The Family Solution Finder Seminar Study Guidebook

Learning Module I

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DISCLAIMER NOTICE*: Nothing in this book is to be acted upon without first consulting with a license professional. These are recommendations as a place to begin the learning process. Always seek the advice from a professional before acting.*

LEARNING MODULE I

(Study Guidebook)

32 Key Issue Seminars

Do not Read Forward, Until After Viewing this Video:

ASSIGNMENT VIDEO: www.youtube.com/

Search Title: The Power of Addiction and The Addiction of Power:

Gabor Maté at TEDxRio+20

Duration: 18:46 min.

Link: https://www.youtube.com/watch?v=66cYcSak6nE

This was important enough we gave the video “its own page” to bring your attention to what is presented in these seminars.

Forward

This Study Guide introduces how to become empowered throughout a family's journey with Substance Use Disorders. It identifies 32 key issues a family is likely to experience during this journey. The learning course material includes a package of four books:

1. *The Family Solution Finder, Study Guidebook Learning Module I.*

2. *The Family Solution Finder, Workbook Learning Module II.*

3. *The Family Solution Finder 3-D's Coping Skills, Learning Module III.*

4. *The Family Solution Finder Local Resource Connections, Learning Module IV.*

All four books work together in support of building an empowerment through increasing your knowledge of the key issues for the family members living with substance use disorders. This entire learning series is provided at no cost on our website. This is a learning series of curriculum sourced from the NIH, SAMHSA, ASAM, Clinical Articles, Empirical Proven Studies and Professional Journals and will become a part of the family home learning resource library for on-demand learning.

The topics covered by The Family Solution Finder Learning Series are selected based on the typical 32 key issues a family will likely have to address in their journey. Each seminar is an issue. Each seminar is a problem they are likely to face as a family. Each seminar is an obstacle your family will need to conquer. This becomes the Families Reference Library in how to determine a solution, develop a decision and design your plan of action.

Unfortunately, the family will have to make great and disruptive changes to how their family members will work together, and to a greater extent this will be driven by the experiences they will have in their journey with substance use disorder.

Each member in the family will benefit by understanding their family dynamic, what this means is the greater an issue impacted the family, the greater is the need to make changes. Everyone will experience pain in this journey, no one will get out of this without making changes.

From within this "*Study Guidebook*", the path towards becoming empowered includes these five categories:

Part 1. Learn about the family dynamic.

Part 2. Learn about the disease.

Part 3. Gain an understanding of the 12 core competency issues, (The Family Solution Finder Certification Program Seminars).

Part 4. Create a family plan of action.

Part 5. Consider other possible situations which may arise.

The "Family Solution Finder Study Guidebook" can be self-administrated by the family in the comfort of their home, presented in small group seminars or as part of a larger group conference with breakout learning sessions.

It is intended that a reader has a copy of both "*The Family Solution Finder Study Guidebook Learning Module I and The Family Solution Finder, Workbook Learning Module II*" and has read this same section in each book, prior to attending a seminar and presentation of the issue.

The learning lessons of each issue complement what is provided in the other books, moving towards the purpose of empowering the family members with knowledge to act together as a strong, single, united front. The family practical life exercises and videos in the *Workbook Learning Module II* are critical to extend the learning of each topic. Do not skip over these assignments.

It is also recommended that a reader not use the content of this book as a singular source of information, but rather as part of many sources of reference material when considering each specific topic. Such action items will be created by completing the exercises found in the *Family Solution Finder, 3-D's Coping Skills Workbook Learning Module III*.

At this point you should be seeing the development of your knowledge as each workbook for that issue is completed for that same issue.

As we suggested this information is not intended for the reader to act upon as a sole source of information, it should be combined into a review with a licensed professional counselor, therapist, or State certified professional prior to taking any action. Thus, the purpose of *The Family Solution Finder, Local Resource Connections Workbook Learning Module IV*.

Everything in this learning series is intended to be viewed as 'how it will be applied in your real-life situation" both now and in the future.

By taking these seminars we seek to build a Family Plan of Action, based on the accumulation of worksheets and knowledge you have completed in the four learning modules (I-IV) for the single issue you are learning more about.

The family plan of action will be your response in each learning session, as to how that information can be applied to your family life issues inside your family dynamic. The instructions for creating your family plan of action is found in: "The *3-D's Coping Skills Workbook Learning Module III*".

Once purchased, the buyer is free to make copies of the pages in the study guide and workbooks with permission. Such copies will be for the purpose of classroom discussion and learning. These learning lessons are also posted for free download on our website: www.familiesimpactedbyopioids.com

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Introduction

There are several studies and reports documenting the adverse effects of substance use disorders (SUDs) on the family system and individual family members, including children, teens, and adults. These SUD's clearly affect the people around the life of one who is abusing substances, often creating a burden for the family members, their friends, and work associates.

The effects on the family may include:

- **Emotional burden**. Members may feel anger, frustration, anxiety, fear, worry, depression, shame and guilt, or embarrassment.
- **Economic burden**. This may be caused by money spent on substances, or money problems associated with the loss of jobs or reliance on public assistance.
- **Relationship distress or dissatisfaction**. Families may experience high rates of tension and conflict related to the SUD's and the problems it causes in the family.
- **Family instability**. This may result from abuse or violence, or family breakup due to separation, divorce, or removal of children from the home by Children and Youth Services.
- **Effects on the developing fetus and children**. Alcohol use during pregnancy can harm fetal development causing birth defects and problems in child development. Infants born to opioid-dependent mothers are at increased risk for neonatal abstinence syndrome, which can contribute to developmental or cognitive delays. Children of parents with SUDs are at increased risk for abuse or neglect, physical problems, poor behavioral or impulse control, poor emotional regulation, conduct or oppositional disorders, poorer academic performance, psychiatric problems such as depression or anxiety, and substance abuse.

Effects on parents. Mothers with SUDs may show less sensitivity and emotional availability to infants. Parents of a child with a SUD may feel guilty, helpless, frustrated, angry, or depressed.

The effects of SUD on a specific family member or concerned significant others are determined by the severity of the disorder, and the presence of other serious problems such as psychiatric mental illnesses. It can be different between others; some family members are more resilient and less prone to the adverse effects of the SUD impact. Everyone experiences the diseases impact in different ways.

We see a raised level of importance to include the family members into "family therapy treatment" so the family members can become a part of the substance use disorder over all recovery environments. This has become an increasing focus of discussion in new addiction recovery modeling approaches.

When we say the person impacts the family, the reverse can be applied, from proven empirical evidence including the family members to the overall therapy plan can positively affect the family as a system, which needs to work together in support of each other. This is happening when one family member is dysfunctional, it impacts the entire family system. So, both require their separate and combined level of family counseling. The loved one goes into treatment and the family members go into family counseling.

Family member interventions can help the family influence or pressure the person with the SUD to enter treatment. But now the family members need help in addressing their own reactions and problems associated with their loved one's SUD. This type of intervention is a whole family affair.

There is considerable literature supporting couples and family approaches to SUDs. These approaches may reduce the emotional burden for family members and enable them to cope more effectively with the affected family member. The following are strategies adapted from the literature on engagement, treatment, and recovery to help families.

- Engage the family members in care when it is possible.
- Engage the family members in the assessment process and early in treatment.
- Outreach efforts may be needed to engage family's members in treatment.

Several effective interventions have been used with family members to increase their rates of involvement as a family with a loved one who is in SUD treatment.

1. **Provide Education: Families benefit from education on SUDs** (symptoms, causes, effects), treatments (including medication-assisted treatments), recovery challenges for their member with a SUD, relapse, mutual support programs, the impact of SUDs on the family members, using professional services and including mutual support programs. The family members need to understand these areas to know where to seek assistance, what to ask for, and what to expect.
2. **Provide or Facilitate the Family Treatment:** These education sessions can help families address their questions and concerns, change how they interact within the family system, and improve communication. Families can also benefit from addressing their own emotional burdens and behaviors that can interfere with the recovery of the member with the SUD.
3. **Treatment can be provided in sessions with the individual family or in multiple family groups**, which provide a supportive environment for families to share their common experiences and concerns. Families can form bonds with each other and learn what has worked for others. Reduce the emotional burden of the family.

Final introduction thoughts

Family members experience a wide range of emotions such as anger, fear, anxiety, and depression. The burden experienced by the family can be reduced as they learn about specific disorders, get support and help for themselves, identify with other families experiencing similar problems, and share their own feelings and concerns.

As families feel empowered by learning information and acquiring new coping skills, their emotional burden often lessens. REF: *Daley Page 3 J Food Drug Anal. Author manuscript; available in PMC 2014 September 09. NIH-PA Author Manuscript* –

The family supports the person with the SUD by attending sessions together to learn ways to help their member with the SUD without "enabling" this individual.

- Learning about potential relapse warning signs or actual episodes of substance use and how to intervene early in the relapse process can empower family members.
- Help family members engage in recovery to meet their own needs.
- Focusing on children, families can be helped to understand the impact of SUDs on children and examining how their own children may have been harmed by the SUD in the family.
- Parents with SUDs, can be encouraged to talk with their children about their impact on their family and the children and maintain an open dialogue with kids to address their feelings, questions, or concerns. They can help kids learn about SUDs, treatment, and recovery.
- Establishing normal routines and rituals in the home, taking an active interest in the child's life, engaging them in family activities, and facilitating an evaluation for a child with a psychiatric or substance use disorder are other ways of helping the family.

Substance Use Disorders are associated with many social and family problems. These problems create challenges for the person with the SUD in treatment and/or recovery, the family, and society. When it comes to the family's needs, so much is known, but so little is share with the family.

Fortunately, there are many effective interventions and treatments, and mutual support programs, to help individuals with SUDs and their family members in how to address these issues.

Families can help their loved one in several ways:

1. Facilitate their involvement in treatment; attend sessions together to address the SUD and recovery needs; engage in ongoing discussions about recovery, and what can and cannot be done to help the member with the SUD.
2. Point out early warning signs of relapse that their loved one may ignore; and help them stabilize from a relapse should one occur.
3. Families can also help themselves by discussing their experiences with the member with the SUD, examining their own behaviors and emotional reactions, and dealing with their own reactions. This can be accomplished by involvement in treatment, mutual support programs, or other programs.

While family members often enter treatment and/or mutual support programs initially to help their loved one, they often discover that they themselves need emotional support and help since SUDs can have many effects on them. *Daley Page 4 J* ***Food Drug Anal. Author manuscript; available in PMC 2014 September 09.***

WHAT IF:

59% reduction in cocaine/methamphetamine and opioid use was possible? It is found in multidimensional family member therapy.

46% reduction in delinquency and criminal behavior related to drug addiction was possible? It is found in multidimensional family member therapy.

86% started living at home during recovery. It is found in multidimensional family member therapy.

85% started showing stable mental health functioning. It is found in multidimensional family member therapy.

These are some of the results from referring the family members into "*Multidimensional Family Therapy*", in addition to the work completed with their loved one in the substance use disorder treatment center programs. REF: www.MDFT.org

It was not until the 1970's when professional family therapy found its way into substance use disorder treatment centers. The full integration of family therapy into standard substance use disorder treatment as a family referral is still relatively rare. These centers offer a "type" of *family orientation to abstinence awareness*, which is valuable and should be attended by the family, but this is not the same as a family seeking its own family member therapy for conditions that may exist and require attention for the family system to properly heal.

It is when we add these types of treatment plans, (Multidimensional Family Therapy) for family members, that the above results are likely to occur. There are other effective courses of behavior therapy programs and they should also be considered as options for the family members.

However, the industry needs to have both substance use disorder treatment center services-based family therapy AND Professional Family Counseling for

the family members. *

The Family Solution Finder Study Guidebook and accompanying Workbook provides a beginner's level of education which empowers the family by getting educated, getting organized and getting networked. They will learn the 32 key issues a typical family might face on this journey, how to get organized and prepared for each issue and how to seek help in building a support network around the family when addressing these issues.

SAMHSA TIP 39 Substance Abuse Treatment and Family Therapy* ***www.samhsa.gov*

PART I

It’s About the Family Dynamic

LEARNING MODULE I

Seminar # 1

The Family is a System

Learning Objectives:

1. Family Balance.
2. Functionality, Potentiality
3. Obstacles.

What is the issue?

What we are seeking to learn is that a family is defined through several different criteria, it is a system, and it seeks balance within the relationship between the family members. So how well a family and its family members interact, is important to the family system. The interaction creates the family dynamic. And from this we have a family unit.

As the family is a dynamic of relationships between its different members, each member of the family brings to the family dynamic their own individual expression of self, or gifts and their talents of how they define and apply their love.

Because individual family members have separate ways of using who they are in the family dynamic, we find different levels of ***functionality*** in their contributions, meaning they might be good at bookkeeping as a functionality, and this might be their contribution when the family is discussing how to budget and pay for treatments of their loved one. They are functional in this area (budgeting) and it is their gift or talent which they are contributing.

Because the person has functionality in a certain area, does not necessarily mean they have the ***potentiality*** to contribute that function into the family dynamic or conversations. Given the example of the family member with bookkeeping skill, they may not be inclined to contribute because they feel helping the loved one with money and payments is the same as enabling their loved one to continue in the misuse of substances. Therefore, they are functional, but their potentiality is likely going to be limited. So, their potentiality is lowered because they are holding back. In this case they are functional to contribute but their potentiality to offer it to the family is low.

In this case the family member has high functionality but low potentiality to contribute. The reverse can also be true. This does not make them a good our bad person, it is simply a matter of understanding that we are all different, even though we are all in the same family.

Knowing this about the family member in advance can help the family to better understand each other and work together towards a family solution when addressing a family issue. Acceptance that we are all different even when in the same family is critical towards achieving family balance.

What is a family? That is the issue we are examining and focused on understanding. To understand ourselves we need to understand the context of where we live, how we are influenced, how we interact and whose opinions do we value.

There is no single definition of family. Because cultures and beliefs change over time, definitions of family also change. To follow is a list of today's definitions:

1. **Traditional Families**, including heterosexual couples (two parents and minor children all living under the same roof), single parents, and families including blood relatives, adoptive families, foster relationships, grandparents raising grandchildren, and stepfamilies.
2. **Extended Families,** which include grandparents, uncles, aunts, cousins, and other relatives.
3. **Elected Families**, which are self-identified and are joined by choice and not by the usual ties:
    - blood
    - marriage
    - and law

For many people, the elected family is more important than the biological family. Examples would include:

■ Emancipated youth who choose to live among peers

■ Godparents and other nonbiologically related people who have an emotional tie (i.e., fictive kin)

■ Gay and lesbian couples or groups (and minor children all living under the same roof) The idea of family implies an enduring involvement on an emotional level.

Family members may disperse around the world, but still be connected emotionally and able to contribute to the dynamics of their family's functioning.

For practical purposes a family can, be defined according to the individual's closest emotional connections. In family therapy, clients are asked to identify who they think should be included in therapy as family members. A counselor or therapist cannot determine which individuals make up another person's family. When commencing therapy, the counselor or therapist would typically ask the client, "Who is important to you? What do you consider your family to be?"

It is critical to identify people who are important in the person's life. Anyone who is instrumental in providing support, maintaining the household, providing financial resources, and with whom there is a strong and enduring emotional bond may be considered family for the purposes of therapy (*see, for example, Pequegnat et al. 2001).*

The family of one's workplace may be an example. As treatment progresses, the idea of family sometimes may be reconfigured, and the notion may change again during continuing care. *Brooks and Rice (1997, p. 57) adopt Sargent's (1983*) definition of family as a "group of people with common ties of affection and responsibility who live in proximity to one another."

We can expand that definition, by pointing out four characteristics of families central to needs of family therapy:

1. Families possess non-combativity, which means that the family is greater than—and different from—the sum of its individual members. If one person is a jerk, the rest of the family may be good.

2. The behavior of individual member is interrelated through the of acquaintances, which means if one family member changes his or her behavior, the others will likely also change therefore, which in turn causes the member who changed initially to change. This also demonstrates that it is difficult to know what comes first: substance abuse or behavior types that are called "enabling."

3. Each family has a pattern of communication traits, interaction which can be verbal or nonverbal, overt, or subtle means of expressing emotion, conflict, affection, etc.

4. Families strive to achieve balance, which portrays family systems as self--regulating with a primary need to maintain this balance. In short, the family helps each other, as a natural process.

How can an issue impact the family?

All family's seek balance. The family understands (knowingly or not) their goal is to help each other in life and in so doing, to keep the family as a system "in-balance". When one family members' behavior becomes disruptive to the family unit, it causes imbalance in their roles, relationships, and communication. This impacts everyone and it does so in different ways for each member of the family. So we will need to understand what is the functionality of each member in the family, and their ability to function in dealing with the impact of substance use disorders issues.

As the family responds to this undesired behavior, it compensates by adjusting. A general rule: The greater the behavior, the greater the required adjustments.

An example of this type of family dynamic would be taking a family of four, (two parents two children). Suddenly one child starts to present substance misuse behavior.

This draws the attention from both parents to that one child, absorbing their time and resources. The second child is left on their own while years of attention, stress and worrying become the family norm.

From a development standpoint, the second child has been emotionally and in many ways physical abandon. The family system is out of its order and it will likely take family therapy sessions to bring the family members back into alignment.

In family therapy, the unit of treatment is the family members, and/or the individuals within the context of how the family is defined. The person abusing substances is regarded as a subunit within the family unit. This person's symptoms now have repercussions throughout their entire family system. What they do, and how they behave is a matter of interest for everyone in the family. It is now a part of the family dynamic.

When the family members are in family counseling, the therapist facilitates discussions and problem-solving sessions, often with the entire family group or subsets thereof, but sometimes with a single participant, who are or may not be the person with the substance use disorder. The first area of focus is what is causing the imbalance and how does it impact the family.

It is only from this vantage point the family members can be clearer in how to move forward and make corrections to the imbalance.

What are the options?

It is in the ability of each family member to function at their best, ***functionality*** of each person, and their potential to contribute to the family dynamic ***potentiality***, where we will find options of how to make improvements. So, family therapy involves strengthening the individual family members ability to function and potential to contribute, within the family dynamic.

There is a theory worthy of consideration, functionality. This means to what level is a family member prepared to deal with the impact of what has been delivered.

It starts as each family member has their own issues, but because there are many family members, each (independently) needs to determine how they will respond to a single issue. The family system consolidates these responses to achieve some combined outcome.

Example: each member has their own way of addressing their loved one's incarceration, but the family system allows their combined responses to achieve some single outcome, i.e., "we will all help him navigate the legal system". Even though they come at it from different perspectives, the result is a single combined outcome. They all showed up at the drug court hearings in his support.

The question is how well the family is EQUIPPED to work together in a **FUNCTIONAL** manner? For many families they are not equipped functionally, although they seem to care about each other, and the family members seem to be functional in their own lives; as a family system is when functionality can become the issue.

Therefore, we have listed the Family System as a **Key Issue** for study by the family members. What happens when they interact and contribute as family members to the family dynamic. This becomes the environment for a successful and sustainable recovery in their loved one's overall recovery plan, or not. That is correct, a dysfunctional family can ruin the chances of a person in recovery to sustain abstinence or sobriety.

Q: Does your family have the ability and skills to respond effectively?

The other theory is potentiality, whereby one issue impacts the family members, and they all respond differently because they all have a different capacity to respond, thus creating several possible outcomes.

In this case, the legal system is intervening in their loved one's life and each family member choose their own way to respond, creating many outcomes. i.e., one member chooses to ignore it, even though they had the potential to help. Another member shows up to drug court in support of him, a third member criticizes him and provides negative input. It is the same issue, with different outcomes. This can present in the positive, also.

The question is how well the family is EQUIPPED to use their **POTENTIALALITY** in support of the family unit? Do they have the capacity of coping skills and ability to use their functionality to the benefit of the family, if yes, are *they willing* to use them?

There is no right or wrong. However, the family needs to focus on how to navigate the journey, not why each obstacle (issue) that comes up must be addressed.

Therefore, the focus for the family is on "What has to be done, and How". Not why this issue is happening. The blame game gets everyone, no where.

When rafting down a stream, we do not ask why the rocks are there, we just determine what needs to be done to navigate around them and how to paddle and steer our effort to move forward.

The Impact of Denial, Enabling, Codependency

Nearly everyone who is in contact with a person mis-using substance is impacted in some way. It is rare that the effects of an addiction are limited solely to this one who is abusing substances.

Frequently, the people who spend the most time around the addict are friends, family, and co-workers – therefore, these are the people who are likely to be most impacted by drug addiction or alcoholism. Our lives start to circle around theirs. And their life is circling around the drug of choice.

Family members, especially non-addicted spouses, are forced to pick up the slack for the substance abuser, making excuses for his or her behavior, and potentially endure sexual, physical, and emotional abuse.

In many cases, extended family members and close friends must help financially and in other ways to account for the ignored responsibilities by the substance abuser.

The children suffer in school and are more likely to be involved with drugs and alcohol as adults. Coworkers are not always as close to the addict, but they may also be affected by having to increase their workloads to make up for diminished job performance. Nearly every person in contact with an addict is impacted in some way.

When a family member is suffering from a substance use disorder, it can affect the entire family in countless ways. One of the most common is through a dynamic where family members are divided on the reality of the addict in their family. In other words, those that see the addiction for what it is and *those that refuse to see that reality*.

1. **Denial** is a common defense for family members that do not want to face the reality of the substance use disorder that is overwhelming their loved one. It is also common to find that other family members clearly see the problem of substance abuse, its costs, and there is a need for stronger intervention. The intervention is with the family member who is in denial.

The reality is that one or more family members understand that helping this family member will require some difficult emotional decisions. They understand how hard it is to do what is right. It is rarely an easy thing to move towards. Telling another family member they are in denial is rarely initially met with acceptance.

The aware family members often see things as they are rather than how they were or would like them to be. Their decisions are based on what will help heal this family member and consequently, the family. This comes with an understanding that even beyond recovery; things will be forever changed from the time before their diagnosis. So, denial is not going to work.

The "aware" family members may be the families only way towards seeing this as a family dilemma. The fact that change is required is one of the greatest sticking points for the family members to address.

The other family member who is in denial are overwhelmed by emotions when they see the perceived magnitude of the addiction and sense of helplessness that this reality poses. They long to see things as they were before this took hold and will avoid seeing the signs in the early stages as well as make excuses for the extreme behaviors that come from the later stage in addiction. It is only going to get worse, until something changes for the addicted family member.

A family member who is in denial can take many forms including enabling and justifying. Both behaviors come in many forms and will further harm this person as well as the family that is divided on what is their new reality. See Seminar # 10 Enabling vs Consequences. There are Ten Types of Enabling.

2. **Enabling,** is when the family members *enable their loved one towards negative behavior.* This can take many forms. For example, it is a good thing to help a family member in need under most circumstances but doing so in certain circumstances where an addict is involved can make matters worse.

   This enabling can be as simple as covering for them when they miss work to providing financial support when they are involved in a DUI. In any situation where family members take care of the problems created by their loved one's behavior, an enabling dynamic is present.

   A family member's justification is often a "*denial tactic*" that comes to the forefront when the family member that sees things from a clearer perspective "**seeks to question the unwise intervention of the other family member who is in denial"**. The family member in denial will make excuses for the behavior of this family member such as their being under a great deal of stress or going through a difficult stage of life. The reality is that we all have these periods in our life, and by enabling them, they are only exacerbated from this behavior.

3. **Codependence** can also be at the heart of the behavior of a family member in denial regarding their treatment of this family member. Although this is a complex dynamic the family member becomes reliant on this person's substance abuse. A simple explanation is that a family member comes to believe that they must support this family member even though their behavior is incredibly destructive.

   The family member who is misusing substances uses their powers of persuasion to manipulate the emotions of each family member in denial by convincing them that they are "sick" and will perish without their help.

   The codependent family member believes them and their fear that this family member will be harmed in some way guides this family members actions.

The codependent family member then becomes an accomplice in the addict's behavior and will lend them money or support them in their behaviors. As the cycle repeats itself, the codependent family member begins to derive satisfaction from "helping" the family member, which leads to even more destructive behavior.

All the dynamics of taking sides can manifest between parents when a child is a substance abuser, and between adult brothers and sisters where another adult sibling is the substance abuser.

This last scenario can pit the husband or wife of the person against their adult siblings from either side of the family. The only way to ultimately get the substance abuser family members the help they need is to have both sides see the reality of the addiction so that they can form a united front. This requires professional guidance and counseling.

REPEAT: ***Both sides of the family (those in denial and enabling with those who are not) need to get on the same page if they want to form a united front to address substance abuse in their family system***.

When these scenarios manifest themselves, it is unlikely that the divided family members in question can resolve the issue of how to help. The assistance of a "***drug and alcohol counselor" or family therapist*** can often provide the guidance to the aware family member as to how to cope with the family members who are in denial and stay the course.

The emotional wellness of the family living with a substance abuser is deep and takes time to reach the bottom to sort out the reality. The goal is to go through this journey without wasting time in arguments. The divided family must come to see a common reality sooner rather than later to provide the necessary support for the addict. This is the surest path to getting them into recovery and getting the whole family on the road to healing.

The Above Material REF: SAMHSA TIP # 39

Conclusion

In conclusion we now understand that one of the differences between family members is their functionality and potentiality, that the family seeks to achieve balance and that "how we define family" may be different than what we first believed.

But just having this awareness is not the end to our learning. Now we will use the *Family Solution Finder, Seminar Workbook Learning Module II* to apply this learning to our own lives through completing the practical exercises.

Then we will use the "The Family Solution Finder, 3-D's Coping Skills Workbook Learning Module III. By apply this learning and the Family Practical Life Exercises of F.T.R to Determine a solution to the issue, Develop a decision, Design a Family Plan of Action. And then seek professional assistance in the family plan of action, using "The Family Solution Finder, Local Resource Connections Workbook Module IV. This is a solution finding learning system. You now have a starting point, for learning more about your family. We start here, because everything starts with the family and returns to the family. So, let's take the time in the beginning to understand the family. From there we will build empowerment through knowledge.

Visit Our Website and download the power point presentation with slide voice over and embedded videos. www.familiesimpactedbyopioids.com

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LEARNING MODULE I

Seminar # 2

The Different Roles of The Family Members

Learning Objectives

1. Patterns of Interaction.
2. 7 Roles of Family Members?
3. Sequence of Thought.

What is the Issue?

Extensive studies have been implemented to better understand the family dynamic when faced with the stresses of substance use disorders. Fortunately, they are common enough for labels with associated behaviors to be identified and understood. It is valuable for the family to become aware of this list, and not use it to punish or create conflict but rather to be understood how each family member has their own role and it might be appropriate for who they are in the family dynamic.

By knowing when a family member is acting in their role then their behavior and contribution to the family becomes more predictable, creating less of an unforeseen conflict, as the family strives to seek balance in the family dynamic.

Example, Jane is the hero, Jane acts like a hero, no one is surprised by Jane's behavior as a hero or the contribution she makes to the family dynamic because she is acting as expected, as a hero. When making a family decision, Jane's opinion may be from the standpoint of her role or just herself. In some ways this may be a positive contribution in creating balance. This needs to be considered. Family members assuming roles is not always negative.

So, how will we use this new knowledge? That will be identified for us in the Learning Module II-IV. For right now, let's get a firm understanding of the characteristic patterns of interacting and the 7 different roles of the family members.

How can the issue impact the family?

A growing body of literature suggests that substance abuse has distinct effects on different family structures. For example, the parent of small children may attempt to compensate for the deficiencies that his or her substance-abusing spouse has developed because of substance abuse (Brown and Lewis 1999). Frequently, children may act as surrogate spouses for the parent who abuses substances. For example, children may develop elaborate systems of denial to protect themselves against the reality of the parent's addictions, doing the parent roles feeling this is acceptable given the current situation.

Because that option could more commonly exist in a single-parent household with a parent who abuses substances, children are likely to behave in a manner that is not age-appropriate to compensate for the parental deficiency (for more information, see *Substance Abuse Treatment: Addressing the Specific Needs of Women* [Center for Substance Abuse Treatment (CSAT) in development *e*] and TIP 32, *Treatment of Adolescents with Substance Use Disorders* [CSAT 1999*e*]).

The effects of substance abuse frequently extend beyond the nuclear family. Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt; they may wish to ignore or cut ties with the person abusing substances. Some family members even may feel the need for legal protection from the person abusing substances.

Moreover, the effects on families may continue for generations. Intergenerational effects of substance abuse can have a negative impact on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations. For example, a child with a parent who abuses substances may grow up to be an overprotective and controlling parent who does not allow his or her children enough autonomy.

Neighbors, friends, and coworkers also experience the effects of substance abuse because a person who abuses substances often is unreliable. Friends may be asked to help financially or in other ways. Coworkers may be forced to compensate for decreased productivity or carry a disproportionate share of the workload. Therefore, they may resent the person abusing substances.

People who abuse substances are likely to find themselves increasingly isolated from their families. Often, they prefer associating with others who abuse substances or participate in some other form of antisocial activity. These associates support and reinforce each other's behavior.

Different treatment issues emerge based on the age and role of the person who uses substances in the family and on whether small children or adolescents are present. In some cases, a family might present a healthy face to the community while substance abuse issues lie just below the surface.

In a study (Reilly (1992) describes several ***Characteristic Patterns of Interaction***, one or more of which are likely to be present in a family that includes parents or children abusing alcohol or illicit drugs:

1. ***Negativism.*** Any communication that occurs among family members is negative, taking the form of complaints, criticism, and other expressions of displeasure. The overall mood of the household is decidedly downbeat, and positive behavior is ignored. In such families, the only way to get attention or enliven the situation is to create a crisis. This negativity may serve to reinforce the substance abuse.

2. ***Parental inconsistency***. Rule setting is erratic, enforcement is inconsistent, and family structure is inadequate. Children are confused because they cannot figure out the boundaries of right and wrong. As a result, they may behave badly in the hope of getting their parents to set clearly defined boundaries. Without known limits, children cannot predict parental responses and adjust their behavior accordingly. These inconsistencies tend to be present regardless of whether the person abusing substances is a parent or child and they create a sense of confusion—a key factor—in the children.

3. ***Parental denial***. Despite obvious warning signs, the parental stance is: (1) "What drug/alcohol problem? We do not see any drug problem!" or (2) after authorities intervene: "You are wrong! My child does not have a drug problem!"

4. ***Miscarried expression of anger***. Children or parents who resent their emotionally deprived home and are afraid to express their outrage use drug abuse as one way to manage their repressed anger.

5. ***Self-medication*****.** Either a parent or child will use drugs or alcohol to cope with intolerable thoughts or feelings, such as severe anxiety or depression.

6. ***Unrealistic parental expectations***. If parental expectations are unrealistic, children can excuse themselves from all future expectations by saying, in essence, "You can't expect anything of me—I'm just a pothead/speed freak/junkie." Alternatively, they may work obsessively to overachieve, all the while feeling that no matter what they do it is never good enough, or they may joke and clown to deflect the pain or may withdraw to side-step the pain. If expectations are too low, and children are told throughout youth that they will certainly fail, they tend to conform their behavior to their parents' predictions, unless meaningful adults intervene with healthy, positive, and supportive messages.

   In all these cases, what is needed is a restructuring of the entire family system, including the relationship between the parents and the relationships between the parents and the children.

The reason this section is important, it gives us a place to start when examining the "Why roles develop" in a family. The above, often is the reason for the list of roles, below.

What are the options?

Learn the 7 Different Roles of Family Members and Common Behaviors.

Most experts identify six dysfunctional family roles. However, in her book, Another Chance: Hope and Health for the Alcoholic Family, addiction and codependency expert Sharon Wegscheider-Cruse identifies the ***seven*** dysfunctional family roles of the alcoholic family as follows:

- The Substance Misuser
- The Enabler
- The Hero
- The Scapegoat
- The Mastermind
- The Mascot
- The Lost Child

The Substance Misuser:

We generally characterize the dependent as the focal point within the greater spectrum of dysfunctional family roles. As they slide farther down the scale and lose themselves in substance misuse, the family's trajectory alters course. Family members change their behaviors, whether willingly or unwillingly, to accommodate the dependent's lifestyle. For some, this means enabling. A family member may find themselves lying to family friends or cancelling obligations to bail their loved one out of a jam. Other family members react more harshly, sometimes even cutting off all contact with the Dependent. At extreme, this changes the whole of the family dynamic.

Naturally, the dependent faces the most obvious struggles in recovery. In fact, some might even say they benefit from the existence of such a clear-cut role. They often need not do much soul-searching to arrive at the conclusion that their behaviors must change. (Obviously, there are exceptions, and not all dependents succeed in recovery or even attempt it.) The dependent will still need to identify certain behavior patterns if they wish to achieve a full recovery. At the onset, however, the problematic aspects of this dysfunction will appear far more tangibly than those stemming from other dysfunctional family roles.

The Enabler:

Also known as the caretaker, we can identify at least one primary similarity between the Caretaker and the Dependent: the bulk of their daily lives seem to revolve around drugs and alcohol.

Common behaviors of the Enabler may include posting bail after an arrest, making excuses for their addicted loved one's behavior, and looking after the Dependent's basic needs when intoxication prevents the Dependent from doing so themselves. Enablers generally suffer from codependency, which affects their relationships with all members of the household. They often facilitate—and sometimes encourage, whether purposefully or not—all dysfunctional family roles. Heaping praise upon the Hero, enabling the Problem Child's behaviors, falling prey to the Mastermind's manipulation, etc.

We usually think of the Enabler as a spouse or parent. In some cases, however, the chemical dependency of an adult in the household may necessitate that one of the children step up to fill this role. In such cases, the Enabler may fit the roles of both Hero and Lost Child. They work to keep the family together but grow up feeling as if they never got to experience a true childhood. This may lead to feelings of bitterness and resentment. Fear and inadequacy also tend to characterize the Enabler, especially those who blame themselves for the Dependent's suffering. There are 10 types of enabling, found in Seminar # 10 "*Enabling vs Consequences".* *www.familiesimpactedbyopioids.com*

The Hero:

The Enabler might make excuses for the Dependent, but the Hero is ultimately the one who does the best job of bringing esteem to the family. Heroes work hard to demonstrate responsibility, seeking achievement in any form possible. Younger Heroes will often find numerous extracurricular activities at school, while working in their free time

Common behaviors despite outward appearances, the Hero suffers as much internal strife as any of the other dysfunctional family roles. Due to their hard-working lifestyle and extreme perfectionism, Heroes suffer high levels of stress. The constant struggle for achievement, the drive to set themselves apart from the family's dysfunction, essentially becomes its own addiction. Much like the Caretaker, the Hero often develops major control issues. They seek validation by trying to control the world around them. To some extent, they may succeed in this. But as each accomplishment fails to provide true inner peace, they respond by working even harder. Eventually, the Hero may take on too much or spread themselves too thin. This leads to extreme feelings of guilt and shame when the Hero finally takes on a task they cannot accomplish and must come to grips with failure.

Relationships between the Hero and other family members sometimes become volatile. The Hero may resent the Dependent or Problem Child, blaming them for the family's struggles. They may even blame the Caretaker for allowing this to happen. In many cases, the Hero feels stuck in their lifestyle simply because nobody else is stepping up to the plate. They may feel as if the family's burdens rest upon their shoulders. Left unresolved, these inflated feelings of self-importance may lead to a difficult life of constant overwork.

The Scapegoat:
Many define the Scapegoat in the same manner as we defined the Problem Child above, particularly regarding those who draw attention away from the Dependent's behavior. They characterize this as an effort to protect their addicted family member, possibly out of feelings of guilt or shame. But in Not My Kid: A Family's Guide to Kids and Drugs—which precedes Wegscheider-Cruse's book by about five years—authors Beth Polson and Dr. Miller Newton define the Scapegoat as a family member who often does nothing to earn their role within the family's dysfunction. In this take on dysfunctional family roles, the Scapegoat suffers misplaced blame for the behaviors of others in the family.

Common behaviors rather than a Problem Child who diverts attention, this definition casts the Scapegoat as an individual who generally exhibits relative stability and emotional health compared to the rest of the household. Nonetheless, they may receive blame for the Dependent's behaviors if even tangentially connected to them. "How could you allow this to happen?" "Why didn't you say something sooner?" In some cases, they may even receive blame for events in which they did not participate by any action or inaction, and in fact did not even know about until they found themselves drawn into the conflict as a wrongly accused culprit.

The Scapegoat will sometimes grow to believe others' perceptions of them. The guilt with which they have been unjustly saddled will characterize future relationships by causing frequent feelings of inferiority and self-loathing. By contrast, some Scapegoats who recognize their unfair treatment may struggle with trust issues. And due to the complexities of human behavior, some Scapegoats will find themselves regularly torn between both extremes.

The Mastermind:

Much like the Problem Child, the Mastermind may fail to appear on most addiction-centered breakdowns of dysfunctional family roles due to the sheer assumption that the Dependent usually takes up this mantle. We associate the Mastermind with manipulation and opportunism, traits sometimes employed by Dependents to hide or facilitate their continued use. From the standpoint of the Enabler, and occasionally the Scapegoat, the Dependent fills this role.

Common behaviors the Mastermind, however, sometimes occupies a much more complex space within the overall family dynamic. Some Masterminds put on the façade of other dysfunctional family roles at will, depending upon the aims they seek to achieve. Usually, however, the Mastermind simply observes the behaviors exhibited by the rest of the family, using them to their advantage. They may use the diversions of the Problem Child or Scapegoat to engage in their own misbehavior. Or they may take advantage of the Caretaker's enabling nature to fulfill desires that might otherwise be denied to them.

We should clarify that, while the above description casts the Mastermind almost as a villain, they do not necessarily act with nefarious intent. Sometimes, in the wake of the chaos caused by competing dysfunctional family roles, opportunism may seem the only way to meet their needs.

The Mascot:
All the dysfunctional family roles share one thing in common—regardless of their outlook on the situation, they usually take the Dependent's addiction seriously. The same can be said of the Mascot; however, you would not necessarily know it.

Common behaviors the Mascot often cracks jokes or finds other ways of trying to provide entertainment. They do so to alleviate the family's stress, although sometimes this may backfire. Particularly insensitive jokes or immature antics will sometimes test others' patience. When their jokes are poorly received, this often only heightens their fear and causes them to double down with more humor. On such occasions, the Mascot may briefly switch roles and become the Scapegoat. Eventually, when things calm down, they return to their role as the family jester.

Much like the Hero, the Mascot's outward appearance masks deep-seated insecurities. They use their sense of humor as a defense mechanism to put off dealing with pain, fear, or any other sort of emotional discomfort that might cause them trouble. As a result, these feelings remain unprocessed and unresolved. Mascots find themselves in a state of arrested emotional development, unable to cope properly with negative emotions. Their sense of humor becomes their most defining characteristic, and they fear that any failure on their part to maintain it may result in abandonment. And so, while their antics may gain them some popularity (both inside and outside the family), this popularity feels cheap. The Mascot becomes isolated within a sea of people who enjoy their company, yet do not really know them as anything other than a walking laugh factory.

The Lost Child:
Each of the above dysfunctional family roles manifests through action. The Lost Child stands apart, in that we characterize this role primarily by inaction. Those who fit into this role try hard not to rock the boat.

Common behaviors they may never mention the Dependent's behavior, perhaps even going out of their way to avoid family discussions about it. Introverted and inconspicuous, the Lost Child may take this role by choice. Many times, however, the Lost Child is as their title implies—someone whose needs were simply neglected.

Since we characterize the Lost Child by their neglected needs, they may easily fit into many of the other dysfunctional family roles. A Lost Child who gets fed up and angry with their role may wear the mask of Problem Child for a day, simply to take the spotlight for a short period of time.

The Hero may identify as the Lost Child if they feel the rest of the family does not acknowledge their achievements. Sometimes the Lost Child plays the role of Scapegoat, disappearing from the family's radar until they become entangled in a family dispute against their will. Usually, however, the Lost Child simply stays out of the way. In a dysfunctional household, the Lost Child feels it safer to remain neither seen nor heard.

Even when the Lost Child assumes their role by choice, they may still resent the family for their neglect. Lost Children often grow up feeling ostracized, lonely, and inadequate. They assume their neglect must result from some sort of personal failing. That something must be wrong with them, or else they would receive the love they deserve. This lack of esteem may lead to dangerous behaviors later, such as self-harm or a tendency to become involved in abusive relationships.

The Sequence of Thought

It is a value to consider the path of how we use what we learn.

The sequence of thought is how we use what we know so everyone can benefit from what was learned. The family members role is not an assignment, it happens naturally. Knowing the behavior of a role helps the other family member to understand the interaction that takes place inside the family dynamic.

onclusion

Considering how the family interacts and uses the functionality of each member can be enhanced when also taking into the account a role the family members may have assumed. It helps to determine the potentiality of their contribution (where are they coming from?).

By gathering together the functionality, potentiality, characteristic patterns for interaction and 7 roles family members play, we can start to assemble what creates balance. Also, add to this equation the obstacles that are common which interfere with the family members (denial, enabling and co-dependency) this is a part of defining your family system.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

The Family Solution Finder

Educate, Organize, Network

LEARNING MODULE I

Seminar # 3

Childhood Trauma in the Family System

Learning Objectives:

1. Connection between trauma and addiction
2. Different Scales to evaluate level of trauma exposure
3. The tools used to diagnose childhood trauma

What is the Issue?

CHILDHOOD TRAUMA IN THE FAMILY SYSTEM

This is an overly complex topic and should be address in a dialog with a professional therapist. If you suspect or know of childhood trauma in your family, we encourage you to seek professional assistance to navigate this subject. It should not be addressed by those who are not trained in the care of those involved.

As a psychological term, trauma refers to an event or situation with which a person is unable to successfully cope. It can create high levels of fear and make a person feel as if he or she is faced with imminent harm, either physically or mentally. A person who has suffered from trauma may feel other emotions such as confusion, powerlessness, betrayal, and loss. In some cases, the feelings are temporary, but traumatic events can also lead to post-traumatic stress disorder (PTSD), which can last years or even a lifetime.

Trauma is a personalized experience, so what is traumatic for one person may not be so for someone else. Children are especially susceptible to trauma as they rely on adults for their basic needs and can have their trust shaken instantly or over time. Some of the causes of childhood trauma include child abuse, neglect, bullying, and sexual assault. Even witnessing these acts can be harmful to a child. There is now evidence suggesting that substance abuse and childhood trauma may be linked, therefore having a diagnosis is critical.

https://www.nctsn.org/sites/default/files/resources/making_the_connection_trauma_substance_abuse.pdf

How can the issue impact the family?

The National Child Traumatic Stress Network reports that a person will begin using substances after they experience trauma **76 percent of the time**. A more recent study published in the *Journal of Traumatic Stress* found that there was a positive correlation between childhood abuse (physical, emotional, and sexual) and adult substance abuse. Specifically, a study of more than 2,000 adults revealed that those who suffered from childhood trauma had a greater chance of abusing drugs and alcohol as adults. Substance abuse is often used as a coping mechanism to deal with painful memories associated with abuse. Using drugs and alcohol is also a way to deal with feelings of loneliness and isolation, improve a sense of self-worth, and to cope with untreated mental health issues such as PTSD, depression, and anxiety.

If trauma and the feelings associated with it are not resolved, serious long-term issues can develop. Post-Traumatic Stress Disorder (PTSD) disrupts the lives of people who have experienced unresolved trauma by negatively impacting their relationships, emotions, physical body, thinking, and behavior. PTSD sufferers may experience sleep disturbances, nightmares, anxiety and depression, flashbacks, dissociative episodes in which they feel disconnected from reality, excessive fears, self-injurious behaviors, impulsiveness, and addictive traits/a predisposition to addiction.

THE CONNECTION BETWEEN TRAUMA AND ADDICTION

Researchers have been studying the connection between trauma and addiction to understand why so many drug and alcohol abusers have histories of traumatic experiences. Data from over 17,000 persons in (*Kaiser Permanente's Adverse Childhood Experiences study*) indicate that a child who experiences four or more traumatic events is five times more likely to become an alcoholic, 60% more likely to become obese, and up to 46 times more likely to become an injection-drug user than the general population. Other studies have found similar connections between childhood trauma and addiction, and studies by the Veterans Administration have led to estimates that between 35-75% of veterans with PTSD abuse drugs and alcohol.

The reasons behind this common co-occurrence of addiction and trauma are complex. For one thing, some people struggling to manage the effects of trauma in their lives may turn to drugs and alcohol to self-medicate. PTSD symptoms like agitation, hypersensitivity to loud noises or sudden movements, depression, social withdrawal, and insomnia may seem more manageable using sedating or stimulating drugs depending on the symptom. Before long, the "cure" no longer works and causes far more pain to an already suffering person.

Other possible reasons addiction and trauma are often found together include the theory that a substance abuser's lifestyle puts him/her in harm's way more often than that of a non-addicted person. Unsavory acquaintances, dangerous neighborhoods, impaired driving, and other aspects commonly associated with

drug and alcohol abuse may indeed predispose substance abusers to being traumatized by crime, accidents, violence, and abuse. There may also be a genetic component linking people prone toward PTSD..

RECOGNIZE THE SIGNS: FIRST THINGS FIRST

Sometimes, years of self-medicating through drugs and alcohol have effectively dulled the memory of trauma, so the only problem seems to be substance abuse and addiction. A person who has suppressed or ignored traumatic experiences may work extremely hard to get and stay sober, only to find other addictive behaviors eventually replacing the drugs and alcohol. These might include compulsive overeating, gambling, sexual promiscuity, or any other compulsion-driven behavior. Unfortunately, continuing to avoid resolution of trauma will almost guarantee ongoing suffering.

However, dealing with traumatic experiences is challenging work. Under the influence of drugs and alcohol, it is a nearly impossible task. That is why therapists always recommend working first on recovery from drug addiction and alcoholism. Then, when the trauma survivor is stronger and more clear-minded, he/she can begin working with a therapist in individual or group counseling to address the underlying problem of unresolved trauma. Specific treatment modalities have been developed for people suffering long-term effects after traumatic experiences, including trauma-focused therapies, PTSD Intervention, Body Psychotherapy which targets the physiological response to trauma, and medications for depression and anxiety.

Researchers have examined why child trauma survivors may be at an increased risk of drug abuse and findings showed that substances may be used to:

- cope with or block out the traumatic memories.
- deal with feelings of isolation and loneliness.
- improve feelings of self-worth and self-esteem.
- cope with mental health problems such as anxiety, depression, and PTSD.

Anxiety

Anxiety is an intense emotional state that results in excessive and persistent fear and worry. With CSA survivors, anxiety could be associated with the profound fear that the abuse will occur again. Some survivors may experience intense fear of going in public and lock themselves in the shelter of their homes. Others may experience, another mental health condition often associated with anxiety, known as panic attacks. Panic attacks are intense and overwhelming surges of anxiety and fear that result in physiological reactions, such as rapid heartbeats, and difficulty breathing.

Depression

Depression can be described as the persistent feeling of deep sadness. Common symptoms include prolonged periods of sadness, feelings of hopelessness, unexplainable and uncontrollable bouts of crying, significant weight loss or gain, lethargy, emotional apathy, or lack of interest and pleasure in previously enjoyed activities.

Depression can have a negative impact on a person's day-to-day functioning and can result in poor school and work performance, as well as friendship and relationship problems.

What are the options?

The Different Behaviors

Please read the statements below. If you answer yes to two or more, you may want to consider referring your child for a complete assessment for complex trauma.

The survey below is a tool to help you decide when you need to seek professional help:

- My child has been exposed to many potentially traumatic experiences.
- My child has difficulty controlling emotions and easily can become sad, angry, or scared.
- My child has trouble controlling behaviors. My child often exhibits significant changes in activity level, appearing overactive or agitated sometimes and then calmer, or even quite slowed down at other times.
- My child has trouble remembering, concentrating, and/or focusing. He/she sometimes appears "spacey." My child has problems with eating, sleeping, and/or complains about physical symptoms even though doctors find nothing physically wrong to explain these symptoms.
- My child has difficulties in forming and sustaining relationships with other children and adults.

- My child seems to need and seek out more stimulation than other children and/or can be easily distracted by noises, sounds, movements, and other changes in the environment.
- My child has many mental health diagnoses but none of them quite seem to explain his/her problems.
- My child is taking medication (or many medications) for these diagnoses, but the medicines are not helping.

The challenge of a parent is getting an accurate assessment from the healthcare systems. This is important because it helps clinicians to choose the best treatment possible. Children and adolescents with complex trauma may have a wide range of symptoms. Different children can have different combinations of symptoms, and these symptoms may change over time. How a child reacts depends on age, experiences, personality, strengths, and individual vulnerabilities.

There currently is no official diagnosis that captures the full range of complex trauma symptoms. However, through a comprehensive assessment, informed and experienced mental health professionals can help determine if your child's problems are related to complex trauma.

Children with complex trauma sometimes carry multiple diagnoses (for example, bipolar disorder, attention deficit hyperactivity disorder, posttraumatic stress disorder, and so on) for which they may be prescribed several different medications. This may happen when the professionals making the diagnoses have not fully considered the impact of the child's

trauma history. This can lead to a child's receiving improper diagnoses or treatment.

Different Scales to Evaluate Levels of Trauma Exposure

There are several scales used to evaluate these different levels of trauma and exposure, most common is the Traumatic Events Inventory (TEI). This tool provides more extensive information on trauma history. Take the time to look this up on-line:

Mills KL, Teesson M, Ross J, Peters L. Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being. Am J Psychiatry 2006; 163:652–658.

Deykin EY, Buka SL. Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. Am J Psychiatry 1997; 154:752–757.

Reynolds M, Mezey G, Chapman M, Wheeler M, Drummond C, Baldacchino A. Co-morbid post-traumatic stress disorder in a substance misusing clinical population. Drug Alcohol Depend 2005; 77:251–258.

Clark DB, Lesnick L, Hegedus AM. Traumas, and other adverse life events in adolescents with alcohol abuse and dependence. J Am Acad Child Adolescent Psychiatry 1997; 36:1744–1751.

Giaconia RM, Reinherz HZ, Hauf AC, Paradis AD, Wasserman MS, Langhammer DM. Comorbidity of substance use and post-traumatic stress disorders in a community sample of adolescents. Am J Orthopsychiatry 2000; 70:253–262.

Perkonigg A, Kessler RC, Storz S, Wittchen HU. Traumatic events and post-traumatic stress disorder in the community: prevalence, risk fa

The Tools Used to Diagnose Childhood Trauma

Take the time to look there up on-line:

The Childhood Trauma Questionnaire (CTQ) is a 25-item, validated, reliable self-report measure of childhood abuse (Bernstein, Stein, Newcomb, Walker, & Pogge, 2003).

The Traumatic Events Inventory (TEI) assesses having been exposed over the lifetime to 17 categories of traumatic events
using a yes/no response. (Gillespie et al., 2009).

The Emotional Dysregulation Scale (EDS) is a 12-item self-report measure of ED (Bradley et al., 2011).

The Drug Abuse Screening Test (DAST) is a 20-item measure assessing illicit drug use using a yes/no response (Bohn, Babor, & Kranzler, 1991).

Questions for Family to Address:

1. How prepared are the family members to handle the awareness that childhood trauma has occurred in the family?

_____
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2. How can the family prepare for this announcement before it is made?

First Step:

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Second Step:

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Third Step:

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Fourth Step:

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Recognize the Signs in School Age Children

PRESCHOOL CHILDREN

- ☐ Fear being separated from their parent/caregiver
- ☐ Cry or scream a lot
- ☐ Eat poorly or lose weight
- ☐ Have nightmares

ELEMENTARY SCHOOL CHILDREN

- ☐ Become anxious or fearful
- ☐ Feel guilt or shame
- ☐ Have a hard time concentrating
- ☐ Have difficulty sleeping

MIDDLE AND HIGH SCHOOL CHILDREN

- ☐ Feel depressed or alone
- ☐ Develop eating disorders or self-harming behaviors
- ☐ Begin abusing alcohol or drugs
- ☐ Become involved in risky sexual behavior

AS PART OF THE FAMILY PLAN EVERYONE SHOULD WATCH THIS VIDEO:

Search for Video: Brené Brown on Empathy

Video Link: https://www.youtube.com/watch?v=1Evwgu369Jw

The RSA

What is the best way to ease someone's pain and suffering? In this beautifully animated RSA Short, Dr Brené Brown.

Conclusion

There are too many critical points which are extremely sensitive and fragile that when Childhood or Complex Trauma is suspected, the family members should direct their efforts to find a licensed professional to help guide them in the steps moving forward.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

REF: http://www.archstonerecovery.com/taking-sides-addiction-in-families/

Here are some reference sources:

1. NCBI – Substance Abuse Treatment and Family Therapy
2. Pro Talk a Rehabs.com Community – Substance Abuse and the Impact on the Family System
3. Addiction in Family – Unhealthy Families
4. AAETS – Effects of Parental Substance Abuse on Children and Families
5. American Academy of Child & Adolescent Psychiatry – Alcohol Use in Families
6. Addiction.com – Alcohol Abuse Linked to Higher Divorce Rate
7. Medical Daily – Heavy Drinking Will Lead to Divorce, Unless Both Partners Are Equally Alcoholic
8. DualDiagnosis.org – Codependency and Substance Abuse
9. Center on Addiction – NATIONAL STUDY REVEALS: TEEN SUBSTANCE USE AMERICA'S #1 PUBLIC HEALTH PROBLEM
10. NCCP – Adolescent Substance Use in the U.S.
11. U.S. Census Bureau – Grandparents as Caregivers
12. Psychology Today – Grandparents Raising Grandchildren
13. NCADV – Domestic Violence Fact Sheet
14. SafeHorizon – Domestic Violence – Afraid to stay, afraid to leave?
15. NCBI – Substance Abuse Treatment and Domestic Violence.
16. NCBI – Substance Abuse Treatment and Domestic Violence
17. NIH – Exploring the Role of Child Abuse in Later Drug Abuse
18. CDC – Sexual Violence, Stalking, and Intimate Partner Violence Widespread in the US
19. NCBI – Preventing child abuse and neglect: programmatic interventions.
20. Bureau of Justice Statistics – Violence between Intimates: Domestic Violence

LEARING MODULE I

Seminar # 4

The Different Types of Family Therapy

Learning Objectives:

1. What is the issue
2. How can the issue impact the family?
3. What are the options

What is the Issue

We normally do not start a study guide session with a video, but this video seems to create the dialog of what needs to be considered. In understanding that ***family therapy*** can be one of most important decisions you will make in this journey we need to consider the journey itself. Then we need to clarity of our role in this journey to determine how we can empower ourselves and contribute to the solution. Getting family therapy is an intervention for the family members not just the one abusing substances. It may seem backwards, but it is not. The family needs an intervention before or at the same time as the person abusing needs the intervention.

Go To: youtube.com

IN SEARCH TITLE: 3 Rules That Govern the Family System in Addiction

Many people ask why family therapy is needed, if it is the other family member who needs the care, the one who is misusing substances.

The goal of family member therapy is to help family members identify how specific behaviors affect others, learn new ways of relating to each other, resolve existing conflicts, and open lines of communication between all family members. This is what entails a “Family Dynamic”.

Families can benefit from therapy when they experience any stressful event that may strain family relationships, such as financial hardship, divorce, or the death of a loved one. In addiction it can be effective in treating mental health concerns that impact the family, such as depression, substance abuse, chronic illness, and food issues, or everyday concerns, like communication problems, interpersonal conflict, or behavioral problems in children and adolescents.

Family counseling aims to promote understanding and collaboration among family members to solve the problems of one or more individuals. For example, if a child is having social and academic problems, therapy will focus on the family patterns that may contribute to the child's acting out, rather than evaluating the child's behavior alone.

As the family uncovers the source of the problem, they can learn to support the child and other family members and work proactively on minimizing or altering the conditions that contributes to the child's unwanted behavior.

Family counseling is provided by licensed marriage and family therapists (LMFT). Other mental health professionals—such as professional counselors, social workers, and psychologists—who have received formal training in family therapy approaches may incorporate those principles into their own work.

This mode of therapy is solution-focused and short-term, with as few as nine sessions required, on average. Meetings are often held once per week and typically last for 50 minutes. The number of family members who attend each session may vary, depending on therapy goals, and often a therapist will offer individual sessions to supplement the family sessions. Family counseling is conducted in a variety of settings including family counseling services, community agencies, and residential treatment centers.

Family and marriage counseling costs can vary widely. Rates vary from about $75 to $200 per hour, but many therapists offer sliding scale fees based on income, while some accept insurances, and some do not. The average cost for marriage and family counseling is about $100 per session.

Therefore, it is important to shop around and find the right therapist. Be a good consumer of finding the right fit and type of therapy.

How can the issue impact the family?

Family-based Behavioral Treatment – Parent only

Parents are often an important part of therapy for children, and in family-based therapy, research has shown that in treating children with SUD issues, it can often be beneficial to include only the parent in the therapy process. Taking this approach often involves parents practicing modeling, identifying rewards, implementing consequences, and being more mindful of how children's behaviors get reinforced.

This type of therapy has been proven especially effective when added to a lifestyle or recovery program for children with SUD or Mental Health issues.

Note: Family-Based Behavioral Treatment – Parent Only has only been proven well-established for children, but not for adolescents.

Functional Family Therapy

Functional Family Therapy (FFT) is a family-based therapy that was developed to help youth with behavioral issues and has been proven effective in treating substance use disorders in adolescents. The goals in Functional Family Therapy are to motivate adolescents and their families to reduce negativity in the household and to build skills within each family member to reduce problematic behaviors by using communication, effective parenting, and conflict management.

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) is a family-centered that addresses the individual, family, and environmental factors that influence a variety of behavioral issues in youth. This treatment is based on the idea that behavioral problems in adolescents are caused by many factors and treatment should come from a place of respect and compassion. In MDFT, youth learn coping, problem-solving, and decision-making skills, and the family learns ways to enhance family functioning.

MDFT has been proven through research to be effective in treating substance use disorders in adolescents.

Multisystemic Therapy (MST)

Multisystemic therapy (MST) is a family-focused evidence-based intervention for youth with significant antisocial behaviors, delinquency, and substance problems. MST appraises these behaviors within the larger context of multiple systems of influence, including multiple social-ecological factors such as individual, family, peer, school, and community influences. In a cost-effective framework, MST interventions reduce these problem behaviors and improve youth and family functioning.

QUESTION: Which therapy looks like it might benefit your family more than the others? State Why?

_____
_____
_____
_____
_____

What are the options?

These therapies are used as the bases for treatment and specific interventions for substance misuse:

1. **The Family Disease Model** looks at substance misuse as a disease that affects the entire family. Family members of the people who misuse substances may develop codependence, which causes them to enable the IP's substance misuse. Limited controlled research evidence is available to support the disease model, but it nonetheless is influential in the treatment community as well as in the public (McCrady and Epstein 1996).

2. **The family Systems Model** is based on the idea that families become organized by their interactions around substance misuse. In adapting to the substance misuse, it is possible for the family to maintain balance, or homeostasis. For example, a man with a substance use disorder may be antagonistic or unable to express feelings unless he is intoxicated. Using the systems approach, a therapist would look for and attempt to change the maladaptive patterns of communication or family role structures that require substance misuse for stability (Steinglass et al. 1987).

3. **Cognitive–Behavioral Approaches** are based on the idea that maladaptive behaviors, including substance use and misuse, are reinforced through family interactions. Behaviorally oriented treatment tries to change interactions and target behaviors that trigger substance misuse, to improve communication and problem solving, and to strengthen coping skills (O'Farrell and FalsStewart 1999).

4. **Multidimensional Family Therapy** (MDFT) has integrated several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input (Liddle et al. 1992). MDFT is not the only family therapy model to adopt such an approach. Functional family therapy (Alexander and Parsons 1982), multisystemic therapy (Henggeler et al. 1998), and brief strategic family therapy (Szapocznik et al. in press) all adopt similar multidimensional approaches.

Professional Family Therapy Types

- Structural/strategic family therapy
- Multidimensional family therapy
- Multiple family therapy
- Multisystemic therapy
- Behavioral and cognitive–behavioral family therapy
- Network therapy
- Bowen family systems therapy
- Solution focused brief therapy

Integrated Treatment Models

Several integrated treatment models have been discussed in the literature. Those discussed in this section are among the more frequently used integrated treatment models. For a more detailed discussion of these and other models of family therapy, see chapter 4 of TIP 39.

Structural/Strategic Family Therapy

In this model, family structure (defined as repeated patterns of interaction) is the focus of interventions. It is based on two assumptions:

- Family structure largely determines individual behavior.
- The power of the system is greater than the ability of the individual to resist.

This system can be used to• Identify the function that substance misuse serves in maintaining family stability.

- Guide appropriate changes in family structure (e.g., because the patterns in dysfunctional families are typically rigid, the counselor must take a directive role and coach family members to develop, then practice, different patterns of interaction).

One of the basic techniques of structural family therapy is to mark boundaries so that each member of the family can be responsible for him or herself while respecting the individuality of others. One of the ways to make respectful individuation possible is to make the family aware when a family member:

- Speaks about, rather than to, another person who is present
- Speaks for others, instead of letting them speak for themselves
- Sends nonverbal cues to influence or stop another person from speaking

MULTIDIMENSIONAL FAMILY THERAPY

Multidimensional family therapy (MDFT) was developed as a standalone, outperson therapy to treat adolescent substance misuse and associated behavioral problems of clinically referred teenagers. The model integrates several different techniques with emphasis on the relationships among cognition, affect (emotionality), behavior, and environmental input.

For the adolescent who misuses substances, the goals include:

- Positive peer relations
- Healthy identity formation
- Bonding to school and other prosocial institutions
- Autonomy within the parent–adolescent relationship

For parents, the goals are:

- Increasing parental commitment and preventing parental abdication
- Improving relationship and communication between parent and adolescent
- Increasing knowledge of parenting practices (e.g., limit setting, monitoring, and appropriate autonomy granting)

Behavioral Family Therapy and Cognitive–Behavioral Family Therapy

Behavioral family therapy (BFT) combines individual interventions within a family problem solving framework. The approach assumes that:

- Families of people abusing substances may have problem solving skill deficits.
- The reactions of other family members influence behavior.
- Distorted beliefs lead to dysfunction and distorted behaviors.
- Therapy helps family members develop behaviors that support non-using and nondrinking. Over time, these new behaviors become more and more rewarding, promoting abstinence.

Cognitive–behavioral family therapy views substance misuse as a conditioned behavioral response, one which family cues and contingencies reinforce.

To facilitate behavioral change within a family to support abstinence, the counselor can use the following techniques:

- Contingency contracting. These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, a teenager may agree to call home regularly while attending a concert in exchange for permission to attend
- skills training. The counselor may start with general education about communication or conflict resolution skills, then move to skills practice during therapy, and end with the family's agreement to use the skills at home.

- Cognitive restructuring. The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance misuse or other family problems. Family members are encouraged to see how such beliefs threaten ongoing recovery and family tranquility. Finally, the family is helped to replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

The family has a central role to play in the treatment of any health problem, including substance misuse. Family work has become a strong theme of many treatment approaches, but a primary challenge remains the broadening of the substance misuse treatment focus from the individual to the family.

Though substance misuse counselors should not practice family therapy unless they have proper training and licensing, they can be informed about family therapy to discuss it with their clients and know when a referral is indicated. Substance misuse counselors can also benefit from incorporating family therapy ideas and techniques into their work with individual clients, groups of clients, and family groups. For this reason, family's when seeking family therapy should avoid using a Substance Use Disorders Drug Counselor in place of a Licensed and Experienced Family Therapist.

Addiction is a Family Disease

The National Council on Alcoholism and Drug Dependence calls addiction a ***Family Disease***. That is because addiction affects the entire family system and the individuals who comprise it. Addiction puts family members under a great deal of stress, disrupting routines and causing unsettling or even frightening experiences.

As a result, family members develop unhealthy coping strategies as they strive to maintain equilibrium in the household. The family unit becomes a fragile and dysfunctional system, and this often unwittingly contributes to the addiction as the family adopts destructive behaviors because of it.

Children in the household are particularly affected by addiction. Substance abuse in the home interrupts a child's normal development and leads to a higher risk for physical, mental, and emotional health problems. Children of an addicted parent often have difficulties in school and are more likely than their peers to have a learning disability, skip school or be expelled. They are also four times more likely than their counterparts to become addicted to alcohol or drugs themselves.

Although the effects of substance abuse vary based on family structure, drug and alcohol-abusing behaviors impact family dynamics in several ways that are very unhealthy.

1. **Negative emotions** – As a result of the substance abuse, family members typically experience negative emotions such as anger, resentment, anxiety, concern, guilt, and embarrassment.
2. **Safety** – In some cases, the safety of other family members may be put at risk by a person's substance abuse. Children or spouses may also feel the need to obtain legal protection due to fear of their loved one's actions.
3. **Responsibilities** – Certain family members inherit too many responsibilities or responsibilities that are not age-appropriate. This can cause children or spouses to become overwhelmed, anxious, and resentful.
4. **Communication** – When a family member is abusing drugs, communication within the family unit is often negative and positive interaction is extremely limited. In addition, the needs, concerns, and wants of the family members other than the substance abuser may be overlooked.
5. **Structure and boundaries** – Homes in which substance abuse exists often have a lack of structure with minimal parental involvement and loosely existing or non-existent boundaries. This results in confusion for children and negative/inappropriate behaviors. Parents and siblings may also adopt enabling behaviors that contribute to their loved one's substance abuse.
6. **Denial** – In many cases, when a child has a substance abuse problem, parents will deny that there is an issue. This may be because they do not want to face the problem, or they simply cannot see it clearly.
7. **Relationships** – Substance abuse produces damaged relationships that can continue through generations through negative behavioral modeling. Additionally, drug or alcohol abusers will often isolate themselves from other family members and spend most of their social time with other substance abusers.

Children may develop their own set of unhealthy coping skills in response to addiction in the household and the chaos and uncertainty it inevitably brings.

Many children blame themselves for a parent's substance abuse and may strive for perfection to avoid upsetting the delicate balance in the household. Conversely, they may withdraw for the same reason.

Children who witness or fall victim to physical, emotional, or sexual abuse may develop post-traumatic stress disorder and suffer from related nightmares, insomnia, and flashbacks. They may withdraw socially due to a lack of social skills or the fear that someone may find out the truth, and they may suffer from anxiety born from an unstable living environment or from a deep-seated fear of losing their parent to the addiction.

WHAT DEFINES A FAMILY?

There is no single definition of family. However, several broad categories encompass most families:

Nuclear Family

The nuclear family is the traditional type of family structure. This family type consists of two parents and children. The nuclear family was long held in esteem by society as being the ideal in which to raise children. Children in nuclear families receive strength and stability from the two-parent structure and generally have more opportunities due to the financial ease of two adults. According to 2010 U.S. Census data, almost 70 percent of children live in a nuclear family unit.

Single Parent Family

The single parent family consists of one parent raising one or more children on his own. This family may include a single mother with her children, a single dad with his kids, or a single person with their kids. The single parent family is the biggest change society has seen in terms of the changes in family structures. One in four children is born to a single mother. Single parent families are generally close and find ways to work together to solve problems, such as dividing up household chores. When only one parent is at home, it may be a struggle to find childcare, as there is only one parent working. This limits income and opportunities in many cases, although many single parent families have support from relatives and friends.

Extended Family

The extended family structure consists of two or more adults who are related, either by blood or marriage, living in the same home. This family includes many relatives living together and working toward common goals, such as raising the children and keeping up with the household duties.

Many extended families include cousins, aunts or uncles and grandparents living together. This type of family structure may form due to financial difficulties or because older relatives are unable to care for themselves alone. Extended families are becoming increasingly common all over the world.

Childless Family

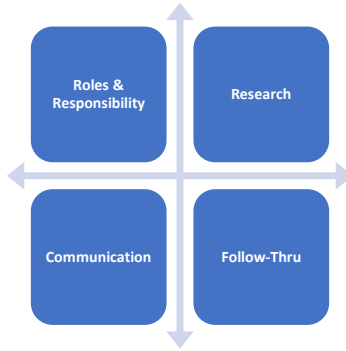
While most people think of family as including children, there are couples who either cannot or choose not to have children. The childless family is sometimes the "forgotten family," as it does not meet the traditional standards set by society. Childless families consist of two partners living and working together. Many childless families take on the responsibility of pets or have extensive contact with nieces and nephews.

Stepfamily

Over half of all marriages end in divorce, and many of these individuals choose to get remarried. This creates the step or blended family which involves two separate families merging into one new unit. It consists of a new husband, wife, or spouse and their children from previous marriages or relationships. Stepfamilies are about as common as the nuclear family, although they tend to have more problems, such as adjustment periods and discipline issues. Stepfamilies need to learn to work together and work with their exes to ensure these family units run smoothly.

Grandparent Family

Many grandparents today are raising their grandchildren for a variety of reasons. One in fourteen children is raised by his grandparents, and the parents are not present in the child's life. This could be due to parents' death, addiction, abandonment or being unfit parents. Many grandparents need to go back to work or find additional sources of income to help raise their grandchildren.



Conclusion

It is a difficult thing to ask all the members of the family to attend a few sessions with a family therapist, but the rewards are enormous. So maybe it would be helpful for one person to first meet and evaluate if this is the right therapist fit for your family before brining all the members together. You can ask the therapist for help in designing the right approach.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

Some Self Reflection Questions:

1. How prepared are the family members to handle a review of therapy alternatives and join in on the selection of which is the best family therapy?

_____
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2. How can the family prepare for this move forward?

First Step:

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Second Step:

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Third Step:

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LEARNING MODULE I

Seminar # 5

Four Primary Family Support Structures

Learning Objectives:

1. What is the issue.
2. How can the issue impact the family?
3. What are the options.

What is the issue?

Imagine a healthcare system where everyone in the U.S. is a knowledgeable, savvy consumer of medical services and plays an active role in purchasing and consuming the services they receive. With the advent of healthcare consumerism – a movement to make the delivery of healthcare services more efficient and cost-effective – it may be here sooner than you think. But what is needed is an informed customer, one that understands where to find the right level of services, what to ask for and what to expect as the outcome.

When the family on a journey with Substance Use Disorders takes a position as being a healthcare consumer it transforms the entire dialog they will have from providers and will likely increase the success a family will have in getting what they need.

However, many providers do not ask much of those that use their services (i.e., the family members) in terms of how these families use their healthcare services. You come, they provide, you leave. This is a problem. The problem is that families are left out of the dialog, are prevented from being an advocate for their loved one and often the healthcare industry will use STIGMA to fend them away. It is unfortunate but true, and a family that is a healthcare consumer can break this unacceptable behavior on the provider's part.

So, the family has their work ahead of them, they need to understand in advance who is out in the community to help, what services do they provide, what should the family expect from each provider and how to get the most out of them.

To make better decisions, healthcare consumers are increasingly expecting – and demanding – better information and more transparency from healthcare providers. They are also asking for more of a partner relationship rather than a one-way dialog from medical provider to person. The industry is not prepared to address these requests. <u>But ask them we shall and provide it they must.</u>

How can the issue impact the family?

The 4 Primary Support Structures

The family cannot go through this journey alone. They will require extensive support during their loved one's road towards recovery. This support will come from *four primary resources* from within the community. Unfortunately, there is no single resource structure that provides all four, (i.e., a family substance use disorders case management company). In this journey the family will learn they are not alone, just the same, they will need to become their strongest advocate.

The family needs to see themselves as a *consumer of services* with purchasing power. This is a consumer type environment where the family is the consumer with ability to determine where money is spent, and the primary support structures (as resources) are selling their services for what the family will need.

Each entity has its own structure. These structures do not talk to each other, they do not collaborate unless within the same health system. In many cases accessing these structures can be incredibly challenging. The problem is many of these resources do not understand the family's holistic needs. They are set up to provide just their services, but not necessarily for all the exact needs of the family. Because the support structure is complex, and these resources lack an understanding of a family whole needs, it is best to use a model that can extract what the family needs from each resource. This is done in the same way a family chooses between other purchased services, they do their homework first, then act to buy.

1. **The Family Support Structure:** The family members are their own, best resource support structure. They need to get educated, organized, and networked. This is their responsibility.

2. **The Local Faith Organizations Support Structure:** The Church is a resource support structure for the family members based on each individual member faith practice.

3. **The Community Agency Services Support Structure:** The Community (professional services, Medical, Govt agencies and Non for Profit) is a support structure for the family members, and their loved one.

4. **The Healthcare System Support Structure:** The healthcare support system is extensive, covering mental health, addiction services, community agencies like home health care and urgent care, hospitals and emergency medical services. The list goes on and the family members need to know what each provides, how and when to access them.

Aligning Expectations:

These support systems are here to help the family, but they have expectations too. They expect when their family calls, they are prepared to use these services, the family understands what they need and has a clear understanding of the problem they are seeking to solve. Therefore, before you pick up the phone, take time to research what the agency offers, and match it to what your family needs. Do your homework and you will get more from the service provider.

Getting Organized

The family needs to see the value of *those who are here to help*. By having the providers resources proactively listed in their organization binder, they are pre-planned and ready to use what is available. Their list of contacts with names, title, phone numbers, and email will be valuable when created ahead of the time. Consider purchasing the book: The Family Solution Finder Local Resource Connections Learning Module IV. by Roy P. Poillon on Amazon.com

What are the options?

By completing a The Family Solution Finder Local Resource Connections worksheets the family is a step ahead.

The 3-D's Coping Skills Model:

1 Identify the Issue (what is the problem).
2 **D**etermine a Solution using a Family Transformational Response Model
3 **D**evelop a Decision using a Family Values Based Decision Making Model.
4 **D**esign a family Plan of Action.

From this initial work using the Family Solution Finder Learning Series worksheet, the family understands their selected issue, has determined the solution, and has developed a decision on the best way to respond. They are now ready to seek the assistance from outside their family using the local community.

The Family

Communities have a great influence in a family's life. Just as plants are more likely to thrive in a garden with good soil, plenty of sunlight and water, families are more likely to thrive in supportive communities. However, of all the resources available to a family, The Family is its own best resource for support. Once unified with a plan, the family can seek services and programs from the community that best match their needs.

1. **In the Preparation**, a family will find the best results from using the Nine by One worksheet listed Appendix One. This will provide the necessary steps to understand the organization and what they provide.

2. **In the Needs Inventory**, a family will see exactly what they need. This clarity will help them to describe to others what services more clearly will help them the best.

3. **In the Services Inventory,** a family will identify what services are available where they can be found and how to access these providers.

4. **In the Family Plan of Action and Needs Matched to Services**, a family will act on the collected information. This knowledge will then be applied to a plan and their knowledge will become a source of empowerment.

The Faith Organizations

Churches will vary in their structure and support of the family needs for their journey with substance use disorders. By taking a church-by-church inventory from within the local community, identify what services each offers and make a list for future reference. Be assured, each is different.

The City Services

There are many resources available to the family from their city, county, and state departments. Often these are categorized by topic, i.e., Law Enforcement, Social Services, Mental Health, Public Safety, and department of educations. The list is extensive and therefore the search is complex.

It is best it the family first completes a community mapping (see seminar # 17 in the Family Solution Finder Learning Series. This will help the family to narrow down their match making of the right level of care, to the correct department. The outcome will be a better fit of resources for the family, less frustration and stress during the search and it allows those who are here to help do their work better in meeting the family needs.

The two recommended workbooks are: The Family Solution Finder 3-S's Coping Skills Workbook Learning Module III, and The Family Solution Finder Local Resource Connections Workbook Learning Module IV. By including these books as the main framework towards seeking assistance the family will have significantly increase their success as an outcome.

Take for example High Schools: They have a High School Guidance Counselor, teacher, and School Principal. All of these with the family therapist can be brought together to support the family plan in how they will respond to an issue. Think of the advantage for the family to have all four working as one to support the next steps on what the family is seeking to achieve.

The Healthcare System

One of the first steps a family will need to take when dealing with the healthcare systems is, get a diagnosis. The diagnosis drives all decisions, eligibility to receive services and access to benefits. The second step the family needs to take is to contact their payer to find out exactly what services are covered, who is in network and how eligibility and authorizations for services are qualified for and completed. This gives the family purchasing power and empowerment to select the right level of services from the best available provider. Once these two steps are taken and learning module I-IV workbooks are completed for this issue, the family is ready to seek assistance from the healthcare systems in their community. They are empowered to act.

The Family Solution Finders Learning Seminars Workbook has practical exercised to strengthen the family for taking the above recommended steps.

Create a Family Plan of Action

Supportive communities that are nurturing to families will have the following:

• List of their services, most likely you will find this on their website.

• Access to learn more about their organization, most likely a phone number, email address, on-line chat room is available.

• A point of contact that will answer questions, usually provided upon your request by calling them.

• A program application. Typically, these forms require the applicant provide documents of proof based on their qualifying criteria. Sometimes finding these documents is stressful. It is better to have them organized before you need them. All the above should be included to the family plan of action and in your "Family Solution Finder 3-D's Coping Skills Workbook binder.

Preparation is About Taking Baby Steps

As in building a house, it is important to have a good plan, hire the right people to help you prepare your work before getting started. The same is true with a family in a journey with SUD.

• Expect things to move slowly in the beginning. The first step is to introduce your family to the organization, let them introduce their services.

• Let them review your information, while you review their information.

• The family will need to understand (clearly) how this organization or agency processes its workflow. Learn each step of their process.

It is only after taking these initial "Baby Steps" that a family will be in position to ask for help.

Share your plan.

• Set up a meeting to review with the organization how their services fit into your *family plan of action*. You will likely find them to be helpful in making other suggestions and these ideas may be in addition to your original thought. It helps them to help you when they know what you want to accomplish.

• Ask if their service provides any collaborative sharing between their clients, discussion groups, seminars, or special topic discussions.

Use the family Plan of Action.

Take each section and place your findings into your plan of action. By doing this, all your organizing activity becomes a useful tool. This step also allows other groups and people the same information so they can better help you in your tasks. People will be more able to help your family, if they have a clear understanding of what you family is planning to accomplish.

Most of your work in dealing with this issue will be from completing the section for the Family Solution Finder 3-D's Coping Skills. Be sure to complete each task to gain the most in developing your family plan of action.

Conclusion

The good news is there are providers, services, and programs for every issue you will face in a journey with substance use disorders. Your challenge comes from finding them at the time they are needed. Or take the time now to identify your local community and what they offer.

You are a consumer of services, do your homework prior to needing the service. Your life will be less stressful, you will be able to better stay on budget and the journey can be experienced from a vantage point of growth, yours and theirs.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

PART II

Learn About the Disease

LEARNING MODULE I

Seminar # 6

Getting the Diagnosis

Learning Objectives:
1. What is the issue.
2. How can the issue impact the family?
3. What are the options.

What is the issue?

Getting a diagnosis

Getting a diagnosis means getting organized. From the diagnosis will stem a slew of other clinical, psychological, social, legal, and spiritual information. For the family members it will become its own challenge to capture this vast amount of information. So, before you travel this path; now is a good time to create a system to capture the different information pieces. It is important for the family to see this journey as "requiring a sense of organization". These areas can be organized and assembled into a family organization binder for future easy to find reference. This is where all critical documents are held and filed. You may be asking why we are first talking about getting organized and not getting the diagnosis. It is because, the diagnosis is so massive of an information flow, you will first be overwhelmed before you start to understand.

Consider the diagnosis as three to five separate categories:

1. The Substance Use Addiction
2. Mental Health, Dual Diagnosis, not always but in many cases.
3. Medical Co-Morbidities, these are other medical health conditions.
4. Ability to function with daily living.
5. Ability to sustain housing, transportation, and employment.

Getting Organized

Using Tab Dividers, the binder can contain, Legal, Medical, and Support Network contacts. Take the time to get organized by using the Families Impacted by Opioids "worksheets" for each issue and place them into this binder. This is empowering. Purchase: The Family Solution Finder 3-D's Coping Skills Workbook written by Roy P. Poillon. www.Amazon.com

Getting Networked:

The family needs to know; what they are dealing with based on the behavior they are observing in their loved one? As is like any other chronic disease, this starts with a diagnosis. One of the differences with this chronic disease, Substance use disorders is primarily diagnosed by the observed and recorded behavior.

It is highly likely there will be more than one diagnosis. Other types of second and third diagnosis may include Medial and Mental Health. So, you can see there will be more to getting a diagnosis than just a visit to the doctor(s). The family's world is about to get overly complicated.

The Assessment Identifies the Diagnosis

It is important to note that an assessment tool is used to derive a diagnosis. The diagnosis derives the plan of treatment, and the plan of treatment derives the type of provider or program. The severity of the diagnosis is what derives the level of a program that is needed.

So, when someone says to a family member, "Get a Diagnosis" the family members will understand that an assessment is what is needed to get to the diagnosis. The family member will also know there are different types of tools used by the clinical team to complete the assessment process. These tools are public information and as a healthcare consumer the family member can learn how they are used in the process of getting a diagnosis. The family members will also understand that a term used "Best Practices" or "Empirical Proven Models" these are plan of treatments used to treat specific types of diagnosis.

So a clinical team my say it this way, "we did an assessment using the "Assessment of Severity" tool, and determined the diagnosis is XXX. From the diagnosis we will use the XXX best practice model for their plan of treatment. Which program and the level of that program will likely be based on the stage of disease progression in this diagnosis and then follow up assessment will help us to understand their progress.

Here is another challenge, the assessment needs to be completed for all three: 1. Medical Assessment, Mental Health Assessment and Addiction Assessment. All three could have a diagnosis which mean all three could have their own plan of treatment.

Now the family members are following three plan of treatments, Medical, Mental Health and Addiction. Each has a role to play in recover, each needs to be managed.

Three Primary Assessments:

1. Addiction
2. Mental Health
3. Medical (Physical)

All three require an assessment, diagnosis, and staging. They will each require a plan of treatment and plan of care. Each will likely require a specialist.

Often, they are managed at the same time, however, it may be that one needs to be addressed before the other can be approached. This is often the case when dual diagnosis of both addiction and mental illness is assessed. Each requires its own assessment and diagnosis.

Unfortunately, when the person is discharged for treatment at a famility, these plans are not continued. Here is where the family can help, by becoming the persons advocate in staying with a plan of care and its coordination.

Do not allow this iudustry to act as if it doesn't matter, because it does. The persons disease did not just stop progressing because the payer is not providing reimbursement. Become a highway builder and continue this journey of care at least to the Five Year absences marker.

How can the issue impact the family?

The DSM-5 is the healthcare industry manual for addiction and mental disorders. It is used as a standard of care in assessment and diagnosis by all healthcare professionals. The DSM-5 recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including amphetamine-type substances, cocaine, and other stimulants); tobacco; and other or unknown substances. Therefore, while some major groupings of psychoactive substances are specifically identified, the use of other or unknown substances can also form the basis of a substance-related or addictive disorder. The DSM-5 is public information and the family members should look up the diagnosis once it is determined by an assessment.

Criteria for a Substance Use Disorder Classified into Stages of Progression:

Substance use disorders are classified as mild, moderate, or severe, depending on how many of the diagnostic criteria you meet. The 11 DSM-V criteria for a substance use disorder include:

1. **Hazardous use:** You've used the substance in ways that are dangerous to yourself and/or others, i.e., overdosed, driven while under the influence, or blacked out.
2. **Social or interpersonal problems related to use**: Your substance use has caused relationship problems or conflicts with others.
3. **Neglected major roles to use**: You've failed to meet your responsibilities at work, school, or home because of your substance use.
4. **Withdrawal:** When you have stopped using the substance, you have experienced withdrawal symptoms.
5. **Tolerance:** You've built up a tolerance to the substance so that you

must use more to get the same effect.

6. Used larger amounts/longer: You've started to use larger amounts or use the substance for longer amounts of time.
7. **Repeated attempts to control use or quit:** You've tried to cut back or quit entirely but have not been successful.
8. **Much time spent using:** You spend a lot of your time using the substance.
9. **Physical or psychological problems related to use: Your** substance use has led to physical health problems like liver damage or lung cancer, or psychological issues, such as depression or anxiety.
10. **Activities given up using:** You've skipped activities or stopped doing activities you once enjoyed using the substance.
11. **Craving:** You've experienced cravings for the substance.

BEING DIAGNOSED WITH A SUBSTANCE USE DISORDER

To be diagnosed with a substance use disorder, you must meet two or more of these criteria within a 12-month period. If you meet two or three of the criteria, you have a mild substance use disorder. Four to five is considered moderate, and if you meet six or more criteria, you have a severe substance use disorder.

The Problem Observed may not be The Actual Problem.

Each substance use disorder typically began from some type of primary source, and by just trying to solve the addiction, and not addressing what caused the addiction, means the problem is not yet solved. It may be other problems are contributing to this condition.

The National Bureau of Economic Research (NBER) reports that there is a "definite connection between mental illness and the use of addictive substances" and that mental health disorder persons are responsible for the consumption of:

- 38 percent of alcohol
- 44 percent of cocaine
- 40 percent of cigarettes

The NBER also reports that people who have been diagnosed with a mental health disorder at some point in their lives are responsible for the consumption of:

- 69 percent of alcohol
- 84 percent of cocaine
- 68 percent of cigarettes

There is clearly a connection between substance abuse and mental health disorders, and any number of combinations can develop, each with its own set of unique causes and symptoms, as well as its own appropriate intervention and Dual Diagnosis treatment methods. Which Dual Diagnosis treatment program is the best fit for your loved one?

Symptoms of One Disorder Triggers the Other

Often, certain drugs can create problems that trigger mental health symptoms. In other cases, substances can create mental health symptoms like paranoia, delusions, or depression while the person is under the influence of the drug. When these symptoms last after the drugs wear off, then it can indicate a co-occurring mental health disorder. Some examples include:

- Chronic drug and alcohol abuse increase the chances of becoming a victim of assault or rape. These traumatic events can create serious mental health issues like PTSD, depression, eating disorders and more.

- Poor decision-making is common under the influence, and persons may break the law or make other choices that cause them to struggle with anxiety in addition to drug addiction.
- Unprotected sex or sharing needles with people infected with HIV or hepatitis C can lead to the contraction of the disease, which in turn can mean a struggle with depression and grief over the life-changing consequences.
- Depression is a common effect of certain drugs like crystal meth and alcohol as they begin to wear off, and it is a symptom that can deepen into a disorder over time.

What are the options?

The Connection Between Mental Health Treatment and Substance Abuse Treatment.

When there is a ***Dual Diagnosis*** of both a mental health disorder and a substance abuse issue, it is important that the person enroll in a treatment program that addresses both problems at the same time. Why? The untreated symptoms of a mental health disorder can cause the person to be unable to remain clean and sober, and untreated substance abuse issues can make mental health treatment ineffective.

To receive a diagnosis of substance use disorder, a person must demonstrate two of the following criteria within a 12-month period:

- regularly consuming larger amounts of a substance than intended or for a longer amount of time than planned.
- often attempting to or expressing a wish to moderate the intake of a substance without reducing consumption.
- spending long periods trying to get hold of a substance, use it, or recover from use.
- craving the substance or expressing a strong desire to use it.
- failing to fulfill professional, educational, and family obligations.
- extensively using a substance despite any social, emotional, or

personal issues it may be causing or making worse.

- giving up pastimes, passions, or social activities because of substance use.
- consuming the substance in places or situations that could cause physical injury.
- continuing to consume a substance despite being aware of any physical or psychological harm it is likely to have caused.
- increased tolerance, meaning that a person must consume more of the substance to achieve intoxication.
- withdrawal symptoms, or a physical response to not consuming the substance that is different for varying substances but might include sweating, shaking and nausea.

An important note: Individual symptoms alone do not make a diagnosis, Schuckit emphasized. "It is the pattern over time." This is what creates a diagnosis.

To accurately diagnose substance-related disorders, practitioners must understand that in most of the alcohol- and drug-dependent persons, psychiatric symptoms are almost always temporary and that symptoms of substance withdrawal, which also cause persons to seek treatment, are exactly the opposite of the effect produced by the drug. Furthermore, to make the final differentiation between substance-induced morphology and long-term psychiatric disorders, practitioners must commit to evaluating persons for four to six weeks following a period of abstinence.

Three Steps for Family Engagement

1. **Get the Assessment:** The first step is to get an assessment, often called a "Screening".

2. **Get the Diagnosis:** The second step is to have a diagnosis; this is performed after the assessment. Once an assessment is made, a second opinion is recommended. This is especially important if the diagnosis is "Dual Diagnosis". Have a mental health person perform the mental health diagnosis on the second opinion, from a different organization than the one which did the initial dual diagnosis. This would preferably come from an outside provider, do not get it from one that is in the same Healthcare System. Remember, you are a healthcare consumer and second opinions from within the same health system is like asking a fox to guard the hen house.

3. **Get the Staging:** The third step is to have the diagnosis Staged as identified by the DMS-5 standards. These diseases progress in stages and the stages are known, according to each diagnosis. The stages are typical: Mild, Moderate and Sever. The three stages have distinct conditions that present in each stage and therefore progression from one stage to the next is quantifiable and indicators are known.

   If a healthcare provider is not providing regular Staging Assessment, then quickly find a different provider, because this one is not doing their job and you will end up paying the price for letting them underperform. Remember you are a healthcare consumer and the advocate for your loved one. Keep your eye on the ball if you want to hit a homerun. Always verify the right steps are being take in the right sequence and according to a best practice procedure timeline.

Get the Assessment.

The best place to learn more about assessment is this webpage: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

Here you will learn the benefits of getting an assessment. Stop reading and visit these two these webpages. The information is too involved and detailed to replicate in this study guide and is important to keep together when learning.

Please do not skip over this assignment.

https://www.integration.samhsa.gov/clinical-practice/screening-tools

Assessment Step 1: Engage the Client

Assessment Step 2: Identify and Contact Collaterals (Family, Friends, Other Providers) To Gather Additional Information

Assessment Step 3: Screen for and Detect Co-Occurring Disorders

Assessment Step 4: Determine Quadrant and Locus of Responsibility

Assessment Step 5: Determine Level of Care

Assessment Step 6: Determine Diagnosis

Assessment Step 7: Determine Disability and Functional Impairment

Assessment Step 8: Identify Strengths and Supports

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

Assessment Step 10: Identify Problem Domains

Assessment Step 11: Determine Stage of Change

Assessment Step 12: Plan Treatment

Assessment Process Summary

REF: https://www.ncbi.nlm.nih.gov/books/NBK64196/

Get the Diagnosis.

The DSM-5 separates substance use disorder into nine different categories:

- alcohol-related disorders
- caffeine-related disorders
- cannabis-related disorders
- hallucinogen-Related Disorders
- inhalant-related disorders
- opioid-related disorders
- sedative-, hypnotic-, or anxiolytic-related disorders
- stimulant-related disorders
- tobacco-related disorders
- other, or unknown, substance-related disorders
- non-substance-related disorders

DSM-V lists varying criteria for each of these categories, and many dependencies have different withdrawal symptoms that occur when an individual does not have access to the substance.

To receive a diagnosis of substance use disorder, a person must demonstrate two of the following criteria within a 12-month period:

- regularly consuming larger amounts of a substance than intended or for a longer amount of time than planned.
- often attempting to or expressing a wish to moderate the intake of a substance without reducing consumption.
- spending long periods trying to get hold of a substance, use it, or recover from use.
- craving the substance, or expressing a strong desire to use it
- failing to fulfill professional, educational, and family obligations.
- extensively using a substance despite any social, emotional, or personal issues it may be causing or making worse.
- giving up pastimes, passions, or social activities because of substance use
- consuming the substance in places or situations that could cause physical injury.
- continuing to consume a substance despite being aware of any physical or psychological harm it is likely to have caused.
- increased tolerance, meaning that a person must consume more of the substance to achieve intoxication.
- withdrawal symptoms, or a physical response to not consuming the substance that is different for varying substances but might include sweating, shaking and nausea.

The number of criteria a person demonstrates defines the severity of the dependence. If a person regularly fulfills two of three of these criteria, the DSM advises that they have mild substance use disorder.

A person with four or five of these criteria would have moderate substance use disorder. Six criteria would denote a severe addiction.

As new evidence emerges around addictive disorders, researchers attempt to determine whether they can develop reliable diagnostic criteria.

Get the Staging.

There are several staging's that will be identified, knowing what stage you are in helps to determine the best way to respond and what might be coming next.

The Staging's: (google any of these topics for more information)

- Five Stages of Treatment
- Five Stages of Recovery
- Staging for an Intervention

Stage models of development typically have the following assumptions:
First, the stages are relatively discrete. There are specific boundaries that can identify at what stage in the development of some function or condition an individual is. These boundaries may not always be clear, but in theory, they are discrete and apart from one another.
Stage models of development assume that people progress through the stages in a specified order, and the order is generally the same for everybody. Of course, there is always some individual variation that occurs in development; however, the order of the stages and the manner through which individuals progress through them is relatively stable.

The specific stages in the model can be identified by factors that signal that the individual is in that stage. Each stage has at least one specific attribute or skill that sets it apart from the stages that occur prior to it.

There are numerous different stage theories that attempt to explain the progression of an addiction. Even the most popular and most recent of these theories have several significant flaws. However, based on the above stage models, it can be surmised that the development of a substance use disorder (addiction) in most individuals occurs over the following general course:

- It begins with a period of occasional or recreational use.
- It progresses to increased use of the substance as a method to cope with some perceived deficiency, some form of stress, or to escape.
- Escalating use of a substance begins to interfere with the individual's health or normal functioning. This may lead to the development of issues controlling use of the drug, such that the individual continues to use the drug even though such use results in several different negative ramifications for them. Often, these individuals do not believe they are having issues with controlling their use of the drug and rationalize such use.
- Some individuals continue their drug use despite noticeably clear signs that it has resulted in significant impairment or dysfunction in important aspects of life. These signs include issues with the legal system, issues with their career or education, relationship issues, financial issues, and/or physical and mental health issues. Some of these individuals may continue to rationalize their drug use even though it is resulting in major problems.
- Some individuals eventually begin to realize that their drug use is problematic for them, though many do not.
- The development of tolerance and withdrawal may occur in the middle to later stages of this process, but its occurrence is neither necessary nor sufficient to indicate that the individual has developed any form of substance use disorder. However, the development of physical dependence nearly always exacerbates the issues associated with substance abuse and results in the cycle of addiction being more difficult to overcome.

One of the interesting observations regarding these theories is that the stage theories of recovery or change are far better developed than the stage theories that attempt to describe how an addiction develops in the first place.

Comorbidity

Although evidence indicates the need for comprehensive and integrated therapy to address comorbidity, research shows that only about 18 percent of SUD treatment programs and 9 percent of mental health treatment organizations have the capacity to serve dually diagnosed persons. Provision of such treatment can be problematic for several reasons:

In the United States, SUD treatment is often siloed from the general health care system. Primary care physicians are most often the front line of treatment for mental disorders. The specialty mental health treatment system typically addresses only severe mental illness, while drug treatment is typically provided by a separate SUD treatment system. Typically, none of these systems have sufficiently broad expertise to address the full range of problems presented by dually diagnosed persons.

A lingering bias remains in some SUD treatment centers against using any medications, including those necessary to treat serious mental illnesses including depression, although this is slowly changing. Additionally, many SUD treatments programs do not employ clinicians who can prescribe, dispense, and monitor medications.

Many individuals who would benefit from treatment are in the criminal justice system. It is estimated that about 45 percent of individuals in state and local prisons and jails have a mental health problem comorbid with substance use or addiction. However, adequate treatment services for both drug use disorders, and other mental illnesses are often not available within these settings. Treatment of comorbid disorders can reduce not only medical comorbidities, but also negative social outcomes by mitigating against a return to criminal behavior and re-incarceration.

While these barriers loom large, changes to the U.S. health care system can help improve care for people with comorbidities. The Mental Health Parity and Addiction Equity Act of 2008 (also known as the Parity Act) and the Person Protection and Affordable Care Act of 2010 (also known as the Affordable Care Act or ACA) have increased the number of people with insurance that covers addiction and mental health treatment.
The Parity Act mandates that health care plans that cover behavioral health treatments do so to the same extent as treatments for physical health conditions. The ACA requires that addiction and mental health treatment be covered as one of the ten Essential Benefit categories. With healthcare reform's other provisions to increase the quality of care, clinicians now have greater support and incentives to implement evidence-based practices and to collaborate in teams that provide integrated care for physical and mental disorders.

REF: https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-4-barriers-to-comprehensive-treatment-individuals-co-occurring-disorders

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Trust then Verify.

All treatment protocols are driven from the diagnosis, so you can see how important getting the right diagnosis will be. If the diagnosis is off, then so too will be their plan of treatment and plan of care.

What drives the plan of care and plan of treatment is Best Practice Protocols. This term will be thrown around a lot in the presentations of treatment centers and healthcare providers. The determination of how well a provider used the Best Practice Protocols is up for determination of the family members.

In other word, just because they say they use Best Practices does not necessarily mean they used Best Practices with your loved one. It will be up to your family members to verify that these practices are being applied to each stage of the care/treatment of your loved one.

Trust then Verify: It is reasonable to trust a facility or provider to do as they say they will do, but in all situations verify that it was done.

To do this Verification, meet with the provider. Ask them to outline on paper what steps they will take that are part of the Best Practice Protocol and Then ask them to give you a confirmation they completed these steps.

Outcomes are a vital aspect to a Best Practice Protocol, what happened because of using each step in the Best Practice Treatment procedure. Therefore, it is a Best Practice, because it can be measured and reported as to the results it produced.

Conclusion

In conclusion, first get organized, then get an assessment, diagnosis, and staging. We now know that mental health diagnosis may be needed and a medical (physical condition) may also require an assessment, diagnosis, and staging.

To assist in the complexity of services, starting a family binder where critical information can be placed is important.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

The good news is there are providers, services, and programs for every issue you will face in a journey with substance use disorders. Your challenge comes from finding them at the time they are needed. Or take the time now to identify your local community and what they offer.

You are a consumer of services, do your homework prior to needing the service. Your life will be less stressful, you will be able to better stay on budget and the journey can be experienced from a vantage point of growth, yours and theirs.

LEARING MODULE I

Seminar # 7

Substance Use Disorder is a Brain Disease

Learning Objectives

1. What is the issue.

2. How can the issue impact the family?

3. What are the options.

Substance Use Disorder is a Brain Disease

This is an incredibly involved topic of reviewing how the brain functions. To dive into this topic, the family member needs to be prepared to become educated in the following:

1. The different parts of the brain and how each function
2. The neuronal firing process and what stimulates our reward system.
3. Memory and how recall are part of the decision-making process.
4. The synapse and how each drug type function differently.

The list is extensive, your search will be exhausting if you are doing this at the same time you are getting a diagnosis. We recommend you get the diagnosis then research how the brain functions in that type of condition by stages of progression. This will make your learning more focused on what you need to know from all the other general information which may not apply.

Addiction is defined as a disease by most medical associations, including the American Medical Association and the American Society of Addiction Medicine.

Like diabetes, cancer and heart disease, addiction is caused by a combination of behavioral, environmental, and biological factors. Genetic risks factors account for about half of the likelihood that an individual will develop addiction.

Addiction involves changes in the functioning of the brain and body. These changes may be brought on by risky substance use or may pre-exist.

The consequences of untreated addiction often include other physical and mental health disorders that require medical attention. If left untreated over time, addiction becomes more severe, disabling and life threatening.

People feel pleasure when basic needs such as hunger, thirst and sex are satisfied. In most cases, these feelings of pleasure are caused by the release of certain chemicals in the brain. Most addictive substances cause the brain to release high levels of these same chemicals that are associated with pleasure or reward.

Over time, continued release of these chemicals causes changes in the brain systems involved in reward, motivation, and memory. When these changes occur, a person may need the substance to feel normal. The individual may also experience intense desires or cravings for the addictive substance and will continue to use it despite the harmful or dangerous consequences. The person will also prefer the drug to other healthy pleasures and may lose interest in normal life activities. In the most chronic form of the disease, addiction can cause a person to stop caring about their own or other's well-being or survival.

These changes in the brain can remain for a long time, even after the person stops using substances. It is believed that these changes may leave those with addiction vulnerable to physical and environmental cues that they associate with substance use, also known as triggers, which can increase their risk of relapse.

A chronic disease is a long-lasting condition that can be controlled but not cured.

About 25-50% of people with a substance use problem appear to have a severe, chronic disorder. For them, addiction is a progressive, relapsing disease that requires intensive treatments and continuing aftercare, monitoring and family or peer support to manage their recovery.

The good news is that even the most severe, chronic form of the disorder can be manageable and reversible, usually with long term treatment and continued monitoring and support for recovery.

References:
CASAColumbia. (2012) Addiction medicine: Closing the gap between science and practice.

Addiction is like other chronic diseases in the following ways:

- It is preventable.
- It is treatable.
- It changes biology.
- If untreated, it can last a lifetime.

The brain can experience pleasure from all sorts of things we like to do in life; eat a piece of cake, have a sexual encounter, play a video game.

The way the brain signals pleasure is through the release of a neurotransmitter (a chemical messenger) called dopamine into the nucleus accumbent, the brain's pleasure center.

This is generally a good thing; it ensures that people will seek out things needed for survival. But drugs of misuse, such as nicotine, alcohol, and heroin, also cause the release of dopamine in the nucleus accumbent, and in some cases these drugs cause much more dopamine release than natural, non-drug rewards.

Ref: The brain's nucleus accumbent activated by alcohol (Gilman et al., 2008)

Addictive drugs can provide a shortcut to the brain's reward system by flooding the nucleus accumbent with dopamine. Additionally, addictive drugs can release 2 to 10 times the amount of dopamine that natural rewards do, and they do it more quickly and reliably.

Over time, drugs become less rewarding, and craving for the drug takes over. The brain adapts to the effects of the drug (an effect known as tolerance), and because of these brain adaptations, dopamine has less impact. People who develop an addiction find that the drug no longer gives them as much pleasure as it used to, and that they must take greater amounts of the drug more frequently to feel high.

Altering the Brain's Reward System

Addiction affects your brain's reward, motivation, memory, and related circuitry to the extent that your motivations are altered so that your addictive behaviors replace healthy, self-care behaviors.

The brain's reward system is also altered in such a way that the memory of previous rewards—be it food, sex, or drugs—can trigger a biological and behavioral response to engage in the addictive behavior again, in spite of negative consequences, and sometimes even though you no longer even find pleasure in the activity.

Addiction also affects the frontal cortex of your brain in such a way as to alter your impulse control and judgment. This results in the "pathological pursuit of rewards," ASAM says when addicts return to their addictive behavior to "feel normal."

The frontal cortex is involved in inhibiting impulsivity and delaying gratification.

Because this area of the brain continues to develop into young adulthood, the ASAM experts believe this is why early-onset exposure to substances is linked to the later development of addiction.

ASAM says that behavioral manifestations and complications of addiction, due to impaired control, can include:

- Engaging in more addictive behavior than you intended
- Increased time lost from work or school.
- Continued substance use despite physical or psychological consequences
- Narrowing of your addictive behavior repertoire; for instance, you only drink one brand of a certain type of alcohol.
- Lack of readiness to get help, despite admitting a problem.
- Traditionally, people with addictions have sought and received treatment for a particular substance or behavior. This has sometimes

resulted in the person substituting one addiction for another—what ASAM calls the "pathological pursuit of rewards"—because the underlying cause was not treated.[3]

- ASAM suggests that comprehensive addiction treatment should focus on all active and potential substances and behaviors that could be addictive. ASAM was careful to point out that the fact that addiction is a primary, chronic brain disease does not absolve addicts from taking responsibility for their behaviors.
- Just as people with heart disease or diabetes must take personal responsibility for managing their illness, if you have an addiction, you also must take the steps necessary to minimize your chance of relapse, ASAM said.

Liking and Wanting

There is a distinction between liking and wanting the drug; over time, the **liking decreases** and the **wanting increases**. Individuals with a substance use disorder continue to seek and use the substance, despite the negative consequences and tremendous problems caused for themselves and for their loved ones, because the substance allows them to simply feel normal.

How the brain recovers from addiction is an exciting and emerging area of research. There is evidence that the brain does recover; the image below shows the healthy brain on the left, and the brain of a person who misused methamphetamine in the center and the right. In the center, after one month of abstinence, the brain looks quite different than the healthy brain; however, after 14 months of abstinence, the dopamine transporter levels (DAT) in the reward region of the brain (an indicator of dopamine system function) return to nearly normal function (Volkow et al., 2001).

There is limited research on the brain's recovery from alcohol and marijuana use. However, recent studies have shown that some recovery does take place. For example, one study found that adolescents that became abstinent from alcohol had significant recovery with respect to behavioral disinhibition and negative emotionality (Hicks et al., 2012). Lisdahl and colleagues propose that this could mean that some recovery is occurring in the prefrontal cortex after a period of abstinence. Furthermore, other research has found that number of days abstinent from alcohol was associated with improved executive functioning, larger cerebellar volumes, and improved short-term memory.

Most of your learning in this issue will come from watching the recommended video's in the Family Solution Finder Learning Seminar Workbook. Take the time to view each video and share with others. In the power point presentations are good sources of embedded videos. This will start your learning about substance use disorders being a disease of the brain.

Conclusion

In conclusion, no single source will be able to educate a person as to why substance use disorders are considered a brain disease. In the follow up workbooks and power point presentation a deeper understanding will be attempted but this is only a starting point for the family member to understand this is not just a matter of willing oneself out from this behavior. There is a lot more going on, it will take time, professional care, and a lot of love. The latter being the strongest therapy.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 8

The disease progresses in stages.

Learning Objective

1. What is the issue.
2. How can the issue impact the family?
3. What are the options.

What is the issue

For many persons one course of treatment plan will not match their changing condition and therefore, a change to the plan of care is required. Just as in relapse not being a result of failure, so too is changing therapy and treatment types.

The adjustments are made to ensure the course of care matches the person's real condition and is keeping up to date with the changes in addiction or recovery.

Increased communication, learning what the family members can do during the change and what to expect are all good steps for the family to consider.

The re-assessment and understanding the stages of progression to the disease is critical in effective management of possible variance and the intervention of services that follow.

How can the issue impact the family?

The disease progresses in 7 stages.

There are numerous different stage theories that attempt to explain the progression of an addiction. Even the most popular and most recent of these theories have several significant flaws. However, based on the above stage models, it can be surmised that the development of a substance use disorder (addiction) in most individuals occurs over the following general course:

It begins with a period of occasional or recreational use.

It progresses to increased use of the substance as a method to cope with some perceived deficiency, some form of stress, or to escape.

Escalating use of a substance begins to interfere with the individual's health or normal functioning. This may lead to the development of issues controlling

use of the drug, such that the individual continues to use the drug even though such use results in several different negative ramifications for them. Often, these individuals do not believe they are having issues with controlling their use of the drug and rationalize such use.

Some individuals continue their drug use despite noticeably clear signs that it has resulted in significant impairment or dysfunction in important aspects of life. These signs include issues with the legal system, issues with their career or education, relationship issues, financial issues, and/or physical and mental health issues. Some of these individuals may continue to rationalize their drug use even though it is resulting in major problems.

Some individuals eventually begin to realize that their drug use is problematic for them, though many do not.

The development of tolerance and withdrawal may occur in the middle to later stages of this process, but its occurrence is neither necessary nor sufficient to indicate that the individual has developed any form of substance use disorder. However, the development of physical dependence nearly always exacerbates the issues associated with substance abuse and results in the cycle of addiction being more difficult to overcome.

One of the interesting observations regarding these theories is that the stage theories of recovery or change are far better developed than the stage theories that attempt to describe how an addiction develops in the first place. Perhaps one reason for this is that the development of addictive behaviors across individuals has quite a bit of individual variation.

The question to consider is this: how do people go from abstaining from drugs and alcohol to developing an SUD? The truth is that there are many stages of addiction, each with their own signs and symptoms to monitor in yourself and others.

Stage 1: Initiation
Most people try drugs or alcohol for the first time before reaching adulthood. According to a survey by the Substance Abuse and Mental Health Services Administration, about 2.8 million people (age 12+) used an illegal drug or abused a legal drug for the first time in 2013. The same survey showed that 3.841 million people drank alcohol for the first time between the ages of 12 and 20.

The initiation stage generally happens during the teen years. Every day in 2013, approximately 4,220 people under the age of 18 used drugs or alcohol for the first time.

Adolescents or teenagers try drugs or alcohol:

- Out of curiosity.
- Because their friends are doing it and they feel pressured into using as well.
- The lack of development in the prefrontal cortex, which manages decision-making and controlling impulses.
- Once someone has tried alcohol or drugs, they may move along to experimentation or they may stop once their curiosity has been satisfied. This depends on a few factors, including:
- Availability of drugs and alcohol within the community.
- Whether or not friends use drugs or alcohol.
- Family environment, including physical or emotional abuse, mental illness, or alcohol or drug use in the house.
- Mental health conditions like depression, anxiety, or ADHD.

Stage 2: Experimentation
The experimentation stage begins when you start to use drugs or alcohol in specific situations, like teens in party atmospheres or adults in times of stress.

Substance use in this stage is a social matter that you associate using with fun, 'unwinding,' and a lack of consequences. You only think of substances every so often, and there are no cravings. At this stage, substance use can be controlled (i.e., you decide consciously to use with the risks in mind, and you can stop if you want to) or impulsive (i.e., you use unpredictably, and unexpected accidents or harm can come from substance use, but you do not use regularly, and you are not dependent).

Even if you consume a lot in an instance, the decision to use is made in the rational brain (i.e., you choose to use drugs or alcohol instead of being unconsciously ruled by an automatic response).

You could even binge drink (i.e., a man having five or more drinks or a woman having four or more drinks within two hours) without straying outside of the experimentation stage, as most binge drinkers do so about four times per month, usually on weekends in social atmospheres.

According to the National Institute on Alcohol Abuse and Alcoholism, you are at low risk for developing an alcohol use disorder if you:

- Are a woman, have no more than three drinks per day, and no more than seven per week.

- Are a man, have no more than four drinks per day, and no more than fourteen per week.

Stage 3: Regular Use
At this point, substance use is more frequent for you. You may not use every day, but there may be a predictable pattern (using every weekend), or you may use under the same set of circumstances (when you are stressed, bored, lonely, etc.).

At this stage, you still probably use drugs or alcohol with other people, but you may begin to use alone, too. You may miss school and work due to substance hangovers. There may be worries about losing your drug source since substance use has become tied to the idea of escaping negative emotions or situations.

Stage 4: Problem/Risky Use
As the name suggests, substance use at this point has begun to take a negative toll on your life. If you drive, you may do so under the influence. You may have gotten a DWI/DUI or had other negative legal consequences. Your performance at work or school may be suffering, and your relationships with others are, too. You may have changed your circle of friends, and your behavior has almost certainly changed.

In short, risky, or problem use threatens your safety and the safety of others but does not meet the criteria for a substance use disorder.

Stage 5: Dependence
There are three steps to dependence:

Tolerance, when you require more alcohol or more of your drug of choice to achieve the same 'high.'

Physical dependence, when going without drugs or alcohol elicits a withdrawal response. It is important to note, though, that physical tolerance can happen even when prescription drugs are taken as your doctor has instructed. But when drugs or alcohol are abused, or illegal drugs are used at a high level, physical tolerance becomes a problem.

Psychological dependence, when you experience drug cravings, a high rate of substance use (using more frequently, using more of your substance of choice, or both), and using again after attempting to quit. This can also be known as 'chemical dependency.'

These stages are cumulative. For example, you can have a tolerance for a substance without being physically dependent and be physically dependent without being psychologically dependent, but you cannot be psychologically dependent without being physically dependent and having developed a tolerance.

Stage 6: A Substance Use Disorder
You know you are living with a substance use disorder when you can meet the following criteria:

- You ‘cannot face life’ with drugs or alcohol.
- You cannot control your use.
- You continue to use despite the harm that comes to your health and life.
- You lie about your use, especially about how much you are using.
- You avoid friends and family.
- You have given up activities you used to enjoy.
- You cannot recognize the problems with your behavior or with your relationships with others.

However, a substance abuse disorder is more than its symptoms. It is a chronic disease, meaning that it is slow to develop and of a long duration.

Substance use disorders are often-relapsing diseases, meaning that recovery will often entail setbacks. However, the relapse rates for SUDs are like those of other chronic conditions, including diabetes, hypertension, and asthma.

SUDs affect the memory, motivation, learning, movement, emotion, judgment, and reward-related circuitry in the brain. This happens because chronic substance use floods the brain with dopamine, first teaching you to use more of the substance that produced such a pleasurable effect, then keeping your brain from producing enough dopamine on its own. You then must continue to use to feel happy or even normal.

Stage 7: Treatment
There are ways to treat SUDs, though, so you can regain control over your life, health, and wellbeing.

After an initial detox period, behavioral therapy combined with medication is often the best course of treatment. The longer you remain in rehab, the less likely you are to relapse, so take that into consideration when choosing a course of treatment.

There is also counseling available for you, your family, and friends to help with recovery, as well as support groups like AA, NA, Al-Anon, and Nar-Anon.

Knowing the stages of addiction is important: not to belittle you, but to help you understand your path to recovery. Enjoy the journey back to health.

Managing the Behavior in Each Stage of Recovery

There are three stages in recovery. Substance Abuse Treatment Group Therapy TIP # 41 SAMHSA

1. Early Stage
2. Middle Stage
3. Late Stage

As the person misusing substances moves through different stages of recovery, treatment must move with them, changing therapeutic strategies and leadership roles with the condition of this person. These changes are vital since interventions that work well early in treatment may be ineffective, and even harmful, if applied in the same way later in treatment (Flores 2001).

Any discussion of intervention adjustments to make treatment appropriate at each stage, however, necessarily must be oversimplified for three reasons.

First, the stages of recovery and stages of treatment will not correspond perfectly for all people. They move in and out of recovery

stages in a nonlinear process. They may fall back, but not necessarily back to the beginning.

After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation.

They may even become precontemplators again, temporarily unwilling or unable to try to change . . . [but] a recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change" (Center for Substance Abuse Treatment 1999*b* , p. 19). See chapters 2 and 3 for a discussion of the stages of change.

What are the options?

Change Therapy of Treatment Approach

Addiction requires individualized treatments that address the symptoms and underlying causes of the disease, as well as the consequences that substance use has on different areas of a person's life. This includes their ability to socialize, their physical and mental health, and consequences at work, home, school, or with the law. There are many types of therapy available to effectively treat addiction.

Substance Use Disorders commonly consists of a combination of group and individual therapy sessions that focus on teaching those in recovery the skills needed to get and stay sober as well as how to navigate various situations without turning to drugs or alcohol. Behavioral therapy is perhaps the most utilized treatment component used during substance rehabilitation. A general behavioral therapeutic approach has been adapted into a variety of effective techniques.

These include:

- **Cognitive Behavior Therapy** (CBT) can be applied in the treatment of many different types of problematic substance use. People treated with CBT techniques learn to recognize and change their maladaptive behaviors. CBT can help people with coping skills, with identifying risky situations and what to do about them, and with preventing relapse. This approach is helpful because it can be paired with other techniques. The skills learned through CBT continue to be of benefit long after the initial therapy, and it can be used to treat co-occurring mental or physical health disorders as well.

- **Contingency Management (CM).** CM may also be effective in treating several types of substance use disorder—for example, alcohol, opioids, marijuana, and stimulants—and is used to encourage or reinforce sobriety. This method provides material rewards as motivation for desirable behaviors, such as maintaining sobriety. A major benefit of CM is that it can result in a reduction in the two of the biggest treatment-related issues: dropping out and relapse.

- **Motivational Interviewing (MI).** MI is a method of resolving ambivalence in recovering individuals to allow them to embrace their treatment efforts to best change their problematic substance use behavior. One benefit of MI is that, despite being facilitated by a therapist, those in recovery develop their own motivation and a plan for change over the course of several sessions, which can provide them with more of a sense of control over the course of their treatment.

- **Dialectal Behavioral Therapy (DBT).** DBT can be adapted for many substance abusers' cases, but mainly focuses on treating severe personality disorders, such as borderline personality disorder.[2] DBT works to reduce cravings, help persons avoid situations or opportunities to relapse, assist in giving up actions that reinforce substance use, and learn healthy coping skills.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

Medical Assisted Treatment has proven to be an amazingly effective inclusion to the treatment plan of care. This is covered in a Seminar # 30.

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See the Family Solution Finder Workbook for Stages of Treatment Learning Section.

LEARNING MODULE I

Seminar # 9

Relapse is part of the journey.

Learning Objectives

1. What is the Issue.
2. How can the issue impact the family?
3. What are the options.

What is the issue

The difficult part to accept is the awareness of the disease as a part of the loved one's life. But what then becomes known this disease is going to be a part of that person's entire lifetime a change in the family's approach needs to take this into mind. It will never leave; however, it can be controlled, it is chronic and can be managed and life can be great. The disease does not have to define the family, but the relapse is a cold shock every time it happens as to be reminding everyone, this is a chronic disease.

A chronic disease does not have to define who we are, what we think and how we live our lives. It is ours and has a name, but it is not our name, it is the diseases name and what it is belongs to the disease, it does not belong to us. An important approach is to separate the disease from the person.

Therefore, let our heats not be worried that this disease is in charge, because it is not in charge and sustainable lifelong recovery is very possible.

The Video: "Addiction is a Chronic Relapsing Brain Disease

We do not normally ask the reader to leave the study guide and spend time viewing a video. It seems disruptive to the learning process. However, this topic can only be truly grasped by seeing a clinical expert present the topic as an introduction to our material. For this reason, we are asking in our introduction, for you to take time, go online and view this video and then return to complete the remainder of this study guide Seminar # 9

GO ONLINE: www.youtube.com
https://www.youtube.com/watch?v=o7O1irTAmvc

How can the issue impact the family?

Relapse is a part of this bran disease journey.

Relapse is common. Studies suggest that approximately half of all individuals who try to get sober return to heavy use, with 70 to 90 percent experiencing at least one mild to moderate slip. In other words, not many people say, "I want to get sober," walk into a treatment center, and never use again.

In this way, addiction is very much akin to other chronic diseases. As with chemical addiction, persons with chronic illnesses such as diabetes, asthma, and hypertension frequently fail to comply with their ongoing treatments—relapsing, if you will, often many times with dire consequences. They too have relapses.

Thus, no matter the chronic disease, it is ultimately up to the individual to adjust his or her lifestyle and assume responsibility for managing his or her own care. Unfortunately, removing the drug (detoxing) is the easy part.

Changing the behaviors that compel the addict to use is significantly more difficult.

The Stages:

Stage one: Numerous studies show that rats will quickly learn to press a lever that delivers a drug in preference to levers that deliver food or water. The more "rewarding" a drug is, the more furiously the rats will press the bar. We should not be surprised, then, that when presented with a drug like cocaine, rats display behaviors alike that seen in addiction, foregoing normal activities such as eating and sleeping in favor of getting high.

Stage two: In addition to going crazy for the drug, rats "remember" and "like" the places where they received it. For instance, when cocaine-addicted rats are placed in an environment where they receive only food and water, they accept that no drug is available, and they push only the food and water levers. However, when placed back in the cage where cocaine had been available, they immediately engage in a drug-bar-pressing frenzy. They recognize the location and associate it with past drug use. They are triggered by the environment and they become incredibly agitated—they crave—in expectation of the drug reward.

The chronic nature of addiction means that for some people *relapse,* or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are like rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse.

Here is the problem in substance use disorders, after discharge from a treatment center there is often no further treatment or plan of care with strong follow up. They are left to fin for themselves. This is not what we do in other chronic disease, so why then are we doing it with substance use disorder. It is simple, there is no healthcare delivery system set up for this level of care, and there is little financial profit in providing such services.

Treatment of chronic diseases involves changing deeply rooted behaviors, and relapse does not mean treatment has failed. When a person is recovering from an addiction relapses, it indicates that the person needs to speak with their doctor to resume treatment, modify it, or try another treatment.

Relapse rates for people treated for substance use disorders are compared with those for people treated for high blood pressure and asthma. Relapse is common and similar across these illnesses, too. Therefore, substance use disorders should be treated like any other chronic illness. Relapse serves as a sign for resumed, modified, or new treatment.

While relapse is a normal part of recovery, for some drugs, it can be extremely dangerous—even deadly. If a person uses as much of the drug as they did before they quit, they can easily overdose because their bodies are no longer adapted to their previous level of drug exposure. An overdose happens when the person uses enough of a drug to produce uncomfortable feelings, life-threatening symptoms, or death.

Science has taught us that stress cues linked to the drug use (such as people, places, things, and moods), and contact with drugs are the most common ***triggers for relapse***. Scientists have been developing therapies to interfere with these triggers to help persons stay in recovery.

In Behavioral Therapies, help people in drug addiction treatment modify their attitudes and behaviors related to drug use. As a result, persons can handle stressful situations and various triggers that might cause another relapse. Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment longer.

In Cognitive-Behavioral Therapy , helps persons recognize, avoid, and cope with the situations in which they are most likely to use drugs.

In Contingency Management, positive reinforcement such as providing rewards or privileges for remaining drugfree, for attending and participating in counseling sessions, or for taking treatment medications as prescribed.
Motivational enhancement therapy uses strategies to make the most of people's readiness to change their behavior and enter treatment.

In Family Therapy, people (especially young people) with drug use problems, as well as their families, address influences on drug use patterns and improve overall family functioning.

What are the options?

The Journey with Substance Use Disorders
The process of seeing 'the truth' starts to happen as soon as the addict takes their first step towards treatment.

Without education, treatment and ongoing focus, addiction will never move from its destructive phase into something that can be managed.

To manage it, the individual must embark upon a complete overhaul in terms of body, mind, and spirit.

We focus on the following factors when helping people to manage their addiction:

- Nutrition – we discuss the benefits of certain food and drinks, and what should be avoided.
- Sleep hygiene – many people who come into treatment need to re-learn how to care for themselves in this area.

- Yoga, meditation, and acupuncture, as well as emotional freedom technique are therapies that we recommend and are all designed to promote calmness.

- Abstinence is the key to recovery, and therapy teaches our persons how to achieve this and stay focused.

- A treatment center that does not consider the impact of addiction on an individual's whole family would not be doing its job properly. The center needs to include the persons' family members throughout treatment in the following ways:

- Encourage interaction with family members and loved ones from exceedingly early in the treatment to recovery journey.
- Encourage loved ones to write letters describing what it was like for them living alongside the illness. These letters are used very sensitively, as another denial-busting exercise.
- Provide a family support hotline and encourage loved ones to access it when needed.
- Offer family members further information and education about addiction.
- Deliver family support groups which are run specifically for loved ones.

PART III

The Pathfinder Community Seminars

LEARNING MODULE I

STUDY GUIDEBOOK

Seminar # 10

Enabling vs. Consequences

Learning Objectives

1. What is the issue.

2. How can it impact the family?

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces

#11 **Bereavement (Learning how to move forward)**

#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

What is the issue?

The desire to help others, especially those who mean the most to us, is one of the noblest of human instincts. Parents want to help their children succeed in school. Spouses want to help each other he problems that life throws at them. Friends want to help each other at work or in their personal relationships. Unfortunately, this well-meaning impulse can backfire tragically when addiction is part of the equation.

In one sense, "enabling" has the same meaning as "empowering." It means lending a hand to help people to accomplish things they could not do by themselves. More recently, however, it has developed the specialized meaning of offering help that perpetuates rather than solves a problem.

A parent who allows a child to stay home from school because he has not studied for a test is enabling irresponsibility. The spouse who makes excuses for his hung-over partner is enabling alcohol abuse. The friend who lends money to a drug addict "so he won't be forced to steal" is enabling that addiction.

Allowing someone to suffer logical consequences is another way of getting them to realize their need for grace. Ideally, we can do that by confronting them, have a difficult conversation and hope they have a willingness to face reality. But sometimes people cannot (or do not) hear the truth of confrontation, and they remain stuck. At those times we often must allow reality to touch their lives.

Either we feel sorry for them and bail them out, or we fear them and try to appease them. No matter what the person's plight, we must help him/her face the truth. And sometimes that means letting them deal with harsh realities.

It is the old idea of letting people "hit bottom." It may mean letting them lose a job, or lose a relationship, or lose a membership in a group or a fellowship.

Reality consequences are used in our lives to get us to see our need for grace and to help us learn what is available for us to help ourselves. Those of us in positions of helping others grow must have the courage to allow people to experience those consequences or else we may be keeping them from grace.

By Loving the family and the one with a substance use disorder, we need to face when we are serving our own needs for emotional support and not truly the needs of one who needs our help.

Enabling behavior:

- Protects the addict from the natural consequences of their behavior.
- Keeps secrets about the addict's behavior from others to keep peace.
- Makes excuses for the addict's behavior (with teachers, friends, legal authorities, employers, and other family members)
- Bails the addict out of trouble (pays debts, fixes ticket, hires lawyers, and provides jobs)
- Blames others for the addicted person's behaviors (friends, teachers, employers, family, and self)
- Sees "the problem" as the result of something else (shyness, adolescence, loneliness, broken home, ADHD, or another illness)
- Avoids the addict to keep peace (out of sight, out of mind)
- Gives money that is undeserved or unearned.
- Attempts to control that which is not within the enabler's ability to control (plans activities, chooses friends, and gets jobs)
- Makes threats that have no follow-through or consistency.
- "Care takes" the addicted person by doing what she is expected to do for herself.

How can the issue impact the family?

There are 10 types of enabling behaviors and knowing them is important if you want to see them stop or change. Each type has a unique description. Our responsibility is to identify which one is being used and seek assistance from a professional in how to best address this type of enabling.

1. Is it Denial

Denial is one of the primary behaviors that families adopt when they learn that their loved one is addicted to drugs. They refuse to accept the reality that their family member has a substance use problem. They convince themselves that treatment is not necessary, and the addict will know how to control their drug or alcohol use.

2. Is it Justification

Justification and denial work hand in hand. Families often reject the problem, making up reasons to justify their loved one's addiction. For example, a family member may feel that it is fine for a loved one to use alcohol or drugs to cope after a stressful day at work. Parents may also believe the substance use is only temporary and will stop after a change in lifestyle such as college graduation.

3. Is it Allowing Substance Use

Family members may think that they are controlling the situation if they allow their loved one to use drugs at home. They may even consume drugs or alcohol with the addict to manage their intake level and to make sure they gravitate toward home when using instead of more dangerous locations.

4. It is Suppressing Feelings

Not expressing your concerns about addiction to a person you love gives them a reason to keep using. In some cases, substance users dismiss their families' fears by reassuring them that they will not consume drugs or alcohol. When an addict dismisses these fears and concerns, it may encourage family members to keep their feelings to themselves.

5. Is it Avoiding the Problem

By ignoring the problem and not confronting the substance user, family members may feel that they are keeping the peace in their home. Instead of getting their loved one proper treatment, the family focuses on keeping up appearances to look normal.

6. Is it Protecting the Family's Image

The stigma of substance use is ever present. People may be ashamed of their substance-using family member, leading them to portray the person in a falsely positive light to friends, co-workers, and acquaintances.

7. Is it Minimizing the Situation

People surrounding the addict may lighten the issue by convincing themselves that the substance user could be in worse situations. They treat the addiction as a phase that will improve on its own with time and patience.

8. Is it Playing the Blame Game

Adopting negative attitudes toward substance users only pushes those struggling with addiction away. Blaming or punishing individuals for their substance use alienates them from their family, which may result in destructive.

9. Isa it Assuming Responsibilities

Family members may be inclined to take over the regular tasks and responsibilities of the addict to prevent their life from falling apart. Instead,

assuming responsibilities and providing money to the substance user removes accountability and allows them to fully indulge in their addiction.

10. Is it Controlling Behaviors

Exerting control on a substance user may worsen their addiction. Constantly treating the addict as an inferior or placing numerous restrictions on their lifestyle may drive them further from the family unit.

What are the options?

Enabling vs. Consequences is the factor to consider when looking at options. It is a matter of what the enabling is creating as an outcome, which draws our attention to this as an issue.

We should first consider the following:

1. Define the Issue, this can be completed in "The Family Solution Finder 3-D's Coping Skills Workbook Learning Module III. The **D**etermine a Solution is a model to find a solution to the issue.
2. **D**evelop a decision, this can be completed in "The Family Solution Finder 3-D's Coping Skills Workbook Learning Module III.
3. **D**esign a family plan of action, this can be completed in "The Family 3-D's Coping Skill Set Workbook Learning Module III"

By taking these steps you have identified the consequences of allowing the enabling to continue. There is little purpose to take time and talk about consequences that are not yours. What is the point? A consequence is only real when it impacts you, the person. So, the best way to talk about and learn about consequences is to make them real to your life and talk about how it came to become a consequence. Therefore, we asked you complete the Practical Family Real Life Exercise in The Family Solution Finder Seminar Workbook Learning Module II. Take the time to do this for yourself and bring light to the consequences of your enabling type. Which of the ten types is part of your family dynamic?

Then consider what you can do:

1.Gain support from peers
Peer support groups like Al-Anon can put family members in touch with others who know a great deal about addiction, and the information shared in these meetings can be transformative. In fact, according to a 2012 Al-Anon membership survey, 88 percent of people who came to meetings for the first time reported understanding the seriousness of the addiction only after they had attended several meetings. In other words, people who go to these meetings may not know very much about the challenges their families are facing, but if they keep going to meetings, they will learn.

Some families go to meetings just to listen. They come to understand that other families are also dealing with this problem, and they learn how these families are focusing on success. Others go to these meetings to network. They seek out peers who have overcome nasty addiction challenges, and they ask for advice on steps that really work. Either method could be helpful. The key is to get started.

2. Talk openly about the shift
After attending Al-Anon meetings, families may have a deep understanding of the habits and behaviors they would like to shift. The best way to make those adjustments is to discuss the plan with the addicted person in an open and honest manner. The Partnership for Drug-Free Kids provides these conversation tips:

- Choose a time to talk when the person will be sober.
- Emphasize the fact that the changes come from love, not a desire for revenge or punishment.

- Use open-ended questions about addiction to help the person come to understand that substance abuse might be the root of the issues the family is facing.
- Set limits clearly and be prepared to stick to them.
- Stay positive and resist the urge to fight or give in to attacks.
- This conversation can be brief, but the family should be sure to point out the specific behaviors that they are planning to change, along with the reasons they are changing those behaviors.

3. Work in teams

After that opening conversation, families should work to limit the one-on-one time they spend with the addicted person. That is a tip from an ARISE Intervention, and according to the Association of Intervention Specialists, it is aimed to help reduce pressure and manipulation. If the family does not have one-on-one talks, it is harder to perform back-door attacks and sneaky innuendo.

One person might be willing to fall under the sway of an addicted person's charm, but the other might be the voice of reason that helps the whole family to stick with their new plan.

4. Do not make excuses or cover up the behavior.

Sponsor-relationship Some of the most egregious things that happen during an addiction take place when the person is actively intoxicated, and often, drugs of abuse cause persistent memory loss. Alcohol, according to the National Institute on Alcohol Abuse and Alcoholism, can cause discernable memory changes after just one or two drinks. The more people drink, the more they forget. Some drugs work in the same way.

The family's goal is to make sure that the addicted person sees the consequences of the addiction, so that means the family cannot be the cleanup crew. If someone stumbles home and falls asleep in the yard, that person stays in the yard. If the person becomes loud at a party, the family does not smooth over the social interaction. The person is forced to deal with all those consequences alone.

Families should also resist the urge to keep a person's workplace reputation pristine. The National Institute on Drug Abuse reports that people with addictions are much more likely to miss work, when compared to people who do not have addictions. Families may try to smooth this by calling in "sick" for an addicted person, or they might push an addicted person to stop working altogether, so there is a smaller chance of embarrassment. All those actions should stop, too.

5. Let law enforcement officers do their job.

Much of the behavior associated with an addiction is illegal. People with addictions might:

- Steal money.
- Steal drugs.
- Purchase illegal drugs.
- Drive while intoxicated.

Sometimes, people do things that are even worse. For example, in Ohio, a man who worked for an ambulance company stole blank doctors' prescription pads, presumably so he could write prescriptions for drugs, and he allegedly obtained about $20,000 of drugs in this manner, per news reports.

These can be awful crimes, and families might have the money, the legal skills, or both to help their loved ones to escape the consequences of these addictions. But in the end, that is not smart.

6. Work with a counselor

Life with a substance abuser is stressful, and according to the Partnership for Drug-Free Kids, it is not unusual for families to develop persistent and uncomfortable health problems, including:

• Backaches
• Digestive problems
• Headaches
• Panic attacks or anxiety
• Depression

Along with all those signs of upset and stress, family members might still believe that they can somehow shift the behavior and make the person's addiction fade away. They might remember the way things used to be before the addiction took hold, and they might be convinced that those good times are right around the corner, just as soon as they say or do the right thing.

These are tough thought patterns to shift, and a counselor might help. Individual counseling sessions can help people to work through their personal thoughts and feelings about the addiction, and counselors may provide coaching that can assist people when the going gets tough.

7. Continue to emphasize treatment for addiction

As families set limits and make the consequences of addiction more palpable for the substance abuser, they could cause the person to really think about healing and how sobriety might help. However, that person is not likely to get better without the help of a treatment team. Again, addictions are brain diseases that cannot simply be pushed to the side with one conversation. They are caused by changes in brain chemicals and brain circuitry, and they need in-depth treatment to amend.

Therefore, families should continue to bring up the promise of treatment as they shift from traditional enabling behaviors. They should remind the addicted person that treatment works, and that treatment could make the whole family feel better. They should keep brochures about treatment facilities on hand, so the addicted person can peruse them on his/her own time.

Families should remember that some addicted people will not accept the possibility of treatment right away. It is a bold idea, and sometimes, people need to think about it and ponder it before they agree to act. Families that respect that process of change, and who refuse to give up hope, may see the sobriety come with time.

Things to consider.

The family member who is using a style of enabling is doing so based on their own interpretation of something within themselves. It this is not address in a profession session, it is likely to come back in some other ways. Therefore, it may be helpful to see if there is an underlying reason for enabling, to properly make a change that will be more significant than to just stop using a particular type of enabling, thinking then things will be better.

Again, this is best addressed in a session between that person and a professional counselor who understanding these issues and how to best approach them for a lasting success.

LEARNING MODULE I

Study Guidebook

Seminar # 11

The Addiction Behavior, Boundaries

Learning Objectives

1. What is the issue
2. How can the issue impact the family
3. What are the options

What is the issue?

Scientific advances over the past 20 years have shown that drug addiction is a chronic, relapsing disease that results from the prolonged effects of drugs on the brain. As with many other brain diseases, addiction has embedded behavioral and social-context aspects that are important parts of the disorder itself.

Therefore, the most effective treatment approaches will include medical, behavioral, and social components. Recognizing addiction as a chronic, relapsing brain disorder characterized by compulsive drug seeking and use can impact the family's overall health and family dynamics and help diminish the health of the family as a cost of being associated with drug abuse and addiction.

The family members need to understand this chronic disease is what causes the behavior their loved one is presenting. It is not them; it is the disease. This is a difficult concept to accept when dealing with this behavior because it is the person that presents this behavior therefore, naturally it is them creating it.

Not the case in addiction, in many cases they do not want to present this behavior. But their brain is being over-ridden in its neurotological firing, and the override is somewhere between the logical and pleasure neurons.

If left by itself the brain would allow logic to dictate and not be kidnapped by pleasure neurons. But the excess drug impact has rewired the brain into allowing pleasure to be the dominating drive in behavioral response. It is something they cannot control.

Drug use tends to significantly alter a person's behavior and habits. Some drugs can impair the brain's ability to focus and think clearly.5

Changes in behavior, such as the following, are sometimes associated with problematic substance use:

- Increased aggression or irritability.
- Changes in attitude/personality.
- Lethargy.
- Depression.
- Sudden changes in a social network.
- Dramatic changes in habits and/or priorities.
- Involvement in criminal activity.

Drug addicts often think only about their next fix of the drug. They have tunnel vision because of how their brain reacts the drug, and they crave it. Their thoughts and actions are often solely dedicated to obtaining more of the drug, and they will do anything necessary.

That is why drug addicts often lie, cheat and steal. They may engage in illegal behaviors aside from the illicit drug use to get more, and they are not able to recognize the pain and harm they are causing themselves and the people around them because of their addiction.

Someone who is addicted to meth or other drugs not only lie and mislead people, but they manipulate them. Someone who was once loving and caring may start to manipulate the people closest to them to facilitate their continued drug use. They feed on the concern and love of their family members.

Someone who is addicted may even beg and try to plead with loved ones and make promises they have no intention of keeping, and it can take a long time before their loved ones accept that this is in fact manipulation.

How can the issue impact the family?

Six Known Behaviors can impact the family.

1. They lie.
They must tell lies to mislead people about where they were when they were out buying or using drugs or alcohol. They must lie about where the hundreds or thousands of dollars went. The more they feel they need drugs, the more likely they are to feel the need to lie.

When you have trusted a person for years and then she begins lying to you, it is extremely hard to set that trust aside. Family and good friends can be fooled by a skillful liar for years. But all this time, the person is slowly destroying herself.

If a person's behavior changes markedly and the explanations do not really add up, you must hold onto your own common sense. If what you are being told does not make sense, then there is probably a particularly good reason—you are being lied to. You might be able to check some of the stories. Most, you probably cannot. You will have no way of knowing if someone siphoned the gas out of his car, causing him to need $20 from you right now. The real tipoff is that these strange things keep happening to him. Gradually, his life descends into chaos, camouflaged by these lies.

2. They manipulate.
Unless they are also addicted, the family and close friends of an addicted person really want her to thrive and be happy. They try to encourage good decisions, but the addicted person is on a destructive track. The allure of the drugs is so powerful, she feels she needs the drugs to function, to be able to get through another day, to not get desperately sick from withdrawal. So, she manipulates those who love her the most.
Drugs like opiates, alcohol, methamphetamine, cocaine, synthetics like Spice and even marijuana can change a person who was loving and open with her family into someone who must manipulate everyone so they will let her keep using drugs.

With love in their hearts, family and close friends try to convince the addicted person to stop using these deadly substances, to go to rehab. But her answer?

“I have it under control.”
“I can stop anytime I want.”
“You are just jealous because I can have fun and you can’t.”
“You never want me to enjoy myself.”
“It’s your fault I’m this way.”
“You don’t even try to understand how I feel.”
“You wouldn’t say that if you loved me.”
And many, many more examples of this type.

And perhaps the most often type of manipulation occurs between a man and wife or girlfriend and boyfriend. When caught using drugs, the addicted person will promise to do better, to go to meetings, to start going to church, to get another job, to stop seeing drug dealers or other drug users.

The non-addict really wants to believe the promises, so he lets up on the pressure. He lets the addict back in the home or backs down from kicking her out. As soon as the pressure is off, the addicted person will probably be attentive and loving for a little while—until the next binge of drug or alcohol use. Then all bets are off.

An addict may call in the middle of the night, crying and professing love, begging to see the one he loves just one more time, but then if they meet, he asks for money just to get some good food and then is gone. The money goes to drugs. It is all manipulation.

Unfortunately, this pattern of manipulation all too often goes on for months or years without there being any change in behavior. When everything valuable is gone and the children are at risk, the non-addict finally moves away or changes the locks.

The sad truth is that while a person is addicted, the promises cannot be believed. They are just more manipulation.

3. They are highly likely to be engaged in criminal acts.
Stealing money

This is not true of every addict, but it is a typical pattern for a person who has been addicted for a considerable time. Eventually, the money runs out. They have pawned or sold everything of value. They owe friends and family money. There are no more assets, but the drugs or alcohol must be obtained.

At this point, many people will begin committing crimes. Selling or manufacturing drugs are common ones. Burglary, robbery, identity theft, credit card theft, car thefts and shoplifting are also common. An employee may steal items from the place of business and pawn or sell them. Someone with access to cash may embezzle from a company. Many people steal items from the homes of family or friends.

When a person is addicted to prescription drugs, the crimes may be a little different. He may visit multiple doctors to get prescriptions for pills or may forge prescriptions. In recent years, there have been more safeguards put in place in most states so that these attempts are less likely to succeed.

Of course, there is driving while drunk or high. Also, some drugs change a person's personality to make him more paranoid or aggressive which can result in assault or domestic violence charges.
And unfortunately, some drugs so deplete a person's sense of self-respect that he or she will turn to prostitution or any degraded activity that will score them their next hit.

4. An addict will shift the blame pointing finger at another.
Irresponsibility is the name of the game for an addict. Whereas this person may have lived their prior life as a highly responsible individual, drug addiction steals that quality away. Whatever happens is never his fault. If he gets fired from a job, it is the boss's fault, the addict was unfairly targeted. If he gets in a car accident, it was totally someone else's fault. If he fails at some activity, those close to him will be blamed.

Family will appeal to him to please care for the children and his spouse, please get another job, please stop using these drugs and so on. Even if he wants to, the addiction is more powerful than he is and he will be drawn to his drug dealer, his drug-using friends and whatever means he must employ to keep the drugs coming. What really must happen is that he must be rehabilitated to the point of having more power than the drugs.

5. An addict is highly likely to become abusive.

It is tragic that an addict's blame can even take a violent and abusive form. With the delusional thinking common to most addicts, he can perceive those around him as being threatening, dangerous or malicious. As he shifts the blame, he may physically, mentally, or emotionally attack those he blames.

The spouse of an addict very often bears the brunt of both the blame and the abuse. It is hard to do anything right. He or she is not supportive. Mental and emotional abuse may be directed at the spouse to completely shut down any ability to effectively fight the real problem—the addiction. It is quite common for spouses and significant others to be browbeaten into submission, often for years.

Of course, physical violence is a very real possibility, especially toward spouses, children, elderly parents—particularly those people who cannot fight back.

It does not matter what drug a person is addicted to—the need to get and use the drug is a compulsion. If it were not bigger and more powerful at this moment than his own will, he would not be addicted, he would stop using drugs and begin to fix his life.

Boundary setting for your addicted loved one involves setting limits of what you will and will not allow in your home or relationship. Setting rules may seem harsh, but if you do not set strict boundaries, you will allow your addicted loved one to continue their drug use and harm your family or relationship further.

What are the options?

Boundary Setting

Boundary setting forces your loved one suffering from addiction to take responsibility for his or her actions.

It is important that you only set consequences you are 100 percent comfortable with following through on if the boundary is violated. For boundary setting to be successful, you must follow through with that consequence 100 percent of the time if the boundary is violated.

First and foremost, it is important to understand that it is perfectly okay and acceptable to want peace in your home, respect, and appropriate behavior from everyone, including your addicted loved one. Begin setting boundaries by asking yourself these questions:

- What is the most loving thing I can do for my addicted loved one?
- How can I show respect for myself that I deserve?

Once you answer these questions, you will realize that it is best for both of you to set strict boundaries that you are able to follow through with. Decide on your boundaries when you are in a calm frame of mind and be prepared to commit to the boundaries you set. For example, threatening to kick your teen or adult child out of the house when you are upset may not be something, you are prepared to enforce the next time he or she makes a mistake.

Follow these additional tips to help you stick with the boundaries you set:

- Be informed on the brain disease of addiction and the extent of its power.
- Learn more about why those suffering from addiction lie, steal, cheat, and hurt those they love (and why it is not personal)
- Understand that change takes time.
- Know why it is never helpful to be an enabler.

Disease Progression, Different Behaviors

- **Problems at school or work** — frequently missing school or work, a sudden disinterest in school activities or work, or a drop in grades or work performance.
- **Physical health issues** — lack of energy and motivation, weight loss or gain, or red eyes.
- **Neglected appearance** — lack of interest in clothing, grooming or looks.
- **Changes in behavior** — exaggerated efforts to bar family members from entering his or her room or being secretive about where he or she goes with friends, or drastic changes in behavior and in relationships with family and friends.
- **Money issues** — sudden requests for money without a reasonable explanation; or your discovery that money is missing or has been stolen or that items have disappeared from your home, indicating maybe they are being sold to support drug use.

Understand the Stages of Disease Progression:

Stage 1: Drug Experimentation

Drug experimentation is defined as the use of alcohol or illicit/mood-altering drugs at any time for experimentation. While in and of itself experimentation may not appear to be abusive, even a single episode of experimentation can result in substantial harm to self or to others. Examples of potentially harmful experimentation include using any alcohol or other drugs during pregnancy, which could result in harm to the fetus; experimental use of alcohol or drugs while driving, which could result in serious harm to the user as well as others; children may be injured when left unsupervised while a parent is intoxicated. Also, if experimental use continues or serves as a gateway to additional use (as it often does), patterns of alcohol/ drug abuse may develop.

Stage 2: Social Drug Use, Regular Use

Social drug use is the use of any drug or combination of drugs in social situations, or for social reasons. If such social use causes any harm, physical or otherwise, to the user or others, it is also considered abuse. Social use of alcohol or other drugs often leads to further and elevated use.

Alternatively, those with strong tendencies to isolate themselves socially may move from experimentation to regular use in the absence of social situations.

Stage 3: Problem Use, Risky Use

Examples of problem use, or risky use of drugs and/or alcohol include binge drinking and drug abuse.

Binge Drinking

Binge drinking is heavy use of alcohol periodically. This can result in harm to the physical health of self and others, and negative behavioral consequences, which may result in bodily harm to self or others. For example, harm may be caused by heavy periodic use of alcohol or other drugs while pregnant, driving while intoxicated, or either neglecting or inflicting violence on self and others while under the influence. The National Household Survey On Drug Abuse (NHSDA) defines binge alcohol use as drinking five or more drinks on the same occasion at least one day in the past thirty days.

Substance Abuse

The characteristic feature of **substance abuse** is the presence of dysfunction related to the person's use of alcohol or other drugs. HHS (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration [HHS/SAMHSA], 1994) describes substance abuse as "the use of a psychoactive drug to such an extent that its effects seriously interfere with health or occupational and social functioning." Substance abuse may or may not involve physiologic dependence or tolerance. For example, use of substances in weekend binge patterns may not involve physiologic dependence; however, it may have adverse effects on a person's and possibly others' lives.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association is used across the medical and mental health fields for diagnosing both substance abuse and mental health disorders. According to the DSM-IV, substance abuse is "a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested
" a variety of possible symptoms of impairment. Neglect of children is specifically listed as a potential symptom of substance abuse (American Psychiatric Association, 1994).

Stage 4: Addiction, Chemical Dependency

With continued use, many persons' use, or abuse of alcohol or other drugs becomes **addiction**: a disease in which the substances have caused changes in body, mind, and behavior. As a result of this disease, addicted people are unable to control their use of substances despite the negative consequences that occur as a result. Addiction may be a chronic, relapsing disorder and as the disease process progresses, recovery becomes increasingly difficult. Chemical dependency occurs most frequently in those who have a family history of the disease. Chemical dependency may cause death if the person does not completely abstain from using alcohol and other mood-altering drugs (HHS/SAMHSA, 1996a). The DSM-IV distinguishes dependence from abuse primarily by the presence of more abuse symptoms (three or more rather than at least one), and the possible presence of tolerance (needing more of the substance for the same intoxicating effect) or withdrawal (physical symptoms that occur when the substance is not used).

The American Society of Addiction Medicine (ASAM) describes drug dependence as having two possible components:

- Psychological dependence
- Physical dependence

Psychological dependence centers on the user's need of a drug to reach a level of functioning or feeling of well-being. Due to the subjective nature of this term, it is not especially useful in making a diagnosis. Physical dependence, however, refers to the issues of physiologic dependence, establishment of tolerance, and evidence of an abstinence syndrome or withdrawal upon cessation of alcohol or other drug use. Tolerance, dependence, and withdrawal develop differently depending on the substance (HHS/SAMHSA, 1994).

Consider these basic boundaries:

As situations in each home and relationship can vary, the following boundaries are not a "one-size-fits-all" – but they are a good place to start when deciding how to set boundaries with the addicted person.

"No drugs or alcohol are allowed around me or in the house."
Let your loved one know what substances are acceptable and unacceptable in the home. Don't want illegal substances like heroin or cocaine under your roof? Let him know. No drinking alcohol when the kids are in the house? Communicate that with her.

Let your loved one understand the consequences if he or she violates those boundaries. Will you force her to find somewhere else to stay if she's been drinking? Will you notify the police if you find heroin in the dresser drawers? Reclaim control over what goes on in your home, within your personal space, and the space around your children or grandchildren.

"No drug-using friends are allowed in the home."
Just because your loved one may not be using at the time, doesn't mean his or her friends aren't using. If you don't want someone who is high on Oxycontin in your home, then you shouldn't have to put up with that. Laying out such a boundary reduces the damaging effect of addiction on the family.

"If you are arrested, I will not bail you out or pay for a lawyer to defend you."
This type of boundary will prompt responsibility for your loved one. Although addiction is a disease that needs to be treated as such, there is a responsibility that lies upon your loved one to take care of him or herself by getting help. When you set such a limit, you are letting him know that he is an adult and is responsible for himself. Make it clear that his drug use or drinking is something that must be confronted.

"No more insults or ridicule."
Retain your own values, your plans, and your goals. By setting boundaries to eliminate the insults, you no longer sacrifice your self-worth. Reestablish the self-respect and integrity that you hold, and that your family holds by defining what is acceptable language and actions. Don't forget that you have a right to expect decent and respectful behavior from others – including a drug addicted loved one.
Must conform to the standards of behavior that you expect – and the law requires.

"I will not give you any more money – whether it is to pay a bill, buy you food, or put gas in your vehicle."
Addiction can distort family roles: it turns family members into caretakers, scapegoats, doormats, enablers and pleasers. By setting the boundary to support no longer financially your loved one, you are focusing on your own well-being and mental health. Remember, setting boundaries won't cure the addiction or control an addicted person – but they will protect you. Protect your mental health, your physical well-being, and your finances.

“I will not lie or ‘cover’ for you anymore – regardless of the circumstances.”
Insisting that your loved one act more responsibly will benefit both of you. The disease of addiction thrives in chaos and lies. Set boundaries that will help to remove you from such mayhem and force your loved one to take ownership in his or her actions and behaviors.
“If you aren’t on time for dinner, you are not welcome to join us.”
With the focus on an addicted individual, family members never put themselves first. If you’re constantly worrying about your loved one and the troubles his drinking or drugging bring onto him or the family – you’re being robbed of your peace of mind. Just as your loved one’s life has been taken over by addiction, so too has that of your family. Set boundaries and take back what is important to *you*.

Setting boundaries is important for both you and your drug or alcohol addicted loved one. With boundaries, you are less likely to become entangled in the chaos of the addiction, you will keep the focus on yourself and your well-being and get off of the emotional roller coaster rides. Free from the extremes of emotions, you’ll think more clearly, healthy, and rationally, reclaim your self-respect, set healthy examples for your family, and give your drug addicted reason to seek help.

Hold firm in your words and actions, and don’t make idle threats. In time, you may find you rely on your loved one less and less as you continue to stand strong – and eventually, your loved one may be forced to accept responsibility for his or her actions – causing motivation for him or her to seek help and seek change, too. Make 2016 the year of change for the whole family unit by taking steps that you can manage and setting boundaries for yourself.

REF:
https://discoveryplace.info/stages-addiction/

https://vertavahealth.com/blog/7-boundaries-to-set-when-a-loved-one-is-addicted/

Given the fact this is a chronic brain disease, many of the behaviors are known and the progress of the disease is known, it makes sense that we can set up boundaries to assist in creating what behavior is going to be accepted, (within reason) and which will not be accepted.

In boundary setting, both parties will change their behavior. The person who is setting the boundaries and the one that must follow them.

Take the time to consider the impact of the boundaries, be clear in what you want the boundary to achieve. Try not to place into the boundary other topics that are not related to the objective of the boundary. Also, try not to set too many boundaries at one time.

It is strongly recommended that the family members work with a professional counselor or coach to develop the boundaries, identify how they will be communicating when setting up the boundaries, and work with updates on how well the boundary is working.

Take the time to view www.youtube.com videos on the topic of boundaries, then go see a professional for assistance.

LEARNING MODULE I

Seminar # 12

Family Intervention, 5 Stages of Change

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

No-one automatically knows how to talk to an addict — someone living with an substance use disorders. Although people who have lived and worked with people with substance use disorders may have discovered effective ways to communicate, it is always difficult, because of the confusion addiction creates in the person with a substance use disorder and in those around them. If you are also going through the shock of just having discovered a loved one has an addiction, you have a recipe for poor communication.

But there are ways of communicating that produce better outcomes than we might expect. Communicating with someone who has an substance use disorder can be especially hard if you have been supporting the person's addiction by enabling them to continue with their addictive behavior.

As humans, we crave social interaction with one another. Communication skills pave the way for meaningful conversations, telling funny jokes or relaying our heartaches.

Despite its importance, our ability to communicate is one of the first skills they lose once substance use disorders, and this becomes a factor. This person often feels isolated and ashamed, while our loved ones are left feeling confused and powerless to help. Make no mistake, t**alking to one another can be extremely difficult. Therefore, we suggest a family therapist be involved in the family journey.**

If we do not know how to effectively communicate with one another, our conversations can quickly turn to anger, avoidance, depression, or indifference, on both sides.

One side of the conversation is made up of friends and family members who do not understand the powerful grip of addiction. They feel betrayed; it is as if they do not recognize us anymore. On the other side of that conversation, you will find they – are chemically dependent. They are also frustrated and confused, but for completely different reasons.

It is hard for this person to verbalize their feelings. Drugs can smother their true emotions and, in many cases, what an act of avoidance provides is appealing. Instead of dealing with painful news or intense heartache, it is often easier to escape reality by turning to mind-altering substances.

Timing is Important:
You may feel that this conversation must happen now and on your terms. When approaching a loved one about their addiction, it is best to inform them that you want to discuss the issue. Allow them the opportunity to choose the time in which you have this conversation. This does not mean that they have the choice to put off the conversation indefinitely. Establish a time frame for the conversation. Allowing your loved one to choose the time for discussion decreases the chances of a hostile and defensive exchange.

Support the process of change and seek information and help:
Discussing the possibility of change is terrifying for an addict. At this point and time, living a life without drugs and alcohol feels impossible. Inform your loved one that it takes courage to ask for help and even more courage to accept it. Tell them that you are willing to support the process of change. Provide them with the assurance that you will be there for them throughout the entire process. Show them you are willing to understand their addiction. If your loved one is willing to listen and willing to change, it is recommended to seek professional assistance to help devise a treatment plan.

How can the issue impact the family?

The Processes of Change

It helps to break down the process of change into 5 stages, but that does not offer much practical insight into what someone can do to change them self. Ref:https://www.inspiremalibu.com/transtheoretical-model-stages-of-change/

The following 10 Processes of Change are implemented throughout the Stages of Change to help addicts quit:

- **Consciousness Raising:**
  recognizing the causes, consequences, and concerns of addiction
- **Dramatic Relief:**
  feeling the positive effects that are produced when substances are no longer misused (less anxiety, improved health, etc.)
- **Environmental Reevaluation:**
  recognizing how substance abuse affects one's environment (family life, career, etc.)
- **Self-Reevaluation:**
  recognizing how substance misuse affects one's self-image.
- **Social Liberation:**
  increased social opportunities because of no longer abusing substances.
- **Self-Liberation:**
  belief that one can change, and the commitment required to follow-through on that belief.
- **Counter Conditioning:**
  using healthy habits to replace the time and energy once spent supporting and engaging in substance abuse.
- **Helping Relationships:**
  using the support of friends and family to strengthen the resolve one needs to go through treatment and prevent a relapse later.
- **Reinforcement Management:**
  encouragement and rewards for when one stays on the right path toward quitting their substance of choice.
- **Stimulus Control:**
  staying away from stimuli and people that have the potential to inspire a relapse.

Prevalence of co-occurring substance use and mental health problems

The prevalence of a substance use disorder in people with a psychiatric disorder is high. In Canada, 16.1 per cent of people diagnosed with a psychiatric disorder during their lifetime experienced a substance use problem in the preceding year (Statistics Canada, 2002). The lifetime prevalence of psychiatric disorders in people with a current alcohol problem is 27.5 per cent (Statistics Canada, 2002).

FIVE STAGES OF CHANGE

Stage 1: Pre-Contemplation (In denial)

In the first stage of the TTM model, the addict is unaware of the negative impact of their addiction or/and unwilling to change.

Family, friends, and qualified professional may try to highlight the source of life problems as the individual's addiction - such efforts will rarely succeed.

The pre-contemplator is metaphorically blind to the adverse effects of their addiction. To them, their addictive tendencies are nothing if not normal!

A helpful strategy to employ is to encourage the individual to rethink their behavior, practice self-analysis, and examine the risks involved.

Some pre-contemplators may have tried multiple times to change but were unsuccessful. This led to feeling demoralized about their ability to change, making them reluctant to try again.

Others will see them resistant, unmotivated, or not ready for change, but the truth is that traditional addiction treatment programs were not designed to help such individuals.

Usually, people in this stage who go to rehab or seek out therapy do so because they are being pressured by others, relatives, friends, or spouse.

The individual feels that the situation is hopeless as the addictive behavior results from genetic makeup, destiny, or society- unchangeable factors.

However, the negative consequences of one's addictive behavior eventually catch up to you, and this is what ultimately prompts one to the next stage.

Stage 2: Contemplation (Getting Ready)
In this stage, the individual is essentially at war with themselves. They are aware of the harm addiction has wrecked in their lives, but the thought of making a change, moderating, or quitting seems ambivalent. Like catching Jerry is for Tom.

For contemplators, the fear of changing far outweighs the potential benefits to the mental, physical, and emotional state. The uncertainty associated with this stage can last upwards of six months.

Nonetheless, the addict is more open to hearing about the negative effects of their addiction than they were in the pre-contemplation stage.

They may also be willing to try out different approaches to cut-down or moderate problematic behavior. That is not to say they are finally ready to commit to quitting altogether, but they have become more open to the idea of changing sometime in the future.

To help a contemplator move to the next stage, confirm the readiness to change, normalize the idea of change by weighing the pros as well as the cons, and identify specific barriers to behavioral change.

Non- judgmental information giving along with motivational approaches of encouraging change will work better than confrontational methods.

Such individuals are still not ready to embark on the traditional addiction recovery treatment programs which advocate for immediate change.

And until the addict decides to take the leap and make a change, they can quickly reverse to the pre-contemplation stage.

This decision to commit to change is the event that propels the addict to the next stage.

Stage 3: Preparation (Ready)
Addicts in the preparation stage acknowledge that their addictive behavior is a problem, realize the need to make a change, and are preparing to fix their lives.

The idea of changing does not seem so impossible anymore, and one may even be taking small steps to prepare oneself for a more significant lifestyle change.

For instance, if you are preparing to quit smoking, you can start with chewing nicotine gum, using a nicotine patch, getting rid of ashtrays and lighters, smoking less each day, or changing cigarette brands.

People in the preparation stage are not content to just sit and wait for change, as the saying goes if the mountain does not come to Muhammad, then Muhammad must go to the mountain.

Plan and begin to take direct action, such as consulting a counselor. Prepare a list of motivating statements and another for the desired goals.

Join NA or an alternative health club. Inform your addiction buddies, family, and friends about your decision to change.

Read up on your addiction to learn different ways to make a successful, lasting change.

After making the necessary preparations, the individual is ready to move to the next transtheoretical stage and can be recruited into action-oriented programs.

Stage 4: Action
In this stage, the addict has made specific overt changes to their overall lifestyle.

It is no longer a question of I do not want to change, or I cannot change and more and I am changing.

Since the changes here are more observable, it is not surprising that behavioral change is often misconstrued as an action rather than the 4th stage of change that it is.

The action stage relies on the goals set in the contemplation and preparation stages.

Many people fail at making lasting changes because they do not give enough thought to the kind of change, they want and prepare a plan of action- stage 2 and stage 3.

Let us take the example of trying to start eating healthier. Most people will be quick to throw out all the junk food in the fridge, immediately enroll in a two-year gym membership, and begin eating only greens.

For a time, your efforts will work, but it may not last. You will come home from a bad day at work/school, and you will not feel like cooking or even eating greens.

You will convince yourself that it is only this one time while you order an All-American burger from the takeout place just around the corner. That first delicious bite will mark the death of your short-lived Healthy Life.

Often, individuals who triumph in the action stage are those who completed the subsequent stages. They seek out rehab, individual counseling, or group meetings to manage the destructive behavior.

The process can seem tedious and boring after the backstage Broadway show that was your addictive life and, therefore, this stage carries the highest risk of relapse.

Nevertheless, if the addict commits to being clean and sober, identifies and eliminates triggers, and enthusiastically embraces their new lifestyle, they should be able to move to the next stage.

Stage 5: Maintenance

Recovering from an addiction is a life-long process, and Prochaska and DiClemente's original last stage recognizes this fact.

The maintenance stage is concerned with keeping to the intentions made in the third stage and the behaviors implemented in the fourth stage.

Cravings and triggers may dissipate over time, but the temptation to use will never be truly eradicated.

Because drugs affect the neural pathways of the brain and the sensations you felt while under the influence can never be completely forgotten.

However, recovering addicts in this stage have learned how to manage their addiction and maintain their new lifestyle with minimal effort.

They have created a new normal where they integrate change into their lives by continually guarding against triggers, focusing on preventing relapses, and consolidating their efforts to maintain a life free of destructive behaviors.

Although most addiction treatment professionals advocate for complete abstinence, there are a few who acknowledge that it may be difficult for some addicts to go completely cold turkey.

Such addicts would benefit from moderating their addictive behavior, practicing controlled drinking, along with reducing drug and substance use.

The entire addiction treatment and recovery community recognize that relapses can occur at any stage and that battling addictive behavior is a life-long process; nonetheless, a sixth stage was added to the transtheoretical model.

First understand what motivates us.

Health care providers are naturally inclined to act as problem solvers, provide advice and argue for positive change. They often overestimate or ignore persons' degree of motivation to change. For persons who are not ready to change, this approach is often counterproductive, resulting in silence, anger, or avoidance.

As a result, health care providers may avoid the issue of substance use or push persons harder to try to stimulate change. These approaches tend to diminish motivation.

Assessing a person's readiness to change is the best way to minimize frustration and improve the chances that change will happen. Interventions that are appropriate to the person's stage of change can increase motivation and promote positive change.

Perhaps the most **important** thing to take away from **Maslow's Hierarchy** of Human **Needs** is his realization that all human beings start fulfilling their **needs** at the bottom levels of the pyramid. ... **Needs** like safety, esteem, and social interaction are insignificant when one's drive is to survive.

Matching motivation interventions to the stage of change:

Precontemplation stage

Provide brief advice about the importance of cutting down or stopping substance use and tell the person that if they are ever interested, you would be willing to help.

Contemplation stage

Ask whether the person would be interested in more information about treatment approaches, or what it would take for the person to be willing to cut down or stop the substance use.

Preparation/action stage

Provide encouragement, help and, if necessary, refer the person for addiction treatment.

Helping persons move toward change:

Attempt to engage person in a discussion about their problematic substance use. Simply asking persons how they feel about their substance use, or if they have ever considered cutting down, encourages them to talk, even if they are not ready to make changes. The important thing is to begin a conversation that is non-judgmental and avoids pressure.

Increasing motivation involves exploring with person their answers to the following questions:

- **"Why do you think you should cut down or stop?"** Explore the importance for persons of cutting down or stopping. Encourage them to weigh competing values, benefits, priorities, and perceptions of risk.
- **"Do you feel that you are going to be able to cut down or stop?"** Explore the persons' confidence in their ability to cut down or stop. This includes issues of self-efficacy, past experiences, and alternative solutions.
- **"When do you think you will be ready to cut down or stop?"** Explore persons' readiness to cut down or stop soon. Allow them to weigh the competing priorities in their lives with their own assessment of their confidence.

  In general, the more important the issue is to the person, and the more confident the person is about succeeding, the more likely it is that they will be ready to commit to making a change – they will be more motivated.

Ambivalence about change:

Some degree of ambivalence about the importance of making changes, about one's confidence in being able to change and about one's readiness to make changes is inevitable.

The level of interest in change and ambivalence corresponds to the person's stage of change:

Stage of change, level of interest and ambivalence:

- Ambivalence is generally lowest when the person is not at all interested in changing (precontemplation) or is clearly ready to make changes (action).
- It is during the process of considering change – of moving from low motivation to high motivation – that the person naturally experiences a rise in ambivalence.
- The contemplation stage is where ambivalence peaks. It is characterized by the phrases "I want to, and I don't want to" or "I know how, and I don't know how."
- Persons who are ambivalent are those most in need of counselling.

Working with resistance:

Signs of resistance to change include "yes, but . . ." statements, outright anger, not showing up or simply forgetting. When persons are resistant, it means they are not ready, or the process is moving too quickly.

When this happens:

- **Slow down or back off**.

  Example:

  "It sounds as though you feel we're moving too fast. Perhaps you're not ready to cut down now."

- **Increase intrinsic motivation by reinforcing the person's ideas and feelings about his or her own goals and personal values.**

  Example:

  "I know this must seem like a big step for you, but I remember you telling me that breaking this habit is the most important thing you can do for yourself."

- **Provide education to the person with the aim of eliciting a response.**

  Example:

  "Did you know that if you quit smoking now, it would have a dramatic effect on your ability to breathe over the next few years?".

This approach is often more effective than information that is meant to scare the person or to support your own perspective (e.g., "If you don't quit, you're going to die").

Counselling strategies for increasing motivation to change:

- **Express empathy,** In all forms of counselling, empathic listening is essential to building trust, which in turn opens possibilities for change.
- **Develop discrepancy,** In general, change is motivated by a discrepancy between a person's current behavior and important personal goals, beliefs, and values. Drawing attention to these discrepancies and encouraging "change talk" may help to resolve or reduce a person's ambivalence.
  - **Roll with resistance,** Avoid arguing for change and other forms of "resistance talk" because it tends to reduce motivation to change.
  - **Support self-confidence,** Small successes and emotional support can increase a person's confidence (the person is responsible for choosing and carrying out change).
  - **Be curious:** While there are many types of questions that can be used to propel a conversation that increases motivation, the most important characteristic of the primary care provider is a genuine curiosity about what motivates and what inhibits the person's path to change.

Increasing motivation: Tip list

- **Provide a decisional balance sheet** to help persons reflect on the relative merits and drawbacks of making the proposed change (e.g., "What are the pros and cons of continuing to smoke?").
- **Ask open-ended questions** that evoke change talk (e.g., "What worries you about your current drug use?").
- **Use scaling questions** to assess motivation and to help set small goals (e.g., "What would it take to increase your confidence to quit smoking from a 2 to a 3 out of 10?").
- **Reflect back and elaborate on small goals** (e.g., "You say you are interested in changing your drinking habits someday. Is there anything you could do now that would be a start in that direction?").
- **Provide information and elicit a response** (e.g., "Drinking more than two to three drinks per day is often a cause of high blood pressure. What do you think about your own drinking pattern?").
- **Back off to reduce resistance** (e.g., "It sounds as though you're not really interested in getting help at the moment").

With the techniques listed here, **aim to resolve ambivalence** to the point where the person feels ready to make a change that is congruent with established goals.

At that point you might say:

"It sounds as though you're ready to give up the drug you've been taking. Would you be interested in starting to talk about this?"

When the person indicates a willingness to try, the process of increasing motivation shifts to negotiating a change plan.

Establish the end point or goal:

Clarify as precisely as possible what a person wants to achieve.

Do not assume that persons' goals are congruent with yours (e.g., in a case of alcohol dependence, you may be recommending abstinence, but the person may be aiming to cut down to four beers per day).

Encourage persons to set their own goals and the rate at which they hope to achieve them. For example, say, "In terms of your drinking, where do you want to be a few weeks from now? How about in a few months from now?"

Consider change options

Discuss different ways of achieving the goal, with an emphasis on what has worked in the past (e.g., "When you quit smoking last year, how did you do it?").

Guide the conversation toward initial small, achievable steps that lead toward the goal. This can be done simply by asking the person to set a small step, or by making gentle suggestions such as, "As a first step, have you considered stopping smoking in your apartment?"

Detail a plan

Attempt to co-establish a first clear, observable step that is as specific and precise as possible. For example, in summarizing the discussion, you might say, "We've been discussing cutting back on your drinking, and you say you want to start today by cutting down to four beers a day. Is that right?"

Elicit commitment

It is crucial that persons feel ready to commit to the plan and that they see it as achievable.

Do not assume commitment. Clarify by asking, "Are you really sure that this is something you can do every day?"

Formalize the commitment

The appropriate level of formality for the plan depends on what each person perceives to be helpful. While some persons are motivated by an explicit written "contract" that they can take with them, most persons see your notations in the chart as the same thing. Others like to acknowledge their commitment with a handshake.

Establish follow-up:

Ongoing support and problem solving around failures and roadblocks is extremely helpful to most persons.

Set up appointments in anticipation of such events. Initially, this could be every week or two. Above all, let your follow-up plan be guided by what the person perceives as appropriate. Ask: "When do you think it would be helpful to see me again?"

Continue this method of carefully moving the person forward and then reassessing the response in subsequent sessions.

When persons do not complete the plan:

An inability to achieve a commitment tends to undermine persons' confidence and decreases their sense of control. You can help to prevent persons from feeling this way by viewing the person's failure to complete the goal as information for both you and the person.

Generally, such failures are a sign that the process was moving too fast. Either the person was not ready and so resisted change, or the goal was too large, and the person was set up to fail.

Failure also suggests a need to reassess the person's readiness, to slow down and to continue the process.

As a rule, it is better to err on the side of moving too slowly or making the goals too small. Faced with a small goal (e.g., not smoking indoors), persons tend to overachieve (e.g., putting off going out for a smoke and thereby cutting down the number smoked daily). You can reinforce and build on these successes.

The goal of this process is to gradually acquire new patterns of behavior, increase awareness of the process of change and develop a greater sense of self-efficacy – the feeling that one can make changes in one's life.

What are the options:

What we are really seeking is for a change to occur. However, to demand change is rarely effective. In change there are stages, change is a matter of evolving from one thing to a next thing. It can be positive or negative of both.

One option is to learn how change take place and then include this knowledge to the family intervention, seeking change, both theirs and ours.

The transtheoretical model of change is a theory introduced by psychologist James Prochaska in the 1980s. Sometimes called the "readiness-to-change" model, this theory identifies five stages through which people progress. Clinicians can use the transtheoretical model to meet clients where they are and help them move forward at any stage.

What are the stages of change? So what is it?

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Prochaska developed this theory after observing a problem with behavior change programs. Participants were expected to adopt healthy behaviors immediately – and blamed for lack of willpower if they failed to change promptly.

Instead, Prochaska suggested the existing model was broken. Even if people were not ready to change, they could still move forward. "Successful self-changing individuals follow a powerful and, perhaps more important, controllable and predictable course," Prochaska writes with fellow psychologists John Norcross and Carlo DiClemente in *Changing for Good*. "No one stage is any more or less important than another."

Stages of Change for Addiction for the purpose of behavior modification
The core of the Transtheoretical Model is breaking down the complex process of changing behavior into 5 distinct stages: precontemplation, contemplation, preparation, action, and maintenance.

- Precontemplation (Expected Duration – 6 months): During the first stage of the Transtheoretical Model, the addict is either uninformed about the risks of substance abuse, or they choose to ignore these risks. They are not reading, talking, or even thinking about the consequence's substance abuse brings to them self and their family. At this point, the addict will actively resist anyone who attempts to get them to change their behavior. They are not ready for treatment. Therefore, the family coming into this topic will likely not get a positive result. So, what is needed?

- **Contemplation (Expected Duration – 6 months):**
  Over time, the addict begins to recognize that there are significant reasons for them to change their behavior. At the same time, they are also aware of the negative effects that will occur if they quit their substance of choice (there is the physical fear of detox, and the possibility they have used substances as a coping mechanism to treat depression, childhood trauma, or some other issue for a long time, and if they stop using, they will have to finally face that issue).

- **Preparation (Expected Duration – 6 months):**
  It is not until the third stage of the model that addicts are ready for treatment. They have weighed the pros and cons of quitting their substance of choice, and they have decided to quit. In fact, they have gone further than just deciding to quit – they have taken concrete steps toward changing their behavior – this could include buying a self-help book, going to see a therapist, or checking into a treatment.
- **Action (Expected Duration – at least 1 month):**
  Now comes the actual act of change. Rather than the traditional 12-step approach, Inspire Malibu focuses less on belief in a higher power and more on techniques that have been developed and reinforced objectively and scientifically. We use numerous types of therapy (individual counseling, group counseling, neurofeedback therapy, cognitive therapies, etc.), as well as improving health and fitness routines.

Other Considerations:

This is a complex chronic disease, and it might have parts to it that are impacting the primary behavior, and not being addressed. When viewing the life of a person with substance use disorders consider these factors, also.

Maintenance (Expected Duration – Indefinite):

Even after a client has left our center, the work required to abstain from destructive substances is not yet over. All it takes is one stressful situation to potentially make an addict relapse. Treatment centers like those at Inspire Malibu, can teach clients techniques that will help them recognize and respond to these triggers without relapsing back into substance misuse. If your treatment center does not work with.

Mental health and substance use problems interact in various ways.

- Alcohol and other drugs are effective short-term anxiolytics and are often used to self-medicate symptoms of anxiety.
- People with alcohol or other drug addiction often attribute withdrawal symptoms to anxiety.
- Alcohol and other drugs tend to exacerbate co-existing primary psychiatric disorders. For example, cannabis worsens symptoms of schizophrenia and can precipitate a psychotic episode.
- Alcohol is often responsible for depressive symptoms (alcohol-induced mood disorder) in people with alcohol dependence.
- All the major drugs can cause substance-induced psychiatric disorders, particularly mood and anxiety disorders.
- People with primary psychiatric disorders can develop substance-induced disorders. For example, someone with an anxiety disorder can develop alcohol-induced depression.
- Substance use can interfere with treatment of the primary psychiatric disorder in various ways:
    - People who use substances are less likely to adhere to psychiatric pharmacotherapy.
    - Substances may interact with psychiatric medications.

  Substance use can contribute to behavioral problems and interpersonal difficulties.

There may be co-occurring disorders:

A co-existing substance use disorder and primary psychiatric disorder is known as a concurrent disorder.

Given the high rates of co-occurring mental health and substance use problems, all persons presenting with a mood, anxiety or psychotic disorder should be screened for substance use, and all persons with a substance use disorder should be screened for depression, anxiety, psychosis, and a history of trauma.

There may be substance-induced psychiatric disorders.
A psychiatric disorder is more likely to be substance induced if:

- the psychiatric symptoms developed during or within a month of substance intoxication or withdrawal.
- the substance used is known to cause symptoms of anxiety, depression, or psychosis.
- the symptoms resolve with abstinence.
- the symptoms cannot be better explained by a disorder that is not substance induced.

Suicide risk with co-occurring disorders:

People with substance-induced disorders have a higher risk for suicide, particularly during acute intoxication and withdrawal. These persons should be carefully assessed, observed and, if necessary, admitted to hospital.

Often a person's mental state improves within 24 to 48 hours of abstinence, which helps to distinguish between substance-induced symptoms and primary psychiatric problems.

Antidepressants and intensive treatment for substance dependence should be initiated in persons with concurrent depression.

What is certain in most families, neither side of the conversation understands exactly what to do, how to change and where a change will take them. Get a professional counselor or therapist involved early in the process. It will ensure a greater success. Ref: https://www.inspiremalibu.com/transtheoretical-model-stages-of-change/

The ten processes of change

These are implemented throughout the Stages of Change to help move the person forward.

1. **Consciousness Raising:**
   recognizing the causes, consequences, and concerns of addiction.
2. **Dramatic Relief:**
   feeling the positive effects that are produced when substances are no longer misused (less anxiety, improved health, etc.)
3. **Environmental Reevaluation:**
   recognizing how substance abuse affects one's environment (family life, career, etc.)
4. **Self-Reevaluation:**
   recognizing how substance misuse affects one's self-image.
5. **Social Liberation:**
   increased social opportunities because of no longer abusing substances.
6. **Self-Liberation:**
   belief that one can change, and the commitment required to follow-through on that belief.
7. **Counter Conditioning:**
   using healthy habits to replace the time and energy once spent supporting and engaging in substance abuse.
8. **Helping Relationships:**
   using the support of friends and family to strengthen the resolve one needs to go through treatment and prevent a relapse later.
9. **Reinforcement Management:**
   encouragement and rewards for when one stays on the right path toward quitting their substance of choice.
10. **Stimulus Control:**
    staying away from stimuli and people that have the potential to inspire a relapse.

Dual-diagnosis, mental health condition

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But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

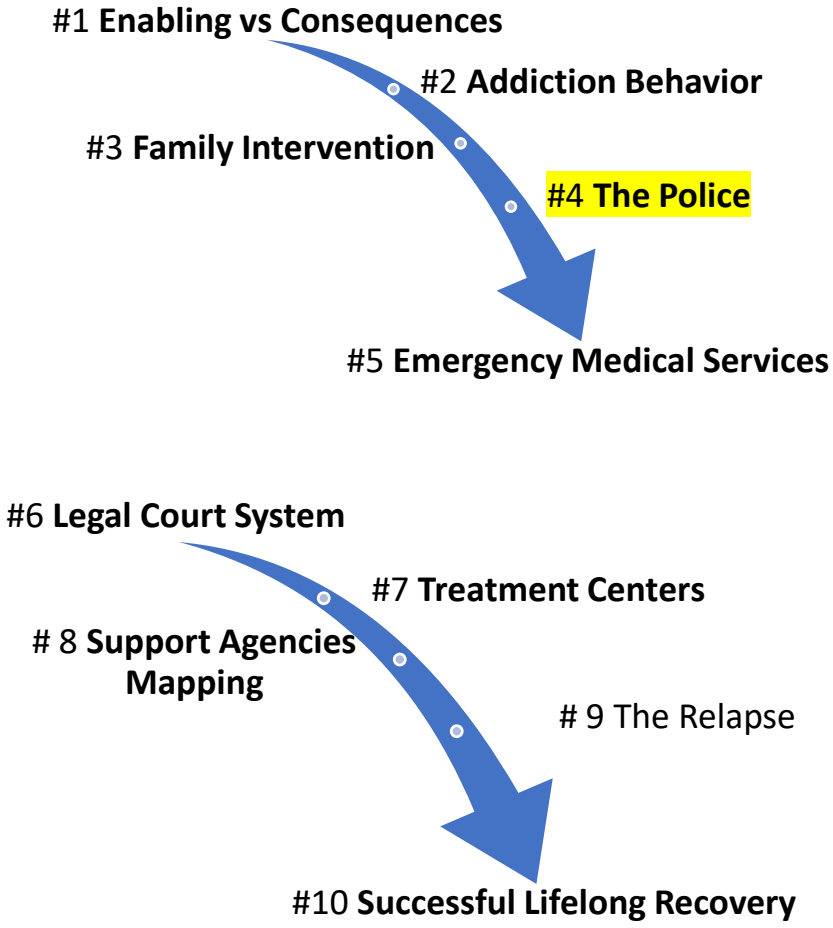
Seminar # 13

The Police Intervention

Learning Objectives

1. Pre and Post Booking
2. Getting Legal Help
3. About the Arrest Process

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement (Learning how to move forward)**
#12 **Spirituality, Faith Practices**

The Police Intervention

There is not much one can say to the prolog of an addict being arrested. When the police call, come to your door or ask you to come to the station, there has mostly likely been a crime committed or associated with one. The next step is to find the person or persons who committed the crime and start the process of arrest.

This seminar will address two areas to inform and build knowledge of the family members about the police intervention: 1. The Arrest process and 2. The missing person's process. In a different seminar (The Legal System Intervention) the legal system and its process will be reviewed.

Learning of Your Rights During an Arrest

In 1966, the U.S. Supreme Court ruled in Miranda v. Arizona, that individuals who are under arrest for suspicion of having committed a crime have certain rights that must be explained to them before any questioning may occur. The rights are designed to protect your Fifth Amendment right to be free from self-incrimination and are read in a warning as follows:

You have the right to remain silent and to refuse to answer questions.
Anything you say may be used against you in a court of law.
You have the right to consult an attorney before speaking to the police and to have an attorney present during questioning now or in the future.
If you cannot afford an attorney, one will be appointed for you before any questioning if you wish.
If you decide to answer questions now without an attorney present, you will still have the right to stop answering at any time until you talk to an attorney.

Note: Miranda rights must only be read when an individual is in police custody and under interrogation which would not apply to situations like traffic stops.

Police Actions During an Arrest and Booking

If you are stopped by the police, they may frisk you by performing a "pat-down" of your outer clothing to see whether you are concealing a weapon. Later, if you are arrested, they can perform a full-blown search of your person and immediate surroundings to ensure that you do not have any weapons, stolen items, contraband, or evidence of a crime. If the police take possession of your car, it may be searched as well.

The police may take and secure any personal property or money that you have with you after performing an inventory. The police will ask you to sign the inventory, but you should only do so if you agree with the contents of the inventory.

Once arrested, you will be booked. During this part of the arrest process, the police will ask for basic information about yourself (such as your address and birthdate), and fingerprint and photograph you. You may also be asked to participate in a line-up or provide a handwriting sample.

If you are detained but not booked within a reasonable period (usually several hours, or overnight) your attorney may go to a judge and obtain a writ of habeas corpus. This is an order issued by the court instructing the police to bring you before the court to determine if you are being lawfully held.

The Post-Booking Process:

Once you are arrested and booked, your case is provided to the appropriate prosecutor's office where an independent decision is made as to what charges should be filed, if any. You have the right to a speedy trial, which usually means that the prosecutor must file any charges within 72 hours (48 hours in some states). A prosecutor is not bound by the initial charge decision and can later change the crimes charged once more evidence is obtained.

Next is your arraignment. At this point, the charges against you are read in court and you will be asked whether you plead guilty or not guilty. You can also plead "nolo contendere" or "no contest," which are not technically pleas, but indicate that you do not contest the charges. The plea of nolo contendere cannot be used in other aspects of the criminal trial as an admission of guilt but can be used in the indictment phase as an implied confession of the specific offense charged and an admission of the facts in the indictment. A plea of nolo contendere is only accepted by a judge if made voluntarily and intelligently.

You may be able to get out of jail after your arrest and before trial by posting bail. During this process, you pay money to the court to ensure that you will make future court appearances. If you do, the bail is refunded to you, but if not, the court keeps the money and can issue a warrant for your arrest.

Getting Legal Help with Questions About the Arrest Process

No one looks forward to an arrest, but if does happen, it is good to understand the process. It is also important to understand that you have rights throughout the arrest process. If you have been arrested and charged with a crime, you may want to contact a qualified criminal defense attorney to discuss your rights and what your legal options are going forward.

What Happens During a Criminal Case?
This process when not known in advance may be confusing to a victim, witness, or family members. The following summary will explain how a case generally progresses through Michigan's criminal justice system. Specific procedures may be modified by local courts or judges in other states.

Step 1: Crime Committed / Police Notified

Step 2: Police Investigate

Step 3: Police Make an Arrest (or Request a Warrant)

Step 4: Warrant/Charging Request Reviewed by Prosecuting Attorney

Step 5: Warrant Issued

Step 6: Suspect Arrested

Step 7: District Court Arraignment

Step 8: Trial (Jury or Bench/Judge)

Step 9: Pre-Sentence Investigation and Report

Step 10: Sentence

Step 11: Appeals

Police Investigate --- Investigation may include interviewing victim, witnesses, suspects; collecting physical evidence; visiting, viewing, photographing, measuring crime scene; identifying suspects; through line-ups ... etc.

Police Make an Arrest (or Request a Warrant)
When a crime is committed in a police officer's presence --- or the officer has probable cause to believe that certain misdemeanors or any felony was committed that the officer did not see happen --- an officer may arrest a suspect on the spot without an arrest warrant. The officer will later submit a charging/warrant request to the Prosecuting Attorney, suggesting potential charges to be authorized.

Warrant/Charging Request Reviewed by Prosecuting Attorney
Most cases begin with a warrant request. This is generally the first time that the Prosecuting Attorney's office is involved in a case unless a prosecutor reviewed a search warrant or visited the crime scene. At this stage, the Prosecutor determines whether a person should be charged with a crime and, if so, what the crime should be. The Prosecutor must thoroughly review all reports and records concerning the case, including witness statements. The Prosecutor also reviews the suspect's prior criminal or traffic record. Occasionally, the reviewing Prosecutor sends the case back to the police to conduct additional investigation.

Warrant Issued
The Prosecutor can issue a charge if he or she reasonably believes that probable cause exists that the suspect committed the offense. But most reviewing Prosecutors apply a higher standard --- whether the charge can be proved beyond a reasonable doubt at trial with the information known at that time.

Suspect Arrested (if not already in custody)
The delay between the crime date and the defendant's arrest on an authorized charge can take any length of time (e.g., if the defendant's whereabouts are unknown, or if the defendant has left the State of Michigan).

District Court Arraignment
This is the first court appearance for any misdemeanor or felony. Once arrested and charged with a felony, the suspect appears in District Court for arraignment. The defendant is told what the charge(s) is (are) and the maximum penalty if convicted, and is advised of his constitutional rights to a jury or bench trial, appointed attorney, presumption of innocence, etc. The charging document is called a Complaint. The conditions and amount of bond are determined by the judge. In some cases --- generally based on the nature of the charge --- the Judge imposes conditions on the bond, such as no contact with the victim. Bond is set in almost every case, but it is up to the defendant's own resources to post the bail money, which allows him to be released.

All further pre-trial procedures are determined by whether the defendant is charged with a felony or misdemeanor:

Misdemeanor

At a misdemeanor arraignment, the defendant will be given a chance to enter a plea to the charge: plead guilty, plead not guilty, or stand mute (i.e., remain silent, which is treated by the court as if the defendant pled not guilty). If the defendant pleads guilty or no contest, the Judge may sentence the defendant on the spot or may reschedule the case for a sentencing date, which will give the probation department time to prepare a pre-sentence report including background information about the defendant and the crime, make a sentencing recommendation, etc. If the defendant stands mute or pleads not guilty, the case will be scheduled for a pre-trial conference.

Pretrial Conference --- All misdemeanor cases are scheduled for a meeting between an Assistant Prosecuting Attorney and the defendant (or his attorney) to determine whether the case will go to trial or be resolved with a plea. These meetings focus on resolving the case short of trial. The Judge and witnesses are not directly involved in misdemeanor pre-trial conferences. If a plea bargain is going to be offered by the Prosecutor, it is done here.

Felony

At a felony arraignment in District Court, the defendant does not plead guilty or not guilty. He is advised of his right to a preliminary examination within 14 days of the arraignment. The arraigning judge may also consider a defendant's request for a court-appointed attorney at this time.

Pre-Exam Conference --- Some courts schedule a "Pre-Exam Conference" several days before the scheduled Preliminary Examination. The Pre-Exam Conference operates like a misdemeanor pre-trial conference, as a meeting between the Prosecutor and defendant (or his attorney) to see if the case can be resolved without the need to subpoena witnesses for the "Prelim".

Felony Preliminary Examination --- This is a contested hearing before a District Court Judge, sometimes called a "probable cause hearing", held within 14 days after arraignment. The Prosecutor presents witnesses to convince the Judge that there is at least probable cause to believe that the charged crime(s) was (were) committed and that the defendant committed the crime(s). Because the burden of proof is much less than at a trial, the Prosecutor generally does not call all potential witnesses to testify at the "prelim"; generally, the victim and some eyewitnesses plus some of the police witnesses testify. The defendant, through his attorney, can cross-examine the witnesses and present his own evidence (including witnesses). If probable cause is established, the defendant is "bound over" (i.e., sent to) Circuit Court for trial. If the Judge decides that there is not probable cause that the defendant committed the charged crime(s), the judge can bind the case over on different charges, can reduce the charges to misdemeanors for trial in District Court, or can dismiss charges. A defendant can give up his right to a Preliminary Examination. Most felonies arrive in Circuit Court after such a "waiver".

Circuit Court Arraignment --- After the case is sent to Circuit Court, the defendant is again arraigned (given formal notice of the charges against him or her). The charging document is called an Information. He or she is again advised of his/her constitutional rights, and enters a plea to the charge (guilty, not guilty or stand mute).

Pre-Trial Conference --- The Circuit Court may schedule a meeting between an Assistant Prosecuting Attorney and the defendant's attorney to determine whether the case will go to trial or be resolved with a plea.

Pretrial Proceedings --- The Circuit Court Judge may be called upon to resolve various pre-trial issues, some of which determine whether the case will continue to a trial, be resolved with a plea, or be dismissed; whether evidence will be admissible at trial; etc.

Trial (Jury or Bench/Judge)
A trial is an adversary proceeding in which the Prosecutor must present evidence to prove the defendant's guilt beyond a reasonable doubt. The defendant is not required to prove his or her innocence or to present any evidence but may challenge the accuracy of the Prosecutor's evidence.

Both the defendant and the Prosecutor (representing the People of the State of Michigan) have the right to a trial by a jury. Sometimes, both sides agree to let a Judge listen to the evidence and decide the case without a jury; this is called a "bench trial". In a jury trial, the jury is the "trier of fact"; in a bench trial, the judge is. After the evidence is presented, the judge or a jury will determine whether the evidence proved that the defendant committed the crime.

General outline of the steps in a jury trial

Residents of the local county are randomly selected from a Secretary of State list of licensed drivers and are summoned to the Court as potential jurors.
a blind draw selects twelve people from that group in felonies (six in District Court misdemeanors).

Voir Dire: The Judge, Prosecutor and defense attorney question the jurors about their backgrounds and beliefs; the attorneys are permitted a limited number of "peremptory" challenges to various jurors (or an unlimited number of challenges for good cause); after twelve (or six) acceptable jurors remain, the Judge administers an oath to the jury and reads basic instructions about the trial process, etc.

- The Prosecutor gives an opening statement to outline the People's case and evidence to the jury.

- The defense may give a similar opening statement or wait until later in the trial.

- The Prosecutor calls witnesses, which the defense may cross examine.

- The People close their proofs.

- The defense may call witnesses, if it wants, and the Prosecutor may cross-examine them.

- The defense rests.

- The Prosecutor may present "rebuttal" witnesses/evidence to challenge evidence presented by the defendant during his proofs.

- The Prosecutor rests.
- occasionally, the trial judge will let the defense present "sur-rebuttal" witnesses to respond to the Prosecutor's rebuttal witnesses' testimony.
- The Prosecutor presents a closing summary to the jury.
- The defense attorney presents a closing summary to the jury.
- The Prosecutor may present a rebuttal argument to the jury to respond to the defendant's attorney's closing summary.
- The judge gives the jury detailed legal instructions about the charged crimes, the deliberation process, etc.
- The jury deliberates and returns a verdict.
- A criminal case jury verdict must be unanimous.
- Pre-Sentence Investigation and Report
- The court's probation department prepares a report for the judge summarizing the crime, and the defendant's personal and criminal backgrounds.

Generally, the victim is contacted for a recommendation of sentence. The probation officer concludes the report with a recommended sentence.

Sentence
Sentencing in Michigan varies with the crime and can be the most confusing part of the criminal process. Most often, sentences are at the judge's discretion. The judge will consider the information in the pre-sentence report (subject to factual corrections by the parties), additional evidence offered by the parties, comments by the crime victim, and other information relevant to the judge's sentencing decision.

For felonies, the Circuit Court judge will consult "sentencing guidelines" (originally established by the Michigan Supreme Court, but now applicable by recent "Truth in Sentencing" laws). The sentencing guidelines factor in aspects of the defendant's criminal conduct and his prior record, to determine the minimum jail/prison sentence. The judge may consider different alternatives, such as a fine, probation, community service, a sentence to jail or prison, or a combination. The judge must also order the defendant to make restitution to any victims who have suffered financial harm.

Appeals
Appeals from the District Court are heard in the Circuit Court. Appeals from a Circuit Court or Probate Court order are heard in the Michigan Court of Appeals. Appeals from Court of Appeals decisions are heard in the Michigan Supreme Court.

There are three kinds of appeals: (1) interlocutory, (2) of right, and (3) by leave.

Interlocutory appeal: occurs when a party tries to appeal a judge's decision before the case has come to trial or before a trial is finished.

Appeal of Right occurs after a final order has been entered by the trial court (either a sentencing order, or an order dismissing the charge). A recent amendment to the Michigan Constitution has eliminated most appeals of right when a defendant pleads guilty. Most appeals of right now focus on the sentence imposed.

Appeal by Leave of the Court occurs when an appeal of right is not available (e.g., because an available appeal of right was not filed on time). The appellate court has the discretion to reject the appeal or can "grant leave".

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 14

Emergency Medical Services Intervention

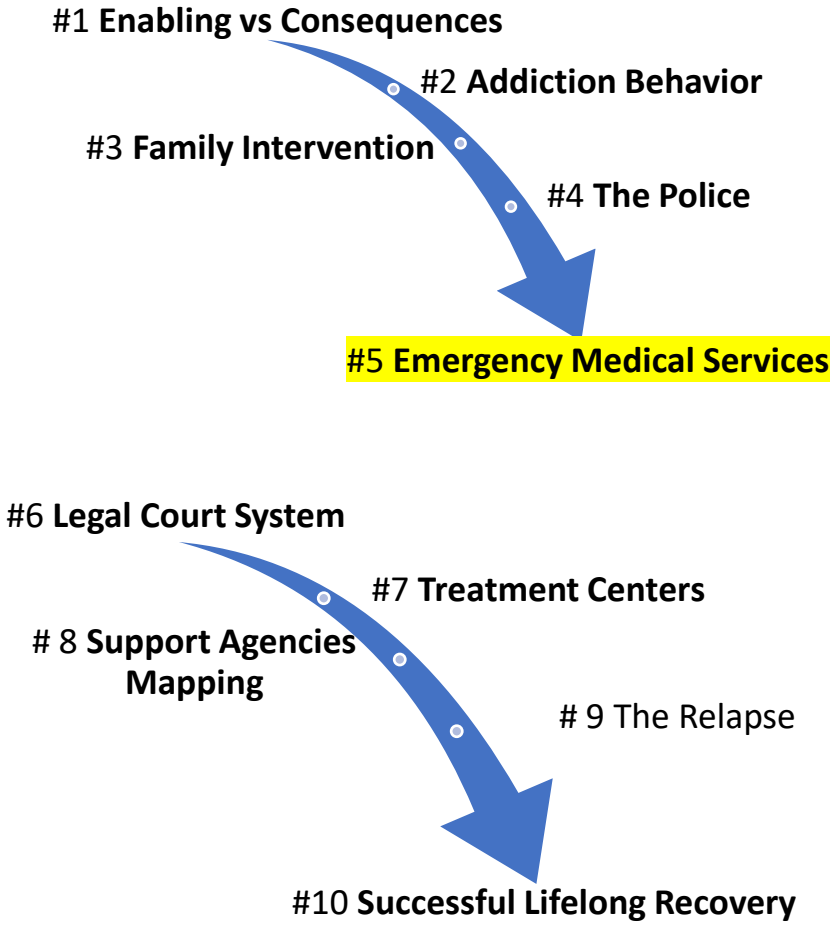
Learning Objectives

1. What is the issue

2. How can the issue impact the family

3. What are the options

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement (Learning how to move forward)**
#12 **Spirituality, Faith Practices**

What is the issue?

Make no mistake about it, when the stages of this disease reach a need for medical intervention, you are at a new phase in the family journey. This is the sever stage and now is not the time to learn about what will happen next and how you need to respond. Fortunately, you are taking this seminar and can start the learning process to be prepare for this likely future event.

This is an intervention and can be a critical turning point at getting your loved one to accept treatment. However, it can go either way; it may yield a successful next step or may be a temporary and frightening experience in the continuation in self-use. It may also be the end of their journey in life.

Signs of OVERDOSE, which is a life-threatening emergency, include the following:

- The face is extremely pale and/or clammy.
to the touch.
- The body is limp.
- Fingernails or lips have a blue or purple cast.
- The person is vomiting or making gurgling noises.
- The person cannot be awakened from sleep or cannot speak.
- Breathing is terribly slow or stopped.
- The heartbeat is terribly slow or stopped.

CALL 911

There are four phases to the “Emergency Medical Service Intervention”:

1. Paramedic First Response Phrase.
2. Hospital Emergency Room Visit.
3. Hospital Intensive Care Unit Admissions or Discharge.

The reality of this experience is a hospital will not be going to take ownership of seeing your loved one through their next steps into recovery. That is going to be your job, not theirs. We need to keep our expectations in line with what is most likely to happen.

The hospital will treat them for their condition, (which is what they are there for) and release them. If your loved one is referred to a Peer-to-Peer coach, great. They may also be seen in follow up visits with behavioral health, admitted to a treatment center or discharged to the custody of the police. All of these are not the responsibility of the hospital to follow that point, it is not their concern, it is yours and yours alone.

But by knowing the steps in an “Emergency Medical Services Intervention”, you can stay one step in front of their process and set up the best next choices for your loved one.

The family members need to:

1. Get Educated on the process.
2. Get Organized to be ready should this occur.
3. Get Networked in advance, to know who is here to help.

How can the issue impact the family?

Get Educated

What is your budget for this expense?
Nothing is free. You will get a bill for transportation to the Emergency Room and it is likely not covered by insurance. The emergency room persons are likely to get a surprise hospital bill from the radiology, medical transport, and other specialty groups such as cardiology departments**.**

They do not necessarily have your back in follow-up.
A new study found that fewer than 10% of ED persons treated for opioid overdoses received medications to treat their substance use disorder. In the years after their overdose, only 10% of those overdose persons received mental health counseling. Experts say a lack of training among health professionals undermines what happens after the overdose person is stabilized. However, the family members could have prevented this by getting their loved one to the right level of care.

How can the family respond for best results?
We should be doing everything we can to get them plugged into treatment. By comparison to someone who came into the emergency room with a heart attack. It is taken for granted that the person would leave with heart medication and a referral to a cardiac specialist. Similarly, you would think persons who come in with an overdose to start buprenorphine in the hospital and leave with a referral to other forms of treatment. The family needs to understand that a lack of training and understanding among health professionals continues to undermine what happens after the overdose person is stabilized. The emergency rooms are not particularly well trained to be able to help people in a situation like this. So, it is up to the family to get educated on what treatments are best practice for their loved one upon discharge from the ER.
McEvoy, M. Naloxone: Drug Whys. EMS1. 2015, October 22.

For this reason, your family is needed in the ER, to advocate for the right level of assessment, treatment and especially follow-up care.

Check list of events which may occur.

Para-Medic

Stablize and Transport

- Stablize VItal Signs for respiratory, cardiac and neurogolgy (brain fuctioning)
- Transport to the ER, non-cobative

Hospital ER Visit

Triage, Assess, Treat, Discharge

- Triage Vitals is the hospitals first priority
- Assess Severity, what drugs are identified, is referral to ICU required?
- Treat condition and Co-Mobidities, stablize condition, treat other identified co-mobidities.

Hospital ICU Admission or Discharge

olice, Treatment Center, Peer to Peer Coach or

Stablize, Improve Condition, Discharge

- Intesive Care Unit (ICU)
- Plan of Treatment
- Discharge

Paramedic, First Responder (NOTE: This is not for the family members to use, it is only for the family members to understand what the clinicians are doing as you observe). Do not take any of these steps unless you are a license professional in this field.

A Case Simulation:
The Emergency responders arrive. An assessment of the person's vital signs reveals a heart rate of 123 beats per minute, blood pressure of 122/86 mmHg, and an oxygen saturation of 98% with assisted ventilation (his room air oxygen saturation was 66%). His initial end tidal CO2 is 70 mmHg and his blood glucose is 269 mg/dL. The person's skin is pale, dry, and cold to the touch. After establishing IV access and starting a normal saline bolus, the crew administers 0.4 mg of IV naloxone (Narcan).

After five minutes, his spontaneous respiratory effort improves, and he becomes agitated and combative. The person's movement is not purposeful, and he is not able to speak. The person is placed on high flow oxygen via non-rebreather mask. Reassessment of vital signs reveals a heart rate of 140 beats per minute, a blood pressure pf 134/83 mmHg, a SpO2 of 99%, a respiratory effort of 30 breaths per minute, and an EtCO2 of 34 mmHg. The person now has a Glasgow coma score of 8.

One of the first responders suggests an additional dose of naloxone because the person is still obtunded. Though the person continues to exhibit decreased mentation, he is breathing adequately, so there is no indication to give additional naloxone. The crew captures an ECG which is unremarkable and prepares the person for transport to the hospital.

While in route to the receiving facility, the person becomes increasingly combative and the crew is forced to sedate him with midazolam (Versed). After two 2.5 mg of IV midazolam, the person is appropriately sedated. The person does not experience any respiratory depression and the rest of the transport is uneventful.

Upon arrival at the ED, the person is transferred to staff, and the crew starts to get their gear back together for the next call. The person's urine drug screen is found to be positive for opioids as well as cocaine, and his core body temperature is 84 degrees F. Active rewarming is initiated in the ED and the person is admitted to the ICU.

What are the options?

Hospital Emergency Room Visit

Stabilization of vital signs is the hospital first concern. The cardiac, respiratory, and neurological (brain) is closely assessed for conditions of decline.

One of the protocols is the use of Naloxone. This may also be the response used on site with the first responders.

With any overdose that results in admission, the first few hours determine not only the outcome, but also the pace at which persons recover.

The key is to identify the important clinical effects. That means figuring out if the overdose is activating (or deactivating) the central nervous system, causing cardiac arrhythmias, or depressing myocardial function, or causing anion gap acidosis. The heart.

"Those are the really big ones you need to be concerned about early on," says Dr. Heard, who is on the faculty at the University of Colorado School of Medicine.

The recognizing of exactly what drug was used is not necessarily as important as recognizing the severity of persons' symptoms and responding to them. With a drug that deactivate the CNS as Opioids, the most common reason people die is because they lose their airway. By managing the persons' airway, they are likely going to survive.

This means ventilation is important, when ER or First Responders overdose the short-acting sedatives to calm the person with a drug like midazolam or propofol, persons may experience longer ICU course because someone gave them multiple doses of lorazepam. They are overly sedated when they might have been ready to extubate.

Naloxone in the ER

1. Opioids cause respiratory compromise and naloxone can reverse it

All opioids stimulate specific receptors in the brain, which decreases perception of pain and causes a feeling of euphoria. When overstimulated, opioid receptors desensitize the brainstem to rises in CO2, which causes respiratory depression, creating a loss of protective airway reflexes and respiratory arrest. Cardiac arrest from opioid overdoses is usually secondary to respiratory arrest. Both are critical and life threatening.

Naloxone reverses narcotic overdoses by binding to opioid receptors in the neuronal channel, which blocks stimulation from the opioid substance. If administered in time, this restores the person's airway reflexes, respiratory drive and level of consciousness.

The major drawback of naloxone is that it can trigger withdrawal symptoms in persons addicted to narcotics, including agitation, tachycardia, vomiting and pulmonary edema. Withdrawal symptoms are usually mild and short lasting, but some persons can become violent after receiving naloxone. Violent reactions are usually after intravenous naloxone is administered at too high a dose or too quickly [2]. Remember the goal of treatment is to restore respiratory drive and airway reflexes, prevent respiratory and cardiac arrest, and avoid causing severe opioid withdrawal [1].

2. Address circulation and ventilation before administering naloxone.

3. Initial care for persons with a suspected narcotic overdose is the same as for any other person with decreased mental status. They may present drowsy, even falling asleep mid-sentence, and require frequent verbal or tactile stimuli for arousal. They may also be unconscious with slow or agonal respirations, diaphoretic and cyanotic. Opioid usage also causes pupils to constrict but taking of another substance or anoxic brain injury may cause pupils to dilate. Once respiratory depression occurs, assisted ventilation and naloxone are vital to prevent permanent brain damage or death [2].

4. The pulse is first checked of an unconscious person. If a pulse is not detected, they start chest compressions and attach the defibrillator. The 2015 American Heart Association guidelines recommend standard ACLS practices for cardiac arrest secondary to opioid overdose and makes no recommendation regarding the administration of naloxone [1].

5. For unconscious persons with a pulse, they will open the airway, assess respiratory rate, and assist ventilation with a bag-valve mask.

6. They will assess pulse-oximetry to guide ventilation rate and to determine if ventilations are effective. The amount of carbon dioxide (CO2) in exhaled air at the end of each breath (end-tidal CO2, or ETCO2) will be monitored.
7. **When giving naloxone, think intranasal administration first.**

Naloxone can be administered intravenously (IV), intramuscularly (IM), intranasally (IN), subcutaneous (SQ), endotracheal and via nebulizer. The most common routes for EMS administration are intranasal, intramuscular, and intravenous, which has several advantages over the other routes for the initial dose.

Persons respond approximately 80 percent of the time to both intravenous and intranasal naloxone, but the onset of intranasal naloxone is longer, the recovery is more gradual, and there is less risk of person agitation and withdrawal symptoms.

Because ventilation and oxygenation are addressed before naloxone administration, other benefits of intranasal administration outweigh the added time needed to restore spontaneous respiration and airway reflexes. A higher dose of naloxone may be needed to reverse longer-lasting oral or transdermal opioids than for heroin. Even if a second intravenous dose is needed later, there is no downside to giving an initial dose intranasal before attempting intravenous access.

Approximately 20 percent of opioid overdose persons do not respond to naloxone. This may be from a high opioid dose, brain damage after a prolonged downtime, or use of other medications.

References:

Lavonas EJ, Drennan IR, Gabrielli A, Heffner AC, Hoyte CO, Orkin AM, Sawyer KN, Donnino MW. Part 10: special circumstances of resuscitation: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Cardiovascular Care. *Circulation.* 2015;132(suppl 2): S501–S518.

Hospital Admission to ICU or Discharge

Hospital Admission to ICU

This admission is not about the drug, it is to address the damaged caused by the drug.

Admission into the Intensive Care Unit (ICU) will be assessed in the emergency room. Note: the death rate among overdose persons treated in ICUs averaged 7% in 2009 and increased to 10% in 2015.

Persons admitted to ICUs due to overdoses have several common comorbidities including aspiration pneumonia (25%), septic shock (6%), rhabdomyolysis (15%) and anoxic brain injury (8%). Ten percent of persons who overdosed needed mechanical ventilation.

A typical length of stay is 3-4 days.

Hospital Discharge

St. Paul's MN Hospital, Early Discharge Rule was derived to determine which persons could be safely discharged from the emergency department after a 1-hour observation period following naloxone administration for opiate overdose. The rule suggested that persons could be safely discharged if they could mobilize as usual and had a normal oxygen saturation, respiratory rate, temperature, heart rate, and Glasgow Coma Scale score. Validation of the St. Paul's Early Discharge Rule is necessary to ensure that these criteria are appropriate to apply to persons presenting after an unintentional presumed opioid overdose in the context of emerging synthetic opioids and expanded naloxone access

Dr. Yngvild Olsen, medical director for the Institutes for Behavior Resources/REACH Health Services in Baltimore, says the study confirms what many in the addiction medicine field have known for a long time: There's a need for interventions beyond what she calls the "usual standard of care, which has been to hand people a phone number or pamphlet and say, 'Here. Good luck.' "

Olsen says such interventions are in the works. She points to a 2015 study by researchers at the Yale School of Medicine who tested three interventions for opioid-dependent persons who came to the emergency department for medical care.

The first group was given a handout with contact information for addiction services. The second group got a 10- to 15-minute interview session with a research associate who provided information about treatment options and helped the person connect with a treatment provider, even arranging transportation. The third group got the same interview, plus a first dose of buprenorphine, additional doses to take home and a scheduled appointment with a primary care provider who could continue the buprenorphine treatment within 72 hours.

Dr. Corey Waller, who trained in emergency medicine and is now senior medical director for the National Center for Complex Health and Social Needs, says medical teams often lack basic knowledge.
"The professionals that are supposed to be able to refer and treat don't have the training to know how and what to do," Waller says, pointing out that as a resident, he received less than one hour of instruction in addiction treatment.

Another problem, he says, is that emergency departments treat an opioid overdose as a toxicological problem, not unlike dealing with a person who took too much Tylenol.

"But what that completely ignores are the psychological aspects of [addiction]," Waller says. "When you ignore that, you are fully ignoring the disease. And you're looking at the person like a toxicological problem and not a human."

He says it is important to remember that opioid addiction changes people's brains in ways that keep them from making logical decisions, such as seeking out treatment after an overdose. "They're not putting a pros and cons list on the refrigerator," he says. "They're just reacting to a situation that feels very much like survival."
The study found that 78 percent of persons in the third group — the group that got a dose of buprenorphine in the hospital — were still in treatment 30 days later, compared with 45 percent in the group that only got the interview and 37 percent who only got the handout.

Based on the study, hospitals across the country are now discussing incorporating buprenorphine into emergency department care for persons who have overdosed, Olsen says. Several Baltimore hospitals have begun doing so. She is hopeful that such a system could provide new paths to treatment for people who need it, while not overburdening emergency department staff who are already stretched thin.

"Conceptually, it makes so much sense," Olsen says. "It is, in my mind, one of those landmark studies that really addresses how to take advantage of those missed opportunities that the JAMA research letter describes."

The initial assessment and treatment of persons attending an emergency department (ED) for suspected drug poisoning takes place in the emergency room, where the busy physicians must rapidly decide on the level of therapeutic measures and disposal. Decontamination procedures for drug overdose are recommended under specific circumstances by the American Academy of Clinical Toxicology and by the European Association of Poison Centers and Clinical Toxicology in a joint position statement,1 but their efficacy is questioned. The most important measure is a correct management of individual persons, according to their clinical status and hospital resources. In unstable persons, lifesaving support is mandatory, independently of laboratory results, whereas in uncomplicated, stable, slightly drowsy persons, with no specific symptoms of drug poisoning, the diagnosis may be uncertain, and there is no definite consensus on treatment and disposal. These persons are a special challenge for the emergency physicians.

A pure clinical approach, without confirmatory laboratory results, makes diagnosis and decision making highly uncertain. Some persons need only a brief period of observation in ED, while others may need care in a high dependency unit (HDU) or in intensive care unit (ICU), in relation to worsening clinical status or long-acting drug overdose.

Comprehensive drug screenings have been proposed to document and confirm any acute drug overdose in persons for suspected poisoning.

2 A screening procedure is operative in our unit, permitting the determination of over 900 drugs and their metabolites in a turnaround of 20 to 60 minutes. Its usefulness has however been questioned.

3 In most cases the results do not change, the decision being mainly based on clinical parameters.

4 Drug screening, limited to life threatening drugs selected based on the clinical suspect, is currently considered a cost-effective diagnostic tool.
The aim of this study was to evaluate the effects of comprehensive drug screening in decision making strategies of persons with suspected drug poisoning. We aimed to determine whether the results of such screening improved the agreement in an expert panel of emergency physicians and changed the decision on persons' disposal, potentially saving hospital resources.

REF: Comprehensive drug screening in decision making of persons attending the emergency department for suspected drug overdose A Fabbri, G Marchesini, A M Morselli-Labate, S Ruggeri, M Fallani, R Melandri, V Bua, A Pasquale, A Vandelli

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Get Organized

RESOURCES FOR OVERDOSE SURVIVORS AND FAMILY MEMBERS

Survivors of opioid overdose have experienced a life-changing and traumatic event. They have had to deal with the emotional consequences of overdosing, which can involve embarrassment, guilt, anger, and gratitude, all accompanied by the discomfort of opioid withdrawal. Most need the support of family and friends to take the next steps toward recovery.

While many factors can contribute to opioid overdose, it is almost always an accident. Moreover, the underlying problem that led to opioid use—most often pain or substance use disorder—still exists and continues to require attention.

The individual who has experienced an overdose is not the only one who has endured a traumatic event. Family members often feel judged or inadequate because they could not prevent the overdose. It is important for family members to work together to help the overdose survivor obtain the help that he or she needs.

FINDING A NETWORK OF SUPPORT

As with any health condition, it is not a sign of weakness to admit that a person or a family cannot deal with overdose and its associated issues without help. It takes real courage to reach out to others for support and to connect with members of the community to get help. Health care providers, including those who specialize in treating substance use disorders, can provide structured, therapeutic support and feedback.

If the survivor's underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the person should be referred to an addiction specialist for assessment and treatment by a physician specializing in the treatment of opioid addiction in a residential treatment program or in a federally certified opioid treatment program.

In each case, counseling can help the individual manage his or her problems in a healthier way. The path to recovery can be a dynamic and challenging process, but there are ways to help. In addition to receiving support from family and friends, overdose survivors can access a variety of community-based organizations and institutions, such as:

- Health care and behavioral health providers.
- Peer-to-peer recovery support groups such as Narcotics Anonymous.
- Faith-based organizations.
- Educational institutions.
- Neighborhood groups.
- Government agencies.
- Family and community support programs.

The Personal Attaché Organized Binder

Because your next step will require request for new information it is best to organize these documents into a Binder. You will complete this exercise in "The Family Solution Finder Workbook" under this section: The Emergency Medical Services Intervention.

There are several steps a family will go through when using a hospital for the care of their loved one. Most of these require documents, billing information, healthcare history information and current health status updates. This can all be contained by the family in a “Family Personal Attaché Binder”, which the family assembles prior to needing this level of information.

The Family Personal Attaché is a binder system that contain important documents and information about the person’s life that are requested by professional service for them to provide their services. In the Binder System there are four parts:

1. The Legal Section
2. The Medical Section
3. The Financial Section
4. Spiritual/Social/Community Networking Sections

All these sections are filled in with specific documents and information about the persons status, history, and future. In the case of completing this family binder for the person with a substance use disorder the medical section is the part that will be most frequency used and updated.

Your Family Plan of Action After Discharge:

Each of the above categories can be learned prior to the event taking place. It will be a great value to the family members if they get educated about each option and then create a plan of action on that topic to pre-determine the choices the family will need to consider.

Because each case is unique it will be difficult to determine all the steps that will be needed. However, having a mutual base understanding will assist the family in communicating, making stronger decision and in the end save time and money for improved outcomes.

Next Steps Following Emergency Medical Services Intervention

At this point, the hospital visit is over and now the next steps will require new decisions and choices of which path to take.

This scenario plays out in emergency departments across the country, where is the next step — unfortunately, the means to divert addicted persons into treatment — remains elusive, creating a missed opportunity in the health system. A recent study of Medicaid claims in West Virginia, which has an opioid overdose rate more than three times the national average and the highest death rate from drug overdoses in the country, documented this disconnect.

Researchers analyzed claims for 301 people who had nonfatal overdoses in 2014 and 2015. By examining hospital codes for opioid poisoning, researchers followed the persons' treatment, seeing if they were billed in the following months for mental health visits, opioid counseling visits or prescriptions for psychiatric and substance abuse medications.

They found that fewer than 10 percent of people in the study received, per month, medications like naltrexone or buprenorphine to treat their substance use disorder. (Methadone is another option to treat substance use, but it is not covered by West Virginia Medicaid and was not included in the study.) In the month of the overdose, about 15 percent received mental health counseling. However, on average, in the year after the overdose, that number fell to fewer than 10 percent per month.

"We expected more … especially given the national news about opioid abuse," said Neel Koyawala, a second-year medical student at Johns Hopkins School of Medicine in Baltimore, and the lead author on the study, which was published last month in the Journal of General Internal Medicine.

It is an opportunity that is being missed in emergency rooms everywhere, said Andrew Kolodny, the co-director of Opioid Policy Research at the Heller School for Social Policy and Management at Brandeis University outside Boston. "There's a lot of evidence that we're failing to take advantage of this low-hanging fruit with individuals who have experienced a nonfatal overdose," Kolodny said. "We should be focusing resources on that population. We should be doing everything we can to get them plugged into treatment."

He compared it to someone who came into the emergency room with a heart attack. It is taken for granted that the person would leave with heart medication and a referral to a cardiac specialist. Similarly, he wants persons who come in with an overdose to start buprenorphine in the hospital and leave with a referral to other forms of treatment.

Kolodny and Koyawala both noted that a lack of training and understanding among health professionals continues to undermine what happens after the overdose person is stabilized.

"Our colleagues in emergency rooms are not particularly well trained to be able to help people in a situation like this," said Dr. Margaret Jarvis, the

It was clear, Angerer said, that her doctors were not equipped to deal with her addiction. They did not know, for instance, what she was talking about when she said she was "dope sick," feeling ill while she was going through withdrawal. "They were completely unaware of so much, and it completely blew my mind,"

Ref: Journal of General Internal Medicine June 2019, Volume 34, Issue 6, pp 789–791| *Cite as Changes in Outperson Services and Medication Use Following a Non-fatal Opioid Overdose in the West Virginia Medicaid Program*

Plan of Care as follow up:
According to a news report, 79% of overdose victims in Delaware died in private homes. Fifty-two percent of overdose deaths occurred within three months of a visit to an emergency room. Most exhibited signs of substance abuse disorder during those ER visits. That is according to a new report from the Delaware Drug Overdose Fatality Review Commission, which was created to better understand the state's overdose death epidemic.

It is absurd that we do not voluntarily offer the best care we have to anyone who wants it in the aftermath of an overdose, on the spot.

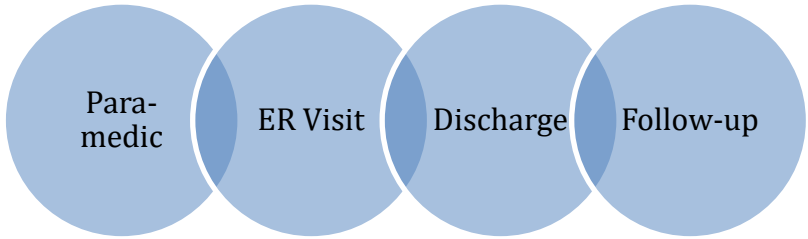
A strategy of offering immediate medication treatment has been studied in a randomized clinical trial published in the *Journal of the American Medical Association* in 2015. 329 persons were included. Of this group, 104 were simply provided a referral to further treatment, 111 were given referrals along with a brief motivational therapy aimed at encouraging them to follow through and enter care and 114 were prescribed buprenorphine right then and there.

Not surprisingly, the buprenorphine persons were twice as likely as those who were simply offered treatment referrals to still be in treatment a month later, and they reduced their illegal opioid use from an average of five days a week to an average of just one.

While 78% of them were still in treatment, fewer than half of the other two groups remained engaged— and their drug use was reduced by far less than in the group who got buprenorphine immediately, according to Dr. Gail D'Onofrio, lead author of the study, and a professor of emergency medicine at Yale.

"Immediate treatment in the emergency room with buprenorphine for a person withdrawing or after an overdose is critical to save more lives and engage more people in treatment, but only if the 100-person limit is eliminated and people have somewhere to go for maintenance," says Dr. Molly Rutherford, a family doctor who treats addiction in Kentucky, which is one of the hardest hit states. She also notes that many E.R. doctors may also be unaware that they are legally able to provide emergency maintenance.

Of these four, follow up is the most often neglected and creates the greatest loss in opportunity to move forward.



So often is the case where the person leaves the ER, says they are fine, and months go by. Then it happens again. Repeatedly.

Stop the cycle by using the ER as a launch into follow up services, know the resources now before you need them. Because it is highly likely you will need them.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEANTING MODULE I

Seminar # 15

The Legal Court System Intervention

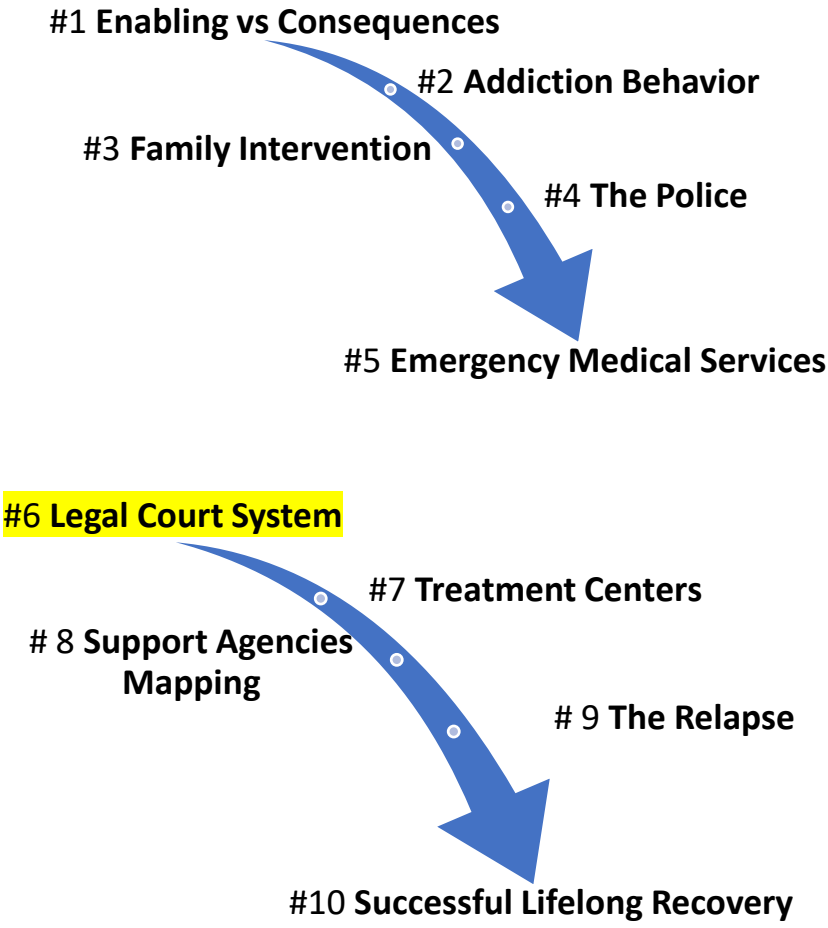
Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement (Learning how to move forward)**
#12 **Spirituality, Faith Practices**

What is the issue?

The Sequential Intercept Model (SIM) is a tool that enables communities to create coherent strategies to divert people with mental and substance use disorders from the criminal justice system. The mapping process associated with SIM (see Figure 1) focuses on five discrete points of potential intervention, or "intercepts" (Munetz & Griffin, 2006). This gives the family members a visual perspective to the legal court systems intervention process.

Intervention 1: Law enforcement.

Intervention 2: Initial detention/first court appearance.

Intervention 3: Jails/courts.

Intervention 4: Reentry from detention into the community

Intervention 5: Community corrections, probation, and parole.

The Crisis Intervention Team model has been disseminated broadly as a strategy to improve law enforcement interventions at Intercept 1-2. Your community may have a mental health court, drug court, or other treatment courts. These have become an increasingly common part of the judicial landscape and define much of the conversation at Intercept 3. Reentry from jail or prison, Intercept 4, has become a core topic in general discussions regarding correctional policies at the federal, state, and local levels. SAMHSA's SSI/SSDI Outreach, Access, and Recovery) (Dennis & Abreu, 2010) ease reentry on release from jail or prison. And while many communities lack much in the way of resources at Intercept 5, a literature has emerged that discusses specialized probation as a strategy to ensure longer community tenure (Skeem & Manchak, 2008).

While each intercept presents opportunities for diversion, Intercept 2 holds the most unexplored
potential. This is because it is at Intercept 2 (initial detention and first court appearance) that most individuals who meet the criminal justice system appear. These numbers overwhelm many court systems.

Many of these individuals have a mental illness and co-occurring substance use disorders; these are the individuals whom communities often try to divert. However, for a variety of reasons discussed below, this intercept is often overlooked.

The optimal diversion strategies that are most often overlooked and involve municipal courts are at first appearance (Intercept 2).

Municipal Courts: Definition and Caseloads
Most people who are arrested appear before a "municipal court" or its equivalent. Municipal courts are courts of limited jurisdiction.
Figure 1. The Sequential Intercept Model
SSI/SSDI Outreach, Access, and Recovery (SOAR) expedites access to Social Security disability benefits – Supplemental Security.

The family members need to:

4. Get Educated on the process.
5. Get Organized to be ready, should this occur.
6. Get Networked in advance, to know who is here to help.

How can the issue impact the family?

Incarceration Diversion Programs

Identification and Screening Is an Important Step
The Identification and screening process for co-occurring disorders in early diversion programs is challenging due to the high number of cases processed in municipal courts and the short time between arrest and arraignment.

Even in communities with police Crisis Intervention Teams, behavioral health information. So, the family needs to confirm this information is passed up the chain and included. It may be needed for the family to pay an attorney to hand carry it through the courts. This confusion is compounded by high volumes of cases, inadequate staffing, and space limitations. All these factors inhibit staff at initial detention from screening for mental illness and co-occurring substance use disorders and eligibility for diversion.

Many communities identify potential candidates for referral to specialty courts or appropriate community-based treatment at arraignment, but they lack the capacity to divert individuals with co-occurring disorders at arraignment. So, the family needs to be proactive.

To initiate prompt and timely diversion, the family needs to solicited resources that are devoted to identification and screening as early as possible following arrest.

For this reason, your family is needed in the ER, to advocate for the right level of assessments, treatment and especially follow-up care.

Pre-Trial Services

In many communities Pre-Trial Services is either under the auspices of the local probation department or a contracted agency. The main objective of Pre-Trial Services is to assess bail risk and determine the likelihood that someone will return to court.

As noted above, justice-involved people with mental illness are more likely to have more bail risk factors lack employment, lack of personal relationships, and most importantly, lack of an address. Consequently, likelihood of incarceration for people with mental illness is high at arraignment.

Pre-Trial Services is uniquely positioned to be a partner in early diversion programs. Adding a screening instrument (e.g., the Brief Jail Mental Health Screen) to the bail assessment will help to identify potential candidates for early diversion. Your courts may or may not have these components. If not ask why.

Get Counsel: Getting a defense counsel is the next strategic entity, to then interview the defendant. By incorporating a behavioral health screening into the initial interview, diversion candidates can be identified by attorneys, and the merits of diversion versus usual case processing can be discussed with this information included.

Many public defender offices employ social work staff to provide clinical assessment and diversion coordination for defendants; Focusing the efforts of clinical staff at arraignment allows the courts to identify and refer to diversion services and enhances prompt referral to post arraignment diversion programs.

Court-Based Clinicians:
When clinicians are present in court, there is added capacity for screening for diversion opportunities. Court-based clinicians may be employed by the court, local behavioral health departments, or contracted providers. Court-based clinicians face challenges regarding interview space, case volume, and time. Larger, municipal courts often operate seven days per week from morning to evening and providing clinical coverage for all hours of court operation may not be feasible.

Judge and Court Staff
Do not expect everyone understands the process. As a family member takes the initiative to confirm each step of the process. Even without clinical training, municipal court judges and their court staff are in a great position to identify defendants who seem to be struggling in the courtroom. Particularly in smaller jurisdictions, judges are familiar with repeat defendants and their families and have a sense about an individual's behavioral health needs. Recognizing there is interest among municipal court judges in gaining skills to understand behavioral health needs from the bench and respond appropriately.

The role of the court-based clinician is to provide both screening and assessment, as described above, and initial engagement and linkage. Once identification through a screening process is accomplished,
assessment is required to determine clinical eligibility and treatment needs. Often there are few clinical records available, so assessment relies heavily on screening/assessment tools, psychosocial history, and mental status examination to determine clinical eligibility.

What are the options?

Drug Court and Veterans Court

Veterans Justice Outreach Specialists the U.S. Department of Veterans Affairs (VA) initiated a Veterans Justice Outreach (VJO) initiative in 2009. VJO specialists are tasked with providing diversion alternatives for justice-involved veterans eligible for VA services.

VJO specialists may not have the capacity to service all municipal courts in their region, but where available, VJO specialists are effective in screening and identifying veterans for diversion programs, offer consultation regarding the most effective strategies for screening veterans, and provide access to VA services (Christie et al., 2012).

Jail to Rehabilitation or Community

The Current Situation:
An estimated 50 percent of the U.S. prison population has a drug addiction issue, but only about 10 percent get the necessary help. Sending many of these offenders to rehab rather than jail or prison could help save money in the following ways:

- Individuals in addiction recovery are less likely to be arrested again, which reduces costs related to arrest and incarceration.

- Fewer crimes committed also would reduce court costs and lawyer fees
  Initial drug rehab and addiction treatment is less costly than prison.

- Addiction treatment and recovery improve health overall, which then reduces healthcare costs in both the short- and long-term.

- Addiction treatment and recovery would reduce costs associated with lost work productivity, either from incarceration or drug-related injury and illness.

- Recovery would save resources spent on caretaking for children of offenders or addicts.

The U.S. Department of Justice estimates that 15 percent to 20 percent of the United States' 2 million prisoners have a mental illness. Unlike clinics and hospitals, however, the prison system was not built to address serious mental-health needs.

Psychologists and, to a lesser extent, psychiatrists do provide mental health care to prison inmates, and may provide helpful rehabilitative services. Such programs, however, are difficult for prison-based therapists to implement on top of their already heavy caseloads. There are also not enough mental-health professionals to address every need in U.S. prisons.
Rehab programs for inmates are also difficult to create and implement because of philosophical and priority differences. While psychology is focused on treating and rehabilitating persons, the current criminal justice system is focused on punishing offenders.
Drug treatment studies for in-prison populations find that when programs are well-designed, carefully implemented, and utilize effective practices they:

- reduce relapse.
- reduce criminality.
- reduce recidivism.
- reduce inmate misconduct.
- increase the level of the offender's stake in societal norms.
- increase levels of education and employment upon return to the community.
- improve health and mental health symptoms and conditions.
- improve relationships.

Collectively, these outcomes represent enormous safety and economic benefits to the public.

Community Treatment Services is the reentry effort of the Psychology Services Branch. CTS, formerly known as Transitional Drug Abuse Treatment or TDAT, provides continuity of care for offenders placed in Residential Reentry Centers (RRCs) and on Home Confinement. Research has found this period to be the most vulnerable time for an offender to relapse into substance use and/or criminal behavior. Research also demonstrates continued treatment and supervision is an essential element to the offender's treatment and success.

CTS provides a comprehensive network of contracted community-based treatment providers in all 50 states, three U.S. Territories and the District of Columbia. The network of professionals consists of licensed individuals (e.g., certified addictions counselors, psychologists, psychiatrists, social workers, professional counselors, medical doctors, certified sex offender therapists, etc.) and specialized agencies resulting in a variety of services available in the community.

The CTS staffs work closely with U.S. Probation to establish a continuum of care as the offender leaves Bureau custody and moves to supervised release under U. S. Probation. To facilitate this process, U. S. Probation is provided with a comprehensive discharge/termination report on all offenders who have participated in treatment in the community. This provides the supervising U. S. Probation Officer valuable information regarding the offender's treatment progress and ongoing treatment needs.

Finding an Attorney

If you are a multiple offender, have several DUI's, or otherwise have a proven track record of committing substance related crimes, your judge may recommend you to a rehabilitation program instead of to prison. In most cases, you will be given a dual option of either rehab or jail, so you can choose which you want to do.

You can also encourage this process by consulting with your lawyer and asking them to recommend you court ordered rehab. Your lawyer can help you to determine if you qualify (for example, if you have a history of drug or alcohol use) and can then recommend the option to the judge as a solution over jail. Importantly, this is only a solution in non-violent crimes.

Here, you will go through a process where you are assigned a case worker who will spend time with you to determine your actual drug and alcohol use and how much it was responsible for your crime. If the case worker agrees, you will be sentenced to rehab, possibly followed by, or including a stint in AA.

The Contents of this Study Guide Session:

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Policy Research Associates, Inc., under SAMHSA IDIQ Prime Contract #HHSS283200700036I, Task Order #HHSS28342003T with SAMHSA, U.S. Department of Health and Human Services (HHS). Numerous people contributed to the development of this publication, and SAMHSA would like to acknowledge the individuals below. Policy Research Associates Henry J. Steadman, PhD Chanson D. Noether, MA Dan Abreu, MS, CRC, LMHC Lisa Callahan, PhD Council of State Governments Justice Center Hallie Fader-Towe, JD University of South Florida College of Public Health John P. Petrila, JD, LLM Substance Abuse and Mental Health Services Administration Pamela S. Hyde, JD Larke N. Huang, PhD Kenneth W. Robertson David Morrissette, PhD, LCSW

Municipal Courts:

An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System SAMHSA Publication

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 16

Treatment Centers Intervention

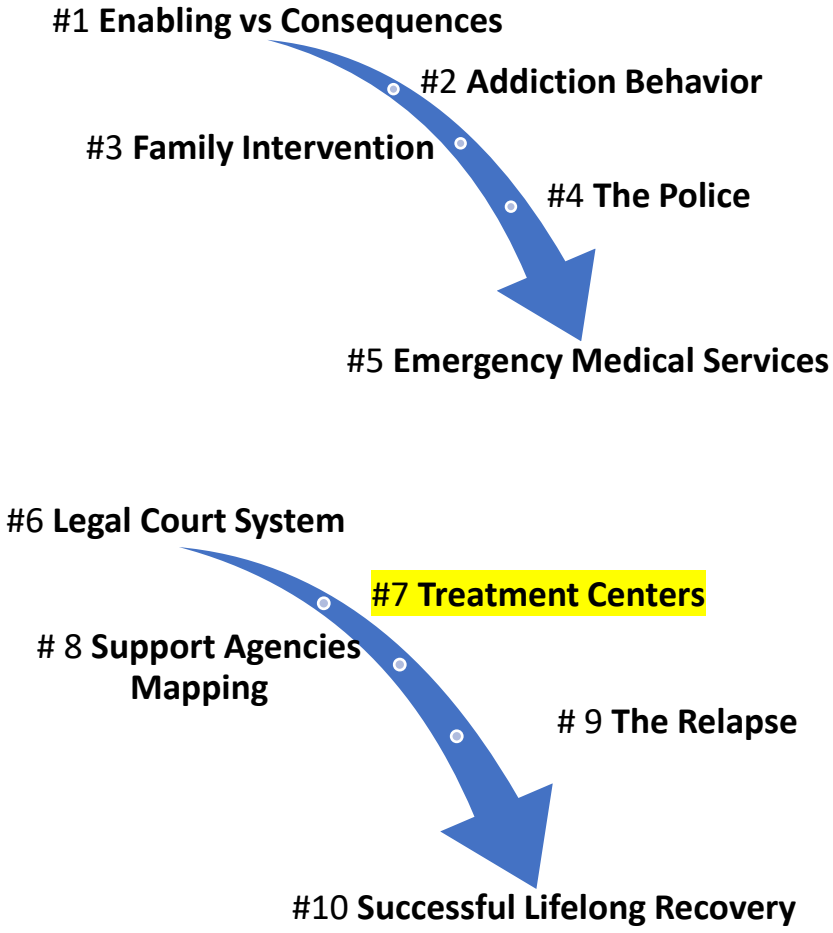
Learning Objectives

1. Types of Treatment Programs.

2. Levels of Treatment.

3. Treatment Paths.

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement (Learning how to move forward)**
#12 **Spirituality, Faith Practices**

What is the issue?

Currently

By the time a treatment center is required the family members have been through a great number of issues and decisions. Most likely, the thought of a treatment center being needed was considered but not fully reviewed, "we will cross that bridge when it comes". As we have identified in the other seminars, this is not to the family's member's best interest. This is because when it is time for a treatment center it is typically at a time when the family members are scared, angry, stressed and not at their best towards making decisions and communicating with others. It is the worst time to be looking for a treatment center. They just want their loved one placed into a facility and treatment started. They want this all to be over, and that is what a treatment center does. **Wrong**, that is not what a treatment center does. It is not over when the person is discharged off service. The family members are setting themselves up for a huge disappointment if they think a treatment center is the final answer.

The point is, the disease existed before the admit to a treatment facility, during the treatment facility therapy and will be there after the treatment facility care. The **Acute Care Treatment** is only a small part of the persons **Chronic Disease Management**. And acute care setting has never been and never will be a proper site of care for managing the long-term needs of a chronic disease. It is the work that follows, which will make the greatest, lasting impact to the loved ones sustained recovery. And that means the family members have a direct role in making the necessary changes which will ensure a stronger, supportive, and empowering environment for everyone that is on this journey.

So, given this is a chronic disease, it is likely the family members will find themselves back at the treatment center, repeatedly until recovery is finally sustained. It may take as many as four to six times through a treatment center before longer recovery is achieved.

Therefore, if you know your loved one is addicted, then start looking now for a facility. Do not wait until you are up against a crucial moment to for a treatment center. Know your options, do your homework now and it will pay off in the future when the time come to use them.

The Challenges

If you ask me if my facility is the right place for your child, I will tell you, yes. Would this surprise you? I have answered your question and you are relieved. If you needed tires, and I sold tires and you asked me if I would sell you tires, I would say, yes. Would this surprise you? I have answered your question and you are relieved. When you call the on-line phone number and get a call center, and ask me for recommendations, as a call center, I will send you to the provider who pays me the most. And you will unknowingly be relieved.

The problem is, when looking for a treatment centers, the family members have no idea what they are asking for, how to evaluate the facility and how to compare them against their competition. And this industry does not make it easy for you to do a "treatment facility search and compare".

Solutions

This seminar is designed to show the family members how to think this through, what to consider and what questions to ask when searching for a drug treatment center. The first and most important step is to have an un-bias evaluation of your loved one. It is only from that vantage point where you will learn what to ask for and expect as an outcome. For example: If your loved one has an addiction, then you treat the addiction. If they have an addiction and mental illness, then you treat the addiction then the mental illness. If you only treat one, you will likely not have a good outcome. It is possible the mental illness will be under treated and the likely hood for relapse is increased after treatment discharge.

Get three types of assessments:

1. Medical Assessment.
2. Addiction Assessment.
3. Mental Health Assessment.

How can the issue impact the family?

First Find Out What You Are Dealing With

There are several levels of treatment centers and all of them depend on a multitude of criteria from insurance, to diagnosis, to severity of disease and stage of addiction cycle, dual diagnosis, Medical Comorbidities. All of these are included to the management of a plan of treatment.

Health care professionals who can conduct your assessment:

- Physicians (M.D.) who are trained in addiction treatment
- Licensed psychologists (with a Ph.D. or a Psy.D.) who are trained in addiction treatment
- Licensed clinical social workers (L.C.S.W.), marriage and family therapists (L.M.F.T.) or mental health counselors (L.M.H.C.; L.P.C. or L.C.M.H.C.) who are trained in addiction treatment
- Licensed or certified addiction counselors

What are the options?

Determine Types of Treatment, (Recommended)

Based on scientific research since the mid-1970s, the following key principles should form the basis of any effective treatment program:

- Addiction is a complex but treatable disease that affects brain function and behavior.
- No single treatment is right for everyone.
- People need to have quick access to treatment.
- Effective treatment addresses all the person's needs, not just his or her drug use.
- Staying in treatment long enough is critical.
- Counseling and other behavioral therapies are the most used forms of treatment.
- Medications are often an important part of treatment, especially when combined with behavioral therapies.
- Treatment plans must be reviewed often and modified to fit the person's changing needs.
- Treatment should address other possible mental disorders.
- Medically assisted detoxification is only the first stage of treatment.
- Treatment does not need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously.
- Treatment programs should test persons for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as teach them about steps they can take to reduce their risk of these illnesses.

There are many options that have been successful in treating drug addiction, including:

- Behavioral counseling
- Medication
- Medical devices and applications used to treat withdrawal symptoms or deliver skills training.
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety
- Long-term follow-up to prevent relapse.
- A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems.

The family will need to research each of these treatments on the internet to find out what is involved with each treatment options.

An integrated treatment program, which may combine medication and behavior modification, is best applied as part of a long-term plan to achieve recovery. Individuals may opt to receive treatment in a long-term residential setting that provides time for easing withdrawal, learning, and employing relapse prevention strategies, and selecting follow-up options for continued care, including community programs that support and encourage an individual to live a drug-free lifestyle.

Acute Care Setting Required

What to ask when contacting a treatment center?

- What types of treatment therapies are offered?
- Can the program offer medication?
- Are staff members qualified to treat both mental health issues and addiction?
- Is treatment tailored for each person?
- What will they have to do during rehab?
- What can and should the family do while they are in treatment?
- Can you provide person rights and responsibilities in writing?

Select Best Facility for Their Level of Care

First Consideration is Detoxification:

Detoxification, or detox, is the process of letting the body remove the drugs in it. The purpose of detox is to safely manage withdrawal symptoms when someone stops taking drugs or alcohol.

Everyone has a different experience with detox. The type of drug and how long it was used affect what detox will be like.

Medications used in detox help keep former users comfortable while the drugs leave their body.

It can take days or months to get through withdrawal symptoms for most drugs. The length of withdrawal depends on several factors, including:

- Type of substance the user is addicted.
- Duration an addiction has lasted.
- The severity of the addiction
- Method of abuse (snorting, smoking, injecting, or swallowing)
- The amount of a substance the user takes at one time.
- Family history
- Genetic makeup
- Medical condition
- Underlying mental health conditions

Speak with someone who can help you find a medically assisted detox.

After Detox, learn about what treatment setting is right for you?

Intensive Outperson

• Overview: Offers similar services to outperson care, but services are offered more frequently. Can also arrange for treatment of mild to moderate physical and mental health conditions at the same time.

• Hours Per Week: Usually 9 or more hours of therapy and education per week involving a mixture of individual and group counseling.

• Best For: People who can benefit from outperson treatment but require more frequent contact with therapists.

• Living Environment: You live at home and may be able to work or go to school Partial

Hospitalization

• Overview: A type of outperson treatment, also called day treatment, for individuals requiring more services than intensive outperson.

• Hours Per Week: Usually 20 or more hours of therapy and education per week—up to 9 hours per day, up to 7 days a week.

• Best For: People with more severe addiction and/or other serious health conditions or whose living environment is safe but does not provide enough structure or positive support for recovery.

• Living Environment: You live at home, but usually spend a lot of time each day in treatment, which can make working or going to school difficult.

Residential (Non-Hospital)
• Overview: Services are provided in a live-in setting. Residential non-hospital care (also called "rehab") includes 3 different levels of care, which differ in the intensity of services offered and their ability to treat more severe forms of addiction and/or other serious health conditions.
• Hours Per Week: Usually 24-hours/day
• Best For: Residential treatment is best for people whose drinking or drug use puts themselves or others at risk for serious harm, who are often unemployed, homeless or in trouble with the law, or who do not have a safe and stable living environment.
• Living Environment: You live at the facility, away from home (for any time between a few weeks to many months), with others in treatment and always have access to professional support.

Inperson (Hospital)
• Overview: Round-the-clock hospital treatment for people with severe medical problems, sometimes due to addiction, or severe psychiatric disorders.
• Hours Per Week: Offers 24-hour treatment supervised or provided by a physician.
• Best For: People with addiction and severe physical or mental health problems who need constant medical supervision and treatment.
• Living Environment: You stay in the hospital until treatment is completed or until you can be safely transferred to another treatment setting Source: Adapted from American Society for Addiction Medicine Person Placement Criteria.

Second Consideration is where is the Level of Care:
The person must first go through detoxification before an y level of care can be used for treatment. After detoxification, the quest is "what level of care is most suitable for the person". Therefore, an assessment needs to be completed for what level of care is best. From the assessment a level is selected. These include:

- **Who has Outperson treatment?** Persons live at home and go to

a clinic or facility regularly for sessions with addiction treatment professionals.

- **Who has Inperson treatment?** Persons stay in a hospital and receive intensive and highly structured care for addiction and other severe medical problems.
- **Who has Residential treatment?** Persons stay in a nonhospital setting and receive intensive and highly structured care for addiction and other medical problems.
- **Who has Recovery housing?** Persons live in supervised, temporary housing and can participate in treatment program.

Other Treatment Settings (ordered from the least to the most intensive)

Outperson

• Overview: Delivered in a variety of locations, such as a professional's office or a health, mental health, or addiction clinic. Other health conditions, including mental health, can also be addressed.
• Hours Per Week: Usually less than 9 hours of therapy and education per week; most often involves once or twice weekly individual, group, or family counseling sessions.
• Best For: People who do not have a serious health problem whose drinking or drug use does not put them at risk for serious harm, who have a good recovery support system and a safe and stable living environment.
• Living Environment: You live at home and may be able to work or go to school.

Methadone Maintenance Clinic.

• Overview: A specially licensed outperson clinic that dispenses methadone to persons with opioid addiction. Some programs also provide buprenorphine (Suboxone)

• Hours Per Week: Methadone doses are picked up once a day during the early stage of treatment and then less frequently over time. Most clinics offer therapy services, but infrequently (monthly), so you may need to seek additional therapy.
• Best For: People with severe or long-term addiction to opioids who have experienced serious health, family, employment, or legal problems.
• Living Environment: Initially, you must live close enough to the clinic to pick up your medication most days of the week Treatment settings range from more to less restrictive. They also vary in the level of medical care provided. The treatment setting that is right for you will depend on your individual needs.

Non-Commercial Search Engines

SAMHSA.COM

RELINK.ORG

PSYCHOLOGYTODAY.COM

Third Consideration is Type of Therapy:

Therapy (also called counseling) is the most common treatment for substance abuse and addiction. There are several different types of therapies that are effective, depending on your individual needs and circumstances. Research does not yet tell us exactly which therapy is best for which people, but we do know that family therapy is usually the best treatment for teens. Look for an addiction treatment provider who offers a range of effective therapies, including one or more of the following:

Motivational Interviewing and Motivational Enhancement

- **Therapy**
- How It Works: Bolsters motivation to change substance use behaviors, encourages planning for change and then making and maintaining changes in behavior

- **Cognitive Behavioral Therapy**
  How It Works: Helps identify, recognize, and avoid thought processes, behaviors and situations associated with substance use. Helps manage cravings, refuse offers of alcohol or other drugs, and develop better problem solving and coping skills.
- **Community Reinforcement Approach**
  How It Works: Focuses on improving family relations, learning skills to reduce substance use, acquiring job skills, and developing recreational activities and social networks that can help to minimize the drive to use substances.

Know the Facilities Treatment Paths

An Individual: addiction treatment provider offers office based, outperson treatments, usually meeting with you once or twice per week. It is important that individual providers have specific training and expertise in addiction treatment. When in doubt, ask about their specialized training in addiction and how long they have been treating persons with addiction. Individual providers can include: • Addiction medicine physicians and addiction psychiatrists (M.D./D.O.)

• Psychologists (Ph.D./Psy.D.)
• Licensed clinical social workers (L.C.S.W.), marriage and family therapists (L.M.F.T.), and mental health counselors (L.M.H.C., L.P.C. or L.C.M.H.C.)

An addiction treatment program usually offers more intensive care. At a program, a team of health care providers will work together to treat you. The team should include a physician (M.D.), a psychologist (Ph.D./Psy.D.) or one of the counselors or social workers listed above and may also include addiction counselors.

Treatment programs may also employ physician's assistants, nurses, and nurse practitioners with training in addiction treatment. If you need addiction medication, you need to find a provider who is licensed to prescribe it.

• Most physicians, including primary care doctors, can prescribe medications for nicotine and alcohol addiction.

• Methadone can only be prescribed at a specially licensed methadone clinic. To find one near you, visit http://dpt2.samhsa.gov/treatment/directory.aspx.

• Physicians with special training can prescribe buprenorphine in their office. To find one near you, visit http://buprenorphine.samhsa.gov/bwns_locator.

• Addiction treatment programs should be able to connect you with a physician who prescribes addiction medications.

Acute Care is Small Part of the Journey

Addiction treatment programs

- should be licensed by the state government. State licensing means that the provider meets basic quality and safety requirements. It does not guarantee that they provide effective treatments. Some states do not require all addiction programs to be licensed.

– In addition to licensing, addiction treatment programs may be accredited. Accreditation means that providers meet standards of care set by a national organization that reviews programs for compliance, but it does not necessarily mean the provider offers effective treatments. Individual health care providers should be licensed and/or certified to practice their profession and have specialized training and experience treating addiction All addiction treatment providers and programs should have a doctor on staff or available for consultation.

– At a treatment program, a doctor will oversee your care and/or work with other health care professionals who are treating you.

– If you are seeing an individual provider, he or she should consult with a physician regarding your health care needs and your need for addiction medication, if appropriate.

– If you are seeking treatment in a residential setting, look for a program that has an addiction medicine physician or addiction psychiatrist on staff full time

Provides treatment for co-occurring physical or mental health conditions.
– Many people with addiction live with other diseases like heart or lung disease, diabetes, cancer, HIV/AIDS, hepatitis C, depression, anxiety, post-traumatic stress disorder and other physical and mental health conditions. Health conditions that can complicate or reduce the effectiveness of addiction treatment should be treated at the same time.

Offers a range of effective treatments.
- Although there is no cure for addiction, there are treatments that are effective, including several medications and therapies.

The best treatment providers or programs offer more than one form of effective treatment.
- People who are addicted to opioids (such as heroin or prescription painkillers), alcohol or nicotine should look for a treatment provider who can prescribe medication for their addiction. Medications can reduce tobacco, drug and alcohol use and cravings, and help keep people in treatment longer. Tobacco-free – Look for a treatment setting that is tobacco-free.
- both inside the facility and on the facility grounds.

- and offers smoking cessation treatment. Continuing care.

- Addiction treatment providers should offer ongoing, continuing care and support after your treatment to help you maintain the progress you achieved during treatment and avoid or treat relapse.

Most do not, so family members should plan to complete this without the acute care facilities involvement.

The Family Needs Therapy, Too

Contingency Management

– How It Works: Alters behavior by rewarding constructive behaviors, like reducing or stopping substance use, and sometimes by discouraging unhealthy behaviors

Behavioral Couples/Family Therapy

– How It Works: Improves communication and support and reduces conflict between couples and
families that have a member with addiction

12-Step Facilitation

– How It Works: Based on the philosophy of anonymous self-help groups like Alcoholics Anonymous (AA), 12-Step Facilitation teaches about the disease of addiction, offers tools to maintain sobriety and encourages people to attend self-help group meetings in their community

Family Therapy for Adolescents Includes

- Multidimensional Family Therapy.
- Functional Family Therapy.

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LEARNING MODULE I

Seminar # 17

Support Agencies Mapping

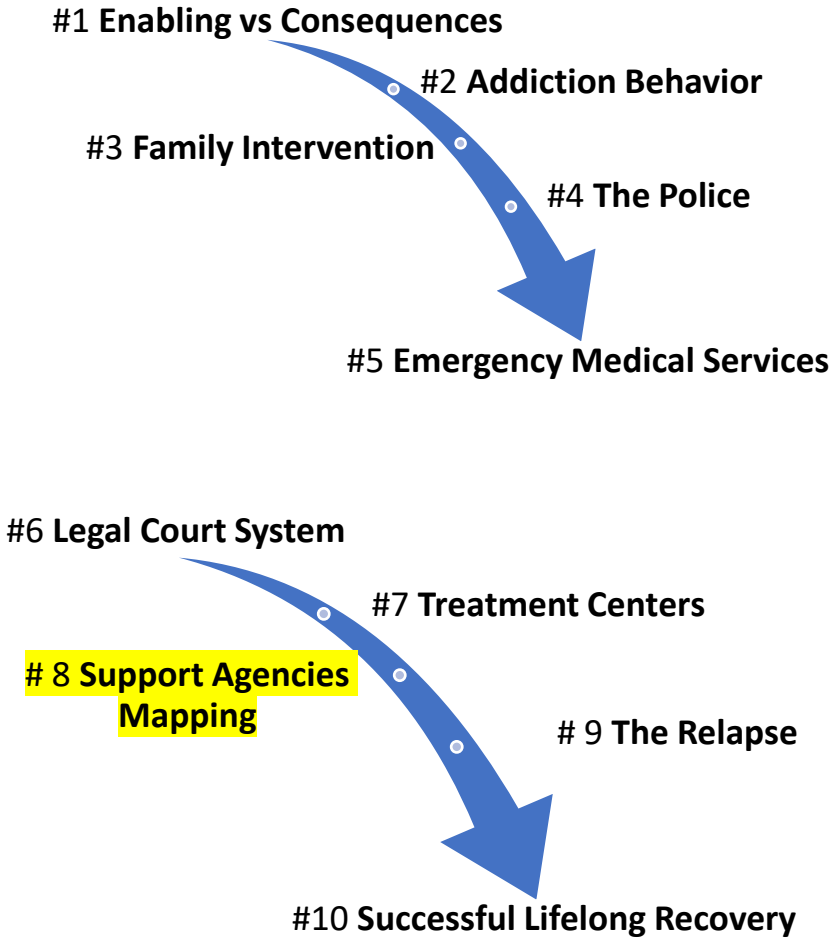
Learning Objective

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement** (Learning how to move forward)
#12 **Spirituality, Faith Practices**

What is the issue?

It is because most families on a journey with Substance Use Disorders do not have a full understanding of what is required to solve the issues they will face on this journey, that makes finding the right level of support so difficult.

Therefore, a tool in determining what the family is facing, i.e., the Family Transformational Response Model, combined with Family Resource Mapping and knowledge of Community Reinforcement Family Training (C.R.A.F.T.) is so important. It may seem like this to overdone but when completed you see its value.

These three components are included in this Seminar # 17 “Support Agencies Mapping” family learning seminar. There is an incredible advantage for each family when a strategy for promoting interagency collaboration by better aligning programs and services becomes a part of the Families Master Plan of Action. The family members can help control communication between inter-links of providers. The plan is to close the gap when transferring information. But this is not what the industry provides. In its place is a disjointed, selection of silo providers that provide no transition paths between services as the family travels through the phases of their journey.

So, it is up to the family to create their own, Support Agencies Network. We already know the 12 key issues a family is likely to experience, and that there are providers, services, and programs available for supporting the family on each issue. Therefore, let us plan, interview them for which is the best fit and include them to the family master plan of action, to use when and if that issue is presented.

what is needed is a community map of who is out there to help. For this we will create our own, family resources map of providers based on each of the 12 key issues. The major goal of the *Family Resource Mapping* is to ensure that all family members have access to a broad, comprehensive, and integrated system of services essential in achieving outcomes related to the issues they are dealing with in their journey with SUD's. Family Resource Mapping can be used to improve personal coping skills, personal mental and medical health, and support in dealing with the 32 plus issues a family will likely face on their journey with SUD's. By identifying areas of need and aligning their needs with available services and resources in the community, streamlining those services and resources from organizations to support the family, the family will have created their own referral network for family member support.

The idea of resource mapping builds on the community's strengths by increasing the frequency, duration, intensity, quality of services and supports from the community. It is a way to organize information and give direction to meet a common family/community goal.

As a result of resource mapping, family members have more flexibility and choice in navigating the system. Family Resource Mapping for the family members is particularly important as a strategy for improving school, work, social and spiritual life for the family members who have a complex and varied list of needs. When collectively pooled, these resources can create a synergy that produces a variety of services going well beyond the scope of what any single system can hope to mobilize. The problem is, when looking for these services, the family members have no idea what they are asking for, how to evaluate the organization and how to compare them against their other options. And this industry does not make it easy for you to do a "search and compare" strategy.

How can the issue impact the family?

Family Resource Mapping is not a new strategy or process. It has been in use for many years in varying forms. Family Resource Mapping is sometimes referred to as asset mapping or environmental scanning. Family Resource Mapping is best noted as a systematic-building process used by many different families at many different stages to align resources and programs in relation to specific family system goals, strategies, and expected outcomes.

Mapping of needed services, support organizations, and programs within a community can have essentially three outcomes: 1) the identification of resources available to the family members 2) the identification of new or additional resources to sustain existing needs of the family with activities or initiatives from within their community, and/or 3) the identification of resources to assist in creating and building capacity to support a more complex family system.

The first step is the outcome typically occur at the local community level while the second and third outcome can happen at any level—local, state, or federal. This seminar "Support Agencies" focuses on strategies for building the capacity of communities to better serve the families in their journey with substance use disorders. There are four steps to the Family Resource Mapping process: 1) pre-mapping; 2) mapping; 3) acting; and 4) maintaining, sustaining, and evaluating mapping effectiveness. The pre-mapping step allows stakeholders/organizations to lay the foundation for their programs and products as a collaboration with the family to establish a clear vision and goals for supporting a family system.

The second step, mapping, determines which resources to map and how to best map them. The collection and analysis of data helps stakeholders/organizations to identify strengths and challenges more clearly based on the family's inquiry prior to needing the services. 3) Acting; this allows stakeholders/organizations to determine the most useful plan of action for effectively addressing the family system likely needs.

Because “No one agency can meet the needs of all family member’s needs, all of the time.” A network of providers and programs and service are required to be included to the Family Resource Mapping strategy. 4) Established goals; Communicating and disseminating information about the family goals and needs is key throughout the implementation step. The final step involves maintaining, sustaining, and evaluating the efforts outlined in the map by continuously evaluating progress, making necessary changes to the plan, and learning from experiences.

What are the options?

Step One: Pre-Mapping

The pre-mapping step allows the necessary partners to come together with the family and establish a purpose and overall direction for the mapping activity. This step in the mapping process should not be overlooked or rushed. Specifically, during the pre-mapping step, you will identify and secure the organizations and key stakeholders and define the vision and goals for aligning the family to the community resources. Establishing clear communication in the beginning will make it easier to achieve your long-term goal of aligning and streamlining community resources meet their needs. This section will highlight strategies to establish the mapping efforts and how to set realistic goals.

The goals need to be specific, measurable, action-oriented, realistic, and time-constrained. The way in which a goal is stated strongly affects its effectiveness. It is important to be positive, precise, and practical when stating goals and setting priorities. Goals set the expectations for overall performance over time.

Therefore, be sure to set goals at a level slightly out of your immediate grasp, but not so distant that there is no hope for achievement. Determining short-term goals allow for the bigger goals to be more manageable.

For Example: It is Foster Care Services:

When thinking about setting realistic yet meaningful goals, ask yourself the following questions:

- What skills, information, and knowledge will be needed to achieve each goal?
- What assistance or collaboration is required to achieve each goal?
- What resources will be needed to achieve each goal?
- What factors may inhibit meeting each goal?
- How will we know when we have met each goal?
- Are there other goals we should be pursuing?

Goal setting is an ongoing and ever-changing process that is accomplished over time. Keep in mind, you will need to periodically review your goals and modify them to reflect any changes in priority.

Step Two: Mapping

The mapping process begins by selecting one issue in the 12 Key Issues a family is likely to face in their journey to map. The usefulness of resources is determined by evaluating the extent to which they assist in meeting strategic goals and objectives of the family system. This stage involves selecting a focus, identifying, and collecting data or resources, and analyzing the information or resources collected. While the mapping step can be time-consuming, efficient organization can make it one of the simplest steps.

The first step in the mapping phase is to determine what resources need to be collected to provide the information necessary for making informed decisions about change. You can collect what will be the family's outcomes using this organization or, what process they use to meet the family's needs.

The type of information you choose to collect depends largely on the issue you select to map. Sources of information extend far beyond those traditionally assessed. Resource identification should not be limited to dollars in support the family; the identification of resources needs to be expanded to include human resources, technical assistance, in-kind resources, academic and spiritual support. Not only are new resources identified during the mapping process, but how other families have utilized current resources is examined.

The primary question is whether current resources can be used differently to help meet the needs presented by this issue or whether new resources are needed. The amount of information collected during the mapping process can often be overwhelming. It is essential to select only what is needed to get the information collection job done. Prioritize your resource mapping issues based on your overall vision of what is most likely, and then map around each of the issues. Strive to organize the information in a manner that is comprehensive, responsive, and meaningful to the family.

Step Three: Set-Up a Map

Mapping Steps 1. Reach consensus on the parameters of the map—select a goal to map. 2. Select the information to be collected based on these parameters— determine what types of resources you would like to collect. 3. Develop tools to collect your information. 4. Collect data with help from stakeholder organizations. 5. Conduct a community (or geographical) scan. 6. Review, analyze, and interpret the information. 7. Communicate your findings. 8. Set priorities. 9. Include to the families, “Master Plan of Action”.

Different methods can be used to gather information. The information collection methods you select depend on the type of information you want and the stakeholders who are sharing the information. Possible methods include questionnaires, on site or by telephone interview meetings, and written or at a public event/presentation. No single collection method can provide all the necessary information to support good decisions, be creative in how you collect the information. Remember, much data already exists within your community and is available for your use, such as state eligibility requirements, referral processes and about us pages on the organization's website.

A significant first step in the resource mapping data collection process is to geographically scan the community for existing and potential resources. A geographical scan includes an analysis of both the external to the community and internal to the community geographical boundaries.

Specifically, you need to determine what your community has to offer that will assist you in meeting your goals. For example, a community may be insufficient in providing resources to effectively address mental health issues by has strong support in addiction treatment of detox services.

The inquiry might encourage the development of new programs within the community to reduce duplication of services and resource use, minimize gaps in services and resources, and expand a community's services/resources to meet the needs of more of its members. This is one advantage from a family being proactive, the community can gain a better understanding about what a family needs and is look for in services.

Ways to Collect Information Keep in mind that there are many suitable ways to collect information. No single collection process is perfect. Some, but not all, options for collecting useful information are listed below.

Geographical or community scans.

• Interviews, presentations with key audiences (e.g., formal/informal leaders, program advocates, service providers to targeted audiences, and end-users).
• Interviews with specialists (e.g., legislators, administrative consultants, and internal/external evaluators).

• Site visits or observation of a setting (e.g., climate, attitudes of specific personnel, professional practices, resources and support services, facilities, and budget allocations).
• Analysis of written and online documents.
• Interaction with existing groups (e.g., support groups, advisors, faith groups, organizations management teams, and staff).
• Case studies and success stories.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 18

The Relapse

Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces

#11 **Bereavement** (Learning how to move forward)
#12 **Spirituality, Faith Practices**

What is the issue?

Marlatt's (1985) cognitive behavioral model of relapse conceptualizes relapse as a "transitional process, a series of events that unfold over time" (Larimer et al., 1999). This contrasts with alternative models which view relapse as an *endpoint or 'treatment failure'*. Flexibility is a key advantage of such transitional models: they provide guidance and opportunities for intervening at multiple stages in the relapse process to prevent or reduce relapse episodes.

Marlatt's full model provides a detail of factors which can lead to relapse episodes. Larimer et al (1999) describe how these factors fall into two core categories:

Immediate determinants – such as high-risk situations, or an individual's coping skills, and
Covert antecedents – such as an imbalanced lifestyle which leads to urges and cravings

The cognitive behavioral model of relapse helps families to develop an understanding of the risk of relapse. Once the characteristics of everyone's high-risk situations have been assessed the clinician can:

- Work forwards by analyzing their client's response to these situations.
- Work backward to examine factors that increase the individual's exposure to high-risk situations.
- With these individual difficulties formulated and understood, the clinician can help their client to broaden their repertoire of cognitive and behavioral strategies to reduce risk of relapse.

This model was designed for working with those persons struggling with alcohol problems it has been applied to addictive and impulsive behaviors more broadly (Marlatt & Donovan, 2005) including all substance use disorders (Mines & Merrill, 1987).

References:

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How can the issue impact the family?

Relapse prevention is why most people seek treatment. By the time an individual seek help, they have already tried to quit on their own and they are looking for a better solution. This seminar offers a practical approach to relapse prevention that works well in both individual and group therapy.

There are four main ideas in relapse prevention. First, relapse is a gradual process with distinct stages. The goal of treatment is to help individuals recognize the early stages, in which the chances of success are greatest [1]. Second, recovery is a process of personal growth with developmental milestones. Each stage of recovery has its own risks of relapse [2]. Third, the main tools of relapse prevention are cognitive therapy and mind-body relaxation, which change negative thinking and develop healthy coping skills [3]. Fourth, most relapses can be explained in terms of a few basic rules [4]. Educating clients in these few rules can help them focus on what is important.

The Stages of Relapse

The key to relapse prevention is to understand that relapse happens gradually [6]. It begins weeks and sometime months before an individual has a drink or use their drug of choice. This means we can catch it early and change its trajectory. The goal of treatment is to help individuals recognize the early warning signs of relapse and to develop coping skills to prevent relapse early in the process when the chances of success are greatest. This has been shown to significantly reduce the risk of relapse [7]. Gorski has broken relapse into 11 phases [6]. This level of detail is helpful to clinicians but can sometimes be overwhelming to families. Many have found it helpful to think in terms of three stages of relapse: emotional, mental, and physical [4].

Emotional Relapse

During emotional relapse, individuals are not thinking about using. They remember their last relapse and they do not want to repeat it. But their emotions and behaviors are setting them up for relapse down the road. Because clients are not consciously thinking about using during this stage, denial is a big part of emotional relapse.

These are some of the signs of emotional relapse [1]: 1) bottling up emotions; 2) isolating; 3) not going to meetings; 4) going to meetings but not sharing; 5) focusing on others (focusing on other people's problems or focusing on how other people affect them); and 6) poor eating and sleeping habits. The common denominator of emotional relapse is poor self-care, in which self-care is broadly defined to include emotional, psychological, and physical care.

One of the main goals of therapy at this stage is to help them understand what self-care means and why it is important [4]. The need for self-care varies from person to person. A simple reminder of poor self-care is the acronym HALT: hungry, angry, lonely, and tired. For some individuals, self-care is as basic as physical self-care, such as sleep, hygiene, and a healthy diet. For most individuals, self-care is about emotional self-care. Both the family and the one abusing substance need to make time for themselves, to be kind to themselves, and to give themselves permission to have fun. These topics usually have to be revisited many times during therapy: "Are you starting to feel exhausted again? Do you feel that you are being good yourself? How are you having fun? Are you putting time aside for yourself or are you getting caught up in life?"

Another goal of therapy at this stage is to help clients identify their denial. I find it helpful to encourage clients to compare their current behavior to behavior during past relapses and see if their self-care is worsening or improving.

The transition between emotional and mental relapse is not arbitrary, but the natural consequence of prolonged, poor self-care. When individuals exhibit poor self-care and live-in emotional relapse long enough, eventually they start to feel uncomfortable in their own skin. They begin to feel restless, irritable, and discontent. As their tension builds, they start to think about using just to escape.

Mental Relapse

In mental relapse, there is a war going on inside people's minds. Part of them wants to use, but part of them does not. As individuals go deeper into mental relapse, their cognitive resistance to relapse diminishes and their need for escape increases.

These are some of the signs of mental relapse [1]: 1) craving for drugs or alcohol; 2) thinking about people, places, and things associated with past use; 3) minimizing consequences of past use or glamorizing past use; 4) bargaining; 5) lying; 6) thinking of schemes to better control using; 7) looking for relapse opportunities; and 8) planning a relapse.

Helping clients avoid high-risk situations is an important goal of therapy. Clinical experience has shown that individuals have a hard time identifying their high-risk situations and believing that they are high-risk. Sometimes they think that avoiding high-risk situations is a sign of weakness.

In bargaining, individuals start to think of scenarios in which it would be acceptable to use. A common example is when people give themselves permission to use on holidays or on a trip. It is a common experience that airports and all-inclusive resorts are high-risk environments in early recovery. Another form of bargaining is when people start to think that they can relapse periodically, perhaps in a controlled way, for example, once or twice a year. Bargaining also can take the form of switching one addictive substance for another.

Occasional, brief thoughts of using are normal in early recovery and are different from mental relapse. When people enter a substance abuse program, I often hear them say, “I want to never have to think about using again.” It can be frightening when they discover that they still have occasional cravings. They feel they are doing something wrong and that they have let themselves and their families down. They are sometimes reluctant to even mention thoughts of using because they are so embarrassed by them.

Clinical experience has shown that occasional thoughts of using need to be normalized in therapy. They do not mean the individual will relapse or that they are doing a poor job of recovery. Once a person has experienced addiction, it is impossible to erase the memory. But with good coping skills, a person can learn to let go of thoughts of using quickly.

Clinicians can distinguish mental relapse from occasional thoughts of using by monitoring a client’s behavior longitudinally. Warning signs are when thoughts of using change in character and become more insistent or increase in frequency.

Physical Relapse

Finally, physical relapse is when an individual starts using again. Some researchers divide physical relapse into a “lapse” (the initial drink or drug use) and a “relapse” (a return to uncontrolled using) [8]. Clinical experience has shown that when clients focus too strongly on how much they used during a lapse; they do not fully appreciate the consequences of one drink. Once an individual has had one drink or one drug use, it may quickly lead to a relapse of uncontrolled using. But more importantly, it usually will lead to a mental relapse of obsessive or uncontrolled thinking about using, which eventually can lead to physical relapse.

Most physical relapses are relapses of opportunity. They occur when the person has a window in which they feel they will not get caught. Part of relapse prevention involves rehearsing these situations and developing healthy exit strategies.

When people do not understand relapse prevention, they think it involves saying no just before they are about to use. But that is the final and most difficult stage to stop, which is why people relapse. If an individual remains in mental relapse long enough without the necessary coping skills, clinical experience has shown they are more likely to turn to drugs or alcohol just to escape their turmoil.

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What are the options?

Trigger Management

Best time to record these answers is after the trigger is presented:

- What was their trigger?
- How were they feeling just before they felt like drinking or drugging?
- What were they telling themselves just before they started to drink or drug? (Look for additional, hidden thoughts.)
- What did they do?
- Which thoughts led to which addictive feelings and behaviors?
- What was the chain of thoughts, feelings, and actions?
- What could they have told themselves?
- What could they have done?
- What emotions could they have pushed themselves to feel, in its place?
- How do they feel now about what happened?

Sit with a drug counselor or peer to peer coach and write a Family ***Plan for Prevention of Relapse,*** using their input and guidance. This will prove to be invaluable.

REF: American Addiction Centers
Follow
Feb 20, 2018

How the Family Responds to a Relapse

There are many things that can trigger the urge to drink or use drugs during active recovery, and some of the most common are stressors and difficulties with loved ones at home. For almost everyone working on staying sober who returns home after treatment or lives at home during outperson care, it can be tricky to navigate the emotional flare-ups that are inevitable. Loved ones are often hurt by the behaviors associated with untreated substance use and trauma-related disorders, and it takes time to rebuild trust and heal.
The process can be tough, and many relationships will need more time than others if they are able to be repaired at all. The truth is that there is no necessary outcome for any relationship for you to stay sober.

The only thing you need is yourself and your dedication to doing what works.

Here is what you need to know:
· If relapse does happen, it is not the end of the world. It does not mean you have lost all you have gained in recovery, and it does not mean you have to continue drinking or getting high.
· However, relapse is not an inevitable part of the process of recovery or dealing with difficult situations. Though it can and does happen to many people, it does not have to, and if you feel like you are at risk, you can act.
· Sharing what you are feeling is essential but not necessarily with your family member. Rather, talking to a sponsor or your therapist is the best way to come up with actionable ways to decrease stress levels while continuing to work on your relationships with loved ones.
· You do not necessarily have to cut someone out of your life to avoid relapse. You may need to limit communications, set healthy boundaries, and/or take a break until you feel more stable and stronger in your ability to avoid relapse.

· Your loved one may benefit from taking part in their own therapeutic treatment and going through a "recovery" of their own.

The Best Answer to Relapse: Treatment

No matter what the reason for a relapse, if you feel that it is a chronic problem and you are unable to sustain sobriety as a result, one of the best choices is to return to treatment for coping mechanisms that work.

As an example: At American Addiction Centers, their First Responder Lifeline Program offers police officers and their families the support they need to heal in recovery with a comprehensive treatment program that provides:

- PTSD assessment and evaluation
- Access to EMDR therapy and other therapies proven to be effective in the treatment of trauma-related disorders like PTSD.
- Therapists and treatment professionals who are trained to work with first responders.
- Family therapy groups and support for loved ones
- Unique treatment plans designed for first responders.
- Long-term aftercare and support

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 19

Successful Lifelong Recovery

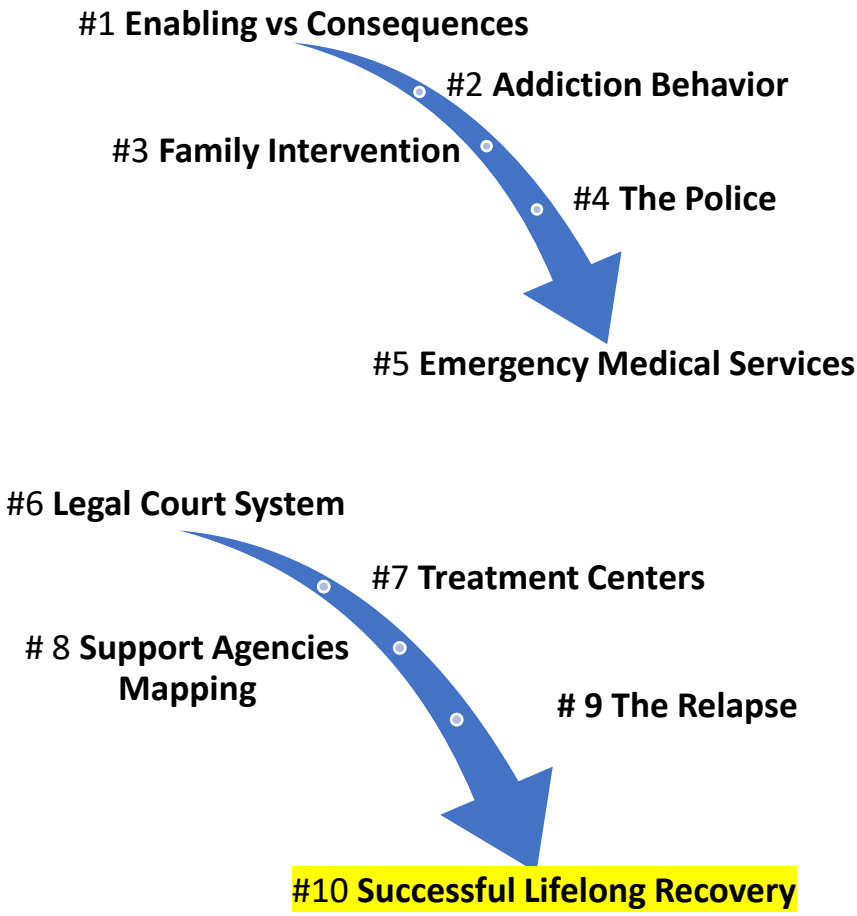
Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 **Bereavement** (Learning how to move forward)
#12 **Spirituality, Faith Practices**

What is the issue?

Create a foundational Understanding about Recovery:

Marlatt's (1985) cognitive behavioral model of relapse conceptualizes relapse as a "transitional process, a series of events that unfold over time" (Larimer et al., 1999). This contrasts with alternative models which view relapse as an *endpoint or 'treatment failure'*. Flexibility is a key advantage of such transitional models: they provide guidance and **opportunities for intervening at multiple stages** in the relapse process to prevent or reduce relapse episodes.

A key point of successful lifelong recovery is management of 1. high-risk situations, 2. an individual's coping skills, 3. an imbalanced lifestyle which leads to urges and cravings.

Once the characteristics of everyone's high-risk situations have been assessed the clinician can:

- Analyze the persons response to these situations.
- Work backward in the timeline to examine the factors that increased the individual's exposure to high-risk situations.
- With these individual difficulties formulated and understood, the clinician can help their client to broaden their tool bag of cognitive and behavioral strategies to reduce risk of relapse.

See References:

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How can the issue impact the family?

Relapse prevention is why most people seek treatment. By the time an individual seeks help, they have already tried to quit on their own and they are looking for a better solution. This seminar offers a practical approach to provide family member support to a relapse prevention that works, by allowing the family to participate.

There are four main ideas in relapse prevention:

First, relapse is a gradual process with distinct stages. The goal of treatment is to help individuals and family members recognize the early stages, in which the chances of success are greatest.

Second, recovery is a process of personal growth with developmental milestones. Each stage of recovery has its own risks of relapse.

Third, the main tools of relapse prevention are cognitive therapy and mind-body relaxation, which change negative thinking and develop healthy coping skills.

Fourth, most relapses can be explained in terms of a few basic rules. Educating family members in these few rules can help them focus on what is important.

What are the options?

The key to relapse prevention is to understand that relapse happens gradually. It begins weeks and sometimes months before an individual picks up a drink or drug. This means we can catch it early and change its trajectory. The goal of treatment is to help individuals recognize the early warning signs of relapse and to develop coping skills to prevent relapse early in the process when the chances of success are greatest. This has been shown to significantly reduce the risk of relapse.

Gorski has broken relapse into 11 phases. This level of detail is helpful to clinicians but can sometimes be overwhelming to families.

Many have found it helpful to think in terms of three stages of relapse:

- Emotional Stage
- Mental Stage
- Physical Stage

A Family's Flexible Support to the Plan of Care

Recovery is not a singular event and does not cease once sobriety is obtained. Rather it is an ongoing process, one that requires that family members change many aspects of their life, including how they think, how they react in certain situations, and how they cope with the emotions created by these new aspects of their life. It requires consistent upkeep and mindfulness and is best approached in a thoughtful and methodical manner. It is this consistency and framework that can provide the family members strength at times when things become overwhelming or uncertain.

A Personal Action Plan: As a family member, taking care of yourself is one of the first things you need to do when you get outside of treatment. It is a unique set of guidelines, goals, methods, notes, and processes that a family member develops to support this person to help them flourish during recovery. It is something that integrates the knowledge and the skills a family member learned through family education seminars with the insights that they learned about themselves both during and after the persons rehabilitation. It keeps the family member hopeful, mindful, focused, and accountable. It is a framework that provides them strength in the moments when the family member resolve falters.

Taking this seminar one can find it to be a deeply personal exercise, one that requires you to be honest and introspective. In preparation, it can be useful to make sure that you have a private time and place set aside for yourself. If you need the assistance of others while you are working on it, you can reach out to your loved ones for their help.

It can be useful to have any notes or materials that you gathered during your other education sessions on hand in case you need a refresher. It can also be helpful to spend some time relaxing or reflecting before you begin, as you will reap the greatest benefit if you feel a positive state of mind. Listening to music, taking a walk, or any other enjoyable hobby might ease you into this reflective state.

Some people prefer to jump right into it, while others prefer to brainstorm first by free writing or journaling. In these instances, it can be helpful to think of the things you would like to see change. For example, you could write: "I'd like to the family united in providing the best most informed support for our loved one," or "I'd like to be a better parent or spouse." These become your goals and driving forces within the recovery.

Family Member Self Care:
This section is a compilation of the activities, practices, and hobbies that you engage in that keep you are feeling balanced. These are things that encourage the proliferation of positive emotions. such as: hope, optimism, self-awareness, self-confidence, gratitude, thankfulness, peace, and happiness. Some are things that should be a part of your daily routine to boost your physical, mental, emotional, and spiritual health, while others are things that you can intersperse on a less regular basis to do the same.

Some examples of things you can include here are:

- Daily essentials: Drinking enough fluids, eating a well-balanced diet, getting enough sleep, or taking supplements or medications.
- Outdoor activities: Gardening, hiking, boating, walking the dog.
- Meditative practices: Yoga or breathing exercises.
- Exercise: Stretching, playing your favorite sport, aerobics, or going to the gym
- Staying in touch with friends and family: Having conversations with your loved ones, writing letters, sharing a cup of tea or coffee with them, or cooking a meal together
- Creative activities: Painting, sewing, knitting, or drawing.
- Taking time for yourself: Reading a favorite book, listening to music, talking a walk, or journaling

SAMSHA cites the following examples:

- Eat three healthy meals and three healthy snacks that include whole grain foods, vegetables,

and smaller portions of protein.

- Drink at least six 8-ounce glasses of water.
- Get exposure to outdoor light for at least 30 minutes.
- Take medications and vitamin supplements.
- Have 20 minutes of relaxation or meditation time or write in a journal for at least 15 minutes.
- Spend at least half an hour enjoying a fun, affirming, and/or creative activity.
- Check in with my partner for at least 10 minutes.
- Check in with myself: "how am I doing physically, emotionally, and spiritually?"
- Go to work, focus just on work while there.
- The benefit of making a list like this is that it can help you to recognize why you might be feeling off-kilter. If you take the time to reference it, it can show you when you are overlooking things that might be making you feel bad.

Open Communication Channels

Communication is an essential part of the human experience. However, it is especially important for people in addiction recovery. Good communication skills are the only way that recovering addicts can make their needs clear and get them met without relying on substances. By learning to express their wants and needs and fears an addict is more likely to have successful results during the recovery process.

Learning Communication Skills in Addiction Recovery:
Having good communication skills allows people to effectively work with others in relationships, education, and work. Other people do not automatically know your needs, so you must be able to tell them in a clear manner what you expect and desire. Take the time to create this type of environment,

In this journey family member journey isolation from others may begin and move towards deliberately avoiding any type of social interaction with others. This does not normally resolve itself. Professional help is required to assist this person overcoming their lack of social skills. They must learn to look within themselves to find the root cause of their behavior and then take proactive steps to learn more effective ways of dealing with daily situations without the need to hide away behind the curtain of drug-stigma solitude.

Communication is, on its most basic level, a way to create and make changes in relationships in our lives. It is also an important factor in helping build confidence. A recovering addict must feel good about their ability to function in the workplace, in school, or in the family. The ability to interact effectively with others can go a long way in building this much needed level of confidence. If a recovering addict is still feeling intimidated by the presence of others, they are more likely to suffer relapse. For example, once or twice a year. Bargaining also can take the form of switching one addictive substance for another.

Often, an addict and family members have integrated negative communication skills. Changing these behaviors will promote a positive environment. It takes effort from not only the addict but also loved ones of the addict to establish trust once again.

An addict's problematic communication skills are often derived from:

1. **Low Self-Worth:** An addict with low self-esteem is especially hard to encourage. They may feel ashamed and unworthy of love or affection. This causes addicts to run away from beneficial relationships and cease communication.

2. **Dishonesty:** Addicts will lie to get what they want, whether it is money, drugs, or a place to sleep. Chances are that if you love an addict, they have lied to you. Lying helps an addict stay in their perpetuating cycle of addiction. Practicing dishonesty removes trust and is very damaging to relationships.

3. **Shame:** When an addict eventually realizes the damage that they have created in their own lives during recovery, they experience shame. Shame can lead to feelings of hopelessness, which may cause communication barriers between the addict and loved ones.

4. **Lack of Proper Boundaries:** Addicts have a way of getting what they want, even if that means overstepping boundaries. Crossing lines makes effective communication between an addict and a loved one more challenging.

5. **High Expectations:** In early recovery, addicts strive to right their wrongs. This leaves them with nearly impossible expectations for themselves, instead of acceptance of who they are. This can cause strained communication between a recovering addict and loved, due to a lack of full honesty and disclosure.

6. **Anger:** When high-stress situations arise, frustration sets in. Addiction not only harms the addict but every surrounding relationship. This anger can translate into a conversation through tone, body language, and language. Practicing anger-management is essential for improved communication.

Incorporate Better Communication Skills in Recovery:

1. **Contemplation:** Especially in an anger-fueled interaction, it is easy to say the first thing that comes to mind. Practice contemplation before reaction. Like your mom has probably told you; if you do not have anything nice to say, do not say it at all. Take time in choosing the words for your responses. Be sure to tell the person this is what you are doing though! Few things are as frustrating as being met with silence in a conversation, let them know you are carefully considering your words.
2. **Environment:** A soft environment and graceful approach are a good way to have a conversation that has the potential to turn south. A relaxed attitude will allow both parties to have a clearer mind and improved chances of reacting in a healthy way.

3. **Support:** Especially in early intervention and recovery, it is best to have a therapist or counselor guide the conversations an addict has with loved ones. This practice allows for a controlled environment where the focus is solely on the discussion topic. This focus keeps the discussion from meandering to old arguments or blame for events that are not the subject of the current conversation.

4. **Empathy:** practicing empathy is the most important communication skill to master in addiction recovery. Trying to understand how another feel is the only way to genuinely acknowledge another's emotions. Once an addict grasps the concept of empathy, relationship healing can begin. Of course, this skill is beneficial to the family member as well. It can be difficult to understand the stresses and guilt that come alongside addiction. Their understanding of the disease will help them be person and understand the addict's perspective.

5. **Balance**: No relationship can be healthy if only one member is putting forth an effort. Beneficial mutual relationships foster respect and have a better chance of flourishing.

6. **Self-Communication:** The most important relationship for an addict to work on during recovery is the relationship with oneself. If one constantly puts the self-down, there will be lack of self-respect. Self-esteem allows an addict to be comfortable with his or her own self and in turn comfortable with relationships with others.

Strong Support System

For family members helping an addict recover from his or her condition, look at the following steps towards helping this loved one move forward and recover completely.

1. DON'T BE AFRAID TO ASK FOR HELP

Oftentimes, a family member will either be too stubborn or fearful to ask for help in his or her current situation. Family members can feel as if they have no problem with the persons behavior or they are embarrassed to admit that they have these problems, thus entering denial.

Asking for help with your problem is the first and most vital step towards recovery. You can ask for help from family members, close friends, or even medical professionals. You can guarantee that all these people are more than willing to listen and support you throughout the entire recovery process. Asking for help is a sign of strength and awareness, which is more to say than someone who refuses to seek help for his or her condition.

2. DETERMINE WHAT YOU WANT FROM YOUR SUPPORT AND GET RID OF ANY BAGGAGE

Once you have identified the people that you want in your support system, decide what it is that you expect from them. You should also be sure to communicate these expectations with them so that way they can ensure that they meet them according to standards of your relationship.

If you are unsure of how to communicate these feelings, recovery treatment centers offer family therapy and counseling to help families get through the recovery process together. Therapy is facilitated in a safe space and helps open the lines of communication and allows you to express what you need from the people that are part of your support system.

It is also a good idea to determine if the people surrounding you in the recovery process are those that will fully support your treatment. This means that they cannot be a negative influence on you while you are in recovery.

Surrounding yourself with people who have positive impacts will only make it easier for you as you go along your progression towards sobriety. Do not feel bad when you no longer associate yourself with people who would encourage you to abuse substances that caused your addiction. There is no longer a place for these people in your life. Recovery is about full abstinence from substances that caused you to become addicted.

3. ATTEND EDUCATION SMEINARS AND FAMILY MEMBER SUPPORT MEETINGS.

Recovery can feel like an isolated process. Sometimes, addicts will need to separate themselves from family members or friends to progressively get better in their addiction.

Treatment centers offer opportunities for addicts to participate in group education and support so that they can continue to socialize with other people, specifically those who may be going through a similar process. Having a way to express themselves and connecting with people who are going through similar situations can greatly help addicts with the healing process.

There are also 12-step programs that support the family members in the recovery process. In these programs, addicts can openly talk about their addiction to group members and be able to sponsor one another to keep others accountable and on track.

Even if you miss a week or two, continue to go to these meetings because the people will always be there to help get you back on the path towards recovery. They understand your situation, and they do not judge you. Having a place that makes you feel comfortable and not judged for your condition can be a great way for you to find peace.

4. RELATIONSHIPS.

If you are at a dead-end job and it negatively impacts you every day, then yes, you should go out and find a new career. However, you should be cautious with your endeavors because sometimes, a big change in employment can cause you to become very overwhelmed, anxious, and put you at risk other health conditions.

People abusing substances use their abuse to escape the everyday stresses of life. You should not place yourself in stressful situations that you know can trigger their desire to relapse. Just as people who have food allergies know that they should not eat a certain food because of what it can do to them, the family members should not place themselves in unnecessary vulnerable or risky situations that can create more stress.

5. BE PERSON AND ALLOW TIME TO RUN ITS COURSE.
Perhaps your biggest and most effective support system will be that of time. The impact of this drug epidemic was not created overnight. It took time to develop, and the setting up of a successful recovery environment process should look just the same, if not longer.

There will be some days where you might feel as though you have made no progression, but if you take a moment to look back on how far you have come, you will see that time helped you get there along with your other support systems. There is no time limit on when you should be recovered or how you should feel after undergoing treatment.

Every person has a different situation, thus will experience various results. Remaining person and positive will help you identify that the recovery process takes time but will be extremely rewarding in the end. At times where you may feel that you are at your wit's end, contact people in your support system to let them know what you are feeling. They will come and provide you with any support you need to help you maintain your progress towards recovery.

The goals of these centers are to help persons identify their problems and find the most feasible solutions to treating those problems. Every individual addict has a unique situation and requires personalized treatment that will help bring this person to a full recovery. Even following treatment, it is important to remember that recovery will be a lifelong struggle, but with the right support from loved ones and programs, it can prove to be phenomenally successful.

Recovery does not have to be an isolated process. There are people all around you who have the capacity to help you feel supported. From the people that you love and know every day to the medical professionals who can properly provide you with treatment, you can be certain that there is help throughout the entire process.

Those suffering from addiction deserve to live a happy life. They deserve to feel as though they have nothing limiting them from living their life to the fullest potential. If you are or know someone who is affected by addiction, find a treatment center as soon as possible. They can provide you with the tools necessary to get the recovery process started as well as giving continuous support and treatment for people dealing with addiction.

Worksheet for Establishing a Support System
By Peggy L. Ferguson, Ph.D.

A social support system consists of a network of relationships with people who support your recovery and offer help to meet your needs. Your support system may consist of family, friends, professionals (i.e., doctor, counselor, dietician, personal trainer, etc.), twelve step meeting members, coworkers, neighbors, spouse, children, or any one with

whom you have a more than superficial relationship. People that utilize an active support system for their recovery have a higher probability of sustained abstinence and continuing recovery.

Socializing and social contact with others helps to reduce isolation, depression, loneliness, boredom, and stress. Social support systems serve as a major tool not only to assist you in staying clean and sober, but with improving your physical and mental health, to improve your problem solving, and to enhance emotional development and maturity. Everyone has a need to feel like they fit in, belong, and are wanted. So many things change in your life with recovery. A social support system helps you know that you are not alone while you are making these changes.

To assess your support system needs and to assemble a support system helpful to your ongoing recovery efforts, answer the following questions:

A. Who was in their support system before they got into recovery?

Name Kind of support they provided?

Are they drinkers/drug users?

Did they drink/use with them?

1.
2.
3.
4.

B. Who of this group, do they need to NOT spend time with right now, and why?

1.
2.
3.
4.

C. What do they need from a social support system now?

___Someone to discuss a personal problem

___Someone to spend time with

___Someone to do things with (shopping, movies, walks, sporting events.)

___Someone to help me with tasks (gardening, fixing something that is broken, taking

care of my dog when I am out of town, etc.)

___Someone that can cheer me up when I am down.

___Someone that reminds me that I am worthwhile and is on my side.

___Someone to give me important feedback.

___Someone to teach me how to do things.

___Someone to work out with

___Someone to provide comfort when I am scared, lonely, tired.

___Someone that I can share my feelings with

___Someone who helps me achieve the next great thing in my life.

___Someone who helps me find things that I need.

___Someone who can serve as an accountability partner.

___Someone who will tell me when my thinking is squirrelly.

___Someone that calls me on my dishonesty.

___Someone that helps me identify my motives.

___Someone that knows how to stay clean and sober and can teach me.

___Someone who helps me solve problems by asking questions, giving me feedback, and

making suggestions.

___Someone who can help me learn how to have fun sober.

___Someone that can give me a ride to meetings.

___Others

D. List reasons why a recovering alcoholic/addict might need a network of people who support their continuing abstinence and ongoing recovery?

1.
2.
3.
4.

Look over the list and identify which ones could be true for them. Instead of thinking of
reasons why these reasons for a support group do not apply to them, identify the ones that could possibly be true.

E. When I stop spending time with people that might not be good for my continuing recovery at this time, who will be left in my support system?

_____
_____
_____
_____

F. When I compare the list of what I need from a support system (C) with the list of who will be left in my support system (E), what needs will not be met by my remaining support system as it is now.

1.
2.
3.
4.

G. Who (among the people that I already know), do I need/want to cultivate as a support person to round out my support network currently?

_____
_____
_____
_____

H. List other resources (places, groups, activities, etc.) that could help me meet new people to add to my support network.

1.
2.
3.
4.

I. What might keep me from asking people to be in my support system, to be my friend, or to cultivate relationships?

___It is difficult for me to ask for help.

___I am shy.

___I have social anxiety.

___I do not want to tell anybody else that I am in recovery or that I have addiction.

___I do not know anybody that would be appropriate.

___I do not want to be a burden to anyone.

___I feel guilty about things that have happened in the past.

___My spouse/partner gets jealous of my spending time with other people.

___I asked people to do things with me in the past and nothing came of it.

___I do not have time.

___I end up providing all the support to the other person.

___I am afraid that I will be rejected.

___I do not want to sound helpless.

___I do not want to be vulnerable by opening to others.

___I do not like the suggestions that other people offer.

___Others

_____

_____

J. What might they do to overcome these obstacles to ask people for help and support?

As a family member need to meet new people, where can I go or what can I do to accomplish that**?**

___Ask someone to coffee, lunch, dinner.

___Ask someone to go to the movies, the theater, roller skating, fishing, or some other.

activity _____

___Ask someone to go to a support group meeting with me.

___Ask someone to start working out with me.

___Volunteer with some organization to help other people.

___Go to twelve step recovery meetings. Go early; stay late, talk to people.

___Attend church.

___Reconcile with people who may still be mad at me.

___Make an appointment with professional helper(s) such as minister, counselor,

psychiatrist, nutritionist, personal trainer, recovery coach, etc.

___Join community organization(s).

___Taking a class; joining a group like yoga/meditation/stress management.

Sense of Purpose

You are going to have days when you think what the point is, but if you do not have a good answer to this then you might not be able to summon up the motivation to keep going. Having a sense of purpose in recovery both as a family member and the individual abusing substances is vital so, considering this, here are 12 tips for how you go about finding it:

1. Stop People-Pleasing

If you try to live your life based on the expectations of others, you will not be following your own path. Being a people-pleaser can open some doors for you in life, but you end up losing more opportunities than you ever gain. To find your purpose in life, you need to be willing to go your own way.

2. Start a Daily Gratitude List

It does not matter how much good stuff enters your life if you just take it all for granted. The Buddhist monk which that Hanh once wrote, "so many conditions of happiness are available – more than enough for you to be happy right now." The purpose of committing to a gratitude list practice is one of you always being aware of the good things in your life – this only needs to take a couple of minutes each day. The fact that you can see how good your life is fills you with a sense of purpose, giving you the energy to obtain even more, as well.

3. Learn to Listen to Your Intuition

Your intuition is made up of a lot of unconscious information that would probably not make sense to your thinking brain. It contains everything you have ever seen, experienced, or read. This inner voice can lead you in the right direction once you learn how to listen to it. Following your gut means your life is sure to feel full of purpose, allowing you to tap into your hidden potential.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: The purpose of pain: Finding meaning in suffering | Katie Mazurek | TEDxBozeman

TEDx Talks
Pain and suffering can be powerful teachers. When mixed with bravery, they can unlock the secret to an incredible life. For Katie Mazurek, an aggressive stage 3 breast cancer diagnoses at age 33 was the opportunity of a lifetime. Her pursuit of love, courage, connection, and vulnerability shine in her moving narrative told alongside stunning portraits that chronicle her battle.

4. Choose to Believe that You Have a Purpose in Life

The idea that you have a purpose in life might sound a bit new age, but this claim can also be found in Humanist psychology. Abraham Maslow is famous for his 'hierarch of needs'; one of these needs is self-actualization. If you are living below your abilities and have not tapped into your potential, you are likely to feel dissatisfied with your life. It is as if people have an in-built need to blossom and reveal all they are capable of, but a feeling of lack of purpose arises when individuals are not actively doing this.

5. Be Flexible with Your Goals

Things are never going to work out exactly as you plan them, but this is one of the great things about life. Whatever goals you have will be self-limiting if you hold onto them too tightly. You need to be willing to deal with the unexpected twists and turns that are almost certainly going to be part of your future. You should set yourself goals, but there are going to be times when you need to change course. If you know that you are on the right path, you do not have to worry about the destination too much.

6. Be Willing to Leave Your Comfort Zone

Developing routines is a good thing to do in their early recovery as it gives you a solid foundation that keeps you and your ability to respond safe. The danger is that if you become too attached to your routines, it can start to limit your life. This is because you get used to staying in your comfort zone, which is bad because to reach your potential you will need to regularly push yourself and try unfamiliar things.

7. Keep the Faith

There are going to be times when life feels unfair and the future looks bleak and uncertain. At these times, you need to have faith that you are still on your path and that something good will come of this current dose of pain. The reality is that these periods of suffering can be when you do most of your growing, and they will be easier for you to deal with if you treat them this way.

8. Keep an Open Mind

One of the lessons you should have learned due to your years lost in this journey to addiction is that you do not always know what is best for you, we never know. If your automatic response to new things is to just resist them, you will likely be pushing away important stuff that could benefit your life. If your response is to automatically accept them, you may find you are on the wrong path. Finding your purpose may involve activities that have little appeal to you at this moment, so you need to keep an open mind and be willing to try and learn about new things.

9. How Mindfulness Can Help You Find Your Sense of Purpose

Mindfulness can help you find your sense of purpose as it allows you to break free of your habitual thought patterns and behaviors. It also stills your mind enough so that good things can rise to the surface to where you are better able to see it. To benefit from mindfulness, you need to make this a part of your daily life – this could include practices such as meditation or Tai Chi.

10. Spend Time with People Who Seem to Have Found Their Purpose
Real success is not about wealth or how obsessed a person is about their job – it is all about a life full of joy and purpose. If you spend time around those who have this type of inner wealth, it will inspire you as well. The things that give your life purpose may be completely different from the activities these individuals engage in, but you can still be inspired and motivated by their energy. Find positive thinking people.

11. View Your Life as a Gift
It should never be too hard to find a purpose in life once you stop taking things for granted. Being alive is an amazing gift once we stop taking it for granted. The opportunity to experience the wild ride that we call life can be enough to give it meaning and purpose – what else do you need?

12. Find Purpose by Helping Others
Devoting some time to helping others is one of the most powerful things you can do to give your life purpose. There is no higher achievement in life than being of service to other people – the incredible thing is that the more you focus on the need of others, the happier you become. This is not the same as people-pleasing because you are not doing it to try to manipulate others into liking you.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 20

Bereavement

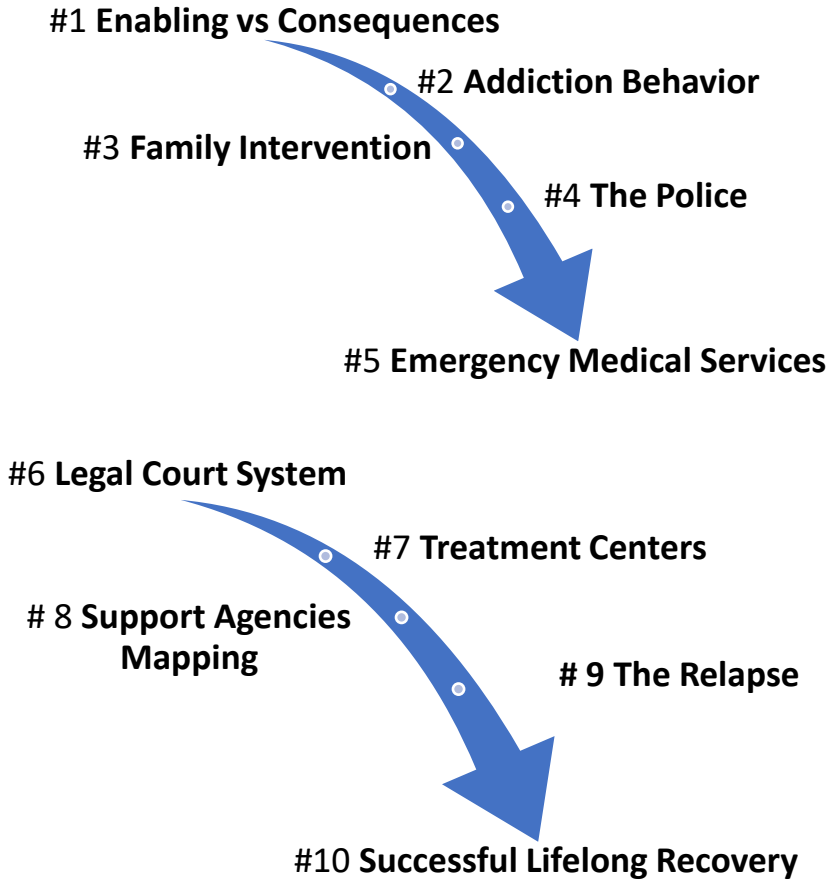
Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 Bereavement (Learning how to move forward)

#12 **Faith, Spiritual Practices**

What is the issue?

There is more than one type of grief in the bereavement process. Let us look to examine the three most common griefs and learn how to determine the difference more closely.

In most journals there are many topics of bereavement under the heading of Greif. Psychiatrists often are ill prepared to identify complicated grief and grief-related major depression and may not always be trained to identify or provide the most appropriate course of treatment. Both conditions overlap with symptoms found in ordinary, uncomplicated grief, and often are written off as "normal" with the faulty assumption that time, strength of character and the natural support system will heal. While uncomplicated grief may be extremely painful, disruptive, and consuming, it is usually tolerable and self-limited and does not require formal treatment. However, both complicated grief and grief-related major depression can be persistent and gravely disabling, can dramatically interfere with function and quality of life, and may even be life threatening in the absence of treatment; and both usually respond to targeted psychiatric interventions.

This is a journey of time, reflection, and love, for the other and for yourself. You might benefit from creating your own guidebook on how to deal with the loss of your loved one. Go on-line and research what the professionals say about this journey. Meet with a hospice counselor and ask them to guide you. Your local hospice has bereavement counselor that will meet with you at no charge. Join a support group and participate/contribute to the discussions.

How can the issue impact the family?

What is uncomplicated (Normal Grief)

Some investigators have attempted to define discrete stages of grief, such as an initial period of numbness leading to depression and finally to reorganization and recovery. However, most modern grief specialists recognize the variations and fluidity of grief experiences, that differ considerably in intensity and length among cultural groups and from person to person 2, 3. To date, no grief stage theory has been able to account for how people cope with loss, why they experience varying degrees and types of distress at different times, and how or when they adjust to a life without their loved one over time.

The terms bereavement and grief are used inconsistently in the literature to refer to either the state of having lost someone to death, or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss; the term grief should then be used to describe the emotional, cognitive, functional, and behavioral responses to the death. Also, grief is often used more broadly to refer to the response to other kinds of loss; people grieve the loss of their youth, of opportunities, and of functional abilities.

Mourning is also sometimes used interchangeably with bereavement and grief, usually referring more specifically to the behavioral manifestations of grief, which are influenced by social and cultural rituals, such as funerals, visitations, or other customs.

Complicated grief, sometimes referred to as unresolved or traumatic grief, is the current designation for a syndrome of prolonged and intense grief that is associated with substantial impairment in work, health, and social functioning.

What constitutes “normal” grief? There is no simple answer. Grief is different for every person and every loss, and it can be damaging to judge or label a person’s grief, especially during early bereavement.

However, a clinician needs to make a judgment about whether a person’s grief is progressing adaptively to make categorical decisions about whether to intervene.

A clinician who does not understand the range of grief symptoms is at risk for intervening in a normal process and possibly derailing it. At the same time, knowledge about the boundaries of uncomplicated, adaptive grief can guard against failure to recognize complicated grief and/or depression occurring in the wake of a loved one’s death. Not all physicians understand these differences.

How long does grief last?

The intensity and duration of grief is highly variable, not only in the same individual over time or after different losses, but also in different people dealing with similar losses. The intensity and duration is determined by multiple forces, including, among others: the individual’s preexisting personality, attachment style, genetic makeup and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; the nature of the relationship (e.g., interdependent vs. distant, loving vs. ambivalent); the relation (parent vs. child vs. spouse vs. sibling vs. friend, etc.); type of loss (sudden and unanticipated vs. gradual and anticipated, or natural causes vs. suicide, accident or homicide) 4.

First, grief is not a state, but rather a process. **Second**, the grief process typically proceeds in fits and starts, with attention to and from the painful reality of the death. **Third,** the spectrum of emotional, cognitive, social, and behavioral disruptions of grief is broad, ranging from barely noticeable alterations to profound anguish and dysfunction.

Bereavement can be one of the most gut-wrenching and painful experiences an individual ever faces. Shock, anguish, loss, anger, guilt, regret, anxiety, fear, loneliness, unhappiness, depression, intrusive images, depersonalization, and the feeling of being overwhelmed are but a few of the sentient states grieving individuals often describe.

At first, these acute feelings of anguish and despair may seem always present, but soon they evolve into waves or bursts, initially unprovoked, and later brought on by specific reminders of the deceased. Healthy, generally adaptive people likely have not experienced such an emotional roller coaster, and typically find the intense, uncontrollable emotionality of acute grief disconcerting, even shameful or frightening.

Yet, grief is not only about pain. In an uncomplicated grief process, painful experiences are intermingled with positive feelings, such as relief, joy, peace, and happiness that emerge after the loss of an important person. Frequently, these positive feelings elicit negative emotions of disloyalty and guilt in the bereaved. Of note, at least one investigator has found that positive feelings at 6 months following a death are a sign of resilience and associated with good long-term outcomes 7.

Fourth, for most people grief is never fully completed. However, there are two easily distinguishable forms of grief 8. First, the acute grief that occurs in the early aftermath of a death can be intensely painful and is often characterized by behaviors and emotions that would be considered unusual in normal everyday life.

These include:

- intense sadness
- crying
- other unfamiliar emotions
- preoccupation with thoughts and memories of the deceased person
- difficulty concentrating
- relative disinterest in other people and in activities of daily life (apart from their role in mourning the deceased).

This form of grief is distinguished from a later form of grief, integrated or abiding grief, in which the deceased is easily called to mind, often with associated sadness and longing. During the transition from acute to integrated grief, usually beginning within the first few months of the death, the wounds begin to heal, and the bereaved person finds his or her way back to a fulfilling life.

Even though the grief has been integrated, they do not forget the people they lost, relinquish their sadness nor do they stop missing their loved ones. The loss becomes integrated into autobiographical memory and the thoughts and memories of the deceased are no longer preoccupying or disabling.

Unlike acute grief, integrated grief does not persistently preoccupy the mind or disrupt other activities. However, there may be periods when the acute grief reawakens. This can occur around the time of significant events, such as holidays, birthdays, anniversaries, another loss, or a particularly stressful time.

Fifth, grief is not only about separation from the person who died, but about finding new and meaningful ways of continuing the relationship with the deceased 9, 10. Faced with the dilemma of balancing inner and outer realities, the bereaved gradually learn to accept the loved one back into their lives as deceased.

What occurs for survivors is the transformation of a relationship that had heretofore operated on several levels of actual, symbolic, internalized, and imagined relatedness to one in which the actual (living and breathing) relationship has been lost.

However, other forms of the relationship remain, and continue to evolve and change. Thus, it is not unusual for bereaved individuals to dream of their deceased loved ones, to half look for them in crowds, to sense their presence, feel them watching out for or protecting them, to rehearse discussions or “speak” to them.

Auditory or visual hallucinations of the deceased person are often seen during acute grief. Sometimes people maintain a sense of connection through objects such as clothing, writings, favorite possessions, and rings, which may be kept indefinitely. Some people continue a relationship with the deceased through living legacies, such as identification phenomena, carrying out the deceased's mission, memorial donations, or seeing them live on in others through genetic endowments. For others, periodically visiting the grave or lighting candles may help keep memories alive. Bereaved individuals may take some comfort in learning that the relationship does not need to be totally severed, but that it is perfectly acceptable and even normal for the relationship to endure indefinitely.

There is no evidence that uncomplicated grief requires formal treatment or professional intervention 11. For most bereaved individuals, the arduous journey through grief will ultimately culminate in an acceptable level of adjustment to a life without their loved one. Thus, most bereaved individuals do fine without treatment. They should have access to empathic support and information that validates that their response is typical after a loss. When support, reassurance, and information generally provided by family, friends, and, sometimes, clergy is not available or sufficient, mutual support groups can help fill the gap. Support groups can be particularly helpful after traumatic losses, such as the death of a child, a death after suicide 12 or deaths from other "unnatural" causes 13.

Complicated Grief

Complicated grief, a syndrome that occurs in about 10% of bereaved people, results from the failure to transition from acute to integrated grief. As a result, acute grief is prolonged, perhaps indefinitely.

Symptoms include:

- Separation distress (recurrent pangs of painful emotions,
- Intense yearning and longing for the deceased,
- Preoccupation with thoughts of the loved one) and traumatic distress (sense of disbelief regarding the death, anger, and bitterness,

- Distressing, intrusive thoughts related to the death,
- Pronounced avoidance of reminders of the painful loss) 10.

Characteristically, individuals experiencing complicated grief have difficulty accepting the death, and the intense separation and traumatic distress may last well beyond six months 1, 4.

Bereaved individuals with complicated grief find themselves in a repetitive loop of intense yearning and longing that becomes the major focus of their lives, albeit accompanied by inevitable sadness, frustration, and anxiety.

Complicated grievers may perceive their grief as frightening, shameful, and strange. They may believe that their life is over and that the intense pain they constantly endure will never cease. Alternatively, there are grievers who do not want the grief to end, as they feel it is all that is left of the relationship with their loved one.

Sometimes, people think that, by enjoying their life, they are betraying their lost loved one. Maladaptive behaviors consist of over-involvement in activities related to the deceased, on the one hand, and excessive avoidance on the other. Preoccupation with the deceased may include daydreaming, sitting at the cemetery, or rearranging belongings. At the same time, the bereaved person may avoid activities and situations that remind them that the loved one is gone, or of the good times they spent with the deceased. Frequently, people with complicated grief feel estranged from others, including people that used to be close.

An assessment is available:
Complicated grief can be reliably identified using the Inventory of Complicated Grief (ICG, 14). It is indicated by a score ≥ 30 on the ICG at least six months after the death. It is associated with significant distress, impairment, and negative health consequences 14, 15.

A targeted intervention, complicated grief treatment (CGT), has demonstrated significantly better outcomes than standard psychotherapy in treating this syndrome 21.

CGT combines cognitive behavioral techniques with aspects of interpersonal psychotherapy and motivational interviewing. The treatment includes a dual focus on coming to terms with the loss and on finding a pathway to restoration. It includes a structured exercise focused on repeatedly revisiting the time of the death as well as gradual re-engagement in activities and situations that have been avoided.

Grief Related Major Depression

Many clinicians are confused by the relationship between grief and depression and find clinical depression difficult to diagnosis in the context of bereavement. Bereavement is a major stressor and has been found to present in major depression, resulting in a diagnostic quandary that may have profound clinical implications 24, 33.

Although there are overlapping symptoms, grief can be distinguished from a full depressive episode. Most bereaved individuals experience intense sadness, but only a minority meets criteria for major depression.

The principal source of confusion is the common occurrence of low mood, sadness, and social withdrawal in both bereavement and major depression. However, there are also clear differences between the two states.

Grief is a complex experience in which positive emotions are experienced alongside negative ones. As time passes, the intense, sad emotions that typically come in waves are spread further apart. Typically, these waves of grief are stimulus bound, correlated to internal and external reminders of the deceased.

What are the options?

Furthermore, grief is a fluctuating state with individual variability, in which cognitive and behavioral adjustments are progressively made until the bereaved can hold the deceased in a comfortable place in his or her memory and a satisfying life can be resumed. In contrast, major depression tends to be more pervasive and is characterized by significant difficulty in experiencing self-validating and positive feelings.

Major depression is composed of a recognizable and stable cluster of debilitating symptoms, accompanied by a protracted, enduring low mood. It tends to be persistent and associated with poor work and social functioning, pathological immunological function, and other neurobiological changes, unless treated. This is as true of major depression after the death of a loved one as in non-bereaved individuals with major depression 34, 38. Moreover, untreated major depression after bereavement carries the extra burden of prolonging the pain and suffering associated with grief.

When a major depressive syndrome occurs soon after the death of a loved one, according to the ICD-10, it should be classified as major depression. The key to successful treatment is the recognition that bereavement related major depression is like other, non-bereavement related major depression.

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PMCID: PMC2691160
PMID: 19516922
Grief and bereavement: what psychiatrists need to know
SIDNEY ZISOOK1 and KATHERINE SHEAR

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: When to Treat Grief and Bereavement

TEDx Talks
Sidney Zisook, MD, Phd, describes the circumstances when bereaved persons may benefit from treatment.
Duration: 5:08 min

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 21

Faith, Spiritual Practices

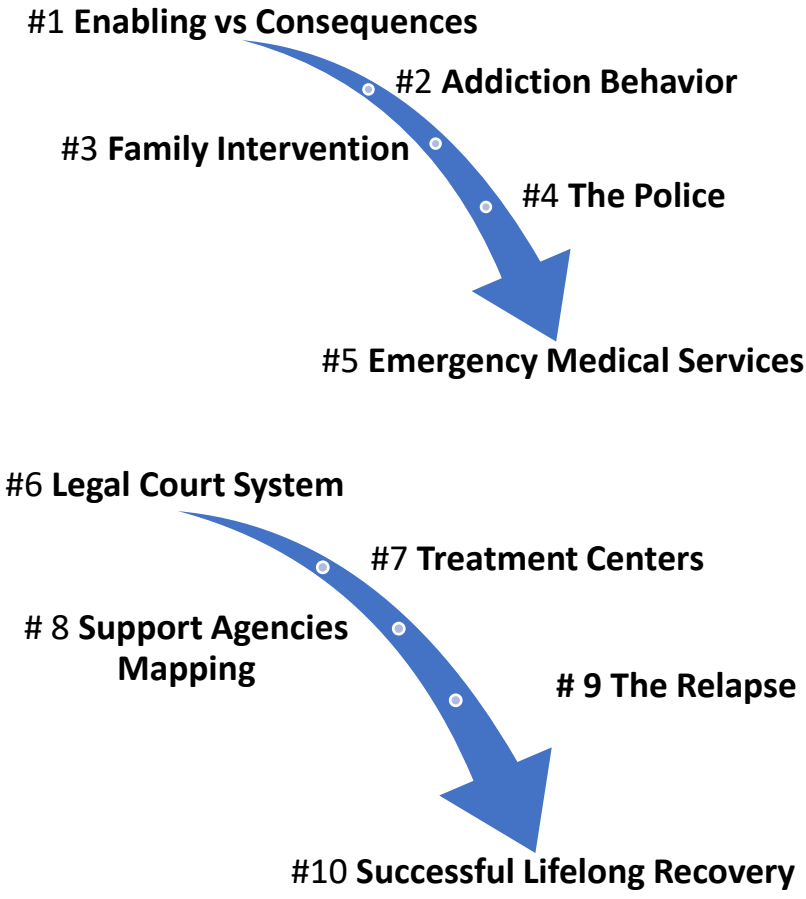
Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces



#11 Bereavement (Learning how to move forward)

#12 Spirituality, Faith Practices

What is the issue?

How can churches help find a solution to the drug epidemic? It seems simple enough, Churches are focused on God, have families in their congregation that are experiencing this epidemic and have knowledge of how to practice faith in suffering. It would seem all three elements exist in what a family experiences on their journey with substance use disorder. However, even though doctors, counselors, politicians, prosecutors, mayors, and treatment centers have all converged to address this issue, the churches have been the least committed to provide a family focused ministry for this large population.

This is the purpose of "Invest in the Family Ministry", a church-based ministry for family's experiencing the substance use disorder epidemic. What has been the case for many churches is most do not have the strategy, structure, process within their existing ministries to adapt and support the unique blend of needs required by this group. Also, their family's needs are not only of a spiritual nature; but include education learning about what the journey with substance use disorder will entail, how to use their faith practices in their suffering. This is a complicated disease only further exasperated by a social stigma which prevents families from seeking help. It becomes more elusive when they do not know where to begin. The "Invest in the Family Ministry" clears up all these issues so they can focus on giving this over to God.

The "Invest in the Family Ministry" model offers a home in your church for these families by providing: 1. Education Learning Seminars, 2. Spiritual faith practice development paths, and 3. Networking to support referral resources. It is a harbor (Ark) in the storm; so, they can get educated, organized, and networked. These are the key elements needed to empower a family. Knowledge is Empowering.

This manual is designed to be modified so it meets the specific attributes of your faith practices. By meeting the family in their suffering and coming to their level we do God's work better, than if we ask the family to rise to our level. The education seminars and spiritual development tracks can be self-administered by the family in their home, at your Church as a group or in a large seminar where the community is invited.

This same approach (meet them where they are) is designed in the ministry model to provide "spiritual development" as a starting point. Again, not asking them to rise to where we are, but rather meeting them where they can grow best, from their world. Given that every family is different, it will be theirs to decide the best path for their family, it is our role to provide options and support in how to move forward.

In connecting the family to referral resources, often a family does not know where to begin, what to ask for, what to expect. This is another role of the ministry. The family's needs will change over time. So will their required support needs change. The ongoing ministry will assist in matching the right level support at each stage of their journey. They will not have to travel this road alone. But first there needs to be a ministry to fulfill this purpose, with purpose driven volunteers.

How can the issue impact the family?

FROM: APOSTOLIC LETTER, SALVIFICI DOLORIS OF THE SUPREME PONTIFF JOHN PAUL II

TO: THE BISHOPS, TO THE PRIESTS,
TO: THE RELIGIOUS FAMILIES AND TO THE FAITHFUL OF THE CATHOLIC CHURCH

RE: ON THE CHRISTIAN MEANING OF HUMAN SUFFERING
THE QUEST FOR AN ANSWER TO THE QUESTION OF THE MEANING OF SUFFERING

Within each form of suffering, we find a core element of what is hard to accept and what is which will remain for us a ministry. But we ask the question just the same: Why is there suffering, especially to those who are justly living their lives?

These questions are difficult, when an individual put them to another individual, the bias of the other is lamented from their understanding, what they feel is true. But when asked of God, our answers are not as direct. This is because, if the question is big enough to bring to God, then the effort to search for His answer is warranted.

God answers our questions in many ways, in prayer, through others, through our faith, spiritual practices and scripture. We encourage you to use all of them in your search for an answer. But in scripture regarding suffering, we can suggest a few parts of the bible to read. Those would be found in both the old testament and new testament.

In the Old Testament we find in the book of Exodus and the people of Israel, God's chosen people are wandering suffering in the desert. Although still being provided for, they are lost yet He is close. At time we are like these people in our own life. We know God is there, we know He loves us, but our suffering is not removed.

Then we can look at all the Book of Job and tell of his story in suffering.

10. Man can put this question to God with all the emotion of his heart and with his mind full of dismay and anxiety; and God expects the question and listens to it, as we see in the Revelation of the Old Testament. In the Book of Job, the question has found its most vivid expression.

The story of this just man, who without any fault of his own is tried by innumerable sufferings, is well known. He loses his possessions, his sons, and daughters, and finally he himself is afflicted by a grave sickness.

In this horrible situation three old acquaintances come to his house, and each one in his own way tries to convince him that since he has been struck down by such varied and terrible sufferings, he must have done something seriously wrong.

For suffering—they say—always strikes a man as punishment for a crime; it is sent by the just God and finds its reason in the order of justice. It can be said that Job's old friends wish not only to convince him of the moral justice of the evil, but in a certain sense they attempt to justify to themselves the moral meaning of suffering. In their eyes suffering can have a meaning only as a punishment for sin, therefore only on the level of God's justice, who repays good with good and evil with evil.

The point of reference in this case is the doctrine expressed in other Old Testament writings which show us suffering as punishment inflicted by God for human sins. The God of Revelation is the Lawgiver and Judge to a degree that no worldly authority can see. For the God of Revelation is first the Creator, from whom comes, together with existence, the essential good of creation.

Therefore, the conscious and free violation of this good by man is not only a transgression of the law but at the same time an offence against the Creator, who is the first Lawgiver.

Such a transgression has the character of sin, according to the exact meaning of this word, namely the biblical and theological one.

Corresponding to the moral evil of sin is punishment, which guarantees the moral order in the same transcendent sense in which this order is laid down by the 11. Job however challenges the truth of the principle that identifies suffering with punishment for sin. For he is aware that he has not deserved such punishment, and in fact he speaks of the good that he has done during his life. In the end, while it is true that suffering has a meaning as punishment, when it relates to a fault, it is not true that all suffering is a consequence of a fault and has the nature of a punishment.

The figure of the just man Job is a special proof of this in the Old Testament. Revelation, which is the word of God himself, with complete frankness presents the problem of the suffering of an innocent man: suffering without guilt.

Job has not been punished, there was no reason for inflicting a punishment on him, even if he has been subjected to a grievous trial.

The Book of Job poses in an extremely acute way the question of the "why" of suffering; it also shows that suffering strikes the innocent, but it does not yet give the solution to the problem.

Thus, in the sufferings inflicted by God upon the Chosen People there is included an invitation of his mercy, which corrects to lead to conversion: "... these punishments were designed not to destroy but to discipline our people"(26).

Therefore, first and foremost we see suffering because it creates the possibility of rebuilding goodness in the subject who suffers.

This is an extremely important aspect of suffering. It is profoundly rooted in the entire Revelation of the Old and above all the New Covenant. Suffering must serve for conversion, that is, for the rebuilding of goodness in the subject, who can recognize the divine mercy in this call to repentance. The purpose of penance is to overcome evil, which under different forms lies dormant in man. Its purpose is also to strengthen goodness both in man himself and in his relationships with others and especially with God.

This answer in the New Testament has been given by God to man in the Cross of Jesus Christ. A just man who suffered for all of humanity.

What are the options?

Hope is Faith in Practice

Addiction recovery is about more than just the absence of drugs in your system. Recovery from drug and alcohol addiction is a complex process and journey. Many parts are unknown and to step forward, one needs to place their faith in front of themselves and rely on Hope that God's promises are real and will be given to you.

In many ways understanding our journey is more than being proactive, it is our part of the deal in receiving God's grace, i.e., we need to do our part. Getting educated or providing education about the issues faced by a family might be for you, part of that deal. Get educated and share what you have learned.

The other area that we can take charge of is to open ourselves towards spiritual development. To strengthen those areas where we see ourselves needing improvement or more understanding. Taking ownership of how well we practice our faith and share it with others.

The third area of Hope is knowing where to go to find help and assistance, to ensure the best possible results. We feel a greater sense of Hope when others around us know how to help. Building a network of referral partners is a way to build hope in your future.

1. Get educated on the journey.
2. Develop our individual spirituality to strengthen our faith practices.
3. Build a network hope, by having the right people to help by bringing the right level of skills to address the issues you are likely to face.

A Faith-Based Approach to Family Empowerment and Intervention

True faith is more than hope. It is trust. When you trust yourself to do your part, trust your loved one to take responsibility for their own life, and trust God to take care of the rest, that is genuine faith.

Accept the Things You Cannot Change

Family members often unwittingly take responsibility for things that are not their responsibility. Here is who is responsible for what…

The family is NOT responsible for:

- Shielding the substance user from the natural consequences of his or her actions
- The emotions or hardships of the substance user
- Feeding and sheltering adult children, especially when they lie, steal, and disrupt family life.

The family is responsible for:

- No longer enabling their loved one to be comfortable in addiction.
- Arranging professional intervention and addiction services for their loved one
- Setting clear boundaries
- Attending to their own needs

The addict or alcoholic is responsible for:

- Admitting he or she has a problem.
- Accepting help when it is offered.
- Doing the hard work to overcome addiction.
- Committing to long-term recovery

Have the Courage to Change What You Can healing:

Substance users avoid addiction treatment because it is a difficult process to go through to achieve the reward of a sober life. Families likewise avoid intervention because they do not want to go through the difficult process of saying "no" to their loved one and weathering the emotional firestorm that it will bring.

To get through this process, families need two things:

Courage: Yes, this will be uncomfortable. Yes, your loved one will probably say that they hate you for refusing to continue accommodating them. Yes, you can weather the storm and enjoy a better life if you have the courage to do so. If you are called to serve, then consider following these steps. If it is to understand, then complete this study guide and workbook seminar.

Your Faith, Your Spirituality are Yours to Share.

Create a Ministry Model of Your Own: In our brokenness we find the long reach of our Lord, our savior Jesus Christ. It is from our weakness where we come together and ascend; because of His grace given freely to us all, He includes those not invited to the banquette of others. We are all called to serve those that cannot serve themselves, as in the Good Samaritan, we seek the broken hearted and build a vessel of refuge for their healing. In providing an "*Invest in the Family Ministry*", such an act of kindness, mercy and love is given to all.

Because no one knows when the thief will come by night, what he will steel or how our hearts will become ill with anxiety and fear, we must prepare ourselves within our spiritual development. It is not enough to become educated about the disease or networked into referral support services. This is the battle of good and evil, and we will fight it from our lowliness and weakness, because from there in our emptiness is our greatest strength, our lord God who gives to us His all. It is His promise in answering our prayers that we have hope. Let us stand up to stand together, from within this ministry, we will form our response to this our pain and suffering with the drug epidemic, a disease that kills our children and loved ones.

The *Invest in the Family Ministry* will start with a calling to all within the church who suffer in this epidemic to come and consider being involved in this new ministry, a calling to serve. From the church members some will lead, others will work, and many will follow but all will grow in their individual spiritual development.

There are four pillars in the ministry design:

1. ***Culture*:** As a ministry we are covering issues that family members are likely to face and provide for them a safe place to learn and grow by strengthening their continence as a family. This ministry will educate them on their journey, develop their spiritual faith and assist in guiding them to referral support resources both inside the church and from their local community.
2. ***Structure***: As a ministry they will find a formal organization structure to support the process and implementation of the ministry services. It will require volunteers to be assigned specific roles and responsibilities supported with volunteer training and strong formal communication channels.
3. ***Process*:** The process consists of those programs that our ministry will provide, how these programs will be delivered and what should be the expected outcome. This will be the ministry's workflow.
4. ***Implementation*:** How the ministry is presented to its members is important; from preparation through the final event, and then follow up. How the ministry communicates is important to ensure the most effective results. How the ministry develops and nurtures the culture of the ministry is important, to ensure it stays true to the teachings of the church in the practice of our faith and ministry.

This Ministry Development Model has Four Programs:

1. **The Purposeful Driven Ministry**, creates structure, process, and implementation, managed by purpose driven volunteers. It takes three volunteers to create the initial leadership in starting the ministry.

2. **The Family Solution Finder**, to educate the family on a journey with substance use disorder. The learning seminars are provided. One seminar for each monthly meeting. There are 32 seminars that cover the family's entire journey with substance use disorder. These are read, plug, and play seminars, no experience required.

3. **The SP~ARK's Program**, to provide learning resources and planning guides for spiritual development. In accordance with your faith, the individual family member will create their own plan for their spiritual development.

4. **The Family Resource Coordination, M.O.R.E.S**. **Program**, connects families with resources and services available from the church and local community.

This is empowerment, and these are the pieces made available through one single ministry, focused on your church family needs. It connects the church to the members that suffer, meeting them in their world, to love one another as God so loved us first.

Once the ministry is up and running, there are three programs that create content for a monthly meeting.

- The Family Solution Finder, 2. The SP~ARK's Program and 3. The M.O.R.E. Program.

I. MINISTRY CULTURE IS A PILLAR

There is work that must be done.

How is this accomplished?

By identifying to the volunteer "what work is needed", be clear, be precise, and be brief. Understanding that everything has its season and time. Those that volunteer need to understand "**what are they being asked to do"**. Such direction will come from their direct leadership. A plan can be easily set-up to follow throughout the year. The process and structure will be set-up to support their personal spiritual development training and volunteer activity. We invest first in those who volunteer.

The time required to do this work.

How is this accomplished?

By identifying how much time it will take to complete each task, a volunteer will have a better understanding regarding the scope of their work contribution and compare it to their commitment in volunteering. Our culture is that "God makes big things from little acts". Therefore, little acts by volunteers will add up to bigger things. We invest in our ministry's.

Volunteer work requires growth.

How is this accomplished?

The spiritual development and growth of our volunteers' needs to be consistent (for all volunteers) moving forward. The objective of the Church ministry is both for the spiritual development of the family and the ministry volunteer. From within the spirit of the volunteer is God's love, to be shared in their visits with acts of kindness and mercy. Let us repeat this: "It does not come from the ministry; it comes from the volunteers". The volunteers are the ***pearl of the Church***, like an oyster nurtures a grain of sand to one day become a beautiful pearl to be shared, so does the Church support a ministry that nurtures the volunteers to then go out and ministers of our faith. One little act begets the other, and the other….

The spiritual development objective will be supported with a continuous training schedule for the volunteer, based on their personal goals with the goals & objectives of the ministry. A "culture of growth" is something that is formed, not something that just happens. When a volunteer grows in their spirituality, the ministry grows in spirituality, the Church grows in mercy and all experience the sharing of God's love which comes alive as we share in communion with Him. When we invest in our Church, all can grow together as one.

When the volunteer prepares for a visit, they will be asked to become familiar with their material which they will present during the visit. This preparation becomes a part of the volunteer's spiritual development. The adage, "*there is no better way to learn something, than to have to teach it"*. This dual development is built into the structure and process of the ministry. Both family member and volunteer share in the experience of renewal, discovery, and application as to what the Holy Spirit is guiding us towards.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

PART IV

Create a Family Plan of Action

LEARNING MODULE I

Seminar # 22

Elements of a Family Plan of Action

Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

What is the issue?

Family members are integral to the health and wellbeing of their families. Medical professionals often remark on how helpful family members and friends can be in reporting changes in persons' symptoms and ensuring that persons consistently follow their treatment plan.

As a family member or friend of someone struggling with a substance use disorders, you are in an incredibly unique position. You can offer a different kind of support than a mental health or medical provider can. You are likely the first to notice changes in your loved one's behavior or functioning. You are also likely the first person with an opportunity to intervene to help improve your loved one's situation.

Your role is to support and empower your loved one, often helping them manage the day-to-day struggles they may face because of their substance use disorder, and ultimately helping them to find the treatment they need to get well. It is important that you learn as much as you can about the substance use disorder that impacts your loved one. By learning more about it, you will be able to help them access resources and the support they need.

How can the issue impact the family?

The Elements of a Family Plan of Action

The family has a central role to play in the treatment of any health problem, including substance abuse. Family work has become a strong and continuing theme of many treatment approaches (Kaufmann and Kaufman 1992*a* ; McCrady and Epstein 1996), but family therapy is not used to its greatest capacity in substance abuse treatment. A primary challenge remains the broadening of the substance abuse recovery support focus from the individual to the family.

THE ELEMENTS OF A “FAMILY PLAN OF ACTION”:

Be Specific: write clearly defined sentences. “we will create a network of at least five therapists to choose from for family therapy”. For example: “We want to understand the process of drug court, each step in their program.”

Make it Measurable: When possible, quantify your action items. This is where being specific helps. What constitutes "more" in more time saves, or less stressful? For example: State a specific amount “to result in a 50% reduction in stress”.

Make it Attainable: It is good to set goals that make you stretch and challenge yourself, but you set yourself up for frustration and failure if your goal is impossible. First think “short term timelines”. Then expand out to quarterly and annually. Short achievable goals are often better than one long difficult goal that may or may not be achievable.

Be sure it is relevant: Your goals should fit within what you want/need to accomplish.

Timelines: Give yourself the time to prepare, collect, develop, and implement. Make time your friend in what you do. You have set a date by which your goal will be achieved, and it is reasonable you can achieve it in that timeline.

2. Work Backwards to Set Milestones

Start with the end in mind. Consider the project or family action step is completed. Now, what happened one step prior towards making that final step possible. Then, what happened two steps prior. Continue to do this up to the point where you are currently. Now you know each step/milestone that needs to be completed to achieve this task.

For example, your loved one started their first day of Intense Outperson Treatment (I.O.P.). The steps it takes to make that happen was we transported them to the facility. The step take before that was, they packed what was required to bring with them to their first session. The step taken before that was, we talked about the positive outcomes that will likely result and what steps the family members will take to be a stronger support in their recovery. And continue, up to where you are currently.

3. Determine What Needs to Happen to Reach Your Goals

During this step, get specific on what it takes to reach your mini and big goals within the time frame. Using a month goal example, to develop a network of support groups to consider, you need to get more than one support group to choose from, because finding the right support group will take several different visits. What is on a to-do list to collect and visit several different support groups and what is the criteria used to evaluate them?

4. Decide What Actions Are Required to Reach Your Goals

For example, to complete the task; I will do this, then this, then this, in sequence. From those steps I can expect to have achieved my task.

5. Put Your Actions into a Schedule

When you complete #4, you should have a list of tasks that need to be completed to reach your goal. Now it is time to put those tasks into your schedule by making a daily plan. These are the tasks you do each day to generate results.

6. Follow Through

Once you have completed the above steps, you should have your daily schedule and targets to shoot for during the process of working on your goal. The next step is to follow your schedule. Do the daily tasks you have assigned yourself to do? When you feel like things are not going well, find a way to keep yourself motivated. That seems like a no-brainer, and yet most people do not achieve their goals because they do not do the work on a regular and consistent basis. In most cases, the plan does not fail, people simply quit.

While you are at it, keep track of your accomplishments and results. Set aside time every month or so to evaluate how well your plan is working and tweak it if you are not making the progress you want.

The true test of whether you will succeed in family plan of action is not only by having a good plan but working your plan. The answer is to get excited about your goals, build in ways to celebrate the small successes, and always keep your eye on the outcome.

Five Effective Steps Video

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Family Action Plan for a Loved One with Depression: Five Effective Steps

Families for Depression Awareness. No one overcomes depression alone. An action plan can help families come together as a team and support someone living with depression. Review these five effective steps to focus your efforts and make progress toward wellness.

What are the options?

It is often helpful to have all the ideas which are action oriented in one place or binder for future reference.

This can be accomplished by purchasing at the office supply store a three-ring binder, Avery Ready Index Tabs, and file folders.

In the Family Plan of Action Binder "table of contents" you will label your different tabs according to the type of material you will store in that section of the binder.

This is a healthy approach towards getting organized because it causes you to make a commitment to a specific course of action (the family plan) and you are now able to share the contents with others, so they can better assist you in the future.

The family members can take this binder with them, containing all 32 key issues and the completed plan of action for each issue, with them when sitting down with a licensed profession for their involvement in the plan.

Because a Family Plan of Action includes the Family Transformational Response (F.T.R.) worksheet and Family Value-Based Decision-Making worksheet, your family plan of action will contain, the solution and decision for this issue and this will be extremely helpful for others to review.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 23

Roles and Responsibilities in the Family Plan of Action

Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

What is the issue?

The family has a central role to play in the treatment of any health problem, including substance abuse. Family work has become a strong and continuing theme of many treatment approaches (Kaufmann and Kaufman 1992a; McCrady and Epstein 1996), but family therapy is not used to its greatest capacity in substance abuse treatment. A primary challenge remains the broadening of the substance abuse treatment focus from the individual to the family members.

Family factors have been part of the drug abuse focus at least since Fort's early (1954) paper commenting on the parents of heroin addicts. The literature on family variables in the process and treatment of drug problems has shown steady and increasing accumulation; there were nearly 400 such publications between 1954 and 1978 (Stanton 1978), and that total would appear to have at least doubled by now (Heath and Atkinson 1988; Kaufman 1985; Mackenson and Cottone 1992; Sorenson 1989; Stanton 1988). If you are a family, you cannot afford to wait for these groups to say what needs to be done, your needs are more immediate.

There are several areas which need to be considered when creating a family plan of action with roles and responsibility assignments. For the best results, creating a family plan of action and assigning roles and responsibilities should be done with the guidance of a family therapist or counselor.

Early views of drug-dependent individuals tended to characterize them as loners—people who were cut off from primary relationships and living a kind of "alley cat" existence. It was not until researchers began inquiring about addicts' living arrangements and familial contacts that the picture began to shift. We now understand the family can make significant contributions to the success of recovery. The opposite is also true.

In this seminar the attendee will review three critical areas for the family members to consider:

1. Communication between family members, with their loved one and with the community.
2. Triangularization within the family, within the treatment facility with the love one.
3. Building stronger internal support between family members

How can the issue impact the family?

Our focus is the communication between family members, not just with the one abusing substances. Because family members avoid sharing subjects that might lead to more pain, they often wind up avoiding genuine connection with each other. Then when painful feelings build up, they may rise to the surface in emotional eruptions or get acted out through impulsive behaviors. Thus, these families become systems for manufacturing and perpetuating trauma.

Trauma affects the internal world of each person, their relationships, and their ability to communicate and be together in a balanced, relaxed and trusting manner. As the "elephant in the living room" increases in size and force, the family must become ever more vigilant in keeping its strength and power from overwhelming their ever-weakening internal structure. But they are engaged in a losing battle. The guilt and shame that family members feel at the erratic behavior within their walls, along with the psychological defenses against seeing the truth, all too often keep this family from getting help.

The development of the individuals within the family, as well as the development of the family as a resilient unit that can adjust to the many natural shifts and changes that any family moves through, becomes impaired. It is no wonder that families such as these produce a range of symptoms in their members that can lead to problems both in the present and later in life. Children from these families may find themselves moving into adult roles carrying huge burdens that they do not know exactly what to do with and that get them into trouble in their relationships and/or work lives.

A good social support system is essential during the early stages of recovery. A network of friends and loved ones helps to minimize the feelings of isolation and frustration that are not uncommon during this challenging period. This is an area where the family member can help.

You can be an important part of your recovering loved one's social support system. Try to maintain open communication with your family member; if your relationship has been strained by the effects of addiction, rely on the communication techniques you practiced in family therapy to defuse some of the tension and encourage open, honest dialogue. Spend time with your family member doing activities that support their recovery and keep them busy.

The Importance of Talking about What's Going on: When what is going on within the family is never talked about, children are left to make sense of it on their own. Talking need not be constant but avoiding talking altogether can lead to confusion and disconnection. Talking about and processing pain is also an important deterrent to developing post traumatic symptoms that show up later in life.

Intense emotions such as sadness, that are an inevitable part of processing pain, can make family members feel like they are "falling apart" and consequently they may resist experiencing the pain they are in. And the problems in an alcoholic family system are perpetual.

For the child in an alcoholic system there may be nowhere to run, as those they would normally turn to are steeped in the problem themselves.

1. Seeing the problem for what it is may alienate them from other family members.
2. If addiction remains untreated, dysfunctional coping strategies become very imbedded in the general behavior of the family.
3. Family members may find themselves in a confusing and painful bind, e.g., wanting to flee from or get angry at those very people who represent home and hearth.

If this highly stressful relational environment persists over time, it can produce cumulative trauma. Trauma can affect both the mind and the body. Intense stress can lead to deregulation in the body's limbic system – that system that helps us to regulate our emotions and our bodily functions.

Because the limbic system governs such fundamental functions as mood, emotional tone, appetite, and sleep cycles, when it becomes deregulated it can affect us in far ranging ways. Problems in regulating our emotional inner world can manifest as an impaired ability to regulate levels of fear, anger, and sadness. This lack of ability to regulate mood may lead to chronic anxiety or depression. Or it can emerge as substance or behavioral disorders, for example, problems in regulating alcohol, eating, sexual or spending habits.
REF: The Set Up Living with Addiction Tian Dayton MA, PhD, TEP What Happens to the Family When Addiction Becomes Part of It?

DID YOU NOTICE: One well-regarded study outlined multiple characteristics that are likely to be found in a family unit where parents or children are abusing alcohol or illicit drugs:[2]

1. **Negativism:** All communication among family members is negative, coming in the form of complaints and criticism. The overall mood of the home is a negative one.
2. **Parental Inconsistency:** The home is an environment that lacks stability, clear boundaries, or any form of consistent enforcement. Children are confused because they do not know what to expect from parents and cannot adjust behavior accordingly.
3. **Parental Denial:** Regardless of mounting evidence and an abundance of signs, parents steadfastly deny their child(ren) has any addiction or substance abuse problem.
4. **Miscarried Expression of Anger:** Due to the lack of proper functioning in the home, children or parents are likely to express displeasure and outrage in the form of substance abuse.
5. **Self-Medication:** To cope with the negative atmosphere in the home or with feelings of depression or anxiety, parents and children may resort to drug or alcohol use.
6. **Unrealistic Parental Expectations:** By parents setting expectations too high, children either obsessively strive to overachieve while never feeling anything is good enough or completely excuse themselves from doing anything because they feel failure is inevitable.

Communication involves family members sharing meaningful information amongst themselves. Family members communicate with one another in a variety of methods including verbal, non-verbal, written, and electronic messages (Lewis, Haviland-Jones, & Barrett, 2008). This component interacts with all others on the list but is particularly important as a mechanism for promoting family cohesion and resiliency (Schrodt, 2005).

Effective communication has the potential to increase intimacy and connections among family members; while hurtful, angry communication can damage relationships. Key Finding: Supportive communication has the potential to increase intimacy and connections among family members; while hurtful, angry communication can damage relationships.

Each family member has their own individual communication style that must be considered in the context of other family members and family cultural norms. Strong families have parents who teach and model effective communication, demonstrating open and honest sharing of feelings, and engaging in responsive listening.

Children learn both by their parents' specific instructions and by observing parental interactions (Adams, Berzonsky, & Keating 2006; Black & Lobo, 2008; DiClemente et al., 2001; Saltzman, 2011). Moreover, it is important to consider the role of positive communication as a strength in the couple's and in the parent-child relationship. Couple. Open, honest communication between the couple is a cornerstone of strong family functioning, as it creates the foundation for how information is shared and provides a model for children. Good communication is marked by mutual, open sharing of thoughts and feelings as well as responsive listening and emotional support (Gottman, 2011).

Couples can foster intimacy and strength in their relationship by showing respect, engaging in frequent conversations, listening to, and responding empathically, making important decisions together, and resolving the inevitable conflicts that arise as part of everyday family life (Harris, Skogrand, & Hatch, 2008). Parent-Child. Strong families demonstrate positive interpartner communication, and effective communication skills with their children. Open and respectful communication benefits the child, parent, and the parent-child relationship (Lochman & Van-den-Steenhoven, 2002).

Good communication within the family offers children a safe place to bring their joys, worries, and hurts to their parents; such intimate sharing strengthens the attachment bond and teaches the child that he/she can count on a parent being available and responsive. Effective communication can provide a buffer against the development of negative or antisocial behaviors (Griffin, 2011).

Positive parent-child communication contributes to improvement in children's social competence, particularly in the areas of social problem-solving skills and social self-efficacy (Leidy & Guerra, 2012). Thus, the literature clearly documents the importance of open, honest, and genuine communication in strong families (Lochman & Van-den-Steenhoven, 2002; Griffin, 2011; Leidy & Guerra, 2012). Setting up Roles and Responsibilities allow these things to formulate within the family dynamic.

Triangulation

Triangulation occurs when an outside person intervenes or is drawn into a conflicted or stressful relationship to ease tension and facilitate communication. This situation is often seen in family therapy.

WHAT IS TRIANGULATION?

Triangulation can happen in nearly any type of relationship. For example, a relationship between two siblings can be triangulated by a parent when the siblings disagree, and a relationship between a couple can be triangulated when one partner relies on a child or parent for support and communication with the other partner. Two friends might also draw another friend into a conflict to resolve it.

Triangulation can lead to problems in relationships, and the individual members of the triangulated relationship may experience stress, anxiety, or other mental health concerns because of the triangulation.

When an individual feels as if he or she has been pushed out of an important relationship by a third party, for example, he or she may often feel angry, confused, or rejected and may experience depression or resentment. Further, when tension and focus is shifted to a third person, that person may feel burdened and frustrated and may attempt to withdraw from the relationship altogether.

What are the options?

Triangulation may be troublesome in a relationship if:

1. Attention is drawn away from important issues in a two-person relationship.
2. The third member of the relationship feels pressured, overtaxed, or manipulated because of being brought into the conflict.
3. One of the three people in the relationship begins to feel ignored, excluded, or rejected.
4. Triangulation pulls a third party into an inappropriate role (for example, when a child becomes a mediator of conflict between two parents or a friend outside a conflicted relationship becomes a confidant for one of the partners).
5. When recognized, triangulation may be best addressed by the individuals in the primary relationship. When a third member recognizes that triangulation is a problem, he or she should encourage the other two people involved to communicate directly about their difficulties.
6. When triangulation persists or leads to increased stress, it can often be helpful to find a qualified therapist or counselor and explore possible causes of the conflict.

What happens in the marital dyad (between the two) when the parents focus on the child or children? If both parents focus on one child, a triangle is established. Family therapy theorist Murray Bowen introduced the concept of triangulation in 1955. Bowen linked the development of maladjustment in children to triangulation, which, in simple terms, is a dysfunctional relationship device where a third person is brought into a two-person relationship.

Two of the people within this relationship will be closer than they are with the third. Focusing on the parent-child relationship is used to divert tension and conflict between the marital couple when they are experiencing stress in their relationship. For triangulation to occur, a third person is drawn into the dyad to diffuse relationship stress.

A triangle is more stable than a dyad, but a triangle creates an "odd man out," which causes anxiety in the one who is left out. Frequently, in a family with more than one child, each parent will make a primary bond with one child and avoid whatever issues the marital dyad may have. And so, helicopter parents are born.

Although we hear about this phenomenon in high-achieving families, another common scenario for triangles in families is when a teen starts acting out and getting into trouble. Finally, the parents agree on something: the kid is the problem, and they want the therapist to fix him or her.

Years ago, I saw a family with several children, the oldest of whom, a teen, was the identified person. She had been flouting curfew and generally challenging the parents but had not violated societal rules and was doing fine in school.

After talking to the family together and then the kids and parents separately, it became clear where the issue in the system lay. The children clearly articulated (and I witnessed) that Mom and Dad undermined each other—if one set a limit, the other countermanded it; if one gave permission, the other nixed it, leaving the kids confused and angry.

With her behavior, the teen was simply calling attention to the pattern. When I presented this pattern to the parents (alone), they were gracious enough (and healthy) to agree that they owned the problem and to begin therapy as a couple. The kids were sent home to be kids, and the oldest was acknowledged as a regular adolescent.

More next time on what happens to kids who grow up with poor boundaries from parents who make primary bonds with them instead of their partner. Have you worked with a family experiencing triangulation? What did you find helpful?

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Stronger Internal Support between Family Members

Based on various assumptions about what a strong family does, researchers have developed lists of structural and behavioral attributes that characterize successful families. Despite differences in discipline and perspective, there seems to be a consensus about the basic dimensions of a strong, healthy family.

The following constructs, which are often interrelated and complex, will be identified, defined, and described briefly as they exist in strong, healthy families:

- communication
- encouragement of individuals
- expressing appreciation
- commitment to family
- religious/spiritual orientation
- social connectedness
- ability to adapt
- clear roles
- time together

The presence of effective ***communication*** patterns is one of the most frequently mentioned characteristics of strong families. Researchers characterize the communication patterns of strong families as clear, open, and frequent. Family members talk to each other often, and when they do, they are honest and open with each other (Stinnett and DeFrain, 1985; Lewis, 1979; Epstein, 1983; Olson, 1986).

Practical Exercise One:
Do your own research on each topic. For the search take each of the above topics and add to it the words, “the family” then type the selected above topic. It is important for the family members to search out their own understandings and not rely on a single source to explain it to them.

BUILDING INTERNAL SUPPORT BETWEEN FAMILY MEMBERS
WORKSHEET

Search: Findings:

Communication between family members:
_____
_____

encouragement of individuals between family members:
_____
_____

expressing appreciation between family members:
_____
_____

commitment to family between family members:
_____
_____

religious/spiritual orientation between family members:
_____
_____

social connectedness between family members:

_____
_____
_____

ability to adapt between family members:

_____
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clear roles between family members:

_____
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_____

time together between family members:

_____
_____
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But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 24

Getting Networked in Advance

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

The “My Organized Resources Evaluation” Program (M.O.R.E.) is designed to provide an organized process of networking families into agencies and services that best meet their evaluated needs. This is completed by first developing a network for the family to use for each of the 32 issues. Then using an evaluation tool to ensure each referral is made to the right resource that best meets the family’s needs. From within the Substance Used Disorder Journey, it’s time to get Networked” is a process for the family to follow.

The Steps:

1. Family member identifies a need or issue requiring support or services from a within the local community.

2. The correct type of provider is contacted, and their services are confirmed to be a value to the family in meeting the needs of their issue.

3. The selected network list is used to contact those local community groups which will best meet the family needs.

4. This is completed for each issue, prior to the time of services being needed and a directory list of providers is created for future reference by the family members.

How can the issue impact the family?

Family Resource Mapping is not a new strategy or process. It has been in use for many years in varying forms. Family Resource Mapping is sometimes referred to as asset mapping or environmental scanning. Family Community Resource Mapping is best noted as a systematic-building process used by many different families at different stages to align resources and programs in relation to specific family system goals, strategies, and expected outcomes.

Mapping of needed services, support organizations, and programs within a community can have essentially three outcomes: 1) the identification of resources available to the family members 2) the identification of new or additional resources to sustain existing needs of the family with activities or initiatives from within their community, and/or 3) the identification of resources to assist in creating and building capacity to support a more complex family system of needs. The first outcome typically occurs at the local community level while the second and third outcome can happen at any level—local, state, or federal.

There are four steps to the Family Resource Mapping process: 1) pre-mapping; 2) mapping; 3) acting; and 4) maintaining, sustaining, and evaluating mapping effectiveness. The pre-mapping step allows with the family to establish a clear vision and goals for supporting a family system. The second step, mapping, determines which resources to map and how to best map them. The collection and analysis of data helps the family to identify strengths and challenges more clearly based on the family's inquiry prior to needing the services. 3) Acting; this allows the families to determine the most useful plan of action for effectively addressing the family system likely needs. Because "No one agency can meet the needs of all family member's needs, all of the time." A network of providers and programs and service are required to be included to the Family Community Resource Mapping strategy. 4) Established goals; Communicating and disseminating information about the family goals and needs is key throughout the implementation step.

What are the options?

Step One: Pre-Mapping, what is the goal?

The pre-mapping step, this step in the mapping process should not be overlooked or rushed. Specifically, during the pre-mapping step, you will identify and secure the organizations and key stakeholders and define the vision and goals for aligning the family to community resources. Establishing clear communication in the beginning with these providers will make it easier to achieve your long-term goal of aligning and streamlining community resources.

The goal needs to be specific, measurable, action-oriented, realistic, and time-constrained. The way in which a goal is stated strongly affects its effectiveness. It is important to be positive, precise, and practical when stating goals and setting priorities. Goals set the expectations for overall performance over time for everyone involved.

Determining short-term objectives allow for the bigger goals to be more manageable. Short term objectives build together to achieve a single goal. State the goal then the objectives needed to achieve the goal.

When thinking about setting realistic yet meaningful goals, ask yourself the following questions:

- What skills, information, and knowledge will be needed to achieve each goal?
- What assistance or collaboration is required to achieve each goal?
- What resources will be needed to achieve each goal?
- What factors may inhibit meeting each goal?
- How will we know when we have met each goal?
- Are there other goals we should be pursuing?

Goal setting is an ongoing and ever-changing process that is accomplished over time. Keep in mind, you will need to periodically review your goals and modify them to reflect any changes in priority.

Step Two: Mapping

The mapping process begins by selecting one issue in the 32 Key Issues a family is likely to face in their journey to map. The usefulness of resources is determined by evaluating the extent to which they assist in meeting strategic goals and objectives of the family system. This stage involves selecting a focus, identifying, and collecting data or resources, and analyzing the information or resources collected. While the mapping step can be time-consuming, efficient organization can make it one of the simplest steps.

The first step in the mapping phase is to determine what resources need to be collected to provide the information necessary for making informed decisions about change. You can collect what will be the family's outcomes using selected organization or, what process they use to meet the family's needs.

The type of information you choose to collect depends largely on the issue you select to map. Sources of information extend far beyond those traditionally assessed. Not only are new resources identified during the mapping process, but how other families have utilized current resources should be examined.

The primary question is whether current resources can be used differently to help meet the needs presented by this issue or whether new resources are needed. The amount of information collected during the mapping process can often be overwhelming. It is essential to select only what is needed to get the report job done.

Prioritize your resource mapping issues based on your overall vision of what is most likely, and then map around each of the issues.

Step Three: Set-Up a Map

Mapping Steps:
1. Reach consensus on the parameters of the map—select a goal to map.
2. Select the information to be collected based on these parameters—determine what types of the resources you would like to collect.
3. Develop tools to collect your information.
4. Collect data with help from stakeholder organizations.
5. Conduct a community (or geographical) scan.
6. Review, analyze, and interpret the information.
7. Communicate your findings.
8. Set priorities.
9. Include to the families, "Master Plan of Action".

Different methods can be used to gather information. The information collection methods you select depends on the type of information you want and the stakeholders who are sharing the information. Possible methods include questionnaires, on site or by telephone interview meetings, and written or at a public event/presentation. No single collection method can provide all the necessary information to support good decisions, be creative in how you collect the information. Remember, much data already exists within your community and is available for your use, such as state eligibility requirements, referral processes and about us pages on the organization's website.

A significant first step in the resource mapping data collection process is to geographically scan the community for existing and potential resources. A geographical scan includes an analysis of both the external to the community and internal to the community geographical boundaries.

Specifically, you need to determine what your community has to offer that will assist you in meeting your goals. For example, a community may be insufficient in providing resources to effectively address mental health issues by it not having a strong support in addiction treatment and detox services.

The inquiry might encourage the development of new programs within the community to reduce duplication of services and resource use, minimize gaps in services and resources, and expand a community's services/resources to meet the needs of more of its members. This is one advantage from a family being proactive, the community can gain a better understanding about what a family needs and is looking for in services. Ways to Collect Information Keep in mind that there are many suitable ways to collect information. No single collection process is perfect.

Some, but not all, options for collecting useful information are listed below:

• Geographical or community scans.

• Interviews formal/informal leaders, program advocates, service providers to targeted audiences, and end-

• Site visits or observation of a setting (e.g., climate, attitudes of specific personnel, professional practices, resources and support services, facilities, and budget allocations).

• Analysis of written and online documents.

• Interaction with existing groups (e.g., support groups, advisors, faith groups, organizations management teams, and staff).

• Case studies and success stories.

The Family Community Resource Mapping

Once the data has been collected and reviewed, the challenging part begins. Acting on the information from the mapping perspective is an important step. What are you going to do with the information now? The misconception exists that once resources are identified and mapped; the work is completed. It is not. The greatest challenge in Family Resource Mapping often exists in developing a *plan of action* for implementing the map. This step in the process allows the family to take pro-active action in planning and building

its system.

Developing a Family Master Plan of Action is a matter of detailing the action the family will take to build their system, so it meets the family's individual needs. Action planning allows you to determine how to strategically act on the information revealed in the information analysis step. The action plan aligns your resources with the goals outlined in the pre-mapping stage. For example, you may identify new resources to support your goal. If this is the case, the action plan would focus on pursuing those resources. You also may discover that existing resources could better meet your goals if they were realigned. This action plan would outline a course for redirecting these resources to support the goals as outlined earlier in the pre-mapping step.

Most important are other possible actions, considering the information analysis, are aligning services to fill gaps or eliminate duplication or un-necessary services.

Many persons' individual needs are such that some program with standardized, one size fits all, may not include these needs to the plan of treatment.

When treating clients with co-occurring mental health and substance use disorders, these cases tend to involve the most from the family because of the exceptional number of community services.

Moreover, substance abuse, medical and mental health programs historically have had problems forming good collaborative relationships. Programs also encounter substantial potential for stakeholder conflict when treating adolescent persons. Families routinely disagree with courts; juvenile justice, child protection, and school representatives all have their opinions on the most appropriate care. Disagreements on the nature and duration of treatment are common, and subtle conflicts are the norm rather than the exception.

The family member will be benefited by knowing their options prior to the issue being presented.

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LEARNING MODULE I

Seminar #25

Suicide Prevention

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

Suicide, addiction, and depression have an awfully close and interconnected relationship. More than 90% of people who fall victim to suicide suffer from depression, have a substance abuse disorder, or both. Depression and substance abuse combine to form a vicious cycle that all too often leads to suicide. Many who experience such severe depression (because of Major Depression, Bipolar Disorder, Obsessive Compulsive Disorder, and other conditions) frequently turn to drugs, alcohol, gambling, and other risky behaviors to numb their pain and/or alleviate their negative feelings.

However, substance abuse and addiction increase the severity and duration of depressive episodes, despite any temporary relief they may provide, greatly increasing the likelihood of suicidal thoughts (suicidal ideation).

This is exacerbated by the fact that addiction frequently damages or destroys familial, professional, personal, and financial relationships, further increasing the risk of suicide. Even worse, many substances severely impact judgment, leading to suicide attempts. REF: SAMHSA.GOV

Common Risk Factors

Some of the most common risk factors for suicide include:

- Suicidal thoughts
- Previous suicide attempts
- Depression
- Drug and alcohol abuse
- Family/community history of suicide
- Family history of violence and/or sexual abuse
- Previous incarceration
- Violent behavior towards others

Individuals with a substance abuse disorder are nearly six times as likely to attempt suicide at some point in their life.

Of all addictions, perhaps none is more likely to result in suicide than opioid addiction. In 2015, over 33,000 Americans died from opioids. Due to the nature of overdose, it is impossible to know how many of these deaths were accidental and how many were suicides. Men with an opioid use disorder were twice as likely to fall victim to suicide, and women with an opioid use disorder were eight times as likely to fall victim to suicide. Opioid use is associated with a 40%-60% increased likelihood of suicidal thought, and a 75% increased likelihood of suicide attempt. Some studies suggest that opioid and injection drug users are 13 times as likely to die by suicide.

How can the issue impact the family?

Common Warning Signs

The most common warning signs for suicide include:

- Expressing a desire for death
- Expressing a feeling of being trapped
- Acting agitated or anxious
- Reckless behavior
- Isolation from friends and family
- Avoiding social situations
- Abandoning hobbies or other sources of enjoyment
- Insomnia
- Heavy drug and alcohol use
- Extreme irritability
- Hopelessness
- Sudden decrease in work or academic performance

What are the options?

Children of Parents that Use Drugs.

Over the past 15 years, the suicide rate among young people in the United States has increased dramatically, researchers pointed out, as has opioid use among adults.

"Until now, there has been little focus on the association between the increase in opioid use among adults and the risk of suicidal behavior by their children," said study senior author Robert D. Gibbons, PhD, a biostatistics professor, and director of the Center for Health Statistics at the University of Chicago in Illinois. "We theorized such a link was plausible because parental substance abuse is a known risk factor for suicide attempts by their children. In addition, depression and suicide attempts by parents—which are known to be related to suicidal behavior in their offspring—are more common among adults who abuse opioids."

Silent Contributor to Overdose Deaths

As the toll of opioid-overdose deaths in the United States rises, we face an urgent need for prevention. But preventing such deaths will require a better understanding of the diverse trajectories by which overdoses occur, including the distinction between intentional (suicide) and unintentional (accidental) deaths, be they in persons with chronic pain who overdose on their opioid analgesics or in those with a primary opioid use disorder (OUD).

Interventions to prevent overdose deaths in suicidal people will differ from interventions targeted at accidental overdoses.
Yet most strategies for reducing opioid-overdose deaths do not include screening for suicide risk, nor do they address the need to tailor interventions for suicidal persons. Moreover, the inaccuracy of available data on the proportion of suicides among opioid-overdose deaths — which are frequently classified as "undetermined" if there is no documented history of depression or a suicide note — hinders deployment of appropriate prevention services. (NEJM)

At Immediate Risk

- Call 911 or the Suicide Prevention Lifeline (1-800-273-8255), which is available 24/7
- Take your child to the nearest emergency room.
- If you or anyone in your household owns a gun, knife, or other dangerous weapon, place these items in a safe, securable location.
- Remove any other objects that could be harmful.
- Make sure your child is not left alone.
- Remove any medications that a child could use to overdose.

Having Suicidal Thoughts

- Take all statements related to suicide seriously.
- Talk to your child to figure out exactly what is causing these thoughts.
- Approach the situation calmly and make sure your child knows you are there to provide understanding, love, and support.
- Find a therapist that can provide professional support to your child, and possibly a psychiatrist or psychologist if a medical course of treatment is deemed necessary.
- Work together to create a plan that avoids people or situations that trigger these thoughts.
- Keep track of their social media activity; consider monitoring their phones to watch for bullying or other harmful behavior.
- Consider an in-person rehabilitation program.
- Get him or her involved in some sort of physical activity to increase endorphins.

At Immediate Risk

- Call the college campus health center and let them know the student is exhibiting dangerous behaviors.
- Call 911 and ask them to go to your child's dorm room.
- Call the resident director of your child's dorm and ask them to assess the situation to ascertain the best course of action.
- Ask campus security or local police to go check on your child.
- Ask one of their friends to stay with your child until help can arrive.
- If the school is not far away, drive there yourself to check on your child.
- Having Suicidal Thoughts.
- Encourage your child to go see a therapist or counselor, on or off campus, if they have not already.
- Find out if your child has been taking any prescribed medications regularly.
- Reinforce your love and support.
- Ensure you are speaking regularly and encourage your child to call you whenever help is needed.
- Remind your child that it is fine to take time off from school if it is too overwhelming.
- Suggest transferring to a school that is closer to home.
- Encourage them to speak to their RD and professors to let them know of the situation and ask for help, if needed

We strongly recommend you visit this sight for more information:
https://www.accreditedschoolsonline.org/resources/suicide-prevention/

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PART V

Other Possible Situations

LEARNING MODULE I

Seminar # 26

Financial Management in the Substance Use Disorder Journey

Learning Objectives

1. What is the issue.
2.How can the issue impact the family.
3. What are the options.

What is the issue?

Understanding your choices of care is one aspect of financial planning for treatment and recovery. However, this is not the families only costs. There are other expenses like.

What type of addiction treatment programs are covered by health insurance? Close to 91% of Americans had health insurance in 2014. Depending on the plan specifics, those with insurance can use that coverage for:

- Inperson care in an approved facility.
- Outperson care with an approved provider.
- Medical detox, including medications.
- Co-occurring mental health conditions.
- Follow-up counseling.
- Maintenance medication…

There are other costs for the family to budget:

- Legal fees are expensive.
- Housing costs, if shared.
- Transportation costs, if shared.

Other Expenses related to long term recovery:

- Entertainment of a responsible type.
- Recreation and physical fitness of a reasonable type.
- Diet requirements sometime cost more to eat healthy.
- Attending social events supportive of recovery.

Other Medical Diagnosis related to substance use disorders, have costs:

- Diabetes
- Cardiac
- Pulmonary (respiratory)
- Allergies

Soft Expenses:

- Caregivers lost time at work.
- Caregivers lost commission wages if on commission salary.
- Caregivers medical and mental health costs related to stress from substance use disorders in the family.

How can the issue impact the family?

How much treatment will insurance cover?

The coverage requirements and limitations depend on the type of policy a person has. There may be some limitations concerning what kind of care is covered by the plan.

For instance, insurance companies may pay for the detox process and the drugs needed during this stage (as most persons require medication during the rehabilitation process,) but they might not or only partially cover the subsequent rehab therapies a person need.

It is vital to check the fine print of the plan before enrolling into an inperson (or outperson) program to see how much of the cost the insurance company can cover.

Check what insurance covers.

Consulting the summary of coverage and benefits by logging into the account provided by the insurance company. This compendium holds a listing of all the services the insurance plan covers.

Call or email an insurance company representative to ask them about the coverage. They will also provide information on what drugs the insurance covers or for what clinics or treatment plans they qualify.

Contact a reputable treatment facility and ask for a verification of benefits with the facility's program.

According to a paper from the Bureau of Labor Statistics, 81% of employees with health insurance also had coverage for alcohol abuse treatment, and 75.5% had it for drug abuse treatment. In some cases, persons can receive coverage as a single plan. The most common type of coverage was for inperson detox, quickly followed by outperson programs and inperson rehabilitation.

What are the options?

Options for individuals with no or poor insurance coverage

Centers that offer fees based on the income of the person; these centers provide individualized care by asking for payment for only what the persons can afford.

State-funded programs, although persons must meet certain requirements to be admitted (specifically low income)

NGOs that specialize in drug rehabilitation can redirect addicts to clinics that admit persons without insurance or without the means to pay medical bills.

The SAMHSA offers grants to low-income people, helping them fund their drug treatment.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Rehab Prices: How Much Does Inperson Residential Treatment Cost? Duration: 4:38 min

How Your Insurance Can Cover Addiction Treatment Costs

Ever wonder how insurance, California insurance specifically, impacts you or your loved ones stay in rehab? Find out how in the video and learn about how California insurance can cover the cost of addiction treatment.

Visit https://windwardway.com/health-insura... to learn more. Watch the entire Windward Way Explainer Series about addiction, insurance, detox, treatment, & more in this playlist. Now ask these questions of your states insurance department or local Medicaid HMO.

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LEARNING MODULE I

Seminar # 27

Foster Care Services in Substance Use Disorder

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

Parental substance abuse is a factor in approximately 50-79% of child welfare cases in which young children are removed from custody. It is a factor in 25 percent of cases with substantiated maltreatment. In these cases, substance abuse treatment is usually an essential component of child welfare family plans.

Unfortunately, drug and alcohol treatment completion rates are low among substance abusing mothers who are involved in the child welfare system. A little over half (56.5%) of these mothers complete at least one treatment episode;3 only 25% complete all treatment requirements. 4,5

Research has shown that substance abusing mothers who had a child removed from their care were twice as likely to have a subsequent birth, and three times as likely to have a subsequent alcohol or drug exposed birth.

For example, there is evidence that suggests that mothers who have a substance addiction tend to visit their children in care less often, further decreasing their chances for reuniting with their children (Leathers, 2002).

Often, parents struggling with substance abuse/dependency are also dealing with a complex array of other issues such as mental health issues, vocational or educational needs, or inadequate parenting skills, and lack concrete resources such as housing, childcare, and transportation (Choi & Ryan, 2006).

In addition, a study in which researchers focused on exploring systemic barriers to reunification for parents with substance abuse issues discovered problems with coordination between child welfare and substance abuse treatment providers (Smith, 2002).

How can the issue impact the family?

Family-level factors associated with delayed or non-reunification include economic status, substance abuse or addiction, emotional or psychological well-being, and family/household structure.

Economic status: In a study conducted in the early 1990s (pre-TANF), children removed from families eligible for Aid to Families with Dependent Children (AFDC) were found to return home at a slower rate, or not at all, compared to children in non-poor families (Courtney, 1994; Courtney & Wong, 1996).

Researchers that looked at children and families receiving Medicaid or SSI funding found that these families were less likely to be reunited (Noonan & Burke, 2005).

In general, reunification rates have continued to decrease over time from pre-welfare reform (AFDC) to post-welfare reform (TANF; Wells & Guo, 2006). Specifically, mothers who lose cash assistance under TANF appear to reunite with their children at slower rates than mothers who continue to receive this support, and mothers with higher incomes reunite with their children more quickly than mothers with lower incomes (Kortenkamp et al., 2004; Wells & Guo, 2003, 2004,
2006).

In fact, for every $100 increase in a mother's post-placement income, the reunification rate rises 11% (Wells & Guo, 2004). Poverty itself may not be a reason for removal, but it is associated with other challenges such as housing or homelessness, or parental incarceration, and can act as a barrier to providing an adequate, safe, and stable living environment for children so that they may return home (Courtney, McMurty & Zinn, 2004; Eamon & Kopels, 2004; Hayward & DePanfilis, 2007; Shdaimah, 2009). Substance abuse/addiction.

Parents with substance abuse/dependency issues experience: These parents major challenges in the path toward reunification as they seek to balance the competing demands of addiction treatment and parenting readiness (Carlson, Matto, Smith, & Eversman, 2006; Carlson, Smith, Matto, & Eversman, 2008; Hohman & Butt, 2001). A California study found that African American mothers with substance abuse issues were at particularly high risk for not reuniting with their children (Hines et al., 2007). Another study found that children removed from their home due to parental drug abuse had a low likelihood of reunification, but better chances for discharge to guardianship with a relative (McDonald, Poertner, & Jennings, 2007

For example, there is evidence that suggests that mothers who have a substance addiction tend to visit their children in care less often, further decreasing their chances for reuniting with their children (Leathers, 2002). Often, parents struggling with substance abuse/dependency are also dealing with a complex array of other issues such as mental health issues, vocational or educational needs, or inadequate parenting skills, and lack concrete resources such as housing, childcare, and transportation (Choi & Ryan, 2006). In addition, a study in which researchers focused on exploring systemic barriers to reunification for parents with substance abuse issues discovered problems with coordination between child welfare and substance abuse treatment providers (Smith, 2002).

Emotional/psychological well-being: Parents who become involved with the child welfare system face emotional challenges associated with their experiences in the system (Haight, Black, Workman, & Tata, 2001). Some evidence suggests that the childhood experiences of parents and attachments with their own parents may affect their ability to build healthy relationships with their own children (Cordero, 2004). In one study researchers found that mothers with mental health issues reunited with their children at a slower rate than mothers without these issues (Wells & Guo, 2004).

In another study researchers identified a relationship between mothers' symptoms of depression and non-reunification with their children (Larrieu, Heller, Smyke, & Zeanah, 2008).

Parents struggling with mental illness also experience multiple problems and face unique systemic hurdles to reunification (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004). Finally, families who are simultaneously experiencing multiple challenges or cumulative risks are associated with lower probabilities for reunification (Larrieu et al., 2008; Wulczyn, 2004).

Family/household structure: Some researchers have found that children removed from a single-parent household had lower chances of reunification than those coming from two-parent households, and children who had been living with adults other than their parents were the least likely to return home (Landsverk et al., 1996; Wells & Guo, 1999).

Other researchers have similarly found that single-parent households, especially father-only households, had lower reunification rates when compared to two-parent households (Harris & Courtney, 2003, Hayward & DePanfilis, 2007; Hines et al., 2007). In one study, however, researchers found that single parents reunified with their children more quickly than other family structure households (Davis et al., 1997).

Examining family structure and race revealed that African American single mothers had the slowest rate of reunification compared to all other parent structures (Harris & Courtney, 2003). Hispanic single fathers have also been linked with slower reunification rates (Harris & Courtney, 2003).

What are the options?

The characteristics of the child that have been associated with a lower likelihood of reunification include age, race and ethnic background, health and disability, and gender and sexual orientation.

Age: Most evidence suggests that children placed in care as infants are less likely to reunify
with their families compared to children of other age groups (Courtney & Wong, 1996; GroganKaylor, 2001). Some researchers, however, have found that young children reunify with their families at a faster rate, or are more likely to reunify, than older children (Hines et al., 2007; Kortenkamp, Geen, & Stagner, 2004; Landsverk et al., 1996). Downloaded by [University of California, Berkeley] at 13:04 25 April 2016 ACHIEVING TIMELY REUNIFICATION 185

Race/ethnic background: Most studies find that African American children are over-represented among those who do not reunify or take longer to reunify with their families (Barth, 1997; Connell et al., 2006; Courtney, 1994; Courtney & Wong, 1996; Harris & Courtney, 2003; Hayward & DePanfilis, 2007; Kortenkamp et al., 2004; Lu et al., 2004; McMurtry & Lie, 1992; Noonan & Burke, 2005; Ryan et al., 2006; Wells & Guo, 1999; Wulczyn, 2003).

However, some studies find that the relationship between being African American and reunifying with one's family is not significant (Hines et al., 2007; Webster et al., 2005) or that the reunification rate does not differ significantly from that of White families (Davis et al., 1997). Researchers examining race and age together have shown that African American infants have the lowest likelihood for reuniting with their families compared to other age or ethnic groups (Courtney, 1994).

However, Hines et al. (2007) found that young African American children had higher rates of reunifying than older African American children.

Research involving Latino or Hispanic children has also yielded mixed results. Studies have found Latino and Hispanic children to be both over-represented and under-represented with respect to reunification rates and timeliness; in some studies, these findings are dependent upon factors such as age of the child or placement in kin versus non-kin care (Courtney, 1994; Davis et al., 1997; Grogan-Kaylor, 2001; McMurtry & Lie, 1992; Noonan & Burke, 2005; Ryan et al., 2006).

In one study that included Asian children and families in its analysis researchers found that Asian families were less likely to reunite than White families (Hines et al., 2007

Health/disability-related needs: Children with disabilities or health problems have been found to reunify less frequently or at a slower rate compared to non-disabled and healthy children (Courtney, 1994; Courtney & Wong, 1996; Davis et al., 1997).

Looking at mental health issues, researchers in one study found that the longer it took for a child to be referred to therapy while in care, the longer it took to be reunited with family (Gries & Cantos, 2008).

In another study researchers found that children with behavioral/emotional problems were half as likely to return home as children without (Landsverk et al., 1996).

Gender/sexual orientation: In most studies researchers have found that gender is not significantly associated with reunification outcomes. However, Harris and Courtney (2003) found that being male was related to a lower rate of reunification than being female. Some evidence indicates that sexual orientation may impact duration in care (Mallon, Aledort, & Ferrera, 2002).

Reunification with Parents with Substance Use Issues

In the context of child welfare, family reunification refers to the services that are provided for purposes of returning children who have been placed in out-of-home care to their families of origin.

Family reunification is the primary goal for the majority children who have been placed temporarily outside of their homes (DeMarco & Austin, 2002), with about half of children placed outside of their homes eventually returned to their families of origin (Berrick, 2009).

Contemporary arguments calling for a less compartmentalized approach have transformed the meaning of family reunification into a continuum that might include varied outcomes such as physical reunification of the family, periodic visitation with the family of origin, or maintaining partial contact via written address correspondence.

This perspective considers family reunification to be a dynamic process, and it acknowledges that each child and family has unique needs, that not every parent can be a full-time caregiver, and that families can still maintain attachment ties even when living apart (Whittaker & Maluccio, 2002).

FACTORS ASSOCIATED WITH NON-REUNIFYING FAMILIES

Although most children who enter foster care are reunited with their families of origin (CWLA, 2009; Pabustan-Claar, 2007), a substantial percentage are not.

While each child and family that becomes involved with the child welfare system brings with them a set of unique challenges and characteristics; studies have identified common individual and systemic factors associated with not achieving reunification.

It is important to note, however, that these studies have not fully identified direct causal mechanisms for no reunification (Biehal, 2007).

Agency/System Factors The agency- and system-level factors associated with non-reunification include reason for removal, and placement characteristics.

Reason for removal: Substantial evidence suggests children who are removed due to neglect are the least likely to return home or return home at slower rates than those experiencing physical, emotional, and/or sexual abuse (Courtney & Wong, 1996).

However, some studies find that children removed due to physical abuse may have a lower likelihood of returning home compared to those removed due to neglect (Hines, Lee, Osterling, & Drabble, 2007; Noonan & Burke, 2005).

Other studies have found that children removed due to sexual abuse had a lower probability of returning home compared to children removed due to neglect (Connell, Katz, Saunders, & Tebes, 2006.
Glisson, Bailey, & Post, 2000

Kindship: Studies examining the impact of kinship placement have typically found that children placed with relatives have a lower likelihood of returning home than children placed with non-relatives (Connell et al., 2006; Davis, Landsverk, & Newton, 1997.

More specifically, a study conducted in California found that the proportion of

children placed in kinship placements that returned home within the first six months of care was considerably smaller than children placed with non-relatives (Courtney, 1994). At the 18-month mark, less than one-third of children living with kin had returned home to their families, while almost half of children placed with non-kin had returned home (Courtney, 1994).

A study examining data from six states found that children placed in kinship care in Arizona, Connecticut, and Illinois were less likely to be reunified than other children; while in Ohio, and Tennessee, children placed with non-relatives were less likely to be reunified (Koh, 2008).

Siblings: Researchers examining the impact of sibling placement found that separated siblings had a lower likelihood of reuniting than siblings who were kept together.

For siblings who enter care at different times, evidence further suggests that siblings who enter care within one month of each other have greater chances for reunification than others (Webster et al., 2005).

Placement stability. Placement stability also appears to be related to reunification, as studies
have found that the more times a child is moved while in care the lower the likelihood there is for reunification (Goerge, 1990; Kortenkamp et al., 2004; Noonan & Burke, 2005) and the probability
for reuniting decreases with each additional move (Hayward & DePanfilis, 2007).

Duration in care: The amount of time that a child spends in foster care continues to be a factor associated with non-reunification for families, despite ASFA's emphasis on timely reunification. In one large study conducted in the early 1990s researchers found that the probability of reunification is greatest during the first four months after a child is placed in care, but then drops dramatically and continues to decrease at a somewhat slower rate with each additional

Caseworker characteristics: Caseworker turnover was found to be associated with a decreased likelihood of reunification. About training, reunification outcomes were not generally affected by whether the caseworker had an MSW, although some impact was found among White caseworkers. The researchers noted in this study that race was likely a proxy for other factors.

Location: Researchers examining the association between location and reunification timeliness are mixed. Some studies have found that children in urban areas have more difficulties in achieving reunification with their families than those in rural areas (Goerge, 1990), while others have found that families residing in rural areas were less likely to be reunited (Courtney & Wong, 1996; Glisson et al., 2000).

LEARNING MODULE I

Seminar # 28

NARCAN (Intervention)

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

What is Narcan? It is a widely available, affordable, and fast-acting remedy for an opioid overdose. It works on any type of opioid, including synthetic opioids like heroin and fentanyl. It will not reverse the effects of other types of overdoses, such as those from cocaine or benzodiazepine medications. Narcan is an opioid agonist, meaning it blocks the opioid receptors in the brain and reverses the symptoms of an opioid overdose.

Narcan works very quickly. A person who fell into an unresponsive state due to an overdose usually wakes up within two to three minutes after receiving a dose of Narcan. The individual will likely require further medical treatment and addiction care, but Narcan is a potentially lifesaving first step toward recovery.

Safely Obtaining Narcan

Most police officers, emergency medical responders, and hospitals receive Narcan training and carry Narcan for emergency uses. The drug generally exists in two forms capable of reversing an overdose: an injectable solution administered intravenously or a nasal spray. A trained professional will need to give a person an IV to administer injectable Narcan, but anyone can administer the nasal spray version when necessary, so it is important to know how to administer Narcan.

If you are wondering how to get Narcan, most people can find Narcan nasal spray in local pharmacies and drug stores. Due to the ongoing and critical nature of the opioid crisis in the U.S., new laws have allowed anyone to purchase Narcan when necessary without the need for a prescription. Narcan uses generally extend to reversing opioid overdoses. The drug does not effectively function for any long-term uses.

How can the issue impact the family?

Only trained medical professionals should administer Narcan through an IV. However, anyone who uses opioids, or who knows someone that does, may want to consider purchasing Narcan and keeping some on hand in case of emergency.

To administer Narcan effectively, follow a few simple steps:

Lay the overdose victim flat on his or her back and tilt the head back slightly.
Confirm the opioid overdose. Check for lowered heart rate, decreased breathing, and unresponsiveness. The only Narcan contraindications are known sensitivity or allergy to Narcan analogs.
Apply the nasal spray applicator into one nostril and squeeze.
After administering the first dose, contact emergency medical services and then wait two to three minutes.

If the victim's symptoms do not improve or he or she remains unresponsive, administer a second dose in the other nostril.
The victim should wake up within a few minutes, but the effects of Narcan only last 45 to 90 minutes. Emergency medical personnel will take over treatment once they arrive, but Narcan can potentially save a victim's life while waiting for an ambulance.

If you suspect your child or spouse has a problem with drugs, you should pick up two NARCAN doses. This would be located at a place of easy access for yourself or any member of your family to administer.

What are the options?

The goal for a Quick Response Team is to be at the doorstep of overdose victims within 6 days of their overdose with one of us (a medic), a police officer, and a counselor from the local ADM Board and we will get the individual to detox and/or treatment if they are ready. If they do not answer the door or are not ready, we will continue to go back until they do."

Not only are people seeing that there is hope in recovering from addiction, first responders are also seeing a positive impact of being able to help people get into treatment. "The Quick Response Team gives us an opportunity to be the starting point of recovery as we continue to focus on education, prevention, enforcement, and treatment to potentially reduce the instances of overdoses in our city," said Cuyahoga Falls Police Chief Jack Davis.

The family needs to prepare for this visit and support this team in whatever way the team asks.

In Hamilton County the team's goal is to help addicts so they do not overdose again. Their findings are encouraging. In the second half of 2015, they saw a **30 percent reduction in opioid-related overdoses**. The departments also hand out information about addiction resources within Colerain's neighborhoods.

This educational work has been credited for also helping to reduce overdoses. The QRT has had a positive impact on the attitude and satisfaction level of first responders who are part of the quick response team, partially due to the response of those they are reaching, but also from the broader community.

Overdose Risk Factors

Overdose Risk Factors and Prevention What is an overdose? An overdose (OD) is when the body is overwhelmed by exposure to a toxic amount of a substance or combination of substances. The body becomes unable to maintain or monitor functions necessary for life, like breathing, heart rate, and body temperature regulation.

Not everyone who overdoses will die; however, there can be long-term medical impacts from overdose, such as brain damage from lack of oxygen. Anyone can overdose regardless of their substance use history (including prescription substances).

Overdose risk is complicated and depends on interaction between several factors. Overdose risk can increase or decrease depending on the substance(s) taken, how the substance is taken, the setting where use occurs and characteristics of the individual.

Risk is very individualized. If several different people use the same amount of the same substance, it might affect them all differently.

Risk Factor – The Substance(s) Taken Mixing Taking more than one substance (including alcohol and over the counter and prescription medications) over a short period of time substantially increases overdose risk.

In fact, most unintentional fatal overdoses involve multiple substances, including alcohol and prescribed medications. People may mix substances because they are unaware of the risk, or because it intensifies their high. Taking more than one downer (including opioids, alcohol, and prescription benzodiazepines [benzos] like Xanax) increases the risk of an overdose. All drugs in this class decrease the rate of breathing.

Despite common beliefs, stimulants will not cancel out the effects of depressants. In fact, people who use speedballs (mix uppers and downers) are at higher risk because the body must process more drugs. Stimulants cause the body to use up more oxygen and depressants reduce the breathing rate. Quantity Taken Overdose can occur if the drugs taken (including alcohol) build up faster than the body can break them down (metabolize). This can occur by taking too much, or too frequently, or if someone is unaware of how long a specific drug lasts in the body.

Some drugs are harder to measure a specific dose (e.g., GHB) or may have varying time release mechanisms (immediate vs. extended). Most benzodiazepines have at least a 12-hour half-life, and the half-life of methadone can be 24 hours or more.

Many opioids come in both immediate release and sustained release formulations – however, the rate at which the drug is "available" may differ depending on the route of administration (e.g., injecting a sustained release medication may have a more toxic effect than swallowing it).

Finally, the actual amount of the active drug may vary depending on how much it has been cut or buffed, making it hard to determine quantity from sample to sample. Despite common beliefs, stimulants do not cancel out the effects of depressants.

Training Manual: Overdose Prevention, Recognition and Response 5 Strength Substances can have unknown content/adulterants due to processing (e.g., PMMA sold as MDMA). Other substances can be added before sale to the consumer either to expand the amount of product or to enhance the effects of the drugs. However, sometimes drugs are not cut prior to sale. A specific substance can have "analogues" – substances that have similar chemical structure but may differ in strength. For example, some analogues of fentanyl (e.g., carfentanil) are stronger, while others are less strong. It is impossible to tell what is present in the drugs you purchase without scientific equipment.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

LEARNING MODULE I

Seminar # 29

Peer to Peer Service's

Learning Objectives

1. What is the issue.
2. How can the issue impact the Family.
3. What are the options.

What is the issue?

This Study Guide introduces how to become empowered throughout a family's journey with Substance Use Disorder. The course material includes: The Solution Finder Study Guidebook, also an accompanying The Solution Finder Workbook which provides worksheets, exercises, Forms and Templates. And the book Substance Use Disorder Journey, It is Time to get Organized. The topics covered by The Family Solution Finder Learning Seminars are 32 Key Issues a family will likely have to address in their journey.

How can the issue impact the family?

Peer support workers engage in a wide range of activities. These include:

- Advocating for people in recovery
- Sharing resources and building skills
- Building community and relationships
- Leading recovery groups
- Mentoring and setting goals
- Peer support roles may also extend to the following:
- Providing services and/or training
- Supervising other peer workers
- Developing resources
- Administering programs or agencies

What are the options?

Core competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

Recovery-oriented: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

Person-centered: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the people served and to respond to specific needs the people has identified to the peer worker.
Voluntary: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

Relationship-focused: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

Trauma-informed: Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Recovery and Recovery Support

Recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully.

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

> **Health**—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
>
> **Home**—having a stable and safe place to live.
>
> Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
> Community—having relationships and social networks that provide support, friendship, love, and hope.
>
> **Hope** - the belief that these challenges and conditions can be overcome, is the foundation of recovery. The process of recovery is highly personal and occurs via many pathways. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. Families of people in recovery may experience adversities that lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.

Recovery services and supports must be flexible. What may work for adults may be quite different for youth or older adults. For example, the nature of social supports, peer mentors, and recovery coaching for adolescents is different than for adults and older adults. Supporting recovery requires that mental health and addiction services:

- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.
- Actively address diversity in the delivery of services.
- Seek to reduce health disparities in access and outcomes.

SAMHSA established recovery support systems to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

SAMHSA demonstrates that behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and/or substance use disorders.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

The Family Solution Finder

Educate, Organize, Network

LEARNING MODULE I

Seminar # 30

Medical Assisted Treatments (M.A.T.)

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

Medication-Assisted Treatment (M.A.T.) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-person" approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, M.A.T. can help sustain recovery. Learn about many of the substance use disorders that M.A.T. is designed to address.

M.A.T. is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug. Medications used in M.A.T. are approved by the Food and Drug Administration (FDA), and M.A.T. programs are clinically driven and tailored to meet each person's needs. Combining medications used in M.A.T. with anxiety treatment medications can be fatal. Types of anxiety treatment medications include derivatives of Benzodiazepine, such as Xanax or valium.

Opioid Treatment Programs (OTPs)

Opioid treatment programs (OTPs) provide M.A.T. for individuals diagnosed with an opioid use disorder. OTPs also provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and/or the spread of infectious disease. OTPs focus on improving the quality of life of those receiving treatment.

OTPs must be accredited by a SAMHSA-approved accrediting body and certified by SAMHSA. The Division of Pharmacologic Therapies (DPT), part of the SAMHSA Center for Substance Abuse Treatment (CSAT), oversees accreditation standards and certification processes for OTPs. Learn more about the certification of OTPs and SAMHSA's oversight of OTP Accreditation Bodies.

Federal law requires persons who receive treatment in an OTP to receive medical, counseling, vocational, educational, and other assessment, and treatment services, in addition to prescribed medication. The law allows MAT professionals to provide treatment and services in a range of settings, including hospitals, jails, offices, and remote clinics. Learn more about the legislation, regulations, and guidelines that govern OTPs.

As of 2015, OTPs were in every U.S. state except North Dakota and Wyoming. The District of Columbia and the territories of Puerto Rico and the Virgin Islands also had OTPs in operation.

How can the issue impact the family?

Under federal law, M.A.T. persons must receive counseling, which could include different forms of behavioral therapy. These services are required along with medical, vocational, educational, and other assessment and treatment services. Learn more about these treatments for substance use disorders.

What are the options?

In 2013, an estimated 1.8 million people had an opioid use disorder related to prescription pain relievers, and about 517,000 had an opioid use disorder related to heroin use. M.A.T. has proved to be clinically effective and to significantly reduce the need for inperson detoxification services for these individuals. M.A.T. provides a more comprehensive, individually tailored program of medication and behavioral therapy. M.A.T. also includes support services that address the needs of most persons.

The goal of M.A.T. is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:

- Improve person survival.
- Increase retention in treatment.
- Decrease illicit opiate use and other criminal activity among people with substance use disorders.
- Increase persons' ability to gain and maintain employment.
- Improve birth outcomes among women who have substance use disorders and are pregnant.

Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse. Learn more about substance misuse and how it relates to HIV, AIDS, and Viral Hepatitis. Learn more about common comorbidities that occur with substance use disorders.

Unfortunately, M.A.T. is greatly underused. For instance, according to SAMHSA's Treatment Episode Data Set (TEDS) 2002-2010, the proportion of heroin admissions with treatment plans that included receiving medication-assisted opioid therapy fell from 35% in 2002 to 28% in 2010. The slow adoption of these evidence-based treatment options for alcohol and opioid dependence is partly due to misconceptions about substituting one drug for another. Discrimination against MAT persons is also a factor, despite state and federal laws clearly prohibiting it. Other factors include lack of training for physicians and negative opinions toward MAT in communities and among health care professionals.

M.A.T. and Person Rights

SAMHSA's Partners for Recovery Initiative produced a brochure designed to assist M.A.T. persons and to educate and inform others.

Under the Confidentiality Regulation, 42 Code of Federal Regulations (CFR) 2, personally identifiable health information relating to substance use and alcohol treatment must be handled with a higher degree of confidentiality than other medical information.

Medications Used in M.A.T.

FDA has approved several different medications to treat opioid addiction and alcohol dependence.

A common misconception associated with MAT is that it substitutes one drug for another. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid. And research has shown that when provided at the proper dose, medications used in MAT have no adverse effects on a person's intelligence, mental capability, physical functioning, or employability.

Medications used in M.A.T. for opioid treatment can only be dispensed through a SAMHSA-certified OTP. Some of the medications used in M.A.T. are controlled substances due to their potential for misuse. Drugs, substances, and certain chemicals used to make drugs are classified by the Drug Enforcement Administration (DEA) into five distinct categories, or schedules, depending upon a drug's acceptable medical use and potential for misuse. Learn more about DEA drug schedules.

Opioid Dependency Medications

Methadone, buprenorphine, and naltrexone are used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor.

Methadone

Methadone tricks the brain into thinking it is still getting the abused drug. In fact, the person is not getting high from it and feels normal, so withdrawal does not occur. Learn more about methadone. Used for decades as a medication-assisted treatment (M.A.T.) for addiction to heroin and narcotic pain medication, methadone helps people sustain long-term success and to reclaim active and meaningful lives.

How Does Methadone Work?

Methadone reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. Methadone, taken once a day, is available in various forms such as liquid, powder, tablets, and diskettes. As with all medications used in medication-assisted treatment (M.A.T.), methadone is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

How Can a Person Receive Methadone?

Persons taking methadone to treat OUD must receive the medication under the supervision of a physician. After a period of stability (based on progress and proven, consistent compliance with the medication dosage), persons may be allowed to take methadone at home between program visits. By law, methadone is only dispensed through a SAMHSA-certified opioid treatment program (OTP).

The length of time in methadone treatment varies from person to person. According to the National Institute on Drug Abuse (NIDA) publication Principles of Drug Addiction Treatment: A Research-Based Guide – 2012 (PDF | 391 KB), the length of methadone treatment should be a minimum of 12 months. However, some persons may require long-term maintenance. Persons must work with M.A.T. physician to gradually reduce their methadone dosage to prevent withdrawal.

Pregnant or breastfeeding women must inform their treatment provider before taking methadone. It is the only drug used in M.A.T. approved for women who are pregnant or breastfeeding. Learn more about pregnant or breastfeeding women and methadone.

Buprenorphine:

Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. It can come in a pill form or sublingual tablet that is placed under the tongue. Learn more about buprenorphine. Approved for clinical use in October 2002 by the Food and Drug Administration (FDA), medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-person approach to the treatment of opioid dependency. When taken as prescribed, buprenorphine is safe and effective.

Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified U.S. physicians, and mid-level practitioners with an X-license can offer buprenorphine for opioid dependency in various settings, including in an office (physicians only), community hospital, health department, or jail (mid-level practitioners). Learn more about SAMHSA's buprenorphine waiver management.

SAMHSA-certified opioid treatment programs (OTPs) also can offer buprenorphine, but only are permitted to dispense treatment. Learn more about certification of OTPs.

As with all medications used in M.A.T., buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

Buprenorphine offers several benefits to those with opioid dependency and to others for whom treatment in a methadone clinic is not preferred or is less convenient. The FDA has approved the following buprenorphine products:

- Bunavail (buprenorphine and naloxone) buccal film
- Suboxone (buprenorphine and naloxone) film
- Zubsolv (buprenorphine and naloxone) sublingual tablets
- Buprenorphine-containing transmucosal products for opioid dependency

Refer to the product websites for a complete listing of drug interactions, warnings, and precautions.

How Buprenorphine Works:

Buprenorphine has unique pharmacological properties that help:

- **Lower the potential for misuse.**
- Diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings.
- Increase safety in cases of overdose.

Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression at low to moderate doses. With buprenorphine, however, these effects are weaker than full opioid agonists such as heroin and methadone.

Buprenorphine's opioid effects increase with each dose until at moderate doses they level off, even with further dose increases. This "ceiling effect" lowers the risk of misuse, dependency, and side effects. Also, because of buprenorphine's long-acting agent, many persons may not have to take it every day.

Naltrexone:

Naltrexone works differently than methadone and buprenorphine in the treatment of opioid dependency. If a person using naltrexone relapses and uses the abused drug, naltrexone blocks the euphoric and sedative effects of the abused drug and prevents feelings of euphoria. Learn more about naltrexone.

Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat opioid use disorders and alcohol use disorders. It comes in a pill form or as an injectable. The pill form of naltrexone (ReVia, Depade) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol) is administered at 380 mg intramuscular once a month. Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications.

To reduce the risk of precipitated withdrawal, persons are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the person must be completely withdrawn from the opioids.

When used as a treatment for alcohol dependency, naltrexone blocks the euphoric effects and feelings of intoxication. This allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment, avoid relapses, and take medications. Learn more about how naltrexone is used to treat alcohol dependency.

How Naltrexone Works:

Naltrexone blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It works differently in the body than buprenorphine and methadone, which activate opioid receptors in the body that suppress cravings. Naltrexone binds and blocks opioid receptors and is reported to reduce opioid cravings. There is no abuse and diversion potential with naltrexone.

If a person relapses and uses the problem drug, naltrexone prevents the feeling of getting high. People using naltrexone should not use any other opioids or illicit drugs; drink alcohol; or take sedatives, tranquilizers, or other drugs.

If persons on naltrexone discontinue use, they may have reduced tolerance to opioids and may be unaware of their potential sensitivity to the same, or lower, doses of opioids that they used to take. If persons who are treated with naltrexone relapse after a period of abstinence, it is possible that the dosage of opioid that was previously used may have life-threatening consequences, including respiratory arrest and circulatory collapse.

As with all medications used in medication-assisted treatment (M.A.T.), naltrexone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

Opioid Overdose Prevention Medication:

FDA approved naloxone; an injectable drug used to prevent an opioid overdose. According to the World Health Organization (WHO), naloxone is one of several medications considered essential to a functioning health care system.

Alcohol Use Disorder Medications:

Disulfiram, acamprosate, and naltrexone are the most common drugs used to treat alcohol use disorder. None of these drugs provide a cure for the disorder, but they are most effective in people who participate in a M.A.T. program. Learn more about the impact of alcohol misuse.

Disulfiram:

Disulfiram is a medication that treats chronic alcoholism. It is most effective in people who have already gone through detoxification or are in the initial stage of abstinence.

This drug is offered in a tablet form and is taken once a day. Disulfiram should never be taken while intoxicated and it should not be taken for at least 12 hours after drinking alcohol. Unpleasant side effects (nausea, headache, vomiting, chest pains, difficulty breathing) can occur as soon as ten minutes after drinking even a small amount of alcohol and can last for an hour or more.

Acamprosate: Acamprosate is a medication for people in recovery who have already stopped drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms after people drink alcohol. It has not been shown to work in people who continue drinking alcohol, consume illicit drugs, and/or engage in prescription drug misuse and abuse. The use of acamprosate typically begins on the fifth day of abstinence, reaching full effectiveness in five to eight days. It is offered in tablet form and taken three times a day, preferably at the same time every day. The medication's side effects may include diarrhea, upset stomach, appetite loss, anxiety, dizziness, and difficulty sleeping.

Access Medication for the Treatment of Alcohol Use Disorder: A Brief Guide – 2015 to learn more about M.A.T. for alcohol use disorder. SAMHSA/ Medical Assisted Treatment

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LEARNING MODULE I

Seminar # 31

Creating a Family Solution Finder Learning Centers

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue

THE PURPOSE

Currently there are few resources available to provide a structured education series designed to support the families in their daily living with substance use disorders.

The family is told to search the internet, find a support group, or ask their doctor. None of these are actual resources for effective and timely learning about the issues these families are facing.

In many cases the family does not know who to ask, what to ask and even less what to expect. It is frightening, confusing, stressful and emotion painful each day. In a short period of time, they are exhausted, and most feel defeated.

We need to add to this reality the family is viewed with an enormous stigma; they get it from the healthcare institutions, the church members, the city officials, their own friends, and family relatives. For the most part they are alone.

Therefore, the community needs to have a place where families can turn and receive education and learning resources about their journey with this disease.

The Family Solution Finder Learning Centers provides 32 key issues seminars for family members living with substance use disorders. Each seminar is 1.5 hours, has a study guidebook, seminar practical exercises workbook, Family Skill Set Workbook, and a Network Management workbook.

The Family Solution Finder Learning Centers also provides learning for the 13 key stakeholders in the community to learn about these families. This will allow us to educate the community about the needs of the family members.

The Family Solution Finder Learning Centers also provides a model designed to assist local faith organizations to offer in the place of faith practice a Ministry for their families living with substance use disorders.

This is further supported with eLearning Program and On-Demand Learning Program, for easy free access to all the seminar materials. These are self-administrated programs.

How can the issue impact the family?

The family has four primary support structures in our society; 1. The Family is its own support structure, the Cities departments, and organizations within the city, 3. The Churches and places of faith practices, 4. The Healthcare Services Industry.

These are organizations and service providers a family can use to support their needs as they face issues that require their response.

Given the family is a system and the members of the families have a certain homeostasis of inner support and reliance, their ability to function both intra-dependently and interdependently will have a great deal to do with the health of their family dynamic.

When substance use disorders are presented inside the family a level of disruption occurs and this creates a disfunction which reduces the family functionality to communicate, make decisions, and complete time sensitive tasks. The needs education resources to help them identify the importance of working towards this balance and seeking assistance to learn how to grow in the area family health.

It is important when considering the structure of services for this type of family, that these new characteristics be considered.

Although most families have similar challenges, not all families are the same and neither are their challenges. This is because, rarely does a family face one challenge at a time. Most have multiple challenges cascading on them at once and they find it difficult to prioritize them, plan and prepare for them and understand what service or organization is available to help them with each issue. Likewise, the services of the community need to understand the family.

Because the drug treatment industry is immensely fragmented, the needs of the family member are most often left unaddressed and unresolved to any degree of satisfaction. The services are there, but to find them, ask the right questions and follow through afterwards is extremely challenging, stressful, and expensive.

This is an industry of silo's and the silos choose to not community with each other. There is little to no continuity of care, transition metrics or accountability in how a family is to navigate, these does not exist, and this is what the drug treatment industry has set up for its customers.

If this were hypertension, diabetes, or asthma we would have a crisis as a society. But we do not. Instead, we have educated families, a health system designed to respond and services with payment system aligned with outcome metrics holding accountable the healthcare delivery system for these diseases. But not with Substance Use Disorder Disease.

To educate the family is our most effective, fastest response strategies to the drug epidemic. However, here too there is no infrastructure by which to have the family access structured education that is specifically designed to meet the learning needs of the family members on their journey.

Creating the family solution finder learning centers within the existing treatment and recovery local community is a reasonable step towards providing access to family's where they can learn and become empowered with what will happened next, how to get ready for it and who is available to help.

But the family member is not the only source that needs to learn Their primary support structure needs to learn about the family, too. This is not something that has taken place, these institutions only seek to have the family understand them, the organizations services, not the other way around where the organization attempts to understand the "Whole Needs of the Family'. This happens because there is no resource for the organization to provide such education for learning about the family.

Therefore, these organizations only speak about their services and educate the family on how to use their programs. This is not family education about their family journey, but more so about the tools needed to deal with the individual person.

It is helpful but limited. It is limited in scope and has extremely limited use for the family with multiple needs that are every changing. It is negligent for an organization to call this "family education" because it leads the family to believe that is all the education available for them, from the community.

If a treatment center provides a Family Solution Finder Learning Centers Level II, that all changes and the family will have access to the whole scope of issues they are likely to face. In this way the treatment center program becomes family education.

What are the options?

Required Registration:

We are asking you to register on www.familiesimpactedbyopioids.com in order that we can provide updates to content, support to your organizations learning center and allow others to find you in their community. These materials can be copied with permission for the purposes of marketing and training. All these materials are available as free downloads on our website.

It may be best to start one level down from where you want to be, to get comfortable with the material, it set up and functioning of these seminars. We recommend most organizations start at Level One, *Book Distribution, and e-learning*. Then move into Level Two. Take time to invite the public as a community relations initiative. There is a required donation fee to register a Family Solution Finder Learning Centers.

Use the books:

Our books help to drive the learning experience, but your presentation and presence is what will matter even more to these family members. The operation for The Family Solution Finder Learning Centers is the same as any other scheduled list of seminars you may have provided in the past. There is nothing specific or special steps needed for the center itself, other than making people aware of your sessions.

Room set-up:
This can be in whatever design you choose. We recommend circle tables because in helps to facilitate conversation and sharing between family members.

Audio/Visual:
Be sure to have access and internet WIFI for the extended learning videos included in these seminars. Laptop, speakers, and TV or screen are needed.

Create a Family Solution Finder, Monthly Learning System

The family solution finder monthly learning system can be presented as a "weekly learning meetings" where an entire month is dedicated to a single issue (topic).
Issue of the Month: Select an issue as the "T*opic of the Month".* Where, the family solution finder learning series seminar (issue) is presented:

1. In the First week, use the Family Solution Finder Learning Seminar Study Guide, Workbook and Power Point Presentation, for that issue. *(PPT is downloaded from our website)*
2. In the Second week, have a speaker from the community come in to speak on this topic.
3. In the Third week, have a person provide their personal testimony on this same topic from that person's experience and perspective in dealing with this issue. Use the "The Substance Use Disorder, It's Time to Get Organized workbook.
4. In a Fourth week, a general discussion covering how to use the lessons learned this month, using the It is Time to Get Organized and It is Time to Get Networked workbook.

In this monthly learning system, the family members are provided an in-depth education experience unlike any they will receive elsewhere. From topic introduction, to life application, to family plan of action.
Through this system, a total number of meetings: 32 seminars x 4 sessions per topic each month equals 128 sessions. It will cover 2.6 years of meeting content. All provided online, free.

Because this is a lifelong journey, it will take time to cover all the topics. Then again, where else can these families go to learn in this deep of a review?

If the family has an urgent need to review a specific issue seminar, they can do so "*On-Demand Learning, Family Library of Seminars*" online through our website in our self-directed eLearning model. They are never without the ability to get information to start a better understanding about what they are facing.

The Meeting Agenda:

It is helpful to have the next meeting's agenda as a handout in each meeting. Also, keep a calendar updated as to time, topic, location and point of contact on a page in your organization's website.

a. Which issue to present:

Some choose to start with Seminar #1 and proceed as it is numerically set up. Others ask their attendees, which topics they want to view. In either case, it is helpful for the attendee and the presenter if a schedule is set up going out six months.

b. Duration:

- It is more effective to have one single topic (issue) in a meeting. Try <u>not</u> to mix one subject with another in the same meeting. For example, do not mix seminar # 1 The Family is a System with Seminar # 2 The Different Roles Family Members Play.
- There should be 40 minutes for slides and video's, 20 minutes for practical exercises, 20 minutes for group discussion. Duration: 1.5hrs/seminar.
- The video sessions are more valuable when there is a discussion to follow, so others can gleam important points from the person next to them. **And again, circle tables work best.**

Pre-Meeting Announcement to Registered Attendee's

1. Greeting, Navigator Time

2. Announcements
3. Seminar Presentation
4. Table Discussions
5. Large Group Discussions
6. Concluding Summary
7. Next Meeting Agenda
8. Social Time

The Family Solution Finder Learning Center covers 32 key issues designed to support the family members learning, each individually as a separate 1.5hr. seminar. The seminar is written with an assumption that family members are not familiar with the topic and may not see its relevance in the beginning.

The Family Solution Finder Study Guidebook sets up the introduction to the issue and outlines the learning without directly associating it to the family members life. This learning process continues in the Family Solution Finder Workbook, where both practical exercises, extended learning video and accompanying worksheets allows the family to take what is presented and then apply this knowledge to their real-life considerations.

Then, in the workbook the family member will develop a plan of action for this issue, making a record of how they will respond to this issue in the future from what was learned in the seminar. To increase a probability of success, a Family Best Practice Protocol exercise creates a collective review in how this will be implemented. Now, the family has knowledge of the issue, is ready to respond, understands what is required, who is available to support them and what to expect as a likely outcome. They are empowered.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

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LEARNING MODULE I

Seminar # 32

Harm Reduction

Learning Objectives

1. What is the issue.
2. How can the issue impact the family.
3. What are the options.

What is the issue?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs, safely.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use moving towards abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

How can the issue impact the family?

Syringe Access is an essential component in the prevention of HIV and hepatitis C among people who inject drugs.

Research consistently demonstrates the effectiveness of syringe access in preventing transmission of infectious disease and skin and soft tissue infections, while also supporting the overall health and wellbeing of drug users through linkages to drug treatment, medical care, housing, overdose prevention and other vital social services.

Overdose
Read online below and download the entire manual as a PDF.
https://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/

What are the options?

Methadone is one of the oldest harm-reduction medications available. This drug works on the same receptors used by heroin, providing users of this drug with relief from cravings and symptoms of withdrawal without providing them with an intense high. This drug has been proven remarkably effective in keeping heroin users alive, even while they are trying to recover from a devastating disease. For example, in one study[5] published in 2001, researchers came to this conclusion:
"Harm-reduction-based methadone treatment, in which the use of illicit drugs is tolerated, is strongly related to decreased mortality from natural causes and from overdoses."

That is a remarkable statement, and it demonstrates just how innovative a methadone strategy might be in helping people to recover from the use and abuse of these powerful drugs.

Buprenorphine is similar, in that it also works on the same receptors used by opiates like heroin, but this drug also has a ceiling effect, meaning that people cannot take massive doses of this drug to get high. They can take the drug to ameliorate cravings and withdrawal, but it is not designed for abuse. The makers of this drug sometimes make that abuse-resistance potential yet stronger by adding in naloxone, which kicks in at high doses and keeps users from overdosing.

Medications containing buprenorphine have been proven effective[6] in helping people to stay motivated to enter treatment programs. They are also considered an ideal form of long-term treatment, as they can be prescribed by a medical doctor, rather than an addiction treatment professional.

In some cases, people can even take these medications at home, rather than walking into a clinic or a pharmacy for a daily dose.
But some drug users resist the idea of replacing a drug they love with a prescription medication that only modifies the high they can feel. These users might benefit from access to naltrexone.

This medication, whether delivered by shot or via nasal spray, can block an overdose in progress by kicking all active bits of drugs from their receptors. It's typically given by an emergency responder, like an ambulance driver,[7] but making the drug widely available could allow drug users to treat one another in the case of an overdose, and that might result in the saving of thousands of lives.

These are just a few of the medications available for pharmaceutical control of addictions. Naltrexone and Antabuse are others, and they work in much the same way and bring about the same kinds of benefits.

The practice of mindfulness can trace its origins back to Buddhist meditations (and, indeed, Buddhism itself has been used as a form of substance abuse therapy), but a secular approach to thinking about mindfulness was developed by Jon Kabat-Zinn, Professor of Medicine Emeritus, and creator of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School.[5] Kabat-Zinn developed a program he calls Mindfulness-Based Stress Reduction, which combines meditation, yoga and psychotherapy techniques to teach people the art of mindfulness to reduce their stress and improve their relaxation and quality of life.[6]

Meditation

While relaxation is always good, the focus of mindfulness has dozens of precise health benefits that make it a valuable tool in the recovery armamentarium. A study published in the Journal of Psychosomatic Medicine found that 25 persons who had eight weeks of training in mindfulness had better immune systems than 16 persons who received no such training.[7] This is relevant because of the effect that drug and alcohol abuse has on the immune system. Alcohol, for example, reduces the effectiveness of white blood cells in their function of killing germs. The more alcohol a person drinks, the fewer white blood cells can multiply and attack an invasive disease.

Similarly, methamphetamine and excessive marijuana consumption can damage the body's ability to fight off infection, by directly attacking the immune system and weakens the lungs, respectively.[8]

A person who has just completed a course of detoxification has a very weak immune system (which is one of many reasons why detox should not be tempted in a domestic environment).

Teaching mindfulness as part of the therapeutic stage of recovery will have a significant effect on the person's recovery, both from the physical and psychological effect of drugs and alcohol on their system.

Mindfulness and Healthy Eating in Recovery

Another area of physical care in recovery has to do with diet. Drugs and alcohol abuse wreak havoc on a body's digestive system, often depriving key organs and systems of the nutrients they need to function. The National Institute of Alcohol Abuse and Alcoholism explains that the liver and the pancreas can be especially compromised.[9] A person who is detoxing will be very physically weak, due to the diarrhea and vomiting associated with the withdrawal process. For that reason, food rich in carbohydrates, vitamins, and amino acids are especially important. Good nutrition can help a person's body to strengthen during recovery, and bad eating habits can even lead to a relapse.[10]

Mindfulness can be incorporated into a treatment program to help persons' practice "mindful eating." Instead of unwittingly replacing an alcohol addiction with a food addiction, persons can learn how to savor the food they have, by being aware of their bodies' hunger cues, and learning where those cues come from and what causes them. Then, instead of simply indulging in more food, the persons can apply this greater understanding to better address the underlying causes of their compulsion to overeat. In doing so, they can improve their eating habits, lose weight, and avoid a relapse pitfall.[11]

In this way, mindfulness can also be the primary method of treatment for persons who have an eating disorder. Mindfulness can help a person focus on her "internal hunger," in the words of a professor emeritus of psychology at Indiana State University, and not their "external hunger." The idea is that by focusing on eating a small (or moderate) amount of food mindfully, persons can enjoy the experience much more than if they ate a larger amount. Addicts, who by nature have demonstrated impulse control issues (as with eating and substance abuse disorders), can benefit from the heightened sense of awareness that mindfulness teaches them about recognizing their levels of hunger and fullness.

Mindfulness and Emotional Regulation in Relationships Affected by Addiction

Since emotional regulation is a big part of the mindfulness approach, the effect that mindfulness has on relationships also plays a key role in recovery.

Couples who embark on mindfulness training together report being more satisfied with their relationships, and individual partners have a greater sense of optimism and relaxation within their union. A study published in the journal Behavior Therapy found that mindfulness helped couples enjoy deeper levels of satisfaction with (and within) the relationship – benefits that persisted three months after the training concluded. Happiness and stress levels were improved, as well as the effectiveness of various methods of coping with stress.[12]

The psychological effects of drug or alcohol dependency on addictions are well known, but the physiological effects of what such substances do are complex. A 2013 study by the University of Granada of 605 men (550 of whom abused drugs) discovered that male drug addicts were sexually impotent even after completing rehabilitation. The study's authors wrote in the Journal of Sexual Medicine that the abuse of cocaine, heroin, and alcohol (the substance that has the greatest negative impact on a man's ability to perform sexually) caused long-term negative impact on sexual climax in men.[14]

Such a form of sexual dysfunction is problematic on its own, but the damage it does to a relationship can be immense. A November 2002 survey conducted by the Journal of Urology on 168 men with erectile dysfunction found that men who reported their impairment having any effect on their lives also reported suffering from depression and anxiety.[15]

Issues like these demonstrate how mindfulness can help couples who are going through recovery together.

Mindfulness and Dialectical Behavior Therapy

The idea of regulating emotions that mindfulness espouses is a cornerstone of Dialectical Behavior Therapy, one of the main lines of therapy that is used in drug and alcohol recovery.

When looked at through the perspective of Dialectical Behavior Therapy (or DBT), mindfulness is used to help persons accept their emotions. This may seem like an easy concept, but the idea of denying the reality behind experiencing powerful impulses to engage in self-destructive and harmful behavior is what often drives persons to seek comfort and relief in that harmful behavior. Instead, mindfulness teaches them to nonjudgmentally acknowledge what they are feeling, and then to use that

acknowledgement as a stepping-stone toward regulating themselves.

For example, a person might attempt to control his behavior by setting limits or goals for himself. This is admirable on its own, but when those plans inevitably go awry (perhaps through no fault of his own), he reacts with negativity and frustration, feeling compelled to give up on the idea of learning to regulate his behavior.

Mindfulness encourages persons to try again, by teaching them that there is never a point of no return. Even after a failure, the person is still capable of trying again – a perspective he may have been robbed of by his compromised state of mind.

Dialectical Behavior Therapy was developed by Marsha M. Linehan, who wrote on the subject that persons who cannot regulate their emotions become trapped by inflexible patterns of thoughts, which compel them to focus on negative perceptions.

Mindfulness plays a vital role in the administration of DBT, because it teaches persons to be in the present moment – not rigidly dwelling on their impressions of depression or stress but accepting those impressions as part of a bigger picture, and then using the other dynamics in that picture to better control their emotions and thoughts.[16]

Mindfulness in Treating Violent Moods

This is also why mindfulness has found success in helping prison inmates reduce their anger, hostility, and unpredictable moods. As inmates understand how and why they react as antagonistically as they do, mindfulness plays a vital role in not only their recovery (in the cases of substance abuse), but also in their rehabilitation and reintegration following their release from prison.

A mindfulness program at the Lowell Correctional Institute for Women in Ocala, Florida, yielded inmates who learned how to:

- Consider their thoughts before acting.
- Be more aware of their emotions and physical sensations.
- Manage their panic and anger more effectively, making the choice to not only withdraw from confrontation, but to also help talk down other inmates who were about to engage in fights [17] man in an angry mood

A 2007 study published in The Prison Journal enrolled 1,350 inmates in drug units in six prisons in the Massachusetts Department of Corrections in 113 mindfulness-based stress reduction courses. Inmates self-reported "highly significant" improvements in measures of hostility, self-esteem, and emotional regulation. The authors of the study were encouraged by the effectiveness of mindfulness-based stress reduction and called for greater implementation of such programs.[18]

Mindfulness: 'Significantly Greater Extent

With drug and alcohol recovery itself, mindfulness therapy has enjoyed a great amount of success and validation from the mental health community. The journal of Substance Use & Misuse published two articles in April 2014 on the topic: one that found mindfulness-based interventions reduced the consumption levels of opiates, cocaine, marijuana, alcohol, cigarettes, and amphetamines to a "significantly greater extent" than other treatment methods; and another that said that substance abuse programs are either making mindfulness a standalone component to their methods or using mindfulness in conjunction with other treatment models.[19],[20]

In the slightly more technical terms of Frontiers in Psychology, "Mindfulness Training Targets Neurocognitive Mechanisms of Addiction." Modern science, says the article's authors, has only just begun to understand the many ways that mindfulness training addresses the connections between addiction, thoughts, and emotions.[21]

How Is Mindfulness Achieved?

When a person feels strong emotions that threaten to overwhelm her, her therapist might suggest that she concentrate on breathing. Simply being aware of the action of breathing in and breathing out can divert feelings of panic and anger and calm the person down.

Achieving mindfulness

Next, the person will be told to pay close and specific attention to every sense she can: sights, sounds and smells that would normally be lost in the noise of stress or muffled by depression can help ground the person and give her something tangible to focus on.

Similarly, being aware of the physical sensations on the body achieves the same purpose. It could be as simple as focusing on the tactile feeling of clothes on skin, or the way the body rests on a chair or couch. Little details like these provide a sense of reality that the person can use as a lifeline.

Lastly, and with encouragement, the person should acknowledge that even the most harmful or overpowering thoughts are momentary at worst. At best, they do not define the person. This may be incredibly difficult to remember, or even accept, for some persons, but guided and curated insights like those are the key to breaking the hold of negative thought patterns.

A specific form of meditation known as “mindfulness meditation” can impart all these lessons. Psychology Today explains how such a practice can improve the amount of activity in the amygdala, the part the brain that deals with regulating emotions. A healthy amygdala is necessary for moderating the body’s natural anxiety response. Even in stressful moments, the heart rate will slow, breathing will become deeper, and the body’s release of adrenaline slows down. While such flight-or-fight responses have their uses, uncontrolled reactions can be very harmful to people who do not know how to calm themselves down.

With practice, mindfulness meditation can strengthen the region of the brain that is responsible for feelings of optimism and well-being. In this way, mindfulness can rewire a suffering brain by teaching it new and better ways to respond to problems.[22] The senior author of a study conducted by the Massachusetts General Hospital, and published in Psychiatry Research: Neuroimaging, said that just two months of mindfulness meditation provides active psychological benefit to persons, in the areas of improving their senses of self and empathy, and decreasing their stress levels.[23]

Read More About: The Amygala, Continue Reading Yoga and Recovery, Acceptance and Commitment Therapy, Borderline Personality Disorder and Addiction
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Family Member Harm Reduction

Self-care includes all the things we do for ourselves to stay well – and to keep ourselves on the road of recovery. Self-care is an essential skill – especially in our work as peer supporters. Why is it so important? Because we know stress has detrimental effects on both our mental and physical health.
The proven effects include:
• Increased levels of cholesterol
• Production of the fat-producing hormone cortisol
• Increased susceptibility to depression and other mental health conditions

• Increased susceptibility to other illnesses including influenza, headaches, heart disease, high blood pressure, diabetes, colds and even cancer • Increased job absenteeism
• Decreased life enjoyment and satisfaction What are the benefits of self-care?

Conversely, we know that if one can both reduce stress and enjoy life, the following benefits can result:
• Resilience from mental health conditions
• Resilience from physical health conditions • Greater success on the job
• Better interpersonal relationships

• A longer, more satisfying life Stress management Learning to manage stress and living an enjoyable life are two separate issues and involve varying—and often overlapping—skills. To manage stress, consider the following recommendations:
• Learn to identify when you are stressed (a daily journal in which you can record stressful times during the day can be helpful).
• Learn to identify (and if possible, avoid) events, people, places, or circumstances that increase your stress.
• Know that YOU CAN decide what you will be stressed about.
• Create a lifestyle that minimizes stress. Recovery to Practice
Participant Workbook–v1 April 2014 Page 1-15 Module 1:
The Transforming Power of Recovery
• Use creativity and/or your sense of humor to deal with stressful situations.
• Plan time for fun.
• Plan time to meditate or just relax, alone or with others, depending upon what works best for you.

• Know that you ARE WORTHY of taking the time and effort necessary to reduce and manage stress in your life.

Life enjoyment Happiness is often thought of as a temporary mindset. It can last a few seconds, minutes, hours, or days. Research has shown, however, that happiness is often fleeting. Enjoying life, however, is creating a lifestyle that maximizes happiness. Interestingly, studies have shown that our minds work in terms of contrast. This means adversity (such as dealing with an addiction and/or mental health condition) can help us learn to appreciate happiness more and more often and, thus, create an enjoyable life.

External vs. internal happiness Seminars, television shows, documentaries, lectures, CDs, books, and other forms of communication have focused on creating a happier life and studies have given birth to "positive psychology." But research has shown that despite these efforts, long-term effects are negligible.

Even when people know what they must do to create a more enjoyable lifestyle, they rarely do so. One apparent problem is how our society generally defines happiness. For many, it is financial success, material possessions, appearance, or status (academic achievements, respected occupations, etc.). But even when these are achieved, we tend to set the bar higher and want more. Researchers have called this the "hedonic treadmill" where we seek more and more and are never satisfied. Interestingly, material possessions, financial success, and status account for only 10 percent of our ability to be happy. The other 90 percent relates to our values, attitudes, and behaviors—things we can change.

 The "hedonic treadmill" that accounts for 10 percent of our ability to be happy is largely "extrinsic." That means they are "outside" of ourselves. The remaining 90 percent are "intrinsic." That means they are "within" us.
You might think of it as the difference between enjoying the aroma of a freshly mowed lawn and the drive that makes you work extra hours so you can afford to own acres of a finely trimmed lawn to impress neighbors.

Happiness brings success New happiness theories are flipping traditional paradigms. The traditional thought that one will be happy with occupational success is incorrect. Instead, it is happiness that brings the success—not the other way around.

To create an enjoyable lifestyle, researchers have identified the following components:

• **Gratitude**: By learning to recognize the good things in life and taking time to intentionally appreciate them, we can cultivate an "attitude of gratitude" that can lead us to evaluate our values in a way that can lead to a lifestyle change.

• **Compassion:** Performing acts of kindness is an important element of an enjoyable life. We can gain pleasure from simple acts such as holding a door open for someone or just smiling at another. More intentional and planned acts can bring greater levels of happiness. These acts may include volunteering, helping someone with chores, or giving a gift (especially handcrafted gifts or meals).

Random Acts of Kindness: can include animals. Most people find it difficult to be depressed when they are petting a dog furiously wagging its tail in appreciation. These acts of kindness are not only appreciated by those receiving them but as much or more by the giver. Many who perform acts of kindness report a "helper's high" as dopamine floods our central nervous system. This high can last a few minutes or even a few days if we intentionally act to keep the memories and feelings alive.

• **Exercise:** Walking, jogging, playing sports or other activities are linked to our happiness. If one regularly plans to be active, it can become a most healthy habit. Although aerobic exercise that increases our heart rates Recovery to Practice Participant Workbook–v1 April 2014 Page 1-17 Module 1: The Transforming Power of Recovery and causes us to breathe deeply is best, even modest exercise offers considerable benefits.

• **Mindfulness:** Taking time for ourselves to be in a quiet, comfortable environment and think a single thought can help us reduce stress and teach us that we are indeed capable of controlling our thoughts and behaviors. Unfortunately, our society values "multi-tasking," which is often a significant contributor to stress. Reducing the number of tasks, we perform and thoughts we think (i.e.: simplifying our lives by prioritizing) can help us reduce stress, focus on important tasks, and live healthier, more satisfying lives.

• **Diversity:** Changing our routines, even slightly, can help us learn and take greater steps to creating a different lifestyle. It has been said: Life begins at the end of our comfort zones. Personal growth is fostered by trying new things, experimenting, and learning how even difficult life challenges can become opportunities for change and growth.

• **Relationships:** Relationships, especially those that are healthy and supportive, can lead to new support networks and opportunities to share activities with others. One researcher studied what persons with mental health conditions preferred to do for enjoyment. He discovered that most people cared little about the activity but were more interested in having someone with whom they could share it. Studies have also shown that happy people attract other happy people. With a positive attitude, it appears you will be more successful in attracting like-minded people.

• **Humor:** With practice, and perhaps with the help of good-natured friends and family, we can find humor in even the most difficult circumstances. The neighbor who complains about where you put your trash on pickup day, the boss who constantly nitpicks your work, or that cousin who jams your e-mail account with social media requests are interactions that can be viewed with frustration or with a slight shift in perspective can all be viewed in a humorous light. Humor is a great antidote to stress. Pick up a good joke book and learn some stupid jokes to share with others. Laughter is contagious! Recovery to Practice Participant Workbook–v1 April 2014 Page 1-18 Module 1:
The Transforming Power of Recovery

• **Meaning:** Meaning in our lives is vital. And meaning is subjective. One may find bird-watching a meaningless activity while others find it extremely meaningful. In our society, we value (even over-value) work. While many may say bringing home a big paycheck by selling vacuum cleaners is meaningful, others may not. Consider that couples with young children are, according to research, somewhat less happy than childless couples. Yet couples continue to have children. Why is that? It is because children bring meaning to our lives (in addition to much frustration). Researchers, unfortunately, have not thoroughly addressed this happiness component but, if they did, they would likely discover that children bring us much intrinsic happiness, which is difficult to measure.

Creating an enjoyable life Again, knowing the benefits of happiness and an enjoyable lifestyle, what you enjoy, and planning a different lifestyle are not enough.

It takes long-term action to create an enjoyable lifestyle. For many with an addiction or mental health history, lifestyle change is not new. That puts you in a good position to understand what it is you must do to create an enjoyable lifestyle filled with happiness. What follows is a checklist of enjoyable activities used in a recent research project. Assignment #5: Fun things to do

Go through the following checklist and mark the appropriate boxes.
People who have completed the checklist have found it an enjoyable experience. They say it is enjoyable just to think about enjoyable activities and it can be a planning tool for self-care as you may discover you have not recently engaged in enjoyable activities you once did. The checklist may also cause you to think about what you COULD be doing to enhance your life. Save the checklist and complete it again in a week or so. You are likely to find you have thought about it and may think of new activities to enjoy. You can also share the checklist with people you support to get a better idea of the kinds of things they enjoy and would like to do more often.

The Transforming Power of Recovery FUN THINGS TO DO CHECKLISTS

The following checklists contain things you may have enjoyed in the past, enjoy now, or hope to enjoy in the future. Please check all boxes that apply (more than one box may be checked per row/activity). There are no right or wrong answers. If there are fun activities missing, add them in the blank spaces.

Out and About I enjoy now I have enjoyed in the past I hope to enjoy in the future

- Go shopping
- Go biking
- Go to a party
- Go to lunch or dinner with friends
- Go to a park
- Go on a date Volunteer or work
- Go to a movie, play or concert Explore a city or neighborhood
- Go for a drive Swim Jog/run
- Walk outdoors
- Go camping
- Go to church Meet new people
- Go hunting or fishing Visit a museum or library
- Do During Quiet Time I enjoy now I have enjoyed in the past I hope to enjoy in the future

Soak in a bathtub Listen to music Watch television Dream about the future
Do puzzles Read Lie in the sun Draw or paint
Grow plants Meditate Light candles Write poems/stories/letters Other

- Repair broken things
- Exercise
- Sing
- Dress up in nice clothes
- Make crafts
- Play with pets
- Watch other people
- Play with children Perform an act of kindness Snuggle with someone Make someone smile Cook Collect things
- Take pictures Play a musical instrument
- Buy gifts for others Dance Watch animals Other Recovery to
- Practice Participant

Links for all these programs are provided in the footnote section below and can also be found in the Resources section for this module. With any of these approaches, it can be helpful to work together in a small group to brainstorm (or as you will learn in the training, heart storm) to identify selfcare tools and techniques and get new ideas to create action plans. Having a recovery buddy to share ideas with who will hold you accountable for following your self-care plans can help too. Note: The Wellness Recovery Action Plan (WRAP™) community has a program called WRAP PALS (Peers Advocating, Listening, and Supporting) in which two WRAP-trained individuals work together on creating and following through with their WRAPs. You can learn more about WRAP™ PALS by visiting www.copelandcenter.com or www.mentalhealthrecovery.com.

1 Wellness Recovery Action Plan™ WRAP™ (Copeland Center for Wellness and Recovery)

2 Pathways to Recovery – Strengths Recovery Workbook – University of Kansas School of Social Welfare

3This Is Your Life: Creating a Self-Directed Life Plan – University of Illinois at Chicago

4 Common Ground / Personal Medicine Toolkit – Pat Deegan Associates

5 Whole Health Action Management (WHAM) – SAMHSA Center for Integrated Health Solutions Recovery to Practice Participant Workbook–v1 April 2014 Page 1-23 Module 1: The Transforming Power of Recovery for Further Study: Resilience

6 refers to the ability to bounce back from highly stressful or traumatic situations. Resiliency depends in many ways on the kinds of "protective" factors that one has in their life, which back to self-care strategies.
For example:
• Happiness
• Satisfaction with Life
• Humor
• Supportive family and friends
• Motivation Self-care creates the kind of protective factors that can lead to more resilience and modeling self-care can help do the same for others.

VIDEO:
A recommended TED video speaks to the nature of resilience.
It is called The Power of Vulnerability: Teachings on Authenticity, Connection, and Courage by Brené Brown

www.ted.com/talks/brene_brown_on_vulnerability. Sampling of articles on developing resilience

• What is resilience and why does it matter?
http://psychology.about.com/od/crisiscounseling/a/resilience.htm
http://psychology.about.com/od/crisiscounseling/p/resilience-2.htm

• A resilience quiz – how resilient are you?
http://psychology.about.com/library/quiz/bl-resilience-quiz.htm

• 10 ways to become more resilient.
http://psychology.about.com/od/crisiscounseling/tp/become-moreresilient.htm

• Readers share strategies for staying emotionally resilient in the face of stress

http://stress.about.com/u/ua/readerresponses/resilient.htm
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For Further Study: Communication Skills Perhaps the most important skill for a peer support provider to develop is the ability to listen with sensitivity and communicate clearly.

There are many skill buildings programs that have designed to increase the "technical" ability to communicate clearly but there is more to good communication than techniques. As a peer support provider, our job is to convey compassion and understanding for those who are going through what we have been through ourselves.

Our ability to authentically share we've "been there" can make the difference in reaching someone else.

A few programs that came highly recommended during the pilot stage of this course were:
• eCPR
• Non-Violent Communication | Compassionate Communication
• Alternatives to Violence Project A summary of these three programs is provided for further investigation if a program sounds like it may benefit your practice of peer support or help others to increase their ability to communicate with compassion.

But just having this awareness is not the end to our learning. Now we will use the Family Solution Finder Seminar Workbook Learning Module II, to apply this learning to our own lives through completing the practical exercises.

Then we will use the Family Solution Finder 3-D's Coping Skills Learning Module III" workbook to Determine a Solution, Develop a Decision, and Design a Plan of Action.

From there we will take our Family Solution Finder Local Resource Connections Learning Module IV workbook and find a licensed professional and seek their guidance and assistance in implementing the plan.

IN CONCLUSION

The choice for your family to spiral up or spiral down is up to you. Your knowledge plus the responsibility to use what you understand is empowerment. The action in climbing up the stairs goes one step at a time, one foot in front of the other and each step will take you in a certain direction.

Given that there are many steps in your journey, your family will want to pace itself. This is best done by getting educated on what you will face, getting organized so you are prepared to face it and getting networked so you can bring others in when you need them.

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YOU ARE NOT ALONE, KEEP LEARNING, KEEP PRAYING, STAY HOPEFULL

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