The Future of Addiction Treatment: Trends and Best Practices

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Objectives/Review

• Discuss future directions of addiction treatment.
• Identify trends in emerging drugs of abuse and patient profiles.
• Relate how current changes in frameworks for the provision of healthcare serve as contextual forces that may benefit or threaten addiction treatment.
• Describe shifts toward data-driven treatment and recovery support, including technologically-based treatment and recovery monitoring vs. traditional treatment and post-treatment evaluation.
• Describe how individual patient variables and styles of 12-step engagement can be understood to improve approaches to formal treatment.
Afterward 1 of 3:

• **What about *practice-based evidence***?
  
  – Clinical research is so tight for inclusion/exclusion of participants and so tight in protocols tested that it has significantly limited real-clinical-practice applicability. That is, clinicians are not able in real practice to filter their patients so extremely, or conduct a protocol so tightly.
  
  – The field needs research trials in real-world clinical services with real-world inclusion criteria.
  
  – One criticism of the traditional residential program is that it is too cookie-cutter. But what’s more cookie-cutter than a CBT manualized protocol?
Afterward 2 of 3:

• The plural of “anecdote” is “data”.
  – Researchers relegate anecdotal data to last-place in value. But the lives of people in recovery aggregate to a large data sample.
  – A surgeon who has done 10,000 of the same procedure has something valuable to say about the illness and course of care.
• Why is addiction treatment held to a standard of symptom-free remission?
  – Chronic diseases have patterns of remitting and returning symptoms.
  – If it were any other disease, a return to symptoms after stopping care might be interpreted as care being effective.
  – Corollary: why require someone to “fail” at a lower level of care first? Do no harm?
Medicalization Means Addiction Treatment Goes Away

• Pressures against the continued existence of the field, regardless of what treatment looks like in 10 years
  – Average age of addiction treatment counselors
  – Meaning of a specialty credential and specialty treatment

• Medication research

• Professionalizing of treatment: Currency of education and credentials
  – vs. recovering counselor;
  – vs. indigenous recovery support

• Hijacking of addiction treatment into and by
  – psychiatry (e.g. changes in DSM)
  – mental health (e.g. Motivational Interviewing & CBT as EBP’s)
  – primary health care (e.g. office-based therapy/medication)
Addiction Treatment Is Changing

• Newer drugs of abuse are emerging.
• Clinical practices shifting & emphasis on disease management/recovery-management models.
• Concepts of addiction (DSM-5?), relapse, and recovery are being clarified at a time when…
  – patient profiles are changing,
  – basic assumptions about addiction treatment are being questioned, and
  – improvements in evidence-based practices are available,
  – including the use of new technologically based protocols.
Let’s define terms

• “Addiction”

• “Recovery”

• “Relapse”
What Is Addiction?

• Addiction is a PRIMARY Neurologic, Chronic Disease
  – PRIMARY = not due to something else (anxiety, depression, ADD/ADHD, Bipolar Disorder)
  – Neurologic = Brain and spinal cord
  – Chronic = Relapsing, Remitting cycle

• Sometimes difficult to differentiate Primary vs. Substance-induced (secondary) Psychiatric disorder
American Society of Addiction Medicine’s Short Definition

“Addiction is a

– primary, chronic disease
– of brain reward, motivation, memory and related circuitry.

Dysfunction in these circuits leads to characteristic

– biological, psychological, social and spiritual manifestations.”
ASAM: Short Definition of Addiction continued

“This is reflected in an individual
• pathologically pursuing reward and/or
• relief by substance use and other behaviors.

Addiction is characterized by:
• inability to consistently abstain,
• impairment in behavioral control, craving,
• diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and
• a dysfunctional emotional response.”
ASAM: Short Definition of Addiction continued

“Like other chronic diseases, addiction often
– involves cycles of relapse and
– remission.

Without treatment or engagement in recovery activities, addiction is
– progressive and
– can result in disability or premature death.”
DSM now states: “Note that the word *addiction* is not applied as a diagnostic term in this classification, although it is in common usage in many countries to describe severe problems related to compulsive and habitual use of substances. The more neutral term *substance use disorder* is used to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive drug taking. Some clinicians will choose to use the word *addiction* to describe more extreme presentations, but the word is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation.”
What is “recovery”?
“Recovery” Defined: The Betty Ford Consensus Panel

“Recovery is defined as a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.”
What is “relapse”? 
What is “Relapse”?  
Alan Marlatt
What is “Relapse”?  
Alan Marlatt

A *lapse* is a single, short-lived action in which someone deviates from the goal of abstaining from alcohol and other drugs.

A *prolapse* occurs when a person learns what triggered a lapse and how to prevent the lapse from happening again.

A *relapse* is a series of lapses in which someone gradually loses all control of alcohol or other drug use.
What is “Relapse”?  
Terry Gorski
What is “Relapse”?  
Terry Gorski

“Relapse is the process of becoming dysfunctional in recovery that ends with the renewed symptoms of addiction or related mental or personality disorders.”
What is relapse (DSM)?

“Relapse” and the DSM criteria

- The substance is often taken in larger amounts or over a longer period than intended
- There is a persistent desire or unsuccessful efforts to cut down or control use of the substance
- A great deal of time is spent in activities necessary to obtain the substance, use, or recover from its effects.
What is relapse (DSM)?

• Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).
Trend: Attempt to define “outcome”

Emerging trend (Norm Hoffman):

• No one can define or measure “recovery”
• Few funders support payment for person-centered goal attainment
• Measure “remission” according to DSM 5 SUD criteria;
• Funders pay for remission in other diseases
Trends in Drugs of Abuse

- Synthetic cannabinoids (Spice, K2, Bonzai, etc.)
- Kratom
- Synthetic cathinones (Bath Salts, Flakka, etc.)
- tramadol (Ultram)
- propofol (Diprivan)
- Liquid nicotine
- THC oil/electronic vaporizer
- Wellbutrin
Synthetic Cannabinoids: Spice/K2

- “Spice”: variety of herbal mixtures that produce experiences similar to marijuana; marketed as safe and legal
- Dried, shredded plant material and chemical additives.
- Easy to purchase: gas stations, head shops, internet
- High potential for abuse, no medical benefit
- DEA designated five active chemicals in Spice as controlled.
- Manufacturers substitute different chemicals in their mixtures
- Popular among young people, second only to marijuana: easy access, “natural” therefore harmless
- Not easily detected in standard drug tests.
Synthetic Cannabinoids: Spice/K2

- Effects similar to marijuana (elevated mood, relaxation, and altered perception); may be stronger.
- Some users report extreme anxiety, paranoia, and hallucinations.
- Compounds in Spice may be unknown, lead to more powerful and unpredictable effects.
- Poison Control Centers report: rapid heart rate, vomiting, agitation, confusion, and hallucinations. Spice can also raise blood pressure, associated with heart attacks.
- Regular users may experience withdrawal and addiction symptoms.
- Effects on human health and toxicity remain unknown
Synthetic Cannabinoids: Bonzai

- Not the benzodiazepine “phenazepam” aka “bonsai” popular in Russia and former Soviet states
- Highly addictive synthetic cannabinoid
- Taking over Turkey since 2009 as crack did in the USA in the 1980’s
- “Like a combination of bath salts, cheap heroin, and battery acid”
- “Poor man’s heroin”
- Extreme anxiety, paranoia, delusions, “death trip”, fear climaxing in panic, sometimes associated with heart failure
Kratom

• Tropical tree indigenous to Thailand. Related to coffee tree.
• Leaves chewed for decades in SE Asia as an herbal drug.
  – Stimulant for physical laborers
  – Relief from muscle strains
  – Substitute for opium when opium is not available;
    manage opioid withdrawal symptoms by chronic opioid users.
• Thailand: 1943 planting tree made illegal; 1979 placed with marijuana in classification of narcotics; Popular in Thailand.
• Young Thai militants drink a Kratom formula to make them “more bold and fearless and easy to control”; coffee shops.
• Promoted as legal psychoactive product on websites in the U.S: vendor listings, preparation of tea, recommended doses, alleged medicinal uses, user reports of drug experiences.
Kratom

- No legitimate medical use for Kratom in the U.S.
- Over 25 alkaloids have been isolated from Kratom;
- Primary alkaloid has opioid-like activity in animals including some smooth muscle contraction, inhibiting gastric secretion and reducing pain response.
- **Low doses, it produces stimulant effects**, with users reporting increased alertness, physical energy, talkativeness and sociable behavior.
- **At high doses, opiate effects are produced**, in addition to sedative and euphoric effects. Effects occur within 5 to 10 minutes after ingestion and last 2 to 5 hours. Acute side effects include nausea, itching, sweating, dry mouth, constipation, increased urination, and loss of appetite.
- In Thai Kratom addicts, mean use was 18 years duration.
- Long-term use: anorexia, weight loss, insomnia, skin darkening, dry mouth, frequent urination, and constipation.
Kratom

- Withdrawal syndrome: hostility, aggression, emotional lability, runny nose, achy, jerky movement of limbs.
- Kratom psychosis: hallucinations, delusion, confusion.
- U.S. information is anecdotal: used as a tea or chewing leaves; users report dominant effects are similar to stimulants.
- Kratom abuse not monitored by national use surveys.
- Widely available on the Internet: leaves (whole or crushed), powder, extract, encapsulated powder and extract resin “pies” or pellets made from reduced extract.
- Seeds and whole trees are also available from some vendors through the Internet.
- Not controlled under the Controlled Substances Act.
Synthetic cathinones: Bath Salts

- Synthetic powder sold legally online and in drug paraphernalia stores under a variety of names
- Relatively new; limited knowledge about composition and both short- and long-term effects
- Often contains amphetamine-like compounds such as mephedrone
- Typically administered orally, inhalation or injection (worst outcomes seen in intravenous use).
- Marketed as cocaine substitute
- Mephedrone is associated with high risk for overdose.
- Acts like a stimulant in the brain; high abuse and addiction liability; triggers intense cravings similar to methamphetamine
- High risk for other medical adverse effects; chest pains, increased blood pressure, increased heart rate, agitation, hallucinations, paranoia, and delusions
- Several states, cities, and local municipalities have introduced legislation to ban these products
Synthetic cathinones: “Flakka”

- Same drug family as bath salts
- Synthetic version of the cathinone present in Khat plant
- Manufactured in China
- Also called “Gravel” due to its appearance
- Becoming more commonly used in FL
- Large release of dopamine
- “Excited delirium”
tramadol: Ultram

• Most commonly abused by narcotic addicts, chronic pain patients, and health professionals
• Novel analgesic: opiate agonist activity and monoamine reuptake inhibition that contribute to its analgesic efficacy. Opioid activity is due to both the parent compound and the more active metabolite.
• Acts on the monoamine reuptake systems by inhibiting the reuptake of norepinephrine and serotonin.
• May cause dizziness, somnolence, nausea, and constipation similar to other opioids. High doses have been associated with a serotonin syndrome consisting of seizure, hyperthermia, muscle rigidity and pain.
• Physical dependence and withdrawal can develop.
• Not currently controlled under the CSA. Some states have designated tramadol as a schedule IV drug under state law.
**propofol (Diprivan)**

- Short acting intravenous anesthetic. Available in the US as prescription medication for use in human and veterinary medicine.
- Non-barbiturate sedative, used in hospital settings for general anesthesia and sedation of ventilated adults receiving intensive care, up to 72 hrs.
- Potentiation of GABA-A receptors. Similar to barbiturates and benzodiazepines; shown to produce rewarding and reinforcing effects in animals. Fast onset of action; crosses the blood-brain barrier very quickly.
- Produces loss of consciousness within 40 seconds of intravenous injection. Mean duration of action is 3 to 5 minutes following a single normal administration.
- Narrow window of safety associated with cessation of breathing in some adults and children. Prolonged high dose infusions associated with cessation of breathing, breakdown of heart muscle, and heart and kidney failure leading to death in some cases.
propofol (Diprivan)

- No antagonist or reversal medication for propofol toxicity; fatalities do occur.
- Studies of recovery profile of propofol have reported that patients anaesthetized with propofol wake-up “elated”, “euphoric”, and “talkative”.
- Sub-anesthetic doses of propofol reported to produce feelings of “high”, light-headedness, “spaced out”, sedation. These doses of propofol have been shown to increase dopamine concentrations in the brain reward system in rats.
- Abused for recreational purposes, mostly by anesthetists, nurses and other health care staff. Look for contusions on the head.
- Rarely encountered by law enforcement personnel or submitted to forensic laboratories for analysis: non-controlled status.
Trends in Patient Profiles: NIDA

• 7 percent of the US population in 2010 were dependent on alcohol or had problems related to their drinking (abuse). Basically unchanged since 2002.

• After alcohol, marijuana has the highest rate of dependence or abuse among all drugs. In 2010, 4.5 million Americans met criteria for dependence or abuse of marijuana in the past year—more than twice the number for dependence/abuse of pain relievers and four times the number for dependence/abuse of cocaine.

• Drug use is increasing among people in their fifties. In part due to the aging of the baby boomers, whose rates of illicit drug use have historically been higher than those of previous cohorts.
Trends in Patient Profiles

• Verbalize symptoms for treatment very well
• Poor sleep hygiene, sleep architecture, use of sleep medications (e.g. Ambien)
• Depression and anxiety
• Somatization; prescription drugs; MD source
• Anxiety:
  • Economic pressures – 401K to support care of family members (elderly parent, young adult’s needs)
  • Employment uncertainty across age groups
  • Trauma spectrum; complex PTSD
• Subtle, unrecognized cognitive impairment
Trend: moving the focus of recovery into the community

“Recovery Capital”…is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Cloud & Granfield, 2004).
Ecology of Recovery: Building Recovery Space in the Community

Physical Space
- Shelter, sanctuary, safety

Psychological Space
- Countering pessimism, stigma; enhancing hope

Social Space
- Meaningful relationships and activities

Spiritual Space?
- ?
Trends Toward Community-Based

- ASAM unbundling setting and service
- Drug Court or Mental Health Court (Recovery Court), ACT, Supported Employment
- Physician Health Program (PHP) models are a great example of combining:
  - Recovery-Oriented Systems of Care (ROSC) principles and practices
  - Evidence-based model of care using best practices (for the subset of patients to whom they apply).
  - Years of monitoring, coaching, field/workplace monitors
- Monitoring, recovery coaching for general population; HOPE Probation, SD Sobriety 24/7 Project
- Payors: Room & Board vs Treatment
Overview of Trends in Clinical Practices

- Community Reinforcement Approach (CRA)
- Community Reinforcement And Family Training (CRAFT)
- Fidelity tools
- Addiction treatment is professionalized, medicalized and goes away
- Medication-assisted treatment
- Treating nicotine dependence
- Paying for functional outcomes – outgrowth of benchmarking

Caveats:
- Evidence-based practices are slow to be adopted.
- Newer evidence-based practices are even slower to be adopted
- Treatment-as-usual tends to be the state of the art.
“Community Reinforcement Approach” (CRA) by Bob Myers.

- Best outcomes for broad patient populations
- CRA-FT is the Family Therapy extension of CRA also by Myers. It is his alternative approach to “Interventions” by Johnson Institute.
- Hazelden booted the Johnson Institute model in favor of using CRAFT.
Use of Fidelity Tools

• But most organizations are not REALLY all that evidence-based, or current.
• Clinicians regress to their strengths and training: solution is fidelity tools for practitioner, and for program
• Measure adherence to protocols by supervisor (behavioral observation).
• Trend: fidelity tools required by payors
• Emerging Trend: rigor, then fidelity
Qualeˈkwälē
plural qua·lia

• Individual instances of subjective conscious experience
  – Spy satellites
  – Cream of mushroom soup
  – Eating a peach
Trend: From Fidelity to Rigor

• Look for the gaps, and fill the gaps with rigor
• Then, apply the lessons across the field
Medication-Assisted Treatment

• Stigma: these patients may be rejected by the treatment community, the recovering community, and the actively addicted community.

• Medication-assisted treatment
  – Not “real” treatment
  – Substituting one drug for another

• Medication-assisted recovery
  – Not “real” sobriety
  – Not “real” recovery

• ASAM’s recent emphasis
Medications

• disulfiram (Antabuse)
• acomprosate (Campral)
• naltrexone (Revia, Vivitrol)
• buprenorphine (Subutex)
• naloxone + buprenorphine (Suboxone)

• Trend includes vaccines (NIDA): cocaine, nicotine, hydrocodone, oxycodone, heroin + HIV combined
Treating Nicotine Addiction

• **Old belief:** trying to stop during treatment or early recovery increases relapse risk

• **New information:** We now know recovery rates are higher for those that include nicotine in their treatment and recovery; DSM-5 includes tobacco use disorder.

• Nationwide, 70% of current smokers are interested in quitting.

• Evidence-based practices: education, counseling, medication support.

• **Emerging Trend:** Smoke and tobacco free campuses and addiction treatment programs.
Legal Implications & Medications

• Disease relative to ADA? According to whom?
• Impacts on hiring and HR management
  – Medications allowable per workplace
  – Workplace safety? Safety to practice?
• Trade publication and MMT
• Trend: ignore disease of addiction and medication-assisted addiction recovery
Emerging Trend: Pay for Functional Outcomes

- One day payors will hold out for higher rates for best practices and functional outcomes.
- Example: range of motion after surgery
- Not clinical outcomes (surgical outcomes vs range of motion).
- Implications for benchmarking real results
- Implications for “treatment” vs recovery support system
- Example of implementation: warranty “recovery”
Technologically-based Treatment and Promising Practices

- Community-based: case management, SBIRT, co-locaters
- “Recovery Priming” pre-admission service
- “Start Now” (counts)
- “E-therapy; tele-medicine”
- Use of chronic disease management technology from outside the MH/SA field (e.g. dentist’s office phone calls)
Technologically-Based Treatment: Promising Practices

- Skype or Smart phone-based monitoring and coaching
- Telephonic recovery management check-ups (RMC protocol: Scott & Dennis)
- GPS for high risk situations & just-in-time coaching
- Recovery-support smart phone apps
Technologically-Based Treatment

• Institution or electronically-based: “Virtual team”

• iPad in residential treatment
  – Patient education: instructions, announcements, maps, FAQ’s, etc. (patient-centered)
  – Worksheets
  – Video
  – Platform for fellowship support board
  – Platform for family or conjoint work

• On-line/mobile: self check, recovery support, recovery fellowships, alumni fellowship
Social media and web-based resources can serve all stages of change

Pre-contemplation
- Resources posted on Facebook, automated screens; e.g., AUDIT & ASSIST, and links to other websites for information

Contemplation
- Web-based, Facebook or phone contacts with program staff to talk about options or receive brief intervention

Determination
- Facebook groups, phone-based protocols for MI & CBT, web-based mutual help groups, access to web-based resources, weekly updates via Facebook lists

Action
- Engagement in Phone-based protocol, use of online, automated CBT/skills training programs, use of smart phones for relapse prevention, e-therapy contacts

Maintenance
- Low intensive phone protocols, Smart phone applications Facebook chat rooms for support & relapse prevention, web-based mutual help, email tips for support
Post-treatment Evaluation vs Recovery Monitoring

• Tom McLellan: Addiction Severity Index (ASI) for pre/post measure of addiction treatment.
• Michael Dennis: Global Appraisal of Individual Needs (GAIN).
• Bill White: Recovery Oriented Systems of Care (ROSC).
• Trend: Continuous Recovery Monitoring
  – Disease management/recovery management approach
  – Coaching and on-going assessment are blended
  – Recovery support and functional outcomes
Emerging Trend: Data-Driven Treatment

Patient matching based on 3 layers:

– Demographic variables
  • Finding: Male, 18-28, unemployed, not married

– Diagnostic variables
  • Are all DSM criteria created equal?

– Outcome variables
  • Disease management trajectory
  • Recovery management trajectory

Trend: “Look inside the data”
# Diagnostic Variables

<table>
<thead>
<tr>
<th>DSM CRITERIA</th>
<th>GROUPING</th>
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<tbody>
<tr>
<td>1. Larger Amounts</td>
<td>1-4 relate to use</td>
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<tr>
<td>2. Persistent desire/efforts</td>
<td></td>
</tr>
<tr>
<td>3. Time spent</td>
<td></td>
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<tr>
<td>4. Craving</td>
<td></td>
</tr>
<tr>
<td>5. Failure to fulfill role obligations</td>
<td>5-8 relate to</td>
</tr>
<tr>
<td>6. Social or interpersonal problems</td>
<td>behavioral issues</td>
</tr>
<tr>
<td>7. Activities given up or reduced</td>
<td>associated with use</td>
</tr>
<tr>
<td>8. Situations physically hazardous</td>
<td></td>
</tr>
<tr>
<td>9. Physical or psychological problem</td>
<td>9-11 relate to</td>
</tr>
<tr>
<td>10. Tolerance</td>
<td>physical/emotional</td>
</tr>
<tr>
<td>11. Withdrawal</td>
<td>issues</td>
</tr>
</tbody>
</table>
DSM-5 Diagnostic Variables (Norm Hoffman)

• Question: What is the distribution of positive alcohol criteria in males vs females for those with no SUD diagnosis, those with mild, or those with moderate to severe?

• Answer: No gender differences emerge in frequency of criteria met.
The Big 5 (Norm Hoffman)

• Question: Which of the 11 DSM criteria for SUD are commonly found among individuals with *no SUD diagnosis* regardless of gender?

• Answer:
  – Tolerance
  – Use in dangerous situations
The Big 5

• Question: Which of the 11 DSM criteria for SUD are commonly found among those with mild to moderate SUD regardless of gender?

• Answer:
  – Unplanned use
  – Time spent
  – Medical/psychological
  – Interpersonal conflicts
The Big 5

• Question: Which DSM criteria for SUD are found primarily in severe SUD’s?
  – Efforts to control/cut down but unable (rule setting)
  – Craving with compulsion to use
  – Activities given up or reduced
  – Failure to fulfill role obligations
  – Withdrawal

• Is this the disease of addiction?

• Where does this leave us relative to DSM?
Medical (Clinical) Necessity?

PERSON A or PERSON B

tolerance    detox
DUI           hx of craving
argue w/ spouse  past attempts
hx of anxiety    loss of activities

Numerically both are “moderate”, but:
The Big 5

1. Larger Amounts
2. **Persistent desire/efforts**
3. Time spent
4. **Craving**
5. **Failure to fulfill role obligations**
6. Social or interpersonal problems
7. **Activities given up or reduced**
8. Situations physically hazardous
9. Physical or psychological problem
10. Tolerance
11. **Withdrawal**

**PERSON A**

**PERSON B**

X indicates presence of a characteristic.
Medical (Clinical) Necessity?

PERSON A
None of big 5
No loss of control
Abstinence?

PERSON B
4 of the big 5
Loss of control
Requires abstinence

• Implications for intensity & duration of tx?
• Implications for prognosis?
• 2 or more of Big 5 may require abstinence and residential treatment?
Norm’s Clinical Implications

• Most with “mild” can probably benefit from moderation strategies?
• “Severe” will require more intense and prolonged services with abstinence.
• Group with “moderate” designation may have cases that fit mild or severe characteristics.
Norm’s Clinical Hypotheses

• Those that are positive on 2 or more of Big 5 require initial residential placement and/or more intense and longer care

• Those with mild to moderate without any of the Big 5 may be able to moderate use with less intense and briefer services.

• Treatment planning can be informed by prior empirical outcome data on comparable cases and modified based on individual response.
Outcome Variables Overview (other than DSM 5 remission)

• Adherence to continuing care recommendations

• Maintenance of their personal recovery plan and personal goal attainment
  – Daily self-care: implementation of their individual bio-psycho-social-spiritual action plans
  – Daily self-check (10th step)

• Relapse prevention self-efficacy
Outcome Variables - detail

• Adherence to continuing care recommendations
  – Implementation of continuing care plan?
  – Adherence to counseling, medication
  – Level of family support/recovery?

• Daily self-care: implementation of bio-psycho-social-spiritual action plans

• Daily self-check (10th Step) examining:
  – Vital Fellowship (AA/NA meeting attendance, home group and service work)
  – Vital relationship with Sponsor
  – Action for spiritual connection
  – In the literature
  – Working and applying the 12 Steps
Outcome Variables - detail

• Relapse prevention self-efficacy:
  – Identification and management of PAWS
  – Avoidance and management of triggers
  – Avoidance and management of high risk situations
  – Identification and management of relapse warning signs
  – Identification and management of relapse justifications
Trend for the Future: Data-Driven Recovery Management

• Roll the outcome variables back to the coach and care team in real-time:
  – Adherence to clinical plan
  – Daily self-care
  – Daily self-check
  – Relapse prevention self-efficacy

• Adjust the plan in real-time based on demographic, diagnostic, and on-going disease/recovery management information.
Objectives/Review

- Discuss future directions of addiction treatment.
- Identify trends in emerging drugs of abuse and patient profiles.
- Relate how current changes in frameworks for the provision of healthcare serve as contextual forces that may benefit or threaten addiction treatment.
- Describe shifts toward data-driven treatment and recovery support, including technologically-based treatment and recovery monitoring vs. traditional treatment and post-treatment evaluation.
- Describe how individual patient variables and styles of 12-step engagement can be understood to improve approaches to formal treatment.
Articles Worth Reading


A Few Resources

Web sites:
• A large repository of articles can be found at www.williamwhitepapers.org
• Examples of tech-based recovery supports can be found at www.mobilewellnessandrecovery.com
• A collection of guidelines for evidence-based practice (and supporting papers) can be found at www.bhrm.org
A Few Resources

Soft cover text:
• Bob Myers: “Get Your Loved One Sober: Alternatives to Nagging, Pleading, and Threatening”

Internet search these articles: