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Skills for Recovery: A Recovery-Oriented Dual Diagnosis Group for Veterans with Serious Mental Illness and Substance Abuse

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Abstract

Individuals with serious mental illness (SMI) are at a high risk for abusing alcohol and illicit substances relative to the general population. This use, even in small quantities, can negatively affect mental and physical health. Group therapy is an evidence-based treatment for individuals dually diagnosed with SMI and a substance abuse disorder. The Skills for Recovery group used a recovery-oriented therapy manual for dual diagnoses and was informed by the International Association for Social Work with Groups' Standards for Social Work Practice with Groups throughout the development and implementation of the group.

Keywords

serious mental illness (SMI); substance abuse; recovery; veterans; group psychotherapy; IASWG Standards

BACKGROUND

Individuals with serious and persistent mental illness, including diagnoses of schizophrenia and bipolar disorder, have traditionally received mental health care through stabilization programs that provided management of chronic symptoms, with limited expectations for recovery. The President's New Freedom Commission on Mental Health (2003) promoted the incorporation of recovery-oriented care for providing treatment for individuals with serious mental illness (SMI) and substance use. Recovery from mental illness and substance use disorders is defined as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2011).

Recovery-oriented care is focused on several domains as identified by Resnick, Fontana, Lehman, and Rosenheck (2005). These domains include empowering individuals to take

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responsibility for their decisions and treatment, fostering hope for achieving goals, increasing knowledge about symptoms of mental illness and available treatments, and identifying methods to increase life satisfaction (Resnick et al., 2005). Recovery-oriented care is consistent with guidelines in the *Code of Ethics of the National Association of Social Workers* (National Association of Social Workers, 2000). Further, the practice of social work is intertwined with the fundamental values of recovery, including empowering people, promoting self-determination, and valuing the worth of each individual (Carpenter, 2002).

The Department of Veterans Affairs (VA) Veterans Health Administration has mandated that recovery-oriented programs be implemented for individuals with SMI (Veterans Health Administration [VHA], 2008). To provide recovery-oriented psychosocial rehabilitation, the VA promoted the creation of Psychosocial Rehabilitation and Recovery Centers (PRRC; VHA, 2011). PRRCs offer individuals a transitional educational center with the goals of instilling hope, validating strengths, teaching life skills, providing proactive symptom management, and facilitating community involvement through meaningful self-determined roles (VHA, 2011).

Person-centered care is essential to the PRRC model. Individuals have choice and input in every aspect of the program. Respect is given to an individual's right to self-determination and autonomy. To promote an emphasis on the multiple strengths individuals have, rather than focus on symptoms of mental illness, PRRC members are referred to by their name, and not as "patient" or "schizophrenic." Individuals are empowered to choose PRRC services to be involved with, that will allow them to achieve self-chosen goals. Individuals develop personalized recovery goals and plans in collaboration with PRRC staff, wherein individual needs and preferences are identified and potential barriers are acknowledged. A holistic approach is used through the identification of areas of strength and need in all domains of functioning, including psychosocial, occupational, and financial. PRRC services concentrate on teaching skills to connect individuals with community resources and on identifying strategies individuals can use to overcome personal barriers to achieving self-stated recovery goals. Hope and optimism that recovery is possible are central to the PRRC mission and evident in all activities and interactions. Individuals have the opportunity to share successes, hopefully inspiring others to pursue their goals. As one person stated, "I saw him do it, so I thought I could." This inspiration serves a powerful purpose in group therapy, consistent with the *Standards for Social Work Practice with Groups* of the International Association for Social Work with Groups (IASWG), formerly the Association for the Advancement of Social Work with Groups (AASWG, 2010).

The PRRC in the Brockton, Massachusetts, division of the Boston VA Healthcare System is staffed by an interdisciplinary team including a social worker, psychologist, and certified peer support technician. Members typically attend the PRRC several times a week. Individuals are empowered to identify recovery-oriented life goals and to attend programs to learn the skills needed to achieve these goals and gain meaningful roles in the community.

A need was identified within the VA and the PRRC to provide evidence-based recovery oriented services for veterans who are dually diagnosed with SMI and substance abuse disorders. The Skills For Recovery (SFR) group is a group therapy offered within the PRRC

to address this need. SFR was developed using the IASWG *Standards* (AASWG, 2010), and the *Standards* were continually adhered to, in order to advance the goals and purpose of the group. Previous research has found group therapy to be effective in increasing medication compliance rates and in offering a supportive environment where discussion of symptoms, normalization of experiences, and progress toward recovery goals can be achieved (Miller & Mason, 2002). Evidence-based practice in psychosocial care for co-occurring disorders includes the development of a supportive therapeutic alliance, the use of individual and group treatment modalities, such as motivational enhancement and cognitive-behavioral therapy for relapse prevention, encouragement and positive support from others, and an integrated treatment team approach (Ziedonis et al., 2005).

SFR used the *Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual* developed by Velasquez, Maurer, Crouch, and DiClemente (2001). This manual is based on stages of change and incorporates models of behavior change (Prochaska & DiClemente, 1984) and motivational approaches developed by Miller and Rollnick (1991). Five stages of change are identified: precontemplation (individuals do not see behavior as problematic), contemplation (individuals wonder how behavior affects others and have thoughts of changing behavior), preparation (individuals have a plan of quitting and see benefits of behavior change), action (individuals change behavior and avoid triggers for relapse), and maintenance (self-acceptance, no use, and help others). The *Group Treatment for Substance Abuse* (Velasquez et al., 2001) therapy manual comprises two main sequences: Precontemplation/Contemplation/Preparation (14 sessions) and Action/Maintenance (15 sessions).

In addition to using the treatment manual, SFR group leaders routinely used techniques from cognitive-behavioral therapy and supportive therapy in the group. Group psychotherapy using these therapeutic modalities has been effective in increasing engagement in the group process and in reducing substance abuse for individuals who experience symptoms of psychosis (Kavanagh et al., 2004). In addition to these evidence-based therapeutic approaches, SFR adhered to the IASWG *Standards* (AASWG, 2010) in all aspects of the group. To our knowledge this is the first article that has examined how the *Standards* (AASWG, 2010) are applied to working with individuals with SMI and substance abuse.

CORE VALUES

Group leaders consistently applied the core values and knowledge of group work described by the *Standards* to SFR. Respect for individuals and their autonomy was emphasized in all sessions. This respect was particularly evident when working with individuals to identify their goals and values, developing individualized treatment plans, and reinforcing individuals' self-efficacy to achieve these goals. Group members were continually empowered to share their ideas and an effort was made to ensure group members appreciated and recognized the contributions of other members. The group was open to veterans of all backgrounds. Group members were diverse in culture, ethnicity, gender, sexual orientation, physical and mental abilities, and age. Democratic principles were continually infused in the group process. Normative behaviors emphasizing equality and autonomy were established and reinforced by the group leaders and members. Member

feedback on group functioning was routinely sought, and changes suggested by members that enhanced the effectiveness of the group were implemented.

CORE KNOWLEDGE

Group leaders possessed the core knowledge, as identified by the *Standards*, necessary to run SFR. This core knowledge included knowledge of the cultural and historical factors affecting treatment of individuals with serious mental illness and substance abuse, including past stigma, lack of services, and a non-recovery-oriented treatment approach. Core knowledge also included awareness and training in evidence-base recovery-oriented treatments for these dual diagnoses and in providing group psychotherapy. SFR group leaders had significant training and therapy experience, and received supervision, in providing group psychotherapy. Group leaders also had training in motivational interviewing and cognitive-behavioral therapy. Motivational interviewing principles include expressing empathy, developing discrepancy between present behavior and future goals, avoiding argumentation, allowing for the expression of resistance, and supporting the group member's self-efficacy (Velasquez et al., 2001). Group leaders also had education and training in the application of psychosocial theories to understand and treat symptoms of serious mental illness and substance abuse.

Consistent with the *Standards*, group leaders had an understanding of the "person in environment" view and applied it to the group process. The unique environmental factors influencing each group member were explored and an effort was made to understand a group member's behavior through this context. This view allowed group members to identify individual situational triggers of their substance use in a therapeutic environment. Some of these situational triggers included family and marital discord and loss of primary residence. The group encouraged members to help and support each other and collectively used each person's strengths to solve issues raised in group. SFR group leaders met to discuss and reflect on the "person in environment" view weekly following the group, to ensure that this view was continually promoted.

The group leaders embraced knowledge of groups and small-group behavior critical to running a successful group (Yalom & Leszcz, 2005). Attention was paid to the influence of the phases of group development, as identified by Yalom and Leszcz (2005), on SFR group functioning. Group members were continually provided with opportunities to take "ownership" of the group and identify specific short- and long-term recovery goals. Factors that facilitated and served as barriers for these goals were identified for each group member.

PREGROUP PHASE: PLANNING, RECRUITMENT, AND NEW GROUP FORMATION

The VA and PRRC identified a need for the development of treatment for individuals who are dually diagnosed with SMI and substance abuse disorders. The planning and conceptualization of the SFR group was consistent with tasks and skills identified by the *Standards* in the pregroup phase. An open-ended therapy group format was selected to meet this need. Open-ended groups keep individuals involved in psychosocial treatment and allow

for more opportunities to build group cohesion, which helps individuals with SMI work on their individual goals and shared group goals (Miller & Mason, 2012). Individuals diagnosed with SMI and substance abuse who remain in treatment achieve more positive outcomes, including abstinence from using alcohol and illicit substances and greater life satisfaction, than those in a shorter treatment program (Drake, Mueser, Brunette, & McHugo, 2004). Organizational support existed within the Boston VA and the PRRC for the creation and maintenance of this group. Time for clinical staff was appropriated to run the group one time a week for 1 hour. Per recommendations in the treatment manual (Velasquez et al., 2001), the group was designed to accommodate between 8 and 12 members.

Potential group members were identified in two ways. First, veterans who were members of the PRRC with active alcohol and substance abuse disorders were recruited for the group. Second, the larger community of veterans in the PRRC was invited to consider joining the group if they have experienced past functional impairment due to alcohol or substance use. All PRRC staff members helped recruit group members, as past research has identified facilitators as helpful with group recruitment (Walsh, Hewitt, & Londeree, 1997). Consistent with the mission of the Defense Centers of Excellence for Psychological Health and Traumatic Brian Injury, the PRRC peer support technician (PST) enhanced both the ability of group leaders to identify appropriate individuals for the group and the motivation of group members to use the skills and strategies discussed in the group (Defense Centers of Excellence, 2011). PSTs share common experiences with members of the PRRC, including being military veterans and being in the recovery process from mental illness. Adhering to the recommendations for an effective facilitator by Walsh et al. (1997), the PRRC PST was empathic, patient, supportive, and allowed prospective members to decide about group participation within their own time frame.

Several methods were developed to assess an individual’s progress toward recovery goals established in the SFR group. A 10-point Likert-type rating scale was included in the individual’s medical record note, with higher numbers indicating more progress toward the individual’s self-stated recovery goal. In addition to the Likert-type scale, group members were routinely asked to assess their own progress and level of motivation to change. This ongoing self-assessment has been used by other groups to identify progress toward goals and to identify discrepancies between self-assessment and group leader assessment of change and motivation (Rose & Chang, 2010). A description of the individual’s progress toward the goal, and current stage of change, was included in the medical record note. Length of sobriety, group participation, and rate of attendance were also recorded. Group leaders consulted on a weekly basis following group to assess these areas. This assessment was used to identify an effective therapeutic approach for each group member and to develop a plan to implement this therapeutic approach the following week in group.

Perspectives from multiple mental health disciplines were important in the leadership of this group. The group was co-led by a social worker and a clinical psychologist. Reflective discussion by the group leaders following each group focused on identifying and appreciating how different training and clinical experiences influenced each group leader and the group process. This discussion allowed for different knowledge bases to be applied to the group process to facilitate group members in establishing and achieving self-identified

recovery goals. The group leaders had a genuine respect for each other's thoughts and perspectives and group members appeared to benefit from this professional and collegial relationship.

GROUP WORK IN THE BEGINNING PHASE

Consistent with the IASWG *Standards for Social Work Practice with Groups* (AASWG, 2010), multiple tasks needed to be accomplished in the beginning phase of the SFR group. Knowledge of these tasks prior to the group beginning was essential. These tasks included: establishing a group contract, cultivating group cohesion, and shaping norms. These tasks were infused into activities in the beginning phase of SFR.

Group leaders and members collaboratively developed a beginning contract that identified individual and group goals, and the group process. Group member input was obtained in identifying a physical location for the group to ensure that group members felt the location was comfortable, accessible, and fostered group participation and discussion. Group rules were established, including respect toward self and others. Confidentiality and limits to confidentiality were explained and discussed. The expectation that group members attend group sober was discussed. The VA protocol for intoxicated individuals was explained. This protocol stipulated that the individual is escorted to the VA Urgent Care Center for evaluation.

A framework for each group therapy session was outlined. Groups began by "checking in" with each member. Individuals discussed their personal goals, progress made toward these goals, and identified any difficulties and obstacles they encountered. By sharing individual progress and obstacles, "check-ins" allow group members to achieve greater group cohesion and sense of support from one another (Rose & Chang, 2010). A "check-in" is an empowering therapeutic technique that allows group members to display autonomy in setting their goals and interact with other group members as equals. "Check-ins" also allowed group leaders to assess each member's general mental wellness, changes in mental status, and current urges to use alcohol or substances. The model used for "check-ins" was consistent with practice guidelines suggested by Clemans (2011), including establishing the norm of "check-ins" in each group session, having group leaders provide guidance on appropriate member disclosure during "check-in," and keeping "check-in" time limited. Although these guidelines were established for educational classes learning group work, it is noted they are relevant for conducting group therapy.

Following the weekly "check-in," appropriate group activities from the *Group Treatment for Substance Abuse* manual (Velasquez et al., 2001) were presented and discussed. In the beginning phase, members were provided with psychoeducation on the relation between SMI and substance abuse. A description of the stages of change was introduced through verbal discussion, handouts from the manual, and written on a chalk-board in the group room, to accommodate different learning styles. Psychoeducation on the physiological effects of alcohol and substances was provided, and group members presented examples of the negative impact alcohol and illicit substances had on multiple domains of their lives, including medical, psychological, family, and occupational. Each group member was asked

to identify “pros and cons” for using alcohol and substances and these were discussed as a group. Group members worked to identify “triggers” of their use and strategies to avoid or minimize exposure to these “triggers.” Stress management techniques, such as progressive muscle relaxation and breathing exercises, were taught and practiced. Effective communication strategies, including ways to refuse alcohol or substances when offered, were discussed, and role-plays were used to practice these skills in the group. Group members were able to receive “real-time” feedback on their communication style from group leaders and other group members in a supportive, therapeutic atmosphere. Strategies to identify negative thoughts and to alter these thoughts were identified, and group members were asked to record their thoughts in journals for discussion in group. Although these topics were particularly emphasized in the beginning phase of the SFR group, they were revisited throughout the group as needed.

Building group cohesion was another important part of the beginning phase of the group. Cohesion is related to the motivation each group member has toward change (Rose & Chang, 2010). Activities related to increasing group cohesion were regularly used, and the impact of cohesion on a member’s individual recovery goals was discussed. These activities were also used when members joined or left the group. Group cohesion was developed and maintained by periodically reminding group members of the group rules, particularly those related to confidentiality and respect. Group members reported these reminders helped to reinforce their perception that SFR group offered a “safe” and respectful environment in which they can share personal information and obstacles they encountered. Individual goals and overarching group goals were also regularly discussed and reviewed.

Group leaders used therapeutic knowledge and expertise to model effective listening skills, which were copied by group members. Leaders displayed reflective and empathic listening techniques, used supportive non-verbal communication, and maintained a positive therapeutic stance. Leaders helped members identify positive changes each member had made and affirmed the efforts the group member had made for this change to occur. Effective listening skills by the group leaders and members allowed the group members to feel supported and “heard.” This created and fostered “mutual aid” within the group. “Mutual aid” is a best practice within social work (Steinberg, 2010) and was promoted throughout the SFR group process. Group members used skills to help and support each other and created a safe and supportive therapeutic group atmosphere in which change and growth can be experienced.

SFR group leaders identified similarities among barriers to sobriety and wellness that group members expressed, encouraged group members to take “ownership” of these barriers, and helped identify strategies to overcome these barriers. For example, one group member identified family discord as a barrier to sobriety. Other group members who have successfully coped with a similar barrier in the past provided mutual aid and support. Group leaders promoted this discussion by asking group members open-ended questions, including “How can anyone relate to this?” or “What does the group think about this situation?” Group leaders took active leadership roles, as clinically indicated, to guide members in identifying strategies to make positive choices and decisions when confronted with barriers. Behavioral

strategies for solving problems were discussed, including how to identify various solutions and potential consequences of each solution.

Consistent with the *Standards*, group leaders were instrumental in helping group members establish normative behaviors regarding participation in the group and interactions with each other. These normative behaviors were role-modeled in a number of ways including effective communication between the group leaders, and between the leaders and members. Group leaders continued to remind members of group rules to cultivate a culture of positive group work, to promote a sense of safety and trust, and to encourage mutual aid. An example of this occurred when a veteran attended group while intoxicated. Per group rules, one group leader escorted the individual to the VA Urgent Care Center for evaluation, while the other leader remained with the group and discussed and processed the incident with the group members.

Group leaders encouraged appropriate turn-taking among the group members, including appropriate time spent speaking and content shared. Over time, group members felt empowered to take on these tasks themselves, which promoted member autonomy and self-determination. Group leaders promoted exploration of nonproductive normative behaviors. For example, when discussing substance use, group members at times accentuated the perceived positive outcomes of alcohol and substance use. Group leaders explored positive and negative consequences of using alcohol and substances and emphasized the short- and long-term impairment on mental and physical health due to substance use. This emphasis contributed to building discrepancy between the recovery goals the group member has for the future and the negative impact substance use can have on these goals. At times, group members made comments tangential to the purpose of the group. Group leaders positively refocused the group discussion to the purpose of the group, promoting an environment of goal-directed work. Activities identified in *Group Treatment for Substance Abuse* (Velasquez et al., 2001) manual were used to refocus the discussion, as consistent with the *Standards*' guidance on using activities and curriculum in the group.

During the beginning phase, group leaders continually reassessed the progress of the group as a whole, as well as the progress of individual members in the group. Group leaders reviewed relevant psychosocial theories and discussed how these theories could be applied in a more effective manner. Appropriate consultation and supervision were sought, when needed. At times, new members joined the group. Consistent with strategies identified by Miller and Mason (2012), group leaders reinforced the beginning stages of group development when a new member joined the group. Group leaders also involved existing group members in helping the new members to learn the culture and normative behaviors of the group, which increased the sense of mutual aid among existing group members.

GROUP WORK IN THE MIDDLE PHASE

In the middle phase of the SFR group, group leaders assisted group members in identifying progress toward individual and group goals and reemphasized the connection between individual and group goals. Maintaining and enhancing group cohesion was essential in the middle phase. The *Group Treatment for Substance Abuse* (Velasquez et al., 2001) manual

provided activities for sessions that were particularly applicable to the middle phase of the SFR group. Group leaders assisted members in solving problems they encountered, identified strategies to overcome present and future obstacles, and assessed progress toward goals. Members' personal values were discussed and ways in which alcohol and substances can impede behaviors consistent with these values were highlighted. Members' successes with abstinence were continually celebrated, and members were encouraged to identify ways to reward themselves. Techniques to identify healthy supports for each member were used. Topics first discussed in the beginning phase were continually reviewed in the middle phase, as needed. Continued identification of current stage of change was promoted as was recognition of differences in current stage of change relative to the stage in the beginning phase of the group.

Recommitment to self-identified values was emphasized, particularly in cases when a group member relapsed and used alcohol or substances. Group leaders encouraged discussion about recommitment to goals and identification of how the relapse occurred. Strategies group members can use following a relapse were also discussed. An emphasis on viewing relapse as an "opportunity to learn," rather than as a failure, was emphasized, and group members were encouraged to use mutual aid in helping the individual address this issue.

Group leaders continued to support the development of mutual aid in group discussions in the middle phase. As obstacles for members arose, other group members were encouraged to identify potential solutions. Ongoing discussions assessed progress toward individual and group goals. Group leaders continued to model and encourage effective, honest communication among group members. Group values and norms were reviewed on a regular basis.

Several examples highlight mutual aid in the middle phase of the SFR group. As all group members were military veterans, the group discussion over time included the interaction of mental health and substance abuse symptoms and experiences in the military. As a result, members began to provide support for one another around difficulties related to military service, including anniversary dates of traumatic events. For instance, one member identified that the anniversary date of a friend's death in the Vietnam War led to increased symptoms of depression and urges to use alcohol. Group members provided additional support and mutual aid for this veteran during the anniversary period. As other group members discussed similar experiences, group members provided additional support for one another, offering to call or visit each other outside of group time. This extended support also included times when a member felt particularly lonely or isolated.

Another example of mutual aid was when a group member shared some of his mental health symptoms in the SFR group that he had not previously discussed in other settings. The member received positive reinforcement and support from the other group members. As a result of this support and increased comfort level discussing his symptoms with others, the member reported he was able to increase his verbal participation at Alcoholics Anonymous (AA) meetings he attended.

Mutual aid was also promoted when new members joined the group. Existing group members were encouraged to help new members understand the purpose and culture of the group. Changes in group membership, including people who joined the group and people who left the group, were regularly discussed and processed in group.

The group structure was continually reviewed, and members were empowered to identify areas of potential change to the group. For example, group members asked that the group environment be changed to a room with more couches than chairs. This change was discussed by the group members and following agreement among group members, group leaders brought this suggested change to PRRC administration. A new room that met the group members' request was located, and the group was moved. This change allowed group members to express their views, see change enacted based on their preferences, and feel empowered about their ownership of the group.

Group leaders assisted group members in identifying and accessing additional therapeutic resources at the VA and in the community. These resources included AA meetings as well as other mental health services in the VA and in the community that could be helpful. Encouraging attendance at 12-Step mutual aid meetings is a practice recommendation for psychosocial treatment for individuals who are dually diagnosed (Ziedonis et al., 2005). Group members shared information on resources they have used in the community and their experiences with these resources.

GROUP WORK IN THE ENDING PHASE

Although SFR was an open-ended group, the *Standards* could be applied if the group was in the ending phase. Specifically, group leaders would prepare members for the group ending in advance and allow time for members and leaders to share feelings about the group ending. Progress toward individual and group goals would be reviewed, and appropriate referrals to other mental health providers would be made. As suggested by the treatment manual, open-ended questions such as, "How has the group affected your life?" and "What will be different for you without the group?" would be asked, and answers processed as a group. Leaders would facilitate discussion on current stage of change, and how this stage has differed over the course of the group. Strategies to help members remain in the "maintenance phase" will be reviewed, as would strategies to cope with future stressors that may arise. Issues about loss and separation would be discussed and feelings processed. These strategies were used when a member of the group terminated and allowed for the terminating group member to process the group experience, and for remaining group members to discuss the change in group membership.

ETHICAL CONSIDERATIONS

Group leaders adhered to strict ethical standards set by the VA and the disciplines of social work and psychology. Group leaders attended continuing education courses to remain knowledgeable on current practice recommendations, and incorporated these recommendations into the SFR group. The VA required continuous education in

confidentiality, individual rights, and ensuring the security of medical records. Ethical issues that arose were discussed with PRRC and VA leadership as needed.

SUMMARY AND CONCLUSIONS

Taken together, the Skills For Recovery group at the PRRC exemplified application of the *Standards* (AASWG, 2010) to a therapeutic group program with individuals who have serious and persistent mental illness and substance abuse disorders. A strengths-based recovery-oriented approach was used to encourage individuals to set their own treatment and recovery goals. Activities from a structured therapy manual assisted group members in understanding triggers of their use and developing effective relapse prevention strategies. An emphasis was placed on developing mutual aid, respect, support, cohesion, and self-efficacy among group members. Group leaders running groups in a variety of mental health treatment settings are encouraged to apply the *Standards* in all aspects and stages of group therapy, as well as to consider how the *Standards* could be applied in interdisciplinary health care settings.

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