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# Brief Integrated Motivational Intervention

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# **Brief Integrated Motivational Intervention**

**A Treatment Manual for  
Co-occurring Mental Health  
and Substance Use Problems**

Hermine L. Graham, Alex Copello,  
Max Birchwood, and Emma Griffith

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*To Chloe and Niamb (HG)*

*To my family and friends (EG)*

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# About the Companion Website

This book is accompanied by a companion website:

**[www.wiley.com/go/graham/bimi](http://www.wiley.com/go/graham/bimi)**

The website includes:

Handouts and worksheets

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# Introduction

## ▶ A Window of Opportunity

In healthcare settings, a number of opportunities to talk to clients about health-related behaviors (e.g., tobacco, alcohol, or drug use) are often “missed,” which may have indirectly contributed to them being admitted or referred for treatment (e.g., Buchbinder, Wilbur, Zuskov, Mclean & Sleath, 2014). Often viewed as “precontemplators,” these clients do not recognize their behavior as causing any problems or as the primary presenting problem. However, it has been suggested that such occasions—that is, when problems are acute—represent “teachable moments” (e.g., Lau et al., 2010; Buchbinder et al., 2014) that present staff in healthcare settings with natural “windows of opportunity” to start conversations about behaviors that may have indirectly impacted on their clients’ physical and mental health (Graham, Copello, Birchwood et al., 2016). As such, there exists a significant need for brief interventions that can be delivered in inpatient or acute healthcare settings, when clients who are not necessarily motivated to talk about their substance

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abuse are more “open” to considering their use. This period can be viewed as a “window of opportunity” to help clients gain insight into the role of substance use in triggering acute mental health symptoms or hospital admissions, and to improve their engagement in treatment.

Drug and alcohol use and misuse are common in clients who experience severe mental health problems (Regier et al., 1990; Mueser et al., 2000; Graham et al., 2001; Swartz et al., 2006). Substance misuse in this population has been found to be associated with poorer engagement in treatment, more symptoms and relapses, and poor treatment outcomes (Mueser et al., 2000; Graham et al., 2001; Swartz et al., 2006). In addition, these clients often express low motivation to change their drug and alcohol use (McHugo, Drake, Burton & Ackerson, 1995; Carey, 1996; Swanson, Pantalon & Cohen, 1999), and are often poorly engaged in treatment, which forms a significant barrier for change and good treatment outcomes (Mueser, Bellack & Blanchard, 1992; Swanson et al., 1999; Drake et al., 2001; Mueser, 2003). Drug and alcohol misuse have also been found to be associated with increased psychiatric hospital admissions, and seems to have a negative impact on inpatient stays (Lai & Sitharthan, 2012). Therefore, unsurprisingly, 22–44% of those admitted in the United Kingdom into psychiatric inpatient facilities for mental health problems have been found to also have coexisting alcohol or drug problems (DOH, 2006). In the United Kingdom, national health policy guidance has pointed to the need to train staff to improve routine assessment and treatment of substance misuse as part of the clinical management strategy of a psychiatric admission (DOH, 2006). Nonetheless, this has remained a significant gap in service provision (DOH, 2006; Healthcare Commission, 2008), and this natural window of opportunity is often missed.

As the acute symptoms of mental ill health decline for an inpatient, this can be a time of contemplation, when he or she reflects on how they “ended up in hospital.” It may be a window of increased awareness and insight into the factors that contributed to him or her becoming unwell and/or being admitted in a hospital. However, this increased “insight” may result in increased emotional distress, and

some research has shown that post-discharge is a time when individuals may “seal over” the experience, in an attempt to reduce emotional distress. That is, the inpatient may deny or minimize any recent mental health symptoms or experiences and precipitating factors, because they may be too upsetting to think about. As a result, he or she may lose awareness of the triggers for becoming unwell (Tait, Birchwood & Trower, 2003). Sealing over the experience of relapse was found to predict low engagement with services 6 months after discharge for inpatients (Tait et al., 2003). However, we know that engagement in treatment is key to improving treatment outcomes for mental health clients (Carey, 1996; Swanson et al., 1999).

The Brief Integrated Motivational Intervention (BIMI) seeks to target this window of contemplation. It provides clinicians with a brief, targeted, easy-to-use intervention that motivates people who experience mental health problems to engage in treatment and make changes in their substance use (Graham, Copello, Griffith et al., 2015). The approach seeks to raise awareness of the impact of drugs and alcohol on mental health. BIMI is empirically grounded in cognitive behavioral therapy (e.g., Beck, Wright, Newman & Liese, 1993; Greenberger & Padesky, 1995) and motivational interviewing (e.g., Hettema, Steele & Miller, 2005). It draws on the initial phases of the longer-term integrated treatment approach C-BIT (Graham et al., 2004), and on developments in the use of brief interventions in the treatment of substance use in those who experience severe mental health problems (Carey, Carey, Maisto & Purnine, 2002; Kavanagh et al., 2004; Edwards et al., 2006; Kay-Lambkin, Baker, Kelly, Lewin & Carr, 2008; Baker et al., 2009). It reflects the research evidence on increasing engagement and motivating behavior change in those with co-morbid mental health and substance misuse. BIMI was initially developed and piloted in a randomized controlled trial in acute mental health inpatient settings and has demonstrated positive outcomes for engaging inpatients with severe mental health problems in addressing their drug and alcohol use (Graham, Copello, Griffith et al., 2015).



## ► Brief Integrated Motivational Intervention (BIMI)

### ***Approach***

BIMI is designed to be delivered by routine mental health staff or specialist practitioners. This treatment manual provides a framework, session content, illustrative case material, and easy-to-use worksheets that can be used when delivering it. BIMI promotes a practical conversational style that seeks to build a good collaborative working relationship as you work together toward the client's self-identified goals. It is targeted in its approach and is recommended to take place over a brief period, ideally *2 weeks*. Sessions can range from *one to a maximum of six*, depending on the client, and are intended to be delivered in short bursts, *each of 15–30 minutes* duration. The evaluation of BIMI was performed by staff members who were trained in the approach and who received case supervision. The evaluation found that, on average, an inpatient received *three sessions*, in addition to the initial assessment session, each of an *average duration of 17 minutes*, and that the total time that clinicians (i.e., nurses, occupational therapists, healthcare assistants, activity workers, specialist dual-diagnosis clinicians) spent receiving the intervention was *57 minutes* over the *2-week period*. This short-burst approach was found to be sufficient to produce improved engagement in substance misuse treatment and some behavior change (Graham, Copello, Griffith et al., 2015). The number of sessions and their duration would best be determined by the needs of the client. Small amounts of information can be discussed in sessions, and it is helpful to provide frequent reflections and summaries of key points talked about during the sessions. Information can be presented in a number of ways (e.g., verbal, written).

### ***Timing***

The primary aim of the treatment approach is to quickly engage clients in meaningful change talk about their alcohol or drug use. BIMI is provided relatively early on in the treatment process (e.g., within the first few weeks of an inpatient's stay in hospital or when presenting at mental health services

when acutely unwell). The idea is to maximize the potential of this *window of opportunity* and *teachable moment*. This would enable the intervention to take place when problems are acute and clients are “primed” to consider health issues. At this point, the clients are considered to be more cognitively open to engage in considering the links between the issue that led to them being referred or admitted and other health-related behaviors. By providing a few minutes of quiet time, over a short period, clients can reflect on their use of drugs and alcohol and start to consider the impact of such use on their physical and mental health. The timing is key and balanced with the initial acute symptoms subsiding and it being considered clinically appropriate.

### **Structure**

BIMI uses a simple three-step framework (see Table 1.1 for an overview of the structure). The initial step (STEP 1) involves carrying out a brief assessment and then providing clients with personalized feedback of the information gathered in this assessment. The feedback details the clients’ patterns of substance use and highlights its potential impacts on their physical and mental health. It is also recommended that clients be provided with individually tailored psychoeducational material/leaflets about the substance(s) they are using. The second step (STEP 2) aims to help clients make decisions about what outcomes/goals they want. This involves using strategies aimed at: increasing awareness of the perceived “benefits” of use and reflection on the “costs” associated with *continued* substance misuse; re-evaluation of positive thoughts and beliefs about substances that promote use; and building awareness of how substance use and mental health may interact and worsen each other by identifying a maintenance/vicious cycle. The third step (STEP 3) encourages clients to contemplate change and develop a change plan based on a self-identified goal, using goal planning. This helps in making change feel possible and achievable. Included are also strategies to cope with setbacks, cravings, and urges, and to provide social support for change. Not all the steps in BIMI need to be delivered. The essential step is STEP 1. The main idea is to

**Table 1.1** Overview of BIMl.

<i>Session Content</i>	<i>Session Goals</i>
<p><b>STEP 1: Building Engagement and Assessment</b></p> <p>Carry out brief assessment and score questionnaires</p> <p>Provide personalized feedback to the client from the assessment regarding:</p> <ul style="list-style-type: none"> <li>■ Levels of use</li> <li>■ Identify the client’s thoughts and feelings about the personalized assessment feedback</li> <li>■ Potential impact of substance use on mental health</li> </ul> <p>Provide material regarding:</p> <ul style="list-style-type: none"> <li>■ Drug and alcohol use and national patterns/norms</li> <li>■ Impact of alcohol and drug use on mental health, functioning, and relapse</li> </ul>	<ul style="list-style-type: none"> <li>■ Engagement and building rapport</li> <li>■ Gathering information about client’s substance use to build awareness about its impact</li> <li>■ Ensuring awareness of the impact of substance use on mental health</li> <li>■ Identifying issues for next session(s)</li> </ul>
<p><b>STEP 2: Making Decisions with Your Client</b></p> <ul style="list-style-type: none"> <li>■ Identify benefits and costs of using for the present and future, and which of these are most important to the client</li> <li>■ Identify positive/mis-held thoughts and beliefs about substance use that promote or maintain use</li> <li>■ Identify positive/mis-held thoughts and beliefs about mental health and how it interacts with substance use</li> <li>■ Begin to discuss how mental health problems and substance use may interact and worsen each other</li> <li>■ Draw out a maintaining cycle of the triggers for drug/alcohol use and the impact of substance use on mental health and functioning</li> <li>■ Identify self-motivational statements of concern and intent to change</li> </ul>	<ul style="list-style-type: none"> <li>■ Engagement and building rapport</li> <li>■ Being able to talk openly about costs and benefits of using</li> <li>■ Building recognition of how positive/mis-held beliefs may promote use</li> <li>■ Recognizing maintenance cycle for mental health problems and substance use</li> <li>■ Being able to state concerns about continued use and state intent to change</li> </ul>
<p><b>STEP 3: Change Plans and Social Support</b></p> <p>Developing a change plan:</p> <ul style="list-style-type: none"> <li>■ Identify a realistic substance-related goal and/or personal goal that cutting down or quitting would help the client achieve</li> <li>■ Look at motivation to change substance use and achieve the goal</li> <li>■ Identify how “important” changing is and how “confident” the client feels about making changes</li> <li>■ Develop an action plan</li> <li>■ Identify skills to cope with cravings, urges, and triggers for use</li> </ul> <p>Social support for change:</p> <ul style="list-style-type: none"> <li>■ Identify social supports that can encourage attempts to change substance misuse</li> <li>■ Draw social network diagram</li> </ul>	<ul style="list-style-type: none"> <li>■ Helping to feel that change is possible</li> <li>■ Identifying potential setbacks (e.g., cravings/urges and social network)</li> <li>■ Being able to use skills to cope with setbacks including cravings, urges, and triggers for use</li> <li>■ Providing social support for change</li> </ul>

**Box 1.1** In Between Sessions

After the second session, encourage participants to:

1. Access websites offering information about alcohol (e.g., “Down your Drink”) and drugs (e.g., “Talk to Frank”) in between each session
2. Read specific psychoeducational information regarding alcohol and drug use and their impacts

**Table 1.2** Booster Session Content.

<i>Session Content</i>	<i>Session Goals</i>
<b>Boosting Change</b> <ul style="list-style-type: none"> <li>■ Review self-motivational statements of concern and intent to change</li> <li>■ Review action plan</li> <li>■ Review social support for change and introduce to community-based treatment</li> </ul>	<ul style="list-style-type: none"> <li>■ Consolidating motivation and transfer skills from BIM1 to the community</li> <li>■ Reviewing progress with substance-related goal and skills to tackle setbacks</li> <li>■ Linking client with community-based substance misuse treatment</li> </ul>

engage clients in the step suitable for them, so that they can meaningfully talk about and re-evaluate their alcohol or drug use (see Box 1.1, page 7, for an overview of how to decide which step is best suited). If necessary, and if the setting allows, a “booster session” (see Table 1.2) can be offered 1 month after the last session to help consolidate motivation and ensure that clients have the skills and strategies necessary to access longer-term help to address their substance use. It is important, if possible, to provide continuity of care—for example, if the client is an inpatient, liaising with the community team concerning the progress that the client has made during BIM1. This process would be facilitated by having a planning meeting with the client and the clinician from the community services team to discuss the work, the client’s goals, and strategies to translate gains to a community setting.

# Getting Started: Engagement and Brief Assessment

## ▶ Staying Motivated

To successfully work with a client, and not become discouraged and despondent when he or she initially engages but the next time says “I am not interested,” it may be necessary for you to take a step back and perhaps remind yourself of how long it may have taken you to change a “habit” in your own life. There is a need to take into account a number of factors that will influence how BIMi progresses and what is seen as a “successful” result. These include reminding yourself that “ambivalence” is a normal part of the change process, and that change usually occurs over time. Also, the client may not have come into treatment or hospital willingly this time or in the past, and hence may be quite angry about mental health services or being in hospital—and yet, however, may welcome having an opportunity to talk to someone. Therefore, keep an open, non-judgmental, and reflective style; remain optimistic; and take a long-term perspective.

During your initial session with the client, you can use the brief assessment to engage the client in talking openly about drug and alcohol use, mental health, and general well-being. It is

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possible that he or she has not really had a chance to sit back and talk about the role of alcohol or drug use in poor mental health and/or hospital admissions. During this hospital admission or period, with time on their hands, it may be an opportunity for clients to reflect and develop greater awareness.

Your aim:

- Build a good working relationship with the client
- Increase the client's awareness about the impact of alcohol and drugs
- Introduce the client to the idea that change is possible

## ▶ STEP 1: Building Engagement and Assessment

### *Session Content*

### *Session Goals*

#### **STEP 1: Building Engagement and Assessment**

Carry out brief assessment and score questionnaires

Provide personalized feedback to the client from the assessment regarding:

- Levels of use
- Identify the client's thoughts about the feedback
- Potential impact of substance use on mental health

Provide material regarding:

- Drug and alcohol use and national patterns/norms
- Impact on mental health, functioning, and relapse

- Engagement and building rapport
- Gathering information about the client's use, to build awareness of the impact of substance use
- Building awareness of the impact of substance use on mental health
- Identifying issues for next session(s)

The assessment completed as part of BIMBI is intended to be completed within the context of the broader clinical and risk assessments, and information gathering completed as part of the psychiatric inpatient admission or mental health treatment care plan. The core elements of the brief assessment do not therefore include the completion of a semi-structured clinical interview; instead, they focus in the first session on the completion of questionnaires by the client and, in the second session, the feedback of these results to the client.

## ► Session One Overview

The first session of BIMI is a vital session. This initial meeting represents the first time you and the client will have met specifically for the purpose of *talking openly about alcohol and drug use and building motivation to change substance misuse*. You may have already been working with this client as part of his or her treatment, and so it is important to ensure that BIMI sessions are seen differently and represent “protected” time for you and the client. In the first session of BIMI, when you are completing the relevant questionnaires on the BIMI Brief Assessment Sheet, it is an important opportunity to build a good collaborative working relationship with the client. Following this, the questionnaires are scored, and then personalized feedback developed. The second session then focuses on sharing the *personalized Assessment Feedback Sheet*, called “Your Results,” with the client and leaving him or her with a copy of it.

The initial session aims:

- To develop a non-judgmental, working relationship where the client feels that he or she can talk openly with you about his or her alcohol and drug use
- Complete the questionnaires that are relevant to the client and develop personalized assessment feedback

## ► Session One Outline

Remember, for this session you will need:

- The BIMI Brief Assessment Sheet to complete with the client

Start by introducing yourself and explaining what BIMI is about. You can use a statement such as the example given in the following text and adapt it according to the setting and client.

- The time people spend in hospital (*or* when they start to feel unwell) can be a time when they think about their lives, including about the use of drugs and alcohol. Our aim is to

help support people to do this and to help them explore how drug and alcohol use may have played an important part in their being admitted to a hospital (*or* them feeling unwell).

- *Why have you been chosen?* We want to invite people who are on inpatient units (*or* are experiencing mental health problems) and who have used alcohol or drugs to have an opportunity to talk.
- *What will it involve?* We will meet for about three to six brief meetings (each will last about 15–30 minutes). This first meeting will involve some questionnaires about how you are feeling and about drugs and alcohol, and hence may take a little longer. Next time we meet, we will look together at all of this information, and you can talk about how you feel and about your drug and alcohol use. If you start to feel uncomfortable and decide that you no longer want to talk about this, we can stop, and it will not affect the care you receive.
- Let us start by talking about alcohol and drug use...

At this point, you will need to systematically take the client through the BIMBI Brief Assessment Sheet (you can find a copy of it on pages 15–19; all the questionnaires included in it are described in the next section titled “BIMI Brief Assessment” on pages 15–19). This information is designed to be collected from the client *using a conversational style*. Completion of this assessment measure will take approximately 30–40 minutes. It is important that you adopt an open, non-judgmental approach while collecting this information about the client’s alcohol and drug use. Remember not to express shock or surprise; your aim is simply to develop a non-judgmental working relationship where the client feels able to talk openly and honestly about his or her alcohol and drug use. If you are not familiar with the drugs the client is using or how he or she uses them, invite him or her to describe the drugs and tell you about them. This will serve to engage the client in a collaborative working relationship with you. If you are certain that the client is using other substances but has not reported it, focus on what he or she is willing to talk about at this stage. The client may feel comfortable to bring it up at a later stage. Remember when you are completing the BIMBI Brief Assessment to turn the worksheet to the client, so that he or she can see it and the information is gathered collaboratively. Ensuring the client feels involved in the process will serve to aide engagement and help them recognize their expertise in their own experience.



### **BIMI Brief Assessment**

The questionnaires included in the BIMI Brief Assessment in Session One are fairly short, easy to complete, and based on the substances the client reports using. The structure for the BIMI Brief Assessment is provided in Table 2.1 (pages 15–19). The important areas covered and information on how to score the questionnaires included in the BIMI Brief Assessment are outlined here. These questionnaires are included as they are quick to complete (takes about 30 minutes), easy to use, and readily available.

#### **■ To measure what and how much the client is currently using**

A useful questionnaire that can be used here is based on Part B of the *Maudsley Addiction Profile (MAP)* (Marsden et al., 1998). The aim here is to systematically take the client through each substance in turn, asking all the questions about alcohol first before moving to the next substance. This will allow you to build a picture of the client's use of each substance and engage the client in feeling comfortable talking to you about it. When you have finished gathering information about each substance, ask the client to identify which substance is the *main* one he or she uses.

#### **■ To measure the severity of the client's substance use**

*Alcohol:* If the client reported using alcohol, a useful questionnaire to measure the severity and impact of alcohol use is the *Alcohol Use Disorders Identification Test*, commonly referred to as "AUDIT." It is well established and was developed by the World Health Organization (Saunders, Aasland, Babor, Fuente & Grant, 1993). It has 10 questions, with each item scored on a scale of 0–4. Total possible scores range from 0 to 40. A score of 8 or more is suggested to indicate a strong likelihood of "hazardous/harmful" alcohol use. Take the client through each of the 10 questions in turn.

*To score it:* Add up the scores from each of the 10 questions to give you the total score. Based on the total score:

Did your client score 8 or more?

This is associated with *harmful* or *hazardous drinking*.

Did your client score 13 or more?

Scores of 13 or more in women and 15 or more in men are likely to indicate *alcohol dependence*.

*Drugs:* If the client reported using drugs, a useful questionnaire to measure the severity and impact of drug use is the *Severity of Dependence Scale* (SDS) (Gossop et al., 1995). It can be used for various drugs and has five questions on a four-point scale that ranges from 0 (never/almost never) to 3 (always/nearly always). Total possible scores range from 0 to 15; a score of 4 or more is suggested to be indicative of *dependency*. If the client identified a drug as his or her *main* substance, take him or her through each of the five questions, inserting the name of the *main* substance.

*To score it:* Add up the scores from each of the five questions to give you the total score. Based on the total score:

Did your client score 4 or more?

This is said to suggest *dependency*.

#### ■ To measure motivation

A simple way to measure motivation is to use the “Importance–Confidence Ruler.” The Importance–Confidence Ruler is a global assessment of the level of motivation and confidence to change, and it assesses two concepts suggested to underpin readiness to change (Rollnick, Butler & Stott, 1997). Using the scale of 0–10, ask the client to (1) rate the importance of making a change to his or her *main* substance use, and to (2) rate how confident he or she feels about making a change in the use of his or her *main* substance.

*To score it:* Ask your client to rate, on a scale of 0–10, how important it is to change the use of the specified substance, and to rate, on a scale of 0–10, how confident they are that they would succeed. Based on the rating they provide, this roughly indicates his or her perceived level of importance and confidence.

#### ■ To measure mental health

Two useful questionnaires that are quick and freely available to download and measure mental health problems that the client might be experiencing are the nine-item version of the *Patient Health Questionnaire* (PHQ-9) and seven-item version of the

*Generalized Anxiety Disorder (GAD-7)*. They assess depression and anxiety, respectively, and are well established and validated questionnaires (Kroenke, Spitzer & Williams, 2001; Spitzer, Kroenke, Williams & Löwe, 2006). The measures can be downloaded from: [www.phqscreeners.com](http://www.phqscreeners.com). Information about them and how to score them can be found at: [www.phqscreeners.com/instructions/instructions.pdf](http://www.phqscreeners.com/instructions/instructions.pdf).

*PHQ-9: To assess the severity of depression*, there are nine questions, with the scores for each ranging from 0 (not at all) to 3 (nearly every day).

*To score it:* The score from each question is added together to give the total score, which can range from 0 to 27.

Did your client score 5?

This represents the cut-off point for *mild depression*.

Did your client score 10?

This represents the cut-off point for *moderate depression*.

Did your client score 15?

This represents the cut-off point for *moderately severe depression*.

Did your client score 20?

This represents the cut-off point for *severe depression*.

*GAD-7: To assess the severity of anxiety*, there are seven questions, and the scores for each range from 0 (not at all) to 3 (nearly every day).

*To score it:* The score from each question is added together to give the total score, which can range from 0 to 21.

Did your client score 5?

This represents the cut-off point for *mild anxiety*.

Did your client score 10?

This represents the cut-off point for *moderate anxiety*.

Did your client score 15?

This represents the cut-off point for *severe anxiety*.

**Table 2.1** BIMl Brief Assessment Sheet.

	<i>Alcohol</i>	<i>Cannabis</i>	<i>Crack Cocaine</i>	<i>Cocaine Powder</i>	<i>Legal Highs</i>	<i>Heroin</i>	<i>Illicit Methadone</i>	<i>Amphetamine</i>	<i>Other</i>
Have you used this in the past 30 days?									
When did you last use this?									
What is the amount you use on a typical day?									
How much do you spend on this on a typical day?									
What route? Oral Smoke/ Chase Snort/Sniff Intravenous									
During a typical week how frequently would you use this?									
How old were you when you first used this?									
Which substance is the <i>main</i> one you use?									

Source: Drug and alcohol use in the past 30 days (based on MAP, Marsden et al., 1998)

## AUDIT

Questions	Scoring System					Your Score
	0	1	2	3	4	
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2 How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
3 How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4 How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5 How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6 How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9 Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10 Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Source: Saunders et al., 1993

**Severity of Dependence Scale** (Gossop et al., 1995)

Tell your client: "Please think of your use of \_\_\_\_\_ during a recent period of using when you answer these questions."

---

**1. Did you think that your use of \_\_\_\_\_ was out of control?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**2. Did the prospect of missing a fix (or dose), make you anxious or worried?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**3. Did you worry about your use of \_\_\_\_\_?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**4. Did you wish you could stop?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**5. How difficult did you find it to stop or go without \_\_\_\_\_?**

0. Not difficult       1. Quite difficult       2. Very difficult       3. Impossible
- 

**IMPORTANCE-CONFIDENCE RULER**

*Ask your client:* On a scale of 0-10, how important is it right now for you to change your use of \_\_\_\_\_ [insert name of substance]?

Importance: 0 \_\_\_\_\_ 10

On a scale of 0-10, if you decide to change, how confident are you that you would succeed?

Confidence: 0 \_\_\_\_\_ 10

**MOOD****PHQ-9**Name Crystal M

Date \_\_\_\_\_

Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Having thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: total score \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score \_\_\_\_\_ = Add Columns \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

The PHQ-9 and GAD-7 questionnaires have been developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Using the illustrative case examples of Sam, Sebastian, and Crystal, you will gain a sense of how to take clients through the *BIMI Brief Assessment* (see pages 26–28, Table 2.2 for their completed assessments).

*Case example: Sam*

Sam is a 33-year-old man who has been admitted to an acute mental health inpatient ward for the past 2 weeks. He has been diagnosed as experiencing schizophrenia for the past 10 years. He has been detained in hospital for assessment and treatment as he was becoming increasingly anxious and paranoid and could not keep himself safe prior to being admitted. He had also stopped taking his medication, as he worries that it



makes him put on a lot of weight and he does not believe it helps him. He has been quite withdrawn and depressed in mood since coming to the hospital. Sam has said that, before coming to the hospital, smoking cannabis was the only thing that interested him, and that he has smoked it since he was 15 years of age.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “have you used *alcohol* in the past 30 days?”

As Sam has reported no alcohol use, you would need to move onto the next substance listed in the BIMBI Brief Assessment, which is cannabis.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “have you used *cannabis* in the past 30 days?”
- “Can you remember when you last used?”
- Thinking about your use in general, “What is the amount you use on a typical day?”
- And “How much do you spend on a typical day?”
- “How do you usually take *cannabis*?”
- And “During a typical week how frequently would you use *cannabis*?”
- Thinking about how long you have used, “How old were you when you first used *cannabis*?”
- And “Is this *cannabis* the main substance you use?”

You would then need to ask the client if he or she has used any of the other drugs. Go through asking if he or she has used each drug in turn, as it may be that the client initially may say he or she is only using one substance but as the client begins to relax and engage with you during the assessment he or she may feel more able to be open about other substances used. So, using the case of Sam, you would ask:

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *crack cocaine* in the past 30 days?”

Sam reports no *crack cocaine* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *cocaine powder* in the past 30 days?”

Sam reports no *cocaine powder* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *legal highs* in the past 30 days?”

Sam reports no *legal high* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *heroin* in the past 30 days?”

Sam reports no *heroin* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *illicit methadone* in the past 30 days?”

Sam reports no *illicit methadone* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *amphetamine* in the past 30 days?”

Sam reports no *amphetamine* use in the past 30 days, so you move onto asking about the next substance.

- So Sam, if we think about the past month, and particularly the weeks just before you came into hospital, “Have you used *any other substance/drug* in the past 30 days?”

Sam reports no *other substance/drug* use in the past 30 days, so you move onto the next questionnaire.

You will now need to complete either the AUDIT or SDS questionnaire with the client, depending on what the client reports as the substance that he or she uses. If the client reports that he or she uses *alcohol*, then you complete AUDIT; if the client reports that he or she uses drugs, you will need to complete *SDS* next. For SDS, insert the name of the main drug the client reports using in the assessment worksheet. So, in the case of Sam, he reports that *cannabis* is the main substance he uses, so SDS is completed for cannabis. Remember to turn the BIMBI Brief Assessment worksheet to the client, so that he or she can see it.

- Thank you Sam, for starting to talk with me about the substance(s) you have used. Thinking a bit more about your use of cannabis ... “Please think of your use of cannabis during a recent period of using when you answer these questions.” Answer using one of the responses listed here: “never/almost never”; “sometimes”; “often”; and “always/nearly always.”
- So, thinking about a recent period of using, “did you think that your use of cannabis was out of control?”
- And “did the prospect of missing a fix make you feel anxious or worried?”
- At that time, “did you worry about your use of cannabis?”
- And “did you wish you could stop?” Leading on from this, “how difficult did you find it to stop or go without cannabis?”
- Thank you for answering these questions Sam, we have three more to complete, and the next one has just two questions.
- The first question is, “On a scale of 0–10, how important is it right now for you to change your use of cannabis?”
- And, should you decide to make a change, on a scale of 0–10, if you decide to change, how confident are you that you would succeed?
- The final area that would be important for us to think about are how you have been feeling over the past 2 weeks. Similar to the questionnaire we did earlier, there are responses to use when you are answering these questions; please have a look at these responses and choose one that best fits with how you have been feeling. So, “Over the *last 2 weeks*, how often have you been bothered by any of the following problems?”

- The first one is “Little interest or pleasure in doing things” and the next “Feeling down, depressed, or hopeless.”
- In the last 2 weeks, have you had “Trouble falling or staying asleep, or sleeping too much,” or with “Feeling tired or having little energy”?
- Have you, found over the last 2 weeks you have experienced “Poor appetite or overeating” or found that you were “Feeling bad about yourself” or that “you are a failure or have let yourself or your family down”?
- Did you have “Trouble concentrating on things, such as reading the newspaper or watching television,” or were you “Moving or speaking so slowly that other people could have noticed”? Or the opposite—“Being so fidgety or restless that you have been moving around a lot more than usual”?
- Finally, during the last 2 weeks, have you had “Thoughts that you would be better off dead or of hurting yourself in some way”?

It would be essential, if the client reported any risk or endorsed question nine on the PHQ-9, that a full risk assessment and risk management plan be implemented in line with your service guidelines.

If the client indicates that he or she experienced any problems on the PHQ-9 questionnaire, then you will need to ask him or her to answer an additional question.

- “If you checked off *any* problems,” we then need to think about “how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?”
- Using the responses here (i.e., “not difficult at all”; “Somewhat difficult”; “very difficult”; and “extremely difficult”), which one represents how you feel?
- We are now on the last questionnaire. This one is quite similar to the one we have just done in the way it is set out, so I would like you to again think “over the past 2 weeks, how often have you been bothered by the following problems?” Use the responses written here to reply.
- So, over the last 2 weeks, have you been “feeling nervous, anxious, or on edge”?

- or found yourself “not being able to stop or control worrying”
- Did you find you were “worrying too much about different things”
- Did you have “trouble relaxing”
- Did you find yourself “being so restless that it is hard to sit still”
- Over the last 2 weeks, did you find you were “becoming easily annoyed or irritable” or “feeling afraid as if something awful might happen”
- Finally, as we did for the last questionnaire: “if you have checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people” Let’s use the rating scale shown to think about this.

*Case example: Sebastian*

Sebastian is a 49-year-old man who has described feeling anxious and very low in mood, and is being seen at home by community mental health services. He describes finding it difficult to leave his house because of these problems over the past 2 weeks. He has been diagnosed as experiencing bipolar affective disorder since he was 28 years of age. He usually takes his medication regularly but sometimes forgets. There are a number of empty alcohol cans around his home, and he regularly smells of alcohol.

Using the illustrative case example of Sebastian, the BIMi Brief Assessment would be completed in the same way with Sebastian as it was with Sam; however, Sebastian only reports *alcohol* use, and, since this is his main substance, you would complete AUDIT, which focuses on his use of alcohol, *rather than* completing SDS. To complete AUDIT, you would read the statements exactly and record Sebastian’s answers. Begin AUDIT by saying:

- “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.”

Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc., and then carry on through each of the AUDIT questions. For example:

- So Sebastian, thinking about your use of *alcohol*; “Now I am going to ask you some questions about your use of

alcoholic beverages during this past year”; when I say alcoholic beverages I mean, for example, “beer, wine, or vodka.” The instructions for this questionnaire say I need to read these questions exactly, so here we go.

You would then proceed with completing the remaining questionnaires in the BIMI Brief Assessment—that is, the *Importance–Confidence Ruler*; *PHQ-9*; and *GAD-7*—as outlined in the case of Sam.

*Case example: Crystal*

Crystal is a 27-year-old woman who has been admitted to an acute mental health inpatient ward for the past 2 weeks. She has been diagnosed as experiencing paranoid psychosis. She voluntarily agreed to stay in hospital for assessment and treatment as she was becoming increasingly anxious and paranoid prior to being admitted. Crystal has said that she drinks alcohol and smokes cannabis. You are also aware, from the information recorded in her case notes, that she uses crack cocaine, but she does not initially report this to you.

Using the illustrative case example of Crystal, you would complete the BIMI Brief Assessment with Crystal in the same way as you would with both Sam and Sebastian, as outlined in the preceding text. Starting with the MAP, you would go through asking her if she has used each substance listed *in turn*. As you go through this with Crystal, she initially reports that she is only using *alcohol* and *cannabis*. At this stage, Crystal reports no crack cocaine use. In this case, it would be important to carry on with asking about the other substances in a non-judgmental manner, without telling her that you know from her clinical notes that she has used crack cocaine. It may be the case that the client may report this at a later stage when he or she feels ready to. In this case scenario, as Crystal begins to relax and engage, you notice that she starts to become more open about her substance use and mentions that she has used crack cocaine in the past. At this stage, you would ask:

- So Crystal, if we think about the past month, and particularly the weeks just before you came into hospital, “have you used crack cocaine in the past 30 days?”

This invites Crystal to revisit the question concerning crack cocaine at a different stage in the meeting. In the case example, Crystal reports her crack cocaine use, and says it is the main substance she uses. This information is then recorded, and both the SDS and AUDIT questionnaires are completed as Crystal reports she is using both drugs and alcohol. When working with Crystal as a poly-substance user, it is important to be specific when completing SDS about which substance is being considered. This would be completed for the *main* substance, since this will be the focus of the information within the assessment feedback. The remaining questionnaires on the BIMI Brief Assessment Sheet would then be completed as outlined in the cases of Sam and Sebastian.

**Table 2.2** BIMI Brief Assessment—Case Example Crystal.

	Alcohol	Cannabis	Crack Cocaine	Cocaine Powder	Legal Highs	Illicit Heroin	Methadone	Amphetamine	Other
<b>Have you used this in the past 30 days?</b>	Yes	Yes	Yes	No	No	No	No	No	No
<b>When did you last use this?</b>	2 weeks ago	2 weeks ago	2 weeks ago						
<b>What is the amount you use on a typical day?</b>	Two cans	About two spliffs	Not every day (£55 each time)						
<b>How much do you spend on this on a typical day?</b>	£2	I spend about £1.25 (£10 per week)	About £55 each time						
<b>What route?</b> Oral Smoke/Chase Snort/Sniff Intravenous	Oral	Smoke	Smoke						
<b>During a typical week, how frequently would you use this?</b>	3 days a week	Every day	About 2 times						
<b>How old were you when you first used this?</b>	13 years old	15 years old	25 years old						
<b>Which substance is the <i>main</i> one you use?</b>			Crack						

Source: Drug and alcohol use in the past 30 days (based on MAP, Marsden et al., 1998)

## AUDIT

Questions	Scoring System					Your Score
	0	1	2	3	4	
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times per month	2–3 times per week	4+ times per week	<b>3</b>
2 How many units of alcohol do you drink on a typical day when you are drinking?	1–2	3–4	5–6	7–8	10+	<b>1</b>
3 How often have you had six or more units if female, or eight or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>1</b>
4 How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>1</b>
5 How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>0</b>
6 How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>0</b>
7 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>0</b>
8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	<b>0</b>
9 Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	<b>0</b>
10 Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	<b>0</b>

Source: Saunders et al., 1993



**SDS**

Tell your client: "Please think of your use of CRACK during a recent period of using when you answer these questions."

---

**1. Did you think that your use of CRACK was out of control?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**2. Did the prospect of missing a fix (or dose), make you anxious or worried?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**3. Did you worry about your use of CRACK?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**4. Did you wish you could stop?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**5. How difficult did you find it to stop or go without CRACK?**

0. Not difficult       1. Quite difficult       2. Very difficult       3. Impossible
- 

Source: Gossop et al., 1995

**IMPORTANCE-CONFIDENCE RULER**

*Ask your client:* On a scale of 0–10, how important is it right now for you to change your use of \_\_\_\_\_ [insert name of substance]?

Importance: 0 \_\_\_\_\_ 5 \_\_\_\_\_ 10

On a scale of 0–10, if you decide to change, how confident are you that you would succeed?

Confidence: 0 \_\_\_\_\_ 2 \_\_\_\_\_ 10

**MOOD  
PHQ-9**

Name Crystal M Date \_\_\_\_\_

Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	<b>3</b>
2. Feeling down, depressed, or hopeless	0	1	2	<b>3</b>
3. Trouble falling or staying asleep, or sleeping too much	0	1	<b>2</b>	3
4. Feeling tired or having little energy	0	1	2	<b>3</b>
5. Poor appetite or overeating	0	<b>1</b>	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	<b>2</b>	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	<b>1</b>	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	<b>1</b>	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<b>0</b>	1	2	3

(For office coding: total score **15** = **4** + **2** + **9**)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score \_\_\_\_\_ = Add Columns \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Not difficult at all     | Somewhat difficult       | Very difficult           | Extremely difficult      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Crystal's score: TOTAL SCORE = 1 + 6 + 12 = 19**

During and after completing the BIMi Brief Assessment, it is important to encourage the client to keep going and acknowledge that the client has worked hard to do this. It may help to remind the client that the information he or she provides will be very helpful, as the results of the assessment will be fed back to him or her the next time you meet. Once you have completed the BIMi Brief Assessment, encourage the client to reflect on the topics covered and how they feel, for example, as shown in the following text.

- Today, we have talked about your substance use and about how you have been feeling, and we have completed a few questionnaires. What did you think about the questionnaires and what they covered?
- Were you surprised by any of the questions? If so, why?

- How have you felt about spending time thinking about you use of \_\_\_\_\_ [insert substance]?
- How are you feeling after having completed the questionnaires?
- Do you have any questions?
- When we meet the next time, I shall give you some feedback on “Your Results,” and we can think about any questions that you might have and information that you might find useful.
- Let us make time to meet again.

At the end of Session One, you will need to finalize the date for the next session with the client.

So, remember:

- When completing the BIMI Brief Assessment with your client, it is important to focus both on engaging the client in the process and on following the guidelines for the completion of the questionnaires (i.e., using the exact wording) on the BIMI Brief Assessment Sheet.
- After completing the BIMI Brief Assessment Sheet, spend time discussing with your client how they found this process and how they are feeling.
- Ensure your client knows that, having invested time in completing the questionnaires, you will discuss the result with him or her the next time you meet.
- If the client reports any risk or endorses question 9 of the PHQ-9, ensure that a full risk assessment and risk management plan be implemented in line with your service guidelines.

### ***Generating the Personalized Assessment Feedback Sheet***

Once you have completed Session One and the questionnaires with the client, score the questionnaires according to the scoring guidelines detailed in the BIMI Brief Assessment section (pages 15–19), and then insert these details into the relevant

sections of the assessment feedback sheet template provided (see Table 2.1, pages 15–19). The illustrative case examples of Sam, Sebastian, and Crystal (given in Table 2.2) illustrate how this can be done.

*Assessment Feedback Sheet, part 1*

In this section, insert the relevant information, obtained from completing the MAP (part B), for each substance used. Indicate in this section how much the client is using per day. For alcohol use, you can include here the units of alcohol. If the client is using alcohol, you will need to work out how many units this equates to by using a units calculator. The units and calories calculator on the Drinkaware website is easy and straightforward to use ([www.drinkaware.co.uk/tips-and-tools/drink-diary](http://www.drinkaware.co.uk/tips-and-tools/drink-diary)). In the “Amount spent” box, include how much money the client’s drug and/or alcohol use equates to per week. If the client reports that he or she is not currently using a particular substance, you can indicate this by including the term “not used.” For alcohol users, you will note that the current “Lower risk guidelines” are already included in the template. There is a box in this section to include the score obtained from AUDIT for alcohol use, and SDS for drug use.

*Assessment Feedback Sheet, part 2*

In this section, alcohol and drug use is explained in words and compared to rates of use in the general population. Information from the measures of mental health and motivation to change are also included. The final section in part 2 of the Assessment Feedback Sheet includes information about the impact of alcohol or drugs on mental health.

## **ALCOHOL OR DRUG USE**

The standard statement included in the provided template that you will need to personalize is:

“You said you were using \_\_\_\_\_ [insert quantity used and frequency of use], which cost about \_\_\_\_\_ [insert financial cost]. When we have a look at the drug/alcohol use across the country for adults, \_\_\_\_\_ [insert relevant

information related to prevalence for relevant country in the general population]. The research suggests that about \_\_\_\_\_ [e.g., insert general population percentage] use more than once a month.”

You then invite the client to reflect on this and discuss it by including statements such as: “What do you make of that information? Is it what you expected, or different from what you expected?”

Following this, a description of what the AUDIT or SDS scores mean, from the scoring guidelines, is included (e.g., in the case of Sebastian, an AUDIT score of 10 equates to the following description: “Your results suggested that your use of alcohol is at a level that is often associated with ‘harmful or hazardous’ drinking”):

“Your results suggested that your use of \_\_\_\_\_ [insert name of substance] is at a level that is often associated with \_\_\_\_\_ [insert information concerning level of use from AUDIT/SDS].”

You then invite the patient to reflect on this and discuss it by including statements such as:

“What do you make of this result?”

## MOTIVATION TO CHANGE

The standard statement included in the provided template that you will need to personalize is:

“Your results suggest that you felt it was \_\_\_\_\_ [insert statement based on the rating on the importance scale], but also felt that you were \_\_\_\_\_ [insert statement based on the rating on the confidence scale] confident that you could make a change in your \_\_\_\_\_ [insert name of substance] used if you decided you wanted to.”

You then invite the patient to reflect on this and discuss it by including a statement such as:

“Is this still the case?”

## YOUR MOOD

The standard statement included in the provided template, that you will need to personalize is:

“Your scores suggested that, at that time, you were feeling \_\_\_\_\_ [insert statement from anxiety scores] and \_\_\_\_\_ [insert statement from depression scores] in mood.”

## WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF \_\_\_\_\_ [insert name of substance] USE ON MENTAL HEALTH

The standard statement included in the provided template that you will need to personalize is:

“One of the leaflets from \_\_\_\_\_ [insert name of the website—e.g., Talk to Frank or Drinkaware] says that \_\_\_\_\_ [insert relevant information about the effect of that substance on mental health].”

It is vital, in this final section of part 2 of the Assessment Feedback Sheet, that some information be provided concerning what the current evidence suggests about the impact of the substance being used on mental health. This allows the relationship between mental health and substance use to be explored in light of the client’s personalized information. In the illustrative case examples, you can see how this can be done. It is important when drawing together this information that you use recognized and reliable websites to obtain this to gather it and that the information be up to date and relevant. The websites used to obtain the information in the case examples above were Talk to Frank ([www.talktofrank.com](http://www.talktofrank.com)) and Drinkaware ([www.drinkaware.co.uk](http://www.drinkaware.co.uk)).

<b>YOUR RESULTS</b>					
Diagnosis: _____		Substance of choice: _____			
<b>Part 1</b> ALCOHOL		<b>DRUGS</b>			
Alcohol	Your current use			United Kingdom (%)	Lower risk guideline
Per day					Females: 2–3 Males: 3–4
Per week					
Amount spent (£)					
AUDIT score					
Impact of alcohol at current pattern of use: _____					
<b>Part 2</b>					
<p>_____ [insert name of substance] USE: You said you were using _____ [insert quantity used and frequency of use], which costs about _____ [insert financial cost]. When we have a look at the drug/alcohol use across the country for adults, _____ [insert relevant information related to prevalence for relevant country in the general population]. The research suggests that about [e.g., insert general population percentage] _____ use more than once a month.</p> <p>What do you make of that information? Is it what you expected, or different from what you expected?</p> <p>Your results suggested that your use of _____ [insert name of substance] is at a level that is often associated with _____ [insert information concerning level of use from AUDIT/SDS].</p> <p>What do you make of this result?</p>					
<p><b>MOTIVATION TO CHANGE:</b> Your results suggest that you felt it was _____ [insert statement based on the rating on the importance scale], but also felt that you were _____ [insert statement based on the rating on the confidence scale] confident that you could make a change in your _____ [insert name of substance] if you decided you wanted to.</p> <p>Is this still the case?</p> <p><b>YOUR MOOD:</b> Your scores suggested that, at that time, you were feeling _____ [insert statement from anxiety scores] and _____ [insert statement from depression scores] in mood.</p> <p><b>WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF _____ [insert name of substance] ON MENTAL HEALTH</b></p> <p>One of the leaflets from the _____ [insert name of the website—i.e., Talk to Frank or Drinkaware] says that _____ [insert relevant information for the substance].</p> <p>We could look at information related to this together next time we meet; what do you think?</p> <p>For more information, you can look on the website _____ [insert name of the website—i.e., Talk to Frank or Drinkaware].</p>					



## ▶ Session Two Overview

You start this process by providing the client with feedback from the questionnaires you completed with him or her in the first session, in an open, non-judgmental way. The feedback is presented in the Assessment Feedback Sheet, called “Your Results” (see illustrative examples in Figure 2.1), and this allows the client to think about his or her use in relation to how other people across the country use and to think about the impact of his or her use.

The client will probably have many questions about the feedback, and so responses to some of these questions are provided in the clients’ Assessment Feedback Sheet. Further information can be found in psychoeducational leaflets, and in the “Frequently Asked Questions” section on page 42. It would be useful if the client is encouraged to read some tailored psychoeducational information that you will provide and/or access Internet resources to help answer any questions they may have after Session Two. A list of some useful websites is included on page 52).

## ▶ Session Two Outline

Remember, for this session you will need:

- The “Your Results” Assessment Feedback Sheet completed with the client’s information
- Some leaflets or psychoeducational information specifically related to the client’s substance use and mental health problems

Session Two initially focuses on discussing with the clients his or her results from the BIMi Brief Assessment. You can start this process by asking the client what he or she thought about the assessment:

- When we first met, we completed a few questionnaires. What did you think about the questionnaires and what they covered?

- Based on the answers you gave when you completed the questionnaires, the results suggest that \_\_\_\_\_.

Take the client through each section of the client's Assessment Feedback Sheet ("Your Results"). At the end of each section, ask the client what his or her thoughts are to encourage the client to reflect on the content and to personally connect with the information. This will help to build awareness of the impact of substance use, and its impact on mental health.

- How do these results fit with how you feel? Is that how you are feeling still?
- Are there any questions you have? Is there any further information you would like?
- I have brought along some leaflets that I thought you might find helpful. There are also some websites on the Internet that you can look at, if you would like to find more information.
- When we meet next time \_\_\_\_\_ [give date of next session], we can talk about what you enjoy about using \_\_\_\_\_ or what keeps you using \_\_\_\_\_ [insert name of substance].

**YOUR RESULTS: Sam**

Diagnosis: *Schizophrenia*

Substance of choice: *Cannabis (skunk)*

Part 1

ALCOHOL

Alcohol	Your current use	United Kingdom (%)	Lower risk guidelines
Per day	None		
Per week			
Amount spent (£)			
AUDIT score			

Impact of alcohol at current pattern of use:

*Not used*

DRUGS

Drug	Your current use (per week)	Amount spent (£) (per week)
Cannabis	2/8	£70
Crack/cocaine		
Ecstasy		
Heroin		
Other		
Total spent (£)	70 (per week)	
Dependence score	3	

Part 2

**CANNABIS USE:** You said you were using about an ounce of skunk a month, which would roughly cost about £280. When we have a look at the drug use across England and Wales (2012–2013) for adults during the previous 12 months, just over 8% had used an illicit drug. Cannabis was the illicit drug most frequently used during the past 12 months, which had been used by under 7% of adults (Home Office, 2013). This report suggests that, when just looking at young adults (age 16–24 years), about 13% had used cannabis during the previous 12 months (Home Office, 2013). What do you make of that information? Is it what you expected, or different from what you expected?

Based on what you said, the results suggest that, due to the level of your use, you could be experiencing some problems related to smoking skunk. Does this fit with what you experience on a daily basis?

**MOTIVATION TO CHANGE:** Your results suggest that you felt it was very important to change (rating 10), the highest point of the scale, but also felt you were not confident that you could make a change in your skunk use if you decided you wanted to (rating 0).

Your results suggest that you were not dependent on skunk, but that it could be causing you some problems. Does that fit with how you feel now?

**YOUR VIEW OF YOUR MENTAL HEALTH/MOOD:** Your scores suggest that, at that time, you were feeling a bit anxious and really low in mood. This perhaps reflects what you said at the start of our meeting today.

**WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF CANNABIS ON MENTAL HEALTH**

One of the Frank (2011) website says that using cannabis “regularly and for a long time” can lead to a greater risk of experiencing anxiety, depression, and paranoia, and put you at risk of experiencing “psychotic symptoms” and of developing mental health problems—for example, schizophrenia. The leaflet says that, for people who already experience mental health problems, cannabis might cause a relapse of symptoms. It suggests that regular use of cannabis “for a long time” can make it difficult for you to concentrate, that you can lose your motivation, and that it can also affect your physical health. Would you like to know more about the impact on your physical health? To sum up, the leaflet suggests that the biggest risks from cannabis seem to be related to using it “regularly and for a long time,” and that these risks could be greater if you are “young, you smoke a lot and you smoke strong cannabis, like skunk.”

We could look together at information related to this the next time we meet. What do you think? For more information, you can look on the website ([www.talktofrank.com](http://www.talktofrank.com)).

**YOUR RESULTS: Sebastian**

Diagnosis: *Bipolar affective disorder*

Substance of choice: *Alcohol*

Part 1  
ALCOHOL

Alcohol	Your current use	Lower risk guidelines
Per day	12 units	Males: 3-4
Per week	84 units	
Amount spent (£)	35	
AUDIT score	10	

DRUG

Drug	Your current use (per week)	Amount spent (£) (per week)
Cannabis	None	
Crack/cocaine	None	
Ecstasy	None	
Heroin	None	
Other	None	
Total spent (£)	None	
Dependence score		

Part 2

ALCOHOL USE: You said that you were using about six cans of 4% lager a day, costing £5, which means if you drank this amount over a week you would have drunk about 42 cans of lager and spend about £35. When we look at this as units of alcohol, this converts to 12 units a day and about 84 units a week.

Do you know what a unit of alcohol is? Shall we look at some information about this first? If we look at the preceding table, we can see the government “lower risk guidelines” for alcohol in units. Drinkaware outline the current UK government lower risk guidelines for men as not regularly having over 3-4 units of alcohol a day; women are recommended to have no more than 2-3 units of alcohol a day regularly (Drinkaware, 2015a). When we look at the numbers of people in the country using alcohol, in England about a quarter of men said “in an average week” they drank over 21 units, and less than a quarter of women described drinking over 14 units “in an average week.” The average number of units they were having in a week was about 16 units for men and eight units for women. A big study in America found that about a third of people who had experienced schizophrenia had used alcohol and gotten into some problems with it in their life time.

In the United Kingdom, the NHS describes “binge drinking” as having eight or more units of alcohol in a single session for men and six or more units for women. However, this definition may not apply to everyone as people vary. Would you like to know more about different patterns of alcohol use? Binge drinking usually involves drinking a large quantity of alcohol in a short space of time, or drinking with the end result of becoming drunk. What do you make of this? We can find out more about units by looking at the Drinkaware website ([www.drinkaware.co.uk](http://www.drinkaware.co.uk)).

Your results suggest that your use of alcohol is at a level that is often associated with “harmful or hazardous” drinking. What do you make of this result?

MOTIVATION TO CHANGE: Your results suggest that you felt it was not important at the moment for you to change your use of alcohol (rating 1 on the scale of 0-10 for importance). However, if you decided to make a change, you felt very confident that you could achieve this (rating this 10/10).

**YOUR VIEW OF YOUR MENTAL HEALTH/MOOD:** Your scores suggested that, at that time, you were feeling really anxious and really depressed. How does this fit with how you are feeling now?

**WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF ALCOHOL ON YOUR MENTAL HEALTH**

The Talk to Frank (2013a) website ([www.talktofrank.com/drug/alcohol](http://www.talktofrank.com/drug/alcohol)) says that “Alcohol is a depressant,” which means it “slows down your body’s responses” in lots of different ways; and also that “way too much alcohol in a single session could put you in a coma or even kill you.” The information indicates that drinking alcohol has risks, and the “risks are higher if you drink excessively in a single occasion or drink higher amounts regularly over time.” They say if you exceed the lower risk limits “persistently over time,” alcohol can cause problems with your physical health, such as cancers, heart disease, and damage to your liver. We can look at more information about the risk of using alcohol for your physical health. Would you like this? Another source of information about alcohol, called Drinkaware (2015; [www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/mental-health/alcohol-and-mental-health](http://www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol/mental-health/alcohol-and-mental-health)), says that, when you drink heavily, “anxiety and depression are more common.” What do you make of this? Would you like to know more about the risk of using alcohol for your mental health?

Would you like us to have a look at some information about binge drinking, which I mentioned earlier?

<b>YOUR RESULTS: <i>Crystal</i></b>																																									
Diagnosis: <i>Paranoid psychosis</i>		Substance of choice: <i>Crack cocaine</i>																																							
<b>Part 1</b> <b>ALCOHOL</b> <table border="1"> <thead> <tr> <th>Alcohol</th> <th>Your current use</th> <th>Lower risk guidelines</th> </tr> </thead> <tbody> <tr> <td>Per day</td> <td>4</td> <td>Women: 2–3 units</td> </tr> <tr> <td>Per week</td> <td>12</td> <td></td> </tr> <tr> <td>Amount spent (£)</td> <td>12</td> <td></td> </tr> <tr> <td>AUDIT score</td> <td>4</td> <td></td> </tr> </tbody> </table>		Alcohol	Your current use	Lower risk guidelines	Per day	4	Women: 2–3 units	Per week	12		Amount spent (£)	12		AUDIT score	4		<b>DRUGS</b> <table border="1"> <thead> <tr> <th>Drug</th> <th>Your current use (per week)</th> <th>Amount spent (£) (per week)</th> </tr> </thead> <tbody> <tr> <td>Cannabis</td> <td>£10</td> <td></td> </tr> <tr> <td>Crack/cocaine</td> <td>£110</td> <td></td> </tr> <tr> <td>Ecstasy</td> <td></td> <td></td> </tr> <tr> <td>Heroin</td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> </tr> <tr> <td>Total spent (£)</td> <td>130</td> <td></td> </tr> <tr> <td>Dependence score</td> <td>8</td> <td></td> </tr> </tbody> </table>	Drug	Your current use (per week)	Amount spent (£) (per week)	Cannabis	£10		Crack/cocaine	£110		Ecstasy			Heroin			Other			Total spent (£)	130		Dependence score	8	
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<b>Part 2</b> <p><b>CRACK USE:</b> You said that you were using about two-tenths (an 1/5th) of crack cocaine a week, which you were smoking using a homemade pipe 3 days a week. Based on what you said you were spending, it would roughly cost you about £140 a week, or £560 a month. When we have a look at the number of people in the country, for adults asked, only about 3% had used a class A drug during the past year, and fewer in the past month. For crack cocaine, it is suggested that only about 0.1% of adults had used this drug during the past month. What do you make of that information?</p> <p>Your results suggest that your use could be contributing to you experiencing some problems related to smoking crack. How does this fit with what you experience?</p> <p><b>MOTIVATION TO CHANGE:</b> You felt that it was perhaps important to change, rating 5, which is the middle point of the scale, but you were not really confident that you could make a change in your crack use if you decided you wanted to (rating 2).</p> <p><b>YOUR VIEW OF YOUR MENTAL HEALTH/MOOD:</b> Your scores suggested that you were feeling really anxious at that time and that your mood was a bit low. Does this perhaps reflect what you said at the start of our meeting today?</p> <p><b>WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF CRACK ON MENTAL HEALTH</b></p> <p>Information on the Talk to Frank (2013b) website (<a href="http://www.talktofrank.com/drug/cocaine#aka=Crack">www.talktofrank.com/drug/cocaine#aka=Crack</a>) describes crack cocaine as a “powerful stimulant” with “short-lived effects.” They outline that crack can affect both your mental and physical health—for example, it says “regularly smoking crack can cause breathing problems and pains in the chest.” The Talk to Frank website says that “using cocaine a lot makes people feel depressed and run down, and that it can sometimes lead to serious problems with anxiety, paranoia and panic attacks.” Importantly, the information indicates that you can die from an overdose, and this risk increases if cocaine is “mixed with other drugs or alcohol.” Did you know that using alcohol and cocaine together “can be particularly dangerous, as they mix together in the body to produce a toxic chemical called cocaethylene.” Would you like to know more about this? There are other risks associated with using crack—for example, debts from using—that we can talk about if you would like.</p> <p>We can look at more information together if you would like. What do you think?</p>																																									

## ► Frequently Asked Questions (FAQs)

Your aim:

- To build the client's awareness about the impact of substance use
- Provide an important initial opportunity to help explore the client's concerns, thoughts, and beliefs about substance use and mental health problems
- To provide the client with relevant, up-to-date information from a reliable source
- To invite the client to comment and reflect on the information provided throughout the process

By now, you will have met with the client for Session One and be preparing to provide the assessment feedback in Session Two. You will have been focusing on developing a rapport with your client and an environment in which substance use can be discussed openly. It is possible that the client may begin to ask any questions they have concerning their experience of both mental health problems and use of substances as you feed back the results to him or her. These may be questions that the client has had for a long time and not shared with anyone, so prioritizing time to explore and discuss these is important. This provides a good opportunity to provide psychoeducation about the risks associated with the client's drug and/or alcohol use, and the relationship between substance use and mental health. This will build on the information you provided in the Assessment Feedback Sheet.

Some examples of FAQs are provided. These represent suggestions of what may be useful to draw on from the current literature that will help answer these questions. You will need to decide what is appropriate to share with the client at this time, bearing in mind the client's current mental state. This information just provides an introduction; you will probably find that you need specific information for each client, as well as the country and setting you are working in (e.g., concerning the risks to physical or mental health). Every effort has been

made to provide relevant and accurate information in our illustrative example answers at the time of preparing the manual. However, when working with your client, it is important to refer to information that is relevant to your client, setting, treatment needs, and country. It is important to note that any information given to a client should be accurate, up-to-date, and from a reliable source. Some suggestions of websites that you might find useful to obtain further information are provided in the following sections.

### **Alcohol**

*How much is OK to drink and what is a unit of alcohol?*

- Drinkaware outlines the current UK government “lower risk guidelines” for men as not regularly having over 3–4 *units* of alcohol a day. Women are recommended to have no more than 2–3 *units* of alcohol a day regularly (Drinkaware, 2015a). We can find out more about this by looking at this page on the Drinkaware website: [www.drinkaware.co.uk/check-the-facts/what-is-alcohol/daily-guidelines](http://www.drinkaware.co.uk/check-the-facts/what-is-alcohol/daily-guidelines).
- “Regularly” is said to mean “every day or most days of the week” (Drinkaware, 2015b). We can find out more about this by looking at this page on the Drinkaware website: [www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking](http://www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking).
- Having looked at these government guidelines, what we need to do now is talk together about what that means in terms of how many units are present in the drinks that you might have. The units and calories calculator on the Drinkaware website might help us to answer this question, available on this page: [www.drinkaware.co.uk/tips-and-tools/drink-diary](http://www.drinkaware.co.uk/tips-and-tools/drink-diary).
- An example on the NHS Choices website (2015) says that there are two units of alcohol in a pint of lower-strength lager (3.6% alcohol by volume; ABV), so if you were having four pints of lager, this would be eight units, which is double the government guidelines we just spoke about.
- What do you make of that information?



*Doesn't everyone drink more than the guidelines?*

- Sometimes you can find that, when you think about the people around you, everyone seems to use alcohol, or it feels as if there are very few people that do not drink. It can be important to think if this has always been the case. If not, what do you think has changed?
- In England, about a quarter of men said that they drank over 21 units “in an average week,” and less than a quarter of women described drinking over 14 units “in an average week” (The Health and Social Care Information Centre, 2011).
- The average number of units they were having in a week was about 16 units for men and eight units for women (The Health and Social Care Information Centre, 2011).
- In a big study in the United States, it was found that about a third of people who experienced schizophrenia had problems with alcohol during their life (Regier et al., 1990).
- What do you think about this information?

*What is binge drinking?*

- Among different countries, the definition of binge drinking varies a little. However, the overall message is generally similar. In the United Kingdom, men are said to be “binge drinking” if they drink *eight or more* units of alcohol in a single drinking session. For women, drinking *six or more* units in a single drinking session is said to be “binge drinking” (NHS, 2014a). We can find out more about this by looking at this web page: [www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking](http://www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking).

*Isn't binge drinking safer, as you drink less often?*

- Binge drinking usually involves drinking a quantity of alcohol in a short space of time or drinking with the end result of becoming drunk (NHS choices, 2014a).
- Binge drinking is said to be associated with risks for your mental and physical health. These can include being involved in accidents and overdose that can result in death. Binge drinking may also affect your mood and memory and sometimes leads to violent or aggressive behavior (Drinkaware, 2015b).

- We can talk more about the risks to your physical and mental health related to binge drinking if that would be useful.

*Does this mean I am an alcoholic?*

- The aim of our meetings is not to say whether you are an alcoholic or not; what we are looking to do is to find out what is going on for you personally and whether there is anything we could do to support you to achieve your goals. If you would like information about dependent drinking and the risks associated with this, we could look at this together.
- In terms of other people, a survey found that just under a quarter of adults in the United Kingdom were considered to be “hazardous drinkers”; of these, 16% were females and 33% males. Included within these numbers were females (2%) and males (6%) they “estimated to be harmful drinkers,” who were considered to be drinking at a level where it was “likely” they would cause damage to their health (The Health and Social Care Information Centre, 2011).
- For adults in the United Kingdom aged 16–74 years, 4% of females and 9% of males were considered to be showing “some signs” of dependence on alcohol (The Health and Social Care Information Centre, 2011).
- What do you make of this?

*My friend said alcohol had lots of calories in it. Is this right?*

- Some people can find it useful to know the calories that are present in the alcohol that they drink. Would you like more information about this?
- There are tables we could look at that give you an idea of the amount of calories in the typical drinks people report using. For example, did you know that Drinkaware (2015c) suggest that a pint of cider (2.6 units) has 210 calories, which is the same as a sugar doughnut?
- We can find out more about this by looking at some web pages:
  - [www.nhs.uk/Livewell/alcohol/Pages/calories-in-alcohol.aspx](http://www.nhs.uk/Livewell/alcohol/Pages/calories-in-alcohol.aspx)
  - [www.drinkaware.co.uk/unitcalculator](http://www.drinkaware.co.uk/unitcalculator)

*How does alcohol affect my body?*

- This is an interesting question; Drinkaware (2015d) outlines a number of ways in which alcohol can affect both our mental and physical health.
- Would you like to look at this further? We can find out more about this by looking at a useful web page: [www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol](http://www.drinkaware.co.uk/check-the-facts/health-effects-of-alcohol).

### ***Drugs and Mental Health***

*I've been using cannabis since I was 13, I got mental health problems in my 20's, so what could they have to do with each other?*

- People often report starting to use cannabis in their teens. You have talked about using it from 13 years of age. When some 15–24-year-old Europeans were asked, they said that the most common drug they used during the previous 12 months was cannabis (EMCDDA, 2014).
- Research suggests that when you compare people not using cannabis to those who use cannabis, the age at which people using cannabis experienced psychosis was nearly 3 years younger (e.g., Large, Sharma, Compton, Slade & Nielsen, 2011).
- Some researchers say that the age you start using cannabis is important in relation to your mental health.
- One study suggests that people who started using cannabis when they were of “age 15 or younger” began to experience psychosis at a younger age than people who began using cannabis after they were 15 years of age (e.g., Di Forti et al., 2014).
- This study also found that the type of cannabis being used was important, with people using “high-potency cannabis (skunk-type)” on a daily basis beginning to first experience psychosis 6 years before people who were not using cannabis (e.g., Di Forti et al., 2014).
- What do you think about this?

*Why do I get problems with mental health from cannabis when all my mates use way more and they are ok?*

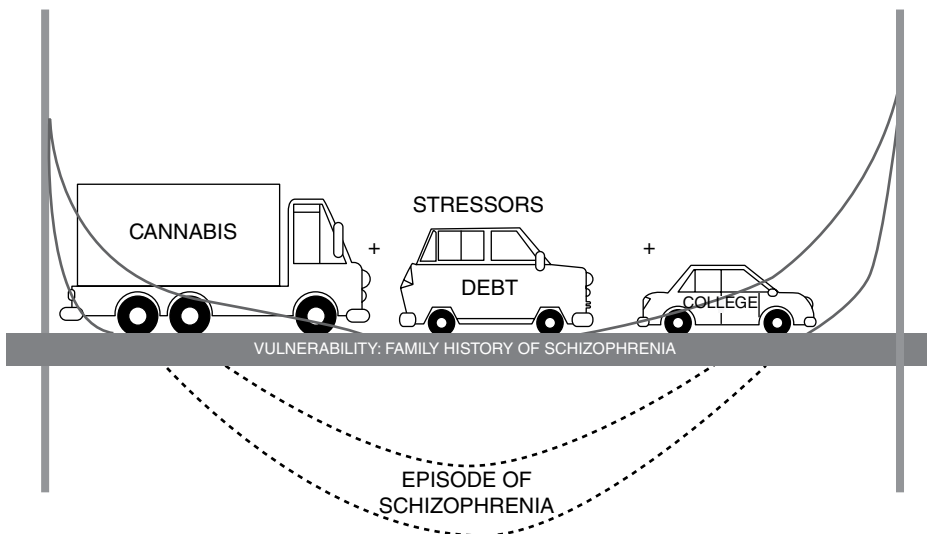
- It is important to say here that everyone is different; we all have different families and have different family histories of mental health. The places we grew up in and the things that

we have done in our lives are all different. It is possible that, in answering this question, both our family history of mental health and the environment we grew up in could be important.

- We could look at this together using a model that can be helpful to understand how our *genes* and *life experiences* could be important. Would you like this? It is called the stress-vulnerability model (see Figure 2.1).

Additional information that may help explain the stress vulnerability model was first provided by Zubin and Spring in the 1970s (for more information, see Zubin & Spring, 1977). This model basically suggests that we all have vulnerabilities. Zubin and Spring said that there are roughly two main types of vulnerability: one that is *inborn* (e.g., genetic) and one that may be *acquired* (e.g., traumatic experiences). What they suggested was that, when the “stressors” (e.g., life events) we experience exceeds our “threshold of vulnerability,” we may experience an episode of mental health difficulties.

Hence, if we think about cannabis using this stress-vulnerability model: Cannabis has been related psychosis (e.g., Van Os, Kenis & Rutten, 2010). Those who start using cannabis early (e.g., by the age of 15 years) have been found to



**Figure 2.1** Example of using stress-vulnerability model.

experience more psychotic symptoms (Arseneault et al., 2002; Konings, Henquet, Maharajh, Hutchinson, & Van Os, 2008), and are twice as likely to develop a psychotic disorder (McGrath et al., 2010) as compared to those who start using later on. Using cannabis appears to cause those who are “vulnerable” to psychosis to experience psychosis at an earlier age (Dragt et al., 2012). *Cannabis and other environmental factors* (e.g., childhood trauma, living in an urban environment) are thought to combine with a *person’s pre-existing vulnerability* (i.e., genetic) to psychosis to trigger off psychosis or schizophrenia. Recently, it has been identified that those who are more genetically vulnerable are more sensitive to the effects of cannabis (GROUP researchers, 2011). Of course, we are all individuals, and therefore all have different vulnerabilities and experience different stressors in our lives, so it can be useful to think with the client about the *genetic* and *environmental* vulnerabilities that are specifically relevant to him or her. There are a number of methods that have been used to explain this stress vulnerability model that you can use with the client—for example, using the original diagram outlining the model (in Zubin & Spring, 1977) or other metaphors such as the bucket metaphor (Brabban & Turkington, 2002). The metaphor we have used in BIMI is of a bridge (see Figure 2.1 on Page 47), as outlined by Macneil, Hasty, Conus, Berk, and Scott (2009).

Figure 2.1 illustrates that when the *stressors*, represented by the cars and the lorry, on the “bridge” (representing the client’s *vulnerability*) are too heavy for the bridge or the person to withstand, they can then experience mental health difficulties (Macneil et al., 2009). In this illustrative example, the lorry representing cannabis that has just come onto the bridge is suggested as too heavy, given the strength of the bridge. This provides a good starting point to then consider in therapy about what would strengthen the bridge and how the “traffic” (i.e., stressors) could be reduced (Macneil et al., 2009).

- As we just discussed, the research also suggests that, when compared to people who had never used cannabis, people with “a history of cannabis use” had contact with mental health services “at a younger age” when they first experienced psychosis (e.g., Di Forti et al., 2014).

- As we also discovered, the research suggests that the age at which you start using cannabis is important in relation to your mental health. What they suggest is that, when compared to people who started using cannabis later (“by age 18”), those who started using “by age 15” had more risk of experiencing symptoms of schizophrenia (e.g., Arseneault et al., 2002).
- Would you like to know more about this?

*Why does everyone have so much to say about me using skunk? It is just another type of weed!*

- The “Talk to Frank” website says that “skunk” is a term used to describe “a group of different types of strong herbal cannabis.”
- In a Talk to Frank leaflet titled “Cannabis: Find out the facts,” skunk is said to be on average over twice as strong as “traditional grass,” and to have greater amounts of the key “active ingredient” found in a cannabis plant, called tetrahydrocannabinol (THC; Crown Copyright, 2009b).
- Another leaflet about cannabis, called “Cannabis: too much too often?” (2009a), says that regular use of cannabis and using it “for a long time” increases the risks to, for example, your mental and physical health, and that these risks can be “worse if you are young, you smoke a lot and you smoke strong cannabis, like skunk” (Crown Copyright, 2009a).
- What do you make of that information? Would you like more information about this? We can have a look at these leaflets and websites that might be helpful:
  - Cannabis: Find out the facts (Crown Copyright, 2009b), available at [www.talktofrank.com/sites/default/files/Cannabis%20Find%20Out%20The%20Facts.pdf](http://www.talktofrank.com/sites/default/files/Cannabis%20Find%20Out%20The%20Facts.pdf)
  - Cannabis: Too much too often? (Crown Copyright, 2009a), available at [www.talktofrank.com/sites/default/files/CannabisTMTO.pdf](http://www.talktofrank.com/sites/default/files/CannabisTMTO.pdf)

*What has my using drugs got to do with my being in hospital or not feeling very well mentally?*

- This is a question that is quite hard to answer; perhaps we can look at what was going on for you in the run-up to your being admitted to hospital or not feeling very well mentally.

- For some people, when they look at what happened in the run-up to the hospital admission, they find that substance use may have played a part.
- It is suggested that over half of the people who experience severe mental health problems use substances (e.g., alcohol and/or drugs; Hunt, Siegfried, Morley, Sitharthan & Cleary, 2013).
- It has also been found that, when you experience severe mental health difficulties and use substances, you can have more difficulties with things such as relapses and homelessness and physical health difficulties (NICE, 2011; Hunt et al., 2013). You can also find you are admitted to psychiatric hospitals more often (NICE, 2011).
- What do you make of this information? Would you like us to find out some more information about this?

*Everyone I know uses drugs. Don't most people?*

- Sometimes you can find that, when you think about the people around you, it feels like everyone uses drugs, or that there are very few people who do not.
- In terms of England and Wales (2012–2013), a survey found that under 10% of adults had, in the previous 12 months, used “an illicit drug,” and less than 3% of 16–59-year-olds had used a class A drug during the same time period (Home Office, 2013).
- What do you make of this information?
- In terms of what drugs were being used, when the same survey asked 16–59-year-olds about the past 12 months, cannabis was found to be the drug used most frequently, with 6.4% of the people asked having used this. The next most frequently used drugs were cocaine powder (about 2%) and then ecstasy (about 1%) (Home Office, 2013).
- Would you like to know more about this?
- When you look at how often people were using drugs, it is reported that, in 2011–2012, just over 3% of people were seen to be using drugs frequently. “Frequent drug use” was said to be typically using “more than once a month” during the previous year (NHS Statistics on drug misuse England, 2012).

- In the United States, a big research study in 1990 found that, over their lifetime, about a quarter of people who experienced schizophrenia had problems with drug use (not including alcohol) (source: Regier et al., 1990).
- What do you think about this information?

*If I do not want to stop, what can I do to reduce the risks/harm?*

- This is a really good question; it is important to know that if you do not want to stop using at the moment, we can still work together to look at ways to reduce the risk or harm your use may cause you. There are lots of techniques and tips that can be useful for reducing the risk and harm related to using alcohol and drugs. We can look at some of the techniques together.
- What do you think about this information?
- So, in our meetings so far, we have thought about the information you gave in the questionnaires and what that means for you and your mental health. We have compared this to what the government's lower risk guidelines are for alcohol and/or what surveys and reports suggest other people in the country are doing for both alcohol and drugs. What we can go on to look at now is where you would like to be.
- We can think together about your use of \_\_\_\_\_ [insert substance] and what you think about this and whether you would like to make any changes, such as looking at ways of reducing the harm that \_\_\_\_\_ [insert name of substance] could be causing you.
- How does that sound to you?

*Do you see people who get better?*

- The answer to that is YES. Services and staff working in this area meet with many people who have achieved or go on to achieve their goals. It does depend on what you mean by getting better—for some people, this means stopping using the substance and getting support from treatment, organizations, and people they know to continue not using. This is a massive achievement, and is the best way to prevent further problems related to drugs or alcohol from happening. For



some people, getting better is reducing the risk associated with their use, and once they have achieved this, some then go on to stop using, as they can see the benefits of doing this.

- Us meeting together could be an important step toward what you consider to be getting better—what do you think?

### ***Additional Resources***

*Websites that might be useful*

[www.talktofrank.com](http://www.talktofrank.com)

[www.drinkaware.co.uk](http://www.drinkaware.co.uk)

[www.youthspace.me](http://www.youthspace.me)

It is important to signpost clients to local and national sources of support that are relevant to them and the substances they are using.

# Making Decisions About Change

## ► How to Decide on the Next STEP

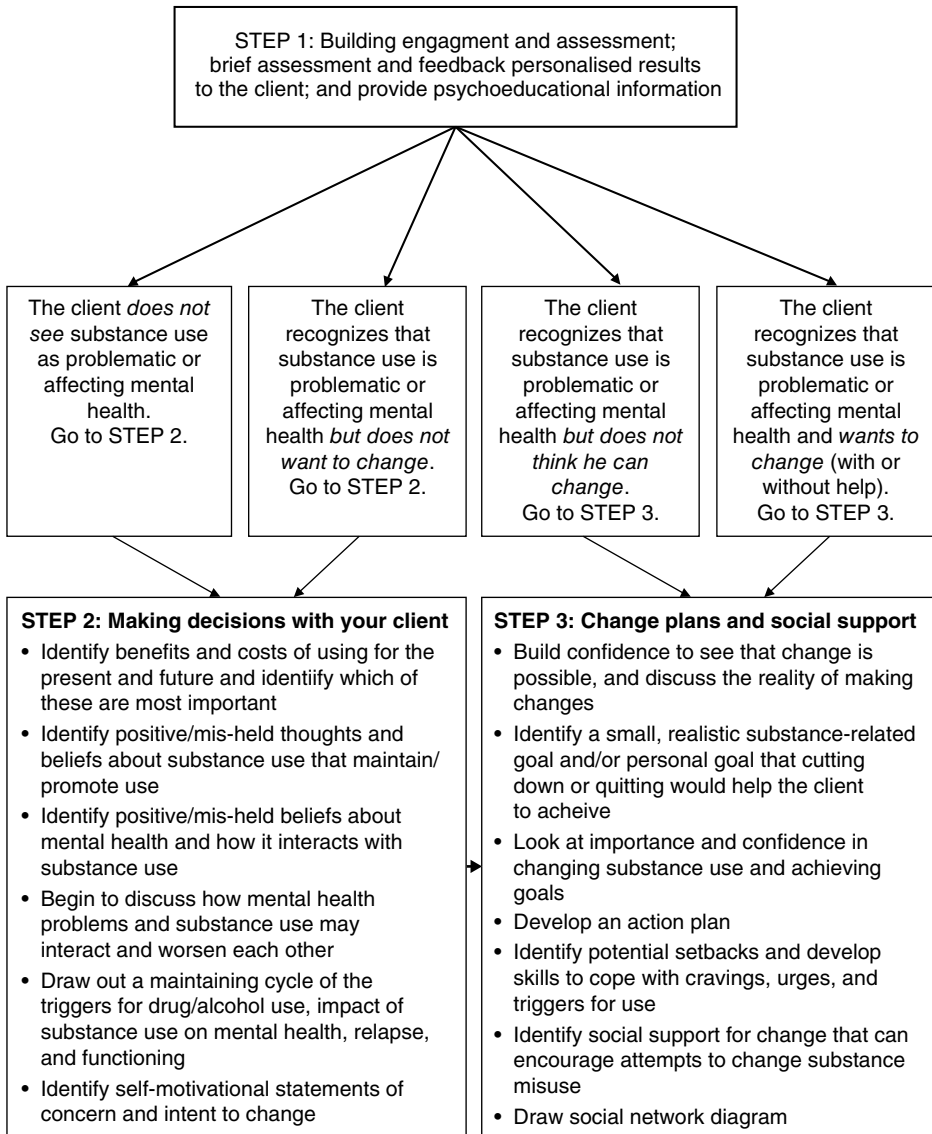
### *How to Decide What STEP Is Appropriate for the Client*

The content and aims of your third session will depend on the client's motivation to change. Once you have completed STEP 1 (Sessions One and Two) and provided the client with the assessment feedback, you will be aware of how the client perceives his or her substance use and whether it is seen as problematic. An additional indicator would be the client's ratings on the "importance–confidence" ruler that he or she completed during the BIMBI Brief Assessment. These will help you to decide what step of the BIMBI Brief Assessment is appropriate for the client next. Figure 3.1 has been developed to help facilitate this decision-making process.

If the client provided low ratings for the "importance" of changing the use of the main substance, this probably indicates that *the client does not see substance use as problematic or affecting mental health*. If this is the case, STEP 2 is probably appropriate to complete with the client next. However, it may be the case that the client provided higher ratings for the

*Brief Integrated Motivational Intervention: A Treatment Manual for Co-occurring Mental Health and Substance Use Problems*, First Edition. Hermine L. Graham, Alex Copello, Max Birchwood, and Emma Griffith.

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Companion Website: [www.wiley.com/go/graham/bimi](http://www.wiley.com/go/graham/bimi)



**Figure 3.1** How to decide which step is best suited.

“importance” of changing the use of the main substance—that is, *the client recognizes that substance use is problematic or affecting mental health but does not want to change*. If this is the case, then STEP 2 is still probably appropriate to complete with the client next. On the other hand, *if the client recognizes that substance use is problematic or affecting mental health but does not think he or she can change*, then STEP 3 is probably appropriate to complete with the client next, to help build confidence to see that change is possible. Also, *if the client recognizes that substance use is problematic or affecting mental health and wants to change (with or without help)*, then STEP 3 is still probably appropriate to complete with the client next.

Remember to keep the sessions brief, 15–30 minutes at most. The materials in STEP 2 or STEP 3 do not need to be completed in one session, but over a few sessions. It may also be the case, depending on a number of factors—such as the setting, the client’s mental state, levels of motivation and engagement, and how ready the client is to change—that it is sufficient for you to only cover some of the information in STEP 2. You will need to be guided by these factors when deciding the session content and session goals. At the end of each session, remember to summarize and reflect back what has been covered, and to arrange a time for the next session.

Remember to:

- Keep the sessions brief, 15–30 minutes at most
- Decide before each session in STEP 2 and STEP 3 what the session content and session goal will be
- Only cover the material that is appropriate to the client’s needs in each session
- At the end of each session, summarize what has been covered and reflect it back to the client
- Arrange a time for the next session

## ► STEP 2: Making Decisions with Your Client

### Session Content

### Session Goals

#### STEP 2: Making decisions with your client

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>■ Identify benefits and costs of using for the present and future, and find out which of these are most important to the client</li> <li>■ Identify positive/mis-held thoughts and beliefs about substance use that promote or maintain use</li> <li>■ Identify positive/mis-held thoughts and beliefs about mental health and how they interact with substance use</li> <li>■ Begin to discuss how mental health problems and substance use may interact and worsen each other</li> <li>■ Draw out a maintaining cycle of the triggers for drug/alcohol use, and the impact of substance use on mental health and functioning</li> <li>■ Identify self-motivational statements of concern and intent to change</li> </ul> | <ul style="list-style-type: none"> <li>■ Engagement and building rapport</li> <li>■ Being able to talk openly about costs and benefits of using</li> <li>■ Building recognition of how positive/mis-held beliefs may promote use</li> <li>■ Recognizing the maintenance cycle for mental health problems and substance use</li> <li>■ Being able to state concerns about continued use and to talk about their intent to change</li> </ul> |
|---|--|

In STEP 2, your aim is to help the client begin to consider the *benefits* that he or she feels are gained by *continuing to use* alcohol or drugs. You will later move on to reflect on the difficulties or *costs* associated with his or her use. This will then give the client an opportunity to weigh up the benefits and costs of *using*, and consider the impact that alcohol or drug use has on mental health or admissions to hospital. Remember at the initial stage of STEP 2 that you are not discussing with the client about changing substance use; you are focusing on how things would be for him or her if he or she *continued using*, as described in the session outline.

Remember at the end of each section and session to summarize what the client has said and reflect it back to him or her, as a method of building the client's awareness.

In STEP 2, your aims are to:

- Seek to help the client begin to consider the “benefits” that he or she feels is gained by *continuing to use* alcohol or drugs
- You will later move on to reflect on the difficulties or “costs” associated with his or her *continued use*

## ► Outline of Sessions

Remember, for these sessions you will need:

- Worksheet 1 or Worksheet 2—“What I Enjoy About Using?”
- Worksheet 3—“How Does My Use Sometimes Affect Me?”

You can begin this session by referring back to the information covered in Session 2:

- When we met a couple of days ago, we looked at your results from the assessment. You said you found some of this information interesting and wanted to talk a bit more about it. What do you think about us having a look at the information together today?
- So, shall we start with the bit that you are most interested in/concerned about?
- Now that we have looked at this information, what do you think?

You now help the client think about what he or she enjoys about using or what keeps him or her using.

### *Identifying the “Benefits” of Using*

What do you enjoy about using \_\_\_\_\_? Or, what keeps you using \_\_\_\_\_?

- When people use alcohol or drugs, they often experience some benefits, and they are very aware of the things they like about using the substance or what keeps them using. So, let us start by talking about all the things you enjoy about using \_\_\_\_\_ [insert name of the substance—e.g., cannabis].
- What are the things you like about \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- How do you feel that using \_\_\_\_\_ [insert name of the substance—e.g., cannabis] helps you? Is there anything more you would like to add to that?

*Further prompt questions if the client says he or she no longer enjoys or likes using*

- If you do not like using, what things do you think seem to keep you using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- We can start writing them down, so that we do not forget.

Use Worksheet 1 or 2 for you or the client to write them down, see pages 97 and 99). See the illustrative example given in the following:

- What I enjoy about using *cannabis* or what keeps me using *cannabis* are:
  - 1 I can relax with my mates
  - 2 It is amazing and sorts out my worries
  - 3 I do not get voices
  - 4 It cheers me up
  - 5 It is a habit and I have always done it
- When you look over your list, how you do feel?  
It is just a habit and I have always done it
- Looking at it, does it make you think differently?  
I seem to rely on it quite a bit

Remember at this point to:

- Summarize what has been said and reflect it back

### ***Identifying Positive Thoughts and Mis-held Beliefs About Alcohol and Drugs***

Now that the client is talking openly about the benefits of using, you can begin to help him or her to recognize *how positive or mis-held beliefs about the substance used may encourage continued use*. For example, “the only way I can relax is by smoking weed,” and so, as you probably guessed, whenever the client feels tense or wants to relax he or she will feel an

urge to use. Within cognitive behavioral therapy, these sorts of beliefs and thoughts are said to have *distortions* and *errors* within them, and are often referred to as “thinking errors” or “cognitive distortions” (Beck, Wright, Newman & Liese, 1993; Graham et al., 2004). As you may have noticed from the example “the only way I can relax is by smoking weed,” this is an “absolute” statement, and there are probably other things that the client can think of that has helped him or her to relax in the past; also, they may have found that, on some occasions, after smoking cannabis, they feel a little anxious or even paranoid. However, believing or telling yourself that “the only way I can relax is by smoking weed” would entice the client to continue using.

You have already started the process of identifying these very important beliefs by asking the client about the “benefits” of using substances and recording them on Worksheet 1 or 2. These discussions can also be quite an important part of the engagement process, and will help you to understand the reasons or beliefs about the substance that keep him or her using. These will often be the thoughts or particular beliefs that block him or her from considering changing. You can continue the session by encouraging the client to review the benefits and to identify the most important benefit:

- Let us look at all the things you have listed down on your worksheet as “benefits” of using. What do you think is the most important benefit or biggest plus of using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- Let us go back to your list and put a star by this one.

*Further prompt questions if the client is unable to identify the most important benefit*

- What thoughts go through your mind just before you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis]? *or*
- What do you think about using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- How do you think \_\_\_\_\_ [insert name of the substance—e.g., cannabis] helps you?



Let us write this down, so that we do not forget [use Worksheet 1 or 2 to write this down]:

I can relax with my mates.

### ► Taking Another Look at What You Think About Alcohol and Drugs

When people think about the benefits of using alcohol or drugs, they mainly think in absolute terms, for example, “whenever I drink alcohol, I always have a laugh with my mates.” However, when we take a closer look at this statement, we can see that it is quite an absolute statement, which suggests that this is always true. However, as we know, because of the effects of alcohol, initially some people might feel quite jovial and disinhibited after a few drinks, but after a few more they may end up feeling quite edgy or agitated, and some people may even end up in fights. If they continue drinking, then the reality is that, at the end of the evening, they may feel quite sad, tearful, or even physically unwell. So, it is very important to encourage the client to take a second look or re-evaluate what he or she believes about the use of alcohol or drugs.

To help clients to take a second look or re-evaluate what they believe about using the substance, you will need to help them reflect on whether they “always” experience that benefit. That is, although the drug or alcohol use may meet *immediate short-term* needs, it may not always satisfy these needs in the *longer term*. Also, there may be times when the substance may have that benefit (e.g., feeling relaxed after smoking cannabis), but other times when it does not (e.g., feeling paranoid after smoking cannabis) because of other things going on in his or her life at that time. You can help the client to re-evaluate this main “benefit” by asking him or her to take a second look.

- Let us take another look at what you said goes through your mind just before you use \_\_\_\_\_ [insert name of the

substance—e.g., cannabis] and how you think \_\_\_\_\_ [insert name of the substance—e.g., cannabis] helps you.

You said when I use *cannabis*, *I can relax with my mates*.

- Do you think you have *always* experienced that benefit from using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- How do feel just after you use it? For example, how do feel later on in the day/night?
- Have there been times when you experienced different effects that are not so pleasant when using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- When you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis], how do you find it changes your mood or mental health?
- What other effects have you experienced when using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]?
- What happens after you use? How do you feel? \_\_\_\_\_  
\_\_\_\_\_

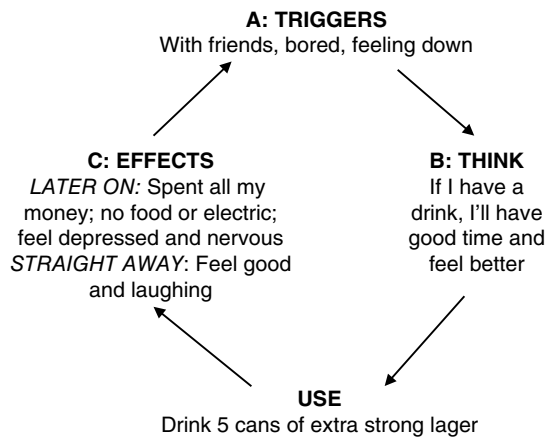
Remember at this point to:

- Summarize what has been said and reflect it back

- So, when we took another look at the things you tend to think about *cannabis*, you noticed that using *cannabis* sometimes has different effects than you expect, such as: Sometimes I can relax with my mates when I smoke cannabis, but sometimes when I smoke with them I feel worried that they are laughing at me.
- Looking at it now, does it make you think differently?  
I guess it does not always help me relax
- Let us write this down, so that we do not forget [use Worksheet 1 or 2].  
I guess it does not always help me relax

## ► Relationship Between Mental Health Problems and Substance Use

After taking a second look at what the client thinks about alcohol or drugs, he or she may be open to reviewing the immediate and longer-term effects of his or her use. If the client is able to talk freely with you about the effects of using, then you could try to help him or her link up what his or her “triggers” (A) are for using; with what he or she “thinks” (B) about using; and what he or she “uses” and then what are the “effects” (C) of using, especially on mental health. This strategy will start to build a picture for the client about how drug or alcohol use and mental health may be connected together and impact on him or her not just immediately but later on. For example:



Later on in the session, this may also be an opportunity to begin to talk with the client about the research evidence that suggests there is a link between poor mental health and substance misuse (see FAQs on page 42). Alternatively, he or she may prefer to read some psycho-educational material or to look on some of the websites.

To start building awareness about the relationship between substance use and mental health, you can start by asking the client to think about the most recent time he or she used. You will need to ask if this reflects a typical time when he or she uses:

- Remember: As you go through this, actually draw out the connections with the client, so they can see the picture building

### *Identify triggers*

- What was going on just before you used? Is that what is usually going on before you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis]? \_\_\_\_\_ [write the trigger down on Worksheet 3]. These can be called your “triggers” for using.

It is important to remember that the things that trigger your client to use can be really varied and personal—that is, it could be internal, for example, such as the way they are feeling, or external, for example, related to the places they go to or certain people they spend time with (Beck et al., 1993; Graham et al., 2004).

### *Identify thoughts and beliefs about use*

- We discovered previously that, before you use, you usually “think” \_\_\_\_\_ [insert main positive beliefs or benefit] about using \_\_\_\_\_ [insert name of the substance—e.g., cannabis]. Let us write this down, so that we do not forget [use Worksheet 3]: \_\_\_\_\_.

### *How much is used?*

You would have obtained this information during Session One, and it will be on the “Your Results” assessment feedback.

- You said that you typically “use” \_\_\_\_\_ [insert quantity and the name of the substance—e.g., £5.00 worth of cannabis] and then \_\_\_\_\_ [write down on Worksheet 3].

### *Identify effects of use—immediate and delayed effects*

- You said that, straightaway after you use, \_\_\_\_\_ [insert what happens].
- So, how do you feel a bit later on \_\_\_\_\_ [insert what happens], and how do you feel after that \_\_\_\_\_ [write down on Worksheet 3]?

*Identify the effects of substance use on mental health/mood*

- What are the “effects” of using on your mood (and mental health) straightaway \_\_\_\_\_ [insert effects] and then later on \_\_\_\_\_ [insert effects]?

*Recognizing the maintenance cycle for mental health problems and substance use*

You can now summarize and take the client through the maintenance cycle or vicious cycle that you have generated together.

- So, what you have said is that, usually just before you use \_\_\_\_\_ [insert name of substance], you are usually \_\_\_\_\_ [insert triggers] and you tend to think that \_\_\_\_\_ [insert main benefit] and that, straightaway after you use, you feel \_\_\_\_\_ [insert immediate effect] but that later on you feel \_\_\_\_\_ [insert delayed or longer-term effect] and your mood (or mental health) is \_\_\_\_\_ [insert effect].
- Now that you have seen how your use of \_\_\_\_\_ [insert name of the substance—e.g., cannabis] affects how you feel, what do you think?
- Had you noticed how they were connected before?
- Looking at it now, does it make you think differently about your use of \_\_\_\_\_ [insert name of substance]?

Remember at this point to:

- Summarize what has been said and reflect it back

- So, when you think about some of the times when you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis], you notice that there are certain effects or consequences.
- Let us try to see if we can find any information about why that may be. I can also leave you information that you can take a look at that may explain why you feel this way after using \_\_\_\_\_ [insert name of the substance—e.g., cannabis].

At this stage, you can review with the client, if appropriate, using the FAQs or psychoeducational material, the effects of substances on mood and mental health.

### ► Reviewing Any “Costs” of Using

- We have looked at the effects of when you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis]. At the beginning, when you thought about what you enjoy when you are using, and what keeps you using \_\_\_\_\_ [insert name of the substance—e.g., cannabis], you came up with a list of things that feel quite important to you.
- The things you like about using \_\_\_\_\_ [insert name of the substance—e.g., cannabis] have been important to you. They are a big factor in keeping a person using alcohol or drugs, even though the effects of using are not always positive.
- So, thinking about making any changes in how you use \_\_\_\_\_ [insert name of the substance—e.g., cannabis] might feel quite difficult as it is hard to give up something you enjoy. However, as we discovered, often the things a person enjoys may also have some “down” sides. It may be hard to spot these at first, so let us look at the case example of Sonny next and see if we can spot any difficulties that his cannabis use may be causing him.

Sonny has been smoking cannabis with his friends since he was 14 years of age. He is 28 now and smokes weed (skunk) pretty much all the time when he has money. Whenever he smokes, he feels like he cannot be bothered to do anything. He dropped out of college last year, because it felt like a waste of time, and he could not be bothered to get out of bed after smoking all evening the night before. Also, after smoking, he can start to feel quite edgy and think that kids in the street are talking about him and laughing at him, so he thinks he is better off staying in. He wants to get on with his life and find a job, but he says he cannot be bothered to look. Sonny says he never has any money to do anything as, whenever he gets any, he spends

it all on weed. He has borrowed quite a bit of money from his mum and sister, and he ends up in arguments with them as he finds it hard to pay them back. He enjoys smoking as he thinks it helps him to relax and chill out, and all of his mates smoke, but he says that sometimes he can feel edgy and paranoid after smoking. Recently, he has been finding it hard to relax or sleep without smoking weed, and it gets quite tense at home. His care-coordinator and family say he used to be outgoing and really into playing sports. They feel he has changed since he started smoking weed every day. He often ends up arguing with his Mum and sister as he owes them money. Sonny has noticed that he recently has quite a chesty cough, and if he tries to run for the bus he gets out of breath really quickly.

- What difficulties do you think his cannabis use may be causing him?
  - Arguments with his family
  - Spending all his money on weed
  - Dropping out of college and not looking for the job he wants
- Some of the difficulties may seem less obvious such as:
  - Feeling like he cannot be bothered to do anything
  - Borrowing money from his family
  - Chesty cough
  - Getting out of breath quickly
  - Finding it hard to relax or go to sleep without cannabis
  - Getting edgy and paranoid and not wanting to go out

*Difficulties my use may be causing?*

- So, let us think a bit more about any difficulties or problems you think your \_\_\_\_\_ [insert name of the substance—e.g., cannabis] use may be causing.
- Let us write them down, so we do not forget [use Worksheet 1 or 2 and add to the second section]: \_\_\_\_\_  
\_\_\_\_\_.

*Further prompt questions, if the client cannot think of any difficulties*

- If you cannot think of any difficulties, first of all let us think about what concerns others (e.g., mum, dad, brothers, sisters, other relatives, girlfriend, boyfriend, friends,

care co-ordinator, mental health team, psychiatrist) may have about your use of \_\_\_\_\_ [insert name of the substance—e.g., cannabis].

- Have there been times in the past when you or anyone else may have been concerned about the impact that your use was having on you?
- If you do not think anyone is worried about your use, or if you do not mind if they are, how does using \_\_\_\_\_ [insert name of the substance—e.g., cannabis] affect how much money you have? Your physical health? Your mood? Your mental health?
- Sometimes a person may not be able to see any immediate problems with their \_\_\_\_\_ [insert name of the substance—e.g., cannabis] use, so it is useful to think further into the future.
- So, think about if you keep using \_\_\_\_\_ [insert name of the substance—e.g., cannabis], as you were before you came into hospital or started to feel unwell, what problems might this cause for you 6 months or a year down the road?
- Let us write them down, so we do not forget [use Worksheet 1 or 2].
- Difficulties that my use of \_\_\_\_\_ [insert name of the substance—e.g., cannabis] may be causing:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

- When you look over your list, how do you feel?

\_\_\_\_\_

- Looking at it, does it make you think differently?

\_\_\_\_\_



- So, if you had to sum up your main concern, or the ones that those who are concerned about you may have, what would it be? Let us write this down, so that we do not forget [use Worksheet 1 or 2]:

I/They feel concerned that my \_\_\_\_\_  
[insert name of the substance—e.g., cannabis] use may \_\_\_\_\_.

Let us think now about what you think might need to change to reduce the level of concern. What would you need to do? Would you need to cut down? Stop all together? Change the way you use? Let us write this down, so that we do not forget [use Worksheet 1 or 2]. To reduce the level of concern, I would need to \_\_\_\_\_.

Remember at this point to:

- Summarize what has been said and reflect it back
- Spend time trying out and identifying strategies for coping with cravings and urges that work for the client

# Change

## ▶ STEP 3: Change Plans and Social Support

### Session Content

### Intervention Goals

#### STEP 3: Change Plans and Social Support

Developing a change plan:

- |  |   |
|--|---|
| ■ Identify a realistic substance-related goal and/or personal goal that cutting down or quitting would help the client achieve | ■ Helping change to feel possible   |
| ■ Look at importance and confidence in changing substance use and achieving the goal   |   |
| ■ Develop an action plan   | ■ Identifying potential setbacks (e.g., cravings/urges and social network)                        |
| ■ Identify skills to cope with cravings, urges, and triggers for use   | ■ Being able to use skills to cope with setbacks, including cravings, urges, and triggers for use |
| Social support for change:   |   |
| ■ Identify social supports that can encourage attempts to change substance misuse  |   |
| ■ Draw social network diagram  | ■ Provide social support for change   |

In STEP 3, your aim is to help *build the client's confidence to make the change that he or she wants and to see that change is possible*. It will be important to work through with the client the

*Brief Integrated Motivational Intervention: A Treatment Manual for Co-occurring Mental Health and Substance Use Problems*, First Edition. Hermine L. Graham, Alex Copello, Max Birchwood, and Emma Griffith.

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reality of what changing in alcohol and drug use would be like and develop strategies that will make change feel more possible.

You can start the process by first reviewing why the client would like to make a change and what change he or she would like (if the client completed STEP 2, see “Reviewing any costs of using,” page 65).

As outlined previously, the client probably has particular things that he or she wants out of life right now. One of them is probably “not being admitted into a psychiatric hospital again,” or to feel mentally well again. It is possible that drug or alcohol misuse has played a part in his or her current hospital admission, or in his or her feeling mentally unwell. Therefore, future alcohol or drug use may well stand in the way of the client achieving the goal of “not being admitted again” or of feeling mentally well again. Other things that he or she may want in life can be personal or life goals, which we all want (e.g., getting a job, learning to drive, going on a holiday, starting a relationship, living independently, making friends, going out socially, having more money to buy food or pay bills, not being in debt to dealers, and appropriate reduction of medication). It is possible that his or her use of alcohol or drugs has prevented the achievement of these goals. So, to continue the process of developing a change plan with the client, you will also need to jointly identify a small, realistic, substance-related goal and/or personal goal that cutting down or quitting would help the client achieve.

In STEP 3, your aims are to:

- Help change to feel possible
- Identify a small, realistic, substance-related goal and/or personal goal that cutting down or quitting would help the client achieve
- Identify social supports that can encourage the client’s attempts to change

## ► Outline of Sessions

Remember, for these sessions you will need:

- Worksheet 4—“Taking Steps Toward My Goal”

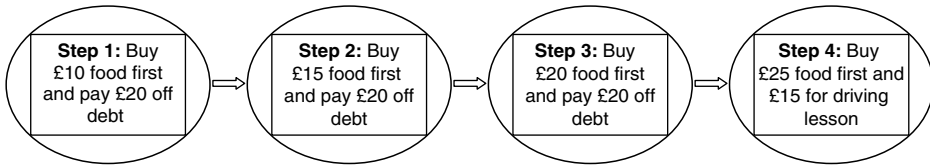
- Now that you have considered what you would need to do to reduce the level of concern about your \_\_\_\_\_ [insert name of substance] use, let us think about what you think could be gained from making this change. What would these be (e.g., having more money, taking driving lessons)?

### ***Taking Steps Toward My Goals***

- Can we call the things that you could gain from making this change as your “goal” (e.g., having more money to be able to buy food)? Which goal should we focus on first? Which one feels more achievable as a first step?
- Let us write them down, so that we do not forget [use Worksheet 4]: \_\_\_\_\_
- OK, so let us write down where you are now (e.g., in £60 debt to dealers).
- Let us break down your goal into steps that feel a bit more achievable on a day-to-day basis (e.g., when I get paid, first of all, I will buy £10 worth of food, then pay £20 off my debt, and spend £20 on cannabis rather than £30).
- What could the next step be in achieving your goal of having more money to buy food (e.g., when I get paid next time, first of all, I will buy £15 worth of food, then pay £20 off my debt, and spend £15 on cannabis rather than £20)?
- And what would your next step be? (e.g., when I get paid next time, first of all I will buy £20 worth of food, then pay £20 off my debt, and spend £10 on cannabis rather than £15)?
- And your next step (e.g., when I get paid next time, first of all I will buy £25 worth of food, then I will have paid off my debt, and I can spend £10 on cannabis and save £15 toward a driving lesson)?

**Now:** £60 debt to dealers

**Goal:** Have money for food



- When you look over your steps to achieve your goal, how do you feel?  
\_\_\_\_\_
- Looking at it, does it make you think differently?  
\_\_\_\_\_

Remember at this point to:

- Summarize what has been said and reflect it back

### ***Coping with Setbacks***

- Let us think of any possible setbacks (e.g., cravings/urges, friends, dealers) that may stand in the way of you achieving your goal. What could these be?

Let us write them down, so we do not forget [use Worksheet 3]:  
When I get paid, I see the dealer first, and he wants me to pay off the £60 I owe him straightaway

- OK, let us think together about how you could tackle this situation: I could go with a non-drug-using friend or care-coordinator to collect my money and buy my food first, and only take £40 to the dealers
- Are there any other possible setbacks you can see with this? I may feel tempted to buy £20 worth of cannabis and get £20 more on credit
- OK, let us think together about how you could tackle this situation: I could go with a non-drug-using friend, or I could take a picture of the car I would love to get when I pass my driving test and remind myself of why getting into debt with dealers never works out well for me

- Are there any other possible setbacks you can see? I'm craving so much for more cannabis that I go back to get more on credit from the dealers
- OK, let us think together about how you could tackle this situation: \_\_\_\_\_

### ***Strategies to Cope with Cravings and Urges***

You may find it useful at this stage to introduce the client to some simple strategies to cope with cravings and urges to use. A range of strategies that the client may find helpful are described here. It is important to encourage the client to identify the one(s) that is most suited to him or her and to practice the strategy in the session to build confidence in using it.

- *Imagery*: Let us try an exercise to help you cope with urges. Imagine you are standing, waiting on a platform at a train station, and your “urge to get more cannabis” is painted all over the outside of the train like graffiti; imagine the train coming into the station, stopping at the platform, and then moving out of the train station with your “urge.” As you see the train moving away with the “urge” on, notice the urge is getting smaller and smaller and fading away.
- *Distraction*: Another strategy may be to go off and do something else that really occupies your mind and time until the urge passes, such as watching TV, listening to music, playing computer games, or talking to someone you find supportive.
- *Relaxation*: Some people also find that trying to relax by breathing in the “urge” to a count of seven and then breathing it out and letting go to a count of 11 really helps.
- *What I tell myself*: Sometimes when we make a decision to change something, we may still feel a bit torn. We can see all the reasons why changing would be a good, but on the other hand we may feel reluctant to change, or that we are not going to be able to succeed. Let us go back to the case of Sonny:

Sonny feels “concerned that his cannabis use is causing arguments in his home, and that his mum will finally kick him out and he’ll be on the streets.” He thinks that “to reduce the level of concern I have that my mum will kick me out, I need to cut

down how much weed I am smoking and get a job.” When Sonny thinks about changing, he thinks:

*The positives of changing are:*

- 1 My mum will be pleased
- 2 My mum will not kick me out
- 3 I will have more money in my pocket to buy the things I want

*The negatives of changing are:*

- 1 I will not be able to chill out with my mates and smoke
  - 2 I will not be able to get to sleep
  - 3 I like smoking weed
  - 4 I have tried before and failed
- What do you think would help Sonny feel more able to succeed?
  - Sometimes what we tell ourselves may prevent us from succeeding—for example, if Sonny tells himself “there is no point in trying to change; I have tried before and failed.” However, if Sonny takes another look at what he is telling himself, he may remember that he had been able to cut down his cannabis use when he had to pay off a few debts. He had also stopped smoking for 2 months when he was last in hospital. Sonny was then able to tell himself, “I have been able to make some changes in the past, but the willpower was not enough. This time, I have a better chance of success as I have some support and a plan.”

Remember at this point to:

- Summarize what has been said and reflect it back

It is important to spend time with the client planning and practicing how to deal with the identified potential setbacks, as these can often derail the client from achieving his or her goal. The result is often a loss of self-efficacy; that is, confidence that he or she can actually make a change. This may have happened to the client in the past, and he or she may

believe that: “I’m not sure that I can change or achieve my goal, too many things stand in my way.”

Here, you can introduce the client to a further imagery exercise.

- *Imagery* (Hayes, 2005; Follette & Pistorello, 2007): Another exercise that you might find helpful is to imagine that you are the driver of a bus, and you know where you are heading to (your goal/destination). But you have many pesky passengers on the bus who constantly bother you and prevent you from driving your bus. What could you do?
- Let us imagine who/what is on your bus that may make achieving your goal difficult (e.g., cravings, drug dealers, friends who I drink alcohol or use drugs with, boredom). How could you deal with each of these pesky passengers (e.g., share your goal with them, put their seatbelts on, ask them to leave you alone and move to the back of the bus, ask them to get off the bus if they are going to distract you, ask someone else to come and help you manage the passengers)?

Remember at this point to:

- Summarize what has been said and reflect it back

- So, in sum, you have been able to identify a goal that you would like to achieve, you can see possible setbacks, but you have been able to identify things that might help, so that you can move forward.
- How do you feel about what we have discussed? \_\_\_\_\_  
\_\_\_\_\_

### ► Social Support for Change

Alcohol and drug use are often social activities, and for some clients they may be the main means of social contact and interaction. However, importantly, non-substance-using social networks are more likely to encourage and or support positive change in alcohol and drug use and prevent people from



slipping back into problem use. So, in STEP 3, a vital part of developing a change plan involves identifying social support for change and goal attainment.

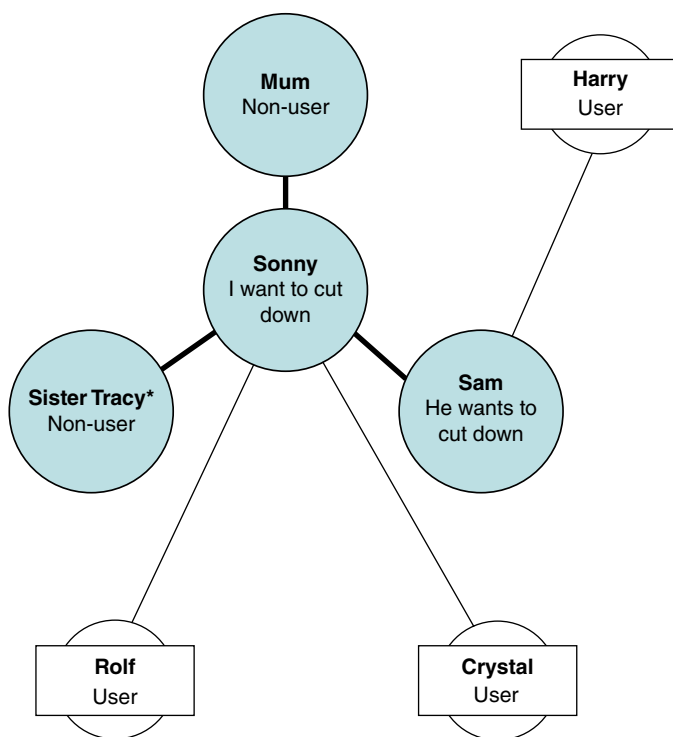
You can encourage the identification of social support for the client's attempts to change alcohol or drug use through the client's *own natural social network*, or by introducing him or her to *groups in the community that can offer positive support*. The session outline focuses on using the clients' own social network. However, in addition, you may be able to identify with his or her supportive groups or services in his or her local community. Strategies for identifying supportive social networks are introduced in these sessions. Further information on developing and building supportive social networks can be found in the treatment manual for social behavior and network therapy (Copello, Orford, Hodgson, & Tober, 2009).

## ► Developing Supportive Social Networks

### ***Outline of Sessions***

- Let us start by looking at who is important to you, and think about how they might help you achieve your goals.
- Draw a social network diagram. Start with a question such as: "Can you think of all the people that are important to you?"

It is useful to start to draw the social network diagram collaboratively with the client, such as the one in Figure 4.1. You place the client at the center and draw other members of the client's social network around him or her. Wherever possible, use people's names, as it makes the network more real and relevant to the client. For each person in the network, indicate whether or not he or she would be supportive of the client making the change or achieving the goal, who the client would be willing to tell about his or her change plan, and who in the client's view would support him or her. At this stage, try to include as many people as possible in the network diagram to start with. Think about local support groups or organizations that may also offer support. Do not engage in a detailed discussion about each individual member too soon as the initial emphasis is on having as many members of the social network included as possible. It is



**Figure 4.1** An example of a social network diagram.

important to identify everyone in the social network at this early stage, as even those with whom there is not much contact at the moment could become potential supporters in the future, and those who encourage continued substance use could be made to be less influential. Certain questions can help the exploration:

- How often do you see him or her?
- Let us note down all the people in your network who use drugs or alcohol.
- Of the people around you, which ones do you think would be supportive of you making a change in your use of \_\_\_\_\_ [insert name of substance—e.g., cannabis]? Let us make a note of them.
- Which people are more likely to encourage you to keep on using?
- Which one of these people could you speak to about the goal that you have set and would be willing to encourage

you? Let us make a note of such people by their name (e.g., I'll tell Sam and my sister Tracy).

- Let us review each person in turn about how specifically they can help you with your goal.

Discuss with the client how he or she can start the process of talking to the person who he or she has identified as someone he or she can tell about his or her goal. Practice using role-play to practice how the client might go about initiating the conversation, and explore strategies to cope with the discussion not going as planned.

Remember at this point to:

- Summarize what has been said and reflect it back
- Develop the social network diagram collaboratively, including as many members of your client's network as possible

It may be useful to provide the identified family members or supportive social network members with some information that would help engage them in the process, and get them to think about how they can best offer support to the client and access support themselves. This is detailed in the following section. This information is also available in the appendix as two handouts.

### ► **Helpful Information for Family Members or Supportive Social Network Members**

This section provides strategies that will encourage family members or supportive social network members to think about how the situation is affecting them and others in the family or network in terms of the stresses faced. In addition, family members or supportive social network members will be encouraged to consider the range of feelings that they are experiencing, and strategies are suggested for how to aim to deal with these in a helpful way. The following information can be given as a handout for family members or close friends.

### ***Understanding Cannabis, Alcohol, and Other Substance Use, and How It Impacts on Family and Others***

This information section is aimed at helping you understand and respond to the challenging experience of having someone close to you who experiences substance misuse and mental health problems, and to think about ways in which you can look after yourself as well as offer support to the person you are concerned about. If you are reading this, it is more than likely that a friend or loved one has developed a problem with substance use in addition to mental health problems. On the other hand, you may be unsure about whether there is a problem, whether the problem is a serious one, but yet you are worried. Finding out that your relative has got a substance problem is unlikely to happen as a single event. You may have been wondering for a while if he or she has been using drugs. Perhaps his or her behavior has at times been unpredictable or changeable in ways that are difficult to explain or fully understand. We also know that, when substance use problems also happen alongside mental health problems, this combination can be complex and challenging.

Let us focus on your experience to start with. We know from research and from what family members or supportive social network members have told us that their experiences can include, for example, being concerned about the person's health and safety, the financial implications of drug use, finding the person difficult to live with, incidents and crises at home, and a lot of worry about the impact on family or friendships. All of these are common experiences that families describe at some length when asked about living with a close relative with a substance use problem or a substance use and mental health problem combined.

One of the most important things to keep in mind as a family member or a supportive social network member in these situations is to not panic. It is likely that, in time, you can find a way of understanding what is happening that will be helpful. A good starting point is to understand your own experience, as this is mostly within your control (although at times it may not feel like this!).

### ***Do Others Experience Similar Problems?***

Before thinking and looking more closely at your own experience, it is worth considering how common these problems are. Living with someone with a drug or alcohol problem is a very common experience. It happens to a lot of people, although it is mostly hidden because people do not like to talk about this to others. A common feeling reported by family members or supportive friends is the shame and worry about what other people may think of the person who is using drugs, of you, or of the family as a whole. If you feel like this, it is problematic because it will make you hide the experience and increase your isolation. In addition, we know that disagreements can take place between different family members or friends when these problems are discussed. This again can increase your sense of hopelessness and isolation, and the feeling that you are dealing with this problem on your own, which in turn can be a really challenging experience. In fact, living with someone with a substance misuse problem and being affected by this experience is so common that it ranks among the most commonly reported forms of severe and chronic stress in the Western world. Here, we are talking about millions of people rather than thousands. In fact, in a recent study we conducted, we estimated that there are over 1 million adult family members significantly affected by serious drug problems, including cannabis, of someone in the family in the United Kingdom. The number increases exponentially if we consider alcohol problems as well. Hence, one of the most important things to remind yourself, if you are feeling like this, is that *YOU ARE NOT ALONE*.

### ***How Do I Make Sense of This?***

Having established that this is a common experience, as we were saying earlier, it is important to think about the aspects of the experience that can be under your control even though they may not feel controllable at present. Gaining some sense of control and understanding of your experience will help you feel less confused, and will allow you to identify and name some of the roller coaster of emotions that you may be feeling at present (e.g., anger, despair, and fear). Being able to name those emotions and

identify why they are happening and where they come from can make you feel better, even when the drug problem of your relative has not changed much or at all. First, you can try and identify a situation or behavior related to your experience, for example, your son coming back home late at night and appearing quite confused and “stoned.” Describe the event as clearly and specifically as you can (e.g., Martin comes home very late and appears to be “stoned”). You may even go onto describe some of the signs that make you think this (e.g., he is giddy, does not make sense, and his eyes look very puffy). Next, try to identify what you felt when this happened. Again, try and be very specific (e.g., “I feel really *annoyed* when this happens but also *frightened* and *upset*,” as opposed to “I feel like my world is collapsing,” which is a rather broad and abstract description). In the first example, you are naming the feelings and making them clear, the first step toward dealing with them. You can also explore some of those feelings in more depth. You can try and think about what you are frightened of, or about what is making you feel upset. For example, we know that a lot of family members or supportive social network members fear for the health and safety of their loved one and feel upset because they feel let down and feel that they cannot trust the person.

At times, you may start wondering whether the only positive thing that can happen is that your loved one seeks help for his or her alcohol or drug use. While this would clearly be a very positive step, it may not happen for a while. However, we know that family members or supportive friends can improve their experience and come to terms with some of the feelings of despair by working on their own understanding of the situation, even in those cases where the person does not access help straightaway or change in the short term. It may also be important at this stage for you to consider what the impact is on other members of the family or network of friends of the person using alcohol or drugs.

### ***Why Do I Feel So Stressed?***

The next area that is important to consider at this early stage is the *strain* that you, as a family member or a friend, may be experiencing. We know that family members of people with

addiction problems have high symptoms of physical and psychological stress. Physical symptoms include experiences such as loss of appetite, difficulty sleeping, and high blood pressure. Psychological symptoms include feeling anxious or depressed, increasing your own intake of substances by drinking or smoking more, and a general sense of worry that is with you most of the time. However, starting to talk to people who are in a position to help may be a very important first step for you to take. Being able to make sense of your experience may allow you to help and support your loved one from a calmer and positive stance.

### ***To Sum It Up***

If you have read up to this point, we hope that this would have helped you to think more about your situation and the problems that you are facing. We hope also that you have been able to identify more specifically and clearly the aspects of the situation that are contributing to your experience of stress and worry, and also considered some of the possible symptoms of stress that you are experiencing as an affected family member or close friend. This is a very important step in order to begin to take control of your situation and your experience, and to plan ways of responding to both your needs and those of your loved one in a helpful way.

The most important thing to remind yourself is that *YOU ARE NOT ALONE*, that there are millions of other people experiencing similar situations, and that some of the most frightening thoughts and feelings you have had are the result of the stress that is arising from your understandable concern and worry about your loved one. Beginning to come to grips with what is going on for yourself and for your relative or friend is the first step in planning what to do in response.

Depending on where you live, there will be organizations that offer support and, in some parts of the world, self-help groups for family members affected by the drug and mental health problems of a relative. In the United Kingdom and other countries, for example, there will be Al-Anon groups supporting families dealing with alcohol misuse and Families Anonymous groups supporting families dealing with drug

misuse. Adfam, again in the United Kingdom, is a national organization working in a range of ways to support families affected by drug use, and can offer advice about local services.

*Some books that you may be interested in reading*

Mueser, K. T. & Gingerich, S. (2006). *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*. New York: Guilford Press. This book is focused on schizophrenia and has an excellent section devoted to the use of alcohol and drugs in those with severe mental health problems.

*Books that cover the impact of drug and alcohol use on families and different family members*

Barnard, M. (2007). *Drug Addiction and Families*. London: Jessica Kingsley.

Orford, J. (2012). *Addiction Dilemmas. Family Experiences in Literature and Research and Their Lessons for Practice*. Chichester: Wiley-Blackwell.

Trimingham, T. (2009). *Not My Family, Never My Child: What To Do If Someone You Love Is a Drug User*. Australia: Allen & Unwin.

You will be able to find additional resources quoted in these books or related websites.

***How Can I Best Support My Family Member or Friend?***

*Keeping communication open*

Your family member, loved one, or friend may have approached you as someone who he or she thinks can offer support to make a change or achieve an identified important goal. This can be helpful for both yourself and the person with the substance misuse and mental health problem, as it means that you will be able to communicate more openly with each other, and you may be able to offer your support and encouragement, which we know is important in helping people change substance use habits and achieve their goals. Keeping communication open is an important aim.

*Supporting his or her goal*

Listen to what your loved one may tell you about his or her goal and talk together if necessary with help from your loved one's



Clinician about the possible ways in which you may support his or her goals. Your loved one's goals may involve, for example, trying to "avoid admission to a mental health unit in the future," and part of this may involve trying to not use substances. Other goals may involve personal aims—for example, getting a job, learning to drive, or getting fitter. Your loved one will be encouraged to identify a small, realistic, substance-related or personal goal, and to think about people who are important and can offer support in achieving this goal. You can support this goal at the simplest level by being genuinely encouraging or, at a more practical level, by helping him or her identify and pursue ways of achieving the goal—for example, visiting the job center together or exploring together ways of increasing physical exercise and getting fitter.

# Boosting Change

## ▶ Booster Session Content

<i>Session Content</i>	<i>Intervention Goals</i>
<ul style="list-style-type: none"> <li>■ Review self-motivational statements of concern and intent to change</li> <li>■ Review action plan</li> <li>■ Review social support for change and introduce to community-based treatment</li> </ul>	<ul style="list-style-type: none"> <li>■ Consolidate motivation and transfer skills from BIMi to the community</li> <li>■ Review progress with substance-related goals and skills to tackle setbacks</li> <li>■ Link participants with community-based substance misuse treatment</li> </ul>

At the final session with the client, you will need to arrange a “booster session.” This session is suggested to occur *1 month after the final session*. If the client was in hospital at the time BIMi was delivered, it can be while he or she is still an inpatient. This session aims to help consolidate the client’s motivation by encouraging him or her to review and remember the sessions you had, including: any changes in thinking about substance use, the links discovered between substance use and mental health, and other effects and additional goals. It also seeks to transfer the skills from BIMi to the community by introducing them to community-based

*Brief Integrated Motivational Intervention: A Treatment Manual for Co-occurring Mental Health and Substance Use Problems*, First Edition. Hermine L. Graham, Alex Copello, Max Birchwood, and Emma Griffith.

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substance misuse treatment and by actively linking clients into community support routinely integrated within community mental health services. This session is also an opportunity to discuss with the client how to integrate what has been learned during the sessions into his or her relapse plan and ongoing treatment plan. This could include the effects of substance use on mental health, goals for substance use, and community-based substance misuse treatment options.

In the booster session, your aims are to:

- Consolidate the client’s motivation and decision to make a change
- Review progress with the client’s goal and tackle any setbacks
- Link client with any additional social supports and treatment options

### ► **Booster Session Outline**

- We met quite a few times when you were admitted to hospital (or not feeling mentally well), and spent time talking about your use of \_\_\_\_\_ [insert name of substance—e.g., cannabis].
- How have things gone for you in relation to your use of \_\_\_\_\_ [insert name of substance—e.g., cannabis] since we last met?
- Let us remind ourselves of what we focused on during our session.

At this stage, you will need to review the key steps and issues covered during your previous sessions and offer support, if necessary, to help the client build on his or her initial motivation to change. If necessary, briefly revisit or go to STEP 2 to remind the client of what he or she thought the “benefits” and “costs” associated with continued use were (Worksheet 1 or 2), and the “effects my use sometimes has on me” (Worksheet 3). Re-establish with the client motivational statements of concern and intention to change. If the client is in agreement, discuss how the effects of substance use on mental health, which had been identified, can be integrated into his or her relapse plan and ongoing treatment plan.

### ***Review Self-Motivational Statements of Concern and Intention to Change***

- At that time, you felt that you wanted to [insert what client wanted to do about his or her substance use]  
\_\_\_\_\_
- Is that how you still feel? Or do you feel differently now?  
\_\_\_\_\_
- What would help you now?  
\_\_\_\_\_

Remember at this point to:

- Summarize what has been covered previously and how the client feels now and reflect it back

### ***Review the Maintenance Cycle for Mental Health Problems and Substance Use***

It may be helpful to summarize and take the client through the maintenance cycle or vicious cycle that you had generated together.

- So, when we discussed this earlier, you noticed that sometimes there is a connection between what you use and how you feel. What you have said was that, usually just before you use \_\_\_\_\_ [insert name of substance], you are usually \_\_\_\_\_ [insert triggers] and you tend to think that \_\_\_\_\_ [insert main benefit], and that straightaway after you use you feel \_\_\_\_\_ [insert immediate effect], but that later on you feel \_\_\_\_\_ [insert delayed or longer-term effect] and your mood (or mental health) is \_\_\_\_\_ [insert effect].
- Is that still how you feel they are connected?

Remember at this point to:

- Summarize what has been covered previously and how the client feels now and reflect it back

It might be necessary to briefly revisit or go to STEP 3 to remind the client of what he or she had decided was the goal to work toward. You can do this by reviewing the “Taking Steps Toward My Goal” worksheet (Worksheet 3), and focusing on developing helpful strategies to manage any setbacks that may have arisen. Discuss how these goals could be integrated into his or her ongoing treatment plan.

***Review Progress with Substance-related Goal and Skills to Tackle Setbacks***

- When we met earlier, you said that you wanted to [insert what client wanted to do about his or use]  
\_\_\_\_\_
- Is that still how you feel? Or do you feel differently now?  
\_\_\_\_\_
- How have you gotten on with taking steps toward your goal?  
\_\_\_\_\_
- What else would help you now?  
\_\_\_\_\_

Remember at this point to:

- Summarize what has been covered previously and how the client feels now and reflect it back

***Review Social Support for Change***

- At that time, you felt that \_\_\_\_\_ [insert name of supportive social network member] could provide you with support in achieving your goals.
- Is that how you still feel? Or do you feel differently now?  
\_\_\_\_\_
- What other support would you need to help you make the changes you would like? \_\_\_\_\_  
\_\_\_\_\_

If necessary, revisit/re-do the clients' social network diagram and re-establish with the client his or her sources of support.

Remember at each point to:

- Summarize what has been covered previously and how the client feels now and reflect it back

### ▶ **Link in with Community-based Substance Misuse Treatment Services**

Toward the end of the session, introduce the client to community-based substance misuse services and any additional support appropriate to support him or her. The reason for actively linking the client with appropriate substance misuse treatment, at this stage, is to ensure that he or she has support and can continue to build on his or her motivation to change and take steps toward the self-identified goal and maintain changes within his or her community setting.

## ◀ APPENDIX ▶

# Worksheets and Handouts

## BIMI—Brief Assessment Sheet

	<i>Alcohol</i>	<i>Cannabis</i>	<i>Crack Cocaine</i>	<i>Cocaine Powder</i>	<i>Legal Highs</i>	<i>Heroin</i>	<i>Illicit Methadone</i>	<i>Amphetamine</i>	<i>Other</i>
<b>Have you used this in the past 30 days?</b>									
<b>When did you last use this?</b>									
<b>What is the amount you use on a typical day?</b>									
<b>How much do you spend on this on a typical day?</b>									

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	<i>Alcohol</i>	<i>Cannabis</i>	<i>Crack Cocaine</i>	<i>Cocaine Powder</i>	<i>Legal Highs</i>	<i>Heroin</i>	<i>Illicit Methadone</i>	<i>Amphetamine</i>	<i>Other</i>
<b>What route?</b> Oral Smoke/ chase Snort/sniff Intravenous									
<b>During a typical week, how frequently would you use this?</b>									
<b>How old were you when you first used this?</b>									
<b>Which substance is the <i>main</i> one you use?</b>									

Source: Drug and alcohol use in the past 30 days (based on MAP, Marsden et al., 1998)



## AUDIT

Questions	Scoring System					Your Score
	0	1	2	3	4	
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2 How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
3 How often have you had six or more units if female, or eight or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4 How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5 How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6 How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9 Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10 Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Source: Saunders et al., 1993

**SDS**

Tell your client: "Please think of your use of \_\_\_\_\_ during a recent period of using when you answer these questions."

---

**1. Did you think that your use of \_\_\_\_\_ was out of control?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**2. Did the prospect of missing a fix (or dose) make you anxious or worried?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**3. Did you worry about your use of \_\_\_\_\_?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**4. Did you wish you could stop?**

0. Never/  
almost never       1. Sometimes       2. Often       3. Always/  
nearly always

**5. How difficult did you find it to stop or go without \_\_\_\_\_?**

0. Not difficult       1. Quite difficult       2. Very difficult       3. Impossible
- 

Source: Gossop et al., 1995.

**IMPORTANCE-CONFIDENCE RULER**

*Ask your client:* On a scale of 0-10, how important is it right now for you to change your use of \_\_\_\_\_ [insert name of substance]?

Importance: 0 \_\_\_\_\_ 10

On a scale of 0-10, if you decide to change, how confident are you that you would succeed?

Confidence: 0 \_\_\_\_\_ 10

**MOOD****PHQ-9**

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

Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: total score \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total \_\_\_\_\_ = Add \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
 Score Columns

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult

The PHQ-9 and GAD-7 questionnaires have been developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

**BIMI ASSESSMENT FEEDBACK—YOUR RESULTS**

Diagnosis: \_\_\_\_\_ Substance of choice: \_\_\_\_\_

Part 1

**ALCOHOL**

Alcohol	Your current use	United Kingdom (%)	Lower risk guidelines
Per day			Females 2–3 Males: 3–4
Per week			
Amount spent (£)			
AUDIT score			

Impact of alcohol at current pattern of use:

**DRUGS**

Drug	Your current use (per week)	Amount spent (£) (per week)
Cannabis		
Crack/cocaine		
Ecstasy		
Heroin		
Other		
Total spent (£)		
Dependence score		

Part 2

\_\_\_\_\_ [insert name of substance] USE: You said you were using \_\_\_\_\_ [insert quantity used and frequency of use], which cost about \_\_\_\_\_ [insert financial cost]. When we have a look at the drug/alcohol use across the country for adults, \_\_\_\_\_ [insert relevant information related to prevalence for relevant country in the general population] \_\_\_\_\_. Research suggests that about \_\_\_\_\_ [e.g., insert general population percentage] \_\_\_\_\_ use more than once a month. What do you make of that information? Is it what you expected, or different from what you expected? Your results suggested that your use of \_\_\_\_\_ [insert name of substance] is at a level that is often associated with \_\_\_\_\_ [insert information concerning level of use from AUDIT/SDS]. What do you make of this result?

MOTIVATION TO CHANGE: Your results suggest you felt that it was \_\_\_\_\_ [insert statement based on the rating on the importance scale], but also felt that you were \_\_\_\_\_ [insert statement based on the rating on the confidence scale] confident that you could make a change in your \_\_\_\_\_ [insert name of substance] use if you decided you wanted to. Is this still the case?

YOUR MOOD: Your scores suggested that, at that time, you were feeling \_\_\_\_\_ [insert statement from anxiety scores] and \_\_\_\_\_ [insert statement from depression scores] in mood.

WHAT RESEARCH SUGGESTS ABOUT THE IMPACT OF \_\_\_\_\_ [insert name of substance] ON MENTAL HEALTH

One of the leaflets from the \_\_\_\_\_ [insert name of the website—i.e., Talk to Frank or Drinkaware] website says that \_\_\_\_\_ [insert relevant information for the substance].

We could look together at information related to this the next time we meet; what do you think?

For more information, you can look on the \_\_\_\_\_ [insert name of the website—i.e., Talk to Frank or Drinkaware] website.

## ► Worksheet 1: What Do I Enjoy About Using or What Keeps Me Using?

What I enjoy about using \_\_\_\_\_ [insert name of the substance], or what keeps me using \_\_\_\_\_ [insert name of the substance]:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

When I look over my list, I feel \_\_\_\_\_

Looking at it, does it make me think differently?

\_\_\_\_\_



The most important benefit or biggest plus of using \_\_\_\_\_ [insert name of the substance] has been \_\_\_\_\_.

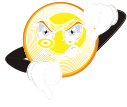


*Taking another look?*

When I took another look at the good things I tend to think about \_\_\_\_\_ [insert name of the substance], I noticed that using sometimes has different effects than I expect, such as \_\_\_\_\_

Looking at it now, does it make me think differently?

\_\_\_\_\_



Difficulties my use may be causing?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

When I look over my list I feel \_\_\_\_\_

Looking at it, does it make me think differently?

\_\_\_\_\_

So, when I sum up the *main concerns*, it is that my use may \_\_\_\_\_

To *reduce the level of concern*, I would need to \_\_\_\_\_

► **Worksheet 2: What I Enjoy About Using or What Keeps Me Using (Table)**

\_\_\_\_\_

[insert name of substance]

What I enjoy about using, or what keeps me using?	Difficulties my substance use may be causing?

When I look over my list, I feel \_\_\_\_\_

Looking at it, does my list make me think differently?

\_\_\_\_\_



The most important benefit or biggest plus of using \_\_\_\_\_ [insert name of the substance] has been \_\_\_\_\_



When I took another look at the good things I tend to think about \_\_\_\_\_ [insert name of the substance], I noticed that using sometimes has different effects than I expect, such as \_\_\_\_\_

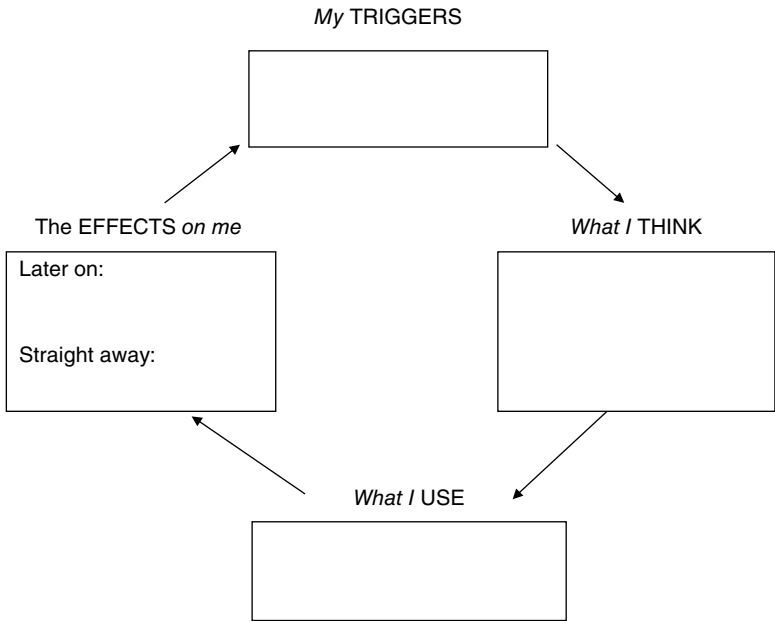
So, when I sum up the *main concerns*, it is that my use may \_\_\_\_\_

To *reduce the level of concern*, I would need to \_\_\_\_\_

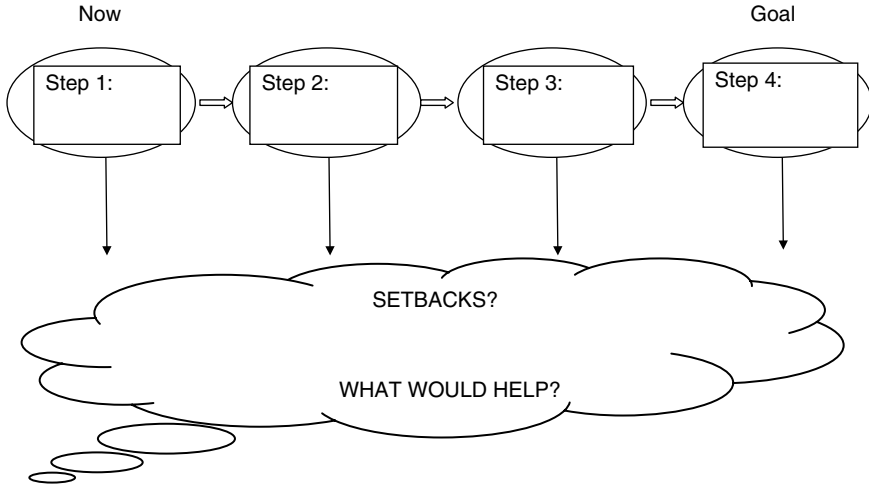
\_\_\_\_\_



► **Worksheet 3: How Does My Use Sometimes Affect Me?**



► **Worksheet 4: Taking Steps Toward My Goal**



## ► Handout 1: Helpful Information for Family Members or Supportive Social Network Members

This section provides strategies that will encourage family members or supportive social network members to think about how the situation is affecting them and others in the family or network in terms of the stresses faced. In addition, family members or supportive social network members will be encouraged to consider the range of feelings that they are experiencing, and strategies are suggested for dealing with these in a helpful way. The following information can be given as a handout for family members or close friends.

### ***Understanding Cannabis, Alcohol, and Other Substance Use, and How It Impacts on Family and Others***

This information section is aimed at helping you understand and respond to the challenging experience of having someone close to you who experiences substance misuse and mental health problems, and to think about ways in which you can look after yourself as well as offer support to the person you are concerned about. If you are reading this, it is more than likely that a friend or loved one has developed a problem with substance use in addition to mental health problems. On the other hand, you may be unsure about whether there is a problem, whether the problem is a serious one, and yet you are worried. Finding out that your relative has got a substance problem is unlikely to happen as a single event. You may have been wondering for a while if he or she has been using drugs. Perhaps his or her behavior has at times been unpredictable or changeable in ways that are difficult to explain or fully understand. We also know that, when substance use problems also happen alongside mental health problems, this combination can be complex and challenging.

Let us focus on your experience to start with. We know from research and from what family members or supportive social network members have told us that their experiences can include, for example, being concerned about the person's health and safety, the financial implications of drug use, finding the

person difficult to live with, incidents and crises at home, and a lot of worry about the impact on family or friendships. All of these are common experiences that families describe at some length when asked about living with a close relative with a substance use problem or a substance use and mental health problem combined.

One of the most important things to keep in mind as a family member or a supportive social network member in these situations is to not panic. It is likely that, in time, you can find a way of understanding what is happening that will be helpful. A good starting point is to understand your own experience, as this is mostly within your control (although at times it may not feel like this!).

### ***Do Others Experience Similar Problems?***

Before thinking and looking more closely at your own experience, it is worth considering how common these problems are. Living with someone with a drug or alcohol problem is a very common experience. It happens to a lot of people, although it is mostly hidden because people do not like to talk about this to others. A common feeling reported by family members or supportive friends is shame and worry about what other people may think of the person who is using the drugs, of you, or of the family as a whole. If you feel like this, it is problematic, because it will make you hide the experience and increase your isolation. In addition, we know that disagreements can take place between different family members or friends when these problems are discussed. This again can increase your sense of hopelessness and isolation and the feeling that you are dealing with this problem on your own, which in turn can be a really challenging experience. In fact, living with someone with a substance misuse problem and being affected by this experience is so common that it ranks among the most commonly reported forms of severe and chronic stress within the Western world. Here, we are talking about millions of people rather than thousands. In fact, in a recent study we conducted, we estimated that there are over 1 million adult family members significantly affected by the serious drug problem, including cannabis, of someone in the family in the United Kingdom.

The number increases exponentially if we consider alcohol problems as well. Hence, one of the most important things to remind yourself, if you are feeling like this, is that *YOU ARE NOT ALONE*.

### ***How Do I Make Sense of This?***

Having established that this is a common experience, as we were saying earlier, it is important to think about the aspects of the experience that can be under your control even though they may not feel controllable at present. Gaining some sense of control and understanding of your experience will help you feel less confused, and will allow you to identify and name some of the roller coaster of emotions that you may be feeling at present (e.g., anger, despair, and fear). Being able to name those emotions and identify why they are happening and where they come from can make you feel better even when the drug problem of your relative has not changed much or at all. First, you can try and identify a situation or behavior related to your experience, for example, your son coming back home late at night and appearing quite confused and “stoned.” Describe the event as clearly and specifically as you can (e.g., Martin comes home very late and appears to be “stoned”). You may even go onto describe some of the signs that make you think this (e.g., he is giddy, does not make sense, and his eyes look very puffy). Next, try to identify what you felt when this happened. Again, try and be very specific (e.g., “I feel really *annoyed* when this happens but also *frightened* and *upset*,” as opposed to “I feel like my world is collapsing,” which is a rather broad and abstract description). In the first example, you are naming the feelings and making them clear, the first step toward dealing with them. You can also explore some of those feelings in more depth. You can try and think about what you are frightened of, or about what is making you feel upset. For example, we know that a lot of family members or supportive social network members fear for the health and safety of their loved one and feel upset because they feel let down and feel that they cannot trust the person.

At times, you may start wondering whether the only positive thing that can happen is that your loved one seeks help for his

or her alcohol or drug use. While this would clearly be a very positive step, it may not happen for a while. However, we know that family members or supportive friends can improve their experience and come to terms with some of the feelings of despair by working on their own understanding of the situation, even in those cases where the person does not access help straightaway or change in the short term. It may also be important at this stage for you to consider what the impact is on other members of the family or network of friends of the person using alcohol or drugs.

### ***Why Do I Feel So Stressed?***

The next area that is important to consider at this early stage is the *strains* that you, as a family member or a friend, may be experiencing. We know that family members of people with addiction problems have high symptoms of physical and psychological stress. Physical symptoms include experiences such as loss of appetite, difficulty sleeping, and high blood pressure. Psychological symptoms include feeling anxious or depressed, increasing your own intake of substances by drinking or smoking more, and a general sense of worry that is with you most of the time. However, starting to talk to people who are in a position to help may be a very important first step for you to take. Being able to make sense of your experience may allow you to help and support your loved one from a calmer and positive stance.

### ***To Sum It Up***

If you have read up to this point, we hope that this would have helped you to think more about your situation and the problems that you are facing. We hope also that you have been able to identify more specifically and clearly the aspects of the situation that are contributing to your experience of stress and worry, and also considered some of the possible symptoms of stress that you are experiencing as an affected family member or close friend. This is a very important step in order to begin to take control of your situation and your experience, and to

plan ways of responding to both your needs and those of your loved one in a helpful way.

The most important thing to remind yourself is that *YOU ARE NOT ALONE*, that there are millions of other people experiencing similar situations, and that some of the most frightening thoughts and feelings you have had are the result of the stress that is arising from your understandable concern and worry about your loved one. Beginning to come to grips with what is going on for yourself and for your relative or friend is the first step in planning what to do in response.

Depending on where you live, there will be organizations that offer support and, in some parts of the world, self-help groups for family members affected by the drug and mental health problems of a relative. In the United Kingdom and other countries, for example, there will be Al-Anon groups supporting families dealing with alcohol misuse and Families Anonymous groups supporting families dealing with drug misuse. Adfam, again in the United Kingdom, is a national organization working in a range of ways to support families affected by drug use and can offer advice about local services.

*Some books that you may be interested in reading*

Mueser, K. T. & Gingerich, S. (2006). *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*. New York: Guilford Press. This book is focused on schizophrenia and has an excellent section devoted to the use of alcohol and drugs in those with severe mental health problems.

*Books that cover the impact of drug and alcohol use on families and different family members*

Barnard, M. (2007). *Drug Addiction and Families*. London: Jessica Kingsley.

Orford, J. (2012). *Addiction Dilemmas. Family Experiences in Literature and Research and Their Lessons for Practice*. Chichester: Wiley-Blackwell.

Trimingham, T. (2009). *Not My Family, Never My Child: What Do To If Someone You Love Is a Drug User*. Australia: Allen & Unwin.

You will be able to find additional resources quoted in these books or related websites.

## ► Handout 2: How Can I Best Support My Family Member or Friend?

### *Keeping Communication Open*

Your family member, loved one, or friend may have approached you as someone who he or she thinks can offer support to make a change or achieve an identified important goal. This can be helpful for both yourself and the person with the substance misuse and mental health problem, as it means that you will be able to communicate more openly with each other, and you may be able to offer your support and encouragement, which we know is important in helping people change substance use habits and achieve their goals. Keeping communication open is an important aim.

### *Supporting His or Her Goals*

Listen to what your loved one may tell you about his or her goals, and talk together if necessary with help from your loved one's Clinician about the possible ways in which you may support his or her goal. Your loved one's goals may involve, for example, trying to "avoid admission to a mental health unit in the future," and part of this may involve trying to not use substances. Other goals may involve personal aims—for example, getting a job, learning to drive, or getting fitter. Your loved one will be encouraged to identify a small, realistic, substance-related or personal goal, and to think about people who are important and can offer support in achieving this goal. You can support this goal at the simplest level by being genuinely encouraging or, at a more practical level, by helping him or her identify and pursue ways of achieving the goal—for example, visiting the job center together or exploring together ways of increasing physical exercise and getting fitter.



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