INTEGRATING COMBINED THERAPIES (ICT) FOR CO-OCCURRING SUBSTANCE USE AND PSYCHIATRIC DISORDERS

2009 MARRCH CONFERENCE
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CO-OCCURRING SUBSTANCE USE AND PSYCHIATRIC DISORDERS

1. Common in the population and even more so in clinical settings.
2. Associated with negative outcomes
3. Integrated treatments associated with improved outcomes.
4. No more than 10% of persons with co-occurring disorders get treatment for both.
5. Chronic illness management and recovery models are necessary.

STAGEWISE ASSESSMENT

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STAGEWISE ASSESSMENT

STAGES OF CHANGE MODEL

(Prochaska & DiClemente, 1986)

Precontemplation
- Not interested
- Risk-reward analysis and decision-making
- COMMITMENT AND CREATING AN EFFECTIVE/ACCEPTABLE PLAN
- Action
- Sustained change

Maintenance
- Sustained change
- Consolidding change into lifestyle

STAGE OF CHANGE LABELS AND PATIENT TASKS

- Precontemplation
  - Become interested and concerned

- Contemplation
  - Risk-reward analysis and decision-making

- Preparation
  - Commitment and creating an effective/acceptable plan

- Action
  - Implementation of plan and revising as needed

- Maintenance
  - Sustained change


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MOTIVATION TO CHANGE

Researchers and clinicians have identified problems with this model:

1. Motivation is dynamic and mercurial
2. Primarily cognitive, not behavioral
3. Differential motivation by substance
4. Does not address "reason" for motivation (internal vs. external)
5. Does not address motivation for help

MOTIVATION FOR HELP

- Step One: “Admitted we were powerless…” (Just because I want to change doesn’t mean I can do it own my own—limits of personal will)
- Tendency to minimize severity of problem (addiction or mental health) and need for professional intervention
- More behavioral (vs. cognitive)
- Also dynamic and mercurial
- Measure available: Substance Abuse Treatment Rating Scale

CORRESPONDENCE BETWEEN STAGES OF CHANGE AND STAGES OF TREATMENT

STAGES OF CHANGE
- Precontemplation
- Contemplation
- Action
- Maintenance

STAGES OF TREATMENT
- Engagement
- Persuasion
- Active
- Relapse Prevention

STAGES OF TREATMENT OVER TIME

MOTIVATION AND CO-OCCURRING DISORDERS

- Motivation to address substance use and psychiatric problems (change; and perceived need for help) could be different
- Important to assess, and assess over time
- 2 (change and treatment) x 2 (substance use and mental health) = 4 dimensions
- Also degree of confidence in plan should be assessed: Perceived self-efficacy
**ASSESSMENT OF MOTIVATION WITH CO-OCCURRING DISORDERS: SOM-TR**

<table>
<thead>
<tr>
<th>Stage of Motivation</th>
<th>Substance Use</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>Admission</td>
<td></td>
</tr>
<tr>
<td>1 - Pre-contemplative</td>
<td>30-days ___</td>
<td>30-days ___</td>
</tr>
<tr>
<td>2 - Contemplative</td>
<td>90-days ___</td>
<td>90-days ___</td>
</tr>
<tr>
<td>3 - Action</td>
<td>Discharge/Transfer ___</td>
<td>Discharge/Transfer ___</td>
</tr>
<tr>
<td>4 - Maintenance</td>
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**Stage of Treatment**

<table>
<thead>
<tr>
<th>Stage of Treatment</th>
<th>Substance Use</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>A: ___</td>
<td>A: ___</td>
</tr>
<tr>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>90</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Discharge/Transfer</td>
<td>D/T: ___</td>
<td>D/T: ___</td>
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</table>

**Degree of Confidence**

1 - None to 10 - Totally

**STAGE OF MOTIVATION AND TREATMENT READINESS SCALE FOR CO-OCCURRING DISORDERS (SOMTR-COD)** (Hazelden CDP, 2008)

**STAGEWISE TREATMENT**

- Most of the integrative treatments support use of motivational approaches to increase engagement and adherence (Barrowclough et al., 2001; Bellack et al., 2006; Carey, 1996; Maris et al, 2002)
- Support that combination of approaches including motivational ones needed for integrated treatments for dually diagnosed (Mueser et al, 2003; Carey et al, 2003; Drake et al., 2001; Martino et al., 2006)

**STAGE, SUBSTANCE USE PROBLEM AND MENTAL HEALTH PROBLEM BY INTERVENTION STRATEGIES**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Substance Use Problem</th>
<th>Mental Health Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplative</td>
<td>Motivational enhancement therapy; contingency management; marital/family therapies</td>
<td>Motivational enhancement therapy; contingency management; marital/family therapies</td>
</tr>
<tr>
<td>Contemplative</td>
<td>Patient education</td>
<td>Patient education</td>
</tr>
<tr>
<td>Action</td>
<td>Therapeutic environment for stabilization; cognitive behavioral therapy; pharmacotherapy</td>
<td>Therapeutic environment for stabilization; cognitive behavioral therapy; pharmacotherapy</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Relapse prevention; ongoing psychotherapy; recovery monitoring; peer recovery</td>
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</tbody>
</table>

**STAGE OF MOTIVATION & TREATMENT MATCHED TO INTERVENTIONS: STAGE-WISE TREATMENT**

- Assessment
  - Characterization, interview, and treatment plan
  - Systematic process for collecting and interpreting information
- Engagement
  - Motivational interviewing, contingency management approaches, session management strategies, family and couple therapies
- Action
  - Therapeutic environment for stabilization, cognitive behavioral therapy, pharmacotherapy
- Maintenance
  - Relapse prevention, ongoing psychotherapy, recovery monitoring, peer recovery support groups connections
**THERAPIST TASKS BY STAGE**

- **Precontemplation** – raise doubt, increase patient’s perceptions of risks & problems of current behavior.
- **Contemplation** – tip the balance of ambivalence into direction of change; elicit reasons to change and identify risks of not changing; strengthen patient’s self-efficacy for change.
- **Preparation** – help patient identify/select the best initial course of action to commence change; reinforce it.

**THERAPIST TASKS BY STAGE**

- **Action** – Continue to help the patient take steps toward change; provide encouragement and positive reinforcement (e.g., praise) for action steps; assist in skill development; build patient self-efficacy.
- **Maintenance** – teach patient relapse prevention skills; self-monitoring; check-ups.

**MOTIVATIONAL ENHANCEMENT THERAPY (MET)**

- Begins with a data-driven, collaborative and honest assessment of motivation to change
- Motivational interviewing to increase desire to work on substance use and/or mental health problems
- The MET therapist matches his or her approach to patient’s level of motivation: “stage-wise treatment”
- Primary emphasis on instilling motivation to change & maintain the desire to change from within, as opposed to external motivation (e.g., coercion)
- Multiple studies have found positive outcomes, including treatment retention and engagement

**MOTIVATIONAL ENHANCEMENT THERAPY (MET)**

- MET ascertains patient life goals
- MET helps patient identify and articulate how life goals are affected by substance and mental health problems
- MET highlights the discrepancy between life goals, who the person wants to be, and the impact of substance use or mental health problems
- The MET therapist tries to solidify a motivation for change
- The MET therapist collaborates with the patient to evaluate the success of the change plan and suggests options (including professional help) if the plan is ineffective

**COGNITIVE BEHAVIORAL THERAPY (CBT)**

- Based on principles of learning
- Includes broad range of techniques, such as social skills training, cognitive restructuring, relapse prevention skills, & coping skills training
- Temporal emphasis on the here-and-now
- Focus on
  1) Reducing urges to use
  2) Managing mental health symptoms
  3) Preventing relapses into substance use or mental health problems
  4) Developing more adaptive living & coping skills

**COGNITIVE BEHAVIORAL THERAPY (CBT)**

- Associated with positive outcomes across a variety of settings (addiction treatment, mental health) and with a broad range of disorders (addiction and psychiatric)
- The therapeutic techniques are found in most addiction treatment, such as Relapse Prevention Therapy, Coping Skills Training, Anger Management
- CBT has been found effective with specific psychiatric disorders and heterogeneous disorder clusters
- CBT is a generically effective psychotherapeutic equivalent of aspirin
RESEARCH STUDIES OF THE EFFECTIVENESS OF CBT WITH CO-OCCURRING DISORDER SUB-TYPES

<table>
<thead>
<tr>
<th>PSYCHIATRIC DISORDER</th>
<th>SUBSTANCE USE DISORDER</th>
<th>TREATMENT APPROACH</th>
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<tbody>
<tr>
<td>Depression/dysthymia</td>
<td>Alcohol dependence</td>
<td>CBT (Brown &amp; Ramsey, 2000)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Alcohol and/or drug dependence</td>
<td>CBT (Weiss et al, 2007)</td>
</tr>
<tr>
<td>Social phobia</td>
<td>Alcohol dependence</td>
<td>CBT (Randell, Thomas &amp; Thermo, 2001)</td>
</tr>
<tr>
<td>PTSD</td>
<td>Cocaine dependence</td>
<td>CBT (Brah, Dansky, Back, Fos &amp; Cartell, 2003)</td>
</tr>
<tr>
<td>PTSD</td>
<td>Alcohol and/or drug dependence</td>
<td>Seeking safety (Najavits, 2002; Hein, Gehin, Miele, Litt &amp; Caprouch, 2006)</td>
</tr>
<tr>
<td>PTSD</td>
<td>Alcohol and/or drug dependence</td>
<td>CBT (McGovern, Alterman, Drake &amp; Dunton, 2008)</td>
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TWELVE-STEP FACILITATION (TSF) THERAPY

- NIAAA (TSF) & NIDA (Individual and Group Drug Counseling) manual-guided therapies
- TSF provides a structured therapeutic introduction to peer recovery support groups
- Informational and experiential
- Debunks common myths and addresses common apprehensions
- Associated with abstinence and other positive outcomes at 3-year follow-up (Project Match; NIDA Cocaine Collaborative Studies)
- Focus on skills & support for the long term

INTEGRATING COMBINED THERAPIES (ICT)

- Combining effective treatments to maximize patient response and outcomes are common in routine health care (e.g. hypertension) and psychiatry (e.g. depression).
- Psychosocial interventions can also be combined to maximize outcomes
- The combination of MET and CBT has been studied in several studies and found effective for substance use disorders, and the combination of MET, CBT and TSF was recently studied and found effective for alcohol use disorders (Miller et al, NIAAA COMBINE Study, 2007)
- The combination of MET/CBT/TSF has been integrated and adapted for persons with co-occurring disorders: ICT

INTEGRATING COMBINED THERAPIES (ICT)

• ICT begins with MET treatment modules focused on identifying and securing patient motivation to address substance use and mental health problems
• ICT continues with CBT to assist the patient to develop confidence and skills to prevent relapse and manage mental health symptoms
• The third component of ICT is TSF, which focuses on sustaining the positive changes of MET and CBT using peer recovery support groups. Common peer challenges for patients with co-occurring disorders are approached with informational and experiential practice.
• ICT is a 16-20 session manual-guided stage-wise treatment for individual or group formats
ICT: CLINICAL FOCUS

1. Engagement
2. Substance use
3. Psychiatric symptoms
4. Shared decision-making (Decision points)
5. Patient education
6. Cognitive-behavioral coping skills development
7. Developing peer recovery supports
8. Recovery checkups

ICT: FORMAT

- Plan: MET > CBT > TSF > Transition
- Module length is flexible
  - MET: 4 modules
  - CBT: 7 modules
  - TSF: 6 modules
  - Transition: 2 modules
- Individual: 45 to 50-minute session
- Group: 60 to 90-minute session
- “Practice” = Homework

ICT: APPLICATIONS

- Residential, intensive outpatient, outpatient, and methadone maintenance clinics
- Open groups
- Closed groups
- Tracks vs. universal
- Use of structured transitions (between phases) as shared clinical decision-making crossroads

THERAPEUTIC ALLIANCE, THERAPEUTIC FRAME AND RELATIONSHIP FACTORS

- “Preverbal” context within which therapy takes place
- Therapeutic alliance (Howard & Orlinsky)
  - Goals
  - Tasks
  - Bond
- Therapeutic frame: Integrity and impact
- Both relationship and content are important

THERAPEUTIC TRIANGLE

ICT HANDOUT REVIEW

- Introduction: Handout #1
- MET: Handout #2 – 3 & 5 – 10
- CBT: Handout #14a, 14b & 20
- TSF: Handout #27 – 28
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