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Recovery Network Awareness: A Training Guide to Help Clients Choose an Aftercare Program for Sobriety

Thomas Bosek
hn2256su@go.minnstate.edu

Recovery Network Awareness: A Training Guide to Help Clients Choose an Aftercare Program for Sobriety

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By

Thomas James Bosek

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Abstract

Recovery environments are a crucial role in any individual's journey to achieve sobriety. A safe environment will allow people who have a history of substance use to work their program effectively and decrease their relapse potential. The purpose of this paper is to identify multiple recovery-based programs for new professionals and providers entering the field of substance abuse treatment that allow their clients to have the best opportunity to succeed with their personal goals. The main programs discussed in this paper include 12 step programs, SMART Recovery, Harm reduction, and Medication Assisted Therapy. Choosing the right program for clients can be a challenge and the information provided in this paper will help identify interventions that align with the client's core beliefs for them to have the autonomy to choose what they feel is the best route for their recovery. A training (Recovery Networking) will be provided that corresponds to the topics discussed in the literature review.

Keywords: recovery, aftercare, alternatives

Table of Contents

Introduction

This paper will focus on providing awareness and education on recovery support systems with a training provided for new clinicians beginning in the field of substance abuse counseling. Most people may have heard of the opioid epidemic that has been hindering our country the past couple of decades but are unaware of the inner workings of how we as a society are dealing with the issue, specifically with treatment interventions. This is not limited to just opioids; it also includes methamphetamine, alcohol, prescription drugs, hallucinogens, club drugs, central nervous system depressants (Benzodiazepines), inhalants, and marijuana. The paper will focus on the rising prevalence of non-traditional 12-step groups and compare how effective they are too traditional 12 step programs that have been in place for nearly a century. Other topics include the prevalence and effectiveness of harm reduction modalities and how they compare to abstinent supports.

Traditional 12-step programs are typically faith-based programs that require an individual to completely surrender themselves over to a higher power and admit they are powerless over their addiction, or substance use dependency. The most prominent 12 step programs include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). They have dominated the self-help group process for all who struggle with substance abuse and remain to be the primary go-to treatment option for clinicians and counselors around the world. According to The Recovery Village, roughly only 20% of people who struggle from substance abuse will remain sober one year after treatment (2020). That number does not look or sound promising, and the purpose of this information is not to diminish 12 step programs or say that they are ineffective in any way, but to bring an awareness of other programs that may be more effective for others because everyone has different core beliefs and principals that do not necessarily align with 12 step

programs. Each section will utilize current and past research to compare the effectiveness of each intervention. New non-twelve step interventions such as SMART Recovery and Harm-Reduction models have gained notoriety within the field of substance abuse. Both are controversial in the field for counselors and practitioners even while being evidence-based practices. The hesitance is due to a paucity of research and intervention methodology. However, with proper training and education on appropriate recovery supports/environments, clients will have a better chance to remain sober for longer duration of time. The paper will be followed by a training (Recovery Networking) which will incorporate research and data to formulate an efficient presentation aiming to establish a foundation for helping professionals to understand and recognize the ins and outs of aftercare programs for substance abuse treatment.

Literature Review

12 Step Programs Overview

AA was founded in 1935 by Bob Smith and Bill Wilson (Gross, 2010). AA is predicated on a fellowship known as the Oxford Group, a religious sect of individuals who attempted to continue the tradition of first-century Christianity practices. One of the co-founders, Bill Wilson himself, was an agnostic person who struggled from alcoholism in the early 20th century when religion was an integral part of every American household and played a major role in how people were viewed in society. This is relevant because traditional 12 step programs are often stereotyped as being over religious. As of 2010, AA has grown from 2 individuals to over 1.6 million members in 160 countries (Gross, 2010). The membership continues to increase every year, which raises concern over what is the underlying issue attributing to the increase in need for substance use programs.

With so many new beliefs and affiliations coming into the world of AA/NA, new approaches may be necessary to meet the needs of a diverse clientele. Sometimes it is not solely the client but rather the attitude of the provider or counselor that could hinder the effectiveness of 12 step programs and the therapeutic relationship between each other. A study was conducted by two Ph.D. level professors with a background in social work and psychology to assess the attitudes substance use professionals have toward 12-step culture. Their study aimed to capture two items: valuing 12 step culture and willingness to learn and adapt, which consisted of 18 items each. To analyze the results from 284 participants, the author's used an exploratory factor analysis. The results indicated that substance use professionals who value 12 step programs personally will more confidently lecture the steps towards clients, knowing that resistance may occur (Dennis, & Earleywine, 2013). Other findings included that a substance use professional's attitude towards 12 step programs influences participation and attendance (Dennis, & Earleywine, 2013). This study highlights the crucial link between the attitude of the provider (towards 12-step programs) and the willingness of the client to attend 12-step support groups. The opposite situation, if a provider does not believe in the 12-steps yet works in a facility that builds treatment and programming around that philosophy, this could create negative treatment outcomes.

The consequences or implications could result in ineffective treatment for the clients, and relapse may occur in the future. Therefore, it is important for counselors to be competent in the 12-step approach if they are going to prescribe it to clients. One disadvantage of the 12-step approach is that it is based on anecdotes, not evidence-based practices; 12-step programs do not embrace scientific research (Gross, 2010). Providers are now responsible for ensuring that the services they provide to clients have empirical support. Currently, there is a paucity of

conclusive evidence that supports 12 step programs to be effective (Kelly, 2017). However, the increase of research for 12 step programs in the last 25 years and the thousands of cases where AA/NA was shown to be effective and help individuals manage their substance abuse disorder cannot be dismissed (Kelly, 2017). AA/NA is an effective public health ally that aids addiction recovery through its ability to mobilize therapeutic mechanisms (Kelly, 2017). Regarding the effectiveness of AA/NA another major study was conducted by Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity). The results from the study discovered that individuals who attended 12-step facilitation had nearly 60-70% more cases of fully sustained remission of alcohol use in the first year following treatment (Longabaugh, Wirtz, Zweben, & Stout, 1998). Three-year follow-ups were conducted, and 12-step facilitation was 50% higher than Cognitive Behavioral Therapy in positive outcomes. Meaning individuals who participated in the 12 step programming perceived their treatment to be more effective than CBT.

Outcomes will be influenced by the general attitude the counselor or client has towards a 12-step program, but the awareness needs to increase concerning recovery programs for people who may have a negative attitude towards 12 step programs. Instead, providers should implement a person-centered approach and allow them to choose the treatment they feel is best for their individual needs and best possible care.

A crucial characteristic of 12 step programs includes for individuals who are participating in community-based AA/NA programs to acquire a sponsor during their time working the steps. AA sponsorship has been said to represent the intersection between the social network support of abstinence and the active ingredients to AA (Tonigan, & Rice, 2013) The prevalence of having a sponsor is reported to be at 75% within the first three months after treatment. However, when 9 month follow ups were conducted, only about 1 and 5 individuals reported still utilizing a

sponsor in their recovery program. (Tonigan, & Rice, 2013). A report from 1988 suggested that relapse occurrence was significantly higher for people who did not acquire sponsors in their treatment programs (Tonigan, & Rice, 2013). A growing body of research has been conducted on the effectiveness and prevalence of sponsors within the 12-step community (Tonigan, & Rice, 2013). One study performed searched for findings on the direct and specific effects of sponsors within community-based self-help groups. The study recruited 253 alcohol dependent adults, 68 were from community-based AA and 185 were prepared to enter outpatient programming. Results from the study indicated that early sponsorship in the first three months saw increased benefits from the sponsor (Tonigan, & Rice, 2013). Participants who utilized a sponsor at three months were 3 times as likely to be alcohol free as individuals who were abstinent with no sponsor at 6 months (Tonigan, & Rice, 2013). Other findings included participants with sponsors at 3 months reported 21% more abstinent days (Tonigan, & Rice, 2013). The evidence appears to show strong support for AA members to consider acquiring a sponsor within their first months outside of treatment or in general for their overall recovery. One question that has yet to be answered is if this data is consistent with the NA community as well. AA and NA are similar in structure and the study indicated that their primary focus was alcohol and not narcotics. The authors did not exclude anyone who had multiple substance disorders. For future studies, looking at the differences between the two self help groups could potentially benefit sponsors more and incentives people struggling with substance abuse to seek out a sponsor.

SMART Recovery Overview

A recent modality and ever-growing approach to recovery is SMART Recovery (Self-Management and Recovery Training). SMART Recovery was founded in 1994 and has exponentially grown over the past 25 years to over 2000 local meetings (Allwood & White,

2017). SMART recovery has been endorsed by major governing bodies such as National Institute on Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration (SAMHSA), among many others. (Allwood & White, 2017). To reinforce its support even more, SMART recovery has been implemented in over 200 prisons worldwide with its InsideOut program (Allwood & White, 2017). Many people outside the realm of substance abuse and recovery programs are not familiar with alternative programs of 12 step programs such as AA/NA. It is important to note that whenever a new intervention/program is offered to a client that it is backed by empirical data and peer reviewed research. SMART Recovery approach was specifically developed to reflect current evidence-based practice in the substance abuse field. As such, SMART Recovery incorporates well-established psychological principles from a range of approaches, including motivational interviewing and cognitive behavior therapy (Kelly et al., 2017). The main objective of SMART recovery for any individual is to discover or rediscover the power of choice in their life (Allwood & White, 2017). People who struggle with substance abuse are often consumed by the drug of their choice and have no control over their desire for the drug or the chemical dependency their body acclimates to over time. The baseline of systems in the body of an individual who struggles from drug use is typically in a heightened or depressed state depending on if they are using stimulants or depressants. Another aspect SMART recovery is known for is eradicating the use of labels such as addict or disease, which is the opposite of traditional 12 step programs. (Allwood & White, 2017).

Programs such as AA/NA require the person to admit they are an addict and live with that label for the rest of their lives as they can never be cured of their disease because they are powerless over the behavior. Many people struggle with labeling themselves as an addict for life and the stigma that comes with such a label. The action is degrading and can cause a negative

interpterion of someone's self-worth in the world and turn them away from recovery. Numerous individuals have reported having negative experiences or even feeling traumatized by their 12-step experiences (Horvath & Yeterian, 2012). SMART recovery instead seeks to convey the message that addiction can be managed by the individual with the proper motivations. For example, finding a point in time of the individual's life where they had hopes and dreams or found joy from meaningful activities. Using those motivations as a frame of reference to get back to in the present will help the individual strive for a life of sobriety. SMART Recovery providers are trying to take the stigma away and provide a more welcoming environment for people having difficulties with substance use disorder behavior. Facilitators in SMART recovery attempt to uplift the individual instead of focusing on the shortcomings of the person. SMART recovery gives all the power to the individual to say they have had enough and want to change their identity or life story, and they can work with the correct tools such as the 4-point system of SMART Recovery.

The 4-point system of SMART recovery includes 1) Build Motivation 2) Cope with Urges 3) Manage Thoughts and Feelings 4) Live a Balanced Life (Allwood, S., & White, W., 2017). An interesting study was conducted to examine the relationship between the consequences of alcohol abuse and motivation to change drinking behavior between members of SMART Recovery and AA. The study used a cross-sectional design between subjects amongst 60 SMART Recovery participants and 56 AA members. One key finding indicated outcomes for SMART Recovery were consistently superior relative to AA when it came to less hazardous use of alcohol (Milan, 2007). When people have a more internal locus of control vs. external, it can potentially change the outcomes of any study drastically. For example, when people have a sense of control over their behavior, their thinking patterns and decision-making skills can improve and

allow the person to manage themselves more appropriately such as making less impulsive decisions. Thus, allowing them to handle cravings or urges more competently and become satisfied with how they are structuring their recovery.

A study conducted in 2016 provided support SMART Recovery as an option over 12-step facilitation. The study focused on perspectives of individuals with co-occurring disorders. The researchers used two focus groups—one for co-occurring clients and one for counselors. The results found that clients and counselors had about 50% positive comments about SMART Recovery, but the second-highest comments were negative towards 12-step programs. (Penn, Brooke, Brooks, Gallagher, & Barnard, 2016). The average participant had about 7.4 years of experience with 12-step groups, and counselors had more positive comments towards 12-step facilitation (Penn, Brooke, Brooks, Gallagher, & Barnard, 2016). The study introduces an interesting dichotomy that could potentially generalize the attitudes counselors and clients may have towards 12-step facilitation and SMART Recovery. Cultural and generational differences could have played a factor in the study.

Harm Reduction/Medication Assisted Therapy Overview

Harm reduction is a term used in public to help those adults who had issues dealing with substance abuse and whose abstinence was unable to be achieved from the treatment they received. Drug overdoses with fentanyl, opioids, and heroin are increasing exponentially over the last few years (Rouhani, Park, Morales, Green, & Sherman 2019). Many harm reduction methods have remained to be effective in reducing mortality and morbidity in such adult populations (Rouhani, Park, Morales, Green, & Sherman 2019). Lately, harm reduction strategies have been employed in sexual health education to reduce both adolescent sexually transmitted diseases and pregnancies (Rouhani, Park, Morales, Green, & Sherman 2019). The programs already designed

to utilize harm reduction strategies have successfully lowered the unsafe use of alcohol (Jiloha, 2017). The context and the target population where the harm reduction strategies are employed impact the particular interventions used. Health care providers need to be aware of the different types of harm reduction strategies that reduce the likely risks related to normative health behaviors.

The research defines harm reduction as a strategy designed to help groups or individuals who focus on reducing those harms that are linked to particular (Kimmel et al., 2021). Substance abuse programs, when harm reduction is implemented, it accepts that a constant level of using drugs, both illicit and licit, within the community is inevitable; hence, it defines the goals as helping to reduce the adverse consequences. The strategy stresses the measurement of economic, health, and social outcomes and not measuring drug usage. Harm reduction has been evolving since its original identification in the 1980s as an alternative option for abstinence-only interventions for adults who suffered from substance abuse disorders (Harper, Powell & Pijl, 2017). During that period, it was apparent that abstinence did not emerge from treatment interventions being provided to be considered effective, therefore a new method was needed. Individuals whose interests were to reduce and not eliminate their use were not well-served in programs that required abstinence. According to Hawk et al., (2017), there is evidence showing that the harm reduction methods have greatly helped in reducing mortality and morbidity related to health behaviors. An example of substance abuse harm reduction is needle-exchange programs. Since needle exchange programs have been introduced, they have shown decreases in the mean annual H.I.V. seroprevalence compared to those that never introduced those programs (Hawk et al., 2017).

The use and access to methadone maintenance programs are connected to the decreased mortality from both overdoses and natural causes, implying that the programs affect general sociomedical health. (Jiloha, 2017). The harm reduction continuum has also received the recent addition of supervised injecting facilities that have been implemented successfully in the Netherlands, Switzerland, and Vancouver, British Colombia (Jiloha, 2017). The health care providers play very significant roles in most of the harm reduction initiatives. In general, long-term trends have proven to be successful within substance use behaviors over time (Jiloha, 2017). Still, it is highly not likely that any of the interventions would help eliminate such behaviors from adolescence (Jiloha, 2017).

However, improved harm reduction strategies were implemented to slow down the past trends in the last decade (Watson, Kolla, van der Meulen & Dodd, 2020). Several studies concerning substance use have shown that the apparent risk of harm is generally inversely linked to the level of substance use. Offering education on the risks and the different ways of reducing or mitigating these risks may typically affect risky behaviors (Watson et al., 2020). It is essential to acknowledge programs that focus on prevention, but it is just as vital to recognize programs that focus on secondary prevention (Watson et al., 2020). Watson et al. (2020) indicated the need to continue and critically theorize harm reduction and to build strong community relationships. With this, Watson et al. (2020) feel harm reduction services need to be innovative, dynamic, and inclusive to individuals with lived experiences, allies, and service providers responding to the opioid crisis and responding to the fast-changing substance abuse patterns.

Today, there is a lot of literature that continues to grow in support of the efficiency of harm reduction strategies in the intervention and prevention of substance abuse behavior that has likely health risks. Witkiewitz and Marlatt (2004) conducted a meta-analysis review concerning

harm reduction methods to alcohol use, summarizing the most appropriate literature about health treatment, promotion, and prevention.

In their review, they discussed the data of a program used across the United States. The program's name was called the Drug Abuse Resistance Education (D.A.R.E.) that aimed at zero-tolerance (Witkiewitz & Marlatt, 2004). According to Ennett et al., (2011), other studies have emerged demonstrating that the program was not efficient in reducing the use of substances. Two other programs were successfully executed and assessed according to the harm reduction philosophy, and they include the School Health and Alcohol Harm Reduction Project in Australia as well as the Alcohol Misuse Prevention Study in the United States (Witkiewitz & Marlatt, 2004). The D.A.R.E. program was created as a program for students in grades five and six. It included data on the harms resulting from alcohol abuse and how to cope with social pressures related to alcohol misuse.

During a controlled randomized study, the participants within the Alcohol Misuse Prevention Study had only fewer alcohol issues than the controls. The program also showed reductions within the normative increase in alcohol and the misuse in early to late adolescence. On the other hand, the school health and alcohol harm reduction project program had the same components as the Alcohol Misuse Prevention Study program and comprised of active learning comprising of alcohol education and incorporating skills training (Kimmel et al., 2021). Assessment of the program showed significant reductions within alcohol-related harms and alcohol consumptions among those students who participated in the program as compared to the controls (Kimmel et al., 2021).

Generally, the prevention programs have not been efficient to change the adolescents' behaviors that get involved in harmful drinking. The idea to learn how one can drink more safely

is consistent with the reality that most adolescents view drinking as being normative. It is developmentally consistent that teenagers have fewer chances of getting involved in treatments or programs that needed them to behave in a particular way and could rebel against anything that they saw as being judgmental (Rouhani et al., 2019). Alcohol management is a harm reduction strategy needing to be adopted in those areas that comprise individuals who abuse drugs. They include the Downtown Emergency Service Center in Seattle.

The Downtown Emergency Service Center serves individuals who are formally homeless women and men with chronic alcohol addiction. Alcohol management is provided to those individuals who generally are at the risk of being harmed in the periods of withdrawing from alcohol or any other dangerous behavior related to the use of alcohol (Collins et al., 2018). The downtown emergency service center is committed to enhancing the standards of living of the participants, reducing the harm of alcohol withdrawal as well as increasing their housing stability. There are about 16 out of 75 residents at the facility who participate in the alcohol management program (Collins et al., 2018). Their research suggests that the intervention is not meant to be effective for everyone.

The program operates through the use of motivational interviewing, where the staff gets to approach the likely program participants and discuss the goals of the client. They then ask them questions such as; Do you drink more in the morning so that you can slat off withdrawals? How many drinks do you have to take to make sure you do not feel sick? How long does it take you to drink before you start going into withdrawal? What is your main objective? Do you want to cut back? Depending on the client's responses, the staff can develop an alcohol management plan the participant will sign, along with the team. The plan developed with the individual offers

information about the alcohol dose that is to be administered to the participants at specific intervals (Collins et al., 2018).

The facility ensures that they collect anecdotal information on the results from the program and reports the increases of stability, allows for the intervention during alcohol withdrawal, fosters engagement, slows health decline, the potential decrease in the use of alcohol over time for some of the participants as well as the risk of loss of independence. Most harm reduction initiatives generally involve educational facilities or campaigns whose main objectives are to reduce drug-related harm (Collins, et al., 2018).

Some of the other harm reduction programs or initiatives include heroin maintenance programs, opioid replacement therapy, opioid substitution therapy as well as supervised injection sites. Substitution drugs are generally not harmful to the body; however, the abuse of those drugs turns to become a problem that results to the morbidity and mortality of many individuals across the country. It is generally essential to deal with the root cause of the problem to provide a solution; however, it is also necessary to control the situation when it has already taken place. The root cause of substance abuse could be by first ensuring that people, when they are young and in school, that they are aware of the harmful effects of using and abusing drugs.

Making sure that everyone is treated equally in the country and that everyone has an equal chance of living a better life in the future is also another way to solve drug abuse among most individuals. People start using the substances primarily because of peer pressure, idleness, harsh living standards, anxiety and depression, stress, and many other factors. To help reduce the mortality rates of substance abuse, it is essential to help such individuals to get solutions to their problems. However, when the situation is that the problem is already there, then the harm-reducing approaches are the best to provide control and are the best solutions.

One more growing intervention being used in today's interventions for the prevention of opioid and alcohol use disorders is medication assistance therapy. Medication assisted therapy can be defined as the use of approved medications combined with counseling, other behavioral therapies, and patient monitoring. Medications approved in the US for MAT include methadone, buprenorphine, buprenorphine combined with naloxone, and naltrexone (Maglione et al., 2018). Other medications include Vivitrol and Disulfiram which are primarily used for alcohol use disorder. There is strong evidence to suggest medication assisted therapy is effective for treating opioid use disorders, however, simultaneously, there is research developing that also suggest people who utilize medications such as methadone have significantly lower cognitive abilities over time such as short/long term memory and attention (Maglione et al., 2018). Medication assisted therapy also has many benefits to counter the risk involved such as with naltrexone. An article by Oesterle, et al., (2019) explained medication-benefit studies have shown that, if taken as intended or prescribed, the medication does increase the chance of sobriety and decreases risk of overdose. Naltrexone has no abuse potential, no street value, and neither tolerance nor dependence develops (Oesterle, et al., 2019).

A second common medication used in medication assisted therapy programs include buprenorphine also called Subutex which is classified as a semisynthetic opioid as a partial agonist at the μ receptor and a full antagonist at the kappa (κ) receptor (Oesterle, et al., 2019). In simpler terms, the medication is a blockade drug to prevent cravings and urges for people administering the medication in replacement of illicit opioids such as heroin. Another version of buprenorphine includes suboxone which is slightly different from Subutex because it contains both buprenorphine and naltrexone. Benefits of buprenorphine include improved rates of sobriety, decreased criminal activity outcomes, and reduction in accidental overdoses (Oesterle,

et al., 2019). Methadone, another common medication administered for MAT is a full opioid agonist. Methadone maintenance programs decreases the use of illicit opioids, overdose death rates, delinquency, and allows recipients to enhance their health and social output. Additionally, enrollment in methadone maintenance reduces the transmission of infectious diseases, such as hepatitis and HIV, connected with heroin injection (Oesterle, et al., 2019).

Conclusion

Substance abuse counseling is a crucial role for the treatment interventions used to help people who struggle with drugs and alcohol. Being aware of up-to-date modalities is important for any professional or provider to be able to deliver the best possible care for the people they are serving. Once the client leaves a treatment setting, they rely on professionals' referrals and the development of aftercare plans on their journey to sobriety. Understanding which programs align with them best will help increase the individual's attendance to the program and remain abstinent from a substance. From the literature review, every program has their benefits and disadvantages, and it is vital to relay that information with clients when working with them in group or individual sessions.

The data suggest that self-help groups such as AA and NA can be highly effective in helping increase social support and participation in a person's recovery. However, not every person is willing to practice the interventions used in 12 step groups, so it is crucial to have alternatives such as SMART Recovery, and Harm Reduction models. The research suggests for people who do not align with the values of 12 step approaches that SMART recovery is an effective program to attempt because if gives the power of choice and management to the individual using evidence-based practices, whereas 12 step groups do not necessarily utilize a scientific approach. For a person who cannot remain abstinent from their substance abuse, harm

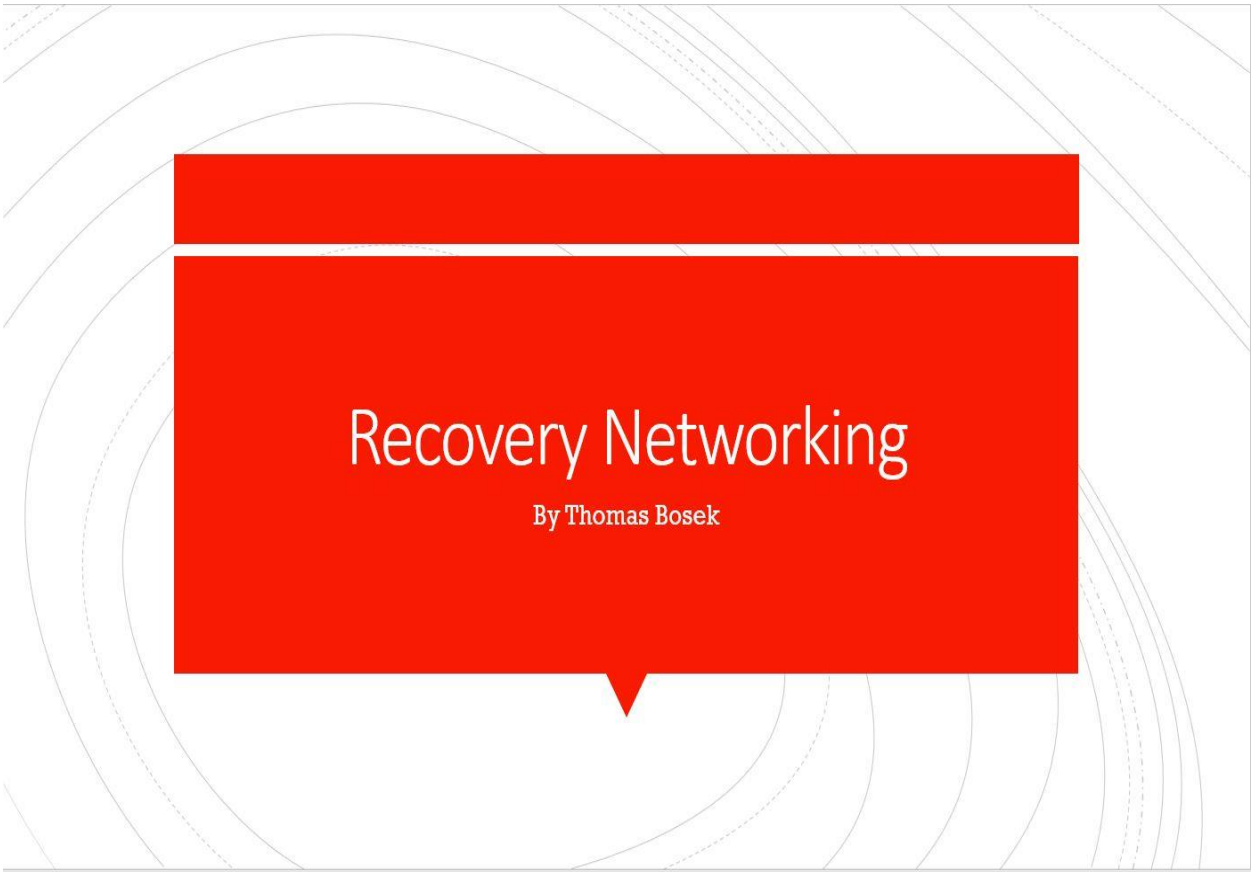
reduction models such as mediation assisted therapy have been shown to be effective in reducing the number of overdoses and public health concerns in a community.

The training following the paper was developed for a more interactive approach to describe how several recovery networks operate and to produce a positive learning experience for people who may not understand the nuances of substance use recovery. The training aims to enhance the quality of information for professionals to understand the in-depth processes of various interventions used in modern treatment planning and aftercare programs for people struggling with a substance use disorder. Training provides a simple and time efficient presentation with opportunity for open discussion and multiple viewpoints to be expressed and debated to further develop a foundation for best practices for working with clients.

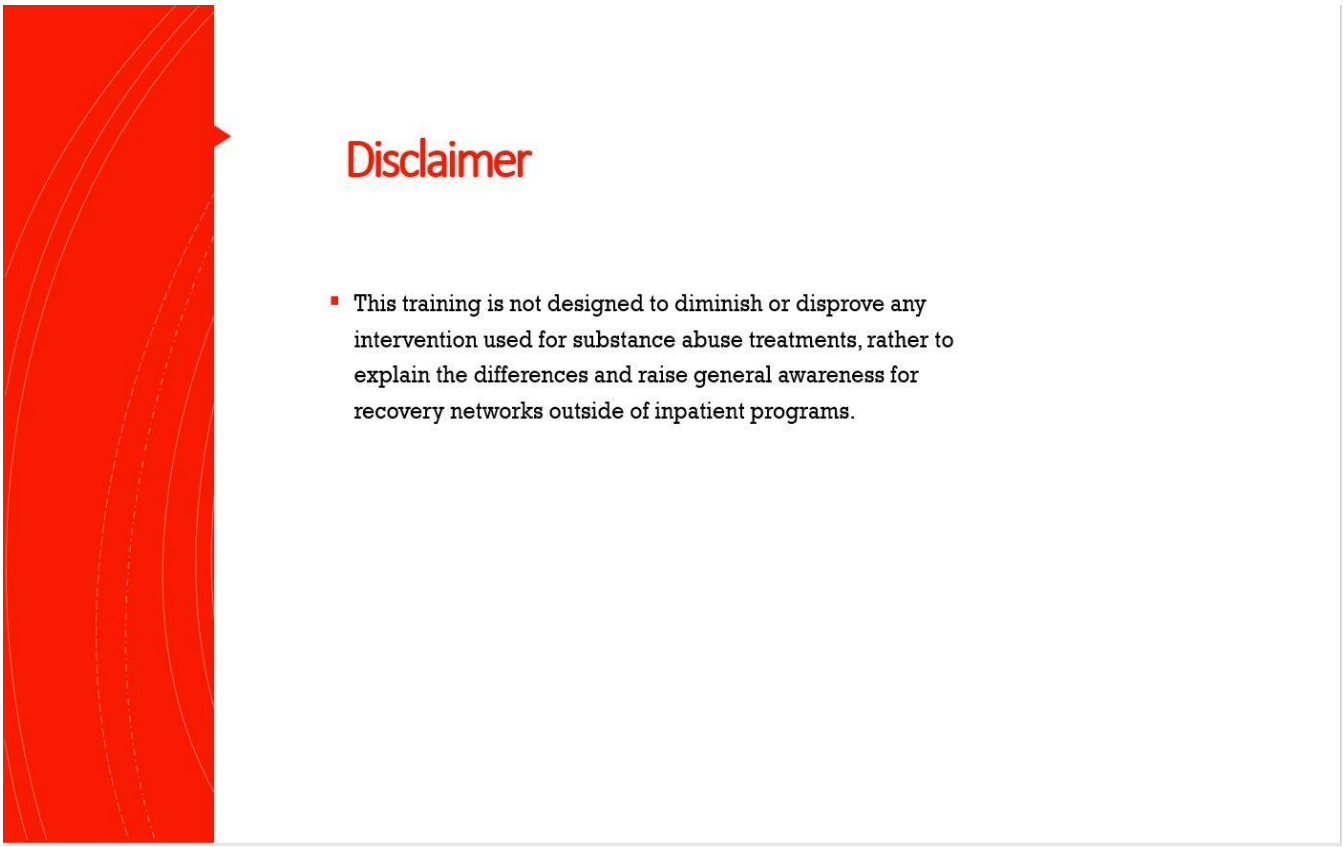
Training Overview

The following training will cover multiple recovery networks new practitioners will be able to utilize in their practice when working with substance abuse disorder populations. The intended audience is for 1st or 2nd year counselors who have recently completed a graduate program or are transitioning to the substance abuse realm from another field of study. The delivery and format of this training will be presented in person via PowerPoint and speaker/guest speakers. The training can be implemented online via zoom or online workshops. The training is developed to be about 45-60 minutes in length and will have open discussions in groups on a variety of topics regarding the information presented. Training can be presented yearly at conventions or workshops. Qualifications for presenter include being a licensed LADC or LPCC. The guest speaker's qualifications, should there be one, will be an individual who has had experience in any self-help group or MAT program.

Recovery Network Training: Slide 1

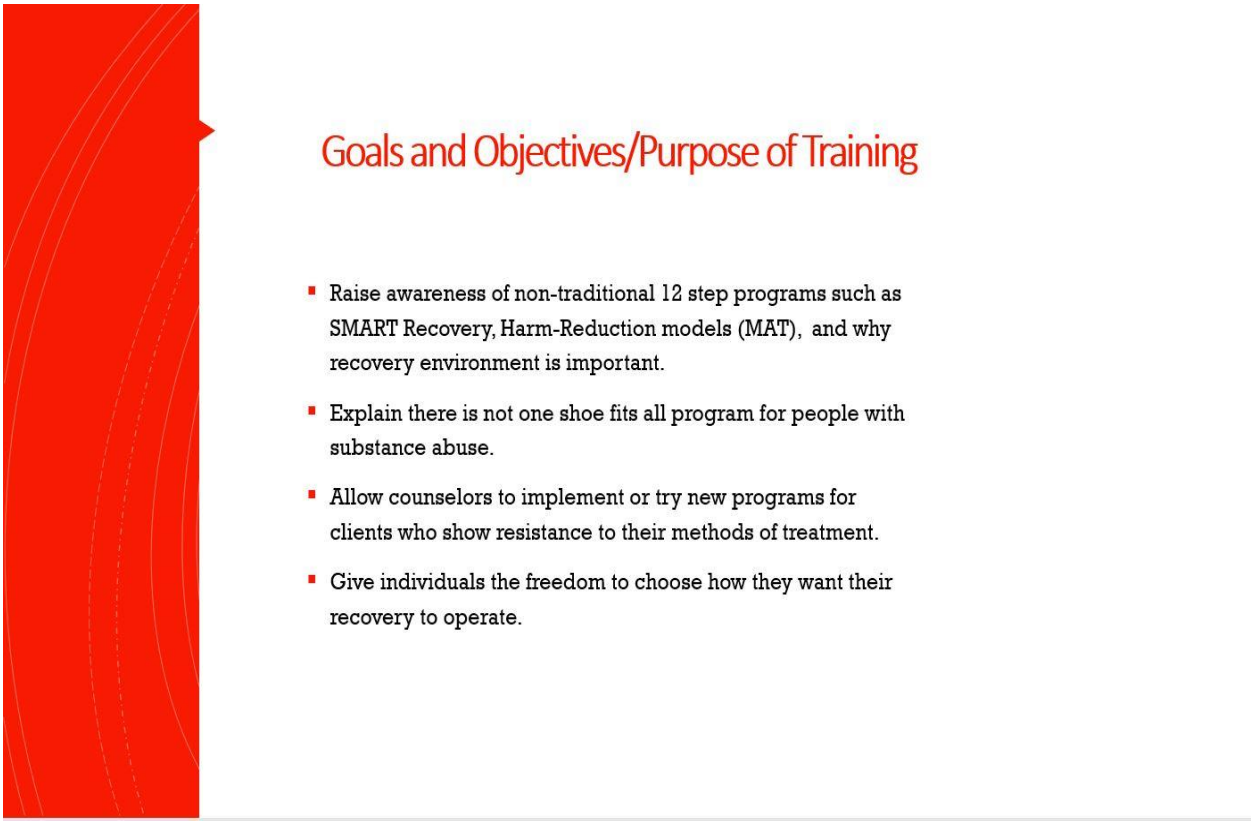


Slide 2



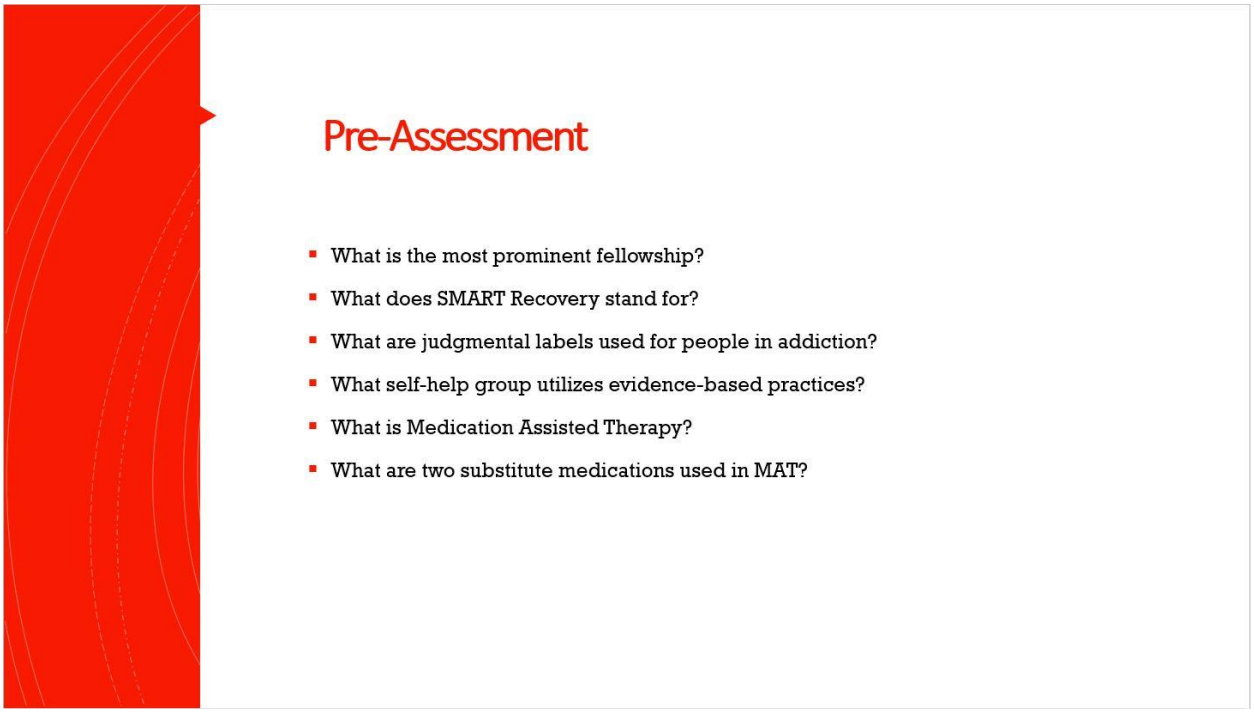
Presenter will read the disclaimer prior to the start of the training because many practitioners in the field of substance abuse treatment are in recovery themselves and practicing specific interventions. Therefore, promoting the idea of having an open mind to learn the process of other programs to provide their future clients the best possible aftercare is important to address. Also, to help other professionals entering the field have a greater scope of practice if they are coming in with generalizations of certain recovery networks.

Slide 3



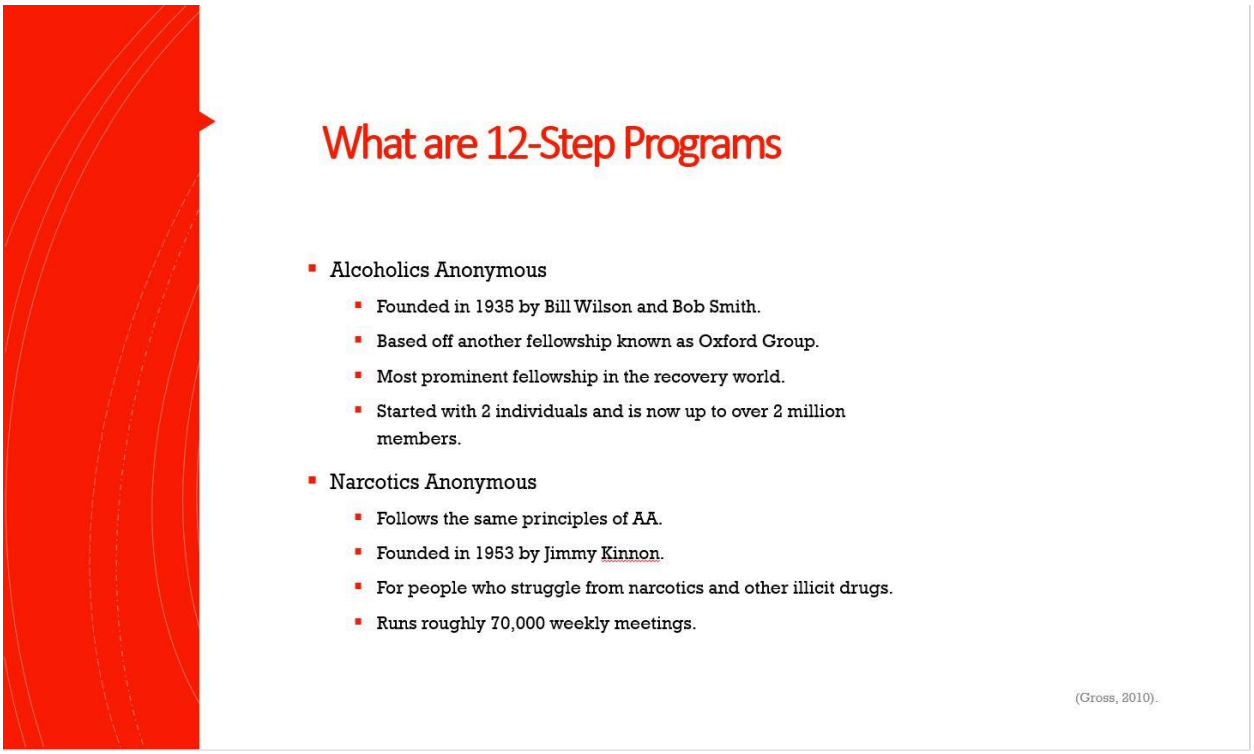
Presenter will identify the goals of the training from the information on the slide so recipients may have an understanding of what the training will entail overall as they progress through the content.

Slide 4



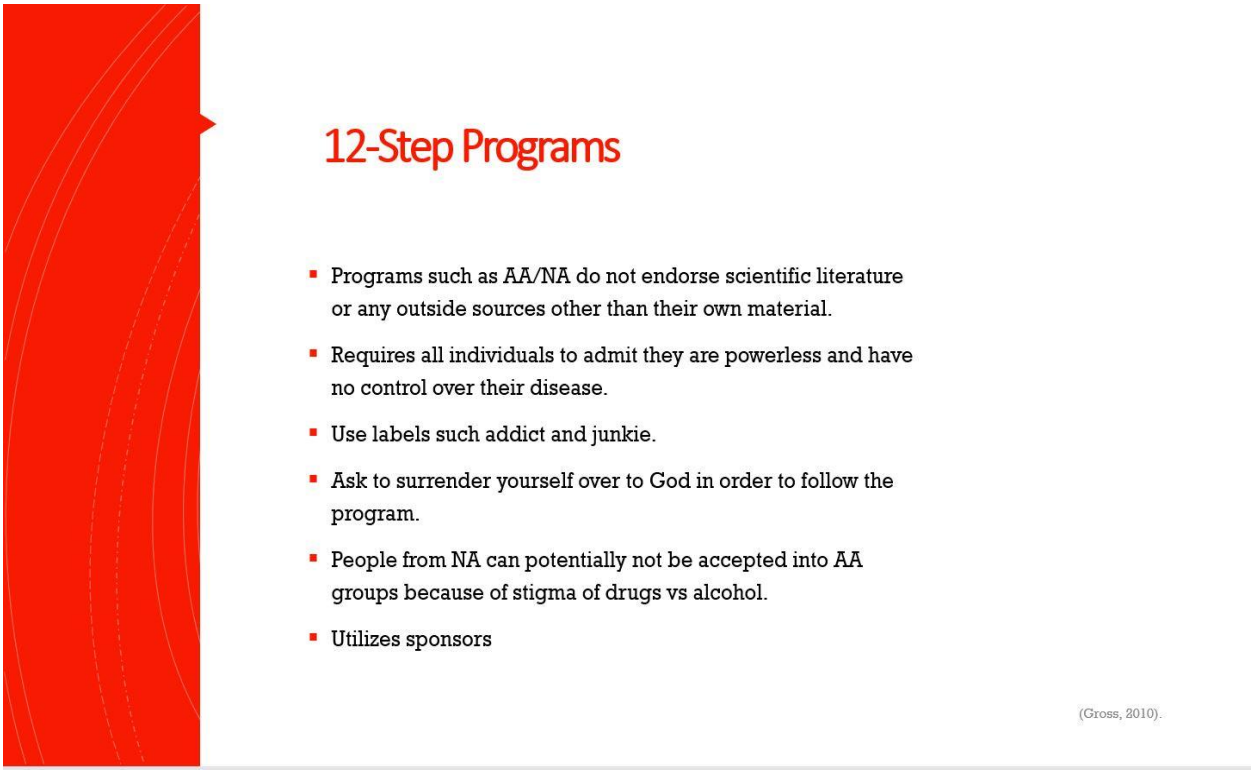
Presenter will provide a handout with questions related to the training material. Recipients may participate in answering the questions before the main information is presented. Assessment provides a way for presenter to gather key information about what attendees know and have a general understanding of going into the training. Once filled out, presenter will begin training. Answers will be provided in the post-test handout and appendices.

Slide 5



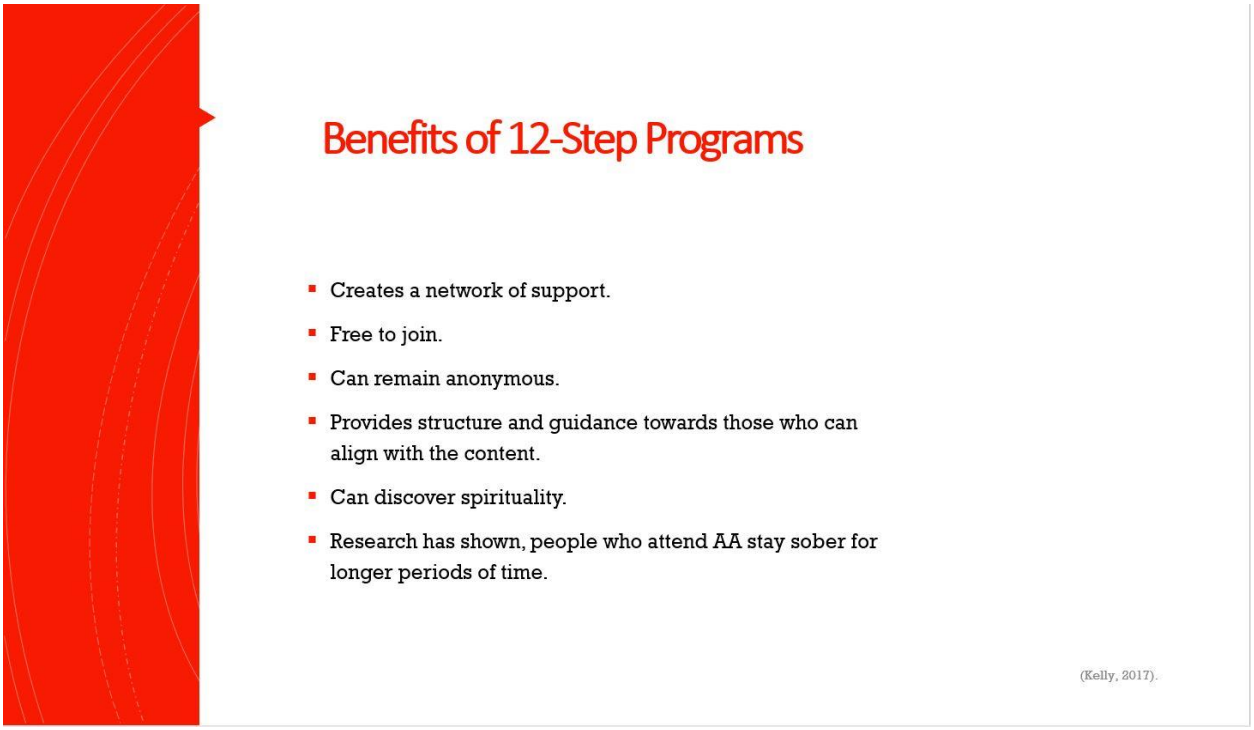
Presenter will begin training with an introduction to 12 step programs. Identifying the two most known self-help groups of Alcoholics Anonymous and Narcotics Anonymous and providing brief background information on the two groups. Presenter can mention there are many other 12 step programs which are utilized for interventions, but for the content of the training, presenter will focus on AA and NA.

Slide 6



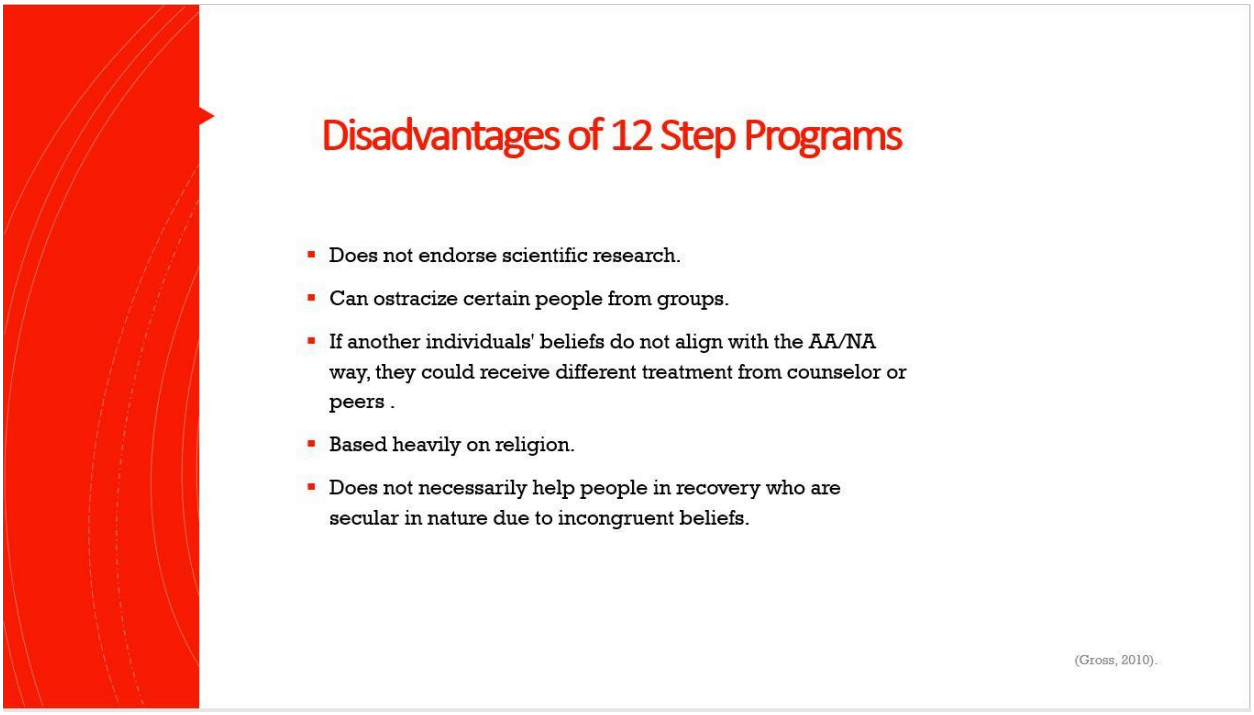
Presenter will dive deeper in to how 12 step programs operate with the information provided and begin a conversation about general attitudes geared towards 12 step programs in the current climate of recovery. Study (Dennis, & Earleywine, 2013) findings included a substance use professional's attitude towards 12 step programs influences participation and attendance. Presenter will discuss how negative labels such as junkie and addict are utilized for 12 step facilitations. Presenter will speak about effectiveness and outcomes of having a sponsor while practicing sobriety. Study (Tonigan, & Rice, 2013) suggested that relapse occurrence was significantly higher for people who did not acquire sponsors in their treatment programs.

Slide 7



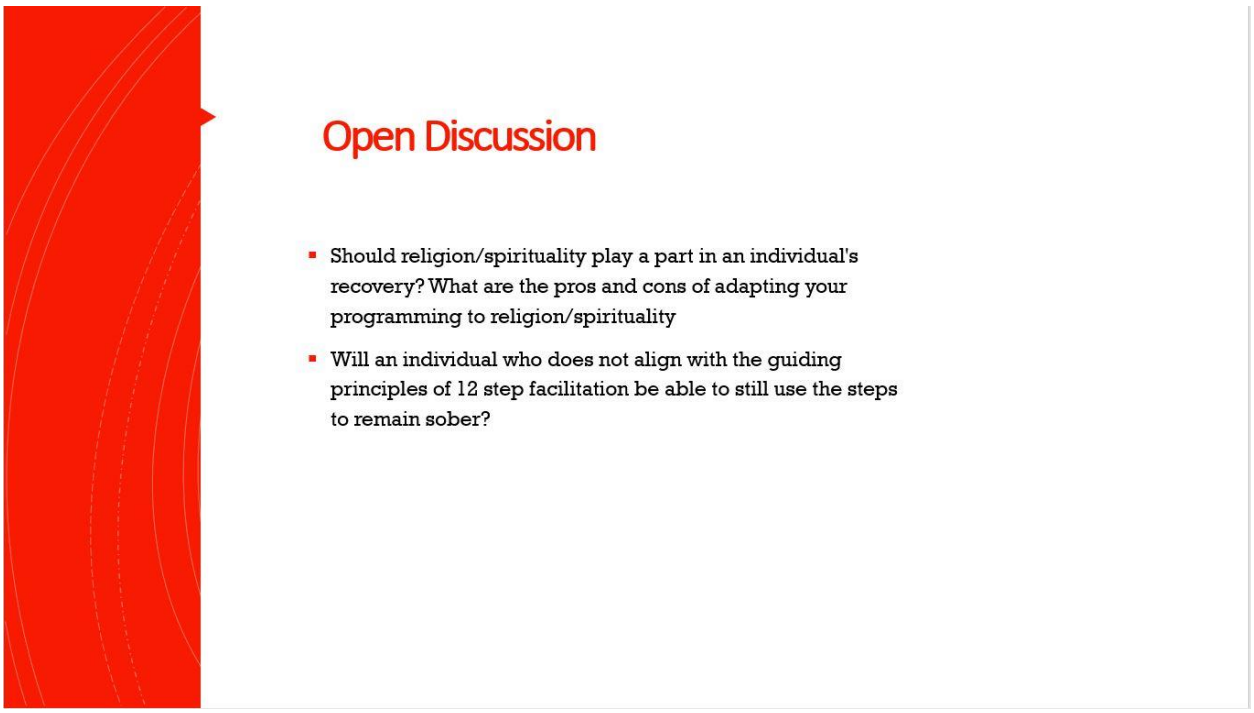
Presenter will identify the benefits of 12 step programs. Study (Longabaugh, Wirtz, Zweben, & Stout, 1998) indicated individuals who attended 12-step facilitation had nearly 60-70% more cases of fully sustained remission of alcohol use in the first year following treatment and clients who attend AA stay sober for longer durations of time. Presenter will take the time in this slide to differentiate the difference between religion and spirituality, and how they are both implemented in a recovery program. Religion is being in the service of a God(s) and spirituality acknowledges something greater than the individual to live for which is personalized by the individual's own definition.

Slide 8



Presenter will speak on the disadvantages involved with 12 step programs. Study (Gross, 2010) reports 12 step programs do not embrace scientific research, therefore, meaning the program is not an evidence-based practice. Presenter discusses moral high ground some individuals in self-help groups display (Alcoholic vs Drug Addict). State remaining information on the slide and transition to a group discussion activity.

Slide 9



Activity: Groups will assemble/be created to cover the questions listed on the slide. Presenter will give groups 5-10 minutes to openly discuss the questions, once time has expired, each group will share their ideas to create other discussions and to allow multiple viewpoints to be heard. Attendees can remain in groups for future group activities.

Slide 10

Presenter will transition to the next main topic by introducing SMART Recovery and provide basic background information about the program from the text on the slide.

Slide 11

Presenter will provide the defining characteristics of SMART recovery and explain how the 4-point system operates for the program. Presenter will begin to identify key similarities and differences between 12 step programs and SMART recovery, which is a non-traditional self-help group. Main similarity includes, both practice full abstinence, but both do not utilize religion/spirituality.

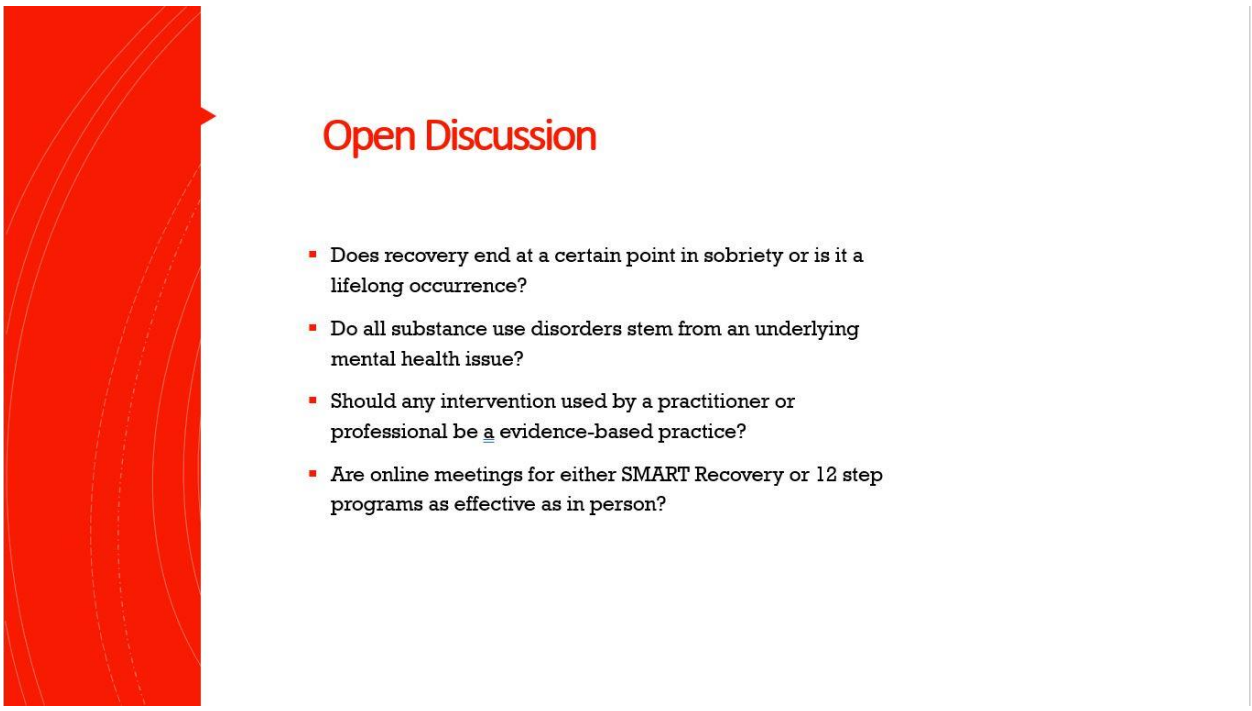
Slide 12

Presenter will list all the benefits of SMART recovery and provide a description of internal locus of control and the power of choice. Discuss the difference between admitting powerlessness to the power of choice: Admitting powerlessness indicates an individual is incapable or unable to manage their addiction in all circumstances. The power of choice re-establishes the idea a person struggling with substance abuse can manage their addiction through internal motivation and personal decision making. Clarify SMART recovery is an evidence-based program that primarily utilizes cognitive behavioral therapy techniques. Presenter explains SMART Recovery may be congruent with individuals who are secular in nature.

Slide 13

Presenter expresses the paucity of research that has been conducted for SMART recovery. Explains how the program is still relatively new, being established in 1992 and there are more researchers looking into the effectiveness and outcomes of the program. Discuss the lack of awareness of the program to people in recovery and for helping professionals.

Slide 14

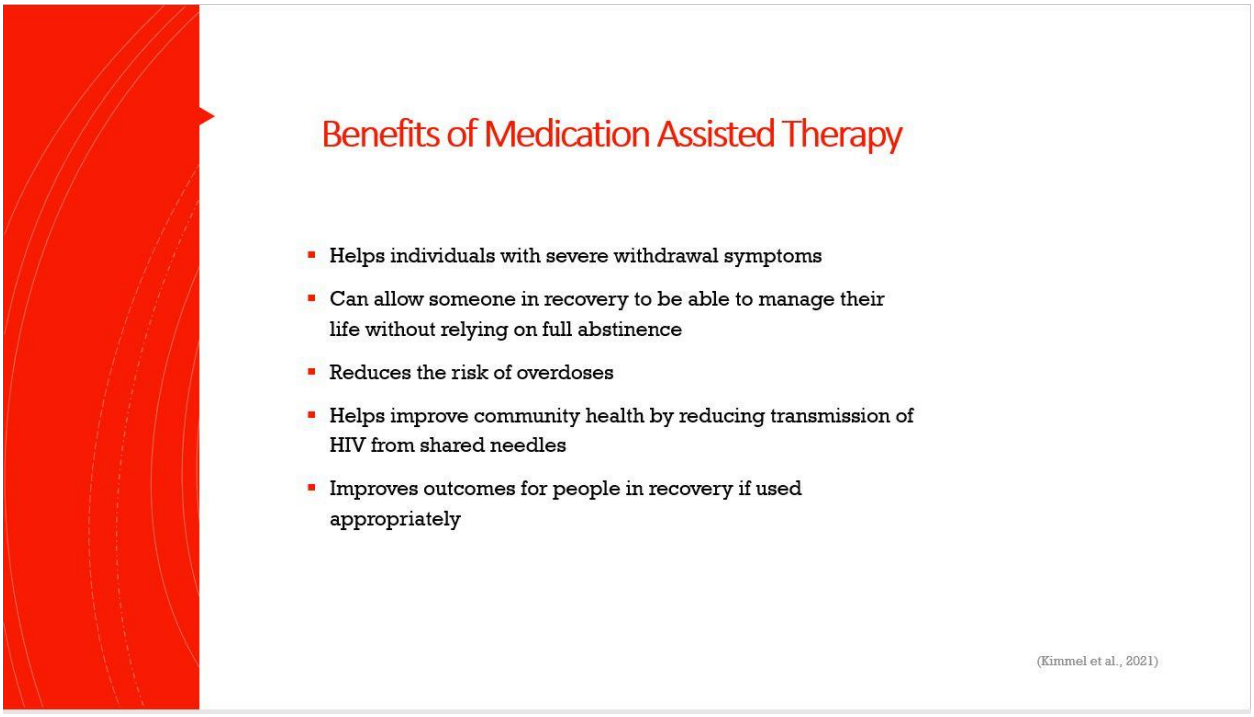


Activity: Groups will assemble/be created to cover the questions listed on the slide. Presenter will give groups 5-10 minutes to openly discuss the questions, once time has expired, each group will share their ideas to create other discussions and to allow multiple viewpoints to be heard. Attendees can remain in groups for future group activities.

Slide 15

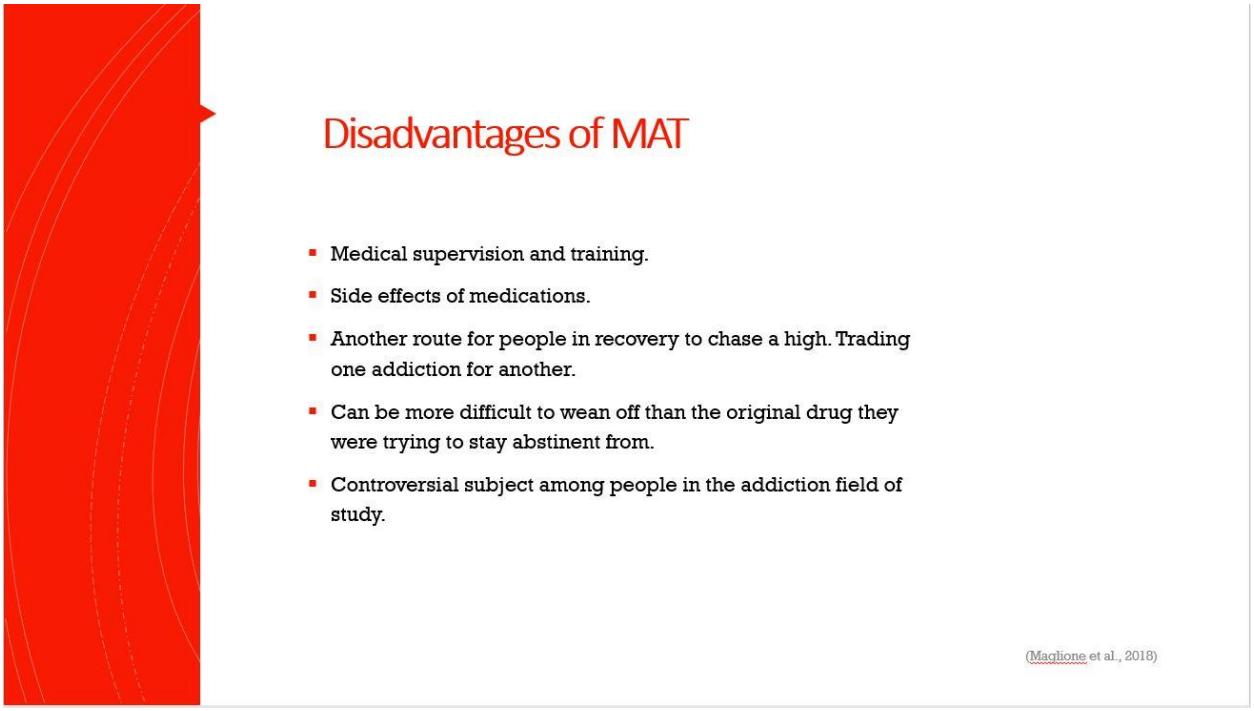
Presenter covers material on screen to begin the topic of medication assisted therapy and provides an educational video. Video is 5:30 in length and is an animation video with commentary explaining the fundamentals of medication assisted therapy. Introduces the content in a simple way for attendees who may have never heard of the intervention.

Slide 16



After video, presenter will shift to explaining the benefits of medication assisted therapy from the information on the slide and utilize research from literature review to reinforce the benefits. Introduce the idea some people are incapable of managing their relapse symptoms and MAT may be the most effective route to administer for their safety and wellbeing.

Slide 17

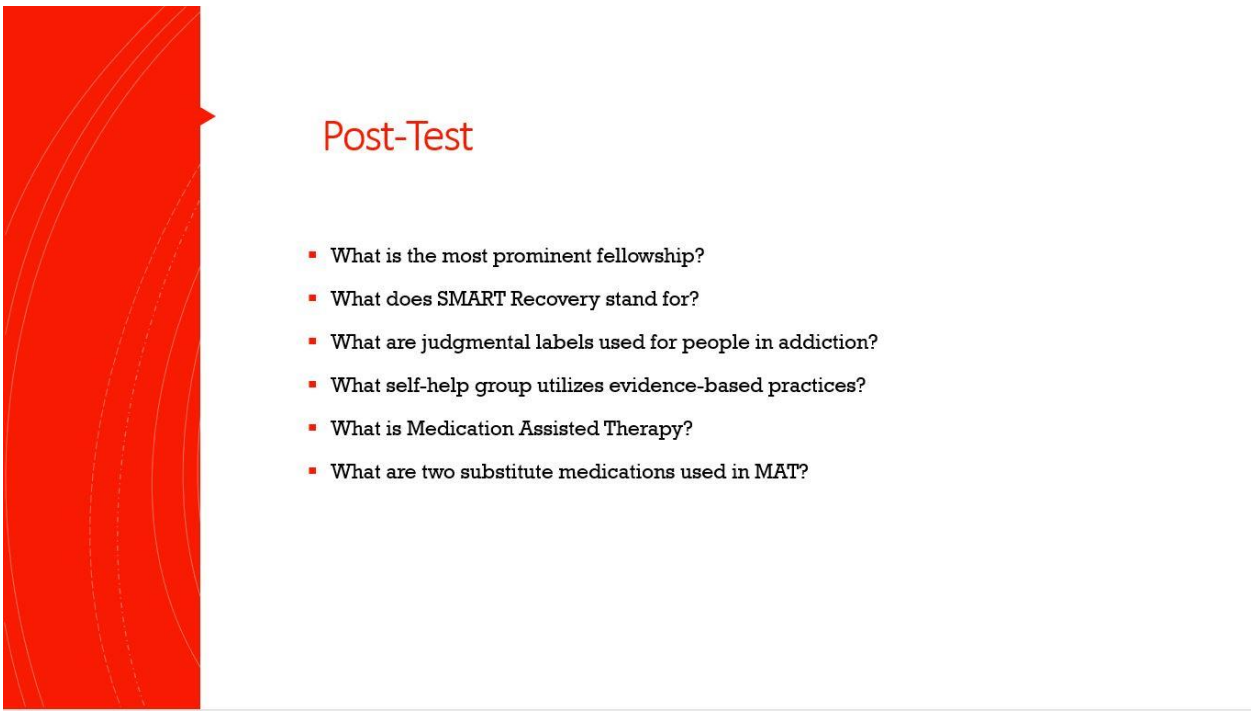


Presenter explains disadvantages of medication assisted treatment and covers research of side effects of substitute medications (Maglione et al., 2018) reports people who utilize medications such as methadone have significantly lower cognitive abilities over time such as short/long term memory and attention. Provide context why medication assisted therapy is not accepted by all professionals in any field due to personal beliefs.

Slide 18

Activity: Groups will assemble/be created to cover the questions listed on the slide. Presenter will give groups 5-10 minutes to openly discuss the questions, once time has expired, each group will share their ideas to create other discussions and to allow multiple viewpoints to be heard. Attendees can return to their original seats if they wish or remain with group for post-test.

Slide 19



Post-Test will be in a separate handout and shared with attendees to complete once training is finished. Presenter will pass out and collect pre-test assessments. Once every attendee has filled out the assessment an answer key will be displayed. Presenter collects post-test sheets for evaluation of training.

Slide 20

Presenter answers any questions or concerns about the material.

Slide 21, 22

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Slide 23, 24

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Appendix

Pre-test Handout

Recovery Training Pre-Test Assessment

(Multiple Choice)

1. What is the most prominent fellowship?
   A. Narcotics Anonymous
   B. Gamblers Anonymous
   C. Alcoholics Anonymous
   D. Al-Anon/Alateen

2. What does SMART Recovery stand for?
   A. Self-Management and Recovery Treatment
   B. Self-Management and Resistant Training
   C. Self-Management and Recovery Training
   D. Self-Management and Recurring Treatment

3. What are judgmental labels used for people in addiction?
   A. Addict
   B. Junkie
   C. Immoral
   D. All the above

4. What self-help group utilizes evidence-based practices?
   A. Alcoholics Anonymous
   B. SMART Recovery
   C. Narcotics Anonymous
   D. None of the above

5. What is Medication Assisted Therapy?
   A. Intervention used to help treat Alcohol Use Disorder
   B. Intervention used to treat Opioid Use Disorder
   C. Intervention used to treat Methamphetamine use Disorder
   D. All the above

6. What are two substitute medications used in MAT
   A. Naltrexone, Buspirone
   B. Naltrexone, Buprenorphine
   C. Vivitrol, Gabapentin
   D. Subutex, Naproxen

Post-Test Handout

Recovery Training Post-Test Assessment

(Multiple Choice)

1. What is the most prominent fellowship?
    A. Narcotics Anonymous
    B. Gamblers Anonymous
    C. Alcoholics Anonymous
    D. Al-Anon/Alateen

2. What does SMART Recovery stand for?
    A. Self-Management and Recovery Treatment
    B. Self-Management and Resistant Training
    C. Self-Management and Recovery Training
    D. Self-Management and Recurring Treatment

3. What are judgmental labels used for people in addiction?
    A. Addict
    B. Junkie
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4. What self-help group utilizes evidence-based practices?
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