

Implementation Guide #4: Skill-Building Interventions for Individuals with Serious Mental Illness (SMI) and Co-Occurring Substance Use Disorders

INTRODUCTION

This implementation guide is the fourth in a series of four such guides designed to provide helpful tips for service providers working in mental health settings serving people with serious mental illness who may also have co-occurring substance use challenges. Service providers who may benefit from these guides include any type of mental health (MH) or Substance Use Disorder (SUD)

professionals, including everyone from prescribers to certified peer support specialists, as well as people who work in front line service roles such as clinicians, case managers or care coordinators. Each of the four guides illustrates simple strategies for applying evidence-based integrated interventions in day to day practice.

FUNDAMENTALS OF SKILL-BUILDING INTERVENTIONS FOR CO-OCCURRING SUD

In Implementation Guide #3 we focused on the importance of aligning our SUD interventions and outcomes with the client's stage of change for using substances. Working on increasing motivation to reduce or discontinue substance use often leads us to focus on "why" it is good for people with SMI to avoid using substances that can disrupt a fragile brain equilibrium. This Implementation Guide focuses on an equally important issue: "How" people with SMI make changes in their substance use. One of the common challenges that needs to be addressed for individuals with serious mental illness, and particularly those with psychiatric disabilities at baseline, is the following: **Now that I've decided to reduce or eliminate my use of any substance, HOW do I develop the skills or tools I need to be successful?**

Let's return to the two stories that we discussed in previous Implementation Guides:

Manuel is a 25-year-old unmarried Hispanic American who lives with his extended family. He is on disability. He has been diagnosed with schizophrenia, and reportedly uses stimulants, marijuana, and alcohol. He has had recurrent hospitalizations as a result of discontinuation of his medication along with increased substance use. Manuel reports he's been trying to cut down on the marijuana because he knows "too much is bad for me." He says he's been using about half as much marijuana as he was before. He says he would like to cut down even further, but his older brother is a marijuana dealer and is always offering free marijuana and encouraging him to use it: "It will help you feel relaxed." He doesn't want to get his brother upset and doesn't know what to do.

Cheryl is a 47-year-old divorced Caucasian woman who used to work as a licensed practical nurse (LPN), and is now diagnosed with major depression and PTSD, as well as having intermittent alcohol binges and suspected misuse of the opioids she is prescribed for chronic back pain. She has a long history of both childhood and adult trauma in her



significant relationships. She says today that she wants help to feel less depressed. When asked about her alcohol use, she tells you that she knows she is an “alcoholic” and has tried to stop for periods of time, but when she’s upset, she often binges, and then feels even more depressed and ashamed. She’s received treatment for alcohol use in the past, but she says she still can’t stay sober. She says she attends AA meetings but isn’t sure what purpose there is for her to go to meetings: “I listen to all the sad stories, and I try to help people out, but that’s about all.”

Answer: For both Manuel and Cheryl, there is a need for concrete skills training to support further success. Manuel needs skills to learn to resist social pressure to be in better control of his marijuana use (mild-moderate marijuana use disorder) Cheryl needs to learn the skills required for her to manage her brain disease of alcohol addiction (severe alcohol use disorder).

Reminder: All skill building interventions occur best within a welcoming, hopeful, empathic, strength-based connection, as described in Implementation Guide #1. All discussions about substance use will occur best if they happen within a positive relationship.

What does the evidence say about skill building?

- There is ample literature describing various types of cognitive-behavioral skills training interventions addressing substance use targeted for individuals with serious mental illness. The most robust of these models are manualized:
 - o The Substance Abuse Management Model (SAMM) constructed by Robert Lieberman’s psychiatric rehabilitation research team. SAMM has been published as a book: *Overcoming Addictions: Skills Training for People with Schizophrenia*, by Roberts, Shaner, and Eckman (1999). (This manual is appropriate for any person with serious mental illness, not just for people with schizophrenia.)
 - o *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals* by Bellack, Bennett, Gearon (2007).



These manuals offer simple practical individual and group exercises for practicing relevant skills. These exercises build on adult learning principles of practice, role-play, and repetition, along with positive feedback for small steps of progress. SAMM is particularly simple. It includes 10-page skill exercise chapters such as: Reporting a Slip (Telling Someone About Your Use); Refusing Drugs Offered by A Friend or a Relative; Refusing Drugs offered by a Dealer.

Therefore: Because these manuals are simple, they are accessible for use by any level of practitioner. Practitioners can practice simple skills training exercises with clients, in order to improve their own skills as “skills-trainers.”

TABLE 1: Examples of Skills

SAMM - 9 Skills

Quitting After a Slip

Reporting a Slip

Refusing Drugs Offered by a Dealer

Refusing Drugs Offered by a Friend or a Relative

Getting an Appointment with a Busy Person

Getting a Support Person

Reporting Symptoms and Side Effects to a Doctor

Asking Someone to Join You in a Healthy Activity

Negotiating with a Representative Payee

Additional Important Skills

Using 12 Step (and other Recovery Support) Meetings Successfully Managing Cravings

Asking for Help from Staff, Family, Friends, Peers

For individuals with more severe disorders, it is helpful to recognize that addiction is a brain disease in which success is based (in part) on learning skills needed to manage that disease. Increasing research demonstrates that addiction, like other chronic diseases, can benefit from disease management skills training. For someone like Cheryl with alcohol use disorder, therefore, medication for addiction treatment (MAT) may be helpful, but—whether or not MAT is used—Cheryl will still benefit from learning disease management skills, including potentially learning skills for utilizing 12-step recovery programs and skills for cognitive-behavioral relapse prevention. Individuals with SMI and addiction need to learn similar disease management skills as those with addiction and no SMI, but because of co-morbid psychiatric symptoms, which often have associated cognitive deficits, these individuals require tailored learning. This includes teaching in smaller chunks, verbal presentations accompanied with written materials, considerable practice, rehearsal and repetition of new learning and bigger rounds of applause for any positive progress.

Therefore: When individuals with SMI are receiving treatment interventions targeted for addiction, it is important to make sure they learn the skills they need to succeed. For example, although AA, NA and other similar programs of recovery are described as “simple programs,” utilizing 12-step meetings requires a set of skills that may not be that simple: What should I do at an AA meeting? What should I say and not say? What should I do if they are going too fast? What do I do if I do not understand? The same approach can be applied to “cognitive-behavioral relapse prevention” skills. Further, it is often helpful for clients to begin skills practice with their MH clinical team, before trying to translate the same skills to people they meet at a 12-step meeting.

Examples of Skill-Building:

The following are examples of how to structure simple role plays that can be utilized with clients with SMI:

For Manuel:

Role play for refusing marijuana offered by his brother. Role plays like this can be based on the relevant skills chapter in *Overcoming Addictions: Skills Training for People with Schizophrenia*. The following example can be done individually or in a group. The role play itself may take only 10-20 minutes but can then be practiced by Manuel in a variety of contexts with his MH staff until he feels that he can use these new skills with his brother.

Staff: You've said that it's hard for you to say no to your brother when he offers you drugs, but you would like to be able to say no, and to say no in a way that doesn't get him upset with you. Is that right? If so, would you like some help with learning how to tell your brother no?

Manuel: *Sure.*

Staff: Okay...let's do a little role play to try to figure out what to say, and then practice how to say it. First, tell me how it goes when your brother offers you marijuana. Where are you? What does he say? What do you say next? How does he respond? And so on.

Manuel: (Describes the conversation. Demonstrates how he has no response to his brother's pressure that marijuana would help him to relax.)

Staff: Okay. Now we're going to do the first part of the role play. I'm going to be playing you, and I want you to play the role of your brother. Is that OK? (Manuel nods). Let's go through exactly what you just described and see if we get it right. (They do that.)

Staff: Great job. You played your brother very well. Any thoughts about how that went?

Manuel: *I thought I sounded like a real pushover.*
(Laughs.)

Staff: You're not a pushover at all. You are a very strong person. But it's hard to know what to say or do when you've never practiced the skills. That's why we're doing this. OK?

Manuel: *Yes...that makes sense. Thanks.*

Staff: Okay...Now let's do the role play again, but this time I'm going to show you a way to say no to your brother.

Manuel: *That'll be cool.*

Staff: (They go through the role play, and at the point where the brother (played by Manuel) pressures him to use marijuana, Staff says the following:) Hey, Luis, thank you so much for offering me marijuana. I know you want to help me, and that's great of you. Marijuana does make me feel good for a little while, but it's bad for my brain. It may help a lot of people but not me. The more I use the more paranoid I get. It would really help me if you didn't offer it to me anymore. I would be so grateful if you could look after me that way.

Manuel: (No longer in role.) *Wow! That's great. I never thought of that. But that was a lot. I don't think I could do that.*

Staff: No worries. Let's practice a little bit at a time. What part of it do you think you could say? Let's do the role play again, but this time you be you and I'll be Luis, and we'll just have you practice doing a little bit that you think you can do. You don't have to try anything with Luis in real life until you're ready.



Roleplay continues by practicing the response repeatedly until Manuel can respond easily without thinking too much. It should almost become a rote response. Practice goes to the point where the client is almost bored repeating the appropriate response.

For Cheryl:

Role play for asking for help (at an AA meeting or elsewhere): In the language of 12 Step Programs of Recovery³, it is often said that AA is a simple program: Don't drink, go to meetings, and ask for help. But none of those things is that simple. Recovery support programs (or individual recovery supports) do not work unless the person has the skills to use them. And asking for help can be very difficult, particularly for people with serious mental illness and/or trauma histories that lead them to feel less able to be vulnerable with others. The following role play is an illustration of how to practice asking for help.

Staff: Cheryl, you've said many times that you feel frustrated because you try to stay sober – and even attend AA meetings – but you feel it doesn't work. One of the things that is important about staying sober is realizing that when you have the disease

of alcoholism, it's like your brain is on the other team. You want to stay sober, but your brain is being triggered all the time. You need to be able to get as much help as you can to gang up with you against your own brain to be successful. Does that make sense?

Cheryl: *It does, but I don't like asking for help...*

Staff: Of course not, most of us don't. And for someone who has been through what you've been through it's even harder. But if you think of asking for help as a skill for managing your addiction, like learning how to ride a bicycle or take your medicine regularly, you can become a great "help asker." You just need to learn and practice the skills. OK? So let's imagine a situation where you need to ask for help. You have had a tough day and you are craving a drink. Show me how you would ask me for help.

Cheryl: **You? I wouldn't do that to you.**

Staff: Why not? I would be honored if you did. You probably don't believe that, but let's practice right now.

How about I do it first? I'll play you and you can play me. That way you can show me how you think I would respond.

Cheryl: (Laughs.) *OK. That will be fun.*

Staff: (Playing Cheryl): Hi Staff. I'm sorry to bother you, but I really need your help. I've had a terrible day and I feel like drinking, and I want you to help me not to drink.

Cheryl: (Smiling.) *Go away, you're bugging me. I've got other clients and your appointment is next week.*

Staff: Do you really think I would say that?

Cheryl: *Well, probably not. But you would be thinking it!!*

Staff: That's why it's so important to practice. I would actually be thinking: "I am so proud of you for having the courage to ask for help." Let's do a role play to practice. I want you to start by saying to me what I just said to you a few minutes ago, and then I will respond.

Cheryl: *Would you really be proud of me?*

Staff: Absolutely. And I will give you a big round of applause just for practicing!



Tip for Staff: As can be seen, role plays like this are easy to set up and can be simple and fun to execute. The hard part is remembering that just doing it once doesn't teach the skill. And that you don't have to make the client learn everything all at once. Consistent practice, roleplay and repetition will help the client make gradual progress while feeling successful and increasing a sense of self-efficacy. This takes time, but in the long run, results in more enduring development of competence and progress.

TIPS FOR AGENCY LEADERS AND PROGRAM MANAGERS

It will be easier for your staff to follow the suggestions in this implementation guide if you build these steps into your policies, procedures, practices, and paperwork. Skills training can be reinforced by developing a standardized approach to utilizing skills training and skills training manuals in both individual and group interventions that are designed to help individuals to address substance use.

Examples of simple steps may include:

- Create a policy that identifies SUD skills training for individuals with SMI and COD as an evidence-based practice that all service providers (licensed and unlicensed) will be working to implement.
- Identify at least one skills manual for staff to learn to use.
- Develop a complementary policy that requires identification of individual and/or group skills training interventions in service planning.
- Provide introductory training to all staff and supervisors regarding how to utilize these interventions. This training should start with overview of the concept but should include staff role playing with one another in order to practice. Everyone can start by practicing with one client, and will improve as they continue to practice, with reinforcement by supervisors. If possible, provide access to consultation for each program or team to get assistance when there are questions.
- Develop the expectation that any groups for people with co-occurring disorders in action stages of change will include skills training role plays.
- Provide guidance to supervisors on how to provide regular case-based individual and group supervision regarding skills training and using skills training manuals.
- Routinely track outcomes for individuals with co-occurring disorders in a way that includes recognition of slow steps of progress learning new skills, rather than just by tracking abstinence.

REFERENCES

1. Bellack AS, Bennet ME, Gearon JS (2007). *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals*. New York: Routledge.
2. Roberts LJ, Shaner A, Eckman TA (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*. New York: Wiley and Sons.
3. *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered From Alcoholism* (2001). New York City: Alcoholics Anonymous World Services.

GRANT STATEMENT: Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.