Best Practices in Treating Dual Diagnosis

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“If all you have is a hammer, everything looks like a nail”

Abraham Maslow
Past Year Mental Illness among Adults Aged 18 or Older, by Use of Illicit Drugs: 2011 (NSDUH)

Past Year Substance Dependence or Abuse among Adults Aged 18 or Older, by Level of Mental Illness: 2010 (NSDUH)
In Treatment Settings, Dual Diagnosis is the Rule

- Studies conducted in mental health settings find 20-50% have a lifetime co-occurring substance use disorder (excluding nicotine)
- Those conducted in substance abuse treatment agencies find 50-75% have a lifetime co-occurring mental disorder
- Rates of DD may be climbing
- Rates of mental disorders increase as the number of substance use disorders increases, and vice versa

Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older with Both Serious Mental Illness and a Substance Use Disorder: 2010 (NSDUH)

- Mental Health Care Only: 45.0%
- Both Mental Health Care and Treatment for Substance Use Problems: 14.5%
- Treatment for Substance Use Problems Only: 4.3%
- No Treatment: 36.0%

2.9 Million Adults with Co-Occurring Serious Mental Illness (SMI) and Substance Use Disorder
Philosophical and Clinical Barriers to Integration

**ADDITION SYSTEM**
- Peer Counseling Model
- Spiritual Recovery
- Self-Help
- Confrontation and expectation
- Detachment/Empowerment
- Episodic Treatment
- Recovery
- Psychopathology is secondary to addiction

**MENTAL HEALTH SYSTEM**
- Medical/Professional Model
- Scientific Treatment
- Medication
- Individualized support
- Case management/Care
- Continuity of Responsibility
- Cure/symptom reduction
- Substance use is secondary to psychopathology
Dual Diagnosis is Associated with a Range of Problems

- DD clients have higher rates of:
  - Relapse
  - Hospitalization
  - Suicide and violence
  - Incarceration
  - Homelessness
  - Serious medical comorbidity
  - Trauma and PTSD
  - Service use – especially costly emergency services

Special Challenges in DD Treatment

- Multiple problems and treatment targets
- Multiple levels of motivation
- Poor treatment adherence and high dropout rates
- With SPMI, cognitive limitations may limit ability to engage in collaborative treatment
- Psychiatric symptoms may be covered up or masked by alcohol or drug use
- Alcohol or drug use or the withdrawal from alcohol or other drugs can mimic some psychiatric illnesses
- Untreated chemical dependency can contribute to a reoccurrence of psychiatric symptoms
- Untreated psychiatric illness can contribute to an alcohol or drug relapse
“We need a variety of tools in our toolbox”

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Core Competencies for Treating Dual Diagnosis (IDDT)

- Demonstrate ability to effectively build rapport and trust
- Demonstrate ability to assertively outreach clients who are difficult to engage
- Self-reflect on personal barriers to engagement with clients as well as empathize with factors related to client’s difficulty with engagement
- Demonstrate the spirit/values of Motivational Interviewing
- Demonstrate competent use of Motivational Interviewing skills
- Demonstrate ability to use cognitive-behavioral techniques
Core Competencies for Treating Dual Diagnosis (1DDT)

- Demonstrate ability to develop Relapse Prevention Plan
- Demonstrate ability to assist client in developing a healthy, recovery-oriented lifestyle
- Assess and ameliorate maladaptive life skills
- Demonstrate collaboration with client to ensure continued recovery from substance abuse and mental illness
- Demonstrate an understanding of/ability to engage family in the recovery process
- Demonstrate and communicate the importance of stage-wise DD treatment

CBT - Functional Analysis

- Substance abuse problems are linked with mental health problems and psychological factors
  - May be cause or effect, or both
  - MH problems may or may not resolve with abstinence
  - When in doubt, assume that each disorder is primary
  - Use a timeline assessment
    - Did mental health symptoms exist prior to substance abuse?
    - Is relapse to one disorder preceded by the other?
    - How are mental health symptoms affected by periods of sustained abstinence?
CBT - Functional Analysis

- To understand substance abuse you must understand its function for the individual
- Overarching questions
  - What does it do to the client?
  - What does it do for the client?
- Specific questions
  - What is the overall impact of substance use on overall quality of life?
  - What is the specific impact on mental health symptoms?

CBT - Functional Analysis

- Specific questions
  - How does the client believe that substances help manage mental health symptoms?
    - Mood
    - Anxiety
    - Psychosis
  - What does the client feel they will lose if they stop using substances?
    - Coping skills
    - Sense of structure, purpose and meaning
    - Social circle
Functional Analysis: The Example of PTSD and Substance Abuse

Substance abuse and trauma may interact in complex and unpredictable ways. These include:

- *Substances as coping mechanisms*:
  - To avoid anxiety and stimuli associated with specific traumatic events.
  - Some substances can induce a temporary sense of elation, euphoria, invulnerability, internal self-control or interpersonal effectiveness that may be absent when not under their influence.

- *Substances as risk factors for traumatic experiences*:
  - Substance abuse increases probability of exposure to traumatic victimization
  - Invulnerability while under the influence that may cause clients to ignore signs of danger and potential victimization
Functional Analysis: The Example of PTSD and Substance Abuse

- Substance use as a form of self-injury or self-punishment.
  - Urge to expose themselves to physical or emotional danger
  - Attempt at self-sabotage which serves to reinforce self-image as defective or incompetent.
  - Relapse may be triggered not by a specific drug craving, but by a need to create a familiar state of self-loathing and self-hatred

Personal Barriers to Engagement

- General guidelines:
  - Admit your own imperfection/personal reactions
  - Review caseload - what client types are most difficult for you?
  - Monitor your own thoughts and feelings when working with client
  - Develop empathy by trying to understand the basic beliefs and assumptions underlying the client's behaviors:
    - "What would I have to be feeling in order to act that way?"
“All good treatment proceeds from an empathic, hopeful, clinical relationship”

Ken Minkoff

Accurate Empathy: The Cornerstone of Engagement

- Rogers: The therapist’s ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view
- “Understanding from the inside out”
- Is not identification or sympathy
- Empathy (as perceived by the client) is strongly linked with positive outcome
- Reflective listening is fundamental to conveying empathy
What are some roadblocks to experiencing empathy?

What can clinicians do to develop and cultivate empathy for clients?

What can clinicians do to communicate empathy for clients?
- Verbal/vocal
- Non-verbal

Accurate Empathy: The Cornerstone of Engagement

Key Principles of Motivation
- Motivation to change is not all-or-nothing
- Two key components: importance and confidence
- Can be different for different substances
- Can be different for MH problems vs. substances
- Can be different for treatment vs. abstinence
- Can fluctuate over time, and can be powerfully influenced by therapist style
- Can evaporate in the face of powerful triggers
Stages of Change
(Prochaska & DiClemente)

- Precontemplation: No perceived need, desire or possibility of change
- Contemplation: Some awareness combined with ambivalence
- Preparation: Intention to change soon; tentative initial attempts
- Action: Initial, meaningful attempts to implement change
- Maintenance: Sustaining change

“I’m not ready to improve my life. I’m still in the complaining stage.”
**Stages of Change Strategies: Precontemplation**

- Goal: Engagement/retention; moving forward
- Raise doubts – without arguing for change
- Provide objective information *where appropriate*
- Evaluate: is the barrier importance or confidence?
- Elicit concerns about change

**Stages of Change Strategies: Contemplation**

- Goal: “tip the decisional balance”
- Explore pros and cons of change
- Evaluate: is the barrier importance or confidence?
- Explore hypothetical change (“if you did decide to...”)
Stages of Change Strategies: Preparation/Action

- **Preparation:**
  - Explore concrete options
  - Discuss your role in change
  - Discuss possible barriers

- **Action:**
  - Work on a change plan
  - Help client implement options
  - Troubleshoot

Stages of Change Strategies: Maintenance

- Support confidence
- Be affirmative of successes
- Beware of dips in importance or confidence
- Troubleshoot barriers to maintenance
Motivational Assessment - Clinical Tips

- Stage mismatches cause clinical problems
- Patients in preparation or action usually still have some ambivalence about change
- Some clients who appear to be in precontemplation are actually in contemplation:
  - Those mandated or coerced to attend treatment
  - Those who are approached in a confrontational style
  - Those with very low confidence in change

Motivational Assessment Questions

- What are some of the good things about X?
- What are some of the not-so-good things about X?
- What concerns you most about X?
- How ready do you feel to change X now?
- What stands in the way of you changing X now?
- If you did decide to change X and were successful, what strategies would have helped?
- What personal qualities would have helped?
Two Definitions of Motivational Interviewing

“A person-centered counseling style for addressing the common problem of ambivalence about change”

“A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion”

Miller & Rollnick, 2013
**Principles of Person-centered Care**

- Our services exist for the benefit of the people we serve
- People are the experts on themselves
- All change is fundamentally self-change. Therefore:
  - Change involves mobilizing each person's strengths, motivations and resources
  - We cannot revoke people’s choices about their own behavior

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**Spirit/ values of MI (PACE)**

“Doing MI with someone is like entering their home. One should enter with respect, interest, and kindness, affirm what is good, and refrain from providing unsolicited advice about how to arrange the furniture.”

Kamila Venner
**Partnership**

- Collaboration: MI is done for and with a person, not to a person
- MI is not a set of techniques for tricking people into change
- MI is a conversation between two people with different but equally important areas of expertise
- Counseling should feel like moving with, not moving against (dancing vs. wrestling)

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**Acceptance**

- Acceptance is not the same as approval, agreement or collusion
- Acceptance facilitates change:
  - Carl Rogers: “The curious paradox is that when I accept myself just as I am, then I can change”
Four Aspects of Acceptance

- **Absolute worth**: non-contingent acceptance of the person as they are.
  - Rogers: unconditional positive regard
- **Autonomy support**: honoring client’s capacity for self-direction; not = passivity or abandonment
- **Affirmation**: active effort to seek and acknowledge strengths and efforts
- **Accurate empathy**

Compassion and Evocation

- **Compassion**:
  - Ability to actively promote another’s welfare; to prioritize their needs
  - Added to MI 3, because compassion ensures that we are applying principles and techniques in the interest of the client
- **Evocation**:
  - Evocation vs. installation (mid-wife vs. surgeon)
  - Strengths vs. deficit world view: “You have what you need, and together we will find it”.
Active Listening - the Key Ingredient to Engagement

The core MI skills (microskills) are the foundation of good listening

- Open-ended questions
- Affirmations
- Reflective listening
- Summaries
- Information exchange

Open Questions

- Cannot be answered with a simple yes or no, or with concrete information
- Do not lead, control or try to manipulate the other person
- Often begin with the words "when," "what," "how," "why" or "where"

General MI guidelines:

- Use more reflections than questions
- Use more open than closed questions
- Never ask 3 questions in a row
**Affirmation**

- Requires clinician to seek out the person's strengths, efforts and struggles
- Can be used as a reframe:
  - Demoralized = cautious
  - Intellectualizing = curious, information-seeking
- A good affirmation is:
  - Genuine
  - Personalized
  - Relevant to treatment
  - Focused on qualities, not just behaviors
  - Not too incongruent with person’s self-perception

**Reflective Listening**

- Your perspective is not present, except as a listener
- Reflective listening:
  - Is a **restatement** of what the person said, meant or experienced
  - Requires “thinking reflectively”: listening for essential meaning, spoken and unspoken
- Reflective listening is not:
  - Agreeing or disagreeing
  - A question
  - A passive activity
  - Easy!
Summaries

- Summaries are “glorified reflections”. Three types:
  - Motivational summary: summarizes both sides of the ambivalence.
  - Gathering summary: organizes multiple change talk themes
  - Transitional summary: provides transition to new topic or to change planning

“Unsolicited advice is the junk mail of life”
Bern Williams

“Advice is what we ask for when we already know the answer but wish we didn’t”
Erica Jong
Principles of Information Exchange

- Know your motivation: Whose needs are being met? Is this what the client needs right now?
- When in doubt – don’t (IE is rarely advisable when in the engaging process)
- Remember spirit of collaboration
- Make it personal ("I statements")
- Clearly convey empathy and personal concern
- Use elicit-provide-elicit format

Elicit-Provide-Elicit

- Elicit
  - Ask permission (unless client asks first)
  - Clarify what information is needed
- Provide
  - Present information clearly and in manageable doses
  - Advice: provide a menu of options
  - Support autonomy; avoid coercion
- Elicit
  - Check person’s understanding and/or reaction
“If you have some respect for people as they are, you can be more effective in helping them to become better than they are.”

John Gardner

For more information...

- SAMHSA: [www.samhsa.gov/co-occurring](http://www.samhsa.gov/co-occurring)
- Co-Occurring Disorders Technical Assistance Center: [http://www.co-occurringdisorders.info](http://www.co-occurringdisorders.info)
- SAMHSA Treatment Improvement Protocol (TIP) #42: [www.kap.samhsa.gov/products/manuals](http://www.kap.samhsa.gov/products/manuals)
- Dual Recovery Anonymous: [www.draonline.org](http://www.draonline.org)
For more information...

- www.motivationalinterview.org