Your roommate is angry because you wore his shirt without asking to borrow it.

#### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. The RC should assist the client in understanding Step 1 by generating a list of ways a person can tell if he or she is either feeling stressed. This is important because many clients are not in touch with what may be stressful to them.
2. It is important to emphasize that this skill is only to be used with people whom the clients know and want to maintain a relationship with. This skill should not be used with "strangers out on the street" as it could have dangerous repercussions. For example, it would be very dangerous to use this skill if you have been approached on the street by someone who wants to rob you. In situations such as that, giving the person what they asked for and going for help after they leave is probably safer than using the skill.

### #4: Expressing Angry Feelings

**RATIONALE:** One type of feeling that many people have special difficulty expressing is anger. At times everyone gets angry. This does not have to lead to shouting or hitting or cutting off friendships or relationships. It is usually helpful to relieve feelings of anger by expressing yourself in a direct, honest way. Sometimes you might want to wait until you have "cooled off" a little and are feeling calm.

#### **STEPS OF THE SKILL:**

1. Look at the person, speak firmly and calmly.

2. Tell the person specifically what he or she did that made you angry. Be brief.
3. Tell the person about your angry feelings. Be brief.
4. Suggest how the person might prevent the situation from happening in the future.

#### **SCENES TO USE IN ROLE PLAYS:**

1. Your roommate smokes in the apartment which makes you feel sick.
2. A family member promises take you somewhere on Friday but then says he/she can't go.
3. Someone spills coffee on you without apologizing.
4. Your roommate borrows your ipod without asking and breaks it.

#### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Many members have a particularly difficult time expressing angry feelings, even in the context of a controlled role play. It is therefore important to devote some time "preparing" clients for this skill. Spending one or two sessions helping members identify common "early warning signs" of anger (such as feeling tense, heart racing, etc.) as well as strategies for managing angry feelings (one of those strategies being the skill at hand), will be extremely useful.
2. Depending on the composition of the group, it may be helpful to divide this skill into three parts and practice each part as a separate role play. The first part would encompass Steps 1 and 2; the second part would encompass Step 3; and the third part would encompass Step
3. Not all members will need the skill divided in this way, but for those who are having some difficulty, this allows them to have positive role-play experiences while practicing the skill.

### **#5: General problem solving**

Rationale: There will be many times when you have a problem that you want to solve. This can be stressful. The following steps can be used to think through a problem and come up with some potential solutions. This can be done individually or with a group of people who have a problem, such as a group of family members.

#### **STEPS OF THE SKILL:**

1. Define the problem in one sentence.
2. List all potential solutions – brainstorm and be creative and get a long list of possibilities from all who are involved.
3. Eliminate potential solutions that are too hard to do or that someone in the group can't agree with.
4. Pick one remaining solution. Decide how to try it out.
5. Try it out and re-evaluate.

#### **SCENES TO USE IN ROLE PLAYS:**

1. Your roommate likes to stay up late with the light on; you like the light to go off earlier.
2. Your parents don't want you to go out at night during the week.
3. You have too many things to do on your schedule.

**SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

This can be done with groups of people. The RC may want to teach this skill to all family members as a way for everyone to engage in problem solving.

## V. Substance Abuse Treatment

### A. Background

Drug and alcohol abuse by people with serious mental illness is one of the most significant problems facing the public mental health system. Lifetime prevalence of substance abuse was assessed at 48 percent for people with schizophrenia and 56 percent for people with bipolar disorder in the Epidemiological Catchment Area study, and estimates of current abuse for people with serious mental illnesses range as high as 65 percent. Rates of abuse are likely even higher among impoverished individuals living in inner city areas where drug use is widespread. Substance use disorders (SUDs) often begin early in the course of illness, and have a profound impact on almost every area of the person's functioning and clinical care. People with comorbid SUDs show more severe symptoms of mental illness, more frequent hospitalizations, more frequent relapses, and a poorer course of illness. They also have higher rates of violence, suicide, and homelessness. They manifest higher rates of incarceration, greater rates of service utilization and cost of health care, poorer treatment adherence, and treatment outcome. People with schizophrenia are now one of the highest risk groups for HIV. Women with schizophrenia and comorbid substance use disorders are at substantial risk of being raped and otherwise physically abused. Substance use also impairs information processing, which is particularly problematic for people with schizophrenia given the range of cognitive deficits that often accompany the disorder. Substance use also can trigger psychotic episodes in individuals with psychotic disorders.

Why do people with serious mental illnesses use alcohol and street drugs if the consequences are so severe? The data suggest that substance abuse by many people with serious mental illness is motivated by the same factors that prompt use of harmful substances in general: negative emotions, interpersonal conflict, and social pressures.

There is an extensive literature on the treatment of individuals with co-occurring disorders, and there is a broad agreement on a number of elements required for effective treatment, including:

1. Integration of psychiatric and substance abuse treatment
2. Treatment should be conceptualized as an ongoing process in which motivation to reduce substance use waxes and wanes
3. A harm reduction model is more successful than an abstinence model, especially during the early stages of treatment when the individual has uncertain motivation to change. The term harm reduction refers to an approach that values anything that reduces risk or harm associated with substance use. As indicated above, people with dual disorders are at increased risk for a host of adverse consequences, including psychiatric relapse, sexual abuse, and HIV infection. Any substance-free day decreases the risk of those adverse consequences. While abstinence may be the most appropriate long-term goal for someone with a co-occurring disorder, the evidence suggests that if abstinence (or a commitment to become abstinent immediately) is a precondition to entering treatment individuals with co occurring disorders will not enroll. Further, if the clinician persistently and aggressively promotes abstinence and is critical of unsuccessful efforts to cut down use, attrition

is very high. Thus, the program should promote reduced drug use in the short term, and keep abstinence in mind as a long term goal. Our treatment program will be guided by these principles.

## B. Substance Use, Abuse, and Dependence in First-Episode Psychosis

High rates of substance abuse and dependence have been documented in samples of people with FEP. In a recently accrued sample of 109 hospitalized first-episode clients in Atlanta, Georgia, Compton and colleagues (2009) determined that 96 (88.1%) had ever consumed alcohol (mean age of first use:  $15.3 \pm 3.64$  years), 50 (45.9%) used alcohol weekly (mean age of first weekly use:  $18.4 \pm 3.34$  years), and 12 (11.0%) used alcohol daily (mean age of first daily use:  $17.8 \pm 3.61$  years). Regarding cannabis, which is the most commonly used illicit drug among people with FEP (Mueser et al., 1990), 87 of these 109 clients (79.8%) had used cannabis (mean age of first use:  $15.8 \pm 4.01$  years), 66 (60.6%) used it weekly (mean age of first weekly use:  $16.5 \pm 2.87$  years), and 49 (45.0%) used cannabis daily (mean age of first daily use:  $17.2 \pm 3.35$  years). Although 16.5 percent of participants met DSM-IV criteria for cannabis abuse, some 41.3 percent met criteria for cannabis dependence. Several studies have found substance use disorders in FEP related to male gender, younger age, better social functioning, and poorer academic functioning. The evidence suggests that drug use, especially cannabis, may precipitate psychotic episodes in vulnerable individuals, as well as magnify the severity and persistence of illness. Others have found that heavy substance use is related to poorer functioning and symptom outcomes. There is some anecdotal evidence to suggest that some young people in their first psychotic episode can and do cease drug use once they become aware of the risks. The desire to seem “normal” and to sustain social relationships with substance abusing peers, so often reported as a reason for use among individuals with serious mental illness, may be especially important and pernicious for adolescents and young adults with psychoses.

It is likely that the OnTrackNY program will work with many clients who are using drugs on a regular basis. Other clients will experiment with drugs. A big hurdle for these clients will be having them decide if their substance use is a “problem” that needs to be addressed in treatment. Many will not consider their substance use an issue and will not believe that it makes their illness worse. In addition, a subset of clients will believe that their drug use accounts for their psychosis. Drug use, especially cannabis use, is one of the more common things that clients attribute the psychosis to. This is a legitimate question, and occasionally they may turn out to be right.

## C. Special Issues in Substance Abuse Treatment in First Episode Psychosis

- 1. Most drug use is illegal, and this can complicate identification of use goals.** Most drug use is illegal, and so drug use can be accompanied by legal consequences. The fact that most drug use is illegal can complicate identifying goals for substance abuse treatment. For treatment providers, goals are often focused on eventual abstinence while clients often want to use drugs recreationally. That is, goals among clients, family members, and treatment providers are likely to differ at the start of treatment, with clients less worried about the illegality of drug use. Family members may be

particularly distressed about the potential legal consequences of drug use, especially since consequences such as arrests and time in jail can remain on a client's record long into adulthood.

- 2. Drinking.** Drinking can be harmful but is legal and not harmful for most people over age 21 without psychosis. Attention will need to be paid to the unique problems that can come from drinking for individuals with psychosis. Here again there are likely to be differing goals among clients, family members, and treatment providers. Some treatment providers will come to this treatment believing that all clients must be abstinent from alcohol. Most clients, especially those who are young adults, will not want to consider a lifetime of abstinence.
- 3. Age of clients.** Many clients who are working with OnTrackNY will be less than 21 years of age and so their use of alcohol will also be illegal. Here again, goals among clients, family members, and treatment providers are likely to differ at the start of treatment.
- 4. Different levels of use and range of drugs.** Clients may have varying levels of use: social use, heavy use, binge use, problem use, abuse, or dependence. Not all substance use is a disorder or an addiction. Clients may also use a range of substances, each at different levels of use. In addition, clients will often view their substance use in a very different light from that of treatment providers. For example, many will compare themselves to others in the using environment and determine that they don't drink or use drugs any more or any more problematically than the others around them. The RC can educate clients and their families about relevant models of substance use and disorders, including stress vulnerability (some underlying vulnerability, such as FEP, will make a client more likely to experience negative outcomes from substance use) and the super-sensitivity model (clients with FEP are, for some reason, more sensitive to the effects of even moderate amounts of substances) that may help them to understand why substance use by individuals with psychosis may cause more problems for them than for others without psychosis.
- 5. Labeling.** The last thing clients will want to hear is that they have an addiction, are an addict, etc. Use of these labels is generally not helpful. Family members may use these labels, so the Primary Clinician and the RC may need to work with families to help them better understand the nature of substance use and abuse and how labeling can be counterproductive in terms of having an open discussion about substance use. In addition, the label of "addict" will not fit many of clients, many of who may use or abuse drugs or alcohol but may not meet criteria for substance dependence. There is some variability here – some clients may like this terminology while others may not.
- 6. Cigarette smoking.** Many clients will smoke cigarettes and not want to quit. Many will believe that they can't quit smoking while working on reducing alcohol/other drug use, or while beginning treatment for FEP. This may or may not be the right time to address cigarette smoking. The RC can assess for smoking and talk with the clients about his/her goals in this area.
- 7. Family involvement.** Family members will likely have information regarding a client's drug or alcohol use and want to be involved in decisions around substance use and treatment, especially for young clients. The ways in which family members will work together with clients and treatment providers will need to be discussed and negotiated at the start of substance abuse treatment. The RC may need to work with the primary clinician to coordinate and streamline efforts with families around substance use and incorporate these into other family work that is taking place. A specific area that the RC and the Primary Clinician can work to address is to educate families about the stages of change model, and how family members are often at a different stage regarding substance use than the client (see Stages of Change section for a more detailed description of this). This may



help family members to be more understanding about the process of change and why behavior change happens slowly.

- 8. Self-medicating symptoms of psychosis.** Many clients will report using substances as a way to cope with symptoms of psychosis. While it is unclear whether, physiologically, substances are helpful in this regard, many clients who experience psychosis believe that substances are helpful in reducing or coping with symptoms and experiences associated with psychosis. OnTrackNY Team members should be aware that self-medicating will be important to many clients as an explanation for their substance use. Rather than try to change minds or educate a client out of this belief, understand that this comes from a client trying to figure out some way of coping with new and distressing experiences. The goal should be to accept that this is a credible reason for substance use and, over time, educate clients about other more effective options for managing symptoms.
- 9. Pain management and use of narcotics.** It is important not to overlook use/abuse of drugs that are not illegal when used according to a prescription, including use of narcotics that are prescribed for pain, or use of drugs such as Ritalin and Adderall that are prescribed for attention problems. The RC should be sure to ask about use of such drugs during the assessment.
- 10. Differences in treatment for alcohol versus drug use.** For clients with more long-standing mental illness, there may be differences among individual who primarily abuse alcohol versus drugs. With younger and less chronically ill clients, it is unclear whether there are differences that impact treatment. It is important for the RC to assess the situations in which drugs/alcohol are used and tailor discussions accordingly.

#### D. Tone of Substance Abuse Treatment

Work with clients with psychosis can be extremely challenging and clients who use and abuse drugs and/or alcohol present a range of additional issues that need to be addressed. The tone of substance abuse treatment provided by OnTrackNY and the clinical skills that are used to engage clients and work with them towards their goals, are based on motivational interviewing (Miller & Rollnick, 1991, 2002). Overall, MI includes a set of strategies that help clients identify and move towards their goals. It is collaborative – the clinician and the client work together to identify reasons for change and changes that are needed. MI recognizes that the client has autonomy and so must decide what actions are best for him/her. Importantly, MI involves an active clinician helping to steer discussion and highlight the client's language that is in support of change. In addition, it is important to remember several things in order to be most effective in talking to clients about their substance use. While most of these will seem obvious at first, these are the sorts of things that often keep clinicians from feeling like they can discuss this topic and help their clients make sound decisions about substance use. These ideas are based on motivational perspectives that view problematic substance use as a problem of ambivalence and stress that the ways that clinicians talk to clients about their substance use can profoundly impact the ways in which the client may be willing to change.

- 1. Many people can't simply stop substance use or abuse.** It can be difficult to understand why people who use or abuse drugs or alcohol can't just change their behavior. However, it is a fact that reducing/stopping drug use can be difficult and requires a lot more than just saying no for most people. It is useful to think about SA as a disorder like any other health problem with a behavioral component. Think about anything you have ever tried to change – change is difficult to commit to

and to follow through with and to maintain for everyone and people with SMI are no exception. Many people use alcohol or drugs to cope with difficult negative emotions and have not learned or practiced other ways of coping in difficult situations. So cutting down or stopping substance use often needs to involve learning new ways to cope with difficult emotions or situations. In addition, there are probably genetic differences between those who can stop substance use easily and those who cannot.

- 2. Substance users are not bad.** Clients who drink alcohol or use drugs or who meet criteria for substance use disorders are not “bad”. Substance abuse treatment has a long history of viewing clients as “evil” or “weak” or “bad”. The earliest models of substance abuse were moral models that explained addiction as a consequence of personal choice. Addiction was and often still is seen as a moral failing, with addicts making a voluntary choice to use drugs. This is simply not the case. Addiction is a complicated biopsychosocial process. There are plenty of “good” people with addictions.
- 3. Accuracy of self-report.** Clients may not be forthcoming with all information about their substance use. This is generally attributed to their not being truthful or being in denial. However, psychosis can be confusing and frightening and can make it genuinely difficult for clients to remember and report accurately about their use. In addition, individuals with FEP have many reasons to downplay their substance use. They may have a lot at stake and have good and important reasons for not telling the truth – fear of losing housing, control of finances, family support, legal issues, or fear of being viewed as more difficult or problematic by service providers.
- 4. Abstinence is not required.** Many clients with first episode psychosis will not want or be able to achieve abstinence at the start of their change efforts. Overall change is best conceptualized as a long-term process with many components, some of which have little to do with drug use per se. For example, many clients need time to come to the idea that alcohol and drug use are things that need to be changed and to feel comfortable talking about their substance use. Experiencing psychosis involves substantial change already, and clients may not be prepared or willing to make other changes in their substance use. That is, many clients will have used drinking and drug use as ways to cope with difficult situations and feelings, and may turn to use as an aid during the difficult time at the start of first episode psychosis. Thus any reductions in use made at any point in this process are significant in and of themselves. In addition, clients often use or abuse multiple substances, making it highly unlikely that total abstinence could be achieved at the start of treatment. Importantly, a requirement of total abstinence could very well turn some clients off to the whole idea of discussing substance use, especially those who are not considering change. For such participants, we need to build motivation for change, to reinforce reductions in the frequency and intensity of drug use, and to teach skills that can be used when and if the client wants to abstain. Importantly, not all clients will want or need to abstain from substance use. Longitudinal data show that clients with substance use disorders make many changes, including cutting down on use, starting to work, and controlling psychiatric symptoms, in the year before they achieve remission. This suggests that there is much productive work to be done if a client is unwilling at the start to consider abstinence.
- 5. Stages of change.** The RC will employ Prochaska and DiClementi’s Transtheoretical Model (TTM) of change to conceptualize motivation throughout treatment. Consistent with a harm reduction perspective, we attempt to help clients move to higher stages of change (i.e., greater motivation to quit) by consistently setting goals for reduced use and teaching clients techniques to decrease use

when they choose to do so. The RC should determine (either clinically or by examination of structured assessment instruments administered during research assessments) what stage of change each client is in addressing their substance use problem: pre-contemplation, contemplation, preparation, action, or maintenance. For those persons in pre- contemplation (e.g., no clear desire to reduce use) the focus should remain on basic skills and steps for conversation/refusal sessions. Discussion with persons who appear to be focusing with more certainty on some sort of recovery (reduction of use or abstinence) can be focused on substance reduction and how it relates to the conversation and refusal skills they learn from early on in group.

- 6. Talk so clients will listen.** Many clients will have been told in the past to stop drinking or drug use, either by professionals or by family members. There is often a lot of anger and resentment and these feelings are reflected in how clients and families talk about substance use. When talking to clients, talk as you would want to be talked to when you have a problem. No one wants to be told what to do or have other people making all the decisions. Clients with psychosis (like the rest of us) want to be listened to and heard.
- 7. Empathy is critical.** The clinician must try to understand the client's feelings and perspectives without judging, criticizing, or blaming. A good strategy when talking about substance use with clients is to listen and reflect. Do not try to solve the problem. Try to understand the client's experience.
- 8. Ambivalence.** Ambivalence is a normal part of the change process. Reluctance or unwillingness to change, especially at the start of treatment, is to be expected. Clients may take a long time to commit to the idea of change, and even when they have expressed some commitment, this may wax and wane over time and may be more related to the threat of punishment than to their actual treatment goals or future plans. Gains will be made and lost. It is important to measure success in small units and to support success, however small it may be. Often at the start of treatment, clinicians are ready to help someone change (from a stage of change viewpoint, clinicians are in the action stage) and clients are not thinking about or are ambivalent about change (in precontemplation or contemplation stages of change) and are not ready to act. This disconnect is often a central reason why clinicians and clients don't make progress in terms of discussing and understanding substance use, its consequences, and the client's goals. Make sure to discuss ambivalence and start where the client is, rather than jump into action. Discussing ambivalence as part of a shared decision making process around substance use goals is an ideal way to both educate a client and for a clinician to learn about why that client is ambivalent about change.
- 9. The role of self-efficacy.** As with SST, a critical aspect of SA treatment is enhancing self-efficacy to reduce use or quit. Many people fail to attempt quitting because they do not believe they can succeed. Others fail after having some success when lapses turn into relapses due to feelings of failure and lack of self-efficacy. Related to this is the need to help clients learn and practice coping skills – skills for getting through difficult situations without using alcohol or drugs. Learning and applying coping skills will help build self-efficacy.
- 10. Culture.** The RC should be particularly aware of the client's culture, including gender, racial, ethnic, and socioeconomic factors, and aspects of the drug culture that influence values, language, styles of interaction, the role of substance use in one's life, and the choices one makes around substance use. Care should be taken not to discredit or devalue the importance of any other type of treatment a client may have received or is participating in (especially double trouble or twelve step type

programs). Acknowledge differences between approaches and suggest how they can be complementary, but emphasize that the most important thing is for the person to find strategies that work for them.

**11. When talking about substance use with clients, do:**

- Talk about client's current concerns
- Listen
- Express concern
- Express empathy and acceptance
- Offer support
- Talk to clients the way you would want to be talked to
- Remember: SA is like other disorders
- Acknowledge that you don't have the answer
- Answer questions in a straightforward manner. Young people have lots of misinformation about alcohol and drugs. Once you have a trusting relationship and they start asking questions, they are very interested in the facts about substances and how they affect psychosis.

**12. When talking about substance use with clients, don't:**

- Be the expert
- Ask lots of questions that elicit one-word answers
- Jump into a discussion of drug use if client has other things to talk about
- Be judgmental ("You need to stop using"; "This is bad")
- Confront/label ("You have a problem"; "You're an addict")
- Tell clients what to do
- Tell clients that their behavior is bad

## E. Levels of Intervention for Substance Use, Abuse, and Dependence

Participants will have varying levels of substance use, abuse, and dependence on different substances. Some will be open and willing to discuss substance use, while others will initially be reluctant to discuss their use. Others will not want to discuss drug use at all. In order to be applicable to clients at all stages of readiness to discuss substance use and to change use patterns, the approach to substance abuse treatment used by the OnTrackNY Team will include several levels of intervention, based on a stage-wise motivational approach to substance abuse in which the information that is provided and the discussion of substance use matches the individual's level of readiness to change, can flexibly incorporate reduction or abstinence goals that change over time of vary by substance, and is collaborative in nature. Specifically, the substance abuse treatment program will include four levels: (1) Assessment of use and discussion of assessment findings; (2) Defining and discussing ambivalence; (3) For heavy, episodic, or substance abusers, skills for limiting use and coping with situations in which you don't want to use; and (4) for those with substance dependence, a more structured program of substance abuse treatment.

## F. Assessment of use and discussion of assessment findings

Assessment – asking questions and gathering information about a client's substance use - is the first step in figuring out what sort of intervention, if any, is needed. Assessment provides a structured way to talk about substance use, allows you to gather information that can inform or impact

treatment, and serves as a baseline for charting progress. Assessment also will introduce to the client how substance use will be discussed by the OnTrackNY program as a whole, and by the RC in particular. Key components of this framework will be introduced: the general view that substance use does not make someone “bad” or “weak,” the collaborative approach in which the client’s ideas and preferences will be taken into account, and that whatever change the client wants to make is possible (self efficacy). It also signals to the client that you are not trying to “fix” him/her, and that you are interested in how he/she sees substance use rather than assuming that he/she is a certain type of user or person. By gathering information and talking to the client about his/her thoughts and ideas about his/her substance use, the RC can gain a better understanding of the quantity and frequency of the substance use, the purpose it serves for the client, and what, if anything, the client is thinking of changing in regards to his/her use. The RC needs to understand what is going on before considering what needs to be done.

Assessment of substance use can include formal tools and structured questionnaires or interviews, but this is not required. Several structured tools are provided in the Appendix that can be used to assess the important domains of use highlighted below. Whether such tools are used or not, assessment really refers to starting and maintaining a conversation about drinking and drug use that is done in such a way that the client is part of the discussion, appreciates the discussion, expresses his/her thoughts and ideas, and decides (with active assistance) what, if anything, he/she wants to change. The way the initial questions about substance use are asked will set the tone for many discussions to come. A general rule to go by is that you can ask a client just about anything as long as the tone of the question is empathic and not harsh/judgmental. To start, use fewer closed ended questions. Use open ended questions and let the client tell you his/her story. Use reflective listening to make sure you have the details correct. Show empathy and concern and don’t try to solve the problem while assessing it.

## 1. Initial questions about substance use

It is useful to start with open-ended questions about a client’s substance use history and first use of different substance use, and then build to use in the present. People often are more comfortable talking about past use and the progression establishes that interviewer is non- judgmental. The following are some examples of good and not good ways to ask some initial questions about substance use:

**Good:** Your Primary Clinician asked me to speak with you about your drug use. To get started, why don’t you tell me a bit about your drug use. When did you first use drugs? What was that like for you?

**Not good:** Your Primary Clinician said that you use drugs.

**Good:** Tell me about your drinking. **Not good:** Do you drink too much? **Good:** When did you first use drugs? Where were you and what was going on?

**Not good:** I understand you have been a drug user for years.

**Good:** What concerns you about your drug use?

**Not good:** Do you know how bad using drugs is for you?

**Good:** My job on the program is to talk with people about drinking and drug use and figure out how they impact your treatment goals. Maybe we can start by your telling me what you hope to get out of your work with the team.

**Not good:** Your family has said that you won't be able to return to school if you keep smoking pot.

After starting the conversation, you can ask some for some specific information about substance use. Ask about situations, specifics, times, days of week. At the start, stay away from judgments ("this is bad for you"). Ask for a time when the client was NOT using and ask the client to tell you about that time in detail. Then ask how these things are different when the client is using. This can sound similar to a medical check up: objective, routine, professional. Be sure to listen to the answers and don't try to solve "the problem". Some sample questions are as follows:

**Good:** Since we're just meeting for the first time, it would be helpful for me to know a bit about your substance use. What is your drug use like in a typical week. Which days would you use drugs, what would you use, and where would you be?

**Not good:** Your family said you use drugs all the time. Is that true?

**Good:** Other people I've worked with tell me that they drink with friends on the weekends. What is that like for you?

**Not good:** Sounds like you spend all weekend drinking.

**Good:** Tell me about when during the week you smoke pot.

**Not good:** Your Primary Clinician told me that you smoke a lot of pot.

## 2. Quantity and frequency of substance use

Quantity of drinking can be discussed in terms of standard drinks [12-ounces of beer, 8-ounces of malt liquor, 5-ounces of wine, 1.5-ounces or a "shot" of 80-proof distilled spirits or liquor (e.g., gin, rum, vodka, or whiskey)]. Quantity of drug use is more difficult since there are not standardized amounts for most drugs. Don't get hung up on the exact quantity of alcohol or drug use. It is more important as you are getting to know the client and getting a good general understanding of the pattern of his/her substance use and its impact on his/her functioning. The following are some good and not good questions to ask regarding quantity and frequency:



**Good:** So you generally drink on the weekends. Which weekend days do you usually drink and what would be a typical amount for you?

**Not good:** Sounds like you spend all weekend drinking.

**Good:** Tell me about when you smoke pot. Would you say you smoke every day, or is it more spaced out over the week? What would be a typical time during the week when you would smoke? How much money do you generally spend on pot in a typical month?

**Not good:** Your Primary Clinician told me that you smoke a lot of pot.

### 3. Reasons for use

Assessment should also include getting the client's thoughts on his/her reasons for using substances. What is useful about substance use? What is not useful? What is it about certain situations that make drinking/drug use enjoyable? It is important to use terms like "positive" and "negative" or "pros" and "cons" when you are talking with a client about reasons for use of alcohol or drugs to avoid the moral tone of "good" and "bad." Labels such as "helpful" and "not so helpful" are good too. These sorts of questions can be asked in an informal way, or can be done as a more structured activity of listing the pros and cons of substance use (see Appendix for Pros and Cons worksheet). Some clients will like a structured exercise while others won't - the RC will have to figure this out. Whether this is done informally or in a structured way, the RC should take some notes and summarize what the client likes about substance use, in order to make sure he/she has a complete understanding of this.

**Good:** It's helpful for me to get a good understanding of what you like about drinking. Everyone has some things that they like or they wouldn't drink. What are some things that you like about drinking? I'm going to keep a list here. Ok, so some of the things you like about drinking include that it makes you feel relaxed, it's something you do with friends to socialize, and it puts you in a good mood. Those are actually pretty common reasons for drinking - lots of people like the way drinking can make them feel. Now I want to find out some of the difficult things that have happened to you because of drinking. Most people who drink have a few times when their drinking got them into trouble or resulted in them feeling badly. Tell me about some of those times for you.

**Not good:** Your Primary Clinician has told me that you hang around kids who drink and you have gotten into trouble with them when you are drinking. Your mother told me you have gotten sick from drinking. Those are really bad things and they show that your drinking is out of control.

The goal here is to identify the good aspects of substance use for the client as well as the consequences that he/she has experienced. The good aspects will help the RC figure out the sorts of skills the client will need in order to succeed without drug use. For example, if a client says that he likes smoking pot because it helps him to relax, then the RC knows that part of the process of reducing/stopping pot smoking will have to include alternative ways to relax. In addition, finding out the consequences of drug use for a client can help the RC learn what are potential sources of motivation for change. For example, if a client reports negative, high-risk sexual encounters while



high, this can be used as a means of approaching the topic of the benefits of reducing/stopping drug use.

**Good:** You have told me a few of the problems you have run into when you have been using drugs. Probably the one that seems the most upsetting to you are the times when you have had sex with someone you don't know when you are high. It sounds like you still feel shame when you think about the times that have happened. I'm wondering how those feelings of shame impact you now.

Another useful exercise is to complete a Looking Back worksheet (see Appendix). This is a self-report of all medication and drug use. This can be useful because it asks about both medication and drug use, rather than singling out drugs – it is thus less judgmental. For example, this form collects information on psychostimulant use, which many clients will have experience with. This format allows for a review of how life got better or worse around medication/substance use, and what is different for the client in terms of thoughts or feelings or behavior in times of non-use. Some people have a psychotic reaction to drugs. Looking back, they may be able to say: "I was doing better when I wasn't using drugs."

#### 4. Thoughts about change

Finally, the RC needs to get an idea of the client's thoughts about change. This is not a time to tell the client he/she has to stop drinking or using drugs. Rather, the RC can find out what the client is willing or unwilling to do about substance use, and if there are related issues the client is willing to work on. The following are some examples of good and not good ways to ask some initial questions about substance use:

**Good:** So you drink mostly on weekend nights when you are out with friends. Everyone else drinks too, and you feel like your drinking is pretty much the same as everyone else's. You have said that drinking makes you feel relaxed and helps you fit in, which are things that you value. You have also told me that your doctor told you that you shouldn't drink while you are taking medication, but it's really hard to think about not drinking when you're out with friends. Do I have that right? I appreciate that you have been honest and have really thought about the pros and cons of drinking. Where do you think we should go from here?

**Not good:** You said that your doctor told you that you can't drink if you are taking medication. I will help you stop drinking.

**Good:** Smoking pot helps you relax and keeps you from feeling anxious, but you are concerned that you are smoking more than you used to. What is your goal regarding smoking pot?

**Not good:** You need to stop smoking pot.

**Good:** It seems like you understand that your parents are concerned about your drug use. Even though you tell them it's not a problem, they view it as something that can be harmful to you. You said that using drugs sometimes is fun for you, and even though you don't agree with it, you have

said you can understand that it's risky for you to use drugs because they are illegal. What sorts of changes do you feel you could make in your drug use?

**Not good:** You are under age and you need to stop using drugs or you will go to jail.

The RC could also use a strategy called Importance and/or Confidence Rulers (also called a Readiness Ruler) to assess motivation to change. This involves creating a written number line and asking the client: "On a scale of 1 to 10, how important is it for you to stop using or cut down on your substance use, where 1 is not important at all and 10 is extremely important?" If the client answers that it is a 1 and not important at all this would lend itself to stage the client in precontemplation. If the client replies that they are a 4 or a 5, the RC would then reply, "Why do you think you are a 4 or a 5 and not a 1?" The client replies that cutting down is important because they are having some problems at home and work. For a Confidence Ruler, the RC asks, "On a scale of 1 to 10 how confident are you that you will be able to stop or cut down, where 1 is not confident at all and 10 is very confident?" The client replies that they are an 8 because they have stopped before.

## 5. Use of drug testing

Drug testing via urinalysis can also be used as part of a comprehensive assessment. Urinalysis can detect drug use for differing numbers of days depending on the substance, with shorter periods of use for some (use in the past 3-4 days for cocaine and heroin) and longer periods of time for others (use in the past 24-28 days for marijuana).

Use of drug testing can be upsetting to clients, so their use must be done thoughtfully and be explained clearly and supportively to the client. If you choose to use drug testing, it will be important to make sure that the client understands the intent behind its use. Some can interpret drug testing as a sign of distrust, which can compromise the therapeutic relationship.

There are some situations in which drug testing would be most warranted. First, drug testing can be useful in situations in which a client is reporting no drug use or no problematic drug use, in contrast to reports of family members that the client is using drugs frequently and with problems. In such a case, although a client may say that drug use isn't a problem, if drug screens are positive then a discussion can be started around the positive screens. Second, drug testing can be useful in cases where a client is unable to describe his/her drug use. Clients experiencing an episode of psychosis may not be able to fully or accurately describe their current use. If problem drug use is suspected, it may be necessary to do drug testing in order to determine whether or not a client is using drugs and what drugs he/she is using. Third, drug testing is useful as a way to monitor progress towards treatment goals, and can be used as a means to provide encouragement and reinforcement (when tests are negative) and problem-solve difficult situations (when tests are positive). Introducing the potential use of drug testing should be done with care, in a nonjudgmental and supportive tone:

**Good:** Tell me what you know about urinalysis. That's right – there is a test that can be used to determine whether or not you have used drugs in the last few days/month. Drug testing can be really helpful as a tool to help figure out what sorts of situations are tough for you to get through

without using drugs and what situations are easier for you. For example, if you give a sample and the test is negative, then we can talk about the various things you did over the prior few days that helped you cope with things that are going on without using drugs. If you give a sample and the test is positive, then we can talk about what tough situations you encountered and try to come up with a plan for dealing with those situations so that the next time you can handle it without drugs.

**Not good:** In order for me to know if you are using drugs, you will have to have a urine test when you come here. The test tells me if you have used or not. Lots of times people don't tell the truth about using, so the test is better because it can't lie.

## 6. Discussion of assessment and clarification of goals

Once you have completed an initial assessment, it is useful to provide feedback about your discussion to the client that summarizes what you have learned and your thoughts about it. One way to do this is to provide the client with a Feedback Form (sample listed in the Appendix) that summarizes information on frequency/pattern of use, consequences of use, and thoughts about change. At this point you will likely want to give advice about a client's substance use. The key is to present your advice so that it doesn't sound like advice. This is important because lots of times people (all people, those in FEP and all others) don't want advice and are inclined to tune out or ignore information if it is presented as a demand. This is a normal reaction to being told to change. Not pathological, not bad, not deviant. Don't tell the client what to do or that substance use is bad. The goal here is to have the client talk and identify the reasons for change. Have the client state why and how things would improve if change occurred. Don't tell the client. Let the client tell you. Ask questions such as "What do you want to do about your drug use?" "What changes do you want to make?" "Tell me how cutting down would help you." Summarize clients' thoughts and ideas. Ideas are better accepted if they are coming from someone empathic and concerned. Advice may not be immediately accepted and this is OK. You don't have to convince someone in one session to give up substance use. Rather, work on creating a relationship based on empathy and understanding. Then you will get more time with a client and have more opportunity to influence ideas about change.

Shared decision making should be used to discuss goals for change. It is important to keep in mind that there are many kinds of goals. Abstinence is one goal and will be appropriate for many clients, including those who are in legal trouble from their substance use (i.e. use would represent a violation of parole or probation and could result in the client going to jail), those who meet criteria for substance dependence and so are using enough to have their substance use severely impact many areas of functioning, or those who are pregnant and so cannot use at any known safe level. In general, clients who use drugs like heroin and crack cocaine that are highly addictive are good candidates for abstinence. These clients may not be willing to consider lifeline abstinence, but may be more willing to discuss a trial period of abstinence. Also, clients using heroin may need assistance with withdrawal symptoms – the RC should consult with the team, especially the psychiatrist, in such cases.

Other clients will not want to consider abstinence as their goal at the start of treatment. If abstinence is presented as the only option, most clients will stop listening and refuse to come back for substance abuse treatment.

Therefore, in addition to abstinence, the Primary Clinician must engage the client around other potential goals, including goals centered on modifying or moderating their use, limiting their use in certain situations, how to decline use in unsafe situations (when driving, when one has responsibilities to attend to, when one is with people one doesn't know well), refusing offers to use drugs or alcohol in certain situations (need to get to sleep and wake up for work the next day), and how to develop friends who do not use substances. The Recovery Coach should use a shared decision making approach to evaluate the benefits of different potential goals and select goals that the client and the RC agree with.

## G. Defining and Discussing Ambivalence

Many clients will know that substance use is not great for them but are not able to discuss what to do about it. This is conceptualized as being "stuck" – the client knows that less or no use would produce some benefits, but there are many benefits to using substances as well. This state of being stuck is referred to as ambivalence (Miller & Rollnick, 1991), and its hallmark is feeling two ways about something such that no change is made. Anyone who has ever tried to convince someone to change a behavior or a situation knows exactly how this feels - you suggest something, they think of a million reasons why it won't work. Thus feeling two ways about something is a common experience for all people as well as being a part of substance use and problems. A helpful way to think about ambivalence involves the metaphor of the balance or seesaw. An individual is on a continual seesaw, going back and forth on whether or not to change. This uncertainty is often viewed as abnormal and as a sign of poor motivation – it's obvious to all that the client should change, but the client only argues against all efforts to convince him/her. However, ambivalence is a normal and common component of change, and one that most individuals experience when they are thinking about change. Change is hard. Staying the same is less hard. Highlighting the ambivalence and helping a client understand it and work through it is a key component of all levels of intervention.

It is important to discuss ambivalence and identify the things that keep a client stuck and unable to change. The RC can introduce the concept of ambivalence, and then engage the client in a discussion of his/her reasons for and against change. The RC should use reflective listening as a way to help the client clarify his/her thoughts and feelings and values. For example, a client says that he drinks in order to fit in with his friends, and that he is a different person when he drinks. The RC can respond by summarizing in a way that repeats back the theme of the client's comments but adds to them: "So while drinking can sometimes help you feel like you belong in the group, your drinking actually often concerns you because it turns you into someone else. So your friends don't really get to know the real person that you are. They only know the person who drinks."

The RC should also try to create a discrepancy between what the client says he/she wants in life and what he/she actually experiences due to substance use. For example, many clients with FEP will talk about wanting to get back school or work, spend time with friends, and be independent.

However, for some, their substance use will keep them from doing these things. The RC can open a

discussion by creating discrepancy: “You have told me that the thing you want most is to return to the things you did before all of this, like going to work each day and doing the things you want to do when you want to do them. It sounds like you value your independence and being able to make decisions for yourself. Those are great goals. It’s interesting to think about how your drinking plays into those values. You have said that drinking has left you feeling bad and tired and slowed down, all things that get in the way of you being independent, getting back to work, and making decisions. What do you make of that?” It is important to remember that the job of the RC here is not to point out the discrepancy, even though it may be very apparent. The goal is to use reflection and questioning so that the client sees the discrepancy and arrives at the conclusion that change is needed on his/her own.

A useful tool when discussing ambivalence is to do a structured Decisional Balance or Pros and Cons exercise. This can take many forms, but generally involves having making notes with the client about the costs and benefits of change and the costs and benefits of no change (samples in Appendix). The goal here is not to tell the client what the costs of drug use are. Rather, the RC should elicit ideas from the client. By gathering the ideas in one place, and providing an empathic and supportive atmosphere in which a client can talk freely, the information collected will show the client, in his/her own words, the factors that are getting in the way of change.

Many times, discussing ambivalence and allowing clients to voice their ideas is all that is needed for someone to decide that change is needed and to identify what change it is they want to make. Other clients will not want to make any change immediately. When this happens, it is useful to find out what would need to happen for the client to be convinced that a change is needed. In other words, if not now, when would you want to make a change? The following is a way to say this:

**Good:** I am glad that you worked with me to identify some of the benefits of change. You have said that reducing your drug use would allow you to feel more confident when you go to apply for jobs, and it would definitely help with your family relationships, since you and your family argue a lot about your drug use. As we have been talking about goals, it seems that right now you don’t feel that you are able to commit to any goal around making a change in your drug use. Tell me about that. What would be going on with you that would signal to you that it’s time to think about making a change?

**Not good:** We’ve been talking about goals and it’s clear that you don’t want to stop using drugs. When you’re ready to quit, let me know and I can talk with you about it.

## H. Skills for limiting use and coping with situations in which you don’t want to use (for heavy users, episodic users, or substance abusers)

Many clients will have the goal of modifying or moderating their use, limiting their use in certain situations, or refusing offers to use drugs or alcohol in certain situations. An important aspect of our treatment program for participants who do not meet criteria for substance dependence will be to help them determine how to limit use, how to decline use in unsafe situations (when driving, when one has responsibilities to attend to, when one is with people one doesn’t know well), and how to

develop friends who do not use substances. For such clients, the general goal of “cutting back” or “reducing use” is good but less helpful than identifying particular times or situations that use should not occur. With alcohol, a client can also identify a certain number of drinks (1-2) to consume in a given situation; this limiting the quantity of use is more difficult with drug use since most drugs do not come in standard doses. Limiting drug use to certain days of the week (such as weekends) or locations can be useful. In addition, moderating drinking or drug use will be well suited to certain users and less useful for individuals with substance dependence. However, some clients with dependence will refuse a goal of abstinence initially. In such cases, a goal of moderating use can be attempted at the start. If the client is successful with moderating use, then no further adjustment is needed. If the client is unsuccessful with moderating use, this is an indication that substance use is perhaps more problematic and that abstinence is a better goal for this client. In such cases, the RC should be truthful with the client and up front about his/her reservations about a moderation goal and about what can be learned if the client is unable to achieve a moderation goal:

**Good:** We have been talking about goals to work towards in terms of substance use. It seems like after talking about the benefits of changing your drug use, you are comfortable with working on a goal of reducing your drug use. I think it’s great that you are willing to work on cutting down your use and I think that less drug use will help you in many ways that we have talked about. That being said, I think it’s important to stress that for many people I’ve worked with who use drugs every day like you do, cutting back use is often a tough thing for them to do, mostly because using a little usually leads to using a lot more. What is that like for you? So you can understand the concern that, for someone like you who uses drugs every day, we may find out that cutting down is too tough, that just being around drugs leads to a lot of drug use. I think we will learn a lot from you’re trying to cut down that will be useful. What I usually tell people who are using every day is that we can work on cutting down for 2-3 weeks, and by that time we should see some sort of change in use. If not, we may need to revisit this goal and talk about whether abstinence might be a better match. How does that sound?

**Not good:** I don’t think you will be able to cut down. I think you need to stop using drugs. Cutting down would be a waste because you use too much for that.

**Good:** I am glad that you are willing to try a goal of moderating your drug use. I do think it’s important that you know that moderation is very difficult when your drug of choice is heroin. Heroin is a drug that is really hard to use in a controlled or moderate way. You know only too well that heroin is highly addictive. Because of this, I would recommend that we focus on short-term abstinence as a goal to get started with. Since you are more willing to try to cut back your use at this point, how about if we try that for the next week and see how it goes. If it’s going well we can keep it as our goal. If it’s not going well, we can revise our goal then. At that point, I can tell you about some of the medication options that are available to help you feel OK when you stop using heroin.

**Not good:** People can’t cut down with heroin, they have to stop. I will talk to your psychiatrist about methadone. For clients who want to moderate or limit substance use, intervention follows a general problem solving framework and can be structured around three main areas: (1) Identifying situations



in which the client doesn't want to use or wants to limit use; (2) Making a plan to not use or limit use for each situation; and (3) Trying out the plan and revising as needed.

## 1. Identifying situations in which the client doesn't want to use or wants to limit use

To get started, the RC and the client should list all situations in which the client uses drugs/alcohol. The RC should be sure to include situations that the client is likely to down play or not bring up. Some common situations are:

- Drinking/using with friends; client must drive to/from location (bar, party, house)
- Drinking/using with friends; client is not driving to/from location (bar, party, house)
- Drinking/using alone; client must drive to/from location
- Drinking/using alone; client is not driving to/from location
- Drinking/using to get to sleep
- Drinking/using to cope with negative feelings (stress, anger, depression)
- Drinking/using the night before work/school
- Drinking/using; nothing to do the next day
- Drinking/using during work/school
- Drinking/using when I have other responsibilities (studying, cleaning up, getting to treatment)

From this list, the RC and the client can pick situations in which the client should not drink/use drugs. These should include any situations that involve driving. It is also good to include situations in which the client needs to be focused, such as at school/work or when he/she has other responsibilities.

## 2. Making a plan to not use or limit use (for drinking only) for each situation

The next step is to make a plan for not using (or limiting use, in the case of drinking) in the situations that have been identified. Some clients may opt for avoiding these situations entirely (such as not going out with friends if he/she needs to drive). The RC can help the client to come up with strategies for coping in these situations without drinking/using drugs. For example, if the situation is "using to get to sleep," the RC and the client can identify other ways to get to sleep that don't involve substance use. If the situation is going out with friends and driving, the RC and client can come up with (and role play if needed) declining offers of alcohol/drugs and ways to have a good time without drinking/using drugs. If the situation is drinking/using to cope with negative feelings, the goal is to come up with other things to do when feeling stressed or angry or sad.

## 3. Trying out the plan and revising as needed

Finally, the client can use the plan and discuss how it went with the RC. Revisions can be made to the plan to account for any unexpected situations. The RC must remember to provide a lot of praise for any attempt at using the plan, even if it didn't work as expected. The goal is to get clients to try something new. If they try it, that is reason for praise, even if they didn't totally succeed. The client can then try the plan again, as well as add a new non- drinking/using situation to the goal if needed.



## I. Structured program of substance abuse treatment (for clients with substance dependence)

For participants who meet criteria for substance dependence and who find that their substance use is having a pervasive negative impact on their lives and functioning, OnTrackNY will also offer a more structured program of substance abuse treatment. The approach will be based on Behavioral Treatment of Substance Abuse for People with Serious Mental Illness (BTSAS; Bellack et al., 2007), a behavioral treatment to address substance use among people with serious mental illness that is fully integrated into mental health care and acknowledges the fluid phases of interest in such treatment. It was specifically designed to address the needs of individuals with serious mental illnesses who have co-occurring substance use disorders. It contains six integrated components: 1) motivational interviewing to enhance motivation to reduce use; 2) structured goal setting to identify realistic, short term goals for decreased substance use; 3) a urinalysis contingency designed to enhance motivation to change and increase the salience of goals; 4) social skills and drug refusal skills training to teach participants how to refuse social pressure to use substances, and to provide success experiences that can increase self-efficacy for change; 5) education about the reasons for substance use and the particular dangers of substance use for people with serious mental illness, in order to shift the decisional balance towards decreased use; and 6) relapse prevention strategies that focus on developing skills for coping with urges and dealing with high risk situations and lapses.

In contrast to traditional substance abuse programs, the atmosphere in BTSAS groups is supportive and positively reinforcing. Therapists actively search for ways to provide social reinforcement and encouragement. Even when members have used drugs or express waning motivation the therapists support effort and encourage participation. Notably, they are never critical or punishing. Members are never admonished to do better or work harder, and they are never made to feel guilty or unwanted. Rather, therapists acknowledge how difficult it is to reduce drug use and work to support participants during difficult times. Clients are encouraged to provide social reinforcement and encourage one another as well. It is common for members to applaud for one another when they provide clean urine samples or work hard in a difficult role play rehearsal. Consequently, it is consistent with the SST approach and is well-suited to adolescents and young adults who would not respond well to a moralistic or guilt-inducing approach. Procedures for implementing BTSAS are described in detail in a book (Bellack et al., 2007) that is included in our set of treatment manuals.

## J. BTSAS Session Outlines

These outlines provide a framework for addressing different skills and topics integral to substance abuse treatment. Each session takes a predictable format. Sessions begin with goal setting in which clients collaborate with the RC to create a concrete goal to work on between sessions. Next, the topic from the previous session is reviewed, and then the new topic for the day is presented. Sessions end with role playing where applicable. Importantly, the skill level and content of sessions should be tailored to the needs and abilities of each client. The RC, based on what he/she knows about the client, should tailor sessions accordingly. Unlike SST, however, BTSAS sessions are generally provided for all clients with substance dependence. That is, all clients complete sessions on drug/alcohol refusal skills, identifying and coping with high risk situations, education about high risk

situations, and relapse prevention. A focus on BTSAS in the context of FEP is to increase clients' awareness of how substance use interferes with managing their symptoms and achieving their goals.

Each BTSAS meeting begins with goal setting. The RC and the client identify a specific, short-term goal, a few personal reasons for not using drugs/drinking, and specific steps for being able to achieve the goal. Usually the goal is focused on reduced or no use of a particular drug/alcohol. Generally, one substance is targeted. For clients who have problems with more than one substance, goal setting should focus on the substance causing the most serious problem. Focusing on one substance at a time increases the likelihood that the client will have some success in reducing or stopping drug use/drinking. After success is achieved with one substance, another can be added to the goal. Goals should be reviewed each session to see if the client wants to make any changes, but the therapists should appraise the chances for success and tailor goals accordingly. If a client fails to achieve a goal after several weeks, the RC should generate an intermediate goal that is more attainable (e.g., if the client can't avoid using crack for a full week, he/she can try to restrict to use on one or two days). It is critical to remember that behavior change is difficult and must be shaped by gradual approximations. Goals should be set to minimize the chances of failure. Clients will often be unrealistic in what they propose to try. Sensible but unrealistic goals (e.g., "I don't want to use cocaine anymore.") should not be rejected. Rather, the RC should frame an intermediate goal that can be achieved and that moves the client toward the more superordinate goal (e.g. "How about if this week we try to use only on weekends?"). The RC must use his/her knowledge of the client, the specific situation, and what he/she knows about behavior change in general in order to determine what is realistic and what is not. The general rule of thumb is to be conservative. It is also important that the RC not imply that the client is being foolish or naive or that it is the client's inadequacy or lack of competence that makes the goal unsatisfactory. Be reinforcing and encouraging as in the social skill module, always couch feedback in positive terms. For example, rather than *"I think that's too much for you to take on."* or *"I don't think you're being realistic here"*, try something like, *"That's a good goal, but it sounds like a really big jump from where you are now. How about if we try..."* or *"I'm glad you want to make such a big change, but it might be hard to not use if your brother keeps bringing stuff home to use with friends. How about if you plan on leaving the house [escape] when he comes up with his friends to use?"*

BTSAS includes three sections: (1) Drug refusal skills; (2) Education and Coping Skills; and (3) Relapse Prevention. The session outlines provided below are the basis of the intervention. It is to be expected that the frequency of sessions and their order would be tailored to each client. For example, while drug refusal skills are presented first and generally are provided for the first several weeks, the RC may decide to intersperse these sessions with those on coping skills in order to keep things from getting monotonous. Also, the outlines below are not fully detailed. Please see Bellack et al., 2006 for full versions of each session.

Drug refusal skills: Repeat these topics as needed. Repeat those that are most relevant to a client more frequently. For example, if a client uses drugs mostly with friends and not strangers, repeat the sessions that are relevant to friends more frequently.

## 1. Refusing drugs/alcohol and suggesting an alternative

Rationale: Because so many people use drugs and alcohol, you may be pressured by someone to get high or drink. Because it is sometimes difficult to say “No”, it is important to practice saying, “No” and to come up with reasons why you don’t want to use drugs or drink. This can be really hard when the person is someone that you know well and you like to spend time with. Sometimes you want to spend time with the person but they want to do drugs and you do not want to do drugs. So you need a way to tell them that you don't want to use, but you might want to do something else with them. The steps we will cover here can be used to tell someone you don't want to use drugs and offering an alternative - suggesting another activity that you could do together instead of using.

### **STEPS OF THE SKILL**

1. STEP 1: Make eye contact.
2. STEP 2: Using a firm voice, tell the person that you don’t want to use drugs or alcohol with them.
3. STEP 3: Give reasons why you don’t want to use
4. STEP 4: Suggest something else to do instead

### **SCENES TO USE IN ROLE PLAYS**

1. Running into or being approached by a dealer on the street
2. Attending a social get together and being offered drugs or alcohol
3. Being asked to use by a family member whom the client uses/drinks with frequently
4. Having a phone conversation with someone who calls asking for drugs or offering to share

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL**

1. It is important to make these role-play situations very personally relevant for clients. The client should identify the people in his/her life who are likely to pressure him/her to use, people that will be hard to say no to, and/or people whom they know and want to spend time with (i.e. a family member or friend). Clients should identify specific people and situations where drug use is likely, and to indicate the specific language that would be used by the partner. Information from the motivational interview will be especially useful herein helping to identify relevant people, places, and substances for client.
2. Role plays should begin easy and increase in difficulty over time (both within and between meetings). The RC should attempt two to three times to get the client to give in, and then agree with the client’s suggested alternative and end the role-play. Clinical judgment should be used at all times when determining the role-play content.
3. The RC should not use personal attacks as a way to convince the member to use.
4. Choose alternatives that would be functionally successful for the individual group member.
5. Role plays can be reversed, with the client playing the person who they are trying to refuse, and the RC playing the client. This allows the RC to gauge how a person who is being refused would respond to the client’s refusal.
6. The skill, “offering an alternative activity,” may be used as a suggestion after refusing an invitation to use drugs as long as the scene does not involve a person who has drugs/alcohol with them at the time, and is someone that the client would want to do something with. It is too risky to invite someone carrying drugs to engage in another activity. The same would be true if a drug dealer made

the offer. If the person DOES have drugs with them, an optimum decision would be for the client to tell them that they would get together some other time and leave the situation.

7. Ask if the client has tried using the refusal skills and whether or not they worked to further understand why a certain strategy may/not work and to create helpful alternatives.
8. The overall message here is to be aware of the need to tailor plans and role-plays to different situations that the client faces.

## 2. Refusing drugs/alcohol under pressure (from someone you know)

Rationale: Sometimes when you refuse an offer to use drugs or alcohol, someone may give you a hard time or keep pressuring you or make you feel bad. Lots of times it is someone you know - a family member or a friend - who is pressuring you to use drugs with them. Here we will practice using the skills to say no under pressure-when a family member or friend or someone you know keeps pressuring you to use drugs.

### **STEPS OF THE SKILL**

1. STEP 1: Make eye contact.
2. STEP 2: Using a firm voice, tell the person that you don't want to use drugs or alcohol with them
3. STEP 3: Give reasons why you don't want to use
4. STEP 4: Request that the person not ask you to use/drink

### **SCENES TO USE IN ROLE PLAYS**

Use the people and places identified by the client earlier. If the client has more than one person or place that is risky, then vary the role-plays accordingly.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL**

1. It is important to make these role-play situations very personally relevant for clients. The client should identify the people in his/her life who are likely to pressure him/her to use, people that will be hard to say no to, and/or people whom they know and want to spend time with (i.e. a family member or friend). Clients should identify specific people and situations where drug use is likely, and to indicate the specific language that would be used by the partner. Information from the motivational interview will be especially useful herein helping to identify relevant people, places, and substances for client.
2. Role plays should begin easy and increase in difficulty over time (both within and between meetings). The RC should attempt two to three times to get the client to give in, and then agree with the client's suggested alternative and end the role-play. Clinical judgment should be used at all times when determining the role-play content.
3. The RC should not use personal attacks as a way to convince the member to use.
4. Role plays can be reversed, with the client playing the person who they are trying to refuse, and the RC playing the client. This allows the RC to gauge how a person who is being refused would respond to the client's refusal.
5. Ask if the client has tried using the refusal skills and whether or not they worked to further understand why a certain strategy may/not work and to create helpful alternatives.

6. The overall message here is to be aware of the need to tailor plans and role-plays to different situations that the client faces.

### 3. Refusing drugs/alcohol and leaving the situation

Rationale: There will be situations in which the person offering you drugs or alcohol is not someone you know or someone you want to spend time with. Rather, the person is a stranger asking you to use, a drug dealer pressuring you to buy drugs, or an acquaintance who you don't want spend time with. You may want to talk differently to people you don't know or don't like, such as saying less and getting out of the situation very quickly.

#### **STEPS OF THE SKILL**

1. STEP 1: Make eye contact.
2. STEP 2: Tell the person that you don't want to use drugs or alcohol
3. STEP 3: Give reasons why you don't want to use
4. STEP 4: Request that the person not ask you to use / leave the situation

#### **SCENES TO USE IN ROLE PLAYS**

Use the people and places identified by the client earlier. If the client has more than one person or place that is risky, then vary the role-plays accordingly.

#### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL**

1. The RC must tailor the above steps to the experience of each client. For example, some will not feel comfortable making eye contact with a drug dealer. Others will want to leave the situation without saying anything, rather than giving a reason. Others might feel that they need to explain why they don't want to use this one time (such as being out of money or needing to be clean for a urine test), with the idea that the dealer might leave them alone if he thinks that they will be back another day.
2. Role plays should begin easy and increase in difficulty over time (both within and between meetings). The RC should attempt two to three times to get the client to give in, and then agree with the client's suggested alternative and end the role-play. Clinical judgment should be used at all times when determining the role-play content.
3. The RC should not use personal attacks as a way to convince the member to use.
4. Ask if the client has tried using the refusal skills and whether or not they worked to further understand why a certain strategy may/not work and to create helpful alternatives.
5. The overall message here is to be aware of the need to tailor plans and role-plays to different situations that the client faces.

### 4. Education and Coping Skills

#### #1. Positive and negative aspects of using drugs/drinking

RATIONALE: People usually use drugs and alcohol because they make them feel good—they like the high. Some people like it because it helps them be friendlier. It might be pretty unusual for you to be asked to think about why you liked to use drugs and alcohol. It's important to figure out what you thought was good about using because it helps us figure out strategies to help you cope with those

situations without using. If you know why you like it, you will have a better idea of the situations in which you tend to use and the situations in which you will be at risk to use. For example, if you liked using because it helped you feel confident around other people, then we know that situations in which you are around other people might be a time when you are at risk to use. Also, we can help you to find other ways to achieve these feelings without using. Using the same example, if you use drugs and alcohol to feel confident around other people, then we need to help you find other ways to feel confident that don't involve using. As another example, some people use drugs to help them feel calm when they are nervous. We can help you find other things to do to feel calm instead of using.

### **MAIN POINTS AND EXERCISES:**

1. Review positive aspects of substance use. Why do/did you like using drugs/drinking?
2. Review negative aspects of substance use. There are lots of negative consequences of drug and alcohol use as well. You have all met in individual motivational interviewing sessions and talked about these - what are some of them?

### **SPECIAL CONSIDERATIONS:**

1. List what client likes about using (draw from information generated in MI sessions). If someone says, "It makes me feel better", then ask specific questions like "Better than what?" If someone says "It makes my illness better" respond with "What symptoms of your illness does it make better?"
2. Probe for specifics regarding what exactly has happened to a client when they experienced particular negative consequences. For example, ask, "What happened that you didn't like? The RC should be empathic here. "You had nasty hangovers. That must have been terrible."
3. The RC should keep the list of positive aspects and negative consequences for review in sessions as relevant.

## **#2. Interaction of drugs and alcohol with symptoms of psychosis**

**RATIONALE:** Drugs and alcohol affect how your brain functions and sends information. Drugs and alcohol alter how the brain works, which results in your brain not functioning the way it is supposed to.

### **MAIN POINTS AND EXERCISES**

Use cocaine as an example. Whenever cocaine is injected, smoked, or snorted, it is carried through the blood into the brain. Cocaine causes release of a brain chemical called dopamine, which can make you feel good when you first use it - more alert, excited, confident or powerful. However, cocaine can also make you feel paranoid, cause hallucinations, or cause you to have strange or unusual thoughts. This is because of the increased dopamine being sent to cells in the brain. This same process is at work with other drugs/alcohol – they impair brain functioning, which alters how we feel, behave, and think.

Overall, using/drinking makes symptoms of psychosis worse. Some people think that using/drinking makes them feel better. This is sometimes referred to as self-medicating – trying to use drugs or alcohol to make the symptoms of psychosis go away. Unfortunately, the opposite is true in the long



run – using/drinking actually, over time, makes symptoms worse and makes any medications you take less effective.

### **SPECIAL CONSIDERATIONS**

1. Clients may feel more comfortable with or better understand the term “brain chemicals” rather than “neurotransmitters.” After introducing the term neurotransmitters, you can use either term, depending on what the client prefers.
2. Be sure to discuss the client’s experience with using/drinking to cope with symptoms of psychosis. They may strongly believe that it helps them, and in the short-term, it might. Need to distinguish between short and long term benefits.
3. It can be helpful to do a functional analysis here. Generate a list of symptoms/feelings that the client uses/drinks to cope with. Then make another list of how the symptoms/feelings respond/change after using/drinking. This will show the client the function of the using/drinking. For example, if someone is feeling anxious and they drink to calm down, you then know that they need other means of calming down.
4. Remember that these are individuals dealing with a first episode of psychosis. Stay away from discussions of how this is the beginning of serious mental illness, a lifetime problem, etc.

### **#3. Habits, cravings, triggers, high-risk situations**

**RATIONALE:** We know about the negative consequences of drug and alcohol use and how these consequences cause problems for you; and we talked about how cutting down could help make life easier for you. It seems hard then to understand why people keep using doesn’t it? So, why do you think people still use even though bad things can happen to them?

### **MAIN POINTS AND EXERCISES:**

1. Discussion of habits: People continue to use drugs/drink even though bad things can happen to them because he/she has developed a HABIT of using and has gotten used to using drugs/alcohol when they feel a certain way or in different situations. A habit is a routine – something that you do without thinking about it - like sitting in the same seat every day in class or at the dinner table. Habits are things we do automatically, without thinking. Some habits are useful, like saying ‘Thank you’ when someone holds an elevator door open for us. Other habits are not useful, like biting your fingernails or scratching a sore. Using drugs/drinking can be a bad habit like that: you can use without thinking about whether you really want to or not because you are used to doing it at a certain time or in a certain place, or when someone asks you to.
2. Discussion of craving. Another reason people use drugs is because they have cravings. Cravings are very strong physical urges or needs to use/drink. Sometimes a craving can be so strong it hurts, and you can’t think of anything else until we take the drug/drink to reduce the bad feelings. Cravings are the body’s way of telling us that it really wants something, like hunger pangs. In the case of hunger, the body has a natural need for food, and when it needs more, it sends out signals that are hard to ignore, kind of like an alarm going off that says, “Feed me.” Cravings occur because drugs gradually make changes to the brain. When you first start using drugs the brain doesn’t expect it: it just reacts to the sudden change caused by the chemicals. Gradually, the brain starts to adapt, and after a while it needs the drug to function properly. Unlike your stomach, brain cells don’t mess around by sending



out gentle little reminders to eat: they hit you with a sledge hammer: "I want drugs NOW and I'm going to make you feel miserable until I get some." The important thing to remember is that a craving doesn't last forever. When a craving begins, it will increase for several minutes, hit its peak (the point where it feels the worse), and then begin to fade away. Depending on what drug and how much you use, this process may take as little as about 7 to 10 minutes. One reason that people become dependent on drugs is that the drug immediately removes the craving and any uncomfortable feelings that come with it. But, remember, the craving will go away on its own if you wait it out. We will talk about ways to cope with those times when cravings seem overwhelming. The longer that you go without using drugs/alcohol, the fewer cravings you have. Also, the longer you are not using, the amount of time between cravings increases. We will also talk about how to avoid situations that produce cravings and make it easier to wait it out until the craving goes away.

3. Discussion of triggers. Cravings can be triggered by people, places or things that you connect to using/drinking. This happens because things you associate with using or drinking – such as people, places, feelings, situations, objects, times of day, smells/sounds/sensations – can remind you of the pleasurable feelings you get from actually using drugs/drinking. Sometimes, several triggers will often occur together, which can make it really difficult to not use/drink.
4. High-risk situations. When you are in a situation where your triggers are present, you are in a HIGH RISK SITUATION (HRS), so-named because there is a high risk that you will use/drink when you are in them. Where there is a trigger there is a high risk for you to use. High Risk Situations can be times when there are many triggers present, or when there is one trigger that is especially strong or hard to avoid.

### **SPECIAL CONSIDERATIONS**

1. Engage the members in a discussion about their own experiences with triggers, cravings, and high risk situations. Use prompt questions such as the following: Has anyone had cravings? What are they like for you? What happens when you get cravings? The purpose of this discussion, as with the discussion of habits, above, is to get members to understand the concept by relating it to their personal experiences and to gather material to be used in developing intervention strategies. The discussion should be kept brief, and should not evolve into an extensive discussion of each member's personal reasons for using and problems in quitting.
2. When discussing craving, draw a diagram of a sine curve (a series of bell curves) to explain craving hitting a peak and recurring periodically.
3. When discussing triggers, use the following flow chart: Triggers==>People, Places, Things==>Remember positive feelings==>Cravings

### **#4. Avoidance**

RATIONALE: When you know what your HRSs are, you can be on the lookout for them. It's always easier to deal with a HRS when you know that it is coming. Then you can be prepared and have a plan ready to help you deal with it. There can be more than one way to cope with a HRS. One way to deal with a HRS is to avoid it.

## MAIN POINTS AND EXERCISES

1. Avoiding a HRS means staying away from it. For example instead of going to a bar and trying to say no or trying to keep yourself from drinking a beer, you don't go to the bar in the first place. That way, you don't see the beer, you avoid the trigger, and you don't put yourself in that HRS. Some ways you can avoid your triggers or HRSs include: distracting yourself with a movie, the television or other activities, doing relaxation or other activities that make you feel good, or going somewhere with people who don't drink/use drugs.

## SPECIAL CONSIDERATIONS

1. The RC can have the client define a HRS, identify a successful coping strategy, and then identify another HRS. Or, the RC can help the client to generate several solutions for one key HRS.
2. The RC should suggest that the client role-play ideas to see if they would work.
3. The RC should be specific and ask the client if he/she has different triggers for different substances.

## #5. Escape and refusal

RATIONALE: Sometimes it's not possible to avoid a HRS. It may be a place you have to go, someone you have to see, or you find that you are already in that situation. One thing that you can do if you find yourself in a HRS is escape, or leave the situation. Another thing you can do is to use drug refusal skills and refuse the drug or alcohol that is being offered to you.

## MAIN POINTS AND EXERCISES

Develop escape and refusal plans. It is important to have a plan of how to escape and/or refuse drugs and alcohol when you find yourself in a HRS. Let's come up with a HRS and figure out a plan.

## SPECIAL CONSIDERATIONS

1. Have the client list HRSs and generate escape and/or refusal-related solutions.
2. The RC should suggest that the client role-play their escape/refusal plans.

## #6. HIV and Hepatitis: Definitions, high-risk behavior, and the link to substance use

RATIONALE: Over the next few sessions will be talking about different diseases that people who use drugs are more likely to get, including HIV/AIDS and Hepatitis. We will review basic information like definitions and how drug use increases risk of getting these diseases. Also, we will talk a lot about ways to keep from getting these diseases - what is safe behavior and what isn't safe behavior.

## MAIN POINTS AND EXERCISES

### Definitions:

**HIV** - Human immunodeficiency virus – a virus that gets spread from one person to another. The HIV virus won't eventually go away. A person who is HIV positive can give the virus to someone else.  
**AIDS** – Acquired Immune Deficiency Syndrome - over ten years - before they actually get AIDS.

AIDS weakens the immune system so that the body can't fight off illnesses like pneumonia, certain cancers, and other infections.

**Hepatitis.** The 3 most common types of hepatitis are A, B and C. They are all caused by viruses that damage the liver. Some of them (especially Hepatitis C) can cause really bad liver damage, leading to cirrhosis (or scarring), liver failure and cancer. The liver works like a filter and cleans toxic stuff out of your blood. It also makes proteins that help your blood clot, helps digest food, and stores sugar and vitamins that provide the body with energy. Bottom line, you can not live without your liver. Both drinking and using drugs makes your liver do a lot of extra work, and for many people it gets to the point where their liver is so tired and unhealthy from all that extra work. Hepatitis A is the most common form of hepatitis and is usually spread by contaminated feces: when people don't wash their hands after making a bowel movement, then touch food. Hep A can also be transmitted during sex by rimming (sticking your tongue in someone's anus) and through contaminated water in places where the water supply is not kept clean. Hepatitis B is usually spread through sexual intercourse (both vaginal and anal). If you have sex without a condom, you are at risk for getting Hepatitis B. Hep B also is spread through blood contact, so it can be spread sharing needles, toothbrushes and shaving razors. (Unlike Hepatitis A, Hepatitis B is NOT spread through food or water). Hepatitis C is the most serious kind of hepatitis and is the most common type among people who shoot drugs. It is spread primarily through blood when people share needles to use heroin and other drugs. Sharing straws to snort drugs also spreads Hepatitis C, as does sharing toothbrushes and shaving razors, because these things all have blood on them. Also, the Hepatitis C virus can live outside of the body for up to 2 weeks. So if it gets on a toothbrush or razor, for example, it can live for a long time and infect someone else if they use it.

**High-risk behaviors.** HIV and Hep C are transmitted by bodily fluids (blood, semen, vaginal fluid, feces, breast milk). First, wash hands. Second, there are 2 general types of behaviors that lead to sharing fluids: sex and drug use.

**High risk sexual behaviors include:**

- Oral sex - sores make it more risky, don't do without protection like cut condom, dental dam, saran wrap
- Anal sex - considered highest risk behavior when unprotected, use two condoms to keep from breakage. Intercourse - unprotected, pulling out, sores make it more risky
- Touching - when sores are present and blood is exchanged
- Engaging in sex work - either paying for sex or getting paid to have sex, prostitution is more dangerous because of having sex with someone who has had a lot of partners, being with more partners, violence, drug use etc.

**High risk drug use behaviors include:**

- IV drug use (shooting up)
- Sharing needles
- Smoking rock/crack

Getting high/drunk makes it more likely to make bad decisions. It's easy to plan to have safe sex when you're sober but you won't always keep your goals when you are high. A lot of unsafe sex occurs when people are high. People put themselves at much greater risk when they use drugs - they lose the ability to use good judgment.

### **SPECIAL CONSIDERATIONS**

The RC may need to include information on other sexually transmitted diseases: Risky sexual behaviors and risky drug use behaviors can put you at risk for other diseases in addition to HIV. Sexually transmitted diseases such as syphilis, herpes, chlamydia, and gonorrhea are all contracted through the risky sexual behaviors we have been discussing today. Research has shown that people with these sorts of STDs are much more likely to contract HIV if they are exposed to it. That is because some of these STDs involve sores or tears that can let HIV into the body. So understanding these risky sexual behaviors is important in terms of reducing risk for HIV as well as other sexually transmitted diseases.

**Bacterial STDs** – treated with antibiotics

**Viral STDs** – can't be cured but can be managed with medications (ex. Herpes)

#### **Other STDs:**

- Bacterial vaginosis
- Chlamydia – often no symptoms
- Gonorrhea
- Herpes – most people with it don't know they have it, can be spread even when symptoms are not visible (i.e. not true that it can only be spread during an outbreak)
- HPV (human papillomavirus) – commonly associated with genital and anal warts, often leads to cervical cancer
- Syphilis
- Trichomoniasis – can lie dormant for months or years

## **#7. HIV and Hepatitis: Decreasing high-risk behaviors**

**RATIONALE:** Everyone has different risk behaviors, but it's important to know all the ways of protecting yourself and then figuring out for yourself which are the most important and effective ones for you to use.

### **MAIN POINTS AND EXERCISES**

#### **Ways to decrease risk of contracting HIV and Hepatitis:**

Wash hands, intercourse with a condom.

Instead of having intercourse: Generate list of other things that people can do besides having sex to show that they care about each other or to make each other feel good. The list can include

masturbation, other sexual activity that does not result in exchange of body fluids but is pleasurable, being together but not having sex, cuddling, kissing, going out and doing something fun, etc.

What about when people do drugs? Generate list. Take a harm reduction approach. Most FEP clients will not be IV drug users so the focus should not be on clean needles for most people. Instead, for most clients, the RC should focus on the fact that that drug use/drinking is a high- risk behavior in and of itself due to loss of judgment and risk of not staying to goal of having safe sex that goes along with being high. Message is don't use drugs. If you do use drugs, then have safe sex or no sex. Have condoms with you. Don't inject drugs. If you inject, have clean needles and don't share needles. Women - don't be vulnerable. Don't use drugs/drink with people you don't know.

What does not protect against HIV? Generate list including pulling out, washing afterwards, having sex with someone who "looks" healthy. Also, many popular methods of female birth control (the pill, Norplant, Depo-Provera, sponge, diaphragm, IUD) cannot reliably prevent HIV infection or risk for getting other STDs.

How to tell someone you want to use a condom or you don't want to have sex. *There will be times when you find yourself with someone who you want to have sex with and who wants to have sex with you. It will be important for you to remember what you need to do to reduce your risk of contracting HIV. The following are the steps you can use.*

STEP 1: Clearly state your position or request (lets your partner know that you mean no)

STEP 2: Give a reason why (helps your partner to understand your position)

STEP 3: Suggest a safe alternative OR

STEP 4: Leave the situation (if the person becomes violent or you think they may get violent)

### **SPECIAL CONSIDERATIONS**

1. The RC can role play with the client. Make sure to use a scenario that reflects the client's goal and be specific about what would really happen and whom it would be with. Probe to check for any sign that a situation could become threatening to the member's health or safety. In such cases, advocate for Leaving the Situation or Avoiding the person entirely.
2. If role-playing with a male client who may not need to convince a female partner to use a condom, set up a role- play in which the client explains to someone else (friend, brother) the reasons he should use a condom (i.e. his brother is about to have sex for the first time with his girlfriend and doesn't want to use a condom).

## **5. Relapse Prevention**

### **#1. Coping with lapses**

RATIONALE. One of the things we know about giving up drugs is most people have a bad day sooner or later. They may think they have it licked and decide they can do just a little. Or, maybe they are

having a bad day and lose self- control. Lots of people who give up drugs talk about how hard it is not to do drugs when they are feeling stressed out or depressed, and that these bad feelings lead them to want to use. Sometimes they just have a weak moment. Lots of people tell us that peer pressure sometimes gets so bad that they have trouble saying no. Whatever the case, most people who are giving up drugs make a slip at one time or another and use. We call these lapses. The most important thing for you to remember is that a lapse does not have to become a relapse. We have found that it is easier to keep a lapse from becoming a full-blown relapse if we talk about it in group and figure out what to do if a lapse happens. I don't want it to happen but if it does, you will be prepared. So it's better when there is a plan - some sort of idea of what you could do if you experience a lapse.

### **MAIN POINTS AND EXERCISES**

There are steps for you to use right after a lapse:

STEP 1: Stop! Keep calm!

STEP 2: Remember your hard work

STEP 3: Implement a plan: get rid of drugs/alcohol, get out of the high-risk situation, do something else.

STEP 4: Ask for help

Who would like to start? How about you John? What's a high-risk situation for you that could lead to a lapse if you don't plan ahead? OK, let's apply the lapse steps to this situation. The first step is STOP. What would you do?

### **SPECIAL CONSIDERATIONS**

1. The RC should write the steps on board and give the client a handout/wallet card before explaining each step. Get the client's thoughts on each step, have they done such a thing before, would they add anything to that step, etc.
2. Give the client time to come up with a high-risk situation. If they have trouble thinking of one, present a situation based on what you know about him/her and his/her use.
3. Go through each step with the client and write his/her plan on the board under each step. Be as concrete as possible. Incorporate role-plays where appropriate. Role-plays might be particularly useful for steps 4 (escaping the situation) and step 5 (asking for help). For example, if the client is in a situation with other people and he/she needs to leave the situation, the role-play can center on the client telling the other people that he/she is not going to use drugs any more and that he/she needs to leave the situation.

## **#2. Addressing other substances of abuse**

RATIONALE. It is important to talk about other drugs or alcohol that you might use, and practice applying the refusal, escape, and avoidance skills to them. We have generally been talking about

your use of \_\_\_\_\_. However, drinking or using drugs other than \_\_\_\_\_ can be a high-risk situation. Sometime people think that as long as they are not using \_\_\_\_\_ it doesn't matter if they drink or smoke pot. But there are a couple of ways that using alcohol or other drugs can be a high-risk situation for relapse to \_\_\_\_\_. First, if you spent a lot of time doing two drugs together or drinking and using \_\_\_\_\_ together \_\_\_\_\_ then using one (such as alcohol) can remind you of the other. When you do two things together over and over again, they become linked together. So one (such as drinking) can become a trigger for the other. Second, drinking/using drugs affect the brain and the ability to think clearly and make good decisions. Drinking or using can lead to bad decisions to use, even when you have been working hard to stop. For example, suppose you have been drinking for a while and you feel drunk. Someone comes around and tells you they have some really good \_\_\_\_\_ and wants you to use with them. When you are drunk it's going to be much harder to use the skills you know and it's going to be much harder to tell people that you don't want to use. Third, situations in which people are drinking and using are more likely to be situations in which \_\_\_\_\_ is around and people are using it too. So just being around a lot of people who are drinking/using could potentially put you in a situation in which people are using \_\_\_\_\_ too.

### **MAIN POINTS AND EXERCISES**

1. Set a goal to cut down or stop drinking or other drug use (for clients who are drinking or using secondary drugs and have made progress in cutting down/stopping their primary drug).
2. Practice skills to refuse, escape, and avoid drinking/other drug use

### **SPECIAL CONSIDERATIONS**

1. Review a drinking/other drug use situation with each group member. The situation can be one that the client has been in recently or one that the client is likely to be in the near future. The situation should involve either the client drinking/using other drugs or being in a situation in which he/she was offered or pressured to drink/use other drugs, or in which he/she would have a hard time not drinking/using other drugs. Make a plan for the situation using refusal, escape, and avoidance skills, then do role-plays to practice. If the plan is to use drug refusal skills, write the skills on the board and what the client will say for each one. If the plan is to use escape (i.e. the client is offered alcohol and plans to leave immediately), write the steps on the board (eye contact, say no, give a reason, leave the situation) and what the client will say for each one.
2. For clients who want to set a goal to cut down/stop drinking/secondary drug use, remember that the goal does NOT have to be that the group member totally stops using. If the group member is using a secondary drug quite frequently and he/she suggests stopping totally, consider whether the group member can do that successfully or if the goal should be scaled back to be drinking/using on fewer days in the last week, or staying free from using any substances for just the next week to try out being totally free from all use - a term for this can be SAMPLING being totally free from all alcohol and drugs for one week to see how it would go).
3. If the clients plans to use avoidance to cope with a drinking/other drug use situation, work to come up with a plan including what time he/she is likely to want to drinking/use other drugs, what he/she can do instead, where else can he/she go except to the bar, how he/she can get to that place, etc. Be very concrete. This will be the client's practice for how to avoid drinking/other drug use situation. Another avoidance scenario is one in which the client is approached by someone else, and that



person wants to go into a drinking/other drug use situation. For example, the client is asked by a friend to go to a bar/party. In this situation, you can use the refusal skills steps: (1) Make eye contact, (2) Say no - State that you do not want to there (e.g. go to the bar), (3) Give a reason - I'm trying to stay away from cocaine and drinking makes me want to use cocaine, I don't do that any more, etc.

4. (4) Suggest an alternative/leave - let's go to the cafeteria instead/you will have to go to there without me.

### #3. Coping with boredom

**RATIONALE.** One important trigger that often is involved when people use drugs is feeling bored. Lots of times people may find themselves at home with nothing to do. We know that sitting at home with nothing to do can get boring, and sometimes people use drugs because they have nothing to do and are bored. However, when you are trying to stop using drugs, it's important to figure out what to do when you feel bored, instead of using drugs.

#### **MAIN POINTS AND EXERCISES**

1. When do you feel bored? What can you do when you are feeling bored?
2. Practice coping with boredom.

#### **SPECIAL CONSIDERATIONS**

Scenes to use in the role play:

- Sitting at home with a friend and not doing anything
- Sitting at home alone feeling bored
- At home alone and the plans that you had with a friend fell through

### #4. Coping with depression or stress

**RATIONALE.** Another high-risk situation that can lead to relapse is feeling depressed or stressed.

#### **MAIN POINTS AND EXERCISES**

Coping strategies:

- Increasing pleasant activities
- Talk to someone
- Get help/Solve the problem
- Talk to your psychiatrist about medication
- Plan ahead / Practice strategies (i.e. asking for help/problem solving)

#### **SPECIAL CONSIDERATIONS**

1. The RC should engage clients in a discussion of how their use changes when they are depressed, stressed, or experiencing other negative affect, and if they have experienced that they use more or relapse when they feel badly. Keep in mind that this is NOT meant to be verbal psychotherapy or an

in-depth discussion of what depression or stress feels like for group members. Do not ask clients how they feel when they are depressed/stressed, what being depressed/stressed is like for them, etc. What therapists should do is explore with clients the connection between negative affect and continued use/greater use/relapse to use so that they understand that depression/stress/negative affect is a high-risk situation. STAY

BEHAVIORAL. Explore how depression/stress/negative affect is linked to greater use or relapse. Examples:

The client feels bad, stops going to treatment, uses cocaine to feel better and be able to get up and out of bed in the morning.

The client has a fight with a family member, feels stressed out, doesn't know what to do or say to the family members so goes and gets high.

The client is having a problem or some sort that he/she doesn't know how to solve and feels upset by it so gets high.

Make notes on the board/flip chart as needed so that the client can see the pattern that feeling depressed/stressed/other negative affect is a high-risk situation that can lead to relapse.

2. If possible, find out what the high-risk negative affect is for a client (i.e. what do they call it - being depressed, stressed out, upset, bad, etc.). You want to use their words. At this point in the group you might know from what a client has already said. If not, just use the term "feeling depressed or stressed". We DO NOT want a big discussion of what types of feelings the client has. Rather, we want to help them make a plan for when they are feeling depressed/stressed/bad. Talk with each client about what they could do if they are feeling that way, using the three strategies discussed in group - doing a pleasant activity, talking to someone, getting help to solve the problem. Give examples for each category. For example, if Bob often feels stressed out, list some pleasant activities that he could do, a person that he could talk to, and how he could get help to solve a problem (who he would go to for help with different sorts of problems, or how to solve one specific problem that affects him repeatedly such as medication side effects, problems getting to treatment appointments, arguments with family members, etc).

## #5. Coping with symptoms of psychosis

RATIONALE. Two more high-risk situations that can lead to relapse are having symptoms of psychosis or and medication side effects. Some people say that they will use drugs or alcohol to cope with symptoms of psychosis, such as delusions, hearing voices, hallucinations, or feeling manic.

### MAIN POINTS AND EXERCISES

Coping with symptoms:

- Talk to your doctor

- Distraction
- Alternative ways to cope
- Talk to someone
- Plan ahead / Practice strategies (i.e. asking for help/problem solving)

### **SPECIAL CONSIDERATIONS**

1. GET SPECIFIC - what specific symptoms does the client experience? Talk with the client about what he/she could do if they are feeling that way, using the three strategies discussed. Give examples for each category.
2. Be sure to review talking to the doctor and role-play talking to the doctor.

## #6. Coping with low motivation

RATIONALE. Another high-risk situation is staying motivated to cut down or quit using drugs. Quitting drugs can be like climbing a huge mountain – at the bottom you feel strong and have tons of energy and like you can get to the top, but as you climb you get more and more tired and your body feels really bad and you just want to stop and give up. This is true with quitting drug use - sometimes you feel really great and motivated and glad to be doing the work, and other days you feel bad and just wanted to forget the whole thing. Low motivation and feeling tired is an important reason that people relapse.

### **MAIN POINTS AND EXERCISES**

Coping with low motivation:

- Talk to someone
- Remember the "bad times"
- Think about how things are better now that you are not using
- Do something that feels good
- Plan ahead / Practice strategies (i.e. asking for help/problem solving)

### **SPECIAL CONSIDERATIONS**

1. The RC should help the client identify a person that he/she could go to when they are experiencing low motivation who might be able to help them and would encourage them. Include professionals and nonprofessionals. Keep a list.
2. When talking about the bad times, probe for specifics regarding what exactly has happened to the client when they experienced the particular negative consequence. The RC should be empathic here. Keep a list generated by the client. If the client has difficulty coming up with consequences, give them the handout that lists negative consequences of drug use.
3. GET SPECIFIC - when does the client experience low motivation? What has worked for him/her in the past? Talk with the client about what he/she could do when feeling that way, using the strategies discussed in group - talking to someone, remember the "bad times", think about how life has improved since stopping drug use, doing something that feels good. Give examples for each category.

## 6. Optional topics

### #1. Money management (having money as a high-risk situation)

RATIONALE: Another important trigger for using drugs for many people is money. People who use drugs often find it really hard not to use when they have money or they know that they are going to get money sometime soon. For example, lots of times when people get a paycheck, they get a big urge to use drugs because they have all of that money there and know that they can buy drugs or alcohol with it. So they go out and spend all the money on drugs or alcohol, but then they have no money left for anything else. To reduce this risk, it is important to manage your money so that you won't use all of it to buy drugs. This involves making sure that your money is safe and is not just sitting in your pocket waiting to be used to buy drugs.

#### **MAIN POINTS AND EXERCISES**

Strategies for money management

- Talk to your social worker or counselor about banking services or getting a representative payee
- Take someone who doesn't use drugs with you when you go to get your money
- Write a budget
- Select a non-using friend, family member, or professional to help you manage your money
- Plan ahead / Practice strategies (i.e. asking for help/problem solving)

#### **SPECIAL CONSIDERATIONS**

1. Get specific. When do clients have money-many times in the month or just the first or 15th of the month? What do they do when they have money? Do they have a bank account, direct deposit, a family member who deals with their money? What has worked for them in the past? Talk with the client about what they could do if they have money and want to use - talking to their counselor or social worker about banking services, taking a non-using friend or relative with them to pick up and deposit the check, writing a budget. Have them role-play where necessary, such as in talking to their counselor about opening a bank account, or asking a non- using friend or relative to come with them to pick up and deposit their check. Be specific and give examples.

### #2. Dealing with a family member/friend/partner that use drugs

RATIONALE: It's hard to stop/decrease use when you have family member/friend/partner who is using/drinking. This situation gets even more complicated because often you really care about the partner that you are with and you try to do what you want to do without hurting them or making them feel bad.

#### **MAIN POINTS AND EXERCISES**

Note: these are general guidelines. For each, develop a specific script for the client and practice having the client talk to the family member/friend/partner via role-plays.

- Explain the situation. Tell the family member/friend/partner that you are trying to stay clean or cut down your use and why.
- Limit your time with that family member/friend/partner - only do things together that don't involve using drugs. See your partner for meals, for activities, etc. that don't involve drug use. This may mean limiting your time together to certain times of the day (i.e. if your family member/friend/partner uses at night then see him/her during the day) or to certain activities (if your family member/friend/partner doesn't use in the mornings in order to get to work, see each other for breakfast; go to a meeting together).
- Take a break from seeing that family member/friend/partner. If you are unable to stop seeing your family member/friend/partner, talking about taking a break might be a good idea. Explain to your family member/friend/partner that you are trying to stay clean and you are involved in treatment and you need a few weeks/months to get going with this and so don't want to be around others who are using because it's too tempting.
- Stop seeing the family member/friend/partner. If this family member/friend/partner is unable to accept what you are doing and unable to support your efforts to stay clean or cut down on your use, it might be time to think about whether it's best not to see that person any more. This is really hard because lots of times you care a lot about the person. But staying away from drugs and alcohol is also really important, and sometimes can be more important than staying with a family member/friend/partner who is using.

Other, client-generated ideas. Has he/she had to deal with this before and what did he/she do that helped?

### **SPECIAL CONSIDERATIONS**

Incorporate skills that the client has learned in other sessions into these role-plays. For example, if a client is telling a partner that they are trying to stay away from drugs and alcohol and want to take a break from the relationship for a month, the client can follow these steps:

1. Make eye contact.
2. Tell partner that you are trying to stay clean from drugs.
3. Give a reason why you are trying to stay free of drugs and alcohol.
4. Suggest a relationship break and why
5. Tell partner when you will contact them again, remind them not to contact you, and leave.

### **#3. Creating a drug free social support network (how to meet people who don't use drugs)**

**RATIONALE:** It is hard to stop using/drinking when all of your friends are using/drinking. It is important to find ways to find, meet, and get to know people who don't use drugs or alcohol. Sometimes figuring out how to change people, places, and things and meet new people is really hard. When you have been using/drinking for a while, it can be tough to remember things you used to like to do and other ways to spend time.

## MAIN POINTS AND EXERCISES

Note: these are general guidelines. For each client, develop a specific script and practice talking to other people via role-plays.

- Do things that support not using/drinking (generate a list with the client)
- Go to AA/NA meetings or other treatment sessions
- Get involved in healthy activities
- Use social skills to meet new people. We have reviewed skills for making conversations with new people and making plans with someone. These are important skills when you are working on not using/drinking. There are often times when you start a conversation with someone and you find out you have something in common.

### STEPS OF THE SKILL:

1. Step 1: Make eye contact and say hello.
2. Step 2: Ask a general question.
3. Step 3: Invite the person to do something with you
4. Step 4: Confirm the invitation with the person, then give a reason and say good- bye.

Do other non-using activities with someone (generate a list with the client)

- have a meal together
- go to a movie
- go for a walk
- visit someone who doesn't use drugs
- other, client-generated ideas.

### SPECIAL CONSIDERATIONS

1. Incorporate skills that the client has learned in other sessions into these role-plays. For example, use skills from Making Small Talk and Making Plans with a Friend in the role-plays

## #4. General assertiveness training

RATIONALE: There are many situations that require you to say how you are feeling about something, but lots of times this is a hard thing to do. Being able to say what you feel in a calm and direct manner is called being assertive. Being assertive means that you say what is on your mind in a calm but firm way. Saying how you feel is important because if you don't say what's on your mind, everything just stays bottled up inside of you and eventually you won't be able to hold it in any more and you might wind up really angry or upset or exploding in a rage.

## MAIN POINTS AND EXERCISES

1. There are a few ways to be assertive. One is when you express negative feelings, stand up for your rights, and refuse unreasonable demands. Examples of appropriate negative assertion include: standing up to someone who is treating you unfairly or inappropriately, telling someone you don't want to do something that you think is unreasonable, and expressing justified anger or annoyance to

someone. Another way to be assertive is to express positive feelings: affection, approval, appreciation, and agreement. For example: thanking someone for doing you a favor; telling someone that he/she has done a really good job; and complimenting someone on his appearance, improvement, etc. Finally, you can be assertive by refusing to do things that you don't want to do. You might remember that we talked about this at the very beginning of group when we learned skills for refusing requests and offering an alternative. Telling people politely but firmly that you do not want to do something will help you feel less put upon by others.

2. Note: these are general guidelines. For each, develop a specific script for the client and practice having the client talk to the partner via role- plays.

### **Expressing negative feelings (review with group members the importance of each):**

1. Make eye contact.
2. Say exactly what the person did that upset you:  
"It really made me feel \_\_\_\_\_ when you \_\_\_\_\_."
3. Say why it upset you:  
"This upset me because \_\_\_\_\_."
4. Make a suggestion to keep this from happening in the future:  
"In the future, could you please \_\_\_\_\_."

### **Expressing positive feelings (review with group members the importance of each):**

1. Make eye contact.
2. Say what the person did that made you feel good:  
"It really made me feel \_\_\_\_\_when you \_\_\_\_\_."
3. Say why it made you feel good:  
"This made me feel \_\_\_\_\_ because \_\_\_\_\_."
4. Say thank you and tell the person you appreciate it:  
"Thanks so much. I really appreciate it."

Refusing a request and offering an alternative (see BTSAS group #3 for details and handouts)

1. Make eye contact and say "Hello"
2. Tell the person that you cannot do what he (she) asked you to do
3. Give a reason why you cannot do what was asked
4. Offer an alternative

## **#5. Dealing with an aggressive partner or family member**

RATIONALE: When people use drugs, they often find themselves in risky or dangerous situations - situations in which they could be harmed or become victimized, either physically or sexually. Many people don't realize it, but people who use drugs are at a much higher risk being victims of many different kinds of violence. The reverse is also true - people who have been the victims of violence are at a much greater risk of using and abusing drugs and alcohol. In fact, experiencing violence is for many something that leads to relapse - but it doesn't have to be that way if you know other things that you can do to handle a violent or victimizing situation. Today we want to talk to you about some of the links between violence and substance abuse. In addition, we want to talk about



what you can do if you find yourself a victim of violence and give you some strategies for dealing with the situation without using drugs or alcohol.

### **MAIN POINTS AND EXERCISES**

- Links between violence/victimization and substance abuse (NOTE: Have the client add to discussion. Be careful not to put the client on the spot to share experiences since he/she might not want to talk about personal experience of violence or victimization. However, try to elicit discussion whenever possible.).
- Victimization causes stress which leads people to use drugs and alcohol
- Victimization makes symptoms of mental illness worse, which leads people to use drugs and alcohol
- Victimization leads to feeling numb and isolated and angry and depressed, which leads to drug and alcohol use to get rid of these feelings

Often a partner who is violent will provide drugs or alcohol to a user to keep that person dependent and in the violent relationship.

### **What can you do?**

Understand that violence, in any form, is WRONG and it needs to be stopped. It is not your fault, even if you were using at the time.

DO NOT KEEP IT INSIDE - talking about what happened will help you cope with the feelings that victimization brings up. If you do not talk about it, you will have stress or symptoms or feel angry and isolated and this will put you at very high risk to use drugs and alcohol. Ways to talk about it:

- call a hotline - give out list of hotline numbers. Hotlines are confidential.
- talk to a therapist or counselor
- talk about it in group
- talk to a trusted friend or family member
- end the relationship
- call the police, restraining orders, etc.
- find somewhere safe to go - list of shelters, family members, talk to your counselor or therapist about things that you can do or places you can go

If you can't leave, be safe in your house. Use the following steps:

1. Make eye contact.
2. Say exactly what the person did that upset you:  
"It really made me feel \_\_\_\_\_ when you \_\_\_\_\_."
3. Say why it upset you:  
"This upset me because \_\_\_\_\_."
4. Make a suggestion to keep this from happening in the future:

"In the future, could you please \_\_\_\_\_."

5. Go out if your partner is using or will be coming home high or drunk
6. Find somewhere where you can be safe.

Other, client-generated ideas.

## #6. Anger Management

RATIONALE: We all get angry. Lots of times people handle anger badly – they get in fights or scream or yell or hurt themselves. However, those reactions can hurt you and others and they don't solve the problem and end whatever was making you angry in the first place. Often what happens when you are angry and you do something bad like get into a fight is that you get into even more trouble and wind up feeling angrier than ever. It's better to do something that will not hurt anyone but that will also solve the problem so that you don't have to feel angry any more. We call this anger management – skills that you can learn so that when you get angry you will be able to feel better and solve the problem without getting into a fight or screaming and yelling and getting even more angry.

### MAIN POINTS AND EXERCISES

There are several things that you can do when you are angry that can help you to feel better without getting you into trouble or having you lose your cool.

- A. Keep calm.
- B. Think about the negative consequences of your actions.
- C. Think of something to solve the problem.
- D. Talk to someone.
- E. Tell the person how you feel – use the steps for telling someone you are angry.

## #7. Relaxation Training

RATIONALE: Relaxation training is a skill that you can learn to help you feel more calm or less tense. There are lots of times when you might feel tense or stressed out and you don't know what to do to feel calm again. Or, you might get a craving and need something to do to help you wait it out without using. Relaxation can help - when you are tense, or stressed, or having a craving, or in a lot of other situations. A reason that relaxation is helpful is because of the connection between our minds and our bodies. When you feel stressed out, your body gets tense and tight and it's hard to relax. You might even get a craving to use drugs or alcohol because you need to relax and feel less tense. If you can relax your mind, then your body will feel relaxed too. The type of relaxation that we are going to do here in group is called The Soles of the Feet.

Technique. This technique involves getting comfortable, doing some deep breathing, and clearing the tension out of your body.

## MAIN POINTS AND EXERCISES

### 1. Relaxation Script

Sit back in your chair and close your eyes. Get real comfortable: lean back so that your back is supported in the chair, rest your head on the back of the chair, put your hands in your lap or let them hang down by the sides of the chair. Pull your feet up until your feet rest flat on the floor. That's good, nice and easy, get real comfortable and start to feel how your body is getting comfortable in the chair. Check yourself for comfort. Get real comfortable. Think about each part of your body and make sure it is comfortable. Your head is resting on the chair. Your back is supported by the chair and is resting comfortably. Your arms are loose and sitting in your lap or hang down. Your legs are resting comfortably on the floor and your feet can feel the floor underneath them.

Now that you are comfortable, take several slow, deep breaths. Take a deep breath way down into your belly. Let your breathing slow down and start to feel relaxed. Each breath continues to relax you. Now take a deep breath in and hold it. Now slowly exhale, let the breath out, and let all the tension out with it. Feel calm and relaxed as you breathe slowly. Again take a deep breath and hold it. Now slowly exhale, let the breath out, and let all the tension out with it. Feel calm and relaxed as you breathe slowly. Each breath leaves you more and more relaxed. Focus your thoughts on your breathing, with each breath making you feel more and more relaxed. You are breathing quietly, peacefully. Feel the calm that spreads over your body with each breath. Now you feel relaxed over your whole body. Every part is feeling relaxed and calm and quiet. You are breathing slowly and peacefully and your body is feeling calm and relaxed. Each breath cleans your whole body and mind. Relax and feel the peace and calm that has spread throughout your body with each deep breath.

Now focus on your feet. Think about your feet inside your shoes and how your feet are filling up your shoes. Feel the bottoms of your feet touch the floor underneath them. Focus on the soles of your feet and how they are touching the floor. Your feet are on the floor and the soles of your feet are touching the floor. As you breathe deeply, in and out, in and out, focus on the soles of your feet. The soles of your feet are heavy, they are heavy against the floor. Now think about your breathing. Imagine with your next deep breath that the clean, pure air is spreading throughout your whole body, collecting all of the tension and stress. The air takes the stress and tension from your body. Imagine this air leaving through the soles of your feet. See the tension leaving your body with each breath. Imagine another breath entering your mouth and taking all the tension and stress with it as it leaves your body through the soles of your feet. As you exhale you feel your body clean and relaxed, deeply relaxed.

Now scan your body for any last bit of tension or stress. Let all the tension go down, through your legs, and out of your body through the soles of your feet. Your face is relaxed. Your forehead is smooth and your face is completely relaxed. Smooth and relaxed. You have let go of all the tension and worry, it goes down your body, through your legs, and out through the soles of your feet. Now your neck and shoulders are relaxed. Your shoulders droop and relax and your neck is free of tension. Free and relaxed. The tension in your shoulders moves down your body, through your legs, and out through the soles of your feet.

Now take a deep breath and as you exhale feel the relaxation spread throughout your body and your back. The tension in your body and your back is running through your legs and out the soles of feet. You feel free and relaxed. Your arms are heavy and relaxed. Heavier and heavier. More and more deeply relaxed. Heavy and relaxed. Letting go, letting go of all the tension. Letting it run out through the soles of your feet. Your legs are relaxed. They get heavier and heavier, more and more deeply relaxed. Letting go of the last bit of tension and stress. Letting any remaining tension run down your legs, out through the soles of your feet.

Now your whole body is feeling relaxed. Feel yourself being calm and relaxed. You are feeling peaceful and calm and relaxed. Now slowly start to open your eyes. Move around in your chair and when you are ready, open your eyes.

## K. Other Issues in Substance Abuse Treatment

### 1. Ambivalence about committing to treatment

At times, some clients may experience a desire to discontinue participation or have difficulty committing themselves to the treatment process. This is to be expected for anyone with a substance use problem and may be accentuated by ambivalence about change. This situation should be addressed without confrontation. The RC should indicate that shifts in motivation are common, that they are not an indication of failure, and that it is important to continue learning skills so they are in the person's repertoire when they do decide to try and reduce substance use. The following is an example of the supportive, but directive approach to be employed:

**Good:** I like that you have been talking with me about your drug use. You may not feel like talking about drugs and alcohol today, but you are doing important work here. You don't have to role-play today if you don't feel up to it. We can take it session by session for a while and work with you on staying involved in this work.

**Good:** I understand that this is not a good time for you to get off crack, but you were motivated to use less when you started treatment, and you will probably become motivated again down the line. This is still a good time to learn strategies that will be helpful when you do want to quit or cut back, so we can increase your chance of being successful.

### 2. Problems engaging clients in role-play

Some clients will be resistant to role-playing, especially if they do not see the purpose. In these instances, the following strategy is useful:

**Good:** I can see that you are having a tough time today, and I appreciate you being here and making an effort. Remember that you are here because you've said that you don't want to continue using like you have been using in the past. Right now, you may not want to role play/stop using. My job here is to help you get ready for the day when you are ready to make that commitment. The way

I can best do that is to help you role play/come up with a reason why you don't want to use at all. Let's see what we can help you come up with.

If the client still doesn't want to role-play, the Recovery Coach may suggest only role playing one or two of the steps of the day's skill.

### 3. Cultural factors in role-plays

The RC should be particularly aware of the client's culture, including gender, racial, ethnic, and socioeconomic factors and aspects of the drug culture that influence values, language, styles of interaction. Role-plays should be done in the most realistic manner possible. This means that the RC should be familiar with vocabulary that would most often be used in the situations being role-played; types and brands of alcoholic drinks, various drug use practices (routes of administration, nicknames for drugs, etc.), and Twelve Step program vocabulary (sponsor, making amends, various slogans). Asking for specifics when eliciting role-play scenarios with clients is one way to gain this sort of information. While it may not always be an option, it is also important for both facilitators and clients to role play one's own gender whenever possible.

Care should be taken not to discredit or devalue the importance of any other type of treatment a client may have received or is participating in (especially double trouble or twelve step type programs). Acknowledge differences between approaches and suggest how they can be complementary, but emphasize that the most important thing is for the person to find strategies that work for them.

### 4. Overcoming Resistance

The RC, and the team as a whole, takes a motivational interviewing approach to interacting with clients. This includes responding to resistance not with arguing, lecturing, or trying to convince the client of the rightness of or the need for treatment. Rather, in line with a motivational interviewing approach, the RC must "roll with resistance" and respond to it as a signal to shift sets and try something new with the client. Rather than arguing for change and opposing resistance, the RC instead "invites the client to consider a different perspective," all the while stressing that the client is in charge of finding the solutions that will be most useful for him/her.

Client says: *"You just want me to say I have a problem but I don't."*

**Good:** "There is nothing about your drinking that concerns you."

**Not Good:** "You drink every day so obviously you do have a problem."

Client says: *"I'm sick of listening to you."*

**Good:** "It's tiring having to talk about things you would rather not talk about."

**Not good:** "You need to listen to me because I'm telling you what you need to hear to get better."

## 5. Use of Self-Help/Peer Support/12- Step Resources in the Community

Most communities have self-help or 12-step resources that are available for clients to use. The RC should have a list of such resources in the community in the event that a client is interested in trying to use them. Such resources can be helpful or not depending on the client. Some will like the idea and others will not want to use these resources. The decision is up to the client. The Recovery Coach can explain what these resources are and what they involve, as well as his/her opinion of how they might be useful to the client.

There are many benefits to self-help and 12-step programs in the community, including as a source of social support for not using drugs/alcohol. There are also potential drawbacks. Standard AA/NA might be a bit confrontational for young first episode clients. Some AA/NA groups stress no use of any drugs including psychiatric medications, which may give clients with FEP confusing messages about medications. AA/NA groups that are tailored for individuals with dual disorders may expose our younger clients to a chronic population that could be a turn off. It is important for the RC to discuss these issues with the client and consider referrals to AA/NA in the community for those who have significant problems, a lack of social support around non- use, or those who are interested in trying out these resources.

## 6. Withdrawal, Detoxification, and Medications that can assist in the treatment of alcohol and drug dependence

The RC should consult with the OnTrackNY psychiatrist around issues related to withdrawal, detoxification, and medications that can assist in the treatment of alcohol and drug dependence. There are medication options to assist people in reducing their drinking or use of narcotics (including methadone for heroin dependence), as well as medications to assist with withdrawal and detoxification. In the event that a client is experiencing withdrawal symptoms and in need of detoxification, the RC and the OnTrackNY psychiatrist must work together to assess the level of care needed and link the client with needed resources.

A related issue is the use of substances when an individual is taking antipsychotic or other psychiatric medications. Generally, mental treatment providers tell clients that when taking antipsychotic or other psychiatric medication, they should not use drugs or alcohol. There are several reasons for this: (1) certain substances can interfere with the pharmacokinetics of a drug (e.g., nicotine use lowers clozapine levels); (2) certain substances can exacerbate the side effects of antipsychotics (e.g. alcohol and barbiturates can increase sedation); (3) substance use can interfere with antipsychotic adherence; and (4) substances can exacerbate the symptoms of schizophrenia. However, many clients continue to use drugs and alcohol while they use medications. For clients with substance dependence, the rule of no substance use while taking medications may actually provide some motivation to NOT take their medications. Thus it is important that OnTrackNY have a coherent stance on substance use while taking psychiatric medications.

This issue must be addressed within a Shared Decision Making framework. Thus the OnTrackNY program, led by the RC, Primary Clinician and the psychiatrist, must have discussions with clients regarding how their decisions to use drugs or alcohol may have greater or lesser effects not only on their medication effects but also on achieving any other goals they identify. That is, the impact of use on medication must be among the issues that are raised when discussing impacts of substance use and goals for changing use. With this approach, rather than telling clients what to do, it is important to provide information about how substance use becomes more harmful when one is taking psychiatric medications and can interfere with medications providing the benefits that clients want from them. Delivering such messages, and using a supportive and empathic tone when delivering them, is critical for all OnTrackNY staff who deal with clients around this issue.



## VI. Coping Skills Training

### A. Background and Use of Coping Skills Training in First-Episode Psychosis (FEP)

Coping Skills Training involves teaching clients strategies for coping with difficult feelings or situations in order to decrease stress in their lives. These feelings may include anxiety or depression; situations may include those that make the client feel scared, sad, bored, or lonely. Clients will present with different concerns that may limit their ability to achieve work or social goals. Included here are several session outlines that address different topics that will be relevant to certain clients at certain times in their work with the Recovery Coach. These sessions are designed to be used either as a unit or as needed to address particular client goals.

### Coping Skills Sessions

#### #1. What are coping skills?

We all have problems that we need to cope with. Sometimes we have difficult feelings such as depression, anger, anxiety, or stress, and these feelings can be overwhelming. Others times we have problems we need to cope with, and the problems can seem too big to address.

NOTE TO RCs – discuss which of these feelings or situations applies to the client. What is client interested in learning to cope with? What does he/she do now? Why is this not working for him/her? Identify things that aren't effective – avoidance, isolating, etc. Why aren't they effective? What would they like to be able to do instead?

Coping skills are skills to use when you have these sorts of difficult feelings or situations. For example, there may be times when you struggle with depression, and so it is important to learn ways to cope with depression before it becomes overwhelming. Same with coping with anxiety or stress or anger. Coping skills can help you feel better and interact with people better, and help keep you doing what you need to be doing for yourself.

#### #2. Coping with depression, stress, anxiety (may repeat this session several times – once for depression, once for stress, once for anxiety)

Feeling depressed or anxious is common for many people. What do you do when you are depressed/anxious? Many people don't know what to do when they are depressed or anxious in order to feel better. Our goal here is to develop some ideas of things that might help you when you are depressed/anxious. Then you have to try them out and see what works for you.

**(a) Increasing pleasant activities.** One thing that helps people when they feel bad is to do something pleasant or something that they like to do. Research shows that when people do things they feel better. They may not have all of their problems solved, but just doing something and getting up and out and active can improve your mood. Have you ever found that just doing

something, anything, pleasant makes you feel better than doing nothing at all? Tell me about that. Doing something pleasant can be tough when you are feeling bad. For example, one thing that happens when a person gets really depressed is that they stay home in bed and stop doing things. What we have learned that if you get involved in something pleasant, it may keep you from getting really depressed. The time to get up and do something pleasant is right when you notice you are feeling a little bit down or anxious - that way you don't wait until you are too upset/depressed to do anything at all. So what can you do that's pleasant? Let's come up with a list. We need to name as many things as we can think of that are pleasant or can get your mind off of feeling bad and might help a person to feel better. Think of the things that you do when you are upset in order to feel better.

**(b) Talk to someone.** Another thing that we have found helps people when they are feeling depressed/stressed/bad is to talk to someone about how they are feeling. Lots of times when we are upset we keep it to ourselves. Does anyone here do that - keep their feelings inside? Tell me a little about that. Does keeping things inside help you to feel better? What we have learned from other clients is that not talking about what's bothering you doesn't help you feel better. In fact, it usually makes you feel worse. Instead of keeping things all bottled up inside so that you feel worse, you can talk to someone about it and at least get it out there in the open. To do this, you have to think of someone who you think will listen. Sometimes that is a family member or a friend or a counselor or a therapist. Think now about who you could talk to when you feel bad? Bob, who do you talk to?

RC should discuss this with all group members and figure out a person for each group member. Suggest counselor/therapist as often as possible, even for people who name a friend or a family member that they could talk to. Keep a list.

**(c) Get help / Solve the problem.** Lots of times people get depressed/stressed/feel bad when they have a problem and they don't know what to do to solve it. Has that ever happened to anyone here? One thing that we know can help is to get help to solve the problem. That often will help people find a solution to a problem so that they don't have to feel really depressed/stressed/bad about it. Can anyone here tell us about a time that they had a problem and they got some help to solve the problem and they felt much better about it?

RC should get examples from the client. Problems to ask about can be related to money (SSI checks, bills), housing, medication (running out of medication), family problems, etc. Pull for examples of when client got help with a problem and got it solved so that he/she didn't have to spend time feeling depressed/stressed/bad about it.

**(d) Talk to your psychiatrist about medication.** There are also medications that help reduce feelings of depression or stress. Talking to your psychiatrist can be helpful to see if any medications might be right for you. Only your psychiatrist can help you with this, so that's the person to talk to. Let's review how you might talk to your psychiatrist about this. First you would need to make the appointment. Second you would need to go to the appointment and tell the doctor that you are feeling depressed or stressed or anxious. Third, you would need to ask the doctor if there are any

medications that they think might help you feel less depressed or stressed out. Let's go around the room and practice.

RCs should go around the room and have each patient discuss who their doctor is and how they would go about making an appointment. Then each patient should do at least one role-play in which they use the above steps to ask the doctor if there is a medication that would help them feel less depressed/stressed out.

**Plan ahead / Practice strategies (i.e. asking for help/problem solving).** Now that we have this list, let's figure out what each of you could do when you are feeling depressed/stressed/bad. Who would like to start?

NOTE TO RC'S: Talk to the client about what he/she could do if he/she is feeling depressed or anxious, using the three strategies discussed above. For example, if Bob often feels stressed out, list some pleasant activities that he could do, a person that he could talk to, and how he could get help to solve a problem (who he would go to for help with different sorts of problems, or how to solve one specific problem that affects him repeatedly such as medication side effects, problems getting to treatment appointments, arguments with family members, etc.).

### #3. Coping with angry feelings

One type of feeling that many people have special difficulty expressing or coping with is anger. At times everyone gets angry. This does not have to lead to shouting or hitting or cutting off friendships or relationships. It is usually helpful to relieve feelings of anger by expressing yourself in a direct, honest way. Sometimes you might want to wait until you have "cooled off" a little and are feeling calm. Other times you may not want to say anything to anyone, but want to do something to feel less angry.

(a) Reduce your angry feelings and keep calm. Generate a list of things to do to calm down. These can include: leave the situation for a while, listen to music, take a walk, deep breathing. Have client take charge of generating list based on what has worked in the past or what he/she believes might be helpful.

(b) Think of something to solve the problem. If anger is due to a problem, think of some possible solutions to the problem. Ask for help implementing the solution if needed.

(c) Talk to someone who is supportive. Who can client talk to who would be supportive and understanding?

(d) Express your anger in calm way to the person you are angry with. Discuss situations when expressing anger is the right thing to do (friend, family member) and other times when you might not want to express anger (at work, to a boss). Talk about importance of keeping calm – why is it hard to keep calm when you are angry and why is it important to try.

#### **STEPS OF THE SKILL:**

1. Look at the person, speak firmly and calmly.
2. Tell the person specifically what he or she did that made you angry. Be brief.

3. Tell the person about your angry feelings. Be brief.
4. Suggest how the person might prevent the situation from happening in the future.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Many members have a particularly difficult time expressing angry feelings, even in the context of a controlled role play. It is important to devote some time “preparing” clients for this skill. Spending one or two sessions helping members identify common “early warning signs” of anger (such as feeling tense, heart racing, etc.) as well as strategies for managing angry feelings (one of those strategies being the skill at hand), will be extremely useful.
2. Depending on the client, it may be helpful to divide this skill into three parts and practice each part as a separate role play. The first part would encompass Steps 1 and 2; the second part would encompass Step 3; and the third part would encompass Step 4. Not all clients will need the skill divided in this way, but for those who are having some difficulty, this allows them to have positive role-play experiences while practicing the skill.

### **#4. Coping with symptoms or medication side effects**

Today we are going to talk about two situations that are difficult to cope with: experiencing an increase in symptoms and experiencing medication side effects. What symptoms are the most troublesome for you? What side effects bother you the most? Why do you think that experiencing symptoms and side effects are tough situations to deal with? Have you ever had symptoms or medication side effects and done something negative in order to cope with them – such as using drugs or alcohol, or having angry outbursts, isolating, or getting depressed? What is that like? Does it help? So it’s pretty clear that those sorts of things don’t help reduce symptoms and side effects. The important thing to keep in mind is that there are things that you can do to cope with symptoms of mental illness and medication side effects instead of using alcohol and drugs. There are things that you can do to cope with symptoms and side effects that will be a lot more effective than using drugs or alcohol.

**(a) Talk to your doctor.** When you have increase symptoms or side effects the first person to talk to is your doctor. This is such an important thing for you to do that we are going to spend the rest of this group practicing ways to talk to your doctor about symptoms and side effects. The reason is that when you have symptoms or side effect, you might need your medication changed. Such a change might help you feel better and relieve your symptoms. In addition, your doctor can give you medication to help lessen these symptoms and that works more effectively and reliably than drugs or alcohol do. Sometimes the doctor will give you medicine like Cogentin or Benadryl to help with side effects. One thing that clients have told us is that it can be hard to talk to their doctor and tell him/her about symptoms or side effects. Have you ever found that to be hard? Why? We have some steps here for talking to your doctor or counselor about symptoms and side effects. Let's go over these now:

- Make eye contact and be firm. Why is this important? So the doctor knows that you are serious and that you have something important to discuss with him/her.

- Tell your doctor that you are having more symptoms or medication side effects. Why is this important? Lots of times your doctor has a lot of questions for you when you come in to see him/her. By telling him/her up front that you are having more symptoms or medication side effects, you make sure that the doctor know that this is an issue that you need to discuss with him/her right away during that appointment. They will know that it's not something that can wait.
- Tell your doctor what they symptoms or side effects are. This is important so that they doctor knows what is happening with you. If you can't tell him/her what is going on, they will not be able to figure out how to help you. Sometimes it might be helpful to write a list of the symptoms or side effects that are bothering you so that you don't have to remember everything. That way you can just give the list right to the doctor and don't have to worry about forgetting something important.
- Ask your doctor if he/she can change your medication or give you something that will help these symptoms/side effects.

RCs should role-play talking to the doctor about symptoms and side effects with client. In setting up the role-plays, RCs should ask for specific descriptions of symptoms and side effects and build this information into the role-plays.

Distraction. Distraction can be helpful when you are experiencing voices or hearing things that others can't hear. Sometimes voices are really strong or get worse and it's hard to know what to do. One thing that some clients find helpful is distraction - paying attention to something else rather than the voices. Research with clients with mental illness has found that when people pay attention to something else rather than the voices, sometimes the voices decrease a bit or don't make you feel as bad. There are several strategies that have been tried to help people distract themselves from voices: listening to music through headphones, reading out loud, listening to something on the radio, and listening to a book on tape. Can anyone here think of any other ways that someone could distract him/her self when they are hearing voices? Has anyone here heard voices and found something helpful in terms of distracting them from the voices?

NOTE TO RCs: Generate a list of ways to distract clients and get input from all group members. See handout to get started if clients are having trouble coming up with items for the list.

**Talk to someone.** Another thing that we have found helps people when they are experiencing symptoms or side effects is to talk to someone about what's going on with them. Lots of times when something serious like symptoms/side effects is happening we don't tell anyone about it. Does anyone here do that - keep that stuff inside and not tell anyone? Does keeping things inside help you to feel better? What we have learned is that not talking about what's bothering you doesn't help you feel better. In fact, it usually makes you feel worse. Instead of keeping things all bottled up inside so that you feel worse, you can talk to someone about it and at least get it out there in the open. To do this, you have to think of someone who you think will listen. Sometimes that is a family member or a friend or a counselor or a therapist. Think now about who you could talk to when you feel bad? Bob, who do you talk to? The RC should discuss this with all group members and figure out a person that

each group member could go to when they are experiencing increased symptoms or side effect who might be able to help them and would encourage them to talk to their doctor about it. Suggest counselor/therapist as often as possible, even for people who name a friend or a family member that they could talk to. Keep a list.

**Plan ahead / Practice strategies (i.e. asking for help/problem solving).** Remember, we think it's best for you to have a plan - to PLAN AHEAD - so that if you are ever in a high-risk situation you will know what to do. So now we need to make a plan for you to follow when you are having symptoms or medication side effects. That way when you are in that situation, you will have a plan and know something that you can do so that you do not relapse.

NOTE TO RCs: GET SPECIFIC - what specific symptoms and side effects do they experience? Talk about what the client could do if he/she is feeling that way, using the above strategies - talking to the doctor, distraction, talking to someone, planning ahead. Give examples for each category. For example, if Bob often feels fatigue from his medication, discuss how Bob could talk to his doctor about this side effect, alternative ways to cope, and talking to someone about it. IMPORTANT: Put great emphasis on talking to the doctor and role-play talking to the doctor. For example: Bob, you have said that you hear voices and that sometimes they get worse. Let's make a plan for you for the next time you hear voices so that you have something to do to cope. First, you can talk to your doctor. Let's role play that right now. (Give handout and set up and complete a role-play). Do role-plays where appropriate.

Those were great role-plays about talking to the doctor about symptoms and side effects. OK, what's another thing we said people can do when they experience symptoms or side effects. Right, they can use distraction or get involved in an activity to get their attention focused on something else. Why is that a good thing to do? Right - getting your attention focused on something else means you are paying less attention to your symptoms. What could you do to get your mind on something else when you are experiencing symptoms or side effects? We also talked about talking to someone as something that might help. Who could you talk to in that situation?

## #5. Asking for help or support and/or creating a positive and supportive network

Today we are going to talk about finding other people to be around who are positive and supportive and are good to go to when you have something you need to cope with. Our goal is to talk about ways to find, meet, and get to know people who will be positive and supportive. Why do you think being around positive and supportive people is important to being able to cope with difficult things and feelings?

Identify someone who is positive and supportive and ask them for help or spend time with them. Who do you know in your life who is caring and supportive? Call that person, visit them, do things with them. What could you do with them-generate a list with clients. Examples are: having a meal together, going to a movie, going for a walk/coffee.



If you want to ask someone supportive for help: There will be times when you, like everyone, need some help, clarification, or support from someone else. It can be hard to ask for help, especially if you are the type of person that tries to do things on his/her own. Having a few easy steps to follow can help you feel better about asking for help.

### **STEPS OF THE SKILL:**

1. Find a quiet time to talk and look at the person.
2. Explain the situation in 1-2 sentences.
3. Ask for help. Be specific about that you would like them to do.
4. Listen to their answer and thank them.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

1. Asking for help can be difficult for some people. The RC and the client should discuss why asking for help can be positive and who to ask for what types of help.
2. Meet new people. If you don't know people who you would go to when you need help coping, meeting new people is always helpful. In order to meet new people, it's important to be able to start a conversation and make plans with someone. These are important skills when you want to try to meet new people- you need to know how to talk to people and make plans with people who don't do drugs. There are often times when you start a conversation with someone and you find out you have something in common. As a result you may want to become friends with them. One way to start a friendship is to make plans to do something fun.

### **STEPS OF THE SKILL:**

Step 1: Make eye contact and say hello. Why is it important to make eye contact with someone when you are talking to them? This gets the person's attention. What if you were talking to someone but you were looking at their feet instead of their face? What do you think they would think of that? They wouldn't know that you were talking to them or they might not be able to hear you.

Step 2: Ask a general question. This starts the conversation and gives the person a chance to talk with you. Some examples of general questions are listed on your handout: How are you? What's up? What's new? How have you been? What do you think about this weather? These are all questions that get a conversation started.

Step 3: Invite the person to do something fun with you. What sorts of things would it be fun to do with someone? Well, you could go to a movie, get something to eat or just a cup or coffee, or just take a walk. On your handout are some ways to ask a person to do something fun with you. Can anyone think of any other fun activities that we could add?

Step 4: Confirm the invitation with the person, then give a reason and say good-bye. Why do you think it is important to confirm the invitation? That's right – just to make sure that the person knows what you are going to do and when you are going to do it. Why do you think it is important to give a reason why you have to go? That's right, it's a polite way to end the conversation. In your handouts there is a list of ways to confirm the plans and say goodbye.



Other, client-generated ideas: Has anyone had to deal with this and what did they do that helped?

NOTE: Incorporate skills that clients have learned in other sessions (or from Social Skills Training) into these role-plays. For example, if a patient is sitting next to someone, use skills from Making Small Talk and Making Plans with a

Friend in the role-plays:

Making Small Talk:

1. Make eye contact and say "Hello"
2. Ask a general question
3. Make small talk by asking questions
4. Give a reason and say good-bye

Making Plans with a Friend:

1. Make eye contact and say "Hello"
2. Ask a general question
3. Invite the person to do something fun with you about an appropriate topic
4. Confirm the invitation with the person, give a reason, say good-bye

**How to decide who is a supportive person.** One thing that is important when you are meeting new people or trying to do new things with people you know is to make sure that people will be supportive and positive and do not make you do things you don't want to do. Some clients tell us that other people in their lives – friends, family members, or people they may not know very well – are not always supportive and have taken advantage of them at times. Has this ever happened to you? When you are trying to meet new people and trying to find new things to do, it's important to know the things that are NOT OK for other people to ask you to do, that you should ALWAYS say no to. Let's make a list. What are some things that you should not do for people, even if they ask you nicely and you think they are nice people? RCs can work with the client to generate a list if applicable.

## #6: General problem solving for coping with problems

There will be many times when you have a problem that you need to cope with and that you want to solve. This can be stressful. The following steps can be used to think through a problem and come up with some potential solutions. This can be done individually or with a group of people who have a problem, such as a group of family members.

### STEPS OF THE SKILL:

1. Define the problem in one sentence.
2. List all potential solutions – brainstorm and be creative and get a long list of possibilities from all who are involved.
3. Eliminate potential solutions that are too hard to do or that someone in the group can't agree with.
4. Pick one remaining solution. Decide how to try it out.
5. Try it out and re-evaluate.

### **SCENES TO USE IN ROLE PLAYS:**

1. Your roommate likes to stay up late with the light on; you like the light to go off earlier.
2. Your parents don't want you to go out at night during the week.
3. You have too many things to do on your schedule.

### **SPECIAL CONSIDERATIONS WHEN TEACHING THIS SKILL:**

This can be done with groups of people. The RC may want to teach this skill to all family members as a way for everyone to engage in problem solving.

## **#7. Relaxation training**

It is always good to have strategies to cope when you feel badly, whether that's feeling anxious or stressed or angry. We've talked about doing pleasant activities, talking to someone, trying to solve the problem, or talking to your doctor about your medication. Today we are going to talk about another thing that you can do when you are feeling badly – relaxation. Relaxation training is a skill that you can learn to help you feel more calm or less tense. There are lots of times when you might feel tense or stressed out and you don't know what to do to feel calm again. Or, you might get a craving and need something to do to help you wait it out without using. Sometimes it's hard to know what to do when you are stressed or having a craving. Relaxation can help - when you are tense, or stressed, or having a craving, or in a lot of other situations. It's also an easy way to cope with stress. After practicing these skills and getting good at them, you will see that they are easy to use and can help you relax even when you don't have a lot of time or when you are not at home. Relaxation takes practice to get good at it. So in group we will do some relaxation and that will give you a chance to practice it and see how it works. You can then practice it at home or when you feel tense or stressed out or when you have a craving. Once you practice it for a while and get good at it, relaxation can help you feel less tense and more relaxed.

A reason that relaxation is helpful is because of the connection between our minds and our bodies. When you feel stressed out, your body gets tense and tight and it's hard to relax. You might even get a craving to use drugs or alcohol because you need to relax and feel less tense.

If you can relax your mind, then your body will feel relaxed too. Relaxation helps people get their minds and their bodies relaxed and calm, which as I said is very helpful when you are stressed out or tense or having a craving. You can't be tense and relaxed at the same time. So doing relaxation and getting yourself calm and relaxed is a good way to feel better and less tense and less stressed-out. In the past you may have turned to drugs or alcohol to help when you are stressed-out or tense. Since our goal here is to help you reduce or stop using drugs, we want to teach you another way of getting calm and relaxed, a way that does not involve drugs or alcohol.

The type of relaxation that we are going to do here in group is called The Soles of the Feet Technique. This type of relaxation comes from the Far East and we know that it is helpful in dealing with urges to use, cravings, and negative feelings like being tense or stressed out. I want to do some relaxation with you all today, and when we are finished you can tell me what you thought of it. We

will do this periodically in group so that you get practice using relaxation. This technique involves getting comfortable, doing some deep breathing, and clearing the tension out of your body.

## **Relaxation Script**

Sit back in your chair and close your eyes. Get real comfortable: lean back so that your back is supported in the chair, rest your head on the back of the chair, put your hands in your lap or let them hang down by the sides of the chair. Pull your feet up until your feet rest flat on the floor. That's good, nice and easy, get real comfortable and start to feel how your body is getting comfortable in the chair. Check yourself for comfort. Get real comfortable. Think about each part of your body and make sure it is comfortable. Your head is resting on the chair. Your back is supported by the chair and is resting comfortably. Your arms are loose and sitting in your lap or hang down. Your legs are resting comfortably on the floor and your feet can feel the floor underneath them.

Now that you are comfortable, take several slow, deep breaths. Take a deep breath way down into your belly. Let your breathing slow down and start to feel relaxed. Each breath continues to relax you. Now take a deep breath in and hold it. Now slowly exhale, let the breath out, and let all the tension out with it. Feel calm and relaxed as you breathe slowly. Again take a deep breath and hold it. Now slowly exhale, let the breath out, and let all the tension out with it. Feel calm and relaxed as you breathe slowly. Each breath leaves you more and more relaxed. Focus your thoughts on your breathing, with each breath making you feel more and more relaxed. You are breathing quietly, peacefully. Feel the calm that spreads over your body with each breath. Now you feel relaxed over your whole body. Every part is feeling relaxed and calm and quiet. You are breathing slowly and peacefully and your body is feeling calm and relaxed. Each breath cleans your whole body and mind. Relax and feel the peace and calm that has spread throughout your body with each deep breath.

Now focus on your feet. Think about your feet inside your shoes and how your feet are filling up your shoes. Feel the bottoms of your feet touch the floor underneath them. Focus on the soles of your feet and how they are touching the floor. Your feet are on the floor and the soles of your feet are touching the floor. As you breathe deeply, in and out, in and out, focus on the soles of your feet. The soles of your feet are heavy, they are heavy against the floor. Now think about your breathing. Imagine with your next deep breath that the clean, pure air is spreading throughout your whole body, collecting all of the tension and stress. The air takes the stress and tension from your body. Imagine this air leaving through the soles of your feet. See the tension leaving your body with each breath. Imagine another breath entering your mouth and taking all the tension and stress with it as it leaves your body through the soles of your feet. As you exhale you feel your body clean and relaxed, deeply relaxed.

Now scan your body for any last bit of tension or stress. Let all the tension go down, through your legs, and out of your body through the soles of your feet. Your face is relaxed. Your forehead is smooth and your face is completely relaxed. Smooth and relaxed. You have let go of all the tension and worry, it goes down your body, through your legs, and out through the soles of your feet. Now your neck and shoulders are relaxed. Your shoulders droop and relax and your neck is free of

tension. Free and relaxed. The tension in your shoulders moves down your body, through your legs, and out through the soles of your feet.

Now take a deep breath and as you exhale feel the relaxation spread throughout your body and your back. The tension in your body and your back is running through your legs and out the soles of feet. You feel free and relaxed. Your arms are heavy and relaxed. Heavier and heavier. More and more deeply relaxed. Heavy and relaxed. Letting go, letting go of all the tension. Letting it run out through the soles of your feet. Your legs are relaxed. They get heavier and heavier, more and more deeply relaxed. Letting go of the last bit of tension and stress. Letting any remaining tension run down your legs, out through the soles of your feet.

Now your whole body is feeling relaxed. Feel yourself being calm and relaxed. You are feeling peaceful and calm and relaxed. Now slowly start to open your eyes. Move around in your chair and when you are ready, open your eyes.

## VII. Increasing Engagement in the Community Using the Principles of Behavioral Activation

Some clients will have difficulty identifying and engaging in activities. There can be many reasons for this. Some may experience negative symptoms - anhedonia (reduced pleasure), avolition (lowered drive and interest in one's environment), asociality (diminished interest in social interaction), blunted affect (diminished emotional expression), and alogia (diminished speech) - that make engagement in the community difficult. Negative symptoms can also have a substantial negative effect on family members who often grow frustrated with their loved ones' lack of interest or effort in pursuing work, school, or other meaningful activities.

Behavioral activation focuses on helping clients identify pleasant activities in the community and do these activities as a way to decrease isolation and depression. Specifically, the RC and the client develop a list of activities that the client values and finds rewarding. Together the RC and the client set goals for how many activities to complete outside of the session. Between meetings, the client tracks the progress made in achieving these goals. A worksheet to guide the behavioral activation is provided in the Appendix. For more in-depth information about behavioral activation, see <http://web.utk.edu/~dhopko/BATDmanual.pdf>

First, talk with the client about monitoring his/her daily activities. Use the Daily Activity Log. This can be filled out together or the client can do this on his/her own and bring to a meeting with the RC. Second, generate a list of 10 activities that the client thinks will be pleasant, interesting, or fun. List these on the Activity Form and rank the activities from least (1) to most difficult (10). Start with the easiest activity and plan how and when this will be done. Make sure the plan is specific and includes the number of times the activity will be done between meetings, how long it will last, how the client will get to and from the activity, who else will be involved, etc. Third, record progress between meetings on the Activity Progress Log. The client should bring the completed Activity Progress Log to meetings for review and discussion.

It is important to use ME skills here. The goal is not to give the client a generic list of activities but one that reflects activities that are liked or are goals for the RC or family members. The activities and plans to attempt them should be discussed and developed through use of SDM and ME so that they truly reflect collaboration between the RC and the client. There will be cases in which a client is not ready to engage fully in behavioral activation. In such cases, a generic handout of "fun activities" (as provided in the SST materials) can be used to start the process of considering pleasant activities.

## VIII. Family Intervention

The RC, in coordination with the Primary Clinician, can also provide some components of the Family Intervention. These include: brief family consultation focused on assistance with communication and problem solving, and monthly family educational groups.

### Brief Family Consultation

The Primary Clinician can make referrals to the RC to work one-on-one with a family to address a specific problem or a particular need, when problem cannot be addressed in the context of meetings with the Primary Clinician. This could include focused skills training on conflict resolution/compromise and negotiation, problem-solving, and/or communication skills. The goal of these consultations is for the RC to teach targeted skills to help reduce stress/conflict, such as:

- Communication skills, including active listening, expressing positive and negative feelings, and compromise and negotiation.
- Problem solving skills, including identifying a problem, generating possible solutions, evaluating the pros and cons of each solution, and, together, making a decision concerning which solution to implement.
- These skills can then be applied to current problems experienced by the family within the sessions. Example of appropriate situations for brief family consultation include:
- A client is having trouble using skills he/she is learning to express feelings to a parent (ex. Client wants to tell parent to stop “reminding” him/her about taking his/her medication)
- A client’s parents are having trouble communicating with each other about their child’s situation and condition without yelling
- A client and his/her family member have a problem they don’t know how to solve (ex. Client wants to try a new activity and parent objects to this)

This consultation should be focused, specific to a particular problem or skill, and brief, lasting 1-3 sessions. Multiple rounds of consultation may be warranted in some circumstances. For example, if a client is working with the RC on social skills, it might be useful to have a parent attend periodically for a consultation in which the client uses the skills he/she is learning and the parent learns what social skills training is about and the client’s goals for learning and implementing new skills. It is important to note that these consultation are not family therapy per se, they are not the appropriate place to work out issues related to complex family dynamics or difficult problems. The goal of these consultation sessions is to teach and practice skills that can be used to improve clients’ functioning or family members’ interactions with or about the client.

Prior to the first consult session, the RC, in collaboration with the team, should map out a plan for the 1-3 consult sessions and be ready to start training in the first session. In the first consult session, the RC can discuss the role of the consult and present the plan developed with the team, asking the client/family for their thoughts and ideas in order to incorporate these into the plan. Once the RC and the client/family members agree on the plan, training can begin. Content for these consults can be taken from the SST or Coping Skills outlines presented above.

## Monthly Family Educational Groups

The Monthly Family Educational Groups accommodate approximately 3-8 families, are offered monthly, and are coordinated by RC and the Primary Clinician. Each group lasts approximately 1 ½ hours and includes presentations on informational and educational topics particularly relevant to families of clients with first episode psychosis. Each group begins with an educational component that lasts for the first half of the group. The first four group topics are ones that have been identified as important for most clients and families: (1) understanding psychosis, (2) the etiology and causes of psychosis, (3) recovery from psychosis, and (4) treatment for psychosis. Subsequent group topics will be chosen by group members at the end of the monthly group session based on the group members' current needs and preferences. Topics may include crisis prevention and planning, communication skills, setting limits and boundaries, co-morbid substance abuse, transition and discharge planning, etc. The second half of the group includes a group discussion of problems or issues that family members may be facing. The RC will facilitate this discussion and help group members resolve any issues or concerns. When appropriate, problem-solving and communication skills can be modeled within the group to help members resolve immediate issues, address communication concerns, and provide additional opportunities for skill-building.

Admission to these groups is ongoing, and families can join whenever they want and attend as many as they want. Outlines and materials for several Monthly Family Educational Groups are provided in the Appendix.



## IX. Preparing for Treatment after the Team

As work begins on the client's transition plan, the Primary Clinician can refer the client to meet with the RC to engage in focused work on practicing specific skills for implementing the transition plan and assistance in practicing key aspects of the plan. The Primary Clinician and the client decide which activities would be most helpful (using SDM) and pick and choose among them for an individualized plan.

### A. Identifying and reviewing the “tools in your toolbox”

During the time the client has been working with the team, he/she has developed a set of tools for solving problems, coping with stress, managing symptoms, and interacting with others. These tools may have developed naturally over time while working with the team towards recovery goals, or may have been learned through specific work with the RC through social skills training. During this phase of treatment, the RC and the client can review what has worked well, what the client does well or feels comfortable doing, and what he/she would need to ask for help with (and who he/she would ask for help). These strategies should be written down and can be refined during this transition time. At the end of this phase, the client should have a list of strategies or “tools,” what they are best used for, and when to ask for help.

### B. Skills for implementing post-OnTrackNY Program plan

The client may be working with the Primary Clinician on a post-OnTrackNY Program plan for receiving care in the community. Implementation of the plan may require certain activities that the RC can assist with. For example, the client may need to contact new treatment providers, visit a clinic in the community, etc. There could be cases when a client does not feel comfortable doing these activities, perhaps due to nervousness at having to talk with people and being unsure of what to say, or feeling unprepared to present oneself in new situations. In such cases, the RC can work with the client to identify the social skills needed for these activities, practice/role play them in session, and develop a plan for conducting these activities that the client could then implement. The goal here is not to do such things for the client, but to help the client plan how to do them and practice them and provide support for doing them on his/her own.

### C. Coping skills “check-up”

This strategy involves the RC working with the client to identify situations that may come up during the transition that will be difficult and create a plan for coping with them. The RC can assist the client in developing a generic coping plan and identifying when this plan would need to be implemented. In addition, the RC can help the client think through specific situations that may be difficult for that particular individual and develop a specific coping plan that is relevant to that situation. For example, a client may be especially concerned about the specific situation of going out socially with friends and limiting/refusing drinking. The RC and the client can discuss this specific situation and identify ways to cope if it should occur.

## D. Community “field trips”

As part of transition planning, the client will have to go into the community and visit new clinics, treatment providers, and other agencies or places that will be involved in his/her community care plan. The RC can accompany the client to some of these places, assisting with how to negotiate new transportation, how to implement social or coping skills in a new environment, and providing support while meeting new people.

## E. Helping the family prepare for transition to care in the community

The RC can assist the family during the transition to community care in different ways. First, the RC can deliver a monthly family education group on transition (see Monthly Family Group Materials in the Appendix). If there are several families coming up to or in Phase 3, the RC can either hold the group in the regular family group time or convene a special family group to discuss transition issues. If family members are interested in several transition-themed groups, the RC can arrange to have several groups on this topic. Second, if a particular family needs extra assistance with planning for the transition, the RC can do the above activities with family members and clients together. For example, if the family and the client need to visit a new agency in the community, the RC can accompany them on this visit. Another example would be working with the family to review “tools” for communicating so that when they are no longer meeting with the team, the family can talk to each other about treatment- or illness- or recovery-related issues. This could involve writing up a coping skills plan for the family in the same way the RC does with the individual client – a generic coping plan that the family can use for most situations plus a specific plan for any particular situation that the family is predicting might be difficult to deal with or talk about together.

## XII. Procedures, Documentation and Fidelity

Procedures and documentation will differ depending on the requirements of the clinic. Below are some ideas that can guide RCs in terms of communication and documentation.

### A. Referrals to the RC

Referrals will come to the RC from the Primary Clinician, who will then set up a meeting for the RC and the client. When other team members (e.g., Education/Employment Specialist) see a need for RC sessions for a given client, this is communicated to the PC and it is the PC that makes the referral to the RC.

If helpful, the OnTrackNY client's first meeting (or set of meetings) with the RC can be held jointly with the PC, to insure clear communication and maximize the client's comfort.

### B. Communication between the RC and the rest of the Team

Communication between the RC and the rest of the team can be done in different ways. Generally there are two main forms a communication. First, teams meet at least weekly to review new intakes and discuss clients within the program. Such weekly team meetings provide an ideal setting for the RC to share information about his/her work with clients with the rest of the team. Second, the RC will see clients throughout the week and may need to communicate with other team members quickly and informally without waiting for the weekly team meeting. In such cases, RCs will find team members informally or set up regular meetings with these team members for discussion and/or consultation. For example, if the RC and the Education/Employment specialist find that they are working with a set of clients on social skills for use in employment situations, they might decide to meet weekly in addition to the team meeting.

As another example, the RC may have worked with a client in the community and may have learned some information that needs to be shared with the Primary Clinician immediately; in such cases the RC wouldn't wait for the weekly team meeting but would seek out the Primary Clinician and discuss the information right away. The RC might also communicate with other team members via email or telephone calls. In situations in which the team meets together with all clients at all appointments, a weekly team meeting might be less necessary, given that all team members are present, at least for some amount of time, at all client appointments.

It is important to remember that the role of the RC is different from that of the other team members. Because of this, the RC may learn information from a client that he/she is not sharing with the rest of the team. For example, the RC may be working with a client on reducing substance use, and the client may be reluctant to share information about his/her use with the Primary Clinician because of he/she is concerned that the Primary Clinician will tell his/her family. It is extremely important to discuss with clients that the RC communicates with the rest of the team and shares information with team members. If the team decided that some limits on sharing information from the team to the family is warranted, this must be worked out and agreed to by all parties before the RC begins his/her work with the client.

## C. Documentation and Fidelity

The RC writes chart notes according to the procedures of the clinic in which the OnTrackNY Program is operating. In addition, a 2-page RC note should be completed as a way to both document more specifically what occurred during the meeting with the client, but also for fidelity. The RC note forms are provided in the Appendix.

### XIII. Readings and Resources for Recovery Coach Role

**For a complete list of Recommended and Suggested Resources for Recovery Coaches, please consult the Center for Practice Innovation's Learning Management System: <http://practiceinnovations.org/>**

**In addition to the materials recommended for all team members, resources for Recovery Coaches include:**

**1. Recovery Coach Manual**

**2. Articles:**

**A. Topic: Co-Occurring Disorders**

Drake, R.E., O'Neal, E.L., & Wallach, M.A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental illness and substance use disorders. *Journal of Substance Abuse Treatment*, 34(1), 123-138.

**B. Topic: Family Involvement**

Drapalski, A.L., Leith, J., & Dixon, L. (2009). Involving families in the care of persons with schizophrenia and other serious mental illnesses: history, evidence, and recommendations. *Clinical Schizophrenia & Related Psychoses*, 3, 39-49.

**C. Topic: Psychosocial Treatments**

Dixon, L.B., Dickerson, F.B., Bellack, A.S., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48-70.

**D. Topic: Social Skills/Social Functioning**

Bellack, A.S. (2004). Skills training for people with severe mental illness. *Psychiatric Rehabilitation Journal*, 27, 375-391.

## XIV. Appendix

1. HIV and AIDS: Definitions and High-Risk Behaviors
2. Sample Pros and Cons Worksheet
3. Sample Importance and/or Confidence Rulers (also called a Readiness Ruler)
4. Structured Tools for Substance Use/Abuse Assessment
5. Sample Assessment Feedback Form
6. Sample Decisional Balance Exercise
7. Forms to use to help clients increase engagement in the community using the principles of behavioral activation
8. Recovery Coach Notes and Checklists
9. Monthly Family Group Materials
10. How to work with the RC can be Useful as I Work Towards my Goals

## 1. HIV and AIDS: Definitions and High-Risk Behaviors

**HIV** - Human immunodeficiency virus

**AIDS** - Acquired immune deficiency syndrome

### High-Risk Behaviors

#### Risky Sexual Behavior

- Oral sex
- Anal sex
- Unprotected intercourse
- Touching (when sores are present and blood is exchanged)
- Hooking/prostituting

#### Risky Drug Use Behavior

- Shooting up
- Sharing needles
- Smoking rock/crack
- Getting high/drunken makes it more likely to make bad decisions



## 2. Sample Pros and Cons Worksheet

### PROS of drug use

Feels good  
Something to do  
Helps me sleep  
Makes me calm  
Makes me feel comfortable around people

### CONS of drug use

Hangovers  
Blackouts  
Costs money  
Makes my mental illness worse  
Get in trouble  
Forget my medicine  
Could lose my housing  
Can't do things I need to do  
Stop eating  
Clothes get dirty Get beat up  
Forget to take my medication  
Forget to do things I need to do  
Argue with family  
Can't get up in the morning

### 3. Sample Importance and/or Confidence Rulers (also called a Readiness Ruler)

#### RWA Questionnaire (Revised 10/2002)

Sometimes there is a difference between the importance of changing your drinking and drug use and your level of confidence in being able to change. We would like to know how it is for you. Circle the number that best describes your answer to each question.

**1. How IMPORTANT is it right now for you to change your drinking/drug use?**

Not at all 1 2 3 4 5 6 7 8 9 10 extremely

**2. If you did decide to change your drinking/drug use, how CONFIDENT are you at this time that you would succeed?**

Not at all 1 2 3 4 5 6 7 8 9 10 extremely

**3. How motivated are you to change your drinking/drug use right now?**

Not at all 1 2 3 4 5 6 7 8 9 10 extremely

Center for Substance Abuse and Addiction (CASAA). (1995). The ready, willing, and able scale.

## 4. Structured Tools for Substance Use/Abuse Assessment

### 1. Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) Self-Administered Form

<http://www.nationalafc.com/images/file/MSSI-SA.pdf>

### 2. Michigan Alcoholism Screening Test

[http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/42\\_MAST.pdf](http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/42_MAST.pdf)

### 3. Drug Abuse Screening Test

[http://www.projectcork.org/clinical\\_tools/html/DAST.html](http://www.projectcork.org/clinical_tools/html/DAST.html)

### 4. CAGE Questions

[http://medicine.yale.edu/sbirt/curriculum/screening/100693\\_CAGE\\_Questions.pdf](http://medicine.yale.edu/sbirt/curriculum/screening/100693_CAGE_Questions.pdf)

### 5. AUDIT

[http://whqlibdoc.who.int/hq/2001/who\\_msd\\_msb\\_01.6a.pdf](http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf)

## 5. Sample Assessment Feedback Form

### Frequency and Pattern of Use

Substance \_\_\_\_\_ Use in a typical week: \_\_\_\_\_

Substance \_\_\_\_\_ Use in a typical week: \_\_\_\_\_

Substance \_\_\_\_\_ Use in a typical week: \_\_\_\_\_

### Consequences of Use

The following things worried me or cause me a lot aggravation:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### Thoughts about Change

Benefits of No Change:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Benefits of Change:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## 6. Sample Decisional Balance Exercise (extended pros and cons list)

### Reasons for not changing (benefits of use)

- being with friends
- having a place to play pool
- feeling comfortable around people

### Costs of changing

- losing friends
- feeling lonely & depressed
- staying away from the bar
- not playing pool at the bar

### Reasons for changing (costs of use)

- hangovers
- could lose job
- could lose housing
- bad for my health
- lost relationships in the past
- makes family mad at me
- could get into legal trouble

### Benefits of changing

- being able to work weekends
- keeping job, apartment
- not arguing with family

7. Forms to use to help clients increase engagement in the community using the principles of behavioral activation

Daily Activity Log:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 am							
10 am							
12 pm							
2 pm							
4 pm							
6 pm							
8 pm							
10 pm							
Notes							

## Activity Form

Identify activities you would like to do.  
Rank each activity from least to most difficult (1-10)

Activity	Rank



# Activity Progress Log

Week of \_\_\_\_\_

Activity	GOAL	Goal for this week		
		How often will I do this activity?	How long will this activity last each time I do it?	Completed

## 8. Recovery Coach Notes and Checklists

Client name: \_\_\_\_\_

Date of meeting: \_\_\_\_\_

### Type of Session (CHECK ONE):

\_\_\_\_\_ Individual

\_\_\_\_\_ Group

\_\_\_\_\_ Family Education Meeting

### Content of Session (CHECK ONE):

\_\_\_\_\_ Introductory Session

\_\_\_\_\_ Planning Session

\_\_\_\_\_ Coaching/Training/Psycho-education Session

\_\_\_\_\_ Supportive Session

### If Coaching/Training/Psycho-education Session, specify type (check all that apply):

\_\_\_\_\_ Social Skills Training

\_\_\_\_\_ Coping Skills Training

\_\_\_\_\_ Substance Abuse Treatment

\_\_\_\_\_ Heavy Use/Episodic Use/Substance Abuse

\_\_\_\_\_ Substance Dependence

\_\_\_\_\_ Behavioral Activation

\_\_\_\_\_ Psycho-education

\_\_\_\_\_ Other, specify: \_\_\_\_\_

Location of Session:

\_\_\_\_\_ Office/Clinic

\_\_\_\_\_ Client's home

\_\_\_\_\_ Community, Specify where in community: \_\_\_\_\_

Was assessment done during the session?

\_\_\_\_\_ No

\_\_\_\_\_ Yes, specify what assessment was done:

Session narrative/note:



Provided or elicited behaviorally specific suggestions for improvement for each group member's role play	N/A		
Repeated role play at least one time.	3 minutes		
Assigned specific homework to practice the skill outside the group	5 minutes		
Wrap up (remind client of homework)	3 minutes		

Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory

Reference: Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (2004). *Social Skills Training for Schizophrenia: A Step-by-Step Guide* (Second ed.). New York: Guilford Press.



Completed role-plays or other problem solving tasks for the lesson (at least two role plays).	10 minutes		
Assigned homework related to achieving substance use goals in new situation.	5 minutes		
Used visual aids and handouts as described in the manual.	n/a		
Wrapped up: Review assignment (abuse) Review goal (dependence)	3 minutes		

Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory





Used visual aids and handouts as described in the manual.	N/A		
Wrapped up: Review HW assignment	3 minutes		

Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory

NOTE: Attach copy of written plan to this form.



Wrapped up: Review HW assignment and plan for overcoming barriers to engaging in selected activities.	3 minutes		
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Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory

NOTE: Attach copy of written plan to this form.



Used visual aids and handouts as described in the manual.	N/A		
Wrapped up: Review HW assignment.	3 minutes		

Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory

## Recovery Coach Note and Checklist

### Planning Session

Client name: \_\_\_\_\_

Date of meeting: \_\_\_\_\_

Please indicate whether or not each task was completed in the table below. The timetable provided for each task is a guideline. For any task not completed, select a code for the reason or describe the reason in the comments section.

Task	Approximate time for task	Completed (yes/no)	If no, reason: 1=client in crisis; 2=difficulty staying on task; 3=client left session early; 4=Other (describe) OR Other comments
Provided overall rationale for planning session.	5 minutes		
Discussed individual's goals for working with Recovery Coach and listed these in writing.	10 minutes		
Discussed individual's preference for the order in which goals would be addressed. Use SDM as needed to help individual decide order of goals.	10 minutes		
Review with individual which strategies would be useful in addressing these goals (i.e. SST for improving social interaction, BA for helping individual engage in more activities, SAT for addressing drinking, drug use, or smoking). Discussed how goals change and need to be flexible.	10 minutes		
Generate a written plan that includes goals, their order of importance to client, and strategies that will be used to address each. Copy of plan provided to individual.	10 minutes		
For HW, provide client with copy of plan to review and think about at home.	N/A		
Used visual aids and handouts as described in the manual.	N/A		



Wrapped up: Review HW assignment.	3 minutes		
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Subjective rating of tone of meeting by clinician:

0. Negative                      1. Some Negative/Some Positive                      2. Positive

Subjective rating of outcome of meeting by clinician:

0. Poor Unsatisfactory    1. Adequate/Some Unsatisfactory and some Satisfactory    2. Good/Satisfactory

NOTE: Attach copy of written plan to this form.

## 9. Monthly Family Group Materials

### Introduction to First Monthly Family Education Group

#### I. Introductions and Welcome

- A. Describe role of Recovery Coach on team.
- B. Introduce any other team members who are present.
- C. Have participants introduce themselves. Suggest they say their names, where they are from, and how long they have been working with the team.

#### II. Describe the Monthly Family Meetings

- A. **Purpose.** The purpose of these meetings is to provide information to family members about topics related to psychosis and its treatment. We have found that often family members are eager to learn about these topics so they can better understand and help their loved ones who are experiencing psychosis. It can also help to answer some questions they have about psychosis and its treatment. We have a number of meetings planned out based on some topics that family members usually find helpful. These include what is psychosis, what causes psychosis, and recovery from psychosis, but if you have a topic that you are interested in learning about, you can let me know and we will plan to address it in one of these meetings. We want these meetings to focus on topics that you feel will be most helpful to you. Also, these meetings provide a way for family members to meet each other, share their experiences, and receive support.
- B. **Structure.** Each meeting has two parts. First, we will start with an informational session on a specific topic. That part of the meeting will take approximately 45 minutes. This will be followed by some time to discuss and potentially problem-solve around any problems/issues that may have come up in the past month in your efforts to support your family member, your efforts to cope, or any additional questions or concerns you might have, which will take the remainder of our time together.

Also, we hope that these meetings are helpful and people are able to attend. However, there will of course be times when you can't make it. That's OK. Feel free to come whenever you can make it. If you miss some weeks, that's OK. You are always welcome. If you miss a meeting and you are interested in the topic, let us know and we can repeat the topic or make sure you get the information.

- C. **Topics.** Today we are going to talk about psychosis: what it is, what are some common symptoms of psychosis, and the different phases of psychosis.

#### III. Ask for Questions

# Monthly Family Meeting 1 - What is Psychosis?

## Part I: Presentation on Specified Educational Topic

### Materials Needed:

Handout: Common Symptoms of Psychosis

Handout: Phases of Psychosis

### TOPIC 1: What is Psychosis?

- Psychosis involves a loss of contact with reality and difficulty telling the difference between what is real and what is not.
- Psychosis can affect the way a person thinks, feels, and acts.
- 3 out of every 100 people experience psychosis at some point in their lives.
- The first episode of psychosis typically occurs in a person's late teens or early twenties
- Symptoms may emerge suddenly or develop gradually over time
- Occurs in both men and women of every ethnicity, culture, and socioeconomic group
- Symptoms of psychosis vary from person to person and over time
- Psychosis is treatable and most people recover

### Common Symptoms of Psychosis

- Hallucinations
- Hallucinations cause people to hear, see, taste, or feel things that are not there
- Hallucinations can seem very real. For that reason, people who experience hallucinations often have difficulty believing that they are not real and that their senses may be tricking them.
- Examples of hallucinations include:
  - a. hearing noises or voices that others don't hear
  - b. seeing things that other don't see
  - c. having unusual sensations in one's body

Discussion: Ask group members if they can share examples of any hallucinations they may have experienced or that they have observed in a family member.

### Delusions

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

- Believing that one is being watched or followed
- Believing that someone else is controlling one's thoughts

- Believing that others want to harm you
  - Believing that things in the environment have a special meaning just for you
- Discussion: Ask group members if they can describe any beliefs or thoughts they may have had or they may have observed in their family member that may not be entirely accurate or where they may question the accuracy. Ask them how these delusions have affected the individual and the family

*(Group leaders: clients may attend the group along with their family members; some may continue to have delusions that are strongly held; based on your knowledge of the group members and their symptoms you may decide to skip this discussion or temper it a bit)*

## Confused thinking

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

Examples include:

- Thoughts don't make sense.
- Thoughts are jumbled together.
- Thoughts are racing too fast or are coming too slow

Discussion: Ask group members if they have had any difficulty communicating with others or have observed a family member appearing to have difficulty communicating their thoughts? What have they noticed? How has that affected the family's ability to effectively communicate or interact with one another?

## Changes in Behavior

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

Discussion: *Ask group members if they have had noticed any changes in their behavior or have observed changed in a family member? What have they noticed?*

## Other symptoms that often go along with psychosis

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

Discussion: *Group leaders should highlight the fact that individual may experience other symptoms that other either associated with the symptoms (e.g. mania for someone with schizoaffective disorder) or a result of the symptoms (e.g. anxiety due to concerns that being followed; depression associated with life changes due to illness)*

## TOPIC 2: Phases of Psychosis

*Group leaders: Should distribute handout on phases of psychosis. Introduce the topic by highlighting the fact that although each person's experience of psychosis is unique, typically an episode or period of psychosis involved 3 phases.*

### Prodromal phase

Early warning phase of psychosis

- Individual starts to experience mild symptoms or vague signs that something is not quite right.
- Family members begin to notice unusual behavior or signs that some is not quite right.

Early warning signs include:

- Changes in sleep or appetite
- Changes in emotions (anxiety, depression, suspiciousness, irritability, depression)
- Problems in thinking (difficulty with concentration, memory, organizing thoughts)
- Changes in behavior (social withdrawal, decreased energy or motivation, difficulty functioning at work, home, school)

Discussion: Ask group members if they can recall any early warning signs they may have experienced or observed? What was their understanding of it? What did they do?

*Group leaders: Highlight the fact that family are often one of the first to notice these warning signs and that by knowing these signs or symptoms, the client and family member can develop a plan for what to do in that situation so they can get additional support and prevent the symptoms from worsening.*

### Active phase

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

*Group leaders: Acknowledge that family members may not know what to do or who to contact to help their family member get the extra support they may need if their symptoms worsen. Can help for the client, family, and team to develop a plan for what to do in that situation.*

## Recovery phase

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

## TOPIC 3: Categories of Psychosis

*Group leaders: Write each one on the board and briefly describe each. Briefly describe how diagnoses are made and highlight the fact that sometimes it can take some time before the diagnosis is clear.*

Psychosis can be a symptom of several types of disorders

### Schizophrenia or Schizoaffective disorder

When psychotic symptoms last for a substantial period of time (6 months or more); schizoaffective-when both psychotic symptoms and mood symptoms last for a substantial period of time

### Bipolar disorder

Psychotic symptoms appear within the context of fluctuating moods which includes both extreme highs (elevated mood) and extreme lows (depression)

### Major Depression

Major depression with psychosis-when psychotic symptoms occur only when a person is depressed

### Substance abuse

Use of or withdrawal from alcohol or other drugs such as marijuana, cocaine, heroin can be associated with symptoms. Oftentimes the symptoms resolve soon after the effects of the substances subside but can last a little longer. Other medical causes such as brain injury or delirium-psychosis can be associated with head injury or certain physical illnesses that disrupt brain functioning. In these cases people usually also have memory and attention problems and at time confusion.

## Final Discussion Regarding Educational Information:

*Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.*

## Part II: Discussion Concerning Issues/Problems Faced Over the Past Month

NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.

*After questions concerning the educational information have been addressed, group leaders should inquire if group members have faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

## Common Symptoms of Psychosis

(Handout for Group 1)

### Hallucinations

Hallucinations cause people to hear, see, taste, or feel things that are not there

Examples:

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

### Delusions/False Beliefs

Beliefs that a person holds despite evidence that those belief are not true or entirely accurate

Examples:

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

### Confused thinking

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

Examples:

- Thoughts don't make sense.
- Thoughts are jumbled together.
- Thoughts are racing too fast or are coming too slow

### Changes in Behavior

Examples:

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



## Phases of Psychosis

(Handout for Group 1)

### Prodromal phase

Early warning phase of psychosis

- Individual starts to experience mild symptoms or vague signs that something is not quite right.
- Family members begin to notice unusual behavior or signs that something is not quite right.
- Early warning signs may include changes in sleep/appetite; changes in emotions, problems in thinking; and/or changes in behavior

### Active phase

An individual is clearly experiencing symptoms of psychosis.

- Typically these include hallucinations and/or delusions but can also include disorganized thinking or behavior

### Recovery phase

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

## Monthly Family Meeting 2 - What Causes Psychosis?

### Part I: Presentation on Specified Educational Topic

#### Materials Needed:

Handout: Causes of Psychosis

What Causes Psychosis?

**Discussion:** Ask group members what they think causes psychosis/mental illness? Anything that others have said or that they have heard others say?

*(Group leaders can highlight commonly held myths about the causes of psychosis and other mental illnesses such as that mental illness doesn't exist, caused by poor parenting, caused by being lazy or weak, caused by the devil, etc. and help to correct them by identifying them as myths. Emphasize the point that many of these myths develop as a way to explain behaviors that people didn't understand.)*

### What We Know: Overview of Causes

#### Overview

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

#### Biological factors (genes)

- Refers to the structure of the brain, chemicals in the brain, and genes that may make an individual more vulnerable to or have a greater risk for developing psychosis

#### Biology

- Psychosis is believed to be associated with an imbalance in chemicals in the brain called neurotransmitters.
- Neurotransmitters are chemicals that transmit impulses or signals throughout the brain and central nervous system.
- The neurotransmitter dopamine is associated with symptoms of psychosis.
- Many medications work to correct this imbalance.
- Genes
- Research suggests that some people may have a genetic predisposition to developing psychosis.
- People who experience psychosis are more likely to have a close relative who has experienced psychosis.
- Maybe add in here heritability of schizophrenia/bipolar, etc. to highlight

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

### **Psychological**

- Personality, personal beliefs, thought, experiences, etc
- Environmental factors (stressors) can increase the likelihood that symptoms are expressed.
- Stressful events in the environment
- Stressful events can increase an individual's vulnerability to psychosis.
- High levels of stress can trigger the onset of symptoms or an increase in symptoms over time.
- Stressful events can include a traumatic life event, a significant loss, increased responsibilities associated with school/work, or a physical illness.

### **Substance use**

- Substance use can trigger the onset of symptoms or an increase in symptoms over time.
- Drugs such as marijuana, speed or LSD are particularly likely to trigger symptoms.
- However, substance use is generally not the underlying cause of psychosis.

*(Group Leaders: Some people with psychosis and/or their family members may think that substance use is the cause. Group leaders should emphasize that while substance may trigger symptoms, if the symptoms were just a result of substance use then they would go away once a person stopped using. Remember that families are looking for a sensible reason for the change in their ill family member and substance use is frequently cited as a cause by both the individuals and the family.)*

### **Common Family Reactions**

*Group leaders: Group leaders should introduce the idea that psychosis significantly affects not only the person with psychosis but also each family member. Each family member will have their own reaction but each family member will be affected.*

### **Discussion:**

Ask group members how they or their family member with psychosis responded when they first starting experiencing or noticing symptoms. How did they feel? What did they think? What did they do?

Group leaders should list and discuss reactions provided by group members on the board. Several common reactions are listed below:

- **Confusion and shock:** not sure what is going on, hard to make sense of experiences and understand what is happening to them
- **Fear and anxiety**
- **Anger and frustration**

- **Grief, sense of loss, or sadness**
- **Helplessness**
- **Feeling overwhelmed**
- **Shame and guilt**
- **Distancing or isolation**

## Common Effects on the Family:

### Discussion:

Ask family members how they reacted when their family member first started experiencing or the family member first started noticing symptoms. How did they feel? What did they think? What did they do? What reactions did the family member with psychosis notice in their family members or in their relationship with their family members?

- Group leaders should list and discuss reactions provided by group members on the board. Several common reactions are listed below:
- Confusion and shock: Family members may not understand changes they see in a family member; person who is normally cheerful may become moody and withdrawn, angry or fearful
- Fear and anxiety: May talk about things and have ideas that are seem impossible, irrational, don't make any sense to you; May say they see things and hear things that you can't see or hear
- Anger and frustration
- Grief, sense of loss, or sadness
- Helplessness: Not sure what to do to help or where to get help
- Feeling overwhelmed: Not sure what to do; feel that they need to make things better
- Shame and guilt: Feel like somehow they are to blame; it is their fault; they could have done something to prevent it
- Distancing or isolation: spend less time with others because

*Group leaders: Many common reactions to psychosis experienced by individuals with psychosis will be similar to those experienced by their family members. Group leaders should highlight this and the fact that oftentimes*

## Final Discussion Regarding Educational Information:

Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.

## Part II: Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the

past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.

# Monthly Family Meeting 3 – Recovery from Psychosis

## Part I: Presentation of Specified Educational Topic

### Materials Needed:

Handout: What is Recovery?

Handout: What Can Families Do to Help a Relative in their Recovery?

### What is Recovery?

**Discussion:** Ask group what their understanding of recovery is? Have they heard this term before? What does this mean to them?

### Defining Recovery

#### 1) Description of recovery

Recovery has been described as:

- "...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles"
- "It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness."
- "...involves the development of new meaning and purpose in one's life as one grows beyond the effects of mental illness" (Anthony, 1993).

#### 2) Recovery is different for each person

Often involves:

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

## What Helps People in their Recovery from Psychosis?

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

### Participation in treatment

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

### Support network in the community

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

#### **Discussion:**

Engage group member in a discussion regarding things that may help family members in their recovery. If group members (clients and/or family members) who have been in the program for a while are in attendance, ask them if they would be willing to share some things that they feel were helpful to them in the recovery.

Group Leader should reiterate the fact that recovery is different for each person. As such, what helps a person to feel well/move forward may vary from person to person. Identifying what is helpful for your family member is what is most important.

### What Can Family Members Do to Help?

- Learn about psychosis and its treatment: This will help you understand what is happening and get help for your family members if they need it.

- Knowledge is key, the more you know the better able you will be to help support your relative
- There is a lot of information out there and the team can help you access it.
- Work together with the treatment team to develop goals and help support your relative in taking steps towards meeting them.
- Be an advocate for your family member in order to make sure that they are getting the supports and services they need.
- Share your observations (e.g. problems, changes in behavior, triggers, improvements, effective coping skills) and your knowledge (e.g. when you notice changes in your relative's behavior and what you notice)

Family members often have information that can help the team work more effectively with a client; this may include information on symptoms, warning signs or triggers, things that have worked/not worked in teams of treatment; coping skills and strengths.

*Group leaders: Acknowledge the fact that many family members may feel uncomfortable about getting too involved out of concerns about privacy, being blamed for their family member illness or current problems, prior negative experiences with mental health services/providers; Stress that getting involved with treatment providers and sharing and obtaining of information is all done in an effort to help the family better support the family member.*

When possible, provide practical supports such as transportation, financial assistance, etc as needed.

Maintain a positive, supportive atmosphere at home. Try to reduce the amount of stress in the home environment

Learning effective communication skills can help reduce stress and help to maintain a supportive environment.

**Example:** Tell families that if their relative suddenly lost their hearing, it might be normal and seem useful to begin yelling at the person to get them to hear better, but that may not be effective. Families may need to learn additional ways to communicate effectively, such as learning sign language or speaking directly to the person so they can read the speaker's lips.

With psychosis, families may also need to learn more effective ways to communicate. The ways they used to use may no longer work when their relative's brain is working differently.

*Group leaders: Make sure to point out to family that it may not be that families and/or clients are doing it wrong; it is just that other ways may be more effective.*

### **Make efforts to include your family member in family and social activities.**

Remind families that their family member may not feel comfortable participating in social activities at first, and that they know best what they are able to handle.



**Example:** Families may ask an ill relative to join them at the holiday dinner table, but if a family member is feeling paranoid, he or she may not want to be at the holiday table with unfamiliar faces. If families are aware of this ahead of time and can prepare, they will less likely pressure their ill relative to be a part of those activities. He or she may be perfectly able to handle having dessert in the kitchen with only some of the cousins, rather than the whole crowd.

## What Can Families Do to Help Themselves?

### Impact of mental illness on the family

Psychotic symptoms are stressful and at times can be traumatic for those involved, including family members; Family members may also experience a number of emotions—shock, fear, sadness, anger, frustration, etc.

Supporting a family member can also lead to stress, anxiety, feeling overwhelmed, helpless, etc.;

Sometimes families can become so focused on the ill family member and how they are doing that they forgot to take care of themselves, stop doing things they enjoy, etc.

### Take care of yourself

Learn ways to take care of yourself and learn ways to manage stress.

**Discussion:** Have group members identify things that group member use or do to reduce stress or anxiety. These may include things like walking/exercising, reading for pleasure, calling/visiting with friends, etc.

### Make time to do things that you enjoy.

**Discussion:** Have group members identify things that they enjoy. Are there things they stopped doing when their relative became ill that they would like to start doing again?

- Get your questions answered. Number of ways that this can be done.
- Written information, articles, books, videos, internet, etc.
- Talk to treatment providers, other families, or your family member.

*Group leaders: Make sure to stress the importance of them talking with each other—the fact that the best way to understand what is going on with their family member and how their family member would like them to help is to hear it from them; note that sometimes communicating with each other isn't always easy and the team can help with that as well*

Make use of your current social supports and develop new supports

- Talk to friends and family
- Don't isolate yourself from others

- Develop relationships with your family member’s treatment providers/team
- Connect with other families that have similar experiences (e.g., this group; NAMI family to family and support groups, online supports, etc)

*Group leaders: You may want to point out that oftentimes family members will shy away from contacts with friends/family due to uncertainty as to how to discuss or reluctance/discomfort discussing the relative’s illness. Fear that others may view or treat them or their family member differently and/or negatively or that others may avoid/distance themselves if they knew (i.e. stigma) may also lead family members to distance themselves for current supports; However, having someone that can provide support when you need it, can be very important)*

### Final Discussion Regarding Educational Information:

Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.

## Part II: Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client’s illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.

## What is Recovery?

(Handout for Group 3)

**Recovery** has been described as:

*"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.*

*...involves the development of new meaning and purpose in one's life as one grows beyond the effects of mental illness" (Anthony, 1993).*

Recovery is different for each person but often involves things like:

- A reduction in symptoms (e.g. fewer or less disruptive hallucinations; ...)
- Improved relationships (e.g., feeling more comfortable around others, more interest in interacting with others, spending more time with friends and family)
- Connections with the outside world (e.g. engaged in work, school, volunteer activities, hobbies/other leisure or recreational activities)
- A focus on important personal life goals (e.g., more likely to make plans for the future, set goals, and take steps towards reaching them)

## What Helps People in their Recovery from Psychosis?

(Handout for Group 3)

Just as recovery is different for each person what helps a person to feel well/move forward can vary from person to person. That is why it is important for you and your family member to identify what is most helpful or most important in their recovery.

### Participation in treatment

Talking with providers about treatment options and working with providers to decide which treatments/services would best serve the individual.

- Attending appointments regularly.
- Ask questions if there are things you don't understand, feel haven't been explained, or information you would like to know.
- Being honest with providers about whether treatment is working or not working.

### Identifying and focusing on personal goals

- Identifying what you would like to change or see different?
- Is there something you would like to be doing that you are not doing now?
- Working with providers to identify personal goals and what steps are necessary to reach those goals.

### Making use of supports

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

## What Can Family Members Do to Help/Support their Family Member?

(Handout for Group 3)

- Learn about psychosis and its treatment
- Work together with the treatment team to develop goals and help support your relative in taking steps towards meeting them.
- Be an advocate for your family member in order to make sure that they are getting the supports and services they need.
- Share your observations (e.g. problems, changes in behavior, triggers, improvements, effective coping skills) and your knowledge (e.g. when you notice changes in your relative's behavior and what you notice)
- When possible, provide practical supports such as transportation, financial assistance, etc. as needed.
- Maintain a positive, supportive atmosphere at home. Try to reduce the amount of stress in the home environment.
- Make efforts to include your family member in family and social activities.

## What Can Families Do to Help/Support Themselves?

(Handout for Group 3)

- Learn ways to take care of yourself and learn ways to manage stress.
- Make time to do things that you enjoy.
- Get your questions answered. This can be accomplished through written information, articles, books, videos, internet, or talking to treatment providers, other families, or your family member.
- Make use of your current social supports and develop new supports.

## Monthly Family Meeting 4 – Treatment for Psychosis

### Part I: Presentation of Specified Educational Topic

#### Materials Needed:

Handout: Antipsychotic Medications Recommended by the OnTrackNY Team

Handout: OnTrackNY Team First-line Antipsychotic Medications: Common Side Effects and OnTrackNY Team Second- and Third-line Antipsychotic Medications: Common Side Effects

### Treatments for Psychosis

#### Discussion:

Ask group their understanding is of treatment for psychosis? What treatments have they heard of? How/where do they get information about treatment? What works and what does not work?

### Treatment for Psychosis: Overview

The plan for today is to discuss different types of services/treatments for psychosis. This will include:

1. Overview of the treatment team
2. Pharmacological treatments
3. Psychosocial treatments
4. Other support services

### The Treatment Team

- The treatment team includes several mental health professionals who provide different treatments/services aimed at helping individuals who have experienced psychosis achieve their treatment/recovery goals.
- The team offers a collaborative approach that relies on everyone's strengths and energy. This means that each member of the team has certain strengths, knowledge, and expertise that they bring to the table.
- Members of the team:

#### Primary clinician

- Works with an individual and their family to help identify treatment goals and develop a plan for getting them met.
- Helps to coordinate care.
- Connects people with resources both those provided by the team as well as those offered in the community.

## **Psychiatrist**

- Works together with an individual and their family to help them make decisions about medication use and to identify medications that may be helpful in reducing symptoms.
- Works with the team to monitor the effectiveness of medication and resolve any medication side effects.

## **Supported Education and Employment Specialist**

- Helps individuals to identify employment and school related goals.
- Assists individuals in finding work/getting enrolled in school and provides supports to increase the likelihood of success.

## **Recovery Coach**

- Assists individuals in building and/or strengthening their communication and coping skills.
- Helps the individual practice and refine these skills so he/she is ready to use them in real-life situations.
- Works with interested individuals to reduce behaviors such as drinking, drug use, and smoking that may block one from achieving recovery goals and increase behaviors that can assist them in reaching their goals.

## **Client**

- Work with the team to identify personal goals and steps needed to reach those goals
- Discuss your treatment options with the team and work with them to decide what services/treatments would be most helpful.

## **Family Member**

- Works with the team to identify ways to support the client.
- Discuss which family services, in any, might be helpful in helping the family to support their relative and themselves.

## **Treatment for Psychosis**

*Group Leader: Discuss the fact that there are a number of treatments for psychosis. Each has been shown to be helpful to individuals experiencing psychosis. Part of their job in collaboration with the rest of the team is to decide which treatments will best help them to reach their treatment goals. Each person's goals may be different and these goals may change over time, so this will be an ongoing discussion.*

### **1) Pharmacological Treatment (e.g. medications)**

#### **Pharmacological Treatment Overview**

- For many individuals, medications can be helpful in reducing symptoms and preventing symptoms that are diminished or are no longer present from reemerging.



- The decision to begin medication treatment and the choice of specific medications should be shared among the client, family members, and treatment team.
  - Medications commonly used for the treatment of psychosis include:
  - Antipsychotic medications that target psychotic symptoms
  - Medications that target other psychiatric symptoms
  - Medications that assist individuals in coping with medication side effects

## Antipsychotic Medications: Overview

Distribute handout: Antipsychotic Medications Recommended by the OnTrackNY Team

*Group Leader (ideally the psychiatrist): Group leader should review the handout on antipsychotic medications recommended by the team. As part of this review they should define highlight that*

1. Antipsychotic medications can help decrease symptoms of psychosis and prevent symptoms that are diminished or are no longer present from reemerging.
2. all of these medications are effective in treating psychosis; however, they differ from one another in terms of which neurotransmitters they target, possible side effects associated with their use, their effectiveness in targeting specific symptoms.
3. define first-generation and second-generation antipsychotics
4. and note that they can be taken orally or as an injection, and that the effect so some may be noticeable after a few days, for others it can take two to four weeks.

*Group Leader: After reviewing the handout, the group leader should point out that medication may work differently for individuals. A certain medication may work particularly well for one person but not as well for another person. Similarly, a medication might work well for a person but has a number of side effects that are difficult to tolerate. As a result, they may need to try a few medications before they figure out which works best for them. This is why it is very important for them to be open and honest with the psychiatrist and the rest of the team about if the medication is working or not, any side effects they are experiences, and any concerns other concerns about the medication.*

## Antipsychotic Medication and Side Effects

*Group Leaders: Note that like most medications, each medication has possible side effects. Side effects are typically unexpected and sometimes unwanted and undesirable effects of medication.*

### **Discussion:**

Have you or your relative ever experienced side effects as a result of a certain medication? What you or your relative experience? What did you do about it?

## Common Side Effects of Antipsychotic Medications

Distribute Handouts: OnTrackNY Team First-line Antipsychotic Medications: Common Side Effects and OnTrackNY Team Second- and Third-line Antipsychotic Medications: Common Side Effects

*Group leader: Review handouts on common side effects of antipsychotic medications. In reviewing these handouts provide a definition/description and examples of each side effect discussed.*

*Group leaders: Stress to group members that although some individuals that take these medications may experience the side effects discussed that not everyone that takes these medications will experience them. Just because you take a medication doesn't mean you will definitely experience the side effects. However, some of these side effects are common and may be annoying, inconvenient, or uncomfortable if they do occur. Therefore, it is important to know the common side effects of the medications that you or your family member are taking so that if you do experience them you and your family can work with the team to decide the best way to address them.*

## Coping with Side Effects of Medications

- As mentioned previously, it is important to inform your psychiatrist or other member of the team about any medication side effects as soon as they occur so you and the team can decide how best to address them.
- Some side effects will subside over time so they may decide to wait a week or two to see if they diminish.
- If they do not subside, there are a number of ways that side effects can be minimized:
  - The dose of the medication may be lowered.
  - The medication may be changed to a different drug that causes fewer side effects.
  - Other medications may be prescribed to help with side effects

## Other Medications

- Antipsychotic medications may not be effective for all symptoms.
- In those cases, other medications may be prescribed, including:
  - Antidepressant medications (e.g. Lexapro, Paxil, Prozac, Zoloft)
  - Mood stabilizers (e.g. lithium, Depakote, Tegretol)
  - Anti-anxiety medications or sedatives (e.g. ativan, klonopin, xanax)
- These medications may also have side effects. If you are taking any of these, talk with your psychiatrist/the team about possible side effects.

## 2) Psychosocial Treatments

*Group Leader: Highlight the fact that there are also a number of psychosocial treatments that have been shown to be very helpful for individuals experiencing psychosis, particularly when they are used in conjunction with medication. These include:*

## Individual Counseling and Support

- Provided by Primary clinician
- Meet one-on-one to discuss issues or problems a person may be facing

## Supported Education and Employment

- The Supported Education and Employment Specialist works with the individual to:
  - Identify and clarify educational and work-related goals.
  - Help individuals find a job/school that matches their interests.
  - Identify supports needed to be successful and helps to make sure those supports are in place.
- The plan for the individual and any supports are highly individualized and based on each person's needs/preferences (e.g. transportation, advocacy, working with teacher/employer and providing them with information, assistance about work/school relationships)

## Coaching/Skills Training/Psychoeducation

Provided by the Recovery Coach and involves teaching and learning a new skill or doing a structured exercise or activity directly related to an individual's goals

1. Social Skills Training
  - a. Involves helping individuals learn and practice communication and skills.
  - b. These skills are important in developing and maintaining relationships with other people and being successful in school, work, or other social settings (e.g., dating, developing and sustaining friendships, job interview skills, medication management skills)
2. Coping Skills Training
  - a. Involves helping individuals learn strategies for coping with difficult feelings or situations in order to decrease stress in their lives (e.g, anxiety or depression)
3. Behavioral Activation
  - a. Involves helping people identify and carry out pleasant activities in the community as a way to decrease isolation and depression
4. Substance Use Treatments
  - a. Increase motivation to change unhealthy substance use behaviors and identify behavior change goals.
  - b. Teach skills to effectively deal with social pressures and stressful situations that lead to unhealthy behaviors and strategies to cope with urges, cravings, high-risk situations, and lapses.
5. Psychoeducation
  - a. Involves providing individuals with information or helping them explore a particular topic about which they want to learn more about.

### Resources for Families

Family education programs focused on providing information, education, and support

- 1) Monthly family meetings
  - monthly groups focused on providing information/education, skill building, and mutual support; topics are chosen by attendees and are flexible and largely dependent on the needs of the group
- 2) NAMI's Family to Family Program
  - Group offered in the community focused on providing education, communication and problems solving skills building, and support
- 3) Family Consultation
  - Conducted with individual families, time-limited, focused on a particular issue or concern
  - Individual work around a particular issue that has come up; could be related to communication skill building, problem-solving, conflict resolution, etc.
- 4) Family Support Groups
  - Opportunities for mutual support

### Other services

- Case management, assistance with housing, Income assistance
- Linking with community resources (e.g., NAMI, Self help groups for substance use (AA, NA), Specialized trauma services)

### Discussion:

- Engage group members in a discussion about services provided? Any other ones they have heard of/are interested in learning more about?

### Final Discussion Regarding Educational Information:

- Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.

## Part II: Discussion Concerning Issues/Problems Faced Over the Past Month

NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

## Antipsychotic Medications Recommended by the OnTrackNY Team\*

(Handout for Group 3)

### First-Generation Antipsychotics

First-line treatments (oral)

Loxapine

Perphenazine

### Second-Generation Antipsychotics

First-line treatments (oral)

Aripiprazole

Risperidone

### First-line treatments (injectable)

Fluphenazine decanoate

Haloperidol decanoate

### First-line treatments (injectable)

Paliperidone palmitate

Risperidone microspheres

### Second- line treatment (oral)

Olanzapine

### Third-line Treatment (oral)

Clozapine

\*Other antipsychotic medications are available and may be prescribed.

## Monthly Family Meeting 5 – Crisis Prevention and Planning

### Part I: Presentation of Specified Educational Topic

#### Materials Needed:

Handout: Components of a Crisis Plan

#### Introduction to Crisis Prevention and Planning

- Although we hope that most of the time individuals will be doing well, it is possible that at some point you/your family member may experience a mental health crisis. Mental health crises can occur even if an individual had been following their treatment plan and is using coping skills and supports that may have been effective in the past.
- When a crisis occurs, it can be scary and overwhelming for everyone involved. Individuals who are feeling distressed or experiencing a crisis may not know what to do to help him/herself feel better or who or where to turn to get additional support. Similarly, family members may not know what to do to help their family member or who they can contact to get additional assistance or support.
- Although crises sometimes appear to come on rather quickly and without much warning, more often than not there are warning signs that a person may be experiencing greater distress and may possibly be in crisis. Knowing these warning signs can help you recognize times when you/your family member may need additional support to manage and minimize the crisis.
- For this reason, it can be extremely helpful to discuss and develop a plan for what to do should you or your family should become distressed or if a crisis occur so that everyone is on the same page with regards to how the situation should be handled and feels more prepared to take action when necessary.
- This meeting will focus on how to recognize signs of a potential crisis and how to use this knowledge to prevent a crisis from occurring. In addition, we will talk about how you might develop a plan for what you/your family member should do should a crisis occur.

#### What Do We Mean by Mental Health Crisis

*Group leader: In order to plan what to do in the event of a mental health crisis, we must first understand what a mental health crisis is.*

#### **Discussion:**

Ask group members how they define a mental health crisis? What would be some examples of a mental health crisis? Have they or their family member experienced this before? What did they learn from that experience? Is there anything the situation that they would have liked to have gone differently/been handled differently?

#### Defining a Mental Health Crisis

- A mental health crisis is a situation in which a person is unable to use their typical coping skills or resources effectively and as a result experiences symptoms or engages in behavior that may put them at risk.
- This may include:
  - Having difficulty thinking clearly; behaving in a disorganized way
  - Thinking about, threatening, or acting in aggressive and/or potential harmful ways either towards him/herself or someone else (e.g. suicidal thoughts or action, thoughts or actions aimed at harming someone else)
  - Intense mood swings or mood states (e.g. being so high, hyper, excited that that person is not their normal state or they get into trouble; feeling so depressed that a person can't take care of themselves)
  - Having hallucinations or delusions that become too difficult to manage, extremely distressing or overwhelming, or cause a person to behave in a way that may be dangerous.
- While symptoms may diminish or lessen over time, some people may continue to experience symptoms. Experiencing symptoms or even an increase in symptoms does not necessarily constitute a crisis; however, this may be a warning sign you/ your family member could benefit from additional support or assistance.

## Developing a Crisis Plan

*Group leaders: Group leaders should reiterate the goals of the crisis plan and why it can be useful for all involved. Leaders can describe "crisis or safety planning" as being analogous to planning for other potential emergencies such as fire/disaster drills to stress the idea that although we hope that we won't have to use them, we plan ahead so that we will feel more prepared to act should an emergency occur.*

### **Discussion:**

- Has anyone ever discussed developing a crisis plan with you/do you have a crisis plan? What might be the benefits of having a plan? How do you think it might help you/your family member if a crisis should emerge? What might be the downsides to not having a plan? Have you ever had to use one? If so, how did it go?
- What do you think you would want to include in a crisis plan? Who do you think should be involved in helping develop one and why?

*Group leaders: Family members can be an important part of developing and implementing a crisis plan. Family members can help suggest coping strategies that can be used. Sometimes family members recognize warning signs that you may not be aware of or notice. As a result, they may be able watch for these signs and prevent the crisis by helping you put your plan into place before it hits a crisis level.*

## Components of a Crisis Plan

### **There are several basic components to crisis or safety planning:**

- Identifying warning signs or red flags that suggest that a person may need some additional support
- Identifying coping strategies or tools that a person can attempt try before contact other supports
- Identifying people who you can ask for help if personal coping strategies are not working as well as you like
- Professionals or agencies you can contact if other coping strategies don't work

## 1) Warning signs or red flags

- The first step in developing a crisis or safety plan any warning signs or red flags that may suggest that a person is not doing so well.
- Warning signs can vary from individual to individual which is why it can be so important to take notice of and try to identify your own personal warning signs. Family members can be particularly helpful in helping individuals with psychosis to do this and may even be able to identify warning signs that are not readily apparent to their family member.
- Some examples of common warning signs individuals experience/family members observe are:
  - Changes in sleep (e.g. sleeping more, sleeping less, waking up throughout the night)
  - Increases in hallucinations or delusions
  - Changes in thinking (e.g. racing thoughts, trouble thinking clearly or formulating thoughts, greater suspiciousness/paranoia)
  - Increased irritability, agitation, angry outbursts, increases in argument/conflicts
  - Changes in mood (e.g. feeling down or depressed, feeling more anxious or worry a lot, feeling hopeless, extremely elevated mood, mood swings)
  - Isolation/withdrawal (e.g. less interest/involvement in social activities, hobbies or other activities typically enjoyed)
  - Reduced involvement in treatment (e.g. not taking medications, less involvement in mental health services)
  - Thoughts of harming themselves or someone else (this can include command hallucinations)

### **Discussion:**

Ask group members if they have ever thought about warning signs that they experience that let them know they might need some additional support? Do these warning signs sound familiar? Any others that weren't listed?

## 2) Using Personal Coping Strategies

- When a person recognizes that they are becoming more distressed they can begin to use coping strategies to minimize and/or manage the distress.
- What is an effective coping strategy for one person may not be an effective strategy for another.



- Moreover, what is an effective strategy for one situation or stressor may not be effective for another.
- That's why it can be helpful for individuals to come up with a number of coping strategies that they know are helpful for them.
- Family members can play an important role in helping their family members to recognize when they seem to be becoming more distressed, helping family members identify coping strategies they can use to minimize their distress, and possibly being part of the strategy for managing their distress.

**Discussion:**

What are some effective coping strategies for you/your family member? Do you find that certain ones work better in certain situations than others?

### 3) Connecting with family members/friends/others to get support

Connecting with others when you are distressed or feeling overwhelmed can help in a couple different ways:

- Socializing with or simply being around other people can sometimes help to distract a person from thoughts or experiences that they may be having difficulty with. Socializing with other may also help minimize distress by helping a person feel more connected with others.
- Connecting with family members/friends/others can also be very helpful.
- Family members/friends/supportive others can help you figure out ways to minimize distress you may be feeling or help to resolve the crisis altogether. This may include helping you to identify other coping strategies or resources that might be available to you—maybe some you never thought of. As a result, as part of developing a plan it can be helpful to come up with several people that you feel comfortable reaching out to when in distress or in crisis.
- For some, simply being in a social setting when feeling distressed can help him/her feel more comfortable or safe, more connected with others, or more relaxed and less distressed.
- Therefore, it also be helpful to identify social settings that a person can seek out if they are unable to reach one of their social supports.
- These can include things like local coffee shops, book stores or library, churches, AA/NA meetings, support groups, etc.

**Discussion:**

Are there specific people that you find yourself reaching out to when you need additional support? How does this help you? Are there certain social settings in which you feel more safe or comfortable? Places that when you are in you feel more connected to others?

### 4) Contacting Professional and Agencies

- There may be times where these coping strategies that you or your family member used may not work as well as you/your family would like and despite best efforts additional assistance may be needed to help in managing a crisis.

- Mental health professionals or mental health agencies can be important resources in helping a person when they are distressed or in crisis and in helping family members to ensure that their family member is getting the support that they need.
- Therefore, it is important to know who to contact when additional assistance is needed and to have contact information for those individuals readily available and that everyone is on the same page in terms of the steps that should be taken.
- This may include:
  - Who you/your family member would like you call during typical clinic hours (e.g. who is the person place that they should call first, if they can't reach that person/place who should they call next)
  - What to do if this doesn't occur during normal clinic hours (e.g. call the pager, call 911, go to the emergency room)
  - Are there any other people that should be called (e.g., family members, friends, providers)? Are there any specific things you would like others to do (e.g., ask someone to do something that would help support you; ask someone to take care of something for you while you are getting help)?
  - Any other action steps you would like others to follow?
  - List of things that have worked well when in crisis before or made getting help go more smoothly; things that did not work well and that you would like to avoid.

### Final Discussion Regarding Educational Information:

*Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.*

## Part II: Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

## Components of a Crisis Plan

(Handout for Group 5)

### Identifying Warning Signs

- signs or signals that might suggest that additional support may be needed
- this can include changes in thinking, mood, or behavior

### Identifying Coping Skills or Strategies

- coping strategies or skills that can be used to manage or minimize distress

### Identifying Family/Friends/Others You Can Turn to for Support or Assistance

- who a person feels comfortable reaching out to when in distress or in crisis

### Mental Health Professional or Agencies You or Your Family Member Can Contact to Get Additional Support

Who to call during typical clinic hours (e.g. who should be called first, if they can't be reached who should be called next)

- what to do if someone needs to be contacted outside of normal clinic hours
- specific things others to do
- other action steps that should be followed

## Monthly Family Meeting 6 – Communication Tips and Tools

### Part I: Presentation of Specified Educational Topic

#### Introduction to Communication Skills

- Communication can be stressful for families; however, being able to effectively communicate with each other is extremely important for families. Effective communication can be particularly important when a person in a family has experiencing symptoms of psychosis or other mental health symptoms.
- Sometimes individuals experiencing symptoms of psychosis may also have difficulties with memory, concentration, or the ability to process information effectively and efficiently. In addition, sensory experiences such as hallucinations or misperceptions or errors in thinking can be distracting and can cause individuals to lose focus when interacting with others. At times, this can make communication between family members difficult and lead to frustration and additional stress for the entire family.
- This additional stress, in turn, can lead to greater symptoms in the family member experiencing psychosis in addition to increasing distress among other family members. Therefore, by finding ways to communicate more effectively with each other you can reduce the amount of stress you and/or your family member may be experiencing.

#### The Impact of Psychosis on Communication

##### **Discussion:**

Ask group members how they think psychosis or symptoms of psychosis could impact communication? In what ways could it make it more difficult? Have any of the group members noticed/experienced communication difficulties in the family? What do they think has caused the difficulties?

There are a number of reasons why difficulties in communication may occur.

##### **Feeling overwhelmed or overstimulated**

Most of us have been in situations where we felt a bit overwhelmed, like things were too loud, there were too many people, too much commotion, etc. Some individuals experiencing psychosis may be particularly sensitive to this and when they feel overwhelmed or overstimulated may decide that it is better to remove themselves from the situation.

Helpful ways to respond:

- If this happens try not to take it personally. Sometimes a family member may need to take a little break or time out from a situation.

## **Social situations may be stressful for individuals experiencing psychosis.**

For some, interacting with others, even family members, can be anxiety provoking. As a result, individuals with psychosis may avoid initiating social interactions and seek to escape them when initiated by others.

Individuals experiencing psychosis may also more sensitive to conflict and criticism. As a result, they may withdraw from or attempt to avoid interactions with others due to fear of criticism or rejection.

### **Helpful ways to respond:**

- Try to be patient and understanding. Do what you can to minimize anxiety or discomfort family members may be experiencing.
- If a family member is more comfortable one on one or in smaller groups you may want to limit the length or frequency of situations where there have to be in larger groups.
- Help them gain confidence in his/her social skills and reduce anxiety and/or discomfort in social situations by practicing with your family member. Make efforts to interact with your family member and as they feel comfortable provide them with opportunities to interact socially with others.

## **Symptoms of psychosis**

Some individuals with psychosis may hear noises or voices that other people can't hear or see things that others don't seem to see. Not surprisingly, for some, these voices or visions can be intrusive, distracting, and make it difficult to focus during a conversation.

- Ask the group: Have you ever been in situation where two people have tried to talk with you at the same time? Were you able to focus on what each person was saying or were you only able to truly hear bits and pieces from each?
- Sometimes it may appear that a family member is not listening to what others are saying or her/she responds in a way that doesn't seem to make sense to you given the topic of the conversation. They may have difficulty sticking to one topic and seem to jump from one topic to another without an apparent reason. Hallucinations can be so distracting that it can make it difficult to pay attention to and fully process information during a conversation. As a result, he/she may miss important pieces or parts of the conversation.

### **Helpful ways to respond:**

- It can be helpful to make sure that your communication is brief, focused, and to the point. You may want to repeat important points to make sure that your family member has understood if they seem distracted or if they didn't appear to understand.
- Try to avoid arguing a family member out of false beliefs or hallucinations. This is likely to be ineffective and can lead to increased family stress and possibly an argument.

## How to Improve Your Family Communication

*Group leaders: Many families are good communicators, but we all can benefit from reviewing and practicing some of the basics of good communication from time to time.*

### **Discussion:**

What do you feel are effective tools/strategies to communicating effectively with others? Anything you tried that worked particularly well? Anything that did not work so well?

### **Suggested strategies or tools for effective communication Be simple, brief, and to the point**

- Stick to 1-2 sentences or statements; only ask one question at a time and give your family member time to answer
- This will minimize confusion and make it more likely that the other person will hear and understand what you are saying

### **Keep your communication focused**

- Keep conversations focused on one subject at a time
- If you jump from topic to topic it will make it more difficult for others to concentrate on what you are saying and to understand the point you are trying to make.
- You may want to give an example of this: Example: "I am upset that you have not been taking your medication. I am concerned that because it seems like your voices are getting worse and you have been spending a lot of time by yourself. Plus you haven't really been talking with us and spending time with the family. We really need to figure out a time to schedule a dinner with the rest of the family. You'll need to check to see what your schedule is at work so we can do that."

### **Focus on behavior and be specific**

- It is much easier for someone to change a behavior than it is to change their feeling or personality
- Focusing on the behavior that is making you feel the way you do and being specific about what that behavior is making you feel that way will help others better understand what you are trying to say.

Examples:

OK: I am proud of you.

BETTER: I am really proud of how hard you have been working at school. OK: I am really concerned about you.

BETTER: I am concerned about you because you seem to be spending a lot of time alone in your room.

### **Listen to what others have to say**

- You will better understand what your family member is trying to say if you listen; listening is a skill and you may need to make a conscious effort to listen to your family member when you are having a conversation, especially if you are angry, upset, or frustrated.
- Everyone is entitled to express how they feel or their thoughts on a subject and to be heard by the person that they are speaking with

### **You can let your family member know that you are listening in a number of ways**

- You can make comments like “uh-huh” or “okay”
- You can repeat back what the other person says to show them that you are listening and that you understand the point they are trying to make
- You can use nonverbal cues, like eye contact and nodding, to show that you are listening
- Use “feeling” and “I” statements to let family members know how you are feeling in supportive and noncritical way

### **Feeling statements**

Use a feeling word to help family members better understand what you are feeling (e.g. angry, upset, happy, pleased, concerned, sad, proud)

### **I statements**

Using I statement makes it clear that you are the one experiencing the feeling or thought Ex: I am proud of the work you have done

Ex: I am concerned that you seem to be feeling more depressed lately

### **Stay calm and be patient**

Do your best to remain calm and patient; the more calm and patient you are the greater the likelihood that you will get a better response

### **Tone of voice**

people tend to respond better and are more likely to listen to what you are saying if you express your thoughts or feelings with a calm tone of voice

*Group leader: may want to use discriminant modeling here to demonstrate the difference; for example, model and example of saying “I would really help if you could clean up your room” in a calm tone of voice and then in an angry/frustrated tone of voice. Have group members discuss the difference between the two and how they are likely to respond to both.*

### **Listen to what your family member is saying**

- When a person is angry/frustrated they are more likely to interrupt the other person they are talking to
- Try to listen to what they have to say before expressing your own thoughts.

### **Be respectful of each other**

- Make sure each person has a chance to talk and do not interrupt each other. Everyone has the right to be heard.
- Do not talk down to your family member (e.g. "you are acting like a child", "You don't know what you are talking about") or call each other names.

### **Limit other distractions that might make communication more difficult**

- The more distractions a person is facing the harder it is to communicate effectively. While you may not be able to minimize some distractions (e.g. psychotic symptoms) you can limit environmental ones.
- Turn off the TV or the radio
- If need be, go to a room where it is quiet or away from others not involved in the conversation

*Group leader: Some individuals with psychosis may benefit from additional communication or social skills training to help him/her feel more confident and comfortable interacting with others or in specific situations (e.g. work, dating, job interviews, etc). Similarly, some families may benefit from strengthening their communication within the family. Group leaders should let group members know that in this group they touched on some of the basics of effective communication but that the OnTrackNY team provides a number of services that can help individuals and families strengthen their communication skills and help them communicate more effectively and successfully, including social skills groups, working individually on communication skills, or working with the family to strengthen communication within the family.*

### **Final Discussion Regarding Educational Information:**

*Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.*

### **Part II: Discussion Concerning Issues/Problems Faced Over the Past Month**

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise*



*with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

*Given the topic of this session, if appropriate and if the group members are willing the group leaders can engage in a communication skills exercise with the group members. The group leaders can either choose a particular communication issue/situation mentioned during the group or one of the key communication skills (e.g., expressing positive feelings, expressing negative feelings, making a request, compromise and negotiation, etc.). Group leaders then can model how the skill is done and if group members are willing have one or two families practice.*

## Monthly Family Meeting 7: Stigma

### Introduction

#### Experiential Exercise:

**Group Leader ask group members to raise their hand if:**

- You went to a doctor's appointment in the past year.
- You were admitted to a hospital for any reason over the past year.
- You took any medication over the past year.

**How would your feelings about raising your hand in a group setting change if you were asked to raise your hand:**

- If you saw a mental health professional over the past year.
- If you took psychiatric medications over the past year.

**Discussion:**

- How would you feel about answering the second set of questions in a public setting? How are these questions different from the previous ones? What makes them different?
- How does this activity relate to your loved one's experience of having a mental illness?

#### What is Stigma? (Give "What is Stigma" handout and "Myth/Facts" handout).

- Mental Illness Stigma is the negative attitudes and discrimination that people with mental health problems face as a result of stereotypes and biases about mental illness that are believed by individuals, groups, and/or social institutions.
- Stigma comes from STEREOTYPES that some members of society hold about people with mental illnesses.

**Discussion:**

What are some common stereotypes about people with mental illness/people receiving mental health treatment?

Where do you think stigma/stereotypes come from? What are some sources of stigma?

Possible answers:

- Portrayals of individuals with mental illnesses as violent/unable to contribute to society (e.g. the media/movies/books)
- Lack of knowledge/ignorance
- Fear of what is different
- Avoidance/lack of exposure to people with a mental illness
- Acquaintances/sometimes even family/friends

## One thing that is important to be aware of is that these stereotypes are false.

### Discussion:

What do you see as evidence for why these stereotypes are false?

See the handout "Facts and Myths about Mental Illness" for a list of these myths. These stereotypes are FALSE, but they can still affect your life. So when you are faced with them or find yourself thinking about them try to remind yourself that they are not true.

How do you think stigma impact a person with a mental illness? Possible answers:

- Feel angry, disrespected, dismissed, sad, frustrated, worthless
- Social discomfort
- Feeling Different/alienated from others
- Isolation; may avoid people/places (can lead to reduced social support)
- Decreased self-esteem
- Problems in loved one's getting/maintaining employment
- Challenges in getting housing
- Insurance Issues
- Seeking treatment (According the NIMH, one in four or five adults has a diagnosable mental disorder in a given year. However, only about half seek treatment. This can be attributed to many causes, including lack of access to treatment/lack of insurance. However, stigma is also a likely culprit).

### What is *internalized stigma*, and what are its impacts?

Sometimes stigma can even come from ourselves. Internalized Stigma (also called Self Stigma) is when people stigmatize themselves by believing negative stereotypes about people with mental health problems are true of themselves. One false stereotype is that people with mental health problems are erratic, unpredictable, and undependable. A person who internalizes this might come to believe that because they are receiving mental health treatment/have a diagnosis that this must be true of themselves. Therefore, they don't feel that they are dependable so they may decide that they cannot hold down a job. Other consequences include:

- Feeling embarrassment for having a mental illness, although it is not your fault
- Low self-esteem / beating yourself up
- Anger at yourself
- Depression, Isolation, Fear or Disinterest of trying new things
- Having lowered expectations for your future

## How does stigma impact families?

Sometimes families experience stigma because they have a family member who has a mental health diagnosis or is receiving mental health treatment. "Associative Stigma" is a term for the stigma and discrimination of others due to their association with a relative with a mental illness.

Unfortunately, the history of mental health treatment in America contributed to the stigmatization of families. For example, in the 1960's mental health professionals were taught that schizophrenia was caused by being raised by a cold/unavailable (which has since been discredited). This unfortunately contributed to a culture of "family blaming." Although this has been shown to be untrue some individuals may still believe this and some family members still experiences this.

### **Discussion:**

What are some other stereotypes/myths about families members of individuals with mental illness? Have you or your family members ever experienced these?

Possible answers:

- The family (oftentimes the mother) is to blame for their child's illness
- Mental illness is a result of bad parenting
- Family is to blame for when a person is not doing well/if a relative relapses
- Parents of children with mental illness are not as responsible or caring as other parents
- Family is responsible for taking care of the individuals/responsible for their actions/behavior

How do you think stigma might affect a family member?

- Lead to anger, depression, guilt/blame, frustration
- Could isolate, separate themselves from their social support
- Often, an understandable result of social stigma is that family members attempt to conceal their family member's illness/treatment from others. Studies have shown 1/5 to 1/3 of families reports a strained relationship with family members or friends as a result; of their family members illness.
- Similar to an individual experiencing psychosis may lead them to stigmatize themselves

Often, an understandable result of social stigma is that family members attempt to conceal their families members illness/treatment from others. Studies have shown 1/5 to 1/3 of families reports a strained relationship with family members or friends as a result; of their family members illness.

## What can you do to combat stigma?

One thing that is important to be aware of is that these stereotypes are false. So when you are faced with them or find yourself thinking about them try to remind yourself that they are not true.

### **On a small scale:**

- Be aware the stereotypes are false; so when you are faced with them or find yourself thinking about them try to remind yourself they are not true so you don't internalize them.
- Point out and help to correct any misconceptions about mental illness by sharing knowledge
- Share your story with others.

- Educate yourself about mental illness and recovery: workshops, presentations, articles/books, OnTrackNY Team Family Nights, NAMI Family to Family.
- Praise your loved one and yourself for seeking help and support.
- Surround yourself with people who are supportive.

**On a larger scale:**

Get involved in larger advocacy efforts and groups like NAMI stigma busters, on our own, legislative efforts, responding to stigmatizing materials in the media, etc.

Remember that you are not alone! Research has revealed that one in four Americans will experience a serious mental illness at some point during the course of his or her life. That means that mental illness has touched most families as well. Many celebrities have disclosed their mental health struggles: Mariah Carey, Rosie O'Donnell, Oprah Winfrey, Elton John, Robin Williams, Ben Affleck.

**Discussion question:**

If there was one message you would want to give the public about mental illness, what would it be?

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

## What is Stigma?

(handout for group 7)

... negative attitudes and assumptions directed towards people with mental illnesses. It is disrespectful and harmful to everyone.

Myths about mental illness are false, but common. Believing them can lead people to avoid, disrespect or discriminate against people who have mental illnesses.

Fear of being treated badly (fear of stigma) can discourage people with mental illnesses and their families from getting assistance and striving to reach their goals.

An estimated 44 million Americans experience a mental disorder in any given year.

Yet, many people would rather tell employers they committed a petty crime and served time in jail than admit to being in a psychiatric hospital.

### *That is stigma.*

Stigma leads to fear, avoidance, mistrust, and even violence against people living with mental illness and their families. And it can cause families and friends to turn their backs on people with mental illness.

Stigma can also lead individuals who have mental illness to feel badly about themselves.

### To avoid stigma...

**DO** use respectful person-first language, such as “a person with schizophrenia” or “someone using mental health services”

**DO** focus on a person’s abilities and strengths, not his or her limitations.

**DO** tell someone, respectfully, if they express a stigmatizing attitude.

**DO** learn more about mental illness, helpful treatments, and the strengths of people who live with it.

**DON’T** use terms like crazy, lunatic, maniac

**DON’T** use someone’s diagnosis instead of their name, such as “a schizophrenic” or “the mental patient”

**DON’T** use generic labels such as retarded, or “the mentally ill”

**DON’T** portray successful persons with disabilities as exceptions to the usual

**DON’T** avoid or discriminate against people who receive mental health services

Adapted from “Anti-Stigma: Do You Know the Facts” (SAMHSA’s Center for Mental Health Services, and the National Mental Health Association) **Facts and Myths about Mental Illness**

**(Handout for group 7)**

<b>MYTH</b>	<b>FACTS</b>
People with mental illness are dangerous	People with mental illness are much more likely to be victims of violence rather than perpetrators. As in the general population, only a very small percentage of people with mental illness ever commit violent acts.
People with mental illness do not make significant contributions to society.	Abraham Lincoln, Catherine Zeta-Jones, Jim Carrey, Beethoven, Ernest Hemingway, Shawn Colvin, Brooke Shields, John Nash, Herschel Walker, are just some of the many accomplished people who have or had a mental illness. Non-famous people with mental illness make important contributions to society and their families and communities every day.
People who have a mental illness cannot get better.	People can and do recover from and manage mental illness, when they have the proper tools and support. Many people with mental illnesses are in recovery and leading active lives. Sometimes, people with mental illness completely recover.
People with mental illness need constant assistance.	Many people with mental illnesses live independently in their own houses or apartments, manage their own money, arrange their own social activities and hold jobs. Everyone, mental illness or not, needs assistance sometimes.
Mental illness is a sign of personal weakness - people with mental illness could get better if they really wanted to.	Mental illness is an illness, just like heart disease and diabetes. It is not a character flaw, a weakness, or laziness. Recovery from any illness is more successful when the person has the proper support.
People with mental illness are unpredictable and unreliable.	Like everybody, people with mental illness can sometimes behave in unpredictable ways. However, most of the time, people with mental illness present few surprises to those who know them. Once they know themselves, people with mental illness can be aware of what they can commit to and carry through. Most are very dedicated to their values and responsibilities
People with mental illness are stupid	Many studies show that most mentally ill people have average or above average intelligence. Mental illness, like physical illness, can affect anyone regardless of intelligence, social class, or income level.

## Monthly Family Meeting 8: Substance Abuse in FEP

### Group 1 – Psycho-education

- I. Introduction
- II. Psychoed on alcohol and drugs generally and in FEP

#### A. Define psychoactive substances and describe their effects

Drugs are also called psychoactive substances and they affect the way people feel, how they think, or how they perceive the world around them. Examples include alcohol, marijuana, and cocaine. This handout (*Psychoactive Substances and Their Effects*) helps to explain the effects of each of them.

Review handout. Ask family members what they know, their experience.

#### B. Explain how substances affect people with a mental illness

Substances such as alcohol, marijuana, and cocaine can produce even more serious effects in people with a mental illness. Psychoactive substances can have a negative effect on mental illness in two ways. First, the substances can directly affect the brain chemicals responsible for the illness, which makes the illness worse. Second, substances can interfere with medications used to treat mental illness, making them less effective. People with a mental illness are often highly sensitive to the effects of psychoactive substances like alcohol and cocaine. This means that people with a mental illness are often affected by even small quantities of drugs.

#### C. Consequences of drug use in people with a mental illness

Substance use can cause a variety of different negative effects in persons with a mental illness. The specific consequences depend on the individual and the type of substance used. Some of the most common consequences experienced by persons with a mental illness are listed on this handout (*Consequences of Drug Use in Patients with Mental Illness*).

Family members can also experience many negative consequences of their loved one's substance use. Family members often have to give their loved ones money or have things taken from them. Family members often experience a lot of anger, worry, fear, and unhappiness because of their loved one's substance use. Family members are often asked to run their loved one's lives, take care of them both when they have increased symptoms of mental illness and when they are high, hung-over, or in withdrawal.

Have some discussion here – ask family members about their experiences.

- III. Reasons for substance use



## A. Your loved ones are not trying to hurt you with their drug use

People with a mental illness use drugs for lots of reasons. Here is a handout that summarizes them (*Reasons Why People with Mental Illness Use Drugs*). It's important to understand why people use drugs because it helps us to understand that they are not using simply to get into trouble or because they are weak or bad. Really, your loved ones use drugs to feel better and to fit in, and after a while they just use drugs without even thinking about it. It becomes a habit. We need to remember this because helping your loved ones can get frustrating and can take a long time. No one knows this better than you – you have been trying to help them for a long time now. But if we can remember that they are not trying to hurt us with their drug use, I think we will be able to keep being positive and supportive. Also, learning why people use drugs shows us several places where we might be able to help.

Have some discussion here – ask family members about their experiences.

## B. Explain habits, cravings, and triggers

### 1. Habits

People continue to use drugs/drink even though bad things can happen to them is he/she has developed a HABIT of using and has gotten used to using drugs/alcohol when they feel a certain way or in different situations. A habit is a routine – something that you do without thinking about it-like sitting in the same seat every day in class or at the dinner table. Habits are things we do automatically, without thinking. Some habits are useful, like saying 'Thank you' when someone holds an elevator door open for us. Other habits are not useful, like biting your fingernails or scratching a sore. Using drugs/drinking can be a bad habit like that: you can use without thinking about whether you really want to or not because you are used to doing it at a certain time or in a certain place, or when someone asks you to.

### 2. Cravings

Another reason people use drugs is because they have cravings. Cravings are very strong physical urges or needs to use/drink. Sometimes a craving can be so strong it hurts, and you can't think of anything else until we take the drug/drink to reduce the bad feelings. Cravings are the body's way of telling us that it really needs something, like hunger pangs. In the case of hunger, the body has a natural need for food, and when it needs more, it sends out signals that are hard to ignore, kind of like an alarm going off that says, "Feed me." Cravings occur because drugs gradually make changes to the brain. When you first start using drugs the brain doesn't expect it: it just reacts to the sudden change caused by the chemicals. Gradually, the brain starts to adapt, and after a while it needs the drug to function properly. Unlike your stomach, brain cells don't mess around by sending out gentle little reminders to eat: they hit you with a sledge hammer: "I want drugs NOW and I'm going to make you feel miserable until I get some."

The important thing to remember is that a craving doesn't last forever. When a craving begins, it will increase for several minutes, hit its peak (the point where it feels the worse), and then begin to fade away. Depending on what drug and how much you use, this process may take as little as about 7 to

10 minutes. One reason that people become dependent on drugs is that the drug immediately removes the craving and any uncomfortable feelings that come with it. But, remember, the craving will go away on its own if you wait it out. We will talk about ways to cope with those times when cravings seem overwhelming. The longer that you go without using drugs/alcohol, the fewer cravings you have. Also, the longer you are not using, the amount of time between cravings increases. We will also talk about how to avoid situations that produce cravings and make it easier to wait it out until the craving goes away.

In order to understand \_\_\_\_\_'s substance use, we need to think about the different situations or things that lead him to use. Lots of times people experience physical cravings in certain situations that they connect to their drug use. Sometimes, there are people, places, or things that the patient connects to using that can cause cravings. We call them "triggers," because they can trigger, or cause, a craving. Triggers can be people, places, things, times of day, emotions, or physical feelings that a person learns to associate with drug use. The two become connected, so that these things or situations become powerful reminders of drug use. This handout summarizes some common triggers (*Triggers to Alcohol and Drug Use*).

### 3. Triggers and high-risk situations (HRs)

Cravings can be triggered by people, places or things that you connect to using/drinking. This happens because things you associate with using or drinking – such as people, places, feelings, situations, objects, times of day, smells/sounds/sensations – can remind you of the pleasurable feelings you get from actually using drugs/drinking. Put flow chart on board:

*Triggers* ==> *People,* ==> *Remember* ==> *Cravings*  
*or Causes* *Places,* *pleasurable* *Urge to Use/*  
*Things, etc./ feelings*

Different types of triggers:

- **People** - sometimes being with a person that you have used within the past or that you use with now, is all it takes for you feel like you want a hit or a drink.
- **Places** - just being somewhere that you used, or even being in the area where you use or used can cause you to crave.
- **Things/Times of Day** - sometimes different things or certain times of the day can be a trigger for some people to want to use drugs or alcohol. For example, seeing the drug, or maybe seeing a pipe may trigger you to want to use. Also, you may want to use more when you have just gotten paid, just eaten a meal, or when you get up in the morning, or before you go to bed at night.
- **Smells/sounds/sensations** - for some people, the smell of the drug/alcohol, or even the smell of cigarettes can be triggers to use. Also, the sound of traffic or certain kinds of music can be a trigger. Some other triggers may include seeing someone having a drink or taking a hit.
- **Feelings** - Sometimes people use when they feel a certain way. Some people use when they are feeling good, and other people tend to use more often when they are feeling bad.

Sometimes, several triggers will often occur together, which can make it really difficult to not use/drink. HRSs occur when there is more than one trigger. When \_\_\_\_\_ is in a situation where his triggers are present, he is in what we call a *high-risk situation*. These situations are called High Risk Situations because there is a high risk that \_\_\_\_\_ will use when he is in them. High Risk Situations occur where there is more than one trigger or when there is one really strong trigger.

#### Part IV: Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

## Psychoactive Substances and Their Effects (handout for group 8)

<b>Drug Name</b>	<b>Slang Names</b>	<b>How is it Taken?</b>	<b>What are the Effects?</b>
Alcohol	Booze Brew	Drinking	Relaxation, Sedation, Slowed Reaction Time, Impaired Judgment, Loss of Inhibition
Marijuana	Pot Reefer Weed Joint Dope Grass	Smoking Eating	Relaxation, Mild Euphoria, Altered Sensory Experiences, Fatigue, Anxiety, Panic, Increased Appetite, Paranoia
Cocaine	Coke Crack Rock Ready	Snorting Smoking Injection	Increased Alertness/Energy, Decreased Appetite, Positive Feelings, Anxiety, Tension, Feeling Jittery, Racing Heart, Paranoia
Heroin	Smack Horse H	Injection Snorting	Euphoria, Pain Relief, Sedation, Slowed Reaction Time, Impaired Judgment

## Consequences of Drug Use in Individuals with A Mental Illness

(handout for group 8)

### Health Consequences:

- Symptom relapses or hospitalizations
- Depression and increased risk of suicide
- Risky sexual behavior and infectious disease
- Health problems

### Social Consequences:

- Legal problems
- Housing instability or homelessness
- Financial problems
- Family conflict
- Poor social relationships
- Anger and violence problems
- Poor work or role functioning
- Giving up important activities

### Victimization Consequences:

- Becoming a target for predators
- Exposure to dangerous situations

### Substance-Related Consequences:

- Increased tolerance
- Using more substances than planned
- Cravings
- Withdrawal (such as headaches, nausea, tremors)
- Spending large amounts of time involved in getting or using drugs

## REASONS WHY PEOPLE WITH A MENTAL ILLNESS USE DRUGS

(handout for group 8)

1. **To Be Social:** People with a mental illness may feel that using drugs or alcohol helps them better relate to others and makes them less anxious around other people. Sometimes, they feel pressured to use by other people and don't know how to say "No."
2. **To Feel Normal:** Some people with mental illness use substances because it helps them feel "normal" and accepted by others. Sometimes people feel as though they don't have a mental illness or are different from others when they are using drugs or alcohol.
3. **To Self-Medicating:** Other people use substances in an attempt to reduce unpleasant symptoms. People sometimes use substances to reduce anxiety, depression, sleep problems, tension, hallucinations (like hearing voices), and medication side effects.
4. **To Feel Pleasure:** Some individuals use substances because it is one of the few sources of pleasure they experience. Sometimes they believe it enhances other enjoyable activities.
5. **Out of Habit:** Some people who have used drugs or alcohol for a long period of time continue to use simply because it has become part of their daily routine -- a habit. They use substances automatically, without much thought, almost like brushing your teeth or taking a shower.
6. **Due to Cravings or Withdrawal:** Individuals who use larger quantities of substances may develop cravings for these substances, or they may experience withdrawal symptoms if they stop using them suddenly. These symptoms are often physical symptoms like nausea, headaches, or tremors. Substance use for these individuals may be primarily motivated by the desire to avoid the cravings or withdrawal symptoms.

## Triggers to alcohol and drug use

(handout for group 8)

A trigger is something that an individual connects to drug use that can cause him or her to have a craving.

Triggers can be:

1. **People:** Sometimes being with a person that they have used within the past can make people want to use drugs.
2. **Places:** Just being somewhere that they used, or even being in a similar area where they have used, can cause people to have cravings.
3. **Things:** Sometimes different things that are associated with drug use can be a trigger. For example, seeing a beer commercial, pipe, a needle, or the actual drug.
4. **Certain Times:** Certain times of the day can be a trigger for some people to want to use drugs. For example, some people use more in the morning or evening. Also, triggers can be certain times of the year, like around the holidays, or certain times of the week, like over the weekend or when payday comes.
5. **Smells, Sounds, and Sensations:** For some people, the smell of the drug, or even the smell of cigarettes can be triggers to use. Also, the sound of traffic or certain kinds of music can be a trigger.
6. **Feelings:** Sometimes people use when they feel a certain way. Some people use when they are feeling good, and other people tend to use more often when they are feeling bad.
7. **Combinations:** Sometimes, many triggers occur together, and this can make it really difficult for someone to not use drugs. For example, if someone is with a good friend who uses drugs, walking through a neighborhood where drugs are sold, and they have money in their pocket because they just got paid, it might make the person want to use. These sorts of situations can be really hard for people to deal with. We call these High Risk Situations.

## Monthly Family Meeting 9: Substance Abuse in FEP

### Group 2 – How to think about change

#### I. Introduction

#### II. Different stages of change

It's important for you to know that lots of people who use drugs have the same sort of pattern: there are times when they are not using and things are going well mixed in with times when they are using and things are not going well. For people who don't use drugs, it is often confusing to try to understand why people use and why they can't see how bad it is for them and how many problems it causes. It is also confusing to try to make sense of why people start using again after a long time of being clean.

What we know from working with lots of people who use drugs is that drug use is kind of like a cycle, and people may go through many times of using and non-using before they stop for good.

There are different points in this cycle that people can go through: 1) times when they are using and don't want to stop no matter how bad things seem; 2) times when they are using and would like to stop but aren't sure how; and 3) times when they want to stop and ask for help and ideas and ways to stop that might work. Others might be at the stage where they have stopped for a little while and are trying to keep it up, and many will relapse and go back in the cycle and have to work their way through again.

The important thing to remember is that just because your loved one is using now doesn't mean that you and I together can't help him get to another stage in the cycle. We just have to figure out how to move him from just thinking about stopping to trying it out for a while. Some people think that yelling at the patient will get him to stop.

#### III. Harm reduction

Another thing that we think is important is that anyone who needs or wants treatment for drug use should be able to get it. At many treatment programs, patients are not able to attend if they are using drugs. This is often tough for a family member who has finally convinced a patient to go to treatment, only to have the treatment program tell the patient to leave because he is not able to stop using right away.

We think that anyone who needs or wants treatment should be able to attend our groups, even if they are using. So, as part of \_\_\_\_\_'s participation in the treatment group, he does not have to be abstinent from using drugs. We use what's called a ***harm reduction approach*** and view any reductions in use as a positive step that will decrease patients' overall level of harm. This means that \_\_\_\_\_ can come to groups even if he is still using – we feel that that is the time when he really needs treatment the most. There are several reasons why we think this is a good approach. **First**, people with SMI have lot of trouble thinking and understanding things, and this makes it really hard for them to stop using. Stopping can take a long time and lots of hard work, and much of the work at



the beginning of treatment is focused on helping them to be comfortable in treatment and help them get to their treatment appointments on time. Many patients need a lot of time to feel comfortable attending sessions and sitting with a group of people. Any reductions in use made at any point in this process are significant in and of themselves, and may bring a patient closer to eventually attempting abstinence. **Second**, patients often abuse lots of substances, making it very unlikely that they could totally stop using drugs at the start of treatment. We want patients to stop using, but cutting down on their use is also praised and encouraged when someone is unwilling or unable to abstain. **Third**, requiring patients to totally stop using right away could very well turn some patients off to treatment, especially people who are not sure about stopping. We try to get people who are using to think about stopping or cutting down, and to teach them skills that they can use when they decide to stop. This is a new idea for a lot of people: that you can go to treatment while still using drugs.

#### IV. Barriers to change

**Change is very hard. It's hard for all of us and it's hard for your loved ones. There are lots of things that keep people from making changes that would be good for them.**

Generate discussion about what makes it hard to change substance use. Keep a list on the board.

There are positive things about drug use. Discuss how this means that clients will have to learn other ways to feel better without using drugs/drinking and that this can be a difficult process for many people.

People often feel bad when they don't make a change that they know they should make.

Generate discussion around what keeps their loved ones from changing and how they think their loved ones feel about this.

Getting support, learning what's helped others – can be good ways to get ideas or help cope with feelings.

#### V. Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill-building.*

## Community Resources: Information on Self-Help Groups for Family Members and Friends of Substance Users

(handout for group 9)

These community organizations provide information and support to people receiving mental health services and their families. They all will welcome your calls, letters, or email. If one does not meet your needs, try another. "Family" refers to anyone with a close family-like relationship, regardless of biological or legal status.

1. **The National Alliance for the Mentally Ill (NAMI)**, <http://www.nami.org>. NAMI is a national support and advocacy organization of and for families and friends of people with serious mental illness. Local family support groups, phone assistance, practical support, and other resources are available for free.

**Maryland: NAMI MD** is located at 10630 Little Patuxent Parkway, Columbia, MD 21044-3264 410-884-8695 [info@namimd.org](mailto:info@namimd.org) and the web site is [www.namimd.org](http://www.namimd.org)

**DC: NAMI National** is located at 3803 Fairfax Dr, Ste 100, Arlington, VA 22203. 703-524-7600 or the helpline at 800-950-6264

2. **On Our Own of Maryland, Inc.** is a statewide mental health client education and advocacy network, sponsoring workshops and conferences throughout the year. Also many of its affiliates/chapters across the state have (free) drop-in centers, support groups, and other activities – call for a list.

1521 South Edgewood Street, Suite C, Baltimore, MD 21227 Phone: 410/646-0262 or 800/704-0262 <http://www.onourownmd.org/> E-Mail: [onourown@frontiernet.net](mailto:onourown@frontiernet.net)

3. **Depression and Related Affective Disorders Association (DRADA)**. A client and professionally run organization working to alleviate the suffering of depression and bipolar disorder through free support groups and one-to-one peer support – both for people receiving services and for their family members – as well as education and information. Works with the Psychiatry Department of Johns Hopkins University.

Meyer 3-181, 600 North Wolfe Street, Baltimore, MD 21287-7381 Phone: 410/955-4647 or from Washington, D.C. 202/955-5800 <http://www/med.jhu.edu/drada>; E-mail: [drada@jhmi.edu](mailto:drada@jhmi.edu)

4. **West Virginia Mental Health Clients Association**. Available to answer questions about client activities in West Virginia. 1036 Quarrier 208A, Charleston, WV 25301; Phone: 800/598- 7303 or 304/345-7312 <http://www.contac.org/WVMHCA>

5. **Black Mental Health Alliance, Inc.** Provides training, education, consultation, support groups, and resource referral regarding mental health and related issues, with guiding principles of concern for others, integrity, respect for diversity & empowerment.

2901 Druid Park Drive, Suite A110, Baltimore, Maryland 21215; Phone: 410/225-7600

6. **Office of Client Affairs/Maryland Mental Hygiene Administration.** State office with a wealth of information about statewide client organizations. Also active in addressing and advocating for mental health system issues. 201 W. Preston Street, 4th floor, Baltimore, MD 21201; Phone: 410/225-1381

7. **National Mental Health Association.** Dedicated to promoting mental health, preventing mental disorders and achieving victory over mental illnesses through advocacy, education, research and service. A wealth of information and advocacy, and OnTrackNYs to local & state Mental Health Associations.

1021 Prince Street, Alexandria, VA 22314-2971; Phone: 703/684-7722 or 800/969-NMHA  
<http://www.nmha.org>

8. **The National Empowerment Center, Inc.** Run by mental health clients/survivors, the NEC provides a wide variety of hopeful, useful information about mental illnesses, recovery, advocacy, referrals, and client organizations, as well as policy work. 599 Canal Street, Lawrence, MA 01840; Phone: 800/769-3728 <http://www.power2u.org>

## Monthly Family Meeting 10: Substance Abuse in FEP

### Group 3 - What can family members do?

#### I. Introduction

#### II. General encouragement and support

#### III. Encouragement and support for getting help

Friends and family members can help patients stay in treatment. Significant others can help remind patients why treatment is important, express support as they enter and continue treatment, and give help as they pursue treatment.

#### IV. Assist the team

Treatment professionals can learn about the patient from the Concerned Significant Other(CSO). Although we have knowledge about substance abuse treatment in patients with SPMI, you have far more knowledge about \_\_\_\_in particular. This information can be very useful during treatment. The CSO knows the patient better than we do. Many times we are meeting patients for the first time and because we don't have an established relationship with them, it can be difficult to get them to come to see us or to attend a treatment group. Your role is important because you have been around the patient for a long time, and know things about what has been helpful in the past. You have a good chance of being able to convince \_\_\_\_to go to doctor's appointments, take medication, and attend treatment groups. He sees you as someone who loves and cares about him. Our thinking is that if you can work together with us, maybe we can figure out how to best get \_\_\_\_to attend treatment and get him more of what he needs once treatment starts.

#### V. Be someone the client can talk to about their substance use

#### VI. Positive Reinforcement for Non-Drug Using Behaviors

The goal of this section is to identify ways that a family member can reward the client for not using, and teach him/her how to properly use positive reinforcement.

##### A. Identify ways that the CSO can reward abstinence

Let's try to come up with ways that you can reward \_\_\_\_when he is not using. Here is a handout (**Ways to Reward Abstinence**) with some ideas that have been helpful in the past. Let's come up with some ideas about which of these things you would feel comfortable doing to reward \_\_\_\_when he is not using. Sometimes, the short-term consequences of not using can be a positive influence in someone's decision to stay clean. For example, if \_\_\_\_is specifically rewarded or complimented for staying clean, this can help him stay clean in the future. We call these rewards positive reinforcement, because it is reinforcing non-drug using behavior. However, there are certain rules

about how and when you should use positive reinforcement. This handout summarizes some of the rules (**Positive Reinforcement for Not Using Drugs**).

## B. Teach CSO how to apply positive reinforcement

Sometimes, the short-term consequences of not using can be a positive influence in someone's decision to stay clean. For example, if someone is specifically rewarded or complimented for staying clean, this can help him stay clean in the future. We call these rewards positive reinforcement, because it is reinforcing non-drug using behavior. However, there are certain rules about how and when you should use positive reinforcement. This handout summarizes some of the rules (**Positive Reinforcement for Not Using Drugs**).

1. First, it is important that you can tell when \_\_\_ is under the influence or hung-over. Rewards should only be given when he is clean, sober, and not hung-over.
2. It is important to communicate to \_\_\_ that the reward is being given because he is not using (Refer to examples in Ways to Reward Abstinence Handout).
3. It is also important to realize that using positive reinforcement is different from what we call "rescuing" or "enabling." Rescuing is when people do things for the patients that they are unable to do because of substance use or hangovers. For example, doing laundry or mailing out bills for patients who are too high to do it themselves. Enabling means that people do things that make it easier for patients to use drugs. For example, calling the patient's workplace to tell the boss that he is sick and won't be in. Positive reinforcement, on the other hand, means you are rewarding non-drug using behavior.

## C. Rules of calm and effective communication

Review handout. Calm and effective communication is always important when talking to your loved one about drug use or anything else.

## VII. Coping with Frustration

This section teaches the CSO ways to cope with frustration. When discussing this material, be sure to tailor the discussion to that particular patient/CSO, and to review the following key points (sample questions in italics):

Explain why frustration might occur. A tough situation might test your ability to remain calm while going through these skills. This is particularly relevant to situations in which \_\_\_ is using or has recently used, or in other situations in which you don't feel perfectly safe with him. You might do your best to use these communication skills, but there might come a time when you get frustrated. We need to have some sort of plan for what you can do if you start getting frustrated, either while you are using these skills, or because whatever issues you are talking about don't seem to be getting solved.

Devise a plan for coping with frustration. There are several different things you can do to cope with this frustration. Let's come up with a plan for what might be helpful for you if this occurs. This handout (Coping with Frustration) lists several different ideas.

## VIII. Discussion Concerning Issues/Problems Faced Over the Past Month

**NOTE TO RCs: Consider use of Recovery Videos if applicable to illustrate the concepts covered in this session.**

*After questions concerning the educational information have been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues, address communication concerns, and support skill building.*

## WAYS TO REWARD ABSTINENCE

(handout for group 10)

1. **Praise:** Praise your loved one for entering treatment and trying to stay clean (i.e., give positive verbal feedback).

*"John, I am so happy that you decided to start treatment, and you are clean, sober, and attending your groups. You are doing a great job, and I'm proud of you!"*

2. **Support:** Offer your loved one support during the difficult transition into treatment (i.e., give positive verbal feedback, offer to help them with a problem).

*"John, I am so happy that you are clean and sober right now. I know it can be difficult trying to stay clean, is there anything you need my help with?"*

3. **Offer Help:** Offer to help your loved one by doing a favor (i.e., take them shopping, give them a ride).

*"Since you're clean and sober and you've been working so hard in treatment, how about I take you to the store today and help you with your grocery shopping?"*

4. **Spend Time Together:** Spend time with your loved one doing a fun activity that does not involve drugs (i.e., go to a movie, church, or out to dinner, go to visit family or friends who do not use).

*"I love spending time with you when you're not using. How about going to a movie on Saturday night?"*

5. **Give Other Rewards:** There are plenty of other things that can be rewarding (i.e., cooking a favorite meal or dessert, giving a card or small gift, giving bus fare).

*"You've been doing such a great job attending your groups that I'm going to cook your favorite meal tonight."*

## Positive reinforcement for not using drugs

(handout for group 10)

**Positive reinforcement means rewarding your family member when he is clean and sober!**

### TIPS TO REMEMBER:

1. Be sure that your loved one is NOT under the influence of drugs.
2. Rewards are given only when your loved one is clean, sober, and not hung-over.
3. Link the reward with being clean and sober right now.
4. If your loved one starts using, give a "time-out" from positive reinforcement and do not give any rewards.
5. Don't confuse positive reinforcement with "rescuing" or "enabling." Remember that rewards are only given when your loved one is clean, sober, and not hung-over.
6. Let your loved one experience the natural consequences for using drugs.



## Rules of calm and effective communication

(Handout for group 10)

### Be Brief.

When people talk a lot, we often tune them out after the first few sentences. It can be hard for patients to follow after a while.

### Be Positive.

Using negative statements and blaming can make the other person more upset and less willing to talk.

### Be Specific and Clear.

Lots of times when people argue, they bring up things that happened hours, days, or even years ago. It is important to be specific and clear about what is going on in the present to understand current problems.

### Label your Feelings.

Sometimes we think that others know what we are thinking and feeling when they really don't. Other people might not be able to tell if we are angry or upset, so we need to tell them if we want them to know. We can't expect them to read our minds.

### Offer an Understanding Statement.

Try to put yourself in the other person's shoes and then let them know that you understand how they feel. You can say something like, "It's probably really hard for you to go to all of these treatment groups along with your doctor's appointments."

### Accept Partial Responsibility (When Appropriate).

If you honestly feel as though you are partly at fault for the argument, let the other person know that you take some of the responsibility.

### Offer to Help.

Offering to help lets the other person know that they are not alone and that you are there to support them and help them in any way you can.

## Coping with frustration

(Handout for group 10)

Talking with a friend or family member about their substance use can be difficult, and sometimes very frustrating. There might be times that the person doesn't want to talk about their problem, and they might get angry, or even violent, and this can be very frustrating. This handout gives some suggestions on how to cope with frustration.

### Ask for Help.

Contact a relative, friend, NA sponsor, or treatment provider who can lend a helping hand. Sometimes, just talking to another person who understands can help you feel less frustrated.

### Take A Break.

It is OK to take a break from the situation. People who use drugs can be difficult to talk to when they are high or hung-over. In this case, you can wait until the person is clean and sober to talk to them. Remember that if the person is high and you feel as though you are in danger, then leave the situation right away and go to a safe place.

### Find a Pleasant Activity.

Find a pleasant activity to do like going for a walk, watching TV, or going to a movie. Such activities can help to decrease frustration and improve your mood. This will put you in a better frame of mind to deal with the issue.

### Do Something Relaxing.

Sometimes doing deep breathing or relaxation exercises can be very helpful in relieving frustration. This will help you relax so that you can deal with the situation when you are feeling better.

### Call the Police.

If all else fails, and the interaction gets dangerous, you should call the police.

## Monthly Family Meeting 11: Disclosure

### Part I: Presentation of Specified Educational Topic

#### Materials Needed:

Handout: Disclosing to Others

#### Brief Review of Previous Session on Effects of Stigma and Self-Stigma

Last week we spoke about stigma and self-stigma and how that can impact individuals that experience psychosis and their family members.

*Group leader: Can anyone tell the group what stigma is? What is self-stigma? How can stigma and self-stigma affect individuals that experience psychosis? How does it affect family members?*

- Stigma is the negative attitudes and discrimination that people with mental health problems face as a result of stereotypes and biases about mental illness that are believed by individuals, groups, and/or social institutions.
- Internalized Stigma (also called Self Stigma) is when people stigmatize themselves by believing negative stereotypes about people with mental health problems are true of themselves.
- Effects: Social discomfort; feeling different/alienated/isolated, decreased self-esteem; problems getting/maintaining employment, housing, Having lowered expectations for your future; feeling angry, disrespected, dismissed, sad, frustrated, worthless

#### Introduction to Disclosure

- One of the things we talked about last week was the fact that stigma or self-stigma can sometimes lead people to attempt to conceal their illness/treatment or their family member's illness/treatment from others.
- There is often a fear that if you were to tell someone, even another family member or a close friend, that you or your family member had an illness that that person may not be supportive, may reject or distance themselves from you, blame you or hold you responsible, or stigmatize you in some other way.
- As a result family members and individuals with psychosis may be reluctant to be as open with others about what they are going through/have gone through, which can lead to fewer opportunities for getting support.

#### Discussion

Have you discussed having psychosis/your family having psychosis with others? How did you make the decision to tell that person? Was it easy/difficult? Why? Have you struggled/are you struggling with the decision to disclose to anyone? What makes you uncertain about whether or not you want to disclose?

## Deciding to Disclose

- The decision to disclose is not simple. There is no hard and fast rule for who needs to know that you are receiving treatment and how much information they need to know. Disclosure is not an all or nothing, black or white, right or wrong issue. No one can tell you whether you should or not disclose to others and who you should disclose to.
- Choosing to disclose is a personal, individualized decision although it can often help to do this with the support of other family, friends, treatment providers, etc.
- Weighing the pros and cons of the decision, deciding what is in your own best interest and what feels most comfortable to you can be helpful when trying to decide whether to disclose

**Group Activity/Discussion** (adapted from Sherman, M.D. (2008). Support And Family Education (SAFE) Program: Mental Health Facts for Families. Oklahoma City VA Medical Center. 3rd edition):

The group leader should have family members create a list of pros and cons of disclosing the mental illness; facilitate discussion surrounding the costs and benefits of disclosure. You may want to write ideas generated up on a board if one is available.

*Group leader: Like we discussed choosing to tell someone and talk about your illness or your family member's illness is not always an easy decision. Just like any decision it can often involve weighing to pros and cons of being more open with that person. So what might be some possible benefits to telling someone about your illness/that you are receiving treatment? What might be some cons?*

### **Possible pros:**

1. You don't have to worry so much about hiding the illness for others and/or explaining confusing behaviors to others.
2. You don't have to spend as much energy keeping it a secret. You don't have to spend some much energy trying to avoid discussing you or your family members experience or feel guilty not being as open or truthful with others.
3. You could relieve some shame that you may experience associated with the illness in the family.
4. Others may be able to provide additional support or future assistance in supporting you and/or your family member.
5. Others may have similar experiences/be coping with similar situations that you may not be aware of. You could feel less alone and they could feel less alone.
6. May provide the opportunity to correct misconceptions that others may have about psychosis, mental health treatment, families of individuals experiencing psychosis, etc. Thus, you may increase the likelihood that that person may respond to you/your family member in a more supportive, positive way.

### **Potential cons:**

1. You risk of being vulnerable.
2. It is possible that others might not respond as positively as you would have hoped.
3. You or your loved one/family might be excluded or experience stigma/ discrimination.

## Once You Decide to Disclose

There are several things you will want to consider once you have made a decision to disclose.

### **Deciding who to disclose to**

- There may be different reasons why you might choose to disclose to someone
- You might disclose to another family member or friends because you feel like they will be supportive and you want them to know what is going on with you
- You might tell an employer or a teacher because you have had to miss several days because of appointments

### **Deciding what to tell**

- It's your decision how much information you share. How much information does that person need to know? How much information do you feel comfortable having them know?
- This will likely vary depending on the person. You may share more information with a family member or close friend than a neighbor or employer or co-worker.

### **Deciding who should disclose/tell**

- Supporting family members in their decision to tell others and helping them figure out the way to do that that is most comfortable to them can be very important
- In some cases a family member may want to disclose the information themselves, other times a family member may want you to disclose the information (e.g., when someone is a minor and disclosing to a teacher/school; to another family member)
- It can be important to talk about and make decisions together about how, who, when, and what to disclose

### **Important Factors That Can Make One Feel More Comfortable Disclosing to Others**

(adapted from Hyman, I. Self-Disclosure and Its Impact on Individuals Who Receive Mental Health Services. HHS Pub. No. (SMA)-08-4337 Rockville, MD. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2008)

*Group leaders: As we mentioned telling other about an illness is not always easy but there are several things that those who have successfully shared their illness/treatment with others suggest that can help to make this easier.*

For each below group leader may want to discuss and then ask the group members how they think that could help someone feel more comfortable sharing information about their relatives/their own illness

- Being educated about you or your family members own experience/illness so that you will feel more comfortable providing information to other when needed
- Disclosing to someone you trust first.

- Knowing that how much you decide to share is up to you. You are in control of how much to share with others and should not feel pressured or obligated to sharing more than you feel comfortable sharing.
- Feeling safe when you self-disclose (e.g. this could be related to who you disclose to, the situation or place you disclose in, how it's done)
- You should disclose in the way that you feel most comfortable. Some people like to be spontaneous and share information with others in the moment if it feels right. Others feel more comfortable and less anxious if they are able to plan out how to tell someone and consider how they might respond to questions or response they might encounter.

### **Discussion**

What would make you feel more comfortable talking about your illness or your family members illness? What would cause you discomfort/make you more reluctant to disclose?

### **Final Discussion Regarding Educational Information:**

*Group leaders should encourage a discussion of any of the information presented during the session and address any questions from the group.*

## Part II: Practice Disclosing to Others or Discussion Concerning Issues/Problems Faced Over the Past Month

### **If group members want to practice disclosing**

*Given the topic of this session, if appropriate and if the group members are willing the group leaders can engage in a skills exercise with the group members focused on illness/treatment. Group leaders should first model how the skill is done. Example of situations that can be modeled are telling another family member about a loved one's illness/treatment, explaining to a friend that you haven't been calling/been able to spend as much time with them lately because of a family members illness, talking to a teacher/administrator to get support for a family member at school. If group members are willing have one or two families practice.*

### **If group members DO NOT want to practice disclosing**

*After questions concerning the educational information has been addressed, group leaders should inquire if group members has faced any particular problems/had any issues arise in their efforts to cope or in trying to support their family member in their efforts to cope with client's illness over the past month. The group leaders should work with the group to help resolve any issues or concerns. When appropriate, group leaders may engage in a problem-solving or communication skills exercise with group members to help resolve an immediate issues and address communication concerns.*

## Part III: Discussion Concerning Issues/Problems Faced Over the Past Month

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## Disclosing To Others

(Handout for group 11)

### Things to Consider Once You Decide to Disclose

Who should you disclose to?

How should you disclose?

Who should do the disclosing?

### Factors that May Increase Your Comfort in Telling Someone Else about a Family Member's Illness

Being knowledgeable about you or your family members own experience/illness

Disclosing to someone you trust first.

Knowing that how much you share is up to you.

Feeling safe when you self-disclose (e.g. this could be related to who you disclose to, the situation or place you disclose in, how it's done)

You should disclose in the way that you feel most comfortable (e.g., spontaneously or in the moment versus planned).



## MORE Part III: Discussion Concerning Issues/Problems Faced Over the Past Month

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10. How Work with the RC can be Useful as I Work Towards my Goals

**Goal:** \_\_\_\_\_

What would help me achieve this goal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How can working with RC be useful: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Goal:** \_\_\_\_\_

What would help me achieve this goal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How can working with RC be useful: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Goal:**  
\_\_\_\_\_

What would help me achieve this goal:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How can working with RC be useful: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do I want to work with the RC:

- Not at all for now, check in with me in a few weeks.
- Let's keep meeting regularly.
- Let's meet a few more times to work on a specific goal and then take a break.
- Let's meet in "bursts" starting in a few weeks when I'm ready to \_\_\_\_\_.