

# Introduction to the Practitioners Guidelines for Enhanced IMR for Co-Occurring Disorders

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This introduction contains the following sections:

- I. Background and Rationale for Enhanced IMR for COD
- II. Description of the Model
- III. Practitioner Skills for Providing Enhanced IMR for COD
- IV. Clinical Recommendations for individual and group Enhanced IMR for COD sessions
- V. Suggestions for Training and additional resources
- VI. Appendix

## I. Background and Rationale

Co-Occurring Disorders (COD) refers to people having both a severe mental illness (such as schizophrenia, major depression, and bipolar disorder) and a substance use disorder. Persons with CODs commonly struggle to find effective treatment. More than half of all adults with severe mental illness are affected by substance use disorders (abuse or dependence related to alcohol or other drugs). In addition, people with CODs are at high risk for many additional problems, such as symptom relapses, hospitalizations, financial problems, family problems, homelessness, suicide, violence, sexual and physical victimization, incarceration, serious medical illnesses (such as HIV and hepatitis B and C) and early death. As a result, it is vital to treat persons with CODs with the most effective treatment possible in order to prevent these serious problems.

Research has shown that most effective approach for COD is to provide integrated treatment, rather than sequential or side-by-side treatment. People receiving integrated treatment get help for both their mental illness and substance use at the same time in the same organization from the same group of treatment providers. People with CODs have a better chance of recovery from both mental illness and substance use when mental health practitioners provide *concurrent, integrated* treatment for both disorders.

Here are the guiding principles of providing COD Integrated Treatment

1. *Integration of mental health and substance use services including mental health and substance abuse treatment and relapse prevention planning.*
2. *Access to comprehensive assessment of mental health and substance use.*
3. *Comprehensive variety of services offered to clients such as family therapy, medications, supported employment, use of self-help services such as Dual Recovery. Providing a full array of services.*
4. *An assertive approach to treatment (i.e., not waiting for client to request treatment but using engagement strategies such as assertive outreach).*
5. *Using a harm reduction approach.*
6. *Motivation-based treatment and stage wise interventions.*
7. *Long-term perspective of treatment or time-unlimited services.*
8. *Providing multiple psychotherapeutic modalities.*

Practitioners are encouraged to learn more details on these principles and other important aspects of COD Integrated Treatment by reading:

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Press. Details about the guiding principles of COD Integrated Treatment can be found on pages 19-33.

The original Illness Management and Recovery (IMR) Program is very compatible with integrated treatment for COD and has many built-in features for working with persons with COD. It helps people develop personal recovery goals, and provides strategies and skills for managing mental illness effectively. IMR includes a whole module about substance use (Module 6, Drug and Alcohol Use) and strategies for developing a sobriety plan. It also includes multiple references to the importance of addressing substance use as a tool for managing mental illness. As examples, Module 1 (Recovery Strategies) includes addressing substance use as a possible personal recovery goal; Module 3 (The Stress Vulnerability Model) includes reducing substance use as one way to reduce biological vulnerability to symptoms returning; and Module 7 (Reducing Relapses) describes avoiding substance use as an important illness management strategy.

Enhanced IMR for COD was developed to provide even more attention to substance use, and to provide a platform for providing integrated treatment for co-occurring disorders. We have revised the practitioners' guidelines to provide strategies and suggestions for practitioners about how they can use IMR to help clients with COD address both their mental illness and their substance use. The Enhanced model stresses that practitioners who are using enhanced IMR for COD follow the principles of both IMR and integrated treatment for COD. It also stresses the importance of recognizing clients' stage of change regarding their interest and motivation in making changes in their substance use and developing interventions that match the clients' stage of change/stage of treatment throughout their participation in Enhanced IMR for COD.

## II. The Model for Enhanced IMR for COD

The following is a list of the key elements of the model for Enhanced IMR for COD. More details will follow in later sections of this document.

1. Practitioners providing IMR for COD should be trained in substance use strategies, IMR, and motivational interviewing.
2. Clients should receive a substance use assessment and a functional assessment prior to entering IMR for COD. This will help determine their stage of change/stage of treatment and identify areas that they would like to focus on in recovery.
3. The Enhanced model is recommended for individuals who have COD and for groups where one or more members has COD.
4. Practitioners should read the revised Guidelines for Enhanced IMR for COD for each module prior to delivering that module. The revised practitioners' guidelines integrates information and strategies that relate COD into each section. There are three additional categories. One, called "Substance Use Strategies," provides specific strategies for COD

within each particular module. The second, “Special Issues for Groups,” gives suggestions for working with groups where at least some of the members have COD. The third, “Additional Resources,” provide practitioners with additional sources of information, both print materials and websites, with handouts and additional educational materials that utilize the integrated approach within the module topic. Finally, there is a clinical vignette for each module, which follows a client named George who has COD as he participates in Enhanced IMR (see appendix for background on George).

5. Practitioners use newly developed Integrated Goal Tracking Sheet, Personal Sobriety Plan, and Integrated Relapse Prevention Plan. At the end of this introduction, we have included an appendix with copies of the blank forms for use in completing the Enhanced IMR for COD modules (Integrated Goal Tracking Sheet, Personal Sobriety Plan, and Integrated Relapse Prevention Plan).
6. In sessions, practitioners can use regular IMR handouts, but should be sure to include examples of both substance use and mental illness when teaching materials and practicing skills in each module, and elicit additional examples from clients. It is especially important to include substance use examples as part of goal setting, relapse prevention planning, and developing a plan to cope with stress and distressing symptoms.
7. Practitioners have the option to move up Module 6 (Drug and Alcohol Use). For individuals with COD and for groups with 50% or more clients with COD, we recommend that Module 6 (Drug and Alcohol Use) should follow Module 1 (Recovery Strategies).
8. Practitioners can change the order of modules based on the person’s desire to change and challenges identified in his or her sobriety plan.

For example, if a person has developed a sobriety plan that includes difficulties being around friends who often ask him to use marijuana, after completing Module 1 (Recovery Strategies) and Module 6 (Drug and Alcohol Use) it could be helpful to do Module 4 (Building Social Support) so that he can develop some activities to do with friends that don’t involve smoking marijuana. In this module, he may also want to develop some refusal skills to use with friends who ask him to smoke with them.

As another example, if a person has identified that she is feeling overwhelmed with caretaking roles and work and that stress is difficult for her to manage, the practitioner can decide to complete module 8 (Coping with Stress) much earlier in IMR.

As still another example, if a person reports that he is having difficulty with a distressing symptom, the practitioner can help him address that symptom as soon as needed. For instance, if a person frequently uses alcohol to help him cope with hearing voices, the practitioner may move to the section on coping with psychotic symptoms in Module 9 (Coping with Symptoms) after completing the sobriety plan in Module 6 (Drug and Alcohol Use).

9. For persons who have decided to make a change in substance use, practitioners should check in about substance use at the beginning of every session.

10. Practitioners should use the newly developed Integrated IMR Goal-Tacking Sheet and Integrated Relapse Prevention Plan provided in the practitioners' guidelines for Enhanced IMR for COD.

### III. Practitioner Skills for providing Enhanced IMR for COD

Basic IMR skills are essential for providing Enhanced IMR for COD. There are also some additional substances use skills that practitioners should learn, including assessment, using motivation-based and stage-wise interventions, using harm reduction strategies, taking an assertive approach to treatment, having a long term perspective on treatment, and being able to connect the client to a comprehensive array of services. These skills are described below and are reflected in the Minnesota Clinical Competency Scale for Enhanced IMR for COD.

#### Assessment

Clients should receive a substance use assessment and a functional assessment prior to entering IMR for COD. This will help determine the clients' stage of change/stage of treatment and help identify areas that they would like to focus on in recovery. There are several substance abuse assessment methods and instruments, and agencies vary on the one(s) they prefer. Some agencies (and states) require specific substance use and functional assessments as part of their intake for services. Other agencies (and states) may use a variety of assessments and/or do them only on a case-by-case basis.

Simply inquiring about recent and past substance abuse in a routine, matter-of-fact manner can be helpful, since many individuals are honest about their use. When inquiring about substance use, it may be helpful to first talk about past use, and to then discuss more recent use, as it is common for people to minimize the extent of their most recent use, but discussion of past use often opens them up to the topic, and may be revealing about current use. When talking about substance use, it is important to avoid taking a judgmental stance.

Brief screens such as the CAGE-AID substance screening tool may be helpful. CAGE is derived from the basic questions of the scale (cut-down, annoyed, guilty, eye-opener), and AID means "Adapted to Include Drug Use." The CAGE-AID is a four-question screening tool that assesses whether the person may have a problem with either alcohol or drugs. If the client answers yes to one of the questions it is possible the person has a problem. If the person answers yes to two of the questions, it is probable that there is a problem and further assessment is needed.

The four CAGE-AID questions are:

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have you people annoyed you, by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hang over?

Clients who respond positively to at least two of the CAGE questions will need ongoing assessments of how their substance use is impacting their mental illness, and their day- to-day

functioning. For these clients, we also suggest that the IMR practitioner consider going to Module 6 (Drug and Alcohol Use) after doing Module 1 (Recovery Strategies). This module will help practitioners continue the assessment process. In Module 6, with the help of some tools like the pay-off matrix and the readiness ruler, practitioners can usually determine the clients' stage of change and stage of treatment around their substance use, and their level of motivation. Practitioners should note that after completing Module 6, some clients might want to change their IMR goal. That is, clients may decide to include a substance use reduction goal as one of their goals. The Integrated IMR Goal-Tracking Sheet should be modified accordingly.

### **Using Motivation-based treatment and stage wise interventions**

The Stages of Change model developed by James Prochaska and Carlos DiClemente suggests that people go through a series of stages when making a behavior change, and at any given stage their level of motivation to make the change varies. The five stages of change are:

Pre-contemplation: No desire to change because the person does not think they have a problem.

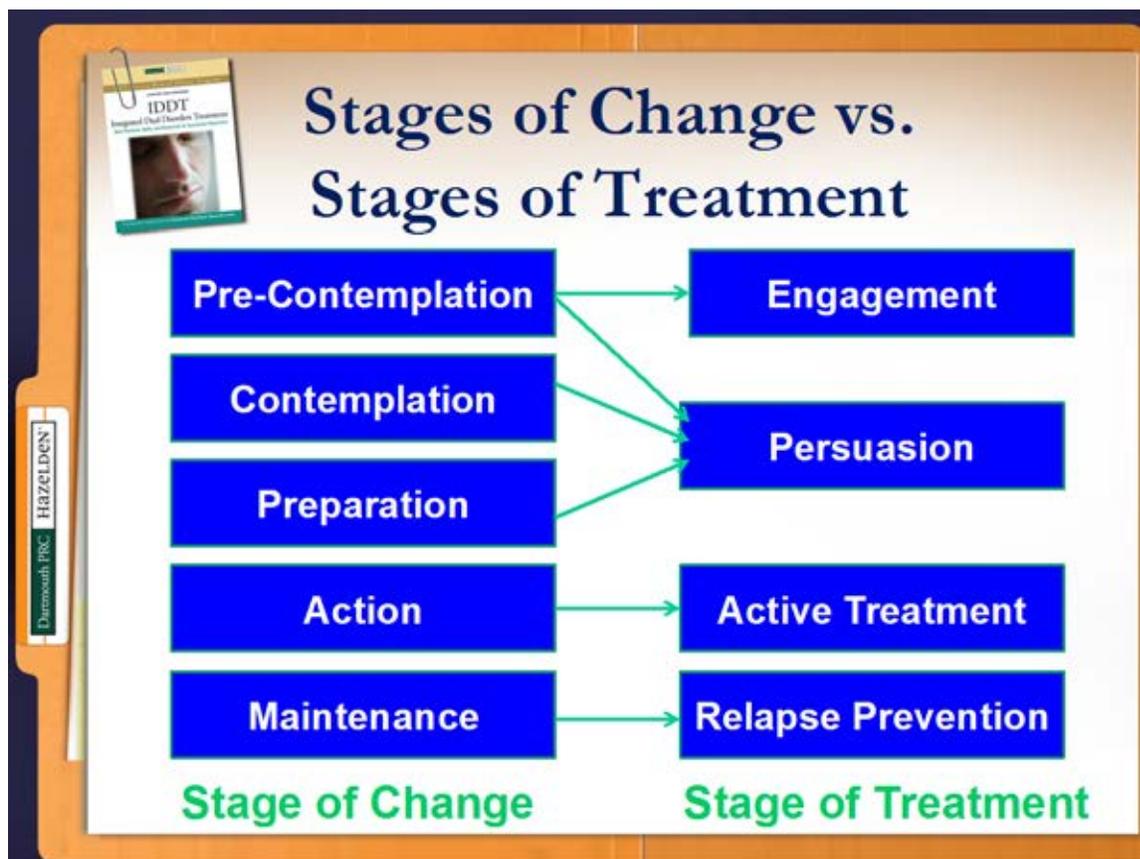
Contemplation: The person thinks they have a problem, but they can't make up their mind about whether or not to make a change. They are very ambivalent.

Preparation: The person has decided to make the change, and they are making plans to do so.

Action: The person is actively working on changing the behavior.

Maintenance: The person has been in the change process for at least 6 months, and they are successfully maintaining the behavior change.

The Stages of Change concept has been adapted to describe the *Stages of Treatment* that people with CODs progress through in the process of recovering from their disorders. The Stages of Treatment overlap with the Stages of Change, but differ in that they provide specific treatment recommendations for helping people move on to the next stage of change. These stages correspond to the Stages of Change as demonstrated in the diagram below:



In Enhanced IMR for COD, we expect practitioners to be able to recognize the client's Stage of Change, which leads to identifying the corresponding Stage of Treatment, which in turn leads to selecting interventions that are helpful to the client at that stage. The following table summarizes the Stages of Treatment, the goals of the practitioner at each stage, and a few examples of stage-appropriate interventions.

## Stages of Treatment for Co-Occurring Disorders

Stage	Definition	Goal	A Few Examples of Interventions
Engagement	Client has not established a relationship with a practitioner around substance abuse	To establish a working alliance	Outreach; practical assistance; provision of support to meet basic needs (food, shelter, legal help; a support for client's social network; crisis management, identification and help towards achieving personal goals
Persuasion	A working alliance has been established, but the client is continuing to abuse substances	To develop the client's awareness that substance use is a problem and create motivation to change	Providing info about nature of substance use and its interactions with mental illness; motivational interviewing (e.g., harnessing motivation to work on substance use by first identifying personal goals and then developing discrepancy between the attainment of those goals and continued use of substances) and help towards achieving personal goals
Active Treatment	The client has begun to reduce his or her use of substances or has temporarily achieved abstinence	To facilitate further reduction or continued abstinence	Teaching skills for dealing with offers to use substances, teaching skills for dealing with cravings, encouraging involvement in self-help groups for addiction or co-occurring disorders, developing coping strategies for symptoms as alternative to self-medicating with substances, developing a relapse prevention plan, and help towards achieving personal goals.
Relapse Prevention	The client has succeeded in achieving abstinence from substance use or use without harm	To help client maintain sobriety and extend the recovery to other areas of functioning	Helping clients improve their functioning across the broad range of life domains (e.g., work, social relationships, creativity), working on other health areas such as tobacco smoking and fitness, helping clients repair their relationships with family and friends

Using Harm Reduction Strategies

People with a psychotic disorder are highly sensitive to interpersonal stress, which can contribute to an increase in symptoms and also lead to a higher dropout rate from treatment. The treatment of co-occurring disorders should minimize such types of stress, such as raised voice tones, "in your face" confrontation, strong criticism such as accusations of lying, or forcing someone to admit that he or she has a problem with substances. Instead the practitioner should take an empathic manner aimed at understanding the person's experiences.

Many clients with a COD experience progress towards recovery, but it may take place gradually, over a period of many months or years. They may have low motivation at times to work on substance use problems, and may be engaging in a wide range of high risk behaviors including not

taking care of their physical health, spending time with dangerous people, trading sex for money or drugs, using dirty needles for IV drug use, being part of an abusive relationship. Taking a harm-reduction approach is therefore essential.

Taking a harm-reduction approach involves recognizing that many clients do not initially accept abstinence from substances as a personal goal, and understanding that motivation to work on substance use problems often develops gradually over time, in the context of treatment. Harm-reduction involves making efforts to reduce the most immediately harmful effects of substance abuse on the client's physical safety and health, without necessarily reducing the substance use behavior itself. Examples of harm-reduction strategies include providing access to clean needles for IV drug users, shifting to a less harmful substance, identifying safer places to use substances, and teaching safe sex skills.

### **Taking an assertive approach to treatment**

Clients with co-occurring disorders often drop out of treatment due to the chaos in their lives, cognitive impairment, low motivation and hopelessness. Taking an assertive approach to treatment means that practitioners do not wait passively for clients to take the initiative for treatment or to aggressively pursue treatment once it is initiated. Taking an assertive approach often means meeting clients in the community, helping them get transportation to and from treatment, providing practical assistance with immediate goals such as housing, legal aid, crisis management, and setting up medical appointments. This kind of assertive outreach can help practitioners develop the client's trust and develop a working alliance between them.

In Enhanced IMR for COD, taking an assertive approach also means following up on missed IMR sessions, doing make-up sessions, asking important questions about ongoing substance use and negative consequences, and providing assistance in a variety of areas of the clients' lives.

### **Having a long term perspective on treatment**

Making changes in one's life often requires several months or years. This is true for people learning to manage their mental illness and it is true for people working on reducing or stopping their substance use. It only makes sense that recovery from both disorders will take significant time. Taking a long-term perspective in Enhanced IMR for COD means that practitioners recognize that individuals recover at their own pace, and give them sufficient time and support. Practitioners also need to understand that clients may move forward and fall back, then move forward again in their recovery process.

Clients may need to re-visit strategies and skills from IMR modules several times during their participation in the program; they may also need to break down their goals into smaller steps, address new goals as they progress, and add steps to their goals (such as attending Dual Recovery meetings) as they recognize the need for additional supports.

### **Connecting the client to a comprehensive array of services.**

Practitioners in Enhanced IMR for COD should have a strong knowledge of the services available to their clients and know when to recommend those services. Some examples of services that helpful to clients with COD are individual counseling, group therapy, family therapy, supported

employment, supported education, ACT services, parenting classes, benefits counseling, self-help groups (such as Dual Recovery, Alcoholics Anonymous, Narcotics Anonymous), social skills training, residential services and pharmacological treatments.

We encourage practitioners to make a list of local services that their clients may find helpful and to be sure to include resources for co-occurring disorders available in their community. Become familiar with all the resources, and develop working alliances with the staff members or peers involved in providing services. Do whatever you can to make a connection between the client and the services and to help the client feel comfortable about using the services. For example, many clients appreciate practitioners going with them to their first Dual Recovery meeting, or role playing with them what a meeting will be like and how they can contribute to the meeting.

#### **IV. Clinical Recommendations for individual and group Enhanced IMR for COD sessions**

##### Individual sessions

For persons who are actively using, practitioners should regularly check in on substance use at the beginning of every session. It is helpful to establish this type of check-in as part of the normal IMR routine when beginning IMR with an individual. For example, “How are things going with you this week? How much have you been smoking marijuana this week?”

Here are some recommendations for completing the check-in and regular assessment of substance use:

- a. If persons are actively using or have had recent past use (last 6 months to 1 year), establish at the beginning of IMR that the practitioner will ask about substance use over the course of treatment.
- b. If the person has decided to make a change in substance use and develops a sobriety plan in Module 6-Drug and Alcohol Use, the practitioner should follow-up with the plan on a regular basis during the process of goal follow-up each week.
- c. If the person is actively using and the practitioner has information about problems or negative consequences (i.e., getting arrested or losing housing) of substance use, the practitioner should share this information during the check-in and/or following up on goals. (e.g., It has come to my attention that you had some problems over the weekend. Your case manger told me that you got kicked out of your apartment because you were smoking marijuana. I'd like to talk about that with you.) The practitioner should use motivational strategies to assess if there have been any changes in the client's desire to change using the Readiness Ruler and tie the known problems and negative consequences to the decisional balance. If the client decides to make a change in substance use then the remainder of the session should focus on developing a sobriety plan outlined in Module 6-Drug and Alcohol Use.
- d. If the person is actively using and there are no known problems or negative consequences, the practitioner should assess substance use at least once a month during the goal follow-up noting past problems. Based on the review and evidence of any new problems or worsening consequences then the practitioner can use the

Readiness Ruler and decisional balance to assess for a desire to make a change in substance use.

- i. If the person decides to make a change in substance use then the remainder of the session should focus on developing a sobriety plan outlined in Module 6-Drug and Alcohol Use.
- ii. If the person decides not to make a change then acknowledge that things seem to be going well and substance use is not a problem for the person at this time and thank the person for his honesty.

Here are some suggestions for completing Module 6 (Drug and Alcohol Use) earlier than the sixth module:

- If person has an active substance use disorder then Module 6-Drug and Alcohol Use should be completed after Module 1-Recovery Strategies.
- If person has a past history of substance use that occurred in the last 6 months to 1 year but no current use then Module 6-Drug and Alcohol Use should be completed after Module 2-Practical Facts about Mental Illness.
- If the person has been in remission from substance use for years and there is no evidence of a current substance use problem then follow the original order of the modules.

### Group Sessions

For groups with less than 50% of persons who are actively using a substance, we recommend the following:

- a. If the persons are in remission for longer than 1 year then follow the original IMR structure.
- b. If the persons in the group are in early remission (used substances in the last year), the practitioner should check-in with the participants at least once a month regarding substance use. If a person begins actively using then it is recommended that the person receive individual IMR to complete Module 6-Drug and Alcohol Use to determine if the client wants to make a change and develop a sobriety plan. After developing a sobriety plan, the person should be given the option of whether or not to share the plan in group in order to get more support.
- c. If the persons in the group are actively using, the practitioner should meet with the persons using substances individually to complete Module 6-Drug and Alcohol Use. Practitioner should then use motivational strategies to determine if the person has a desire to change substance use, use the Readiness Ruler and decisional balance to develop a sobriety plan as needed. If the person decides to make a change in substance use, she should be given the option to continue to have individual IMR sessions as needed to check-in about substance use, the use of the sobriety plan, and the remaining IMR materials if she does not feel comfortable sharing information in the group.

For groups with greater than 50% of persons who are actively using a substance, we recommend the following:

- If persons in the group are actively using or have had recent past use (last 6 months to 1 year), establish at the beginning of IMR that the practitioner will ask about substance use over the course of treatment.
- If persons in the group have decided to make a change in substance use and develop a sobriety plan in Module 6-Drug and Alcohol Use, the practitioner should follow-up with the plan on a regular basis (at least once a month or more) during the process of goal follow-up each week.
- If persons in the group are actively using and the practitioner has information about problems or negative consequences of substance use, the practitioner should share information during the check-in and/or following up on goals. The practitioner may also choose to meet with the person individually to follow-up about negative consequences or problems. The practitioner should use motivational strategies to assess if there have been any changes in the client's desire to change using the Readiness Ruler and tie the known problems and negative consequences to the decisional balance. If the client decides to make a change in substance use then the remainder of the session should focus on developing a sobriety plan outlined in Module 6-Drug and Alcohol Use.
- If persons in the group are actively using and there are no known problems or negative consequences, the practitioner should assess substance use at least once a month during the goal follow-up noting past problems. Based on the review and evidence of any new problems or worsening consequences then the practitioner can use the Readiness Ruler and decisional balance to assess for a desire to make a change in substance use.

Completing Module 6-Drug and Alcohol Use earlier in IMR with a group that is greater than 50% COD is associated with the following recommendations:

- If persons in the group have an active substance use disorder then Module 6-Drug and Alcohol Use should be completed after Module 1-Recovery Strategies.
- If persons in the group have a past history of substance use that occurred in the last 6 months to 1 year but no current use then Module 6-Drug and Alcohol Use should be completed after Module 2-Practical Facts about Mental Illness.
- If persons in the group have been in remission from substance use for years and there is no evidence of a current substance use problem then follow the original order of the modules.
- If needed sooner, the practitioner has the option of delivering Module 6-Drug and Alcohol Use individually with a person who is actively using in order to facilitate a desire to make a change and develop a sobriety plan.

## V. Training recommendations and overall references

### Training

Practitioners need the following in order to be effective in delivering Enhanced IMR for COD:

- Training in IMR
- Training in motivational interviewing
- Training in CBT strategies
- Training in principles of co-occurring substance use treatment (including stage of change/stage of treatment, and strategies for enhancing motivation to make changes in substance use)

### Resources

Practitioners can find helpful information and strategies in the following books and websites:

- For more information about the COD model: Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Press.
- Team Solutions is a recovery-based illness and life skills management resource. It includes 10 psychoeducational workbooks on the following topics: Recovering: Achieving Your Life Goals, Partnering With Your Treatment Team, Understanding Your Illness, Understanding Your Treatment, Getting the Best Results From Your Medicine, Managing Stress and Problems, Making Choices: Substances and You, Recognizing and Responding to Relapse, Managing Crisis, and Recovery in Process: Putting It All Together. To access this resource on the web type in [www.treatmentteam.com](http://www.treatmentteam.com), click on learn more for team solutions.
- For additional information and free resources on integrated treatment for COD please see the following website from Behavioral Health Evolution:  
[http://www.bhevolution.org/public/co-occurring\\_disorders.page](http://www.bhevolution.org/public/co-occurring_disorders.page)
- For more information about using cognitive behavior therapy for persons with serious mental illness: Mueser, K. T., Rosenberg, S. D., and Rosenberg, H. J. (2009). *Treatment of Posttraumatic Stress Disorder in Special Populations: A Cognitive Restructuring Program*. Washington, DC: American Psychological Association.
- For more information on social skills training: Bellack, A. S., Mueser, K. T., Gingerich, S., and Agresta, J. (2004). *Social Skills Training for Schizophrenia*. New York: Guilford Press.

## **VI. Appendix**

- A. Integrated Goal Tracking Sheet-Blank Copy**
- B. Sobriety Plan-Blank Copy**
- C. Integrated Relapse Prevention Plan-Blank Copy**
- D. Introduction to Clinical Vignette-George's Story**

## Integrated Goal Tracking Sheet

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Use this sheet to record progress toward goals, including steps taken, new steps, new short-term goals, and new recovery goals.

Name: \_\_\_\_\_ Date that personal recovery goal set: \_\_\_\_\_  
 Personal Strengths: \_\_\_\_\_  
 Personal Recovery Goal: \_\_\_\_\_  
 Personal recovery goal achieved (date): \_\_\_\_\_ Modified (date): \_\_\_\_\_

Short-term goal (Objective) 1 related to personal recovery goal:	Short-term goal (Objective) 2 related to personal recovery goal:	Short-term goal (Objective) 3 related to personal recovery goal:
Steps:  1.  2.  3.  4.	Steps:  1.  2.  3.  4.	Steps:  1.  2.  3.  4.
Start Date: _____	Start Date: _____	Start Date: _____
Date Reviewed: _____	Date Reviewed: _____	Date Reviewed: _____
Achieved?  Fully   Partially   Not at all	Achieved?  Fully   Partially   Not at all	Achieved?  Fully   Partially   Not at all
Modified/next steps:	Modified/next steps:	Modified/next steps:

Date Reviewed: _____	Date Reviewed: _____	Date Reviewed: _____
Achieved? Fully   Partially   Not at all	Achieved? Fully   Partially   Not at all	Achieved? Fully   Partially   Not at all
Modified/next steps:	Modified/next steps:	Modified/next steps:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Practitioner Signature

## Practitioner Goal Update Form

### 1. Diagnosis:

<b>Axis I:</b>		
<b>Axis II:</b>		
<b>Axis III: (Medical)</b>		

### 2. Stage of change for Mental Illness:

Pre-Contemplation       Contemplation       Preparation  
 Action                       Maintenance

### Stage of Change for Substance use:

Pre-Contemplation       Contemplation       Preparation  
 Action                       Maintenance

### 3. Outcome Measures:

In the past 6 months has the client:

- |                                 |           |          |
|---------------------------------|-----------|----------|
| 1. Been hospitalized?           | _____ yes | _____ no |
| 2. Been employed?               | _____ yes | _____ no |
| 3. Been in school?              | _____ yes | _____ no |
| 4. Been arrested?               | _____ yes | _____ no |
| 5. Been in jail or prison?      | _____ yes | _____ no |
| 6. Been on probation or parole? | _____ yes | _____ no |
| 7. Been homeless?               | _____ yes | _____ no |
| 8. Been using substances?       | _____ yes | _____ no |

### 4. Barriers to Treatment: (The things that are keeping the client from achieving goals)

**5. Prompts to be used when completing the Integrated Recovery Plan:** (Use these prompts to help in setting up a recovery plan for your client)

- a) Why is this long-term goal important to you?
- b) How confident do you feel in your ability to achieve this long/short-term goal? Why or Why not?
- c) Do you feel you have the skills to achieve this long/short-term goal? If not, what would help you feel more ready?
- d) For the short-term goals: How does this goal connect back to your recovery goal? Or How will achieving this short-term goal help you make progress towards your long-term recovery goal?
- e) What are your expectations for me (your practitioner) in helping you make progress towards your goal? (How can I best help you make progress towards your goal?)
- f) What are your expectations for yourself to make progress towards your goal? (What are you committing to do to make progress towards your goal?)

## Personal Sobriety Plan

Congratulations! You've taken the first and most important step toward being free of problems related to alcohol and drug use. Complete this plan by following the steps outlined. Don't worry about making the plan perfect—you can change it as you go along based on how well it is working for you. Share your plan with people who are close to you so they can support you in your sober lifestyle.

**STEP 1.** List one to three ways that your life will be better by stopping using substances. Consider how sobriety may help you achieve your personal recovery goals.

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**STEP 2.** List at least one person who will support your sobriety (by talking with you, helping you solve problems, encouraging your efforts, etc.).

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**STEP 3.** Identify one to three high-risk situations that can lead to unintended use of alcohol or drugs. Consider situations in which you have used substances in the past, such as people offering you substances, being pressured to use, feeling bad, having nothing to do, and cravings.

1.

2.

3.

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**STEP 4.** Make a plan for how to deal with those high-risk situations. For each high-risk situation, identify one or two ways of dealing with it.

*Situation 1:*

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*Plan for dealing with it:*

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*Situation 2:*

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*Plan for dealing with it:*

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*Situation 3:*

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*Plan for dealing with it:*

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**STEP 5.** Find new ways of getting your needs met. Consider the ways using substances have met your needs in the past, such as hanging out with friends, feeling relaxed or “high,” dealing with symptoms, or having something to do. What needs did they meet? For each need you identify, think of at least one new strategy for getting that need met.

*Need 1:*

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*New strategy for meeting this need:*

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*Need 2:*

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*New strategy for meeting this need:*

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*Need 3:*

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*New strategy for meeting this need:*

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## Integrated Relapse Prevention Plan for Co-Occurring Disorders

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Part I: Preventing Triggers (things that were associated with relapses of my mental health symptoms in the past)

Common Trigger	What I plan to do to prevent this trigger
Not taking medication regularly	
Difficulty coping with high levels of stress	
Starting (or increasing) the use of substances (see Sobriety Plan in Module 6, Drug & Alcohol Use)	
Other:	

### Part II. Monitoring Early Warning Signs (first signs that my mental health symptoms were coming back)

List of my most important Early Warning Signs

- A.
- B.
- C.

**Part III. Plan for Responding to Early Warning Signs (what you think would help you keep Early Warning Signs from becoming a full relapse)**

<b>Common things that help people respond to Early Warning Signs</b>	<b>Action Steps I plan to take (include names and contact #'s)</b>
Contacting the doctor or member of my team	1. 2.
Getting more social support	1. 2.
Keeping track of the early warning	1. 2.
Stopping or reducing substance use (See Sobriety Plan in module 6, Drug and Alcohol Use)	1. 2.
Using my coping Strategies:	1. 2.
Other:	1. 2.

Congratulations! You have just developed an Integrated Relapse Prevention Plan that could help you prevent a relapse. Over the next few weeks make a plan to practice the skills and strategies on your plan at least 3 times. Share it with at least one supportive person in your life. And remember, your plan is a living document. Revise it whenever you need to.

### Dates I have practiced skills and strategies on my plan:

Dates:	Strategies I practiced
	1.  2.
	1.  2.
	1.  2.

Even when you do everything you can and follow your relapse prevention plan to prevent triggers and respond to early warning signs, there is a possibility that a crisis may develop and that you may need additional support. In this situation, it will be helpful to answer the following questions:

1. Who would you like to be contacted to help you?

Name: \_\_\_\_\_ Contact Information \_\_\_\_\_

Name: \_\_\_\_\_ Contact Information \_\_\_\_\_

2. Where can you go for help? \_\_\_\_\_

3. When you go for help, what would you like for them to do?

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## Enhanced IMR for COD Clinical Vignette Introduction to George's Story

George is a 50-year-old single man who has never married, and who has been receiving mental health treatment for 25 years. He is diagnosed with Bipolar Disorder Type II, and is usually slightly depressed. George used to live with his mother in her home until approximately 10 years ago, when she passed away. Since then, George has lived on his own in a housing apartment complex. He qualified for housing there because of his mental health disability. George has always had a drinking problem, but after his mom passed away, George's drinking escalated significantly. He is currently drinking a fifth of vodka per day. George says he would like to find a job, but has found it hard to find one because of his drinking. George does have an interest in music and he plays guitar and writes his own songs. He would like to make a CD.

George gets up around 9am, and spends the day in his apartment chain smoking cigarettes, watching TV, and drinking. Sometimes he plays his guitar. His sister lives in apartment complex that is very close to him, but he doesn't see her very often. Prior to the death of their mother they had a closer relationship and saw each other a few times a week when the sister would visit at the home of their mother. After the mom's death George's sister helped him get an apartment, but with his increased use of alcohol their relationship has become distant. George seems motivated by his music. He also seems motivated to alleviate the symptoms of alcohol withdrawal and he recognizes that he has bipolar disorder and takes his medication every day but remains slightly depressed. George has tried in the past and failed to stop drinking, and states that he would like to have a better life.

George comes into the mental health program once a week to pick up his medication. He does not start drinking until later in the day, so he is sober when he comes in to check-in and pick up his prescriptions. George is very lonely and has been talking about places he might be able to go to meet people and also to find places he might go to play music. George's practitioner Lynette asked him if he might be interested in IMR where he could learn ways to meet other people and get help in setting goals to work on achieving things that are important to him such as his music. Lynette showed George the IMR introductory video, and George was excited about the artist in the video and decided he would like to give Enhanced IMR for COD a try.