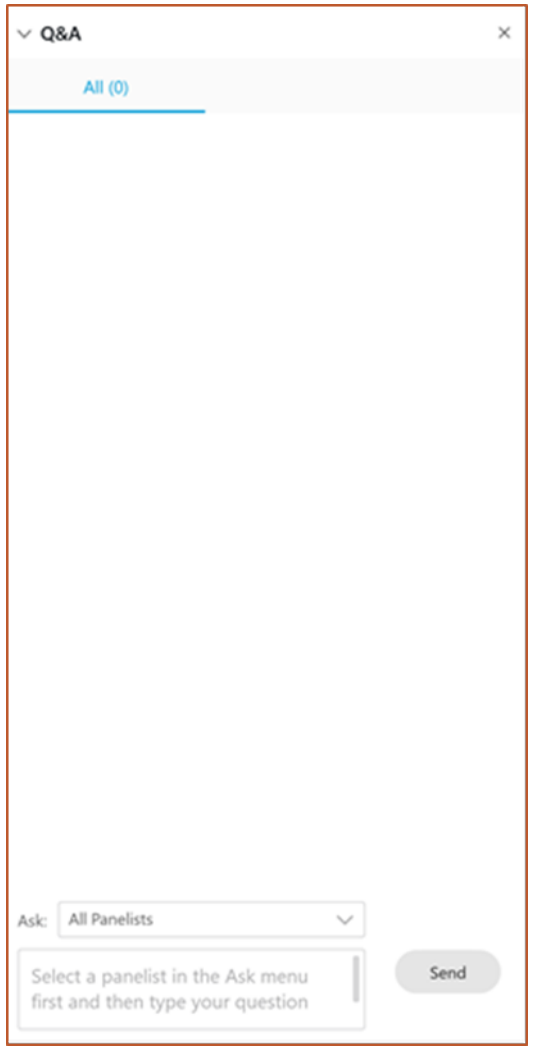
WISCONSIN OVERDOSE FATALITY REVIEW 2020 WEBINAR SERIES

Thank you for joining us. The webinar will begin shortly.

Webex reminders

- All attendees are muted.
- Use the chat box only for webinar technical issues.
- Click to view the list of participants.
- Today's webinar will be recorded.



Use the Q&A box to ask the panelists questions.

“Treatment of Substance Use Disorder: Principles of Addiction Treatment and Implications in Wisconsin”

Wisconsin Overdose Fatality Review (OFR) Summit
Wisconsin Department of Health Services and
Wisconsin Department of Justice

Webinar: October 13, 2020

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Wisconsin's Opioid Epidemic

- Epidemic: the occurrence of a disease at rates greater than usual baseline rates
- A "spike" that is "out of the ordinary"

- Is Wisconsin any different from other states in USA? Not by much.
- Thanks to Hank Weiss for all he has done on the epidemiology

Wisconsin's Opioid Epidemic

But what has occurred at epidemic rates?

1. Opioid prescribing (pharmaceuticals)
2. Opioid use (pharmaceuticals, heroin, fentanyl, fentanyl analogs)
3. Opioid overdoses
4. Opioid deaths (role of benzos in lethality?)
5. Opioid ER encounters
6. Opioid overdose rescues with naloxone
7. Opioid addiction
8. Opioid addiction treatment encounters
9. Secondary epidemics due to route of administration (Hep C, HIV)

Commentary

April 6, 2011

Curtailing Diversion and Abuse of Opioid Analgesics Without Jeopardizing Pain Treatment

Nora D. Volkow, MD; Thomas A. McLellan, PhD

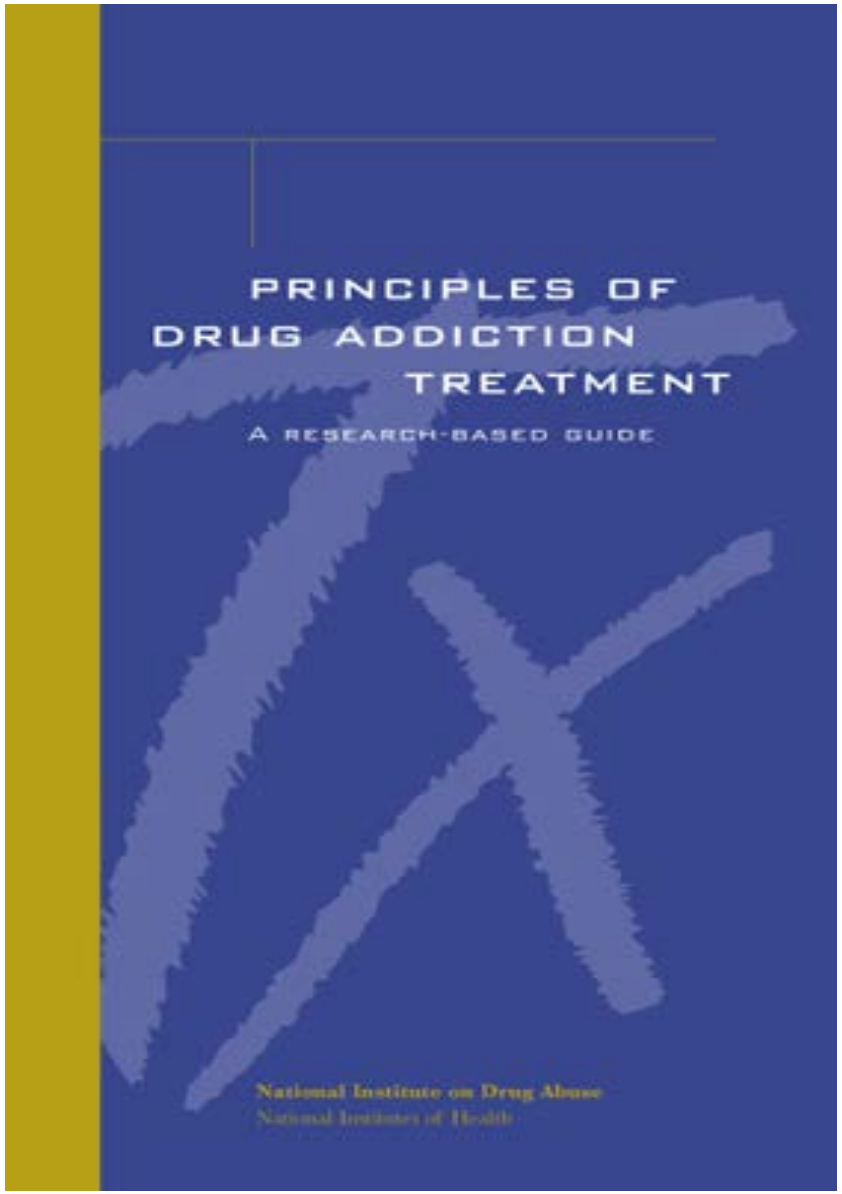
JAMA. 2011;305(13):1346-1347.
doi:10.1001/jama.2011.369

Principles

- Substance Use and Addiction are important conditions -- but they are not the same.
- “Using a lot” and “Using often” are not what makes a person someone with addiction.
- The difference between a person with addiction and a person who uses, is a qualitative, not a quantitative, difference: it’s about *what happens* when the person uses, what the drug does to the person’s brain, and what the person’s brain does to affect the person’s behavior.

Principles

- Substance Use and Addiction are important conditions -- but they are not the same.
- Substance Use is what people do when they start using, before their brain changes into a brain with active addiction.
- Substance Use is what changes the body (e.g., heavy drinking, or transmission of infectious diseases via IVDU, leading to endocarditis, cirrhosis or AIDS)



NIDA NATIONAL INSTITUTE ON DRUG ABUSE

www.drugabuse.gov

NIDA Principles of Drug Addiction Treatment (1999, rev 2009)

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased.

2. **No single treatment is appropriate for everyone.**

NIH Publication No. 09–4180

So what is there to understand about addiction treatment?

- That management of addiction improves functioning, restores lives, reduces symptoms, and that treatment serves as *secondary prevention:* it prevents progression on disease once the disease is present
  - It prevents organ damage and complications (HIV, HCV)
  - It prevents substance induced depression, psychosis and dementia
  - It prevents suicide and a range of forms of accidental death
- That general medical care and general psychiatric care are not specialty treatment of addiction
- That self-help (AA/NA) is very helpful but is not professional treatment.
- That harm reduction can prevent dysfunction, disability and death, without being addiction treatment *per se.*

Treatment of Addiction

- Abstinence is the standard treatment goal for addiction
  - Loss of control over substance use is a core feature (along with preoccupation, craving, et al.)
  - Persons stable and in remission on medications to treat OUD are still ‘abstinent’

- Treatment includes
  - Psychosocial Rehabilitation
    (various methods of counseling/psychotherapy)
  - Pharmacotherapy
  - Recovery supports/peer-led/ “self-help” as an adjunct to professional tx

What is addiction treatment?

- “Addiction treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from alcoholism or from another drug addiction, and which is designed to enable the affected individual to achieve and maintain sobriety, physical, spiritual and mental health, and a maximum functional ability.”

ASAM Public Policy Statement on Treatment for Alcohol and Other Drug Addiction. Adopted by ASAM Board of Directors May 1980; revised 1986, 1997, 2001, 2009, and January 2010.

What is addiction treatment? (continued)

- "Addiction treatment services are professional healthcare services, offered to a person diagnosed with addiction, or to that person's family, by an addiction professional. Addiction professionals providing addiction treatment services are licensed or certified to practice in their local jurisdiction and may be nationally certified by a professional certification body for their professional discipline."

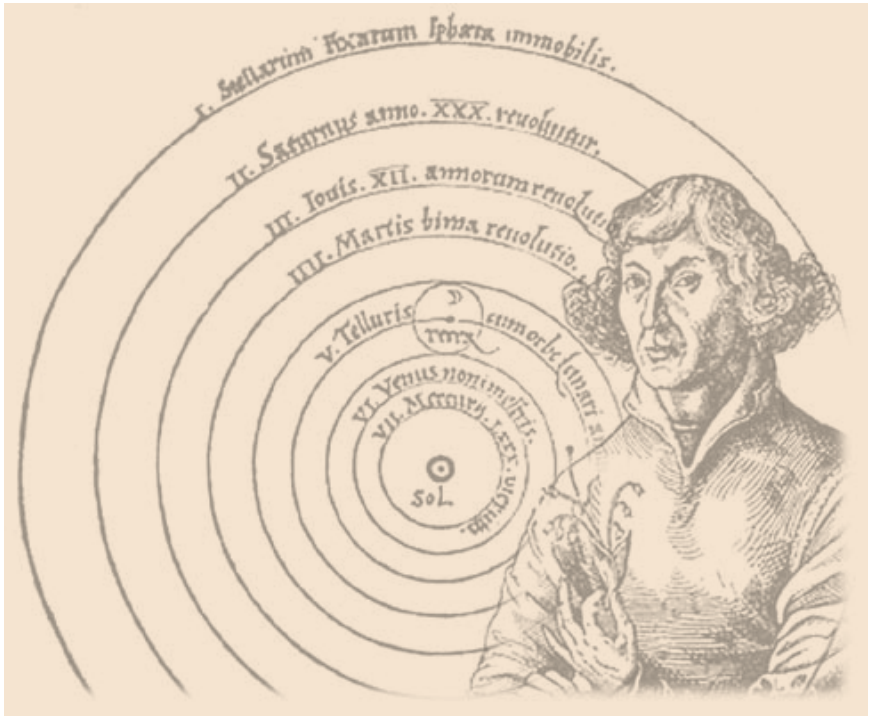
ASAM Public Policy Statement on Treatment for Alcohol and Other Drug Addiction. Adopted by ASAM Board of Directors May 1980; revised 1986, 1997, 2001, 2009, and January 2010.

Interventions

- Professional Treatment (Clinical Interventions)
  - Pharmacotherapy
  - Psychosocial Interventions/Therapies

- Recovery Activities/Peer Support (Complementary)
  - Alcoholics Anonymous
  - Narcotics Anonymous
  - SMART Recovery
  - Working with a Recovery Coach

Using DRUGS to treat Drug Addiction



“M.A.T.”

- Odd term.
- We don’t talk about “medication assisted treatment” of hypertension, diabetes, or pneumonia
- Bureaucratic term to distinguish methadone treatment of heroin addiction from “drug-free treatment,” i.e., psychosocial tx alone
- For Opioid Use Disorder, it means use of agonists (methadone, buprenorphine) or antagonists (naltrexone, oral or injectable long-acting) for treatment
- If you’re going to use the term, it should be broadly applied for all addiction pharmacotherapy (for AUD and TUD also!)

What is medication-as-treatment (MAT)

- Medications to treat addiction itself – not just medications to manage withdrawal or to manage co-occurring psychiatric disorders
- Medications treating addiction involving:

- **Alcohol:**
  - Antabuse®. (disulfiram)
  - Oral naltrexone: ReVia®.
  - Long-acting injectable naltrexone: Vivitrol®.
  - Acamprosate (Campral®).
- **Opioids:**
  - Methadone
  - Buprenorphine (Suboxone®, Zubsolv®, Bunavail®, Probuphine®, Sublocade®)
  - Naltrexone (oral or long-acting injectable, Revia® and Vivitrol®)
- **Nicotine:**
  - Nicotine replacement therapies ("gum," lozenges, inhalers)
  - Zyban® brand of bupropion (same as Wellbutrin®)
  - Chantix® brand of varenicline

From *The ASAM Definition of Addiction:*

- In some cases of addiction, medication management can improve treatment outcomes.
- In most cases of addiction, the integration of psychosocial rehabilitation and ongoing care with evidence-based pharmacological therapy provides the best results.
- Chronic disease management is important for minimization of episodes of relapse and their impact.
- Treatment of addiction saves lives.

Non-Pharmacological Tx

- Addiction Counseling (supportive / RET / confrontational)
- Cognitive Behavioral Therapy (CBT)
- Coping Skills Training
- Recreational Therapy
- Psychoanalytically-oriented Psychotherapy
- Motivational Enhancement Therapy (MET)
- Community Reinforcement Approach (CRAFT)
- Twelve-Step Facilitation (TSF)
- Network Therapy
- Behavioral Therapy
- Aversion Therapy

The Major Evidence Based Psychotherapies

- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Twelve-Step Facilitation (TSF)
- Contingency Management

Evidence Based Treatment

Contingency Management

- Establish contingencies
- Monitor outcomes
- Treatment expectations/contracts
- Offer rewards (e.g., vouchers for negative urine test results)
- Offer consequences (agree in advance: tell spouse about relapse)
- Examples
  - Professionals Health Programs
  - Drug Courts

Non-Professional Treatment

- Peer support / mutual support
  - (Almost always, the misnomer “self-help” is used, but it’s not “yourself”, it’s via others!)
- Alcoholics Anonymous (AA), et al. (12-step recovery)
  - Narcotics Anonymous (NA)
  - Cocaine Anonymous (CA) and Heroin Anonymous (HA)
  - Gamblers Anonymous (GA)
  - Overeaters Anonymous (OA)
  - Sex Addicts Anonymous (SAA)
- It is for recovering people, and offered by recovering people, without a trained professional to ‘lead’ the group, without any charges or documentation

Public Policy Statement on the Relationship Between Treatment and Self Help:

A Joint Statement of the
American Society of Addiction Medicine, Inc.,
the American Academy of Addiction Psychiatry,
and the American Psychiatric Association

https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/16/relationship-between-treatment-and-self-help-a-joint-statement

https://www.aaap.org/wp-content/uploads/2018/07/Relat-bw-Treatment-SelfHelp-1997.pdf

Public Policy Statement (1997) on the Relationship between Treatment and Self Help: a Joint Statement of the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, and the American Psychiatric Association

ASAM, AAAP and APA recommend that:

1. Patients in need of treatment for alcohol or other drug-related disorders should be treated by qualified professionals in a manner consonant with professionally accepted practice guidelines and patient placement criteria;
2. Self help groups should be recognized as valuable community resources for many patients in addiction treatment and their families. Addiction treatment professionals and programs should develop cooperative relationships with self help groups;
3. Insurers, managed care organizations and others should be aware of the difference between self help fellowships and treatment;
4. Self help should not be substituted for professional treatment, but should be considered a compliment to treatment directed by professionals. Professional treatment should not be denied to patients or families in need of care.

As in other health conditions, self-management, with mutual support, is very important in recovery from addiction.

Peer support such as that found in various “self-help” activities is beneficial in optimizing health status and functional outcomes in recovery. ‡

Recovery Coaches (Wikipedia)

- Recovery coaches do not offer primary treatment for addiction, do not diagnose, and are not associated with any particular method or means of recovery. They support any positive change, helping persons coming home from treatment to avoid relapse, build community support for recovery, or work on life goals not related to addiction such as relationships, work, or education. Recovery coaching is action-oriented with an emphasis on improving present life and reaching future goals.
- Recovery coaching is unlike most therapy because coaches do not address the past, do not work to heal trauma, and put little emphasis on feelings. Recovery coaches are unlike licensed addiction counselors in that they are non-clinical and do not diagnose or treat addiction or any mental health issues.

From *The ASAM Definition of Addiction (2011)*

[now referred to as the ASAM Description of Addiction]:

Recovery from addiction is best achieved through a combination of self-management, mutual support, and professional care provided by trained and certified professionals.

The ASAM Criteria (2013 edition)

Assessment Dimensions

- Intoxication/Withdrawal Potential
- Biomedical Conditions/Complications
- Emotional/Behavioral/Cognitive Conditions
- Treatment Acceptance/Readiness/Motivation
- Relapse/Continued Use Potential
- Recovery Environment

Levels of Care for Specialty Treatment

0.5 Screening/Brief Intervention/Education

1.0 General Outpatient

2.0 Intensive Outpatient/Partial Hospital

3.0 Medically Monitored/Residential

halfway houses, extended care, TC's

4.0 Medically Managed/Inpatient

The ASAM Criteria

- Intensity of Service should derive from Severity of Illness
- Treatment should follow multidimensional Assessment
- Diagnosis—Treatment Plan—Determination of Level of Care

Treatment of addiction

- Psychosocial treatments:
  - Residential, partial hospitalization, intensive outpatient, and general outpatient
  - Cognitive Behavioral Therapy, Motivational Enhancement Therapy, Twelve Step Facilitation Therapy, Contingency Management, and Individual/Group/Family Therapy
- Pharmacological treatments:
  - Medication management (as in psychiatric care)
  - Can be in specialty treatment system for addiction, or within general medical care system
  - Can be initiated in Emergency Departments

A Broader View of Addiction Treatment

- Manage Addiction as any other Chronic Disease
- Primarily Office Based
- Often by Primary Care
- Refer to Specialists as needed for help with assessment/differential diagnosis, for advice when primary care management isn’t reaching clinical goals, for acute exacerbations

Treatment of Addiction

- **What are the treatment goals for chronic disease management?**
- Decrease frequency of relapses
- Decrease severity of relapses
- Increase duration of remission
- Optimize level of function during remissions

Addiction as a Chronic Disease

- You don’t cure it, you manage it
- You remain with the patient and available to them
- You act like a doctor!
- *After* the phase of active treatment, when the condition is stabilized and the patient is in remission, you *continue* your relationship: MAINTENANCE ‘well-patient’ visits, to MONITOR their status of remission.

Benefits of Chronic Disease Mgmt

- Early detection of relapse
- Detection of risk factors for relapse
- Facilitate re-engagement with active efforts
  - Therapy for addiction
  - Self-help
  - Re-institution of pharmacotherapy?
  - Referral for co-occurring conditions (mental health issues that can set patient up to return to use)

However…

- Most prisons and jails do not allow treatment of opioid use disorder for inmates if it includes pharmacotherapy.
- Concerns with “substituting one addiction for another.”
- Concerns with having opioid agonists inside the prison walls.
- Concerns about contraband/bartering/overdoses.

The Problem

- The period of highest risk for opioid overdose death is when the person's tolerance is significantly lower due to a period of forced abstinence related to institutionalization, e.g., just after discharge from addiction rehab, or just after release from incarceration.
- Persons who are incarcerated are not covered by private health insurance or Medicaid, so they receive their health care via correctional health care services.
- If the person does not receive medication inside the walls, and if that person has to re-apply for Medicaid or other coverage when they leave the walls, there is a gap period when overdose risk is very high.

Proposed Solutions

- Re-entry programs to offer Vivitrol or opioid agonist therapy (methadone or buprenorphine) just prior to release from incarceration back into the community.
- Re-entry programs to re-start Medicaid in the last month of incarceration so that the person walks out of prison/jail with an active Medicaid card, and can seek services on Day 1 from any sort of health care clinic, including an Opioid Treatment Program or an office-based opioid treatment service (an outpatient buprenorphine prescriber).

One other thing about opioid agonist therapy in prisons/jails

- In an April 30 decision, the First Circuit Court of Appeals agreed with a lower federal court that the Americans with Disabilities Act did indeed require that Smith be allowed to continue taking buprenorphine while incarcerated. The decision joined a November ruling from a federal judge in Massachusetts in Pesce v. Coppinger. As in Smith's case, the judge in the Pesce case held that denying medication-assisted treatment to an opioid-dependent prisoner likely violates the ADA.

https://www.aclum.org/en/news/federal-prison-provide-medication-addiction-treatment-massachusetts-woman

- A Massachusetts woman diagnosed with opioid use disorder will be provided her prescribed medication for addiction treatment (MAT) while incarcerated by the Federal Bureau of Prisons. A final settlement agreement executed today in an ACLU of Massachusetts lawsuit marks a first-of-its-kind victory.
- “This resolution affirms one basic principle: People suffering from substance use disorder deserve just treatment,” said Carol Rose, executive director of the ACLU of Massachusetts. “Medication for addiction treatment is the standard of care for opioid use disorder. The evidence is clear: MAT saves lives. Jails and prisons throughout the country should do all they can to support people in their efforts to overcome opioid use disorder, not obstruct them.”

ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015)

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder - *2020 Focused Update*

Medications addressed

- Buprenorphine—sublingual and long-acting injectables/implants
- Naltrexone—oral and long-acting injectable
- Methadone in OTPs

Who should receive pharmacotherapy for OUD?

- Every patient should be made aware of tx options: psychosocial treatment and pharmacological treatment
- Patients should not be deprived of medical treatments while incarcerated (including full opioid agonists and partial opioid agonists)
- Re-entry into the community after incarceration is a critical period of risk for overdose and death; medications should be in place before the individual returns to the community.
- Abstinence-based residential treatment can present similar risks.
- Induction onto medication maintenance is preferable to withdrawal management (“detox”)

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD’s

Addiction Treatment in Wisconsin

- Harm Reduction
  - Needle/syringe exchanges. Naloxone distribution and prescribing. Integration of HepC treatment into addiction treatment. Intoxicated Driver Programs.
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD's

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
  - People like the idea of addressing MH sx/MH origins of addiction
  - Most effective for SUD-mild (‘Substance abuse’ under DSM-IV)
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD’s

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
  - Still not many addiction psychiatrists or addiction med physicians in Wisc
  - Generally: Medication Management (what 'doctors do')
  - Not "programs" so not Ch 75 certified or 42.CFR Part 2 protected necessarily
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD's

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
  - Ch 51.42, Unified Services Board (USB) funded (CSAT→SSA→grantees)
  - Some counties “provide,” most counties “contract,” usually w NFP agencies
  - The default for residential treatment for uninsured or Medicaid/Medicare
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD’s

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
  - Specialty addiction treatment/WADTPA members
  - General hospitals, specialty hospitals (Rogers), free-standing (The Manor)
  - IOPs in private MH/AOD clinics
  - In-network for private insurance or self-pay
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD's

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
  - FQHCs
  - Academic health care systems
  - Addiction Care in Emergency Departments
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of TUD with Alcohol and Other SUD's

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
  - Public sector providers (SPMI)
  - Psychiatric specialty health systems (Aurora, Rogers, All Saints/Ascension)
  - Private practice addiction psychiatrists or general psychiatrists
- Integration of Tx of TUD with Alcohol and Other SUD's

Addiction Treatment in Wisconsin

- Harm Reduction
- Psychological Approaches/Psychotherapy/Private Practices
- Addiction Medicine Practices
- Public Sector Treatment
- Private Sector Treatment
- Collaborative Care/Integration of Addiction Care & General Medical Care
- Dual Diagnosis/Integration of Addiction Care & MH Care
- Integration of Tx of Tobacco Use Disorder with Alcohol & Other SUD's
  - St Josephs Hospital (Marshfield) was flagship; now closed
  - WINTIP
  - A huge need

Addiction Treatment in Wisconsin

- Specialty Treatment
- Level I
- Level II
- Level III
- Treatment in the General Medical system
- Treatment in the MH system
- Treatment initiation in Emergency Departments

Addiction Treatment in Wisconsin

- Specialty Treatment
  - Addiction Treatment according to The ASAM Criteria
    - Level I
    - Level II
    - Level III
- Treatment in the General Medical system
- Treatment in the MH system
- Treatment initiation in Emergency Departments

Addiction Treatment in Wisconsin

- Specialty Treatment
- Level I
- Level II
- Level III
- Treatment in the General Medical system
  - OBOT = Office Based Opioid Treatment
  - Collaborative Care in FQHC
  - Consult clinics in medical specialty clinics (Hep C, HIV, pain)
  - Inpatient (med/surg units) Addiction Consultation Services
- Treatment in the MH system
- Treatment initiation in Emergency Departments

Addiction Treatment in Wisconsin

- Specialty Treatment
- Level I
- Level II
- Level III
- Treatment in the General Medical system
- Treatment in the MH system
  - Community Mental Health Centers (CMHCs), private MH clinics, offering addiction services (individual, group, family, medication management)
  - Private Psychiatric Hospitals offering residential/PHP/IOP addiction care
- Treatment initiation in Emergency Departments

Addiction Treatment in Wisconsin

- Specialty Treatment
- Level I
- Level II
- Level III
- Treatment in the General Medical system
- Treatment in the MH system
- Treatment initiation in Emergency Departments
  - Counselors assigned to EDs, consult services going to Eds
  - Buprenorphine induction in the ED after an overdose or otherwise
  - Recovery Coaches in the ED to connect and continue later with patients

The Correctional Setting

- Treatment while in jail/prison
- Treatment while in community corrections
- Treatment while in corrections-operated halfway houses/sober living
- Treatment before release from incarceration

- Vivitrol programs in several counties
- Not widespread

Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings
July 15, 2020

- Individuals who are incarcerated are a vulnerable population and withholding evidence-based opioid use disorder (OUD) treatment increases risk for death during detainment and upon release. ASAM recognizes that correctional settings are diverse and that not all resources are universally available. This policy statement describes the standard of care that ASAM believes all detained and incarcerated individuals with OUD should receive. ASAM also advocates for systemic changes to ensure universal access to such care within correctional institutions.

Appendix

- Details on psychosocial interventions for addicton

Enhancing Motivation to Change

- http://www.motivationalinterview.org/
- Miller WR and Rollnick S. (1991)

  Motivational Interviewing: Preparing People to Change Addictive Behavior.

  New York: Guilford Press.

Motivational Enhancement Therapy (MET)

Motivational Interviewing (M.I.)

- Identify what the patient wants
- Identify what you want
- Try to get the patient's goals and the therapist's goals to align

MET
(Motivational Enhancement Therapy)

- What concerns you?
- What are you using?
- Do you see a problem, a link?
- Help patient see the problem, the link.
- Get them to start contemplating the issue, gradually move them to start contemplating change, to begin planning for change…

There are Four General Principles of M.I.

- **Express Empathy:** this guides therapists to share with clients their understanding of the clients' perspective.

- **Develop Discrepancy:** this guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior).

General Principles of M.I.

- **Roll with Resistance:** this guides therapists to accept client reluctance to change as natural rather than as pathological.

- **Support Self-efficacy:** this guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence.

Principles of CBT

- Thoughts
- Behaviors
- Emotions
- Other lingo = ABC (Affect, Behaviors, Cognitions)
- If you're depressed or anxious, it could relate to what you think/believe, and what you're doing
- DO IT DIFFERENTLY
- RE-THINK IT

CBT

- Behavioral Journals/Logs
- Thought Journals/Logs
- Feelings Journals/Logs

Thought Challenging (irrational/un-useful T's)

Cognitive Reframing

Behavior Change: Do It Different!

Do things that make you feel successful/happy.

Evidence Based Psychotherapies

- Twelve-Step Facilitation (not just “go to A.A.”)
  - Explain/educate
  - Promote attendance/participation
  - Explore experiences: Attendance? Participation? Barriers?
  - Reflect, process, problem-solve
  - Working the Steps
  - Working with a Sponsor