Envisioning Radical Change in Research, Clinical Training, and Service for Severe SUDs

This document summarizes and consolidates several years of my work on what turned out to be one large project. The material is now presented here, all in one location, in 5 parts.

1. A Population-Sized View with Lifespan Length

Imagine all patients currently enrolled in any and all SUD services of every kind being evaluated on all kinds and levels of wellness (covering biological, psychological, social, and spiritual indicators) and all problem indicators across those domains as well. Now imagine that evaluation being continuous over all the years of each individual's lifespan, prospectively over decades. In that project we would evaluate not only those who are treatment completers and survivors, but we would also study those that drop out, no-show, and pass away. And as the large data set builds, we would transform it into a norm-reference group.

I suspect the norm-reference group would hold practical information for helping individual people, such as average critical periods for making improvement, regressing, or being stuck. That is, various stages might fall out of that information. And with that data set we could compare a specific patient to the subset of those in the norm-reference group sharing those features to make a second layer of useful comparisons. That is, the continuous data collection and aggregation process itself, and the particular and aggregate information obtained, would improve our work with individuals. Now also imagine the data for each individual being recursive to their care and also rolled into the large data set. In that way the data set would constantly improve. Ultimately, the large data set would allow us to have something analogous to the kind of knowledge and manual that allows for the preventative, routine, and responsive care of automobiles. But that kind of care would require a new service structure.

2. Building New Services and a New Service Structure

Now imagine a vastly different service structure to go with that – one that would stretch over the patient's lifetime. Imagine a service with no appointment necessary, an expert technician guided by the norm reference group and related manual, the known service intervals, and responsive to any concerns raised by the patient. With shorter appointments. And imagine a clinical approach that is manualized for both the patient and the clinician by the continuous aggregation of this knowledge. This would result in known time frames and methods for easy routine maintenance and care, known service intervals for longer/more difficult (but predicted) needs, and information for the patient and their family about what problems to look for, how to detect problems, and what to do about them. This would allow the clinician to do quicker work based on actually knowing what to proactively look for and knowledge of the predictable results of care. And we would still retain other kinds of service shops for higher complexity work and situate them inside this structure. All of this activity would also be recursive to both individual care and the mega-data project as well. That is to say, we would have the data set required to develop the sufficient knowledge required, to build the service manual (so we could be effective while nimble), and the newer service structures to go with that capability.

3. Redesigning our Academic and Clinical Training

Further, what if we shifted our academic and clinical training of addiction counselors to focus on more than only acute problems and include: (1) health across the lifespan, (2) preventative care,

(3) substance use problems from tiny to life-threatening, and (4) all available and relevant clinical methods? And what if that material was shifted toward a more wholistic competency that was focused across the lifespan? After all, being well is a life-long pursuit. While doing so we would also always retain specialty services for more complex and severe presentations for whom no routinely available care could suffice.

Doing all of this would be a project I call *Addiction and the Stages of Healing.*[1, 2] But it's too ambitious and that could never happen. Right?

4. Feasibility and Lessons from Outside the Field

The Framingham Heart Study[3] began with examination of its first participant in 1948 and the study continues to the present day. The study aims to understand the epidemiology and treatment of cardiovascular disease and is built on the premise that this is an endeavor without end. It has led to many individual studies that have been recursive to the project. Naturally, the study has expanded the clinical focus to include genetic and environmental risk factors, as innovation proceeded. It enrolled cohorts of participants across time; these have included descendants of earlier participants, allowing family-based approaches in the development of questions and care. The Study serves for me as the *problem side* of my thinking about Addiction and the Stages of Healing. That is, it applies to understanding the pathology of addiction, its prevention, and its care (e.g. clinical targets and measures).

The Nurses' Health Study[4] began with a questionnaire in 1976 and the study continues to the present day. The study has generated "long-term, multi-generational data, including lifestyle- and health-related information across the life course." The study is characterized by "…integrative analyses…" and studies that have "…sustained a high level of scientific productivity." The work has been centered in an academic environment "…with great strengths in many disciplines, particularly epidemiology, medicine, and biostatistics…" and has retained energy and creativity over time by its involvement of students, maintaining the nature of the research as "fresh". The Nurses' Health Study serves for me as the *wellness side* of my thinking about Addiction and the Stages of Healing. That is, it applies to understanding people being well, and better than well (e.g. wellness targets and measures).

The World Parkinson Congress[5] is a non-profit international learning collaborative; it started as an idea in 2002 with the question of why such a meeting consisting of all of those touched by Parkinson's did not exist. This World Congress involves all stakeholders (persons with Parkinson's disease, their family members, personal and policy advocates, researchers and academics interested in neuro-degenerative disorders collectively or Parkinson's specifically, and clinical professionals from all disciplines involved in care of Parkinson's patients). The effort includes a world-gathering of all of these groups of people, coming together to share information, advancements, and directions for all involved, and to promote cross-fertilization of ideas and methods. It continues to the present day. The World Parkinson Congress for me serves as the *awareness, collaboration, advocacy and action* side of my thinking about Addiction and the Stages of Healing.

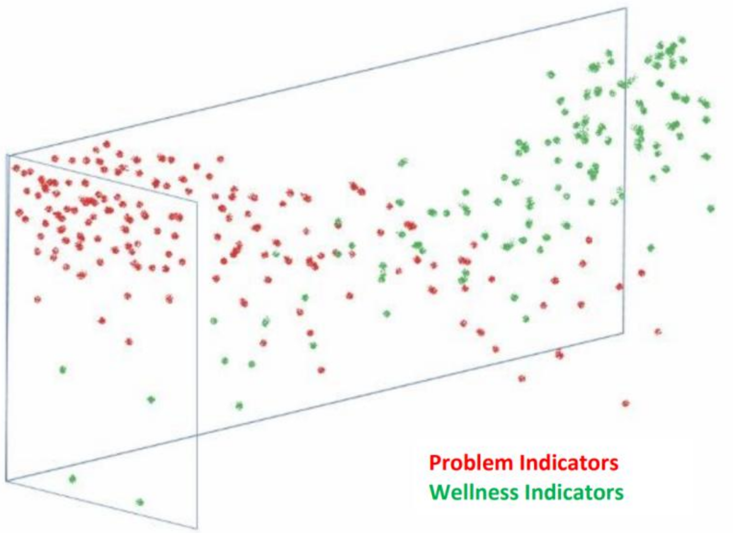
Addiction and addiction patients deserve all three of these efforts rather than a continuation of these specific kinds of historical neglect. I would do them as one.

But what can we do in the meanwhile?

5. A Newer Practice Guideline for Severe SUDs

For now, while we await the above developments, we can consolidate the longitudinal information that we do have into a preliminary practice guideline. Ideally, it would be built around points of convergence among accumulated academic research, clinical understanding and practice, and indigenous recovery-related fellowships. Fortunately, a first draft of such a practice guideline for management of severe, complex, and chronic SUDs has been completed.[6] The guideline frames and guides the first five years of clinical engagement and is summarized below.

5 years of clinical engagement for one person with a complex, chronic and severe SUD are shown below.



"5 years" is the answer to the question: "When does present sobriety/remission predict lifetime sobriety/remission?" The starting point for the clinician is the **universal benchmark** of sustained remission and improving quality of life **five years after** the last clinical touch. As shown, during the five years of care, the active problem indicators are becoming fewer and are falling. And the active wellness indicators are increasing in number and are rising. At the start some wellness indicators are present. And at five years some problem indicators are still present.

Critical thresholds are as follows:

- **First 4 appointments.** If the patient makes the fourth appointment, the intake or transfer was a "take". Until they come to their fourth appointment, one does not know.
- **30th day.** Drop out is highest in the first 30 days.
- **90 days.** After this point relapse risk levels off; SUD early remission.
- **1 year.** After this point relapse risk levels off; SUD sustained remission.
- **2 years.** At this point improvements from year 1 are maintained; relapse risk levels off.
- **5 years.** If the patient gets to year five their risk of relapse returns to the base rate of occurrence of the general population and are in remission as with other chronic diseases.

System form and function:

1. The **psychology of chronic illness** is the milieu within which the clinical targets reside.
2. Do not assume **associated clinical problems** are less important than the SUD itself.
3. Apply the **universal benchmarks** of wellbeing.
4. **All** clinical methods should be available.
5. Group therapy, Individual counseling, Coaching, Check-ups: sustained and individualized.
6. Outcomes are **rolled back in** for individualization of care.

A significant number of **clinical targets are pre-identified** from the relevant experimental and clinical literature. Some are brought in by the **individual patient's case data**. Some clinical targets represent **milestones** of improvement, some are only relevant within specific **critical thresholds** of time, and some targets remain **relevant throughout** the duration of service.

Focus Areas of the Patient, Clinician, and Patient-Clinician Team

Patient Activities	Clinician Activities	Shared Responsibility
The six core processes:	• Routine **check-up** intervals. • Group and individual counseling. Adjust dose, frequency, and duration.	**1. Process management:**
(1) Self-efficacy (in-gear effort, as pursuit, in the "do" direction)	• Provide clinical service with predetermined stage-specific relevance. • Data concerning the patient's condition is recursive to care. • Clinical service and check-up schedules are adjusted in emerging responses to new information.	Development of: emotion experiencing, mindfulness, acceptance, sense of self, meta-cognition, the relationship, attentional flexibility, values, cognitive flexibility, defusion /distancing.
(2) Distress tolerance (mindfulness-clutch, as release)	Assist in development of: emotion experiencing, mindfulness, acceptance, sense of self, meta-cognition, the relationship, attentional flexibility, values, cognitive flexibility, defusion/distancing.	Development of: 1) Self-awareness 2) Empathy 3) Mentalizing
(3) Self-inventory	Assist in development of: 1) Self-awareness 2) Empathy 3) Mentalizing	Illness self-management process
(4) Telling on one's illness	As critical thresholds of time and progress are met, move on to the targets and methods specific to the next relevant window of time	**2. Monitor & manage 3 areas:** 1) Problem indicators 2) Wellness indicators 3) Core processes
(5) Apply disease management knowledge & skills	Provide a Balint group method through years 3-5 focused on recovery management.	
(6) Apply recovery management knowledge and skills		

References

[1] Coon, B. December 1 – December 10, 2019. Addiction and the Stages of Healing (Introduction and Parts 1-11). *Recovery Review*.

[2] Coon, B. July 31, 2024. Addiction and the Stages of Healing – Full Text Version. *Recovery Review*.

[3] Mahood, S. S., Levy, D., Vasan, R. S. & Wang, T. J. (2014). The Framingham Heart Study and the Epidemiology of Cardiovascular Diseases: A Historical Perspective. The Lancet. 383(9921): 999-1008.

[4] Bao, Y., Bertoia, M. L., Lenart, E. B., Stampfer, M. J., Willett, W. C., Speizer, F. E. & Chavarro, J. E. (2016). Origin, Methods, and Evolution of the Three Nurses' Health Studies. The American Journal of Public Health. 106(9): 1573-1581.

[5] World Parkinson Coalition: History and Purpose. Retrieved from the world wide web on 11/26/19 at: https://www.worldpdcoalition.org/page/HistoryMission

[6] Coon, B. April 8, 2025. 5 Year Continuing Care System for High Severity, Complexity, and Chronicity SUD's: Clinical Targets, Methods, and Increments of Time. (2022 monograph). RM/ROSC Library of the William White archives: Chestnut.