NAADAC

Peer Recovery Support Series, Section III:

Understanding the Pathway and the Process

April 15, 2020

CAPTIONING PROVIDED BY

CAPTIONACCESS

contact@captionaccess.com

www.captionaccess.com

* * * * *

This transcript is being provided in a rough-draft format.

(Communication Access Realtime Translation (CART)

is provided in order to facilitate communication accessibility and may not be

a totally verbatim record of the proceedings)

* * * * *

>> MODERATOR: Hello everyone and welcome to today's webinar on addiction and recovery. Peer Recovery Support Series, Section III: Understanding the Pathway and the Process Section III of our Peer Recovery Report Series presented by Dr. Carlo DiClemente. It is provided as a collaborative effort between Great Lakes ATTC and NAADAC.

The Great Lakes Addiction Technology Transfer Center is located at the University of Wisconsin Madison Center for health and enhancement study systems and funded by SAMSHA to help people and organizations implement effective practices for SUD recovery of services. It serves the state of Illinois, Indiana, Michigan, Ohio and Health and Human Services region five. It is great you can join us today in my name is Samson Teklemariam the director of professional develop for NAADAC the Association for Addiction Professionals. I will be to organize for your training experience today.

The permanent homepage for NAADAC webinars is listed on the slide. Make sure to bookmark the webpage to stay up-to-date on the latest in addiction education. Closed captioning is provided by CaptionAccess. Please check your most recent confirmation email or our Q&A and check box for the links to use closed captioning.

As you see on your screen, circled in red with a bright yellow arrow pointing at it whenever you visit our webinars page, click here to download a simple user guide on how to get your CE certificate from this webinar. Part we are using go to webinar for this live event put on notice the go to webinar control panel that looks like the one you see on my slide. A few important instructions.

You entered into listen only mode which means your microphone is automatically muted to prevent disruptive background noise. If you have trouble hearing the presenter, consider switching to a telephone line using the audio option which is right next to the orange arrow on your go to webinar control panel. You can use the orange arrow to minimize or maximize the control panel and if you have questions for Dr. Carlo DiClemente type them into the questions box. We will gather those questions and post them to the presenter during each area or our live Q&A.

Any questions we do not get do we will collect and document them on the Q&A document and send them to the presenter and get them on our website and the same one you used to register for this webinar. You will notice hand out. Right underneath the questions box. You can quit anytime throughout the webinar and downloaded quick reference guide on how to get your CE certificate from this webinar.

Dr. Carlo DiClemente received his Doctorate in Psychology at the University of Rhode Island. He directs the MDQUIT Tobacco Resource Center, the Center for Community Collaboration in the Home Visiting Training Center at UMBC.

He is the codeveloper of the Transtheoretical Model of behavior of change and author of over many publications on motivation and behavior change with a variety of health and addictive behaviors.

It is conducted and funded research for over 35 years with funding from the National Institutes of Health Institute, SAMSHA in private institutions. His book Addiction and Change: How Addictions Develop and Addictive People Recover second edition was published in 2018 and offers the view of addiction recovery using behavior change process. For his work he has received awards from the Robert Woods Johnson Foundation American Society of Addiction Medicine Association for behavioral cognitive therapies as well as presidential citation from the APA.

He received a 2019 National Institute on alcohol abuse and alcoholism Jack Mendelson, MD, Award and Alfred Wellner Lifetime Achievement Award.

For the national register of health psychologist and we know Dr. Clemente does not need an introduction and we are excited to provide the webinar to you presented by this experienced trainer and close friend. If you're ready, we will hand this over to you.

>> CARLO DICLEMENTE: Thank you, Samson. That was wonderful. I appreciate the info. I did want to say thank you to all of you for all of the work you are doing during this time working with clients and helping them through this difficult time, especially, if working with people with addictions. This COVID close down is not helpful and are doing the best we can and hoping to help and work with them. I think you for all the work you are doing.

Today, we will try to look through this addiction and recovery and look at the pathway and process I have identified as we go along. Acknowledgments and conflict of interest information. The work here has been funded and supported by a number of groups as has been said. Some of the concepts I have worked with Ray Daughtery you may know from the prevention research Institute. I am a consultant for prevention research institution and have royalties from programs with them and the Advisory Board for Westbridge a dual diagnosis treatment program in New Hampshire.

I wanted to thank everyone and no one does all of the stuff I have been doing. And getting recognition but there are a lot of people involved. I want to thank all the graduates and undergraduates and collaborators I have had over the years who helped me go through this.

What we are going to try to do day is look at three critical challenges for treatment and understanding addictions. First is how to understand use disorders and addiction mechanisms and making sure we understand those as multidimensional. Second is understanding addiction and recovery as a change process and within the change process there are different kinds of mechanisms working. Change in generating mechanisms and change regulating mechanisms and we will explain them along the way.

Talking a little bit about how can we try to support individuals with problematic self-regulation and self-control which is a hallmark of addiction?

The first challenge is how do we move toward a better understanding of the addiction and recovery? How can we really understand severity of addiction in a new way beyond the DSM five list of consequences. A way that is multidimensional. A way that gives us a guide for prevention but also relevant for recovery? That is my goal for today is try to help you get there. Let me start with my view of addictions. These are my definitions of what are addictions.

Habitual patterns of intentional, and repetitive behaviors. Both of those words are important. You could get any one dependent on a substance. Basically, I can get you dependent on opioids. I put a drip and leave it in long enough and your body would adjust and you would be dependent on opiates. But you will still not be addicted. Basically, you need some intentional aspect of that. You choose to do this. You could, after I let you go from your prescribed course of treatment on opiates and then you started choosing and taking new opioids in different ways and using it is not prescribed in the intentional peace comes in and you could be addicted to opioid medications just as you could be to heroin.

All of the addictions are a repetitive behaviors. No one is addicted to something that does not hit the limbic system and the pleasure systems of the brain. That is part of the process.

These behaviors become excessive, problematic and produce serious consequences. That is a critical piece. You can be involved in some of these behaviors without them becoming excessive or problematic as we know with social drinking.

These problematic behaviors become stable over time. Many people I work with who are smokers where smoking 20-30 years a couple of packs a day. Some heroin folks we have seen have been using heroin for 5-15 years. These patterns become stable and part of who the person is almost. The other thing about addictions I think are fascinating as well is important to understand is there are interrelationship between physiological, psychological and social components.

And one hallmark everyone seems to identify is addicted individuals have difficulty modifying and stopping his patterns of behavior even when there are consequences. That is true whether talking about tobacco and nicotine or alcohol or marijuana or heroin or some of the process are behavioral addictions like gambling, sex, Internet gaming and those kinds of things. They become very difficult to modify because they are so connected to our lives.

If you think how do people get in and out of addiction? It is a journey. It is a personal journey. They're very unique journeys people do get into and getting out of. It is a journey through intentional change process. It is marked by personal decisions and choices people make but is also influenced by a lot of different biological, psychological and social factors.

If we want to define addiction, we should describe the problematic nature of behavior that would give us some clues on if this is what the problem is, how are we going to solve it? That is what I hope to do today is give you a better picture of addiction and severity of addiction that leads to understanding where are we going with this?

Is how I see addiction. This is a model. The top parts are moving across the top the process of initiation and people move from precontemplation to contemplation to preparation and action and maintenance as they move into addictive patterns. Maintenance is the well-established pattern of behavior, problematic behavior that we call addiction. And people move through that in a variety of ways and at different times during their lives.

We found you can characterize the process of initiation of a behavior as well as recovery or cessation of a behavior and that's a way you can think about whether people are in the process of initiation are working with them in the process of recovery. Most of you will be working with folks in the bottom line. Trying to move them to the process successfully towards sustained success will change of and addiction.

We found there is the same processes and context of markers have changed and they operate differentially in the initiation process that in the recovery process. They are similar in both processes. It is a single process of human intentional behavior change.

If you think of addiction as individuals move through stages of initiation, they move from thinking about doing it to experimenting to developing a pattern of behavior. That pattern becomes habitual or consistent over-time. Some of the patterns we have or normative.

There are 60% of the population that drink. But that is not the number people who have severe use disorders that we call addiction. There are patterns where people can use the substance in a socially acceptable and self-regulated way. They do not create problems or get judged as excessive. What is the difference between that kind of pattern and addiction?

Addiction is well-maintained, problematic pattern of engagement in this behavior or in using the substance. That is what we call moderate to severe use disorders. In the past we used dependence before we went to the DSM five. Once an individual has created this maintain stable pattern of this nature, what you have to do is think the interventions have to switch because if I'm in a pattern of initiation, I am doing preventive. If I'm in a pattern of recovery, I need to use the stages of recovery.

Many of us move through stages of initiation to achieve regular patterns of consuming alcohol, smoking and gambling. Some of us have gone to problematic extremes and with some of those behaviors and had to go in and change those behaviors. It is important to distinguish among engagement patterns. This is true because were getting more people to try to screen for problematic patterns of substance abuse.

When we try to do that, we want people to distinguish between use and misuse which is used a lot in England more than here but I like it because it does indicate, especially, with alcohol you can have use and misuse.

Use and dependence we are not using but abuse is have more legal consequences and dependence had its physiological consequences and different patterns we are looking at. Currently, DSM as mild, moderate, severe use disorder categories. The trajectories of engagement can also change over time. We need to understand that people can go from social use to misuse to dependence to a severe use disorder.

Sometimes that depends on developmental and contextual factors. Sometimes the birth of a child is a marker of motivation to change my patterns of behavior. Luckily, I teach in a university that the binge drinking pattern that some of the students in college have changes over time after they get out of college. It seems to be a limited heavy pattern for many of the people and for some it continues to be a problem. Casino gambling and the more casinos we have, the more people can get in to trouble in problematic gambling in terms of doing that. There are contextual factors and developmental factors that can shift the pattern of behavior over time.

When you think about it, motivation as we talk about focuses on how the individuals move into and out of these different patterns of behavior. It is really about the process of change. Addiction focuses on the end state with the final part of it. If I think of addiction which we currently defined as severe use disorder and probably moderate and it really depends. When you start try to go from four to six and eight or whatever of the criteria, it is not clear where the dividing line is.

Addiction ends up being an ending and a beginning. It is the end state of a process of initiation. It is also, because people are the well-established pattern of behavior, it is often the beginning of a process of recovery. When you're in a well-established pattern of behavior, you do not want to leave. This is part of who I am. This is how I live. This is me.

And you go through stages of recovery starting often in precontemplation. Let's look at this well-maintained state and get a picture of severity of addiction. Let's look at severity and

patterns of use. How do people define severity? How do all of you look at severity in terms of when you're doing your evaluations?

Many of issues different metrics and some people use consumption. Some people use consequences for both of those. Some people use context and some people use the ability to control. Often those are considered part of the pattern. There is a problem with all of these single factor ways of defining severity.

The patterns can change and we need to identify both current as well as lifetime severity. That is critical for harm reduction and recovery and it's critical in terms of consequences because they accumulate over time and as we see and the NESARC study tested a large number of people who met the criteria for dependence and looked at the drinking during this past year, you saw a lot of different patterns and some work drinking heavily like they used to and some are absent in summer drinking without consequences and some were drinking with minor consequences.

These patterns can change over time.

When we think of severity and patterns of use, is different within assessing risky behaviors. NIAAA had a metric for measuring low risk or move in a high risk. That is different than using a DSM criteria. We have to be clear about what we do. How do you measure to severity? In DSM use number of symptoms or indicators. Severe would be six or more of 11 of these indicators. If you using quantity and frequency, what we've done in some of our studies is look percent days abstinent or drinks or drugs per day and that makes one way of looking at quantity.

You have consequences or problems attributable to problems. The first person I had who taught me about alcohol problems said -- people said how do you know alcohol is a problem? His definition was if it causes a problem, it is a problem. That is how he identified that.

A lot of people use craving. Craving is an indicator of severity of addiction. Others will use comorbidity. There are other conditions are diagnosable conditions and sometimes it's multiple problems in life context. Sometimes homelessness, domestic violence. Sometimes it is in the environment. How much is the environment saturated by the substance and this individual is living there? The IPA is important people in activities measure that tries to measure the saturation among peers and in the environment of substance abuse.

There are a lot of ways to do that. Some of you may have used ASI and many of you may know about it. ASI is the addiction and severity index but what it does is it evaluates not just alcohol and drug but evaluates other problems. It is part of what Tom McCllelan was working on trying to understand that severity is not just the alcohol or drug but often there's a lot of other things going on. Family, psych, social, legal, medical, employment.

It is based on the individual's rating of the problem. It is a self-evaluation measure and their desire for drinking. It does try to incorporate some readiness in their even in the severity of evaluation.

I don't know how many of you use the ASAM criteria but a lot of places are using that. That was another attempt to try to create dimensions of the multidimensional problems for assessment. These are the six dimensions they developed.

[Reading slide]

They did a mix up of a variety of different aspects of a person's life and try to put them into dimensions and evaluate that. The whole point being that if I can do some metric for those, then I can maybe play somebody on a continuum of what they need for treatment.

This was trying to connect severity defined with this multidimensional package of six indicators. And trying to make severity match onto window somebody need residential or inpatient care or medically managed or intensive care? It is a great idea. I think it is hard as some of you know. Sometimes people qualify if you want to use qualifications for medically monitored intensive patient services. Sometimes it is really difficult to say the difference between 2.5 and 3 or a 3.1 and 3.5.

I think it's a great attempt at severity but it has its limitations as they all do. If we wanted to try and look at addiction severity, all of these attempts have limitations. One single dimension of the behavior. How much are you drinking and how often are you drinking seems inadequate to see how bad the problem is. Collections of categories or symptoms seem somewhat arbitrary. Six of 11. Five of 11. It does not matter which five. They give you a category and may help you get reimbursed for treatment but they do not necessarily connect well to treatment.

There is no unifying or conceptual framework or perspective. With the ASAM criteria those different aspects put in these categories. It is not always clear if multiple dimensions indicate severity of addiction or if we are talk about severity of other problems.

That makes it more difficult as Tom McClellan would say that if you treat somebody with a psychological problem as well as addiction problem, that is true but it does not help us understand the severity of this addiction. That is a comorbidity issue and we need to understand it that way.

I will stop quickly to see if there are any questions and let Samson break it up a little bit if people have questions for me so far. We can talk about that.

>> MODERATOR: Thank you so much, Carlo. We have great questions. Everyone, as a reminder in your go to webinar control panel, you can open it by clicking the little orange arrow and it was a questions box. You can send questions to us and we will ask those questions to Carlo. A few came in. Carlo, I will try to squeeze in a few and let me know if you need more.

The first one is can you talk a little more about the connections between diagnosis and severity?

>> CARLO DICLEMENTE: Diagnosis has always been trying to pinpoint a syndrome. DSM focused mostly on syndromes. When did the symptoms come together and reach the level we say this is diagnosable. This is a disorder as opposed to this is normal or this is a little abnormal but not diagnosable. Diagnosis tries to kind of get a clear cut defined boundary between it is or it is not. It is dualistic in some ways. Severity is not like that. Severity is on dimension and it seems diagnosis does not help you very much when you're talking about the dimensions of severity because all you get is yes or no. They meet or do not meet this criteria. That is an important distinction and will go into that as we go along.

Carlo, Adam asked I have seen this question before. He asked the omission of the sixth stage of "change termination". And how we almost never sees the stage of termination and if you could speak to the application of "termination" stage of change to recover from SUDs?

>> CARLO DICLEMENTE: I will defer some of that a later when I go more in depth into the stages. Termination -- Jim and I have a little bit different perspective on those. I know and the change for good book termination was put in as a six stage of change. I consider work termination as a state rather than stage. Basically, it is coming to a point where the new behavior is so ingrained in my life that I don't have to put much energy or effort into it.

From my perspective I am a former smoker. 35 years ago and has been quite a while since I have been a smoker. Currently, I am in termination for nicotine dependence. What does that mean? It means I don't have to put any effort into it. I don't have any temptation. I am very confident I am not going to smoke.

I have MDQUIT Tobacco Resource Center and I worked to get other people to quit smoking. I do not have to do anything because most of us only have a certain amount of focus and energy to put into the change process.

While I'm doing that with tobacco, I cannot do it with a lot of other things. Sometimes you do two or three things at the same time but it takes energy and focus and attention.

When I'm finished with that particular behavior and have established I am no longer doing it, I consider myself in termination. I am not like any one he was never used nicotine before. My brain probably still has some residual neurotransmitter receptors that are nicotine receptors more than anyone who is never smoke. I am still available but for me, I would not go from termination -- you should not -- if I went back to smoking, it would not be relapse but what I call the initiation. I would go back to the stages of initiation and I can do that much more quickly than any of you have never smoke. You would be going -- I can move through the stage so re-initiation relatively quickly. At this point it seems not helpful to call my going back a relapse.

Termination indicates when we make the distinction between the initiation or relapse and recycling. That is how I see it. Do you have one more?

>> MODERATOR: Yes. I will squeeze in one more and then turn it back on your presentation. David from Virginia and thank you for sending them in and keep sending in your questions. We will do another break later on in the presentation. This is the last one for the break. David from

Virginia asks when and how did you realize or did the light come on from earlier when you mentioned TTM and stages of change in addiction as well as out of addiction? When did that come on and can you speak more about how that realization came?

>> CARLO DICLEMENTE: Excellent question. The issue was when we are first working on this process, we realized that we were working with smoking cessation. That is where we got our first grant and we followed most of the people and how we measured a lot of the measures or processes of changes and stages of change and self-efficacy. It was around smoking and about smoking cessation.

As we came to understand more and more, wait a minute. This process seems relevant also for initiating a behavior. People took it and said let's think about starting exercise. You can characterize starting exercise behavior going to the processes of change. People start using it for cancer prevention and getting screening. That would be initiating a new behavior.

People started using it also for diet. When you start thinking about these three behaviors, there are different patterns of change. Initiation, modification and cessation are three different patterns of a process of change. What is interesting is the stages seem to be able to characterize the journey through each of those patterns. It is a little different. In initiation of a behavior, it looks different than is cessation of a behavior. Modification of behavior is also different.

The pattern is different but the process seems to be very similar. What you had to do was say let me understand this. About 15 years ago we had data in Maryland on kids starting smoking. We were able to stage kids in terms of what stage of change were they in with regard to beginning smoking? We had them in precontemplation and contemplation and preparation. We studied that and multiple waves of kids and looked at, you can characterize the process very easily. You can see what is happening as more and more kids started quitting, more kids ended up in precontemplation and fewer in maintenance.

The process of change over time was able to be captured. That is when the light bulb went on and I said we need to be talking about that. I got the idea about addiction and change. My first version of that book is 2003. In the late 1990sand early 2000s, I got this is start working on it. Do you want me to move on? Samson? I will keep moving. My microphone says we are working. I will move through.

Now I will move and try to get you to think differently about addiction severity. The challenge is to create a new view that really looks at the multidimensionality but also helps us in a number of different ways. Ways that addiction severity helps us with diagnosis and help us understand how severity influences innovation. It helps us offer specifics for treatment planning and matching. That is the idea and I deal of what we are trying to do.

Let me give you some of my own critical assumptions about this. I think quantity and frequency have to be a part of how we define severity. It is not the only thing but it is something and we need to have it in there. We need dimensions and not categories. We do not want something present or absent. We really need something that is dimensional. Something on a ruler that can be measured in terms of severity how to get from mild to moderate to severe by looking at three versus four from the DSM.

It should highlight critical mechanisms based on the addictive behavior and include biological, psychological and behavioral factors. It should include a little piece of looking at the larger context. Addictions happen in the context of the individual's life. Severity has to also be viewed in the context of the individuals a life. Those are my assumptions.

This is why work with Ray Daughtery and came up with this and said let's look at it this way. Let's look at use patterns. Maybe we can find use patterns because every pattern is different and we can say excessive drinking but that is one thing. Let's look at quantity frequency. You have

no risk. You have low risk. Infrequent high-risk, frequent high risk and extensive high risk. Those are ways to characterize what the use pattern looks like.

We said let's look at three key indicators of addiction. Neurobiological add that to option, reduced self-regulation and salience. Each of those could be on a scale from mild to moderate.

Let's look at consequences as they affect the social, psychological and physical dimensions of that person's life. If I get a picture of this in terms of the use patterns, where they are in terms of indicators of addiction and what are the consequences are cross the context of that person's life? I get a good picture of what severity of addiction would look like.

Let's start with use patterns. Although it is open to interpretation, quantity and frequency are important for assessing relative risk. We need that for a lot of different things. Some of the people who can drink the most or have the most risk because they have the most tolerance. It is risk but you cannot see it sometimes.

We had a project in Texas where we were looking at people who are coming into the VA and did the assessment of this individual and sent data to the coordinating center and they sent the data back and said this is impossible. If this person where drinking this much, they would be in a coma. We went back and looked at the data and look at everything and said no, that person is drinking that much. But they are functioning. There in inpatient unit but they were functioning out in the world at that level of drinking.

Quantity and frequency can give you some good indicators of severity. We need to know that. Quantity and frequency are also important because they are important for motivational goals. How do I get to cutting down? I don't know unless I know quantity and frequency.

How do we indicate different patterns of use? Unless I know what your pattern used to be, then I don't know. That is a challenge for all of us to look at. The interesting thing is in the DSM five, quantity and frequency are not at all included in their definition. Dissolve really consequences and you can see those in the 11 different indicators.

Let's keep the use pattern in there and see where we go. How can you define it? Let's look at this way of defining it. No risk, low risk. Infrequent like in frequent binge drinking and people do binge of marijuana use or whatever on a weekend or at a party or something like that and it is high risk but it is infrequent. Do you have frequent high-risk. Then have extensive high risk. You have people using daily. It is daily excessive use and that can be heroin, drinking alcohol, marijuana or any of those.

That is one way to characterize it might be helpful to understand severity by using that kind of characterization. And the World Health Organization recently came out with their own risk levels and using a similar kind of way of thinking about things where they look at low risk, medium risk, high-risk and very high risk and do it with numbers of standard risks.

We do have the World Health Organization saying this is a way to look at this. If we move away from that let's look at mechanisms. I think there is a small set of key mechanisms that can help characterize the end state of addiction and used to measure severity. Here is my candidates. Neurobiological adaptation. All of the substances, all of the addictive behaviors change the brain. They change the neurotransmitter. Sometimes they change morphology or the size of the brain when you're exposed to excessive use. There is neurobiological adaptation and it is a reason why people call this a brain disease. It is significant.

There is reduced or impaired self-regulation. The sense of a loss of self-control and compromised self-regulation. People using despite consequences, despite saying I know it could really harmony but I'm going to do it anyway.

And impaired self-regulation is a hallmark of addiction. It is related to neurobiological adaptation because the neurology we know affects not just the go system, the attractive pleasure systems of the brain but also impairs the stop system or the prefrontal cortex of the brain. You have impairment there that supports this impaired self-regulation but impaired self-revelation is also an indicator of people getting into addictions.

We know impulsiveness and ADHD are risk factors already for getting into addiction. There are some behavioral aspects and that is what is called behavioral control disease. Behavior economics. People are willing to focus more on the immediate benefit in the long term benefit. We know that is there as well.

And the third element is salience or narrowing of the behavioral repertoire. Salience is a lot of the DSM kind of characterizations or indicative of salience. The addictive behavior becomes more valued as a reinforcer. People let other things go so you do not live up to some of your other responsibilities. The behavior becomes more ubiquitous in your life and more potent. In some ways this is a crisis of values or spirituality we sometimes talk about in terms of addiction because it does take over the value system in a lot of ways.

People will do things they would never have imagined doing. When they were not addicted to go in and steal from their parents and take stuff and go sell it so they can get a fix. It is a crisis of value as well. It is a brain, a behavioral and a value crisis of values.

Think for a minute about your clients and let's think about what would you see if you are able to assess neurobiological adaptation? How could we tell weather was mild or severe? There are a number of indicators that we have that would help us understand this.

Tolerance is an indicator there is neurobiological adaptation going on. State-dependent learning that you do not member what happened in an intoxicated state unless you're back in the intoxicated state. Compulsive like use is when people are using and craving can be an element of this but it is that. Altered thresholds of stress and pleasure people respond to stress and addictions create a lot of low stress tolerance and high distress. You change those. Increased strength and scope of cues. The more you see neurobiological adaptation means the firing of the brain cells when you see cues for the substance get more intense but they're more variable. Anything happens, I need to use drugs.

Negative emotional states when use is blocked. People get frustrated and angry sometimes or even violent. You see withdrawal and other rebound effects and when you see some of those you know what is withdrawal? The body and the brain going only God. No, I don't have this. How am I going to adapt? It is neurobiological adaptation at the end of the process.

And we do know and while we know there's neurobiological adaptation we have FMRI dictators and we know that MRIs can show the changes in the brain of people both while using and during recovery.

The more you see any of those things, the more severe the process is. If we do the same thing for reduced self-regulation, what do we see? Use becomes more automatic. They are looking and doing it. There is difficulty controlling or cutting back at all. They are using to cope and self-regulate. It becomes a coping mechanism.

They use despite consequences. That indicates loss of control. Impulsivity increases for those folks. They cannot function if use is interfered with. They underestimate consequences and it really is not that bad. I have this under control. They have a sense they have control. And it really affects both executive cognitive function and affect regulation.

You see disinhibition and difficulty managing strong affect and you will see executive function in planning and doing those things really affected and that is all part of reduced self-regulation. The more you see that because of the more severe it is. If you look at salience, there are similar. What happens in salience more highly valued and meaningful and expectancies people have. This drugs going to help me do this and this. And live a better life. And alcohol will make me a more fun person and help me with sex and with all of those kinds of things.

As the expectancies grow, salience grows and other behaviors become less frequent. It becomes integral. It substitutes for more basic needs. See people putting aside food, sleep, shelter or whatever to have access to the substance. It is difficult to imagine life without it. I had a cocaine addict once tell me that quitting cocaine was going from watching color television to going to black and white. He was having trouble figuring out while you ever go back to black and white?

It is difficult to imagine life and living a normal life without that substance. There is conflict when it is incongruent with other values and people go along and continue to do those things. You see decreases and other important pleasurable activities. The question is should we go bowling or should I did a hit of heroin? Bowling is way down the list.

It changes our metric of how we measure the things that are important to us and the things that give us pleasure. People spend more time does this is DSM criteria -- using and arranging for use. People narrow their networks. They are usually hanging with folks. The more you see any of these things, the more you move down the mild to severe level.

We do not have a way to quantify that right now but we should be looking at that. The final piece is a consequences. How do I look at consequences? We should be looking at consequences in the important domains of functioning of the individual. The more consequences there, the more severity. The key domains are biological.

Not only do they need substance to feel normal, but there are biological things that are happening in have organic brain syndrome's and delusions and DTs and craving and serious physical consequences. Liver and COPD and HPC and other complications. There are a lot of consequences that complicate the change process and indicate greater severity because the severity is also consequences and not just in the mechanisms or quantity and frequency.

And psychological becomes a coping mechanism in a way to manage negative emotions and stress. George Coomb looks at stress coping mechanisms and I want your in addiction, you're in this loop and you anticipate. You use and get depressed and get stressed and you go back and start using again and it becomes a vicious cycle.

And the social. How integrated into the social context and network. Do I use it for sex and fun and social events? Is it meeting all of my needs at times? If we do this and have these, we can say how would I define severity? I have to look at use patterns and indicators and severity of those indicators and then look at the consequences across all of these different areas.

That seems to me to give you a picture of severity that is rich and rich also in ways to think about what do I have to do now in terms of my treatment plan? Let's look at a couple of examples. Here is a college drinker. This person is infrequent high-risk. You see neurobiological adaptation but not much. You see some moderate amount of self-regulation, problematic salience and narrowing and it looks like you go into the social.

The main problems in this person our social. There are more mild psychological and physical symptoms beginning to show with this infrequent use but that is a picture of a college drinker and he would say here I need to address what do I need to address? And how can I reach this particular individual and keep those metrics from increasing? Moving from frequent to infrequent and moving up the ladder in terms of severity and consequences?

If you look at a binge drinker you can see this is frequent high-risk and that is different. You see indicators and have indicators would work. They may be a little more and moving further towards the severe level. The narrowing because it is frequent high-risk but there working and doing other things, the salience may be milder but you also beginning to see more serious consequences across psychological, physical and certainly social frequent high-risk binge drink or often creates a lot of social chaos in their lives.

That is a way to look at that and try to understand how severity would look like in a picture but also using those metrics. The ideas how would severity interact with motivation when the severity makes recovery and completing tasks of the stages more challenging. Motivation is behavior and goal specific. The pattern I use and severity are critical to my goal setting and what are the plans I am going to do to change this behavior?

Severity impairs self-regulation and self-control. The more it is impaired, the harder it is to get people to use coping skills to manage their recovery journey. And severity interacts with a lot of the things that we talk about in the stages of change. It interacts with motivation, ambivalence, decision-making, commitment. Severity undermines those kinds of things. Support, planning and implementation of an action plan as well as relapse and recycling.

If I understand these mechanisms and the consequences and the quantity frequency, it can help me understand how can I put this plan together that's going to work with this person and how does this impair their journey through the stages of change and through motivational and behavioral aspects of that change process?

If you think of stages of change, these are the stages you have probably heard about it. Maybe at ad nauseam. I am sorry about that. But the stages and labels are not as important as the tasks. The stages indicate what would you need to do to get that person interested, concerned, willing to consider? That is a task they need to do. These are the clients task and not your task. Your

tasks are how do I get them moving on these? How do I engage their interest and their concern and willingness? How do I get them to do risk analysis that will lead to a decision? How do I get them to build their own commitment and create a plan that is effective but also acceptable and accessible? They have to be able to do that plan.

Depending on severity, that plan may look very different depending on where that person is. In action it is implementing the plan and revising the plan. No plan is perfect. You have to revise the plan as needed. In maintenance it is consolidating the change into your lifestyle until it becomes substantial and solidly established.

The tasks are the critical part of the stages. This is how it look if it were linear. You have motivation pieces. You have decision-making pieces and efficacy pieces of the process. You have to figure out what do I do to get people to move through this process? For personal concerns environmental pressure how do I get them to move from there to here and resolve and ambivalence? How do I get them to use the cognitive experience or processes that are important to get them there and how do I get them to be engage in shift from cognitive to more the behavioral processes over here and build their self-efficacy?

And what happens when there is relapse? In this model, relapse is also not a stage and leads to recycling. I will talk more about that as we go down the road. Relapse and recycling. Movement through the stages is not linear. It really is not. Some people get stuck in places. We had people in one of our projects we were in contemplation we said are you serious about quitting smoking and they would say yes and six must later they say yes and six months later they say yes. For the whole two years of the project, there is substantial group who were chronic contemplators. Always sitting there saying they were thinking about it.

But that is not unusual. It is not unusual about New York resolutions. It takes 5-7 years sometimes before somebody making the same resolution actually follows through. You're not

changers in any case. But people get stuck and they move forward but that they also move backward.

Just because your contemplation does not mean you're going to stay different may do risk analysis and say I am not doing this and move back to precontemplation. In the action phase there is a challenge of what happens when I'm tempted and go back and do this and relapse and recycle? Relapse is not a stage of change. Recycling is really at the heart of recovery. It is recycling through this process of change. There seems to be a difference if someone is recycling and spiraling. They are trying and failing. They are trying and failing. If you see that kind of a process, that is not successful recycling. That seems to be someone who is stuck in a circle that they cannot get out of.

What I think happens is you have to step back and look at other problems of the individual. This is where severity might be helpful. What is going on? Maybe it is all of the consequences not allowing this person to build a plan and stable action plan they can do.

Maybe it is environment. Maybe there is stuff in the environment they cannot overcome. If you see redo and not recycling, you need to step back and figure out wait a minute. There is something wrong with the process. It is not working like it should. It is not a learning process. It is become a self-defeating process. You try to understand that.

It looks like this the cycling through processing going and moving to contemplation and then relapsing and recycling through and the whole idea is you need to do this multiple times a lot of times in order to get all of these tasks done well enough to be able to support maintenance, long-term maintenance and the state of termination if you think about it.

You have regression, slips. Slips are important. Another difference is out there in terms of that. A slip tells you that your action plan is not working. It does not mean you are in relapse. It means the action plan is not working. Need to fix your action plan. Need to revise the plan. You do not necessarily have to begin again.

Relapse is a return to using the behavior in a similar way as before. I think relapse is best defined as giving up on change. Once you give upon making the attempt to change, you are in relapse. The relapse does not signify anything. All it means once you relapse, where are you now? You are usually in one or always in one of the pre-action stages. People relapse and recycle back to precontemplation. Some relapse and go back into preparation. I will try to do this again.

I think that is different than somebody slipping in action and catching themselves and fixing the plan so they can keep going on. I make that distinction.

This is a relapse curve. This is from the 70s but it is not any better these days. This is everybody here and 12 months later is 20-30% success and that is if I say it is complete absence all the way through this one year. Total abstinence from here to one year later in usually about 20-30%. People think that is bad and part of the problem with addictions. But that is not true. Addictions got a bad rap. Relapse is not a problem of addiction. You can see that as we go through. Relapse is probable in any health behavior change. It occurs at the same rates as addictive behaviors.

Relapse is really a problem of instigating or starting and sustaining a behavior change. It is a problem of adequately completing the critical tasks of the stages of change. That is what is happening. If you look, this is Tom McClellan's work looking at article he did in JAMA. Drug addiction percent of patients who relapse and who is doing 40-60% type one diabetes is 50%

[Reading slide]

The problem is with asthma and hypertension and diabetes we do not call it relapse. You have had a recurrence. Maybe we need to get rid of the term and do something at NAADAC's conference coming up on relapse and we can talk more about it than. We may need to get rid of the term relapse because it is stigmatizing to people in addictions and it is not other people.

People said that of relapse of cancer but is really recurrence of the cancer. It is not really blaming them whereas when you going to drug addiction and someone has a relapse, it is your fault. Nobody wants to take blame, of course. The person said the program did not work in the program people go oh, no. Our program works. You do not work the program. Everyone is fighting over what seems to be a natural process.

When we get. We think this is the picture of the process of change. You have people moving through this process and our challenge, for those of us were helpers, is to look at that, look at the severity of the addiction and look at the process of change and put those two together and try to see how can I move people through this process to successfully stay and move into maintenance?

Many times it takes multiple times. Many of the severity indicators that I showed earlier undermine this process and undermine the recycling process. What treatment is supposed to do is really support this process in the client. That is really what we can talk about.

Let's stop again for just a minute or two and talk a little bit about any questions. Samson?

>> MODERATOR: Thank you so much, Carlo. We have great ones coming in. The first question is about being a peer recovery support coach and what kind of assessment tools they can

use. This is Paul from Texas. He asked how would recovery coach document severity? Is there any assessment tool or assessment guidelines that recovery coach can use?

>> CARLO DICLEMENTE: There are a lot of assessments out there and indicators. I am proposing something new and no, there are no measures of that at the present time.

The only thing I can say is you could take some of these quantity frequency measures and look at some of those indicators of those and write those down as you use those as your support for your judgment of the severity of that particular individual. If you see a lot of indicators or adaptation and self-regulation and salience, then I would try to document those. They are somewhat documented when you do your DSM if you're doing a diagnostic because the 11 things kind of overlap with some of the categories that I brought in. But there is not any one measure we have now that measures what I just said.

Or how I did that. In alcohol, many years ago, we used to use the alcohol use inventory and that was a very helpful one because it had a lot of questions and had multiple dimensions you could look at and had a second order and third order factor that indicated severity. I don't know how much it is used and it was specifically for alcohol and not drugs. I am sorry I'm not more helpful but that is the only answer I have at the present time.

>> MODERATOR: Thank you, Carlo. Thank you for the question. Shelby from Indiana asks what was your advice to the client that felt like quitting cocaine was like living with black-and-white TV? We mentioned earlier what I go back to watching black-and-white TV, how did you answer that?

>> CARLO DICLEMENTE: Nice. Good question. I think part is helping people to rediscover some of the important values that are in black and white. And to help them see that the

Technicolor was not always that pleasant. Again, the challenge is you are asking someone to make a significant change. To leave something behind. There is always a loss. With alcohol stuff, there is a loss of a friend. Alcohol became a friend or close confident and support system for that particular individual.

It is always the case what you're trying to do is help them let go of that and mourn the loss of color and embrace the black-and-white to see if we can get that to be more colorful. That is part of the brain thing and what takes so long sometimes for people to recover is the brain recovers slowly. That normal brain activity we have seen FMRIs one month after cocaine use and one month and four months after the brain still looks like someone who never used cocaine. It takes a while for the process to happen. I will go into scaffolding which is the other thing I suggest for this particular individual is to support that person while they're watching the black-and-white TV for a while.

>> MODERATOR: Thank you, Carlo. Janice asked a question a few people ask. We had three similar. Janice from Kentucky ask shouldn't they teach relapse as a stage of change and how should we talk to our clients about relapse?

>> CARLO DICLEMENTE: That is a good question. I do not think we should teach relapse is a stage of change. It's an event or a series of events that happens along the road. Individuals slip and lapse and maybe something we need to look at because if we are too rigid about it has to be absolute. You cannot touch this. If you touch the substance, you will have to go back to day one. I know that is a perspective out there in the field. I do not sure that perspective because sometimes touching that substance really indicates wait a minute. There is a problem here.

How can I fix that? We should look is relapse as part of a learning process. I am talking to people more about recycling. Most people you are talking to have already done that once. I used to tell people you do not see treatment virgins. You do not see change virgins in treatment.

Nobody comes to treatment first. They all try to change on their own before they come to treatment. When they decide they cannot do it by themselves, that is when they come to treatment. Most of the people you see have been through this process and understand it.

I would try to help them understand the process and talk to them about how recycling is a learning process and let's learn from what you did and what happened even if you relapsed and let's make the next change better. And see if we can make it better and permanent. I would treated as a learning process.

>> MODERATOR: Thank you, Carlo. We will squeeze in one more. We have a lot. I will squeeze in one more and let me know what you want to do next if you want to go back to the presentation. This comes from Melissa. Thank you for this question and for a couple of others. Is the neurobiological adaptation you mentioned earlier reversible or is it a permanent condition?

>> CARLO DICLEMENTE: Excellent question. We know it is reversible to some degree. Basically, many of these functions, we did Oscar persons who did a lot of work in alcohol looking at trajectory of recovery of the brain and neuropsychological function. You do see it.

It may be there may be parts of that will never totally recover. It is not clear to me. We have seen a FMRI for example, if you see someone who's used a substance for a very long period of time, you see brain shrinkage. You see morphological changes in the brain. That is going to be really hard to make it bigger again.

But I think you see amazing recovery and the brain is a wonderful instrument in a lot of ways and has a lot of corporative ability even though people say once you have brain cells that are did you lose brain cells all of the time. That may be true but the brain can really recover. My

mother-in-law had a stroke at age 50 something and was in a coma for six months. The whole left side of her brain was blank when you saw it on x-ray.

You would see she lost her use of her right side and lost language. But she recovered enough to communicate, laugh, watch Vikings games, call us on the phone and make noises to let us know the Vikings were on.

She was able to recover enough to do minimal work like she could and build ceramics and do those kinds of things. I think the brain has a remarkable recovery process. There may be some elements you cannot totally recover. And we had that discussion and argument sometimes with methadone. Many people believe some of the brains of folks who have used heroin for long periods of time that you need methadone. There is no way they could function without methadone or some opioid thing substance they could use that keeps them functional and functioning better but still addicted to opioids.

That is a complicated question and I think a lot of recovery depends on how soon. I just learned a few years ago that some the people were saying even those people who smoke, we have talked a lot about people recovering a lot of health after quitting smoking. Even the people who smoked a long time ago, they are still probably high risk for cancer, lung cancer. I do not think everything goes but I think there's a lot of things that happen in terms of recovery in the brain functioning as well in the behavior and the life of the individual.

Maybe we can do one more?

>> MODERATOR: Marine from Vermont asked specifically about COVID-19 and I will rephrase the question. Please do not throw a virtual tomato at me. We had comments on this. With COVID-19 and the topic of slipping or reoccurring and relapses, there is an attention a lot

of clients are experiencing fear, loneliness, isolation and maybe even disruption in the routine that promote recovery.

I hear her question and I am adding to it with other questions we see. Is there room for this diagnostically or in treatment to see this as an adjustment issue or adjustment disorders we use to lean heavily back on in the day or is this recurrence relapse something we need to treat the way we have always?

>> CARLO DICLEMENTE: The COVID-19 affects all of us and affects all of us differentially depending on our personalities and their experiences and their age and who we are living with. There is a lot of different things there. I think for people in recovery, it is important to pay attention to the isolation. I have seen smart recovery now has a lot of online activities for individuals to do. I do think we need to reach out and use the electronic as much as possible and we can do Telehealth and those kinds of things.

I don't think you overcome the fear by going back to using substances, especially, if you have been off for a while and have a new life. But depression might indicate will help you lose steam in terms of your recovery. I think we have to focus on recovery and keep the person focused on recovery and make sure we avoid the awfulizing that it is going to be terrible.

We have to do that and then we have to support them in whatever ways we can and I will talk about that in this next piece because I do think there are people who are more vulnerable. People with more problems and self-regulation need more support and we should be reaching out, not just waiting for them to come to us. I think peer recovery coaches can be very important in this time to reach out to them virtually through telephone or in a meeting or however you could reach out and touch these individuals and support them in their recovery.

Speaking of recovery, we will move to the next piece because that is where we are going next. Recovery is a lot of things. That is what we are beginning to understand. Recovery is not just the absence of relapse or the absence of the substance. Recovery has a lot to do with health and wellness.

In fact, SAMSHA has a working definition of recovery from both mental health and substance abuse disorders. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. We are not talking about living a crippled like. We are talking about someone coming out of an addiction and living a full life, self-directed and living up to their potential and full of health and well-being. We need to think about that in the larger context of recovery that there is a larger context of recovery in multiple dimensions of recovery.

We need to focus on the individual. That has been part of what the stages of change model has helped us do is take us off of thinking too much about treatment and focus on the consumer or the client. Because the key mechanisms for change are in the client. They had the potential for change. When we think about services both as peer recovery coaches and others, they are consumers of our services.

If you think about them as consumers instead of clients, it changes the way you see them. What happens to consumers? Consumers need to be valued. They need to be engaged. We need to build products and services that they need that are tailored to them. They are consumer focused and friendly and that is a critical piece to be consumer-oriented.

I did a project once with a group from IDEA and we want to know how to create more consumer friendly products for smoking cessation. They came in and showed us two and went to the drugstore and took two pictures and came up and gave a talk. His talk where is the tobacco? It was in the front of the store by the cash register. Where is the tobacco cessation medications and

other things? It was in the back locked up in a cabinet back in the pharmacy. He said I rest my case.

A lot of times what we are bringing to people is not what they need. What we need to understand is what are the needs of the consumer and how can we reach them? Each consumer or client has a unique history, unique set of problems that make this challenging. We need to treat people and not diagnoses. You are talking about the whole person and not a single problem.

You have to think holistically when talking about this. Every time you change a targeted problem, it involves changing multiple areas of my life. I cannot just diet or just exercise without changing other areas of my life. It is the same with I cannot go in recovery without changing other areas of my life. And many of those are behavioral kinds of things we need to do.

Healthcare providers is the WHO is 70% of global deaths in 2015 were due to what we call noncommunicable diseases. We are freaked out with COVID-19 virus that is communicable but in fact the majority of deaths in the world happened because of noncommunicable diseases that are related to behavioral health issues. COPD, CVD, diabetes and addictions, these are all noncommunicable illnesses and chronic conditions that we need to be dealing with. That is why we need integrated care.

The problem is a lot of times you will see if you have multiple untreated problems, they complicate the process of change. I know you are looking at this and sometimes you see two faces looking at each other and some of you see a chalice or base of some kind. It is hard to see both of those at the same time. When it is a figure ground problem and that is what happens when we focus on the addiction. Let me focus on your cocaine use and we lose the context and

loose some other issues in the context that complicate the process. It is not as successful. We have to think about how to pull these things together and see them all in the same system.

In the Transtheoretical Model we have come up with the levels or context of change where you look at our there situational resources and problems like homelessness, depression and other things going on? What about cognitions and belief systems? What about interpersonal resources and problems? What about family and family systems? What about the personality characteristics of the individual? Sexual identity and other things that are personal characteristics that are long-standing and enduring?

It is also true that multiple problems exhaust self-control and impaired self-regulation. Now I have somebody who is trying to recover self-regulation and I have these problems that are exhausting. We need to keep that in context and think about that as a person is going on. In fact, that is probably what AA said focus on the drinking and that is it. Do not try to change anything else because it is too complicated and you need all the energy to focus on the drinking.

But sometimes if you're just focused on that and not some of these others, it triggers the relapse process and leads you to relapse. There are a lot of typical complications. You have seen all of them. You have seen them in a lot of different areas. I will not go through these but those are some things you can look for the different areas of life.

The bad news is there are multiple problems. The good news is there is a common process. Whenever you think of problems in any of these areas, there is usually a change that has to happen and people have to move to this process of change to make those changes happen. Whether it is marital problem they need to do. They both have to be in the same area and figure out how do I do that? Preparing and build an action plan and following through with the action plan to follow through to resolve the marital issue of the relationship issue. The whole idea of

the stages if behavioral changes is involved, there is a common process you can think about and used to help people across these other problem areas.

The challenge is how do you prioritize problems? Many people come in with a lot of problems. One thing I learned from Steve Rollick, when he was working in consultation liaison people came to him with a lot of problems. He would always put in a couple of extra circles with question marks asking these are some problems I have assessed that you have. What else is going on?

Are there other problems I missed? Are there other things you are concerned about? A lot of times if they are focused down here on a problem that you do not know about and you are focused up here on drinking or cocaine use, their energy is back down here. Their motivation is down here and here pushing things. Maybe you want to incorporate this in to trying to also bring some of these things together.

It is a quick kind of thought to help you think about that along the way. How do you strategize and identify priorities? AS all of you know safety and security of clients is important and that is the first thing. After that, you think what am I going to focus on? Is it the critical first problem to be addressed and identified by the patient or client? Is it the problem you have identified? I think this is the key. We need to do this. You also need to make sure that the client is on board with you.

Is it the problem where you have the most leverage? Where they have the most motivation and what they think is most important which they call the identified problem. So maybe that is where you want to start. Wherever you decide and however you try to figure this out, it has to be done in collaboration and you should be prioritizing with the client. Not separate from the client. A lot of times treatment plans, the treatment plan is over here and the client's plan is on the other

side. The treatment plan always should be in the service of the change plan of the client. That is something.

How do you get and stay in recovery? Most of you know it better than I. The peer recovery folks you have navigated this journey for yourselves. Hopefully, this picture of the journey is constant with the journey taken but requires completion of the stage tasks in a sufficient way to support long-term recovery. You use the processes of change. Things like self-reevaluation and behavioral processes like reinforcement and those kinds of things. You have to use those processes to complete and deepen these tasks. You are building confidence. Avoiding overconfidence and trying to be realistic.

When I say completing the tasks well enough, a lot of people think that relapse happens here because they met a cue they cannot resist. If you think about this process of change, relapse can happen not because of the cue but because the decision was not strong enough. Relapse can happen because interest was not there.

I had people come through the alcohol cue and they came through and did well in treatment and stop drinking and whatever and that argument with the wife and said the hell with it. But I was so interested in doing this because I thought would help but she does not appreciate it so I am going back to drinking. That was not personal interest and concern. It was doing it for the wife and it was not very strong. It did not lead to a good decision or good commitment and there was failure in the action plan. Relapse happens and recycling happens because you have to get these things right enough.

You have to have enough interesting concern to support solid decision-making and risk reward analysis to support a solid commitment and good plan and prioritizing you're going to do this. Implementing a plan in a way that works and when the plan is not working, revising the plan instead of throwing out the change.

And integrating it and avoiding relapse and making sure your new life is filled with new things and is not the absence of the substance. You have to complete all of these things in a way that is adequate to be able to support long-term sustained change.

When we think of mechanism, what is a client's work in making this happen and what is the providers tasks? The client is their process and coping activities they have to engage in. That is what we do. We as providers provide strategies and services to help them in their process of change. That is how I envision the change process working.

There are behavior specific. They have to use cognitive behavioral processes to change to move through stages. If you think of client activity and recovery, it requires self-regulation. Self-regulation is the ability to manage internal and external demands. That is responsive to feedback, flexible in seeking solutions and not rigid and does not overtax the system. You want a self-regulatory system that works so you get feedback on your daily life. You consider it. To change the way you are doing it and try to do it in a way that does not overtax the system.

All of this is being taxed in this COVID with parents being workers and teachers and caregivers all at the same time and that really taxes the system and if we do not have good self-regulatory processes, it gets to be overwhelming. That is a current way to think about that.

When you think of all the things we are asking people to do, observe your own behavior, evaluate yourself, think of change, plan, all of those required self-regulation. It is an essential peace, self-regulation and self-control is important piece of recovery. We do not always think about that. This guy Baumeister has done interesting work on self-control and self-control is necessary for doing all kinds of behaviors but is a limited resource. We can all get exhausted. It is like a muscle. That is how he sees it.

Your self-control and even most of us who have great self-relation and self-control can be tapped out. That happens to all of us. It is not just a skill or capacity. It is something you can build. We have to rebuild self-control in the individuals we are working with and help them support their self-control.

What do please self-control strength? All the things we have talked about. Quitting addictions, managing negative emotions, coping with stress. It is not a limitless resource. You can increase it like a muscle and you can exercise self-control. That is good. A lot of the 12 steps are ways to exercise self-control. It is really an interesting kind of process and support system for that.

What I have been thinking of is we need to think more about scaffolding. When we have problematic self-control, we have to provide support and scaffolding for those individuals. Scaffolding can be a lot of different things. In education, they talk about what I can't do. Scaffolding helps us with what I can do with help and these are pieces you cannot do already. You are trying to increase this what I can do with myself or with support from other people and make that bigger and bigger. That is a part of the recovery process as well.

What can we do about impaired self-regulation? Recognize it disrupts the client's process of change. Provide scaffolding. I think of scaffolding as residential care. 90 meetings in 90 days is scaffolding. Giving your phone number to somebody and making sure they know how to call you get in touch with you. That is scaffolding. All of the different things we do to put external supports around the individual to help them when they have weak self-regulation and weak self-control.

Provide a way the client can build and rebuild the self-control muscle. And make sure the building is well-built before you take on the scaffolding. In a lot of our programs we have a 28 day program. 28 days you're good to go and now go to aftercare. What the heck? Aftercare was

-- I don't need aftercare. I am good because they said I was good. But that was not enough scaffolding and we had a lot of relapse. We need to think more carefully about that.

The last couple of things. If I'm going to suggest how do you support recovery, focus on the client and the patient needs and desires, motivation and self-regulation. Use scaffolding for impaired self-regulation. Create what I'm calling systems of care and not treatment programs. We do not need more treatment programs.

We need more comprehensive systems that take care of all of the needs of the individuals in recovery. Build integrated care. We need to be working with other folks and need to have the capacity to help people with health as well as housing as well as other things and you need integrated care to do that.

You only do that be creating a system of communication with peers and providers that focus on client and use it to coordinate interventions and treatment and support systems. That is my hope of where we go in the future.

Just finishing up so we have time for a few questions. Change is a complicated process. No question about that. You need a roadmap. What I have given you today was a roadmap looking at addiction severity and what can I do about some of those things in the process of change. We need both broader view of the larger process as well as a focused view of the journey of that particular client.

That template, the stages provide a template and give you the broader view but it is the journey of the individual through that process that is the key view and a more focused and important view. For all of you know this in a lot of ways that negotiating change and entering the client's change process is challenging. I think it requires patience and persistence. You cannot just give

up. It requires optimism but also realism. You cannot just be Mary Poppins. You have to understand there are real challenges here and help them navigate those challenges. And I like to think of it as think of your work out of the perspective of a minor league coach.

The major league coach has all of the people you know exactly what they are doing and the minor league coach has people -- I coached my daughter's soccer team. Sometimes it is thinking about like coaching the 7-year-old soccer team that can get disrupted very quickly and they do not have the skills. You have to teach them the skills and help them with the skills and help them negotiate the motivation and also negotiate to help them through the change process.

Hopefully, this was helpful and gives you some ideas and helps you in your work. The hard work of this is not me presenting it. It is you working with these individuals on an individual basis and helping them navigate this journey. I wish you all of the best of luck as you go through and help and remind you to take care of yourselves also in this process.

You cannot be motivated for these people. You have to help them with their motivation. You have to help them with their problems but you cannot be consumed by their problems. You need to take care of yourselves as well. Thank you. There are references for those who want to look up some of those things and some of this I have talked about is in the addiction and change book as well. That is a shameless self-promotion. We will go from there and say thank you.

>> MODERATOR: Thank you so much, Carlo, and not shameless. I am sure they would love to find out how to use additional resources. We have great questions. Because I read it so much of your work I know some of the answers to the questions you have written on. I am going to Josh's we want give me the ones you know I the answer to.

>> MODERATOR: That is what I'm starting with [laughter. This is a geek moment for me. This question I want to know. Raymond, thank you and a shout out to you for asking this question. How many times has your view changed on stages of change cycle? How many times has it changed altered or evolved throughout these last 20 plus years? What has the journey been like? What have you tossed out and kept?

>> CARLO DICLEMENTE: That is a very interesting question. I see this stage of change as a heuristic model. Heuristic means it helps you understand some things. We have had critics. We had a number of critics of the model and the critics have been helpful because they pointed out some things that were important to us.

We started with smoking cessation and said can you use this for mammograms? Women getting mammograms? You have to rethink and change some of the ways you think about this process and you change this is starting a behavior and this is stopping smoking. We then have people challenge us and say that is smoking. This model works for smoking and not for other things. It is too simplistic.

That pushed us to think in the context of change. And the processes of change and look at those and we had different processes that we thought of and when we got research data back, we decided wait a minute. These 10 processes -- they are not the only ones in other people can have process but we think these 10 processes of change represent important processes that would support movement through the stages of change.

It has changed a lot. Measuring things has changed. Trying to measure the stages of change. We have used a ruler. We have used your recap. We have used algorithm for smoking and asked questions and able to stage people. You figure okay. Do they correlate? When we saw yes and you look at the algorithm on the ruler, they are similar. People rank themselves as ones or twos or three on a readiness ruler would say there in precontemplation. We have had a lot of

things and challenges have been instructive to me. But is still a work in process as far as I'm concerned.

The recycling process and understanding what that means and understanding.

We need a better understanding of recycling. Yes, I said it's a learning process. How does that really work? Is there a better way to help people through recycling? As long as it remains heuristic and something that is a life and do not make the stages boxes. Do not fix them. That was another thing people said.

Albert Mandora a long time ago said those stages, you cannot do that. Stages are like butterflies. You cannot go from a moth to a butterfly and go back again. But no, that is not right. That is not what we're talking about in stages. Stages are the changes that never change back again. People can move back and forth. The challenges have been instructive and helped me shift my perspective on some of the elements of the model but also have added and subtracted some things from the model to help people understand it better.

>> MODERATOR: Thank you so much, Carlo, and thank you Raymond. I next question is from Madeleine. She asks what is the maintenance timeframe? Carlo we had a lot of questions about time. Some in recovery on the webinar admitting that even five years and one person said 20 years of recovery and congratulations on that by the way. They feel they will always be in maintenance stage.

Madeleine asked something more specific. As a clinician, what is the maintenance timeframe and can our clients have slips and still be in maintenance?

>> CARLO DICLEMENTE: I think the answer to the second part is yes. The timeframe is interesting. We put arbitrary time frames in the model because people were thinking about action is something that happened and the day after you quit, you were in maintenance. Wait a minute. You have not established a new pattern of behavior. If we think the process of change as establishing a change in behavior, you need 3-6 months in action before you can talk about maintenance. That is the action fades establishing a new pattern of behavior. We said 3-6 months because it was not totally arbitrary. We looked at relapse curves.

If you do that, if somebody has sustained the behavior for the first six months of the relapse curve, it flattens out.

What we are saying is it must be once you have established a pattern, and relapse is less likely to happen. That is what we found. If you think of maintenance stage and classify somebody in the maintenance stage, it is because relapse is less likely to happen. It is not totally unlikely or cannot happen, not at all. You have to establish a pattern and that is action.

Then you move into maintenance where the cues become less frequent but sometimes more intense. Maintenance is also a very active time where you're trying to make sure that you have established other things and other priorities and building a new life as well as leaving the old one behind.

That is a critical time. In research we have used anywhere from 2 years-5 years and when doing research in tobacco for example, there are so many people here more than 10 years off. It is incredible. We have 32 million people out there who are former nicotine dependent individuals. There are a lot of people out there in maintenance. You are asking about maintenance.

When I talk about termination, I do not think you can define termination. One of my first people, did you on the maintenance piece, I said when did you think you are completely off cigarettes? He said seven years after I quit. What happened seven years after you quit? I was an automobile accident. My truck was destroyed. I came out with only some scratches and I did not want a cigarette. That was his definition of maintenance moving into termination. You are right.

For some people and it is very individualist whether it's perpetual maintenance or move into termination. For some people, long-term I need to keep working on this. As long as you put in energy and you need to pay attention and work on these kinds of things, I think you are still in maintenance. That is how I think about it.

It is not arbitrary. The journey is individual. We have put a template out there but people have to see how the template works for them. If you are 20 years out and still working on things, God bless you. You could stay in maintenance forever. That is what you need to do in order to protect your recovery and keep going. If you are five years out and feel you have things under control and doing okay, you still have to be careful. You are still not immune. It is not like when you get into termination. That is not what we are talking about. It is not immunity like were trying to define for the coronavirus. These are behavioral things and you can always go back.

I know people who are smokers who said I have been off 15 years but let me tell you. I still love the stuff. If I knew I had a terminal illness, the first place I go is 7-Eleven and buy a pack of cigarettes. That is not termination. That person is maintaining well and doing it but is still in love with the behavior. I think it is a personal journey and that personal journey you have to think about and not arbitrarily defined it as you can only be in the stage for this long or period. Does that help?

>> MODERATOR: That is awesome. Carlo, thank you so much and I'm sorry. We had great questions that come in about resistance, denial and precontemplation stage of change but we do not have time to get all of them. Carlo, we will gather these questions and send them to you in a document and work with Carlo to get them answered and added as a resource on the webpage you use to register for this webinar.

If you are wondering about your CE quiz for the webinar if you do not have the instructions earlier, you can access the recording of the live event, remember every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar immediately following the live event, you will find the online CE quiz link on the exact same website you used to register for this webinar.

Everything you need to know will be permanently hosted at the email listed on the slide. Please tune in as you can for the upcoming webinars. There are interesting topics with great presenters and here are peer recovery support continues April 17th as this concludes part three of the six part series and part far for will be Friday this week from 12:00-1:00 Eastern with John Shinholser and Honesty Lillar from them action foundation and you can learn more about this series of the six webinars at the website.

Currently, NAADAC is offering two specialty online training series. There is one on clinical supervision in the addiction profession and the website is listed at the bottom of the slide. It collaborates with our manual that you can find in our bookstore and you can visit our website any time to learn more.

The second series is on addiction treatment in military and veteran culture. These two series our specialty online training series that have a different model than our regular webinar series that is exclusive content. Visit the website you see on the slide in it's on the printable slide deck you get from our website.

As a reminder as a NAADAC member, there are a lot of member benefits. This webinar and other free webinars like this, your CEs could be free as a NAADAC member. If you been paying for the CE processing fee, every time you pay for that, you could have put that toward your membership. If you want to learn more about becoming a NAADAC member go to the website on the slide or email us any time.

Please note in your thank you email, you will receive a dedicated link to complete a training survey that's for the Great Lakes ATTC who helped us bring along Dr. Carlo DiClemente to this webinar. Many thanks to the Great Lakes ATTC and complete that survey that you see in your email from the go to webinar. Thank you all for participating Carlo, thank you for your level expertise. Encourage you to stay connected with us on Facebook and LinkedIn and Twitter. Have a great day. Thank you, Carlo.

[End]