Integrated Social Behaviour and Network Therapy

iSBNT

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The manual is designed to link to webpages from:
www.result4addiction.net

result4addiction
improving addiction outcomes

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Introduction

Integrated Social Behaviour and Network Therapy, iSBNT, is the practice of helping to bring about substance use behaviour change in a supportive network of family and friends. The person with the substance use problem is called the **focal person (FP)** throughout. The manual directs the practitioner to use a motivational style of dialogue to deliver behaviour change interventions with the help of supportive **network members (NMs)**. Some good practice essentials...

➜ The **assessment**, the first session, is best seen as part of the treatment itself and should be conducted in the style of motivational dialogue

➜ **Treatment** should be delivered in a fixed number of sessions, to be agreed in the network early on, and in line with the practitioner's resources

➜ The **substance use goal** will be based upon the assessment of the severity of the addiction and related problems, and on the motivation of the client and those around them to change their drinking or drug taking behaviour

➜ **Ending treatment** is about ensuring sustainable change plans are in place

The key to the application of the manual is **flexibility**, that is, agreeing and completing tasks at the pace of the FP's and NMs' efforts to change and actual progress. The manual describes **four core sessions**, which may be repeated or added to with novel sessions (created by the practitioner) as required. This does not mean that treatment is open-ended. On the contrary, it is task driven and non-completion of tasks does not mean endless treatment.

A manual cannot anticipate all of the situations that you will encounter; the skill of practitioners is to apply the principles and practices outlined here to particular cases. The manual provides a framework for the delivery of structured work. Using the manual flexibly means adapting to the FP's and NMs' particular needs.

Follow these guiding principles...

➜ The overarching principle of the treatment is to **think network** – always think about how to involve and support network members.

➜ The provisional treatment plan may be modified as treatment proceeds - iSBNT can be a brief or extended intervention.

➜ The duration of each session needs to be adapted to circumstances; 30-60 minutes (including completion of admin tasks) is ideal.

What needs to remain constant is that **each session has structure and purpose** and that these are set out at the beginning of the session and summarised at the end. In the face of crises and apparent chaos that sometimes characterises addiction lifestyles, 'fire-fighting' inadvertently becomes the dominant style of working. Good planning and maintaining the structure of sessions mitigate this risk.

Practitioners are encouraged to **use worksheets** and examples are given. Worksheets are **never an end in themselves**. Completing worksheets...

1. helps **focus** the FP and NMs on important topics
2. provides the practitioner with a framework of areas to **explore in depth**
3. when repeated provides a **record of progress**.

Practitioner Competences

Effective practitioners will have the ability to build a working alliance with their FPs and NMs. A working alliance refers to the degree of mutual respect and understanding between the practitioner, the FP and the NMs. It comes from the practitioner's ability to communicate empathy, a non-judgmental approach and a task orientation. It will be built upon the perception of the practitioner as a source of help in the resolution of particular problems. The practitioner's role is team leader in modelling these behaviours.

The **Working Alliance Inventory** rates how good practitioners are at i) goal setting ii) bonding with their client and iii) keeping task orientated. Try it yourself in from the '*Practitioner Self Assessment and Appraisal*' page...

Go

Training and supervision underpin the acquisition and maintenance of practitioner competence. The basic skills on which the interventions are built derive from the well-established core skills of listening, expressing empathy, positive regard and respect, as described by Carl Rogers and demonstrated to be effective in repeated studies of practitioner behaviours. These are combined with the directiveness expressed in motivational interviewing and cognitive behavioural counselling to produce a purposeful, agenda driven, non-confrontational practice style.

From the 'Effective People' webpage watch the video of Carl Rogers talking about empathy...

Go

Regular supervision has been shown to be essential: competences are lost without constant vigilance and supervision of recorded practice, and even the most experienced practitioners lose focus and drift away from good practice habits. The manual is no substitute either for training or supervision but forms the reference point on which to build both.

The **Brief Process Rating Scale** measures the frequency and quality of practitioners' use of core skills. Try it yourself in RESULT from the '*Practitioner Self Assessment and Appraisal*' page

Go

The content of treatment is as important as the style of its delivery; the evidence informs us which behaviour change techniques are associated with good outcomes. The competent practitioner will...

- set goals
- elicit commitment to goals
- plan specific behaviours that result in alternative rewards to drinking or taking drugs
- monitor behaviour change
- review goals
- set and monitor Take-home-tasks to achieve goals

It should go without saying that good knowledge of the effects of alcohol and drugs on behaviour, psychological and physical health, social functioning and the outcomes of treatment is a prerequisite for the acceptance of the practitioner as an authoritative source of help who will have legitimacy for the task in the eyes of service users, their families and concerned others.

From the *'How do Psychoactive Drugs Work'* webpage, work through the *'Understanding How Drugs Work'* slide show... Go

From the *'Why are Drugs Addictive'* webpage, work through the slide show... Go

Timing of Interventions

The starting point of treatment is determined by the motivation of the FP and NMs: there may be resistance to change, ambivalence about change, contemplation of change, or determination to change along with behaviour change plans and actions. Some FPs will be in the business of maintaining changes already made. People who are **undecided about change** are likely to have:

- an overriding perception of the good things about drinking or drug use
- denial, rationalisation or minimisation of the adverse consequences
- low self-efficacy for change
- low positive outcome expectancy for change

As people move towards **thinking about change**, their motivation will be more evenly balanced and they may experience:

- greater ambivalence regarding their drinking or drug use
- recognition of actual or potential adverse consequences
- greater concerns about their drinking or drug use
- more thoughts about the possibility and benefits of change

The three pillars of reaching the action stage of change, or determination to change are i) believing that you can change (self efficacy) ii) believing that things will be better (positive outcome expectancy) and iii) believing that you are worth it (self esteem). On reaching a **determination** to change people will:

- express a definite commitment to a change plan
- believe in an ability to carry out the plan
- believe in the benefits of carrying out the plan

Once people have changed their drinking or drug use and are faced with the tasks of maintaining the changes, they need to:

- stay vigilant for high risk situations
- identify rewards for their changed behaviour
- affirm their self-efficacy for change

There will be an overall goal for the intervention which should be stated at the outset of each session. Specific and concrete goals need to be set for each step in the change process, and these will depend upon changing motivation, self-efficacy, coping ability, and the therapeutic alliance with the FP. The key is to agree that treatment is a collaborative venture – the agreement of treatment goals and treatment tasks are elements of an effective therapeutic alliance.

Basic skills #1 motivational dialogue the essential skill set

Aim

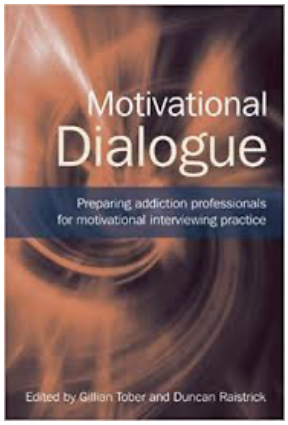
- Always use motivational dialogue when interacting with clients
- Elicit concerns and set goals

To do

1. Use open ended questions
2. Show accurate empathy
3. Use selective complex reflections

Outcome

- Discovery of your client's biggest concern
- Having agreed goals always including the substance use goal
- Avoidance of confrontations or arguments



Motivational dialogue is a purposeful way of talking that allows the practitioner to address the FP's and NMs' pace and stage of change, as well as appreciating their perceptions, thoughts and feelings about the work at hand. It is a style of working.

If you have the book, Motivational Dialogue, have a read of Chapter 12

Problem solving is a good way to get the network doing tasks collaboratively. The plan should be carried out as a take-home-task, then reviewed for level of success or need to modify.

Basic skills #2
problem solving

Aim

- Be creative in finding possible solutions to a problem
- Choose a realistic solution likely to be implemented

To do

1. Clearly define the problem (rather than 'I don't have enough money', make it specific such as 'I need to find £X a week to pay off my credit card bill')
2. Think of as many solutions to the problem as you can
3. Look at the advantages & disadvantages of each solution
4. Choose the solution that works best
5. Plan and agree the steps to carry it out
6. Put the plan into action
7. Review the outcome (Was it successful? Did we achieve the goal? What did we learn?)

Outcome

- Have a selection of possible solutions to the problem
- Agree a plan to implement the best solution

Setting expectations

At the beginning of treatment it is worth stating some expectations and ground rules. Some circumstances take precedence over the treatment plan and need urgently to be addressed, for example safeguarding children, risk of suicide or self-harm, homelessness and need for sustenance. Agree the rules and then be flexible…

➜ Get all planned appointments in the **diary** at the outset

➜ A **treatment goal** or goals will be decided and worked towards. This may be negotiated with the FP alone or with FP and NMs and will form the kernel of the work to be done in sessions.

➜ **Attendance** at all sessions is expected. With the consent of the FP, NMs will be encouraged to attend whether or not the FP does.

➜ The treatment will be a **collaborative process** involving practical tasks for all during and between sessions. Skills rehearsal and between session practice are essential to success.

➜ The content of sessions is **confidential** and this will be agreed with all NMs. Recording sessions for supervision and training purposes is good practice and will need the informed consent of the FP and NMs.

➜ Drinking and drug use are the focus of this treatment; other problems often co-exist, and will need to be dealt with, but getting **some control** over the problem drinking or drug use is an important first step.

Summary of tasks for practitioners

1. Focus on **engaging and motivating** your FP and network from the outset.
2. Treatment is collaborative and the practitioner is responsible for **building the therapeutic alliance**.
3. Goals and **tasks are agreed** by the network.
4. The **motivational dialogue** skills of open-ended questions and selective reflective listening are used throughout.
5. The focus is on the **present and the future**, rather than the past.
6. Use **positive language** and emphasise strengths.
7. Focus on **making changes** to your FP's and NMs' behaviour.
8. Give a clear rationale for **take-home-tasks**, make it relevant and interesting, within everyone's skill level, and manageable. Review take-home-tasks at the start of the session, affirm effort, address achievements and make different plans where necessary.
9. **Rehearse** tasks and skills with your FP and NMs in the session.

If you have yet to try the **Working Alliance Inventory** and the **Brief Process Rating Scale** yourself, then give them a go now from the '*Practitioner Self Assessment and Appraisal*' page...

Go

Remember that most service users will use a mobile phone to do take-home-tasks or just use the educational sections of the *result4addiction* website. Make sure they have easy access.

Go to the 'Mobiles and posters' webpage and see how to give your clients easy access...

iSBNT core topic #1

Building a social support network

Always remember the therapist's mantra...

- ✔ Where are you now?
- ✔ Where do you want to be?
- ✔ Who is going to help you to get there?
- ✔ What will everyone be doing that is going to be helpful
- ✔ How shall we know whether this worked?

Why have a network?

- People who have support for change do better
- Family and friends do better when they are involved in treatment
- Improvements are sustained past the period of formal treatment

The social network is the forum for the agreement and achievement of treatment goals. The practitioner's role is to mobilise a social network supportive of change. This is the distinctive feature of iSBNT.

The FP's existing social situation will vary along a spectrum from total isolation to having an extensive range of people willing to offer support. The objective is to develop positive support for change and the maintenance of change, with at least one supportive person. It may be that not everybody in the FP's existing network will support change and therefore may not be a suitable NM. Problem drinking and drug use affect both the FP and their family and friends.

NMs affected by the FP's drinking or drug use may well be under stress and at risk of developing problems themselves; working in the network can lead to reduced stress and increased confidence for them.

The ideal NM should:

- Be available to the FP
- Have a positive relationship with the FP
- Be prepared to be firm but kind with the FP
- Be able to agree with the FP about their drinking and drug use goals
- Be willing to work with other members of the network, during treatment and afterwards to develop and maintain a consistent, agreed policy with regards to maintenance of change and relapse prevention

NMs should not:

- Have an alcohol or drug misuse problem themselves
- Be under 16 years of age
- Have a chaotic lifestyle or untreated mental illness
- Be in a position of power regarding the FP

The essence of iSBNT is always **think network**. The FP may already have a supportive and constructive network of people who are concerned and want to help bring about change. More commonly the FP will say that they have no support or support may be limited in which case NMs will need to be recruited.

From the 'Trusted People Research' page check out how important NMs are ... Go

Role of the practitioner

The practitioner is a member of the network too and needs to be an active participant. This can involve assistance and support for NMs as well as the FP, though NMs with their own problems should be advised to seek help for these elsewhere. Identify who in the network could be involved in sessions and who might play a more indirectly supportive role. Negotiate tasks with different NMs and add these to a network map.

Gather information on relationships between NMs and the FP, for example their views/attitudes about the drinking problem, the support offered at present or in the past, the frequency of contact, activities they do or have done together. Help the FP to distinguish different types of support, for example direct support for finding non drinking/drug use activities, or indirect support such as looking after the children while the FP goes to the cinema.

The practitioner needs to establish how the treatment plan is going to look and agree the way forward with the FP and NMs. Working with NMs in the absence of the FP should be agreed as a possibility at the outset. Research has shown that this approach can help to re-engage the FP in treatment. It is advisable to review the network periodically and consider recruiting new members to it.

From the 'What Works: iSBNT' webpage, watch the video demonstration by Gillian Tober... Go

Role of the network members

NMs are encouraged to attend as often as possible. It may be that some network members join temporarily for particular tasks. Support can vary from friendship to providing helpful information and may be offered not just from close friends and relatives but also from others in the community. Support can also change: what starts as a contact for information may become a source of moral support or even a friendship. Dependable friendships take time to develop or recover.

Here are some specific types of support:

- **Moral support:** giving encouragement and positive feedback to the FP
- **Solving problems:** other people may have had a similar problem and/or be good at weighing up different sides to a situation
- **Help with tasks:** simply sharing the load and/or bringing some particular knowledge or skills to a situation
- **Organisational help:** arranging a fun social activity, a rewarding task, or practical support such as driving to and from activities
- **Providing information:** making available resources or information for example about courses, jobs, leisure activities, support services, specialist advice
- **Emergency help:** for example, financial or equipment loans, transport.

Basic skills #3
recruiting a network

Aim

To identify, recruit and maintain a network supportive of positive change.

To do

1. Explain the importance of social support in achieving positive outcomes
2. State the preliminary goal for which you are recruiting support
3. Identify people who can provide positive support
4. Draw a network map with NMs' roles defined
5. Plan and rehearse contacting potential network members and involve them
6. Plan and monitor FP and NMs' activities
7. Plan maintenance and renewal of the network

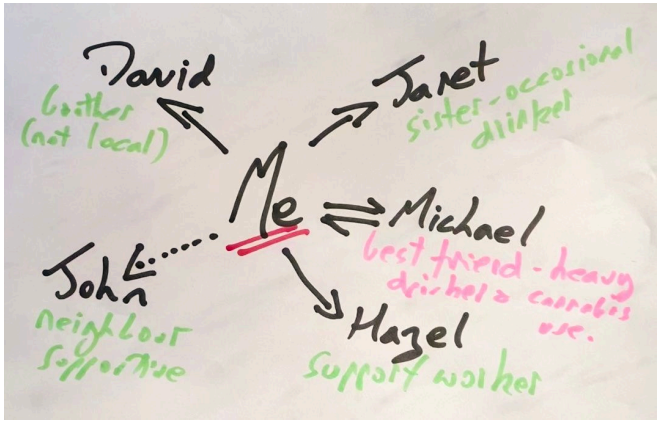
People can give support without being a network member.
There are people who can give support outside the network. For example, the local shopkeeper who sells alcohol can be persuaded not to sell alcohol to the focal person, and this can be set up by the FP helped by an NM; the local pharmacist is often willing to provide support beyond giving out medication.

How to create a network map

You will do this with your FP and NMs if present. Describe the rationale of the network-based treatment including the benefits of developing a supportive network compared to working alone. Describe the nature of the people suitable to be members of the network: that they are not problem drinkers or drug takers, that they are concerned about the FP and support their goal, that they are available to give support.

Draw the network, build up an understanding of who is already in the FP's social network, and identify who may be supportive to the FP. Do not be afraid to say that the FP's nearest and dearest might not be suitable for this network.

This is what your network map might look like...
Be creative in how you draw the network map - there is no right or wrong way - make it informative...



Here are **examples of dialogue** you might use when drawing your map...
"Who is there who you care about and who cares about you?"
"Who would be willing to do things with you which would help you to avoid drinking?" "Who would you like to spend more time with when you are not drinking/taking drugs?"
"How do you think you might describe to your friend what it is that we are doing?"
"What sorts of things do you think they might want to know?"

In cases that have a safeguarding or dual diagnosis dimension, and where there is active involvement from social services or health professionals, it may be useful to invite these people to some sessions. Such professionals will have a keen interest in what is happening in treatment, the FP's response to it and the extent of their social support for change. However, the nature of the power relationship between the FP and NMs is an important one to keep in mind. The FP needs to feel support rather than coercion from members of the network. This does not preclude parents, social workers or senior colleagues being members of the network for a period of time, as long as they come in the spirit of mutual aid and support.

Agree a plan to recruit potential NMs, namely who will approach them, when and how. If the FP lacks the communication skills necessary to make this achievable, role play the dialogue that needs to take place. You can keep updating the map - bring it to sessions and use it as a check that the network is functioning well.

Issues that might arise

Here are some issues that commonly arise alongside the business of building a network – there may be others. It is up to the practitioner to use their judgement on how best to deal with these if they become a concern during treatment.

1. Communication in the network

Good communication in the network stems from the ability of the FP and NMs to tell each other how they feel and what is helpful, without fear of criticism and rejection. Network members may need to practise listening to each other and responding in turn, not interrupting, not blaming, and respecting each other's point of view.

The iSBNT practitioner should be aware that the FP and NMs could have damaging communication patterns. Such patterns may contribute to the re-occurrence, maintenance or escalation of the substance misuse problem. Look out for unhelpful communication styles. For instance:

- **Blaming** "It's your fault that I..."
- **Defensiveness** "What do you expect me to say..."
- **Being judgemental** "That's what you always do..."
- **Making assumptions** "I know what you are thinking..."

Communication patterns and their effects on the FP and NMs need to be highlighted and discussed. It may be helpful to facilitate a conversation where each person present has the opportunity to say how it makes them feel and what they would prefer to happen.

Try out **alternative ways of communicating** - agree and rehearse the best ideas...

Michael says that when Maria tells him *"I can't cope with you going back to drinking"* Michael assumes that she is threatening to end their relationship. Michael responds by saying *"do what you have to do then"* whereupon he leaves the house, feeling angry, hurt, let down and at high risk of drinking or taking drugs.

The practitioner can ask Michael to check this understanding with Maria. This will give Maria the opportunity to tell Michael how she feels, and ask him what would be a helpful response from his point of view.
The practitioner can then ask *"how would you want to say this to each other? What would you do differently in the future?"*

Explore current communication and responses between members of the network and plan new, constructive styles where necessary. To do this:

- Ask the FP and NM to describe actual situations
- Ask the FP and NMs to describe the impact of poor communication styles, and the way they affect their relationships and behaviours
- Make plans for new strategies, record the plans and their outcomes
- Review and amend as necessary

Here are some communication challenges to discuss:

Asking for help

- dealing with drinking or drug use situations
- with practical matters
- dealing with craving
- recruiting additional NMs

Managing criticism

- exploring feelings that result from criticism
- building self esteem
- turning it into a positive, helpful experience

Listening and conversation skills

- talking in turn
- acknowledging feelings
- talking about things other than drinking

2. NM coping responses

These are the ways that network members respond to actual drinking and drug use, or the risk of these. Some of these responses, or styles of responding are associated with better outcomes than others. 'Tolerant' (putting up with) and 'withdrawal' (distancing from) styles of coping are frequently used by network members, and are understandable responses but may in some cases exacerbate the problem. 'Engaged' coping refers to the principle of rejecting the drinking and drug use behaviour and not the person and is understood to be the most effective coping style from the point of view of helping the FP.

Whatever the current style of coping, it is important to avoid any suggestion of blame. Response styles can be explored and effective coping strategies can be planned and implemented...

Examples of positive coping:

- Avoiding the FP only when drinking or taking drugs
- Preventing children seeing their parent when drinking or taking drugs
- Pouring away the drink, if there is no risk of it resulting in aggression
- Taking away funds for drink or drugs
- Buying food
- Discussing with the FP which responses are helpful, and which unhelpful

Examples of unhelpful coping:

- Avoiding or leaving the FP unless there are safeguarding concerns
- Preventing the children from seeing the FP
- Buying or providing alcohol or drugs
- Giving money for drink or drugs
- Making excuses and covering up

It is important for the FP and NMs to discuss what is helpful to each of them. The FP needs to describe which of the NM's coping responses they find supportive and which unsupportive and the NM needs to be able to share their fears and anxieties. It is then possible to agree the common ground, what is the agreed goal, and make plans for shaping coping responses by all parties in the future.

If no NMs are present, the FP can be asked how NMs respond and in turn, how this affects their thinking or behaviour. There can then be a discussion or rehearsal of the conversation to be had with the relevant NM.
The practitioner's task is to turn an unhelpful into a helpful way of dealing with situations.

Here is a typical scenario :
A harm reduction drinking goal has been agreed for the time being. More often than not, June (Michael's mother), gives him money when he has turned up at her house asking for it. Although he says that he needs the money for food, she strongly suspects that he will use it to buy alcohol. His mother understands that her actions may compound the problem, but does not know what else to do, as she fears that he may do something undesirable, such as stealing from a supermarket and be in deeper trouble.

The practitioner should not suggest that this coping response is 'wrong', but rather, help Michael's mother and Michael to see that her 'tolerance' of his problem is a function of her managing her anxieties about him and his situation. The issue could be opened with a question to Michael's mother:
"What do you do when Michael asks for money?"

Agreement could be reached between Michael and his mother that giving him money is not a helpful response, that he could be given food to take away or a meal cooked for him. That way, June can give expression to her need to care for him without creating an anxiety that she is adding to the problem.

If Michael does want money for alcohol or drugs, he needs to say so, but agreement should be reached about the circumstances in which he should receive money and the amount, for example, to buy enough to avoid withdrawal and only when he has no other course of action.

As with any behaviour change intervention, the new responses need to be discussed and agreed, tried out and reviewed to see whether they worked. If yes then practice can continue and if no then an exploration of why they did not work is required. Was the wrong decision made about the alternative behaviour? Was it possible to do? Did someone change their mind about doing it?

3. Problem NMs
Where the concerned others present are angry, frustrated, or do not share an appropriate treatment goal, their presence in the network will be unhelpful. The network approach is not an opportunity to sort out NMs' problems and they may need to be steered elsewhere for this purpose.

Example dialogue...
" Now may not be the right time for you to give support to your brother; perhaps if you are still feeling angry with him, it might help you to speak to someone, a friend or a professional person, and we can come back to this at a later date."

4. FP resistant to networking
Some people see their drinking or drug use as their own problem and believe they should be self-reliant when dealing with it. However, the most common reason for this kind of resistance is that the FP is reluctant to change their drinking or drug use.

While the practitioner respects the FP's reluctance to involve others they may...

- Elicit from the FP their thoughts on what their concerned others would say in response
- Assess the motivational state with reference to changing drinking or drug use, and find an area of the FP's life that they do want to change
- Where the FP says she/he does not want to involve anyone else, think about a virtual network where the FP is getting positive support without those people knowing that the support is to avoid drinking or drug use.

5. Alienated potential NMs or absence of NMs

The FP may have alienated potentially supportive NMs or may lack the skills to communicate with them.

Possible action...

Consider those with whom relationships have become strained or distant, to explore whether they might be suitable NMs in the future. Discuss ways of contacting potential NMs that are acceptable to the FP, for instance by message or email rather than more direct phone call or face-to-face encounter. If there are no identifiable NMs it may be necessary to look at recruiting alternative support from outside the FP's network, for example support groups or other professionals.

6. Ensuring support for the FP and NMs

The point of network treatment is that everyone is supported – the FP, the NMs and the practitioner and no one person carries all the responsibility. It is shared in the network. If there are indications that the FP or NMs are not feeling supported then this needs to be explored.

Example dialogue...

To the NM *"What sort of support do you think would be useful? Have you got a friend or family member who can support you? Have you tried Al-Anon (or other mutual support group for family members)?"*

To the FP *"What do you think you could do to make things easier for your mother, in understanding what is going on, what would be helpful?" "Is there something you could do in return?"*

Possible action...

AA/NA, Al-Anon and carers' groups can offer high levels of easily accessible support, as can other befriending agencies/day-centres/community support services. It is important to convey optimism about the possibilities of developing positive social support, even if the current network is limited. It is good to give out lists of support agencies.

7. Bad influences

Where some or all of the FP's social contact is still with other problem drinkers or drug takers, they are exposed to attitudes and behaviours that are unhelpful to, or at odds with, attempts to make positive changes through treatment. The challenge for the practitioner is to make and elicit suggestions about how to minimise these contacts and their effects whilst ensuring the FP does not feel even more socially isolated and unsupported. If this is not handled carefully, the FP could withdraw their consent to receive this intervention, believing that it is doing more harm than good.

Example dialogue...

"What is going to help in avoiding person x in the future?"

"What sorts of things can we think of putting in place to build a network that will help communicate to them that you are not going to be drinking/taking drugs in the future?"

"Can we try out some things that you might say to them?"

"Let's have a look at what sort of support groups for abstinence are available and let's get some information on activities that are planned for service users who are abstinent"

"What sorts of things can we think of that would bring you into contact with new (non-drinking/non drug-taking) people?"

"What would you feel comfortable trying out?"

"Who could we ask to go to this with you?"

Possible action...

At this point think about the available community resources for employment, training, alternative pleasurable activities. The practitioner might suggest recruiting a housing support worker, a health care assistant or other available support worker to accompany the FP to get them engaged in identifying new sources of social support and alternative activities. All AA and NA groups hold open meetings to which a NM could accompany the FP.

Outcomes from topic #1
Building My Social Network

- A supportive network is in place, illustrated by the Network Map, and may include both carers and professionals
- NMs understand and plan to carry out their roles
- NMs provide support for each other
- Plans are in place for future network support and next meeting time and place agreed

It is important that practitioners have prepared themselves for what should happen on completion of each topic. In particular, practitioners will need to be ready with take home tasks for the network members, so should go to the following pages...

Check out the 'Take Home Tasks' page and see all the options for education, tests and tasks... Go

Try the 'My Support Network' task for recovery from the 'My Checkups' page... Go

Take-home-task suggestions for network building

Decide and agree which NMs will do these tasks with the FP

- Complete the **My Support Network** recovery task from the **My Checkups** page
- Approach individuals who have been identified in the session, explain the nature of the treatment, report the treatment goal and ask them if they will join the network.
- Practise writing to people as well as speaking to them to see if they can offer support however low-key that might be.

iSBNT - core topic #2

Setting the drinking and drug use goal

Always remember the therapist's mantra...

- ✔ Where are you now?
- ✔ Where do you want to be?
- ✔ Who is going to help you to get there?
- ✔ What will everyone be doing that is going to be helpful
- ✔ How shall we know whether this worked?

Why set goals?

Effective practitioners are more likely to maintain focus by agreeing and stating a goal at the outset, and re-stating it throughout treatment. The problem solving approach is a good way to set goals, which should be decided at the outset, providing the starting point for behaviour change planning.

There are good practice guidelines for deciding the substance use goal. An abstinence goal is best for both drinking and drug use where there are physical or psychological harms, pregnancy or safeguarding concerns. Practitioners cannot condone or sanction illegal or harmful behaviours.

Moderation goals may be appropriate where FPs have shown some ability to control their substance use, have good social support for control and an absence of physical damage and mental illness.

Practitioners should be familiar with the FP's circumstances and previous history in order accurately to focus on areas of greatest concern. If dealing with complex cases, integrate mental and physical health concerns or pregnancy and parenting issues alongside those about the drinking or drug use. Get the NMs to contribute their perspective.

Basic skills #4
goal setting

Aim

- Understand the FP's current substance use
- Establish substance use harms
- Agree where the FP wants to be in relation to their substance use
- Elicit commitment to change by setting a goal or goals

To do

1. Get an account of the recent substance use behaviour
2. Elicit concerns about the behaviour and its consequences (change talk)
3. Explore motivation for change and self-efficacy for achieving a concrete plan
4. Agree a change plan accompanied by optimism about the outcomes of change (commitment talk)

How to elicit change talk...

Expressions of concern and/or desire to change are called change talk.

"Tell me about a typical day when you drink/take drugs"
"What kinds of things happen when you have been drinking/taking drugs?"
"Having looked at your liver function tests, tell me what you think? What does this mean to you?"
Try to establish the one thing that most concerns the FP: *"What is the worst thing that has happened?"* and continue with *"Tell me more about that"* or *"What worries you the most about your drinking/drug taking?"*

How to elicit commitment talk...

Commitment talk is an expression of determination to change in a specific way, at a specific time, to a new specific behaviour and is an important predictor of behaviour change. The strength of commitment talk is important.

An example of commitment talk...

"I'm going to stop drinking on Monday."

An example of how to elicit commitment talk...

"What are you going to do next?"

Feedback of test results

If the FP has completed some tests before or during a treatment session then give feedback as soon as possible - the aim is to inform the discussion and secure a commitment for change. You will need to seek consent for this to be done in the presence of NMs ...

- Explain the tests and the results to the FP and NMs
- Ensure that everyone understands the results and their implications
- Feedback all available results and elicit concerns
- Highlight how results are likely to change i) with abstinence or reduced substance use ii) if substance use continues unchanged
- Elicit expressions of optimism for the consequences of change

Health problems, physical and mental, that can be improved by a change in substance use can be a powerful motivating tool. Share your opinion with the FP and the NMs, who may all need education on drugs and alcohol harms at this point.

“Tell me what you understand about the effect of your drinking on your liver?"
"Tell me what you expect to happen when you stop drinking?"
"Here are the results of your drug testing - what has changed over recent months?"
"What does the result of your dependence questionnaire mean to you?"

Firming up the substance use goal

If the FP has decided on abstinence...

Where the FP has decided that they want to stop drinking or taking drugs, then the assessment results are used to strengthen their resolve and to elicit optimism for the outcome of change, and not to explore concerns about drinking or drug taking that have already been dealt with, as this would be a backward step.

“What is going to be better from stopping drinking/drug taking?”
"Who in the network can help you to stay off drink/drugs?"
"In what ways can they help?"
"What are going to be risky situations for you?"

If the FP expresses a wish to moderate drinking or drug use...

1. The FP meets the criteria for a moderation goal

The practitioner needs to share the pros and cons of opting for moderation. Particularly share the concept of there being rules to set if moderation is to succeed. Aim to elicit a commitment to some rules:

"How will your drinking/drug taking be different now?" "How will you make sure your drinking/drug use doesn't slip out of control?" "Who is going to support your goal of moderation?" "What sort of things would be helpful?"

2. The FP does not meet the criteria for a moderation goal

It may be that the FP still enjoys drinking or drug use and is reluctant to say so, or the FP may not be concerned about the consequences of drinking or drug use, or they may be unsure about the benefits of change. In short the FP is resistant to change. There are two possibilities...

2a. The FP is unlikely to be succeed at moderation

The FP is severely dependent or lacks control (check responses to the Leeds Dependence Questionnaire), lacks social support, or is impulsive for example. It may be expedient to go along with a moderation goal in the first instance - if it is not successful then abstinence is the next step. In any case aim to steer the FP to abstinence:

"What do you make of your responses to the dependence questionnaire?" "If you think it is too difficult to stop now, what other options can we talk about?" "Who will be able to help you?"

2b. A moderation goal is clearly not an option

For example, the FP has significant physical illness related to drinking or drug use, where there is unacceptable occupational risk, where there is a co-existing mental health problem or pregnancy, or where family and friends do not support a moderation goal.

"You said in your questionnaire that you can't stop once you have started - what does this mean for your drinking and keeping your job?" "You say you have been given stark warnings about using ketamine while you are pregnant - let's look at what is possible from now?"

Self-efficacy

The practitioner needs to be sensitive to the reasons for resistance to change. The FP might express strong desire and reasons for change, yet have no belief in their ability to change. The network is an important source of enhancing self-efficacy for change by offering help and expressing their belief that change can occur.

Dialogue to strengthen self-efficacy...

“People in your network have said they really want to help - let's decide the best ways for them to do this" "What is going to make a difference to you?" “What is going to make you confident that you can do it?” "How are you going to tell people what will be helpful?"

If the substance use goal is not agreed

From an ethical standpoint the practitioner can only agree to a goal that is likely to be beneficial to the FP. Share your opinion with the FP and the NMs, who may all need education on drugs and alcohol harms. If the FP is not ready to make changes to their substance use then a conversation about harm reduction strategies should follow, but always aim to strengthen motivation to change:

“What do you most dislike about your drinking/drug taking" "How do you see yourself now compared to you at your very best?" "What things would you like to do right away to make things better?" " Who is going to help you?" "How would you like to see yourself in three months?" "How are you going to get there?"

Using worksheets

We encourage practitioners to use worksheets - they are not an end in themselves but they do...

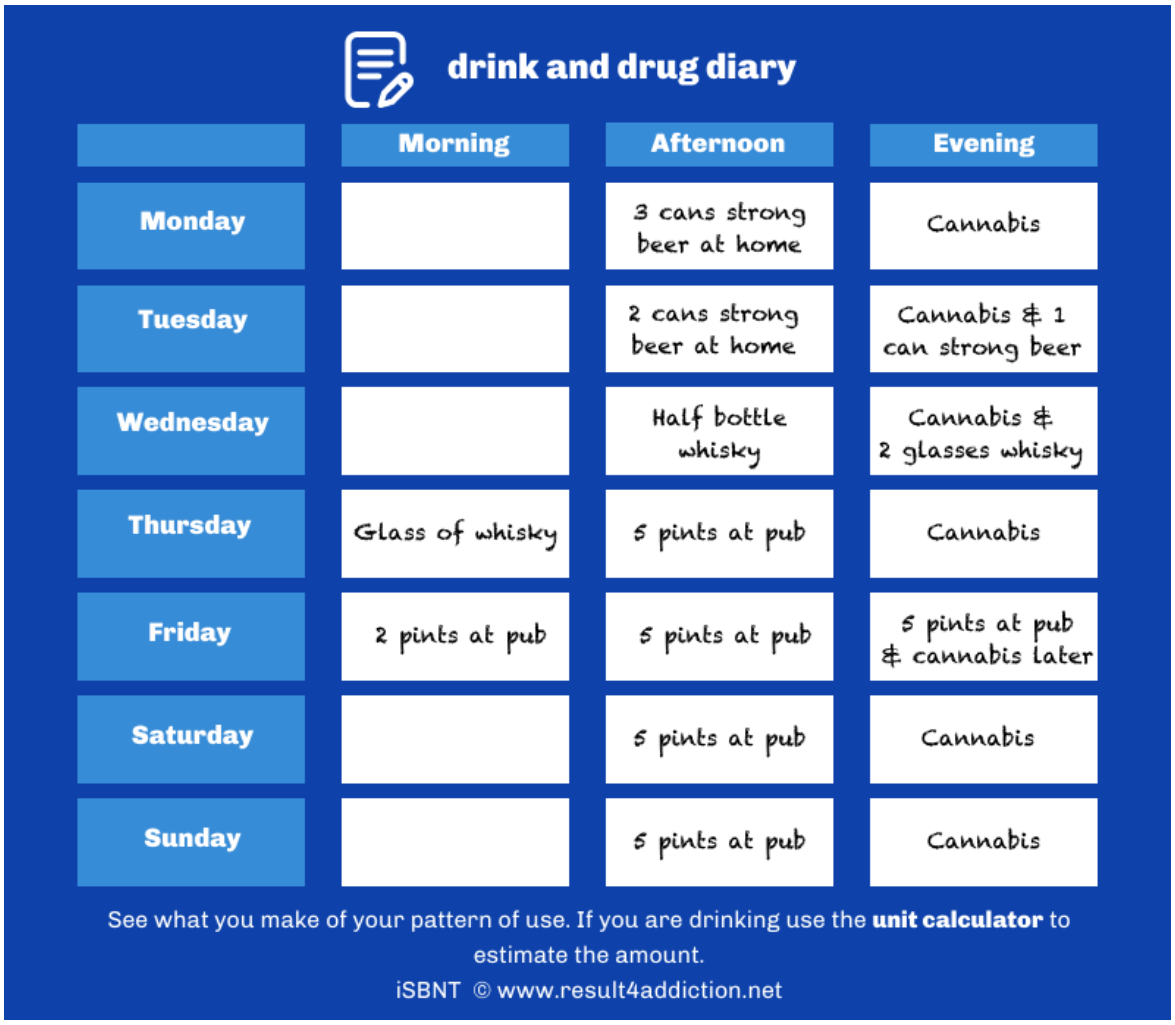
- provide a framework for discussing a topic
- facilitate monitoring and evidence of progress when repeated several times
- bring important issues to the attention of service users

On the next two pages there are examples of two commonly used tools: the **drinking and drug use diary** and the **decision matrix...**

Example of a drink and drug use diary

The aim of this worksheet is to i) **identify** what drink or drugs are being consumed ii) to see if there is a **pattern** that might suggest ways to change.

1. Ask the FP to fill out the diary for the previous week.
2. Discuss the different substances being used and where they are used - is there some indication as to the triggers for drinking or drug taking.
3. If drinking is a significant part of the weekly substance use ask the FP to use an alcohol **unit calculator** to sum the units.
4. Use a **blank diary sheet** to set goals for the coming week and monitor achievement
5. **Repeat** the exercise from time to time and keep the diaries as a record of progress.



drink and drug diary

	Morning	Afternoon	Evening
Monday		3 cans strong beer at home	Cannabis
Tuesday		2 cans strong beer at home	Cannabis & 1 can strong beer
Wednesday		Half bottle whisky	Cannabis & 2 glasses whisky
Thursday	Glass of whisky	5 pints at pub	Cannabis
Friday	2 pints at pub	5 pints at pub	5 pints at pub & cannabis later
Saturday		5 pints at pub	Cannabis
Sunday		5 pints at pub	Cannabis

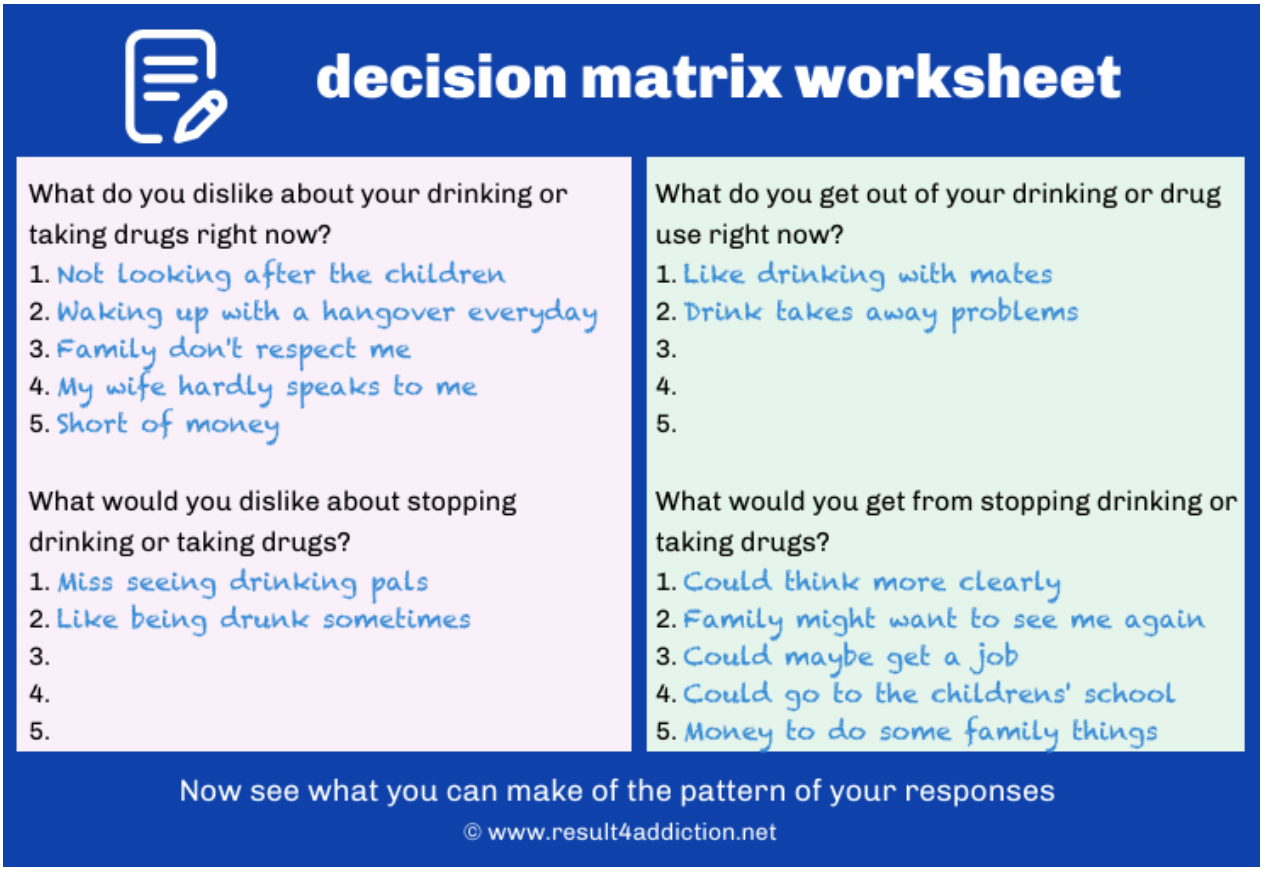
See what you make of your pattern of use. If you are drinking use the **unit calculator** to estimate the amount.

You can get worksheets printed or just use a blank sheet of paper or an online version.

Example of a decision matrix worksheet

The aim of this worksheet is to increase or consolidate **motivation for change**. It is a useful tool for people who are still pre-contemplators but can also be useful if someone is making changes but gets stuck and needs to be reminded of why they want to change. The idea is to draw attention to the discrepancy between dislikes and what the FP gets out of drinking or drug taking. The practitioner needs to be sure to highlight the discrepancy.

1. Ask the FP to complete each of the four boxes.
2. Feedback your observations particularly regarding dislikes.
3. Ask the FP what they make of what they have written.
4. Point out the balance in favour of stopping drinking or taking drugs. It is a good idea to test out abstinence in the first instance but the matrix can equally be applied to moderation.



You can get worksheets printed or just use a blank sheet of paper or an online version.

Outcomes from topic #2
Setting drink and drug use goals

There are three possible goals: i) abstinence ii) moderation iii) harm reduction.
Ideally the practitioner will have achieved:

- A definite commitment to the goal from the FP and the network
- A completed Decision Making worksheet
- Summary of areas for change agreed by all

As with the first topic it is important that practitioners have prepared themselves for what should happen on completion of each topic. In particular practitioners will need to be ready with take home tasks for the network members, so should go to the following pages..

Check out the 'Take Home Tasks' page and see all the options for education, tests and tasks... Go

Try the 'My Readiness to Change' task for recovery from the 'My Checkups' page... Go

Take-home-task suggestions for goal setting

Decide and agree which NMs will do these tasks with the FP

- Complete the **My Readiness to Change** recovery task from the **My Checkups** page
- Keep a **Drinking or Drug Diary** even if the FP has already changed their substance use.

iSBNT - core topic #3

Coping skills

Always remember the therapist's mantra...

- ✔ Where are you now?
- ✔ Where do you want to be?
- ✔ Who is going to help you to get there?
- ✔ What will everyone be doing that is going to be helpful
- ✔ How shall we know whether this worked?

Why coping skills?

Coping skills are commonly understood to be the way the FP and NMs respond to high risk situations for drinking or drug use. There are two questions:

1. Can the FP refuse drink or drugs when they are available?
2. Can high risk situations be anticipated and dealt with?

Whether the chosen goal is abstinence or moderation, the FP will need to apply coping skills to deal with high risk situations. There are situations where the temptation to drink or use drugs is strong, whether during a period of abstinence or when a slip or relapse occur. Once high risk situations have been agreed in the network, coping skills can be explored using the problem solving approach and then rehearsed.

Basic skills #5
identify high risk situations and rehearse coping strategies

Aim

- Identify high risk situations for drinking or drug taking
- Agree a coping strategy for each situation

To do

1. Provide information about the nature of high-risk situations
2. Create a network based coping strategy
3. Practise coping in high-risk situations
4. Select topics to address eg coping with craving and refusal skills

Discuss with the network as a whole, including the FP, that lapses and relapses can be avoided and planned for. That is different to saying that such events are normal in addictive behaviours, as this may be interpreted that they are inevitable, the implication being that one is powerless in the face of a chronically relapsing condition. If a lapse or relapse does occur during a treatment episode or after it, it is best seen as a learning opportunity, rather than a symptom of personal or network failure or pathology.

Coping with high risk situations

1. General principles

The practitioner's aim is to get to the heart of what it is that makes a specific situation a high-risk one. The detail that comes from the use of very focused questions – the 'what, when, where and with whom' aspects, can be valuable to the FP and NMs in helping them to see that such situations do not just happen, but can be explained in terms of the relationship between thinking and acting. The learning that comes from understanding the link between thoughts, feelings and behaviour can present some concrete ideas and options for coping with such situations without recourse to drinking or drug use. The network brings the collective minds of the FP, NMs and the practitioner together in deciding what will be most helpful and when.

- Rank all high-risk situations identified in order of risk. Riskiness is assessed by asking the FP to rate how confident they feel in terms of coping with each one right now.

- Agree with the FP and NMs the plan and tactics for coping with each high-risk situation.

- Where there are skills deficits, the network can suggest coping responses and role-play or otherwise explore them until everyone has confidence to apply them.

- Agree the role of each member of the network in helping the FP to cope. Once coping strategies are agreed they can be recorded and rated for confidence to strengthen self-efficacy.

2. Coping with high risk situations - drink/drug refusal skills

Being able to refuse drink or drugs is an important skill regardless of whether the agreed substance use goal is abstinence or moderation. This is a case where avoidance is a good strategy – simply stay away from people who might want the FP to drink or take drugs. If avoidance is not an option:

- Discuss the difficulty of using refusal skills – how is it for the FP?
- Practise adopting the right body language
- Practise an example of refusal

Elicit a risky situation and ask the FP to play the person offering alcohol or drugs. This will help for two reasons 1) the network will get an idea of how the other person offers the alcohol or drugs so you can play it realistically later and 2) the FP can see members of the network successfully modelling the skill steps. Role-play and discuss then change roles. Break down the skill into manageable steps for the FP (including body language) ensure that all participants get a sense of success at each step.

Feedback and repeat as necessary, adding additional skill and pressure until it feels realistic and the FP feels they have some mastery of the skill. Remember to reinforce positive approximations, and provide coaching to strengthen the skills. Plan to do this in real life situations with one or more network members present.

3. Coping with high risk situations - craving

The experience of craving is usual and an indication that abstinence is at risk, and this risk should be taken seriously. Craving is experienced as a physical state accompanied by feelings of discomfort and thoughts of drinking or drug use to relieve discomfort. Cravings come in waves each of which is usually short-lived.

It is difficult to avoid every situation that might trigger cravings and different coping strategies might be needed for different situations...

- Explore the nature of craving – what is it like for the FP
- Agree an understanding of the circumstances of craving
- Define the craving in detail

Create a Risk Situations Worksheet as a way of understanding the circumstances in which craving is more and less likely to occur. Situations which tend to evoke craving can then be explored and the coping with craving strategies can be adopted where needed. It is a good idea to monitor and record cravings and actions taken.

10 coping strategies for craving...

1. Talk about your cravings
Discuss with the FP options for talking to someone when they feel they are experiencing a craving. Decide which NM might be best placed for this.

2. Distract yourself
Agree things to do which will distract the FP from the craving. This needs to be something a person can do instantly, for example, some quick exercise, meditation or talking to the NM or other friend.
"Who will you be able to call if you are feeling at a loose end, or you meet someone who is going to tempt you to drink/take drugs?"

3. Escape the situation
Discuss with the FP options around how to remove themselves from the situation they are in if a craving is developing. For example leave the area, find a safe place or a safe person. Then use another skill to bring the urge down.

4. Change thoughts about drinking or drug taking
Help the person to challenge the thoughts. For example say:
"I can't have just one drink/one hit and then stop" or "If I give in I'll have to start all over again."

Think about all the benefits of abstinence and think about the negative consequences of relapse. Encourage the person to try not to make catastrophic predictions about cravings, like:
"there's no way I can stand this, so I might as well just drink/take drugs and get it over with", "I keep having cravings, so I must be an alcoholic/addict, I can't beat this..."

Cravings usually subside fairly quickly anyway, so think about saying:
"this will pass".

Restructuring these thoughts and developing strong self-efficacy beliefs will reduce the risk of drinking or drug taking, so they need to practise saying
"the craving won't last long.... I can deal with it."

5. Guided imagery

Use guided imagery with your FP to demonstrate to NMs how they might help with this. Ask the FP and NMs to close their eyes and run through an imagery exercise:

Command the craving to STOP (e.g. see a big stop sign), then refocus on a relaxing location of choice – a favourite peaceful spot. You can guide the imagery and elicit the detail of the scene to help focus the FP e.g. *"tell me what you can see?" "what do you find relaxing about that?" "describe the place".* Elicit how relaxing they found the exercise and once they have learned the technique with you they can do it by themselves during a craving.

If the craving is associated with good times when they were drinking, replace that image with the bad times, your lowest ebb when you felt ashamed and disgusted *"do you want to end up back there?"* Again guide the person to imagine the scene so they can imagine it when a craving occurs.

If it's negative, depressing images that are giving the FP cravings, then get them to imagine an optimistic view of the near future, with friends or family, having fun without a drink.

If there is a high risk event coming up then imagine the situation and how you deal with it successfully. Run through the feelings you'll have so you are not caught off-guard by them. Get the FP to take the network through the whole event if needs be.

6. Coping flashcards

When the FP is in the grip of a strong craving, it can be hard to think rationally and remember all the things they're supposed to, so writing some instructions on a phone alert can be useful. The priority is for the FP to be convinced that they can cope with the situation. Here are a few examples of things they might write:

- Things are going well right now, I don't want to mess it up
- This craving will pass if I do something else
- Recite a poem or count backwards from 100
- I'm not helpless here, what action can I take?
- What are the pros and cons right now?
- Name of person to phone

7. Relaxation

Anxiety, anger, frustration and stress are amongst the biggest triggers for cravings. Learning some relaxation techniques can be helpful. If the FP is less tense, they're less likely to act impulsively and if they've been using alcohol or drugs to relax for years, they are going to have to learn some other methods. Options include breathing exercises, progressive muscle relaxation, taking a hot bath, listening to relaxing music, listening to a relaxation app or a podcast, taking a walk.

8. Plan ahead to prevent avoidable triggers

Ask the FP and NMs to plan ahead to avoid places and people likely to stimulate craving. Introduce a fifteen minute rule so that when craving is experienced, the rule is not to act on the craving for fifteen minutes, using distraction, escape, talking about it to someone or any of the above strategies to complement this rule. The idea is that after 15 minutes the craving may have passed, especially if another strategy is used. The 15 minute rule can be extended to suit the FP, however within this time period the craving tends to wear off.

9. Activity

If the FP has had an addiction for a long time, they may not have many interests left. Quite often, drinking or drug use are the only activities they have done for fun. So when trying to stop, boredom can be the biggest hurdle and can evoke craving. New activities can be planned for times most likely to evoke craving. An iSBNT essential is life style change designed to minimise craving risks.

10. Reminders of important things

Keep a photograph of a loved one, or favourite activity in something the focal person usually carries with them. This can help to refocus on the desired goal. Also having a list in a place where it can be seen every day can help to keep focused and vigilant (for example, the fridge door). Keeping photographs of important others (such as children) may also provide good visual imagery to protect against relapse.

Issues that might arise

1. Mental health problems

Mental health problems are very commonly associated with substance misuse. What appears to be a mental illness may be confused with symptoms caused by the substance misuse itself, may be a consequence of substance misuse and therefore expected to resolve if the substance misuse is stopped, or may be independent of substance use but exacerbated by it. The interplay between substance misuse and mental health must be taken into consideration when goal setting.

It is helpful to ensure the FP and NMs understand the relationship between mental illness symptoms and substance use effects. You might ask...

"How does drinking/drug taking affect your mood in the short term? And what about later?"

If the FP has experienced psychotic symptoms, you might ask

"How does drinking/taking drugs effect things when you hear voices?"

"How does drinking interfere with taking your medication?" "When you were abstinent how was your mental health?"

2. Pregnancy and parenting

Pregnancy or parenting will raise concerns for the practitioner with regard to setting goals other than abstinence. Safeguarding children is a responsibility for all practitioners.

In addition to eliciting general concerns about drinking or drug use, if the FP is pregnant or a parent, you will want to direct the dialogue towards eliciting concerns about drinking and drug use and its effect on the pregnancy or parenting.

The focus of the dialogue will be the potential impact on the unborn child, or on the parents' capacity adequately to care for and protect their children.

"Tell me what you understand about the way alcohol/(specified)drugs can affect your pregnancy?" "What you have heard about this"
"What does your child know about your drinking?"
"How do you see things working out in the future?"
"Tell me what sorts of things you do with your children"
"What sorts of things you do with your children when you have been drinking/taking drugs"
"What effect does your drinking have on the way you are with your child?"
"Give me an example of a time you thought your drinking affected the way you were with your child".

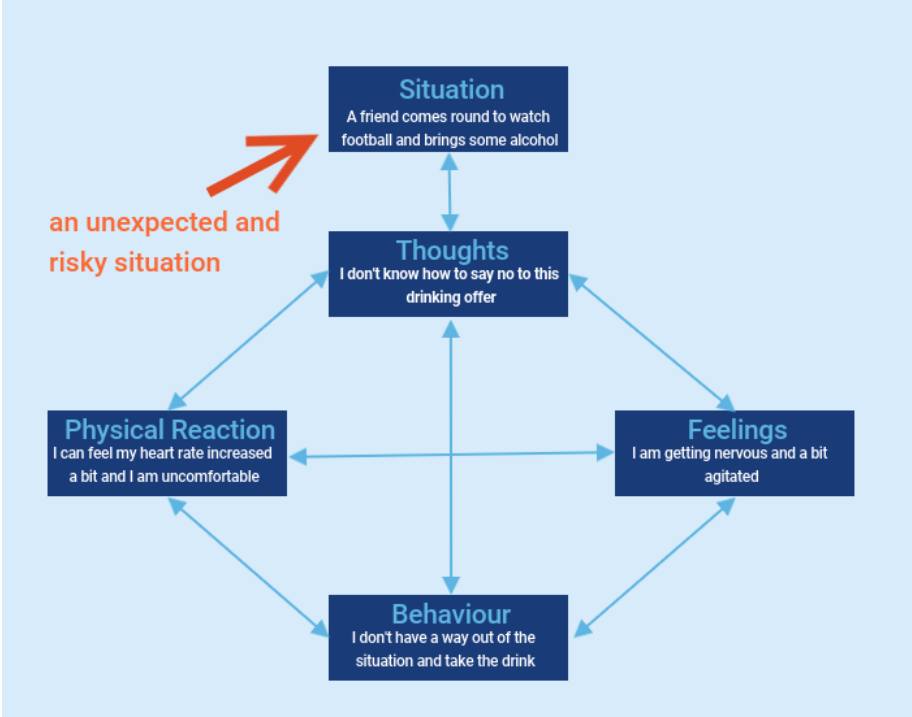
3. Emotionally high-risk situations

There may be high-risk situations that are more emotive than others and need more than common sense to be understood. The Five Areas approach has typically been used for finding coping strategies to use where there are unhelpful psychological responses to situations.

Possible actions:

Introduce the Five Areas model and explain that the aim is to identify the connections between thoughts, feelings, behaviours and physical reactions – in this case looking at relapse triggers. Take your FP and ideally one NM through a single thread example as in the two graphics on the next page...

The example below illustrates how a common **situation** can lead to a sequence of thoughts and feelings that lead to drinking or drug taking. Often the **situation** is unexpected. Take the FP and NM through the chain of thoughts and feelings that lead on to drinking or drug taking...



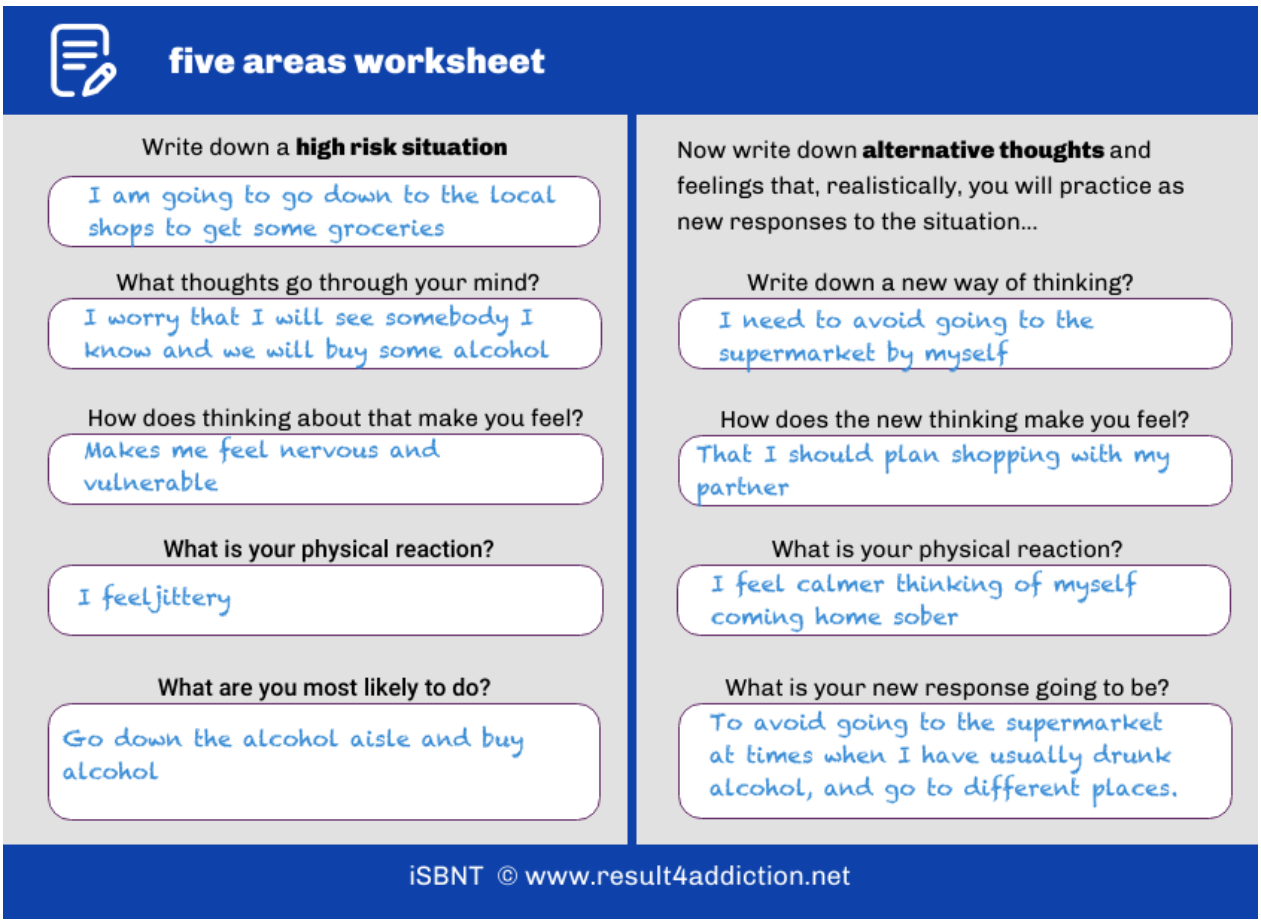
Now go through the same sequence of thoughts and feelings but see what happens when the **situation** has been anticipated and the subsequent thoughts and feelings do **not** lead to drinking or drug taking...

Now go through the exercise again but this time use a **situation** chosen by the FP...

Example of a five areas worksheet

The aim of this worksheet is to i) **identify situations** that are a high risk for triggering drinking or drug taking; these will be situations causing an emotional and physical response ii) to develop a plan to use **coping strategies** in these situations.

1. Explain the five areas model as described on the previous page.
2. Complete a five areas worksheet (below). This is a measure of **self-efficacy** (how likely am I to resist this temptation?)
3. Write down a **plausible** (likely to happen) change in thinking and follow through how that might prevent drinking or drug taking.
4. **Rehearse** the situation with a **role-play or accompany** the FP in the real world situation.
5. **Repeat** the exercise for more high risk situations until all major risks are dealt with.

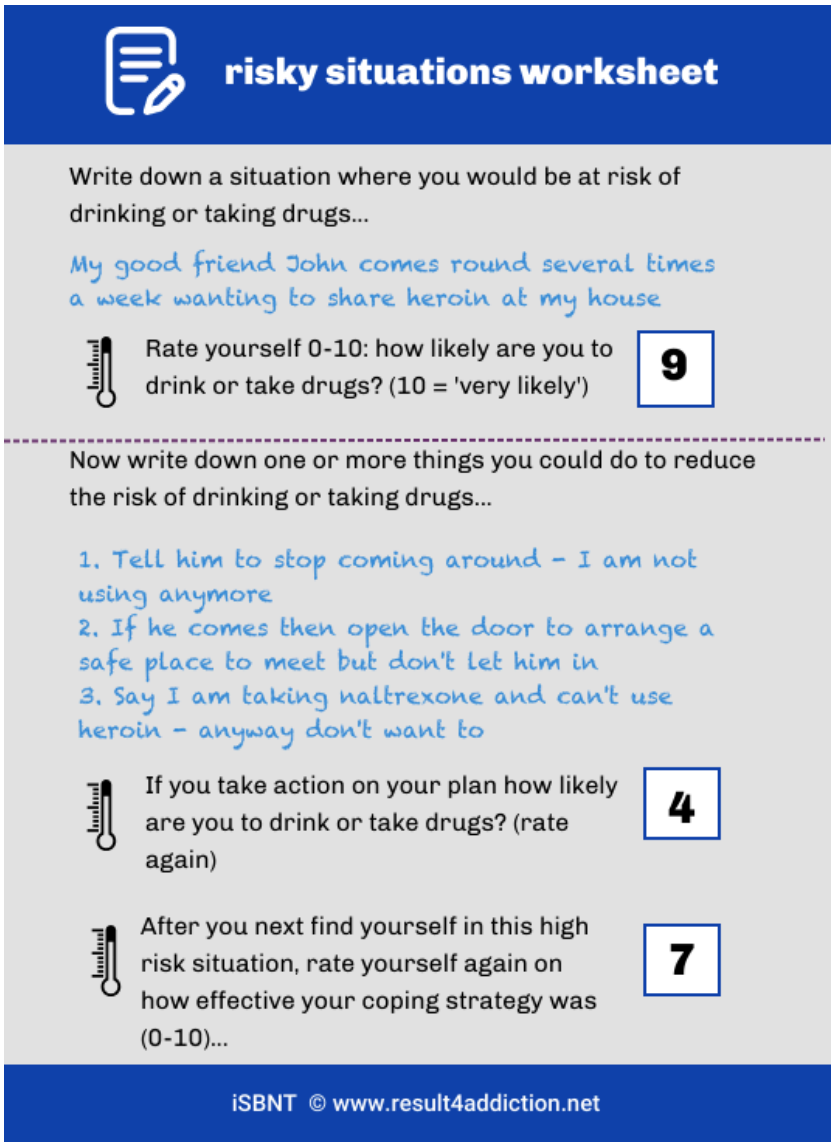


You can get worksheets printed or just use a blank sheet of paper or an online version.

Example of a high risk situations worksheet

The aim of this worksheet is to i) **identify situations** that are a high risk for triggering drinking or drug taking ii) to develop a plan to use **coping strategies** in these situations.

1. Write down the high risk situation. The act of writing (or typing) is itself important as it strengthens the FP's awareness of the risk.
2. Give a rating to the risk of drinking or drug taking if the high risk situation is encountered. This is a measure of **self-efficacy** *("how likely am I to resist this temptation?")*
3. Write down one or more **plausible** (likely to happen) coping strategies.
4. Rate **self-efficacy** again but this time in expectation of the plan being actioned.
5. **Repeat** the exercise for more high risk situations until all major risks are dealt with.
6. Be sure to **check out** if the plans worked in the **real world** and rate its effectiveness.



You can get worksheets printed or just use a blank sheet of paper or an online version.

Outcomes from topic #3
Coping strategies

- Agreement on 2-3 key high risk situations
- Coping strategies rehearsed with practitioner and NMs
- Have a plan for future slips or relapse

As with the previous topics it is important that practitioners have prepared themselves for what should happen on completion of each topic. In particular practitioners will need to be ready with take home tasks for the network members, so should go to the following pages..

Check out the 'Take Home Tasks' page and see all the options for education, tests and tasks... Go

Try out the 'My Medication Check' task for recovery from the 'My Checkups' page (medication is often used as a coping strategy)... Go

Take-home-task suggestions for coping strategies

Decide and agree which NMs will do these tasks with the FP

- Repeat the **My Medication Check** recovery task from the **My Checkups** page
- Complete a **High Risk Situations** and/or **Five Areas** worksheet
- Rehearse coping strategies
- Monitor high risk situations
- Use coping skills and record their use and success

iSBNT core topic #4

making lifestyle changes

Always remember the therapist's mantra...

- ✔ Where are you now?
- ✔ Where do you want to be?
- ✔ Who is going to help you to get there?
- ✔ What will everyone be doing that is going to be helpful
- ✔ How shall we know whether this worked?

Why lifestyle change?

Once abstinence or reasonable control of substance use is achieved you can shift the focus to lifestyle change. Lifestyle and drinking or drug taking are so intertwined that the two change together but, in any event, it is a good idea to plan lifestyle change as early as possible as it can support change in substance use itself.

There are two elements to lifestyle change – a change in daily routine and the introduction of nice things to do that are incompatible with drinking or drug use. Daily routines may have been taken over by the desire to procure and drink alcohol or take drugs. Establishing or re-establishing a new daily routine is sometimes difficult and needs planning. Pleasurable activities that do not involve drinking alcohol or drug use may have been abandoned, both by the FP and often also by their close friends and NMs.

Lifestyle change is positively associated with the maintenance of abstinence and successful moderation, which may include a substitute prescription. Doing fun things can result in positive feelings, reduce negative emotions such as boredom or feeling isolated, which are relapse risks. Alternative activities can build self-efficacy for abstinence and facilitate cohesion and positive support in the longer term. This topic requires the participation of NMs in contributing ideas and concrete plans.

Watch the video of Rudolph Moos talking about outcome predictors on the 'What is Treatment?' webpage

Go

Ensure that there is a good balance of things that need to be done and things that are enjoyable, particularly for times when drinking or drug taking occurred in the past. It is a good idea to make the plan as precise as possible, including planning meals and shopping in such a way that drinking/drug use triggers are avoided (places and people for instance). A change in shopping habits is a good idea for people who have associated shopping with buying alcohol: for example the shopping could be done with an NM for support and in different places.

Basic skills #6
promoting
lifestyle change

Aim

To establish a lifestyle free of alcohol and drug problems with network support

To do

1. Establish an understanding of an alcohol/drug problem free lifestyle based on the vision of the FP and NMs
2. Identify roles in achieving new routines and activities
3. Have an action plan in place for activities including a weekly schedule for routine activities and nice things to do
4. Use a problem solving approach to address challenges to the plan

Establishing a daily routine

- Describe how a new routine can kickstart a new lifestyle
- Identify desirable routine activities
- Identify NMs to support the FP with specific activities and share the enjoyment
- Agree a daily plan for the coming week
- Summarise; get session feedback; agree to review

Examples of daily routine dialogue

"Let's discuss your previous shopping routines and how these might be changed to avoid triggers for buying alcohol" "Who in the network is likely to be able to help?"

"How would you like your daily life to look in three months' time?" "What would you like your daily routine to look like?"

"Who are the people you want to avoid? Who is going to help you to avoid them?"

Increasing pleasurable activities

- Describe the importance of pleasurable activities
- Identify pleasurable activities
- Identify NMs to support the FP with specific activities
- Agree 2-3 activities for the forthcoming week
- Summarise; get session feedback; agree to review next session

Examples of pleasurable activities dialogue

"Let's think of some things that you have enjoyed doing in the past; what is the likelihood of being able to do these again?"

"What sorts of things might be a good idea to do after the chores have been done?"

"Who will you see as a matter of course during the day?"

"What new activities will you plan to do on a regular basis?"

Issues that might arise

1. Financial constraints

People with addiction problems have often run into financial difficulties. There is of course some reality to the constraints that this imposes, however, it is important that the practitioner takes a positive stance.

Possible actions:

- Explore nice things to do that are free
- Explore possible sources of funding for essentials
- Explore charitable donations of essentials

2. Identity crisis

For people who have been lifetime drinkers or drug takers to the exclusion of developing adult relationships or life skills and a sense of belonging other than in drinking or drug taking circles, giving up substance use may threaten their sense of identity. In circumstances where an FP decides abstinence is the best goal it may turn out that they feel stressed and no longer sure of 'who they are'.

Possible actions:

- Suggest joining a mutual aid group
- Have a discussion about this difficult issue with NMs and the FP to explore ideas creatively. Identity is an issue for people in many different situations and walks of life

Example of a daily activities worksheet

The aim of this worksheet is to **sketch out** how your FP **spends the day**. It is not a detailed account of every moment in the day, rather it is a way of getting into talking about daily routines and what these might look like. You can supplement this with asking your FP to complete the **My Daily Routines** and **My Nice Things to Do** recovery tasks in the website.

1. Explain to the FP what you are trying to get from the worksheet.
2. Ask the FP to fill out the worksheet.
3. Ask the FP what they make of their daily activity.
4. Make observations about the importance having some structure to the day and to be doing some enjoyable activities.
5. **Repeat** the exercise from time to time and keep the worksheets as a record of progress. You want to see positive entries for each section of the worksheet.

You can get worksheets printed or just use a blank sheet of paper or an online version.

Outcomes from topic #4
Making lifestyle changes

- Having a Daily Activities worksheet
- NMs supporting and participating in a range of activities
- Evidence that the activities are enjoyable, sustainable and likely to increase
- **It is important that the plan includes things that bring short term rewards as well as long term - it is about replacing the immediate gratification that comes from drinking or drug use**

As with the previous topics it is important that practitioners have prepared themselves for what should happen on completion of each topic. In particular practitioners will need to be ready with take home tasks for the network members, so should go to the following pages...

Check out the 'Take Home Tasks' page and see all the options for education, tests and tasks... Go

Try the 'My Daily Routines' task for recovery from the 'My Checkups' page... Go

Try the 'My Nice Things to Do' task for recovery from the 'My Checkups' page... Go

Take-home-task suggestions for lifestyle change

Decide and agree which NMs will do these tasks with the FP

- Suggest completing **My Daily Routines** and **My Nice Things to Do** recovery tasks from the **My Checkups** page
- Complete a weekly timetable with some routine and some new activities
- Record what has been done and set future plans
- If plans have not been carried out, record with the reason and make new plans

iSBNT

ending treatment

Expectations

Keeping to the treatment plan is associated with better outcomes and fewer readmissions. The flexibility of iSBNT is such that the duration of treatment may be brief or extended, depending on what is needed. From the outset the practitioner has set an expectation that the network should continue after the end of formal treatment.

The last session

The last session should not come as a surprise as the end date should have been agreed early on. The work undertaken to date will be for the network itself to follow up. People should be given an opportunity to say what they have got out of the sessions, what they have learnt and what they will do differently in the future.

Reluctance to end

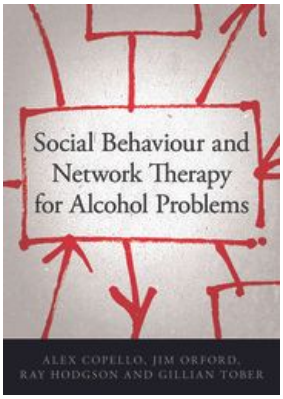
The FP and NMs may wish to continue beyond the previously agreed term of treatment when no progress has been made, or when the group feels less secure in being able to continue without the practitioner.

1. In the first instance, the practitioner could use a problem solving approach to identify what didn't work and propose a different course of action to take, eg residential rehabilitation.
2. Secondly, the practitioner can review who is in the network and what sort of support is needed to strengthen it.
3. Thirdly, consider re-admission – it is not a good idea to have a dogmatic policy, rather to view each case on the grounds of need.

Development of SBNT and iSBNT

Social Behaviour and Network Therapy, SBNT, was originally developed as one of two of the most promising treatments for addiction problems. SBNT was compared with Motivational Enhancement Therapy, MET, in the United Kingdom Alcohol Treatment Trial - UKATT. The UKATT principal investigators were:

Alex Copello, Christine Godfrey, Nick Heather, Ray Hodgson, Jim Orford, Duncan Raistrick, Ian Russell and Gillian Tober.



A book was published which described core topics and elective topics for what was an eight session treatment in UKATT:
ISBN 9781583918036
Published June 22, 2009 by Routledge
176 Pages

Following UKATT it was recognised that MET was best seen as a style of intervention and so we combined it with SBNT as Integrated or iSBNT. It was also found that few people attended more than 3-4 sessions and so iSBNT was designed with four core sessions and the option to repeat or add sessions as required.