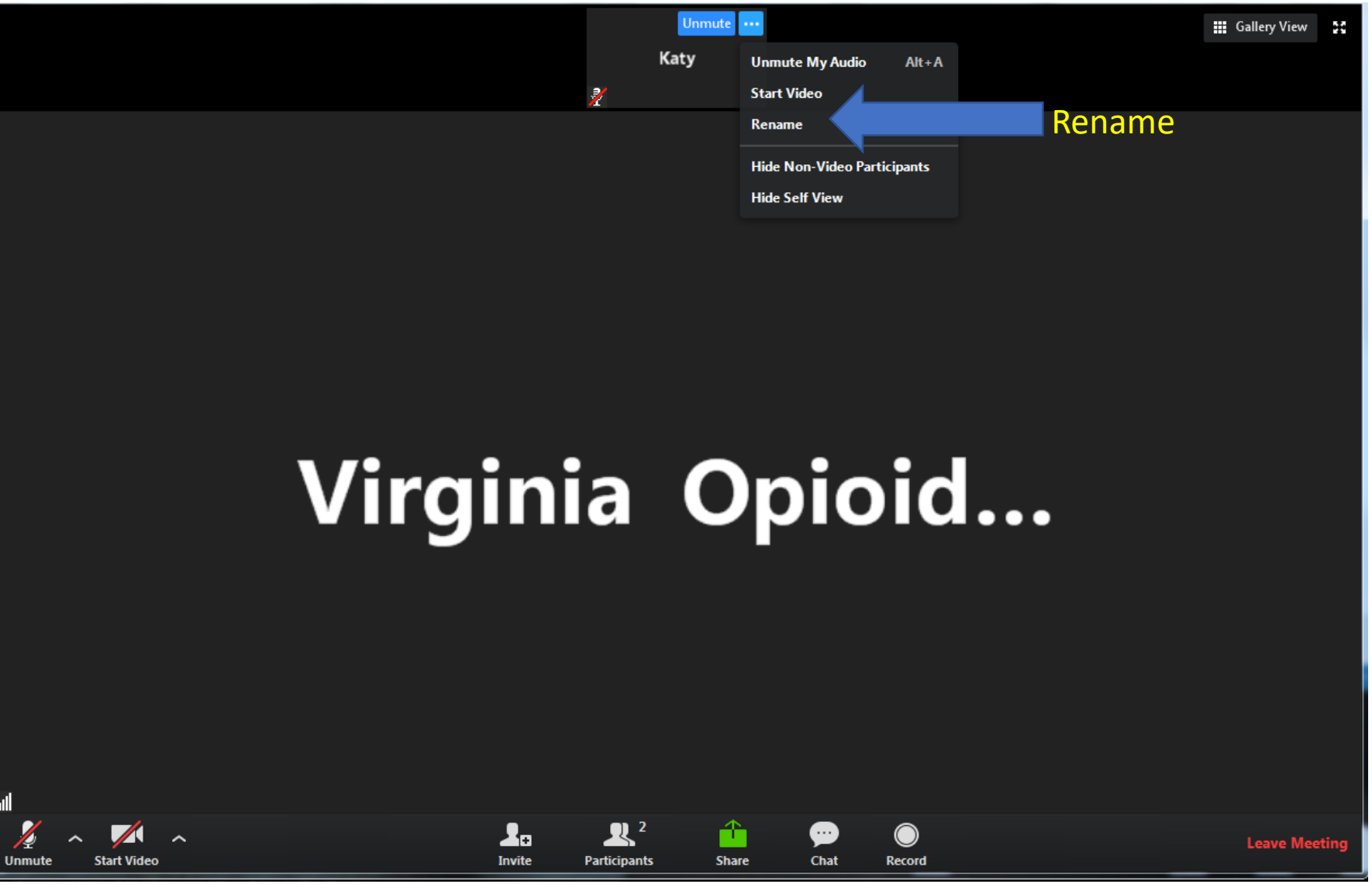
Virginia Opioid Addiction ECHO* Clinic

January 31, 2020

*ECHO: Extension of Community Healthcare Outcomes

Helpful Reminders



- Rename your Zoom screen, with your name and organization

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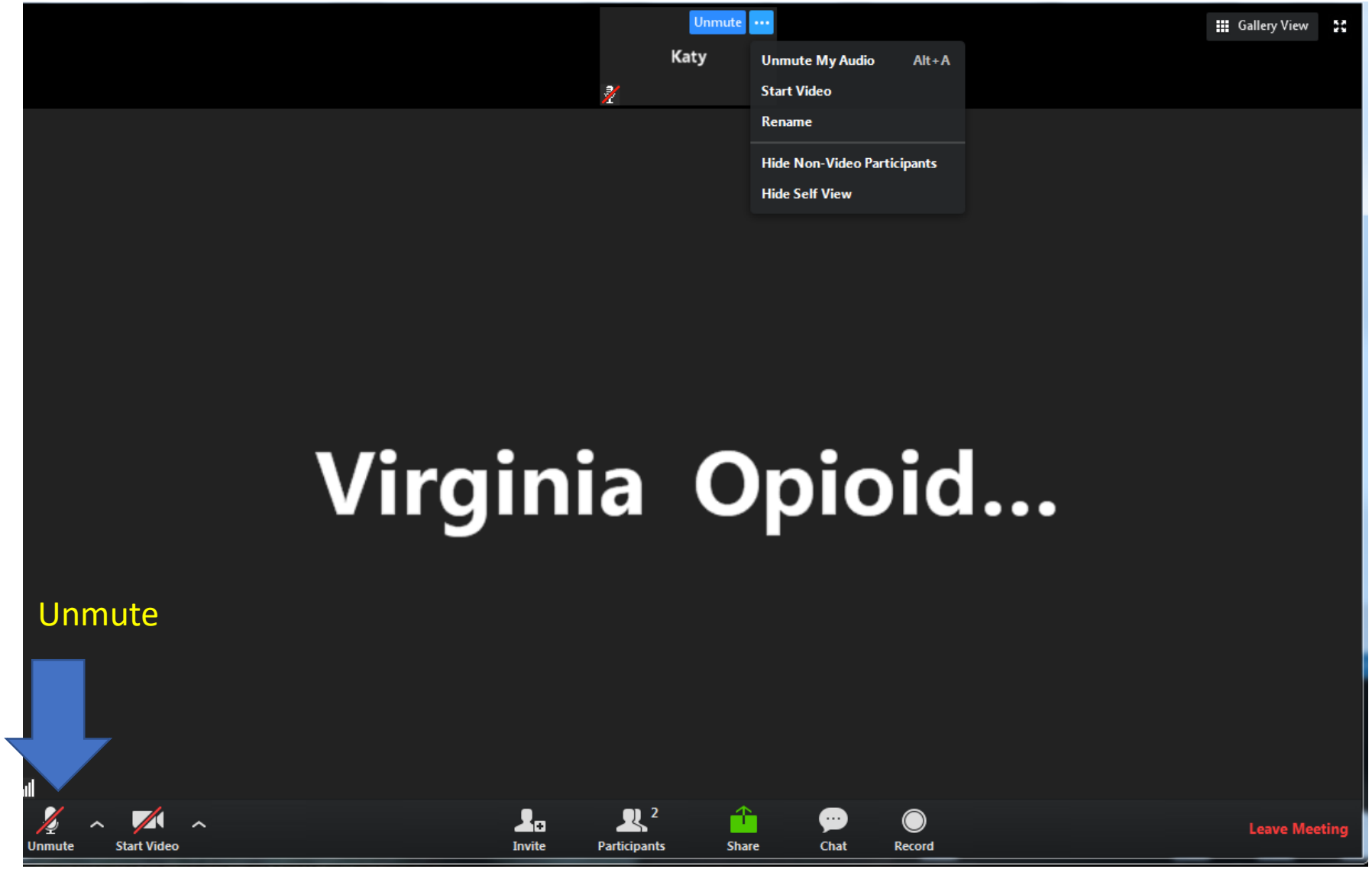

- You are all on mute please unmute to talk
- If joining by telephone audio only, *6 to mute and unmute
  - ❖ Do **NOT** put on hold

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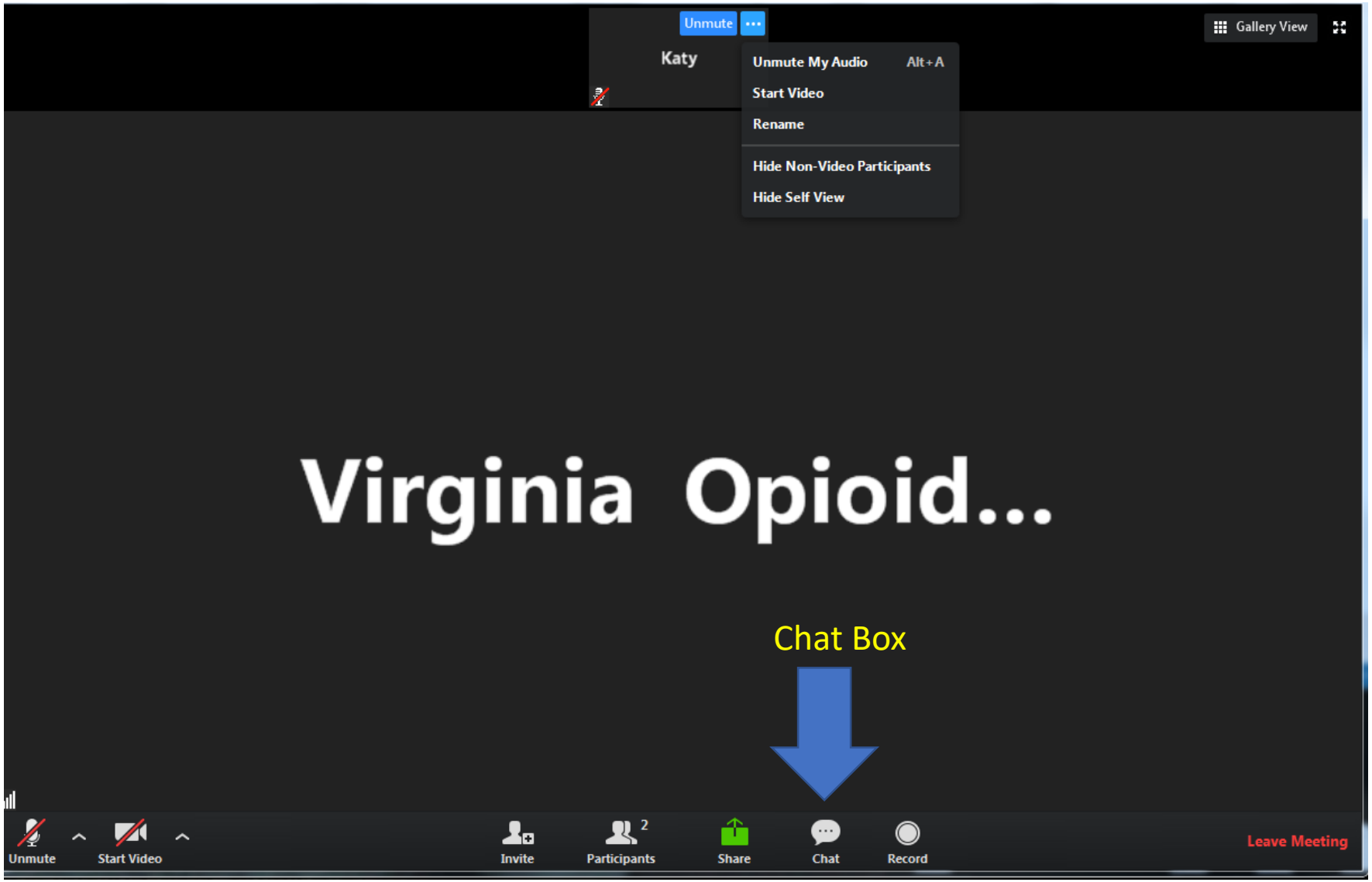


- Please type your full name and organization into the chat box
- Use the chat function to speak with IT or ask questions

VCU Opioid Addiction ECHO Clinics

VCU Health
VCU School of Medicine

VDH Virginia Department of Health | VDHLiveWell.com | Virginia Department of Behavioral Health & Developmental Services

- Bi-Weekly 1.5 hour tele-ECHO Clinics
- Every tele-ECHO clinic includes a 30 minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by inter-professional experts
- Website Link: www.vcuhealth.org/echo

Hub and Participant Introductions

VCU Team	
Clinical Director	Gerard Moeller, MD
Administrative Medical Director ECHO Hub	Vimal Mishra, MD, MMCi
Clinical Experts	Lori Keyser-Marcus, PhD Courtney Holmes, PhD Albert Arias, MD
Didactic Presentation	Gerry Moeller, MD
Program Manager	Bhakti Dave, MPH
Practice Administrator	David Collins, MHA
IT Support	Vladimir Lavrentyev, MBA

- Name
- Organization

Reminder: Mute and Unmute screen to talk

*6 for phone audio

Use chat function for Introduction

What to Expect

I. Didactic Presentation
   I. **Lori Keyser-Marcus, PhD**
      Courtney Holmes, PhD
II. Case presentations
   I. Case 1
      I. Case summary
      II. Clarifying questions
      III. Recommendations

   II. Case 2
      I. Case summary
      II. Clarifying questions
      III. Recommendations

III. Closing and questions

Lets get started!

Didactic Presentation

Disclosures

Courtney Holmes, PhD and Lori Keyser-Marcus, PhD have no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.

Integrating Group Counseling into Substance Use Treatment

Courtney Holmes, Ph.D.
Lori Keyser-Marcus, Ph.D.

January 31, 2020

Impact of Addiction

- Addiction/Substance use is complex
- Addiction is not only a physical dependence on a substance
- Addiction and recovery are intricately related to a person's mental health, mental illness, and history (family relationships, trauma, etc.)

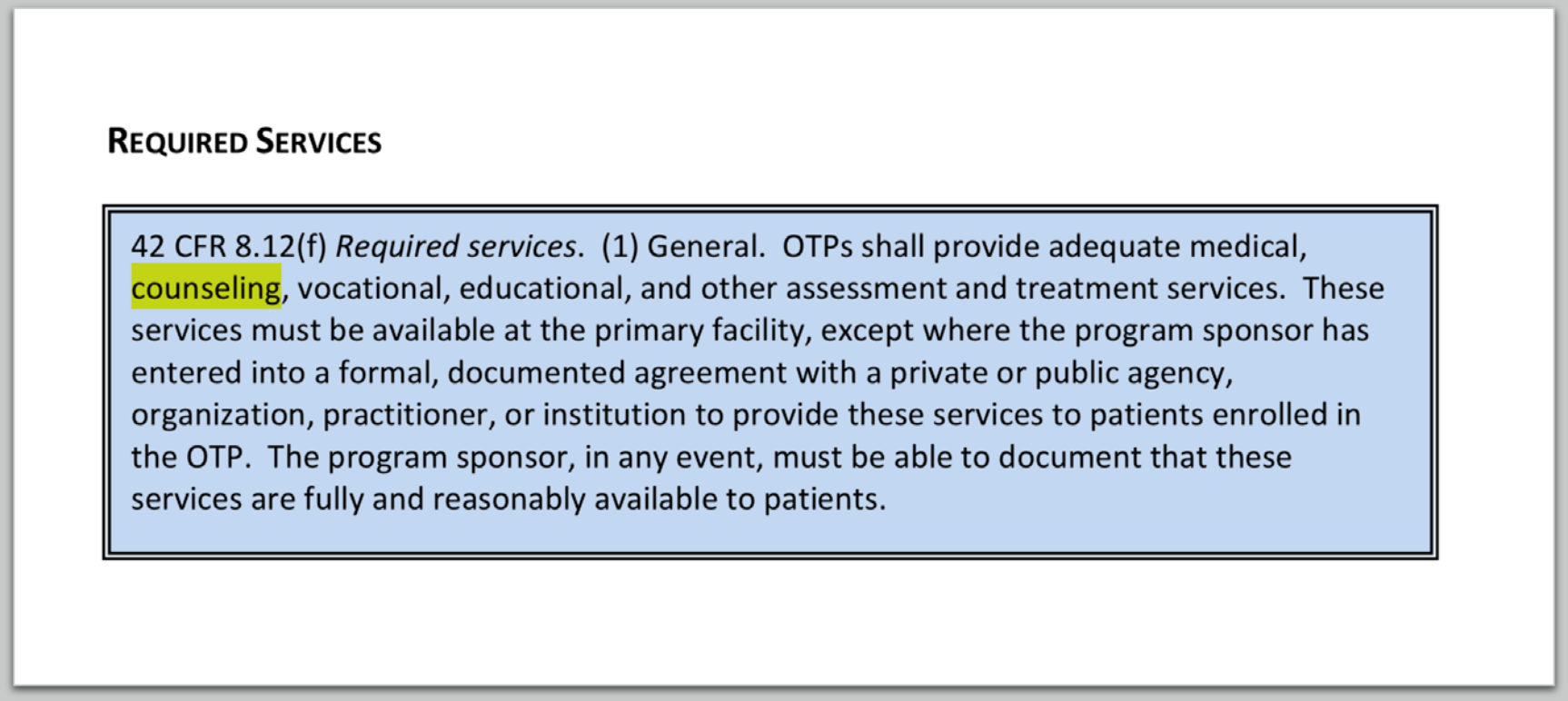
- What do people receive? Judgment and stigma
- What do people need? Support

Risks in early treatment

- Overdose/death
- Relapse
- Criminal justice problems
- Underemployment/unemployment
- Family challenges
- Suicidal ideation
- Mental health symptoms- depression, anxiety, PTSD, trauma

Federal Guide for Opioid Treatment Programs

- SAHMSA guidelines - https://store.samhsa.gov/system/files/pep15-fedguideotp.pdf



REQUIRED SERVICES

42 CFR 8.12(f) *Required services*. (1) General. OTPs shall provide adequate medical, counseling, vocational, educational, and other assessment and treatment services. These services must be available at the primary facility, except where the program sponsor has entered into a formal, documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.

Background of Group Work

- Alcoholics Anonymous founded in 1930 – depends on group work
- Time and resource effective
- People are more likely to stay in recovery when treatment is provided in groups (Reading & Weegman, 2004).
- **Counseling is more effective than no counseling**
- No specific type of group is more effective than other types
- Behavioral and mental health support outcomes consistently show immediate and sustained improvement when compared with medication management only or no treatment (Dugos et al., 2016; Shareh et al., 2018; Weiss et al., 2004)

SAHMSA – Tip 41

- Group therapy has advantages over other modalities. These include:
  - positive peer support
  - a reduction in clients' sense of isolation
  - real life examples of people in recovery
  - help from peers in coping with substance abuse and other life problems
  - information and feedback from peers
  - a substitute family that may be healthier than a client's family of origin
  - social skills training and practice
  - peer confrontation
  - a way to help many clients at one time
  - structure and discipline often absent in the lives of people abusing substances
  - the hope, support, and encouragement necessary to break free from substance abuse.

What makes groups therapeutic?

- Yalom (1995) identified 11 therapeutic factors:
  - Installation of hope
  - Universality
  - Imparting information
  - Altruism
  - Corrective recapitulation of the primary family group
  - Development of socializing techniques
  - Imitative behaviors
  - Interpersonal learning
  - Group cohesiveness
  - Catharsis
  - Existential factors

Current State of Affairs

Programs or Groups for Specific Client Types

Table 3.5b. Facilities were asked about the provision of treatment programs or groups specifically tailored for the client types listed below. Overall, 83 percent of facilities offered at least one specifically tailored program or group. The percentages of facilities providing specifically tailored programs or groups were:

- Clients with co-occurring mental and substance abuse disorders — 50 percent
- Adult women — 49 percent
- Adult men — 47 percent
- Clients who have experienced trauma — 40 percent
- Criminal justice clients (other than DUI/DWI)[12] — 35 percent
- Young adults — 30 percent
- Clients who have experienced intimate partner violence, domestic violence — 26 percent
- Clients who have experienced sexual abuse — 26 percent
- Adolescents — 25 percent
- Clients arrested for DUI or DWI — 25 percent
- Pregnant or postpartum women — 23 percent
- Seniors or older adults — 21 percent
- Lesbian, gay, bisexual, or transgender (LGBT) clients — 20 percent
- Veterans — 19 percent
- Clients with HIV or AIDS — 18 percent

- Members of military families — 12 percent
- Active duty military — 11 percent

Clinical/Therapeutic Approaches

Table 3.4a. Facilities were asked to indicate if they used any of 15 specific clinical/therapeutic approaches.

Two approaches were each used "always or often" by nearly all facilities:

- Substance abuse counseling was used "always or often" by 94 percent of facilities.
- Relapse prevention was used "always or often" by 87 percent of facilities.

By treatment approach, the percentages of facilities that used the approaches at least sometimes ("always or often" or "sometimes") were:

- Substance abuse counseling — 99 percent
- Relapse prevention — 96 percent
- Cognitive-behavioral therapy — 94 percent
- Motivational interviewing — 93 percent
- Anger management — 83 percent
- Brief intervention — 83 percent
- Trauma-related counseling — 82 percent
- 12-step facilitation — 72 percent
- Dialectical behavior therapy — 58 percent
- Contingency management/motivational incentives — 56 percent
- Rational emotive behavioral therapy — 45 percent

National Survey of Substance Abuse Treatment Services (N-SSATS) - 2018

Types of Groups

- Five group models are common in substance abuse treatment:
  - Psychoeducational groups, which educate clients about substance abuse
  - Skills development groups, which cultivate the skills needed to attain and sustain abstinence, such as those needed to manage anger or cope with urges to use substances
  - Cognitive–behavioral groups, which alter thoughts and actions that lead to substance abuse
  - Support groups, which buoy members and provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life
  - Interpersonal process groups, which delve into major developmental issues that con tribute to addiction or interfere with recovery

Group Leadership (SAHMSA)

- Leaders should be able to
  - Adjust their professional styles to the particular needs of different groups
  - Model group appropriate behaviors
  - Resolve issues within ethical dimensions
  - Manage emotional contagion
  - Work only within modalities for which they are trained
  - Prevent the development of rigid roles in the group
  - Avoid acting in different roles inside and out side the group
  - Motivate clients in substance abuse treatment
  - Ensure emotional safety in the group
  - Maintain a safe therapeutic setting (which involves deflecting defensive behavior with out shaming the offender, recognizing and countering the resumption of substance use, and protecting physical boundaries according to group agreements)
  - Curtail emotion when it becomes too intense for group members to tolerate
  - Stimulate communication among group members

Considerations

- Group work can be more than just giving information or worksheets
- The major benefits of group work come when members are able to feel as if they belong
- What approach will guide you?
  - Cognitive behavioral therapy
  - Motivational interviewing
  - Acceptance and Commitment Therapy
- What will you focus on?
  - Relapse prevention
  - Coping skills
  - Specific aspects of recovery
  - Ancillary topics such as mindfulness, anger management, trauma

Considerations, continued

- Group logistics
  - Open or closed
  - How many times a week
  - How long
  - Will members be screened
  - Who will be able to participate? What stage of recovery? What co-occurring issues are relevant?
  - Who will lead the group? Co-leadership model?
  - Billing and funding
- What is the leader's role?
  - To give information only
  - To help members process and integrate information, build relationships

Challenges

- Open enrollment and member turnover
- Member safety within the group
- Member defensiveness, resistance, disruptive group behavior
- Discouraging unhealthy relationships between members (diversion, etc.)
- Shifting the focus of groups from information giving-only to include processing and inter-relating of members does require more skilled facilitation
- Differing perspectives from those in recovery around continued use of agonist, partial agonist, and antagonist medications

Closed versus Open Groups

	Pros	Cons
Closed groups	Capitalizes on group cohesion	Typically requires a waiting period where patients may lose interest or seek treatment elsewhere
	Allows for developing and following coherent treatment plan	
Open groups	Eliminates the need for waitlist	Group composition may vary considerably from one week to the next

Weiss, Jaffee, deMenil, & Cogley, 2004

Which modality is more effective?

- Integrated Group Therapy vs Treatment as Usual
    - Integrated
- Group vs No group
    - Group
- Group vs Individual
    - No difference
- Group plus Individual vs Individual
    - No difference
- Group plus Individual vs Group
    - No difference

Weiss, Jaffee, deMenil, & Cogley, 2004

Not always a Field of Dreams

ORIGINAL ARTICLE

No-Show for Treatment in Substance Abuse Patients with Comorbid Symptomatology: Validity Results from a Controlled Trial of the ASAM Patient Placement Criteria

Gustavo A. Angarita, MD, Sharon Reif, PhD, Sandrine Pirard, MD, Sang Lee, BSc, Estee Sharon, PsyD, and David R. Gastfriend, MD

Matching to Level of Care

- Overall, mismatched patients had more no-shows than matched (52.4% versus 43.5%).
- Within the Undermatched group, comorbids had more no-shows (71.2%) than noncomorbids (61.7%);
- The overmatched group, comorbids had significantly more no-shows than noncomorbids (54% versus 28%).
- Patients who no showed compared were more likely to be females (70.4% versus 34.8%), to have anxiety (63% versus 17.4%), or have supportive family/social environments (81.5% versus 34.8%).

Angarita et al, 2007

Barriers (perceived and otherwise)

Survey of 80 patients at VCU Motivate clinic. Focused on behavioral counseling services received. Patients received a $10 gift card for completing the interview. Study was approved by VCU IRB.

- Demographics and substance use (treatment) history
- Satisfaction with behavioral treatment services
- Intake appointment
- **Perceived barriers**
- Items regarding electronic based treatment

Participant characteristics

Sex

- Male 32 (40%)
- Female 48 (60%)

Age

- Mean 45 years (Range 25-71 years)

Time in treatment

- Less than 1 month (n=11) average 2 weeks
- More than 1 month (n=69) average 10 months

Primary drug addressing with treatment services

• **Heroin**	**58 (72.5%)**	Cannabis	1 (1.3%)
• **Other opioids**	**11 (13.8%)**	Amphetamines	1 (1.3%)
• Cocaine	5 (6.3%)	Alcohol	4 (5.0%)

Study goal

- Low/inconsistent attendance in groups
- Restructuring the program
- Patient feedback
- Identify barriers

Barriers: Practical (e.g., times)

Group times aren't convenient

= 30% agree/strongly agree

Childcare unavailable

= 1.3% strongly agree

Transportation

= 20% agree/strongly agree

Barriers: Practical (e.g., times)

My schedule is too full to make time for group

= 13.8% agree/strongly agree

Groups that are offered when I can come are always full

= 3.8% agree

Barriers: Group context-based

I don't like talking about my problems in a group

- 25.1% Agree/Strongly agree

I am very anxious/uncomfortable being in a group

- 22.5% Agree/Strongly agree

There are too many disruptions in group (people coming in/out)

- 8.8% Agree

People in the group are always changing

- 12.5% Agree

Barriers: Counselor-based

I don't really like my counselor

- 3.8% Agree/Strongly agree

The group leaders make it a safe place to share

- 68.7% Agree/Strongly agree

I feel like the counselors have a good understanding of my treatment goals

- 66.3% Agree/Strongly agree

I feel like the counselors genuinely care about me and my recovery

- 67.6% Agree/Strongly agree

Barriers: Value of behavioral treatment

Group is a waste of my time

- 5.1% Agree/Strongly agree

The medication is all I need for my recovery

- 17.6% Agree/Strongly agree

Rules of Engagement

- Mismatched placement, according to the ASAM Patient Placement Criteria (PPC), promotes no-shows to treatment
- Treatment-matching seeks to engage patients in the optimal setting and modalities for a good outcome.
- Consider ways to reduce/eliminate practical barriers that may influence treatment engagement (e.g., transportation vouchers, evening groups)
- Consider trying a few group formats to see what your patients respond to (as training/staffing may allow)
- Consistency is key
- Make sure message of importance of behavioral therapy is being conveyed by all clinic staff (support from medical providers is critical)

Resources

- SAHMSA group therapy for substance use treatment:

https://store.samhsa.gov/system/files/sma15-3991.pdf

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Questions?

Case Presentation #1
Faisal Mohsin, MD

- 12:35-12:55 [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get the patient's Primary Care Provider engaged in his treatment?

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

46 yr. single, unemployed white male, residing with his mother. Patient's mother and brother are also being prescribed benzodiazepines from the same PCP.

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

The patient is currently being treated for an OUD and has been stable on Suboxone 8mg-2mg 1/2 strip twice daily. Previously was on a total of Suboxone 12mg-3mg daily until end of last year.

Patient is being prescribed multiple benzodiazepines by his primary care physician. Prior to the start of the Suboxone treatment, he had agreed to being weaned off the benzodiazepines. In fact it was a condition for the initiation of Suboxone.

8.6.10	Alphahydroxyalprazolam 7-Aminiclonazepam Temazepam	892 ng/ml 389 ng/ml 99 ng/ml	Temazepam 30mg #90 pills, 90 days Alprazolam 1mg #90 pills for 90 days
8.29.19	7-Aminoclonazepam no additional benzos	714 ng/ml	same prescriptions as above.
10.3.19	Alprazolam metab. Clonazepam metab.	179 ng/ml 1590 ng/ml	9.18.19 Alprazolam 1mg #90, 90 days 8.22.19 Alprazolam 1mg #90, 90 days
10.10.19	Alprazolam metb. Clonazepam metab.	10 ng/ml 1010 ng/ml	10.11.19 Temazepam 30mg #90, 90 days 9.18.19 Alprazolam 1mg 90, 90 days 7.25.19 Temazepam 30mg, #90, 90 days
11.21.19	Alprazolam metab. Clonazepam metab.	50 ng/ml 448 ng/ml	11.19.19 Clonazepam 2mg, #60, 15 days 11.5.19 Clonazepam 2mg, #60 in 15 days. No alprazolam written
12.12.19	Clonazepam metab. Zolpidem carboxyzolpidem	>2000 ng/ml 5ng/ml 2020 ng/ml	12.2.19 Clonazepam 2mg, #60, 15 days 12.3.19 Clonazepam 2mg, #60 in 15 days
1.21.20	Clonazepam metab.	>2000 ng/ml	12.30.19 Clonazepam 2mg , #53, 15 days 1.13.20 Clonazepam 2mg, #53, 13 days

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

He is currently engaged in group therapy at Partners in Recovery. Attends weekly sessions.

He is being prescribed Seroquel and Paxil ? doses by his PCP.

We fax over a copy of his labs to his PCP. Also I have attempted to call his PCP several times to update him and remind him of the plan to taper off the benzodiazepines. PCP believes he is exercising harm reduction; he believes if he will not prescribe the benzos, the patient will attempt to procure them illegally. However labs suggest the patient is likely getting additional benzos beyond what is being prescribed. PCP makes no acknowledgment of receiving the labs. It's always a one way communication.

What is your plan for future treatment? What are the patient's goals for treatment?

The goal for this patient is to be off all benzodiazepines!! Maybe an unrealistic goal?

Considering writing a formal letter to the PCP, strongly recommending he begin a scheduled taper of the clonazepam to reduce the risk of harm to the patient. This could also help reducing liability for the PCP.

If no response, consider notifying the Dept. of Health Professions?

Other relevant information

There have been occasional "slip ups". He obtained Perocets from a friend recently to treat pain from his hemorrhoids. He stopped Suboxone for 3-4 days while taking the Percocets.

Restate Main Question

Please state your main question(s) or what feedback/suggestions you would like from the group today?

How can we get the patient's Primary Care Provider engaged in his treatment?

End of Case Study

Case Presentation #2
Maureen Murphy-Ryan, MD

- 12:55pm-1:25pm [20 min]
  - 5 min: Presentation
  - 2 min: Clarifying questions- Spokes (participants)
  - 2 min: Clarifying questions – Hub
  - 2 min: Recommendations – Spokes (participants)
  - 2 min: Recommendations – Hub
  - 5 min: Summary - Hub

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Please state your main question(s) or what feedback/suggestions you would like from the group today?

Managing insomnia in a patient with opioid dependence on MAT and stimulant use disorder in early remission who has developed tolerance to diphenhydramine and has comorbid bipolar affective disorder partially treated with mood stabilizer

Case History

Attention: Please DO NOT provide any patient specific information nor include any Protected Health Information!

Demographic Information (e.g. age, sex, race, education level, employment, living situation, social support, etc.)

29 yo single Caucasian male high school education mother is major social support is trying to disentangle from ex-boyfriend who is still using drugs works full time as a cook and lives alone in a trailer, formerly on disability for bipolar affective disorder

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

Physical, Behavioral, and Mental health background information (e.g. medical diagnosis, reason for receiving opioids, lab results, current medications, current or past counseling or therapy treatment, barriers to patient care, etc.)

Short, thin young-appearing man.
Dx: Opioid use disorder, severe, on buprenorphine maintenance, recent UDS + buprenorphine only. Most recent other substance use alcohol to blackout around January 1, uses alcohol for social anxiety.
Stimulant use disorder in early remission
Marijuana use intermittently.
More stable on lithium and lamictal in the past but had been off all psychiatric meds for 6 months prior to intake except gabapentin for neuropathic pain 2/2 injuries sustained in a motor vehicle collision during an episode of mania with psychosis several years ago. Got addicted to opioids after surgical intervention for broken femoral and lumbar spine in car accident.
Buprenorphine to manage opioid dependence more safely, very effective for cravings, no opioid seeking. Still using alcohol and MJ in social stress situations. Started lithium 2 months ago. Brief period of non adherence during last relapse, lithium level several days after was 0.43 on 450mg ER, now on 450mg AM/ 300mg PM

What interventions have you tried up to this point ?
Additional case history (e.g. treatments, medications, referrals, etc.)

Trazodone between 25mg to 150mg ineffective, does not notice it. Has been taking "1 bottle" of liquid diphenhydramine (no alcohol) weekly. Often goes 2 days without sleep. Paranoid thoughts and feelings related to current mixed episode of bipolar worsen significantly when awake all night, good insight during the day. No SI or HI. Has been offered antipsychotic medication options but declined due to hx of dystonia include laryngeal, high risk for recurrence of this due to body habitus and gender. Offered short term voluntary mental health hospitalization for more rapid medication titration to manage sleep and has declined. Has been close to threshold of safe outpatient management given history of injury to self and others during manic episode involving vehicle collision and current paranoia, protective factors are high cooperation, intellectual insight, future planning, strong will to live, attending SMART recovery groups at local peer center, employment. Has small hatchet but no guns at home.

What is your plan for future treatment? What are the patient's goals for treatment?

Patient wants to be able to work more effectively and make fewer mistakes and support himself financially and not feel so anxious. He doesnt want to lose his ability to feel "highs" in life and is afraid the treatment to become stable will take away his ability to feel good.

I would like to see his lithium level approach 1.0 and see him able to sleep reliably and his paranoia decrease significantly. Plan to titrate his lamotrigine once the lithium is stable. Plan to titrate down diphenhydramine gradually once stable with patients cooperation.

Restate Main Question

Please state your main question(s) or what feedback/suggestions you would like from the group today?

Managing insomnia in a patient with opioid dependence on MAT and stimulant use disorder in early remission who has developed tolerance to diphenhydramine and has comorbid bipolar affective disorder partially treated with mood stabilizer

End of Case Study

Case Studies

- Case studies
  - Submit: www.vcuhealth.org/echo
  - Receive feedback from participants and content experts
  - Earn **$100** for presenting

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/virginia-opioid-addiction-echo-thank-you

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- Sickle Cell Disease ECHO +

Thank You

The success of our telehealth program depends on our participants and those who submit case studies to be discussed during clinics. We recognize the following providers for their contributions:

- **Michael Bohan, MD** from Meridian Psychotherapy
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- **Sharon Hardy, BSW, CSAC** from Hampton-Newport News CSB
- **Sunny Kim, NP** from VCU Health
- **Thokozeni Lipato, MD** from VCU Health
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- **Barbara Trandel, MD** from Colonial Behavioral Health
- **Bill Trost, MD** from Danville-Pittsylvania Community Service
- **Art Van Zee, MD** from Stone Mountain Health Services
- **Sarah Woodhouse, MD** from Chesterfield Mental Health

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  - Ideas for guest speakers?

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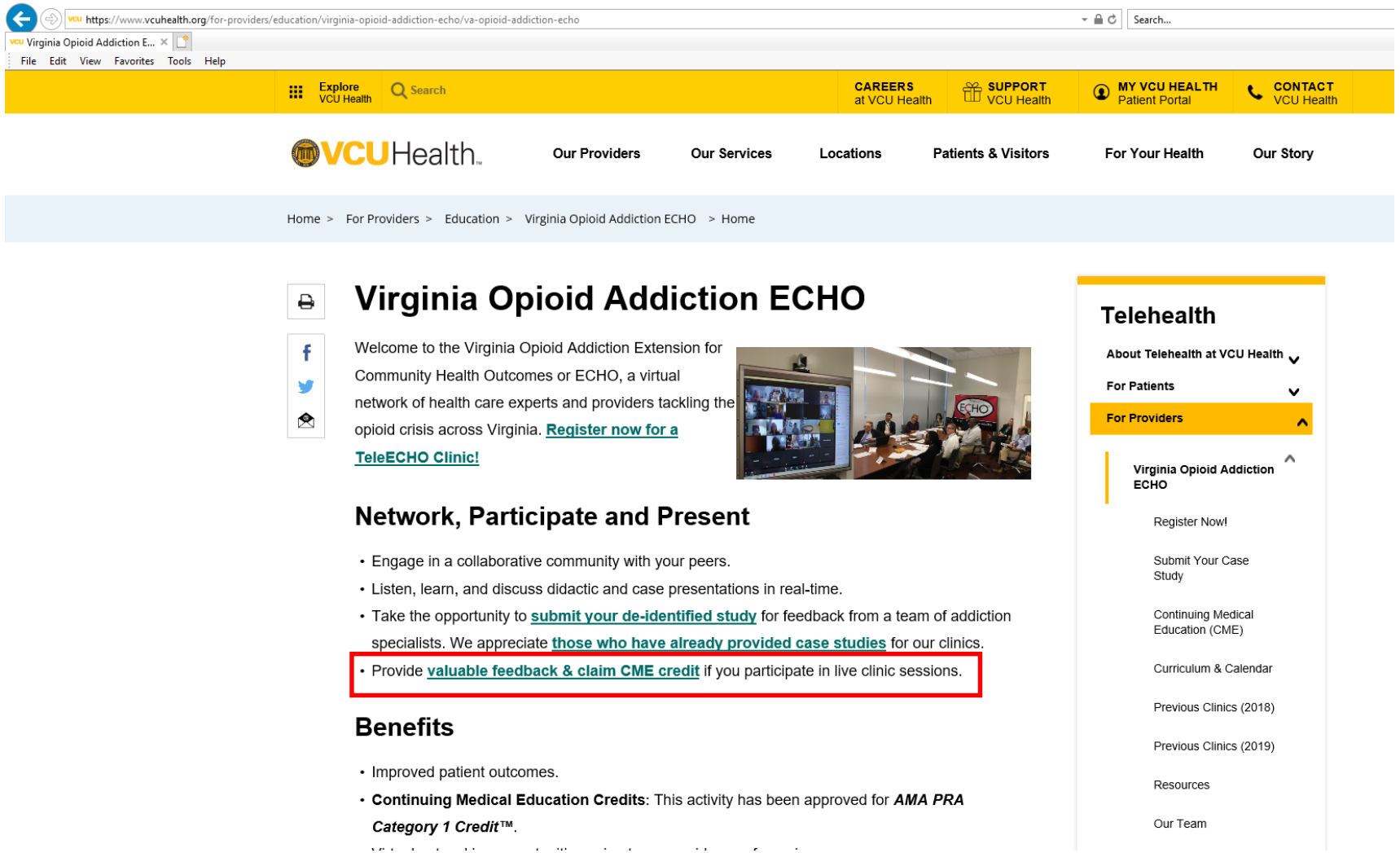

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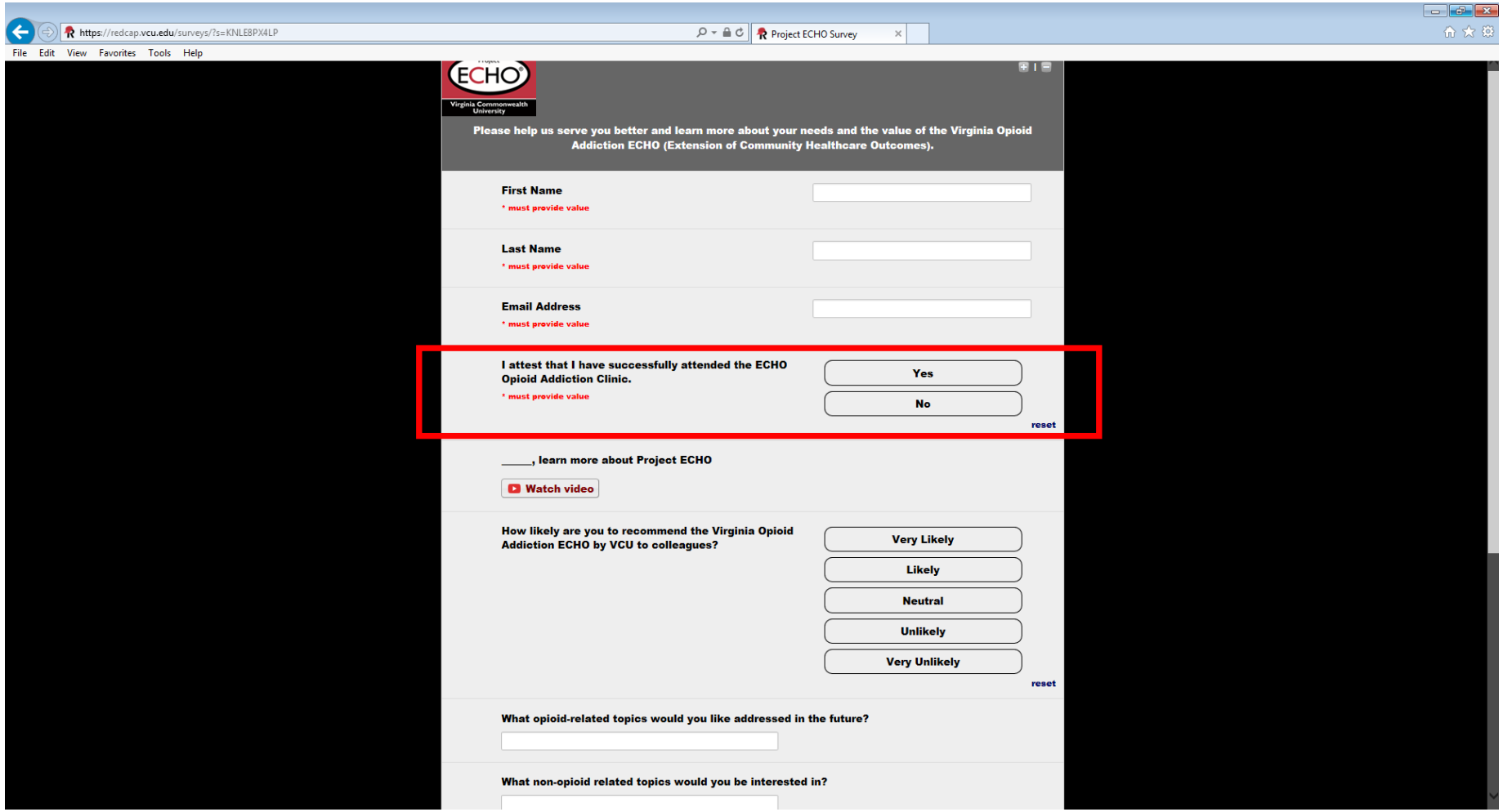

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- www.vcuhealth.org/echo
  - To view previously recorded clinics and claim credit

Access Your Evaluation and Claim Your CME

https://www.vcuhealth.org/for-providers/education/virginia-opioid-addiction-echo/va-opioid-addiction-echo

Virginia Opioid Addiction E...

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Virginia Opioid Addiction ECHO

Welcome to the Virginia Opioid Addiction Extension for Community Health Outcomes or ECHO, a virtual network of health care experts and providers tackling the opioid crisis across Virginia. **Register now for a TeleECHO Clinic!**

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn, and discuss didactic and case presentations in real-time.
- Take the opportunity to **submit your de-identified study** for feedback from a team of addiction specialists. We appreciate **those who have already provided case studies** for our clinics.
- Provide **valuable feedback & claim CME credit** if you participate in live clinic sessions.

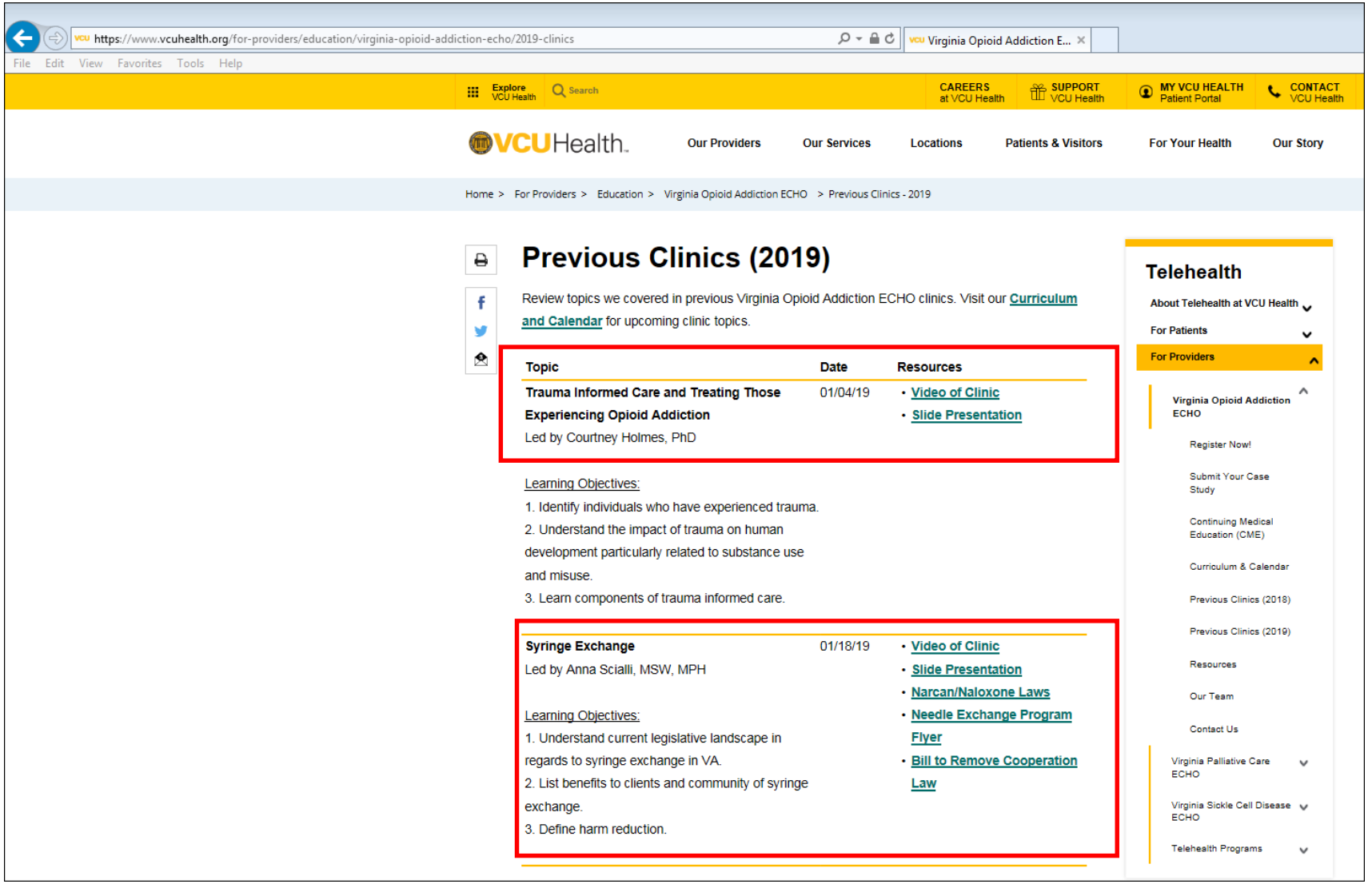
Benefits

- Improved patient outcomes.
- **Continuing Medical Education Credits**: This activity has been approved for ***AMA PRA Category 1 Credit™***.

Telehealth

- About Telehealth at VCU Health
- For Patients
- For Providers
  - Virginia Opioid Addiction ECHO
    - Register Now!
    - Submit Your Case Study
    - Continuing Medical Education (CME)
    - Curriculum & Calendar
    - Previous Clinics (2018)
    - Previous Clinics (2019)
    - Resources
    - Our Team

Access Your Evaluation and Claim Your CME



VCU Virginia Opioid Addiction TeleECHO Clinics

Bi-Weekly Fridays - 12-1:30 pm

Mark Your Calendar --- Upcoming Sessions

Feb 21:	Pharmacotherapy for Methamphetamines	Gerry Moeller, MD
March 6:	Enhanced Recovery After Surgery: Opioid Reduction Program	Nirav Patel, MD

Please refer and register at vcuhealth.org/echo

Project ECHO®
Virginia Commonwealth University

THANK YOU!

Reminder: Mute and Unmute to talk
*6 for phone audio
Use chat function for questions

VCU

Resources

1. SAHMSA group therapy for substance use treatment: https://store.samhsa.gov/system/files/sma15-3991.pdf
2. Angarita, Reif, Pirard, & Lee (2007). No-Show for Treatment in Substance Abuse Patients with Comorbid Symptomatology: Validity Results from a Controlled Trial of the ASAM Patient Placement Criteria. J Addict Med, 1(2), 79-87.
3. Simon Fehr, S. (2017). *101 Interventions in Group Therapy.* Routledge.
4. Wenzel, Liese, Beck & Friedman-Wheeler. (2012). *Group Cognitive Therapy for Addictions.* The Guildford Press.