5 Year
Continuing Care System for High Severity, Complexity, and Chronicity SUD's:
Clinical Targets, Methods, and Increments of Time

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Preface: ***"What is this document and why does it exist?"***

Beginning in the late 1990's, William "Bill" White launched a revolution in addiction-related work in the USA through a variety of projects with various colleagues and co-authors (Boyle, White, Corrigan & Loveland, 2001; Kelly & White, Eds., 2011; White, 2006; White, 2008; White, & Mojer-Torres, 2010). The revolution permeated otherwise-separated professionals and their sectors including academics, researchers, clinicians, policy, government, regulatory bodies, credentialing bodies, advocates, public health, etc. And this revolution ended up having an international reach.

What was the revolution? In short, the revolution was to **study recovery** – and to **have that inform treatment** – rather than to merely continue to study various treatments and compare them against each other.

That change is called a "recovery-orientation".

One of the simplest changes in a formal addiction treatment program based on recovery orientation and its lessons would be to schedule services in such a way that attending a mandatory clinical group therapy did not conflict with attending a community-based mutual aid meeting.

- That effort would be **structural and passive** – the changed structure of the treatment accommodates access to recovery support.

A slightly more advanced example would be to specifically inspire hope while providing care, based on accurate empathy and the positive contagion of authentic wellbeing – to function as a "recovery carrier" (White, 2012).

- That effort would be **integral and active** – the nature or quality of the people delivering clinical care would impart recovery as a contagion.

Pressure for change was present in those years. As Bill has pointed out in many of his writings, these included: 1) Increased awareness of the limitations of dominant treatments that are very brief, and the recycling of people through multiple treatment episodes over time without sustainable recovery; 2) Calls for conceptualization of addiction as a chronic disorder, rather than an acute disorder, and applying principles of disease management to the treatment of addictions (e.g. McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle & Loveland, 2003); and 3) Cultural and political mobilization of people in recovery and their families/allies to shift the governing center of the field toward support for long-term recovery.

But what about Bill's desire for the more formal research of recovery to inform treatment?

Prior to the influence of Bill and his colleagues, the formal description, evaluation, and application of recovery-as-information for clinical services was relatively uncommon in the academic literature, empirical research, and clinical-applied literature on addictions. As a result of adding a recovery-orientation to research, however, such efforts now abound by comparison.

One interesting source of information that has been gathered, compiled, and aggregated is from the people **being helped** and the people **doing the helping**. Naturalistic inputs from sources such as these are largely considered low-quality from an academic or research perspective and thus excluded or weighted most lightly in building formal practice guidelines. Those kinds of studies are ethnographic, observational, capture narrative storytelling, and so forth; their procedures do not reflect academically rigorous research methods.

But recovery-orientation has also impacted more formal, rigorous, and academic research. Studies of top academic quality that evaluate people seeking or maintaining addiction recovery, and follow them over years or decades, are now rather numerous. Rigorous methods have also been applied to program evaluation from a recovery-orientation perspective.

Bill has pointed out (White, 2022) that "most recovery definitions" include three core elements:

1. **Positive change in the person-drug relationship** - now measured by reported days of use, abstinence, or diagnostic remission – and also could include measures of craving, compulsion (loss of control over use), and negative use-related consequences;
2. **Improvements in global health and social functioning**;
3. **Citizenship** - cessation/reduction in antisocial behavior, evidence of prosocial community participation, and community service.

And he has inquired if these dimensions might be incorporated as universal measurements within the 5-year model this document proposes.

My approach in selecting clinical targets for this document has been to gather them from the relevant empirical literature and related sources. As a result, "positive change in the drug-person relationship" as he has outlined seems relatively well represented in this monograph.

I will state that by comparison the empirical literature seems to lack the coverage of global physical health and social functioning Bill identifies. Some rudimentary markers related to physical health such as age of death, years of life lost, various morbidity and mortality reports, etc. do seem to penetrate the research literature. But given the paucity of specific information in the research literature, this area of content is relatively lacking in the current document. If the reader is interested, I have addressed the possibilities within this treatment response domain and its related measurement elsewhere (Coon, 2019).

The empirical literature does a somewhat better job, though, at examining social function and also citizenship as Bill describes – but the work in these areas within our arena are still rather under-developed. In this document I do include work by Kelly, Greene & Bergman (2018) and their wellbeing indicator of a person's eventual involvement in their *own development* of their *own recovery capital*. However, work in that area within the empirical literature has not yet examined an array of measurable indicators and compared them to various methods attempting to address the relevant clinical targets that evoke such improvement. I agree with Bill that this area of empirical inquiry is a relative priority for our clinical work with this sub-population. In the meanwhile, it probably behooves the clinician to monitor, assist, and support this area of person-centered improvement.

Fortunately, rigorous research has been completed more recently that formally identifies the mechanisms of change and processes related to maintaining stable wellbeing for those with addiction illness – including clinical methods to promote and support such change. Such studies have extracted common underlying variables independent of a person's chosen personal pathway or means of personal support.

I had always assumed that well before now someone would have compiled and consolidated some of the later-arriving recovery-oriented academic research findings into a framework suitable for clinical implementation. If such work has been completed, I have not seen it. Now, having waited longer than I had hoped, I ventured out on my own to help distill and consolidate such work in writing. This document is my writing in that direction.

Although some dates of publication for studies I drew from in this monograph are quite recent, some of what I eventually suggested in this document for clinical implementation is far from new. For example, over ten years ago I made a visit to an IOP/aftercare provider that turned out to be wonderfully inspiring. The founder of the small not-for-profit organization was a then-older man who was himself in recovery. With calm conviction he warmly and passionately informed me of a policy he had been enacting. He stated that after completing his 12-month course of weekly group therapy for aftercare, any patient can choose to continue to attend forever, free of charge – as long as they are in a minimum of 4 mutual aid meetings a week and work regularly with a sponsor. That person was implementing Behavioral Health Recovery Management (BHRM) principles having never heard of the BHRM Project or Bill's name. Hooray.

And yet, I am not satisfied to have our field succeed on its own by instinct, intuition, or even purposeful intent in small and limited ways in matters related to this knowledge area. So, I wanted to pull together academically sound and recovery-oriented research, theory, and clinical practice materials, and begin to formalize a comprehensive framework and method for addressing complex, severe, and chronic addiction illness. My hope is this information can begin to inform systematic improvements in care.

As you proceed through this document, you will find it describes a 5-year model of care, identifies common assumptions that underlie our field and provides revisions of them, and outlines critical time frames within the five-year model. Those initial areas of content are probably more conventional and expected. But the document also outlines newer methods. These include 3rd wave CBT/ACT, structural models for long-term services, and material from outside our field related to the management of chronic illness and later-stage long-term group therapy methods we can apply to the formation of enduring recovery. The portion of the monograph addressing these newer methods is somewhat more instructive by nature, given those sections address areas of the field that are largely absent or significantly under-developed.

After the references and suggested readings, you will find an Appendix with two sections of content. First you encounter some supplementary information pertaining to the delivery of a

kind of group therapy specifically included for later-stage patients. Lastly you will find summary tables that consolidate the material found in this document. My idea for the summary tables is that these could be adapted or adopted for staff education, training, clinical team meetings, or clinical supervision to help us clarify our targets and methods with an eye toward fidelity and sustainability. I also have the idea they could be adapted or adopted for clinical direct service with patients and their family members to help inform, educate, inspire, empower, encourage, and support change more effectively in our mutual collaboration with them as a team.

The basics of this monograph are simple. Clinical service delivery for this sub-population should sit in ***a 5-year container***. The first 2 years is largely disease management and years 3-5 are largely recovery management. Within the 5-year journey the patient develops efficacy in ***managing their disease, recovery, and wellbeing***. There are four necessary ingredients of service provision: ***group counseling, individual counseling, coaching, and check-ups***. These four services happen across all five years, but they are individualized in frequency, duration, and content across the 5 years. And during that time, the clinician's attention to ***normed content*** is preserved as a constant, and the patient's responses over time are rolled back in for ***individualization of care***.

My disclaimer is as follows:

- This document is neither comprehensive nor exhaustive. To make it so would be beyond my personal scope to complete.
- This document is out of date by its nature even before it is completed; as research findings continue to become available, they can inform and improve our understanding and our methods.
- This document should not replace continuing education, clinical training, instruction, or clinical supervision.
- My use of the word "recovery" in this document is in its most simple sense, synonymous with "getting better". Its meaning is not linked to any particular mutual aid fellowship, academic, or government body's definition of recovery. At times my choice of that word reflects its use by an author whose work is being incorporated in the document.
- When I come across a more competent synthesis of research related to clinical care promoting long-term disease management and recovery management for persons with high severity, complexity, and chronicity SUD's, I'll gladly abandon use of this document.
- The basic frameworks and targets in this document are approximations; continuous evaluation of this model and inputs from outside research reports should be recursive to this model and refine it over time. This is a starting point, not a final document.

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5 Year Continuing Care System for High Severity, Complexity, and Chronicity SUD's: Clinical Targets, Methods, and Increments of Time

Treatment as usual in the substance use disorder (SUD) clinical arena is very short compared to the presenting needs of patients with high addiction severity, complexity, and chronicity (White, Boyle & Loveland, 2003). And this is also the case compared to the length of addiction illness and of the process necessary for the restoration of stable wellbeing (DuPont, 2016).

Some studies and descriptions of long term trajectories of those with severe SUD's exist (De Soto, O'Donnel & De Soto, 1989; Dennis, Foss & Scott, 2007; Dennis, Scott, Funk, & Foss, 2005; Hser, Hoffman, Grella, & Anglin 2001; Jin, Rourke, Patterson, Taylor & Grant, 1998; Jorquez, 1983; Klingemann, 2012; Martinellia, Nagelhouta, Bellaert, Beste, Vanderplasschend, & van de Mheen, 2020; Narcotics Anonymous, 2012; Schutte, Byrne, Brennan, & Moos, 2001; Vaillant, 1996, 2003, 2012; White & Schulstad, 2009) but incorporation of such information in routine clinical practice is not common.

Of further concern is that treatment as usual for SUD's is generally built upon a programmatic model (DuPont, 2015) rather than an on-going process that is: empirically-derived; reflects known stages of stabilization, improvement, and critical periods; and responds to the individual's trajectory of current and emergent needs, treatment response, and function.

One approach to improving upon the programmatic model has been the installation of evidence-based practices (EBP's) or wholesale removal of traditional programming and entire replacement of those with various EBP's. A full exposition of the inherent limitations and problems associated with the evidence-based practice movement, its research enterprises and clinical delivery is beyond the scope of this monograph. However, a few highlights relevant to long-term management of severe SUD's follow.

Marquis, Douthit & Elliot (2011) in their caution about best practices note that:

1. The phrase "best practices" often functions as a pretense to promote narrow/medicalized approaches to research methods and easily measured outcomes;
2. "Best" becomes institutionally dominant while other recovery and clinical practices are marginalized;
3. An emphasis on treatment models develops at the expense of the person (both the patient and the counselor), the relationship, and non-diagnostic characteristics of the person served.

They state that clinical judgment, intuition, creativity, and flexibility often suffer under manualized approaches. They also note that accompanying the phrase "best practice" is often a reduced appreciation of diversity considerations, developmental frameworks, person-

centered considerations, wellness, strengths, and a recovery-orientation rather than a pathology orientation. And that these often stem from the research trial world with single diagnoses, a focus on short-term treatments, and symptom reduction or acute treatment responses, rather than a real-world approach that is not of a pre-fixed duration, that is self-correcting, and whose focus is on overall improvement or recovery over the longer term. They question if in developing best practices we are measuring what is most likely to be studied, or most likely to work?

Further, the authors express concern that under a best practice emphasis: counselors are reduced to expert technicians implementing guidelines; clients are reduced to disorders; and it is harder for counselors to explore subjective dimensions of client concerns and sense of change strategies.

They state that by contrast, clinical and research methods should focus on understanding the basic principles and strategies of change. And thus, in the SUD arena, we could attend to alliance, empathy, goal-consensus, and collaboration – while we factor in levels of reactance, internalizing/externalizing coping styles, treatment preferences, and readiness for change. The authors conclude by emphasizing that the development of best practices should rest on 3 pillars: best research, clinical expertise, and client non-diagnostic characteristics.

William White (2008) summarized a vast body of literature within and proposed central changes for the SUD arena in a monograph focused on "Recovery-Oriented Systems of Care" and "Recovery Management." He comments on those concepts as follows:

> *"Recovery-oriented Systems of Care as a Macrosystem Organizing Philosophy. The phrase recovery-oriented systems of care…refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The 'system' in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested.*
>
> *Recovery Management as a Microsystem Organizing Philosophy. Recovery management…is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery. As we shall see, achieving both a recovery-oriented system of care and the implementation of a recovery management philosophy requires substantial changes in treatment philosophies, purchase of-care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships."*

Currently the clinical literature lacks a comprehensive synthesis of information for clinical care of severe SUD's that also begins to overcome the limitations and implement the principles that have been noted so far in this document.

This monograph attempts to respond to that lack in the clinical literature by outlining a continuing care system for high severity, complexity, and chronicity addiction illness. The content of this document frames and identifies methods and targets as they differ and change over time, as outlined by the empirical literature. (Though beyond the focus of this monograph, the reader might be interested in exploring consensus development as a formal methodology, e.g. Murphy, Black, Lamping, McKee, Sanderson, Askham, & Mateau, 1998). And in doing so, the material in this document rests upon three notions.

First, that SUD services for severe, complex, and chronic addiction illness should evaluate clinical effectiveness against full remission and wellbeing over the long term as the benchmark - **the same one best result** for all people served (DuPont, Seppala & White, 2015). Notably, such an approach would require a tobacco-free method (Prochaska, Das & Young-Wolff, 2017; Prochaska, Delucchi, & Hall 2004; Taylor, McNeill, Girling, Farley, Lindson-Hawley & Aveyard, 2014; Weinberger, Platt, Esan, Galea, Erlich & Goodwin, 2017).

Second, that providers of SUD services for that population should have **all methods** available, and not assume **associated clinical problems** are less important to directly address than the SUD itself.

Third, that SUD providers for patients with severe, complex, and chronic SUD's must incorporate two key matters related to **process management**. These are 1.) the methods found to be effective in management of chronic illnesses generally, and 2.) the psychological processes that underlie production of presenting symptoms across categories of psychological disturbance and diagnoses.

The monograph outlines these topics, provides theoretical and empirical bases for them, and begins to identify markers and methods applicable to these matters in clinical practice. While doing so it outlines the modulation of clinical targets and methods for SUD services as the average patient moves through time. Collectively, this information can aid the proactive standardization and responsive individualization of care for this sub-population.

These three notions and the resulting care model presented in the monograph can be understood in a historical context, as follows (White, 2022). Given that treatment providing and other organizations within the SUD arena arose independently and locally, the field split into siloed approaches with each claiming their own superiority. And by contrast, an essential principle of chronic illness management is the integration of multiple methods of treatment and support that are uniquely combined and sequenced over time for each patient based on a process of continual assessment. An example might be an integrated menu of medication

support, psychosocial support, and environmental interventions to support long-term personal and family recovery.

The content of the monograph is organized in the following major parts:

1. Overview of the 5 Year Model
2. Beyond Common Assumptions
3. Critical Time Frames
4. Psychology of Chronic Illness
5. Recipe of Clinical Methods

Part 1: Overview of the 5 Year Model

The image above shows 5 years of clinical engagement in SUD services for one person.

(One might immediately ask why the care model in this monograph includes a minimum of 5 years of length. In short, the accumulated empirical and clinical-applied evidence converge to show 5 years is the answer to question: "When does present sobriety/remission predict lifetime sobriety/remission?" This benchmark will be discussed, and its supporting evidence will be provided, later in the monograph.)

In the image above, the starting point of formal clinical engagement (which could be in either an outpatient or residential program, for example) is shown as the side wall in the foreground on the far left. The 5-year path is shown moving forward in time from left to right along the back wall.

The example shown is for one individual person; the red dots are different ***problem indicators***, and the green dots are different ***wellness indicators***. With regard to the inclusion of wellness indicators, it should be noted that literature concerning matters related to quality of life and wellness as SUD-related outcomes has emerged (e.g. The Betty Ford Consensus Panel, 2007; Bray, Aden, Eggman, Hellerstein, Wittenberg, Nosyk, Stribling & Schackman, 2017; Linden-Carmichael, Stull, Scott & Dennis, 2021).

Various indicators might be *continuous over time* – a particular red or green dot on the left might be the early measurement value of one factor (such as blood pressure). And another particular red or green dot on the right might be a later measurement value of that same factor.

Other indicators might be of a *discreet or categorical variable*, rather than a continuous one – a particular red or green dot might indicate the mere dichotomous presence or absence of a factor (such as employment status).

Over the five years, as this example shows, the active problem indicators are becoming **fewer** in number (less density) and are **falling**. And the active wellness indicators are **increasing** in number (more density) and are also **rising**. Even at the very start there are wellness indicators present (specific strengths, assets, resiliencies and so forth). And out at five years there are also some problem indicators that are still present.

It should be noted that some information found in the *theory* portion of the academic literature about multi-year trajectories for severe SUD patients also happens to be found in the *clinical-applied research* literature (e.g. Freed, 2021). And some of that information is also separately found in *experiences* and *understandings* accumulated and held over time among SUD clinicians as well as people overcoming serious SUD problems (Coon, 2022a). Content on the topic of long-term improvement for this sub-population of SUD patients that represents convergence from all of those sources is likely noteworthy.

One example of such remarkable convergence is the notion that certain critical time periods for people with severe, complex, and chronic SUD's seem to exist within their path of longer-term improvement. The segments of time that have notable congruence are listed below, and the supporting evidence for each will be presented later in the monograph.

Critical thresholds as a function of time:

- **First 4 appointments.** If the patient makes the fourth appointment, the 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 returns to the base rate of occurrence of the general population and are in remission as with other chronic diseases.

Before describing clinical targets and clinical methods as they should differ across these five years, some basic assumptions within existing clinical practices will be acknowledged and *eliminated* or *replaced*. That material, labeled "beyond common assumptions", follows.

PART 2: Beyond Common Assumptions

This portion of the monograph will begin to outline goals and practical action for the portion of the SUD field dedicated to the care of those with severe, complex, and chronic addiction illness – as improvements to longstanding practices built on common assumptions. Included in the scope of commentary are matters related to: inclusivity of all individuals and their data; broadness and therefore sufficiency of available clinical strategies including those specifically relevant to associated clinical problems; and shifting to an emphasis on self-management over time as the person improves. These will be addressed separately, in order.

A. Issues Related to Measurement

Totality of Measurement Strategy:

Treatments for this sub-population are typically based on findings from research studies leading to evidence-based practices. And delivery of treatments is typically improved at the program level by examining the results for those people that completed the treatment and were followed up. Both research reports and program evaluations rely on data from those that entered and completed the treatment (a protocol).

But we should include all people initially enrolled in clinical services, continuously over time, regardless of their ongoing enrollment status. And if we only study the uniform, compliant, responders, completers, and those that survive and participate in follow-up, what have we learned about everyone else? Put differently, "Why study survivors instead of those that drop out, no-show, or pass away?" (Coon, 2019).

How many years does it take to get one year of sobriety?

Treatment for this sub-population is typically aimed at stopping one's use. But quitting is diagnostic, not prognostic (see DSM-5-TR SUD criteria #2: persistent desire or unsuccessful efforts to cut back or stop use). As it has been famously put, "Quitting is easy – I've done it a thousand times." A far less common approach is to ask how many years it takes to get one year of sobriety.

Dennis, Scott, Funk & Foss (2005) state that "…rather than thinking of multiple episodes in terms of 'cumulative dosage,' it might be better thought of as further evidence of chronicity and that we need to develop and evaluate models of longer-term recovery management."

Thus, we should examine trajectories of the person's *addiction career, treatment career,* and *recovery career* as Dennis and his colleagues describe them. In the 5-year model it is far too limited to merely measure "outcome" variables before (pre) and after (post) a specific treatment episode, or even separate treatment episodes over time. For example, attending mutual aid meetings during care might say little about attending them after care is concluded.

One study (Witbrodt, Mertens, Kaskutas, Bond, Chi, & Weisner, 2012) following people across 9 years found subsets of patients.

- One subset showed the highest attendance of mutual aid and no use.
- The second showed high baseline alcohol severity, long treatment episodes, high initial mutual aid attendance and no use, but by year-5 their attendance and use resumed.
- The third subset evidenced high attendance and no use but low problem severity; they reported no mutual aid attendance after year 1.
- The fourth showed fairly high alcohol and psychiatric severity throughout and reported initially low attendance, followed by increasing attendance paralleling not using.

Aside from those four groups, two additional groups with low problem severity and very low severity/no attendance had the most use. Female gender and high alcohol severity predicted mutual aid attendance all years.

Thus, the summary of the study was to promote high attendance early but to avoid indiscriminate and generalized recommendations as identical for all problem severities.

In short, information of this nature represents a call to:

1. Exclude low and moderate problem severity persons (Linden-Carmichael, Stull, Scott & Dennis, 2021) from the 5-year model;
2. Examine trajectories over numbers of years;
3. Individualize strategies targeting factors that promote the person's continuing mutual aid and clinical *engagement* as an intrinsic ingredient of care (rather than relegate engagement and its related factors as ancillary to general improvement or merely a relational context of care).

Moos & Moos (2004) recommend that rather than quantify mutual aid participation as a dichotomous variable, one should examine frequency, duration, and trajectory of attendance. For example, they present a call to evaluate varying levels of delay to enter mutual aid following treatment for differential impacts, and to determine if those impacts are independent of treatment. In keeping with their recommendations, one could construct a self-monitoring form or dashboard in the patient record system to track this data for clinical use. They also recommend examining psychological and social outcomes, rather than mere substance use, and using-related outcomes other than mere abstinence.

This recommended approach of examining psychological and social outcomes rather than mere abstinence, and using-related outcomes other than mere use, is approximated by a recent study (Eddie, Bergman, Hoffman & Kelly, 2022). The authors examined a nationally-representative sample of people who endorsed the question, "Did you used to have a problems with drugs or alcohol, but no longer do?" by stratifying their amount and recency of use against functioning and wellbeing. Findings

included that the best functioning and wellbeing were among those with no use, but they also found improvement (albeit less) among those with some use.

One benefit of that study (examining a range of function and life satisfaction rather than abstinence only) is echoed throughout the current document. One limitation of that study is that the information was self-reported among those for whom the clinically confirmed presence of a substance use disorder was unknown. Thus, it is also not known if those continuing some use, but experiencing some improvement, had a DSM-5-TR SUD in the mild, moderate, or severe range. Another key limitation of that study was that the data was collected cross-sectionally in time rather than longitudinally; we are left without an indication of the relevance of their findings as a function of course over time. The current document proposes a model that overcomes the limitation of strictly cross-sectional data gathering and lack of longitudinal follow up.

Overall, our field continues to await long-term prospective follow-up of individuals diagnosed with DSM-5-TR SUD severe in research studies examining quality of life, a broad array of indicators of life function, and subjective wellbeing.

B. Sufficiency of Clinical Method

Totality of Clinical Perspective and Distribution of Techniques:
The SUD clinical service arena largely consists of geographically and relationally siloed programs with limited methods or special focus of programming. Or a variety of such programs under a larger organizational banner, but that function independently.
The SUD treatment field should re-engineer to academically educate and clinically train all SUD professionals in the essential/basic information and skills related to all existing major clinical programs/methods. For example, academic coursework and initial practice-related training could include ***validating exposures*** to: prevention, child and adolescent, adult, senior, harm reduction, moderation management, MAT, IOP, residential, long-term residential, aftercare counseling, pre-treatment or recovery priming in individual and group counseling, recovery coaching, peer support, etc.

And in this combination of a total perspective and all available techniques, there is no presumption within the proposed model of implementation that any particular…

- initial **engagement strategy** (such as harm reduction methods or a professional intervention);
- type of **setting** (such as a residential treatment program or sober residence) or **service** (such as an intensive outpatient program); or
- **medication management strategy** (e.g. medical withdrawal management, opioid maintenance therapy using agonists or partial agonists, other medication strategies including pharmacological agents with or without addiction potential for either SUD or mental health indications);

is used or not. Rather, all engagement methods, settings, services, medications, and their related strategies should be available, including in combinations (Coon, 2021).

Collectively, this approach reflects what Hofmann and Hayes (2019) have summarized as "the decline of general schools" of therapy and the "rise of testable models" as it applies to care of this SUD sub-population.

- Their paper describes a mega-trend in mental health counseling where pre-packaged total treatments specifically matched to a particular diagnosis will give way to therapies targeting underlying psychological processes that promote differences in clinical signs and symptoms across disorders.
- Applied to the SUD treatment response to severe addiction illness, the broad empirically-rooted approach delineated by the 5 year model combines methods and does so in an on-going way regardless of classic program structures. This allows evaluation of therapeutic ingredients rather than mere total programs.

Two related questions (Coon, 2019) that illuminate some opportunities for improvement are as follows:

1. "What if we had the competency and skill analogous to dentists: health across the lifespan, preventative care, problems from tiny to life-threatening, and held all available routine clinical methods?"
2. "What if we had something similar to the kind of knowledge that allows for routine maintenance and preventative care of automobiles, and the service structures to go with it (no appointment necessary, expert technician, short appointments, known service intervals, etc.)?"

Beyond the importance of the totality of measurement and sufficiency of clinical method, clinical work for severe, complex, and chronic addiction illness should also specifically consider and address **associated clinical problems**. Some of these, such as Post-Acute Withdrawal Syndrome (PAWS) and free-standing cognitive impairments, can necessitate separate and specific evaluation and clinical care. That is, major problems often associated with severe, chronic, and complex SUD's may be present, and predictably emerge as a function of time. One such example follows.

C. <u>Associated Clinical Problems</u>

Post-Acute Withdrawal Syndrome (PAWS)

Haskell (2022) states, concerning PAWS that "…literature on this topic is limited but growing steadily…Providers must assess PAWS symptoms on an ongoing basis and decide, along with the patient, to continue, decrease, or discontinue medical interventions. Providers should also assess for relapse in patients as this is an ongoing risk."

Lerner & Klein (2019) note, "Protracted withdrawal syndrome is not only characteristic of drugs of abuse but also was described for nonscheduled drug classes, such as SSRIs and antipsychotics. In this study, we present some known examples of post-acute withdrawal syndromes."

> And no less than the Substance Abuse and Mental Health Services Administration (SAMHSA; 2010) states, "Despite clinical observation and clients' reports of symptoms experienced past the acute withdrawal stage, the research on protracted withdrawal (particularly for substances other than alcohol) is limited, and no consensus on the term or definition exists. These reasons have precluded the Diagnostic and Statistical Manual of Mental Disorders from including a protracted withdrawal diagnosis for any psychoactive substance. For these reasons also, this Advisory does not provide timeframes for protracted withdrawal as is done for acute withdrawal…"
>
> Gorski & Miller (1986) delineate specific PAWS targets in their foundational work.
>
> For specific problem indicators related to PAWS in the 5-year model, the clinician would import the list of known PAWS symptoms associated with the relevant substances/classes and observe, assess, and symptomatically relieve those signs and symptoms. For specific wellbeing indicators, the clinician would import methods relevant to proactive stress prevention and stress management and observe for implementation of these lifestyle and self-care activities.

But beyond addressing associated clinical problems, providers must also incorporate *process* management methods. These take two forms. One concerns clinical techniques that help develop the patient's process-related strategies for **management of chronic illnesses.** The other are those that address the **general psychological processes** that underlie production and manifestation of psychological presenting symptoms.

A full description of the evolution of evidence-based practice away from matching total treatments to separate categorical syndromes, and toward improvement of psychological mechanisms that underlie a variety of disorders, is beyond the purpose of this monograph. What follows are clinical structures related to **core processes**, **self-care processes**, and **illness self-management processes**.

D. Self-Management

We should add to our clinical attention matters of process and proximal markers of fuller improvement. Clinical care should focus on themes such as: patterns of participation, motivations for and perceptions of benefit, and reducing barriers to mutual aid engagement; attending to matters such as these would raise remission (Moos & Moos, 2005).

Subbaraman & Kaskutas (2012) show us helpful points in this regard. Specifically, over a quarter of the effect size of treatment is explained by social support. Thus, it is important to intervene on this variable. For example, control of comfort being and speaking at mutual aid meetings is important; comfort variables are highly predictive of abstinence. Further, those with less mutual aid exposure may need to focus on basic principles and receive basic education about their chosen mutual aid modality before they benefit from measures that emphasize comfort with their chosen fellowship.

What follows is a table of targets and methods pertaining to Core Processes, the Self-Care Process, and Illness Self-Management Processes. The information is divided by those categories and stratified by various sources (theorists, researchers, etc.) on an author-by-author or source-by-source basis. The reader should note that in the 5-year model the targets and methods reflected in this table would be continuously relevant across the 5 years, by their nature.

Author(s)	**Core Processes**	
Hofmann & Hayes (2019)	Assist in development of: emotion experiencing, mindfulness, acceptance, sense of self, meta-cognition, the relationship, attentional flexibility, values, cognitive flexibility, and defusion/distancing	
Galanter (2014)	Assist in development of the following mechanisms: 1) Self-awareness 2) Empathy 3) Mentalizing (ability to recognize one's own and others' mental states, and to see these mental states as separate from behavior)	
Author(s)	**Self-Care Process** (continuous through time, not stage-specific)	
	Problem Indicators	**Wellbeing Indicators**
Melemis (2015)	1) Bottling up emotions 2) Isolating 3) Not going to support meetings 4) Going to support meetings but not sharing 5) Focusing on other people's problems or how other people affect them 6) Poor eating and sleeping habits	1) Make time for themselves 2) Be kind to themselves 3) Give self the permission to have fun 4) Identify their own denial
Author(s)	**Illness Self-Management Process** (continuous through time, not stage-specific)	
	Problem Indicators	**Wellness Indicators**
Melemis (2015) *Assist in development of process management* 1) Change your life 2) Be completely honest 3) Ask for help 4) Practice self-care including mind-body relaxation 5) Don't bend the rules.	1) Craving for drugs or alcohol 2) Thinking about people, places, and things associated with past use 3) Minimizing consequences of past use or glamorizing past use 4) Bargaining 5) Lying 6) Thinking of schemes to better control using 7) Looking for relapse opportunities 8) Planning a relapse 9) All or nothing thinking in event of a slip	1) Identify and manage triggers 2) Avoid or proactively manage high risk situations 3) Rapidly report a slip and return to active self-management 4) Becoming comfortable with being uncomfortable 5) Separates self-care from being selfish

Galanter (2014) Assist in development of process management that concerns mutuality (the building of relationships)		1) Emotional contagion 2) Cognitive perspective taking 1) Understanding and experiencing another person's mental and emotional state 2) Sharing of self-other representations 3) Being motivated to improve another person's experiences
Morgenstern, Bux, Labouvie, Morgan, Blanchard & Muench (2003)		1) Mutual aid attendance pattern 2) Level of reliance on mutual aid coach 3) Level of mutual aid affiliation 4) Engagement in mutual aid related activities 5) Level of use of personal spiritual path 6) Use of mutual aid resources for advice or information 7) Degree of mutual aid-centered life

So far, this document has highlighted some major revisions for our work. For example:

1) SUD services for chronic, complex, and severe presentations should evaluate clinical effectiveness against the same best result for all people served;
2) Providers of such SUD services should have all methods available;
3) Providers of SUD services should not assume associated clinical problems are less important to address directly than the SUD itself;
4) SUD providers must incorporate *process* management methods. These include patient strategies for management of chronic illnesses, and of general psychological processes that underlie manifestation of presenting symptoms.

We now turn our attention to clinical targets and methods as they are currently known to *specifically and predictably differ* over time.

Part 3: Critical Time Frames

A. **<u>4th Outpatient Appointment.</u>** The Network for the Improvement of Addiction Treatment (NIATx) concerns itself with improving the SUD treatment sector through empirical approaches as well as bottom-up innovation using structured methods. Their national efforts have shown that an outpatient admission (starting in outpatient or transferring from residential) is a "take" if the patient comes to the first four sessions in a row. Their aim in this regard is to, *"Increase continuation from the first through the fourth treatment session."*

B. **<u>30 Days.</u>** According to the common oral tradition of clinical staff in many treatment organizations and many members of 12 step fellowships, the first 30 days is a well-known period against return to using and important for regular attendance of mutual-aid meetings.

C. **<u>90 Days.</u>** A duration of 90 days of primary care in a residential setting or IOP service is the Standard of care for length of treatment (SAMHSA); and for treatment of health professionals, especially physicians (Federation of State Physician Health Programs). Interestingly, 90 days is also the early remission threshold for SUD's (American Psychiatric Association, 2022). Although attending "90 meetings in 90 days" is a common colloquial phrase among addiction counselors, many might not know that the Basic Text (Narcotics Anonymous, 2008) suggests that going to a meeting each day for the first 3 months "…is a good idea."

90 Days		
	Problem Indicators	**Wellbeing Indicators**
Kelly, Greene & Bergman (2018)	Self-esteem, happiness (drops the first 6 months, then improves)	
Kelly, Hoeppner, Sout, & Pagano (2011)	Reducing pro-drinking network	Enhancing self-efficacy

D. **<u>1 year.</u>** Congruence among kinds of facts and information abounds concerning the critical period of the first year. The first 12 months is found in the following as a clinically relevant framework of time: outpatient aftercare standard duration for the Federal Bureau of Prisons, ASAM Level 1 by clinical tradition, and the Gorski model of relapse prevention therapy. 12 months is also the sustained remission threshold in the DSM-5-TR (American Psychiatric Association, 2022). Many 12 step fellowships hold the first year as a celebratory milestone by their oral tradition.

First Year		
Author(s)	**Problem Indicators**	**Wellbeing Indicators**
Hoffmann (2016): First year template	1) Have you used since last follow-up? Yes/No; 2) Days of use since last follow-up? By drug. 3) Based on # 1 above, problems associated with use: a) spent more time <u>drinking/ using</u> than intended? b) Neglected usual responsibilities because of <u>drinking/using?</u> c) Wanted to cut down on <u>drinking/using?</u> d) Has anyone objected to your <u>drinking/using?</u> e) Have you found yourself thinking a lot about <u>drinking/using?</u> f) <u>Drank/ used</u> to relieve emotional distress, such as sadness, anger or boredom? g) Are there are any other problems associated with use?	1) Have you attended mutual aid meetings since last follow up? Yes/No 2) If yes to meetings #1 above, what frequency of attendance? a) What number per week? b) What number per month? 3) Are you attending any other professional services since last follow-up?

First Year		
Author(s)	**Problem Indicators**	**Wellbeing Indicators**
Chih, Patton, McTavish, Isham, Judkins-Fisher, Atwood & Gustafson (2014)	Sleeping problems Depression Urges Risky situation Relationship troubles	Answer the weekly check-in Confidence Mutual aid meeting or religious activities Other activities; Time with family
Kelly, Greene & Bergman (2018)	Psychological distress	Happiness Self-esteem Quality of life
Kelly, Hoeppner, Sout, & Pagano (2011)	Reducing negative affect Change in social networks	Self-efficacy in high-risk situations Improving psychological wellbeing Coping, Motivation Change in social networks Fostering spirituality
Kelly, Stout, Magill, Tonigan & Pagano (2010)	Decreased depression Decreased negative affect	Hope Universality Cohesion with a support group Catharsis
Kelly, Stout, Magill, Tonigan & Pagano (2011)	Self-directing spiritual style Deferring spiritual style	Mutual aid attendance Find or form own personal spiritual system Pursue personal spiritual pathway Collaborative spiritual style (as shown effective in coping with other chronic illnesses)
Moos & Moos (2004)	No mutual aid attendance year 1 Limit of 2-4 meetings per week for year 1 Delaying participation for a year	More than 4 meetings a week for the first year

E. **<u>2 years.</u>** The opioid maintenance therapy literature in aggregate notes the main gains happen in the first year but are retained after participation through the second year. Some professional monitoring contract lengths are 2 years rather than five, by clinical oral tradition. And PAWS is known and shown to last through the second year for some individuals (Gorski & Miller, 1986; Lerner & Klein, 2019; Haskell, 2022).

Second Year		
Author(s)	**Problem Indicators**	**Wellbeing Indicators**
Melemis (2015)	1) Mood swings 2) Anxiety 3) Irritability 4) Variable energy 5) Low enthusiasm 6) Variable concentration 7) Disturbed sleep 8) Cravings 9) Using	1) Accept that you have an addiction 2) Practice honesty in life 3) Develop coping skills for dealing with cravings 4) Become active in self-help groups 5) Practice self-care and saying no 6) Understand the stages of relapse 7) Get rid of friends who are using 8) Understand the dangers of cross addiction 9) Deal with post-acute withdrawal 10) Develop healthy alternatives to using 11) See yourself as a non-user
Starting after year 2		
Author(s)	**Problem Indicators**	**Wellbeing Indicators**
Melemis (2015)		1) Overcome negative self-labeling and catastrophizing 2) Understand that individuals are not their addiction 3) Repair relationships and make amends when possible 4) Start to feel comfortable with being uncomfortable 5) Improve self-care and make it an integral part of lifestyle 6) Develop a balanced and healthy lifestyle 7) Continue to engage in mutual aid groups 8) Develop more healthy alternatives to using
Kelly, Greene & Bergman (2018)		Recovery capital
Kelly, Magill & Stout (2009)	Low/Lack: Self-efficacy, Commitment to abstinence, Active coping efforts, Primary appraisal, Mutual aid attendance Reading mutual aid literature Completing mutual aid homework	

F. **<u>5 years.</u>** At 5 years the risk of recurrence returns to the base rate of occurrence of the general population (White & Kelly, 2011, pg 71). Five years is the physician health program standard monitoring duration (DuPont, McLellan, White, Merlo & Gold, 2009). It has also been used as a benchmark of comparison by a variety of researchers and theorists (e.g. Dennis, Foss & Scott, 2007; DuPont, 2015; Kelly, Bergman, Hoeppner, Vilsainta & White, 2017; White, 2013).

Five Years		
Author(s)	**Problem Indicators**	**Wellbeing Indicators**
Kaskutas, Ammon, Delucchi, Room, Bond & Weisner (2005)	Never "connect" with mutual aid Negative disengagement from mutual aid (e.g. slip or fall off of attending)	Positive disengagement from mutual aid
DuPont (2015): in remission as with other chronic diseases		
Melemis (2015) 3-5 years	1) Put their addiction behind them and forget that they ever had an addiction; feel they have lost part of their life to addiction and don't want to spend the rest of their life focused on recovery; start to go to fewer meetings. 2) As life improves, focus less on self-care; take on more responsibilities and try to make up for lost time; in a sense, trying to get back to their old life without the using; stop doing the healthy things that contributed to their recovery 3) Feel they are not learning anything new at self-help meetings and begin to go less frequently 4) People feel that they should be beyond the basics; think it is almost embarrassing to talk about the basics of recovery; embarrassed to mention that they still have occasional cravings or that they are no longer sure if they had an addiction. 5) Think that they have a better understanding of drugs and alcohol and, therefore, think they should be able to control a relapse or avoid the negative consequences	1) Identify and repair negative thinking and self-destructive patterns; 2) Understand how negative familial patterns have been passed down, which will help individuals let go of resentments and move forward 3) Challenge fears with cognitive therapy and mind-body relaxation 4) Set healthy boundaries 5) Begin to give back and help others 6) Reevaluate one's lifestyle periodically and make sure the individual is on track 7) Need to understand that one of the benefits of going to meetings is to be reminded of what the "voice of addiction" sounds like, because it is easy to forget

G. <u>"Five years after the last clinical touch".</u> Dr. DuPont discussed full remission and wellbeing, and the durability of improvement with me in personal communication (2016). He stated the standard of comparison he wishes our field would adopt is actually "Five years after the last clinical touch". He stated we should wonder how someone is doing *five years after* the five years of care are concluded, not just *during* the five years of care. He said he wanted to know how people were doing "Five years after the last clinical touch."

But what about the person's own perspective of their own history – their historical drug use, attempts to change, and involvement in clinical care? Naturally, their own perspective of these matters pre-dates their time in the five-year model and outlasts the end of the five year model.

One set of operational definitions for these segments of personal experience are as follows:

- **Addiction career:** the time from the person's initial use until 1 year after their last use.
- **Recovery career:** the time from the person's first attempt to stop until 1 year after their last use.
- **Treatment career:** the time from the person's first formal counseling, detoxification, or treatment attempt until 1 year after their last use.

During that journey the person might encounter a variety of **struggles with meaning-making**. This struggle could concern their functional status, illness, assistance received, and matters of personhood such as personal identity.

For example, Murphy and Irwin (1992) describe, pertaining to the personal journey of methadone maintenance patients, that they might:

- experience **"identity limbo"** where the person is considered "not in recovery" by the recovery culture, "sold out to the system" by those in active addiction, and "still addicted" by the uninformed lay-public;
- thus maintain the **"concealing work"** of efforts to hide one's status;
- resulting in **"pretense awareness"** (the patient and another person both knowing the person's status, but neither one acknowledging it to the other, while being aware the other person is aware) with some people in their lives.

Likewise, some addiction professionals make every effort to side-step the word "recovery" due to its tribal connections to 12 step fellowships. Others do the opposite and expect the patient to eventually and consciously adopt a personal identity of "in-recovery" using that language.

As an alternative to avoiding or requiring a particular identity shift, the reader might be interested in pursuing the body of literature called "Possible Selves" and its relevance to mechanisms of change during clinical care for severe substance use disorders. The Possible Selves literature describes the common human cognitive operations involved in: exploration of possible future selves (aka "identities") both hoped-for and feared; the prioritization of those; selection processes of a "self"; and ultimate establishment of a goal related to the self that was chosen and the tasks to achieve that goal. Possible Selves and their associated cognitive

processes have been formally evaluated as they co-vary with Stages of Change model metrics in a long-term substance use disorder treatment context (Dunkel, Kelts & Coon, 2006). Accordingly, we now turn to the psychology of chronic illness and include it in the 5-year model.

Part 4: Psychology of Chronic Illness

The clinician should include **the spiritual dimension of the person** in understanding the person (bio-psycho-social-spiritual). These factors may contribute to a fundamental match or mismatch between the patient and counselor on a number of dimensions including basic **understandings** (of the problem, the goal, etc.), practical **role expectations** (e.g. what happens during sessions, between sessions, etc.), and the **rationale for care** (Coon, 2022c).

Additionally, the course of illness and related life events prior to their first visit in the five-year model might have strained, changed, or entrenched the patient's personal cosmology, basic belief system (e.g. values, spirituality, religion, etc.), or multi-generational assumptions significantly. Alternatively, the person may have experienced a clarifying improvement in how they represent their search for help, relief, or answers to life's questions.

Particularly, the patient might hold a belief system that resembles a theistically-informed view of their disturbance or of a personally-proposed path toward improvement (Hollis, 2013a, 2013b; James, 2016). Regardless, the spiritual dimension is important for the clinician to consider and bring into the case conceptualization as a part of the psychology of chronic illness.

This relative match or mismatch can show up quite early in the professional relationship, and concern matters that are rather elementary and practical. For example, the counselor might have an anti-medication bias while the patient is seeking or undergoing a medication-maintenance therapy as a method of improving (White & Coon, 2003).

Further, the clinician should consider **the psychological implications of chronic illness** as a particular personal experience.

Goodheart & Lansing (1997) provide a practical framework with general applicability to understanding and addressing persons experiencing a chronic illness. Their framework applies regardless of the category of problem (primary health, psychiatric, substance, etc.) and can serve as a starting point for understanding the person's reaction to and position toward their own condition.

A full treatment of their content is outside the scope of this monograph. Some of their contributions are summarized below. Their method consists of the following factors:

A. **Holographic View of Illness**. This is described as the notion of the wholeness of the *person*, their *illness*, and the *care* they receive in view as *one totality*. This centrality-based yet multi-view approach promotes better detection of relevant factors that might improve or undermine the whole.

The clinician can retain the whole of the *person/illness/care* in mind while bearing with the person, and in that way retain sensitivity to the interdependence *of the three, for the whole.*

B. **Disease Perspective: Medical Template & Threat Template.** The medical template frames the disease on dimensions of "outcome, process, etiology, and needs". The threat template shows a continuum of disease severity from "life threatening, to progressive, unpredictable, and manageable."

   The clinician can hold readiness to educate or encourage the patient concerning the patient's illness itself on its own terms – toward maximizing self-efficacy, and accurate hope. These matters remain relevant as the patient shifts, improves, and specifically resists over the years of the five-year model (independent of a "recovery identity" and other culture-bound matters that might promote or undermine progress in the work or wellbeing).

C. **Response Template. "**The response template shows a continuum of awareness and adaptation to disease." For severe, chronic, complex SUD's, this template brings to mind topics such as hope, self-efficacy, partnering, and an oasis of resources from which to draw.

   The clinician can consider if the patient takes on less helpful postures, including being lost and absorbed within the illness, or obfuscating their own basic acknowledgement of the facts and related understandings of their condition.

D. **Psychological Template**. This frames *personality structure and functioning* including topics such as "reality, anxiety, relationships, cognition, and mastery-competence" in management of the illness and of wellbeing.

   The clinician can consider to what extent the patient's personality facets promote functioning within their personal wellbeing, related change and support strategies, or progression of signs, symptoms, and etiology of their illness.

E. **Chronic Disease Psychological Strategies**. This work takes on two components.
   1. *Shared patient-clinician tasks* including, "facing the challenge to self and identity", reorganization and "reshaping of a changed self (according to coping resources and illness trajectory); "achieving the desired outcome for the patient"; and providing a structure and process "to support the 'hold' of the therapeutic work".
   2. *Treatment strategies* including: obtaining sufficient medical information; assessing the response to illness and psychological status; integrating the clinician's theoretical orientation and the illness; offering a menu of

interventions; matching the psychological focus to the need; and facing countertransference responses.

Within the framework of the psychology of chronic illness, in the proposed 5 year model, is the notion of **receiving coaching** (Loveland & Boyle, 2005) and **participating in checkups** (Scott & Dennis, 2003; Scott & Dennis, 2011; Linden-Carmichael, Stull, Scott & Dennis, 2021). These become both a **contextual container** for, and a **service within**, the 5-year model.

Coaching and check-ups have both undergone continuing evaluation, refinement, and evolution of their implementation for SUD's. For example, Linden-Carmichael, Stull, Scott & Dennis (2021) note that among other impacts the effect of checkups, "…on positive change outcomes of satisfaction, cognitive avoidance, and self-efficacy was apparent for approximately the first year after the intervention, waned for years two and three, and then increased during the last few quarters of monitoring…"

They go on to describe "…ongoing monitoring that occurs at least quarterly over several years and early-intervention when problems may escalate."

They also discuss the enduring impacts and adaptability of these methods. They state that "…This empirical demonstration…helps establish the value of this longer-term approach to improve outcomes by showing additive effects in the early quarters. However, it also shows a diminishing return of simply continuing to do the same thing indefinitely." They state that coaching, "…and other longer-term interventions will likely require modifications over time to maintain the positive impact."

Previously, Witbrodt, Kaskutas, Bond & Deluchi (2012) had found that, after controlling for mutual aid attendance, high sponsor/coach activity predicts better outcomes, overall.

And so, what essential methods can be employed to maximize benefit and likelihood of the best enduring effects for this severe, chronic, and complex SUD sub-population? The next portion of this monograph outlines such a recipe of clinical methods.

Part 5: Recipe of Clinical Methods

Collegiate recovery programs, professional monitoring programs, and some criminal justice-related programs serving the SUD population are known for high levels of effectiveness compared to treatment-as-usual for patients within the routine SUD arena. And they each achieve these results with differing sub-populations that are known as hard to treat. Upon careful observation, one may note these programs have **shared features** that provide hints at methods for long-term management of complex, chronic and severe addiction illness (Coon, B., 2015; Crowe, Hennen & Coon, 2017).

Carefully considering the structural and functional components of these three very different systems reveals some similarities - and these features differ significantly from treatment-as-usual (Coon, 2022b). Each of these three systems:

- Take the long view
- Use a multi-year structure
- Work in the natural or indigenous environment
- See the family as central rather than peripheral
- Work with person-centered goals using contingency management

We can apply these shared structural and functional methods to the current model.

Earlier in the course of care specific goals/rewards and various contingencies (as defined by the person served) may incent initial engagement, early change-work, and retention. But later in care the incentive structure should shift toward a values-based or internalized desire to continue in long-term follow-up services for the sake of continued wellbeing. Ensuring these earlier and later differences in strategy and incentive are real, preserved, and effective is the duty of the addiction counselor, not the patient.

The **twin strategies** of ***downforce*** on problem indicators and simultaneous ***up-force*** in support of wellbeing indicators, implementing the clinical strategies that specifically promote the relevant mechanisms of change for each, are employed simultaneously (Hennen & Coon, 2020).

These twin strategies are retained regardless of the patient's length of time in care and their stage of progress in response to care. Within the first two years of a person's engagement in the five-year model, referral to and between existing types of pre-existing clinical SUD programs would tend to suffice, on the whole. That is, existing treatment-as-usual is built for management of immediate needs over the shorter term.

Regardless, the clinician should modulate the relative emphasis of downforce and up-force over time, according to the current presenting picture. And in the larger picture, the clinician should expect a shift from a general emphasis in symptom reduction in the first 2 years to up-force methods as the person progresses, around or soon after the second year.

But in our SUD arena, continuing clinical services from the second year through five years are missing. A model for longer term group work is presented below. For context, consider that by this point in the patient's trajectory, immediate stabilization, engagement, important change work perhaps in a "treatment" program has already been concluded. At this stage, the approach to group work would differ from routine group therapy in the SUD arena, by necessity. What could the methods, targets, and framework for group therapy consist of for years 3-5?

Incorporating Balint Group methods for group counseling during years 3-5

Does a group therapy model exist that specifically targets the space between the attendee and their long-term mindful navigation of life and life's duties? One that is fitted to the target of "recovery-surfing" during years 3-5 of clinical service and personal navigation of establishing, maintaining and improving personal wellbeing? The Balint Group model (with some modification) is proposed as suited to these needs.

Attending a "Balint group" is a standard part of the training of Family Practice physicians during their years of residency. The group is typically led by a psychoanalyst or at least a psychodynamically-oriented clinical psychologist. Members attend the Balint group over a long duration (years). What is the focus of the group? They present and discuss cases they find challenging or difficult to manage. But the area of interest and topics addressed within the group process is the **space between** the physician and the challenge.

Long-term attendance of a Balint Group by a family practice physician achieves a number of results. Some of these include:

- Management of transference, counter-transference, and their themes over time;
- Preventative maintenance of the clinician in the face of accumulating multi-generational debris within the community where the clinician and patient reside;
- Improving or at least maintaining clinician effectiveness in the face of a long-term career sitting within a multi-generational community context.

This particularly applies to years 3-5 of this 5 year model. At that developmental stage of improvement, the switch from disease management to recovery management is occurring and has occurred. Thus, the question becomes, "How does one navigate one's own recovery from the position of mindfulness, noting the space between self and one's own recovery?" It is the development, surfing, and improvement of wellbeing that is the general target during that timeframe.

The "doctor-patient" relationship in the Balint Group method would change to the "person in recovery-recovery itself" relationship. And at times the focus would be the "person in recovery-family member" relationship.

A more detailed discussion of the content, method and relevance of this model of group therapy for years 3-5 within the 5 year framework is in the Appendix of this document.

The main body of content for this monograph has now been presented. The following pages contain a **summary/conclusion**, the **references** and **supplemental readings**, an appendix with a discussion of the **Balint group model** and its application to this sub-population, and a consolidation of the targets and timeframes in a **table format** for easy practical use.

Summary and Conclusion:

White (2008) summarized key variables upon which disease management/recovery management of chronic, severe, and complex SUD's could be built. Those variables reflected the revolution of clinically adopting a recovery orientation (combining a macro-level recovery-oriented systems of care approach, and micro-level disease management and recovery management approaches). Currently, our field languishes relatively unchanged within each variable. The current monograph has provided a remedy for each variable, separately, and has done so in the form of a coherent whole system.

Those key variables (with examples of relevant concepts and practices contained in this monograph in italics) are as follows:

1. **Attraction** (e.g. assertive intervention at precovery stage; motivation as a treatment outcome rather than a prerequisite for admission, etc.).
   The suggested 5-year clinical method assumes no "right" or "wrong" initial door of entry, or type of initial service.

2. **Access** (e.g. proactive resolution of obstacles to engagement).
   Beyond the above, the suggested model educates and informs the patient and family on the model prior to the start of care, and includes ongoing coaching and check-ups from the time of the initiation of services.

3. **Retention** (e.g. continual re-engagement; abandonment of administration discharge for symptomatic behavior – clinical rather than disciplinary management ala White, Scott, Dennis & Boyle, 2005).
   In addition to the basic framework of continuous provision of group and individual counseling, coaching, and check-ups in a recursively inclusive process across 5 years, the model holds all SUD services available as possible referral options during the years of engagement.

4. **Screening and Assessment** (e.g moving from the older notion of assessment as a pre-intake or post-intake activity at one point in time, to that of a continual process).
   The proposed model outlines continually relevant targets, critical time frames, developmental stages with related clinical targets and milestones, with continuation of these processes over years.

5. **Composition of Service Team** (e.g. the inclusion of peer recovery support and indigenous healers).
   The proposed model: integrates elements of this factor as an essential ingredient in the care system; targets, promotes, and assesses the patient's linkage in the community; and addresses personal involvement and style of relationship with their chosen 1:1 helper in their support network.

6. **Service Relationship** (e.g. from technical expert to sustained partnership models).
   The proposed methodology includes this shift over time (noting the developmental challenges of two major and distinct phases) as well as a novel group methodology and counseling milieu for promotion of illness self-management, through "recovery surfing", and recovery self-management processes, and assessing development of a collaborative spiritual style and healthy autonomy.

7. **Service Dose, Scope, Quality** (e.g. expansive time and service menu; rigorous evaluation of recovery outcomes—**see later note**).
   The methods proposed in this monograph range from the widest possible scope of all services, to dose factors of intensity (such as possible admission to a formal program) and of duration. Quality is addressed through combining proactively normed targets with individually recursive planning, as well as group methods from outside the field promoting open exchange and autonomy.

8. **Locus of Service Delivery** (e.g. from clinical setting to natural environments; family support).
   The proposed model construes family as central rather than peripheral with their inclusion from the outset; coaching and check-ups are not always tied to institutional settings.

9. **Linkage to Recovery Community Resources** (e.g. assertive rather than passive).
   The monograph details clinical matters such as targets and methods specific to timing, duration, group and individual mutual aid methods, and the nature/quality of these activities, as well as developing a collaborative style.

10. **Post-Stabilization monitoring and support** (e.g. from aftercare as an afterthought rather than long-term recovery check-ups and early re-intervention as necessary - analogous to five-year post cancer monitoring ala White, 2012b).
    The model in this monograph builds-in both uplift (coaching) and downforce against problem indicators/symptoms (check-ups). Both of these methods apply to both problem resolution (reduction of problem indicators) and on-going wellbeing (raising of wellness indicators) across years. The model includes the time sufficient to bring the risk of return to illness to the base rate of occurrence in the general population and extends to 5 years after the minimum 5 years. This is the best goal and is the benchmark against which services are compared.

This monograph also responds to newer evidence and clinical consensus concerning the best goal and methods for the SUD sub-population presenting with **complex, chronic, and severe addiction illness** with a service framework that is very specific compared to the broad problems and methods within the total SUD arena. Provision of care for this sub-population is extended a minimum of 5 years and consists of **on-going clinical services, coaching,** and **intermittent check-ups**. The starting point for the clinician within the 5-year service framework is the

universal benchmark of sustained remission *and* improving quality of life five years after the last clinical touch.

The **psychology of chronic illness** is the milieu within which the relevant clinical targets reside. The clinical targets within the 5-year framework are a variety of discreet and continuous variables. These variables are contained within three categories: **problem indicators, wellness indicators, and core processes.**

The six core processes are as follows:

1. Self-efficacy (in-gear effort, as pursuit)
2. Distress tolerance (mindfulness-clutch, as release)
3. Self-inventory
4. Telling on one's illness
5. Application of Disease Management knowledge and skills
6. Application of Recovery Management knowledge and skills

A significant number of **clinical targets are pre-identified** from the relevant experimental and clinical literature, while some are brought on-board 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.

The pre-established **timing of routine check-up intervals** and patterns of **clinical service** dose, frequency and duration are based on the empirical and clinical literature. Throughout the patient's engagement in the five-year service model, **data** concerning the patient's condition **is recursive to care**, and care is adjusted accordingly. Clinical services are provided with pre-determined **stage-specific relevance** and can be adjusted in **emerging responses** to new information. Likewise, temporarily **modifying the check-up schedule** can also result. This approach approximates measurement-based care, which is rarely used in community-based SUD treatment even when digital and remote (Hallgren, Cohn, Ries & Atkins, 2022).

In this way, the patient receives services that are informed both by averages and personal data (that is, both nomothetically and ideographically; Hofmann & Hayes, 2019), while being provided in a contextual frame whose duration matches their type and length of illness on average, and the personally-evidenced time necessary to solidify enduring wellbeing.

References

American Psychiatric Association (2022). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Text Revision. American Psychiatric Publishing: Washington, DC.

Bach, P. A., Moran, D. J. & Hayes, S. C. (2008). ACT in Practice: Case Conceptualization in Acceptance and Commitment Therapy. New Harbinger Publications: Oakland, CA.

The Betty Ford Consensus Panel (2007). What Is Recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment. 33: 221–228.

Bion, W. (1967). Notes on Memory and Desire. The Psychoanalytic Forum. 2:272–3, 279–80.

Boyle, M. G., White, W. L., Corrigan, P. W. & Loveland, D. L. (2001). Behavioral Health Recovery Management: A Statement of Principles. Accessed at www.chestnut.org on 09/04/2022.

Bray, J. W., Aden, B., Eggman, A. A., Hellerstein, L., Wittenberg, E., Nosyk, B., Stribling, J. C. & Schackman, B. R. (2017). Quality of Life as an Outcome of Opioid Use Disorder Treatment: A systematic review. Journal of Substance Abuse Treatment. 76: 88–93.

Chih, M-Y, Patton, T., McTavish, F. M., Isham, A. J., Judkins-Fisher, C. L., Atwood, A. K. & Gustafson, D. H. (2014). Predictive Modeling of Addiction Lapses in a Mobile Health Application. Journal of Substance Abuse Treatment. 46: 29–35.

Coon, B. (2015). Recovering Students Need Support As They Transition. Addiction Professional. 13(1): 22-26.

Coon, B. (2019). Planes, Car Repair Shops, and Dentists. *Recovery Review.*

Coon, B. (2019). Addiction and the Stages of Healing. *Recovery Review.*

Coon, B. (2021). We All Need to Learn "Prevention". *Recovery Review.*

Coon, B. (2022a). Coast Guard Search and Rescue: Lessons and Inspiration. *Recovery Review.*

Coon, B. (2022b). The Recovery Alliance Initiative – A Recipe We Uncovered. *Recovery Review.*

Coon, B. (2022c). Addiction: understandings and enactments of the current era. *Recovery Review.*

Crowe, K., Hennen, B. & Coon, B. March 31, 2017. A Seamless Transition: Linking College-Bound Emerging Adults with Collegiate Recovery Programs. Recovery Campus Newsletter.

Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An Eight-Year Perspective on the Relationship Between the Duration of Abstinence and Other Aspects of Recovery. Evaluation Review. 31(6): 585-612.

Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The Duration and Correlates of Addiction and Treatment Careers. Journal of Substance Abuse Treatment. 28: S51-S62.

De Soto, C.B., O'Donnel, W.E., & De Soto, J.L. (1989). Long-Term Recovery in Alcoholics. Alcoholism: Clinical and Experimental Research. 13: 693-697.

DuPont, R. (2015). Five-Year Recovery: A New Standard for Assessing Effectiveness of Substance Use Disorder Treatment. Journal of Substance Abuse Treatment. 58: 1–5.

DuPont, R. (2016). Personal communication.

DuPont, R. L, McLellan, A. T., White, W. L., Merlo, L. J. & Gold, M. S. (2009). Setting the Standard for Recovery: Physicians' health programs. Journal of Substance Abuse Treatment. 36: 159–171.

DuPont, R. L., Seppala, M. D. & White, W. L. (2015). The Three Missing Elements in the Treatment of Substance Use Disorders: Lessons from the physician health programs. Journal of Addictive Diseases.

Dunkel, C., Kelts, D. & Coon, B. (2006). Possible Selves as Mechanisms of Change in Therapy, in C. Dunkel & J. Kerpelman (Eds.). Possible Selves: Theory, Research and Application. (pp. 186-204). Nova Publishers.

Freed, C. R. (2021). The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery - the virtues of an interdisciplinary perspective of alcoholism and alcoholism recovery. Addiction. 117: 506-509.

Eddie, D., Bergman, B.G., Hoffman, L.A. & Kelly, J.F. (2022) Abstinence Versus Moderation Recovery Pathways Following Resolution of a Substance Use Problem: Prevalence, predictors, and relationship to psychosocial well-being in a U.S. national sample. Alcoholism: Clinical and Experimental Research. 46: 312–325

Galanter, M. (2014). Alcoholics Anonymous and Twelve-Step Recovery: A Model Based on Social and Cognitive Neuroscience. The American Journal on Addictions. 23: 300–307.

Goodheart, C. D. & Lansing, M. H. (1997). Treating People With Chronic Disease: A Psychological Guide. American Psychological Association: Washington, DC.

Gorski, T. T. & Miller, M. (1986). Staying Sober: A Guide for Relapse Prevention. Independence Press.

Hallgren, K. A., Cohn, E. B., Ries, R. K. & Atkins, D. C. (2022). Delivering Remote Measurement-Based Care in Community Addiction Treatment: Engagement and usability over a 6-month clinical pilot. Frontiers in Psychiatry. 13:840409.

Haskell, B. (2022). Identification and Evidence-Based Treatment of Poste-Acute Withdrawal Syndrome. The Journal for Nurse Practitioners. 18: 272-275.

Hennen, B. & Coon, B. (2020). Recovery Coaching, Breathalyzer Boost Retention in Outpatient SUD Treatment. Addiction Professional. September 23, 2020.

Hoffmann, N. (2016). Personal communication.

Hollis, J. (2013a). The Ghosts of Our Parents. Hauntings: Dispelling the Ghosts Who Run Our Lives. pp. 28-38. Chiron: Asheville, NC.

Hollis, J. (2013b). The Sailor Cannot See the North: The Haunted Soul of Modernism. Hauntings: Dispelling the Ghosts Who Run Our Lives. pp. 103-115. Chiron: Asheville, NC.

Hofmann, S. G. & Hayes, S. C. (2019). The Future of Intervention Science: Process-Based Therapy. Clinical Psychological Science. 7(1): 37-50.

Hser, Y.I., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-Year Follow-Up of Narcotics Addicts. Archives of General Psychiatry. 58: 503-508.

James, L. (2016). Carl Jung and Alcoholics Anonymous: Is a theistic psychopathology feasible? Acta Psychopathologica. 2:1.

Jin, H., Rourke, S.B., Patterson, T.L., Taylor, M.J., & Grant, I. (1998). Predictors of Relapse in Long-Term Abstinent Alcoholics. Journal of Studies on Alcohol. 59: 640-646.

Johnson, A. H., Nease, Jr, D. E., Milberg, L. C. & Addison, R. B. (2004). Essential Characteristics of Effective Balint Group Leadership. Family Medicine. 36(4):253-259.

Jorquez, J. S. (1983). The Retirement Phase of Heroin Using Careers. Journal of Drug Issues. 13(3): 343–365.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. Alcoholism: Clinical and Experimental Research. 29(11): 1983-1990.

Kelly, J. F., Greene, M. C., & Bergman, B. G. (2018). Beyond Abstinence: Changes in indices of quality of life with time in recovery in a nationally representative sample of U.S. adults. Alcoholism, Clinical and Experimental Research. 42(4): 770–780.

Kelly, J.F., Hoeppner, B., Sout, R.L. & Pagano, M. (2011). Determining the Relative Importance of the Mechanism of Behavior Change Within Alcoholics Anonymous: A multiple mediator analysis. Addiction. 107: 289-299.

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How Do People Recover From Alcohol Dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. Addiction Research and Theory. 17(3): 236-259.

Kelly, J. F., Stout, R., Magill, M. J., Tonigan, J. S, & Pagano, M. (2010). Mechanisms of Behavior Change in Alcoholics Anonymous: Does AA lead to better alcohol use outcomes by reducing depression symptoms? Addiction. 105(4): 626-636.

Kelly, J.F., Stout, R.L., Magill, M.J., Tonigan, J. S. & Pagano, M.E. (2011). Spirituality in Recovery: A lagged mediational analysis of Alcoholics Anonymous' principles theoretical mechanism of behavioral change. Alcoholism: Clinical and Experimental Research. 35(3): 454-463.

Kelly, J. F. & White, W. L., Eds. (2011). Addiction Recovery Management: Theory, Research and Practice. Springer: NY.

Klingemann, J. I. (2012). Mapping the Maintenance Stage of Recovery: A qualitative study among treated and non-treated former alcohol dependents in Poland. Alcohol and Alcoholism. 47(3): 296–303.

Lerner, A & Klein, M. (2019). Dependence, Withdrawal and Rebound of CNS Drugs: An Update and Regulatory Considerations for New Drugs Development. Brain Communications. 1(1): fcz025.

Linden-Carmichael, A. N., Stull, S. W., Scott, C. K. & Dennis, M. L. (2021). "Time-Varying Effect Modeling to Examine Recovery Outcomes across Four Years". In (Tucker, J. A. & Witkiewitz, K., Eds.) Dynamic Pathways to Recovery from Alcohol Use Disorder. Cambridge University Press.

Loveland, D. & Boyle, M. (2005). Manual for Recovery Coaching and Personal Recovery Plan Development. www.chestnut.org/resources

Martinellia, T. F., Nagelhouta, G. E., Bellaert, L., Beste, D., Vanderplasschend, W. & van de Mheen, D. (2020). Comparing Three Stages of Addiction Recovery: Long-term recovery and its relation to housing problems, crime, occupation situation, and substance use. Drugs: Education, Prevention, and Policy. 27(5): 387–396.

Marquis, A., Douthit, K. Z. & Elliot, A. J. (2011). Best Practices: A critical yet inclusive vision for the counseling profession. Journal of Counseling & Development. 89: 397-405.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug Dependence, a Chronic Medical Illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 284(13): 1689–1695.

Melemis, S. M. (2015). Relapse Prevention and the Five Rules of Recovery. Yale Journal of Biology and Medicine. 88: 325-332.

Moos, R. H., & Moos, B.S. (2004). Long-term Influence of Duration and Frequency of Participation in Alcoholics Anonymous On Individuals with Alcohol Use Disorders. Journal of Consulting and Clinical Psychology. 72(1): 81-90.

Moos, R. H., & Moos, B. S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. Alcoholism: Clinical & Experimental Research. 29(10): 1858-1868.

Morgenstern, J., Bux, D. A., Jr., Labouvie, E., Morgan, T., Blanchard, K. A., & Muench, F. (2003). Examining Mechanisms of action in 12-Step community outpatient treatment. Drug and Alcohol Dependence. 72(3): 237-247.

Murphy, M. K., Black, N. A., Lamping, D. L., McKee, C. M., Sanderson, C. F. B., Askham, J. & Mateau, T. (1998). Consensus Development Methods, and Their Use In Clinical Guideline Development. Health Technology Assessment. 2(3).

Murphy, S. & Irwin, J. I. (1992). "Living with the dirty secret": Problems of Disclosure for Methadone Maintenance Clients. Journal of Psychoactive Drugs. 24(3): 257-264.

Narcotics Anonymous. (2008). "What Can I Do?" In Narcotics Anonymous, 6th Edition. (pg. 55). Narcotics Anonymous World Services, Inc. Van Nuys, CA.

Narcotics Anonymous. (2012). Living Clean: The journey continues. Narcotics Anonymous World Services, Inc. Van Nuys, CA.

Network for the Improvement of Addiction Treatment (NIATx).

Prochaska, J. J, Das. S. & Young-Wolff, K.C. (2017). Smoking, Mental Illness, and Public Health. Annual Review of Public Health. 38: 165–85.

Prochaska, J.J., Delucchi, K. & Hall, S.M. (2004). A Meta-Analysis of Smoking Cessation Interventions with Individuals in Substance Abuse Treatment or Recovery. Journal of Consulting and Clinical Psychology. 72(6): 1144–56.

Schutte, K., Byrne, F., Brennan, P. & Moos, R. (2001). Successful Remission of Late-Life Drinking Problems: A 10-year follow-up. Journal of Studies on Alcohol. 62: 322-34.

Scott, C. K. & Dennis, M. L. (2003). Recovery Management Check-ups: An Early Re-Intervention Model. Chicago: Chestnut Health Systems. www.chestnut.org/store/products/27/recovery-management-checkups/product-details/

Scott, C. K., & Dennis, M. L. (2011). Recovery Management Checkups with Adult Chronic Substance Users. In J. F. Kelly & W. L. White (Eds.), Addiction recovery management: Theory, research and practice. (pp. 87–101). Humana Press.

Subbaraman, M. S. & Kaskutas, L. A. (2012). Social support and comfort in AA as mediators of "Making AA Easier" (MAAEZ), a 12-step facilitation intervention. Psychology of Addictive Behaviors. 26(4): 759-765.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). Protracted Withdrawal. Substance Abuse Treatment Advisory. 9(1): 1-8.

Taylor, G., McNeil, A., Girling, A., Farley, A., Lindson-Hawley, N. & Aveyard, P. (2014). Change In Mental Health After Smoking Cessation: Systematic review and meta-analysis. BMJ (Online). 348.

Vaillant, G. E. (1996). A Long-Term Follow-Up of Male Alcohol Abuse. Archives of General Psychiatry. 53(3): 243-249.

Vaillant, G. E. (2003). A 60-year Follow-up of Alcoholic Men. Addiction. 98: 1043-1051.

Vaillant, G. E. (2012). Triumphs of Experience — The Men of the Harvard Grant Study. Cambridge, MA: Harvard University Press.

Weinberger, A. H., Platt, J., Esan, H., Galea, S., Erlich, D., & Goodwin, R. D. (2017). Cigarette Smoking Is Associated With Increased Risk of Substance Use Disorder Relapse: A Nationally Representative, Prospective Longitudinal Investigation. The Journal of Clinical Psychiatry. 78(2), e152–e160.

White, W. (2006). Frontline Implementation of Recovery Management Principles. An Interview with Michael Boyle. Perspectives on Systems Transformation: Frontline Implementation of Recovery Management Principles. Great Lakes Addiction Technology Transfer Center.

White, W. L. (2008). Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices. Northeast ATTC, GLATTC, and Philadelphia Department of Behavioral Health/Mental Retardation Services.

White, W. (2012). Recovery Carriers. Posted at www.williamwhitepapers.com

White, W. (2012b). Addiction Treatment and Cancer Treatment: Personal reflections of a long-tenured addiction professional. Posted at www.williamwhitepapers.com

White, W. (2013). Recovery Durability – The 5 Year Set Point. Posted at www.williamwhitepapers.com

White, W. (2022). Personal communication.

White, W., Boyle, M. & Loveland, D. (2003). Behavioral Health Recovery Management: Transcending the limitations of addiction treatment. Behavioral Health Management. 23(3):38-44.

White, W., Boyle, M., & Loveland, D. (2003). Addiction as Chronic Disease: From rhetoric to clinical application. Alcoholism Treatment Quarterly. 3/4: 107-130.

White, W. & Chaney, R. (1992). Metaphors of Transformation: Feminine and Masculine. Bloomington, IL: Chestnut Health Systems.

White, W. L. & Coon, B. F. (2003). Methadone and the Anti-Medication Bias in Addiction Treatment, Counselor. 4(5): 58-63.

White, W. L. & Kelly, J. F. (2011). Recovery Management: What if we *really* believed that addiction was a chronic disorder? In Kelly, J. F. & White, W. L., Eds. Addiction Recovery Management: Theory, Research and Practice. Springer: NY.

White, W. L. & Mojer-Torres, L. (2010). Recovery-Oriented Methadone Maintenance. Northeast ATTC, GLATTC, and Philadelphia Department of Behavioral Health/Mental Retardation Services.

White, W. & Schulstad, M. (2009). Relapse Following Prolonged Addiction Recovery: Time for answers to critical questions. Counselor. 10(4): 36-39.

White, W. L., Scott, C.K., Dennis, M.L. & Boyle, M.G. (2005). It's Time to Stop Kicking People Out of Addiction Treatment. Counselor, 6(2): 12-25.

Witbrodt. J., Kaskutas, L., Bond, J. & Deluchi, K. (2012). Does Sponsorship Improve Outcomes Above Alcoholics Anonymous Attendance? A latent class growth curve analysis. Addiction. 107: 301-311.

Witbrodt, J., Mertens, J., Kaskutas, L. A., Bond, J., Chi, F. & Weisner, C. (2012) Do 12-step Meeting Trajectories Over 9 Years Predict Abstinence? Journal of Substance Abuse Treatment. 43: 30-43.

Supplemental Readings

Eshel, N., & Leibenluft, E. (2020). New Frontiers in Irritability Research-From Cradle to Grave and Bench to Bedside. JAMA Psychiatry. 77(3): 227–228.

Kashdan, T. D. (2010). Psychological Flexibility as a Fundamental Aspect of Health. Clinical Psychology Review. 30(7): 865-878.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J. & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. Alcoholism: Clinical and Experimental Research. 29(11): 1983-1990.

Kaskutas, L. A., Bond, J., & Ammon Avalos, L. (2009). 7-year Trajectories of Alcoholics Anonymous Attendance and Associations with Treatment. Addictive Behaviors. 34(12): 1029-1035.

Kelly, J. F., Bergman, B., Hoeppner, B. B., Vilsainta, C. & White, W. L. (2017). Prevalence and Pathways of Recovery From Drug and Alcohol Problems in the United States Population: Implications for practice, research, and policy. Drug and Alcohol Dependence. 181: 162–169.

Langendam, M.W., Van Brussell, G., Coutinho, R.A., Van Ameijden, E.J. (2000). Methadone Maintenance and Cessation of Injecting Drug Use: Results from the Amsterdam cohort study. Addiction. 94: 591-600.

McKay, J. R., Gustafson, D. H., Ivey, M., Pe-Romashko, K., Curtis, B., Thomas, T., Oslin, D. W., Polsky, D., Quanbeck, A., & Lynch, K. G. (2022). Efficacy and Comparative Effectiveness of Telephone and Smartphone Remote Continuing Care Interventions for Alcohol Use Disorder: A randomized controlled trial. Addiction. 117(5): 1326–1337.

Richardson, G. B. & McGee, N. (2022). Extending the Two-Component Model of Delusion to Substance Use Disorder Etiology and Recovery. New Ideas in Psychology. 66:100935.

Roose, K. M. & Williams, W. L. (2018). An Evaluation of the Effects of Very Difficult Goals. Journal of Organizational Behavioral Management. 38(1): 18-48.

Scott, C. K., Dennis, M. L. & Gustafson, D. H. (2018). Using Ecological Momentary Assessments to Predict Relapse After Adult Substance Use Treatment. Addictive Behaviors. 82: 72–78.

Shah, N.G., Galai, N., Celentano, D.D., Vlahov, & Strathdee, S.A. (2000). Longitudinal Predictors of Injection Cessation and Subsequent Relapse Among a Cohort of Injection Drug Users in Baltimore, MD, 1988-2000. Drug and Alcohol Dependence. 83: 147-156.

White, W. L. (1990, 1996). Pathways from the Culture of Addiction to the Culture of Recovery, Second Edition. Hazelden Publishing: Center City, MN.

Windle, E., Tee, H., Sabitova, A., Jovanovic, N., Priebe, S., & Carr, C. (2020). Association of Patient Treatment Preference With Dropout and Clinical Outcomes in Adult Psychosocial Mental Health Interventions: A Systematic Review and Meta-analysis. JAMA Psychiatry. 77(3): 294–302.

World Health Organization, Eds. (2012). The World Health Organization Quality of Life (WHOQOL) User Manual.

Appendix

The clinical practices within the SUD arena for people with complex, chronic, and severe addiction illness lack a group work methodology specifically suited to the needs of people following the second year and through the fifth year of their improvement. The content and method of a Balint Group can apply well to SUD professionals and patients especially within years 3-5 of the 5-year model.

The reader might be unfamiliar with what is known as a Balint Group. The website for The Balint Society has elementary content that specifically addresses the content and method of a Balint Group. Attendance of a Balint Group is a common requirement for Family Practice physicians during the years of their residency training. This training component was designed for the purpose of identifying and understanding the emotional content in the space between the physician and patient. Participation addresses several important factors related to management of wellbeing at the patient, clinician, and community levels.

What are some of the concerns the Balint Group addresses, and why is it included in Family Practice physician training?

- Family Practice physicians, by the nature of their career, often work in relative geographic isolation. This can have a corrosive effect due to lack of peer contact and team context. Thus, problems might emerge that are evidenced in shifting levels of fidelity to clinical practice standards and resulting clinician effectiveness.
- They also often work with patients across much, if not all, of the same person's entire life span. This can have a corrosive effect beginning with potential difficulties in boundary management.
- Family practice physicians are often faced with multi-generational family system content found in the report of the individual patient, and perhaps the patient's family members, whether treated separately or accompanying the patient to an appointment.
- Further, these physicians face the collective central concerns and assumptions of the local community that are preserved within and by the community over time.

I offer the notion that a version of the Balint Group method could be the basic template for a group whose main chore is "recovery management" during years 3-5 of this model. By that point the major concern of the patient, given their developmental stage of improvement is no longer "disease management". And by that point the mechanism of the group should not major on problem identification or decreasing problem indicators. Rather, the major focus of the work would concern the *space between* the patient and their own recovery, and their *stance* with their own on-going wellbeing.

During a Balint Group, after a participant presents a case they find challenging, the group members discuss their understanding of the doctor-patient relationship. This allows the presenter to listen and for the nature of the space and clarity of the stance to emerge.

What follows is a list of some core concepts and methods for Balint Group leadership as quoted within the literature (Johnson, Nease Jr., Milberg & Addison, 2004). Some of the concepts and methods are then discussed as they could apply to a group for wellness-focused maintenance of wellbeing in years 3-5 of care for those with severe, complex and chronic SUD.

1. *"…operate to create a safe environment and move the group toward a new understanding of a specific doctor-patient relationship."*
    - This is the specific space to bring about the mindfulness and defusion (ACT; see Bach, Moran & Hayes, 2008) necessary to set the occasion for emergence of new understandings, generally. Such a space is relevant to clinically focused assistance in promotion of recovery management as a mental context and skill.
    - Whereas the first 2 years of engagement of the five-year model would necessarily have a problem-focus on average and could be synopsized with the phrase "urge surfing" as a disease management moniker, years 3-5 could be thought of under the heading "recovery surfing" by a majority of emphasis (over a disease focus) with all its accompanying implications.
    - Metaphors have a long history of application in the SUD space (White & Chaney, 1992, White, 1990, 1996) and one particular metaphor applies here.
        - A lake typically has warmer water near the surface and cooler water at depth. Seasonal variations produce lake-turnover and mixing.
        - Once a year for some lakes and twice a year for other lakes, the lake "flips" and the layers of water invert (warmer/colder). Sometime near or soon following year 2 the emphasis of the needs of the patient will transform from disease management to recovery management. They are never perfectly separated, but the emphasis does flip.
        - At some times of the year, for some lakes, the lake is un-stratified; and we know some seasons in disease management or recovery management are also like that.

2. *"Although Balint group leaders rely on behaviors common to other small-group methods, they create a space and purpose markedly different from that seen in other small groups in medical education. Balint group leaders model and create a safe environment for shared, creative speculation and a more empathic experience of the doctor-patient relationship."*
    - We would re-word that to be "…in recovery education and support…" and "…counselor-patient relationship."
    - Thus that would read as follows: *"Although Balint group leaders rely on behaviors common to other small-group methods, they create a space and purpose markedly different from that seen in other small groups in recovery education and support. Balint group leaders model and create a safe environment for shared, creative speculation and a more empathic experience of the counselor-patient relationship."*

3. *"Specific leader behaviors include protecting the presenter from interrogation, encouraging open speculation by group members, avoiding premature solutions, and tolerating silence and uncertainty."*
    - This is the specific space to bring about awareness raising. If the patient and clinician both know something, that something is not important (Bion, 1967).

4. *"…the most effective leaders are moderate in stimulating the group, high in caring for the group, use some interpretations of group process, and are moderate in asserting their group authority…"*

5. *"…leading in a 'nourishing manner' without 'coercion' or 'taking credit' and being in the moment…"*
    - In this sense, then, the group leader for years 3-5 takes on a catalytic function, rather than a directive or even facilitative function, by emphasis.

6. *"The absolute necessity of creating a safe environment that models empathy and allows for divergent viewpoints is of particular importance..."*

7. *"…avoids making any group member the object of a teaching lesson or of psychological analysis…"*
    - A shift to this kind of focus and process method would be a rather distinct challenge for the average addiction counselor.

8. *"…establishment and maintenance of particular group norms such as self-reflection and exploration of meaning rather than problem solving…"*

9. *"…must possess a grasp of the group's process, understanding the complexity of the case and its dynamics as manifested by the presenter's and group's response. Keeping the group responsible for doing the work…"*
    - Here, "…*complexity of the case and its dynamics*…" would change to "…complexity of personal recovery and its dynamics…" – as the main content is the person-recovery relationship, not a physician-patient relationship.

10. *"…It is not the leader's individual brilliance that illuminates the case but the richness and diversity of group participation and interactions he/she facilitates."*

With the outline of the Balint Group and its potential for improving our group methods for years 3-5 concluded, the final portion of the document follows. It is a set of tables that are a consolidation of key content from the main body of this monograph.

Core Processes
1) Development of: emotion experiencing, mindfulness, acceptance, sense of self, meta-cognition, relationship with, attentional flexibility, values, cognitive flexibility, and defusion/distancing 2) Development of the following mechanisms: A) Self-awareness; B) Empathy; C) Mentalizing (ability to recognize one's own and others' mental states, and to see these mental states as separate from behavior)

Self-Care Process (continuous through time, not stage-specific)	
Problem Indicators	**Wellbeing Indicators**
○ Bottling up emotions ○ Isolating ○ Not going to support meetings ○ Going to support meetings but not sharing ○ Focusing on other people's problems or how other people affect them ○ Poor eating and sleeping habits	○ Make time for themselves ○ Be kind to themselves ○ Give yourself permission to have fun ○ Identify their own denial

Illness Self-Management Process (continuous through time, not stage-specific)		
	Problem Indicators	**Wellness Indicators**
Development of process management: 1) Change your life 2) Be completely honest 3) Ask for help 4) Practice self-care including mind-body relaxation 5) Don't bend the rules *…that concerns mutuality/the building of relationships*	○ Craving for drugs or alcohol ○ Thinking about people, places, and things associated with past use ○ Minimizing consequences of past use or glamorizing past use ○ Bargaining ○ Lying ○ Thinking of schemes to better control using ○ Looking for relapse opportunities ○ Planning a relapse ○ All-or-nothing thinking in event of a slip	1) Emotional contagion 2) Cognitive perspective taking a) Understanding and experiencing another person's mental and emotional state b) Sharing of self-other representations c) Being motivated to improve another person's experiences ○ Mutual aid attendance pattern ○ Level of reliance on mutual aid coach ○ Level of mutual aid affiliation ○ Engagement in mutual aid related activities ○ Level of use of personal spiritual path ○ Use of mutual aid resources for advice or information ○ Degree of mutual aid-centered life

90 Days	
Wellbeing Indicators	
Self-esteem, happiness (drops the first 6 months, then improves)	
Reducing pro-drinking network	Enhancing self-efficacy

First Year	
Problem Indicators	**Wellbeing Indicators**
1) Have you used since last follow-up? Yes/No 2) Days of use since last follow-up? by drug, and *other* 3) Based on # 1 above, problems associated with use: a) spent more time drinking/ using than intended? b) Neglected usual responsibilities because of drinking/using? c) Wanted to cut down on drinking/using? d) Has anyone objected to your drinking/using? e) Have you found yourself thinking a lot about drinking/using? f) Drank/ used to relieve emotional distress, such as sadness, anger or boredom? g) Are there are any other problems associated with use?	1) Have you attended mutual aid meetings since last follow up? Yes/No 2) If yes to meetings #1 above, what frequency of attendance? a) What number per week? b) What number per month? 3) Are you attending any other professional services since last follow-up?
○ Sleeping problems ○ Depression ○ Urges ○ Risky situation ○ Relationship troubles ○ Psychological distress ○ Reducing negative affect ○ Change in social networks ○ Decreased depression ○ Decreased negative affect ○ Self-directing spiritual style ○ Deferring spiritual style ○ No mutual aid attendance year 1 ○ Limit of 2-4 meetings per week for year 1 ○ Delaying participation for a year	○ Answer the weekly check-in ○ Confidence ○ Mutual aid meeting or religious activities ○ Other activities ○ Time with family ○ Happiness ○ Self-esteem ○ Quality of life ○ Self-efficacy in high-risk situations ○ Improving psychological wellbeing ○ Coping ○ Motivation ○ Change in social networks ○ Fostering spirituality ○ Hope ○ Universality ○ Cohesion with a support group ○ Catharsis ○ Mutual aid attendance ○ Find or form own personal spiritual system ○ Pursue personal spiritual pathway ○ Collaborative spiritual style (as shown effective in coping with other chronic illnesses) ○ More than 4 meetings a week for the first year

Second Year	
Problem Indicators	**Wellbeing Indicators**
○ Mood swings ○ Anxiety ○ Irritability ○ Variable energy ○ Low enthusiasm ○ Variable concentration ○ Disturbed sleep ○ Cravings ○ Using	○ Accept that you have an addiction ○ Practice honesty in life 1) Develop coping skills for dealing with cravings 2) Become active in self-help groups 3) Practice self-care and saying no ○ Understand the stages of relapse ○ Get rid of friends who are using ○ Understand the dangers of cross addiction ○ Deal with post-acute withdrawal ○ Develop healthy alternatives to using ○ See yourself as a non-user
Starting after year 2	
Problem Indicators	**Wellbeing Indicators**
Difficulties with: ○ Self-efficacy ○ Commitment to abstinence ○ Active coping efforts ○ Primary appraisal ○ Mutual aid attendance ○ Reading mutual aid literature ○ Completing mutual aid homework	○ Overcome negative self-labeling and catastrophizing ○ Understand that individuals are not their addiction ○ Repair relationships and make amends when possible ○ Start to feel comfortable with being uncomfortable ○ Improve self-care and make it an integral part of lifestyle ○ Develop a balanced and healthy lifestyle ○ Continue to engage in mutual aid groups ○ Develop more healthy alternatives to using ○ Their own development of recovery capital

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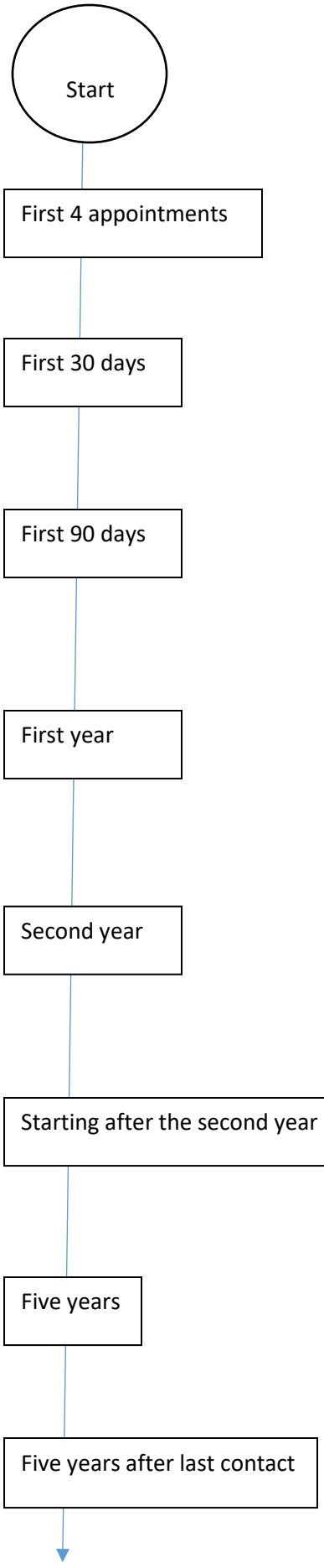
<tr><th colspan="2">Five Years</th></tr>
<tr><th>Problem Indicators</th><th>Wellbeing Indicators</th></tr>
<tr><td>○ Never “connect” with mutual aid
○ Negative disengagement from mutual aid (e.g. slip or fall off of attending)
1) Put addiction behind them, forget that they ever had addiction; feel they have lost part of their life to addiction and don’t want to spend the rest of their life focused on recovery; start to go to fewer meetings
2) As life improves, focus less on self-care; take on more responsibilities and try to make up for lost time; in a sense, trying to get back to their old life without the using; stop doing the healthy things that contributed to their recovery
3) Feel they are not learning anything new at self-help meetings and begin to go less frequently
4) People feel that they should be beyond the basics; think it is almost embarrassing to talk about the basics of recovery; embarrassed to mention that they still have occasional cravings or that they are no longer sure if they had an addiction
5) Think that they have a better understanding of drugs and alcohol and, therefore, think they should be able to control a relapse or avoid the negative consequences</td><td>○ Positive disengagement from mutual aid

1) Identify and repair negative thinking and self-destructive patterns
2) Understand how negative familial patterns have been passed down, which will help individuals let go of resentments and move forward
3) Challenge fears with cognitive therapy and mind-body relaxation
4) Set healthy boundaries
5) Begin to give back and help others
6) Reevaluate one’s lifestyle periodically and make sure the individual is on track
7) Need to understand that one of the benefits of going to meetings is to be reminded of what the “voice of addiction” sounds like, because it is easy to forget</td></tr>
<tr><th colspan="2">Five years after the last clinical touch</th></tr>
</table>



The patient begins primary treatment in an IOP or residential program. Patient and family receive education and consulting on traversing the 5 years. Begin attention to the core processes.

Warm, high-tech/high-touch intake must produce a 100% show-rate in the first 4 appointments. The difficult 1st year begins.

Attending a meeting each day for the first 90 is a good idea. Separating from using friends; bonding with a sober network. Obtaining relief from distress. Acknowledge that self-efficacy will decrease while feeling worse at times, is simply expected.

From the first appointment through the first 90 days promote self-efficacy. Bring relief and effective means of coping or obtaining relief. Reduce pro-drinking network. Complete the 90-day dose of primary care. Self-soothe proactively against PAWS. The rest of the difficult first year is ahead. Ask for help.

Develop a collaborative spiritual style and a high-density, meaningful, routine participation in mutual support and the literature. Focus on effective coping. Find new activities and fun including with family. Develop the quality of life. Things get easier after the second year. *Disease management* is 2 years.

On-going, effective self-care prevents stress and PAWS. Form an identity around personal wellbeing as a status. Develop a lifestyle in wellbeing and methods for primary self-appraisal. Become active in fellowship. Understand relapse processes.

Defuse from idea that addiction signs/symptoms are your identity. Become comfortable as uncomfortable. Build recovery capital. Integrate wellbeing into lifestyle. Work on self-appraisal while exiting labeling. Long haul; stay engaged. PAWS ends. Now it's *recovery management*.

Re-arrange your family function to support wellbeing. Keep your addiction in the foreground. Keep things fresh. Continue to learn and make new changes. Stay consistent at working on wellbeing. Give back, help others, stay connected. Listen for your addiction. Notice stance with recovery. Stay honest with support people.

Brian Coon has been working full time in residential addiction treatment programs from the time of his graduate internship in 1988 to the present. Following his internship, his first 19 years were spent serving in a 9-12 month residential Therapeutic Community (TC) program that shared a staff and physical plant with an outpatient methadone maintenance program. The TC had a nursery component for children up to 12 months of age to live with their mothers during treatment.

In the early 1990's that residential program was improved when the organization won a 5-year CSAT demonstration grant for pregnant, post-partum, and parenting women including a physical plant and staff expansion in the TC to include a nursery component and capacity for 14 children from newborn to age 4, training and standards for gender-specific and culturally-relevant care, nurturing parenting programming, developmental assessments (cognitive, social, motor) and corresponding manualized therapeutic interventions for the children, and addition of a women's health focus. That grant included various additional improvements across the organization. Brian sat on the steering committee of that effort after funding was concluded. During all of his last 12 years in that organization, he had full clinical and managerial responsibility for the TC and outpatient methadone maintenance program. Later in those 12 years he had additional responsibility to guide a criminal justice halfway house under contract with the Federal Bureau of Prisons (FBOP), an intensive outpatient program provided inside a 300-bed city/county work release detention facility, and a one-year outpatient SUD aftercare program for FBOP, among other duties.

Notably, that organizational workplace was the community agency within which the Behavioral Health Recovery Management (BHRM) project was begun and operated. Brian served on the BHRM implementation steering committee for the entire 10-year lifespan of the BHRM project starting in 1998. The BHRM project was the living clinical laboratory where the principles and practices of recovery orientation for clinical services, such as recovery coaching, and approaches that later came to be known as "Recovery-Oriented Systems of Care" and "Recovery Management" were innovated and developed. The steering committee expanded and sharpened its focus when that workplace was allowed to participate in NIATx at the start of Round 2 during the Robert Wood Johnson Foundation-funded portion of NIATx's history.

Throughout its 10-year lifespan the BHRM steering committee also led change in the area of co-occurring SUD and MH disorders by identification of national experts in best practices and promising practices and contracting those experts in: authorship of clinical practice guidelines for the organization, provision of training within the organization, and on-going consultation in implementation of their protocols in a multi-year state-funded effort within that organization. The steering committee led by taking responsibility for initial clinical fidelity at the clinician, program and organizational levels based on those protocols, ongoing clinical supervision and sustainability of fidelity in those practices, continuous quality improvement of service delivery, and a focus on change management integrating those clinical practices with BHRM principles and NIATx change methods in the dozens of programs across the organization.

Since 2008 he has worked in a freestanding interdisciplinary program that includes specialized services for young adults and for medical, legal, and other major professionals. He assisted that organization's senior leadership in 2013 with transformation to a smoke-free approach to addiction treatment, and the successful sustaining of that approach to the present time. In that workplace, his routine duties include the clinical supervision of clinical supervision, and of counseling. Immediately prior to his current role and its focus on innovation, training, and research he served as clinical director there for 10 years.

Brian holds a BS in psychology and MA in community-clinical psychology. He is a licensed clinical addiction specialist (LCAS), certified clinical supervisor (CCS), and nationally credentialed as a master addiction counselor (MAC). His academic and clinical background is in the scientist-practitioner model, cognitive-behavioral psychology, and evidence-based treatment of co-occurring substance use and mental health disorders in adult populations. He has a strong life-long interest in biology and philosophy. His recent years have been marked by an interest in the analytic tradition/depth psychology, the mentoring of clinical supervision, and the impacts of each upon systems of care, individual clinicians, and clinical teams. In his spare time, he serves as an Affiliate at *addictionandbehavioralhealthalliance.com* and has written beyond his published work as a Contributor at *recoveryreview.blog.*