



2011 Web Seminar Series

Integrated Treatment of Co-Occurring Disorders


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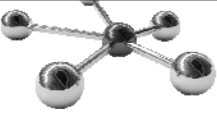
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Objectives

- Provide overview of co-occurring disorders
 - Challenges, prevalence, patterns, effects
- Review assessment strategies
- Review integrated treatment strategies
 - Psychosocial
 - Psychopharmacological and medical
 - Treatment and recovery issues


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1. Overview of Co-Occurring Disorders


- Challenges: patients, families, caregivers, systems
- Prevalence, patterns, effects
- Relationships between substance use and psychiatric disorders


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Challenges Facing 
<ul style="list-style-type: none">■ Patients■ Families■ Clinicians and service delivery systems


Challenges for Patients 
<ul style="list-style-type: none">■ Engage in treatment & comply with plan■ Develop motivation to change■ Use appropriate level of care■ Deal with stigma & negative systems■ Do the work of recovery<ul style="list-style-type: none">• Use recovery skills to manage disorders■ Develop and use a support system


Patient Perception of Recovery Challenges (n=168) 
<ul style="list-style-type: none">■ Managing emotions■ Family, relationship, support systems■ People, places and events■ Lifestyle issues and life skills■ Changing thinking■ Personality & psychological issues■ Managing cravings & triggers■ Spirituality and 12-step involvement <p>-Daley QI Study, 2006</p>


Challenges for Families 
<ul style="list-style-type: none">■ Support the family member's recovery■ Focus on family and self■ Reduce "enabling"■ Manage emotional reactions■ Take care of self■ Focus on children■ Prepare for setbacks


Challenges for Clinicians and Service Delivery Systems 
<ul style="list-style-type: none">■ Convey helpful attitudes to patients and their families■ Understand disorders "from the inside out" (subjective burden)■ Think "family," not just patient■ Use evidenced-based practices<ul style="list-style-type: none">• Psychosocial, medications, combined

Challenges for Clinicians and Service Delivery Systems 
<ul style="list-style-type: none">■ Reduce use of more costly inpatient and residential services■ Offer various levels of partial hospital and intensive outpatient services to prevent hospitalization and as "step-down" from higher level of care■ Facilitate linkages with mutual support programs■ Work as "team" (clinicians, doctors, etc)

Prevalence of Co-Occurring Disorders 
<ul style="list-style-type: none">■ Epidemiologic Catchment Area Study■ National Co-morbidity Study■ Clinical Studies
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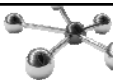
Epidemiology: ECA Study Lifetime Prevalence 
<ul style="list-style-type: none">■ 16.4% had a substance use disorder<ul style="list-style-type: none">• 53% of those with a lifetime drug use diagnosis had a mental illness diagnosis• 37% of those with a lifetime alcohol use disorder diagnosis had a mental illness diagnosis
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Epidemiology: National Co-morbidity Study 
<ul style="list-style-type: none">■ Over 10 million have dual disorders<ul style="list-style-type: none">• 51% with a mental disorder have a substance use disorder• 41-66% with a substance use disorder have a mental disorder <p>-Kessler et al</p>
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Many Clinical Studies Show High Rates of Co-Occurring Dxs 

- **High Rates (50-80+%)**
 - Antisocial & borderline personality disorders
 - Bipolar disorder & schizophrenia
- **Significant Rates (25+%)**
 - Anxiety disorders
 - Depression
 - Other
- **Many clients have 3+ diagnoses!**


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Patterns of Dual Disorders 

- Any combination of severity of substance use or psychiatric disorders
- **Substance severity**
 - high, moderate or low
- **Psychiatric severity**
 - high, moderate low
- Clinical presentation will vary according to a given patient's pattern of disorders


-Rosenthal & Weinreich; Daley & Moss


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Relationships Between Substance Use and Psychiatric Disorders 

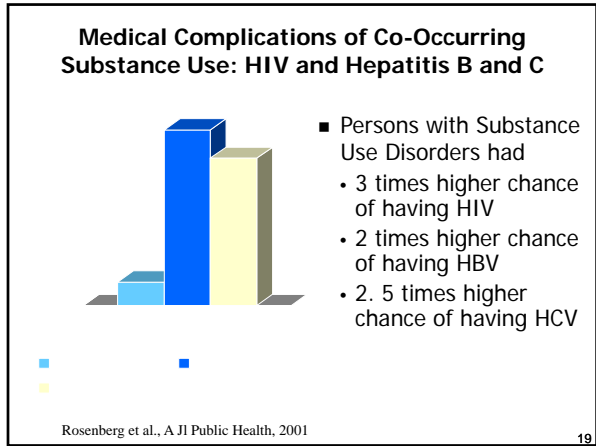
- Axis I and II psychiatric disorders
 - Increase the **risk** for a SUD
 - Can **modify the course** of a SUD
- Psychiatric symptoms may **develop in the course of chronic intoxications**
 - Depression, anxiety, psychosis

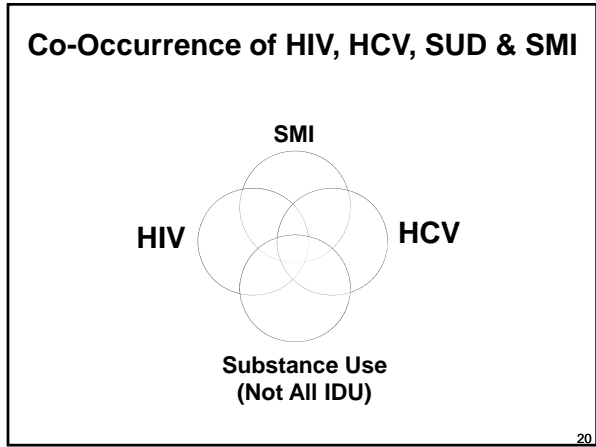
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Relationships Between Substance Use and Psychiatric Disorders	
<ul style="list-style-type: none">■ Psychiatric symptoms may emerge as a <i>consequence of chronic use</i>■ Symptoms <i>become linked</i> over the course of time■ Co-occurring disorders <i>can develop at different points in time</i>	
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Over 100 Studies Show Higher Rates of:	
<ul style="list-style-type: none">■ Severe financial problems■ Unstable housing and homelessness■ Medication non-compliance■ Relapse, psychiatric service use: ER, hospital■ Highest costs for services received■ Violence, legal problems, incarceration■ Depression & suicide; family burden■ Sexually transmitted diseases; HIV infection	
-Drake & Mueser	
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Studies at Western Psychiatric Institute & Clinic	
<ul style="list-style-type: none">■ Co-Occurring Patients Have:<ul style="list-style-type: none">• More diagnoses, days in the hospital, and psychiatric re-hospitalizations leading to higher costs of treatment received• Higher rates of suicidality and homicidality• Lower rates of treatment entry, completion, or attending sessions• Higher rates of HIV+	
-Cornelius et al; Daley et al; Douaihy et al; Salloum et al	
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2. Assessment of Co-Occurring Disorders

Purposes of Screening and Assessment 
<ul style="list-style-type: none">■ Screening<ul style="list-style-type: none">• To detect problems that may require further assessment■ Treatment planning:<ul style="list-style-type: none">• To aid in the development of plans to address the disorder(s) assessed■ Monitoring progress & outcome:<ul style="list-style-type: none">• To monitor change over time and outcome of treatment (or lack of progress)
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Approaches to Assessment 
<ul style="list-style-type: none">■ Clinician interview & review of records<ul style="list-style-type: none">• Patient• Family/concerned significant other• Other (evaluations, records, etc)■ Pen and paper questionnaires<ul style="list-style-type: none">• BDI, BAI, PANSS, SCL-90, DALI, etc■ Laboratory tests<ul style="list-style-type: none">• Urinalysis, breathalyzer, blood
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Areas of Assessment 
<ul style="list-style-type: none">■ Thorough review of all domains of life<ul style="list-style-type: none">• Substance use, mental health, medical health, family, social, interpersonal, spiritual, financial, legal, occupational■ Motivation to change■ Involvement/interest in recovery■ History of adherence and/or relapse■ Quality of life
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3. Treatment of Co-Occurring Disorders

- Stages of Change & Treatment Phases
- Principles of Treatment
- Integrated Treatment

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**Stages of Change (SUDs)
Phases of Tx (Depression)**

<p>Addiction</p> <ul style="list-style-type: none"> ■ Precontemplation ■ Contemplation ■ Preparation ■ Action ■ Maintenance ■ Termination 	<p>Depression</p> <ul style="list-style-type: none"> ■ Acute ■ Continuation ■ Maintenance
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Principles of Drug Addiction Treatment (NIDA 2009)





1. No single treatment for everyone
2. Make treatment readily available
3. Address multiple needs
4. Modify plan as needed
5. Need adequate time in tx
6. Counseling is critical
7. Medications are important
8. Use integrated treatment for Co-occurring disorders
9. Detoxification is only a start
10. Involuntary treatment can help
11. Monitor drug use in treatment
12. Address HIV/AIDS, Hep B & C
13. Recovery is long-term process


www.drugabuse.gov

NIDA

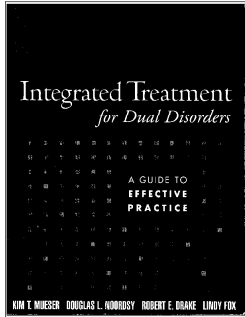
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	<h2>Integrated Treatment </h2>
	<ul style="list-style-type: none">■ Treat both disorders in same place by same treatment team when possible<ul style="list-style-type: none">• Addiction: integrate MH interventions• MH: integrate addiction interventions■ Specific focus of treatment depends on current symptoms & problems■ Dose not imply 50-50 balance (varies with patients)■ Integrated services or counseling <p style="text-align: right;">28</p>

	<h2>Examples of Treatment Approaches (WPIC) </h2>
	<ul style="list-style-type: none">■ Cornelius et al<ul style="list-style-type: none">• Depression+ and SUD■ Daley et al (Douaihy, Montrose, Salloum, Thase, Zuckoff)<ul style="list-style-type: none">• Any combination of disorders• Depression and SUD• Bipolar Illness and SUD• Chronic mental disorders and SUD <p style="text-align: right;">29</p>

	<h2>Examples of Treatment Approaches </h2>
	<ul style="list-style-type: none">■ Drake, Mueser, et al; Minkoff & Drake; Pepper & Ryglewicz<ul style="list-style-type: none">• Chronic mental illness + SUD■ Liberman; Ziedonis; Rosenthal<ul style="list-style-type: none">• Schizophrenia + SUD■ Linehan: Borderline disorders + SUD■ Najavits; Brady et al: PTSD/Trauma + SUD■ Salloum; Weiss: Bipolar illness + SUD <p style="text-align: right;">30</p>

Chronic Mental Illness & Substance Abuse Disorders

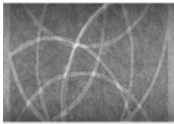


- Assessment
- Individual approaches
- Groups: persuasion, treatment, social skills, self-help
- Family approaches
- Research summary
- Educ. handouts
- Instruments

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Bipolar + SUD

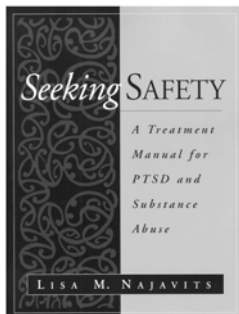
Integrated Group Therapy for Bipolar Disorder and Substance Abuse



- Used in several trials
- 12-20 structured group sessions + sessions with doctor
- Improves mood sx's
- Reduces substance use
- Results better than control condition

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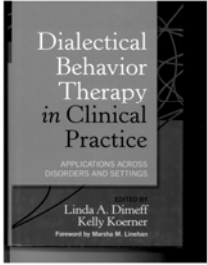
PTSD & SUD



- Cognitive, behavioral, interpersonal, case management
- Up to 25+ group sessions available
- Sample topics: PTSD, substance use, triggers, recovery, detachment, meaning, healthy relationships, self nurturing, etc

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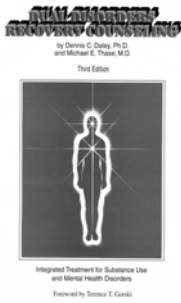
Addresses Disorders and Treatment Settings



- Includes a chapter on substance dependence
- Adapts DBT to substance use disorders

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Dual Disorders Recovery Counseling (3rd edition)



1. An integrated model
2. Used with all combinations
3. Overview of dual disorders
4. Counselor training and supervision
5. Assessment
6. Role of family
7. Overview of groups txs
8. Curriculum for 43 structured group sessions

(Daley & Thase)

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SAMHSA Treatment Improvement Protocols



- #42: Co-occurring Disorders
- #44: Depression and SUDS
- #50: Suicidal Thoughts & Behaviors

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SAMHSA T.I.P. #48

Managing Depressive
Symptoms in Substance
Abuse Clients During
Early Recovery

A Treatment
Improvement
Protocol
**TIP
48**



- For SUD counselors
- Screening/assessment
- Treatment planning
- Treatment issues
- Case discussions
- Guide for administrators
- Resources
 - Bibliography
 - Fidelity checklists

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Research on Integrated Treatment



- Much focus has been on adults with severe mental illness with a SUD
- More than 30 controlled studies show integrated treatment is more effective than traditional separate treatment
- Leads to better substance abuse outcomes
- Long-term outpatient more effective than intensive residential or day programs

Drake et al, Schiz Bull 1998 and Drake et al, Psych Services 2001 ; Mueser et al 2003

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Clinical Quality Improvement Initiatives

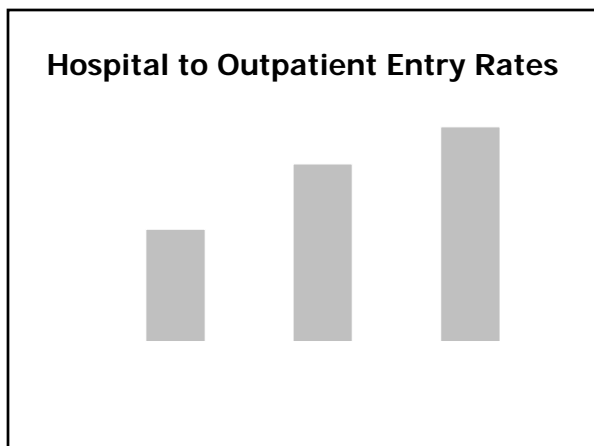
- Our CQI projects show that integrated care leads to:
 - Significant reduction of psychiatric symptoms
 - Significant reduction of substance use
 - Higher rates of engagement in outpatient care following psychiatric inpatient care
- We also found that motivational incentives significantly increases attendance in partial hospital program

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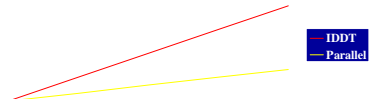
Dual Diagnosis Inpatient to Outpatient Treatment Entry

- **Subjects:** 3 cohorts of inpatients with psychiatric + substance use disorders
- **Intervention:** Single motivational session by outpatient clinician prior to hospital discharge(1-1 & small group)
- **Results:** Increased initial show rate to 63-76% (n=57+51) from 40.4% (n=183)

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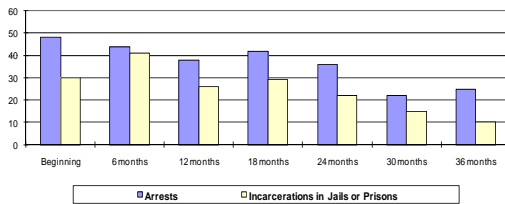
Integrated treatment improves abstinence outcomes



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New Haven Dual Diagnosis Study (1989-1994)

Number of Arrests and Incarcerations (N=203)

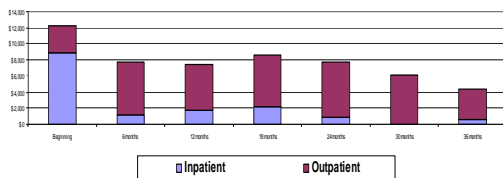


Arrests and Incarcerations decline as persons treated for dual disorders recover from substance abuse.

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NH Dual Diagnosis Study (1989-1994)

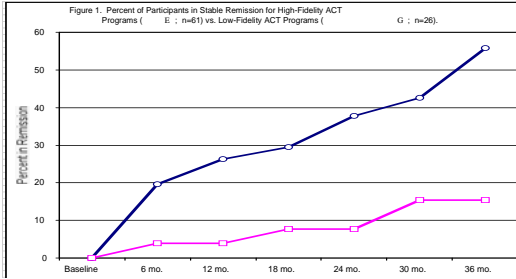
Median Treatment Costs: Patients in Recovery (N=54)



1. Median treatment costs decline more for persons in recovery.
2. Inpatient costs decrease.
3. There is a shift to community based treatment.
4. Those who are most successful often begin with higher than average treatment costs.

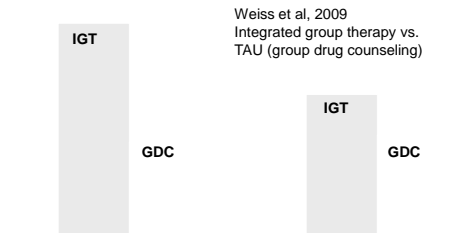
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Integrated Dual Diagnosis Treatment (IDDT) improves outcomes McHugo et al, 1999

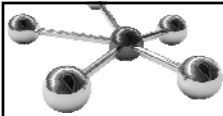


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“Good clinical outcome by tx condition: Abstinent & no mood episodes in last month



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4. Continuum of Services for Co-Occurring Disorders

- Psychosocial Treatments & Services
- Pharmacotherapy & Medical
- Mutual Support Programs

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Psychosocial Treatments and Services

Psychosocial Treatments and Services

<ul style="list-style-type: none">■ Hospital■ Residential■ Ambulatory■ Case management■ Crisis intervention■ Therapy: individual, group, family■ Housing, economic, medical	<ul style="list-style-type: none">■ Psychosocial rehab■ Disorder specific therapies<ul style="list-style-type: none">• Addiction• Mental Health■ Integrated therapies for co-occurring disorders
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Treatment of Dual Disorders:


- Six Key Program Components
 1. Case Management
 2. Close Monitoring
 3. Substance Abuse Treatment
 4. Rehabilitation
 5. Housing
 6. Medication

-Drake & Mueser

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Pharmacotherapy

Reluctance to Prescribe 
<ul style="list-style-type: none">■ Lack of available prescribing providers■ Concerns about psychological issues: over-reliance on medications■ Concerns about “enabling”■ Concerns about medication safety and related issues
<small>53</small>

Abuse Liability 
<ul style="list-style-type: none">■ Are psychotropics abusable/addictive?■ Two relevant questions:<ol style="list-style-type: none">1. Are they rewarding?2. Do they cause physiological dependence?■ A related question:<ul style="list-style-type: none">• Are they sedating?
<small>54</small>

Abuse Potential of Psychotropics

Little/None	Some	Significant
Antipsychotics*	Tricyclic antidepressants	Benzodiazepines
Mood stabilizers	Anticholinergic antiparkinsonians	Barbiturates
Most anticonvulsants		Stimulants
Non-tricyclic antidepressants buspirone		
* little or none (however, sedating atypical APs may be overused, e.g. quetiapine)	<ul style="list-style-type: none"> • zolpidem • zaleplon • eszopiclone • pregabalin • modafinil 	

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Pharmacotherapy See Attached List



- Alcohol dependence
- Opioid dependence
- Nicotine dependence
- Cocaine dependence
- Marijuana dependence

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Pharmacotherapy See Attached List



- Mood disorders
- Anxiety disorders
- Psychotic disorders
- Other


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Medications for Psychiatric & Addictive Disorders

<http://www.mattc.org/information/psychotherapeutic/index.html>

You can print a "free" PDF file of medications

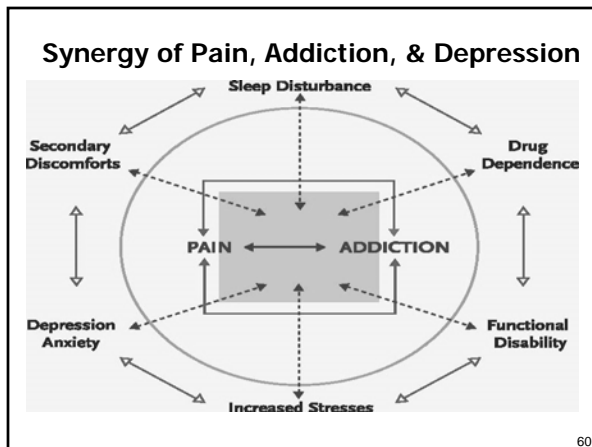
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Medical Services


- Pain
- HIV+
- HCV


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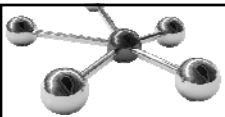
<h3>HIV/AIDS & Co-occurring Disorders</h3> 
<ul style="list-style-type: none">■ Co-occurring disorders and HIV link■ High prevalence of triple diagnosis■ Psychiatric issues in HIV+ substance abusers■ Need for early diagnosis■ SUD and HIV: impact on cART adherence■ Barriers to effective treatment of triple diagnosis■ Integrated treatment
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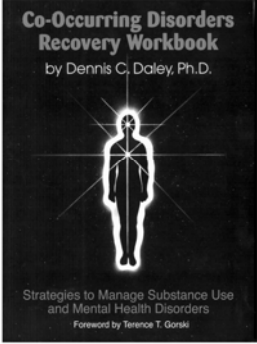
<h3>Triple Diagnosis (TD)</h3> 
<ul style="list-style-type: none">■ Women, racial, ethnic minorities, socially and economically marginalized people are disproportionately affected by the <i>co-occurrence of HIV infection, SMI and SUD</i>■ Patient-centered approach based on empathy and unconditional positive regard.■ Ambivalence is common and multifaceted.■ TD patients manifest hopelessness, depression, suicidality, which affect motivation 
(Douaihy, et al, 2003) 62

<h3>Psychiatric Features of HCV</h3> 
<ul style="list-style-type: none">■ Have increased prevalence of:<ul style="list-style-type: none">• Substance use disorders (up to 95%)• Depressive disorders (31% - 58%)• Fatigue (40% - 100%)• Anxiety disorders (18% - 26%)■ May be caused or be exacerbated by:<ul style="list-style-type: none">• Direct CNS effects of the virus• IFN■ Are screened using tools similar to those used for HIV
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HIV/HCV Co-infection	
<ul style="list-style-type: none">■ Prevalence of HCV among HIV+ is estimated to be 30% & among IDUs 70% to 90%■ Both affect CNS functioning & associated with cognitive dysfunction■ Methamphetamine factor■ Serious mental illness and co-infection■ HIV complicates <i>the course and treatment of HCV: it also increases the importance of treatment</i>■ <i>Persons with SMI can tolerate treatment</i>	
<p>Douaihy, Hilsabeck et al, 2008 64</p>	

	
Treatment Plan for Coinfected	
<ul style="list-style-type: none">■ Integrated services for medical, psychiatric and substance use problems■ Include on-site medical, psychiatric, psychological , social work providers■ Outreach services especially to minority communities and case management■ Referral to specialty and subspecialty care, if necessary	
<p>Neuropsychiatric Aspects of Coinfection With HIV and Hepatitis C Virus Douaihy A, Hilsabeck RC, et al. AIDS Reader. 2008;18:425-432, 438-441 65</p>	

	
5. Dual Disorders Recovery Counseling (DDRC)	
<ul style="list-style-type: none">■ An Integrated Model■ Use Individual, Family & Group Sessions■ Medication Assisted Treatment	
<p style="text-align: right;">66</p>	



Patient guide used since 1990 (4th ed)

1. Dual disorders & recovery
2. Foundation: goals, effects
3. Acceptance: denial, roadblocks, recovery
4. Emotions: anger, anxiety, boredom, depression
5. Relationships: family, others, AA/NA
6. Self change: behaviors, thinking, spirituality
7. Lifestyle: daily plan, goals, financial
8. Relapse: F/U after hospital, warning signs, emergencies

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Goals of Treatment

- Eliminate or reduce psychiatric symptoms
- Stop or reduce substance use
- Enhance motivation to change
- Facilitate engagement in recovery
- Improve coping skills
- Improve functioning
- Lifestyle change
- Decrease relapse risk
- Early intervention in relapse



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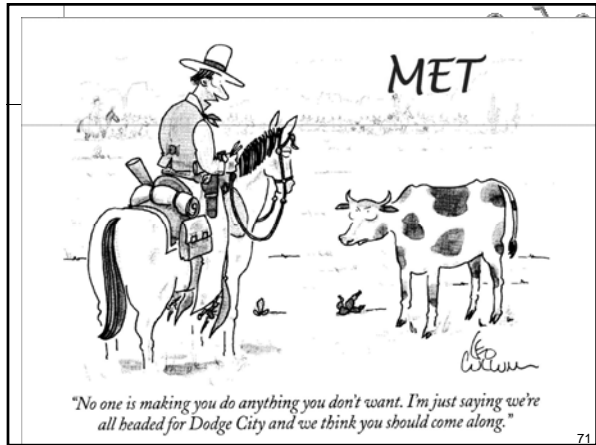
Build a Therapeutic Alliance

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Dual Recovery Counseling


- Develop a therapeutic alliance
 - Patients want to feel heard, not judged, respected and valued
- Establish a contract (both disorders)
 - Problems, goals, steps to goals, services, types and frequency of sessions, when to change plan
- Help patient "accept" disorders:
 - Review details of history, give feedback, assess motivation to change, use motivational approach

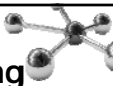
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Address Substance Use and Strategies to Achieve Abstinence

Dual Recovery Counseling 	
<ul style="list-style-type: none">■ Review details of substance use history■ Perceived positive effects of substances■ Pros & cons of abstinence. What will patient miss about not using?■ Effects of substance use on:<ul style="list-style-type: none">• Psychiatric disorder• Self (medical, emotional, spiritual, social)• Family and others	

Dual Recovery Counseling 	
<ul style="list-style-type: none">■ Monitor for withdrawal symptoms■ Use objective measures (urinalysis)■ Use withdrawal scales (e.g., CIWA)■ Facilitate detoxification when indicated■ Use medications as needed	


Dual Recovery Counseling 	
<ul style="list-style-type: none">■ Facilitate medication assessment■ Facilitate augmentation therapy■ Deal with perception of being in recovery and taking medications■ Help anticipate and prepare for pressures to stop taking medications■ Monitor medication adherence	

**Educate, Educate, Educate
Your Patients**

Dual Recovery Counseling 

- Provide education on recovery
 - Stages of change
 - Domains of recovery
 - Helpful recovery attitudes
 - Helpful recovery behaviors
 - Recovery support programs
 - Relapse precipitants


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Dual Recovery Counseling 

- Provide education on disorder(s)
 - Causes, effects, treatments, relapse, recovery
- Review treatment options
- For patients with "persistent symptoms," of psychiatric illness teach strategies to monitor symptoms over time
- For patients with multiple substance use relapses, teach addiction recovery skills

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Manage Cravings and Obsessions

Dual Recovery Counseling 


- Monitor cravings, close calls and use
 - Use a daily log
 - Record actual use and context
 - Rate cravings and context
 - Record coping strategies used
- Teach strategies to manage cravings
 - Cognitive, behavioral,
 - Consider pharmacologic interventions

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Challenge Faulty Thinking

	<h2>Negative Thinking</h2> 
	<ul style="list-style-type: none">■ Mark Twain Said. . .<ul style="list-style-type: none">↳ "I am an old man and have known many troubles, but most of them never happened"

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	<h2>Using Slogans, Self-Talk or Mottos</h2> 
	<ul style="list-style-type: none">■ Anxiety is part of life■ My anxiety/panic/fear won't last forever■ I can't live the rest of my life afraid■ Avoiding things I fear feed my anxiety■ People are not as critical as I think■ Live in the here and now■ Being imperfect is humble

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	<h2>Common Relapse Thoughts with SUDs</h2> 
	<ul style="list-style-type: none">■ Relapse can't happen to me■ I'll "never" use alcohol or drugs again■ I can "control" my use of alcohol or other drugs■ A few drinks, tokes, pills, lines, won't hurt■ Recovery isn't happening fast enough■ I "need" alcohol or drugs to have fun■ My problem is "cured"


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Challenging Faulty Thinking Worksheet



- Identify thought that is faulty:
- State what's wrong with it:
- Ask what is the evidence it is true?
- Create new statement(s) to challenge faulty thinking:

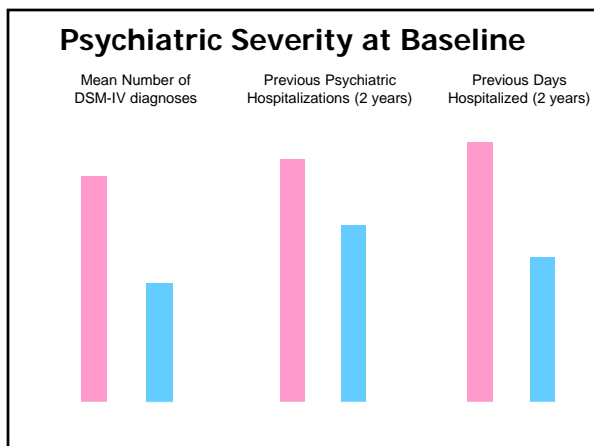
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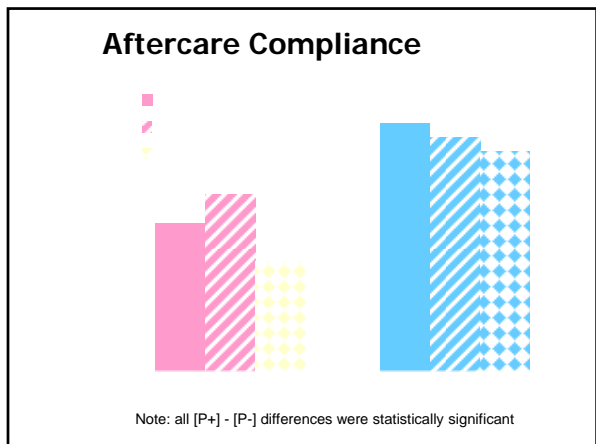


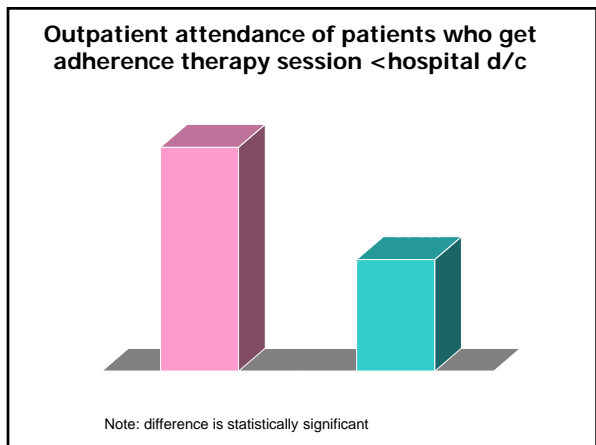
Facilitate Transition from Residential or Hospital to Follow-Up Care

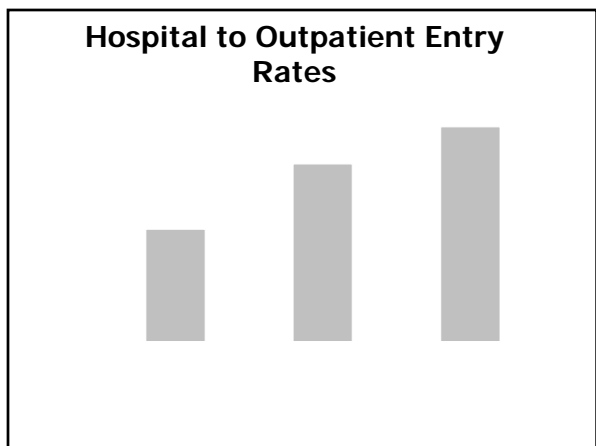
- Motivational Counseling
- Case Managers (chronic psychiatric disorders)

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Help Patients Learn Skills to Manage Emotions

- Common emotions in recovery
- Emotions vs. "mood" disorders

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Introduction to Emotions


- Emotions describe "inner" life or "subjective" experiences
- Mood is a prolonged emotion
- Emotions seen as positive or negative
- However, any emotion can have +/- effects (e.g., excitement, fear, anger)
- Many psychiatric disorders have mood components


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Emotions and Axis 1 Psychiatric Disorders


- **Depression:** common with mood, anxiety, personality, substance use, psychotic and eating disorders
- **Anxiety:** common with anxiety, mood, psychotic, eating and substance use disorders
- **Anger:** common with may Axis 1 disorders

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	Emotions and Axis 2 Psychiatric Disorders 
	<ul style="list-style-type: none">■ Anger: common with many Axis 2 disorders (especially borderline and antisocial disorders)■ Boredom and emptiness: common with Borderline and Antisocial personality disorders <p style="text-align: right;">94</p>

	Emotions and Substance Use Disorders 
	<ul style="list-style-type: none">■ Anger, anxiety, boredom, depression, emptiness, guilt & shame or loneliness are common issues with many patients■ Many people with SUDs also have a mood, anxiety, or personality disorder■ Inability to manage negative mood states is highest relapse factor■ Positive emotional states also contribute to relapse <p style="text-align: right;">95</p>

	Dual Recovery Counseling 
	<ul style="list-style-type: none">■ Help patient identify and manage emotions (emotional regulation)■ Help patient reduce negative emotions especially anger, anxiety, boredom, depression, guilt & shame, and loneliness■ Help patient increase positive emotions <p style="text-align: right;">96</p>


Dual Recovery Counseling 

Social Anxiety

- Assess level of social anxiety and avoidant behavior related to group treatments and self-help programs
- Help reduce social anxiety through the use of cognitive & behavioral strategies

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Improve Relationships and Support Systems

Dual Recovery Counseling 

Help patient develop support network and know how to ask for help

Family and friends Community
Church Other
Mutual support programs

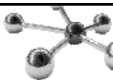
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Dual Recovery Counseling 

Address Family Issues


- Assess impact of disorder(s) on family unit and individual members
- Assess need to involve family
- Provide support and help to family
- Facilitate family involvement in:
 - Treatment
 - Recovery

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Impact of Dual Disorders on the Family (Daley) 


- Emotional burden 91%
- Family neglect 84%
- Irresponsibility 74%
- Economic burden 64%
- Family enabling 51%
- Physical abuse 45%
- Loss of children 25%


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Symptoms of Family Members with Psychiatrically Ill Member 

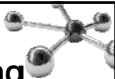
- Anxiety 58%
- Frustration 58%
- Worry 56%
- Sense of burden 55%
- Depression 48%
- Grief 47%
- Anger 42%
- Shame/guilt 21% & 18%


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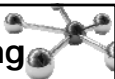
Dual Recovery Counseling 	
Interpersonal Skills and Conflicts <ul style="list-style-type: none">■ Assess interpersonal skills and deficits■ Improve existing or develop new interpersonal skills■ Learn to manage conflicts■ Identify specific interpersonal problems in relationships and strategies to address these	
<small>103</small>	

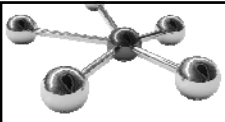
Dual Recovery Counseling 	
Identify People, Places, and Events That Increase Risk of Substance Use <ul style="list-style-type: none">■ Direct and indirect social pressures■ High risk activities and events■ High risk relationships■ Early recovery romances	
<small>104</small>	

Dual Recovery Counseling 	
Amends <ul style="list-style-type: none">■ Help patient understand "making amends" process	
<small>105</small>	

	
Dual Recovery Counseling	
Mutual Support Programs	
<ul style="list-style-type: none">■ Discuss negative views, perceptions and experiences with these programs■ How these programs can help■ Facilitate linkage to programs■ Encourage "active" involvement■ Monitor attendance and involvement	
<small>106</small>	

	
Dual Recovery Counseling	
<ul style="list-style-type: none">■ Addiction (AA, NA, CA, RR, WFS, etc.)■ Dual Recovery (DT, DRA, MISA, etc.)■ Mental Health - General (EA, EHA, Recovery, Inc., etc.)■ Mental Health - Diagnosis specific■ Recovery clubs	
<small>107</small>	

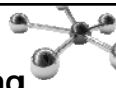
	
Dual Recovery Counseling	
Lifestyle Issues	
<ul style="list-style-type: none">■ High risk times (evenings and weekends)■ Importance of regularity in schedule■ Identify and practice new leisure activities■ Academic/occupational issues■ Life skills and use of community resources (especially for patient with chronic illness)■ Budgeting, "check" day stressors	
<small>108</small>	



Reducing Risk of Relapse or Recurrence

- Lapse or relapse (addiction)
- Relapse or recurrence (psychiatric illness)


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Dual Recovery Counseling

- Educate on relapse and recurrence
 - Process or warning signs
 - High-risk factors
- Teach coping skills
 - Managing warning signs & risk factors
- Deal with lapses, relapses, recurrence
- Learn from mistakes or setbacks


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Relapse in Schizophrenia

- **Predictors of relapse:**
 - Poor adherence to medications;
 - Alcohol or drug abuse
- **Strategies to reduce risk:**
 - Keep personal relapse symptom list
 - Identify things exacerbating stress
 - Get enough medications

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Dual Recovery Counseling 

- Encourage use of recovery tools on a daily basis
 - Checklists
 - Inventories
 - Daily reviews

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Personal Growth Issues

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Dual Recovery Counseling 

- Help patient deal with emotional wounds from the past
- Address spirituality issues
- Address "character defects" (12-step program)

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Reducing Suicidal Risk

Dual Recovery Counseling: Suicidality


- Assess suicidality
- Be aware of risk factors
- Decrease suicidal risk
- Use more aggressive interventions if needed to manage suicidality

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Suicidal Clients

- Discuss suicidal thoughts and feelings
- Develop suicide prevention contract
- Seek help immediately if there is an actual plan
- Make agreement with family or significant other that hospitalization should be initiated if an attempt has been made or appears imminent

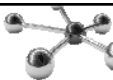
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Suicidal Clients

- Focus on the “why” of suicide in therapy sessions
- Remind client that suicide thoughts and feelings go away
- Catch early warning signs of psychiatric relapse -- this reduces likelihood of suicidal thoughts and feelings

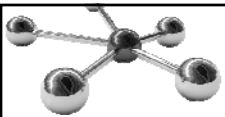
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Suicidal Clients

- Avoid drug/alcohol use
- Remind client that suicide is a permanent solution to a temporary problem


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Group Treatment of Dual Disorders


- Psychoeducation
- Therapy
- Family Groups


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Common Challenges and Mistakes of Group Leaders 
<ul style="list-style-type: none">■ Boredom with group or burnout■ Hard to deal with boredom of clients (especially multiple treatment attendees)■ Not enough interaction with or among clients■ Not engaging quiet members■ Not limiting talkative members■ Too much time off topic or problems■ Too much time on problems & not solutions <p>121</p>


Types of Groups 
<ul style="list-style-type: none">■ Psychoeducational■ Skills development■ Cognitive-behavioral (RP)■ Interpersonal process■ Support groups <p>-SAMHSA T.I.P. #41</p> <p>122</p>


Format for Psycho-educational DDRC Groups 
<ul style="list-style-type: none">■ Topic or recovery theme■ Objectives and purpose of session■ Major points to review■ Methods of covering material■ Review of handouts■ Check-in and check-out procedures <p>123</p>


Conducting DDRC Groups 	
<ul style="list-style-type: none">■ Keep focused but be flexible■ Focus on solutions, not just problems■ Make members work■ Get everyone to talk	
<small>124</small>	


Conducting DDRC Groups 	
<ul style="list-style-type: none">■ Connect substance use and psychiatric illness■ Focus on thoughts, feelings, behaviors and relationships■ Shift to group process issues if needed	
<small>125</small>	

Action Techniques In DDRC Sessions 	
<ul style="list-style-type: none">■ Interactive discussions in groups■ Educational videos■ Role-plays (behavioral rehearsals)■ Monodramas■ Written materials & assignments■ Other (creative media)	
<small>126</small>	


Psychoeducation Group Topics	
<ul style="list-style-type: none">■ Setting goals■ Advantages of recovery■ Denial■ Roadblocks to recovery■ Managing cravings■ Managing people, places, things, events■ Managing persistent psychiatric sx's	
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Psychoeducation Group Topics	
<ul style="list-style-type: none">■ Anger■ Boredom■ Depression■ Guilt and shame■ Positive feelings■ Family issues■ Impact of disorders on relationships	
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Psychoeducation Group Topics	
<ul style="list-style-type: none">■ Refusing substance offers■ Building a recovery network■ Self-help programs■ Changing thinking■ Changing self-defeating behaviors■ Personality problems■ Spirituality	
129	


Psychoeducation Group Topics 
<ul style="list-style-type: none">■ Using a daily plan of recovery■ Financial issues■ Relapse warning signs■ High-risk relapse factors■ Coping with setbacks and emergencies■ Suicidality
130

Sample Group Sessions
Curriculum for Co-Occurring Disorders Group Sessions
131

Objectives of Session: Managing Depression 
<ul style="list-style-type: none">■ Review types of depression and sx's■ Review causes and effects of depression■ Discuss relationships between substance use depression■ Discuss treatments for depression■ Identify strategies to manage depression & improve mood
132

Objectives of Session: Resisting Social Pressures 
<ul style="list-style-type: none">■ Identify social pressures to use substances OR stop psychiatric meds<ul style="list-style-type: none">• Direct & Indirect pressures• How SP affect thoughts, feelings, behaviors■ Identify who and how to avoid HR people■ Identify strategies to manage social pressures to use

Objectives of Session: Establishing a Support System 
<ul style="list-style-type: none">■ Identify benefits of support system■ Identify supportive people and organizations for a support system■ Identify barriers to asking for help and support■ Identify ways to ask for help and support from others

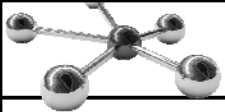
Objectives of Session: Warning Signs of Relapse 
<ul style="list-style-type: none">■ Definitions: lapse, relapse, recurrence■ Define relapse as a process and event■ Review warning signs of relapse for both types of disorders■ Develop plan to manage warning signs■ Use previous lapse, relapse, recurrence experiences as learning experiences

Therapy Groups


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Family Groups

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Questions or Comments?



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Mark Your Calendar



- **October 12**
 - Informed Consent
- **December 7**
 - A New Look at Manual of Procedure (MOP) Development

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Clinical Trials Network · Dissemination Library

National Drug Abuse Treatment

A copy of this presentation will be available electronically after the meeting from:

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and

NIDA Livelink
<https://livelink.nida.nih.gov>

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