Evidence Based Practices and Current Innovations in the Treatment of Substance Use Disorders

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Today’s Question

- What is the best evidence to guide the treatment of individuals with substance use disorders (SUDs) within California

- Specifically
  - What are the most effective elements of SUD treatment, regardless of the specific level of care?
  - What is the evidence for treating patients with SUD in specific levels of care?
  - What are the key issues in determining optimal patient placement in a specific level of care?
A point of clarification

- There is very little research evidence to state that one level of SUD treatment is superior to another in general.
- There is evidence to say that certain practices are superior (associated with better patient outcomes) than others. These practices are referred to as evidence-based practices.
- Regardless of the level of care, evidence-based practices should be employed when possible to achieve best treatment outcomes.
EVIDENCE-BASED PRACTICES
Definition of EBP

Institute of Medicine (2001):

Evidence-based behavioral practice (EBBP) "entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected. Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and testing of hypotheses" (www.ebbp.org).
Criteria for EBP Designation for SUD Practices

- National Registry of Evidence Based Programs and Practices (NREPP)
- The approach has demonstrated positive outcomes ($p < 0.05$) in $\geq 1$ studies
- The results of the research have been published in a peer-reviewed journal or documented in a comprehensive evaluation report
- Sufficient documentation exists in the form of manuals, training materials, etc. to facilitate dissemination of the approach

http://www.nrepp.samhsa.gov/
Which Evidence-Based Practices can be implemented into community SUD treatment settings?
Screening, Brief Intervention and Referral to Treatment (SBIRT)
2M people (0.8%) receiving treatment*

21M people (7%) have problems needing treatment, but not receiving it*

≈ 60-80M people (≈20-25%) using at risky levels

US Population:
307,006,550

US Census Bureau, Population Division
July 2009 estimate
*NSUDH, 2008
• Brief interventions trigger change.
• A little counseling can lead to significant change, e.g., 5 min. has same impact as 20 min.
• SBI can reduce accidents, injuries, trauma, emergency department visits, depression, drug-related infections and infectious diseases
• Can save $ - SBI for alcohol saves $2 - $4 for each $1.00 expended
• Research is less extensive for illicit drugs, but promising.
Pre-Screening

Negative Screen
- Positive Reinforcement

Positive Screen
- AUDIT Screen
  - Moderate/High Use
    - Brief Intervention/Brief Treatment
  - Abuse/Dependence
    - Referral to Treatment

SBI Procedures:
Follow-up Action Depends on Score
CONDUCTING A BRIEF INTERVENTION
Conducting the Brief Intervention (F L O)

- **Feedback**
  - Setting the stage
  - Tell screening results

- **Listen & understand**
  - Explore pros & cons
  - Explain importance
  - Assess readiness to change

- **Options explored**
  - Discuss change options
  - Follow up
What are the most important EBPs?

- Behavioral Approaches
  - Motivational Interviewing/Brief Intervention
  - Contingency Management
  - Cognitive-Behavioral Coping Skills Training
  - Couples and Family Counseling
  - 12 Step Facilitation and 12 Step Program Participation

- Medications
  - Methadone
  - Buprenorphine
  - Naltrexone (oral and extended release)
  - Naloxone (for overdose prevention)
  - Acamprosate
  - Antabuse
Motivational Interviewing: Definition

Motivational interviewing is a client-centered style of interaction aimed at helping people explore their ambivalence about their substance use and begin to make positive behavioral and psychological changes.
Summary of Motivational Interviewing

Goal is to enhance motivation to change behavior and elicit self-motivational statements using a supportive, non-confrontational style.

The 5 principles of M.I. are:

1. Express empathy
2. Develop discrepancy
3. Avoid argument
4. Roll with resistance
5. Support self-efficacy
Contingency Management

- Basic Assumptions
  - Drug and alcohol use behavior can be controlled using operant reinforcement procedures
  - Incentives can be used for money or goods
  - Incentives should be redeemed for items incompatible with drug use
  - CM can be extremely useful in promoting treatment retention and promoting medication adherence
  - CM for drug free urine tests can be useful in decreasing drug use.
Contingency Management

Key concepts

- Behavior to be modified must be objectively measured
- Behavior to be modified (e.g., urine test results) must be monitored frequently
- Reinforcement must be immediate
- Penalties for unsuccessful behavior (e.g., positive urine test) can reduce voucher amount
- Incentives may be applied to a wide range of prosocial alternative behaviors
Principles of Cognitive Behavioral Therapy (CBT)

- CBT is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people to achieve initial abstinence from drugs (or to reduce their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention).
Behavioral CBT Concepts

In the early stages of CBT treatment, strategies emphasize behavior change, and include:

- Setting a schedule to promote engagement in behaviors that are inconsistent with substance use
- Recognizing and avoiding “high risk” situations
- Facilitating positive coping skills
Cognitive CBT Concepts

As CBT treatment continues into later phases of recovery, more emphasis is given to the “cognitive” part of CBT. This includes:

- Psychoeducation regarding addiction
- Teaching clients about triggers and cravings
- Teaching clients cognitive skills (e.g., “thought stopping” and “urge surfing”)
- Identifying “red flag thoughts”
There are a number of evidence-based family and couples treatment interventions for SUD.

Although the intensity and specific techniques for working with couples and families vary, there is one overarching finding: Treatment programs that engage the significant others/families into the SUD treatment process result in better retention and outcomes for the individual in SUD treatment.
12 Step Facilitation Therapy

- Project Match and a number of other studies have demonstrated that 12 Step Facilitation Therapy (an approach that educates patients about the 12 Step program and promotes 12 step program involvement) can increase involvement in 12 Step program participation.
12 Step Participation

- There is an expanding body of research literature that documents the benefits of 12 Step program participation. Researchers at Stanford University (Moos, Finney, Humphreys and others) have amassed a substantial body of evidence that individuals who engage in the 12 Step program have better SUD outcomes and more improvement in the quality of life measures, than individuals who do not participate.

- The more extensively people are engaged in 12 Step programs, the better are outcomes.
Medication Assisted Treatment

- Medications with evidence of efficacy.
  - Methadone
  - Buprenorphine
  - Naltrexone (oral and extended release)
  - Naloxone (for overdose prevention)
  - Acamprosate
  - Antabuse
Buprenorphine and opiate addiction

Positive effect = addictive potential

Super agonist - fentanyl

Full agonist - morphine/heroin hydromorphone

Potentially lethal dose

Partial agonist - buprenorphine

Antagonist - naltrexone

Antagonist + agonist/partial agonist
Methadone: Clinical Properties

- Synthetic opioid with a long half-life
- \(\mu\) agonist with morphine-like properties and actions
- Effects usually last about 24 hours
- Daily dosing (same time, daily) maintains constant blood levels and facilitates normal everyday activity
- Adequate dosage prevents opioid withdrawal (without intoxication).
Rationale for methadone treatment

- Highly effective treatment for opioid dependence
- Controlled studies have shown that with long term maintenance treatment using appropriate doses, there are significant:
  - Decreases in illicit opioid use
  - Decreases in other drug use
  - Decreases in criminal activity
  - Decreases in needle sharing and HIV transmission
  - Improvements in prosocial activities
  - Improvements in mental health
Death Rates in Treated and Untreated Heroin Addicts

- Matched Cohort: 0.15
- Methadone: 0.85
- Voluntary Discharge: 1.65
- Involuntary Discharge: 6.91
- Untreated: 7.20
Buprenorphine (Suboxone)
Maintenance Treatment Using Buprenorphine

Studies conclude:

Buprenorphine equally effective as moderate doses of methadone (e.g., 60 mg per day)

Not clear if buprenorphine can be as effective as higher doses of methadone and therefore may not be the treatment of choice for some patients with higher levels of physical dependence.

Withdrawal symptoms from buprenorphine less severe than from morphine or methadone.
Buprenorphine Safety

- Low risk of clinically significant problems
- No reports of respiratory depression in clinical trials comparing buprenorphine to methadone
- There is concern about increasing evidence that buprenorphine is being abused and sold to non-patients.
Oral Naltrexone and Acamprosate

- Effective
- Work well with variety of supportive treatments e.g. brief intervention, CBT, supportive group therapy
- Start following alcohol withdrawal – proven efficacy where goal is abstinence, uncertain with goal of moderation
- No contraindication while person is still drinking, although efficacy uncertain
- Generally safe and well tolerated
- Medication adherence is a significant problem.
Vivitrol Dosage and Administration

- **VIVITROL** is given as an intramuscular (IM) gluteal injection every 4 weeks or once a month
  - **VIVITROL** should not be given subcutaneously or in the adipose layer

- **VIVITROL** must not be administered intravenously

- **VIVITROL** should be administered by a healthcare professional, into alternating buttocks each month

- **VIVITROL** should be injected into the upper outer quadrant of the buttock, deep into the muscle—not the adipose.

VIVITROL Full Prescribing Information. Alkermes, Inc.
Extended Release Naltrexone Significantly Reduces Drinking Days$^{1,2}$

Reductions were substantial$^{1+}$

These results are from a post hoc subgroup analysis of a 6-month, multicenter, double-blind, placebo-controlled clinical trial of alcohol dependent patients. This subset analysis evaluated patients who were abstinent for 4 or more days prior to treatment initiation$^1$

Disulfiram

- Acetaldehyde dehydrogenase inhibitor – 200 mg daily
- Unpleasant reaction with alcohol ingestion
- Indications: alcohol dependence + goal of abstinence + need for external aid to abstinence
- Controlled trials: ↑ abstinence rate in first 3–6 months
- Best results with supervised ingestion & contingency management strategies
Naloxone for overdose prevention
OVERDOSE PREVENTION
Prevencion de sobredosis
Equipo de prevencion
Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis

Lawsuits change clinical practice

- Osheroff vs Chestnut Lodge (1984). A lawsuit in which a depressed patient who had been treated unsuccessfully for over a decade with psychotherapy, sued the treatment center where they had not offered him treatment with antidepressant medication.

- This landmark case in which the plaintiff was awarded a large settlement was a major turning point in widespread acceptance of the use antidepressant medication for the treatment of severe depression. Refusal to use effective medications to treat depression on “philosophical grounds” was established as grounds for medical malpractice.
“Osheroff” and opiate dependence treatment

- An increasing number of lawsuits in which family members of patients who have been discharged from residential care without the benefit of medication and who subsequently overdosed and died are being filed and “settled” with sealed results.

- Opiate overdose is a medically preventable condition. Providers who refuse to educate patients about the availability and potential benefits of opioid medications will likely face legal liability when patients die from preventable overdoses.
Other evidence-based treatment principles

- Programs with poor rates of treatment engagement have poorer treatment outcomes.
- For individuals with severe SUD, longer treatment episodes (across levels of care) are associated with better outcomes.
- Residential programs that successfully “step patients down” to IOP or OP produce better long term outcomes.
- For patients with co-occurring psychiatric or medical disorders concurrent treatment of these conditions improves SUD outcomes.
DEFINITIONS AND SERVICES
Drug Medi-Cal SUD Benefits

**Base DMC benefits:**
- NTP outpatient treatment (methadone)
- Outpatient naltrexone services
- Outpatient group counseling, limited individual counseling
- Perinatal intensive outpatient
- Perinatal residential services

**Expanded benefits:**
- Intensive outpatient, ALL adults
- Residential services, ALL adults
- Inpatient detox
ASAM Levels*

- **Level 1: Outpatient**
  - < 9 hours of service /week (recovery or motivational enhancement therapies/strategies)

- **Level 2.1: Intensive Outpatient**
  - 9+ hours of service /week (to treat multidimensional instability)

- **Level 3.1-3.5: Residential**
  - 24-hour structure with available trained personnel; at least 5 hours of clinical service /week

* ASAM Criteria are a consensus-based document, not an evidence-based practice
Level I: Outpatient Treatment

- Programs at this level are designed to: treat the individual’s level of problem severity, assist in achieving permanent changes in using behaviors, and improve mental functioning. 8 or fewer hours of service per week.

- It is imperative that programs address personal lifestyles, attitudes, and behaviors that can impact and prevent accomplishing the goals of treatment.

- Level I may be: the initial phase of treatment; a step down phase; or for the individual who is not ready or willing to commit to a full recovery program (pre-contemplation).

- Level I is an excellent way to engage resistant individuals.
Covered Outpatient Services

- **At least 2 group counseling sessions per month**
  - Up to 90 minutes

- **Individual counseling**
  - Up to 50 minutes per session per day

**Editorial Comment:** This benefit is inadequate. There is no rational foundation for the limits on individual counseling

Outpatient Admission Guidelines

- **Minimal risk** of severe withdrawal
- **No** or stable/monitored biomedical complications
- **No** or stable/monitored behavioral complications
- Ready for treatment but needs motivating to strengthen readiness; or low interest in treatment but low severity in other dimensions
- **Able to maintain abstinence or control use** with minimal support
- **Supportive recovery environment** or individual has skills to cope
Level II: Intensive Outpatient

- Provides **9 or more hours** of structured treatment per week for adults.
- Consists of counseling and education relating to **substance-related and mental health** problems and/or disorders.
- Psychiatric and medical services are addressed through consultation and referral arrangements depending on the stability of the individual.
- IOP’s generally **do not have the capacity to treat** individuals with unstable medical and psychiatric problems.
Covered IOP Services under Drug Medi-Cal

- Services received 3+ times /week, 3 hrs /day
  - Intake
  - Individual counseling
  - Group counseling
  - Medication services
  - Collateral services
  - Crisis intervention
  - Treatment and discharge planning

IOP Admission Guidelines

- Minimal/manageable risk of withdrawal
- Biomedical conditions not a distraction from treatment
- Mild behavioral complications with potential to distract from recovery
- Variable or poor engagement in treatment
- **Intensifying symptoms** show high likelihood of relapse
- **Unsupportive recovery environment**, but patient can cope with structure and support
Level III: Residential Services

General Characteristics of Level III:

- Individuals needing this level of care have functional deficits; require safe and stable living environments to assist in developing their recovery skills.
- Treatment services are provided in a 24-hour residential setting and are staffed 24 hours a day.
- Self-help meetings are usually available on site.
- The living environment and the treatment provider must be close enough so the treatment plan can be addressed in both facilities.
Low Intensity Residential Services

- Substance abuse services are provided for a minimum of 5 hours per week.
- The treatment focus is on recovery skills, preventing relapse, improving emotional functioning, and working.
- Toward integration into productive employment, family life, and/or educational programs.
- Self-help meetings are typically provided on site.

Not Intended To Include
Sober Houses, Boarding Houses, Or Group Homes Where Treatment Services Are Not Provided
Placement In Level III.5

- Is appropriate for the individual who presents with chaotic, non-supportive, and abusive interpersonal relationships.
- There is also a long history of treatment attempts or criminal justice histories, and limited work and/or educational experiences.
- Antisocial value systems are also present.
Covered Residential Services under Drug Medi-Cal

- Intake
- Individual counseling
- Group counseling
- Medication services
- Collateral services
- Crisis intervention
- Service access*
- Beneficiary education*
- Coordination of ancillary services*
- Treatment and discharge planning

Residential Admission Guidelines

- **Minimal risk of severe withdrawal** (high risk needs medical monitoring)
- No or stable/monitored biomedical conditions
- Range of *minimal to moderate severity behavioral* complications; needs a co-occurring capable program
- Range of *motivation* from open to recovery, to opposition to treatment
- **Low skills** to prevent continued use; *needs structure* or potentially imminent/dangerous consequences
- Environment is dangerous; patient needs 24-hour structure to cope
Sober Living

- Initial research on SLEs seems to support reduced AOD use
  - Limitations: no randomized control trials; research on benefits of linking SLEs with outpatient treatment is limited

- Social support and involvement in 12-step groups correlated with improved outcomes (Polcin et al., 2010a)

Sources:
Polcin et al., 2010a. Sober living houses for alcohol and drug dependence: 18-Month outcomes.
Polcin et al., 2010b. Eighteen-month outcomes for clients receiving combined outpatient treatment and sober living houses.
Polcin et al., 2010c. Recovery from addiction in two types of sober living houses: 12-Month outcomes.
Policin & Borkman, 2008. The impact of AA on non-professional substance abuse recovery programs and sober living houses.
Research on Effectiveness
Inpatient vs. IOP

- Studies **slightly favor inpatient**, but patients benefit from **both** levels of care.
- The important question: which level is more appropriate at a given time for each client?
  - Using **patient placement criteria** to optimally match patient needs with level of care is key.
  - Length of stay should be based on degree of functional improvement and patient strengths/challenges.
  - Availability of a **broad continuum** of treatment options benefits the client.

*Source: SAMHSA CSAT TIP 47: Clinical Issues in Intensive Outpatient Treatment*
Research On Treatments for Clients with Co-occurring Substance Use and Mental Health Disorders
CIHS COD Core Competencies

I. Interpersonal Communication
II. Collaboration & Teamwork
III. Screening & Assessment
IV. Care Planning & Care Coordination
V. Intervention
VI. Cultural Competence & Adaptation
VII. Systems Oriented Practice
VIII. Practice Based Learning & Quality Improvement
IX. Informatics

How Clinicians Can Respond

- **MODIFY TREATMENT PROTOCOLS**
- **Decrease** length of sessions (attention, memory)
- **Take** structured breaks (attention, focus, memory)
  
  (Bates, et al., 2013; Huckans, et al., 2013)

- **Increase** session frequency (practice)
- **Repeat** presentations of therapeutic information (detox, 2 weeks, 4 weeks, 1 month, 3 months, etc.)
- **Multi-modal presentations**—audio, visual, experiential, verbal, hot/cold situations, etc.

How Clinicians Can Respond

- Use **memory aids**— calendars, planners, phone apps, diagrams
  
  (Bates, et al., 2013; Huckans, et al., 2013)

- Teach **stress management, breathing, relaxation, and mindfulness meditation skills**
  
  (Bates, et al., 2013; Huckans, et al., 2013)

- Provide **immediate feedback** and corrective experiences

- Repeat instructions, **put things in writing**, provide short/direct instructions
STRENGTHEN THE BRAIN

- **Games**—Scrabble®, Uno®, chess, etc.
- **Computerized games**
- **Problem solving** and strategy activities
- **Interdisciplinary team approach**, coordination with community resources, emphasis on self awareness of strengths and weaknesses, supported risk taking and feedback, peer group therapy, and opportunities to practice social and emotional coping skill
In research conducted with Iraq and Afghanistan war veterans, the veterans reported **significantly increased use** and perceived usefulness of cognitive remediation strategies and aids; **reduced depression** and cognitive symptom severity, and **increased life satisfaction** following CST.

- The reduction in depressive symptoms and increase in life satisfaction is **noteworthy** given that treatment focused on cognitive remediation strategies rather than targeting specific emotional difficulties.

(Huckans, et al., 2010)
Research on Promising Practices. Not EBPs yet, but...
Exercise as a Novel Approach to Treat Substance Use Disorders
Acknowledgments

PI: Richard Rawson, PhD
Collaborators: Christopher Cooper, MD,
            Catherine Domier, PhD

The research presented in this talk is supported by NIDA (1 R01 DA027633-01).
Aerobic Exercise to Improve Treatment Outcomes for Methamphetamine (MA) Dependence

- NIDA-funded study to characterize effects of an aerobic and resistance exercise intervention (“EX”) compared to health education (“ED”) in a population of MA-dependent individuals in a residential drug treatment facility (N=150).

- Will assess effects on:
  - MA craving and negative affective states, including anxiety, depression, and anhedonia
  - Neurocognitive functioning
  - Health-related outcomes (BMI, blood pressure, strength)
  - Addiction-relevant behaviors (pro-social vs. drug use)

- Neuroimaging subset: examine changes in dopamine D$_2$/D$_3$ receptor availability in abstinent MA-dependent participants assigned to EX vs. ED (N=15 per group).
Inclusion Criteria

- 150 participants (N=75 per group)
- In residential treatment facility
- Ages 18-45 (men); 18-55 (women)
- Methamphetamine dependent
- No clinically significant contraindications for study participation
Subjects assigned to EX receive individualized programs for endurance and resistance exercise training developed from baseline CXT and 1-RM tests as well as subsequent assessments during training.

Subjects in the ED group receive equal attention via group health education sessions.
Change in VO$_2$ max (L/min) after 8 wk exercise or education
Change in relative body fat % after 8 wk exercise training or education
Change in CP & LP strength after 8 wk exercise training or education
Change in repetitions to failure 85% baseline 1-RM for CP & LP after 8 wk training or education

![Bar graph showing change in 85% 1-RM for Chest Press and Leg Press. Chest Press shows a slight increase, while Leg Press shows a substantial increase in 1-RM pounds.]
Preliminary Beck Anxiety Scale

Baseline | Week 5 | Week 8
---|---|---

BAI Exercise

BAI Education
Preliminary BDI Data

BDI Exercise
- Baseline
- Week 5
- Week 8

BDI Education
- Baseline
- Week 5
- Week 8
Preliminary Cognitive Data

- **Stroop Test**
  - Selective attention
  - Executive functioning
  - Reaction time

- **2 Choice Reaction Time**
  - Alertness
  - Reaction time
Stroop Test

Units of Improvement in Functioning

Reaction Time (ms)

26

Exercise

Education

8
2 Choice Reaction Time

Units of Improvement from BL to Week 8

Reaction Time (ms)

Exercise
Education
Summary

- Thus far, 70 randomized, 40 completers:
  - 67% EX
  - 77% ED

- What we don’t know about Exercise in MH/SUDs:
  - Type of exercise, optimal intensity
  - How much is necessary
  - Whether works best in conjunction with other therapies
  - Mechanisms of action: dopamine, serotonin, BDNF, indirect (via sleep, mood, anxiety)
Mindfulness based interventions for substance use disorders
Mindfulness

- An approach to life based on Zen traditions
- A particular way of paying attention to the present moment
- Moment-to-moment, non-judgmental awareness
- Promotes cognitive, emotional, behavioral flexibility
- Reduces stress reactivity
- Improves self regulation
How Does Mindfulness Reduce Stress?

- Mindfulness meditation cultivates greater concentration and relaxation through:
  - Awareness of one’s breathing
  - Cognitive focus on seeing and accepting things as they are without attempting to change them
Mindfulness versus CBT

- CBT focuses on challenging cognitive *content*
  - Ex: Identifying and challenging dysfunctional thoughts

- Mindfulness focuses on altering cognitive *processes*
  - Ex: Tendency to shift one’s attention away from the present
Evidence for MBRP

- In one pilot study, MBRP was used as a continuing care approach for adults who completed intensive inpatient or outpatient treatment vs. TAU (Bowen et al., 2009), with positive effects on substance use and craving.

- Another study compared MBRP to CBT for outpatients with alcohol and/or cocaine dependence (n=36) (Brewer et al., 2009)
  - Both treatments were equally effective in reducing drug use.
  - MBRP reduced stress reactivity.
MBRP Skills: Session 1

- **Automatic Pilot:** tendency to behave mechanically, without awareness
- Relation to urges and cravings
- Learning to increase awareness
- **Body Scan:** purposely pay attention to the body
MBRP Skills: Session 2

- Possibility that we can experience cravings and urges without reacting
- Recognizing what cravings feel like in the body
- Using mindfulness and awareness to “pause” meaningfully and make better choices
- Begin formal sitting meditation
MBRP Skills: Session 3

- “Breathing Spaces”
- Mindful walking
- “Being with” sensations that arise
MBRP Skills: Session 4

- Staying **present** and **aware** in high risk situations

- Using mindfulness to relate to urges to use without automatically seeking a substance

- Identify individual relapse risks and explore ways to cope with the intensity of feelings that come up in a tempting situation
MBRP Skills: Sessions 5 & 6

- Balancing acceptance and skillful action
- Seeing thoughts as just thoughts (i.e., rather than as “truths”)
- Role of thoughts in the relapse cycle
MBRP Skills: Sessions 7 & 8

- Creating a more balanced life (e.g., nourishing personal activities)
- Building a recovery support system
- Incorporating mindfulness practice in everyday life
Conclusions

- Mindfulness involves cultivating awareness of one’s moment-to-moment experience without judgment.
- Mindfulness-based interventions have been studied for the treatment of a range of medical and psychiatric illnesses and have most recently shown great promise in the treatment of substance use disorders, including MBRP approach.
- Basic skills that can be taught without a formal mindfulness “program” include awareness of the here and now, awareness of one’s breath, and balancing acceptance and action in risky situations.
Thank you
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www.psattc.org