

Questions Asked During the Live Webinar Broadcast on 2/5/14

Q: I would like to hear about professional recovery coaching evidence versus peer coaching.

A: I know of no randomized trial that has compared these two schools of recovery coaching nor studies of each that would be comparable in terms of methodologies. Such studies are needed as are studies that measure potential differences in recovery outcomes across delivery sites. We need to know if recovery status and other potentially critical match factors (e.g., gender, ethnicity, recovery pathway) within the delivery of recovery support services affect recovery outcomes and we need to know if recovery outcomes differ depending on whether these services are delivered from an addiction treatment program, a recovery community organization, a managed behavioral healthcare organizations or another setting.

Q: Are the "solo" recovery people self diagnosed or were they diagnosed with the disease by an addiction professional?

A: Neither. In the research literature, they are identified in epidemiological surveys and other community studies of the general population as people who reported have experienced lifetime symptoms (DSM criteria) of a substance use disorder at some time in their life but not in the past 12 months and who also report not having sought professional treatment for an alcohol or drug problem nor participating in a recovery mutual aid group.

Q: Here is where the global "substance use disorder" causes my confusion without the differentiation - I don't see how a person can be in Recovery if they don't have the disease and I can easily see the partial remission recognized as recovery in those without the disease. Please explain.

A: This is critical. Here is what I wrote on this in 2007:

Recovery is a medical term that connotes a return to health following trauma or illness. The boundary of the concept of recovery in the AOD problems arena is greatly dependent on an understanding of what one is recovering from. Technically, there is no recovery if one has no condition from which to recover. AOD use exists on a continuum from AOD abstinence, non-problematic AOD use, subclinical AOD problems (transient problems not meeting severity or persistence criteria for a substance use disorder), and the two broad diagnostic entities *substance abuse* and *substance dependence*, each of which represents a variable span of severity, complexity, and duration. Any definition of recovery should link this term to a previous clinical state. In a survey of natural cessation of illicit drug use, Cunningham (1999) described people who had ever used an illicit drug in their lifetime but had not used an illicit drug in the past year in terms of "recoveries" and "remissions." Such use of the term *recovery* medicalizes AOD use and transient AOD problems that bear little resemblance to severe and persistent substance use disorders. This has contributed to confusion and controversies about the best strategies for resolving AOD problems.

There is considerable evidence that casual users and persons who naturally resolve AOD problems differ significantly from the mostly dependent users admitted to addiction treatment programs. Comparisons of the characteristics of those who achieve natural recovery in community populations with the characteristics of those entering addiction treatment reveal that the former are distinguished by less personal vulnerability, lower problem severity, less medical/psychiatric co-morbidity, greater family and social supports (Grella & Joshi, 1999; Finney & Moos, 1995; Dawson, 1996; Ross, Lin, & Cunningham, 1999), as well as qualitatively different resolution processes (Tuchfeld, 1981; Biernacki, 1986; Cloud & Granfield, 1994). The term "recovery" is best reserved for those persons who have resolved or are in the process of resolving severe AOD-related

problems that meet DSM-IV criteria for “abuse” or “dependence” (APA, 1994). The less medicalized terms, *quit* and *cessation*, more aptly describe the problem-solving processes in cases marked by less severity. The broader term *resolution* embraces both patterns of problem solving.

White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

Q: Dr. White indicated that the recovery model was gaining ground, but could you be specific about how much it is in the field, and how it compares with something like the medical model? My impression is that the medical model has been increasing in programs, while the recovery model seems to have less emphasis. I will appreciate learning more about what the status is of the model and how much it has been gaining or losing ground in the field.

A: Recovery management (RM) and recovery-oriented systems of care (ROSC) have been embraced by the White House Office of Drug Control Policy (ONDCP) and the Center for Substance Abuse Treatment (CSAT). CSAT has promoted this model through such publications as:

Center for Substance Abuse Treatment (CSAT). (2007). *National Summit on Recovery: Conference report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Clark, W. (2007). *Recovery as an organizing concept*. In White, W. (2008). *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, pp. 7-21. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Kaplan, L., (2008). *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008.

Kaplan, L., Nugent, C., Baker, M., Clark, H. (2010). *Mobilizing the addiction recovery community: The Center for Substance Abuse Treatment’s Recovery Community Services Program*. *Alcoholism Treatment Quarterly*, 28(3), 244-255.

Sheedy C. K., and Whitter M., *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research?* HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

CSAT has also promoted ROSC through a series of monographs developed through CSAT’s Addiction Technology Transfer Centers. They can be downloaded for free at http://www.williamwhitepapers.com/books_monographs/

You can also get a recent review of the state of recovery support services implementation in the U.S. at the link below:

<http://www.williamwhitepapers.com/pr/2013%20Betty%20Ford%20Institute%20Consensus%20Statement%20on%20Recovery%20Support%20Services.pdf>

White, W., Humphreys, K., Bourgeois, M., Chiapella, P., Evans, A., Flaherty, M., Gaumond, P., Haggerson, P., Haberle, B., Hill, T., Kaskutas, L.A., Kelly, J., McDaid, C., Powell, J., Scott, C., & Taylor, P., (2013) *The status and future of addiction recovery support services in the United*

States: Report of the BFI/UCLA Consensus Conference on Recovery Support Services, February 2012.

The state of implementation of RM & ROSC is very inconsistent across the country with some states have been involved in this process for over a decade and others that have not yet begun the move toward greater recovery orientation.

Q: Could you please explain amplified recovery again?

A: Some individuals experience changes so profound within recovery from addiction that they come to view recovery as a “gift” that brought a depth of experience and meaning far superior to their pre-addiction lives. Such individuals achieve an *enriched or amplified state of recovery*. You might think of this as getting better than well—development of a quality of life and life meaning and purpose that would not have been present without the reconstruction of identity and interpersonal relationships within the recovery process. This enriched state of recovery is evident across recovery traditions. Here are some examples:

The walls crumpled -- and the light streamed in. I wasn't trapped. I wasn't helpless. I was free, and I didn't have to drink to "show them." This wasn't "religion" -- this was freedom! Freedom from anger and fear, freedom to know happiness and love. (From Alcoholics Anonymous, 1976, p. 228).

It is impossible to put on paper all the benefits I have derived . . . physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the truth. From Alcoholics Anonymous, 1976, p. 481.

My life is well-rounded and I am becoming a more comfortable version of myself, not the neurotic, boring person that I thought I would be without drugs.....I have a way to live cleanly, honestly and comfortably. I have all I need. (From Narcotics Anonymous, 1988, p. 262).

It's been a very long, long struggle but worth every single minute of it. I'm really happy to be alive, and life is truly great and wonderful for me right now. (Women for Sobriety member, From Kirkpatrick, 1986, p. 258).

Back in 1970 I found myself dying from the abuse of my body....The Creator had something he had for me to learn. First, I had to learn who he was. Then I had to learn who I was. I began to visit with my Elders....I had to come to grips with who I am as an Indian, as being a castaway, as being an unloved person. The Creator has love for each of us but we have to find that foundation. (From Red Road to Wellbriety, 2002, p. 187).