FAVOR Greenville Academy

Family Recovery Coach Training

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Context and history of the family in recovery...

We can’t understand where we are…if we don’t understand where we have been.

Where is addiction located?

Addiction is seen as a problem that is “housed” within the individual.

• The addicted individual is the one with the problem. The addicted individual is the one with the underlying issues and behaviors that lead to the problem.
• You Did NOT:
  • Cause it...
  • You Can’t:
    • Control it...
    • Cure it...
• The individual is responsible for his or her recovery

Why is addiction seen as an “individual” problem?

• The disease model
  • Disease impacts an organ, impacts an individual
  • There is little precedent for talking about a “systemic disease”
• The historical context
  • Alanon and detaching with love. The culture at the time.
  • Tough love
  • REHAB was made for the individual
  • Hospitals housed the individual
• Units of service delivery eliminate all other constructs
  • Example: Insure does not pay for a family unit...

Positive trends toward a systems orientation...

National Registry of Evidence Based Programs: SUD with Family= 17 + 13 legacy programs
Mental Health and Family: NREBP
- 38 new programs
- 27 legacy programs
- 65 Total MENTAL HEALTH
- 30 Total SUD

Progress. Yet the tendency toward individual emphasis and orientation is real, tangible and ultimately destined to lead to failure. If we are going to make a real difference it will upon full mobilization of the family.

Positive Trends...

Characteristics:
- Intergenerational trauma
- Family System Problem=System Solution (everyone commits to plan)
- Building a team
- Recovery Messaging
  - Level 1
  - Level 2
  - Level 3
- Continuing Care
FAVOR Greenville Recovery Coach Academy
**note the Jones Solutions Academy is the official educational provider for all FAVOR-Greenville coaching. Richard Jones is a certified National Association of Alcohol and Drug Abuse Counselors (NAADAC | www.naadac.org education provider. Provider number 144243. The NAADAC approved education provider emblem signifies the highest level of consistent, reliable and quality training. All Recovery Coach Academy training meets nationally approved standards of education developed for the alcoholism and drug abuse counseling field. All Recovery Academy participants are assured contact hours or CEUs that are nationally recognized by NAADAC and most other state licensing and certification bodies.**

**What is Recovery Coaching in general?**

Recovery coaching, also known as Peer Recovery Based Support (PRBS), has been identified as a key aspect of helping individuals find and maintain recovery. The nature and functions of mentoring or coaching vary from one project to another. Academy coaches assist individuals with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as making new friends, finding new uses of spare time, and improving one’s job skills. They may also provide assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges. The relationship of the Academy coach to the peer receiving help is highly supportive, rather than directive. The duration of the relationship between the two depends on a number of factors such as how much recovery time the peer has, how much other support the peer is receiving, or how quickly the peer’s most pressing problems can be addressed.

The Academy distinguishes the role of the peer mentor or coach from that of a 12-Step sponsor in several ways. For example, the sponsor works within the 12-Step framework and is expected to help the person in early recovery understand and follow the specific guidance of the 12-Step program. The typical Academy recovery coach, on the other hand, is often described as helping peers in early recovery make choices about which recovery pathway(s) will work for them, rather than urging them to adopt the coach’s own program or any specific program of recovery. The mentor or coach is often described as devoting a greater amount of time than the typical 12-Step sponsor to connecting the person in early recovery to community health, employment, housing, educational, and social services and resources and often has more specific knowledge about a larger range of available services and resources.

We also emphasize the difference between “Coach” and “Counselor”: Coach is focused on practical advice and support around recovery not on processing past issues and seeking resolution of therapeutic concerns. In addition, coaching services can be provided in a variety of settings including community meetings, coffee shops, community centers, and even in homes. The “Coach” is also able to provide practical support related to vocational support, educational support, and other “life” issues. Many times a coach will “refer” to a therapist and/or clinic when additional therapeutic support is indicated.

In addition to conducting one-on-one coaching or mentoring and resource connecting activities, Academy recovery coaches facilitate and lead recovery-oriented group activities for individuals
seeking recovery. Some of these activities are structured as support groups, while others have educational purposes. Many have components of both. The group activities that are structured as support groups typically involve the sharing of personal stories and some degree of collective problem-solving. Many of these groups are formed around shared identity, such as belonging to a common cultural or religious group, or shared experience related to the substance use disorder, such as the need to re-enter the community following incarceration, being HIV positive, or facing challenges in parenting.

Generally speaking, recovery coaching is done by an individual in recovery “at least one year” although exceptions to the “time” requirement are handled on a case-by-case basis. There is no specific requirement in terms of education or certification. Most organizations do background checks and have standards in relation to character and skills/abilities.

“Coaches” rely on their own recovery experience to guide a client through the recovery process. However, training and ongoing supervision is required to ensure appropriate and ethical delivery of services. Training and supervision should be provided by a licensed professional with appropriate educational and experiential background. The person providing the training/supervision should come with an appropriate mix of education, certification and his/her own recovery experience.

There is no single authority on recovery coaching and there are many competing ideas of where to look for the most reliable information and training. We base our training on extensive experience providing recovery coaching services. At FAVOR Greenville we have developed a high quality professional recovery coaching organization. We are one of 9 CAPRSS accredited programs in the nation. We are a member of the association of recovery community organizations. We have served over 17,000 people and we have provided more than 40,000 hours of recovery coaching. The majority of those hours to people who do not necessarily "want" recovery. We serve the "unwilling". We are engagement experts. We believe this type of independent, autonomous organization (not affiliated with a treatment organization) is the future of professional recovery services. We know how to do this.

**What is Family Recovery Coaching?**

From its inception FAVOR Greenville and the Academy has placed great emphasis on the value of "Family Recovery." We have swung the doors of our recovery community center wide open to families regardless of the recovery status of their loved ones. We operate with a few basic principles that have guided our family programming from the very beginning. 1) We believe that there is merit in family recovery in and of itself. Family members experience profound health concerns when substance use disorders are present. These include chronic stress, physical problems, sleep difficulties, depression and anxiety. Even if the person suffering with a substance use disorder never makes a change, the family deserves special focus and support to deal with these issues. 2) The family has tremendous power that can be harnessed and focused in a way that increases the likelihood their loved one will seek recovery. Frequently, when family members start to change, the person with a substance use disorder will start to change. Family systems theory tells us that if you move one part of the family, you move the entire family. Like a mobile above a baby's crib, it is impossible to move one part without impacting the whole. 3) Family members are frequently the first point of contact in the process of recovery initiation.
Family members constitute a more willing customer base. They will call for information and options well before their loved one darkens the doors of our center. They are open to feedback and, in many cases, begging for information and options. Therefore, FAVOR Greenville sees the family as a ready-made channel for engagement of those in need. 4) Family recovery coaching is a unique discipline and the shared experience of families in recovery can be capitalized on in a manner consistent with basic peer support services.

With these principles in mind FAVOR Greenville started family programs in 2013 with a simple open "Family Recovery Group." The group was modeled on basic group facilitation processes of universality, mutual support and mutual respect. Our initial group attendance was 12 people. We held these groups every Monday night at 6:30pm. The group exploded in attendance based nearly entirely on word of mouth. In 2016 this group averaged 54 people per week with a high December of 103 people in attendance. The group has become more didactic and educational in nature. However, we start each group with questions from the week and we make sure the topic of education/discussion is generated by the group. There are usually 10 to 15 new people at the group and an equal number of "veterans" who have been in attendance since the group started. Over time an interesting phenomenon arose. The group was intended for any and all family members, spouses, children, siblings and parents together in one group. However, the group quickly morphed to 90% parents.

In response to this we developed our second family recovery group. Every Thursday night at 6:30pm we hold our S.O.S. (Significant Other Support) group. This group focuses on spouses or adult children. This group has a different tone than the parent group because the dynamics are different spouse to spouse versus parent to child. This group has operated for 2 years and average attendance is 20 people.

Also we have just added an offsite Family Recovery Group in our neighboring town of Spartanburg, SC. Many people from Spartanburg had been making the trip to Greenville. However, it became clear that the community needed a satellite group. We launched this group in 2016 by forming a partnership with a local church. We rent the space and facilitate essentially the same group. Average attendance at that group has been 30 people.

We also have a children's program for children of parents in recovery and/or children of parents struggling with active substance use disorder. This is a curriculum based program and we run it periodically based on community response/need. We have had 103 children complete this program.

Another distinct area of family recovery support at FAVOR Greenville is our family recovery coaching. These are parent to parent, spouse to spouse, family to family coaching relationships put in place to supplement the various groups provided at FAVOR Greenville. We actively recruited family members who had been "working a recovery program" and developed a specific curriculum to supplement our regular coach academy. These family members completed a specialized training academy to become FAVOR Family Recovery Coaches. To date we have trained 53 family coaches and currently have 29 active Family Recovery Coaches who volunteer on average five hours per week to coach and support other families. We have been overjoyed with the Family Recovery Coaching programming. We have provided over 8,000 hours of family recovery coaching since initiating the program. The family coaches are incredibly enthusiastic and grateful, this is reflected in the way they engage our families in need. This has been magical to watch.
Finally, we offer intervention services to support the family in crisis. We have two ARISE interventionists on staff and have completed over 305 interventions to date. We are in the process of developing a second tier of interventionists to address this area of need. The number of interventions has risen dramatically over the past year and half and we need more support to respond to the needs of the community.

Overall, it is important to note, 48% of the service hours delivered at FAVOR Greenville are delivered to family members in need. The distinct difference with our program is the following: Family recovery is not an add-on or adjunct to service; family recovery is front and center and a cornerstone of the center. We have found that family members want to be included in the process and they make great volunteers and supporters. FAVOR Greenville will continue to place formal emphasis on family recovery and we believe our program will expand in the area of family recovery as we move forward in our mission.

**Family Recovery Coaching Requirements**

Family members must have the ability to articulate their own personal pathway of family recovery. Their process should be consistent and they should be able to reliably manage their own recovery plan. Family coaches will be interviewed and approved by the executive director and will perform duties under the direct supervision of our executive director.

Specialized training hours will be offered for family members. These areas of specialization will be described in detail later in this manual. We anticipate that we will have participants who meet qualifications to do both individual and family recovery coaching. They will be trained accordingly. Primacy of one discipline over the other is the decision of the coach, in consultation with the executive director. Performing both roles is also an option.

Family recovery coaching requires a baseline understanding of recovery coaching and peer recovery support services. The organization should make sure that their candidates have that baseline knowledge, or ensure they acquire that baseline knowledge through training and supervision. If a person meets the requirement of this fundamental base the family specialization will require 16 hours. We also recommend ongoing technical assistance and a tight supervision package as family recovery coaching is a high impact profession.
Module 1: Content and History of the Family in Recovery

9/13/2017

Context and history of the family in recovery...

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Why is addiction seen as an “individual” problem?

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  - Disease impacts an organ, impacts an individual
  - There is little precedent for talking about a “systemic disease”

- The historical context
  - Alcance and detoxing with time
  - Tough love
  - Rehab was made for the individual
  - Hospitals housed the individual
  - Units of service delivery eliminated all other constructs
  - Example: Insure does not pay for a family unit...

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Addiction is seen as a problem that is “housed” within the individual.

- The addicted individual is the one with the problem
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- You Did NOT:
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  - Control...

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National Registry of Evidence Based Programs S/O with Family - 17 + 12 legacy programs
Mental Health and Family: NREBP

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- 50 Total SUD

Progress. Yet the tendency toward individual emphasis and orientation is real, tangible and ultimately destined to lead to failure. If we are going to make a real difference it will upon full mobilization of the family.

Positive Trends...

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- Family System Problem-Solution (everyone commits to plan)
- Building a team
- Recovery Messaging
  - Level 1
  - Level 2
  - Level 3
- Continuing Care

An Overview of ARISE® Continuing Care with Intervention
Module 2: Addiction and Recovery--OVERVIEW

What is Addiction?  What is recovery?
Richard Jones MA, MBA, LCAS, CCS, SAP, CEAP

SUD DSM-5 Criteria
Severe=6 or more | Moderate 4-5 | Mild 2-3

- Heavy use, "party like", "had a bad night"
- Age onset, frequency, drug specific
- Reward potential
- Genetic factors

Crossing "line" into addiction
- Tolerance
- Withdrawal
- Craving/pre-occupation
- Can’t control
- Can’t cut back
- Interpersonal issues
- Avoid non-using activities
- Great deal of time spent on using
- Use despite physical/psychological dangers
- Use in physically hazardous situations
- Role failure due to use

Judgment last to develop
The area of the brain that controls "executive functions" — including weighting long-term consequences and controlling impulses — is among the last to fully mature. Brain development from childhood to adulthood:

- Front view
- Top view
- Brain less fully mature

- Blue/purple: Parts of brain more fully mature

Progression...

- Age 14
- Age 16
- Age 18
- Age 20
- Age 22

- Initiation
- Alcohol
- Alcohol use
- Alcohol abuse
- Alcohol dependency

- "I will cut pills and also can’t tell the nurses staff. Once again, and see they were right.

Progression Accelerated

- Age 14
- Age 16
- Age 18
- Age 20
- Age 22

- THC
- Hair test
- Alcohol
- Alcohol use
- Alcohol abuse

Disease:
Organ – Defect – Symptoms

- Diabetes
  - Organs= Pancreas
  - Defect= Cannot produce insulin
  - Symptoms= blurred vision, wounds that won’t heal, numbness

- Drug or Alcohol Addiction
  - Organs=Mid Brain
  - Defect= dysregulation of dopamine (hedonic) system
  - Symptoms= drug seeking, craving, loss of control, use despite consequences
Dopamine feedback loop

- Drugs cause a greatly amplified level of dopamine: TOO MUCH; TOO LONG; TOO INTENSE
- In order to compensate and "rebalance" the brain responds by dampening its ability to produce dopamine (turn the water off on the toilet).
- Baseline dopamine levels become abnormally low and ability to experience pleasure is reduced.
- In the meantime, the midbrain has been paying close attention. More dopamine is good so the drug is "tagged" as good at a survival level (glutamate-tag).

Dopamine Feedback loop cont.

- It becomes a matter of survival not pleasure or choice...
- The drug is a fundamental part of existence. Just like food, water, etc...
- Cravings are regulated by glutamate through its impact on memory and learning.
- In time, trying to regain optimal glutamate levels, the brain develops habits in the deep seated, non-conscious memory system of the mid-brain.
- As a result environmental cues associated with the drug can trigger memories of use causing uncontrollable cravings.
STAGES OF RECOVERY

- Acute withdrawal-Detox
- Early recovery-Post Acute Withdrawal
  - “Honeymoon-Pink Cloud”
  - “The Wall”
- Full Integration-Maintenance

Stage One: Stabilization
Tasks Include:
- learning about addiction
- staying clean and sober, bet free no matter what
- physical detox and stabilization
- learning to socialize in a group setting
- learning to break the pattern of isolation
- developing role models for healthy recovery
- anxiety management
- staying away from risky places, situations and people
- developing self-responsibility
- learning to ask for help and support

Stage Two: Deepening
Tasks Include:
- identifying old behaviors that don’t feel right anymore
- emotional detox
- changes in verbal attitude, feeling and behavior
- increase in the quality of physical health
- increase in the ability to tolerate feelings
- beginning to make distinctions between and among feeling states
- increase commitment to working on recovery

Stage Three: Connectedness
Tasks Include:
- the depth of joy and misery can be profound
- the need to go back and redo some earlier tasks in recovery
- learning to avoid the creation of drama in one’s life
- the outer world of the person is beginning to reflect the inner world
- connections are made to a wider circle of people both in and out of recovery
- there is an increase in honesty

Stage Four: Integration
Tasks Include:
- relationships based on love rather than need
- avoiding stickiness
- the automatic use of tools of recovery
- an ability to act on knowledge and insight and follow through
- self-forgiveness
- having fun and joy in life
Scope of Recovery

- Primary – focuses primarily on addiction health
- Primary and Secondary – focus on addiction health and global health

Types of Recovery

- Abstinence-based: Complete and sustained cessation of one’s primary drug(s), any other non-medical psychoactive drug and/or gambling with nicotine and caffeine historically allowed
- Moderation-based recovery: Sustained deceleration of alcohol, other drug use and/or gambling to a sub-clinical level, that is, a level that no longer meets diagnostic criteria
- Medication-assisted recovery: The use of medically monitored pharmacological drugs to support recovery from addiction

Context of Recovery

- Solo (natural) recovery: Involves the use of one’s own intrapersonal and interpersonal resources (family, kinship and social networks) to resolve addiction problems without the benefit of professional treatment or involvement in a recovery support group
- Treatment-assisted recovery: Involves the use of professional help in the initiation and stabilization of recovery
- Peer-assisted recovery: Involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery

Frameworks of Recovery

- Religious: A framework in which severe addiction problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship and support of a community of shared faith.
- Spiritual: Frameworks of recovery that flow out of the human condition or wounded imperfection, involve experiences of connection with resources within and beyond self and involves a core set of values (e.g., humility, gratitude and forgiveness) Religious and spiritual frameworks of recovery can closely co-exist and overlap.
- Secular: A style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or rituals (prayer).

Recovery Identity

- Neutral: Persons who have resolved severe alcohol, other drug and/or gambling problems but do not identify themselves as alcoholics, addicts or persons in recovery
- Recovery-positive: Persons for whom the status of recovery from an addiction has become an important part of their personal identities
- Recovery-negative: Persons for whom the recovery status is self-acknowledged but not shared with others due to a personal shame derived from this status

Recovery Terminology

- In Recovery: A person in sustained recovery for less than five years
- Recovered: A person in sustained recovery for more than five years
- Recovering: A term used to imply that recovery takes constant vigilance throughout one’s life
The Stages of Change Model

- One of the most influential models in Substance Use Disorders treatment in the last 20 years
- Model developed by Prochaska and DiClemente (1982)
- Developed for and with people with substance use disorders
- Has been used widely to understand change including in prevention and systems change

Stage of Change: Precontemplation

- Person shows no intent to change a problem behavior
- Person may be unaware behavior is a problem, or unwilling to do anything about it
- Person may lack confidence to change behavior due to previous failed attempts
- Person tends to view target behavior as having more positive than negative (Decisional Balance)
- Person believes behavior to be under control or at least manageable

Stage of Change: Contemplation

- Person is considering change, but has not yet initiated any change behavior
- Person is considering implications and consequences of target behavior
- Person is visibly distressed by target behavior
- Person has started to weigh the positive and negatives of the target behavior
- Person will typically seek out relevant information about the target behavior

Stage of Change: Preparation

- Person is getting ready to change the target behavior, both in attitude and behavior
- Person intends to change soon
- Person may have already started to increase self-regulation around target behavior
- Person may have been prepared to make or may already be making small changes to the target behavior

Stage of Change: Action

- Person is actively making change to target behavior
- Person is modifying their attitudes and responses to target behavior
- Person is learning skills to prevent relapse or reversal of target behavior
- Action stage typically lasts an average of 6 months in people working to change substance use.
Stage of Change: Maintenance

- Person sustains and strengthens changes made to the target behavior
- Person is practicing skills to prevent relapse or reversal of target behavior
- Establishes basic “habits” and “rituals” around modified behavior

Common Characteristics of People in the Precontemplation Stage

- Defensive
- Resistant to suggestions of problems associated with their drug use
- Uncommitted or passive in treatment
- Avoid steps to change drug use
- Lack awareness of the problem
- Often pressured or mandated to seek treatment

Common Characteristics of People in the Contemplation Stage

- Seeking to evaluate and understand their behavior
- Distressed about behavior
- Desire to exert control over behavior
- Thinking about making change
- Have not started to make change and are not yet prepared to do so
- Have made frequent attempts to change behavior in the past
- Actively evaluating pros and cons of making change

Common Characteristics of People in the Preparation Stage

- Intending to change their behavior
- Ready and committed to change behavior both in attitude and behavior
- On the verge of taking action
- Engaged in the change process and TX
- Prepared to make firm commitments
- Making or prepared to make decision to change

Common Characteristics of People in the Action Stage

- Client has decided to make change
- Client has made a firm commitment to change and is involved in process
- Efforts to modify behavior and environment have begun
- Client presents motivation and effort to achieve behavioral change
- Client is willing to follow suggested strategies and activities to change behavior

Common Characteristics of People in the Maintenance Stage

- Person has made change and is working to sustain change behavior
- Considerable attention is focused on avoiding relapses
- Person may feel anxiety and fear around relapse and high risk situations
- Less frequent urges to use

Conners, Donovan and DiClemente, 2001
Recoveree Tasks:
Precontemplation to Contemplation

- Person must acknowledge the problem
- Person must recognize the harm caused by the target behavior
- Person must increase awareness of negatives of target behavior
- Person should begin building confidence and self-efficacy around change in that domain

Connors, Donovan and DiClemente, 2001
Slide 3.26

Coach’s Role:
Precontemplation to Contemplation

- To raise doubts and increase concern and awareness around the target behaviors; develop hope and optimism

DiClemente, 2003
Slide 3.25

Recoveree Task:
Contemplation to Preparation

- Person must make a decision to act and commitment to change target behavior
- Person must begin to take preliminary steps towards making change
- Ambivalence around decisional balance should be resolved

Connors, Donovan and DiClemente, 2001
Slide 3.27

Coach’s Role:
Contemplation to Preparation

- To examine the impact of the target behavior and to consider the pros and cons in order to tip the decisional balance in favor of a commitment to change the target behavior.

DiClemente, 2003
Slide 3.28

Recoveree Task:
Preparation to Action

- Person must begin to set goals and priorities to achieve change
- Person must begin to develop a change plan
- Person may not have stopped using alcohol and/or other drugs at this point. Change in using behavior may not occur until person reaches action stage

Connors, Donovan and DiClemente, 2001
Slide 3.29

Coach’s Role:
Preparation to Action

- To strengthen the commitment to change and to develop an action plan and strategies that facilitate the desired change to the target behavior.

DiClemente, 2003
Slide 3.30
Recoveree Task: Action to Maintenance

- Person must apply behavior change methods and techniques for at least 6 months
- Person continues to develop self-efficacy around behavior change and continually refines change behavior
- Person must be actively meeting their recovery goals to be considered in action stage.

Connor, Donovan and DiClemente, 2001

Coach’s Role: Action to Maintenance

- To support the implementation of the change plan, modifications of the plan as needed and development of new behaviors and attitudes conducive to change.

DiClemente, 2003

Cycling Between the Stages of Change

- Model is considered cyclical not linear
- People typically cycle back from advanced stages to previous ones, however rarely back to precontemplation.

“The Wall”

Recovery Capital-Scale Available

- The resources (social, physical, human and cultural), which are necessary to begin and maintain recovery from substance use, abuse, and dependence (Best & Lauder, 2010; Cloud & Granfield, 2008).

Breaking thru the wall...
No sense getting into recovery and being miserable...
Recovery Capital

Recovery Capital Scale—Examples

* Recovery Capital Scale Place a number by each statement that best summaries your situation.

1. Strongly Agree
2. Agree
3. Somewhat
4. Disagree
5. Strongly Disagree

- I have the financial resources to provide for myself and my family.
- I have personal transportation or access to public transportation.
- I live in a home and neighborhood that is safe and secure.
- I live in an environment free from alcohol and other drugs.
- I have an intimate partner supportive of my recovery process.
- I have family members who are supportive of my recovery process.
- I have friends who are supportive of my recovery process.
Module 2-Notes

On Addiction:

Much has been written recently on addiction driven mainly by the media storm around the “opioid epidemic”. There are articles in mainstream press and the attention has brought this issue out of the shadows. The debate has escalated around the etiology of addiction. There are competing camps popping up related to the most accurate label for addiction. These are important discussions. Understanding the issue is central to society’s response. Our outlook on any given problem will guide our response to that problem. At a global level, outside of those professionally or personally touched by addiction, the moral model remains our default explanation for addictive behavior. The moral model holds that addiction is essentially bad behavior and the individual needs to use willpower to make better decisions. Public opinion polls show 44% to 63% of Americans view addiction this way (CASA, 2011). If you believe in the moral model you believe addicts should be locked up. Clearly America sees addiction as a moral issue. Incarceration remains the preferred systemic response. However, it is obvious that addiction goes way beyond “bad people doing bad things”.

In direct contrast to the moral model, the disease model states that addiction is a brain disease. A complex neurobiological process in which the regulation of key transmitters (dopamine) becomes dysfunctional. This, along with the over-stimulation of the naturally occurring craving mechanism glutamate, leads to substance use despite clear consequences, substance seeking behaviors and the overwhelming pre-occupation or mental obsession associated with addiction. The American Society for Addiction Medicine (ASAM) describes addiction as follows:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

If you agree with the disease model you, theoretical, believe that addiction should be treated as a medical issue. This would imply that addiction is addressed within the bounds of our healthcare system. Addiction would be viewed the same as any other disease. A doctor would assess, diagnosis and refer for treatment. Hospitals would provide care. However, America find itself in the middle of a strange paradox. On one hand, we proclaim the disease model and on the other we refuse to treat it within the healthcare system. The divide between general healthcare and addiction treatment creates confusion. The implication is that people with substance use disorders are a special group that need to be isolated from general healthcare and reprogrammed. The facts are (despite the reality that more than 2/3 of people with addiction were in contact with medical personnel the past year) most physicians and health professionals do not identify or diagnose the disease or know what to do if the issue is uncovered (CASA, 2012). I therefore contend that the disease concept is a feel-good term serving merely as window dressing for a society that is frightened to look addiction in the eye. We prefer to keep it locked in a closet and out of sight out of mind. Bringing addiction into the healthcare system would improve results but require major shift in policy, reimbursement, and turf. The status quo would be upended.
There is one area of exception as it relates to healthcare integration. It is in relation to medication assisted treatment. For example, physicians are able to become certified as prescribers of buprenorphine. They can then provide medication to address opioid dependence. This is an area that is going to receive more attention moving forward. Regulations have been changed to support more patient engagement. Doctors can now serve up to 275 patients instead of maximum of 100. In addition, funding is changing. Subsidies are coming to support those who cannot afford medication assisted treatment. Insurance companies are liberally reimbursing suboxone treatment in parts of the country. Surely this will expand all corners of the nation.

Maia Salvitz’s Unbroken Brain challenges the conventional disease model. However, hers is not a return to the shaming and blaming moral model. Instead Salvitz holds that addiction is closer to a learning disorder than a degenerative disease. Salvitz’s position is that those of us who became addicted did so because of misfiring cause and effect system in the brain. Our neurotransmitters become confused and we are unable to prioritize or make rational decisions where the substance is concerned. I will not go into great detail and would encourage you to read Salvitz’s Unbroken Brain. However, I view her interpretation as merely a reframing of the neurobiological disease model. Both concern the same parts of the brain and both acknowledge fundamental change in processing that occurs in the brain.

The significance of Slavitz’s position is not so much etiological insight. The significance is the potential impact this viewpoint has on treatment response and recovery services. The most obvious implication: if it is a learning issue then the person can potential unlearn the behavior. Furthermore, Slavitz’s position opens the door for an expansion of new approaches to addressing addiction. A person with addiction does not necessarily require the old paradigm of treatment plus 12-step recovery meetings. There are other pathways to recovery. Professional providers can support creative solutions including harm reduction oriented interventions. Medication assisted treatment also is held in high regard in this model and seen as an under-utilized intervention. Salvitz uses an analogy of ADHD in some of her work. She talks about how medication is effective in addressing this issue and allowing the individual to more fully engage in the learning experience. In a similar way medication could be used to support recovery.

However, there is a dilemma that springs from this perspective, it seems logical that addiction as a learning issue eliminates addiction as a healthcare issue. It can’t be both. What are the practice implications if addiction moves further away, in terms of semantics, from the disease model? Slavitz’s position is unlikely to gain traction due to the firmly entrenched “theoretical disease model” that exists in the treatment industry today. It is very unlikely that anyone will take her seriously on a mass scale. If open-mindedness did exist and this view was given serious consideration reconciliation with healthcare would prove difficult.

Another model that has received a great deal of attention is Johann Hari’s addiction versus connection theory famously presented through his 2015 TED talk entitled “Everything You Know About Addiction Is Wrong”. The short story version of Hari’s work is the following: Rat park was an infamous study where scientists got some rats strung out on cocaine resulting in a group of rats who refused to eat, have sex, reproduce or do anything other than cocaine. They then get some other rats strung out but create opportunity for connection with other rats and create a “park” where these critters can frolic about. This second group chooses to eat, drink, reproduce rather than use cocaine.

The conclusion was connection mitigates the effects of addiction. Hari also talks about the phenomena of apparent transformational change that occurred with Vietnam vets and heroin addiction. It seems that the overwhelming majority of Vietnam vets stopped using heroin upon their return to the states. Again, this was attributed to the connection that occurred back in their native country. Of
course, the talk and Hari’s thesis contains much more depth and detail. However, the overall emphasis is on lack of connection as the problem and connection as a major part of the solution.

The practice implications of connection versus addiction are interesting. It is a widely-held belief that recovery involves community. Therefore, the emphasis on connection makes sense to many in the addiction treatment and recovery world. However, over-emphasis on the connection presents a challenge to the disease model. There have been some who criticized Hari for removing the neurobiology of the process. Hari is quick to say that was never his intent. At a policy level this theory could easily lead to less emphasis on integration into healthcare. At the same time connection-theory could lead to an increase emphasis on recovery support as recovery support is all about connection. Obviously, this appeals to me on a personal and professional level.

There are many other perspectives on addiction these are simply the most commonly held. It is very interesting to see addiction discussed so openly. Hari’s TED talk yielded 15 million or more views. The danger is confusion on the part of the general public. If we don’t have agreement on what addiction is then we will automatically default to the moral model. That is the position people are most comfortable with and the position people are naturally drawn to. I believe addiction is a brain issue. Call it a disease or disorder or “brain problem”. The “theoretical” disease model is not going anywhere soon, it is firmly entrenched. However, it could be threatened based on two factors:

1) Our societal practices do not reflect a belief in the disease model. In other words, we call it a disease but refuse to treat it within healthcare.
2) Our current response, which is based in theory on the disease model, is inadequate (CASA, 2012). In other words, we have not slowed addiction down in the slightest.

This leaves us ripe for an alternative theory. I fear it may be a doubling down on the moral model.

At the Academy we believe that addiction is in fact a biopsychosocial neurological based disease. It is centered in the mid-brain and driven by compulsive use despite clear consequence, pre-occupation, inability to control or cut down/quit use, and the physical symptoms of tolerance and withdrawal.

ON RECOVERY

Recoveryism is a term used to describe an unfortunate attitude that pervades much of the addiction treatment and recovery world. This attitude crosses all modalities of recovery and is present within many prestigious treatment organizations. The attitude is one of superiority in regards to one’s individual recovery. People engaging in recoveryism hold tight to the view that there is a right way to approach recovery. Of course, these people believe their way is the correct pathway to recovery. William White defined recoveryism in the following way:

“In 2006, Tom Horvath, President of SMART Recovery, penned a brief article in which he coined the term recoveryism. He used the term to depict assertions that a particular approach to addiction recovery was superior to all others – that there really is only ONE effective approach to addiction recovery. Horvath rightly called our attention to a special form of bigotry sometimes exhibited by people who are grateful for their own brand of recovery. There are those in secular, spiritual, and religious pathways of recovery who have claimed ultimate eminence for their particular ideas and methods and viewed alternatives as inherently inferior. Radical abstentionists and radical medicationists continue acrimonious debates marked by more heat than illumination. Those who enter recovery with and without specialized addiction treatment have each claimed a form of superiority, as have those who maintain recovery with and without participation in recovery mutual aid groups. Each of these approaches is in turn subject to internal dissension about how that approach should best be pursued”. (White, 2013)
Of course, recoveryism involves 12-step versus alternative pathways. However, it also involves 12-step versus 12-step. For example, some in the AA fellowship will challenge the validity of the NA fellowship and vice versa. It can even go deeper. Many times, people will disparage different home groups. We do it the right way at “our group” and they don’t do it right at the “other group” is a position held by some. It is even possible for dissension to arise within a home group regarding the “right way” to do recovery. The same can be said for those attached to a “clinical” solution. These individuals emphasize a specific therapeutic method to the exclusion of all others. As White says above, medication assisted treatment advocates can sometimes become married to the medication only solution.

Despite these assertions, we know the facts. Recovery takes on many forms. There are multiple pathways to recovery and there are millions in recovery. Rather than taking a “my recovery is better than yours” approach, perhaps a better approach would include a focus on the common factors of recovery. What if we shifted the question from: What is the best pathway? To What is common across many of the pathways? The more actively one engages in these various components of recovery, the more likely recovery becomes. This does not mean recovery will not happen with the absence of any given factor.

At the Academy we focus on the “Common Factors” associated with recovery experiences:

1) Recovery works best when addiction is in remission. Stating the obvious. It is very hard to find recovery if you are actively abusing drugs or alcohol. However, you can certainly initiate the recovery process while still using. Many people need time to “figure it out” and we recommend that people “keep coming back” no matter what. This includes active use. But for the record, recovery works best when you “put it down”.

2) Change in lifestyle and minimizing environmental triggers. Most people who make a substantial change in using behavior also make a substantial change in people, places and things. It is very hard to stop a behavior if you continuously expose yourself to temptations and reminders related to that behavior.

3) The curative factors of the group experience. Irvin Yalom articulated best what happens in group therapy. Group is a unique place. Group gives participants an opportunity to hear from a wide variety of people and tap into some of Yalom’s curative factors:
   - Universality: you realize you are not alone.
   - Instillation of Hope: you can look around the room and see people who have overcome.
   - Interpersonal Learning/Socialization: you can get tips and pointers on how to do life from group members.
   - Altruism: you have an opportunity to help another person. That is invaluable.

4) One-on-one with an “expert”. Group is very important but we also believe that a one-on-one relationship is very important. Furthermore, we believe this individual contact should be with an expert in recovery. Preferably someone in recovery. However, I will go on the record. I have known people who found recovery primarily through a therapist or a clinician who was not in recovery. One-on-one is important because it allows for in-depth exploration of issues. You can receive more attention and focus individually. In addition, there are some things that you just don’t want to discuss at the group level.

5) Pursuit of continuous self-improvement. People in recovery tend to focus on self-improvement. However, the pathways of self-improvement are highly variable. Some focus on exercise and physical health initially. Many use the 12-step program. Some work diligently in therapy and life-coaching. There are many who go back to school and pursue their work dreams. Some do
all of the above. Whatever the details we know; the escalator is going up or going down.
Staying put is not an option.

6) Filling the void. The obvious thought that comes to mind here is the spiritual component of
recovery and certainly spiritual pursuits meet the criteria for filling the void. Again, the facts are
there is no one way to work on these spiritual matters. The idea that one person can dictate
spiritual experiences to another person is fundamentally unspiritual. I would encourage a
broader look at the issue of filling the void. Victor Frankl in Man’s Search for Meaning summed
it up very well when he said: “When a person can’t find a deep sense of meaning they distract
themselves with pleasure”. And on addiction Frankl said: “Addiction is the result of living a life
without personal meaning”. For Frankl finding meaning came in a wide variety of forms and we
would agree with him.

7) Keep coming back. Finally, and most importantly, never give up. If you keep showing up for
therapy, recovery meetings, individual meetings you will find recovery. It is available to all of us.
Bibliography


National Center on Addiction and Substance Abuse (2011). *Train the Trainer. Powerpoints DAY 1 and DAY 3*


Recommended Reading
Module 3: Coaches (Family) Role

Distinguishing the Addiction Counselor, Recovery Coach and & Mutual Aid Sponsor/Guide

Module 3 - William White

Group supervision vs Individual Supervision
- Group supervision/case review
- Coaches rotate presenting cases/stuck points, boundary issues, ethical issues, any other concerns
- Emphasis on mutual support and self-care
- Emphasis on processing counter-transference.
- Individual more focused on transference and individual "stuck points"

“Stay in your lane”
- Coaching is not...
  - Therapy
  - Counseling
  - Sponsorship
  - Medical Advice
  - Friendship

Supervisor Role
- Mentor
- Competence
- Accountability
- Support/encouragement
- Expertise
- Administrative functions
- Coach for coach...

Supervision/Training
- Coaches are accountable to an organization/supervisor
- Protocols vary across organizations
- Training hours vary
- Protocol for Academy: at least 2 hours per week ongoing supervision/case consultation.

Coach Responsibility in Supervision
- Attend scheduled supervision sessions
- Monitor himself/herself and access supervision as needed
- Participate in professional development
- Push comfort level around vulnerability
- Honestly share concerns/struggles
- Avoid superhero complex
Distinguishing Characteristics: Starting Points for Discussion

Contrast professional addiction counseling, peer-based recovery coaching and sponsorship on key characteristics—recognizing that these characteristics exist on a continuum across organizations and groups that evolve over time.

Service/Support Framework

Counselor: Works within a particular organizational treatment philosophy
Recovery Coach: Works across multiple frameworks of recovery via choices of those with whom they work
Sponsor: Works within beliefs & practices of a particular recovery fellowship

Foundational Knowledge

Counselor: Emphasis on formal education (theory and science); vetted by the profession
Recovery Coach: Emphasis on experiential knowledge and training; vetted by the community
Sponsor: Emphasis on experiential knowledge; vetted by reputation within a community of recovery

Service/Support Relationship

Counselor: Significant power differential; extreme separation of helper/helpee roles; explicit ethical guidelines; high external accountability
Recovery Coach: Minimal power differential; ethical guidelines being developed; moderate external accountability
Sponsor: Minimal power differential; support is reciprocal; relationship governed by group conscience; no external accountability

Organizational Context

Counselor: Works within organizational hierarchy of treatment organization & with direct supervision
Recovery Coach: Organizational settings span treatment organizations, allied service organizations and recovery community organizations; varied degree of supervision
Sponsor: Minimal hierarchy and no formal supervision

Style of helping

Counselor: Formal, personally guarded and strategic
Recovery Coach: Variable by organizational setting but generally personal and informal
Sponsor: Informal, open and spontaneous
Use of Self

Counselor: Self-disclosure discouraged or prohibited
Recovery Coach: Strategic use of one's own story; role model expectation
Sponsor: Strategic use of one's own story; role model expectation

Role of Community in Recovery

Counselor: Intrapersonal & interpersonal focus; minimal focus on ecology of recovery; minimal advocacy
Recovery Coach: Focus on linking to community resources and building community recovery capital; significant advocacy work
Sponsor: Intrapersonal & interpersonal focus; minimal focus on ecology of recovery; minimal advocacy

Temporal Orientation

Counselor: Considerable focus on past experience
Recovery Coach: Focus on present: What can you do today to strengthen your recovery?
Sponsor: Variable by fellowship and stage of recovery of seee

Documentation

Counselor: Extensive and burdensome
Recovery Coach: Minimal but growing
Sponsor: None

Duration of Service/Support Relationship

Counselor: Brief and ever briefer
Recovery Coach: Measured in months or years (via sustained recovery checkups)
Sponsor: Variable but can span years

Money

Counselor: Works as paid helper; client or third party pays for service
Recovery Coach: Works in paid or volunteer role; service may be paid for by person being coached or a third party
Sponsor: Provides support only as part of one's own service work; no fees paid to sponsor or recovery fellowship
For more distinguishing characteristics, see the following at www.facesandvoicesofrecovery.org


Recovery Coaching vs. Sponsorship

Recovery coaching, also known as Peer Recovery Based Support (PRBS), has been identified as a key aspect of helping individuals find and maintain recovery. The nature and functions of mentoring or coaching vary from one project to another. Academy coaches assist individuals with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, such as making new friends, finding new uses of spare time, and improving one’s job skills. They may also provide assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges. The relationship of the coach to the peer receiving help is highly supportive, rather than directive. The duration of the relationship between the two depends on a number of factors such as how much recovery time the peer has, how much other support the peer is receiving, or how quickly the peer’s most pressing problems can be addressed.

We distinguish the role of the peer mentor or coach from that of a 12-Step sponsor in several ways. For example, the sponsor works within the 12-Step framework and is expected to help the person in early recovery understand and follow the specific guidance of the 12-Step program. The typical recovery coach, on the other hand, is often described as helping peers in early recovery make choices about which recovery pathway(s) will work for them, rather than urging them to adopt the coach’s own program or any specific program of recovery. The mentor or coach is often described as devoting a greater amount of time than the typical 12-Step sponsor to connecting the person in early recovery to community health, employment, housing, educational, and social services and resources and often has more specific knowledge about a larger range of available services and resources.

In addition to conducting one-on-one coaching or mentoring and resource connecting activities, recovery coaches facilitate and lead recovery-oriented group activities individuals seeking recovery. Some of these activities are structured as support groups, while others have educational purposes. Many have components of both. The group activities that are structured as support groups typically involve the sharing of personal stories and some degree of collective problem-solving. Many of these groups are formed around shared identity, such as belonging to a common cultural or religious group, or shared experience related to the substance use disorder, such as the need to re-enter the community following incarceration, being HIV positive, or facing challenges in parenting.

Recovery Coaching vs. Therapist

Recovery coaching differs from therapy in significant ways. Coaching is meant to be a present focused, solution oriented process with an emphasis on shared experiences and practical feedback. In coaching, there is minimal time spent on “going back” and exploring deep rooted issues. Instead the coach address immediate concerns and helps the participant develop a recovery plan. Recovery plans have specific steps and action items, such as attending meetings or attending therapy, in this regard the coach takes on the role of accountability partner.

Coaching does not include assessment of disorders, diagnosis or prescription of any particular treatment. However, there are clearly times where the coach will recommend specific action steps. For example, it is common for the coach to be involved in a referral to a higher level of care (inpatient rehab
for example) and many times when the coach will encourage the participant to seek outside support for issues such as trauma or other co-occurring disorders. Other differences include the following:

- Time frame: therapy tends to be time limited coaching more long term and open ended.
- Documentation: therapy tends to be laden with documentation. Coaching is minimal but growing.
- Self-disclosure: therapy tends to be limited. Coaching self-disclosure is integral to the process.
- Location: therapy tends to occur in an office or clinic setting. Coaching can be conducted in any setting, community or via phone.

A word on Supervision and Training:

Supervision and training of peer recovery coaches is essential to the process. Boundary issues, competence and self-care issues can best be addressed through ongoing high quality supervision. At the Academy, all supervisors are trained and certified as Peer Supervisors. The curriculum for this training is as follows:

**Module 1: What is Peer Supervision/What is purpose of Peer Supervision?**

- Participant protection
- “Professional” responsibility/protection
- Organizational responsibility/protection
- Coach evaluation/development (level 1, level 2, level 3)
- Ethical Considerations/legal issues
- How does peer supervision differ from Clinical Supervision?

**Module 2: Who can do Peer Supervision?**

- Individual considerations: Ideally—a peer
  --Other qualifications
- Organizational considerations: Ideally—a peer recovery organization
  --Legitimate and authentic peer recovery services (CAPRSS)

**Module 3: How is Peer Supervision done?**

- UNDERSTANDING PARALLEL PROCESS
- THE SUPERVISORY RELATIONSHIP
- Balancing Act: Management/Administration vs. Counselor Development
- Models of supervision (clinical traditions)
  --Which models transfer/make sense in the realm of peer recovery?
- Procedures of Peer Supervision (case review, consultation, & training)
--Group Supervision
--Individual Supervision
--Phone Support/Other
--Unique challenges of peer supervision
  --VOLUNTEERS/Staff Access
  --Across various roles (phone coaching, individual, group facilitation etc..)
--Techniques for skill development
  --Co-facilitation
  --Observation
  --Modeling

DAY 2: FAVOR SC Peer Recovery Supervisor Curriculum

Module 4: What are the traits of an effective Peer Recovery Supervisor?
  --Contextual aspects of peer supervision (cultural competency for recovery supervision)
  --What do you bring with you that will impact your supervision?
  --Dual relationships and supervision
  --Leadership styles (DISC)
  --Four A’s of supervision (Accessible, Available, Able, Affable)
  --Knowledge/expertise/able to teach
  --Shortcoming/potential pitfalls (example: authoritarian, incompetence, no time, arrogant)
  --Know yourself as a peer recovery supervisor (no HEROS)
    --Level 1, Level 2, or Level 3 supervisor (borrowing from clinical supervision)
  --Self-care for peer supervisors
  --Supervisor Development

Module 5: How does an organization implement peer supervision?
  --Developing personal model of supervision
  --Developing organizational model of supervision (workgroups)
    --Logistics
    --Framework
    --Follow up
Shared Accountability

Examples: Independent Recovery Community Organization
Within treatment organization
Hybrid

Module 6: How do we ensure quality peer supervision in South Carolina?

--Chapters document active coaches
--Chapters designate supervisor(s)
--Chapters articulate organizational model
--Once per quarter supervisor “retreat” (virtual/live) to coach/support supervisors...
Bibliography


Module 3: Family Systems/History Family Recovery?

**SUBSTANCE ABUSE AND FAMILY SYSTEMS IN DEPENDENCY AND RECOVERY**

Families can be seen as systems. They all have:
- Rules
- Values
- Verbal and nonverbal methods of communication
- Boundaries
- Roles
- Patterns of interaction

Substance dependency causes dysfunction in the family

Looking at the family as a system, it is very important to address the problem of substance abuse and dependency!!

If the family system does not change and family members do not do their own recovery work...

The styles of communication and interaction don’t change, and those old interactions put the alcoholic/addict at risk for relapse!
Reasons families may be resistant to treatment:

- Too often the alcoholic/addict is the focus of treatment...“just fix him and we’ll be okay!”
- Family members resist looking at their own behaviors and painful feelings.
- Fear that the family system won’t survive, that it’s damaged beyond repair.

Family Rules

- Family rules often involve rules of communication
  - Who is allowed to express feelings
  - How and when they are expressed
  - How they are received

The rules of the dysfunction family are:

- DON’T TALK
- DON’T TRUST
- DON’T FEEL

Don’t Talk

- Talking about the problem will only make it worse
- It’s the family secret and is NEVER mentioned to anyone outside the family
- Nothing is going to change so why bother

Don’t Trust

- Trusting will only lead to disappointment
- You don’t trust what you hear or what you see
- Promises are made to be broken

Don’t Feel

- Feelings are for wimps
- Feelings are too painful
- Expression of painful feelings is not allowed because it might cause more problems
DYSFUNCTIONAL FAMILY SYSTEMS
- Rigid family system
- Ambiguous family system
- Overextended family system
- Distorted family system
As each is addressed, see if you identify with a particular system.

RIGID FAMILY SYSTEM
- RULES
  - Strict rules with no exceptions. The rule keeper is exempt from the rules.
- VALUES
  - It's my way or the highway. Things are right or wrong, black or white.
- MOTTO
  - Do it right or else!
- COMMUNICATION
  - From the top down, only.

AMBIGUOUS FAMILY SYSTEM
- RULES
  - We have rules but we don't enforce them.
- VALUES
  - Ever changing, based on the situation.
- MOTTO
  - Avoid conflict at all costs.
- COMMUNICATION
  - Mixed messages that are confusing.

OVEREXTENDED FAMILY SYSTEM
- RULES
  - Be productive, get busy, stay on the move.
- VALUES
  - Look good, achieve through willpower, no time for feelings.
- MOTTO
  - We can achieve anything!
- COMMUNICATION
  - Whatever is pleasing to the parents.

DISTORTED FAMILY SYSTEM
- RULES
  - Don't let outsiders know we're crazy, act normal.
- VALUES
  - Maintain illusion of normalcy despite all the problems.
- MOTTO
  - Aren't most families like ours?
- COMMUNICATION
  - Mixed messages, most family members unavailable.

Communication within the dysfunctional family is often:
- Confusing
- Threatening
- From the top down
- Has double messages

The different types of communication styles are:
Placater
- Discount themselves. Their goal is to avoid conflict and to avoid other’s anger.
- Use words of agreement: “whatever you want is okay with me.”
- Body language is of being submissive.
- Feelings are of being worthless.

Blamer
- Elevate themselves by discounting others.
- Use words that are critical: “you can’t do anything right!”
- Body language is of being more powerful and dominant.
- Feelings are that is other people’s fault they are unhappy.

Intellectualizer
- Goal is to place rigid emphasis on the cognitive to figure out problems.
- Use words that extremely logical; that makes sense and is reasonable.
- Body language is of being in control.
- Feelings are avoided... it’s the thinking that’s important.

Distracter
- Goal is to keep others and themselves away from painful feelings.
- Use words that are confusing and irrelevant to the situation.
- Body language is of being somewhere else.
- Feelings are avoided because they may cause pain.

LEVELING
- Leveling is the healthy state of communication.
- Words, body language, and feelings match the message.

FAMILY SYSTEM ROLES
- These roles are labeled in terms of the coping mechanisms family members use to survive in the dysfunctional family system.
- These roles are illustrations of dysfunctional patterns and are not used to “diagnose.”
Victim/Addict
- Hostile
- Manipulative
- Aggressive
- Blaming
- Self-pity
- Charming
- Rigid

Chief Enabler
- Assumes primary responsibility for the chemically dependent person
- Protects, shelters, and even denies the problem
- Attempts to control, takes over responsibility, rationalizes and accepts

Hero
- The achiever, the good child, the model child
- The family can point to this child and say "we don't have problems, just look at him/her"
- Family's self-worth is tied to this child's accomplishments

Scapegoat
- Their primary function is to divert the families' attention from the real problem
- Family member can blame the scapegoat for all their problems
- Often exhibits acting out behaviors in school, at home, and displays anti-social behavior

Lost Child
- Often the most tragic
- Role is to allow the family to expend less energy
- Family reinforces this child for not having "needs"
- Frequently disconnects emotionally

Mascot
- Primary role is to divert attention away from the family issues and pain
- Uses humor, silliness, and even making fun of him/herself
- Often denies a sense of self and may feel unworthy unless they can alleviate pain
The stages of grieving can also be used to describe the stages of recovery:
- Denial
- Anger
- Bargaining
- Feeling
- Acceptance

**Denial**
- Family members rarely acknowledge something is wrong
- May seek help in an indirect, nonspecific way
- Friends and relatives often reinforce the denial

**Anger**
- Effective defense to keep family members from talking about the real problem
- Can involve actual or threatened abandonment or rejection
- Used by the dependent person to avoid feelings of shame
- Family members may reach out beyond relatives but information continues to be vague or minimized

**Bargaining**
- Usually follows a major crisis
- Family can no longer deny that there is a problem
- Family still not ready to effect real change so tries to "buy" their way out
- Family members may reach out to professionals but are not really ready to follow through

**Feeling**
- Family member can no longer deny, cover with anger, or bargain their feelings away
- Family members become anxious and hyper-vigilant
- Intense feelings force family members to seek help
Acceptance

- Family members recognize the problem for what it really is
- They are ready to do work necessary to heal
- Recognizing that all are suffering, they have the courage to get help
- This is where treatment and recovery begin

The End

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Module 4: Theoretical Foundations: Structure; ARISE

Family Structure and Addiction
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Structural Family Therapy and Addiction
- Family structure: An invisible yet functional demands, predictable sequences, and organized patterns by which family members associate with each other. Seen only through family interactions.
- Coalition: Alliances between specific family members against a third member.
- Stable Coalition: Fixed and inflexible unions, such as mother and son, that become a part of the family's every day functioning.
- How does a coalition develop in an addicted family system?
  - Scenario 1: Addicted Individual (A) is the spouse. Family has 2 children boy and girl.
  - Scenario 2: Addict is the son, Parents still together. Siblings 2 additional boys.
- What are the negative implications?

Clear Boundaries (different than limits)
- Clear boundaries: Rules and habits that allow and encourage dialogue and thus help family members to enhance their communication and relationships with one another rigid boundaries.
- Rigid boundaries: Overly restrictive in that little contact with outside systems is permitted. They have inflexible rules and habits that keep family members separated from each other. family members become emotionally detached. Don’t Talk, Don’t Trust, Don’t Tell...
- Diffuse boundaries: Structural arrangements that do not allow enough separation between family members. This results in some family members becoming fused and dependent on other family members.
- Enmeshment: A family system where boundaries are unclear or weak, creating a loss of individual self and ineffective subsystems. Don’t know where I end and you begin.

PROTOCOLS
- CRISIS Calls
  - Provide support and listen. Be supportive. EXPLORE OPTIONS:
    - FAMILY RECOVERY GROUP: MONDAY NIGHT 6:30PM; THURSDAY NIGHT 6:30PM
    - ALANON; NARANON etc..
    - FAMILY RECOVERY COACH—TO BE ASSIGNED ON WEDNESDAY NIGHT
- INTERVENTIONS

More on Structure
- Scapegoating: Occurs when the wife and husband are incapable of resolving their conflicts between each other and redirect their focus of concern onto their child. In lieu of worrying about each other, they worry about the child. This diminishes the strain on the parents, however, it victimizes the child and is therefore dysfunctional.
- Subsystem: Smaller units of the system as whole, usually composed of members in a family who because of age of function are logically grouped together, such as children or parents. They exist to carry out assorted family responsibilities from changing the oil to walking the dog, and vary in length of existence. Key systems include spousal, parental and sibling.
- Implications related to addiction?
More on Structure

- Disengagement: Detachment or segregation of a member or members within a family system because the boundaries of the system, subsystems, or single members are too fixed and inflexible.

Frozen Feelings: Emotional Suppression

- Emotional suppression sometimes serves a useful, even essential purpose. When suffering a severe traumatic injury the body automatically passes into the physiological state of shock, blocking all feeling and sensation and numbing consciousness, so that the injured person can better begin recovery. Similarly, when we experience other trauma individuals commonly report feeling numb, losing consciousness, and sometimes even leaving their bodies (they may remember objectively observing the event from above). In such cases emotional suppression serves as a mercy, a blessing, and a necessary first step in the healing process.
- Addiction in the family is TRAUMATIC...

What if you stay stuck?

- Emotional Suppression...stuff the feelings. No longer angry. Frozen with no emotional investment or response. Body and psyche is protecting you...This person is "checked out". But at what expense:
  - Physical problems
  - Extreme fatigue
  - Less capable in everyday life; less responsive to other people
  - Problems in all our relationships
  - How do you get unstuck? How do you get a loved one unstuck?

Parenting: A special challenge...United front?

Families Have Tremendous Power-Work with Families; Not Just the AI

- Often times the addiction is multigenerational. Many times a root cause and working with families can help find that root cause.
- Unresolved grief...Carried by the family Acted out in addiction...
- Recovery happens when the individual and the family realize both the magnitude of the problem and the hope of recovery.
- The impact on the family is unbelievable: “the 36 hour day”...
- Addicted individuals are MORE involved with their families, have more frequent contact. Research Study: 90% of 22 year old narcotics addicts returning from treatment lived alone with their mother (Vaillant, 1966).
- 89% of 25-30 year old opioid addicts saw one or both parents face to face at least weekly...

Adult Drug Users Still Living with Parents

- Italy: 80%
- England: 62%
- Puerto Rico: 57%
- Mexico: 87%
- United States: 83%
- Daily Phone Contact with Parents-Heroin Addicts: 64% have daily contact with their parents.
Power of the Family

- Few with substance use disorder enter treatment without pressure from their network.
- Engaging the natural support system significantly improves the chances of treatment entry and completion, therefore improving likelihood of long term recovery.
- Families, friends, and the support network:
  - Care the most
  - Stand to gain the most
  - Have the most leverage
  - Have the most regular contact

Multigenerational and Triggered

- Unresolved grief...carried by the family or a member of the family. Addiction (from a structural point of view) serves a purpose. Takes pressure off the grief. The addict becomes central and the grief takes a back seat—temporarily.
- Addiction: numbs sadness, distracts family members, perpetuated subconsciously, and eventually becomes ingrained and takes on the classic characteristics of dependency. Passed on from generation to generation with no awareness of the initiation of addiction.
- If it runs in the family (biological pre-disposition) when and where did it start in the family... How far “back”? And why?

Genogram

- Family Tree
- Useful tool for identifying origins of addiction and bringing a big picture understanding to the addicted individual (he/she not “a bad person”). Useful in identifying urgency and need to “recover” the addiction out of the family tree. Opens up stories about family strengths and the formulation of a recovery message...
- Rich Jones Genogram Example...

How to help...A.R.I.S.E Intervention System

- The intervention must be facilitated by A.R.I.S.E. trained interventionist. Rich Jones is an A.R.I.S.E. interventionist.
- Invitational: no secrets; no surprises vs. Johnson Model.
- Starts with formulation of a consistent recovery message that is stated and re-stated by all members of the team.
- Identification of the team and all associated subsystems and coalitions. Who are the dyads? Where do the triangles lie? Who is frozen and needs activated?

Recovery Message

- Positive
- Out of love and caring
- Example: “This family has been through a lot and addiction runs up and down our family tree starting with your grandfather. This is not about you being a bad person and it is about more than just you individually. It is about this family starting to heal from the pain of addiction and... We will not stand by and watch you kill yourself. We love you too much... so please go to treatment today and follow through with all recommendations”....

But it doesn’t stop there

- The recovery message is repeated and reinforced on an ongoing basis throughout continuing care (at least 6 months)...
- Must become the rallying call for the family. Even if others in the family are actively using. This individual just happens to be the privileged one who is going to change the course for the entire family. We don’t worry about what others are doing. We will get to them later....focus on the addicted individual.
The Team

- Strength in numbers
- More on alliances. Capitalize on these; use them to your advantage.
- Interventions vs. Continuing Care (not a one shot deal...usually involves 8 months continuing care; but continuing care can go on indefinitely)
- Schedule a first meeting and invite the Addicted Individual (AI). But tell him or her..."we are meeting with or without you and we will be talking about how we can pursue our own recovery with or without you..." This makes any good addict very uncomfortable...

Structure of an ARISE intervention...Not like this:

Think of it as a board of directors

- The board makes collective decisions. They (the team and the ARISE Interventionist, not Rich) decide where the Algoes to treatment (remember the AI is on the team). They decide how to handle the inevitable negotiations. But they do it as a team. No one person changes the plan, no one person has the power to veto, no one person has the power to make unilateral decisions.
- Signed Contract: Examples: All team members agree that they will share information with one another regarding AI acting for money or selling to threaten early release from treatment or etc... No SDOETS among the team.
- The long term treatment plan does not change unless a meeting is convened (with the Interventionist present if still in continuing care) and all agree. For example: John's plan was to go to treatment and complete sober living for 4 months following treatment but he is becoming frustrated. Mom gets a call...

The board agrees (in writing) to pursue their own recovery

- Each member of the board states what they are going to do to pursue their recovery...
- Alcoholic
- Family Group
- Counselling
- Rehab
- AA meetings
- Not just about the AI...And you hold each other accountable to the plan.

FAVOR Resources

- Rich Jones ARISE Interventions. Contact Rich at 864-764-8204 to schedule consult
- Family Support Group: Mondays 6:30pm (closed Labor Day)
- Naranon, Alanon, Support Groups, Meeting lists available
- Alateen: Wade Hampton Group: Tuesday 8pm
- Children's Program at FAVOR: start date TBA. Registrations being taken now. Ages 10 to 14.
- One to one coaching with "family coach" or one to one phone support. Contact Rich Jones at 864-764-8204.
Module 4: What is Family Recovery? Notes

The following basic principles guide our family recovery work:

- The family is deeply impacted—this is self-evident. Chronic stress, sleeplessness, anxiety, panic, substance misuse to cope, and the related health issues destroy millions of families every year.
- Family recovery stands on its own merit. It is necessary yet has been historically neglected. Family recovery has historically been an add-on. Quality family recovery programs exist but they exist mainly in connection to inpatient programs and “pockets” of outpatient clinical providers. Family recovery needs to become an easily accessible and affordable option on a more universal basis.
- Family recovery is a unique process that should be guided by “family systems theory”. Not limited to traditional avenues of “detach with love” and “tough love”. It is important that professional family recovery services are not a mirror or approximation of Alanon family group meetings. Interventions should be individualized to the family.
- Family recovery is primary intervention; not an add-on or after-thought. Family recovery should become a feature element of community-based programs. Not just an add on to supplement programming.
- Family recovery should not be dependent on the addicted loved one’s “recovery status”. Family recovery programming should be universally offered. The addicted individual’s recovery status may influence the specific support provided. However, families should have access to professional family recovery support even if the addicted individual is disengaged.
- The family has tremendous power and family recovery contributes to individual recovery. Ultimately, family recovery benefits everyone including the addicted individual. Change one part of the family and you change the entire family.

From the beginning FAVOR Greenville, has placed great emphasis on the value of "Family Recovery". We have swung the doors of our recovery community center wide open to families regardless of the recovery status of their loved ones. We operate with a few basic principles that have guided our family programming from the very beginning. 1) We believe that there is merit in family recovery in and of itself. Family members experience profound health concerns when substance use disorders are present. These include chronic stress, physical problems, sleep difficulties, depression and anxiety. Even if the person suffering with a substance use disorder never makes a change the family deserves special focus and support to deal with these issues. 2) The family has tremendous power that can be harnessed and focused in a way that increases the likelihood their loved one will seek recovery. Frequently, when family members start to change the person with a substance use disorder will start to change. Family systems theory tells us that if you move one part of the family you move the entire family. Like a mobile above a baby's crib it is impossible to move one part without impacting the whole. 3) Family members are frequently the first point of contact in the process of recovery initiation. Family members constitute a more willing customer base. They will call for information and options well before their loved one darkens the doors of our center. They are open to feedback and, in many cases, begging for information and options. Therefore, FAVOR Greenville sees the family as a ready-made channel for engagement of those in need. 4) Family recovery coaching is a unique discipline and the shared experience of families in recovery can be capitalized on in a manner consistent with basic peer support services.

With these principles in mind FAVOR Greenville started family programs in 2013 with a simple open "Family Recovery Group". The group was modeled on basic group facilitation processes of universality,
mutual support and mutual respect. Our initial group attendance was 12 people. We held these groups every Monday night at 6:30pm. The group exploded in attendance based nearly entirely on word of mouth. In 2016 this group averages 54 people per week with a high this past month of 103 people in attendance. The group has become more didactic and educational in nature. However, we start each group with questions from the week and we make sure the topic of education/discussion is generated by the group. There are usually 10 to 15 new people at group and an equal number of "veterans" who have been in attendance since the group started. Over time an interesting phenomenon arose. The group was intended for any and all family members. Spouses, children, siblings and parents together in one group. However, the group quickly morphed to 90% parents.

In response to this we developed our second family recovery group. Every Thursday night at 6:30pm we hold our S.O.S. (Significant Other Support) group. This group focuses on spouses or adult children. This group has a different tone than the parent group because the dynamics are different spouse to spouse versus parent to child. This group has operated for 2 years and average attendance is 20 people.

Finally we have just added an offsite Family Recovery Group in our neighboring town of Spartanburg SC. Many people from Spartanburg had been making the trip to Greenville. However, it became clear that the community needed a satellite group. We launched this group in 2016 by forming a partnership with a local church. We rent the space and facilitate essentially the same group. Average attendance at that group has been 30 people.

We also have a children’s program for children of parents in recovery and/or children of parents struggling with active substance use disorder. This is a curriculum based program and we run it periodically based on community response/need. We have had 103 children complete this program.

Another distinct area of family recovery support at FAVOR Greenville is our family recovery coaching. These are parent to parent; spouse to spouse; family to family coaching relationships put in place to supplement the various groups provided at FAVOR Greenville. We actively recruited family members who had been "working a recovery program" and developed a specific curriculum to supplement our regular coach academy. These family members completed a specialized training academy to become FAVOR Family Recovery Coaches. To date we have trained 53 family coaches and currently have 29 active Family Recovery Coaches who volunteer on average 5 hours per week to coach and support other families. We have been over-joyed with the Family Recovery Coaching programming. We have provided over 8,000 hours of family recovery coaching since initiating the program. The family coaches are incredibly enthusiastic and grateful and this is reflected in the way they engage our families in need. This has been magical to watch.

Finally, we offer intervention services to support the family in crisis. We have 2 ARISE interventionists on staff and have completed over 305 interventions to date. We are in the process of developing a second tier of interventionists to address this area of need. The number of interventions have risen dramatically over the past 1 and half years and we need more support to respond to the needs of the community.

Overall, it is important to note, 48% of the service hours delivered at FAVOR Greenville are delivered to family members in need. The distinct difference with our program is the following: Family recovery is
not an add on or adjunct to service; family recovery is front and center and a cornerstone of the center. We have found that family members want to be included in the process and they make great volunteers and supporters. FAVOR Greenville will continue to place formal emphasis on family recovery and we believe our program will expand in the area of family recovery as we move forward in our mission.

My experience in launching these family programs at the FAVOR Greenville Center has given me a unique perspective on the process of family recovery. The reality of family recovery as it is lived out by the parents, spouses, siblings and friends of the person struggling with a substance use disorder. As is the case with many things in the “addiction treatment” industry much of what is done for family recovery springs out of long held views. These views have been ingrained in our thinking. Although they may work very well for any given person the reputation these have views have gained as effective is based largely on anecdotal evidence.

Of course, there are good clinical programs and clinicians working with families. Of course, there is good work being done in the traditional family groups. This is not about isolated success. This is about articulating an approach that could be scaled in a realistic manner. On its most practical level, it is about finding and training a workforce that can deliver family services in a cost-effective manner on a wide scale. This will be difficult to accomplish via traditional clinical routes. Family clinicians may illustrate the ideal answer. If we could all families involved with a licensed Marriage and Family Therapist that would be wonderful. However, that is not realistic. The expenses would be prohibitive. In addition, we are not even close to having a sufficient number of clinicians. What is a realistic option?

I am of the opinion that this can best be accomplished by developing family recovery coaches. This is an eager, enthusiastic, bright, and teachable group. They are hungry for information. By blending the experiential with professional training and supervision we will build that workforce. The Substance Abuse Mental Health Services Administration (SAMHSA), in their TIP on Substance Abuse and Family Therapy, lays out the following continuum as a guideline:
Typically, SUD support involves referrals to Alanon, Naranon. Very few programs “ignore” the family component. However, the emphasis is traditional SUD

FAMILY COACHING PROGRAMS WOULD “MOVE TOWARD” A STRONGER FAMILY COUNSELING ORIENTATION. BUT NOT ABANDON SUD

SUD program with no family work

Family counselor who does no SUD work
Module 4: Bibliography


Recommended reading
Module 5: Ethics and Confidentiality

So many Codes of Ethics

- An important note before we continue: If you are a licensed professional you are obligated to follow the code of ethical conduct for your specific profession. However, as an Outside in employee you are obligated to follow the company code of ethics. In addition, if you are credentialed by PCB you must follow their code as well. The most restrictive ethical rules should apply and it is your responsibility to be aware of what those rules involve.

Ethical Dilemma

- Please describe an ethical dilemma you or one of your colleagues has faced. Leave out details that would compromise confidentiality for you, the client(s), and your colleagues.

Company Code of Ethics

- Best interests of persons served
- Highest quality of service to those who seek service
- Confidentiality of all records at all times
- Respect the rights of colleagues
- Evaluate students and staff in a responsible, fair, considerate and equitable manner

Scenario

- A colleague insists on talking about his cases while out to lunch in a restaurant. You ask him to stop when you realize other people can hear him. What, if any, further action would you take?

PCB Code of Ethical Conduct

- If you are pursuing or possess a credential you must comply with the PCB code of ethics
- Protects consumers
- Assures competence to clients, public and employers
- Clear about what disciplinary procedures are in place
PCB Rules of Conduct

- Minimum standards that all certified professionals are expected to honor
  - Unlawful Conduct
  - Sexual Misconduct
  - Fraud Related Conduct
  - Exploitation of Clients
  - Professional Standards
  - Safety & Welfare
  - Record Keeping
  - Assisting unqualified/Unlicensed practice
  - Discipline in other jurisdictions
  - Cooperation with the board

Scenario 1

- A drug & alcohol counselor (who is in recovery) is charged and convicted of possession of a small amount of marijuana
  - Is this an ethical violation?
  - If no- why not?
  - If yes- cite the applicable PCB rule

Scenario 2

- A substance abuse counselor is assigned to work with "Dan." The counselor and "Dan" had a one night stand ten years ago. The counselor does not want to explain to her supervisor so she chooses to meet with the client...
  - Is this an ethical violation?
  - If no- why not?
  - If yes- cite the applicable PCB rule

Scenario 3

- A substance abuse counselor adds fifteen minutes to the session length and submits the paperwork for billing. He wants the overtime to help with the cost of repairing his car...
  - Is this an ethical violation?
  - If no- why not?
  - If yes- cite the applicable PCB rule

Scenario 4

- A substance abuse clinical supervisor is asked to “sign off” on supervision hours for someone he does not directly supervise. He does sign because his boss told him to do so.
  - Is this an ethical violation?
  - If no- why not?
  - If yes- cite the applicable PCB rule

Social Work Ethics

- Mission
  - Enhance human well-being & meet basic human needs
  - Focus on individual well being in a social context and the well-being of society
<table>
<thead>
<tr>
<th><strong>Social Work</strong></th>
<th><strong>NASW Code</strong></th>
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<tbody>
<tr>
<td>• Core Values</td>
<td>• Does not specify which values, principles or standards are most important</td>
</tr>
<tr>
<td>- Service</td>
<td>• People do have different opinions about ethical decisions</td>
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<tr>
<td>- Social justice</td>
<td>• Ethical decision making is a process</td>
</tr>
<tr>
<td>- Dignity &amp; worth of the person</td>
<td>• Consider the impact on clients, own personal values, cultural and religious beliefs</td>
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<tr>
<td>- Importance of human relationships</td>
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<tr>
<td>- Competence</td>
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<tr>
<td>• Informed Judgment</td>
<td></td>
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<tr>
<td>• Ethical responsibilities flow from all human relationships</td>
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</table>

<table>
<thead>
<tr>
<th><strong>NASW Ethical Principles</strong></th>
<th><strong>Value: Dignity and Worth of the Person</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td>• Social workers respect the inherent dignity and worth of the person</td>
</tr>
<tr>
<td>• Social workers' primary goal is to help people in need and to address social problems</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Value: Importance of Human relationships</strong></th>
<th><strong>Value: Integrity</strong></th>
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</thead>
<tbody>
<tr>
<td>• Social workers recognize the central importance of human relationships</td>
<td>• Social workers behave in a trustworthy manner</td>
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</table>
Value: Competence

• Social workers practice within their areas of competence and develop and enhance their professional expertise

Social Workers’ Ethical Responsibilities to Clients

• Commitment to Clients
• Self-Determination
• Informed Consent
• Competence
• Cultural Competence & Social Diversity
• Conflicts of Interest
• Privacy & Confidentiality
• Access to Records
• Sexual Relationships
• Physical Contact
• Sexual Harassment
• Derogatory Language
• Payment for Services
• Clients who lack decision-making capacity
• Interruption of Services
• Termination of Services

Social Workers’ Ethical Responsibilities to Colleagues

• Respect
• Confidentiality
• Interdisciplinary Collaboration
• Disputes Involving Colleagues
• Consultation
• Referral for Services
• Sexual Relationships
• Sexual Misconduct
• Sexual Harassment
• Impairment of Colleagues
• Unethical Conduct of Colleagues

Social Workers’ Ethical Responsibilities in Practice Settings

• Supervision and Consultation
• Education and training
• Performance Evaluation
• Client Records
• Billing
• Client Transfer
• Administration
• Continuing Education & Staff Development
• Commitments to Employers
• Labor-Management Disputes

Social Workers’ Ethical Responsibilities as Professionals

• Competence
• Discrimination
• Private Conduct
• Dishonesty, Fraud, and Deception
• Impairment
• Misrepresentation
• Solicitations
• Acknowledging Credit

Social Workers’ Ethical Responsibility to the Social Work Profession

• Integrity of the profession
• Evaluation and research
Social Workers’ Ethical Responsibilities to the Broader Society
- Social Welfare
- Public Participation
- Public Emergencies
- Social and Political Action

Scenario 5
A Social Worker in a Substance Abuse Treatment clinic refuses to meet with a client who cannot pay for services
- Is this an ethical violation?
- If no- why not?
- If yes- cite the applicable NASW standard

Scenario 6
A Social Worker determines and informs her client with a co-occurring disorder that a partial program is “exactly what you need”...
- Is this an ethical violation?
- If no- why not?
- If yes- cite the applicable NASW Standard

Scenario 7
A social worker turns his attention elsewhere when a residential substance abuse treatment client reports he is not allowed to call home because he called a staff member lazy...
- Is this an ethical violation?
- If no- why not?
- If yes- cite the applicable NASW Standard

Scenario 8
A Social Worker is asked to tell an adolescent client he cannot attend a concert because there will be drug use there...
- Is this an ethical violation?
- If no- why not?
- If yes- cite the applicable NASW Standard

Scenario 9
Cleaning staff (who are not agency employees) find paperwork (progress notes and treatment plans) turned face down on a social worker’s desk. The cleaning staff read the paperwork...
- Is this an ethical violation?
- If no- why not?
- If yes- cite the applicable NASW Standard
Scenario 10

- A supervisor flirts with and begins dating his boss, the program director. Although they try to keep the relationship private, they engage in PDAs during work hours.
  - Is this an ethical violation?
  - If no- why not?
  - If yes- cite the applicable NASW Standard

Role and Practice Boundaries

- Obvious boundary violations are unethical
  - Prohibit sexual activity
  - Prohibit abuse of clients
  - Prohibit taking favors/gifts from clients
- What about the "grey areas?"
  - A client offers you a glass of water
  - A client offers you a slice of pizza
  - A client offers to buy lunch for you

Boundaries

- Are best understood and processed by using the various codes of ethics we have discussed
- Important to keep in mind the nature of the helping relationship
  - Ask yourself is this going to cause potential harm?
  - What would the benefit be to the client?
  - What should my relationship with the client teach him or her about interactions

Value Clarification Exercise

- Please complete the value clarification exercise. No one will be required to share a response. This is intended to be an honest self-evaluation to help you determine who you are going to work with most effectively.

A Boundary Problem

- A counselor is working with a fourteen year old client with a history of trauma, depression, and cocaine abuse. Sessions are held in the client's foster home. The counselor arrives just as the foster family is having dinner and joins the family for the meal. The client responds very well and shares a lot of information while eating. The foster family then asks the counselor personal questions about other children. Where she lives and what she does on the weekends. A strong relationship develops in part because of the client's willingness to open up during dinner. The client and counselor meet privately at times. During a private session, she discusses that the foster father has been physically threatening her and she does not feel safe. The counselor asks about what is going on in her home. She responds that the foster family is furious. The foster father informs the caseworker that the counselor knew that the foster father threatened the teen. He even did it while they were at having dinner together. He had never actually hurt her. The counselor is called in for a meeting with management. The counselor's documentation is not up to date.

Boundary Problem Questions

- What action can the agency take in regard to the counselor?
- What should the counselor do?
- What could have prevented this situation?
- What could help the counselor in this situation?
- What might happen with the client?
- What have we covered so far to help us make an ethical decision?
Duty to Protect

- You are working with a 25 year old male named Dave who has entered treatment due to his past drug and alcohol abuse. Dave described a history of becoming violent with his girlfriend and admitted to coming close to killing her on at least one occasion. He admits that his alcohol use often led to blackouts and he cannot recall specific acts of violence he inflicted while intoxicated. His girlfriend has been treated at the ER following their altercation for broken bones and a concussion. He has disclosed that he has thoughts of killing her for forcing him to enter treatment. What would you do? (hint - more than one applies):
  - __________ would notify Dave’s girlfriend that she might be in danger
  - __________ would keep Dave’s threats to myself based on 42 CFR Part 2 and 4PA Code 255.5 Substance Abuse Treatment Confidentiality Laws
  - __________ would seek supervision
  - __________ would inform the Program Director of CBO
  - __________ would refer Dave to another therapist
  - __________ would arrange for an attempt at a 302 commitment hearing
  - __________ would encourage Dave to seek additional help for his anger issues
  - __________ would encourage Dave to talk with his girlfriend about his thoughts

Mental Health vs Substance Abuse Laws

- Although our instinct may be to always follow the Duty to Protect Substance Abuse Confidentiality does not allow for a duty to protect. We, as substance abuse treatment providers - under 42 CFR Part 2 and 4PA Code 255.5 cannot identify a substance abuse treatment client to authorities for making a threat against someone else.

Mental Health vs Substance Abuse Laws

- Mental Health standards are different and would support the report of a client who made a threat against another person.
- Attached is information about the Tarasoff decision - review for your information but keep in mind the limitations under 42 CFR Part 2 and 4PA Code 255.5

Mental Health vs Substance Abuse Laws

- What can we do in a Duty to Protect situation?
- Make an anonymous report to the proper authorities
- Ensure that you do not use the phrase "substance abuse treatment"
- Ensure that you only provide the information necessary for the authorities to determine if someone is in danger
- Advocate for changes to 42 CFR Part 2 and 4PA Code 255.5

Ethical Dilemma

- Each small group will be given an ethical dilemma to dramatize and present to the entire group. You will role play the scenario and show the counselor/supervisor/client reactions.

42CFR-Confidentiality
42 CFR Covers:

- Records of the identity, diagnosis, prognosis, or treatment of any patient, which are maintained in connection with the performance of any program or activity relating to drug abuse, alcoholism or alcohol abuse education that is conducted, regulated or assisted by the Federal government must be confidential.

42 CFR Impacts any federally assisted program:

- Those receiving Medicaid funds
- Those certified for Medicare reimbursements
- Those receiving federal pass-through dollars from the state

A program is defined as: Any individual or entity that declares they'll provide and does provide alcohol/drug abuse diagnosis, treatment, counseling, or referral to treatment.

42 CFR protects:

- Current patients
- Past patients, including deceased
- Those who are applying for treatment

Patient is defined as an individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program.

42 CFR Protects:

This means the patient is protected from divulging information to:

- Family members
- The patient’s attorney
- Police (even with a search warrant, or in civil cases without additional legal requirements)
- Employer

Patient or legal guardian must sign a written release for these entities to acquire personal information.

Key benchmark for 42 CFR, Part 2

Diagnosis and treatment:

- The act or process of deciding the nature of a diseases condition by examination of the symptoms
- A careful analysis of the facts meant to explain something

General Rule: Information that identifies an individual as a patient of a program may not be used or disclosed without the patient’s signed authorization, unless an exception for the use or disclosures applies.

HIPAA:

- Designed to ensure maintenance of health insurance coverage when you change jobs
- Administrative simplification – Healthcare processes becoming very complex, – look to standardize information – make it easier
- Protects privacy of health information held by health plans, health care clearinghouses and most providers, including drug & alcohol programs.
HIPAA Mandates:
- Patient access to records
- Form and content of patient notice
- Form and content of agreements with qualified service organizations
- Method for revoking consent
- Protocols and procedures for research
- Circumstances under which past crimes may be reported

HIPAA-permitted Disclosures, Government & Other Purposes
- As required by other laws
- Public health activities
- Victims of abuse, etc.
- Health oversight activities
- Workers' compensation
- Law enforcement purposes
- Decedents - coroners and medical examiners
- Research purposes, under limited circumstances
- Imminent threat to health or safety (to the individual or the public)
- Organ procurement
- Specialized government functions
- Judicial and administrative proceedings

Which One When???

HIPAA vs. 42 CFR, Part 2
- HIPAA: health care industry
- 42 CFR: drug and alcohol programs
- The laws cover a lot of the same material
- Some points of difference - more specific or more recent rule usually applies

For treatment providers, in most cases the rules of 42 CFR Part 2 are more stringent

Standards for Uses and Disclosures
HIPAA or 42 CFR?
- Apply whichever standard is more restrictive (usually 42 CFR, Part 2)
- Standards that provide greater privacy protections
  - Exceptions:
    - Disclosures to the individual whose health information is at issue
    - Disclosures to federal Department of Health and Human Services for HIPAA compliance determinations

Disclosures:

<table>
<thead>
<tr>
<th>HIPAA</th>
<th>42 CFR, Part 2</th>
<th>Rule to Follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release, transfer, provision of access to, or divulging information in any other manner outside the entity organization.</td>
<td>A communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the records of a person who has been identified as a alcohol or drug abuser.</td>
<td>42 CFR, Part 2</td>
</tr>
</tbody>
</table>
### Uses and Disclosure Standards:

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<tbody>
<tr>
<td>Entity may not use or disclose Personal Health Information (PHI) except as permitted or required under the regulations.</td>
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<tr>
<td>PHI may be used or disclosed only as permitted by the regulations and may not be used in any civil, criminal, administrative or legislative proceedings. Court orders must be signed by a judge in order to have records released in a court of law.</td>
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### Treatment:

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<tr>
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<th>Rule to Follow</th>
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</thead>
<tbody>
<tr>
<td>Entity may use or disclose PHI to carry out treatment.</td>
<td>42 CFR, Part 2</td>
<td>No disclosures are allowed to outside providers without consent by patient.</td>
</tr>
</tbody>
</table>

### Payments:

<table>
<thead>
<tr>
<th>HIPAA</th>
<th>42 CFR, Part 2</th>
<th>Rule to Follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHI may be reused to provide or obtain reimbursement for health care services.</td>
<td></td>
<td>No disclosures are allowed to external sources without consent by patient.</td>
</tr>
</tbody>
</table>

### Judicial & Administrative Proceedings:

<table>
<thead>
<tr>
<th>HIPAA</th>
<th>42 CFR, Part 2</th>
<th>Rule to Follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information may be disclosed only under a unique court order meeting requirements of 42 CFR Part 3. A subpoena is not sufficient. Both the court order and a subpoena must be issued to compel disclosure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Right To Access:

<table>
<thead>
<tr>
<th>HIPAA</th>
<th>42 CFR, Part 2</th>
<th>Rule to Follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals have the right to inspect and obtain copies of their information for as long as the information is maintained, except for: A. Psychotherapy notes. B. Information compiled for civil, criminal, or administrative action or proceeding. C. Information subject to health law.</td>
<td></td>
<td>Regulators do not prohibit patient access to records, including opportunity to inspect and copy any records maintained about the patient. The program is not required to obtain written authorization in order to provide access to the patient.</td>
</tr>
</tbody>
</table>

### What About The Judicial System?
The first step is a consent form with language fitting both regulations:

- Elements
  - Patient name
  - Meaningful and specific description of information
  - Specific name or general description of Persons
  - Identification of studies
  - Name of individual or organization to receive
  - Purpose of disclosure
  - Explanation data event no longer than reasonably necessary for purpose
- Required statements:
  - Right to roam
  - Whether authorization is a condition of treatment
  - 42 CFR Part 2 re-disclosure statement
- Obtain appropriate signature or signatures copy to individual

Sample ROI (electronic)

Sample ROI w/ Revoke

ROI Log

Patient Authorization/Consent

- Statement to accompany disclosure
  - This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules

Court Orders

- HIPAA's More Permissive Provisions won't work here
- Subpoena alone is not sufficient
- Court Order, including search warrant, alone not sufficient
- Satisfactory Assurances?
- No
Court Orders: Civil

- Motion for Release of Records filed in court
  - Petitioner's name or
  - Sealed proceeding
- Notice to patient and provider
  - Opportunity to respond
- Hearing
- Criteria for order
  - Other ways of obtaining information not available or effective
  - Public interest and need for disclosure outweigh injury to patient, physician-patient, and treatment

Court Orders: Civil

- Confidential communications
  - Necessary to protect against an existing threat, including child abuse
  - Necessary to prosecute a serious crime, or
  - Door opened
- Content of Order
  - Limit disclosure to essential
  - Limit recipients
- Court Order alone is not sufficient
  - Subpoena is required, also

Court Order: Criminal

- Motion, Notice, and Hearing like Civil Court Order
- Criteria
  - Extremely serious crime
  - Reasonable likelihood of substantial value
  - Other ways of obtaining information not effective
  - Public interest weighing
  - Independent representation for record holder
- Content of order
  - Limit disclosure to essential
  - Limit recipients
- Order alone is not sufficient
  - Subpoena is required

Are there disclosures permitted without consent?

Permitted Disclosure—No Consent

- Medical emergency
  - Immediate threat to health and in need of treatment
  - Cannot disclose to family w/o consent but medical personnel can disclose
- Crimes on the premises -- staff can call police, regardless of whether on or off premises, e.g. counselor on way home is accosted by patient -- but only basic facts.
  - Limited to circumstances, but can disclose:
    - Patient name
    - Patient status
    - Address or last known location

Permitted Disclosure—No Consent

- Internal communications
  - Staff within a program can share information on a need to know basis
  - Staff may share information with a supervising or billing agency
  - Important to define scope of program -- who exactly is a member of the program?
- Administration/Qualified Service Organization Agreement
  - Written agreement between program and an outside agency that provides supportive services (cannot have agreement between 2 agencies where both are subject to 42 CFR)
  - May not enter into QSO with law enforcement without consent
Permitted Disclosure—No Consent
- Outside auditors, central registries and researchers - funders, licensing agencies permitted to audit, provided there is a signed agreement regarding redisclosure.
- May not redisclose patient identities in any manner.
- Communications that do not disclose patient-identifying information, e.g., aggregate data about patients.
- Research - No identifying information and must either have a consent (which can be unwieldy) or a waiver from an Institutional Review Board (IRB).

Mandatory Disclosure: No Consent
- State child abuse and neglect reporting laws
  - Report according to state law
  - Does not cover release of records
- Other Disclosures?
  - Vulnerable Adult Abuse
  - Gunshot wound or burn
  - Birth or death
  - Public Health Crises
  - Attended or unattended death

Audit & Evaluation Activities
- Disclosure is permissible if recipient agrees in writing on redisclosure restrictions
  - Person who conducts an audit or evaluation on behalf of federal, state, or local agencies providing financial assistance to the program or authorized by law to regulate the program's activities.
  - Third party payer
  - Peer review organization
  - Otherwise qualified to conduct audit/evaluation activities (on premises only)
  - Special rules for Medicare/Medicaid audits (42 C.F.R. 2.350)

Audit, Evaluation, & Oversight
- Key Factors for 42 CFR compliance
  - Get statement in writing on redisclosure restriction operations
  - Feds and state should provide in request for disclosure
  - Some organizations may rise to level of BA (e.g., accreditation organizations)
  - Third party payer disclosure could fall here
  - Do you need to identify patient status?

Qualified Service Organizations
- Person that provides services to a program that has entered into a written agreement acknowledging it is bound by 42 CFR Part 2 and will respect judicial disclosure (other than as permitted).
- Exemptions (operational services to organization, not program to program for substance abuse treatment):
  - Data processing
  - Bill collecting
  - Dosage preparation
  - Laboratory analysis
  - Professional services (legal, medical, accounting)
  - Services to prevent, treat child abuse, including training on nutrition and child care or individual and group counseling

QSOs and Business Associates
- Identify QSO status
- Identify business associate status
  - e.g., laboratory analyses would fall under treatment
  - Written Agreement
- Bound by 42 CFR Part 2 disclosure and judicial resistance provisions
  - Other business associate provisions
42 CFR, Part 2 and Minors:

☐ If a minor has legal capacity to consent under State law, no other consent is required
☐ If parental consent is required, need both consents
☐ In states requiring parental consent:
  ✓ Minor must consent to disclosure to parent or
  ✓ Provider must decide minor lacks capacity to make rational choice

☐ Criteria for Examining lack of capacity
  ✓ Extreme youth
  ✓ Presence of mental or physical condition
  ✓ Minor’s situation poses substantial threat to life and well-being of minor
  ✓ Communicating can reduce that threat
Module 6: The 5-Fold Model

The 5-Fold Model
Crisis, Stabilization, Acceptance, Family Recovery Initiation, Family Recovery Integration

What is the family “behavior change”?

Crisis...

“Crisis” is defined by the person going through the crisis. What is a crisis to one person may be routine experience for another person.

"crisis"
krisis/
a time of intense difficulty, trouble, or danger

Family in Crisis.

- “On-set” of addiction: when the family first “discovers” or realizes “something is wrong”. NOTE: THIS DOES NOT MEAN ACCEPT something is wrong.
- Relapse after some time in recovery.
- Escalation of use.
- Legal crisis.
- Health crisis.
- “Jumping” to another substance.

Role of the coach in the “crisis” stage

- Do NOT discount the crisis. “I’m sorry for what is happening but you need to focus on taking care of yourself. You can’t do anything about to make your son change. See you at Alano on Tuesday night.”
- Acknowledge the crisis and enter into the process. Be there for the person. Listening skills.
- Provide information in non-judgmental way.
- Explore options.
- KNOW LOCAL CRISIS RESOURCES. Gain understanding of the commitment process. Using 911? What hospital is most “workable”?&n
- Problem-solving with the family.

Crisis...
**Skills for the crisis stage...**

- Coach must remain grounded.
- Slow it down
- Slow is smooth and smooth is quick
- Listening skills
- Maintaining your composure while everyone around you unravels...
- Create space
- Breath
- Model appropriate response

**The “crisis” can help the coach establish a relationship. “You were there for me”...**

*NOTE: Let’s talk about constant crisis and the frustrations with “constant” crisis.*

---

**Pitfalls of the crisis stage...**

- Chronic crisis
- Families get angry if you don’t have answers
- Sometimes the crisis serves another purpose (ARISE “trauma” philosophy—holds the family together)
- Sometimes the crisis distracts from other issues
- Stage of change related to “changing my response to crisis”

**Stabilization**

- The “addicted individual” and the family both have been unable to move into any type of recovery.
- But... It is not a crisis...
- The focus, from the family perspective, remains on the addicted individual
  
  “Fix my kid...”

---

**Role of the coach during stabilization**

- Meet the family where they are...
- Explore options. Honor this part of the process.

**Motivational Interviewing techniques to support movement through the stages of change. Motivational Interviewing to support movement toward acceptance.**

**Skills for the stabilization stage...**

- Motivational Interviewing
- Listening
- Teaching Recovery Messaging—Reframing “what YOU did wrong” to “we are in this together”...
- Timing of becoming more direct? Discussion...
Stabilization is not “time dependent. “Chronic Stabilizer”....similar to “chronic contemplators”.

Recognizing where the family is “in their process” will help you remain focused, goal directed. Also will keep you from the burnout train...

Acceptance

• This a transition period. Very similar to the preparation stage of change.
• Acceptance of the need for “family recovery”... not acceptance of that loved one is addicted. 2 different things.
• Move into a period of actively applying family recovery principles.

Role of the coach

• Develop plan
• Offer options
• Reinforce motivation
• Work through and problem-solve barriers

Skills...

Initiation...

• This is what most people view as “family recovery”...
• Go to Alanon
• Prayer
• Meditation
• Stress Management
• FAVOR Recovery Groups
• Naration Groups
• Therapist
• SMART Recovery for the family
FAVOR “ACTIVE” recovery-How do we do it?

Integration...

- Family recovery and the associated routines, behaviors, response to crisis becomes “second nature”.
- Consistently involved in a recovery group, individual therapy, church group...some type of positive support.
- Can articulate and identify “what works for you” in family recovery.

• TIME TO GIVE BACK
The 5-Fold Model
Crisis, Stabilization, Acceptance, Family Recovery
Initiation, Family Recovery Integration

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the person going
through the crisis.
What is a crisis to
one person may be
routine experience
for another person.

Crisis...

Can you recognize
the crisis escalating.
Example: Can you
see the relapse?
Can you see the
escalation of use?
How dangerous is
the situation?

Family in Crisis.

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THIS DOES NOT MEAN ACCEPT something is wrong.
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Role of the coach
• Develop plan
• Offer options
• Reinforce motivation
• Work through and problem-solve barriers

Skills...
Knowledge, advice, feedback provided in manner consistent with motivational principles.

Initiation...
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• Meditation
• Stress Management
• FAVOR Recovery Groups
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  • TIME TO GIVE BACK
Your Flowchart

Start

Do they have insurance/ $$?

Enter Client / Family "Boundaries"

Are they willing to go?

Is the family ready to "intervene"?

No

Yes

Maintain contact w/ Family and Participant

Contact placement specialist (Ex. Kristine Nutt, Elements Tyler, Cepolis, Acadia, 2 Dreams Pavilion, Carolina and Phoenix Center)

Consult regarding appropriate fit. Ask for help, narrow choices

No

Yes

Work free resources Ex. Morris Village, Phoenix Center Detox

Call/follow up on admission - Mark ePrevention "Completed" entered treatment etc.

Build a Team & Prevention videos sent out.

Family mtg. w/ client

Level 1 intervention

Level 2 intervention

Call recipient

Refer/Prep for level 3 intervention

Participant agrees

Ongoing coaching

Weekly contact

Family agrees
Substance Use Disorders and Family Systems—Throw Back

Family as a “system”
- Rules
- Norms
- Communication
- Interaction Patterns
- Roles
- Narrative...family story... “motto”...

Interconnected...interdependent...move one...move all...

Change...
- The way we communicate, interact...our roles and “rules”. Challenge the system.
- Remember...systems do not want to change!

The System Produces The Exact Result...
- It was designed to produce...
- The “identified patient” serves a purpose
- Painful feelings keep the system in tact
- Fear of change... “the devil you know”...

Rules on Communication
- Don’t Talk: will only make it worse. Family secret. Never get better. Why bother.
- Don’t Trust: leads to disappointment. Promises are made to be broken.
- Don’t Feel: Man-up! Feelings are too painful. If you feel it may lead to more problems. Better to stuff and keep quiet.
Typical Systems Associated with SUD

- Rigid-Strict | my way or the highway | Get it right! | Top Down Control
- Ambiguous- Have rules but don’t enforce them | Ever changing values | Motto is “avoid conflict” | Mixed messages
- Overextended- Busy equals safe; productive equals safe | overly concerned with appearance | All things to “please” the parents
- Distorted- Put on act to the external world; don’t let outsiders know “we are screwed up” | All families are/should be like ours | Mixed messages
- Universal among these systems: confusion, danger, fear driven...

Typical Roles

- Placater: minimize conflict; people pleaser; discount your own feelings.
- Blamer: focus on others; criticize everyone; other people’s fault; angry at the world
- Intellectualizer: “gonna figure it out”; “google it”; logical; business plan solution to addiction
- Distracter: avoid painful feelings; confusion; talk about the irrelevant issues; arrange the paintings on the wall while the house is burning down

Other Ways To Describe “roles”

- Chief Enabler-primary responsibility for person
- Hero-achiever; family self worth is tied to this person
- Scapegoat-diverts attention; trouble maker; focus of the family
- Lost child- doesn’t get in the way; disconnected; literally lost in the shuffle
- Mascot- use humor to distract and cope; court jester