

Recovery Fundamentals

Deep Dive Modules · Clinical Strength

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Part 1 • Overview

The Recovery Files • Clinical Edition

Recovery Fundamentals

for Clinicians & Staff

"Clinicians cannot effectively teach what they do not deeply understand. The fundamentals of recovery must be internalized — not just studied — by every member of a treatment team."

Competency Score

—

Not Yet Assessed

Assessment

Complete

Clinical Knowledge—

Clinical Application—

Clinical Implementation PlanIntegrating Fundamentals Into Care

Part 2 · Why Clinicians Must Know ThisThe Case for Staff Fluency

Why Clinicians Must Know This

The Clinical Case for Deep Fluency in Recovery Fundamentals

The Clinical Imperative

A treatment team that cannot articulate, model, and facilitate the fundamentals of recovery — powerlessness, acceptance, connection, sponsorship, fellowship, meeting attendance, and active engagement — is providing treatment without its foundational vocabulary.

Clinical training programs in counseling, social work, psychology, and even addiction-specific credentialing often provide extensive education in therapeutic modalities — CBT, DBT, motivational interviewing, trauma-informed care — while devoting relatively little time to the practical mechanics of how recovery actually works in the lived experience of patients. The result is a competency gap: clinicians who can facilitate a brilliant therapy session but cannot explain to a patient what a home group is, why sponsorship matters, how to compare in rather than out, or what the practical difference is between attendance and engagement. This gap matters because the fundamentals of recovery are not therapeutic add-ons. They are the infrastructure that sustains the clinical gains made in treatment.

1. Assess your own training honestly: how much of your clinical education focused on therapeutic technique versus the practical mechanics of how patients build and sustain recovery in the community? Where are the gaps?

Reflect on your clinical practice...

2. Can you explain — right now, without preparation — what a home group is, how to choose a sponsor, what "comparing in" means, and why meeting attendance predicts outcomes? Which of these would you struggle with?

Reflect on your clinical practice...

Clinicians who deeply understand recovery fundamentals — not just intellectually but experientially, through observation, conversation with people in long-term recovery, attendance at open meetings, and immersion in recovery community culture — consistently produce better clinical outcomes. A clinician who has never attended an open meeting cannot credibly recommend meeting attendance. A clinician who does not understand the dynamics of sponsorship cannot help a patient navigate the search for a sponsor. Clinical fluency in recovery

fundamentals is not about the clinician's personal recovery status. It is about the clinician's depth of understanding of the world their patients are being asked to enter.

1. Have you attended open recovery meetings (AA, NA, or equivalent)? If so, what did you observe about the dynamics that you could not have learned from a textbook? If not, what has prevented you?

Reflect on your clinical practice...

2. Describe a clinical situation where your understanding (or lack of understanding) of recovery fundamentals directly affected the quality of care you provided. What happened?

Reflect on your clinical practice...

The Cochrane Review of Alcoholics Anonymous (Kelly et al., 2020) found that AA participation produced abstinence outcomes at least as good as — and frequently superior to — professional clinical interventions alone, particularly at longer follow-up periods. The mechanism is not mysterious: active community involvement provides accountability, social modeling, identity transformation, and a sense of belonging that professional treatment cannot fully replicate. For clinicians, the practical implication is this: treatment that connects patients to recovery community and equips them with the skills to engage — sponsorship, home group, fellowship, active participation — is treatment that dramatically improves long-term outcomes.

1. How does your current clinical practice actively connect patients to recovery community structures — meetings, sponsorship, fellowship, home groups? Is this an explicit treatment goal or an afterthought?

Reflect on your clinical practice...

2. What is your response to a patient who says "Meetings don't work for me" or "I don't need a sponsor"? Do you have the clinical fluency to explore this with genuine depth, or do you defer?

Reflect on your clinical practice...

Treatment staff do not merely teach recovery fundamentals — they embody them, whether they intend to or not. A treatment environment where staff demonstrate acceptance, vulnerability, accountability, connection, and genuine engagement teaches patients more about these fundamentals than any curriculum. The parallel process is powerful: when a clinical team functions as a genuine community — supporting each other, holding each other accountable, practicing honest communication, modeling humility — patients observe a living demonstration of what recovery community can look like.

1. How does your clinical team function as a community? Do staff members practice genuine accountability, honest feedback, and mutual support — or is the team environment disconnected from the recovery principles being taught?

Reflect on your clinical practice...

2. What is the most important recovery fundamental that your team needs to practice better internally? How would improving it affect patient care?

Reflect on your clinical practice...

Recovery fundamentals are universal in principle but culturally specific in application. The clinician who teaches sponsorship must understand that for first responders, the prospect of disclosing vulnerability to another person may carry career-threatening implications that require population-specific navigation. Cultural competency in recovery fundamentals means teaching the principles while adapting the practices to the specific cultural context, professional identity, and lived experience of each patient — without watering down what the evidence shows is essential.

1. What population-specific barriers to recovery fundamentals exist for the patients you serve? How does your clinical practice address these barriers rather than ignoring them?

Reflect on your clinical practice...

2. How do you adapt recommendations about meetings, sponsorship, and fellowship for patients whose cultural identity, professional status, or personal history creates legitimate barriers to standard recovery community engagement?

Reflect on your clinical practice...

Part 3 • Teaching PowerlessnessFacilitating Step One

Teaching Powerlessness & Unmanageability

Facilitating the Most Counter-Instinctive Admission in Recovery

The Clinical Challenge

Powerlessness is the gateway to recovery — and the concept patients resist most vigorously. Clinicians must understand not only what powerlessness means but why patients resist it, how to facilitate its acceptance without coercion, and how to distinguish genuine acceptance from intellectual compliance.

Powerlessness, as defined in Step One of 12-step programs and as understood in contemporary addiction medicine, refers to the inability of an individual to consistently and reliably control their use of substances through willpower and self-management alone. This is not a moral concept — it is a neurobiological one. The brain changes caused by substance use disorders — particularly the downregulation of prefrontal cortex executive function, the hijacking of the reward system, and the sensitization of stress-response circuitry — compromise the very cognitive faculties a person would need to control the behavior.

Facilitation Note

Staff discussion: Share one clinical approach to facilitating powerlessness that has been effective in your practice. What made it work?

1. How do you currently explain powerlessness to patients? Can you articulate the neurobiological basis clearly enough that a patient with no science background would understand why willpower is not sufficient?

Reflect on your clinical practice...

2. What are the most common forms of resistance to powerlessness that you encounter in your clinical work? How do you currently address them — and what could you do better?

Reflect on your clinical practice...

Unmanageability presents differently across populations and levels of functioning. The clinician who only recognizes dramatic, visible unmanageability — homelessness, arrest, hospitalization — will miss the profound private unmanageability experienced by high-functioning patients: the sleepless nights, the broken self-promises, the internal chaos behind a maintained exterior. A

comprehensive unmanageability assessment examines multiple domains: physical health, mental health, relationships, finances, career, legal status, spirituality, self-respect, and identity.

Facilitation Note

Staff discussion: Share one clinical approach to facilitating powerlessness that has been effective in your practice. What made it work?

1. How does your current assessment protocol capture private unmanageability — the internal damage that is not visible to observers? What questions do you ask? What do you miss?

Reflect on your clinical practice...

2. Describe a patient whose unmanageability was primarily hidden. How did you recognize it? What clinical approach helped surface it without shame or coercion?

Reflect on your clinical practice...

The acceptance of powerlessness cannot be imposed. It must be arrived at — and the clinician's role is to create the conditions in which genuine arrival becomes possible. Motivational interviewing provides the foundational framework: express empathy, develop discrepancy, roll with resistance, support self-efficacy. The goal is not to extract a confession of powerlessness but to create a space safe enough that the patient can see the evidence clearly and draw their own conclusion.

Facilitation Note

Staff discussion: Share one clinical approach to facilitating powerlessness that has been effective in your practice. What made it work?

1. How do you distinguish between a patient who is productively working through resistance to powerlessness and a patient whose denial is entrenched and requires a different approach?

Reflect on your clinical practice...

2. Describe your most effective clinical approach for helping a patient arrive at genuine acceptance of powerlessness. What made it effective? Could you replicate it?

Reflect on your clinical practice...

Clinical Workshop: Building Your Powerlessness Facilitation Toolkit

This exercise asks clinicians to build a practical toolkit for facilitating powerlessness and unmanageability work across different patient presentations.

Facilitation Note

Staff discussion: Share one clinical approach to facilitating powerlessness that has been effective in your practice. What made it work?

1. Write three clinical questions you can use to help a patient identify their own evidence for powerlessness — questions that open exploration rather than impose conclusions.

Reflect on your clinical practice...

2. How would you adapt your approach to powerlessness for: (a) a high-functioning executive; (b) a first responder whose professional identity is built on control; (c) a young adult who believes addiction "happens to other people"?

Reflect on your clinical practice...

3. What resources — readings, exercises, experiential activities — do you currently use to facilitate unmanageability exploration? What gaps exist in your clinical toolkit?

Reflect on your clinical practice...

Part 4 · Comparing In, Not Out Guiding Identification

Guiding Patients to Compare In

Teaching Identification Over Disqualification

A Critical Clinical Skill

Comparing out — focusing on differences rather than similarities — is one of the most common ways patients disengage from recovery. Clinicians who recognize this pattern in real time and can redirect it effectively prevent one of the primary exit ramps from treatment engagement.

Comparing out presents in predictable clinical patterns. The patient in group therapy who says, "I'm not as bad as these other people." The professional who says, "My situation is different — I have a career, a family." The first responder who says, "I'm not like a street addict." Clinicians must recognize that comparing out is not arrogance — it is fear. The patient who compares out is terrified of what it means to belong in a room full of people with addiction.

Clinical Application

When a patient compares out, respond with curiosity rather than confrontation. "What would it mean for you if your experience were similar to theirs?" opens the door. "You're in denial" slams it shut.

1. How frequently do you observe comparing out in your clinical work — in group settings, in individual sessions? What are the most common forms it takes in your patient population?

Reflect on your clinical practice...

2. What is your current clinical intervention when you observe a patient comparing out? How effective is it? What could improve it?

Reflect on your clinical practice...

Group therapy and psychoeducation settings are where comparing out most frequently occurs — and where the clinician has the greatest opportunity to redirect it. Effective facilitation strategies include: pre-framing groups with explicit instruction to "listen for what sounds like your story, not what sounds different"; interrupting comparing out in real time with curious rather than corrective questions; and creating structured exercises that require identification.

Clinical Application

When a patient compares out, respond with curiosity rather than confrontation.

1. How do you set up groups to promote comparing in rather than comparing out? What language, framing, or structure do you use? What has been most effective?

Reflect on your clinical practice...

2. Design a group exercise that specifically builds the muscle of identification. What would the prompt be? How would you debrief it?

Reflect on your clinical practice...

The "yet" principle — that unexperienced consequences are not evidence of difference but indicators of where progression has not yet arrived — is one of the most clinically useful tools for addressing comparing out. When a patient says, "I've never lost a job," the clinician can introduce the concept: "Addiction is a progressive disease. Everything that hasn't happened is a 'yet' — not a 'never.'" Clinically, the "yet" principle is most effective when the patient generates their own list rather than having it imposed.

Clinical Application

When a patient compares out, respond with curiosity rather than confrontation.

1. How do you currently introduce the concept of progression and "yets" in your clinical work? What language resonates with patients and what language triggers defensiveness?

Reflect on your clinical practice...

2. Describe a patient who was using the absence of severe consequences as evidence that their use was manageable. How did you address it clinically? What was the outcome?

Reflect on your clinical practice...

Different populations present unique challenges for comparing in. This exercise builds population-specific clinical fluency.

Clinical Application

When a patient compares out, respond with curiosity rather than confrontation.

1. First responders often compare out based on professional identity ("I help people — I'm not the person who needs help"). How do you address this clinically while honoring their professional identity?

Reflect on your clinical practice...

2. High-functioning professionals compare out based on maintained achievements ("I still have my career, my house, my marriage"). How do you introduce private unmanageability as the relevant comparison point?

Reflect on your clinical practice...

3. In mixed-population groups, what specific strategies prevent comparing out from fragmenting the group's cohesion?

Reflect on your clinical practice...

Part 5 · Facilitating AcceptanceSurrender Without Passivity

Facilitating Acceptance & Surrender

Guiding Patients From Resistance to Genuine Letting Go

The Clinician's Role

Acceptance cannot be assigned as homework. It unfolds through a relational process in which the clinician creates safety, models honesty, and helps the patient distinguish between acceptance (acknowledging reality) and resignation (giving up).

Clinicians must understand that acceptance operates on multiple simultaneous levels. Level one: accepting the diagnosis. Level two: accepting the unmanageability. Level three: accepting the need for fundamental change. Level four: accepting the need for help. Level five: accepting oneself. A patient may have arrived at acceptance on one level while remaining fiercely resistant on another. The clinician who treats acceptance as a single binary event misses the nuance of a multilayered process.

Facilitation Note

Staff reflection: Where in your own professional life have you struggled with acceptance? How does personal familiarity with the process inform your clinical facilitation?

1. Choose a current patient. Assess their level of acceptance on each of the five levels described above. Where are they most advanced? Where are they most resistant? What clinical intervention does each level require?

Reflect on your clinical practice...

2. How do you distinguish between intellectual acceptance ("I know I have a problem") and genuine emotional acceptance ("I feel the truth of this in my body and my behavior has changed")?

Reflect on your clinical practice...

One of the most important clinical distinctions in facilitating acceptance is the difference between surrender and defeat. Defeat is hopeless. Surrender is strategic. Defeat says, "I give up — nothing matters." Surrender says, "I stop fighting this battle on terms that guarantee I lose." The clinician's task is to reframe surrender as the most powerful choice available — the choice to stop relying on a strategy that has failed every time and to adopt a strategy that has succeeded for millions.

Facilitation Note

Staff reflection: Where in your own professional life have you struggled with acceptance?

1. How do you help patients distinguish between surrender and defeat in your clinical work? What specific language, metaphors, or approaches have been most effective?

Reflect on your clinical practice...

2. Describe a patient who resisted acceptance because they confused it with giving up. How did you help them see the distinction? What shifted?

Reflect on your clinical practice...

Acceptance is not an event that occurs once in treatment and then is complete. It is a daily practice that must be reinforced, supported, and assessed throughout the course of care. The Serenity Prayer, whether or not a patient has a spiritual orientation, provides a useful clinical framework: "What do you need to accept today that you cannot change? What do you have the power to change today? What is the difference?"

Facilitation Note

Staff reflection: Where in your own professional life have you struggled with acceptance?

1. How does your treatment program build daily acceptance practice into the milieu — not just in therapeutic sessions but in the overall environment? What could be added?

Reflect on your clinical practice...

2. Design three acceptance-focused check-in questions that could be used in morning groups or daily therapeutic contact. What would you want to assess and reinforce?

Reflect on your clinical practice...

Part 6 • Connection & Fellowship Breaking the Isolation Cycle

Teaching Connection & Fellowship

Helping Patients Break Isolation and Build Recovery Community

Connection as Treatment

Johann Hari's observation that the opposite of addiction is connection is supported by extensive neuroscience research. Clinicians must understand that facilitating genuine connection is not a soft skill — it is a core clinical intervention with measurable neurobiological and outcome effects.

Isolation in patients presents along a spectrum. The most dangerous form of isolation is the kind that looks like connection — the patient who appears engaged on the surface while maintaining an internal fortress that no genuine relationship penetrates. Clinical assessment of isolation should examine not just social contact frequency but emotional accessibility, depth of disclosure, willingness to receive support, and the presence or absence of relationships where the patient is genuinely known.

Clinical Application

Treatment environments that actively practice fellowship produce patients who transition more effectively to recovery community. Use the milieu as a training ground for the relational skills recovery requires.

1. How do you assess isolation in patients beyond surface-level social behavior? What specific clinical indicators do you look for to distinguish genuine connection from the appearance of connection?

Reflect on your clinical practice...

2. Describe a patient who appeared socially engaged but was fundamentally isolated. How did you recognize the pattern? What intervention broke through?

Reflect on your clinical practice...

Many patients in treatment lack the basic relational skills needed to build recovery fellowship — not because they are deficient but because addiction has atrophied those skills through years of secrecy, manipulation, and transactional relationship patterns. Clinicians can actively build fellowship skills within the treatment environment through structured exercises: guided vulnerability practice, accountability partnering, and group cohesion activities that require

genuine collaboration rather than passive co-attendance.

Clinical Application

Treatment environments that actively practice fellowship produce patients who transition more effectively to recovery community.

1. How does your treatment environment actively build fellowship skills — not just provide the opportunity for connection but actively teach and practice the skills? What structured exercises do you use?

Reflect on your clinical practice...

2. What specific barriers to connection do your patients most commonly present with — shame, trust deficits, social anxiety, learned self-sufficiency? How do you address each clinically?

Reflect on your clinical practice...

One of the most critical clinical functions is building the bridge between the treatment environment and the recovery community. This bridge includes: helping patients identify appropriate meetings before discharge; practicing meeting attendance during treatment; facilitating introductions to recovery community members; addressing specific barriers to meeting engagement; and actively processing meeting experiences in therapeutic sessions. The clinician who says "Go to meetings" without helping the patient navigate the actual process has given a prescription without teaching the patient how to fill it.

Clinical Application

Treatment environments that actively practice fellowship produce patients who transition more effectively to recovery community.

1. What specific steps does your program take to bridge patients from treatment into community recovery? Not general recommendations — what structured, practical supports are in place?

Reflect on your clinical practice...

2. How do you prepare patients for the actual experience of attending their first community meeting — the awkwardness, the unfamiliar format, the anxiety? What would better preparation look like?

Reflect on your clinical practice...

Part 7 • Sponsorship & Guidance Supporting the Sponsor Search

Supporting the Sponsor Search

Helping Patients Find, Choose & Utilize Recovery Guidance

Clinical Sponsorship Fluency

Clinicians do not serve as sponsors, but they play a critical role in helping patients understand what sponsorship is, overcome barriers to seeking it, and develop the skills to use it effectively.

Clinical fluency in sponsorship requires understanding several key distinctions. A sponsor is not a therapist — they do not treat clinical disorders, interpret trauma, or provide professional mental health services. A sponsor is a peer recovery guide who has worked the steps themselves and offers experiential guidance through the same process. The clinician and the sponsor serve complementary functions. When both are present and appropriately utilized, the patient has access to professional clinical expertise AND lived recovery experience — a combination that the research consistently shows produces superior outcomes.

Facilitation Note

Staff discussion: What is your personal understanding of sponsorship? Have you observed sponsor relationships that significantly helped — or hindered — a patient's recovery?

1. How do you currently discuss sponsorship with patients? Do you actively encourage it, passively mention it, or avoid the topic? What informs your approach?

Reflect on your clinical practice...

2. Have you ever had concerns about a patient's sponsor — providing advice that contradicted clinical guidance, overstepping boundaries, or being unavailable? How did you navigate it?

Reflect on your clinical practice...

Patients present predictable barriers to seeking sponsorship, and each requires specific clinical attention. Fear of vulnerability: "I can't tell a stranger everything about me." Pride: "I don't need anyone telling me what to do." Perfectionism: "I haven't found the right sponsor yet." For first responders and professionals: "I can't risk someone knowing my business." Each of these requires a specific, empathic, evidence-informed clinical response.

Facilitation Note

Staff discussion: What is your personal understanding of sponsorship?

1. What are the three most common barriers to sponsorship in your patient population? What specific clinical language and interventions do you use to address each?

Reflect on your clinical practice...

2. How do you help patients who are "looking for a sponsor" but never finding one? What clinical strategies move the patient from searching to asking?

Reflect on your clinical practice...

The relationship between the clinical team and the patient's sponsor requires thoughtful navigation. Common challenges include: sponsors who recommend medication discontinuation; sponsors who give advice that conflicts with clinical recommendations; and patients who use sponsor guidance as a reason to resist clinical recommendations. The goal is collaborative integration — where clinical treatment and sponsor guidance work in concert rather than in competition.

Facilitation Note

Staff discussion: What is your personal understanding of sponsorship?

1. How does your treatment program currently support the integration of sponsorship with clinical care? Are there formal processes, or is it left to individual clinician judgment?

Reflect on your clinical practice...

2. Describe a situation where a sponsor's guidance conflicted with your clinical recommendations. How did you handle it? What would you do differently?

Reflect on your clinical practice...

Part 8 · Home Group & Meetings Structure, Belonging & Attendance

Home Group & Meeting Attendance

Equipping Patients With Recovery Structure and Belonging

Structure Predicts Outcomes

The research is unambiguous: meeting attendance — particularly regular, sustained attendance at a home group — is one of the strongest behavioral predictors of sustained recovery.

The landmark 2020 Cochrane Review conducted by John Kelly and colleagues at Harvard analyzed 27 studies involving over 10,000 participants and concluded that AA/NA participation was at least as effective as — and in many analyses more effective than — other established treatments for producing sustained abstinence. For clinicians, this evidence provides a strong scientific foundation for recommending meeting attendance. It is not a folk remedy or a spiritual preference — it is an evidence-based intervention with a substantial research base.

Clinical Application

The most common clinical error with meetings is recommending them without facilitating them. "Go to meetings" without help navigating how to find, attend, and engage is a prescription without a pharmacy.

1. How familiar are you with the Cochrane Review findings and the broader research on meeting attendance outcomes? Could you articulate this evidence to a skeptical patient or colleague? Practice now.

Reflect on your clinical practice...

2. How does your clinical program specifically facilitate meeting attendance — not just recommend it but actively remove barriers, process experiences, and track engagement?

Reflect on your clinical practice...

Many patients in early recovery attend meetings without understanding the concept of a home group. A home group is not simply the meeting attended most frequently. It is a specific recovery community where the patient commits to regular attendance, takes on a service role, develops relationships of genuine mutual knowledge, and experiences belonging rather than mere attendance. The transition from "going to meetings" to "belonging to a home group" represents one of the most important shifts in early recovery.

Clinical Application

The most common clinical error with meetings is recommending them without facilitating them.

1. Can you explain to a patient — clearly and specifically — what a home group is, why it matters, and how to choose one? Practice your explanation here.

Reflect on your clinical practice...

2. What percentage of your discharged patients leave treatment with a specific home group identified and an initial service commitment in place? If the percentage is low, what systemic changes would increase it?

Reflect on your clinical practice...

Resistance to meeting attendance is predictable, and clinicians should be prepared with evidence-based responses rather than generic encouragement. Common resistance: "I don't relate to anyone there" — explore comparing out behavior. "I don't have time" — examine how the patient's schedule reflects their actual priorities. "Meetings are too religious" — distinguish between spirituality and religion. "I can stay sober without meetings" — acknowledge autonomy while presenting the evidence.

Clinical Application

The most common clinical error with meetings is recommending them without facilitating them.

1. What is the most common meeting resistance you encounter in your patient population? Write your ideal clinical response — specific, evidence-informed, empathic, and non-coercive.

Reflect on your clinical practice...

2. How do you help patients find meetings that are a good fit — considering culture, identity, substance-specific needs, and schedule? What resources and processes do you use?

Reflect on your clinical practice...

Part 9 • Engagement & Action Closing the Knowing-Doing Gap

Fostering Engagement & Action

Closing the Gap Between Patient Knowledge and Patient Behavior

The Knowing-Doing Gap

The most clinically dangerous patients are often those who understand recovery perfectly and practice it not at all. Clinicians must develop the ability to assess genuine engagement versus performative compliance and to intervene at the knowing-doing gap with evidence-based strategies.

Genuine engagement and performative compliance can look identical on the surface — both patients attend sessions, complete assignments, and say the right things. The clinical distinction lies in several indicators: Does the patient initiate recovery behavior or only respond to structure? Is the patient's language about recovery integrated (first-person, specific, emotionally connected) or scripted (abstract, generic, emotionally flat)? The compliant patient satisfies program requirements. The engaged patient is building a recovery.

Facilitation Note

Staff exercise: Review your last five discharges. How many patients left with a specific home group, a named sponsor (or dated plan), and a tested daily recovery action plan? What does the answer tell you?

1. How do you currently distinguish between genuine engagement and performative compliance in your clinical work? What specific behavioral indicators guide your assessment?

Reflect on your clinical practice...

2. Describe a patient who appeared compliant but was not genuinely engaged. What did you miss? What would you look for differently now?

Reflect on your clinical practice...

The knowing-doing gap is not bridged by more education — it is bridged by structured behavioral activation within a supportive relational context. Effective interventions include: behavioral contracting; graduated exposure; community-based practice during treatment (attending meetings, exchanging numbers, making phone calls as treatment activities rather than homework); public commitment (sharing recovery intentions with peers creates social

accountability); and process-focused therapy that directly addresses the discrepancy between what the patient knows and what the patient does.

Facilitation Note

Staff exercise: Review your last five discharges.

1. What specific clinical interventions do you use to move patients from understanding recovery to practicing recovery? Which have been most effective?

Reflect on your clinical practice...

2. Design a treatment week that includes at least three structured opportunities for patients to practice recovery behaviors — not just discuss them. What would the schedule include?

Reflect on your clinical practice...

Discharge planning is where engagement either continues or collapses. Effective discharge planning builds engagement architecture: a specific, committed weekly meeting schedule (not "attend meetings" but "Tuesday 7 PM at Grace Church, Thursday noon at Downtown Club"); a named sponsor or a dated plan for acquiring one; identified sober supports with contact information tested before discharge; a daily recovery action plan that is practiced during the final week of treatment; and a specific re-engagement protocol.

Facilitation Note

Staff exercise: Review your last five discharges.

1. How does your current discharge planning process build specific engagement architecture — not generic recommendations but concrete, testable recovery structures?

Reflect on your clinical practice...

2. What is the gap between your ideal discharge planning process and your actual one? What systemic changes would close that gap?

Reflect on your clinical practice...

Part 10 · Clinical Competency Assessment40

Questions · Two Parts

Clinical Competency Assessment

40 Questions · Two Parts · Recovery Fundamentals Fluency Profile

Instructions

Rate each statement 1-5: 1 = Rarely or not at all true; 3 = Sometimes true; 5 = Consistently and strongly true. Assess your actual clinical practice today — not your aspirational practice.

Part A — Clinical Knowledge of Recovery Fundamentals

How deeply do I understand the principles, evidence base, and clinical application of each recovery fundamental?

I can articulate the neurobiological basis of powerlessness with sufficient clarity to explain it to a patient who has no science background.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the difference between public and private unmanageability and can assess both in clinical settings.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can recognize comparing out behavior in real time during group therapy and individual sessions.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the multiple levels of acceptance (diagnosis, unmanageability, need for change, need for help, self-acceptance) and can assess each independently.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the neuroscience of connection — how social bonding counteracts the neurobiological effects of addiction.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can clearly articulate what a sponsor is, what they are not, and how the sponsor relationship complements clinical treatment.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the distinction between meeting attendance and home group membership and can explain it to patients.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can cite the research evidence (Cochrane Review, William White, Kelly & Humphreys) for meeting attendance and recovery community involvement.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the difference between genuine engagement and performative compliance and can assess the distinction clinically.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how recovery fundamentals form an interconnected ecosystem where each element strengthens the others.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can explain the "yet" principle and use it clinically to address the comparing out pattern of focusing on consequences not yet experienced.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how the knowing-doing gap operates in patients and what clinical interventions close it.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how cultural identity, professional status, and trauma history affect patient engagement with recovery fundamentals.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how service commitments function as both recovery practice and network-building strategy.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how to distinguish between productive resistance (part of the process) and entrenched denial (requiring different intervention) in Step One work.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the clinical distinction between surrender and defeat and can help patients navigate it.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can articulate why willingness — rather than motivation — is the essential ingredient in early recovery engagement.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand how treatment staff model recovery fundamentals through the milieu and team functioning, whether intentionally or not.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I understand the complementary roles of clinical treatment and community recovery support and can navigate their integration.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I can identify the specific recovery fundamental deficits in a patient's current recovery and target clinical interventions accordingly.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Part B — Clinical Application of Recovery Fundamentals

How consistently do I integrate recovery fundamentals into my actual clinical practice?

I routinely facilitate exploration of powerlessness and unmanageability with patients using evidence-based approaches.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I actively redirect comparing out behavior when I observe it in group or individual settings.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I assess acceptance at multiple levels and tailor interventions to the specific level where a patient is stuck.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I actively help patients identify, attend, and process community meeting experiences as part of treatment.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I specifically discuss sponsorship with patients and help address barriers to seeking a sponsor.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I help patients identify potential home groups and set concrete goals for belonging rather than just attending.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I build fellowship skills into the treatment milieu through structured relational exercises, not just group attendance.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I assess the difference between genuine engagement and performative compliance in each patient and intervene at the gap.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I build specific engagement architecture into discharge plans — named meetings, dated sponsor plans, tested support contacts.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I process patient resistance to recovery fundamentals with empathy and clinical depth rather than generic encouragement or confrontation.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I have attended open recovery meetings to deepen my own understanding of the recovery community my patients enter.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I adapt my teaching of recovery fundamentals to the specific cultural, professional, and identity-based context of each patient.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I use the treatment milieu as a laboratory for connection, fellowship, and engagement — not just a setting for therapy sessions.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I collaborate effectively with patients' sponsors, alumni mentors, and recovery community contacts rather than operating in clinical isolation.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I track patient engagement with recovery fundamentals (meeting attendance, sponsor contact, fellowship development) as clinical outcomes.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I help patients develop daily recovery action plans that are practiced during treatment and refined before discharge.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I address meeting resistance with specific, evidence-based responses rather than generic insistence or passive deferral.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I model recovery values — honesty, vulnerability, accountability, connection — in my interactions with patients and colleagues.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

I participate in ongoing professional development specifically focused on recovery community engagement and fundamentals.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

When I recognize gaps in my own clinical fluency regarding recovery fundamentals, I take specific action to address them.

Rarely ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Always

Part 11 • Clinical Implementation Plan Integrating Fundamentals Into Care

Clinical Implementation Plan

Integrating Recovery Fundamentals Into Daily Practice

From Workshop to Clinical Practice

This implementation plan translates workshop learning into specific, accountable changes in clinical practice. The goal is not to add work but to integrate recovery fundamentals fluency into what you already do — assessment, treatment planning, group facilitation, individual therapy, discharge planning, and team functioning.

1. Based on this workshop, what is the single greatest strength in your current clinical approach to recovery fundamentals? What are you already doing well?

Be specific — implementation plans require specificity...

2. What is the single greatest gap — the recovery fundamental you are least equipped to teach, facilitate, or assess? What has contributed to this gap?

Be specific — implementation plans require specificity...

3. If a patient asked you today to explain powerlessness, home groups, sponsorship, and comparing in — all in one conversation — how confident would you be? Rate each 1-10 and identify the lowest.

Be specific — implementation plans require specificity...

Integrating Fundamentals Into Assessment & Treatment Planning

1. What specific questions will you add to your clinical assessment to evaluate a patient's relationship with each recovery fundamental — powerlessness, acceptance, connection, sponsorship, meetings, engagement?

Be specific — implementation plans require specificity...

2. How will you incorporate recovery fundamental goals into individualized treatment plans — not as generic objectives but as specific, measurable, time-bound clinical targets?

Be specific — implementation plans require specificity...

3. What tracking systems will you use to monitor patient engagement with recovery fundamentals as ongoing clinical outcomes?

Be specific — implementation plans require specificity...

1. What specific changes will you make to your group facilitation to actively address comparing out, promote identification, and build fellowship skills?

Be specific — implementation plans require specificity...

2. Design one new group exercise focused on a recovery fundamental you have not previously facilitated well. What is the exercise, how would you set it up, and how would you debrief it?

Be specific — implementation plans require specificity...

3. How will you create structured opportunities within the treatment milieu for patients to practice recovery behaviors — not just discuss them?

Be specific — implementation plans require specificity...

1. What specific changes will you make to your discharge planning to ensure patients leave with concrete recovery structures in place — named home group, sponsor plan, tested support contacts, daily action plan?

Be specific — implementation plans require specificity...

2. How will you prepare patients for the actual experience of entering community recovery — the practical challenges of finding meetings, asking for a sponsor, building fellowship from scratch?

Be specific — implementation plans require specificity...

3. What follow-up or alumni support will you build or recommend to monitor engagement with recovery fundamentals post-discharge?

Be specific — implementation plans require specificity...

1. What is the single most important insight from this workshop — the one that will most directly improve your clinical practice? How will you implement it this week?

Be specific — implementation plans require specificity...

2. Will you commit to attending at least two open recovery meetings in the next 30 days to deepen your experiential understanding of the recovery community? If yes, which meetings and when? If no, what prevents this?

Be specific — implementation plans require specificity...

3. Write your Clinical Implementation Commitment Statement: What specific changes will you make in assessment, treatment planning, group facilitation, and discharge planning to better integrate recovery fundamentals into patient care? Who will hold you accountable?

Be specific — implementation plans require specificity...

Clinical Pairing Note

This workshop is designed as a multi-session staff development curriculum for SUD treatment teams. Recommended delivery: 4 sessions covering 2 modules each. Pairs with the patient-facing Recovery Fundamentals Workshop, the Building a Recovery Support Network intensive, and the Helpers Helping Helpers clinical team development series. By Sheamus Moran - Founder of The Recovery Files · www.TheRecoveryFiles.com