Evidence-Based Clinical Practice Guidelines for the Management of Persons with Substance Use Disorders

Daniel Kivlahan, PhD

Associate Professor,

Department of Psychiatry and Behavioral Sciences

University of Washington School of Medicine

Former (2012-2015) National Mental Health Program Director,

Addictive Disorders, Mental Health Services,

Veterans Health Administration

kivlahan@u.washington.edu

drkivlahan@gmail.com



AMERICAN PSYCHOLOGICAL ASSOCIATION

Disclosure Statement

- Former Member of APA Clinical Treatment Guidelines Advisory Steering Committee
- Co-Chair, Working Group for VA/DoD Guideline for Treatment of Substance Use Disorders (SUD)
- Previous funding from VA HSR&D and VA Quality Enhancement Research Initiative, NIAAA, NIDA
- Experienced, currently inactive clinician

Preview of Concluding Comments

- Multiple pathways to recovery via treatment
- *Ideally* treatment involves access to a choice of recommended interventions
- Recommended options differ across the four major SUDs reviewed
  - Numerous "evidence gaps" to address
- Very limited basis at intake for "counseling" people which options will work best for them
  - emphasize shared decision making and measurement-based care

Essence of Measurement Based Care

"We have several good treatment options to choose from. On average, they have about the same chance of success. But you are not an average; you are an individual.

At this time, there is no scientific way to predict which treatment will work best for you."

Simon and Perlis (Am J Psychiatry 2010; 167:1445–1455)

Essence of Measurement Based Care (2)

"Together, we will look at your options and decide what treatment to start with.

But it is important to remember that there are other options. If the first treatment we pick does not work out for you, some other treatment might work well.

Regular follow-up over the next several weeks will tell us whether to stay with our first choice or try something else."

Simon and Perlis (Am J Psychiatry 2010; 167:1445–1455)

Preview of Concluding Comments (cont.)

- Fundamental principles of psychological practice apply to people with SUD (e.g., relationship, promoting engagement)
- Pursue effective training about unfamiliar options and/or identify others with that expertise (e.g., pharmacotherapy)
- All psychologists can advocate for timely and non-stigmatizing access to evidence-based services for whatever people with SUD you inevitably will care for (or care about)

Guideline Working Group

Department of Veterans Affairs	Department of Defense
Karen Drexler, MD (Co-Chair)	LTC Christopher Perry, MD (Co-Chair)
Daniel Kivlahan, PhD (Co-Chair)	CDR Jennifer Bodart, PsyD
Michael O. Chaffman, PharmD, BCPS	LCDR Danyell Brenner, BCD, LCSW, MBA
Carol Essenmacher, PMHCNS-BC, DNP	Corinne K. B. Devlin, MSN, RN, FNP-BC
Francine Goodman, PharmD, BCPS	Marina Khusid, MD, ND, MSA
Adam Gordon, MD, MPH, FACP, FASAM	Timothy Lacy, MD
James R. McKay, PhD	CDR Marisol Martinez, PharmD
Renee Redden, MSN, PMHCNS, BC	CH (LTC) Robert Miller, DMin, MDiv, MABMH
Marghani Reever, PhD, LCSW	CDR Robert M. Selvester, MD
Andrew Saxon, MD	Maj Tracy L. Snyder, MS, RD
	Christopher Spevak, MD, MPH, JD

What is an Evidence-Based Clinical Practice Guideline?

"Clinical practice guidelines (CPGs) are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." – IOM 2011

Institute of Medicine. Clinical Practice Guidelines We Can Trust. Washington, DC: National Academies Press, 2011.

Clinical Practice Guidelines are NOT

- Performance measures
- Legal standards of care
- Treatment manuals or protocols
- Sole determinants of treatment plans
- Coverage policies
- A substitute for clinical judgment

Clinical Practice Guidelines Aspire to Be:

- Evidence-based and clinically informed
- Helpful educational tools for practitioners, patients and supportive others
- Clear, concise & actionable recommendations
- Guidance to facilitate individualized clinical decision making and to improve patient care
- A critical link between research & practice

Outline of VA/DoD CPG Development

- Update of 2009 Clinical Practice Guideline
- Goals and Scope of the Guideline
- Guideline Development Process
- Evidence Review – based on Key Questions
- Grading Recommendations
- Selected Evidence-based Recommendations

Update of Existing Clinical Practice Guideline

- Prior evidence-based CPG published 2009
  - Included 181 “recommendations” many based on panel consensus
- Challenge to prioritize Key Questions
  - Many multipart Key Q’s among original 10
  - Added 2 KQ’s on stabilization/withdrawal management
- Guideline was updated with new evidence from November 2007 - **January 2015**

Goals of the Guideline

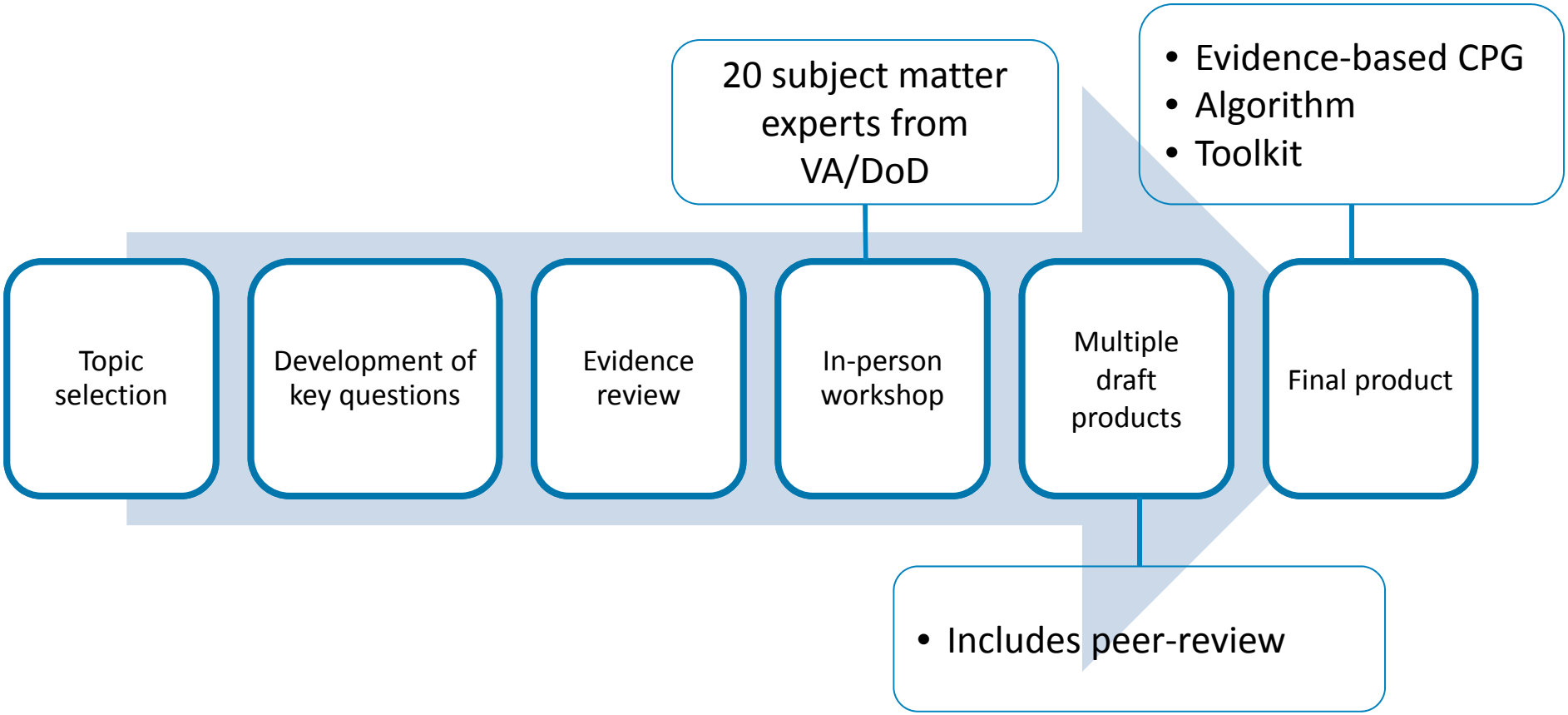
- Determine in collaboration with the patient the best initial and subsequent treatment plans
- Optimize each individual's recovery to decrease or eliminate consumption, improve health and wellness, live a self-directed life, and strive to reach their full potential[1]
- Minimize preventable complications and morbidity

[1]Substance Abuse and Mental Health Services Administration. *SAMHSA's working definition of recovery updated*. 2012; http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.VjDxiP7bLct. Accessed January 7, 2017

Scope of the Guideline

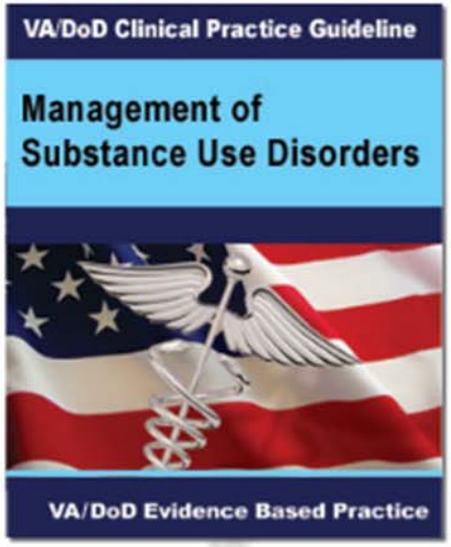
- Adults 18 years or older who have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of
  - Alcohol Use Disorder (AUD)
  - Opioid Use Disorder (OUD)
  - Cannabis Use Disorder (CUD)
  - Stimulant Use Disorder
- With or without other health conditions

Guideline Development Process



http://www.healthquality.va.gov/guidelines/mh/sud/

Management of Substance Use Disorder (SUD) (2015)



The guideline describes the critical decision points in the Management of Substance Use Disorder and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with substance use disorder.

Disclaimer: This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.

About the CPG	Guideline Links	Patient-Provider Tools	Related Guidelines
The guideline is formatted as two algorithms and 36 evidence-based recommendations: • Module A - Screening and Treatment • Module B	Full Guideline (2015) Clinician Summary (2015) Screening & Treatment Pocket Card (2015) Stabilization Pocket Card (2015)	Patient Summary Substance Abuse Affects Families Brochure Medication-Assisted Treatment for Alcohol Dependence Booklet	Major Depressive Disorder (MDD) Opioid Therapy (OT) for Chronic Pain Post Traumatic Stress Disorder (PTSD) Diabetes Mellitus (DM)

Key Questions Focus Evidence Review

- Criteria used to help prioritize key questions included:
  - Relative importance to the target population
  - Variability in current practice
  - Potential to inform clinical decisions
  - Likelihood of finding higher quality evidence

Clinically Important Topics Not Included in Systematic Review

- Patient-centered Care
- Shared Decision-making
- Engagement Strategies/Common Factors
- Addiction-focused Medical Management
- Accreditation Standards
- SUD and Co-occurring Conditions

Fundamental Principles

1. Emphasize that treatment is more effective than no treatment ("Treatment works")

2. Consider prior treatment experience and respect patient preference for the initial intervention approach

   - no single intervention approach is definitive treatment of choice

3. Use motivational interviewing (MI)style during therapeutic encounters

Fundamental Principles

4. Emphasize the common elements of effective interventions:

- promote therapeutic relationship
- improve self-efficacy for change
- strengthen coping skills
- change reinforcement contingencies for recovery
- enhance social support for recovery

Miller WR, Moyers TB. (2015). The forest and the trees; relational factors in addiction treatment
Miller, WR (2016) Sacred Cows and Greener Pastures: Reflections from 40 Years in Addiction Research,

Fundamental Principles (cont.)

5. Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support

6. Encourage the least restrictive setting necessary to promote access to care, safety and effectiveness

Fundamental Principles (cont.)

7. Following premature treatment drop out, make outreach efforts to re-engage

8. Emphasize future options for patients presently unwilling/unable to engage in any addiction-focused care

- What would it take for you to consider treatment?

Clinically Important Topics Not Included in Systematic Review

- Patient-centered Care
- Shared Decision-making
- Engagement Strategies/Common Factors
- **Addiction-focused Medical Management**
- Accreditation Standards
- SUD and Co-occurring Conditions

Medical Management
Typical Components

1. **Monitoring** self-reported use, laboratory markers, and consequences
2. **Monitoring** adherence, response to treatment, and adverse effects
3. **Education** about AUD and/or OUD consequences and treatments
4. **Encouragement** to abstain from non-prescribed addictive substances
5. **Encouragement** to attend community supports for recovery (e.g., mutual help groups) and to make lifestyle changes that support recovery

Medical Management Manual https://pubs.niaaa.nih.gov/publications/MedicalManual/MMManual.pdf

Clinically Important Topics Not Included in Systematic Review

- Patient-centered Care
- Shared Decision-making
- Engagement Strategies
- Addiction-focused Medical Management
- Accreditation Standards
- **SUD and Co-occurring Conditions**

#1 Co-Occurring Disorder: Tobacco Use Disorder

- Consistently offering tobacco use disorder treatment throughout SUD treatment supports recovery.

- Treating Tobacco Use & Dependence: 2008 Update from the U.S. Department of Health and Human Services, available at: http://bphc.hrsa.gov/buckets/treatingtobacco.pdf
- USPSTF Final Recommendation Statement Behavioral and Pharmacotherapy Interventions for Tobacco Smoking Cessation in Adults and Pregnant Women, available at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1

Co-occurring Mental Health Conditions and Psychosocial Problems

Recommendation (*not from systematic review*)	**Strength**
Among patients in early recovery from SUD or following relapse, we suggest prioritizing other needs through shared decision-making among identified biopsychosocial problems and arranging services to address them. (e.g., related to other mental health conditions, housing, supportive recovery environment, employment, etc.)	Weak For

Outline of VA/DoD CPG Development

- Update of 2009 Clinical Practice Guideline
- Goals and Scope of the Guideline
- Guideline Development Process
- Evidence Review – **based on Key Questions**
- Grading Recommendations
- Selected Evidence-based Recommendations

Specifying the Key Questions
PICOTS Format

P	**Patients, Population, or Problem**	e.g., the populations or sub-populations with the disorder, disorder severity
I	**Intervention**	e.g. medication, psychotherapy, dose
C	**Comparison**	e.g., other drugs, placebo, active psychosocial interventions, “treatment as usual” (TAU)
O	**Outcome**	e.g., consumption outcomes, functioning, quality of life, mortality, morbidity, etc.
(T)	**Timing, if applicable**	e.g., duration of follow-up
(S)	**Setting, if applicable**	e.g., primary or specialty

Example of a Key Question

Key Question	P Patient, Population or Problem	I Intervention or Exposure	C Comparison	O Outcome	(T) Timing (if applicable)	(S) Setting (if app.)
In adults with a DSM diagnosis of alcohol use disorder, what is the comparative effectiveness of different medications for improving consumption outcomes, adherence outcomes, and adverse events in primary care and specialty care?	Adults with a DSM diagnosis of alcohol use disorder	Medications Acamprosate Disulfiram Naltrexone Amitriptyline Aripiprazole Atomoxetine Baclofen Buspirone Citalopram Desipramine Escitalopram Fluoxetine Fluvoxamine Gabapentin Imipramine Olanzapine Ondansetron Paroxetine Prazosin Quetiapine Sertraline Topiramate Valproic acid Varenicline	Other of these medications, usual care plus placebo, usual care, waitlist	Consumption outcomes, adherence outcomes, and adverse events	At least 12 week follow-up assessment after randomization	Primary care; specialty care

Grading Recommendations - GRADE

- Evidence review, informed by the 12 key Q's
- Grading of Recommendations Assessment, Development and Evaluation (GRADE)
- Four decision domains used to determine strength and direction
  - Relative strength (Strong or Weak)
  - Direction (For or Against)

Andrews J, et al: Grade guidelines…The significance and presentation of recommendations. *J Clin Epidemiol.* Jul 2013;66(7):719-725.

Four Domains to Assess Strength of Recommendation

Balance of desirable & undesirable outcomes	Confidence in the quality of the evidence
Values and preferences of patient	Other implications, e.g.: Resource Use Feasibility Acceptability Subgroup considerations

Andrews J, et al: Grade guidelines…The significance and presentation of recommendations. *J Clin Epidemiol.* Jul 2013;66(7):719-725.

Balance = Average Benefit - Harm

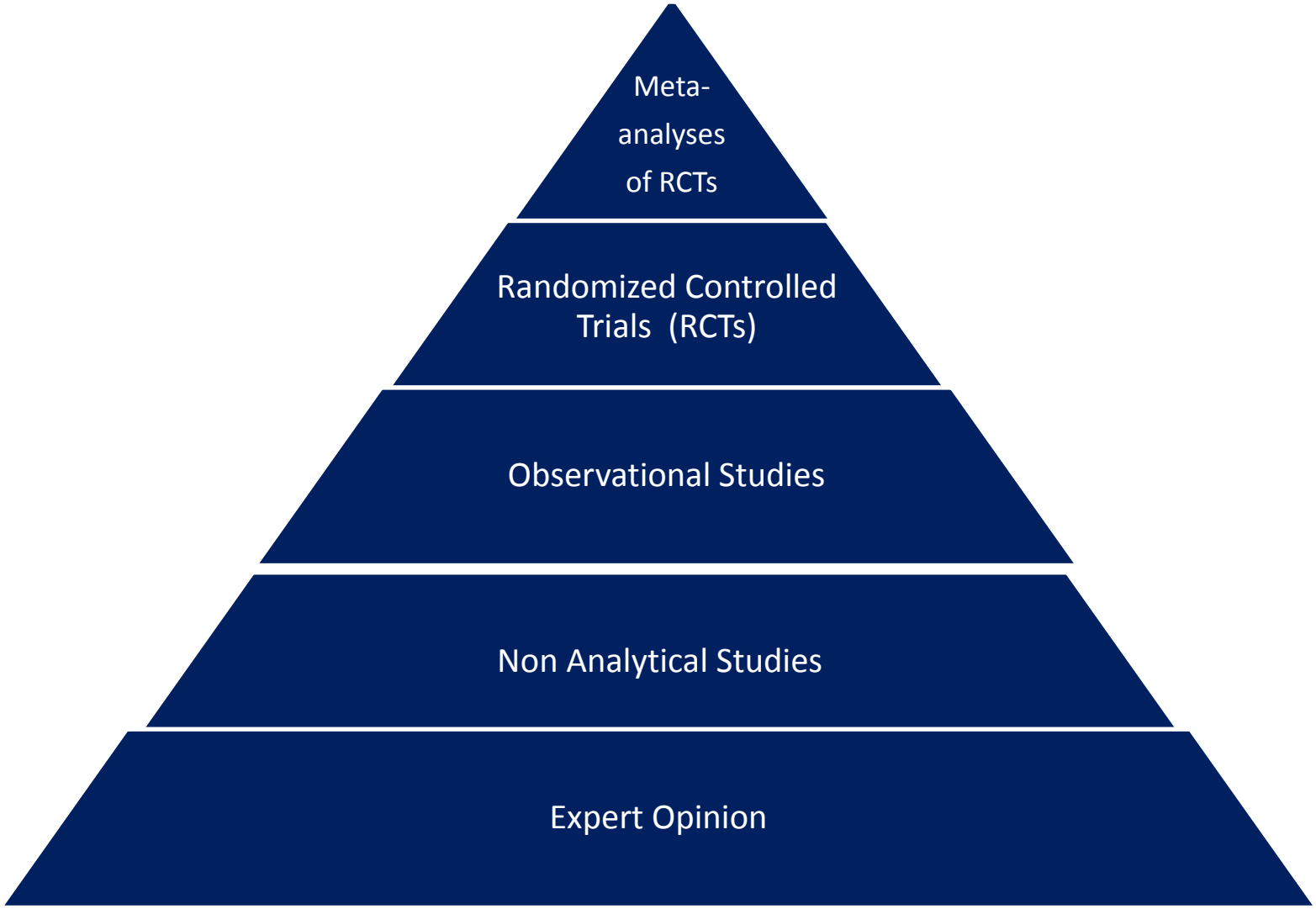
SUBSTANTIAL	• substantially improves important health outcomes; benefits substantially outweigh harm
MODERATE	• improves health outcomes for some and the benefits outweigh harm
SMALL	• can improve health outcomes –small benefit may involve potential harm
ZERO-Negative	• provides no benefit and/or may cause harm

Four Domains to Assess Strength of Recommendation

Balance of desirable & undesirable outcomes	**Confidence in the quality of the evidence**
Values and preferences of patient	Other implications, e.g.: Resource Use Feasibility Acceptability Subgroup considerations

Andrews J, et al: Grade guidelines…The significance and presentation of recommendations. *J Clin Epidemiol.* Jul 2013;66(7):719-725.

EVIDENCE HIERARCHY



Quality of the Evidence

GOOD (***High***)	• Further research is unlikely to change confidence in the estimate of effect.
FAIR (***Moderate***)	• Further research is likely to have important impact on our confidence in the estimate of effect and may change the estimate.
POOR (***Low/Very Low***)	• Confidence in the estimate of effect and is likely to change with further research. Any estimate of effect is very uncertain.

Four Domains to Assess Strength of Recommendation

Balance of desirable & undesirable outcomes	Confidence in the quality of the evidence
Values and preferences of patient	Other implications, e.g.: Resource Use Feasibility Acceptability Subgroup considerations

Andrews J, et al: Grade guidelines…The significance and presentation of recommendations. *J Clin Epidemiol.* Jul 2013;66(7):719-725.

Strength of a Recommendation Continuum

- **Strong For**
  - (*"We recommend **offering** this option …")*
- **Weak For**
  - (*"We suggest **offering** this option …")*
- **Weak Against**
  - (*"We suggest not **offering** this option …")*
- **Strong Against**
  - (*"We recommend against **offering** this option …")*

Source: GRADE Guidelines: 15. Going from evidence to recommendation determinants of a recommendation's direction and strength. Journal of Clinical Epidemiology 66 (2013) 726-735.

Categories of Recommendations

- Screening
- Brief Intervention
- ***Determination of Treatment Setting***
- ***Treatment***
  - ***Pharmacotherapy***
  - ***Psychosocial Intervention***
- ***Promoting Group Mutual Help Involvement***
- ***Follow-up – Measurement Based Care***
- Stabilization and Withdrawal

Determination of Initial Treatment Intensity and Setting

In adults with a DSM diagnosis of substance use disorder, what criteria can be used to determine the appropriate initial intensity and setting of specialty substance use care for improving consumption, health, and engagement outcomes?

(No Systematic Review (SR) or RCTs identified)

Determination of Treatment Setting

Recommendation	Strength
For patients with SUD, there is **insufficient evidence** to recommend for or against using a standardized assessment that would determine initial intensity and setting of SUD care	N/A

See handout of Consumer Checklist from Fletcher, AM (2013). Inside Rehab. New York, NY: Viking.

AUD Pharmacotherapy

In adults with a DSM diagnosis of **alcohol use disorder**, what is the comparative effectiveness of different medications for improving consumption outcomes, adherence outcomes, and adverse events in the following?

a) Primary care
b) Specialty care

(3 SR and 6 RCTs since 2007)

AUD Pharmacotherapy

Recommendation	Strength
For patients with moderate-severe alcohol use disorder, we recommend offering one of the following medications: • Acamprosate • Disulfiram • Naltrexone- oral or extended release • Topiramate	Strong For
For patients with moderate-severe alcohol use disorder for whom first-line pharmacotherapy is contraindicated or ineffective, we suggest offering gabapentin.	Weak For

OUD Pharmacotherapy

In adults with a DSM diagnosis of **opioid use disorder**, what is the comparative effectiveness of different medications with or without non-pharmacologic therapy for improving consumption outcomes, adherence outcomes, and adverse events?

(2 systematic reviews and 2 RCTs)

OUD Pharmacotherapy

Recommendation	Strength
For patients with opioid use disorder, we recommend offering one of the following medications considering patient preferences: • Buprenorphine/naloxone • Methadone in an Opioid Treatment Program	Strong For

OUD Pharmacotherapy

Recommendation	Strength
At initiation of office-based buprenorphine, we recommend addiction-focused Medical Management alone or in conjunction with another psychosocial intervention.	Strong For

OUD Pharmacotherapy

Recommendation	Strength
For patients with OUD for whom opioid agonist treatment is contraindicated, unacceptable, unavailable, or discontinued and who have established abstinence for a sufficient period of time we recommend offering: • Extended-release injectable naltrexone	Strong For

Key Question 5

Pharmacotherapy

In adults with a DSM diagnosis of **stimulant use disorder**, what is the comparative effectiveness of disulfiram, topiramate, and other off-label medications for improving consumption outcomes, adherence outcomes, and adverse events?

(2 systematic reviews and 14 RCTs)

Pharmacotherapy for Stimulant Use Disorder

Recommendation	Strength
There is **insufficient evidence** to recommend for or against the use of any pharmacotherapy for the treatment of cocaine use disorder or methamphetamine use disorder.	N/A

Key Question 7

Pharmacotherapy

7. In adults with a DSM diagnosis of a cannabis use disorder, what is the comparative effectiveness of different management approaches for improving consumption outcomes, adherence outcomes, and adverse events in the following?
   a) Primary or general mental health care
   b) Specialty SUD care (5 RCTs)

(5 RCTs)

Pharmacotherapy for Cannabis Use Disorder

Recommendation	Strength
There is **insufficient evidence** to recommend for or against the use of pharmacotherapy in the treatment of cannabis use disorder.	N/A

Key Question 8

Psychosocial Interventions

In adults with a DSM diagnosis of a **substance use disorder [Note: Separate reviews for alcohol, opioid, stimulant, cannabis)**, what is the comparative effectiveness of addiction-focused psychotherapies or psychosocial interventions for improving consumption, adherence, and recovery outcomes?

(8 SR and 30 RCTs)

Psychosocial Interventions for AUD

Recommendation	Strength
For patients with alcohol use disorder we recommend offering one or more of the following interventions considering patient preference and provider training/competence: • Behavioral Couples Therapy • Cognitive Behavioral Therapy • Community Reinforcement Approach • Motivational Enhancement Therapy • 12-Step Facilitation	Strong For

Psychosocial Interventions for OUD *With* Pharmacotherapy

For patients **in office-based buprenorphine treatment**, there is **insufficient evidence** to recommend for or against any specific psychosocial interventions **in addition to addiction-focused Medical Management**. Choice of psychosocial intervention should be made considering patient preferences and provider training/competence.	**N/A**

Carroll KM, Weiss RD. The Role of Behavioral Interventions in Buprenorphine Maintenance Treatment: A Review. American Journal of Psychiatry. 2016 Epub ahead of print]

Psychosocial Interventions for OUD *With* Pharmacotherapy

Recommendation	Strength
In Opioid Treatment Program settings, we suggest offering Individual Drug Counseling and/or Contingency Management, considering patient preferences and provider training/competence.	Weak For

Psychosocial Interventions for OUD *Without* Pharmacotherapy

Recommendation	Strength
For patients with opioid use disorder for whom opioid use disorder pharmacotherapy is contraindicated, unacceptable or unavailable, there is **insufficient evidence** to recommend for or against any specific psychosocial interventions.	N/A

Psychosocial Interventions for Stimulant Use Disorder

Recommendation	Strength
For patients with stimulant use disorder, we recommend offering one or more of the following interventions as initial treatment considering patient preference and provider training/competence: • Cognitive Behavioral Therapy • Individual Drug Counseling • Community Reinforcement Approach • Contingency Management in combination with one of the above	Strong For

Psychosocial Interventions for Cannabis Use Disorder

Recommendation	Strength
For patients with cannabis use disorder, we recommend offering one of the following interventions as initial treatment considering patient preference and provider training/competence: • Cognitive Behavioral Therapy (CBT) • Motivational Enhancement Therapy (MET) • Combined CBT/MET	Strong For

Summary of Treatment Recommendations

SUD	Medications	Psychosocial Interventions
Alcohol	acamprosate disulfiram naltrexone (NTX) topirimate gabapentin*	Behavioral Couples Therapy (BCT) Cognitive Behavioral Therapy (CBT) Community Reinforcement Approach (CRA) Motivational Enhancement Therapy (MET) 12-Step Facilitation (TSF)
Opioid	buprenorphine methadone ER-injectible NTX*	Medical Management** Contingency Management** Individual Drug Counseling**
Stimulant		Cognitive Behavioral Therapy (CBT) Community Reinforcement Approach (CRA) Individual Drug Counseling +/- Contingency Management
Cannabis		Cognitive Behavioral Therapy (CBT) Motivational Enhancement Therapy (MET) Combined CBT/MET

Strategies for Promoting Involvement in Mutual Help Programs

In adults with a DSM diagnosis of a substance use disorder, what is the comparative effectiveness of strategies used for promoting active involvement in available mutual help programs (e.g., AA or alternatives) for improving consumption, health, and engagement outcomes?

(2 SR and 8 RCTs)

Joseph tape vignette #17
About AA?

Promoting Mutual Help Involvement

Recommendation	Strength
For patients with SUD in early recovery or following relapse, we recommend promoting active involvement in mutual help programs using one of the following systematic approaches considering patient preference and provider training/competence: • Peer linkage • Network support • 12-Step Facilitation	Strong For

Follow-up with Measurement-based Care

In adults with a DSM diagnosis of a substance use disorder, what is the comparative effectiveness of the following aspects of measurement-based care in primary care and specialty care settings for improving consumption and health outcomes?

a) Components of measurement-based care
b) Frequency of measurement

(2 RCTs)

Joseph tape vignette #18: "What helped?"

Measurement-based Care

Recommendation	Strength
We suggest assessing response to treatment periodically and systematically, using standardized and valid instrument(s) whenever possible. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc.	Weak For

Brief Addiction Monitor- 17- Items

Substance Use	Risk Factors	Protective Factors
Any alcohol use	Craving	Self-efficacy
Heavy alcohol use	Sleep	Self-help
Drug use	Mood	Religion/spirituality
	Risky situations	Work/school
	Family/social	Income
	Physical health	Social support

http://www.mentalhealth.va.gov/communityproviders/docs/bam_continuous_3-10-14.pdf

Brief Addiction Monitor

Method of Administration:
Clinician Interview Self Report Phone

1. In the past 30 days, would you say your physical health has been?

   0-Excellent 1-Very Good 2-Good 3-Fair 4-Poor

2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?

   ___ ___

3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?

   ___ ___

4. In the past 30 days, how many days did you drink ANY alcohol?

   ___ ___ (If 00, *Skip* to #6)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5-ounce glass of wine.]

Brief Addiction Monitor

6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?

___ ___ (If 00, *Skip* to #8)

7. What did you take? (*Check* all that apply)

- 7A. Marijuana (cannabis, pot, weed)?
- 7B. Sedatives/Tranquilizers (e.g., "benzos", Valium, Xanax, Ativan, Ambien, "barbs", Phenobarbital, downers, etc.)?
- 7C. Cocaine/Crack?
- 7D. Other Stimulants (e.g., amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", etc.)?
- 7E. Opiates (e.g., Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?
- 7F. Inhalants (glues/adhesives, nail polish remover, paint thinner, etc.)?
- 7G. Other drugs (steroids, non-prescription sleep/diet pills, Benadryl, Ephedra, other over-the-counter/unknown medications)?

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?

0-Not at all 1-Slightly 2-Moderately 3-Considerably 4-Extremely

9. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days?

0-Not at all 1-Slightly 2-Moderately 3-Considerably 4-Extremely

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?

Concluding Comments

- Multiple pathways to recovery via treatment
- *Ideally* treatment involves access to a choice of recommended interventions
- Recommended options differ across the four major substance categories reviewed
  - Numerous “evidence gaps” to address
- Very limited basis at intake for “counseling” people which options will work best for them
  - emphasize shared decision making and measurement-based care.

Concluding Comments (cont.)

- Fundamental principles of psychological practice apply to people with SUD (e.g., relationship, promoting engagement)
- Pursue effective training about unfamiliar options and/or identify others with that expertise (e.g., pharmacotherapy)
- All psychologists can advocate for timely and non-stigmatizing access to evidence-based services for whatever people with SUD you inevitably will care for (or care about)

Botticelli & Koh (2016). Changing the Language of Addiction. *JAMA*.

Questions and Discussion

kivlahan@u.washington.edu
drkivlahan@gmail.com