

CO-OCCURRING DISORDERS: Mental Health & Drugs

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Doug: “Yes I think I am a dual diagnosis because I been diagnosed with schizophrenia several times, chronic paranoid schizophrenia, and I’ve been an alcoholic for many years.”

Talin: “I overdosed on heroin, cocaine, and alcohol and I was admitted Harborview Hospital, at Harborview Mental Health.”

Kim: “I would completely lose control of myself. At that time I had not been diagnosed with bipolar. And I didn’t—I was once told by a young lady I was in a relationship with that I had mood swings.”

Studies show that up to 60% of individuals with a substance abuse disorder also have at least one other mental disorder. Conversely, up to 60% of those with one or more mental disorders also have a substance abuse disorder.

Mike Miller, Counselor, Genesis (Recovery Center): “Every person in this group has a dual diagnosis, right, so if we take away our drug of choice, we’re okay, right? How come?”

Kurt: “If someone is a drug addict without a dual diagnosis, their drug’s going to make their life worse, but having a dual diagnosis makes it double worse. I mea, it’s just the problem is more complex and more difficult to untangle.”

There are a large number of mental illnesses that can be part of a co-occurring or dual diagnosis.

SCHIZOPHRENIA

Schizophrenia is a thought disorder characterized by inappropriate emotional responses, difficulty making decisions or connecting thoughts, an impaired ability to care for oneself, delusions, and auditory or visual hallucinations.

Bill: “I haven’t heard voices for 10 years but I remember exactly what they used to say. They used to tell me what to do. And after a while I was listening to them on the streets and a 12 gage in the back seat and a 45 in my belt, stolen car.”

DEPRESSION

Depression is a mood disorder experienced by 8.6% of Americans in any given year.

Casey: “Deep heavy depression is like, it’s like a heavy fog. It actually, it starts where I can’t sleep and I have, I have very low energy. I don’t want to do anything.”

BIPOLAR DISORDER (MANIC DEPRESSION)

Bipolar illness is another mood disorder characterized by alternating periods of severe depression, normalcy, and manic episodes.

Talin: “I hear voices and I have hallucinations, and I still get really depressed. I get very, very, very depressed sometimes so I can’t get out of bed or I don’t get out of bed anyway and I have anxiety.”

POSTTRAUMATIC STRESS DISORDER (PTSD)

Mark: "PTSD is posttraumatic stress disorder. It's a mental illness caused by a traumatic event that happens during your life."

Richard Ries, M.D., Director, Mental Health Services, Harborview Medical Center, Seattle: "How did you get your PTSD?"

Mark: "I was a medic in Vietnam for a year and a half. The most common symptoms are nightmares, reliving the event."

PANIC DISORDER

Panic disorder consists of recurrent unexpected panic attacks, which are discrete periods of intense fear in the absence of real danger.

Janyne: "I lived in a state of panic for years and to admit that something was wrong, something that was not tangible, that I couldn't see, I couldn't identify, I couldn't explain to anybody else would mean that I was less than perfect."

SOCIAL PHOBIA

Social phobia, another anxiety illness, is a fear of being seen by others acting in an embarrassing or humiliating way.

Paul: "I can't seem to get around too many people, I panic a lot. I don't know how to socialize with people. I have a phobia with things. The only way I dealt with it was to shoot some heroin and I could deal with anybody around me."

OBSESSIVE-COMPULSIVE DISORDER (OCD)

Obsessive-compulsive disorder, an anxiety illness, is marked by uncontrollable intrusive thoughts and irresistible actions to calm those thoughts.

John: "It used to be at one time it would take me 2 to 2 1/2 hours to get out of my apartment and, you know, wash my hands and all this stuff 'cause I was worried about germs and stuff and it just drives me crazy."

PERSONALITY DISORDERS

Personality disorders are characterized by inflexible behavioral patterns that lead to substantial distress or functional impairment. Anger is intrinsic to personality disorders as are chronic feelings of unhappiness and alienation from others, conflicts with authority, and family discord. There is much controversy about the prevalence of these conditions.

Richard Ries, M.D.: "Almost everybody who shows up at an addiction agency for treatment looks like they have a personality disorder. If you do the same personality tests a month later and then 3 months later and 6 months later, it's just like depression, the percentages drop and drop and drop every few months. That's not the definition of a personality disorder. A personality disorder doesn't change with a month of sobriety. So we assume that most personality disorders in people with addiction are actually substance induced."

Often a client has more than one mental illness.

Kurt: "Uh, dysthymic depression, anxiety with psychotic features, and posttraumatic stress disorder."

Mark: "I have a pretty big problem with PTSD and I'm also bipolar."

Similarly, the majority of dually diagnosed clients abuse more than one drug.

Talin: "I used crack cocaine, every day, heroin every day, I drank alcohol every other day or so to kind of mellow out from the other drugs."

CAUSES OF MENTAL ILLNESS

There are a variety of mechanisms that can cause mental illness.

HEREDITY

Talin: "Mental illness runs in my family. I think it would have—my father has real deep issues. He had some mental illness looking back on it. He's never been treated and I do have a schizophrenic aunt."

The odds of developing schizophrenia when relatives have the same disease are directly related to the biological closeness of that relationship.

Bill: "Well my little brother Brian, he's a schizophrenic, I guess, I can't really tell sometimes."

Close relatives of those with depression have a 3-fold chance of developing the same illness compared to those with no depression. With bipolar illness, the odds increase to 7- to 8-fold if a close relative has the same condition.

Kim: "There is—depression runs in my family and bipolar does run in my family."

Even a familial tendency to addiction can signal a tendency to mental illness.

Mark: "Maybe it was because my mom and dad were both alcoholics and having real depressed modes and then becoming real manic and just bouncing off, all over the place and then getting depressed again."

Remember though, heredity is not destiny. Mental illness in the family only means that the odds of developing that same illness are increased.

ENVIRONMENT

The second factor causing mental illness, environment, can mean anything from emotional and physical traumas, to everyday extreme stress, and even to physical damage.

Bill: "My stepdad, he'd catch you doing anything he'd just drop and tell you to go into the other room and he'd beat the shit out of you with a belt, about 20 or 30 times, 40, 50 times. I had to move out of the house when I was 17, I couldn't take it no more."

Brett: "When I was 14 years old, I got in a bicycle accident. I hit a tree, a garage, and another tree. It put me in a coma for 13 days and it started the symptoms. I was a normal human being until then."

DRUG-INDUCED MENTAL ILLNESSES

Heavy or chronic use of psychoactive drugs is the third factor that can induce a mental illness, often temporarily but occasionally persisting well past the cessation of use.

Darryl Inaba, Pharm.D., CEO, Haight Ashbury Free Clinics: "You can have someone who's an ice addict or methamphetamine addict look very much like they're having major thought disorders and paranoid schizophrenia while they're high and then when they crash or are in withdrawal, they'll look very much like they have a major affective disorder, a major depression, and in between those getting high and kicking, they're going to look like they have bipolar disease."

Adam: "From doing so much cocaine, I was believing there was people out to get me, believing there was people in the same room when there was nobody in the room talking to me."

Mike Miller: "When you stopped using cocaine, did the symptoms of schizophrenia go away?"

Adam: "Yeah."

Mike Miller: "Did that whole disorder go away then, the schizophrenia?"

Adam: "Yeah. To me I feel like it's totally gone."

Mike Miller: "Sometimes it goes away. Adam, you're fortunate. I know of cases unfortunately where it's a permanent condition."

Dr. Arthur W. Toga, Director, LONI Brain Imaging Lab., UCLA: "Well neurochemical changes can ultimately result in anatomic changes. I think the duration and the severity of the exposure to the compound is likely going to be the determining factor as to whether we can see it anatomically or not. So when one has a drug abuser who is exhibiting these behaviors, it may be in an acute phase that has not yet had time to affect the brain."

Chance: "Because of speed and alcohol I lost my house, my wife, and my job in one ultimate night."

Mike Miller: "In one night."

Chance: "In just one terrible, frenzied, out-of-control, cranked out, psychotic episode, you know. I scared all the people that I love away from me to the point where the police were involved. It meant jail for me."

DIAGNOSIS

Jerry Clarke, Senior Residential Counselor, Genesis (Recovery Center): "When you do a diagnostic assessment when you work with a client, you want to look at history, you want to look at family history, and you begin to define what characteristics that that person might have that would include dual diagnosis."

Kim: "I never told the truth. I was very dishonest with my doctor about my addiction or whatever. I just, I would take the antidepressants when I felt like it."

Richard Ries, M.D.: "Did anybody during that 8 years or so before the crisis, did anybody make a diagnosis of drug or alcohol problems, your friends or any doctor, or your family, or anybody?"

Kim: "Yes, yes, yes, uh, yes."

Richard Ries, M.D.: "I think the important thing about dual disorder treatment is to accept that diagnoses change over time and treatment plans change over time as patients' intensities of illness change."

Lonny Maeda, Clinical Supervisor, Genesis (Recovery Center): "A majority of our clients come in already diagnosed with some kind of a depression disorder, maybe long standing and they just simply have gotten off their medication as they've gotten into their addiction, those are fairly easy, we just get them back on track."

In order to advance the art of diagnosis, new scanning techniques that examine structural and chemical changes in the brain are being developed.

Dr. Arthur W. Toga: "The basic idea here is to create maps of the human brain that describe it in a structural sense that allows us to examine it's anatomy and use that as a framework for the mapping of other characteristics of the human brain. One of the applications has been examination of schizophrenia. It's interesting to note that schizophrenics often have an accelerated rate of gray matter loss. This quadrant right here, are normal control females, this quadrant right here are schizophrenic female, and what you're

looking at is the variability in gray matter of these two groups of individuals. We aren't going to go in and surgically alter the anatomy but by examining the anatomy, it tells us what circuits may be responsible and perhaps what receptors need to be modified using particular drug therapies or biochemical approaches to achieve that change."

WHICH CAME FIRST?

Even with a good diagnosis, it can be difficult to know if the mental illness predated the drug use.

Doug: "In the beginning I didn't drink, but I was diagnosed with schizophrenia. That was when I was 16. I started drinking when I was 18."

Paul: "I didn't know I had mental health problems until I was going to jail so much, you know they finally wanted, one doctor wanted to find out why, so they referred me to Harborview."

SELF-MEDICATION

Until clients get into treatment for their mental illness, they often try many methods to control their symptoms, further confusing the answer to the question, "which came first."

Doug: "When I drank, it made me feel more together. I wasn't, I didn't think I was sick when I drank, I thought I was OK, but afterwards when it wore off and I was sick, everything got a lot worse."

Richard Ries, M.D.: "When patients use the term, 'Well I was self-medicating,' I say, 'Well, you know, alcoholism is a disorder of self-medication. It's a disorder where people think they're taking medicine to make themselves better and it actually makes themselves worse.'"

Janyne: "I drank so that I could go to sleep and then that caused everything to become more out of control. The alcohol affected what little ability I still had left to cope with the panic and terror and so I would drink to just black out."

Joan Zweben, Ph.D., Clinical Psychologist, University of California Medical Center, SF: "Yes, these drugs do make you feel better, really very good, quickly, but look at the downside because over time you'll find you're less able to maintain a good social adjustment, you may lose your housing, you may lose your health."

Paul: "I don't know how to live a clean and sober life. I don't know how to deal with things around me. The only way I know how to deal with things is if I'm high on some kind, some kind of illegal narcotic 'cause when I'm loaded I'm 7-foot tall, you know, I'm 500 pounds. Nobody can hurt me."

Simply giving up the drug doesn't guarantee that symptoms will disappear.

Talin: "At first they were worse. It was harder. It was worse. I felt more psychotic at first and it really actually made me very upset because I thought that once I got off drugs, things would be better and they didn't seem to be better at first. Now of course it's much better."

PSYCHIATRIC MEDICATIONS

Because the use of street drugs to control the symptoms of mental illness often leads to abuse and addiction, several classes of non-addicting medications have been developed over the past 50 years to treat these conditions.

Darryl Inaba, Pharm.D.: *“In research with animals we’ve been able to show that drugs like cocaine, drugs like amphetamine, drugs like the opiates are strong in that category of making people want to take it over and over whereas the neuroleptic drugs, the drugs used in psychiatric thought disorder conditions, or the antidepressants are not reinforcing and therefore are not classically prone to lead a person into uncontrolled use of that drug.”*

Mark: *“I’m on a combination of four medications, most of them are sleep aids to help with the nightmares that’s my major problem right now—and a couple of them are for the bipolar. I take Depakote, Seroquel, Prazosin, and Remeron.”*

The most commonly used psychiatric medications are

- **antipsychotics,**
- **antidepressants,**
- **bipolar medications,**
- **and various antianxiety medications.**

Bill: *“Okay, we got Prozac for moods. That was hearing voices. The use of Prozac, that slowed it down. I’m on 1, 2, 3, 4, 5, 6, 7, 8, 7 or 8 medications now.”*

Mike Miller: *“How many of you used your antidepressant, antipsychotic or other types of psychiatric meds at the same time you were using?”*

Chance: *“What a waste of time and money.”*

Mike Miller: *“Right, right, right. The second piece is, again, the medications are not a cure-all. They stabilize, which enables you to stabilize who you are and to get a better view, a better perception of life, a better view of yourself.”*

Kurt: *“My whole life was under a gray cloud and I didn’t even know that it was until the cloud went away.”*

Mike Miller: *“Excellent. Excellent example of how medications can really change a person’s life. It certainly has changed yours, Kurt.”*

Kurt: *“Well it’s enabling me to be reasonably contented in this life and not have to consume my drug of choice. I mean I never thought I would be at that point. I thought that I was going to have to smoke marijuana every day until I die.”*

Darryl Inaba, Pharm.D.: *“Medication is being much more accepted now in the chemical treatment field and people who are being medicated are participating in groups, participating in treatment, participating in chemical dependency interactions that in the past they would have been told they couldn’t participate in.”*

STIGMA

Carrie: *“When I was an addict in my addiction I didn’t want anybody to know I was sick. I tried to hide it the best that I could. I wouldn’t look at anybody ’cause, you know what, I knew they could just see in my eyes. You know I didn’t want any. I had this mask that I’d wear because I didn’t want anyone to know that I was so depressed and just was not happy with life at all.”*

Brett: *“I don’t let anybody know. That’s one thing I keep to myself. Because if the people think you’re slow or weak, they take advantage of you.”*

Jerry Clarke, Senior Residential Counselor, Genesis (Recovery Center): *“The stereotype for the mentally ill is not entirely accurate. Many people think of a person in the inner city who is standing on the street corner, raving on, making no sense. That’s not your typical mentally ill person. Mental illness affects all areas in our society. Most of the people that I’ve come in contact with are successful, they’re working people, they’re the working class, they’re being treated, they’re being medicated. And they have hope in*

their lives and they're handling their mental illness the same way that a recovering alcoholic would handle recovery.?

TREATMENT

Doug, "I drank until 1991. I went to AA. I didn't get sober right away but I did keep coming back and finally I did get sober. And after that I didn't go to jail anymore and I didn't get hospitalized for my mental illness anymore."

Before treatment begins, the diagnosis has to assess the relative severity of each of the co-occurring disorders. There can be

- **severe mental illness and severe addiction;**
- **severe mental illness and milder addiction;**
- **milder mental illness and severe addiction;**
- **and finally milder mental illness and milder addiction.**

Richard Ries, M.D.: "If, for example, they look like a more mental health-based treatment need, and it's acute, they go into the patient psych unit. If they have acute intoxication, they would go to our detox unit. We have mental health tracks built into our addiction treatment programs and we've got addiction tracks into our mental health-based programs."

Casey: "I don't think my medication was working right because I started hearing voices, too, and I was hospitalized five times last year for suicidal ideas and attempt."

Richard Ries, M.D.: "Your instability this last year was more around psychiatric destabilization than drug and alcohol destabilization?"

Casey: "Oh yeah, definitely. I've been clean and sober for 21 years."

When a client comes in for treatment, the physician, psychologist, or counselor has to decide which illness needs to be treated first.

Richard Ries, M.D.: "You need to go first where the patient is interested, you know, where you can get them engaged. Because if you can't engage the patient, you're not going to get anywhere with either, you know, their mental disorder or their addiction problem, so the first parts of treatment may be focusing on housing or maybe focusing on food."

Kim: "You know I have a drug problem, I'm an alcoholic, I'm a drug addict, I have mental health issues. You know what I mean, I have these problems. If I take just one and leave the other one out, for sure the other one's going to come back and get me."

Jerry Clarke: "I think they're interrelated. I think both issues need to be addressed and they need to be addressed simultaneously. My philosophy is that if you don't work on them simultaneously, more than likely, the person will relapse."

Richard Ries, M.D.: "I've always stated that every psychiatric, acute care psychiatric unit in the country should be a dual disorder unit because half the patients that are admitted have co-occurring psychiatric and substance problems with often the substance disorder being the primary reason for the person's decompensation, suicidality, or the fact that they stopped taking their medications and decompensated with their original psychiatric disorder."

Some of the techniques that have been found effective are those which help impose a structure on the client's often chaotic lifestyle.

Nancy Cooper, OT, Mental Health Practitioner, Harborview Mental Health Services: “So to get them to be able to make a decision, keep an appointment, get housing, make a friend, there are just very small steps of recovery that have to come before you can think about sobriety.”

John: “I kind of like the structure and stuff like that. You know, them being my payee and giving me medicines, that’s once a week and stuff like that, it’s a lot better. I have overmedicated myself in the past with that but they just did enough to get me stable and then I would just continue on the way I was before.”

Kristen: “I was driving home one night and I had outbursts of tears and I started feeling paranoid, and I felt like someone was following me. I started to have suicidal thoughts of pill overdoses, so I voluntarily admitted myself because I knew something wasn’t right.”

Mike Miller: “That’s incredible. She had enough insight through education, through life experience, coming to groups, right? You had enough insight, you knew, you knew that something was going on and you needed help immediately.”

Kristen: “Yeah, I had a lot of education.”

INDIVIDUAL & GROUP COUNSELING

There are three main kinds of counseling that are used in both mental health and substance abuse treatment settings. They are

- 1. facilitated groups, led by a professional,**
- 2. peer groups that include 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous,**
- 3. and one-on-one counseling with a psychiatrist, psychologist, or counselor.**

Mark: “I still think about drugs a lot.”

Richard Ries, M.D.: “So you think about drugs a lot? What does that mean, you think about drugs a lot?”

Mark: “I think about using drugs a lot.”

Richard Ries, M.D.: “You think about using drugs?”

Mark: “Yeah, I still do.”

Richard Ries, M.D.: “How real does that get?”

Mark: “Not as real as it used to. I’m able to get my mind off of it. Before I couldn’t, I just wouldn’t be able to stop thinking about it but now I can focus on other things, I go to meetings and that’ll make me quit thinking about it.”

Linda Taylor-Smith, Mental Health Practitioner, Harborview Mental Health Services, Seattle: “I have to think on my toes because it very much depends on what my group brings to me, how they present, what particular issues they’re dealing with that day and it might be that they’re dealing with side effects to their meds, or paranoia, or depression, or it might be they’ve just relapsed.”

Casey: “I actually go to one fellowship hall called Fremont and I have talked about my mental illness, I have talked about being bipolar, I’ve talked about how I went to the Aurora bridge and wanted to commit suicide and how I got to a hospital. And actually, they’ve been very supportive of me because other people have known what that kind of depression is too.”

Katie: “The dual diagnosis addict/alcoholic is not welcomed as freely into the general population. At AA meetings there’s always that podium pounder who will insult you because of taking medication. They’re accusing us of getting our recovery in a pill, and that that’s not at all what needs to be done. So it takes careful and hard work to find that place that’s therapeutic for you, that keeps you going forward.”

Doug: “I took psych meds for many years. I was on Stelazine for maybe 20 years and when I got sober, my sponsor told me to keep taking my medication and keep seeing my doctor and that’s what I did.”

COMPLIANCE

Joan Zweben, Ph.D.: “I have heard many people tell me, ‘I took these antidepressants, I felt so much better, I was sure I was cured, I was normal. So I just quietly, without discussing it with you, or any of my other treaters, discontinued them.’”

Mark: “And I decided after 7 years that I didn’t need the meds no more so I quit taking them. In less than 3 weeks I relapsed and ended up back in the hospital after trying to kill myself. And I have been on a relapse ever since then, until last August.”

Kristen: “If I don’t take the Risperidol, I feel a difference.”

Mike Miller: “In what way?”

Kristen: “I have high levels of anxiety and I can’t sleep. I wake up like every hour.”

Bill: “Well where I’m living now is a foster home and they dish out the medication, everything at medication time at 4 and they’re sitting there to make sure we take it, for real. That’s their job though, to make sure we take the medication.”

Kurt: “I’ve talked to various doctors and they gave me some pills and maybe the reason they didn’t work was because I was smoking weed and taking the pills. But I didn’t know that and now I’m to the point where I’m not smoking the weed and I’m taking the pills and my life is better and more stable and more rewarding that it has been for many years.”

RELAPSE

Mike Miller: “Oftentimes we learn that with post-acute withdrawal symptoms, right, that phenomena that occurs when we become too stressed or the anxiety becomes too high, then we go into relapse behavior and of course the relapse behavior occurs way before we actually go into relapse in terms of taking our drug of choice.”

Casey: “Yes, I was going to jump off the bridge because I wanted to die.”

Richard Ries, M.D.: “And that was within the last year?”

Casey: “Yes.”

Richard Ries, M.D.: “And during this whole time you were actually taking medicines?”

Casey: “Oh yes, I took medication the whole time.”

Richard Ries, M.D.: “Did you ever stop your medicines?”

Casey: “No, I never did.”

Richard Ries, M.D.: “So maybe an important issue that people with co-occurring disorders need to hear is even if you are doing everything right, sometimes symptoms can come back.”

Casey: “Sure.”

For a number of clients, particularly those with bipolar affective disorder, the desire to become manic can be a powerful trigger for relapse.

Richard Ries, M.D.: “Do you think manic or depressive people ever just stop their medicines in order to get manic?”

Casey: “Oh definitely. And some people think they can be better singers or do better writing or have more fun.”

Most often, however, it is a relapse to drug use that triggers the mental illness in those with co-occurring disorders.

Paul: *"I picked up right where I left off too. It was just like bam, man, I'm gonna lose everything again."*

Richard Ries, M.D.: *"Cunning, baffling, and powerful."*

Paul: *"Yeah."*

Kim: *"When I was clean, before I ended up relapsing, going into the hospital, I was hopeless. That was the reason I relapse, you know, because I just felt hopeless and I had been clean for 11 months."*

Mike Miller: *"That's why recovery is an everyday process and especially with the dual diagnosis."*

Janyne: *"I just keep doing the things that I know that works. I still have all my early systems in place from my very first discharge plan. I still have all those numbers handy and if I find a new trigger, then that goes on my list, you know. I'm still working it as I was the first couple of weeks that I was here, after the fog lifted and I knew what I was doing."*

Chance: *"We are in a state of recovery and we're vulnerable right now and so the more people we enlist for help, the higher percentage of our recovery being a success will happen."*

Janyne: *"My family helps me, my friends help me, my coworkers even help me. And they spot physical triggers in me that I am not even aware of. My shoulder's coming up into my ears for no particular reason."*

Mike Miller: *"You taught other people of your support system that you trusted and that you felt safe with to help recognize when those symptoms became too much for you to possibly manage."*

HOPE

Charles Curie, Administrator, Substance Abuse and Mental Health Services Administration: *"I think the hope is real. I know the hope is real. The hope is real because I hear it from consumers. I hear it from family members. There are people that when I look back in my own practice that 20 years ago I would have said basically they were going to be in an institution all their lives. Today those same people are living in the community, many pursuing education, vocational goals, having a relationship with their families."*

Doug: *"I have hope that I can live a good life in spite of being mentally ill as long as I cooperate with my doctor and take my medication. I have hope that I won't have to drink anymore and I haven't had to drink now for over 12 years, so that says something in itself."*

Linda (counselor): *"They may go back out and relapse and not return to a sober lifestyle for quite a while. But there's a hope that something I've said, a group member has said, something in the group interaction, a prompting to go to AA and develop support and structure, something hopefully will plant a seed and they will get back to sobriety, if not today, tomorrow."*

Janyne: *"I go to work. I love my work. I love what I do. Nobody runs screaming from me in horror because I'm an ugly monster. People actually come to me voluntarily and talk to me willingly."*

Kim: *"I see my future as a good future today. It's not right where I would like it to be but I have strong faith, I have strong hope. I'm focused and I believe as long as I keep God in my heart and keep a plan in my mind, everything's going to work it's way out."*

Paul: *"The things I got is not much but to me I treasure what I have. I'm clean and I got me an apartment and I'm happy with that. I love it 'cause I never accomplished this in my entire life, you know, I've always been a screw up since 10 years old. I've always been in trouble with the law or something."*

Bill: *Well I've been out of the Oregon State Hospital 2 years on April 2. Just about a month from now you know is all. This is living. This is living. I recognized that the first month I was here. I used to tell a few people that. This is living again."*

Strategies for Recovery

Take prescribed psych medications.
Stay abstinent from drugs and alcohol.
Stay in touch with clinicians.
Use support groups.
Do something productive.
Stick with recovering people.
Believe in hope.

Closing Credits

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