Memo to Self:
Protecting Sobriety with the Science of Safety

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Kevin McCauley declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The interventions used in this program are for educational purposes. While application of these interventions is encouraged, other factors could contribute to the outcomes when applied in clinical practice.
Recovery Management

a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.
Tasks to get done . . .

• Explain: what is “Recovery Management?”
  - Recovery Capital
  - Recovery Residence
  - Recovery Management Check-up
  - Recovery Coach
  - Recovery Literacy
  - Recovery-Oriented System of Care

• Be inclusive of all “Mutual Support Groups”

• Explain: what is an “Addiction Medicine Specialist?”

• Explain: what is Extended-Release Naltrexone?

• Take on the problem of smoking and sugar in relapse

• Take a stand against the use of punishment to motivate people to stay sober
Narrative Medicine

- A response to the problems inherent in Evidence-Based Medicine
- An attempt to re-humanize medicine
- Treats patients as humans with individual stories rather than simply symptoms and pathology
- Recognizes the value of peoples’ narratives in clinical practice, research and education
- Assisting people in the construction of meaning in understanding their illness experience
- Can generate new hypotheses & greater analysis regarding disease and recovery
“Let’s go make some history”
(suddenly this whole addiction-thing’s not such a bad narrative)
Culture of Safety: the worse mistake is not learning from a mistake ...
HIMS Program

—an occupational substance abuse treatment program

Help is available through an easy 1-2-3 step process. Click and start now.

HIMS is specific to commercial pilots and coordinates the identification, treatment and return to the cockpit of impaired aviators. It is an industry-wide effort in which companies, pilot unions, and FAA work together to preserve careers and further air safety.

Dana Archibald (919)608-1735, E-MAIL: Darchibald.HIMS@gmail.com

Mike Lorenz, ALPA HIMS Vice Chairman (913)568-2846, E-MAIL: Mike.lorenz@alpa.org

Mini Seminar - Phoenix, AZ - Saturday March 19, 2011
Aviation Safety Practices

1. Checklists
2. Sterile Cockpit (distraction avoidance)
3. Briefings, Standardized Comm, Read-backs
6. Shared-value safety slogans
   (“Aviate, Navigate, Communicate”)
   (“Confess, Climb, Conserve, Communicate, Comply”)
The Reason Model and Accident Causal Chain

- Organizational Influences
- Latent Failures
- Unsafe Supervision
- Latent Failures
- Preconditions for Unsafe Acts
- Latent Failures
- Unsafe Acts
- Active Failures
- Mishap

Source: Adapted from Reason, 1990
Anterior Cingulate Cortex (ACC)

- Works with OFC: decision-making based on reward values
- But also generates new actions based on past rewards/punishments
- Appreciation and valuation of social cues
- MRI: active in tasks requiring empathy and trust
Orbitofrontal Cortex (OFC)

- Decision-making guided by rewards
- Integrates sensory and emotional information from lower limbic structures
- Flexible assignment of value to environmental stimuli to motivate or inhibit choices & actions
- Self-monitoring and social responding
The Brain is a Bayesian Calculator

Rev. Thomas Bayes (1701 – 1761)
In addiction, the brain’s ability to correctly calculate 1. value and 2. probability becomes severely biased.

This means that people in early recovery have a hard time assessing likelihood of future harm … or RISK
The Problem:
How can I protect myself from relapse (decision-making) when my ability to assess relapse risk is itself impaired (loss of insight)?
ASAM Definition: Relapse

- Persistent relapse / and risk thereof
- Even after periods of abstinence
- Triggered by:
  1. Brief re-exposure to drug itself (DA release in NAc)
  2. 
  3.
Dopamine and Addiction

- Drugs of abuse cause supraphysiologic increases in extracellular dopamine in the striatum that correlate with subjective feelings of being “high”
- PET scan studies: impaired striatal dopamine signaling due to decreased DAD2 receptors
- fMRI scan studies: brain activation abnormalities in striato-cortical pathways that regulate reward, self-control, and affect
- Overlap in brain circuitry underlying addiction and disorders such as binge eating and pathological gambling
- Other brain chemicals matter, too (glutamate, GABA, endogenous opioid and cannabinoids)

Nora D. Volkow, MD
Director, National Institute on Drug Abuse

Drugs cause Dopamine surges in the midbrain reward system.
Nicotine Alchohol

Opiates

VTA interneuron

GABA

Alcohol

Nicotine

Glutamate inputs (e.g., from amygdala PPT/LDT)

VTA

Opioid peptides

Stimulants

DA

Cannabinoids

DA

Glutamate inputs (e.g., from cortex)

Alcohol

PCP

NAc

?
Functionally...

Dopamine D2 Receptors are Decreased by Addiction

Cocaine

Meth

Alcohol

Heroin

Control

Addicted
Correlations Between D2 Receptors in Striatum and Brain Glucose Metabolism

Cocaine Abusers

METH Abusers

### Periodic Table of the Intoxicants

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Kevin T. McCauley, MD
THE OPIOID EPIDEMIC & SMOKING

Quick Facts

1) SMOKING IS A RISK FACTOR FOR NONMEDICAL USE OF PRESCRIPTION OPIOIDS

2) DAILY & INTERMITTENT SMOKERS ARE 3X MORE LIKELY TO REPORT PAST-YEAR NONMEDICAL PRESCRIPTION OPIOID USE

3) THERE IS A SIGNIFICANT ASSOCIATION BETWEEN SMOKING & PAIN

85%

4) OF PATIENTS IN TREATMENT FOR OPIOID ADDICTION SMOKE (HIGHER THAN ALCOHOL USE DISORDER)

5) NICOTINE MAY ENHANCE THE REWARDING PROPERTIES OF OPIOID MEDICATIONS TO THE NEURAL SYSTEM

6) PAIN CAN INCREASE SMOKING AND THE MAINTENANCE OF TOBACCO ADDICTION CREATING A POSITIVE FEEDBACK LOOP

7) ACTION STEP: ALWAYS TAKE INTO ACCOUNT TOBACCO USE WHEN ASSESSING THE ABUSE POTENTIAL OF PRESCRIBING OPIOIDS

For References Click Here
ASAM Definition: Relapse

- Persistent relapse / and risk thereof
- Even after periods of abstinence
- Triggered by:
  1. Brief re-exposure to drug itself (DA release in NAc)
     - drug-induced reinstatement
  2. Exposure to drug cues (GLU release in Amygdala/Hipp)
     - cue-induced reinstatement
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ASAM Definition: Relapse

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     - cue-induced reinstatement
  3. Exposure to Envir Stress (CRF release in Amygdala)  
     - stress-induced reinstatement
Hedonic Allostasis Theory
(Koob & LeMoal)

• With continued drug use and withdrawal, the “anti-reward” system is recruited to counter-balance excess Dopamine using the stress hormone CRF

• Brain is unable to maintain normal “homeostasis”

• So the brain reverts to “allostasis” - change of the hedonic “set point” under stress in an attempt to maintain stability

• The result is anhedonia – an inability to find pleasure in normally pleasurable activities
CRF
Stress
Dopamine
Solution: this is a safety problem
Aviation Safety Practices

1. Checklists
2. Sterile Cockpit (distraction avoidance)
3. Briefings, Standardized Comm, Read-backs
6. Shared-value safety slogans
   ("Aviate, Navigate, Communicate")
   ("Confess, Climb, Conserve, Communicate, Comply")
... applied to Recovery

1. Checklists: 12-Steps & 12-Traditions, Relapse Safety Plan
2. Sterile Cockpit: support during critical moments of sobriety - first hours after discharge, surgeries, court appearances
3. Standardized Comm: recovery vocabulary
4. Read-backs: calling my sponsor
5. CRM: Network Therapy
6. Non-hierarchical social structure: “the most important person at any meeting ...”
7. Protective devices: Extended-release NTX
8. Shared-value Slogans: “Keep coming back,” “Take the next indicated step,” “When we were wrong ...” etc.
High Reliability Organization

*a safety strategy to cope with complacency*

A system that is able to perform in a risky and complex environment where mishaps can be expected

An HRO must perform reliably and continuously because mishaps are catastrophic
The “Blueprint Studies”

Dupont RL, McLellan AT, White WL, Merlo LJ, Gold MS.
Setting the standard for recovery: physicians’ health programs.
PHPs: 6 lessons ...

1. Treatment & Ongoing Support
2. Abstinence
3. Relapse Plan
4. Testing
5. Mutual Support Groups
6. "Leverage"
Recovery Management Plan

1. Treatment (Residential or IOP)

2.

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10.
What happens when people leave inpatient treatment?
Treatment Outcome Subgroups

1. Continued, uninterrupted abstinence after D/C
2. No effect (no interruption of drug use)
3. Early period of recovery, then rapid deterioration
4. Period of recovery, relapse, then stable recovery
5. Precariously balanced between relapse and recovery for 12 – 18 months after D/C (with unclear prognosis)

50% of all people leaving Inpatient Treatment

WL White, 2009, ATTC
The Problem:
How can I continuously protect myself from risk when my ability to assess risk is itself impaired.
“Memos to Self”

1. “In the times that we’re strong … “
2. “ ... We plan for the times we might be weak.”
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3.
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Recovery Management Check-Ups (weekly)
Recovery-Oriented System of Care (ROSC)

- Mutual Support Groups (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, LifeRing, etc)
- Therapists (Cognitive Behavioral & Motivational Therapies)
- Residential Support/Sober Living
- Counselors & Aftercare Groups
- Family Support Family Therapy
- Social Support Sober Friends
- Hedonic Rehabilitation
- Workplace
- Addiction Medicine Physicians (Pharmacotherapy)
- Daily Drug & Alcohol Testing
- Schools and Colleges
- Faith-based Organizations
- Relapse Plan
- Cultural Groups Recovery Activism
Recovery-Oriented System of Care
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
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Four related theories about the social processes that shield individuals from developing substance use disorders and foster the long-term process of stable remission & recovery

Processes that Promote Recovery
(Moos)

1. Social Control: provision of support, goal direction, and monitoring
   - bonding, social cohesion & support
   - goal direction (family, friends, work, school, religion)
   - structure, monitoring

2. Social Learning

3. Stress and Coping

4. Behavioral Economics/Behavioral Choice

Processes that Promote Recovery (Moos)

1. Social Control

2. Social Learning: emphasis on abstinence-oriented norms and models
   - observation/imitation of family/peer/community norms
   - expectations of positive & negative consequences

3. Stress and Coping

4. Behavioral Economics/Behavioral Choice

Processes that Promote Recovery (Moos)

1. Social Control
2. Social Learning
3. Stress and Coping: self-efficacy and coping skills
   - substance-specific coping skills (avoidance of high-risk situations, reinforcement for maintaining abstinence)
   - general coping skills (approach > avoidance coping)
4. Behavioral Economics/Behavioral Choice

This manual examines the legal remedies available to alcohol and drug treatment providers who wish to challenge discriminatory zoning and siting decisions that result from the NIMBY syndrome.
“Memos to Self”

1. “In the times that I’m strong … “
2. “... I plan for the times we might be weak.”
3. “Where I live matters”
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
4. Mutual Support Groups
5.
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Does A. A. work?

- A.A. confers short- and long-term therapeutic benefits on a par with professional interventions
- A.A. decreases health-care costs
- A.A. improves treatment outcomes
- A.A. attendance during the first three months of sobriety was associated with recovery-related benefits one year later over and above treatment effects.

AA works, but why ... ?

- Most likely through multiple mechanisms
- **Self-efficacy**
- Reduction of negative affect (anger, irritability, depression, boredom)
- **Adaptive social networks**
- Spiritual practices
AA, abstinence and anger

• AA singles out anger as a high-risk emotion for relapse
• “If we were to live, we had to be free of anger.” (p. 66, B.B of A.A.)
• Detailed, column-based worksheet to help document, analyze, and remediate anger
• Increased anger = increased drinking intensity
• AA attendance, alcohol abstinence, and anger are … UNRELATED

AA, abstinence, and anger

The hypothesis that AA leads to sobriety because it reduces anger is **NOT SHOWN**

But … patients higher in anger were more likely to attend A.A. and with greater frequency

And … greater A.A. attendance is strongly associated with positive outcomes

So … it could be that AA doesn’t reduce anger, but it improves one’s tolerance and coping for anger

Also … client anger + therapist confrontation = poor outcome

AA Mediating Variables

1. Depression (decreased)
2. Spirituality
3. Self-efficacy in coping with negative affect
4. Self-efficacy in coping with high-risk social situations
5. Social network: number of pro-abstinence members
6. Social network: number of pro-drinking members

... which are the most important?
AA Mediating Variables

1. Depression (decreased)
2. Spirituality
3. Self-efficacy in coping with negative affect
4. Self-efficacy in coping with high-risk social situations
5. Social network: number of pro-abstinence members
6. Social network: fewer number of pro-drinking members
What is Alcoholism?

A.A. Concept of “powerlessness”

“The idea that somehow, someday he will control and enjoy his drinking is the great obsession for every abnormal drinker.” (AA BB pg. 30)

“The delusion that we are like other people, or presently may be, has to be smashed.” (AA BB pg. 30)
“A.A. is not about the steps, it’s not about the meetings, it’s not about a Higher Power or the Big Book or the birthday cakes or the coffee.

“A.A. is about the power of one alcoholic talking with another alcoholic, and the two of them identifying with each other to such an extent that they becomes willing to take actions to get sober that they do not yet have faith in.”

Clancy I.
(Pacific Group, Los Angeles)
AA: using NON - Rational Concepts

- TRIBE (“the fellowship of alcoholics”)
- MYTH (Bill’s Story, etc.)
- RITUAL (“what it was like, what happened, and…”)
- FAITH (“Keep coming back, it works”)
- HOPE (The Promises)
- ACCEPTANCE (“…the answer to all my problems”)
SMART Recovery

- Cognitive-behavioral approach; open to idea that addiction is not a disease; focus on empowerment and having “recovered”
- Recognition of environmental and emotional factors contributing to continued intoxication
- Utilizes Motivational Interviewing concepts
- Abstinence-based, but welcoming of those ambivalent to quitting
- 635 mutual support-type groups in U.S. and around 600 internationally; Youth program; Friends and Family program
Women for Sobriety (WFS)

- Founded by sociologist Dr. Jean Kirkpatrick in 1976 through the observation that women require different approaches than men
- Abstinence-based program focusing on personal empowerment and emotional growth as opposed to humility & self-centeredness focus of AA
- Substitutes negative, self-destructive thoughts with Thirteen Statements of positive self-affirmation & self-worth
- Around 100 mutual support-type groups, annual conference, nutrition emphasis
Secular Organization for Sobriety (SOS) & LifeRing Secular Recovery (LSR)

- Founded by James Christopher in mid-1980s
- Uncomfortable with the notion of turning one’s life over to a “higher power.”
- Focus on self-reliance and personal responsibility was more helpful dealing with problem drinking on one’s own
- Self-help: the key to recovery lies in the individual’s own motivation and effort rather than on divine intervention
- SOS: no structured program; “Do not use, no matter what.”
- LifeRing: founded by ex-SOS members, wanted more structure
- SOS: “over 1000 meetings” (from website)
- LifeRing: 159 groups in U.S.; 41 international groups
Faith-based Mutual Support: Celebrate Recovery

- Christian-based mutual support group
- Started by Pastor Rick Warren (author of “Purpose Driven Life”) at Saddleback Church, Orange County, California
- Eight recovery principles based on biblical beatitudes
- Twelve-steps with quotes from Bible attached
- 10,000 churches offer Celebrate Recovery meetings
Mutual Support Groups

“These organizations probably benefit participants because they share curative features (e.g. abstinence role models, social support) with organizations that have been shown effective in longitudinal research.

“For some organizations, like SMART Recovery, an ... argument can be made for effectiveness because the organization’s change technology is adopted from well-established treatment approaches.”

- Lee Ann Kaskutas, PhD
“Memos to Self”

1. “In the times that I’m strong … “
2. “ … I plan for the times we might be weak.”
3. “Where I live matters”
4. “Who my friends are are matters”
“Memos to Self”

1. “In the times that I’m strong … “
2. “... I plan for the times we might be weak.”
3. “Where I live matters”
4. “Who my friends are matters”
5. “Plan for relapse”
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
4. Mutual Support Groups
5. **Relapse Plan**
6.
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RELAPSE SAFETY CHECKLIST

1. CALL MY SPONSOR (555-1212)
2. CALL MY THERAPIST (666-3434)
3. MEET MY SPONSOR AT BAYWOOD MEETING
4. HAVE HIM TAKE ME TO DETOX (345 W. MAIN STREET, DOWNTOWN)
5. CALL MY OLD TREATMENT CENTER, ASK THEIR ADVICE
6. GET NALTREXONE SHOT BEFORE LEAVING DETOX
Relapse Plan

• “DO NOT PANIC!”
• Have anAutomatic Relapse Plan
  (previously agreed upon/no discussion)
• Detox (incapacitation)
• Return to Treatment (residential vs. outpatient)
• Review Testing Protocol
• Validate success
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
4. Mutual Support Groups
5. Relapse Plan
6. Testing
a good testing bathroom
Immunoassay & Breathalyser

• daily screening tests
## Two Kinds of Tests in Addiction Medicine

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<td>Not very specific</td>
<td>Not very sensitive</td>
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<td>Not an insignificant false positive rate</td>
<td>Forensic standard</td>
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**Comprehensive Panel**

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<th>Analyte [Methodology]</th>
<th>Flag</th>
<th>Result</th>
<th>Cutoff</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (Ethanol)</td>
<td>Alcohol (Ethanol) [EIA Screen]</td>
<td>Not detected</td>
<td>0.04</td>
<td>µg/dL</td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td>Amphetamines [EIA Screen]</td>
<td>Not detected</td>
<td>1000</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylamphetamine (MDA) [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylenedioxymethamphetamine (MDMA) [GCMS Screen]</td>
<td>Not detected</td>
<td>10</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methylenedioxymethylamphetamine (MDMA) [GCMS Screen]</td>
<td>Not detected</td>
<td>10</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Carbamazepine Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxcarbazepine Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Amitriptyline/Nortriptyline [GCMS Screen]</td>
<td>Not detected</td>
<td>10</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Buropipetone Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>250</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citralopram/Eslicarbazepin [GCMS Screen]</td>
<td>See confirmation</td>
<td>150</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Citralopram/Citalopram [GCMS Confirmation]</td>
<td>DETECTED</td>
<td>150</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desipramine/Imipramine [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donepezil [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluoxetine Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>150</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mirtazapine [GCMS Screen]</td>
<td>Not detected</td>
<td>100</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paroxetine [GCMS Screen]</td>
<td>Not detected</td>
<td>150</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sertraline Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>Qualitative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tranylcypromine/Fluoxetine Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>200</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Barbital [EIA Screen]</td>
<td>Not detected</td>
<td>200</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td>Benzoctines</td>
<td>Alprazolam Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clonazepam Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flunitrazepam Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flurazepam Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lorazepam [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meclozole Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nordiazepam [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxazepam [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Temazepam [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triazolam Metabolite [GCMS Screen]</td>
<td>Not detected</td>
<td>50</td>
<td>ng/mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cocaine</td>
<td>Cocaine (Benzoylecgonine) [EIA Screen]</td>
<td>Not detected</td>
<td>300</td>
<td>ng/mL</td>
</tr>
</tbody>
</table>

**Specimen Validity Tests**

- **Analyte [Methodology]:** Creatinine [Colorimetric]
- **Flag:** 200.0
- **Reference Range:** ±20
- **Units:** mg/dL

**Comments:**

Analytical testing has been performed in accordance to all Redwood Toxicology Laboratory standard operating procedures and final results have been reviewed by laboratory certifying scientists.

Chief Toxicologist: Wayne Ross, M.C.L.S. / MT(AAB)

**Method Index**

- **EA - Enzyme Assay**
- **ELISA - Enzyme-Linked Immunosorbent Assay**
- **RIA - Radio-Immunosay**
- **TLC - Thin Layer Chromatography**
- **GC-FID - Gas Chromatography - Flame Ionization Detector**
- **HPLC - High Performance Liquid Chromatography**
- **LC/MS/MS - Liquid Chromatography Mass Spectrometry**

Specimens are disposed of as follows: Negatives - after 2 days, Positives - after 6 months; Methadone Maintenance - after 2 months
“Memos to Self”

1. “In the times that I’m strong … “
2. “… I plan for the times we might be weak.”
3. “Where I live matters”
4. “Who my friends are matters”
5. “Plan for relapse”
6. “Build a paper trail”
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
4. Mutual Support Groups
5. Relapse Plan
6. Testing
7. Job/School/Future
8. 
9. 
10. 
“Memos to Self”

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2. “... I plan for the times we might be weak.”
3. “Where I live matters”
4. “Who my friends are matters”
5. “Plan for relapse”
6. “Build a paper trail”
7. “Get back in the cockpit”
HIMS Program

—an occupational substance abuse treatment program

Help is available through an easy 1-2-3 step process. Click and start now.

HIMS is specific to commercial pilots and coordinates the identification, treatment and return to the cockpit of impaired aviators. It is an industry-wide effort in which companies, pilot unions, and FAA work together to preserve careers and further air safety.

Dana Archibald (919)608-1735, E-MAIL: Darchibald.HIMS@gmail.com

Mike Lorenz, ALPA HIMS Vice Chairman (913)568-2846, E-MAIL: Mike.lorenz@alpa.org

Mini Seminar - Phoenix, AZ - Saturday March 19, 2011
Collegiate Recovery Communities

PROGRAMS

COLLEGIATE RECOVERY PROGRAM MEMBERS

Universities and colleges across the nation are leading the way in supporting students in recovery from addiction. Each member University or College listed below incorporates recovery on their campus in a way that is unique to their population and culture.

A collegiate recovery program can be implemented in many ways, utilizing many services, models and tools. The main point of a CRP is that it focuses on student support in higher education.

Please feel free to contact the member University/College directly.
CENTER FOR THE STUDY OF ADDICTION AND RECOVERY

CENTER FOR PREVENTION AND RESILIENCY
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
3. Recovery Residence
4. Mutual Support Groups
5. Relapse Plan
6. Testing
7. Job/School/Future
8. Addiction Medicine Specialist
9.
10.
“Memos to Self”

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3. “Where I live matters”
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5. “Plan for relapse”
6. “Build a paper trail”
7. “Get back in the cockpit”
8. “Get a doc, Doc”
Addiction Medicine Specialist

- Certified by the American Society of Addiction Medicine
- Understand the special needs of recovering patients
- Not likely to make stupid mistakes
- Doctors who **LIKE** addicts, Offices that are safe places

- [www.asam.org](http://www.asam.org)
- [www.abam.net](http://www.abam.net)
- [www.csam-asam.org](http://www.csam-asam.org)
CALL FOR ABSTRACTS
Submit proposals for workshops, courses, component sessions, papers and posters by October 15 (EXTENDED).
» Learn More

NEWS
9/13/2013
115th Meeting of the National Advisory Council on Drug Abuse at NIDA
Last Wednesday, September 4.

RESOURCES
The ASAM Criteria
The most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with

EDUCATION
ASAM Call for Abstracts Open Now Until October 15th (EXTENDED)
Submit your abstract now for the 45th Annual Medical Scientific Conference, April 10-13, 2014 in Orlando, FL.
Science, Skill, and Compassion

Quality Healthcare, Public Trust, and Setting the Standards in Addiction Medicine:

The American Board of Addiction Medicine provides assurance to the American public that Addiction Medicine physicians have the knowledge and skills to prevent, recognize and treat addiction.
Recovery Management Plan

1. Treatment (Residential or IOP)
2. Therapist/Counselor/Coach/Advocate
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4. Mutual Support Groups
5. Relapse Plan
6. Testing
7. Job/School/Future
8. Addiction Medicine Specialist
9. Medication
10.
Enforced Abstinence from Tobacco During In-Patient Dual-Diagnosis Treatment Improves Substance Abuse Treatment Outcomes in Smokers

Elizabeth B. Suyf, MD.1, 2

1Department of Psychiatry, University of Colorado, Denver, Colorado
2Center for Addiction, Colorado Mental Health Institute at Pueblo, Pueblo, Colorado

Background and Objectives: Although the prevalence of tobacco use in patients with substance abuse treatment is high, few treatment programs specifically target tobacco use. The purpose of this study was to determine if tobacco treatment improves substance abuse treatment outcomes in patients with dual-diagnosis disorders.

Methods: This study included patients with dual-diagnosis disorders who were prescribed an 18-month treatment program. Patients were randomized to receive either standard care or an additional treatment program, which included counseling and nicotine replacement therapy. The primary outcome was substance abuse treatment outcome, and the secondary outcome was smoking cessation.

Results: At the end of the treatment program, patients in the additional treatment group had significantly lower rates of substance use and were more likely to be abstinent from nicotine use. Additionally, patients in the additional treatment group had significantly higher rates of smoking cessation.

Conclusions: This study demonstrates the importance of addressing tobacco use in the treatment of patients with dual-diagnosis disorders. Addition of a tobacco treatment program can significantly improve substance abuse treatment outcomes and smoking cessation.

Scientific Significance: This study highlights the importance of integrating tobacco treatment into the care of patients with dual-diagnosis disorders. The findings suggest that additional treatment programs can improve outcomes for these patients.
“Memos to Self”

1. “In the times that I’m strong … “
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3. “Where I live matters”
4. “Who my friends are matters”
5. “Plan for relapse”
6. “Build a paper trail”
7. “Get back in the cockpit”
8. “Get a doc, Doc”
9. “You need to quit”
Recovery Management Plan

1. Treatment (Residential or IOP)
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4. Mutual Support Groups
5. Relapse Plan
6. Testing
7. Job/School/Future
8. Addiction Medicine Specialist
9. Medication
10. Hedonic Rehabilitation
Processes that Promote Recovery (Moos)

1. Social Control
2. Social Learning
3. Stress and Coping
4. Behavioral Economics/Behavioral Choice: engagement in rewarding activities other than substance use
   - involvement in protective activities (effective rewards from family, friends, school, work, religion, physical activity)

“I wonder if you/we need to learn new ways to celebrate and to reward ourselves?

Work is easy, but play…?”

- LeClair Bissel, MD (1928 – 2008)
“Memos to Self”

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9. Medication
10. Hedonic Rehabilitation
Kevin McCauley, MD
kevintmccauley@hotmail.com

The Meadows of Wickenburg
(808) 745-0199

www.protectingsobriety.com
References:

Dennis ML, Scott CK. Four-year outcomes from the early re-intervention (ERI) experiment using recovery management checkups (RMCs). Drug and Alcohol Dependence 121 (2012) 10-17.


