

The Vestibule Intensive Outpatient Program (VIOP)

Recognizing the individual differences in philosophical orientation of patients in a general population, hospital-based CD [Chemical Dependency] units "match" patients to highly contrasted therapeutic approaches. These "tracks" are based on differential diagnosis between subsets of alcohol dependence (DSM-III-R). Administrative rationale for the two-track Vestibule Intensive Outpatient Program (VIOP) is provided along with clinical guidelines for running Rational Emotive Behavior Therapy groups. The VIOP is incorporated into a community-based, two-track system with continuing outpatient follow-up provided in both A.A. and REBT/S.M.A.R.T. Recovery meetings for the first year following graduation.

At present, the majority of American outpatient addiction care is based on the 12-step program of A.A. Statistics have shown that the majority of patients continue their addictions during the year following discharge. Client receptivity to the central concepts of the 12-step program is predictive of treatment outcome. Ideally, patients with a secular or humanistic orientation would select institutions where non-spiritual and non-religious methods are employed, either as a matter of personal preference or on the advice of a referring professional, but these services are only sparsely available (other than our Vestibule Program, S.M.A.R.T. Recovery and a handful of other low profile Harm Reduction support modalities). VIOP is a means for any 12-step inpatient, outpatient, or intensive outpatient program to immediately diversify its theoretical basis for addiction care, and to clinically accommodate those patients who give early indicators that the 12- step approach will not lead to a satisfactory outcome. This paper will specifically deal with the intensive outpatient model, although the principals contained herein will vary only slightly from the other two.

Transition to the two-track VIOP system is accomplished through systematic staff development with administrative support and encouragement. On-site consultation with qualified S.M.A.R.T. Recovery consultants, along with Rational Emotive Behavior Therapy supervision is highly recommended in order to benefit from in-service training in clinical methods. The material presented here includes:

- 1) Conceptual Backdrop
- 2) Guidelines for Differential Diagnosis
- 3) Demographic Considerations
- 4) Competitive Conditions

- 5) The Solution
- 6) Operations
- 7) Common Problems in VIOP
- 8) Clinical Protocol
- 9) Conducting the Daily REBT/ S.M.A.R.T. Recovery Group Sessions
- 10) The Role of the Family in VIOP
- 11) Suggestions for Rational Milieu Therapy
- 12) A.A./ S.M.A.R.T. Recovery VIOP Outpatient Follow-up and Alumni Support

The required readings in the VIOP are [Rational Recovery from Alcoholism: The Small Book](#), by Jack Trimpey, LCSW, and [Rational-Emotive Therapy with Alcoholics and other Substance Abusers](#) by Albert Ellis, Ph.D., John F. McInerney, Ph.D., Raymond DiGuseppi, Ph.D. and Raymond Yeager, Ph.D., of the Institute for Rational-Emotive Therapy, New York. It is assumed that therapists are already familiar with Bill Wilson's "Big Book" (*Alcoholics Anonymous*) and the program of Alcoholics Anonymous.

Conceptual Backdrop for VIOP: A philosophical dichotomy has been present throughout history, and its division continues today in our pluralistic American society. Aristotelians (rationalists) and Platonists (supernaturalists) hold fundamentally different premises, and therefore, require different psycho-emotional management. Addicts themselves represent a cross section of the general population, as reflected in their viewpoints on matters such as politics, religion, philosophy, psychology, education, economics, and chemical dependency. Indeed, values and perceptions concerning all of the above vary widely from country to country and from culture to culture. Although the physiology of addiction may be fairly uniform between social and ethnic groups, the philosophical underpinnings are not. Therefore, we have defined two subsets of Alcohol Dependence (DSM-III-R) that must be differentiated as part of the diagnostic protocol. It's called Differential Diagnosis. Its purpose is to identify traits of personality and philosophy that will promote, for any given person or group of persons, a high degree of success in one program as distinct from a high probability of failure in another.

Subtype 1: Aristotelian, without theistic beliefs: REBT/ S.M.A.R.T. Recovery

Subtype 2. Platonic, with theistic beliefs: A.A.

Guidelines for Differential Diagnosis: Proper treatment reflects a proper differential diagnosis. For a program to be successful, it must be relevant to the client. The diagnosis of addiction itself is

sometimes a challenging, multi-faceted task. We obtain the client's subjective complaints, observe his or her behavior, take a relevant history, sometimes obtain the observations of friends and family, and from this database can determine the appropriate diagnostic category for any person. Those who are substance abusers may be differentiated on the basis of values assessment. Differential diagnosis, in this context, is the quest for additional information that will help in the selection of the treatment of their choice. Just as age, concurrent diagnoses, allergies, cultural and ethnic considerations, client motivations, history of previous treatment outcomes, chronicity, and lethality issues bear on treatment, so do religious and philosophical orientations. [The Myers-Briggs Type Indicator may be especially helpful in this determination.]

[In [The Small Book](#), Trimpey notes that professionals often assume that their clients hold a fixed belief about the existence of God. They further assume that in cases of uncertainty, ambivalence, or non-belief, clients are both willing and able to construct a positive theistic belief in order to build a better life. He points out that these are not valid assumptions, and when put into practice can often be harmful to clients. These assumptions may also be construed as a projection of the personal values of the therapist, imposed on the client.

The typical institutional therapist seems to feel that the purpose of differential diagnosis is to identify traits that suggest success or failure in the 12-step spiritual healing program, whereas Martin and Trimpey would argue that the purpose of differential diagnosis is to identify those personality traits that would produce a greater probability of success in either a traditional or a nontraditional program. Thus, two sets of traits, two programs. Some clients will strongly prefer the orientation of one program over the other, but will not necessarily reject all of the tenets of the other program. The two programs are indeed antithetical, but not necessarily antagonistic to one another, and there is some common ground. To continue now with Trimpey and Martin:]

There are two ways to tell if a chemically dependent person is a candidate for a given therapeutic approach: 1) a history of recidivism in that approach; and 2) the client's answers to our questions. There is no reason why we should not ask a patient if he or she believes in God, especially when this element represents one of the major differences between A.A. and REBT/ S.M.A.R.T. Recovery.

It is vital and proper to inform the client of the treatment proposed before asking him or her to consent to it [especially since Motivational Interviewing is the new norm]. A copy of the 12 steps of Alcoholics Anonymous may be presented to the client, and he may be frankly asked, "What do you think of this way of handling your problems with alcohol?" Is there anything about it that you find hard to understand or difficult to accept? If the client expresses no objections, but has had previous

unsuccessful experiences with A.A., it is fair to ask, "Why did you leave A.A. the last time? Was there something you didn't like? Were you able to use the Higher Power concept?" To these questions, many addicts will confess their faith in God and assert their willingness to pursue a spiritual awakening as a way of remaining sober. But others will say that they don't want to seek spiritual goals, that they do not even know or want to know what the word spiritual means, and that the idea of a rescuing deity for alcoholics seems absurd to them. Some may say they have no belief in God, others may say they believe in some kind of a cosmic being, but choose not to bring that belief into the recovery process. Still others may say that all that "God stuff" in A.A. bothers them.

It has long been common to interpret these kinds of statements as resistance to treatment, as a sign of poor motivation, of passive aggression, or an expression of a desire to continue drinking. Disbelief in a higher power and refusal or failure to work a program of moral betterment are still regarded by many in the field as part of the illness of alcoholism. Thus, nontheistic treatment plans are often viewed as not only incompatible with standard recovery concepts, but pathogenic, in the sense of being a cause or a contributing factor to the disease of alcoholism.

In the VIOP, however, the client is regarded as a Very Important Person with very important opinions. Assertions of doubt and skepticism are the basic strengths upon which S.M.A.R.T. Recovery builds a sober life. Rather than suggest that the client had better "come around" to the Theistic A.A. viewpoint, VIOP treatment staff commend 12-step-resistant clients for exercising critical judgment, and advise them that they are well-suited for S.M.A.R.T. Recovery, wherein they will be encouraged to turn that critical energy inward to eliminate the ideas and beliefs that have caused and maintained their state of chemical dependency.

Demographic Considerations: Because of the diversity of clients who make home of a typical hospital chemical dependency unit, it will be impossible for reasons of time and money to have programs catering to each cultural and ethnic group. For example, separate programs for Catholics, Protestants, Black Americans, Hispanics, and Jews. It has already been shown that one program fills-with serious limitations-the needs of a segment of a population of Type 2 (emotionally oriented) clients; however, A.A. does not help those who find the 12 steps unsuited to their needs. Many clients who have fixed humanistic values (Type 1s, and some Type 2s) will have specific objections to 12-step requirements such as those pertaining to the Higher Power, group dependency, personal confession, moral inventories, and lifelong recovery. Other people may offer no serious objections to the spiritual and religious approach, but by virtue of their recidivism demonstrate the need for a different approach to the problem.

As the market for inpatient services becomes saturated, and as insurers become more disposed toward outpatient rather than inpatient service, some new programs based on humanistic values are targeting persons resistant to A.A.'s 12-step program. There is a very clear trend toward diversification of treatment. It is supported by humanistic organizations and by the media. The market for recovery programs of a non-spiritual nature is expanding but as yet unmet.

Competitive Conditions: Until recently, bed occupancy supported continued growth of inpatient care for addictions. But, in addition to an overall tightening of health care dollars in recent years, new outcome studies have contributed to current occupancy problems by raising questions about the cost-effectiveness of inpatient versus outpatient programming. Hence, insurers have become increasingly reluctant to pay for inpatient treatment. Doomsayers predict the collapse of the hospital-based inpatient concept, while the hospital industry continues with traditional marketing approaches in which the spiritual healing model is the sine qua non of hospital-based practice. Market saturation and the decrease of third-party (insurance) dollars seem to explain low occupancy.

Administrators face a dilemma when they contemplate breaking away from traditional patterns. They have reason to fear that they will lose credibility with referral sources because of established loyalties to the 12-step program. The more orthodox A.A. believers hold that anything other than the 12-step approach is not only inferior, but harmful. In a few cases, key people feel that if they were to recognize a recovery plan that was not based on spiritual principles, they would then fall from grace with their own personal deities and lose the resolve to remain sober themselves. Such is the totalistic quality of 12-step recovery (among some of the "recovering") that the Higher Power itself seems to argue for strict adherence to traditional programming. Still, there are many recidivists who come to the attention of local mental health and law enforcement officials, and many of them are prime candidates for alternative programs. Convincing these relapsers and recidivists to endure yet another round of 12-step therapy, however, is all too often impossible.

The Solution: The vast majority of these refuseniks and recidivists are good candidates for S.M.A.R.T. Recovery, the successor to Rational Recovery, an application of the system of self-help and psychotherapy devised in the 1950s by eminent psychologist Albert Ellis. The system is called Rational-Emotive Behavior Therapy (REBT), and it is taught to the helping professions in most universities. Based on the scientific method, it is ideal for those with inquiring, skeptical attitudes, and it has been shown to provide potent guidance for persons seeking personal change.

For decades, experts in the field of chemical dependency have recognized the high degree of relevance of REBT to addiction care, so that today many 12-step recovery programs already offer REBT

or one of its cognitive-behavioral variants as an adjunct to their spiritually oriented programs. S.M.A.R.T. Recovery, in its Vestibule Program, presents REBT as a comprehensive alternative to traditional programming. Between A.A. and S.M.A.R.T. Recovery, both comprehensive plans for the achievement and maintenance of sobriety, we make a workable program available to perhaps 99% of those in need.

Rational Recovery Systems, started in 1986, was a coalition of qualified professionals who advocated for individuals with fixed humanistic values and who were, therefore, poor candidates for traditional services that include spiritual and religious components. This program went through a series of improvements and was re-offered to the recovery community as S.M.A.R.T. Recovery. It is heralded as the counter offering to A.A. in the recovery field. Whereas A.A. can be oversimplistically epitomized as focusing on "powerlessness," S.M.A.R.T. Recovery offers a balance by offering a "powerful" alternative. Offered together in our Vestibule, they represent two opposite spectrums along with any combination between the two which can be offered to the client and customized to meet any client where they're at.

Local S.M.A.R.T. Recovery groups have professional advisors who, by virtue of being professionals, are qualified to handle special problems that pertain to psychotic states, mood disorders, suicide risks, etc., and who can make referrals to medical and other resources when indicated. Among S.M.A.R.T. Recovery's many advisors were Albert Ellis, Ph.D., Forrest Martin, M.D., Emmett Velten, Ph.D., Raymond Yeager, Ph.D., and Joseph Gerstein, M.D., all of whom were cognizant and supportive of the movement advancing a two-track service system.

The VIOP program offers an innovative market approach that requires negligible capital outlay to reach a large, ready clientele. In addition to an inventory of The Small Book, the only other expense (recommended) may be monies apportioned for an on-site S.M.A.R.T. Recovery consultant, full-time or part-time. Demographically, the market for recovery programs that depart from the traditional recovery model will expand during a time when existing markets are diminishing. Management market share will be based more on a regional presence than on gaining a larger share of a local market. Functional alcoholics, who have been refractory to previous 12-step programs, will travel many miles to avail themselves of a program that appears relevant to them. Identifying and targeting substance abusers will provide new, statistical support for an industry errantly based on the waning concept of inpatient care for substance abuse.

Operations: As a way to explore multi-modal inpatient care, S.M.A.R.T. Recovery encourages direct communication among managers and administrators who are contemplating the A.A./ S.M.A.R.T.

Recovery Vestibule two-track system. This document would make a good agenda item for any meeting of managers or administrators, whether or not an S.M.A.R.T. Recovery representative is present. When the discussion begins, you will probably find a common concern for the many clients who go away with complaints about the 12-step program and then proceed with their addicted way of life. Most managers have an inner sense that there are many possible ways to fill an inpatient treatment day, and they realize that A.A. is only one of them. By talking with your peers you may get a clearer sense that there is plenty of leeway for innovation in the two-track Vestibule arrangement. In fact, you may come away hoping to be among the first to address a vast, untapped market of agnostics, humanists, atheists, freethinkers, Buddhists, Jews, and liberal and nominal Christians who have been avoiding traditional 12-step recovery programs.

Getting started in S.M.A.R.T. Recovery:VIOP will require an initial survey of the clinical staff to determine the degree of readiness for and commitment to organizational change. The perceptions of your clinical staff are critical to the success of VIOP, but experience has shown that uniform or unanimous support among the staff is not necessary. To the contrary, you will be looking for the predictable spectrum of opinions from "liberal" (pro- S.M.A.R.T. Recovery) to "conservative" (anti-S.M.A.R.T. Recovery), and then assigning responsibility for S.M.A.R.T. Recovery to those who show an inclination to work outside of the traditional 12-step paradigm.

Some administrators may view multi-modal inpatient care as a way to preempt perceptions that their institutions skirt or even violate equal opportunity employment practices. Traditional hiring practices, whether by default or design, favor applicants who show evidence of accepting the steps and traditions of A.A., many of which have theological content. Some agencies have designed application forms with specific questions about the 12 steps, for example, 'What do you think about the Higher Power idea?' Other pre-employment inquiries have to do with the extent of participation in A.A. meetings and organizational involvement.

The VIOP will provide ample evidence that any treatment center employing it is not violating equal employment opportunity provisions relating to religious preference.

Common Problems in VIOP: We may anticipate some early difficulties in transition from homogeneous 12-step programming just as we would in any major program change or development. Some problems may center on how A.A. and S.M.A.R.T. Recovery interface ideologically and socially. The following issues may surface among staff or within the patient population. They are perceptions that are natural, understandable, and ultimately desirable in the process of program development. Although most

mature organizations will have the depth of supervision to manage the probable transitional problems listed below, a skilled S.M.A.R.T. Recovery practitioner may well serve as an invaluable adjunct to staff.

Issue No. One: A.A. is the only thing that works. It is timeless and proven, but S.M.A.R.T. Recovery is newer, somewhat unproven, and troublesome.

Within the fellowship of A.A. there is consensus that there are many paths to recovery, and many who are loyal to A.A. admit that their own recoveries were atypical, that they bent the meaning of the 12 steps to suit their own fixed values. If A.A. is to work through attraction rather than coercion, then the presence of an alternative program would not seem to pose a problem.

Because of the virtual monopoly of the 12-step program in hospital settings, it has become the standard of the industry. Therefore, research statistics largely reflect outcomes of the 12-step approach. Even though there has been little against which to compare 12-step recovery statistics, it is widely assumed that statistics prove the effectiveness of that approach when applied to the general population. For example, if a report shows that 24% of those discharged after completing a 28-day program are sober after one year, we tend to think of that program as successful. But how can a program be considered successful if it has a 76% rate of non-sobriety? If 24% constitutes "success," then a 76% relapse rate must be considered acceptable.

If we interpret the hypothetical but not unrealistic figures above to simply mean that only 24% of the patients were receptive enough to the 12 steps to achieve one-year's sobriety, then we are left with an unknown percentage who may have been candidates for S.M.A.R.T. Recovery. If Vaillant is correct in observing that "Some treatment is better than no treatment," then we may easily extrapolate that "Treatment perceived as relevant by the patient is better than treatment perceived as irrelevant." To use a loose analogy to the hospital CD unit, think of a blood bank. If type A.A. blood is the only type given to all patients, and 24% of them survive, how many more could be treated successfully by adding type S.M.A.R.T. Recovery blood to the inventory? If either blood type helps more patients than the other, can we then say that one kind of blood is better than the other? If so, for whom?

Issue No. Two: Ideological contempt.

It is true that the differences between A.A. and S.M.A.R.T. Recovery outnumber the similarities, but the similarities outweigh the differences. As the differences become apparent, it may be helpful for the clinical director to emphasize the following viewpoints that are common to both A.A. and S.M.A.R.T. Recovery:

First, the goal of treatment is to enable a patient to become reasonably happy and successful in life without psychoactive intoxicants;

Second, group meetings centering around the goal of abstinence are ideally suited to helping individuals free themselves of alcohol dependence; and

Third, the only qualification for participation in the program is a sincere desire to stop drinking and remain sober.

Occasionally, tension can develop between staff members with divergent clinical orientations. Focusing on management priorities, rather than on differences of opinion, will give a broader format for the resolution of problems of this kind. By consistently supporting both parties, escalating conflict with an eventual loser can be avoided. Some staff may defensively note that [The Small Book](#) presents an aggressive critique of the 12 steps and also portrays A.A. as having overstepped its role in addiction care to the point of being detrimental to some recovering alcoholics. Staff may become alarmed that S.M.A.R.T. Recovery seems to undermine the very faith that is required in 12-step recovery, that S.M.A.R.T. Recovery directs one toward self-centered sobriety, and that S.M.A.R.T. Recovery views the issue of "control" in a clearly opposite way to that of A.A. Staff members may perceive S.M.A.R.T. Recovery as a program that, in effect, strengthens character defects rather than treats them.

At this juncture, you or your clinical director may suggest that they review Chapter 4 of the Big Book, and put themselves in the place of a humanist who values his disbelief just as highly as others the love God. If they will do this, they will find there is mutual antagonism between the Big Book and The Small Book. Moreover, you may remind your dissenting staff that whatever conflict exists between theistic and humanistic alcoholics was started by Bill Wilson and Dr. Bob Smith in 1935, and that this is one institution that will no longer exclude those who sincerely want to stop drinking but have no use for the 12 theological steps of A.A.

Both A.A. and S.M.A.R.T. Recovery vigorously and unashamedly argue for their perspective viewpoints in things philosophical, but neither would intentionally place the importance of its own ideology above the individual lives that are at stake in addiction recovery. When proponents of each approach recognize the value of the other regardless of the path they have chosen to recovery, we will have placed a transcendent value on the principle of self-determination.

The VIOP is an advanced concept in addiction care, in that management is aspiring to a higher principle than that contained in any clinical methodology. The unifying concept is the value placed on helping clients abstain from drinking alcohol or using drugs and then growing in society.

Issue No. 3: Failure to accept a higher power is part of the illness of alcoholism.

There are two common versions of this view: first, that disbelief in mystical beings or higher authority is a symptomatic character defect of drunkenness; and second, that this character defect is part the cause of alcoholism. It is well known that acceptance of a Higher Power is traditionally viewed as intrinsically therapeutic, and inculcation of it is therefore a necessary therapeutic task.

While this may be true for many who aspire to sobriety, others with fixed, human-centered values will find a thoroughly secular, cognitive-behavioral approach more palatable and effective. When humanists, agnostics, atheists, Buddhists, and other disbelievers are that their central values are symptoms of a terminal illness, their chances of remaining in treatment and of benefiting from it are seriously reduced.

Some authors make a convincing argument that devout belief in supernatural entities is a form of mental illness; indeed, a number such books-well-written ones at that-do exist. But this is an extreme point of view, and one that can incite conflict between believers and disbelievers. No one likes to be diagnosed as "sick" because of what he or she believes.

Clinical Protocol: The purpose of the Vestibule is: 1) to give each patient an exposure to both programs as a way of ensuring informed consent to care; and 2) to enhance commitment to recovery through participation in treatment planning. "Vestibule" refers to a status that is assigned to each patient at the time of admission. While the patient is "in the vestibule," s/he is unassigned (and uncommitted) to either recovery track, but he or she is free to make a program selection as early as the second day, and no later than the third day. The patient will be provided reading material from both programs, including pamphlets, short articles, and the two books, the Big Book of AA and [The Small Book](#) of S.M.A.R.T. Recovery. The patient can be advised to attend meetings of A.A. and S.M.A.R.T. Recovery during this preliminary and exploratory period.

Concerning the books, some guidance is desirable and practical. For example, the Big Book is indeed big (575 pages), but only because more than two-thirds of it consists of personal narratives. The actual text consists of only 146 pages. In The Small Book (275 pages of text) the patient could be advised to concentrate on the first 200 pages, including the introduction (by Albert Ellis) and the preface.

Having done this reading, the patient then experiences the Orientation Interview, the object of which is to select a recovery program: track one, S.M.A.R.T. Recovery, or track two, A.A. The importance of this interview is obvious. The interviewer can be a department head or a highly

experienced caseworker, but must always be a professional. It is extremely important that the patient make the final decision regarding her or his participation in the recovery program. Nothing is rigid, and there will always be a number of borderline cases in which professional guidance is needed.

Conducting the Daily S.M.A.R.T. Recovery Group Sessions: The therapist shall have a working knowledge of Rational-Emotive Behavior Therapy, gained from university training in cognitive-behavioral methods, or through the Chicago Institute for Rational-Emotive Behavior Therapy, or through S.M.A.R.T. Recovery-sponsored consultation or in-service training. An REBT therapist may of course be recruited from the community on a full- or part-time basis. Paraprofessionals may assist in REBT sessions under the supervision of a fully qualified professional. Group sessions will be held twice daily, a 60-minute morning session and a 90-minute afternoon session. The morning session will be devoted to information about REBT presented by a therapist. This session, although essentially didactic in content, will provide opportunities for patient participation. For example, questions may be asked, illustrations made, and specific exercises employed.

The afternoon session will be less structured and more spontaneous, and the therapist will interject lines of rational thought as he or she directs the group therapeutic process. An S.M.A.R.T. Recovery therapist will meet with each patient individually at least once during the course of a hospital stay, and more often if clinical judgment indicates the need.

The Role of the Family in VIOP: In contrast with traditional approaches, family members are not viewed as afflicted with an illness or adjustment disorder stemming from having a chemically dependent family member. Because they may have purposely or unwittingly enabled the addict to use or drink prior to hospitalization, family counseling sessions would seem to be in order so as to address these issues. Accordingly, they are helped through direct one-to-one REBT counseling to start thinking, emoting, and acting more independently of their alcoholic spouses or relatives.

Suggestions for Rational Milieu Therapy: [*Rational-Emotive Therapy With Alcoholics and Other Substance Abusers*](#), by Albert Ellis, Raymond Yeager, et al., includes a chapter on REBT in the therapeutic community. This chapter provides some excellent examples of the REBT "ABCs" in structured residential programs. Generally, the hospital milieu is regarded as consisting of many consecutive activating events, emotional reactions, and behavioral consequences. These consequences become the grist for endless therapeutic interventions by alert staff members who can help the patient identify the specific irrational beliefs that are causing dysfunctional emotions and behavior. The staff can learn to help the patient to dispute the irrational beliefs that are causing negative emotions such as anger, guilt, and depression.

A.A./ S.M.A.R.T. Recovery VIOP Outpatient Follow-up: Your community may already have an active S.M.A.R.T. Recovery chapter. If so, arranging for this kind of patient follow-up will be as simple as the familiar referral to an A.A. group. S.M.A.R.T. Recovery was established over thirty years ago, and reinvented. Yet, some communities do not yet have a S.M.A.R.T. Recovery chapter. In such cases it then becomes very desirable to start an S.M.A.R.T. Recovery chapter as a project that will be a part of your VIOP program development. Little effort is required, and S.M.A.R.T. Recovery will help by identifying professionals who will participate, even as staff members from the hospital may choose to do.

S.M.A.R.T. Recovery meetings are usually held twice a week, often in the early evening hours and on weekends. They are always free of charge, and they last 90 minutes. These meetings are actually a continuation of the sessions begun in the VIOP program, and they will be open to new members who seek them out or are referred to them from community agencies. Any hospital would do well to promote such meetings, not only as an extension of its VIOP program, but as a matter of public relations. Certainly, when inpatient care is needed, the legitimate self-interest of the hospital is also served.

Administrators and professional therapists will immediately see the logic and workability of our VIOP program. Just as important is the quality of its underlying concern, its humanity, and its compassion. We have paraphrased and quoted Trimpey's and Martin's thoughts, research, and works at length and with little of our own commentary because we could not have expressed it any better, or even as well. If the VIOP program is not the wave of the future, there is no future. We can no longer continue to do things because "they have always been done that way." That hasn't worked; the VIOP program will work, and in fact, is already working.

An inpatient version of this model worked quite well in Hampstead Hospital in the late 1980's, in Hampstead, New Hampshire. In past years, Hampstead served as an outstanding example of an institution that successfully installed a two-track system. The effort was spearheaded by Alan Karney, the then Director of their Chemical Dependency Treatment, and it worked like the proverbial charm. Initially there was some anxiety that change - any change - always brings. The staff of Hampstead, however, were totally professional (as distinct from "paraprofessional") and were familiar with both the traditional recovery approach and the cognitive/behavioral concepts of Albert Ellis, Maxie Maultsby, William Glasser, Eric Berne, and others. Although most of the Hampstead staff had been immersed in the traditional system since graduate school, they were immediately appreciative of the merits of the two-track system and adapted to it with little difficulty. The late founder of Rational Recovery, Vince Fox, was very familiar with the success of this model and he wrote about it before his passing in his

book entitled [Addiction, Change and Choice: The New View of Alcoholism](#). Because of staff turnover, the passing of Vince Fox, and the many changes that our health system has endured in the years since, their program was mothballed, notwithstanding its success as a model for successors such as Above and Beyond Family Recovery Center.

It is highly significant that the clients of Above and Beyond have enthusiastically accepted the new system. While in the "Vestibule", they listen to objective, balanced descriptions about each track (A.A. and S.M.A.R.T. Recovery), and with help from the staff, choose the program most suited to their needs and compatible with their basic life values. Problems have not appeared; they've disappeared.

We've talked with our clients about the spirituality issue. Again, no problem. "What patients really want," says Brenda Dixon of Above and Beyond, "is a tool kit, a 'how-to' approach to problem solving." Some patients, it seems, resent the theological component of A.A., or are turned off by the drunkalogs ("war stories") presented at meetings, or resent being told that they are powerless over their addictions. But others welcome the life-long support program of Alcoholics Anonymous. They find that A.A. enhances their spiritual and religious convictions, and they freely accept the traditional tenet that the "disease" of alcoholism can be constrained, but only in cooperation with a power greater than themselves. It seems that a few patients in both tracks retain belief in the disease concept as an ace in the hole, a built-in excuse for a possible future drinking bout. Incidents of A.A./ S.M.A.R.T. Recovery criticism among patients are minimal; members of both groups respect the decisions made by their peers.

The overriding feature of the Above and Beyond approach is patient participation in a program which they, themselves, have selected as applicable to their needs. Others talk about "fitting the program to the client." Above and Beyond *does* it, and in doing so, is making history.