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SMI Severe Mental Illness Program

Integrated Dual Disorders Treatment (IDDT)

Recovery Life Skills Program

A Group Approach to Relapse Prevention and Healthy Living

Lindy Fox, MA, LADC

Dartmouth PRC HAZELDEN

Integrated Dual Disorders Treatment

Recovery Life Skills Program

A Group Approach to Relapse Prevention
and Healthy Living

Facilitator Manual

Lindy Fox

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Our mission is to create and publish a comprehensive, state-of-the-art line of professional resources—including curricula, books, multimedia tools, and staff-development training materials—to serve professionals treating people with mental health, addiction, and co-occurring disorders at every point along the continuum of care.

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This manual is dedicated

to all the people

with co-occurring disorders

who have shared their recovery with me.

I have learned so much from all of you.

Thank you for sharing

a part of your journey with me.

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CONTENTS

Acknowledgments ix

Introduction 1

A Key to the Session Outlines 17

Session Checklists 27

Session Outlines

- **Session 1:** Orientation and Working on Goals 31
- **Session 2:** Recovery and Goal Identification 43
- **Session 3:** Preventing Relapse I: Triggers for Substance Use 51
- **Session 4:** Preventing Relapse II: Early Warning Signs of Mental Illness 61
- **Session 5:** Coping with Negative Feelings I 69
- **Session 6:** Coping with Negative Feelings II 83
- **Session 7:** Developing Leisure and Recreational Activities 95
- **Session 8:** Dealing with Social Situations Where Alcohol and Drugs Are Offered 105
- **Session 9:** Open Topic 117
- **Session 10:** Developing a Social Network 125
- **Session 11:** Relationship Skills 133
- **Session 12:** Communication Skills 141
- **Session 13:** Peer Recovery Support Groups 151
- **Session 14** Open Topic 165
- **Session 15:** Spirituality and Inner Peace 173
- **Session 16:** Developing a Positive Self-Image 185
- **Session 17:** Healthy Lifestyles 193
- **Session 18:** Review Personal Recovery Plan 205

References 209

About the Author 211

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INTRODUCTION

The *Integrated Dual Disorders Treatment (IDDT) Recovery Life Skills Program* is a group counseling program for people with dual, or co-occurring, disorders who are in active treatment or the relapse prevention stage of treatment. This manual is designed to help you, the practitioner, work with group members who have severe mental illnesses and addiction—whether you are newly treating people with co-occurring disorders, have an established co-occurring disorders program, or are anywhere along that continuum.

Group interventions are the most effective treatments we have to help people with co-occurring disorders. The *Recovery Life Skills Program* incorporates several evidence-based approaches including psycho-education, social skills training, and cognitive-behavioral techniques.

This program was piloted at several sites, both urban and rural, inpatient and outpatient, and was well received by the group members. Members reported that they liked the group and being with peers who were similar to them. Sometimes the measure of a group such as this is whether or not the members enjoy it, find it useful to their recovery, and keep coming back. That was the feedback received from the pilot groups, with several sites having waiting lists of potential members wanting to join.

About Co-Occurring Disorders

The term *co-occurring disorders* generally refers to a co-existing mental illness and substance abuse disorder. *Co-occurring disorders* is more often used today instead of the term *dual disorders,* which is restricted by use of the word *dual,* meaning "two." Co-occurring disorders may refer to people who have one or more mental health disorders coupled with one or more addictions.

The Need for Integrated Treatment

For about three decades, the mental health field has recognized the prevalence of substance use disorders among people with a severe mental illness such as schizophrenia, bipolar disorder, and recurrent depression. About half of all adults with severe mental illness also have an alcohol or drug use disorder at some time in their lives.

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The rates are higher for people in acute care settings (such as emergency rooms and psychiatric hospitals), those involved in the criminal justice system, or people who are homeless.

During this time the mental health field has also come to recognize that parallel or sequential treatment approaches to these problems are ineffective. For example, treating mental health and addiction problems separately, either one at a time (sequential) or in separate settings (parallel), never really made sense, since the problems are experienced together. Indeed, people striving to recover from co-occurring disorders experience mental illness and addiction as intertwined, interacting, and relatively inseparable. They often experience psychiatric symptoms and substance use at the same time or in close proximity, and relapses often involve both problems.

Integrated Dual Disorders Treatment is an evidence-based practice where a clinician, or team of clinicians, treat a person's mental illness and substance use disorder at the same time. The integrated treatment model addresses the problem of access by ensuring that one visit, in one setting, is sufficient to receive treatment for both disorders. It addresses the problem of combining messages and philosophies by giving this responsibility clearly to the treatment provider instead of the client. One of the key features of Integrated Dual Disorders Treatment is motivation-based or stage-wise treatment.

Stages of Change and the Stages of Treatment Model

For years, researchers have proposed that people make behavioral changes in stages, moving from unawareness or pre-contemplation to contemplation of change, then from action to maintenance of change. This approach—the stages of change model developed by James Prochaska and Carlo DiClemente—can be useful when creating treatment plans for people who have substance abuse disorders. Pinpointing where people are in the stages of change process can help clinicians determine what interventions might be the most beneficial as the person being treated moves forward.

In a similar vein, identifying where people are in their stage of treatment helps clinicians work with them on developing goals to pursue and determining which interventions to try. The stages of treatment model, while similar to the stages of change model, is specific to co-occurring disorders; it is an intervention-based approach that occurs within the context of the therapeutic relationship.

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The stages of treatment model includes four stages: engagement, persuasion, active treatment, and relapse prevention.

The table below compares the two models.

STAGES OF CHANGE	STAGES OF TREATMENT
Pre-contemplation	Engagement
Contemplation Preparation	Persuasion
Action	Active treatment
Maintenance	Relapse prevention

To effectively address a person's co-occurring disorders, treatment must target the person's stage of change, or motivation for recovery. Specific interventions are most effective at the appropriate stage of treatment.

In the first stage of treatment, *engagement,* the clinician's goal is to develop a trusting relationship with clients, who are often avoiding treatment. This means clinicians have to reach out to clients in the community through practical strategies such as helping them get benefits, food, clothing, housing, or jobs, or helping them reconnect with their families. These strategies help the person stabilize and become motivated for recovery.

Once a relationship has developed, the clinician tries to help the client develop a positive view of the future. This is known as the *persuasion* stage. Persuasion typically involves the clients recognizing that substance use is interfering with their mental health and diminishing their quality of life. Motivational strategies are key at this point. With the help of clinical support, clients identify important goals to work on and begin to move forward with that work.

Once they have reached the *active treatment* stage, clients have decided to cut back or end their substance use, and they actively work to reduce use and become abstinent. Several interventions are commonly used during this stage, including

- cognitive behavioral therapy
- group work

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- peer support in the community
- alcohol or drug refusal skill building

Once a person has been abstinent or without problems related to substance use for six months, the *relapse prevention* stage begins. This stage focuses on maintaining these gains in sobriety. Clients also focus on managing their mental illness symptoms and on improving their overall quality of life. The tasks in relapse prevention are to

- develop a relapse plan
- continue group work
- continue with peer-support practices
- work on quality-of-life issues (such as work, recreation, and wellness)

The *Recovery Life Skills Program* is specifically designed for people with co-occurring disorders who are in the active treatment stage or relapse prevention stage of treatment. This program is tailored to support people who have either achieved abstinence or made a commitment to work toward abstinence.

Theoretical Framework of the Program

Educational, motivational, and substance abuse treatment and cognitive behavior therapy (CBT) techniques form the foundation of this program. The program builds on the approach to integrated treatment that is described in *Integrated Treatment for Dual Disorders (IDDT): Best Practices, Skills, and Resources for Successful Client Care* (2010). Although group facilitators/clinicians using the *Recovery Life Skills Program* do not need to be experts on the *IDDT* manual, those who want to learn more about the evidence-based techniques used in this group may wish to read that manual. For more information on *IDDT,* please visit hazelden.org/bookstore.

Motivational Interviewing Techniques

One of the ways motivational interviewing is used in the program is by helping group members set goals and break their large goals into short-term, smaller goals. Facilitators also use the following motivational interviewing techniques: asking open-ended questions, using affirmations, and practicing reflective listening. Summarizing is also a helpful technique that is incorporated into this program. In each session, you will see suggestions for when to wrap up a discussion or when to link information from one discussion to another. All of these motivational interviewing techniques come together as you help group members work toward their short- and long-term goals.

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Cognitive Behavioral Therapy

Simply providing group members with information about their illnesses will not help them learn the skills needed to make life changes. But the behavioral therapy known as cognitive behavioral therapy (CBT) can help members learn these skills. CBT helps people learn how to set and work toward goals to find the quality of life they want. Most mental health practitioners are already familiar with CBT, and many counselors use CBT without even realizing it. For example, they give reinforcement all the time with praise, encouragement, or a smile—each of which is a part of the practice of CBT.

Here are some of the CBT techniques used in the *Recovery Life Skills Program:*

- Relapse prevention skills help group members identify triggers and high-risk situations and develop a relapse plan.
- Role-playing involves demonstrating, or modeling, the new skill or behavior for group members; having them practice the behavior in the role-playing exercises; and shaping and reinforcing these skills.
- Coping skills help manage symptoms and cravings.
- Cognitive restructuring helps group members challenge negative thoughts associated with depression, anxiety, trauma, and substance use.
- Social skills training gives group members practice in dealing with high-stress situations without triggering a relapse. It also helps them build supportive relationships.

Substance Abuse Counseling

This group makes use of techniques and practices found in substance abuse counseling. Most group members should be familiar with peer recovery support groups. In this group, they will learn more about these peer support groups, and they will revisit the Twelve Steps. Group members will consider the role of spirituality in their lives.

Psycho-education

The group member handouts in this program are designed to provide basic information for both group members and facilitators. They are written in a simple, everyday language for ease of reading and comprehension. You can begin each session by reviewing the content of the handout. You might share the title of the topic and read the first few sentences, then ask open-ended questions to assess the group's knowledge of the topic.

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Learning is meant to be an interactive process. Sometimes you may want to read part of a handout to the group, and other times you may wish to convey information to group members. Group members may also want to take turns reading a particular handout. At other times, they may just want to discuss it. Remember to always be sensitive to members who might not be able to read or write. During the pre-group interview, ask potential members how they feel about reading and writing tasks. If some of your group members struggle with reading or writing, discuss how they want to handle the situation when they need to fill out a worksheet. They might want a facilitator to help them or they may want to work with someone in their group.

This facilitator guide includes suggestions for when to check for understanding and when to review information with the group. Additionally, the section on literacy (page 13) offers suggestions for talking about reading and writing skills with potential group members.

The Benefits of Working in a Group

One of the best ways to treat people with substance use problems is in groups, which makes sense since people also tend to use substances in groups. Having peers in a group who struggle with the same problems helps group members feel they are not alone in their battle with addiction. The peer role modeling and peer support in these groups can be powerful and effective.

The members of an active treatment or relapse prevention group, such as the *Recovery Life Skills Program,* are all working on reducing substance use or becoming abstinent. As a result, members tend to be highly motivated to participate in the group and work on their recovery skills. This level of motivation also means that facilitators do not usually need strategies to promote attendance.

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Another benefit of group work is that members help each other achieve their recovery goals. Peers often confront each other about their intentions and behaviors. When someone in the group has a slip, or briefly returns to substance use, for example, other members of the group might call the person out, ask about the use, and question what he or she is doing about it.

As the facilitator in the group, you can monitor such interactions so they do not become emotionally charged and so that the atmosphere remains supportive of the group member who had the slip. (In terms of therapeutic style, an active treatment group will tolerate a higher level of confrontation than will be permitted by a persuasion group.)

The Goal of the *Recovery Life Skills Program*

A person's ability to maintain stability in the active treatment and relapse prevention stages of treatment is directly connected to the ability to achieve a satisfying quality of life. Helping and supporting group members as they practice new behaviors that will enhance their daily lives is one of the overarching goals of this program. This focus on quality of life will be present in each session and is at the core of the design and tone of the *Recovery Life Skills Program.*

People attending this group will find that it is different from other relapse groups. Although the topics may sound very traditional, each one is designed to address the unique needs of people in this stage of recovery from substance use who are now ready to get on with living their lives. This means, for instance, that instead of only developing a sober peer group (which should have already been accomplished by this stage), group members work on developing a social network. Group members will learn substance-refusal skills and skills to develop close, intimate relationships.

How to Use the *Recovery Life Skills Program* Materials

The Materials

The *Recovery Life Skills Program* materials consist of this facilitator manual, a CD-ROM, and a three-ring binder. Use the materials in any way that fits your teaching style. The CD-ROM includes PDFs of all the session handouts and worksheets as well as the group facilitator records and materials. You will need Adobe Acrobat or Adobe Reader to open the PDFs on the CD-ROM. These materials also appear in print form in your three-ring binder. Group facilitators can either copy the handouts they need from the three-ring binder or print

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them from the CD-ROM. The handouts are organized by the session where they are used.

Tip: ▶ If you have access to audiovisual equipment, you may find it convenient to project the handouts for a particular session on a screen and refer to the visual images as you discuss the topic with the group.

Session Format

Each of the eighteen sessions includes the following five steps:

1. ***Step 1:*** Welcome and Check-In
2. ***Step 2:*** Review of Previous Session
3. ***Step 3***: Topic Discussion
4. ***Step 4:*** Personal Recovery Plan Worksheet and Goals
5. ***Step 5:*** Home Assignment

A Key to the Session Outlines (pages 17–25 of this manual and also repeated as a document on the CD-ROM), along with the individual session outlines in this manual, provides detailed information on guiding a group through each of these five steps.

Each session covers a topic in recovery. Sessions 9 and 14 are open topics. During these group sessions, members can raise topics they are interested in discussing or return to issues that have already been covered in the group. You should alert group members a session or two before the open topic groups so they can consider which topics they might like to discuss. If members do not have a topic for these group sessions, three alternative topics are listed for groups to choose from.

Length of Sessions

The sessions are designed to be delivered in a 1-hour group session or over two 1-hour sessions held consecutively. If you choose to extend one or more topics

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into two sessions, recommendations for how to do this are noted in A Key to the Session Outlines as well as in the Session Checklists section. A Key to the Session Outlines also provides time estimates for conducting each step of the session. Keep in mind that these are ballpark estimates to help you plan, not times fixed in stone. Your facility may conduct sessions that are 90 minutes long, or only 45 minutes. Programs that have less than 1 hour for their group may find it difficult to cover the topic in one session—that is why we have designed the program so that you can extend each topic from one session into two sessions.

Flexibility is crucial. You should approach each session with a focus on listening to the needs and wants of the group. The program will not suffer if you extend a session or if you take additional time on a step.

The sessions are intended to be delivered sequentially. At the end of the eighteen sessions, group members are given the opportunity to repeat the curriculum. Many people find that because so much material is covered, they would like to go over it one more time.

Meeting Logistics

Where and when you hold the group can be a particularly important detail for potential group members. By this stage of recovery, people often have other important time commitments, such as work and family obligations. Setting group times that are late in the day or in the evening is one way to support people who are trying to move forward with their lives while strengthening their recovery. In an outpatient setting, groups typically meet weekly for four to six months. In an inpatient or residential setting where groups may be held more frequently, the curriculum may be completed within a month.

How to Form a Group

Forming and facilitating a co-occurring disorders group takes planning and, above all, organizational commitment to make the group work. Organizations hosting the groups will need to find, and sometimes train, skilled facilitators;

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set aside the time needed to both plan for and conduct groups; and find space and any other needed material resources.

Choosing Facilitators

Experience

Facilitators of the *Recovery Life Skills Program* can be relatively new to working with people with co-occurring disorders, but they should be knowledgeable about co-occurring disorders, substance abuse counseling, and peer recovery support groups. Group facilitators need to be warm and friendly but also able to set healthy, firm boundaries. They need to be skilled in group facilitation, motivational interviewing, and social skills training.

Communication

Facilitators are also responsible for keeping the treatment team informed of members' progress in the group. This communication can include giving the treatment team an overview of the group curriculum and its goals before the group starts, and updating the team at regular treatment team meetings.

When treatment team members know what topics their clients are working on in the group, they are in a better position to help them. They can help review handouts, help with home assignments and work on goals, offer support and encouragement, or all of the above. By coordinating with the treatment team, you can help group members get the most out of the group.

Co-facilitators

The *Recovery Life Skills Program* group can also be co-facilitated. Many of the topics are skills-based and are enhanced by role-plays. It is always helpful in these situations to have co-facilitators do the role-play first—and demonstrate what works, what skills were used, what did not work, and why. Pairing a more inexperienced facilitator with a seasoned group leader to co-facilitate the group can also be a great training opportunity for the new facilitator.

Having co-facilitators also becomes an advantage when one facilitator needs to leave the group for any reason. Losing a group facilitator can be very disruptive to a group process. If, however, only one of two facilitators leaves the group, members do not feel the change as dramatically as they might if they had to begin with a completely new facilitator. Of course, many programs do not have the staff to co-facilitate groups. Having two group leaders is not necessary, just desirable.

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Group Member Eligibility

The *Recovery Life Skills Program* is a group for people with co-occurring disorders in the active treatment or relapse prevention stage. People who are still actively using or who have never used substances are not appropriate for this group. The ideal group member is someone who has made a commitment to sobriety and wants to learn some new life skills and set some new goals to support this lifestyle change.

Group members also need to be in active treatment or relapse prevention for their mental illness. If their mental illness symptoms are not stable, their ability to focus on the material in the group will be limited, and it might also affect other group members. As a facilitator, you could work with these potential group members and their clinicians to help get them stabilized in their mental illness so they can become eligible for the group. Once in the group, if they relapse in their mental health symptoms to the point that it becomes difficult for them to participate and benefit from the group, they will be asked to leave until their symptoms stabilize. Members will be welcomed back when their mental health symptoms are under control.

If a group member has a slip (returns to substance use for a brief period of time) and has a desire to stay in the group and commit to working on a goal of abstinence, then that person is eligible to remain in the group. If a person has a relapse in substance use and continues to use with no commitment to working toward abstinence, then you will need to ask that person to leave the group. You can pursue appropriate supports for such individuals and let them know they will be welcomed back as soon as they are ready to recommit to the goals of the group.

Group Size

The *Recovery Life Skills Program*'s optimal group size is six to eight members. In groups with more than ten members, individual members do not have enough time to process the materials and learn the necessary skills, even when additional sessions are included.

Group Format

The program is designed to be run as an open group. New members can join the group at the beginning of any new topic as long as you, the facilitator, have met with the person beforehand for a pre-group interview. Facilitators should also discuss the

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orientation and recovery goal-setting handouts with new members and help them set a recovery goal to work on over the course of the group. Some programs may choose to operate the group as a closed group to increase cohesion. This is certainly acceptable, but the group may become smaller than optimal if members drop out. With an open group, you can simply return to session 1 once all eighteen sessions have been covered. You can also review specific sessions, according to the group's needs and interests. If a large number of new members join the group, it's best to simply begin with orientation and go straight through the curriculum again. If the group members have already been through the program, skip the orientation session but repeat session 2, Recovery and Goal Identification. Returning to session 2 allows members to review the goals they set in the first round of the curriculum and revise or change them.

Recruiting Potential Group Members

Advertise the group three to four weeks before enrolling group members. You can advertise by writing an article about the group in a newsletter on mental health or substance abuse issues, posting flyers in waiting rooms, and asking case managers, therapists, and other practitioners to inform potential group members about the upcoming group.

Pre-Group Interviews

Before the first group session, meet individually with each potential group member for a brief interview. The purpose of these pre-group interviews is to begin forming a relationship with the person, answer questions, and ensure that the person understands the goals of the group. It also allows you, the facilitator, to get to know potential members and be sure they are in the appropriate stage of treatment to get the most out of the group.

The pre-group interview also gives you an opportunity to explain the group policy around slips versus relapses:

- If group members have a slip and remain committed to working toward abstinence, they are welcome to remain in the group.
- If they have a slip and then return to use and are no longer committed to working on their sobriety, they will be asked to leave the group.
- If they find they are ready to recommit to abstinence, they may return to the group at that time.
- If they have a relapse in the symptoms of their mental illness, they may need to leave the group for a period of time to achieve stability. Once they

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have obtained stability in their symptoms, they will be welcomed back to the group.

The pre-group interview is also a time to discuss the importance of completing home assignments. Talk about the importance of practicing the skills covered in group between sessions, perhaps with people in their support network.

When conducting a pre-group interview with a member joining an open group that has been running for some time, you may choose to add the orientation session to the interview. You can then follow that up by meeting individually with the person to cover the Recovery and Goal Identification session so that the new member will be ready to join a group already in progress.

A Pre-Group Interview Checklist is available on the CD-ROM and in the three-ring binder for you to use during the interview.

Literacy

The literacy level of members is a sensitive issue that often comes up in a curriculum-based group with handouts and home assignments. This issue is best dealt with one-on-one with individual members *before* they are faced with the situation in front of others.

In the pre-group interview, you can simply ask potential members if they would be comfortable reading a paragraph from a handout in the group. If the person says no, follow up in an empathetic way with a few questions about the person's ability to read or write. If the person is not able to read or write or struggles with reading or writing because of a learning disability or physical impairment, ask if he or she would be comfortable with you or another group member or facilitator helping them fill out the forms in each session.

Literacy may well be a factor in a person's decision to join the group, so be sure to reassure potential members that they will not be left out because of their reading or writing struggles. The best way to do this is simply ask the person what they need in order to learn and feel comfortable in the group. People with literacy struggles are most likely to join the group if you have taken the time to discuss options with them that normalize the situation and allow them to feel safe.

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Helping Members Set and Follow Through on Goals

As the facilitator, you need to be very actively involved in helping members both set goals and monitor their progress toward achieving those goals. In the beginning, you should help members set goals that are both behavioral and measureable. A goal of "being happy" is a great goal, but is not measureable. It can mean different things to different people so it will be difficult to know when it is accomplished, and the group member may never feel the satisfaction of a job well done.

During the first part of session 1, members learn about the group format and develop guidelines for the group. The second part of this session is spent talking about the basic theme of the group—finding a balance in your life now that you are not using substances.

In session 2, group members define long-term recovery goals. Then they are asked to set short-terms goals that will help them develop the skills and strategies needed to reach their long-term goal. In session 2, they will receive a worksheet that will help them formulate one recovery goal to work on throughout the program, with short-term goals that act as stepping stones to the accomplishment of that long-term goal.

Each session will include time to focus on the group members' goals. It is important for group members to track their goals from session to session, and the program is designed to help you do this with members. There is a place on the Personal Recovery Plan Worksheet for group members to write a few sentences about what work they have done on their recovery goal since the last session. If they haven't done any work, they need to explain why. Then they should write down what they plan to do in the time before the next session.

Suggest to members that they always have a copy handy of the original Working on Goals 1 worksheet from session 1 where they recorded their long- and short-term goals. If they have crossed off or revised their short-term goals, or revised their long-term goal, give them some blank copies of this worksheet so they can fill it out with the new information. You might encourage members to put all their completed worksheets in a three-ring binder or folder to keep them organized and together. They will also have an opportunity during the open topics sessions (9 and 14) to revise their goals on the Working on Goals 2 worksheet and the Working on Goals 3 worksheet.

Check in with group members on a regular basis about their progress with their goals. If they are not making any progress, use motivational interviewing

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techniques to determine what's happening. It may be that this is not really a goal the group member is invested in, or it could be an important goal but the short-term goals are not broken down into small enough steps and the group member is frustrated and stuck.

Remember that the recovery goals in this group are not meant to be goals that are arduous and difficult, and that members don't want to work on. These are meant to be fun things that people really want to do. Try to communicate this difference to group members. Encourage members to explore leisure or recreational goals. Find out what being happy means to everyone, and push people to dream a bit. "Dream job," "Dream house," "What could you do if you won the lottery?" When members start dreaming, it may lead to ideas about goals.

Getting family, friends, and other support people involved in working on a recovery goal is a wonderful way for a group member to use skills they are learning in the group, as well as get help and support with their goal. There is such richness when a group member includes their support system as a part of the process.

So you might ask "What does being happy mean to you? How will I know, how will you know, when you're happy?" The member may say he will have a job, or have his own home, or a girlfriend, or many other things, and those are the real goals. Being specific is very important.

The short-term goals group members choose are also important. If the short-term goals are not realistic, they will not be helpful stepping stones to accomplishing that long-term goal. Once all the goals are set, and members have several short-term steps to accomplish the long-term goal, it is important that they, and you as the facilitator, begin tracking the short-term steps.

These long- and short-term goals should also be enjoyable and rewarding for group members to work on. This practice is not about slogging through projects that feel impossible to accomplish. The group members should see themselves, and you should see them, grow in strength and confidence as they set, practice, and accomplish these goals, with your help and with the help of their fellow group members.

The goals can often be very down-to-earth and basic, but important. For example, a group member who tends to be shy and afraid of making new friends, but feels alone, might set a long-term recovery goal of surrounding him- or herself with a healthy group of friends that can be supportive in his or her recovery. This person's short-term goal might be to approach and engage with someone

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the person admires and would like to make a friend. The group member might then practice a role-play in the group, and this way practice approaching that person and asking if they are free for coffee.

In many ways, setting and accomplishing these goals, within the context of support and feedback from the group, is the core purpose of the group. The work of setting and monitoring goals is woven throughout each session. As a facilitator, you will be actively involved in helping members set workable and achievable goals, goals that they want to reach. Each of the sessions in the facilitator manual includes suggestions for how to help move members in the direction of their goals.

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As many as half of the men and women who arrive at mental health clinics or addiction treatment facilities have co-occurring disorders (addiction combined with a psychiatric disorder). These clients need effective, integrated care for both disorders—and they need guidance in preventing relapse and developing the skills necessary to maintain healthy, balanced lives. Clients who are ready to manage their mental health symptoms, move on from substance use, and improve their quality of life are ideal participants in the *Recovery Life Skills Program.*

Developed by Lindy Fox, MA, LADC, of the Dartmouth Psychiatric Research Center (PRC) to work hand-in-hand with Integrated Dual Disorders Treatment (IDDT), the *Recovery Life Skills Program* is a stage-wise, eighteen-module curriculum for clients who are at the treatment, continuing care, or recovery support stages of care. Sessions are presented in a group format, starting with traditional relapse-prevention topics and then moving on to the life skills necessary to maintain a healthy recovery life plan. Focus areas include

- coping with negative feelings
- recognizing triggers for substance use
- dealing with social situations involving alcohol or other drugs
- developing communication skills and social networks
- participating in peer support groups
- practicing spirituality and inner peace
- developing a positive self-image
- adopting healthy eating and exercise habits

Utilizing evidence-based protocols, the *Recovery Life Skills Program* has been research tested at eight pilot sites by Dartmouth researchers. This easy-to-implement curriculum includes a facilitator's guide with step-by-step session instructions and reproducible client handouts—everything you need for rapid integration into your program.

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