
Pathfinder
Certificate of Completion Learning Seminar

Because we know,

"An empowered family is unstoppable".

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Community

Pathfinder

Certificate of Completion Learning Seminar

Community/Family Members

“Certificate of Completion Course”

Study Guide & Workbook w/video’s

I. TABLE OF CONTENTS

Introduction

The family will be traveling on a path that many before them have taken. Each family is different and the circumstances they face are rarely identical. However, there are many aspects by category which remain common to all. Substance use disorders is a chronic disease of the brain and needs to be managed as a chronic disease. In all chronic diseases the family has a role to play, they are a family system and this chronic disease has now been added to the family dynamic.

As a Counsel for family members with your staff, the family needs for you to understand some of the issues they are going to be facing in their journey. We believe that when one understands the mile they walk, the better we can relate to what they are experiencing. For a family that is living with substance use disorders, they need all the understanding they can get, from those who are in their lives and want to be a positive influence for the members of their family. During a Counselor's role as part of the clinical team, education of family members, for their team and others in the area of healthcare delivery, understanding of the families entire journey will matter.

THE PATHFINDER CERTIFICATE OF COMPLETION SEMINAR

There are the 12 key issues a family is likely to face and needs to prepare for in their journey. In "The Pathfinder Certificate of Completion Seminar" we present these issues to you as core competency seminars, so you will have a more thorough understanding of what they are facing in their daily lives.

Each seminar has three sections that take you through your learning:

1. **The Issue**, (this is where the issue is clearly defined),

2. **The issues obstacle,** (these are things related to the issue which will likely come up and make it difficult for the family to addresses the issue)

3. **The solution to the obstacle and issue, this** is provided as a family practical exercise and plan of action next step.

For each issue, please read both books and watch the assigned video. Again, watch the assigned video or you will miss a major part of the learning experience.

An Example: The Legal System will possibly be a part of the family journey, and the issue that will come up is "Drug Court". The Drug Court has a specific process which each family will follow the good news is this information about how drug courts work can be presented and learned in advance. By learning this information in advance, the result for a family is EMPOWERMENT THROUGH KNOWELDGE.

Learning these issues in advance reduces stress of the unknown, saves time, allows the family to budget their expenses, and gives them room to gather the needed resources. Now, you can better understand what they are going through.

Completing these 12 key issue seminars awards the attendee with a "CERTIFICATE OF COMPLETION COURSE SEMINAR"

These selected seminars are pulled from "*The Family Solution Finder Learning Series*" of 32 seminars. They are essential to the family members knowledge base in becoming empowered to address issues in their journey. And therefore, essential for the community to learn.

The purpose of this seminar is to educate the stakeholders in our community, those who the family will typically turn to for support.

How the Pathfinder Seminar works

This learning can take place in a small group study, as an individual self-administrated study or to a large seminar audience. There are download power point presentations as an eLearning Program on our website: https://familiesimpactedbyopioids.com/32-key-issues-learning-series-and-e-learning

Each of the 12 Key Issues is a separate seminar, designed as separate learning modules. They do not have to be taken in sequence; the reader can jump to any topic they choose. The seminar is divided into two parts, a study guide and a workbook.

Each seminar has:

- ✓ Seminar Study Guide and Workbook Handout
- ✓ Power Point Presentation with slide Audio (self-administrated)
- ✓ Practical Exercises and Video Worksheets
- ✓ Responding to Family Issues Process
- ✓ Monthly Meeting Agenda
- ✓ Clinical Paper Handout

The study material is a collective approach to a particular issue. For example, the issue might be "The Police Intervention". In this study material the reader is asked to consider special considerations needed to prepare prior to the issue being presented. It answers the question; "what do we do when the police are involved".

Example Steps:

1. Actions during the arrest
2. Post Booking Process
3. Getting Legal Help
4. Types of Charges at Arraignment

These are areas the family members need to understand, so they know what is going to take place and what will come next.

In the workbook section is for the attendee to take what they learned in the study material and apply it to their own real-world situation. For this reason the workbook presents the selected issue for study (key issue), then identifies some of the Obstacles the family is likely to face in dealing with this issue, then provides practical exercises where the family can prepare for the issue in how they will overcome the obstacles and identify what support they will likely require to successfully address this issue.

A family plan of action section is included at the end of each lesson. A list of steps the family plans to take when this issue is presented is drafted by the family. It helps the family to assign roles and responsibilities to other family members, creates "To-Do" lists so important steps are not left out, and keeps the communication channels open which is critical during times of distress and conflict.

The Pathfinder; How to get started

The reader can start at the beginning and then progress through each of the 12 issues. If this is a group study, these issues can be placed on a meeting calendar.

1. Choose an issue from the 12 key issues listed or dive into an issue that is most important for the time. These are essential issues a family will want to understand. Learn one issue at a time, do not blend the sessions together.
2. Before starting the learning session, complete a *Family Transformational Response (F.T.R.)* work sheet for the issue. This step helps the family look at the issue as they currently see it prior to learning more about how they will respond.
3. Read the Study Guide, be sure to view any video by stopping, going to www.youtube.com and viewing before you continue in the book. These videos are excellent learning enhancement to what you are reading in this part of the book. Do not skip the videos.
4. Move to the Workbook section and complete the practical exercises. There are typically one or more video's in the Workbook for each issue.
5. By using what was learned from the study guide and workbook, write a Master Plan of Action. This will create a summary for future reference in how the family will respond to each issue.

NOTE: The attendee will want their learning to be a starting point of getting educated. The reader needs to take this information and discuss it with a licensed professional. None of this material is to be acted upon by itself. These seminars are designed to help the community ask better questions, find the right level of support and take the right steps. We are all in this together and the Family is our center focus.

The community learning is a part of the bigger picture in combating demand for drugs at the family level, reducing stigma, and increasing successful outcomes. Please join us in our slogan: "***Hope, Hugs & Family Love"***

The Pathfinder Certificate of Completion is in the back of the book. Once completed, register with Families Impacted by Opioids (F.I.O.), to be included as a "Friends of the Family" program. See our website for more information about "Friends of the Family" tab. **www.familiesimpactedbyopioids.com**

These Section Identifiers in the Workbook

The workbook has the following <u>topic identifiers</u> to help guide the reader through their learning exercises.

Issues the Family Faces

This section will clearly explain the issue and by using the F.T.R. model allow the family to break it down into a solution.

Obstacle the Family Faces

These are obstacle a family faces when trying to address each issue.

Solutions to Issues & Obstacles

Each of these issues has their own obstacle and by knowing the issue and its obstacles the family will find a solution.

These are the 12 Key Issues a Family Needs to Understand

ISSUE # 1. Enabling vs. Disabling

Goals: 1. Learn the 10 Types of Enabling, 2. How to deal with an enabler who is in denial of their enabling behavior, 3. Understanding how to change enabling behavior.

ISSUE # 2. Addiction Behavior

Goals: 1. To learn the behavior traits of substance misuse, 2. To understand how the behavior progresses and changes over time. 3. To learn how to responds to these behaviors.

ISSUE # 3. Family Intervention

Goals: 1. Identify the five stages of change, 2. Learn the ten processes of change. 3. Gain an understanding dual diagnosis, mental health condition.

ISSUE # 4. The Police Intervention

Goals: 1. Identify the six phases of Police intervention, 2. Learn the Do's and do not's of a missing person's report, 3. How to compete a missing person's report.

ISSUE # 5. The Emergency Medical Services Intervention

Goals: 1. Understand the paramedic first response phrase, 2. Learn what happens in a hospital emergency room visit. 3. Understanding the value of SBIRT.

ISSUE # 6. The Legal System Intervention

Goal: 1. Have a working knowledge of the Sequential Intercept Model (SIM), 2. Finding an attorney, 3. What is Drug Court.

ISSUE #7. The Treatment Center Intervention

Goal: 1. Determine the right level of treatment, 2. What is Intensive Outpatient Treatment, IOP. 3. Communicating with Treatment Center Staff.

ISSUE #8. Support Agency Mapping

Goal: 1. Define family community mapping, 2. Steps to create a family community map 3. Advantages gained by having a family community map

ISSUE #9. The Relapse

Goal: 1. What is relapse, 2. List three stages of relapse, 3. How can the family identify these stages.

ISSUE #10. Successful Lifelong Recovery

Goals: 1. Four main ideas in relapse presentation. 2. Learn the Stages of Recovery 3. How to create a strong support system

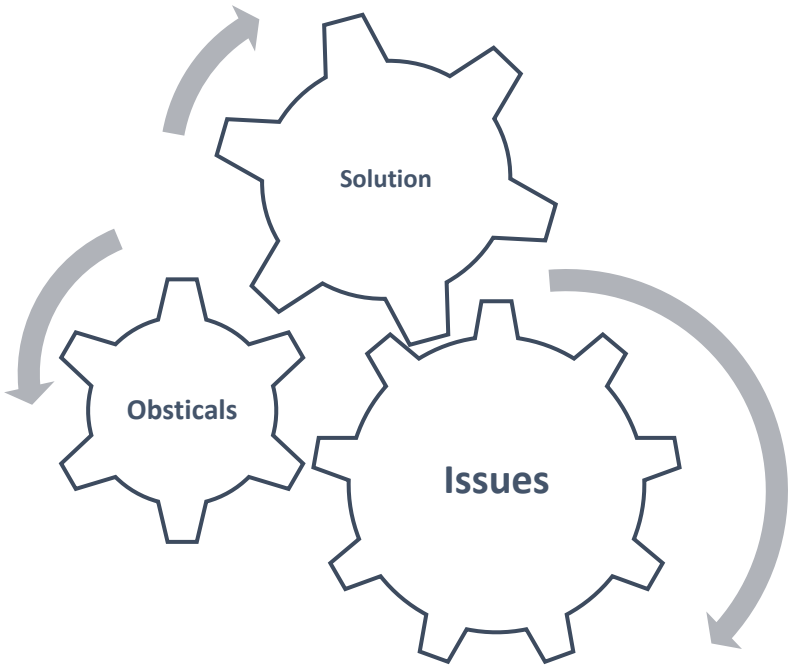
ISSUE #11. Bereavement

Goal: 1. Learn the 3 types of grief, 2. Understand the grief cycle, 3. Create an inventory for complicated grief

ISSUE # 12. Faith, Spiritual Practices

Goal: 1. Review the need for faith organization participation, 2. Create an Invest in the Family Ministry, 3. Offer the Invest in the Family Ministry at your place of worship.

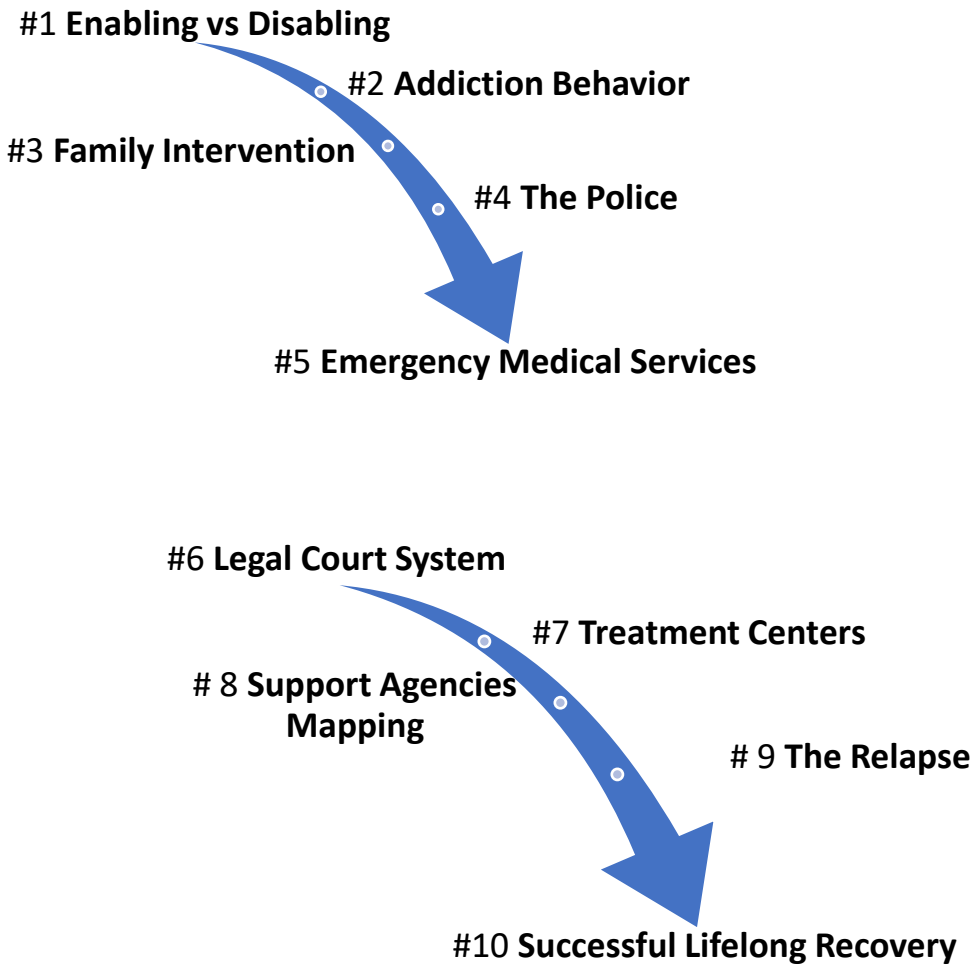
Each ***Issue*** has an ***Obstacle,*** before the ***Solution*** can be obtained



The Pathfinder Certificate of Completion Addresses All Three

Pathfinder
Certificate of Completion Learning Seminar

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)**

Breakdown the Issue: Family Transformational Response Model (F.T.R.)

The family system will benefit by having a standardized model to use when addressing each issue.

Instruction: Take each issue and in clear details define what the issue is, then state how this issue will impact the family, then identify what steps your family can take to prepare or respond to this issue, then find those organizations/professionals who can help the family in dealing with this issue**.**

This model creates a known expectation for the outcome.

This model/tool is part of the Substance Use Disorders Chronic Disease Management, Family Model.

The F.T.R. Model Steps:

I. Define the Issue?

II. How does this issue impact the family?

III. What steps can the family take to prepare and respond to this issue?

IV. Creates of list of who can help and assist the family in their response?

V. What should the family expect as their outcome?

Breakdown the Issue: The F.T.R. Model Worksheet

I. Define the Issue?

- ❖ Clearly State what happened or will happen.

_____

_____

_____

- ❖ Identify who is involved or should be involved.

_____

_____

_____

- ❖ What would you like to have happened, or like to see happen?

_____

_____

_____

II. How does the issue impact the family?

- ❖ Who in the family?

_____

_____

_____

- ❖ In what way?

_____

_____

_____

- ❖ What is needed to move forward?

_____

_____

_____

III. What steps can the family take to prepare and then respond to the issue?

- ❖ What needs to be done, prioritize the list.

_____

_____

_____

- ❖ Who needs to be involved?

_____

_____

_____

- ❖ What will it look like when completed?

_____

_____

_____

IV. Who can help and assist the family in their response?

- ❖ How to search for an organization to help.

_____

_____

_____

- ❖ What to ask from them?

_____

_____

_____

- ❖ What to expect?

_____

_____

_____

V. What should the family expect as their outcome?

- Timeline.

_____

_____

_____

- The expenses/cost involved in this issue.

_____

_____

_____

- Required changes to successful respond to this issue.

_____

_____

_____

NOTICE: Use the F.T.R. model for every issue, to find your best solution.

Issue # 1: Enabling vs. Consequences Seminar

Seminar One: Study Guide

Seminar Objectives:

1. Learn the 10 Types of Enabling.
2. How to deal with an enabler who is in denial of their enabling behavior.
3. Understanding how to change enabling behavior.

These are the 12 Key Issues a Family Faces

#1 **Enabling vs Consequences**

#2 **Addiction Behavior**

#3 **Family Intervention**

#4 **The Police**

#5 **Emergency Medical Services**

#6 **Legal Court System**

#7 **Treatment Centers**

8 **Support Agencies Mapping**

9 **The Relapse**

#10 **Successful Lifelong Recovery**

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

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

Introduction

Enabling vs. Consequences is an Issue many Family Face

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 solve the problems that life throws at them. Friends want to help each other at work or in their personal relationships. Unfortunately, though, 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 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 hasn't 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 change. 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 have to allow reality to touch their lives.

Too often in our lives, we protect people from the harsh realities of logical consequences that would force them to see their need for grace and what it can provide. 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 face the truth. And sometimes that means letting him deal with harsh realities.

This isn't necessarily about discipline and correction, but how it's important to see that sometimes our "helping" may keep others from experiencing the tough realities that will ultimately lead them to the change they need. It's 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.

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.

Ten types of enabling

Practical Exercise # One: To follow are areas to consider in self-reflection.

1. **Denial __Yes, __No, __Maybe**

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 isn't necessary, and the addict will know how to control their drug or alcohol use.

2. **Justification __Yes, __No, __Maybe**

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. **Allowing Substance Use __Yes, __No, __Maybe**

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. **Suppressing Feelings __Yes, __No, __Maybe**

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. **Avoiding the Problem __Yes, __No, __Maybe**

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. **Protecting the Family's Image __Yes, __No, __Maybe**

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. **Minimizing the Situation __Yes, __No, __Maybe**

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. Playing the Blame Game __Yes, __No, __Maybe

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. Assuming Responsibilities __Yes, __No, __Maybe

Family members may be inclined to take over the regular tasks and responsibilities of the addict in an effort 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. Controlling Behaviors __Yes, __No, __Maybe

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 and closer to their substance-using peers. This is the final consequence.

What is a Consequence

Enabling vs. Consequences:

con·se·quence

/ˈkänsikwəns/

Noun a result or effect of an action or condition
ISSUE: Enabling by Mother:

Bill is able to keep using drugs, because his life has no consequences that might cause him to consider a different alterative.

Enabling, Type: Denial, my mother is in denial of his addiction and believes Bill will die if she does not provide him money and a place to live.

Consequence, Bill can keep using drugs, because his life has no consequences that might cause him to consider a different alterative.

Complete an F.T.R. and find the solution. This will only get worse with time.

How to deal with an enabler

I. Define their Enabling and (*your type of enabling here*) Issue?

- Clearly State what happened or will happen.

_____
_____

- Identify who is involved or should be involved.

_____
_____

- What would you like to have happened, or like to see happen?

_____
_____

II. How does their enabling issue impact the family?

- Who in the family.

_____
_____

- In what way.

_____
_____

- What is needed to move forward.

_____
_____

III. What steps can the family take to prepare and then respond to their enabling issue?

- What needs to be done, prioritize the list.

_____
_____

- Who needs to be involved.

_____
_____

- What will it look like when completed?

_____
_____

IV. Who can help and assist the family in their response to the enabling issue?

- How to search for an organization to help.

_____
_____

- What to ask from them?

_____
_____

- What to expect.

_____
_____

V. What should the family expect as their outcome, after they have addressed the enabling issue?

- Timeline.

_____
_____

- The expenses/cost involved in this issue.

_____
_____

- Required changes to successful respond to this issue.

_____
_____

REF: http://www.sharc.org.au/wp-content/uploads/2017/06/How-to-stop-enabling-someone-who-is-addicted-Alternatives-in-Treatment.pdf

Issue # 1: Enabling vs. Consequences Seminar

Seminar One: Workbook

Enabling vs. Consequences is an Issue the Family Faces

Those who habitually enable dysfunctional behavior are often referred to as co-dependent. It's a telling word, because an enabler's self-esteem is often dependent on his or her ability and willingness to "help" in inappropriate ways.

This "help" allows the enabler to feel in control of an unmanageable situation. The reality, though, is that enabling not only doesn't help, but it actively causes harm and makes the situation worse.

By stepping in to "solve" the addict's problems, the enabler takes away any motivation for the addict to take responsibility for his or her own actions. Without that motivation, there is little reason for the addict to change. Enablers help addicts dig themselves deeper into trouble.

Here are some questions to ask yourself when considering whether you are an enabler:

- Do you often ignore unacceptable behavior?
- Do you find yourself resenting the responsibilities you take on?
- Do you consistently put your own needs and desires aside in order to help someone else?
- Do you have trouble expressing your own emotions?
- Do you ever feel fearful that not doing something will cause a blowup, make the person leave you, or even result in violence?
- Do you ever lie to cover for someone else's mistakes?
- Do you consistently assign blame for problems to other people rather than the one who is responsible?
- Do you continue to offer help when it is never appreciated or acknowledged?

Obstacle the Family Addresses

Enabling behavior:

- Protects the addict from the natural consequences of his behavior
- Keeps secrets about the addict's behavior from others in order 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 in order 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

Understanding how to deal with an enabler

Solutions to Issues & Obstacles

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'd 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'll 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'd 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're planning to change, along with the reasons they're 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's a tip from an ARISE Intervention, and according to the Association of Intervention Specialists, it's aimed to help reduce pressure and manipulation. If the family doesn't have one-on-one talks, it's 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. Don't make excuses or cover up the behavior
Sponsor-relationship Some of the most egregious things that happen during the course of 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 can't 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 doesn't 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 don't 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's a smaller chance of embarrassment. All of 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's not smart.

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

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

Along with all of 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 isn't likely to get better without the help of a treatment team. Again, addictions are brain diseases that can't simply be pushed to the side with one conversation. They're caused by changes in brain chemicals and brain circuitry, and they need in-depth treatment to amend.

That's why 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 won't accept the possibility of treatment right away. It's a bold idea, and sometimes, people need to think about it and ponder it before they agree to take action. Families that respect that process of change, and who refuse to give up hope, may see the sobriety come with time.

Practical Exercise # One

ENABLING THE WRONG OUTCOMES?
FAMILY WORKSHEET

Their Behavior?	What you would like to see?	Your Actions?	Outcome?	Were your actions productive or destructive? Why?

The Story

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VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Signs of Enabling Addicts

Candace Plattor

Educates family members of those in recovery about substance abuse disorders. Three sessions cover triggers and cravings; phases of recovery; and typical family reactions to the stages of addiction and recovery and how they can best support their loved one.

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

Duration: 15:14 min

NOTES FROM VIDEO:

FAMILY WORK SHEET
ISSUE # 1 "Enabling vs. Consequences"

ISSUE # 1. Enabling vs. Disabling (30-minute session)

GOAL: 1. To use this seminar content as a foundation into building communication techniques that do not enable reinforcement of negative substance misuse behavior. 2. To learn how to avoid communication that disables the positive habits of successful recovery. 3. How communication makes a safe place for the family.

QUESTION: **ANSWER:**

1. Do you take steps to cover up the addiction and help keep it hidden? _____

2. Do you make excuses for your loved one's addiction or behavior? _____

3. Do you avoid confronting the addiction to avoid conflict? _____

4. Do you believe your loved one is just going through a phase? _____

5. Do you believe the problem will eventually resolve itself without help? _____

6. Do you handle the responsibilities of your loved one? _____

7. Have you bailed your loved one out of jail? _____

8. Have you paid bills for your loved one, who likely used income on their addiction? _____

9. Do you have a parent-child relationship with your loved one even though they're your spouse? _____

10. Do you enjoy the feeling of being 'needed' by your loved one? _____

11. Are you guilty of giving second, third, and fourth chances? _____

12. Do you ever participate in risky behaviors alongside your loved one? _____

TOTAL: _____

SCORE: 1 - Never, 3 – Sometimes, 4 – Often.

If your Score Totals:

12 You are doing great. 36 You could do better. 48 You should seek professional family therapist to learn how.

Practical Exercise # Two:

1. In what way am I enabling?

2. What can I do to stop enabling?

3. How is my enabling self-gratifying my emotional needs?

To Do List: Next Steps

1.
2.
3.

MASTER FAMILY PLAN OF ACTION FOR: "Enabling vs. Consequences"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Our family will identify the characteristic of Enabling and address them using the FTR model.

2. Our Family will use the Individual Family Member Self-Assessment of Denial Worksheet to first understand each member degree of possible enabling and agree that it is accurate then gather the resources which will empower each family member in dealing with their response to the issue.

3. As part of the Master Family Plan of Action we will complete the "Enabling the Wrong Outcomes" worksheet.

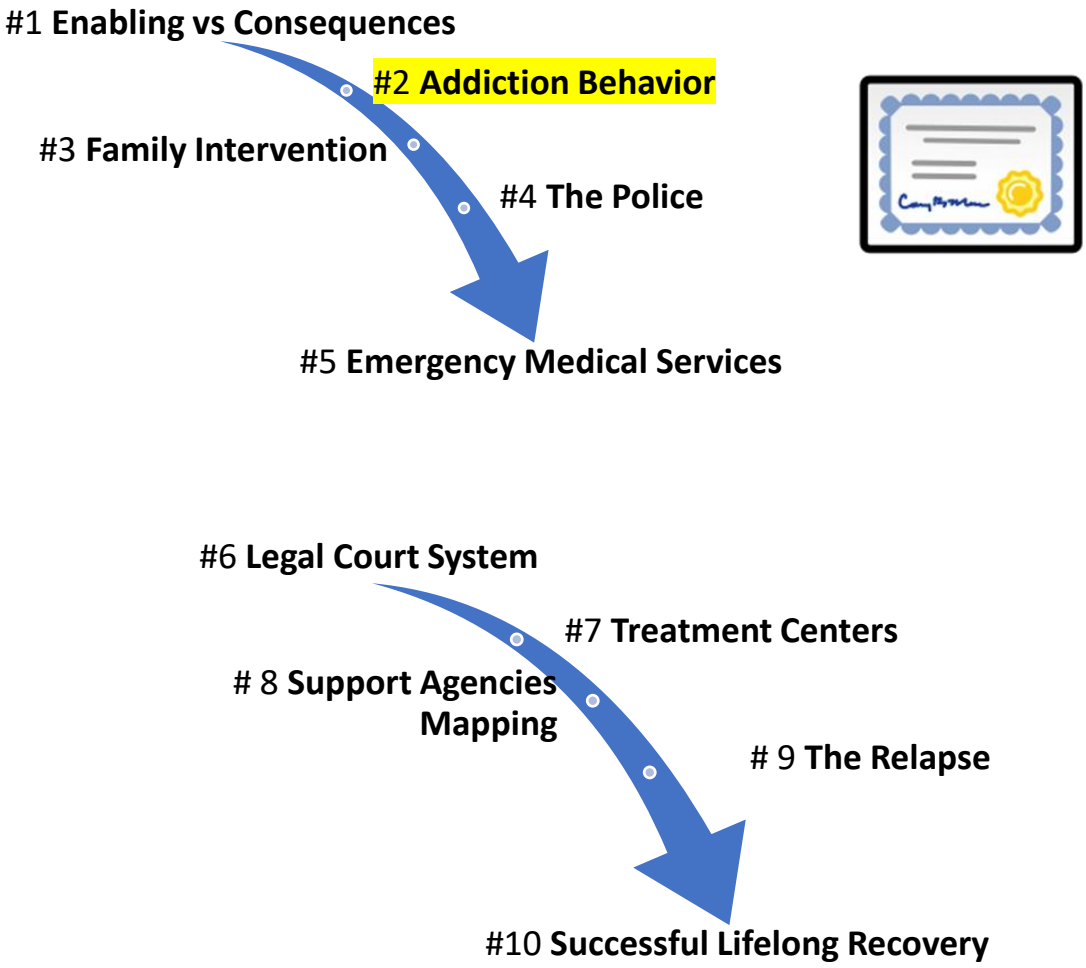
Issue # 2: Addiction Behavior Seminar

Seminar Two: Study Guide

Seminar Two Objectives:

1. The five types of addiction behavior.
2. Setting boundaries.
3. Understanding the brain science of this disease.

These are 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)**

The five types of Addiction Behavior

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 impacts that are important to understand about this disorder.

Therefore, the most effective treatment approaches will include biological, behavioral, and social-context components. Recognizing addiction as a chronic, relapsing brain disorder characterized by compulsive drug seeking and use can impact the family's overall health Financial and social associations for each family member.

The family members need to understand what causes the behavior of their loved one. It is not them; *it is the disease*. This is a difficult concept to accept when dealing with addiction 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.

This is how it happens; if left by itself the brain would allow logic to dictate and not be kidnapped by pleasure thinking. But the excess drug impact has rewired the brain into allowing pleasure to be the dominating drive in how they respond and make decisions. 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.

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 to 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's why drug addicts often lie, cheat and steal. They may engage in illegal behaviors aside from the illicit drug use in a drive to get more, and they're not able to recognize the pain and harm they're causing themselves and the people around them because of their mind's 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 in order to facilitate their continued drug use. They feed on the concern and love of their family members.

Someone who's 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.

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's very 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 don't really add up, you have to hold onto your own common sense. If what you're being told doesn't make sense, then there's probably a very good reason—you're being lied to. You might be able to check some of the stories. Most, you probably can't. You will have no way of knowing if someone actually 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.

Couple hugging looking aside

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 awful 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's 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 can't be believed. They are just more manipulation.

3. They are very likely to be engaged in criminal acts.
Stealing money, **t**his isn't 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's 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 has to happen is that he must be rehabilitated to the point of having more power than the drugs.

5. An addict is very likely to become abusive.
It's 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's 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's very 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 can't fight back.

It doesn't 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 don't set strict boundaries, you will allow your addicted loved one to continue their drug use and harm your family or relationship further.

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'll 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're upset may not be something, you're actually 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 isn't personal)
- Understand that change takes time
- Know why it is never helpful to be an enabler

List Here Some Behaviors You Are Seeing:

_____
_____
_____
_____
_____
_____
_____
_____

Issue # 2: Addiction Behavior Seminar

Seminar Two: Workbook

Setting Boundaries

Issues the Family Faces

Normally, we would not start a workbook session with a video. However, this video so clearly states the introduction to this topic we could not miss the opportunity to let it guide our discussions.

Please view this video.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: HOW TO—Set Boundaries when a Loved One has an Addiction

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

Duration: 9:04 hrs.

One mother spent years of her life trying to help a son who was heavily involved in addiction and other poor choices. She felt like a failure because she couldn't save her son from his choices. Her son spent years away from the family. As he began a slow journey back to building a relationship, she set boundaries of what she would and would not allow in her home. These boundaries protected her and ensured that she would not enable his addiction. Set Boundaries: "The boundaries we set will help us meet our spiritual, emotional, and physical needs and ultimately help us feel safe and at peace" (Principle 8: "Support Guide: Help for Spouses and Family of Those in Recovery"; read more here: https://addictionrecovery.lds.org/spo...). Bad choices thrive in secrecy, and deceit is its lifeblood. A turning point for our loved ones occurs when they recognize the role secrecy and deceit play in enabling their bad choices. When our loved ones lie to us or deceive us and minimize their bad behavior, we lose trust in them. Open and honest communication is the beginning of rebuilding trust.

Is it true; setting boundaries in a way that you know they will be broken is likely not realistic?

You can expect boundaries to be broken by substance users – especially when they are first put in place. They will often react to changes by pushing you and other family members to previous ways of behaving. They will probably

be less motivated to change than you are. They will also usually hope that you will be unable to keep boundaries in place based on their previous experience of you giving way. If a boundary is broken you need to respond quickly, appropriately and assertively.

Practical Exercise # One: How to do it?

The first step is to recognize and acknowledge that it has happened. Then take a step back as you consider your response. It is important to take time to consider everything rather than reacting from feelings of frustration and anger.

Responses:

- I believe our agreed boundary regarding ---------- has been broken
- I feel ---------- about this
- We need to discuss this. (You may need to negotiate whether right now is the time to have a discussion or to set a more appropriate time.)

In making your initial statement you need to include:

1. What behavior is unreasonable (focus on behavior, not them as a person). How will you do this?

   _____
   _____
   _____

2. What your feeling is about the behavior (feeling not blaming response). Describe what you are feeling?

   _____
   _____
   _____

3. Say what you want to do now or restate the boundary. What boundaries need to be restated?

   _____
   _____
   _____

For example – "When you broke the agreement about using in front of your brother I felt let down, sad and angry. I ask again that you honor our agreement". It may be necessary then to restate and/or renegotiate the boundary.

You also then need to implement the consequence for breaking the boundary. It is important that you don't let them off the hook for the consequences.

You may need to develop a 'broken record' technique – especially if they become defensive or start justifying their actions i.e. "Yes, I hear what you are saying about why this happened, but I still need you to keep to the agreed boundary!"

It is important to comment on disparages in the drug user's words and their behavior – example – "I notice that every time something like this happens you always say sorry but then you carry on as if we didn't have an agreement".

You should then request that things be put right – repay money taken, apology to an affected family member, repair damaged property etc. Be consistent.
When making the above statement it is important to remember a few things because as with any new skill it needs to be developed, practiced and refined.

Be assertive but not aggressive. Begin with the word 'I', maintain eye contact, speak from the same level – don't stand over them. Avoid pointing, jabbing your finger or raising your voice.

Be prepared for them to try and put you off track, appeal to your emotions, argue, get angry etc. You may even need to have another person as a mediator or negotiator but if you do it is important that they trust the other party and the other party doesn't take sides.

You are neither all powerful nor powerless. You do have influence and you do have bargaining power. You can ask for what you want, say no to what you don't want and invite them to do the same.

If they apologize, be gracious but consider both their words and how they say it. Actions speak louder than words though.

Obstacle the Family Addresses

Keeping a Boundary

The last stage in the process is keeping the boundary.
This is done by:

- Observing if the boundary is being kept
- Acknowledging that it is being kept or if it is broken
- Responding appropriately if it is broken

When Dialogue and Negotiation Doesn't Work

This maybe means that the first boundary to ask for is that there is to be dialogue and negotiation.

If your attempts to achieve negotiation have not worked, you may then have to impose it. This can be done verbally and/or in writing e.g. 'I notice that whenever I try to discuss your drug using in the house you seem unwilling to talk about it. I tried to talk to you twice last week and you said "later Mum" but it still hasn't happened. I cannot stop you using drugs even though I don't like it and am fearful of about what might happen. I am worried that something illegal is happening in our house but am particularly concerned that you do it even when your young brother and sister are here.

I assume now that you are unwilling to cooperate with me on this and therefore, I am not going to buy food or cook meals for you. Further, I have said that if there is one more instance of your siblings seeing you use, I will have to ask you to leave. I regret it has come to this and would prefer it if we could now have an open discussion about your drug use and the impact on the family. I love you and will continue to no matter what and I will continue to have contact with you!'

You will note that this letter:

- Addresses their behavior rather than attacks them as a person
- Gives the impact of the broken boundary
- Uses “I” statements and not 'you' statements
- Asks for the boundary to be respected
- Is honest, open, direct and assertive
- Is not aggressive
- Is balanced
- Sets out the boundary clearly as well as the consequences for breaking it
- It leaves things open for further discussion, dialogue and negotiation
- It gives the substance user responsibility for their behavior and the choice they made

Communicating this way has three benefits. You get to say what is important to you and you say it in a way that is easier for the other person to hear. It also models good communication to the other person.

Setting A Boundary

Having thought about the boundary you would like to set and being prepared to talk about it, the next thing is to set it with the substance user. The skill to utilize is negotiation. It is important to build and maintain a dialogue between the user and other family members – this will work well if negotiation skills are utilized.
Effective dialogue involves:

- Listening to each other
- Being open and honest
- Respecting the other person – not necessarily liking their behavior
- Accepting and understanding their point of view – even when you don't agree
- Use 'I' statements. Start everything you say with 'I'. I think, I believe, I feel, I would like etc.
- Take responsibility for your actions and contribution to the situation
- Not taking responsibility for other people's behavior, actions and choices
- Acknowledging both your own feelings and the other person's feelings
- Appropriately expressing your feelings e.g. 'I am really angry that you are using in front of your brothers' rather than exploding and becoming aggressive
- Recognizing the need for all to exercise their rights and responsibilities
- Work to collaborate rather than confront
- Stay calm and focused on the task of setting the boundary even if the user loses control
- Modelling appropriate behavior may bring them back on track

Effective dialogue builds trust, which can lead to people taking more risks with being honest, open and taking responsibility.

Using the transactional analysis model, we are trying to work with - Adult to Adult dialogue rather than Parent to Child or Child to Child dialogues.

Developing effective negotiation skills:

- Always look for win/win outcomes
- Asking for what you want – not demanding or avoiding asking
- Acknowledge power differences between you and the drug user
- Checking their response to your request and how they feel about it
- Not making assumptions regarding their feelings, thoughts or desires
- Collaborating and being flexible. Being prepared to give some ground and compromise
- Holding onto what is really important while being willing to let go of what is not important
- Start easy and if necessary, finish strong. Use your negotiation skills and then move onto imposition if necessary
- Agreeing the terms of the boundary – when it will start, when you will review it and the consequences of the breach of the boundary. Make sure the substance user is fully involved and understands what the consequences will be
- Make a clear agreement of what has been decided

Solutions to Issues & Obstacles

Defining "The Boundary"

- What is the issue, circumstance, area of concern?
- What do you need to achieve?
- Examine your motive in wanting to set this boundary. Is it in response to clear thinking about an area of concern or is it an angry response to a set of circumstances?

If the person wasn't using substances would you accept the behavior? In other words, it is important not to treat people differently just because they are substance users.

Know the distinction between them as a person and their behavior. Even 'I' statements can be phrased in more positive ways on occasion. Note the difference between:

'I don't want you living at home when you're using!' *and* 'I don't want you to use drugs in our home'

1. Is the boundary encouraging them to be responsible for their life, the choices they made, their behavior and the impact on those around them or is it just treating them like a child?
2. What are the risks of the boundary for everyone involved?

Using the 'using at home' example, the home and people within it may be safer if there is no use at home but the user may be at more risk if they then use outside the home. There is no 'right' or 'wrong' answer. Options and consequences must be considered, and each family may take different approaches. Child safety and protection should always be a serious consideration. The rights of young children need to be the most important element.

- Set clear consequences for what happens if the boundary is breached. Consequences should be negotiated together including the substance user and may be graded from mild to severe. Consequences need to be appropriate to the breach and everyone needs to be able to live with them. Any action tied up in the consequence needs to come from you – the user may not be 'made' to do something.

Example:

'Because you used at home twice last week, I am going to look for alternative living arrangements for you' – *rather than* 'Because you used drugs last week you now have to go into rehab.'

- How will you 'measure' if the boundary has been kept?
- Is there a time limit on the boundary or does it go on indefinitely?
- How often and when will you review the boundary?

- What flexibility – and it will help if there is some – will be made for changes in circumstances?
- When and where will the boundary be set and commence?
- Other family members of an appropriate age who live in the home should be party to the agreement partly to prevent 'divide and rule' circumstances. It will be no good setting a boundary where the key people involved disagree with the boundary
- Is the boundary realistic now in the current circumstances?
- Can a win/win be achieved? In other words, set the boundary in a way that you, the other family members and the drug user gain something from keeping the boundary. Boundaries set as revenge or to express your anger or to punish the drug user are doomed to failure
- When will the boundary commence? Immediately or is there a need for a commencement date?
- How will you get support from within yourself or from others to be able to set and keep the boundary? How will you deal with harmful feelings and other issues that may arise? Support groups can be very important for supporting you
- Remember we live in the real world and not a fantasy one. The choice of a boundary is likely to be a compromise rather than the ideal you might like
- Be prepared to reward the drug user for respecting and keeping the boundary. They often don't get 'pay-offs' and it will encourage them if they see that keeping the boundary is appreciated
- Prepare and rehearse the discussion on setting the boundary. Imagine their likely response. Be prepared for negative reactions. Use 'I' statements. Rehearse the conversation going the way you would like it to.
- Remember your needs are equal to not greater or less than those of others. Your needs are worth respecting and you are entitled to set and have boundaries kept.

Take your time and get it right. You can't change other people but you can change your response to them – which may in turn invite them to change.

Ref: Family Drug Support Australia PO BOX 7363 Leura NSW 2780

You need to know if it is addiction and this is when a clinical assessment of the behavior is warranted. By having them clinically assessed, a baseline of conditions is established and a diagnosis can be given.

Once you have a diagnosis, you will want to know what stage they are currently experiencing. Now you can start to research on-line that exact diagnosis and all its characteristics. No more guessing.

Also, with a diagnosis, plan of care can be set up, insurance benefits can be authorized, professional services can be administered. **Ask the clinical team how they use best practices in the care of your loved one. When seeking follow up information about their status ask how the best practice is helping in their plan of care.**

Understanding the brain science of this disease

The Story

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: The Brain and Recovery: An Update on the Neuroscience of Addiction

Published on May 4, 2018

The last twenty years produced an explosion of understanding about addiction (substance use disorders) and how our brains enable our most human capacities such as assigning value to pleasure and making decisions based upon that value. This lecture summarizes the most current neuroscientific research about addiction -- research that explains how the brain constructs pleasurable experiences, what happens when this process goes wrong and why this can have a dramatic impact on our ability to make proper choices. By Dr. Kevin McCauley

Link: https://www.youtube.com/watch?v=zYphZvRHm6Y

Duration: 1:14 hrs.
By Dr. Kevin McCauley
Support provided by:
NCADD Juneau
Juneau Community Foundation
Alaska Department of Behavioral Health
Juneau Reentry Coalition

Notes From Video:

Practical Exercise # Two:

1. **How does choice work?**

At its heart addiction is a disorder of the brains to perceive pleasure. T____ F ____

Addiction is a disorder of choice. T ____ F ____

Addiction is caused by stress T ____ F ____

2. **ASAM Addiction Definition There are five different systems in the brain that break. Which of these is <u>NOT</u> one of them.**

___ Genes

___ Reward

___ Memory

___ Stress

___ Choice

___ Your Mother

3. **Where does the brain fail?**

Fontal Cortex is decision making T ____ F ____

Interior Singular Cortex aids us in using how we see our rewards T ____ F ____

4. **Genetics:**

A person with genes that expose them to addiction can be reversed T ____ F ____

MASTER FAMILY PLAN OF ACTION FOR: "FAMILY IS A SYSTEM"

Complete answers and move to "Master Family Plan of Action".

1. Our family will identify the characteristic of our loved one's behaviors and address them using the FTR model from the issues these behaviors cause.
2. Our Family will use the lessons provided in setting boundaries.
3. State how the understanding of brain disease changes the way our family will look at the behavior of our loved one.
4. As part of the Master Family Plan of Action we will complete the review of setting boundaries and seek professional counseling on how the family members can support setting an appropriate level of boundaries.

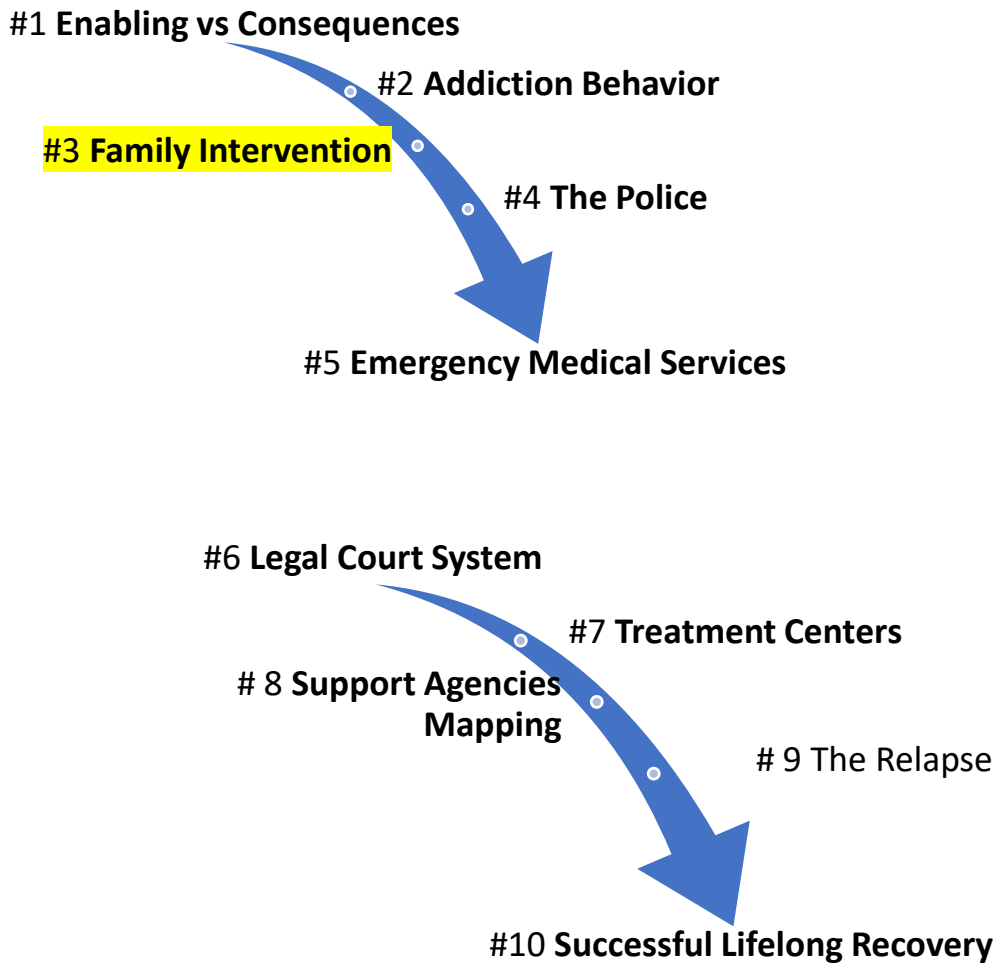
Issue # Three: Family Intervention Seminar

Seminar Three: Study Guide

Seminar Objectives:

1. Identify the five stages of change.
2. Matching motivations to the stage.
3. Gain an understanding dual diagnosis, mental health condition.

These are 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)**

Introduction

No-one automatically knows how to talk to an addict — someone living with an addiction. Although people who have lived and worked with people with addictions may have discovered effective ways to communicate, it is always difficult, because of the confusion addiction creates in the person with the addiction, 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 addiction 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, their ability to communicate is one of the first skills they lose once addiction becomes a factor. As addicts, they often feel 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. This is why we suggest a family therapist be involved in the family journey.**

If we don't know how to properly communicate with one another, our conversations can quickly turn to anger, avoidance, depression or indifference, on both sides.

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

It's hard for addicts 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's often easier to escape reality by turning to mind-altering substances.

Timing is Important:

You may feel that this conversation has to 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.

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?

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

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."

The transtheoretical model includes key concepts from other theories to form a comprehensive theory of change. This broader model can be applied to a wide range of people and behaviors. It identifies helpful actions that build forward momentum, no matter where individuals are in the change process.

Five Stages of Change

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're 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're not ready for treatment. Therefore, the family coming into this topic will likely not get a positive result. So what is needed? The steps that are required can be found in motivational interviewing, whereby pre discussion steps are taken to prepare the person to receive the consideration that a problem does exist and gaining their acceptance in this area is the families first step.

- **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're also aware of the negative effects that will occur if they quit their substance of choice (there's the physical fear of detox, and the possibility they've 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'll have to finally face that issue).

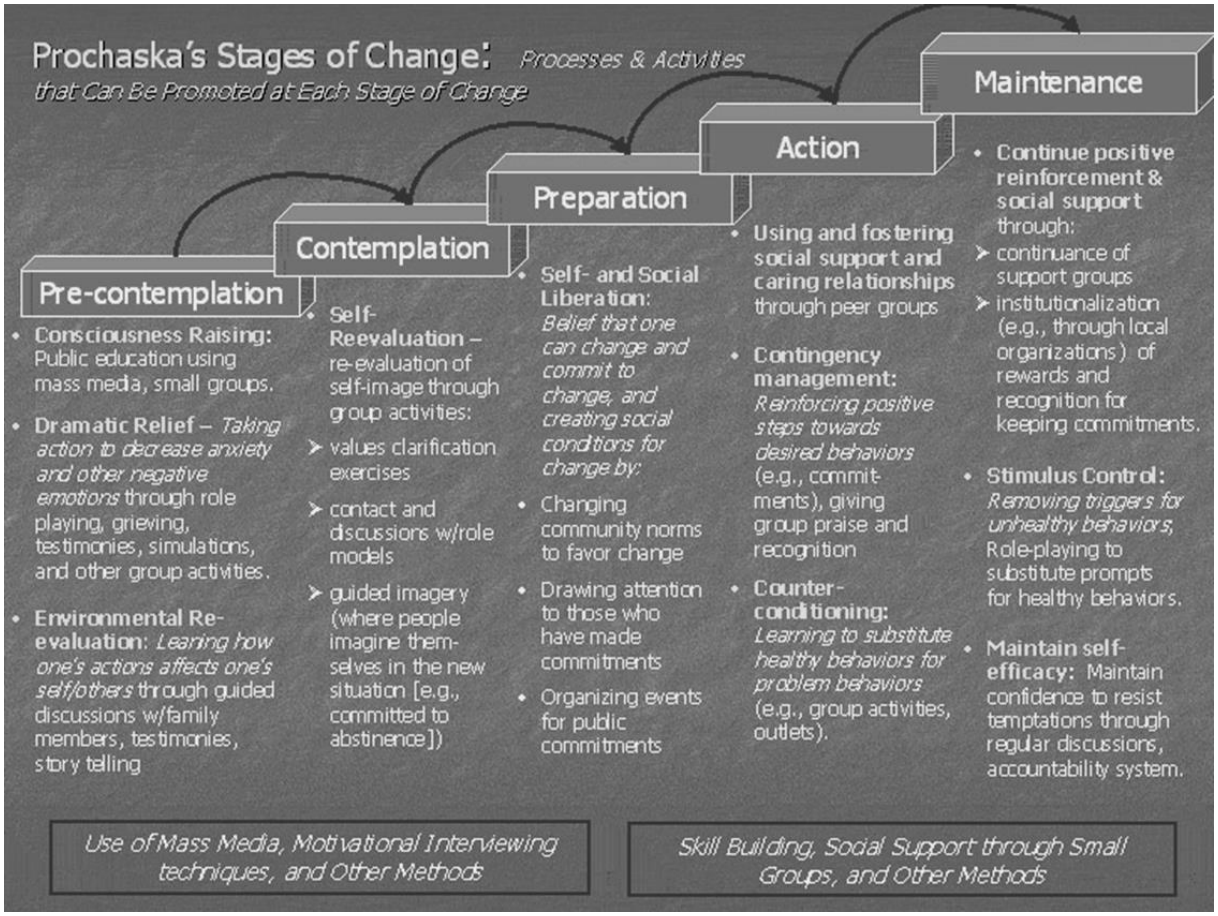
- **Preparation (Expected Duration – 6 months):**
  It is not until the third stage of the model that addicts are ready for treatment. They've weighed the pros and cons of quitting their substance of choice, and they've decided to quit. In fact, they've gone further than just deciding to quit – they've 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 center.

- **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.

- **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 training families, then find one that does.

The Processes of Change

It helps to break down the process of change into 5 stages, but that doesn't offer much practical insight into what someone can do to change them self.



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 as a result of no longer abusing substances
6. **Self-Liberation:**
   belief that one has the ability to change, and also 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 on
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

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 patients presenting with a mood, anxiety or psychotic disorder should be screened for substance use, and all patients 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.

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 of 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.

Suicide risk with co-occurring disorders

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

Often a patient'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 patients 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.

Issue # 3: Family Intervention Seminar

Seminar Three: Workbook

Family Intervention

Issues the Family Faces

Normally, we would not start a workbook session with a video. However, this video so clearly states the introduction to this topic we could not miss the opportunity to let it guide our discussions.

Please view this video.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Prochaska: Stages of Change

http://amzn.to/2aDmRKX Being able to get through transformation, whether its getting over a breakup or quitting an addiction or cultivating a new habit, you may benefit by discovering the stages of change. For more visit http://reprogrammingmind.com/prochask...
loved ones lie to us or deceive us and minimize their bad behavior, we lose trust in them. Open and honest communication is the beginning of rebuilding trust. As we patiently speak with our

Link: https://www.youtube.com/watch?v=eE2gw5eF4Ro

Duration: 11:41 hrs.

Obstacle the Family Addresses

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's 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 doesn't 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 doesn't come to Muhammad, then Muhammad must go to the mountain.

Make a 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 don't want to change, or I can't change and more an I am changing.

Since the changes here are more observable, it's 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 don't give enough thought to the kind of change, they want and prepare a plan of action- stage 2 and stage 3.Let's 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 won't feel like cooking or even eating greens.

You'll convince yourself that it's 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 as a means to manage the destructive behavior.

The process can seem tedious and boring after the backstage Broadway show that was your addictive life and, therefore, the 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.

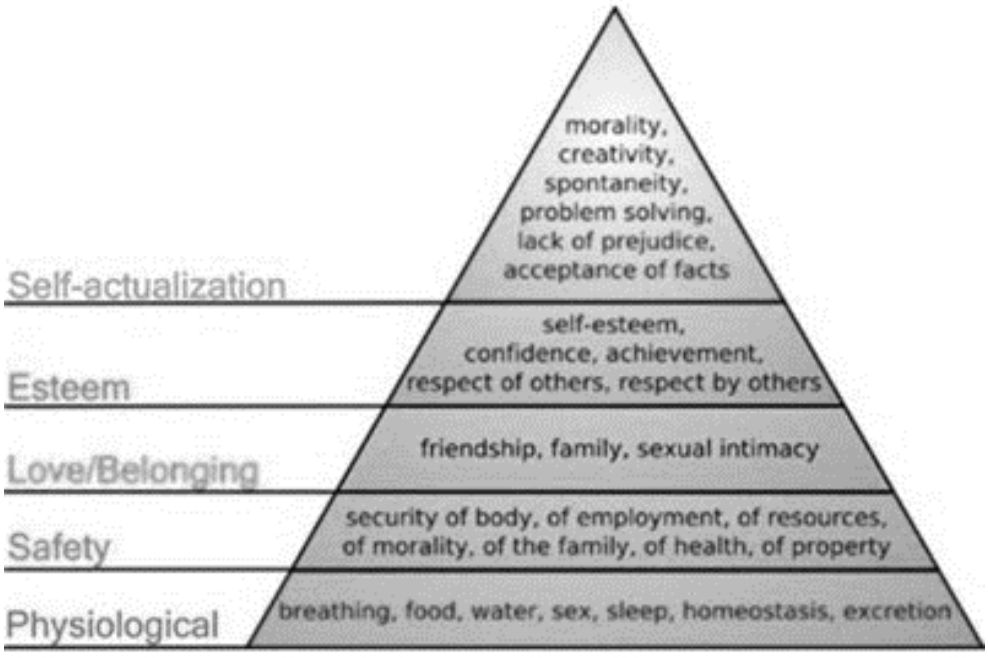
The entire addiction treatment and recovery community recognize that relapses can occur at any stage and that battling addictive behavior is a life-long process; nonetheless, a sixth stage was added to the transtheoretical model.

Solutions to Issues & Obstacles

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 patients' degree of motivation to change. For patients 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 patients harder to try to stimulate change. These approaches tend to diminish motivation.
- Assessing a patient'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 patient'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 interventions to the stage of change

Precontemplation stage

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

Contemplation stage

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

Preparation/action stage

Provide encouragement, offer assistance and, if necessary, refer the patient for addiction treatment.

Helping patients move toward change

Attempt to engage patients in a discussion about their problematic substance use. Simply asking patients 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 patients their answers to the following questions:

- **"Why do you think you should you cut down or stop?"** Explore the importance for patients 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 patients' 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 patients' readiness to cut down or stop in the near future. 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 patient, and the more confident the patient 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 makes changes is inevitable.

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

Stage of change, level of interest and ambivalence

- Ambivalence is generally lowest when the patient 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 patient 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."
- Patients 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 patients 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 at the moment."

- **Increase intrinsic motivation by reinforcing the patient'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 patient 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 patient 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 up 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 patient'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 patient's confidence (the patient 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 patient's path to change.

Increasing motivation: Tip list

- **Provide a decisional balance sheet** to help patients 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 patient 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 patient 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 patient wants to achieve.

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

Encourage patients 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 patient 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 patients 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 patient perceives to be helpful. While some patients are motivated by an explicit written "contract" that they can take with them, most patients 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 very helpful to most patients.

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 patient perceives as appropriate. Ask: "When do you think it would be helpful to see me again?"

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

When patients do not complete the plan

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

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

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

As a general 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), patients 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 is capable of making changes in one's life.

The Story

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VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Introduction to Motivational Interviewing

Bill Matulich

In this slide presentation I talk about the basic concepts of Motivational Interviewing (MI). After a brief definition, topics include: the Spirit of MI, The four basic OARS skills, and the "processes" of MI.

Link: https://www.youtube.com/watch?v=s3MCJZ7OGRk

Duration: 17:22 hrs.

Practical Exercise # One:

Decisional Balance Worksheet When we think about making changes, most of us don't really consider all "sides" in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to "hang on" to our plan in times of stress or temptation. Below, write in the reasons that you can think of in each of the boxes. For most people, "making a change" will probably mean quitting alcohol and drugs, but it is important that you consider what specific change you might want to make, which may be something else. Benefits/Pros Costs/Cons Making a change Not changing.

Decision Balance Worksheet

	Benefits Pros to changing	**Cost or Cons to changing**
Making a Change	**1.** **2.** **3.**	**1.** **2.** **3.**
Not Changing	**1.** **2.** **3.**	**1.** **2.** **3.**

Exercise # Two:

VIDEO THREE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: How to do a Change Plan Worksheet: Worksheet included

Published on May 4, 2018

Dr. Russ Curtis
http://www.thecounselingacademy.com. For an example of a change plan worksheet visit http://motivationalinterview.net/clin... Motivational Interviewing 3: Change Plan

Search Link: https://www.youtube.com/watch?v=HOWvpl06zoQ

Duration: 6:41

VIDEO FOUR

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: How to do an intervention | How to do a drug intervention | How to do an alcohol intervention

Published on May 4, 2018

Cassidy Cousens

Cassidy Cousens, CCDC (dressed down) offers helpful tips and free information in order to intervene on a family member, loved one, or friend. The steps he outlines are simple and effective. It would be advisable to review the suggestions he provides if you are considering conducting an addiction or co-occurring disorders intervention. For more information on the steps to intervening visit triple w [dot] Method Treatment [dot][com]

Search Link: https://www.youtube.com/watch?v=ad01XlRbRls

Duration: 6:41

MASTER FAMILY PLAN OF ACTION FOR: "The Family Intervention"

Complete answers and move to "Master Family Plan of Action".

1. Our Family will use the five stages of change of Behavior scales to determine what to expect.
2. The tips for matching motivations to the stage will be applied in the family intervention.
3. Using the understanding a dual diagnosis might be involved in how the loved one is able to respond to our intervention.

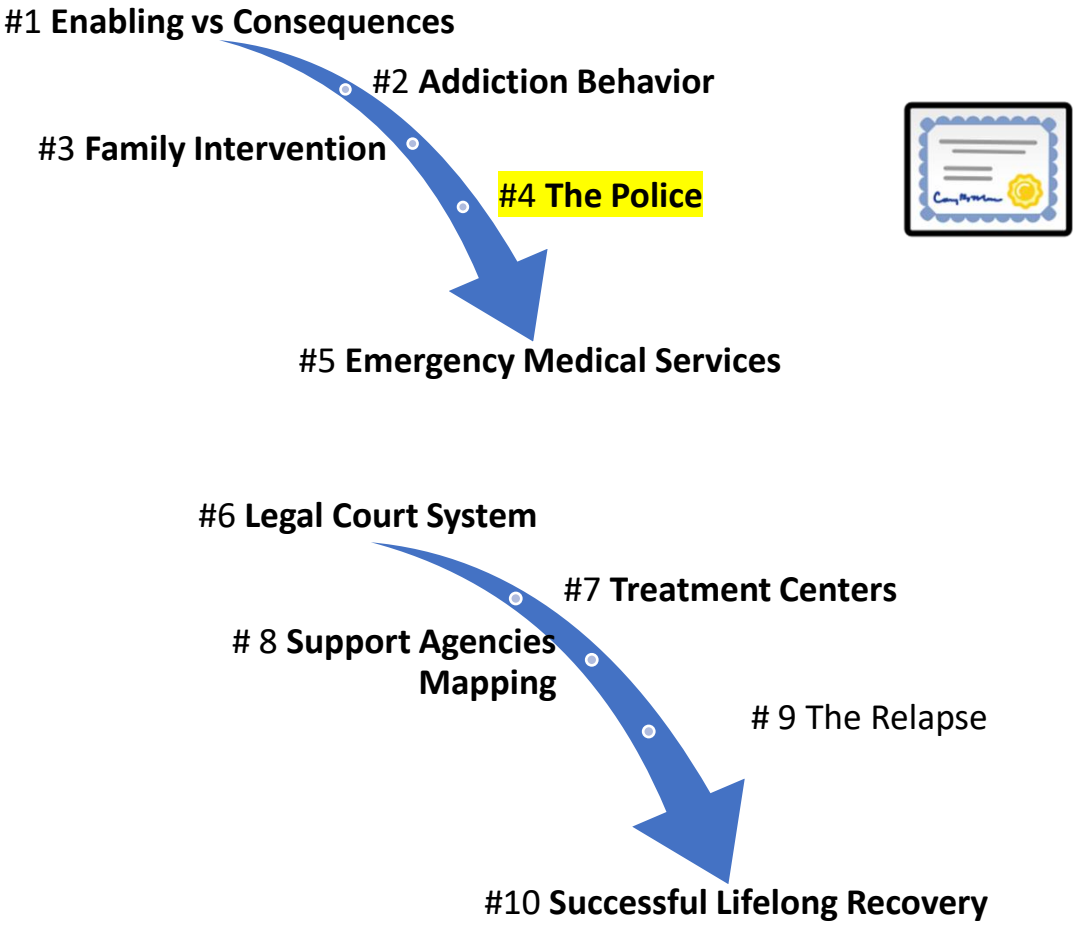
Issue # 4: The Police Intervention Seminar

Seminar Four: Study Guide

Seminar Objectives:

1. Identify the six phases of Police intervention.
2. Learn the Do's and do nots of a missing person's report.
3. How to compete a missing person's report

These are 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)**

The Police Intervention, The Six Phases

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 persons process. In a different seminar (The Legal System Intervention) the legal system and its process will be reviewed.

One: 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.

Two: Police Actions During an Arrest and Booking

If you're stopped by the police, they may frisk you by performing a "pat-down" of your outer clothing to see whether you're concealing a weapon. Later, if you're arrested, they can perform a full-blown search of your person and immediate surroundings to ensure that you don't 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'll 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're 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're being lawfully held.

Three: *The Post-Booking Process:*

Once you're 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'll be asked whether you plead guilty or not guilty. You can also plead "nolo contendere" or "no contest," which aren't technically pleas, but indicate that you don't 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'll 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.

Four: *Getting Legal Help with Questions About the Arrest Process*

No one looks forward to an arrest, but if does happen, it's good to understand the process. It's also important to understand that you have rights throughout the arrest process. If you've 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:

Five: *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.

Six: 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.

1) **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.

2) **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.

3) **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".

Issue # 4: The Police Intervention Seminar

Seminar Four: Workbook

The Police Intervention

Issues the Family Faces

The countdown to finding a missing person begins the moment someone concerned for his or her well-being alerts law enforcement. Investigators are essentially working against the clock, as with each passing hour decreases the likelihood that the subject will be found.

Protect the integrity of the evidence: One of law enforcement's first steps in investigating a missing person case is trying to prevent the loss of evidence, Dr. Michelle Jeanis, criminology professor at the University of Louisiana at Lafayette, told ABC News. And it isn't just the person's family who investigators are looking to speak to. Law enforcement will often seek information from the public, including people who may have happened to be going on with their daily lives but witnessed a crucial moment in the subject's disappearance, said former FBI Special Agent in Charge and ABC News contributor Steve Gomez.

The victim could be in grave danger. Those first few days are especially crucial if an individual is being transported or is in danger. Investigations on missing persons who authorities believe may be vulnerable -- such as children and those with a mental illness -- are expedited because time is of the essence to get the word out to the public to look for them. Although stranger kidnappings are "very, very rare," children are usually murdered quickly, sometimes within the first three hours but usually within the first two days.

The fact is people usually see something, so that period of time is absolutely vital in order to find the person right away,

In addition, it's important to generate as much awareness and as many leads as possible, Gomez said, adding that they tend to slow down after the 72-hour mark. "That's why it's just so important to try and move the investigation along and to get the public's help," he said.

The first 48 hours are also critical because that's when investigators have the best chance of following up on leads, before people's memories start to fade, Dr. Bryanna Fox, former FBI agent and criminology professor at the University of South Florida told ABC News. "The information that law enforcement gets tends to be a little more accurate, and they are able to act on the information and hopefully get that person who is missing quicker."

As soon as police get a call reporting that someone is missing, they'll begin to evaluate whether the case even involves a missing person at all. Law enforcement then chooses how they will allocate resources to missing persons cases on a "case-by-case basis." For adults who are reported missing, one of the things investigators look to first is whether the subject was displaying a-typical behavior.

Amber Alter: In "serious cases" of missing children, in which law enforcement has a reason to believe the child has been abducted or is in imminent danger, an Amber Alert may be issued. The Amber Alerts were designed "especially for those kids who are perceived to be in immediate danger," but there are specific criteria for the level of danger the case must meet to warrant the alert. For example, a runaway child would not qualify for an Amber Alert. The reason for the selectivity, in part, is to not desensitize the public. Law enforcement wants the public to be "alert and aware" when a message is sent out, and too many could cause people to ignore it.

Media coverage makes a difference in closing the case

Getting the word out to the public that someone is missing is "integral" to closing the case, "Every family wants that media attention" to help find their loved one. However, not all missing persons cases get the same media attention. Research suggests that there's a disparity in media attention, especially at the national level.

Women received nearly 12 times more media coverage, on average, than male victims, while white victims received nearly three times as much total media attention than minority victims, as well as higher word counts within articles. White, young, female victims -- often college co-eds or mothers -- "definitely get the most amount of attention. The phenomenon is known as "missing white woman syndrome."

In addition, the age of the victim correlated inversely with the word count within a story, with each additional year of age corresponding to a 4.4 percent decrease in the word count.

Social media now plays a vital role in missing persons cases

Social media has become a "huge asset to safely recovering people," purely due to the ease of spreading the message.

While people pay attention when seeing stories of missing persons on broadcast news, it "brings it a little closer to home" when they see someone they know or trust talking about it on Facebook or Twitter.

The social media awareness "energizes the public to help the family and law enforcement," which generates leads. Our law enforcement makes sure posting information on missing persons on their social media accounts increases the odds that they'll be able to find them sooner. Before social media, law enforcement would release BOLOs -- or "be on the lookout" notices -- that would be posted to various neighborhoods, It is now the standard practice for those BOLOs to be posted to the law enforcement agency's social media accounts. The sooner an announcement is made, the more likely the person will be safely recovered, Fox said.

Do's and do nots of a missing person's report

It's not necessary to wait 24 to 48 hours before filing a report, according to **www.Findlaw.com**. When filing the report, give law enforcement a detailed description of the subject's physical appearance such as his or her height, weight and age, as well as any identifying markers such as a tattoo or birth mark. Be sure to include clear photos of the missing person.

Obstacle the Family Addresses

A Viable Option: Delivering your son or daughter into police custody is a severe but rational measure for distraught parents who've exhausted other options, addiction clinicians say. "I know parents [of people who went into treatment] who say if they hadn't turned their kids in to the police, their kids would be dead now," says Deni Carise, chief clinical officer at Recovery Centers of America, which has addiction treatment centers in four northeast states. "For a lot of parents, going to the police is a matter of getting their child off the street so he doesn't die."

For some parents of addicts, turning their child in to authorities is a matter of protecting themselves or others, says Tina Muller, program manager for the family wellness department at Mountainside Treatment Center in Canaan, Connecticut. "If an opiate addict is being abusive and creating safety issues, threatening or engaging in violence and bringing drugs into a home where younger siblings may find them, you need to call the police," Muller says. While opioid addiction gets the most attention because it's currently claiming the most lives, some parents of people addicted to cocaine and other drugs also turn their sons or daughters into police.

Though it's an agonizing step for parents, turning one's own child in to law enforcement to save his or her life makes sense in the context of the deadly opioid epidemic, clinicians say. In 2015, drug overdoses driven by the opioid scourge – including heroin, which is illegal, as well as prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine and fentanyl – were the leading cause of accidental death in the U.S., according to the American Society of Addiction Medicine.

Be sure you've exhausted every option. You may think you've tried everything, but before you call the police, make certain you've explored every potential resource to try to get your son or daughter help, Muller says. "I would definitely recommend that parents and families seek advice from local treatment centers," she says, as treatment clinicians may be aware of resources parents don't know about. If your child is a juvenile, check with local and state social services officials and authorities at the school your child attends and ask if there are resources such as counseling or therapy for addicts, she says. Some school districts have alternative schools that can help students with addiction issues. If they haven't already tried one, parents can try to stage an intervention, in which relatives and friends confront a person to describe how his or her drug use is affecting them and urge them to seek help.

Explain to law enforcement officers why you are turning in your child. Once you've decided you have no other recourse, call the police to explain why you're about to turn your child in, says Howard Samuels, owner and chief executive officer of The Hills Treatment Center, an alcohol and drug rehabilitation facility in Los Angeles. "You want the police to know that you want the person arrested because he or she is out of control because of drugs," Samuels says. "That's the way to handle it. You don't want to call 911 and have the cops come in with guns drawn."

Don't assume your son or daughter will be in jail for long. The amount of time someone spends in jail varies depending on the charge, the person's prior criminal record, if any, and local statutes. Someone who's arrested for a first offense on a charge that doesn't involve violence, or a weapon may be incarcerated for a brief time, overnight or maybe even a matter of hours, Samuels says. Let your child's lawyer know what's going on and ask him or her what treatment resources the local criminal justice system provides, he says.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Smart Justice - What Happens When You Get Arrested

Buncombe County Government
Have you ever had a family member or friend arrested? It can be a very scary and confusing experience for everyone involved. In this video, we are going to take a tour of the arrest and pre-trial phase of the criminal justice system here in Buncombe County. If you ever find yourself in this situation, you will have the needed information for the best possible outcome.

Link: https://www.youtube.com/watch?v=Rwwx-YY5f0U **Duration: 7:22 hrs.**

Solutions to Issues & Obstacles

This approach is often more effective, than information that is meant to scare the patient into support service. Putting an addict in jail may temporarily prevent him or her from becoming a grim statistic, but it won't guarantee immediate treatment. Throughout the U.S., there are more than 3,000 drug courts, which refer people to treatment instead of jail, according to the National Association of Drug Court Professionals. Drug courts put about 150,000 people annually into treatment. Meanwhile, there are about 650,000 people incarcerated in local jails at any given time, according to the Prison Policy Initiative, a nonprofit that produces research on the criminal justice system and advocates against mass incarceration. "We realize we're just scratching the surface of meeting the need," says Chris Deutsch, a spokesman for the NADCP.

Seek support for yourself and other family members. Just as addicts in recovery need a support system, so do their loved ones. "This is an epidemic" that affects not only addicts, but those close to them, he says. Parents and other relatives need to know they are not alone, and they need to learn strategies for supporting the addict without enabling him or her, he says. Resources include clinical licensed therapists and support groups, such as Nar-Anon Family Groups, which is similar to the Alcoholics Anonymous model in that it uses 12 steps to help people deal with their feelings about their loved one's addiction. "Counselors can help and being part of a group in which you hear from other people who are going through similar experiences is invaluable". "There's a feeling of fellowship.

Practical Exercise # One:

MISSING PERSON REPORT

Adult ___ Child ___

Date and Time of Report:

_____
_____

Date and Time of Last Contact:

_____
_____

Reported by: Name

_____
_____

Voluntary Missing Adult

_____
_____

Parental/Family Abduction

_____
_____

Drug Addiction Related Circumstances: Drugs Currently Taking, past rehabilitation center treatments: Name and phone.

_____
_____

Current or Past Drug Counselors:

_____
_____

Suspicious Circumstances:

_____
_____

Possible Stranger Abduction?

_____
_____

Prior Missing: Date, location

_____

_____

Sexual Exploitation:

_____

_____

At Risk, Medical or Mental Health Concerns

_____

_____

Missing Persons Name (Last, First, Middle):

_____

_____

Sex:

_____

_____

Race:

_____

_____

Corrective Lenses: Facial Hair: Eye Color:

_____

_____

Alias/Moniker/Nickname: DOB/Age: Height: Weight:

_____

_____

Scars/Marks/Tattoos:

_____

_____

Residence Phone Number:

_____

_____

Cell Phone Number:

_____

_____

Business Phone Number:

_____
_____

Employer: Name, Address Phone

_____
_____

Residence Address, City, State, Zip Code:

_____
_____

Social Security Number: Driver's License/ID Number: State:

_____
_____

Business Address, City, State, Zip Code:

_____
_____

Probation/Parole/Social Worker Name & Phone:

_____
_____

Social Networking Site(s) and Screen Name(s):

_____
_____

Email Address:

_____
_____

Clothing:

_____
_____

Piece of DNA: toothbrush, hair etc.

_____
_____

Last Known Location/Activity (Description or Address, City, State, Zip Code): Possible Destination (Description or Address, City, State, Zip Code):

_____
_____

Alcohol, Drug, Mental Health, or Medical Condition(s):

_____
_____

Jewelry:

_____
_____

Known Associates and Lifestyle:

_____
_____

Visible Dental Work:

_____
_____

Dentist Name, Address, Phone Number:

_____
_____

Medical Provider Name, Address, Phone Number:

_____
_____

Photo Available:

_____
_____

Fingerprints: Ever had taken?

_____
_____

Describe Tattoos:

_____
_____

Any Suspect Names of who might know him best: Name, Cell Phone.

_____
_____

Car Registered Owner Vin Number:

_____
_____

Type, Model, Make, Color, Condition markings

_____
_____

License Number: State/Province/Country: Reg. Year: Damage to Vehicle:

_____
_____

Primary Bank:

_____
_____

Friends Names:

_____
_____

Friends Cell Phone:

_____
_____

Common Area for Hanging Out:

_____
_____

Names of people they hang out with:

_____
_____

_____
_____

Dealer locations:

_____
_____

_____
_____

Past or Current Girlfriend/boyfriend: Name, Cell Phone

_____
_____

Other Comments to Disclose:

_____
_____
_____
_____
_____

THE STORY

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: How to file a missing person report: What to do when a person is missing

Search Link: https://www.youtube.com/watch?v=yoepCbMfAzQ
Published on Sep 28, 2018

Justice for the Missing

If you need to know what to do when someone goes missing, watch this video. I answer the question, "do i have to wait 24 hours to file a missing person report?" I talk about when to file a missing person report and how to file a police report to find your missing loved one. If you are looking for a missing person report example, contact your local authorities. We also talk about what to do if someone goes missing. Whether you are looking to find a missing person for free, how to track down a missing person, or missing person cases in general you will want to subscribe to this channel. We talk about missing person cases that are solved, police missing person procedures, solved missing person cases, and unsolved missing person cases Contact us at justicefordaniellebell@gmail.com Facebook: https://www.facebook.com/missingdanie... Twitter: @JusticefortheM2 Instagram: Justice for the missing Ensure your case is listed on these sites. https://api.missingkids.org/missingki... http://charleyproject.org/ Search and Rescue Nonprofit http://klaaskids.org/pg-leg/

Duration: 7:41

MASTER FAMILY PLAN OF ACTION FOR: "The Police Intervention"

Complete answers and move to "Master Family Plan of Action".

1. The family will follow the identified the six phases of Police intervention to determine what's next.
2. The family will apply the learned the Do's and do not's of a missing person's report.
3. The family will compete a missing person's report, now before it is needed.

Issue # Five: Emergency Medical Services Seminar

Seminar Five: Study Guide

Seminar Objectives:

1. Understand the paramedic first response phrase.
2. Learn what happens in a hospital emergency room visit.
3. Understanding the value of SBIRT.

These are the 12 Key Issues a Family Faces

#1 **Enabling vs Consequences**

#2 **Addiction Behavior**

#3 **Family Intervention**

#4 **The Police**

#5 **Emergency Medical Services**

#6 **Legal Court System**

#7 **Treatment Centers**

8 **Support Agencies Mapping**

9 The Relapse

#10 **Successful Lifelong Recovery**

#11 **Bereavement (Learning how to move forward)**
#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

Introduction: The Emergency Medical Services Intervention

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 very slow or stopped.
- The heartbeat is very slow or stopped.

CALL 911

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 after 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.

Get Educated, Include the Family Members

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 patients are likely to get a surprise hospital bill from the radiology, medical transport and other specialty groups such as cardiology departments**.**

They don't necessarily have your back in follow-up.
A new study found that fewer than 10% of ED patients treated for opioid overdoses received medications to treat their substance use disorder. In the years after their overdose, only 10% of those overdose patients received mental health counseling. Experts say a lack of training among health professionals undermines what happens after the overdose patient 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's taken for granted that the patient would leave with heart medication and a referral to a cardiac specialist. Similarly, you would think patients 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 patient 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.
- Discharge to Police, Treatment Center, Peer to Peer Coach or Home.

Hospital ICU Admission or Discharge

Stablize, Improve Condition, Discharge

- Intesive Care Unit (ICU)
- Plan of Treatment
- Discharge

The Paramedic, First Responder

Para-Medic, First Responder ONLY (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 patient'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 patient'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 patient's movement isn't purposeful and he isn't able to speak. The patient 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 patient now has a Glasgow coma score of 8.

One of the first responders suggests an additional dose of naloxone because the patient is still obtunded. Though the patient continues to exhibit decreased mentation, he's breathing adequately, so there's no indication to give additional naloxone. The crew captures an ECG which is unremarkable and prepares the patient for transport to the hospital.

While enroute to the receiving facility, the patient becomes increasingly combative and the crew is forced to sedate him with midazolam (Versed). After two 2.5 mg of IV midazolam, the patient is appropriately sedated. The patient doesn't experience any respiratory depression and the rest of the transport is uneventful.

Upon arrival at the ED, the patient is transferred to staff, and the crew starts to get their gear back together for the next call. The patient'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 patient is admitted to the ICU.

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 patients 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 isn't necessarily as important as recognizing the severity of patients' 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 patients' airway, they're likely going to survive.

This means ventilation is important, when ER or First Responders overdose the short-acting sedatives to calm the patient with a drug like midazolam or propofol, patients may experience longer ICU course because someone gave them multiple doses of lorazepam. They're 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 patient's airway reflexes, respiratory drive and level of consciousness.

The major drawback of naloxone is that it can trigger withdrawal symptoms in patients addicted to narcotics, including agitation, tachycardia, vomiting and pulmonary edema. Withdrawal symptoms are usually mild and short lasting, but some patients 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

> Initial care for patients with a suspected narcotic overdose is the same as for any other patient 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].
>
> The pulse is first checked of an unconscious patient. 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].

For unconscious patients with a pulse, they will open the airway, assess respiratory rate and assist ventilation with a bag-valve mask.

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.

2. 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.

Patients 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 patient agitation and withdrawal symptoms.

Because ventilation and oxygenation is 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 patients 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:

1. 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 patients treated in ICUs averaged 7% in 2009 and increased to 10% in 2015.

Patients 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 patients 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 patients could be safely discharged from the emergency department after a 1-hour observation period following naloxone administration for opiate overdose. The rule suggested that patients 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 patients 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 patients 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 patient 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 patient 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 patient like a toxicological problem and not a human."

He says it's 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 patients 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 patients 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 patients 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 patients, according to their clinical status and hospital resources. In unstable patients, lifesaving support is mandatory, independently of laboratory results, whereas in uncomplicated, stable, slightly drowsy patients, with no specific symptoms of drug poisoning, the diagnosis may be uncertain, and there is no definite consensus on treatment and disposal. These patients are a special challenge for the emergency physicians.

A pure clinical approach, without confirmatory laboratory results, makes diagnosis and decision making highly uncertain. Some patients 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

patients for suspected poisoning.

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

In most cases the results do not change, the decision being mainly based on clinical parameters.

Drug screening, limited to life threatening drugs selected on the basis of 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 patients with suspected drug poisoning. In particular, 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 patients' disposal, potentially saving hospital resources.

REF: Comprehensive drug screening in decision making of patients 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 patient 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 Substance Use Disorder Journey, It's Time to Get 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 a number of 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. Purchase on-line: **www.amazon.com** search Roy Poillon

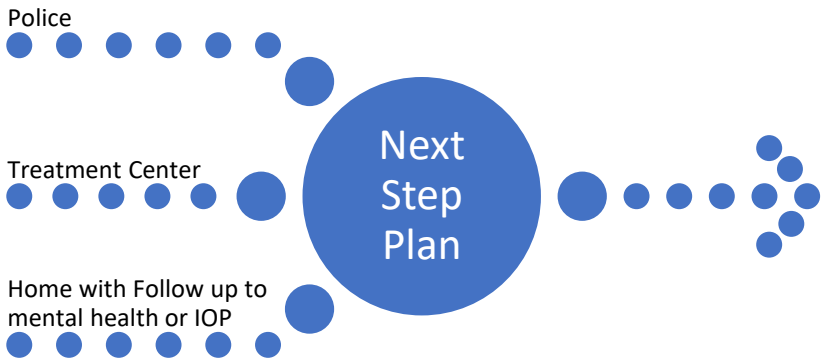
The SUD, It's Time to Get Organized is a binder system that contain important documents and information about the persons life that are requested by professional service in order for them to provide their services. In the Binder System there are four parts:

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.

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 patients 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 patients' 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 isn't covered by West Virginia Medicaid and wasn't 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's an opportunity that's 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's taken for granted that the patient would leave with heart medication and a referral to a cardiac specialist. Similarly, he wants patients 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 patient 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 didn't 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 Outpatient 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's 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 don't voluntarily offer the best care we have to anyone who wants it in the aftermath of an overdose, on the spot.

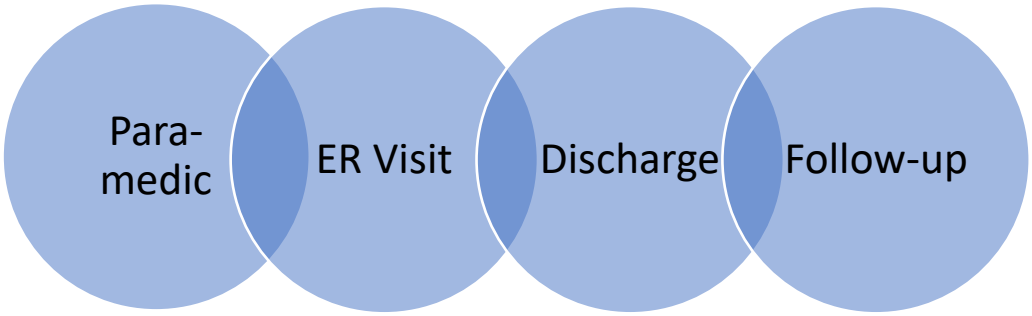
A strategy of offering immediate medication treatment has been studied in a randomized clinical trial published in the *Journal of the American Medical Association* in 2015. 329 patients were included. Of this group, 104 were simply provided a referral to further treatment, 111 were given referrals along 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 patients 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 patient withdrawing or after an overdose is critical to save more lives and engage more people in treatment, but only if the 100 patient 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 patient leaves the ER, says they are fine and months go by. Then it happens again. Over and over again.

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 very likely you will need them.

Issue # 5: Emergency Medical Services Seminar

Seminar Five: Workbook

Going Forward

We are going to begin with this video. Stop reading and view the recommending link. Afterward, you will now understand more about what is likely to happen. So, do you want to know how you can learn and be ready to respond so that when this is done you can act in a way that takes the most advantage of a bad situation. The emergency medical services intervention is the first place where everything stops, and the focus demands their attention. It typically does not last long, and when over is the point that a family has the opportunity to make a difference.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Opioid rescue in action (simulation)

UMass Medical School

This dramatization depicts a simulated emergency room encounter for the management of an opioid overdose. The individuals in this simulation are real medical professionals acting in the roles they serve in a real-world emergency room setting.

Published on May 4, 2018

Link:
https://www.youtube.com/watch?v=kuIOltSBOMU&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=37&t=0s

The Emergency Medical Services is an Intervention

Issues the Family Faces

INTRODUCTION TO SBIRT

Because emergency medical services are an intervention and assessment is a matter of set procedures, this will happen in a sequence according to those that respond to your call for help. However, it is equally important to the family members that what is done next includes their participation. This is often not the case because family members are not aware to the choices involved or the decisions that need to be made by them.

The family being included as an advocatory activist is important. Your family members need to become Advocatory Activist in order to address your family needs in a manner that will make a difference especially as it concerns the next steps in the process. We are sorry to tell you this, but you will need to stick up for yourself and make this industry do for you, that which needs to be done.

Therefore, you will need to know more about "best practices" that are being provided This may seem like an un-necessary step and is going to extremes; but consider the alterative, you knowing little about what is happening, you being told nothing and therefore you can do nothing. If you want nothing to do with this, then stay where you are and put this book away. If you want to be empowered to act then learn what is possible, what has been proven to work, and be an advocatory activist by learning and speaking up for yourself and your loved one. This level of knowledge is empowering.

GO TO THIS LINK FOR SBIRT stands for Screening Brief Intervention and Referral Treatment. You will learn "nothing gets done in this industry until an assessment is completed" Therefore, getting the assessment screening completed to move forward to the referral for treatment phase is the first phase.
https://www.integration.samhsa.gov/clinical-practice/sbirt

HERE IS WHERE THE FAMILY MEMBERS CAN LEARN MORE: **Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services**, Fact Sheet, created by CMS, provides education on substance abuse structured assessment and brief intervention (SBIRT). It includes an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. **Why SBIRT?** is a primer developed by the Colorado SBIRT initiative to acquaint readers with SBIRT.

The BIG (Brief Intervention Group) Initiative SBIRT Education is a national organization of individuals and organizations founded by Drs. Eric Goplerud and Tracy McPherson that promotes routine screening for hazardous alcohol use and brief solution-focused counseling in the workplace. Access a comprehensive training on SBIRT or view the webinar series on SBIRT implementation in various settings and populations. This will give a perspective of how professionals view this process.

Care for hospitalized patients with unhealthy alcohol use: A Narrative Review
The review summarizes the major issues involved in caring for patients with unhealthy alcohol use in the general hospital setting, including prevalence, detection, assessment of severity, reduction in drinking with brief intervention, common acute management scenarios for heavy drinkers, and discharge planning.

TAP 33: Systems-Level Implementation of SBIRT
This SAMHSA Technical Assistance Publication (TAP) is a compilation of research and experience from over a decade of federally-funded work on SBIRT. It includes specific implementation models, details about reimbursement and sustainability and case studies from across the nation.

Frequently Asked Questions by Healthcare Providers developed by the Colorado Clinical Guidelines Collaborative provides answers to questions commonly asked by providers when beginning to implement SBIRT. Since 2003, SAMHSA has funded 17 Medical Residency Cooperative Agreements, 15 State Cooperative Agreements, and 12 Targeted Capacity Expansion Campus Screening and Brief Intervention (SBI) Grants. Learn more about **SAMHSA's SBIRT grantees**. A presentation for HRSA grantees discusses **SBIRT implementation in Ryan White settings**.

The American Public Health Association manual, **Alcohol Screening and Brief Intervention: A guide for public health practitioners**, provides public health professionals such as health educators and community health workers with the information, skills, and tools needed to conduct screening and brief intervention to help at-risk drinkers limit or stop drinking. SAMHSA's **TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders** provides substance abuse providers with updated information on co-occurring substance use and mental disorders and advances in treatment for these individuals. TIP 42 discusses terminology, assessment, and treatment strategies and models.

The **"Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse"** booklet announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women.

EMERGENCY ROOMS **Reducing Patient At Risk Drinking** developed by the Emergency Nurses Association guides nurses and other healthcare professionals through implementation of SBIRT in emergency room settings. The Institute for Research and Education in the Addictions developed **SBIRT Screening, Brief Intervention and Referral to Treatment** , which provides an array of useful information for emergency departments.

TRAUMA CENTERS Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide The CDC's **Screening and Brief Interventions for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers** helps Level I and II trauma centers plan and implement the American College of Surgeon's Committee on Trauma's alcohol-screening and brief intervention requirements.

Obstacle the Family Addresses

- **The four common barriers to substance abuse treatment were:**

- **Patient Eligibility.** Healthcare providers often find it difficult to determine whether or not patients meet the criteria for admission to certain treatment centers.

- **Knowledge of Treatment Options.** Providers that make referrals may not understand the different types of addiction treatment options available and how to make recommendations to patients for choosing the right type of addiction treatment.

- **Treatment Capacity.** When patients are eligible for services, providers may not be able to get timely information on space availability at certain treatment centers.

- **Communication.** There may exist some difficulty in communication between the providers that refer to addiction treatment services, patients, and the facilities that can deliver the care.

Referral to treatment is a critical yet often overlooked component of the SBIRT process. It involves establishing a clear method of follow-up with patients that have been that have been identified as having a possible dependency on a substance or in need of specialized treatment.

The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting. The manner in which a referral to further treatment is provided can have tremendous impact on whether the client will actually receive services with the preferred provider.

RESOURCES

Bridging the Gap Between Primary Care and Behavioral Health - Referral Forms
Community Care of North Carolina, in partnership with other stakeholders, has developed a set of three referral forms (below) for primary care and behavioral health providers to facilitate easier consultation and communication.

Form #1 – Behavioral Health Request for Information – this form is for behavioral health providers who begin working with a new consumer or identify a potential medical need and wish to make contact with the PCP.
Form #2 – Referral to Behavioral Health Services Section I – this form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or service.
Form #3 – Behavioral Health Feedback to Primary Care Section II – this form is to be used in conjunction with the 2nd form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

Sample Warm Hands-Off Scripts and Procedures was created by California's Integrated Behavioral Health Project and provides several examples of scripts that can be used to make a "warm handoff" referral.
SAMHSA Treatment Locator is a searchable directory of drug and alcohol treatment programs by location.
SAMHSA Mental Health Treatment Locator provides professionals, consumers and their families, and the public with comprehensive information about mental health services and resources across the country.

Sample Business Association Contract from the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) that provides details of the privacy related information that could be included in a contractual agreement between a health clinic and a behavioral health organization.

Sample MOU from the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) is an example of what types of information may need to be included in a Memorandum of Understanding between to a community health organization and a behavioral health organization to deliver SBIRT services.

Enhancing the Continuum of Care: Integrating Behavioral Health and Primary Care through Affiliations with FQHCs this document walks providers through the process of setting up a formal partnership between an FQHC and a Community behavioral health organization.

For more information on Contracts and MOU please refer to the Center for Integrated Health Solutions page.
REF: https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: RaffertyWeiss Media | SBIRT - "Substance Abuse Screening"

Published on May 4, 2018

Link: https://www.youtube.com/watch?v=aaUm4qgk7kg

Duration: 5:17 min.

So why view this video? The answer is just because your hospital does not provide the Behavioral Referral does not mean your family con does not take this as their next step. By being prepared for this intervention, the family can ask a local mental health network to complete the follow up steps you have determined are needed.

Pay close attention to the title of the screening assessment tools., These will be administered several times each year in order to stay ahead of any changes that occur with your loved one. The objective is to respond to their changes in a timely and level appropriate level.

What we are asking of the family is to take charge and participate in the plan of care, what is provided, frequency and appropriateness. You are now a consumer of healthcare service, because this is an emergency medical service intervention.

SUD, It's Time to Get Organized

Solutions to Issues & Obstacles

The primary solution it to move forward after the emergency medical services are finished and your loved one prepares to be discharged from the hospital. To take the time now, gather the critical documents which will be asked of you to provide as you seek the help from those in the different service fields that understand your journey. They will need certain pieces of information which you can prepare now to provide, by having them in a binder broken into specific categories.

In the Personal Attaché for Substance Use Disorders Binder the family will find a selection of categories to assist in getting organized. The purchase of the "It's Time to Get Organized in the Substance Use Disorder Journey workbook, is strongly recommended.

Practical Exercise # One:

1. Purchase the "**The Substance Use Disorder Journey, It's Time to get Organized" Critical Documents Binder**.

2. Take the time to create your own Family Substance Use Disorder Binder, with all the required critical documents.

3. Go to the "It's Time to Get Organized" workbook and complete the exercise for each chapter in the binder.

Buy On-Line: The Substance Abuse Disorder Journey, It's Time to Get Organized. By Roy P. Poillon www.amazon.com

Another activity is "Assessment & Screening" . This is implemented to ensure the right level of services are provided for our loved one. These two screening tools are those which are typically used in conjunction with other assessments. We are providing these two tools so your family members have an idea of what an assessment looks like. Ask your case worker, counselor to explain results and build your knowledge, ask what you and your family members can do to positively impact the results going forward.

Practical Exercise # Two: Standard Screening Tools

Drug Screening Questionnaire (DAST)

Patient name:
Date of birth:
Which recreational drugs have you used in the past year? (Check all that apply)
☐ methamphetamines (speed, crystal)
☐ cocaine
☐ cannabis (marijuana, pot)
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ inhalants (paint thinner, aerosol, glue)
☐ hallucinogens (LSD, mushrooms)
☐ tranquilizers (valium) ☐ other

How often have you used these drugs? Monthly or less Weekly Daily or almost daily:

1. Have you used drugs other than those required for medical reasons? No Yes

2. Do you abuse (use) more than one drug at a time? No Yes

3. Are you unable to stop using drugs when you want to? No Yes

4. Have you ever had blackouts or flashbacks as a result of drug use? No Yes

5. Do you ever feel bad or guilty about your drug use? No Yes

6. Does your spouse (or parents) ever complain about your involvement with

drugs? No Yes

7. Have you neglected your family because of your use of drugs? No Yes

8. Have you engaged in illegal activities in order to obtain drugs? No Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you

stopped taking drugs? No Yes

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? No Yes

Do you inject drugs? No Yes

Have you ever been in treatment for a drug problem? No Yes

SCORING KEY:

PHASES:	I	II	III	IV
0	1-2	3-5	6	

Alcohol screening questionnaire (AUDIT)

Patient name: _____

_

STANDARD: One drink equal: 12 oz. Beer 5 oz. wine 1.5 oz. Liquor (one shot)

1. How often do you have a drink containing alcohol?
Ans: Never Monthly or less 2 – 4 times a month, 2 – 3 times a week, 4 or more times a week.

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
Ans: 0 - 2 3 or 4, 5 or 6, 7 – 9, 10 or more

3. How often do you have five or more drinks on one occasion?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost daily

4. How often during the last year have you found
that you were not able to stop drinking once you
had started?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost Daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
Ans: Never Less than monthly, Weekly, Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

9. Have you or someone else been injured because of your drinking?
Ans: No__ Yes, but not in the last year, Yes, in the last year

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
Ans: No__ Yes, but not in the last year, Yes, in the last year

11. Have you ever been in treatment for an alcohol problem
Ans: Never, Currently, In the past

Scoring and interpreting the audit

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score Zone Explanation

I - Low Risk 0-3
"Someone using alcohol at this level is at low risk for health or social complications."
Counselor Action: Positive Health Message – describe low risk drinking guidelines 4-9

II – Risky: 4-9
"Someone using alcohol at this level may develop health problems or existing problems may worsen."
Counselor Action: Brief intervention to reduce use 10-13

III – Harmful: 10-13
"Someone using alcohol at this level has experienced negative effects from alcohol use."
Counselor Action: Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available) 14+

IV – Severe: 14
"Someone using alcohol at this level could benefit from more assessment and assistance."
Counselor Action: Brief Intervention to accept referral to specialty treatment for a full assessment.

Positive Health Message, an opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior.

Brief interventions are typically 5-15 minutes and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended

behavior change is to cut back to low risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up.

The recommended behavior change is to cut back to low risk
drinking levels or abstain from use.

Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

* Johnson J, Lee A, Vinson D, Seale P. “Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol
Dependence in Primary Care: A Validation Study.” Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

MASTER FAMILY PLAN OF ACTION FOR: “EMERGENCY MEDICAL SERVICES”

Complete answers and move to “Master Family Plan of Action”.

1. Use the understand the paramedic first response phrase to identify what will happen next.
2. Prepare for a hospital emergency room visit.
3. Have an expectation of what care can look like through a community concept of SBIRT.

Issue # 6: The Legal Court System Seminar

Seminar Six: Study Guide

Seminar Objectives:

1. Have a working knowledge of the Sequential Intercept Model (SIM)
2. Finding an attorney
3. What is Drug Court

These are 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)**

Introduction: The Emergency Medical Services Intervention

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.

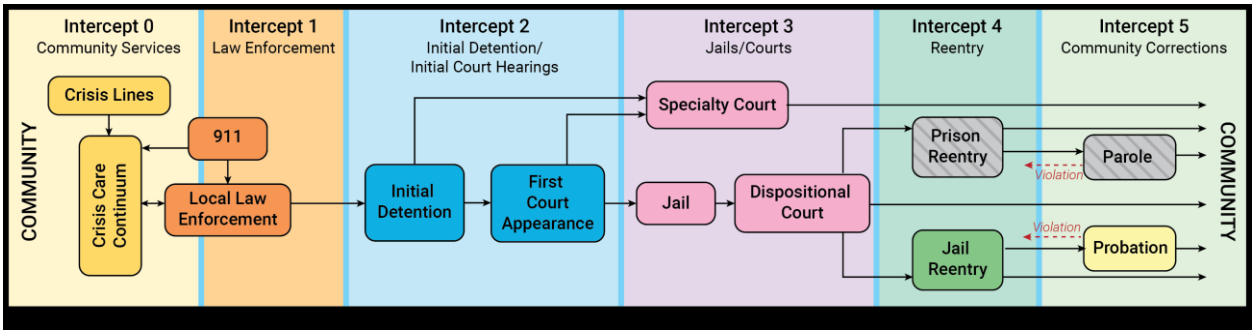
Intervention 1: Law enforcement;

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 the vast majority of individuals who come into contact with 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 purpose of this document is to turn the family's attention to the possibilities that Intercept 2, especially when the first appearance is at a municipal court, presents for diversion.

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

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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.

NOTES: For this reason, <u>your family is needed in the ER, to advocate for the right level of assessment</u>, 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 of 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

Don’t 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 this, there is interest among municipal court judges in gaining skills
to recognize 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.

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 actually 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 patients, 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 to 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:

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Municipal Courts:
An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System
SAMHSA Publication

Issue # 6: The Legal Court System Seminar

Seminar Six: Workbook

Incarceration Diversion

INSTRUCTIONS: View this video prior to continuing in this workbook.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: What is Court Diversion?

Published on April, 2014

Link: https://www.youtube.com/watch?v=A4dNLFEG58s

By: Patrick Warn

Issues the Family Faces

INTRODUCTION DRUG COURT

In many of these courts there are far fewer procedural limitations, the drug court judge controls the agenda; has informal conversations with the parties, the treatment providers and correctional officials; and ultimately does almost “whatever is needed” to ensure that everyone promotes the shared goal. This sort of informal, flexible system can work toward the long-term benefit of defendants by increasing the chances that they will be able to overcome drug addiction. However, this system of increased power and authority for judges presents, at least, some increased risks for the defendant as well, since drug court judges retain the power, albeit after discussing issues among all team members, to impose a variety of punitive sanctions, which often include removing defendants from the program entirely and requiring them to serve lengthy criminal sentences. Thus, while everyone enters the drug court system with the same stated interest, the interests of the defendant may eventually diverge from those of the judge and the treatment team, especially when the judge resorts to the variety of punitive sanctions available in a drug court program.

Before any decision on participation is made, the defense lawyer will raise and address with the client the confidentiality consequences of entering drug court. Drug courts often require defendants to execute confidentiality waivers that allow relevant portions of their medical treatment information to be distributed not just to the court but to prosecutors, as well.

Clients should be made aware of the potential dangers of disclosing such information and informed that it is to help them on the road to recovery. They also should be informed that they have complete power over whether or not to do so and that other than under limited circumstances, disclosure of such information would not be permitted if they were to secure treatment without court supervision. In addition, every defendant needs to know that participation in the drug court system may compel a formal admission of guilt and may result in the waiver of legal defenses should treatment fail and the defendant is eventually brought to trial. Unfortunately, providing competent advice on all of these subjects may be further complicated by the desire of the drug court to place a defendant in treatment as soon as possible after the defendant’s arrest.

Although this speedy treatment may provide therapeutic benefits, it may hinder the ability of a defense attorney to conduct a factual and legal investigation into the merits of the case. Nevertheless, without such an investigation, it is impossible to make a reasoned assessment of what a likely criminal court disposition would be or to assess the costs of waiving various legal defenses. Lacking some reasonable projection of the possible penalties and the possible defenses at trial, a client cannot make a meaningful decision as to whether to participate in drug court.

Practical Exercise # One:

Laying the Family Knowledge Foundation

1. Identify the Drug Court Advisory Council

□ Chief Judge: _____

□ Elected Prosecutor: _____

□ Chief Public Defender: _____

□ Chief Court Administrator/Court Clerk: _____

□ Chief of Police: _____

□ Elected Sherriff: _____

□ Chief Probation Officer: _____

□ Director of Treatment Services: _____

□ County Commissioner(s): _____

□ City Council Member(s) : _____

2. Identify the Drug Court Planning Team Members

a. Judicial

□ Judge: _____

□ Magistrate: _____

b. Prosecution

□ District Attorney: _____

c. Defense

□ Public Defender: _____

□ Private Defense Attorney: _____

□ Local Bar Association: _____

d. Coordination

□ Court Administrator: _____

□ Clerk: _____

□ Other: _____

e. Community Supervision Point of Contacts, (Name & Phone #)

□ Pre-trial: _____

□ Probation: _____

□ Parole: _____

□ Community Corrections: _____

□ Police: _____

□ Sherriff: _____

□ Highway Patrol: _____

f. Treatment Point of Contact

□ Private Provider Treatment: _____

□ Private Provider: _____

□ County/State Provider: _____

□ Health Department: _____

□ Mental Health: _____

g. Evaluator

□ Local College/University Professor:

□ Research/Evaluation Company:

□ Other State Agencies- Children & Families, Education etc.

□ Vocational & Educational Communities:

□ Job Skills -Training & Placement Agencies

□ Welfare to Work Programs:

3. Designed Entry Process to Drug Court

a. Risk and Need Assessment

□ Determines who is most suited for Drug Court

□ Identify tool(s) to be used:

□ Identify who will administer risk and needs assessment

b. Identify who will conduct legal screening

□ Prosecutor:

□ Defense Attorney:

□ Coordinator:

□ Entire Team:

c. Determine Your Point of Entry

□ At Arrest:

□ Bail:

□ Pre-trial Review:

□ Initial Court Appearance:

□ Pre-sentence Hearings:

□ Probation Revocation Hearing:

d. Clinical Screening

□ Identify and select a tool:

□ Identify who will conduct the screening:

□ Drug Court case managers:

□ Pretrial Services:

□ Probation:

□ TASC:

□ Treatment Provider:

e. Purpose of Screening

□ Determine the presence and severity of substance abuse:

□ Weed out persons who do not have substance abuse problems:

□ Determine if the severity of substance abuse problem is appropriate to the level of available drug court services:

f. Clinical Assessment (notice clinical screening is different from Clinical Assessment)

□ Identify which selected a tool will be used for assessment, then research it on-line:

□ Do they address biological, psychological and sociological factors:

□ Identify the clinically trained and qualified counselor, psychologist, psychiatrist, social worker, or nurse to administer tool.

□ Determine if the severity of substance abuse problem is appropriate for the drug court program:

g. Purpose of Assessment

□ Examine scope and nature of substance abuse problem:

□ Identify full range of service needs, pursuant to treatment planning:

□ Match participants to appropriate services:

□ Determine where and when the legal and clinical screening will be

Administered:

□ Determine where and when the clinical assessment will be delivered:

7. What are the Establish Drug Court Phases to this System

a. Determine Length of Program

□ Legal Requirements:

□ Treatment Needs:

b. Determine Number and Length of Phases

□ Phase Advancement Requirements:

c. Define Specific Court-Imposed Rules

□ Rules and regulations of treatment:

□ 12 Step Meetings/Support Meetings:

□ Community Service:

□ Employment:

□ Program Fees/Court Costs:

□ Alumni/Continuing Care:

□ Court Appearances:

□ Drug Tests:

□ Curfew:

□ Ancillary Services:

□ Case Management:

□ Educational/Vocational Training/GED:

□ Drug-Free/Pro-Social Activities:

8. What are their Developed Treatment Protocols

a. Assess Treatment Resources and "Levels of Care" in the Community

□ Detoxification:

□ Intensive Outpatient:

□ Outpatient:

□ Day Treatment:

□ Inpatient Residential:

□ Halfway House:

□ Sober Living:

□ Medical Care:

□ Mental Health Care:

□ Medication Assisted Programs:

□ Case Management Services:

b. Ensure an Assessment of Other Ancillary Resources Available in the Community

□ Community Mapping Tool:

c. Choose the Treatment Program(s) to Serve the Drug Court:

□ Duration of Treatment:

□ Goals of Treatment:

□ Frequency of Treatment in each Phase:

□ Culturally Appropriate Services and Staff:

□ Individualized Treatment Plans:

□ Type of evidence-based treatment used by provider:

□ Cognitive Behavioral Therapy:

□ Motivational Enhancement Therapy:

□ Community Reinforcement Approach:

□ Medically Assisted Treatments:

□ Relapse Prevention:

□ Aftercare/Continuing Care:

□ Determine Administrative Responsibilities for Providers:

□ Types of reports to be generated:

□ Information to be shared with team:

9. Identify Community Resources

□ Complete Community Mapping:

10. Develop Community Supervision Protocol

a. Determine Which Agency Supervises Clients

□ Probation:

□ Parole:

□ Police:

□ Sheriff:

□ Pre-trial Services:

□ Marshalls:

□ Community Supervision Officers:

11. Case Managers

b. What are their Develop Practices

□ Determine the Frequency of Contact by Phase

□ On-going Assessment, how frequent

□ On-going Home Visits, how frequent

□ Office Visits, how frequent

11. Develop Drug Testing Protocol, how frequent

a. Determine Which Agency Administers Drug Tests, Point of Contact: _____

□ Probation, how frequent do they communicate

□ Parole, how frequent do they communicate

□ Police

□ Sheriff

□ Pre-trial Services

□ Marshalls

□ Community Supervision Officers

□ Case Managers

□ Treatment Providers

b. Determine Type(s) of Drug Test Methodology

□ Onsite/Laboratory, do they perform these tests, how frequent

- Urine
- Hair
- Silva
- Breath
- Blood
- Sweat

c. Determine Frequency of Testing in Each Phase for all the above

12. Develop Court Responses Protocol

□ What are the Court Responses Based on the NDCI Ten Science-Based Principles to Changing Behavior

13. Develop Communication Protocol

□ Is there an Authorization/Consent Form. i.e. HIPPA

14. Develop a Monitoring and Evaluation Protocol

□ Select an Evaluator (public or private)

□ What are the drug courts Identified Performance Measures

15. Identify and Develop Waivers

□ Develop Search Waiver

□ Develop Offender Contract

□ Develop Offender Consent Form

Obstacle the Family Addresses

To address the obstacles of this intervention it is critical to get an assessment of your loved one. The “Assessment & Screening” is implemented to ensure the right level of services are provided and has an important consideration as to the review of their case by the courts. These two screening tools are those which are typically used in conjunction with other assessments. We are providing these two tools, so your family members have an idea of what an assessment looks like. Ask your case worker, counselor or your attorney to explain results and build your knowledge, ask what you and your family members can do to positively impact the results going forward.

Practical Exercise # One: Standard Screening Tools

Drug Screening Questionnaire (DAST)

Patient name:
Date of birth:
Which recreational drugs have you used in the past year? (Check all that apply)
- methamphetamines (speed, crystal)
- cocaine
- cannabis (marijuana, pot)
- narcotics (heroin, oxycodone, methadone, etc.)
- inhalants (paint thinner, aerosol, glue)
- hallucinogens (LSD, mushrooms)
- tranquilizers (valium) other

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

1. Have you used drugs other than those required for medical reasons? No Yes

2. Do you abuse (use) more than one drug at a time? No Yes

3. Are you unable to stop using drugs when you want to? No Yes

4. Have you ever had blackouts or flashbacks as a result of drug use? No Yes

5. Do you ever feel bad or guilty about your drug use? No Yes

6. Does your spouse (or parents) ever complain about your involvement with drugs? No Yes

7. Have you neglected your family because of your use of drugs? No Yes

8. Have you engaged in illegal activities in order to obtain drugs? No Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? No Yes

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? No Yes

Do you inject drugs? No Yes
Have you ever been in treatment for a drug problem? No Yes

SCORING KEY:

I	II	III	IV
0	1-2	3-5	6

Alcohol screening questionnaire (AUDIT)

Patient name:
Date of birth: _
One drink equals: 12 oz. Beer 5 oz. wine 1.5 oz. Liquor (one shot)
2. How often do you have a drink containing alcohol?
Ans: Never Monthly or less 2 – 4 times a month, 2 – 3 times a week, 4 or more times a week.

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
Ans: 0 - 2 3 or 4, 5 or 6, 7 – 9, 10 or more

3. How often do you have five or more drinks on one occasion?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost daily

4. How often during the last year have you found
that you were not able to stop drinking once you
had started?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost Daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
Ans: Never Less than monthly, Weekly, Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

9. Have you or someone else been injured because of your drinking?
Ans: No__ Yes, but not in the last year, Yes, in the last year

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
Ans: No__ Yes, but not in the last year, Yes, in the last year

11. Have you ever been in treatment for an alcohol problem
Ans: Never, Currently, In the past

Scoring and interpreting the audit

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score Zone Explanation

I - Low Risk 0-3
"Someone using alcohol at this level is at low risk for health or social complications."
Counselor Action: Positive Health Message – describe low risk drinking guidelines 4-9

II – Risky: 4-9
"Someone using alcohol at this level may develop health problems or existing problems may worsen."
Counselor Action: Brief intervention to reduce use 10-13

III – Harmful: 10-13
"Someone using alcohol at this level has experienced negative effects from alcohol use."
Counselor Action: Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available) 14+

IV – Severe: 14
"Someone using alcohol at this level could benefit from more assessment and assistance."
Counselor Action: Brief Intervention to accept referral to specialty treatment for a full assessment.

Positive Health Message, an opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior.

Brief interventions are typically 5-15 minutes and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up.

The recommended behavior change is to cut back to low risk drinking levels or abstain from use.

Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment.

More resources: www.sbirtoregon.org

* Johnson J, Lee A, Vinson D, Seale P. “Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol
Dependence in Primary Care: A Validation Study.” Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

Solutions to Issues & Obstacles

- **Finding the Right Attorney:**

One of the best ways to assess a lawyer’s legal ability is by interviewing them. Most attorneys will provide an initial consultation (usually an hour or less) at no charge. Below are a few questions to consider:

- What experience does the lawyer have in your type of legal matter?
- How long have they been in practice?
- What is their track record of success?
- What percentage of their caseload is dedicated to handling your type of legal problem?
- Do they have any special skills or certifications?
- What are their fees and how are they structured?
- Do they carry malpractice insurance? If so, how much?
- Who else would be working on your case and what are their rates?
- Do they outsource any key legal tasks for functions?
- What additional costs may be involved in addition to lawyer fees (postage, filing fees, copy fees, etc.)?
- **How often will you be billed?**
- Can they provide references from other clients?
- Do they have a written fee agreement or representation agreement?
- How will they inform you of developments in your case?

Standard Hourly Rates

A flat fee is a composite of the attorney's standard hourly rate and how many hours he thinks he'll have to invest in your case to resolve it. Ask what that hourly rate is and find out how much you'll be charged for the services of other attorneys and paralegals in the firm.

This will give you an idea of how many hours the attorney expects the firm to spend on your estate plan. If he quotes you a $5,000 flat fee and he bills his time at $200 an hour, he expects that he and his firm will spend about 20 to 25 hours on your case.

The general rule is that the higher an attorney's hourly rate, the more experience he has. All those hours might seem like a lot to you, but the attorney should have a pretty good idea of the time it will take to meet with you, answer your questions, design and draft your estate plan, review your plan with you, help you sign your plan, then help you fund your trust if you've chosen to include one.

Meet by Telephone First

It's common these days to handle a significant amount of business by telephone. Consider setting up telephone interviews with at least two estate planning attorneys before meeting in person. This will save your time and the attorney's time...if she's willing.

Don't expect a great deal of decisive information in an initial phone interview. That would be like the attorney giving her advice away for free. Your goal for this phone conversation should be determining whether you want to work with her or not.

Each attorney should be able to get a feel for what your needs are during this conversation and quote you a flat fee for your basic estate plan. Remember, you're not asking what you should do, but rather how much it's likely to cost you to do what you have in mind. This gives you the opportunity to compare the flat fees quoted by each attorney and narrow down your choice as to who you want to meet with in person.

Busier attorneys might not offer this option.

Keep in mind that a higher fee does not necessarily equate with a more qualified attorney. Consequently, a rock bottom fee may signal problems, inexperience, or incompetence.

After meeting with the lawyer, you should ask yourself the following questions:

- Are the lawyer's experience and background compatible with your legal needs?
- Did they provide prompt and courteous responses to your questions?
- Are they someone with whom you would be comfortable working with?
- Are you confident they possess the skills and experience to handle your case?
- Are you comfortable with the fees and how they are structured?
- Are you comfortable with the terms of the fee agreement and/or representation agreement?

Consult Martindale-Hubbell Law Directory.

Found online at Martindale.com and at your local public and law libraries, Martindale-Hubbell is a great resource for information about a law firm and its lawyers. This guide is often used by lawyers when choosing legal talent in another jurisdiction. The directory includes basic practice profile data on virtually every lawyer in the United States and Canada and detailed professional biographies of leading lawyers and firms in 160 countries. It also includes lawyer and law firm ratings based upon peer reviews, which may help when choosing between two equally qualified candidates.

Ask Other Attorneys

Lawyers know the skill and reputation of other lawyers. Attorneys may be able to provide information about a fellow lawyer that you may not find in a book or online, such as information about a lawyer's ethics, competence level, demeanor, practice habits, and reputation.

Conduct a Background Check

Before hiring any lawyer, contact the lawyer disciplinary agency in your state to confirm that they are in good standing as a member of the bar. For an online listing of each state's lawyer disciplinary agency, review this directory of lawyer disciplinary agencies. You should always check references, especially if you located the attorney through the Internet. You can also check a lawyer's peer review ratings online at Martindale.com. Peer review ratings provide an objective indicator of a lawyer's ethical standards and professional ability, generated from evaluations of lawyers by other members of the bar and the judiciary in the United States and Canada.

Tour the Lawyer's Law Office

You can tell a lot about an attorney from his law office. Request a brief tour of his office, beyond the office or conference room where you met with the lawyer. Is the law office neat, orderly, efficient and well-run? What kind of support staff does the lawyer employ? Does staff appear friendly and helpful? Is the lawyer's office local and easily accessible? Is a large portion of his office space unoccupied? Watch for red flags, such as mass disarray, unhappy staff members, and empty offices.

By taking these five steps, you can select a lawyer with the legal skills and personal qualities that will best serve your needs.

VIDEO TWO: Jail Diversion

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: The Bexar County Story Jail Diversion

Published on May 4, 2018

Link: https://www.youtube.com/watch?v=_mAEoVPqq64

Duration: 8:06 min.

Model Jail Diversion Program diverting the nonviolent mentally ill person from inappropriate incarceration and hospitalization.

VIDEO THREE: Drug Courts

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: DRUG COURT - Program Steps

Published on May 4, 2018

Link: https://www.youtube.com/watch?v=jnt7a-VBcN4

Duration: 8:47 min.

Judge Bucci outlines what it takes to get through Drug Court.

VIDEO FOUR: Jail Diversion

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: A rehab jail for heroin addicts

Published on May 4, 2018

Link: https://www.youtube.com/watch?v=_mAEoVPqq64

Duration: 9:53 min.

MASTER FAMILY PLAN OF ACTION FOR: "The Legal Court System"

Complete answers and move to "Master Family Plan of Action".

1. Use our knowledge of the Sequential Intercept Model (SIM), to understand the flow of court.
2. Start now to find the right attorney
3. Apply the check list of drug court.

Issue # 7: Treatment Centers Seminar

Seminar Seven: Study Guide

Seminar Objectives:

1. Determine the right level of treatment.
2. What is Intensive Outpatient Treatment, IOP.
3. Communicating with Treatment Center Staff.

These are 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)**

Introduction: The Treatment Center Intervention

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 members best interest. This is because when it's 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 becomes 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 patient is discharged off service from their treatment center. The family members are setting themselves up for a huge disappointment if they think a treatment center is the final answer.

The point is, this 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 patients **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 in their 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 comes to look.

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 member has 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.

First Find Out What You Are Dealing With

There are several levels of treatment center and all of them depend on a multitude of criteria from insurance, to diagnosis, to severity of disease and stage of addiction cycle.

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

Determine Types of Treatment, (Recommended)

With an assessment in hand, you are now ready to search for a treatment center. 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 patient's needs, not just his or her drug use.
    - Staying in treatment long enough is critical.
    - Counseling and other behavioral therapies are the most commonly 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 patient's changing needs.
- Treatment should address other possible mental disorders.
- Medically assisted detoxification is only the first stage of treatment.
- Treatment doesn't need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously.
- Treatment programs should test patients 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 patient?
- What will they have to do during rehab?
- What can and should the family do while they are in treatment?
- Can you provide patient 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 to
- 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 Outpatient

• Overview: Offers similar services to outpatient 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 outpatient 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 outpatient treatment, also called day treatment, for individuals requiring more services than intensive outpatient.

• 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.

Inpatient (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 Patient Placement Criteria.

Second Consideration is where is the Level of Care:

The patient 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 patient". 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 Outpatient treatment?** Patients live at home and go to a clinic or facility regularly for sessions with addiction treatment professionals.
- **Who has Inpatient treatment?** Patients stay in a hospital and receive intensive and highly structured care for addiction and other severe medical problems.
- **Who has Residential treatment?** Patients stay in a nonhospital setting and receive intensive and highly structured care for addiction and other medical problems.

- **Who has Recovery housing?** Patients live in supervised, temporary housing and can participate in treatment program

Other Treatment Settings (ordered from the least to the most intensive)

Outpatient
• 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 outpatient clinic that dispenses methadone to patients 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

DRUGHELP.CARES

EMERALDJENNINGS.ORG

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 doesn't 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

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Know the Facilities Treatment Paths

An Individual: addiction treatment provider offers office based, outpatient 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 patients 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.)

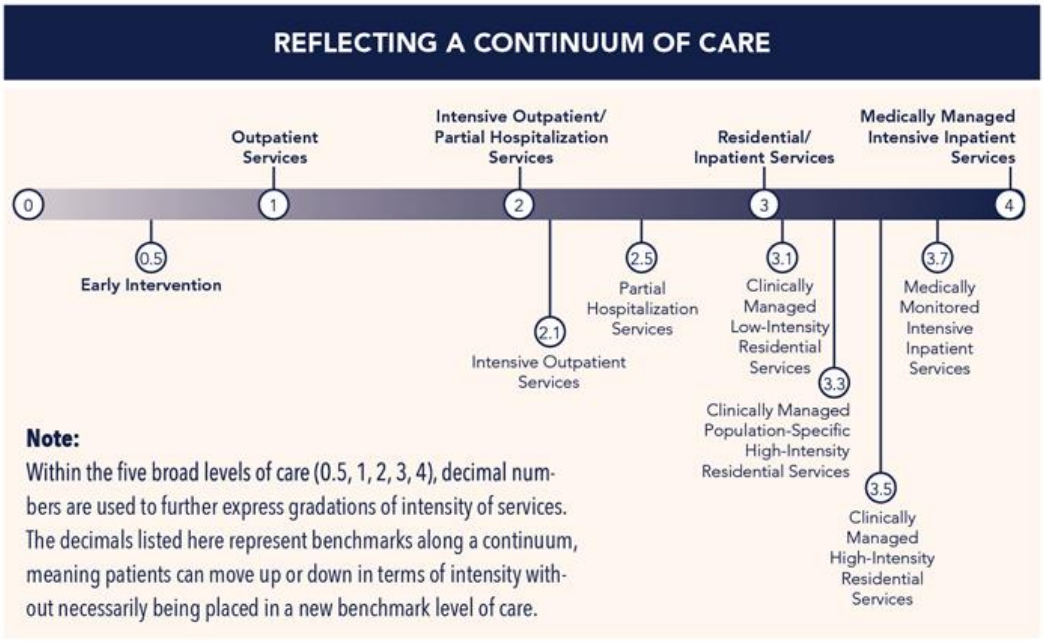
An addiction treatment program usually offers more intensive care. At a program, a team of health care providers will work together to treat you. The team should include a physician (M.D.), a psychologist (Ph.D./Psy.D.) or one of the counselors or social workers listed above and may also include addiction 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 doesn't 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,
- Multi-Systemic Therapy,
- Brief Strategic Family Therapy,

- Ecologically Based Family Therapy,
- Strengths-Oriented Family Therapy

– How It Works: Engages adolescents and families to make long-term changes, address individual, family, peer and community-level influences, and reduce problem behaviors

Adolescent Community Reinforcement Approach

– How It Works: Helps to reduce negative environmental influences and replace them with positive structures that promote a healthy lifestyle and safe behavior

Issue # 7: Treatment Centers Seminar

Seminar Seven: Workbook

How the Family Participates

INSTRUCTIONS: View this video prior to continuing in this workbook.

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: How to Choose a Rehab

Published on May, 2018
Cassidy Cousens

How to choose a drug rehab center, how to choose an alcohol rehab program and how to choose a mental health treatment center. Cassidy Cousens, offers helpful tips to assist family members in finding and choosing the right treatment center for a loved one, friend, or themselves.

Link:
https://www.youtube.com/watch?v=sr4iq4WGLtU&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=47

The Treatment Center is an Intervention

Issues the Family Faces

Getting a Diagnosis:

Visit this website, REF: http://www.bhevolution.org/public/livingwith.page

The person with suspected substance use disorder visits a family doctor or primary care physician, who may then refer them to an addiction or rehabilitation specialist.

The doctor will ask questions about frequency of use, impairment of daily living, and whether the use of a substance is increasing and how the pattern of use is impacting important social, occupational, educational or other functional areas.

They will also ask about withdrawal symptoms which may have occurred at times when the person attempted to decrease or stop use.

The doctor will complete a physical examination and run some blood work to assess overall health. This helps to determine if medical treatment is needed.

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

The 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
- regularly using a substance in spite of any social, emotional, or personal issues it may be causing or making worse
- giving up pastimes, passions, or social activities as a result 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

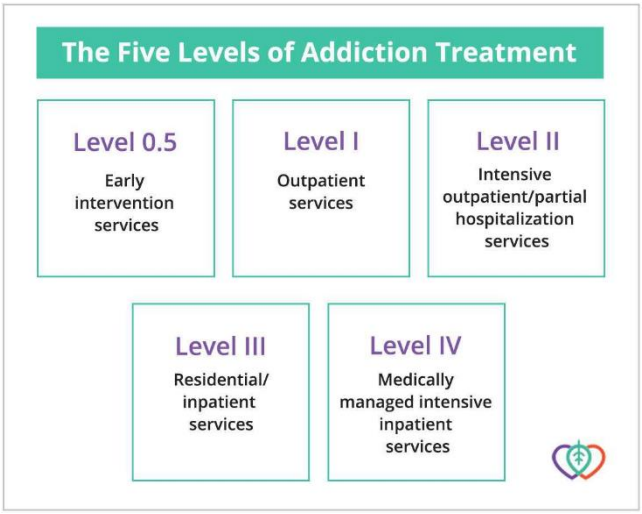
- increased tolerance, meaning that a person must consume more of the substance to achieve intoxication
- withdrawal symptoms, or a physical response to not consuming the substance that is different for varying substances but might include sweating, shaking and nausea

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.

Finding a Treatment Center:

ASAM: The first step is an ASAM Assessment tool. Ask for it, ask to have it explained to you. Connect to this link and review their website: https://www.asam.org/resources/the-asam-criteria/about



ASAM: The second step, From the ASAM Assessment is to decide what level is right for this person.

Ask the "Treatment Center" to include the family members into the discharge and set-up of a useful continuity of care plan.

Involving client families in therapy can improve communications, reduce stress, and help your loved one's recovery from co-occurring disorders. Despite these benefits, many clinicians find it difficult to include family members in their clients' care. Here are some tips and guides for getting families involved.

Engagement Checklist
Clinicians may want to use the Engagement Checklist during the initial contact over the phone. The checklist was developed by the authors of IDDT.

Despite the effectiveness of family work, many mental health and addiction programs do not have a family component. Many clinicians never ask clients whether they would like to involve a family member in their treatment. Some just assume the clients don't have family, while others believe that family would be more of a problem than a help.

Even when clinicians do ask clients about family, some clients fear involvement would be too stressful or too burdensome for their families. These issues can usually be successfully addressed. Clinicians who lack experience working with families could benefit from practicing with colleagues who have done family work. In addition, clinicians can use motivational techniques to help them in their work with families.

Several key principles should guide the family education process to help make it effective:

- First, information must be provided through a variety of teaching methods to allow for different learning styles.
- Second, family education must be presented in a low-stress environment; it is easier to learn if everyone in the family is relaxed and feeling safe.
- Third, there must be an atmosphere of hope, where clinician’s express confidence that recovery from co-occurring disorders is possible. This helps the family members feel hopeful as well. Fourth, the focus is always on the present and future, not the past.
- Finally, family psychoeducation is strengths-based. It focuses on the client's and family members' personal strengths instead of deficits.
- How to Get Families Involved in Treatment

Family involvement begins with a recommendation from the treatment team. This is easier if family clinicians are members of the treatment team and attend meetings regularly to reinforce the relevance of family psychoeducation. Whenever a family is engaged, the intervention should be listed on the client's treatment plan. In terms of stages of treatment, any stage is appropriate for family psychoeducation. Sometimes a family in crisis may be easier to engage, but families can be involved at any point. Here are the basic steps for involving a family in a treatment plan.

- Clinicians need to inform clients about the family psychoeducation program.
- Clients need to identify family members that they would like to involve.
- Clinicians need to contact the family members to schedule a meeting to discuss the program.
- Family members and the client will meet with the clinician to discuss the program and decide if they want to participate. (Meeting in the family members' home can be an effective engagement tool.)
- If there is interest, an orientation meeting is then held. At this meeting, the program is described in more detail, any concerns of the family are addressed, and family work begins.

Possible client issues

Clients often feel that they have put their families through enough and don't want to burden them any further. Clinicians can help clients see that family psychoeducation will reduce stress by improving communication and problem-solving skills within the family.

Some clients worry about family members finding out about their alcohol or drug use or other private issues. Clinicians need to reassure clients that private matters can be kept confidential if they wish. Certain information, such as relapses, will be important to share with the family, and clinicians should encourage clients to do so.

Possible family issues

The initial contact with a family member is often by phone. The goal of the contact is to get family members interested enough to meet the clinician in person. The personal contact allows family members the opportunity to tell their story. If possible, clinicians should arrange to meet in clients' homes. In this way, clinicians see clients in their own environment and can learn more about the clients' situation.

Often family members of clients with co-occurring disorders feel stigmatized. They may have given up friends and activities because of embarrassment over the client's behavior. Family members often have built up strong negative feelings and need to vent. By using active and reflective listening, clinicians communicate their understanding to the family members. Clinicians should look for ways to point out how the family psychoeducation program can address the family's present and future needs. Clinicians should also convey the message that change is possible.

This text is excerpted from Integrated Dual Disorders Treatment: Best Practices, Skills, and Resources for Successful Client Care by Lindy Fox et al. Hazelden, 2010.

Paying for the Treatment Center

1. **Detox** Outpatient detox ranges from $1,000 to $1,500 in total. Most inpatient rehabs include detox in the cost of a program. The exact cost of detox depends on whether it’s part of an inpatient program and the type of drug addiction being treated. Substances with dangerous detox side effects require more careful monitoring, making the price higher.
2. **Inpatient Rehab** Some inpatient rehabs may cost around $6,000 for a 30-day program. Well-known centers often cost up to $20,000 for a 30-day program. For those requiring 60- or 90-day programs, the total average of costs could range anywhere from $12,000 to $60,000.
3. **Outpatient Rehab** Outpatient programs for mild to moderate addictions are cheaper than inpatient rehab. Many costs $5,000 for a three-month program. Some outpatient programs, such as the program at Hazelden Betty Ford, cost $10,000. The price tag depends on how often the individual visits the center each week and for how long.
4. **Medications** The type of treatment and medications needed affects the price tag on rehab. Some people don’t need medication for their addiction. Medications most often treat alcohol and opiate addiction. It can cost several thousand dollars a year. Year-long methadone treatment for heroin users costs around $4,700.

Medicaid covers, all or part of the following services:

- Screenings
- Intervention
- Maintenance and craving medications
- Family counseling
- Inpatient care
- Long-term residential treatment
- Detox
- Outpatient visits

Medicare can cover, the costs of inpatient and outpatient drug rehabilitation. It consists of four parts that cover different parts of addiction recovery programs.

The Four Parts of Medicare

1. **Part A Insurance for Hospital Stays**. Medicare Part A can help pay for inpatient rehabilitation. Part A covers up to 60 days in treatment without a co-insurance payment. People using Part A do have to pay a deductible. Medicare only covers 190 days of inpatient care for a person's lifetime.
2. **Part B Medical Insurance.** Part B can cover outpatient care for addicted people. Medicare Part B covers up to 80 percent of these costs. Part B covers outpatient care, therapy, drugs administered via clinics and professional interventions. Part B also covers treatment for co-occurring disorders like depression.
3. **Part C Medicare-approved Private Insurance**. People who want more benefits under Medicare can opt for Part C. Out-of-pocket costs and coverage is different and may be more expensive.
4. **Part D Prescription Insurance.** Medicare Part D can help cover the costs of addiction medications. People in recovery often need medication to manage withdrawal symptoms and cravings. These medications increase the likelihood of staying sober.

Obstacles the family will likely address

Many families choose not to be involved; therefore, the treatment centers don't ask much from the family members.

When the treatment center is asked by the family member; who you are making the inquiry too, will make all the difference in the world as to the response you will get. For example, a nurse will not give your financial information and the front desk is only going to pass you to the next selected person to speak with. Many are watching out for patient confidentiality and that is a good thing. But it will seem like they are not being cooperative, so be sure to ask the person you are speaking with, if they handle the subject matter you are seeking to discuss. Try to ask for the title of the person who is closest to the topic you want to discuss.

Getting Questions Answered from the right person is important. **For example:**

Clinical: Medical Directors, supervisors and mental health coordinators

Financial: Accounts Payable, Billing or Admissions

Discharge: Social Worker, Case Manager, Utilization Nurse

Behavior Health: Might be a different person from the addiction care staff, ask the facility if asking a mental health type question.

Medical Healthcare: A primary healthcare physician or Physician Assistant is the person to ask for medical related questions. Important medical issues should be under the care of a licensed primary care physician or Internal Medicine practicing physician. Make sure an RN is not the one addressing your important medical healthcare concerns.

Solutions to Issues & Obstacles

PRACTICAL EXERCISE # ONE:

The family will benefit if you understand two key areas of the Treatment Facility:

1. The Organization Chart with Name, Title, Phone Extension, and email address.

Patient Care Technician
Liaison between the clinical, administration, nursing staff, and patients while maintaining an environment which provides safety, ethical practices. The Patient Care Technician will be required to effectively direct, monitor, assess and report patient behavior. Must be able to maintain a safe environment responding to a variety of changing situations and conditions.

Behavioral Health Technician (BHT)
The BHT is to assist clinicians in organizing clients for group counseling, individual counseling, and case management in a learning role, while providing a safe environment for individuals in the detox and residential units. The BHT assists in the admission process, answers patient questions, assists patient in adjusting to the program routine, and provides transport services for clients. The BHT is the liaison between the patient and the nursing and clinical treatment staff to report any changes in the patient's physical or mental condition. The BHT is responsible for supervising patients during intensive levels of care with an emphasis on patient safety and well-being.

Admission Center Treatment Advisor
Specific Responsibilities:

Receives and processes inbound Admission Center interactions via phone, email, chat and/or social media channels while comforting, motivating, and inspires patients to accept help and successfully intervenes, as needed.

Can help family members understand the defined policies and procedures, responsible for all phases of the Admissions process from providing program and services information and triage to completing the intake process for admission including, but not limited to:

- Pre-screens patients for treatment, identifying psychosocial, mental health and medical issues
- Ensures intake documentation is accurate in the RCA salesforce.com system and other relevant systems/technologies
- Responsible for the accurate collection of fees including co-pays, deductibles and all other out-of-pocket, cash collections (i.e. full self-pay payment plans) required as part of the process
- Reviews and understands insurance eligibility, determines which benefits are available and communicates options to the patient

Assesses facility and bed availability based on patient needs and schedules logistics for admissions, including reserving a bed, transportation and intervention services as necessary/requested * Works collaboratively with the Admissions Center team members, field business development team, the facility, and professionals in the community to support desired outcome for our patient

Works to obtain the patient's commitment to treatment and provide quick admission into one of our facilities. Addresses the service levels, goals and metrics that measure the performance of the Admission Center, its team members and its services

Counselor - Drug and Alcohol Treatment Services
Previous knowledge in the disease of chemical dependency, dual diagnosis, opiate addiction, recovery, and 12 step recovery programs preferred. Counselors are responsible for providing intensive, counseling services to a caseload of clients with a primary diagnosis of alcohol and/or drug addiction.

Responsibilities and Duties

- Oversees implementation of treatment plans
- Has regular contact with referral sources. Identifies family issues needing addressed before discharge.
- Plans treatment services as required.
- Provides Group and Individual Therapy to clients

Alternate Site Healthcare Coordination

Title:	Name:	Phone:	Email:
Director of Nursing			
Director of Drug Counseling			
Medical Director, Physician			
Psychiatrist			
Admissions Director			
Accounts Payable/ Billing Super.			

PRACTICAL EXERCISE # TWO **This Correspondence has been copied to the following:**

Communication & Coordination Memo

Your Name:_____
Relation: _____
*Patient's Name:*_____
Date: _____
_____I have,_____Do not have a HIPPA Release Form on file. Date on File:

Visit Date:	Time of Day:	Talked with Staff, Name:	Reviewed Chart:	Areas of Concern:	Unresolved previous issues:
					See Notes dated:
					See Notes dated:
					See Notes dated:
Corrective Action Has Been Noticed					
1.					
2.					
3.					
4.					
5.					

VIDEO TWO:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Intensive Outpatient Treatment for Addictions

Published on March, 2012

Link: https://www.youtube.com/watch?v=ri3rShj4S_4

Duration: 1:36 hrs.
AllCEUs Counseling Continuing Education for LPC and LMHC. This course provides a guide to what is commonly referred to as Methadone treatment based on TIP 46 and 47 by SAMHSA. Executive Summary: Along with the increased complexity of the treatment landscape come more challenges for the administrators who oversee IOT programs. When TIP 8 was written, IOT was seen primarily as a bridge between 28-day inpatient treatment and low-intensity outpatient treatment or mutual-help relapse prevention; most clients were insuring privately. IOT programs proved to be adept at filling that treatment gap, and they took on more roles. Public funding sources began to refer more of their Medicaid patients to IOT programs. This development compelled IOT administrators to adapt existing programs and develop new methods to treat diverse clients. A second force that drove the diversification of IOT programs was managed behavioral health care. Because IOT was cheaper than residential treatment and was being used successfully to treat a wider range of clients, IOT increasingly was a way for managed care organizations (MCOs) to reduce costs. As a result of IOT's successes and the cost containment it made possible, today IOT is a valuable treatment modality, in addition to be an intermediate stage in the clinical continuum.

MASTER FAMILY PLAN OF ACTION FOR: "Treatment Centers"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Determine the right level of treatment for your loved one, then seek a treatment center
2. Identify how Intensive Outpatient Treatment, IOP, is the right level of care.
3. Create a communication matrix, Communicating with Treatment Center Staff

As part of the Master Family Plan of Action the family members will complete the review the needed "points of contact" at the treatment facility. Also, the family will have a diagram level understanding of the "plan of care" for their loved one while in therapy at the facility.

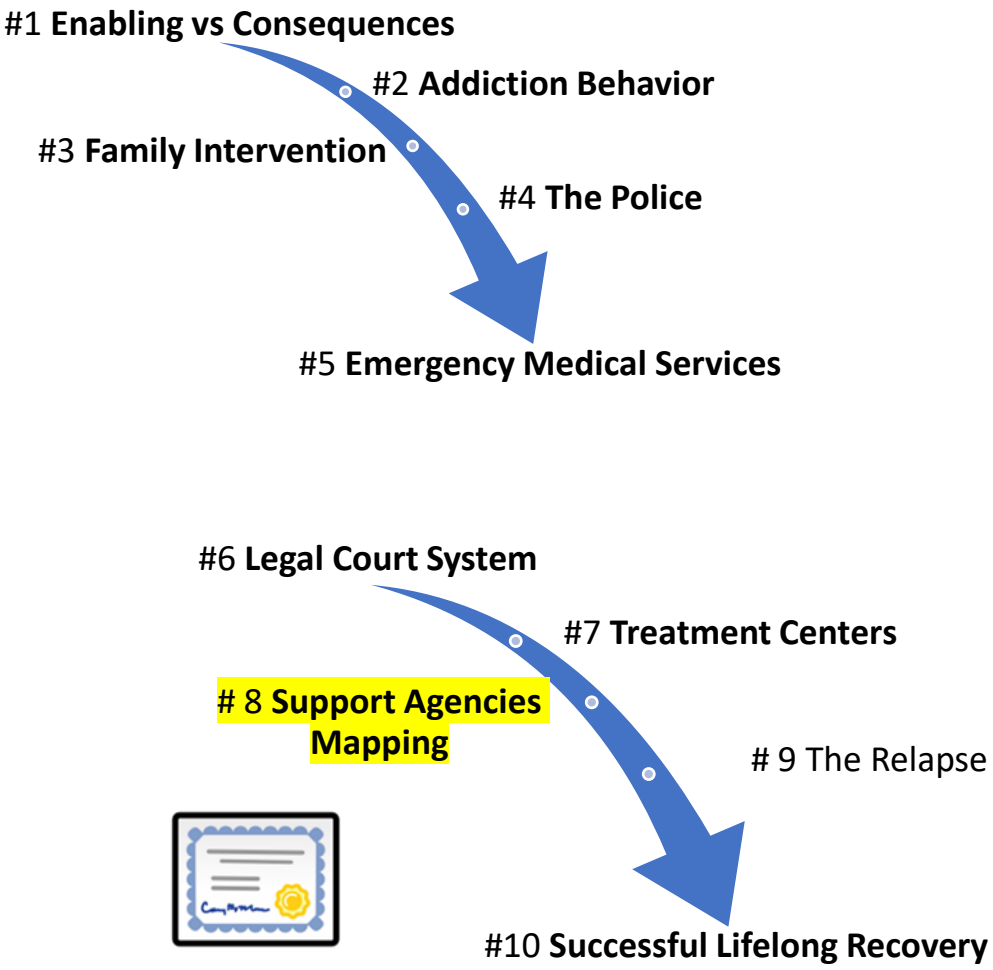
Issue # 8: Support Agency Mapping Seminar

Seminar Eight: Study Guide

Seminar Objectives:

1. Define Support Agency Mapping
2. Steps to create a family community map
3. Advantages gained by having a family community map

These are the 12 Key Issues a Family Faces



#11 **Bereavement** (Learning how to move forward)
#12 **Faith, Spiritual Practices**

Introduction: Support Agencies Mapping

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 for 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.

These three components are included in the Family Solution Finder Learning Seminars, Seminar # 17 "Support Agencies Mapping" family learning seminar. There is an incredible advantage for the family when their strategy for promoting interagency collaboration by better aligning programs and services is part of the Families Master Plan of Action. 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's plan ahead, interview them for which has 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 a 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.

What is Family Resources Mapping?

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 in order 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 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) taking action; 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) Taking action; 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 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.

Step One: Pre-Mapping

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 will make it easier to achieve your long-term goal of aligning and streamlining community resources.

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.

Determining short-term goals allow for the bigger goals to be more manageable.

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 in order 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. 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 reporting 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 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 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 in an effort 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, 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.

Issue # 8: Support Agency Mapping Seminar

Seminar Eight: Workbook

How the Family Participates

INSTRUCTIONS: View this video prior to continuing in this workbook.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Six Skills for Families Affected by Addiction

By: Jan Ligon

This brief video provides an overview of six skills to help families and significant others who are affected by a person who has a substance abuse or addiction problem. http://helpingfamiliesaffectedbysubst...

Link: https://www.youtube.com/watch?v=3sBff2khxpo
Duration: 8:36 min

The Support Agencies Mapping

Issues the Family Faces

A Dual Diagnosis?

Search Title: REF: Supporting Recovery: Integrated Treatment for Co-Occurring Disorders.

VIEW VIDEO LINK: https://www.youtube.com/watch?v=DfwaLQRWBaQ

The reason we are viewing the topic of Co-Occurring Disorders is these diagnoses are very common and require more extensive coordinated care and integration. The person with suspected substance use disorder visits a family doctor or primary care physician, who may then refer them to an addiction or rehabilitation specialist. But did they mis the mental health diagnosis? The doctor will ask questions about frequency of use, impairment of daily living, and whether the use of a substance is increasing and how the pattern of use is impacting important social, occupational, educational or other functional areas.

They will also ask about withdrawal symptoms which may have occurred at times when the person attempted to decrease or stop use.

The doctor will complete a physical examination and run some blood work to assess overall health. This helps to determine if medical treatment is needed. Now comes the question, how prepared is the family to use the diagnosis in setting up a path of services for their loved one?

It is important to engage the family in the results of diagnosis findings, during your family resource mapping. The information gained from the diagnosis to include mental health, drug addiction and medical co-morbidities is a part of the mapping process and it can be used to help stakeholders make decisions on whether to improve, develop, and/or continue new and existing practices or programs.

Throughout the analysis of the map, keep your goals in mind, and think about how you want to present your findings to meet the needs of diverse audiences and ultimately improve the performance outcomes. You may choose to prepare summaries from other partners services and share them between your network of the family, as well as summary sheets that highlight key findings.

Regardless of the communication method, it is imperative that content necessary for audiences to place the findings and results in a proper context and perspective. Simple, user-friendly summaries briefly review and highlight the major aspects of a program's outcomes, its conclusions, and its significance to the audience may be invaluable.

Reflection Questions for your past programs and services outcomes:

• Have you identified the goals to a past program and service?
• Have you included the set priorities for that program and service?
• Have you determined how to collect the information?
• What collection process will be used?
• How does the use of a summary and outcomes collected relate to your goals/outcomes for the next provider?
• Are existing resources effectively targeted and used to meet the goals of care?
• Are your findings reliable and credible?
• Are the products being considered for the next phase responsive to the needs of the patient and the capabilities of the families? Is there other provider in the community that may be a better fit? Consider sharing your past summaries with new providers so they can understand what worked in the past and what did not.

The Family Resource Mapping:

Once the data has been collected and analyzed, the challenging part begins. Acting on the information from the mapping process 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.

Consider when a family is documenting the person(s) or organization(s) is now accountable for a particular action, the completion of the action, and how you will measure success. Identifying your past results, allows others to see they too will be measured, and that level of self-administered accountability can go a long way.

Many patients' individual needs are such that some program with standardized, one size fits all, may not include these needs to the plan of care. Often, the family in one patient's outcomes stand at cross-purposes with each other.

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 patients. 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. In a context of limited financial resources, programs must balance competing claims for access to services coming from courts and corrections, employers, schools, and families.

Obstacles the family will likely address

Adopting a holistic view of clients in substance abuse treatment is especially important for any service provider making referrals to other providers or agencies. At the point of referral, there is both an opportunity to address a client's unmet needs and a potential danger of losing the client. Collaboration is crucial for preventing clients from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration. Examples of obstacles are designation of which agency has major responsibility for a client, structural barriers driven by funding sources (e.g., payment to only one treatment agency), difficult-to-treat clients, and differing staff credentials.

The issue of which agency "takes credit" for a client is a difficult question arising from competition among different agencies, each of which has an interest in maintaining a certain "head count" to ensure continued funding. This barrier highlights the need to change the way that agencies are credited for their participation in a client's recovery. In many treatment systems, only one agency can receive credit for clients who are served by several service providers.

It would be preferable to allow all participating agencies to take credit for these clients. For example, this happens in communities that have collaborative relationships based on shared outcomes negotiated across agencies. These cross-agency outcomes can occur across service systems (e.g., substance abuse treatment and social services) or across provider networks (e.g., residential and outpatient providers). Outcomes are negotiated both across agencies and with funders of services. Funders play a critical role because they must "change the rules" that allow only one agency to receive credit for a client.

This change from a rules-driven system to a results-based system encourages all participating agencies to be recognized for their contribution to client outcomes. Also, it is important that each provider understand the role of the other providers so that it does not seem as if they are competing. Each provider must create an appropriate working relationship with the other providers so the client can benefit from all.

Structural barriers may also be posed by program policies that are determined by the program's primary funding source. Such policies may dictate, for example, that clients cannot engage in concurrent activities, such as vocational training and treatment of substance abuse disorders. If the State or a managed care system does not allow clients to participate in concurrent services, then collaboration efforts will be difficult, or even impossible. However, in some cases, this is simply a program philosophy and not a formal policy, and efforts should be made to change this mode of operation. Another major barrier in the past has been confidentiality requirements. One answer to addressing this problem is joint training.

In the present system, there are no rewards for serving difficult-to-treat clients, and sometimes agencies set criteria under which only the clients with the greatest potential for success are accepted. Incentives are needed for programs to accept those clients who have the greatest problem severity or multiple needs. This is known as "case mix adjustment."

Staff licensing can sometimes be a barrier to collaboration because it is defined categorically. For example, sometimes the referring agency has a policy requiring that the staff members of the receiving agency have the same licenses and credentials as the referring agency's staff. In addition to requiring specific types of expertise, a referring agency sometimes requires the staff members of the other agency to be "professionals" with advanced degrees. The unfortunate consequence is that credentialing standards, rather than transdisciplinary collaboration, often dictate the services clients receive.

Vocational Training & Substance Use Disorders Treatment

Agencies and organizations that provide vocational training in collaboration with substance abuse treatment programs can be divided into two levels--agencies providing specific training for employment (Level 1), and agencies with resources and services needed by clients at the same time they are receiving substance abuse treatment and employment rehabilitation services (Level 2).

Examples of Level 1 resources include:

- City-, county-, and State-operated vocational rehabilitation (VR) services
- Public and private employment and job placement services
- Public and private employers in the community
- Vocational-technical colleges
- Community colleges
    - Privately owned VR facilities

- Criminal justice vocational training programs

Examples of Level 2 resources include:

- Economic Development Centers (One-Stop or Workforce Development Centers)
- Shelters for survivors of domestic violence
- Mental health agencies
- Homeless shelters
- Child welfare agencies
- Childcare services
- Family services
- Housing authorities
- Evening adult education programs
- Alternative education programs
- Literacy programs
- Adult basic education programs and general equivalency diploma (GED) programs
- Young Men's Christian Associations (YMCAs), Young Women's Christian Associations (YWCAs), Young Men's Hebrew Associations (YMHAs), and Young Women's Hebrew Associations (YWHAs)

- Social service organizations
- HIV/AIDS programs
- Health and disability organizations
- Independent living centers
- Religious groups
- Self-help meetings
- Accessible meetings

These are just a sample of what is to be considered when building the Family Resource Map.

Solutions to Issues & Obstacles

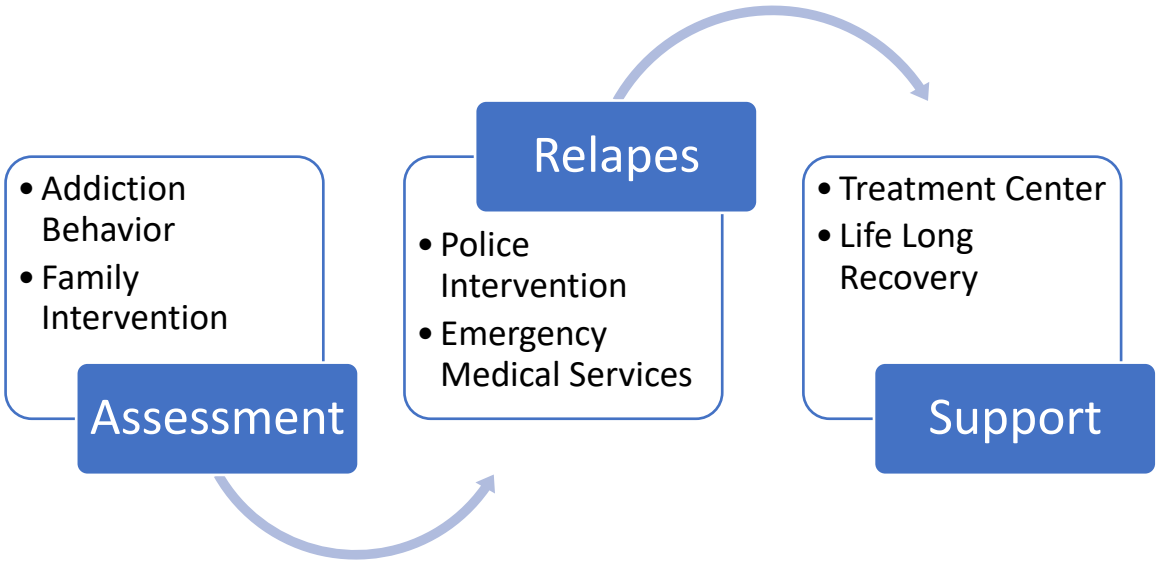
People live in different environments, and service providers have a responsibility to understand the contexts in which their clients operate, but many do not. Client-focused treatment and referral needs to be based on an understanding of the family relationships, cultures, and communities of the clients. Culture can be broadly defined as incorporating demographic variables (e.g., age, sex, family), status variables (e.g., socioeconomic, educational, vocational, disability), affiliations (formal and informal), and ethnographic variables (e.g., nationality, religion, language, ethnicity). In many cases the client's belief system is intricately woven with culture, and providers should start where the client is and acknowledge the spiritual part of the work. Substance Use Disorders treatment programs typically are not open to faith-based organizations in their communities, which could be a valuable collaborative partner. So, it will be up to the family resource mapping to include.

Substance abuse treatment that is both client-centered and client-focused is more likely to improve the lives of client. Collaboration among agencies providing requisite services is an initial step toward client-centered care. Referral can be a way for agencies to hold each other accountable for getting results for clients. Referrals are necessary and appropriate when the substance abuse treatment program cannot provide special services needed by their clients. Some of the areas for which referrals may be needed include job readiness, job training, medical care, and ethnic/cultural expertise. The family resource mapping needs to consider the transition of services as a special part of the overall treatment effectiveness. It is only the family who will have the transition and persons interest as a foremost part of the criteria in discharge from one service to admission into the next.

If the rationale for integrated treatment is a successful outcome for the client, there must be some way of measuring whether the referral is successful. From the referring provider's perspective, referral represents an act of faith, hope, and trust that the agency to which the client is referred will be accountable and will share the goal of client success along with the referring agency. Referrals also represent an opportunity for change, growth, and development. Far too often, however, a referral consists merely of handing a client a list of names and telephone numbers and assuming or hoping that the client will take the initiative to make the necessary contacts.

PRACTICAL EXERCISE # ONE:

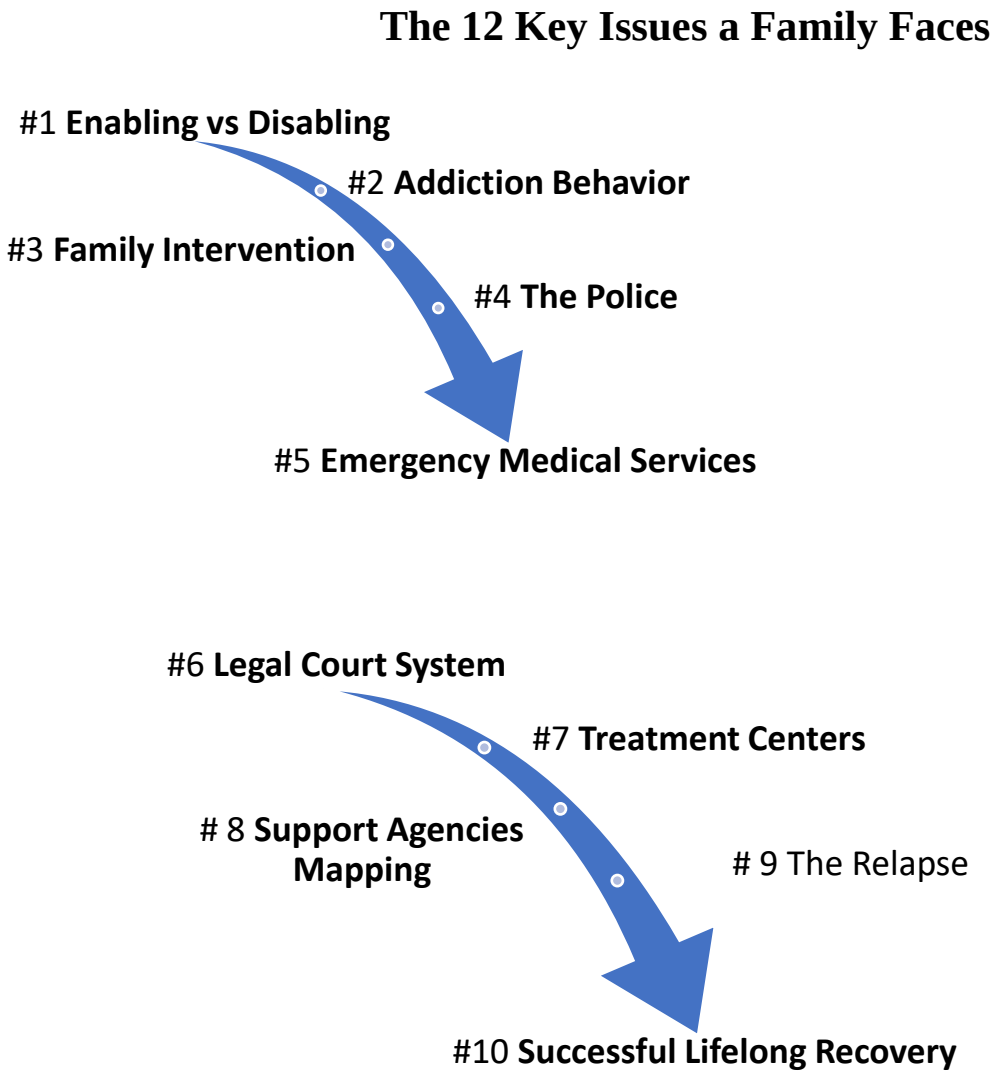
This is what gets mapped.



Knowing what stage of the journey you are in, helps to determine what services is going to be needed next. The purpose of completing this seminar is to become aware of the family members support services, having the family ready to engage these resources at the right time and knowing what is going to be the possible outcome.

STEP TWO:

Take the 12 Key Issues and submit each to a Family Transformational Response exercise:



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

#12 **Faith, Spiritual Practices**

STEP THREE:

Apply the F.T.R. Model for Each Issue Worksheet

VI. Define the Issue?

- ❖ Clearly State what happened or will happen.

_____
_____
_____

- ❖ Identify who is involved or should be involved.

_____
_____
_____

- ❖ What would you like to have happened, or like to see happen?

_____
_____
_____

VII. How does the issue impact the family?

- ❖ Who in the family?

_____
_____
_____

- ❖ In what way?

_____
_____
_____

- ❖ What is needed to move forward?

_____
_____
_____

VIII. What steps can the family take to prepare and then respond to the issue?

- ❖ What needs to be done, prioritize the list.

_____
_____
_____

- ❖ Who needs to be involved?

_____

- ❖ What will it look like when completed?

_____
_____
_____

IX. Who can help and assist the family in their response?

- ❖ How to search for an organization to help.

_____
_____
_____

- ❖ What to ask from them?

_____
_____
_____

- ❖ What to expect?

_____
_____
_____

X. What should the family expect as their outcome?

- ❖ Timeline.

_____
_____
_____

- ❖ The expenses/cost involved in this issue.

_____
_____
_____

- ❖ Required changes to successful respond to this issue.

_____
_____

You are projecting in this exercise because the actual event has not occurred, updating this for each issue as it happens may be required.

STEP FOUR:

Make an inventory of each provider that has services or programs which address each issue:

The 12 Key Issues a Family Faces

ISSUE # 1. Enabling vs. Consequences (Type: Denial)

GOAL: To build a foundation *denial coping techniques* that do not enable substance misuse. Also learn the consequences of enabling and denial that disables the positive habits of successful recovery. Learn how communication makes a safe place for the family. A family counselor or life coach is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #2. Addiction Behavior

GOAL: To learn the *behavior traits of substance use disorder*. To understand how boundaries work to create change over time. Also, learn how to responds to these behaviors. A drug addiction counselor is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #3. Family Intervention

GOAL: Gain a practical understanding of the *5 Stages of Change* theory. Be able to apply the motivational interview (family level) work sheet for each stage. A Family Therapist using Bowden Family Therapy models is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #4. The Police Intervention

GOAL: To learn the typical steps needed when the police intervein. Create a *missing person's report* in advance. Learn the options and paths this intervention might take. Be able to bridge from the police intervention to the next level of intervention. The recommendations of the local Chief of Police or Quick Response Team is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #5. The Emergency Medical Services Intervention

GOAL: Learn what to do in the case of a medical emergency. Understand what to expect at an Emergency Room. Be prepared to make the needed decisions required at this part of the journey. An Emergency Room Social Worker is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #6. The Legal System Intervention

GOAL: Learn how to navigate the court system. What is the requirement for drug court and other options? The prosecutor's office staff is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #7. The Treatment Center Intervention

GOAL: Learn what the treatment center will do and what it will not do. How to select the right treatment center using a criterion check list. The local treatment center admission director is considered in the mapping process.

Providers:

1.

2.

3.

ISSUE #8. Support Agencies

GOAL: Learn how to create a family Resources Plan by using a *Family Resources Plan of Action Work Sheet.* Using the list of available agencies to properly match the agency with the needs of the family. Take this seminar.

ISSUE #9. Relapse

GOAL: Learn how to create a *Getting Back to Work Plan*. Using the Getting Back to Work Planning Guide match each step with the proper agency or program. Taking seminar # 18 Relapse, and Support Agencies Seminar # 17.

ISSUE #10. Successful Lifelong Recovery

GOAL: Learn how to create a supportive and safe space for the family and the loved one in recovery. A peer to peer director is considered in this mapping process.

Providers:

1.

2.

ISSUE #11. Bereavement

GOAL: Learn how to navigate the journey of grief and all that life give us in these times. A bereavement MSW is considered in this mapping process. Contact a hospice company.

Providers:

1.

2.

3.

ISSUE # 12. Faith, Spiritual Practices

GOAL: How to use your faith in the journey of substance use disorders. Also, create an "Invest in the Family Ministry" at your place of faith practice. www.amazon.com

Providers:

1.

2.

PRACTICAL EXERCISE TWO:

SUMMARY OF SERVICES AND PROGRAMS

Previous Providers, contact information	Services/Programs Provided	Duration of program	Outcome of Program	Un met needs	New Expectations

PRACTICAL EXERCISE THREE:

FAMILY RESOURCE MAP

ISSUE	Services/Programs Provided	Title of Program	Point of Contact	Required Eligibility Criteria	Expectations

PRACTICAL EXERCISE FOUR:

Communication & Coordination Memo

Organization:_____
Point of Contact: _____
*Email:*_____
Website: _____
_____I have,_____do not have a HIPPA Release Form on file. Date on File:

ISSUE: _____

What program does the provider have to address this issue	How many of the criteria points were met by this program	What is the primary reason for selecting this program	How will you monitor progress in the program
			See Notes dated:
			See Notes dated:
			See Notes dated:

VIDEO THREE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: CRAFT: Community Reinforcement And Family Training

Advance video to minute 7.min if you want to bypass the introductions.

Published on March, 2012

Link: https://www.youtube.com/watch?v=hlYFcXb0JBk

Duration: 58 min.

Greenfieldcc

Dominique Simon-Levine with Allies in Recovery presents the CRAFT process for helping individuals and families with addiction problems at an OPIOID Task Force event. She introduces the website developed using the CRAFT process to help families in working with addiction problems.

MASTER FAMILY PLAN OF ACTION FOR: "Support Agencies Mapping"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Determine what needs to be included to your family community map.
2. Design a family community map.
3. Complete an F.T.R. for your family community map.

As part of the Master Family Plan of Action the family members will complete the review the needed "points of contact" at the agencies they will possibly need to work with in the future.

Issue # 9: The Relapse Seminar

Seminar Nine: Study Guide

Seminar Objectives:

1. **What is relapse**
2. **What are the three stages of relapse.**
3. **How can the family identify these stages.**

These are the 12 Key Issues a Family Faces

#11 **Bereavement** (Learning how to move forward)
#12 **Faith, Spiritual Practices**

Introduction: Relapse

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 in order 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 each individual'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 in order 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:

Larimer, M. E., & Palmer, R. S. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioral model. Alcohol Research and Health, 23(2), 151-160.
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Mines, R. A., & Merrill, C. A. (1987). Bulimia: Cognitive-behavioral treatment and relapse prevention. Journal of Counseling & Development, 65(10), 562-564.

What is a Relapse?

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 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. It begins weeks and sometime months before an individual pick 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, mental, and physical.

Stage One: Emotional Relapse

During emotional relapse, individuals are not thinking about using. They remember their last relapse and they don't 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) 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)
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. 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 a substance needs to make time for themselves, to be kind to themselves, and to give themselves permission to have fun.

These topics usually must be revisited many times during therapy:

- Are you starting to feel exhausted again?
- Do you feel that you're 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.

Stage Two: 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 doesn't. 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.

Stage Three: Physical Relapse

Finally, physical relapse is when an individual start 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 don’t 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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Prevention of Relapse

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 plan for Prevention of Relapse, using their input and guidance. This will prove to be invaluable.

How the Family Responds to a Relapse

REF: American Addiction Centers
Follow
Feb 20, 2018

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 outpatient 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.

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 doesn't 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 take action.

· 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 still continuing to work on your relationships with loved ones.

· You do not necessarily have to cut someone out of your life in order to avoid relapse. You may need to limit communications, set healthy boundaries, and/or take a break until you feel more stable and strong 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. At American Addiction Centers, our 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

Issue # 9: The Relapse Seminar

Seminar Nine: Workbook

How the Family Participates, Know the signs

INSTRUCTIONS: View this video prior to continuing in this workbook.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Relapse Prevention: Early warning signs and important coping skills

Dr. Steven Melemis

Learn the stages of relapse and how to recognize the early warning signs of relapse. Learn coping skills to prevent relapse in the future. By Dr. Steven M Melemis MD PhD

Link: https://www.youtube.com/watch?v=FmjjxdDwOIc
Duration: 5:52 min

The Relapse

Issues the Family Faces

Understand What They Experience.

Search Title:, REF: How To Create An Addiction Relapse Prevention Plan

VIEW VIDEO LINK: https://www.youtube.com/watch?v=yd3ESsbtCzY
Duration: 6:13 min

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. 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 clients in these few rules can help them focus on what is important. Consider when a family is documenting the person(s) or organization(s) is now accountable for a particular action, the completion of the action, and how you will measure success. Identifying your past results, allows others to see they too will be measured, and that level of self-administered accountability can go a long way.

The key to relapse prevention is to understand that relapse happens gradually. It begins weeks and sometime months before an individual pick up a drink or drug. 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 clients. I have found it helpful to think in terms of three stages of relapse: emotional, mental, and physical.

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 doesn't. As individuals go deeper into mental relapse, their cognitive resistance to relapse diminishes and their need for escape increases.

Practical Exercise # One:
These are some of the signs of mental relapse:
1) craving for drugs or alcohol.
Describe what you are seeing _____
2) thinking about people, places, and things associated with past use.
Describe what you are seeing _____
3) minimizing consequences of past use or glamorizing past use.
Describe what you are seeing _____
4) bargaining.
Describe what you are seeing _____
5) lying.
Describe what you are seeing _____
6) thinking of schemes to better control using.
Describe what you are seeing _____
7) looking for relapse opportunities.
Describe what you are seeing _____
8) planning a relapse.
Describe what you are seeing _____

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:

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 don’t 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.

Obstacles the family will likely address

Adopting a holistic view of clients in substance abuse treatment is especially important for the family to consider. At the point of referral, there is both an opportunity to address a their unmet needs and a potential danger of losing them losing their interest in treatment. Collaboration is crucial for preventing them from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration.

Goals and Outcomes of Family Members

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- Increase family support for the client's recovery. Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.
- Identify and support change of family patterns that work against recovery. Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.
- Prepare family members for what to expect in early recovery. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- Educate the family about relapse warning signs. Family members who understand warning signs can help prevent the client's relapses.
- Help family members understand the causes and effects of substance use disorders from a family perspective. Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- Take advantage of family strengths. Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- Encourage family members to obtain long-term support. As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

Solutions to Issues & Obstacles

Practical Exercise One:

Did you know that there are definite warning signs that come before a relapse into drug or alcohol abuse? In fact, a relapse happens in stages. The first stage is known as “emotional relapse”.

Emotional Relapse:

In this earliest stage, you have not even started to think about using or drinking. Rather, you start feeling negative emotions that cause you to act in self-destructive ways. Even when you are sober and abstaining, some of the aspects of your disease can still impact your life.

Emotional relapse precedes physical relapse, when your own thoughts and behaviors begin to undermine everything you have worked for. At this point, you’re not drinking or using, but that is the direction in which you are heading.
Anxiety – excessive fear, worry, or uncertainty about your sober new life.
Q: What can the family do: _____

Depression – overwhelming sadness; loss of appetite; no motivation.
Q: What can the family do: _____

Intolerance – poor cooperation with others, an uncompromising attitude, or rigid, inflexible opinions
Q: What can the family do: _____

Anger – resentment or hostility that flares up whenever expectations are not met
Q: What can the family do: _____

Defensiveness – intensely rejecting any criticism
Q: What can the family do: _____

Mood Swings – an inability to control one’s feelings and reactions; unpredictable emotional volatility
Q: What can the family do: _____

If any of these emotional conditions are left undone with, they can be a factor in the stress factors that can lead to physical relapse.

Practical Exercise Two:

What are you seeing?
Possible dysfunctional behaviors include:

Social withdrawal or isolation – avoiding family and friends; a marked preference to be alone.

Q: What can the family do: _____

Refusal of any concerned efforts – denial of need; an insistence of doing everything "on your own" with no help from anyone.

Q: What can the family do_____

Sporadic counseling/therapy/12-Step meetings attendance – Fellowship with other recovering addicts and alcoholics can be a major source of strength and inspiration, but as the saying goes, "it only works if you work it".

Q: What can the family do: _____

Poor eating habits – responding to stress or emotional pain with food; eating only junk food or fast food; alternately – loss of appetite

Q: What can the family do: _____

Sleep disturbances – insomnia, wakefulness, poor sleep quality; alternately, excessive sleeping or an inability to get out of bed

Q: What can the family do: _____

Practical Exercise Three:

There are 3 things to practice if you want to avoid emotional relapse:

1. Self-Awareness – Maintaining an active knowledge of your feelings, thoughts, and behaviors. There are several ways to practice self-awareness:

- Mindfulness meditation – A 2017 study suggests that practicing mindfulness for as little as 11 minutes a day can help reduce cravings.
- Journaling - Daily reflection and affirmation

Self-Care – Doing the things that are necessary to maintain and improve your physical, emotional, and mental health.
Q: What can the family do: _____

Proper nutrition – Addiction takes a terrible toll on the body, robbing it of essential nutrients. Eating right gets you healthier by restoring the vitamins and minerals you may have lost. Also, hunger is easy to misinterpret as drug cravings.

Q: What can the family do: _____

Reducing stress – A 2011 study revealed a biological link between chronic stress and addiction. Key benefit – when you are calm, you are far less likely to overreact to the problematic situation.
Q: What can the family do: _____

Getting enough quality sleep – Insomnia is the biggest complaint among people in early recovery. Inadequate sleep can lead to irritability, depression, and confusion – each of which can trigger a relapse.
Q: What can the family do: _____

They need to know to ask for help when you need it – The disease of addiction is too large of a problem to try to tackle alone. Asking for and receiving the help you need from supportive, positive people lets you take advantage of new perspectives and additional resources.
Q: What can the family do: _____

Practical Exercise Four:

Mental Relapse.

This is when the recovering addict/alcoholic is torn between conflicting desires.
Q: What can the family do: _____

They don't want to use – They are fully aware that using or drinking again is a terrible idea that could tear down what they are trying to build. Intellectually, they understand the dangers.
Q: What can the family do: _____

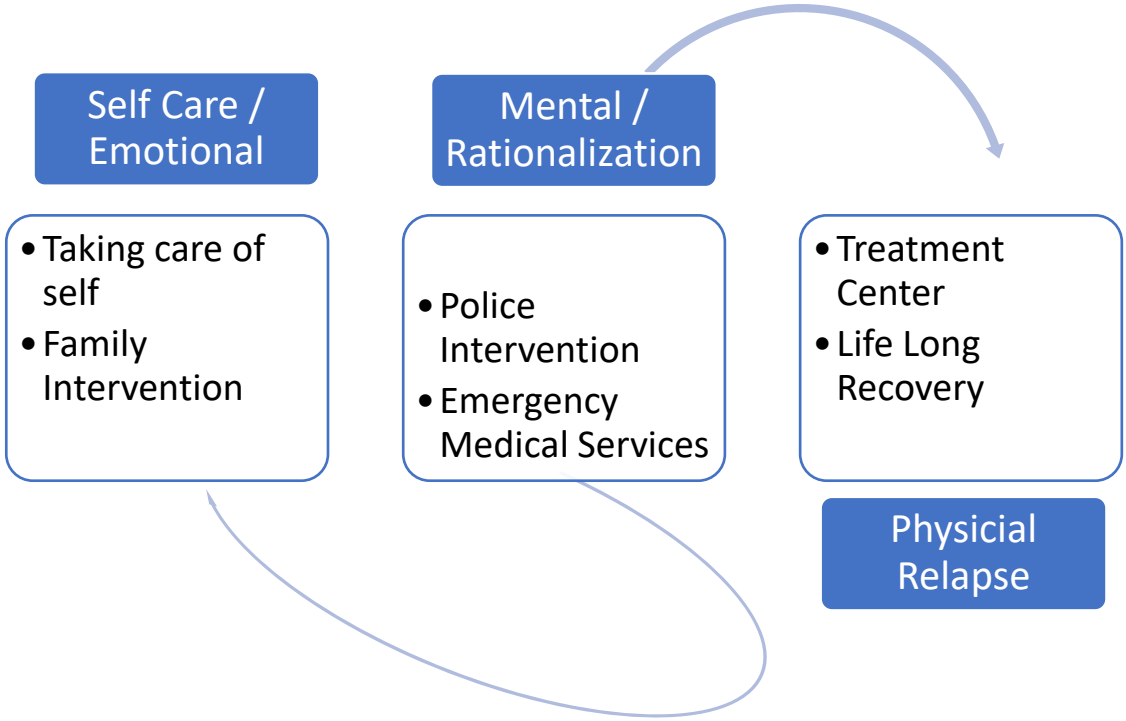
They want to use – Some emotional trigger has set off uncontrollable alcohol/drug cravings, and in the face of such an overwhelming compulsion, the rational arguments for abstinence don't seem to matter.
Q: What can the family do: _____

Physical Relapse.

After emotional relapse comes physical relapse – this is when the person actively returns to substance use and a pattern of dysfunctional behaviors. It is a complete reversal of the progress made so far.
Q: What can the family do: _____

Obviously, a physical relapse is the most dangerous stage, since the person often drops out of treatment at this point. Because of the progressive nature of addiction, an untreated relapse can be fatal.
Q: What can the family do: _____

This is completely different from a slip – and impulsive and brief fall back into active substance use, followed almost immediately by a prompt return to recovery practices and abstinence. Some people referred to a physical relapse as a "slip that got out of control."



Knowing what stage of the journey you are in, helps to determine what services is going to be needed next. The purpose of completing this seminar is to become aware of the family members support services, having the family ready to engage these resources at the right time and knowing what is going to be the possible outcome.

Practical Exercise Five:

Apply the F.T.R. Model for Each Issue Worksheet

Define the Issue?

Clearly State what happened or will happen.

Identify who is involved or should be involved.

What would you like to have happened, or like to see happen?

How does the issue impact the family?

Who in the family?

In what way?

What is needed to move forward?

What steps can the family take to prepare and then respond to the issue?

What needs to be done, prioritize the list.

Who needs to be involved?

- What will it look like when completed?

Who can help and assist the family in their response?

How to search for an organization to help.

What to ask from them?

_____

_____

What to expect?

_____

_____

What should the family expect as their outcome?

Timeline.

_____

_____

The expenses/cost involved in this issue.

_____

_____

Required changes to successful respond to this issue.

_____

_____

You are projecting in this exercise because the actual event has not occurred, updating this for each issue as it happens may be required.

Practical Exercise Six: During Relapse, be ready to "Return to Treatment"

SUMMARY OF SERVICES AND PROGRAMS

Previous Providers, contact information	Services/Programs Provided	Duration of program	Outcome of Program	Un met needs	New Expectations

Practical Exercise Seven: After Relapse

FAMILY RESOURCE MAP

ISSUE	Services/Programs Provided	Title of Program	Point of Contact	Required Eligibility Criteria	Expectations

Practical Exercise Eight: Moving forward from a Relapse

Communication & Coordination Memo

Organization:_____
Point of Contact: _____
*Email:*_____
Website: _____
_____I have,_____do not have a HIPPA Release Form on file. Date on File:

ISSUE: _____

What program does the provider have to address this issue	How many of the criteria points were met by this program	What is the primary reason for selecting this program	How will you monitor progress in the program
			See Notes dated:
			See Notes dated:
			See Notes dated:

MASTER FAMILY PLAN OF ACTION FOR: "The Relapse"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. **List what may causes relapse in their life.**
2. **Create a scale based on their life of how these stages might present in behaviors.**
3. **State how the family will respond to indicators in the early stage.**

As part of the Master Family Plan of Action the family members will complete the review the needed "points of contact" at the agencies they will possibly need to work with in the future.

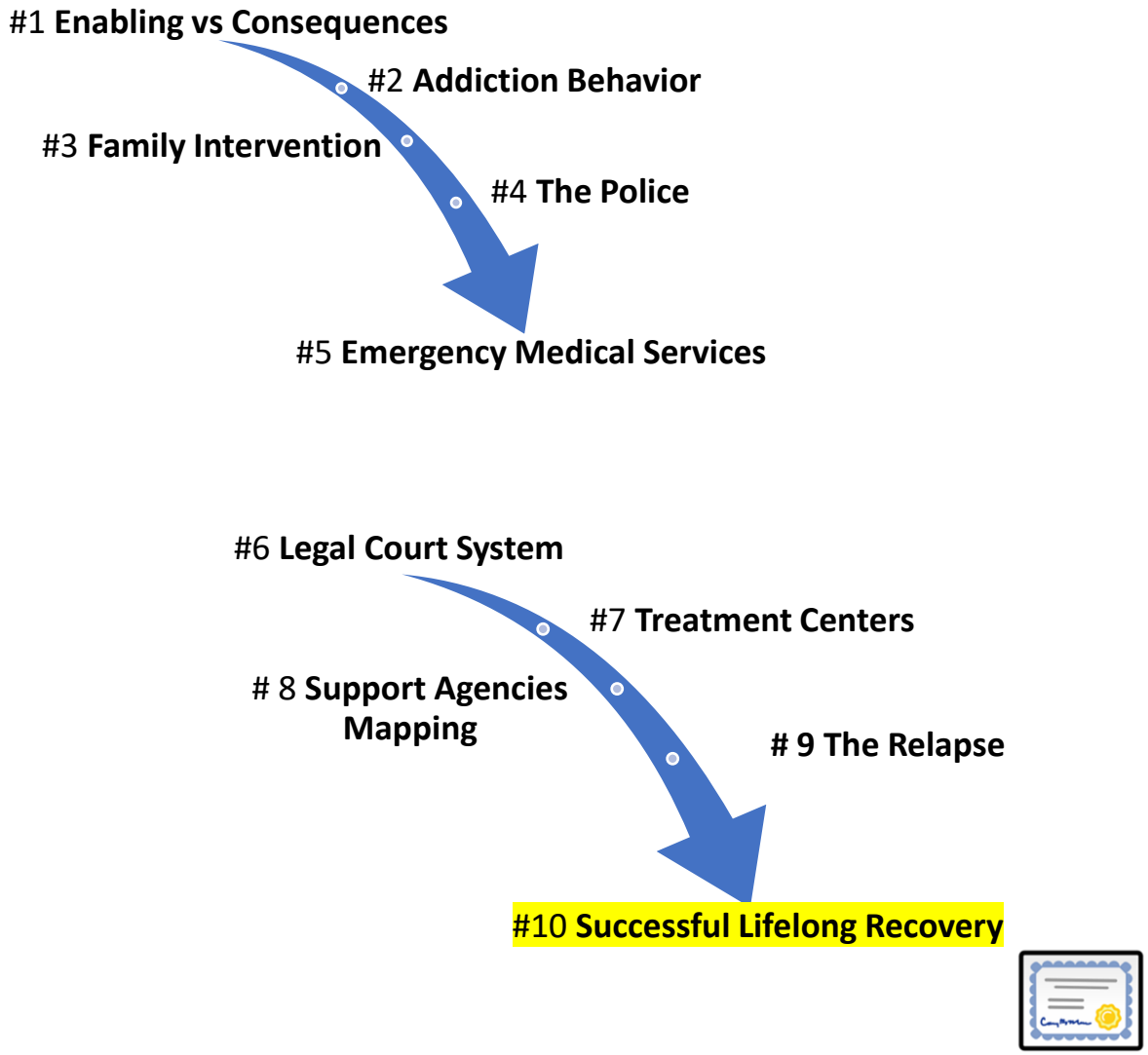
Issue # Ten: Successful Lifelong Recovery Seminar

Seminar Ten: Study Guide

Seminar Objectives:

1. **Four main ideas in relapse presentation.**
2. **Learn the Stages of Recovery**
3. **How to create a strong support system**

The 12 Key Issues a Family Faces



#11 **Bereavement** (Learning how to move forward)
#12 **Faith, Spiritual Practices**

Introduction: Successful Lifelong Recovery

Create a foundational Understanding about Recovery:

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 each individual'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 in order to reduce risk of relapse.

See References:

Larimer, M. E., & Palmer, R. S. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioral model. Alcohol Research and Health, 23(2), 151-160.

Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention (1st ed., pp. 280–250). New York: Guilford Press.

Marlatt, G. A., & Donovan, D. M. (Eds.). (2005). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. Guilford press.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors (1st ed.). New York: Guilford Press.

Mines, R. A., & Merrill, C. A. (1987). Bulimia: Cognitive-behavioral treatment and relapse prevention. journal of Counseling & Development, 65(10), 562-564.

What drives Successful Lifelong Recovery?

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.

The Stages of Recovery

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.

A Family's Flexible Support to the Plan of Care

Recovery is not a singular event and doesn't 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: 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're 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'd 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 your recovery.

Family Member Self Care:
This section is a compilation of the activities, practices, and hobbies that you engaged in that keep you 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, or biking
- 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 if and when you're 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 have to be able to tell them in a clear manner what you expect and desire.

In this journey a person is during their addiction situation, they often become isolated from others and over time, they begin to deliberately avoid any type of social interaction with others. This doesn't 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 this 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's money, drugs, or a place to sleep. Chances are that if you love an addict, they've lied to you. Lying helps an addict stay in their perpetuating cycle of addiction. Practicing dishonesty removes trust and is very damaging to relationships.
   - ❖
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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 don't have anything nice to say, don't say it at all. Take time in choosing the words for your responses. Be sure to tell the person this is what you're 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 patient 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, take a 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, an addict will either be too stubborn or fearful to ask for help in his or her current situation. Addicts can feel as if they have no problem with addiction or they are embarrassed to admit that they have these problems, thus entering into 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 of 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've 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're 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 up the lines of communication and allows you to express what you need from the people that are part of your support system.

It's 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're 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. Don't 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 REGULAR RECOVERY AND SUPPORT MEETINGS.

Recovery can feel like an isolated process. Sometimes, addicts will need to separate themselves from family members or friends in order to progressively get better in their addiction.

Treatment centers offer opportunities for addicts to participate in group therapy 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 addicts 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. DON'T GET INTO ANY NEW RELATIONSHIPS OR LIFE-ALTERING CAREERS.

One of the first things that addicts tend to mistakenly do after getting out of treatment is jumping into new relationships or finding new jobs.

A relationship is a commitment to another person that requires more work than an addict would be able to handle. Once treatment is complete, an addict must take the time to work on him or herself, that way they can truly recover and practice self-love.

We have all heard the phrase that we cannot love someone until we can learn to love ourselves. This could not be truer when it comes to an addict trying to find a sense of peace and awareness before giving love in a relationship. You cannot afford to jeopardize all of the work that you've done in recovery for the temporary feeling of being in a romantic relationship.

If you're 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 for a relapse.

Addicts use substances as a way to escape the everyday stresses of life. You shouldn't place yourself in stressful situations that you know can trigger your desire to relapse. Just as people who have food allergies know that they shouldn't eat a certain food because of what it can do to them, an addict should not place him or herself in any vulnerable or risky situations that can create more stress.

5. BE PATIENT AND ALLOW TIME TO RUN ITS COURSE.

Perhaps your biggest and most effective support system will be that of time. Addiction was not created overnight. It took time to develop, and the recovery process should look just the same, if not longer.

There will be some days where you might feel as though you've made no progression, but if you take a moment to look back on how far you've come, you'll 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 patient and positive will help you identify that the recovery process takes time but will be very rewarding in the end. At times where you may feel that you're at your wit's end, contact people in your support system to let them know what you're feeling. They will come and provide you with any support you need to help you maintain your progress towards recovery.

Addiction does not have to take over your life. It has no right to. Because addiction is such a staggering epidemic in America, there are plenty of reliable and effective treatment centers around the country to help patients get better and stay better.

The goals of these centers are to help patients 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's 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 very successful.

Recovery doesn't 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.
5.
6.
7.
8.
9.
10.

B. Who of this group, do they need to NOT spend time with right now, and why?

1.
2.
3.
4.
5.

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, going out to eat, etc.)

___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.
5.

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.
5.

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 at this time?

_____

_____

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 don't want to tell anybody else that I am in recovery or that I have addiction.

___I don't know anybody that would be appropriate.

___I don't 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 don't have time.

___I end up providing all the support to the other person.

___I am afraid that I will be rejected.

___I don't want to sound helpless.

___I don't want to be vulnerable by opening up to others.

___I don't 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

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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, in light of 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 actually end up losing more opportunities than you ever gain. In order 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 are able to 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

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. Katie Mazurek is a charismatic and dynamic speaker whose battle with Stage III breast cancer sets the tone for an authentic and deeply relatable presentation. Mazurek is a Collaborative family law attorney in Bozeman, Montana who founded her firm, Element Law Group, four days prior to her diagnosis. She is the mother of two young children whom she raises with her husband, Tom Mazurek. Katie is a passionate writer and blogger who touches readers through personal stories of pain, triumph, loss, growth, and acceptance. Her blog, katieovercancer.com, has reached over 100,000 readers and she has been featured in print and television media for her accomplishments and inspirational lifestyle. She engages audiences by speaking with vulnerability, courage, and compassion for ourselves and others. She has created a community of love and support through her battle with cancer. Her work has been healing and restorative for many following her writing.

This talk was given at a TEDx event using the TED conference format but independently organized by a local community. Learn more at https://www.ted.com/tedx
Link: https://www.youtube.com/watch?v=LJiKhOMNbY0

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 actually 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. As long as 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 actually start to limit your life. This is because you get used to staying in your comfort zone, which is bad because in order 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 behaviours. It also stills your mind enough so that good things can rise to the surface to where you are better able to see it. In order 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.

Issue # 10: Successful Lifelong Recovery Seminar

Seminar Ten: Workbook

Introduction

Substance abuse and addiction can damage family dynamics, erode trust, and weaken communication. Family members who experience a loved one battling with a substance use disorder often endure a host of painful emotions. Equally frustrating is the hopelessness loved ones feel in response to substance abuse. Family members may feel at a loss when seeing a loved one caught in the grips of substance abuse. For example, stumbling upon burnt spoons and used syringes can create a paralyzing feeling of fear and shock.

When individuals are in recovery, they need support and encouragement to strengthen their resolve. The strongest forms of support and nurturing come from those closest to us. Family members often represent our closest connections, and even in instances where there is tension and strife between family members, the bonds often remain very salient.

Maintaining strong family bonds or reinforcing bonds that are stressed or damaged is extremely important for an individual in recovery. Research indicates that strong family support is one of the most important aspects of recovery. Strong family bonds reinforce the notion that the recovering individual is not alone and can rely on others to help them through the rough times.

The relapse process causes the addict to feel pain and discomfort when not using. This pain and discomfort can become so bad that the addict becomes unable to live normally when not using. In Alcoholics Anonymous this is called a dry drunk but the syndrome is recognized in all areas of addiction and is in essence, abstinence without recovery. The discomfort can become so bad that the addict feels that using can't be any worse than the pain of staying clean.

PHASE 1: RETURN OF DENIAL.

During this phase the addict becomes unable to recognize and honestly tell others what s/he is thinking or feeling. The most common symptoms are:

1. Concern about well-being: The addict feels uneasy, afraid and anxious. At times s/he is afraid of not being able to stay drug-free. This uneasiness comes and goes, and usually lasts only a short time.

2. Denial of the concern: In order to tolerate these periods of worry, fear and anxiety, the addict ignores or denies these feelings in the same way s/he had at other times denied being addicted. The denial may be so strong that there is no awareness of it while it is happening. Even when there is awareness of the feelings, they are often forgotten as soon as the feelings are gone. It is only when the addict thinks back about the situation at a later time that s/he is able to recognize the feelings of anxiety and the denial of those feelings.

PHASE 2: AVOIDANCE AND DEFENSIVE BEHAVIOUR.

During this phase the addict doesn't want to think about anything that will cause the painful and uncomfortable feelings to come back. As a result, s/he begins to avoid anything or anybody that will force an honest look at self. When asked direct questions about well-being, s/he tends to become defensive. The most common symptoms are:

3. Believing "I'll never use again": The addict convinces self that s/he will never use again and sometimes will tell this to others, but usually keeps it to self. Many are afraid to tell their counsellors or other fellowship members about this belief. When the addict firmly believes s/he will never use again, the need for a daily recovery programmed seems less important.

4. Worrying about others instead of self: The addict becomes more concerned with the recovery of others than with personal recovery. S/he doesn't talk directly about these concerns, but privately judges the recovery programmed of other recovering persons. In the fellowship this is called "working the other guy's programmed".

5. Defensiveness: The addict tends to defend when talking about personal problems, feelings or his/her recovery programmed even when no defense is necessary.

6. Compulsive behavior: The addict becomes compulsive ("stuck" or "fixed" or "rigid") in the way s/he thinks and behaves. There is a tendency to do the same things over and over again without a good reason. There is a tendency to control conversations either by talking too much or not talking at all. S/he tends to work more than is needed, becomes involved in many activities and may appear to be the model of recovery because of heavy involvement in Fellowship 12 step work e.g. chairing meetings. S/he is often a leader in counselling groups by "playing therapist." Casual or informal involvement with people however is avoided.

7. Impulsive behavior: Sometimes the rigid behavior is interrupted by actions taken without thought or self-control. This usually happens at times of high stress. Sometimes these impulsive actions cause the addict to make decisions that seriously damage his/her life and recovery programmed.

8. Tendencies towards loneliness: The addict begins to spend more time alone. S/he usually has good reasons and excuses for staying away from other people. These periods of being alone begins to occur more often and the addict begins to feel more and more lonely. Instead of dealing with the loneliness by trying to meet and be around other people, he or she becomes more compulsive and impulsive.

PHASE 3: CRISIS BUILDING

During this phase the addict begins experiencing a sequence of life problems that are caused by denying personal feelings, isolating self and neglecting the recovery programmed. Even though S/he wants to solve these problems and works hard at it, two new problems pop up to replace every problem that is solved. The most common symptoms are.

9. Tunnel vision: Tunnel vision is seeing only one small part of life and not being able to see "The big picture." The addict looks at life as being made up of separate, unrelated parts. S/he focuses on one part without looking at other parts or how they are related. Sometimes this creates the mistaken belief that everything is secure and going well. At other times, this results in seeing only what is going wrong. Small problems are blown up out of proportion. When this happens, the addict comes to believe s/he is being treated unfairly and has no power to do anything about it.

10. Minor depression: Symptoms of depression begin to appear and to persist. The person feels down, blue, listless, empty of feelings. Oversleeping becomes common. S/he can distract self from these moods by getting busy with other things and not talking about the depression.

11. Loss of constructive planning: The addict stops planning each day and the future. S/he often mistakes the slogan "One day at a time" to mean that one shouldn't plan or think about what s/he is going to do. Less and less attention is paid to details. S/he becomes listless. Plans are based more on wishful thinking (how the addict wishes things would be) than reality (how things really are)

12. Plans begin to fail: Because s/he makes plans that are not realistic and does not pay attention to details, plans begin to fail. Each failure causes new life problems. Some of these problems are similar to the problems that had occurred during using. S/he often feels guilty and remorseful when the problems occur.

PHASE 4. IMMOBILISATION

During this phase the addict is totally unable to initiate action. S/he goes through the motions of living but is controlled by life rather than controlling his/her life. The most common symptoms are.

13. Daydreaming and wishful thinking: It becomes more difficult to concentrate. The "if only" syndrome becomes more common in conversation. The addict begins to have fantasies of escaping or "being rescued from it all" by an event unlikely to happen.

14. Feelings that nothing can be solved: A sense of failure begins to develop. The failure may be real, or it may be imagined. Small failures are exaggerated and blown out of proportion. The belief that "I've tried my best and recovery isn't working" begins to develop.

15. Immature wish to be happy: a vague desire "to be happy" or to have "things work out" develops without the person identifying what is necessary to be happy or have things work out. "Magical thinking" is used: wanting things to get better without doing anything to make them better.

PHASE 5. CONFUSION AND OVERREACTION

During this period the addict can't think clearly. S/he becomes upset with self and others, becomes irritable and overacts to small things.

16. Periods of confusion: Periods of confusion become more frequent, last longer and cause more problems. The addict often feels angry with self because of the inability to figure things out.

17. Irritation with friends: Relationships become strained with friends, family, counsellors and fellowship members. The addict feels threatened when these people talk about the changes in behavior and mood that are becoming apparent. The conflicts continue to increase despite the addict's efforts to resolve them. The addict begins to feel guilty and remorseful about his/her role in these conflicts.

18. Easily angered: The addict experiences episodes of anger, frustration, resentment, and irritability for no real reason. Overreaction to small things becomes more frequent. Stress and anxiety increase because of the fear that overreaction might result in violence. The efforts to control self adds to the stress and tension.

PHASE 6: DEPRESSION

During this period the addict becomes so depressed that s/he has difficulty keeping to normal routines. At

times there may be thoughts of suicide, using or drinking to end the depression. The depression is severe and persistent and cannot be easily ignored or hidden from others. The most common symptoms are.

19. Irregular eating habits: The addict begins overeating or undereating. There is weight gain or loss. S/he stops having meals at regular times and replaces a well-balanced, nourishing diet with "junk food."

20. Lack of desire to act: There are periods when the addict is unable to get started or get anything done. At those times s/he is unable to concentrate, feels anxious, fearful and uneasy, and often feels trapped with no way out.

21. Irregular sleeping habits: The addict has difficulty sleeping and is restless and fitful when sleep does occur. Sleep is often marked by strange and frightening dreams. Because of exhaustion s/he may sleep for twelve to twenty hours at a time. These "sleeping marathons" may happen as often as every six to fifteen days.

22. Loss of daily structure: Daily routine becomes haphazard. The addict stops getting up and going to bed at regular times. Sometimes s/he is unable to sleep, and this results in oversleeping at other times. Regular mealtimes are discontinued. It becomes more difficult to keep appointments and plan social events. The addict feels rushed and overburdened at times and then has nothing to do at other times. S/he is unable to follow through on plans and decisions and experiences tension, frustration, fear, or anxiety that keep him/her from doing what needs to be done.

23. Periods of deep depression: The addict feels depressed more often. The depression becomes worse, lasts longer, and interferes with living. The depression is so bad that it is noticed by others and cannot be easily denied. The depression is most severe during unplanned or unstructured periods of time. Fatigue, hunger and loneliness make the depression worse. When the addict feels depressed, s/he separates from other people, becomes irritable and angry with others, and often complains that nobody cares or understands what s/he is going through.

PHASE 7: BEHAVIOURAL LOSS OF CONTROL

During this phase the addict becomes unable to control or regulate personal behavior and a daily schedule. There is still heavy denial and no full awareness of being out of control. His/her life becomes chaotic and many problems are created in all areas of life and recovery. The most common symptoms are.

24. Irregular attendance at fellowship and treatment meetings: The addict stops attending fellowship meetings regularly and begins to miss scheduled appointments for counselling or treatment. S/he finds excuses to justify this and doesn't recognize the importance of fellowship and treatment. S/he develops the attitude that meetings and counselling aren't making me feel better, so why should I make it a number one priority? Other things are more important.

25. Development of an "I don't care" attitude: The addict tries to act as if s/he doesn't care about the problems that are occurring. This is to hide feelings of helplessness and a growing lack of self-respect and self-confidence.

26. Open rejection of help: The addict cuts self-off from people who can help. S/he does this by having fits of anger that drive others away, by criticizing and putting others down, or by quietly withdrawing from others.

27. Dissatisfaction with life: Things seem so bad that the addict begins to think that s/he might as well use because things couldn't get worse. Life seems to have become unmanageable since using has stopped.

28. Feelings of powerlessness and helplessness: The addict develops difficulty in "getting started;" has trouble thinking clearly, concentrating, and thinking abstractly; and feels that s/he can't do anything and begins to believe that there is no way out.

PHASE 8: RECOGNITION OF LOSS OF CONTROL

The addict's denial breaks and suddenly s/he recognizes how severe the problems are, how unmanageable life has become, and how little power and control s/he must solve any of the problems. This awareness is extremely painful and frightening. By this time s/he has become so isolated that there is no one to turn to for help. The most common symptoms are.

29. Self-pity: The addict begins to feel sorry for self and often uses self-pity to get attention at Fellowship meetings or from members of family.

30. Thoughts of social using: The addict realizes that drinking or using drugs would help him/her to feel better and begins to hope that s/he can drink/use normally again and be able to control it. Sometimes these thoughts are so strong that they can't be stopped or put out of mind. There is a feeling that drinking/using is the only alternative to going crazy or committing suicide. Drinking/using looks like a sane and rational alternative.

31. Conscious lying: The addict begins to recognize the lying and the denial and the excuses but is unable to interrupt them.

32. Complete loss of control: The addict feels trapped and overwhelmed by the inability to think clearly and take action. This feeling of powerlessness causes the belief that s/he is useless and incompetent. As a result, there is the belief that life is unmanageable.

PHASE 9: OPTION REDUCTION

During this phase the addict feels trapped by the pain and inability to manage his/her life. There seems to be only three ways out – insanity, suicide, or drug use. S/he no longer believes that anyone or anything can help him/her. The most common symptoms are.

33. Unreasonable resentment: The addict feels angry because of the inability to behave the way s/he wants to. Sometimes the anger is with the world in general, sometimes with someone, and sometimes with self.

34. Discontinuance of fellowship attendance and all treatment: The addict stops attending Fellowship meetings. When a helping person is part of treatment, tension and conflict develop and become so severe that the relationship usually ends. The addict drops out of professional counselling even though s/he needs help and knows it.

35. Overwhelming loneliness, frustration, anger and tension: The addict feels completely overwhelmed. S/he believes that there is no way out except using, drinking, suicide, or insanity. There are intense fears of insanity and feelings of helplessness and desperation.

PHASE 10: ACUTE RELAPSE PERIOD

During this phase the addict becomes totally unable to function normally. S/he may use drugs or alcohol or may become disabled with other conditions that make it impossible to function. The most common symptoms are.

36. Loss of behavioral control: The addict experiences more and more difficulty in controlling thoughts, emotions, judgements, and behaviors. This progressive and disabling loss of control begins to cause serious problems in all areas of life. It begins to affect health and well-being. No matter how hard s/he tries to regain control it is impossible to do so.

37. Acute relapse period: The addict experiences periods of time when s/he is totally unable to function normally. These periods become more frequent, last longer, and begin to produce more serious life problems. The relapse cycle is ended by a crisis which causes the person to become totally unable to function for a period of time due to one or more of the following:

A. DEGENERATION OF ALL LIFE AREAS: The addict may become unable to contribute to the work, social, family, and intimate areas of life. As a result, all life areas suffer due to neglect.

B. DRUG OR ALCOHOL USE: The addict may begin to use drugs or alcohol as a means to escape the pain and desperation. There may be an attempt to control using/drinking by limiting the amount or attempting one short term binge. The ability to control using/drinking is soon lost. This sometimes happens very quickly. Sometimes it occurs after a period of controlled using/drinking. The addict returns to out of control using/drinking with symptoms experienced during the last period of addictive use.

C. EMOTIONAL COLLAPSE: The addict may become emotionally unable to function, may overreact or become emotionally numb, or cry or fly into a rage for no reason at all.

D. PHYSICAL EXHAUSTION: It may become impossible for the addict to continue to function due to physical exhaustion.

E. STRESS RELATED ILLNESS: The addict may become physically sick due to the severe stress that has been occurring for a long period of time.

F. PSYCHIATRIC ILLNESS: The addict develops a severe psychiatric illness such as psychosis, severe anxiety, or severe depression. The psychiatric illness may be so severe that it forces the addict into treatment.

G. SUICIDE: The addict may become suicidal and may attempt or commit suicide.

H. ACCIDENT PRONENESS: The addict may become careless and unable to take normal precautions in acts of living, resulting in a sequence of accidents. These accidents may take the form of car accidents, falls, burns, etc. Often the accidents are life threatening or create serious injury.

I. DISRUPTION OF SOCIAL STRUCTURES: The addict may be unable to maintain involvement in normal life activities, may become socially unable to function

If you notice a warning sign, evaluate your need to seek help.

Practical Exercise # One

Families Members part in the "Plan for a Successful Lifelong Recovery"

1. **Learn the persons plan of care and adjusts to meet their current conditions:**

Q: What can the family members do to support this plan?

_____
_____
_____
_____
_____

2. **Communication Channels that are Two Way, supporting and linked to those who can help maintain recovery.**

Q: What can the family members do to support this plan?

_____
_____
_____
_____

3. **Strong Support Systems, flexible to meet day by day issues and challenges.**

Q: What can the family members do to support this plan?

_____
_____
_____
_____
_____

4. **A family environment that provides a sense of Purpose towards daily life.**

Q: What can the family members do to support this plan?

_____
_____
_____

How the Family Participates, Know the signs

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Six Skills for Families Affected by Addiction

Jan Ligon

This brief video provides an overview of six skills to help families and significant others who are affected by a person who has a substance abuse or addiction problem.

Link: **https://www.youtube.com/watch?v=3sBff2khxpo&t=379s** **Duration:** 8:26 min

Issues the Family Faces

Understand What They Experience.

Search Title:, REF: How To Create An Addiction Relapse Prevention Plan

VIEW VIDEO LINK: https://www.youtube.com/watch?v=yd3ESsbtCzY
Duration: 6:13 min

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. 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 the family members in these few rules can help them focus on what is important. Consider when a family is documenting the person(s) or organization(s) is now accountable for a particular action, the completion of the action, and how you will measure success. Identifying your past results, allows others to see they too will be measured, and that level of self-administered accountability can go a long way.

The key to relapse prevention is to understand that relapse happens gradually. It begins weeks and sometime months before an individual pick up a drink or drug. 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 clients. I have found it helpful to think in terms of three stages of relapse: emotional, mental, and physical.

The transition between emotional and mental relapse is not meaningless, 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.

Obstacles the family will likely address

Adopting a holistic view of clients in substance abuse treatment is especially important for the family to consider. At the point of referral, there is both an opportunity to address a their unmet needs and a potential danger of losing them losing their interest in treatment. Collaboration is crucial for preventing them from "falling through the cracks" among independent and autonomous agencies. Effective collaboration is also the key to serving the client in the broadest possible context, beyond the boundaries of the substance abuse treatment agency and provider.

The traditional referral system from substance abuse treatment programs to outside agencies can create obstacles to effective collaboration.

Goals and Outcomes of Family Members

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- Increase family support for the person's recovery. Family sessions can increase a client's motivation for recovery, especially as the family members realize that the person's substance use disorder is intertwined with problems in the family.
- Identify and support change of family patterns that work against recovery. Relationship patterns among family members can work against recovery by supporting the person's substance use, family conflicts, and inappropriate coalitions.
- Prepare family members for what to expect in early recovery. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- Educate the family about relapse warning signs. Family members who understand warning signs can help prevent the person's relapses.
- Help family members understand the causes and effects of substance use disorders from a family perspective. Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- Take advantage of family strengths. Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- Encourage family members to obtain long-term support. As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

Solutions to Issues & Obstacles

Practical Exercise One: Investigate the Future of What Will Likely Happen

A. What are you seeing?
Possible dysfunctional behaviors include:

B. **Social withdrawal or isolation** – avoiding family and friends; a marked preference to be alone.

Q: What can the family do: _____

C. **Refusal of any concerned efforts – denial of need**; an insistence of doing everything "on your own" with no help from anyone.

Q: What can the family do_____

D. **Sporadic counseling/therapy/12-Step meetings attendance** – Fellowship with other recovering addicts and alcoholics can be a major source of strength and inspiration, but as the saying goes, "it only works if you work it".

Q: What can the family do: _____

E. **Poor eating habits** – responding to stress or emotional pain with food; eating only junk food or fast food; alternately – loss of appetite

Q: What can the family do: _____

F. **Sleep disturbances** – insomnia, wakefulness, poor sleep quality; alternately, excessive sleeping or an inability to get out of bed

Q: What can the family do: _____

Practical Exercise Two: Emotional Relapse

In this earliest stage, the person likely will not even start to think about using or drinking. Rather, they start feeling negative emotions that cause you to act in self-destructive ways. Even when they are sober and abstaining, some of the aspects of their disease can still impact their life.

Emotional relapse precedes physical relapse:

1. **Anxiety** – excessive fear, worry, or uncertainty about your sober new life.
Q: What can the family do: _____

2. **Depression** – overwhelming sadness; loss of appetite; no motivation.
Q: What can the family do: _____

3. **Intolerance** – poor cooperation with others, an uncompromising attitude, or rigid, inflexible opinions
Q: What can the family do: _____

4. **Anger** – resentment or hostility that flares up whenever expectations are not met
Q: What can the family do: _____

5. **Defensiveness** – intensely rejecting any criticism
Q: What can the family do: _____

6. **Mood Swings** – an inability to control one's feelings and reactions, unpredictable emotional volatility
Q: What can the family do: _____

If any of these emotional conditions are left undone with, they can be a factor in the stress factors that can lead to physical relapse.

Practical Exercise Three: How can a family member prepare for what is happening?

1. **Self-Awareness** – Maintaining an active knowledge of your feelings, thoughts, and behaviors. There are several ways to practice self-awareness:

2. **Mindfulness meditation** – A 2017 study suggests that practicing mindfulness for as little as 11 minutes a day can help reduce cravings. Google how to practice mindfulness. www.youtube.com

3. **Journaling -** Daily reflection and affirmation

4. **Self-Care** – Doing the things that are necessary to maintain and improve your physical, emotional, and mental health.
5. Q: What can the family member do for themselves:
_____
_____

6. **Proper nutrition** – Addiction takes a terrible toll on the body, robbing it of essential nutrients. Eating right gets you healthier by restoring the vitamins and minerals you may have lost. Also, hunger is easy to misinterpret as drug cravings.

7. Q: What can the family member do for themselves:
   _____
   _____
   _____

8. **Reducing stress** – A 2011 study revealed a biological link between chronic stress and addiction. Key benefit: when you are calm, you are far less likely to overreact to the problematic situation.

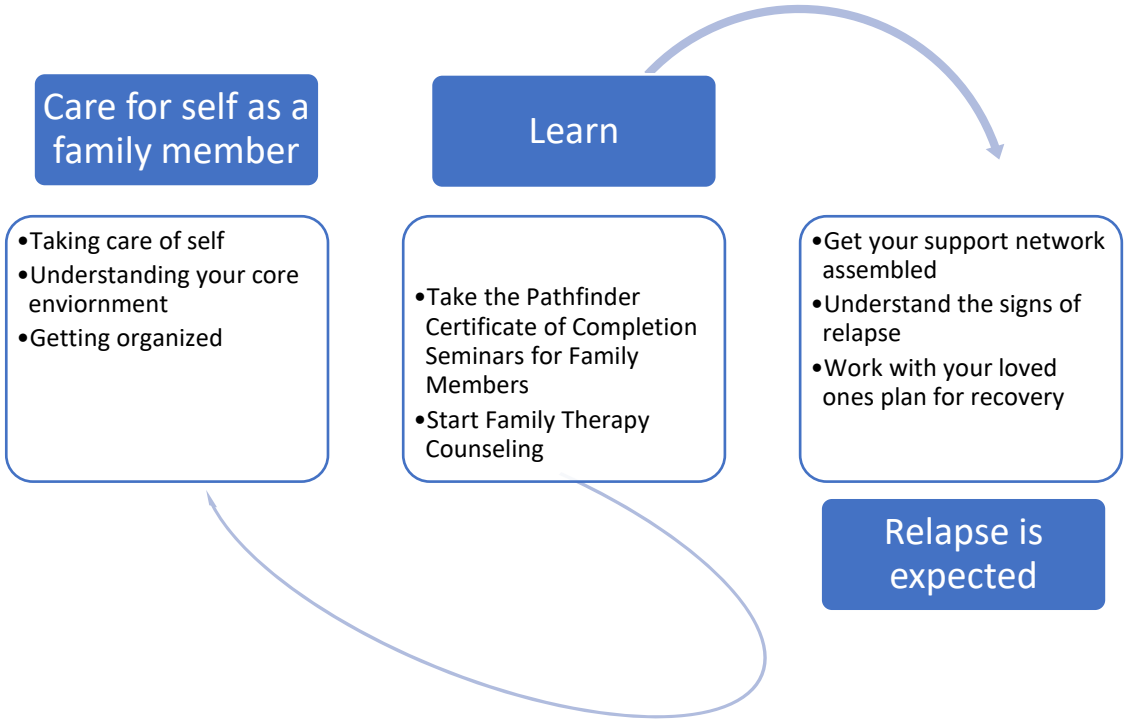
9. Q: What can the family member do for themselves:
   _____
   _____
   _____

7. **Getting enough quality sleep** – Insomnia is the biggest complaint among people in early recovery. Inadequate sleep can lead to irritability, depression, and confusion – each of which can trigger a relapse.

8. Q: What can the family member do for themselves:
   _____
   _____
   _____

9. **Ask for help when you need it** – The disease of addiction is too large of a problem to try to tackle alone. Asking for and receiving the help you need from supportive, positive people lets you take advantage of new perspectives and additional resources.

10. Q: What can the family member do for themselves:
    _____
    _____
    _____



Knowing what stage of the journey you are in, helps to determine what services is going to be needed next. The purpose of completing this seminar is to become aware of the family members support services, having the family ready to engage these resources at the right time and knowing what is going to be the possible outcome.

Practical Exercise Four:

Apply the F.T.R. Model for Each Issue Worksheet

Define the Issue?

Clearly State what happened or will happen.

_____

_____

_____

Identify who is involved or should be involved.

_____

_____

_____

What would you like to have happened, or like to see happen?

_____

_____

_____

How does the issue impact the family?

Who in the family?

_____

_____

_____

In what way?

_____

_____

_____

What is needed to move forward?

_____

_____

_____

What steps can the family take to prepare and then respond to the issue?

What needs to be done, prioritize the list.

_____

_____

_____

Who needs to be involved?

_____

_____

_____

What will it look like when completed?

_____

_____

_____

Who can help and assist the family in their response?

How to search for an organization to help.

_____

_____

_____

What to ask from them?

_____

_____

_____

What to expect?

_____

_____

_____

What should the family expect as their outcome?

Timeline.

_____

_____

_____

The expenses/cost involved in this issue.

_____

_____

_____

Required changes to successful respond to this issue.

_____

_____

_____

You are projecting in this exercise because the actual event has not occurred, updating this for each issue as it happens may be required.

VIDEO THREE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: Relapse Prevention June 2015

Published on Dec 17, 2012

Link: https://www.youtube.com/watch?v=0CVMJ1XXFlE

Duration: 1.19 hrs.

"Relapse Prevention" was presented on June 23, 2015; by Erik Anderson LLMSW, CAADC; Dawn Farm Outpatient Therapist. Addiction has been identified as an illness that requires long-term management. Relapse is a process that begins before alcohol/other drug use is resumed and is usually preceded by a pattern of progressive warning signs. Understanding the relapse process assists recovering people to develop an effective plan to identify and prevent relapse. This program will discuss the dynamics of relapse, signs that may forewarn of relapse, how to develop a relapse prevention plan and strategies to handle both every day and high-risk situations. the presentation includes discussion of Marlatt and Gorski's models of the relapse process, the roles played by will power and habit, and ways to use the Six Sources of Influence Inventory for initiating and maintaining behavior change.

This presentation is part of the Dawn Farm Education Series, a FREE, annual workshop series developed to provide accurate, helpful, hopeful, practical, current information about chemical dependency, recovery, family and related issues. The Education Series is organized by Dawn Farm, a non-profit community of programs providing a continuum of chemical dependency services. For information, please see dawnfarm.org/programs/education-series.

MASTER FAMILY PLAN OF ACTION FOR: "Successful Lifelong Recovery"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Your family will use the elements of supporting the loved ones plan of care in recovery.
2. A family action plan will be written on how the family will respond in stage of emotion, for potential relapse. Early intervention
3. The family members will use the steps for care for themselves in managing the stress of recovery.

As part of the Master Family Plan of Action the family members will complete the review the needed "points of contact" at the agencies they will possibly need to work with in the future.

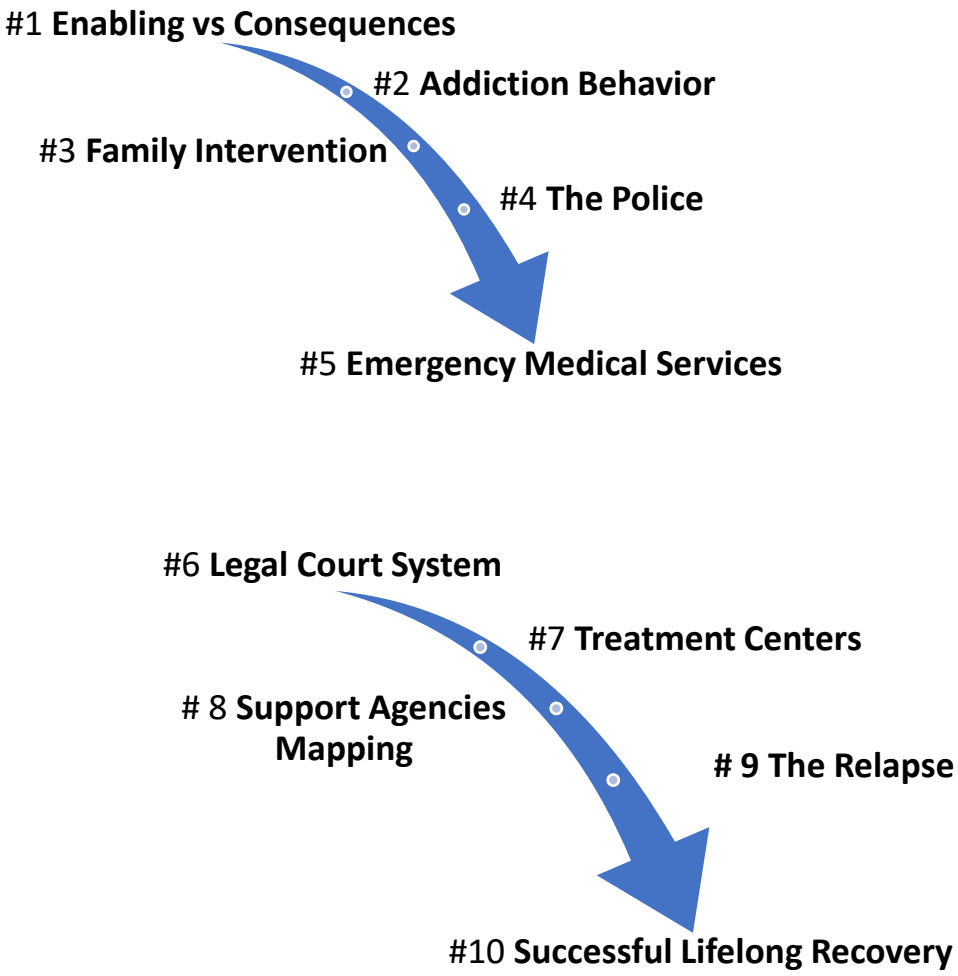
Issue # Eleven: The Bereavement Seminar

Seminar Eleven: Study Guide

Seminar Objectives:

1. Learn the three types of grief.
2. Understand the grief cycle.
3. Create an inventory for complicated grief

These are the 12 Key Issues a Family Faces



#11 Bereavement (Learning how to move forward)

#12 **Faith, Spiritual Practices**

Introduction: Bereavement

There is more than one type of grief in the bereavement process. Let us take a look to more closely examine the three most common griefs and learn how to determine the difference.

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.

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 in order 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.

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.

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. 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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World Psychiatry. 2009 Jun; 8(2): 67–74.
doi: 10.1002/j.2051-5545.2009.tb00217.x
PMCID: PMC2691160
PMID: 19516922
Grief and bereavement: what psychiatrists need to know

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 patients may benefit from treatment.

Duration: 5:08 min

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

Issue # 11: The Bereavement Seminar

Seminar Eleven: Workbook

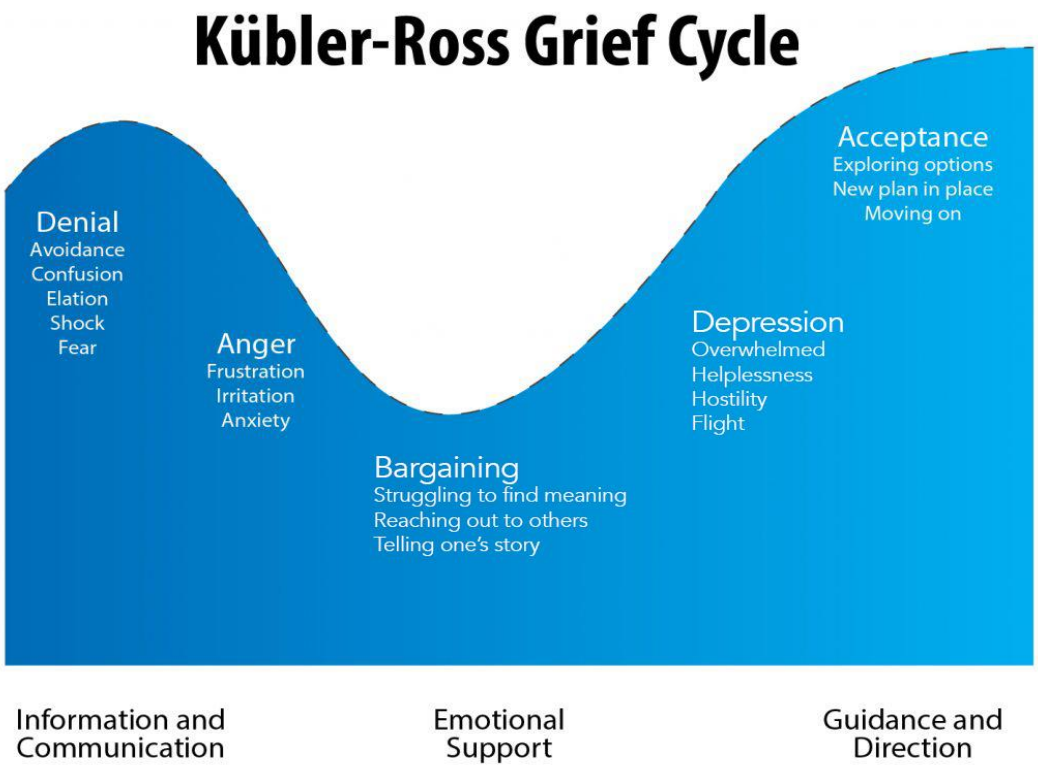
Introduction

Coping with the death of a loved one is a tremendous load to bear. It sparks a traumatic grief that can lead to feelings of abandonment or anger, in addition to deep sadness. During wartime, parents of fallen service members grieve the loss of the child they tried to protect. A grieving spouse or significant other may have the additional responsibility of caring for the children, helping them cope with the loss and change in their lives. Families also experience an additional sense of loss from having to move outside of their military community, which often includes a change of schools for their children. The surviving spouse or other family member may suddenly be solely responsible for the family's financial situation or simply must face the challenges of being alone.

Grief Model Background:

Throughout life, we experience many instances of grief. Grief can be caused by situations, relationships, or even substance abuse. Children may grieve a divorce, a wife may grieve the death of her husband, a teenager might grieve the ending of a relationship, or you might have received terminal medical news and are grieving your pending death. In 1969, Elisabeth Kübler-Ross described five popular stages of grief, popularly referred to as DABDA. They include:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance



Denial

Denial is the stage that can initially help you survive the loss. You might think life makes no sense, has no meaning, and is too overwhelming. You start to deny the news and, in effect, go numb. It's common in this stage to wonder how life will go on in this different state – you are in a state of shock because life as you once knew it, has changed in an instant. If you were diagnosed with a deadly disease, you might believe the news is incorrect – a mistake must have occurred somewhere in the lab–they mixed up your blood work with someone else. If you receive news on the death of a loved one, perhaps you cling to a false hope that they identified the wrong person. In the denial stage, you are not living in 'actual reality,' rather, you are living in a 'preferable' reality. Interestingly, it is denial and shock that help you cope and survive the grief event. Denial aids in pacing your feelings of grief. Instead of becoming completely overwhelmed with grief, we deny it, do not accept it, and stagger its full impact on us at one time. Think of it as your body's natural defense mechanism saying "hey, there's only so much I can handle at once." Once the denial and shock starts to fade, the start of the healing process begins. At this point, those feelings that you were once suppressing are coming to the surface.

Anger

Once you start to live in 'actual' reality again and not in 'preferable' reality, anger might start to set in. This is a common stage to think "why me?" and "life's not fair!" You might look to blame others for the cause of your grief and also may redirect your anger to close friends and family. You find it incomprehensible of how something like this could happen to you. If you are strong in faith, you might start to question your belief in God. "Where is God? Why didn't he protect me?" Researchers and mental health professionals agree that this anger is a necessary stage of grief. And encourage the anger. It's important to truly feel the anger. It's thought that even though you might seem like you are in an endless cycle of anger, it will dissipate – and the more you truly feel the anger, the more quickly it will dissipate, and the more quickly you will heal. It is not healthy to suppress your feelings of anger – it is a natural response – and perhaps, arguably, a necessary one. In every day life, we are normally told to control our anger toward situations and toward others. When you experience a grief event, you might feel disconnected from reality – that you have no grounding anymore. Your life has shattered and there's nothing solid to hold onto. Think of anger as a strength to bind you to reality. You might feel deserted or abandoned during a grief event. That no one is there. You are alone in this world. The direction of anger toward something or somebody is what might bridge you back to reality and connect you to people again. It is a "thing." It's something to grasp onto – a natural step in healing.

Bargaining

When something bad happens, have you ever caught yourself making a deal with God? “Please God, if you heal my husband, I will strive to be the best wife I can ever be – and never complain again.” This is bargaining. In a way, this stage is false hope. You might falsely make yourself believe that you can avoid the grief through a type of negotiation. If you change this, I’ll change that. You are so desperate to get your life back to how it was before the grief event, you are willing to make a major life change in an attempt toward normality. Guilt is a common wing man of bargaining. This is when you endure the endless “what if” statements. What if I had left the house 5 minutes sooner – the accident would have never happened. What if I encouraged him to go to the doctor six months ago like I first thought – the cancer could have been found sooner and he could have been saved.

Depression

Depression is a commonly accepted form of grief. In fact, most people associate depression immediately with grief – as it is a “present” emotion. It represents the emptiness we feel when we are living in reality and realize the person or situation is gone or over. In this stage, you might withdraw from life, feel numb, live in a fog, and not want to get out of bed. The world might seem too much and too overwhelming for you to face. You don’t want to be around others, don’t feel like talking, and experience feelings of hopelessness.

Acceptance

The last stage of grief identified by Kübler-Ross is acceptance. Not in the sense that “it’s okay my husband died” rather, “my husband died, but I’m going to be okay.” In this stage, your emotions may begin to stabilize. You re-enter reality. You come to terms with the fact that the “new” reality is that your partner is never coming back – or that you are going to succumb to your illness and die soon – and you’re okay with that. It’s not a “good” thing – but it’s something you can live with. It is definitely a time of adjustment and readjustment. There are good days, there are bad days, and then there are good days again. In this stage, it does not mean you’ll never have another bad day – where you are uncontrollably sad. But, the good days tend to outnumber the bad days. In this stage, you may lift from your fog, you start to engage with friends again, and might even make new relationships as time goes on. You understand your loved one can never be replaced, but you move, grow, and evolve into your new reality.

The prescription of medication and engagement in counseling have been the most common methods of treating grief. Initially, your doctor may prescribe you medications to help you function more fully. These might include sedatives, antidepressants, or anti-anxiety medications to help you get through the day. In addition, your doctor might prescribe you medication to help you sleep. This treatment area often causes some differences in opinion in the medical field. Some doctors choose not to prescribe medications because they believe they are doing you a disservice in the grieving process. That is, if a doctor prescribes you anti-anxiety pills or sedation pills – you are not truly experiencing the grief

in full effect – you are being subdued from it – potentially interfering with the five stages of grief and eventual acceptance of reality.

Counseling is a more solid approach toward grief. Support groups, bereavement groups, or individual counseling can help you work through unresolved grief. This is a beneficial treatment alternative when you find the grief event is creating obstacles in your everyday life. That is, you are having trouble functioning and need some support to get back on track. This in no way means it "cures" you of your loss, rather, it provides you with coping strategies to help you deal with your grief in an effective way. The Kubler-Ross Model is a tried and true guideline but there is no right or wrong way to work through your grief and it is normal that your personal experience may vary as you work through the grieving process.

If you or a loved one is having a hard time coping with a grief event, seek treatment from a health professional or mental health provider. Call a doctor right away if you experience thoughts of suicide, feelings of detachment for more than two weeks, you experience a sudden change in behavior, or believe.

The Five Stages of Grief

Issues the Family Faces

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: The Grieving Process: Coping with Death

There is no right or wrong way to deal with the loss of a loved one. The grieving process is rough—and it's different for everyone. It's not just a matter of coping with a loss, but coping with change—and that takes time. Duration: 4:14 min

Link: https://www.youtube.com/watch?v=gsYL4PC0hyk
Loss can take many forms, some of which are more devastating than others. When our spouse blindsides us by asking for a divorce, when an immediate family member dies, when we get let go from our long-term place of employment or when we become disabled by chronic illness or injury—our lives can feel as if they have been upended. Indeed, loss forces us to confront five specific psychological challenges.

1. **Overcoming Paralyzing Emotional Pain:** The first and most immediate challenge we face is that of excruciating and paralyzing emotional pain. At first, the pain is so severe we might be in shock and feel as though in a haze, trapped in a terrible alternate reality from which we cannot escape. We might lose the ability to think straight or even to function in the most basic ways. The one thing that helps diminish the pain is time. Therefore, our challenge is to find ways to simply get through those first terrible hours, days, and weeks. Once the initial shock begins to fade and the new realities set in, we face our second challenge:

2. **Adjusting to Changes in Our Daily Lives:** Grief and loss can change almost every aspect of our daily routines. We might no longer have a spouse with whom to socialize, losing our jobs means we have nowhere to go each morning, becoming disabled can mean having to retrain ourselves to do the most basic tasks. To recover we face the challenge of coming to terms with the changes that were forced upon us. Only then can we begin the process of finding new ways of living and being that can substitute for those we've lost.

3. **Reformulating Our Identities:** Significant grief and loss can impact our very sense of identity—how we define who we are. We feel as if the person we once were is lost and that the person facing us in the mirror is a stranger. We might have defined ourselves by our career but lost our job (or retired), we might have defined ourselves by our couple hood but lost our spouse, or we might have defined ourselves by our physicality but become crippled by Multiple Sclerosis. To recover we face the challenge of reexamining and redefining who we are, how we see ourselves, and how we want others to view us. We have to reconstruct our identities and come to peace with our new selves and our new lives.

4. **Reconstructing Our Relationships:** It is common for people to respond to profound loss by withdrawing into themselves. We might try to hold on to a deceased loved one by talking to them in our heads throughout the day, trying to keep them alive and present in our minds. At times, we might avoid other people, as they provide stark reminders of our loss. After failing out of college or losing our jobs we might lose touch with classmates and colleagues. Unfortunately, sickness and disability often make others uncomfortable and make them withdraw from us. To recover we face the challenge of reconnecting to those who remain and forming new connections that reflect the new realities of our situation.

5. **Adjusting Our Belief Systems:** Trying to make sense of our experiences in life is a compelling human drive. Although some of us articulate it more clearly than others do, we each have our way of understanding how the world works; a unique set of beliefs and assumptions that form the lens through which we view the world and our place in it. Loss and grief can challenge these basic assumptions and make us question everything we thought we knew. We're flooded with doubts and questions, the simplest and most compelling of which is often simply—why? Our challenge is to find ways of making sense of what happened and adjusting our belief systems accordingly. And to thrive, we must find within ourselves a way to ascribe meaning to the events and discover a new purpose to drive our existence.

REF: Psychology Today: The 5 Psychological Challenges of Loss and Grief
How loss disrupts our lives and how to heal
Posted Apr 01, 2014

Obstacles the family will likely address

The Children see grief having different faces:

It is increasingly clear that not only do children grieve, but they also grieve in different ways or express their grief differently than do adults. "Kids often grieve in spurts because they can't seem to tolerate grief for long periods of time," says Susan Thomas, LCSW-R, FT, program director for the Center for H.O.P.E. at Cohen's Children's Medical Center of New York. Adults, she explains, "have one foot in grief and one foot on the outside, but kids jump in and out of grief." Children may give the appearance of coping well, when suddenly a seemingly innocuous event unrelated to the loss triggers a disproportional response. For example, says Thomas, "A child may scrape her knee and say, 'I wish Daddy were here. If he were here this wouldn't have happened.' Kids are masters at being able to distract themselves and focus on other things, but when something happens, all of the emotion they've been pushing away comes back." This coping mechanism, Thomas says, allows them to "handle the intensity of the experience."

Not only may children and adults grieve in dissimilar ways, but, McNiel says, "Children also grieve in different ways at different ages and stages of life. Their grief might be expressed in an array of emotions such as anger, sadness, fear, and sometimes relief, particularly when there had been long-term illness or perhaps a contentious relationship with the person who died."

It's important to remember, however, DeCristofaro says, that when it comes to grief, those developmental stages are fluid and permeable. "Sometimes you'll see a 3-year-old grappling with something existential as a teenager might."

"Grief does not happen in nice, neat stages, but is unique to the person grieving and influenced by a number of factors in addition to age, including temperament and personality, the relationship they had with the deceased, the relationship they have with the surviving caregiver, the type of death, and the reaction of the adults around them," McNiel says. Grief, he adds, is not very well structured, and all children, like all adults, grieve in their own ways.

Solutions to Issues & Obstacles

Practical Exercise One:

Source:
Prigerson, H. G., Shear, M. K., Frank, E., Beey, L. C., Silberman, R., Prigerson, J., et al. (1997). Traumatic grief: A case of loss-induced trauma. American Journal of Psychiatry, 154(7), 1003-1009. Reprinted with permission from the American Journal of Psychiatry, Copyright 1997, American Psychiatric Association

Module 7 Table 6: Inventory of Complicated Grief

PLEASE fill in the circle next to the answer which best describes how you feel right now:

1. I think about this person so much that it's hard for me to do the things I normally do…
□ never□ □ rarely □ sometimes □ often □ always

2. Memories of the person who died upset me…
□ never□ □ rarely □ sometimes □ often □ always

3. I cannot accept the death of the person who died…
□ never□ □ rarely □ sometimes □ often □ always

4. I feel myself longing for the person who died…
□ never□ □ rarely □ sometimes □ often □ always

5. I feel drawn to places and things associated with the person who died…
□ never□ □ rarely □ sometimes □ often □ always

6. I can't help feeling angry about his/her death…
□ never□ □ rarely □ sometimes □ often □ always

7. I feel disbelief over what happened…
□ never□ □ rarely □ sometimes □ often □ always

8. I feel stunned or dazed over what happened…
□ never□ □ rarely □ sometimes □ often □ always

9. Ever since s/he died it is hard for me to trust people…
□ never□ □ rarely □ sometimes □ often □ always

10. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about…

□ never□ □ rarely □ sometimes □ often □ always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died…
□ never□ □ rarely □ sometimes □ often □ always

12. I go out of my way to avoid reminders of the person who died…
□ never □ rarely □□□□□□ sometimes □ often □ always

13. I feel that life is empty without the person who died…
□ never□ □ rarely □ sometimes □ often □ always

14. I hear the voice of the person who died speak to me…
□ never□ □ rarely □ sometimes □ often □ always

15. I see the person who died stand before me…
□ never□ □ rarely □ sometimes □ often □ always

16. I feel that it is unfair that I should live when this person died…
□ never□ □ rarely □ sometimes □ often □ always

17. I feel bitter over this person's death…
□ never□ □ rarely □ sometimes □ often □ always

18. I feel envious of others who have not lost someone close…
□ never□ □ rarely □ sometimes □ often □ always

19. I feel lonely a great deal of the time ever since s/he died…
□ never□ □ rarely □ sometimes □ often □ always

Practical Exercise Two:

Module 7 Figure 4: Self-Care Assessment

Self-Care Assessment

Take a moment to consider the frequency with which you do the following acts of self-care. Rate using the scale below:

4 = Often 3 = Sometimes 2 = Rarely 1 = Are you kidding? It never even crossed my mind!

Physical Self-Care

__ Eat regularly (no skipping meals)

__ Eat healthfully

__ Exercise at least 30 minutes five times a week

__ Sleep 7–9 hours per night

__ Schedule regular preventative health-care appointments

__ Take time off when ill

__ Get massages or other body work

__ Do enjoyable physical work

Psychological Self-Care

__ Read a good novel or other nonwork-related literature

__ Write in a journal

__ Develop or maintain a hobby

__ Make time for self-reflection

__ Seek the services of a counselor or therapist

__ Spend time outdoors

__ Say “no” to extra responsibilities when stressed

__ Allow the gift of receiving (instead of just giving)

Emotional Self-Care

__ Stay in contact with important people

__ Spend time with the people whose company is most comfortable

__ Practice supportive self-talk; speak kindly in internal thoughts

__ Allow both tears and laughter to erupt spontaneously

__ Play with children and animals

__ Identify comforting activities and seek them out

__ “Brag” to a trusted friend or family member; be proud of accomplishments

__ Express anger in a constructive way

Spiritual Self-Care

__ Make time for regular prayer, meditation, and reflection

__ Seek community among friends, neighbors, or other gatherings

__ Cherish optimism and hope

__ Contribute to or participate in meaningful activities of choice

__ Be open to inspiration

__ Use ritual to celebrate milestones and to memorialize loved ones

__ Be aware of the nontangible of life

__ Listen to or create music

Workplace Self-Care

__ Take time to eat lunch

__ Make time to address both the physical and emotional needs of residents

__ Take time to chat and laugh with co-workers

__ Seek regular supervision and mentoring

__ Set limits with residents, families, and colleagues

__ Find a project or task that is exciting and rewarding in which to be involved

__ Decrease time spent comparing work performance to others

__ Seek a support group – even if it is only one other person

Scoring the Results:

121-160 You’re a self-care guru! Share the wisdom with everyone around you.

81-120 You’re on the right track. Get creative in the areas of least scoring.

41-80 Uh-oh. There’s some work to do. Hunker down and focus on yourself.

 40 Are you still reading this? You’re about to self-destruct. Call 911!

MASTER FAMILY PLAN OF ACTION FOR: "Bereavement"

Complete answers and move to "Master Family Plan of Action".

4. Determine which of the three types of grief fits your type of condition.
5. Use the grief cycle as a status indicator for yourself and others.
6. Create an inventory for complicated grief and review with a physician or counselor.

As part of the Master Family Plan of Action the family members will complete the review and needed "points of contact" list of agencies they will possibly need to work with in addressing this issue.

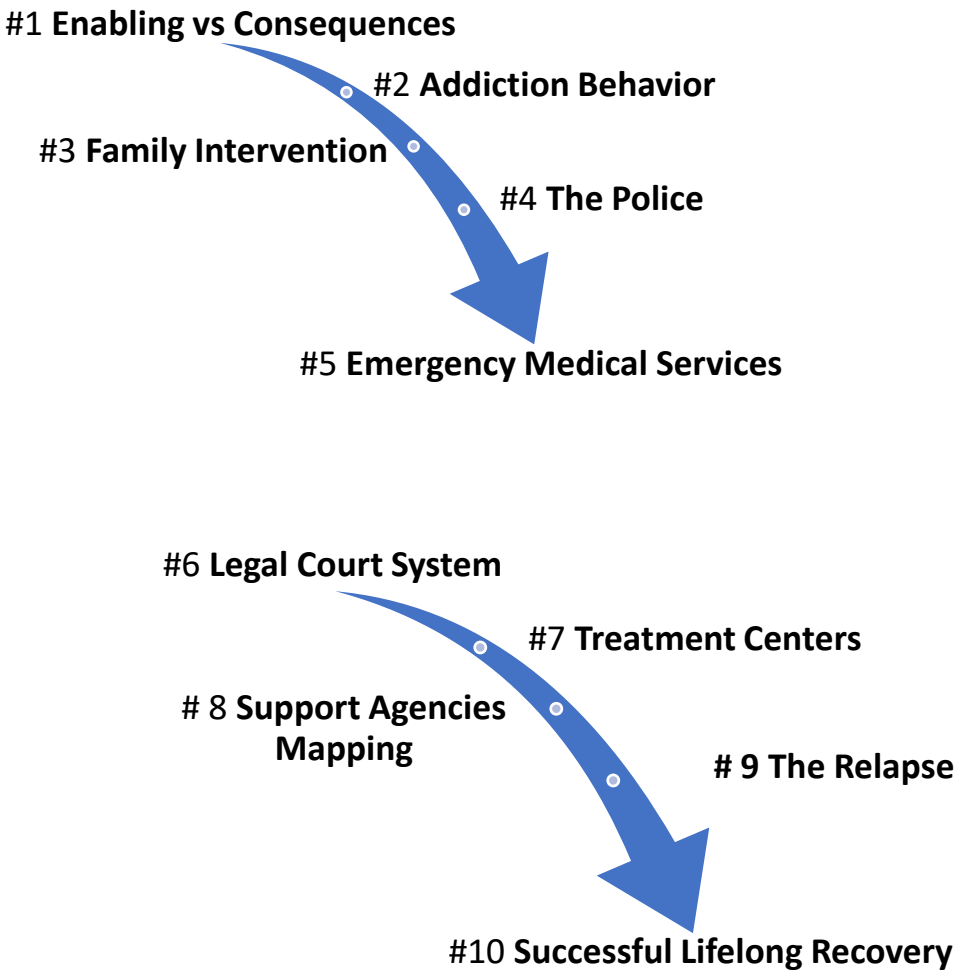
Issue # 12: Faith, Spiritual Practices Seminar

Seminar Twelve: Study Guide

Seminar Objectives:

1. **A review of how faith and suffering are presented in the substance use disorders journey.**
2. **Consideration of how to create a personal response to the issue of "where faith fits into the family lives" as it relates to three key areas: 1. Education, 2. Spiritual Development and 3. Family Referral Resource networking.**
3. **How to start an Invest in the Family Ministry.**

These are the 12 Key Issues a Family Faces



#11 Bereavement (Learning how to move forward)
#12 **Faith, Spiritual Practices**

Introduction: Faith, Spiritual Practice

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,
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.

The Invest in the Family User 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.

Family Suffering, it takes several times reading to absorb

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 mystery. But we ask the question just the same: Why is there suffering, especially to those who are justly living their lives?

When asked of God, our answers are not 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 the area of 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 times 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 at 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 absolutely 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 of all 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.

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 is connected with 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 in order 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

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's 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's who's really 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's a difficult process to go through in order to achieve the reward of a sober life. Families likewise avoid intervention because they don't 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 calling is to serve, then follow these steps. If it is to understand, then complete this study guide and work book 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's 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 to 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:

1. The Family Solution Finder
2. The SP~ARK's Program
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's 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.

Create a Mission Statement

Create a Mission Statement Work Sheet

The mission statement allows other to understand what our ministry is about, what we want to accomplish, how we will do this and who it will impact.

I. First Understand "Who You Are" As A Ministry

Three Values:

A value is a core priority for the ministry.

1. The spiritual needs of others.

2. Bringing to and being Christ for Others.

3. A volunteer who is in a constant state of spiritual development, is one who values their spirituality.

What are you competent in doing:

1. Being a Good Listener, we see first to understand, before we try to be understood.

2. Organizing towards a purpose driven response.

3. Providing resources to help people develop their spirit and soul.

What is our goal:

1. Being the communion of Christ to the family's members impacted by the drug epidemic

2. Each family member will have an individual spiritual development plan

3. Each volunteer will have their own individual spiritual development plan

4. All family members will learn the issues that will come next in their journey.

Who receives our ministry service?

Internal Customer: Staff, Church Volunteer and their families.

External Customer: Family's members impacted by the drug epidemic.

Ancillary Customer: Local community services.

Why are we concerned that we do this?

1. God is inviting us to be concerned.

2. A love for one another.

3. Because we know they are suffering.

II. How to set up the Mission Statement Structure

State the purpose and values

Our purpose is to…… Care for the education and spiritual needs of others, both our families and our volunteer's.

Our values are…. Organizing our purpose to provide learning and developmental resources that match what is effective to their needs.

State the responsibilities of the ministry to the family members

It is our responsibility to…… Work with each person as an individual person in Christ.

State the main objectives that support the ministry

We seek to ……. Attach the family through our volunteer to Christ communion through us all by being present in their lives.

Mission Statement (Sample)

Our mission is to share God's love with the homebound, in a faith journey of their lives and ours in service to the lord, to the greater glory of God.

Create a Vision Statement

Create a Vision Statement Work sheet

I. First understand, "what you want to become"

A vision is a focal point for planning as to where you want to be in the future. It is stated in 3, 5-year period. It gives direction as to where the ministry is going, how they will look. It should be inspiring.

What will the ministry look like in 3 years?

People it serves:

Families members it educates

People volunteering within the ministry:

Quality of the service:

What will the ministry look like in 5 years?

People it serves:

Families members it educates

People volunteering within the ministry:

Quality of the service:

Include vivid descriptions, the image it creates

State an attractive image, make it motivational

Image of Three Years:

Image of Five Years:

Why is what we are doing important

II. Building the structure of a Vision Statement

The Invest in the Family Ministry sees our future in the next 3 years as having…….

And in the next 5 years this ministry will be……

We believe this is important in order to…….

We strive to be a faith community whose gratitude for God's countless blessings is expressed in our prayerful relationships with Jesus Christ. We provide a compassionate service to those in need, and joyful welcoming to all people at the celebration of our Church life.

Ministry Vision (Sample)

The "Invest in the Family Ministry" in five years will have approximately 50 families on service at any given point in the year. These families will be gaining skills and understanding about the substance use disorder journey through "The Family Solution Finder" learning program seminars. They will be engaged in some type of personal or family spiritual development learning track from the SP~ARK's Program and will be connected to support services through the Family Resource Coordination M.O.R.E. program. From this both volunteer, Church and family members are receiving the acts of mercy the Lord shares with us all. In this we share freely that which has been given to us from God, as stewards of His grace for others to share.

Create a Philosophy Statement Work Sheet

The philosophy statement tells others how you see the world around the ministry and what value the ministry being into this world.

I. First Understand what guide the Ministry, Principles, Beliefs

What is the ministry's Principle?

The main reason this ministry exists is to:

1.

2.

3.

What are the ministry's Beliefs?

The ministry believes in:

1.

2.

3.

In Theory we are made up of:

1.

2.

3.

How will this be used to benefit others:

1.

2.

3.

II. Building the Structure of a Ministry Philosophy Statement

What you are:

The philosophy of Invest in the Family Ministry is a combination of ….

Why we do it:

We base this on the foundations of……

How we do it:

This is done by ……

Why it is important to do:

This will give those the ministry serves……

Ministry Philosophy (Sample)

The spiritual development and growth of our volunteers' needs to be consistent (for all volunteers) moving forward. The objective of the Church ministry is ministering our faith practices and spiritual development to the family members on a journey with substance use disorder and Educating them about the issues and challenges they will likely face while connecting them to resources that support them along their path. From within the spirit of the volunteer is God's love to be shared in their visits, through their acts of kindness and His mercy. Let's repeat this: "It does not come from the ministry; it comes from the volunteer". The volunteer is 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 volunteer to then go out and minister to others.

Invest in the Family Ministry Culture

It is through a desire to please God that we seek to serve Him by obeying his commandments to "Love One Another". As a Church, it becomes the soul of who we are as disciples of the our faith. As a volunteer, as a believer and as a child of God. Discipleship is what we do.

In our Invest in the Family Ministry culture, we believe it is possible to harness the gifts of our volunteers in a new way. Their desires to share God's love, their wanting's to be obedient to His word, is alive. This desire to serve will become our sustainable ministry focus, is practiced through a design which feeds the spiritual development of our volunteers, as they serve in our ministry's. It is our structure, process, training and a willingness to try and at times possibly fail, while knowing that God oversees all that we do, this is where we will sustain and grow our ministries.

The first assumption is that all of us, in the Church seek our Church ministry to be alive and functioning at its fullest potential. If "good enough is enough" then we will not bother doing any of this, we know it would be futile, because maintaining the status quo is a pathway to failure.

By following this ministry use manual steps and adding a flavor of our own we will create something that is exciting and forward thinking. We will be bold in prayer, assertive in faith and know that our God is here, every step we take.

YOUR MINISTRY'S CULTURE

Mission Statement:

_____
_____
_____
_____

Vision Statement:

_____
_____
_____
_____

Philosophy Statement:

_____
_____
_____
_____

Values Statement:

_____
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_____
_____

Issue # 12: Faith, Spiritual Practices Seminar

Seminar Twelve: Workbook

Seminar Objectives:

1. Review the need for faith organization participation.
2. Create an Invest in the Family Ministry.
3. Offer the Invest in the Family Ministry at your place of worship.

It is through a desire to please God that we seek to serve Him by obeying his commandments to "Love One Another". As a Church, it becomes the soul of who we are and in our ministering of our faith, this becomes what we do from within the structure of the ministry.

We find most Churches are not set up to provide purpose driven Church ministry's, with highly effective volunteers. In its place where excuses of "because, that is the way we've always done it" statements are perceived as "go away, don't bother me, can't you see I am overloaded". This can become a combination of wasted spiritual gifts inside our volunteers and valuable ministering experience from those leaders that could have inspired others to serve in ministry.

But it is possible to harness the gifts of our volunteers in a new way. Their desire is to share God's love, their desire is to be obedient to His word. These can become the volunteer's shared gifts and will create a sustainable ministry program that is designed to feed the spiritual development of the volunteers, the families and Church. What is missing is structure, process, training and a willingness to fail, while knowing that God oversees all that we do.

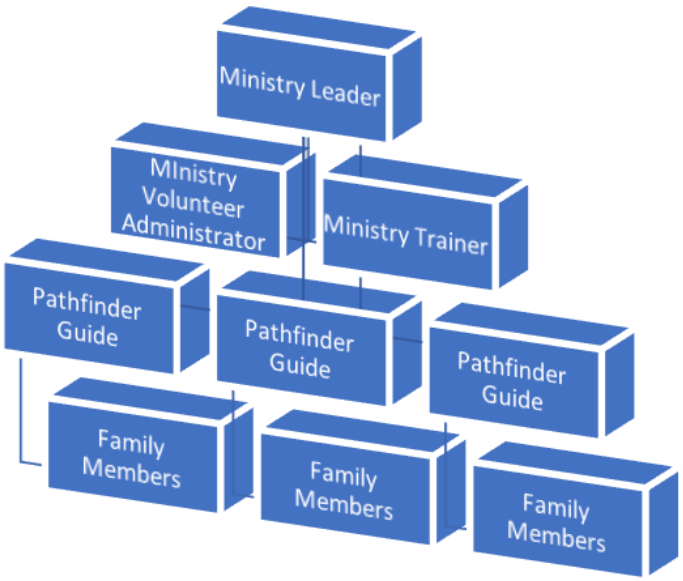
The first step is to develop the ***culture*** from which the "Invest in the Family Ministry" will operate. This is done when leadership gathers those who will volunteer and asks them, "What are your **VALUES**, what are your **BELIEFS**"? Once this is out in the open, the leadership can ask, "*how do you want to serve the Lord our God*"? And with their answer, build an organized ministry supported with processes, training and budget. This is how an organization can set a new path, one where those who will travel it, help to design it, and therefore have ownership in how well it works in serving the needs of others with God's mercy, love and compassion.

The first assumption is that a Church leadership seeks their Church ministry's alive and functioning at its fullest potential. If "good enough is enough" then do not bother going any further with this ministry development. It would be futile, because maintaining the status quo is a pathway to failure.

This section will outline how to take a culture and design a sustainable, successful Purposeful Driven Ministry, with Purpose Driven Volunteers.

Please follow these implementation steps and add a flavor of your own to create something that is exciting and forward thinking. Be bold in prayer, be assertive in faith and know that our God is here, every step we take.

The structure of a ministry is where all this comes alive.



Identify the three main programs of the ministry

Issues the Family Faces

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: How to Start a Church Ministry | Mission, Ideas, Organizing, Leadership, and Money

Street Bishops

How to Start a Church | Start a Ministry | Mission, Ideas, Organizing, Leadership, and Money http://www.StreetBishops.com What is keeping your from starring the ministry that the Lord has put on your heart? Now is the time to take the lead from the Holy Spirit and take action towards starting your ministry. This video will provide you with the first steps leading to a successful start. This video addresses the following: how to start a ministry how to start a ministry with no money how to start a ministry step by step how to start a ministry from scratch how to start a ministry business how to start a ministry blog how to start a ministry online Email Rev Lance at secretary@streetbishops.com for clarification of any issue touched on in this video. Do you want a ministry coach that will guide you towards you successful start up? Lance is

Duration: 19:27

Link: https://www.youtube.com/watch?v=vTYIkH9-JHo

Ministry Leader, Process is Leadership

Ministry Leadership:

The Ministry Leader will meet with the Ministry Administrator and Ministry Trainer to review status of education, development and networking resources for each individual ministry member. The review is conducted quarterly to determine if the programs offered are being utilized and if the meetings are on target towards developing the needs of the ministry members. The members

are not held accountable to progress in any of the two programs. But if they are taking these programs, we want to confirm the programs are meeting their needs and obstacles are removed.

Family Education is Leadership:

The ministry leader will focus a portion of their time in speaking with the group during monthly meetings, to facilitate healthy, supportive relationships within the ministry. and grooming the experience of a selected few to take the roles of leader, administrator and trainer (succession planning steps) at some point in the future. Their focus will also be on affairs outside the ministry. The leader will be notified by the Ministry Administrator if a family misses three or more consecutive meetings, to call and follow up with that family. This supports our ministry culture "No Family Left Forgotten" Policy.

Because family education equals family empowerment, this area will likely take up most of the leader's time.

Family Spiritual Development is Leadership:

The Ministry Leader will have an annual meeting to design the individual spiritual development plan with the Ministry Administrator, Ministry Trainer and Ministry Pathfinder Guides. Although we are all titled volunteers, our true calling is in being disciples of Jesus Christ. This is the reason for the development of our combined spirit. We believed that our Church of volunteer's are also Disciples of Jesus Christ created for a greater service to the Lord as we respond to His call to serve others. For this reason, the Ministry Leader will oversee all members of the ministry who choose to participate in the Spiritual Development SP~ARK's Program.

Family Resource Networking is Leadership:

There are many resources available to assist the ministry, its volunteers and members. The Ministry Leader will ensure that a balanced list of Govt, Private and Professional resources are made available to the ministry membership and connection to inner Church ministry's is also included to this list.

A TYPICAL MEETING AGENDA:

I. Welcome & Update Announcements
II. Family & Pathfinder Guide, Small Group Session
III. Family Education Seminar, Large Group Session
IV. Networking Connections, Large Group Session
V. Conclusion and next meeting assignments

MINISTRY MONTHLY MEETINGS

In the monthly meetings is where all education learning track will be presented. The ministry is designed to hold monthly meetings. Each meeting will be led by the Ministry Trainer and Ministry Pathfinder Guide. The next meeting agenda will be announced at the end of all previous meetings.

Process Family Member Education: "The Family Solution Finder" Program

- **The Pathfinder Segment**: Because each family is assigned a Pathfinder, they will begin their meeting with a time to breakout and address issues that are current, open for discussion with their families. **20min**
- **The Small Group Segment**: Then as the meeting progresses, all the small groups will gather together and share challenges that are common to everyone's concerns. **20min**
- **The Large Group Education Segment**: A selected Learning Track from "The Family Solution Finder "Learning Seminar Library will be given to the large group audience. **1hr.**

Process Individual Spiritual Development: SP~ ARK's Program

- The individual family member will be invited by their assigned Pathfinder to complete a voluntary personal assessment to more clearly determine where they are in their faith practices.

- The individual will complete an "annual development plan" based on the results of their personal assessment and desires to learn more about their faith. A subscription to an on-line religious education site will provide the necessary learning selection tracks.
- The Ministry Pathfinder Guide will ask the individual about their spiritual development progress during the meeting. If follow up is needed, this can be completed in a dialog outside the group meeting time.

Both the Education Learning Seminars and Spiritual Development programs are not required for a ministry member to be a part of this ministry. However, most families will likely participate in at least one.

Process Family Referral Resources Networking: M.O.R.E. Program

- The family will be invited to complete a "Current Needs Assessment" Worksheet prior to the meeting which will be brought up for discussion with their Pathfinder. This worksheet will aid in directing both parties to find the right level of support for the family to follow up with in the month to follow.
- The Pathfinder will present these sheets to the leadership, if finding resources is difficult or a connection is not to the family's satisfaction.

Obstacles the family will likely address

Typically, volunteers come to a ministry under-trained to do their assigned tasks.

7 Habits of a Highly Effective Volunteer

To become a "Highly Effective Volunteer" there is work on the volunteer's part to make the choice that they are going to take the time to volunteer. Because our time is valuable, it only makes sense to do it to their best ability.

Given that volunteering has typically been practiced as a "learn as you go" job, few are trained in the art of volunteering, and even fewer are trained to be leaders.

To be Highly Effective as a volunteer, training is going to be necessary.

To guide the volunteer in their training, it is helpful to consider the top habits that other successful volunteers have used in the course of their lives as volunteer's. What better way to learn than from someone who has already learned those habit's which are required on how to be effective.

Habit # One: Reading and Obeying the word of God.
Habit # Two: Active Prayer Life.
Habit # Three: Setting Spiritual Goals.
Habit # Four: Cultivate the Talents of Others.
Habit # Five: Take Responsibility for Their Souls.
Habit # Six: Service to Others.
Habit # Seven: Remain Focused on Eternity

Highly effective volunteer's lives are powered by God. When in a situation, they know the scripture, they know what God says about each life situation, and they can quote it, to remind themselves of what Jesus would do or say.

Solutions to Issues & Obstacles

SOLUTION ONE: Educate the Family about their journey

The Family Solution Finder

Workbook

The Family Solution Finder
Educate, Organize, Network

Four Learning Tracks

There are four (4) learning tracts in the substance use disorder learning seminar's library. These seminars are not sequential; therefore, each can stand alone and be delivered on an as needed design. The seminars can be self-administered, presented in a small support group, as a ministry monthly meeting or as a larger Church wide, local community seminar.

Learning Track One: It's About the Family Dynamic

The Family Is a System, Seminar: The goal is to 1. Be able to identify the four domain parts in the family system 2. Identify how functionality and potentiality impact the family's desired outcomes 3. Use the Functionality and Potentiality worksheet to understand each family member capability to work towards a common goal.

Different Roles of Family Members, Seminar: The goal is to 1. The attendee will be able to name the eight

(8) roles family members play within the family system dealing with substance use disorder. 2. To identify which role applies to each family member using the list of eight roles in the family system. 3. Using the "Family Roles Worksheet", the attendee will be able to provide their understanding of each role and how that person might respond to a family issue, given their role in the family system.

Childhood Trauma and Substance Use Disorder, Seminar: The goal is to 1. Increase the awareness of the impact childhood trauma has on teenager and adults in their resilience towards using drugs. 2. What scales are used to determine the level of trauma. 3. What are the diagnostic tools used to identify childhood trauma.

Different Types of Family Therapy, Seminar: The goal is to 1. Identify the 8 foundations of family therapy 2. What is Multi-Dimensional Family Therapy and how is it different from other therapies 3. What are the other therapy models for families on a journey with substance use disorder?

The Four Primary Family Support Structures, Seminar: The goal is to 1. The attendee will be able to name the four (4) primary family support structures. 2. The attendee will be able to identify organizations within their geographic area that provide services for the family to access within their geographic area. 3. Using the information identified within these exercises the family will complete their family plan of action with information needed to access services from the four primary family support structures.

Learning Track Two: Getting Educated about the Disease

Getting a Diagnosis, Seminar: The goal is to 1. Identify the warning signs of addiction 2. List the primary assessment tools used to create a diagnosis 3. Understand how to use the diagnosis information and respond to the family.

Substance Use Disorder is a Disease of the Brain, Seminar: The goal is to 1. Identify how the brain works with and without substance use disorder 2. Create an understanding of why it is a disease of the brain 3. Develop a working knowledge of how this is a lifelong disease.

The Disease Progresses in Stages, Seminar: The goal is to 1. Identify how disease progress 2. Create an understanding of what is required to manage the progression of the disease 3. Have a working knowledge of what to expect in each stage of the disease.

Relapse is Part of the Journey, Seminar: The goal is to 1. Understand what causes relapse to occur 2. Identify the three stages of relapse 3. Have a working knowledge of how the relapse stages are assessed and then managed.

Learning Track Three: Getting Organized Around the Disease

Obstacles a Family Faces in this Journey, Seminar: The goal is to 1. Identify the 12 Key Family Obstacles 2. Apply this model to the family's current situation 3. Determine how the family can proactively address the obstacle.

12 Key Issues a Family Faces in Substance Use Disorder

This section of the learning tracks qualifies the Family to be certified as "Completing the Essential Learning Tools"

The Families Impacted by Opioids (C.E.L.T.) and is supported in a bi-annual conference "Addiction and Family Empowerment". The goal of completing the C.E.L.T. offered by Families Impacted by Opioids is ensure the needed selection of instruction has been provided to the family members in empowering the family for their journey with substance use disorders. This is a confirmation that you have competed this part of the course material. This certification is only for identification of completion and has no formal or informal education credits provided.

The 12 Key Issues Family Study Criteria

ISSUE # 1. Enabling vs. Disabling

Goals: 1. Learn the 10 Types of Enabling, 2. How to deal with an enabler who is in denial of their enabling behavior, 3. Understanding how to change enabling behavior.

ISSUE # 2. Addiction Behavior

Goals: 1. To learn the behavior traits of substance misuse, 2. To understand how the behavior progresses and changes over time. 3. To learn how to responds to these behaviors.

ISSUE # 3. Family Intervention

Goals: 1. Identify the five stages of change, 2. Learn the ten processes of change. 3. Gain an understanding dual diagnosis, mental health condition.

ISSUE # 4. The Police Intervention

Goals: 1. Identify the six phases of Police intervention, 2. Learn the Do's and do not's of a missing person's report, 3. How to compete a missing person's report.

ISSUE # 5. The Emergency Medical Services Intervention

Goals: 1. Understand the paramedic first response phrase, 2. Learn what happens in a hospital emergency room visit. 3. Understanding the value of SBIRT.

ISSUE # 6. The Legal System Intervention

Goal: 1. Have a working knowledge of the Sequential Intercept Model (SIM), 2. Finding an attorney, 3. What is Drug Court.

ISSUE #7. The Treatment Center Intervention

Goal: 1. Determine the right level of treatment, 2. What is Intensive Outpatient Treatment, IOP. 3. Communicating with Treatment Center Staff.

ISSUE #8. Support Agency Mapping

Goal: 1. Define family community mapping, 2. Steps to create a family community map 3. Advantages gained by having a family community map

ISSUE #9. The Relapse

Goal: 1. What is relapse, 2. List three stages of relapse, 3. How can the family identify these stages.

ISSUE #10. Successful Lifelong Recovery

Goals: 1. Four main ideas in relapse presentation. 2. Learn the Stages of Recovery 3. How to create a strong support system

ISSUE #11. Bereavement

Goal: 1. Learn the 3 types of grief, 2. Understand the grief cycle, 3. Create an inventory for complicated grief

ISSUE # 12. Faith, Spiritual Practices

Goal: 1. Review the need for faith organization participation, 2. Create an Invest in the Family Ministry, 3. Offer the Invest in the Family Ministry at your place of worship.

Using the Family Transformation Response Model (F.T.R.), Seminar: The goal is to 1. Identify the five steps in breaking down an issue 2. Learn how to apply the criteria for reviewing each step 3. Gain a working knowledge of using the F.T.R. in a real-life family issue.

Family Decision Making Model, Seminar: The goal is to 1. Identify the sequence of steps necessary to develop a decision 2. Learn the application of each step 3. Create a current family decision and how to take that result to use in a family plan of action.

SOLUTION TWO:

SPARK's
Ministry's Set Afire

Spiritual Development of Family Members & Volunteers

From a review of many Church ministry's we find people who desire fulfillment by sharing in God's love through the gifts of volunteering. In the bible we read: "The third time he said to him, "Simon son of John, do you love me?" Peter was hurt because Jesus asked him the third time, "Do you love me?" He said, "Lord, you know all things; you know that I love you." Jesus said, "Feed my sheep". John 21:17

In many ways the Church, is Peter, the families on a journey with substance use disorders are the Lord's sheep and Jesus Christ calls the Church to feed them. He did not say feed some of my sheep, some of the time.

It is with this understanding that a Church needs to have a deliberate and responsive structure that reaches out into our family's homes and shares God's love. This is especially true for those who are not able to come to the church for a sharing in the Sunday services and Mass. Here they will find the worship in the Sacred Scripture and Communio as a church family, His family, our community in faith as a family.

It will become the case that unless a Church has designed Family focused ministry program that is purposefully structured by design to support these families, it is likely they will not see the way of practiced faith in their suffering. By ministering to the family, making available education to learn how to survive in this epidemic, they will not be alone or abandoned in their suffering.

In a recent case review, a member of the congregation spoke of a family that has a child experiencing the throws of addiction. This was a person with great faith and commitment, contributed to the church life for years. Unfortunately, from the advancement of this addiction and now brain disease of her child she must stopped volunteering and stopped coming to Sunday service. Her daughter asked for someone to come and visit from the church. Although the church office was contacted, the request had no formal channel to follow and therefore No One Responded. Now because of the stress in caring about this child, the mother and daughter also cannot make it to Sunday services.

They are depressed, and their anger is directed at the church, "where are they, why aren't they asking how we are doing"? What is my faith worth if when I am in need, why doesn't anyone care enough to contact us and help? They are angry because they feel abandon. This church has many ministry programs, but no formal process or structure in place as a response to this type of request.

THE SP~ARK's PROGRAM

There are three (3) levels of programs available to the church within the "Invest in the Family Ministry": The Culture of the ministry develops the ministries volunteers through a) Purposefully Driven Ministry program and b) Habits of Highly Effective Disciples program. The Invest in the Family Ministry model is needed in order to have highly focused ministries that are run by well-trained ministry leaders using spiritually developed volunteers as family Pathfinder Guides.

The SP~ARK's Program sets into place the needed structure, culture awareness and path for volunteers to follow in directing their synergies towards the mission and goals of the Church. The SP~ARK's Program is needed in order to have structure spiritual education which will effectively and consistently meet the needs of the Church volunteers and family members towards the development of their personal spirituality and faith journey.

- The family is an ARK, the same way that Noah had built God's Ark, *"Invest in the Family Ministry"* becomes the families Ark. Building such an Ark is the role of ministry volunteers. This is where God will take His believers into His protection from the storm, He nurtures them with His spirit and covers them with empowerment. Then releases them into the world. So does the Ministry create a place in the family Spiritual - ARK program, with the volunteers who nurture them to be supported and released into the world as a family connected to their faith and practices of the Church.

- The other Ark is from the old testament that of "God's Covenant". In this manner, God's Ark is inside His written word of scripture. This same covenant exists inside the families and volunteers, where the scriptures come a live through education development within the ministry design. To be carried into the home and place of caring of our Church families. The ARK is in the temple of the volunteer and the family. We Stand up to Stand Together as one in the face of our drug epidemic.

- What we are creating is a Culture of "Spirituality, developed in these two Arks' of the Church", SP~ARK's, a new twist on the word SPARK's, to light a fire one needs a spark. To light a Church on spiritual fire, what is needed is the SP~ARK's program, structure, process, training. Designing the Ministry into purposeful ministering, The Volunteer into disciples of Christ and the Family into practicing our faith in worship to the lord during times of suffering and doubt.

We see the Church ministry culture as the spark, the filament it ignites is the volunteer's "their developed spirituality". These lamps are lighted to assure when the groom comes, we will be included to the wedding banquet. The Church leadership desires to bring all its Church members to this feast and celebration. To do this it needs to create a structure where this can all take place. The SP~ARK's Program will build the needed structure, process, roles and training for the Church.

SOLUTION THREE: Building a Referral Network

FAMILY RESOURCE COORDINATION,

The M.O.R.E. Program

The family resource coordination Evaluation (M.O.R.E.) is designed to provide structure and process to networking families into agencies and services that best meet their needs. Here is where the Pathfinder Guide and family meet to review their needs and match them with resource both from within the church and the local community.

I. Take an Inside the Church Inventory

The ministry Administrator will complete a list of church ministry's and their contact information to ensure Invest in the Family Ministry members have this list as a referral resource. They will keep this list available and updated for both Pathfinder Guides and Families.

EXAMPLE:

- The Women's Prayer Group.
- Religious Education Group.
- Men's Fellowship Group.
- Social Justice Group.
- Children's Religious Education Group.
- Spiritual Retreats.

COORDINATION OUTLINE

Recruiting the right mix of services and providers, Operating, and Sustaining Effective Partnerships: A Critical Step in Community Resource Mapping.

Recruiting Partners (Mix of services within your referral network)
1. Prepare yourself. a. Develop a list of desirable characteristics in potential partners. b. Look for diversity among your partners.

2. Develop a common vision.
   a. Be clear on what you are trying to accomplish within the community (i.e., develop healthy youth equipped with the skills necessary to contribute to the community).
   b. Understand the needs and goals of the organizations with which you wish to partner.
   c. Find ways to shape how a partnership will help meet your needs and goals.
   d. Remind partners that their involvement may give them more visibility within a community.

3. Be clear on the role you want the partner to play. a. Clarity from the beginning will allow you to find the right partners. b. Try to involve decision-makers and top management.

Operating the Partnership, The partnership will be comprised of multiple agencies from diverse backgrounds. All partners should feel a sense of ownership and commitment.
1. Involve top-level people. a. Keep in mind what an organization hopes to achieve through involvement in the partnership. Show them how their involvement is working for them.

2. Involve the community.
   a. Inform the community of your vision. Communicate this vision to parents, civic and youth groups, churches, and others who may share your vision.
   b. Involve the community in your work.

3. Get organized.
   a. Make sure your goals are established and that they are obtainable.
   b. Establish policy-making procedures that will frame the work of the partnership (e.g., lines of communication, reporting, etc.).
   c. Hold regular leadership and work group meetings with concise, well-planned agendas.
   d. Assign a lead person in each organization to facilitate the work.

Sustaining the Partnership, It is important to make the partners feel that they are part of something important to the community. Also, it is critical that they see the return on their investment.

1. Support all partners. a. Establish committees and workgroups. b. Orient and support all new partners. c. Mentor any new partners.

2. Make work meaningful.
   a. Rotate leadership.

3. Recognize contributions.
   a. Create opportunities for partners to celebrate success and develop mutual trust.

COORDINATING THE CHURCH OFFICE AND LEADERSHIP

For this process to work smoothly, the Church staff needs to have a clear and practiced understanding of the Organization Chart, Communication Diagram and Process Flow of request to the ministry. The Church leadership

needs to support the importance of the staff understanding and using the process as it is designed. A brief 30-minute instruction (Lunch and Learn) should accomplish this level of training.

COORDINATING THE MINISTRIES

By using the "*Invest in the Family Ministry*" seminar and inviting the selected ministries to participate; a standardized understanding can be established. Setting up an ongoing quarterly Church ministry meeting will also help to communicate activity and improve communication.

COMMUNICATION CHANNELS TO CHURCH MEMBERS

The process for the Invest in the Family Ministry has a standard design for communication to the Church staff and Leadership, to the ministries and to the Church members. For the Church members, a direct phone line and email address will be provided. As for the marketing and announcements, these too are standardized for effect and purpose.

Three types of channels are considered:

1. Church members to ministry.
2. Ministry to Church, Church to Ministry.
3. Ministry to Family.
4. Ministry to local community.

COMMUNICATING WITH THE FAMILY

The family will begin the sequence of communication by requesting to learn more about the ministry.

This will necessitate a response from the Invest in the Family Ministry once the Families request has been processed through the proper communication channels.

Then monthly ministering activity will take place to ensure a proper level of contact is maintained. The level of contact will be determined by the family and is subject to change.

Answers and move to "Master Family Plan of Action":

1. The family member will have a working knowledge of the steps needed to start a ministry.
2. The family member will understand the three different programs to be considered for the ministry: 1. The Family Solution Finder, 2. The SP~ARK's Program, The M.O.R.E. Model.
3. The family members will purchase The Family Solution Finder Learning Seminars Study Guide and Workbook, The Invest in the Family Ministry User Manual and The Substance Use Disorder Journey, It's Time to get Organized book.

ABOUT US:

Families Impacted by Opioids is a nonprofit founded by Mr. Roy P. Poillon. Our primary goal is to develop the families in Ohio, into the most informed and educated families throughout the nation on the topic of Substance Use Disorders. To accomplish this mission, we are incorporating four primary programs:

4. The Family Solution Finder Learning Seminars. 32 seminars with Study Guide and Workbook and Learning Video links, 1.5 hrs. in duration. The Pathfinder is a Certificate of Completion Seminar for families, addressing the 12 Key Issues that are essential for all families on a journey with Substance Use Disorders.
5. Invest In The Family Ministry. A turnkey ministry for faith organizations to start a family ministry for those in their congregation on a journey with substance use abuses. All the steps and content are provided in the Invest in the Family Ministry User Manual. To purchase go to **www.amazon.com** Invest In The Family Ministry, by: Roy P. Poillon
6. Best of the Cities Best, is a county by county review of current best practices provided by programs and services with these community that directly impact the needs of the family members. This publication lists all 88 Counties of Ohio and their best programs for family members to find and use in addressing the issue they face.
7. The Abacus Chronic Disease Management for Substance Use Disorders is a model to ensure there is structured care in the timeline after the treatment center leading up to the 5-year abstinence marker. This model combines the Family Members and patient with the primary care physicians, home healthcare agency, managed care case management and specialty services where required.

We are available to answer questions:*

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*Because of the importance concerning all matters reviewed in this program, we will not provide advice on medical, legal or financial matters. It is strongly encouraged that these subjects be reviewed by licensed professionals.

Family Member Certificate of Completion

This certifies to all that

Student Name

has successfully completed the

"The Family Member 12 Key Issues In Substance Use Disorders" Seminars

Roy P. Poillon

Roy P. Poillon, Executive Director

Families Impacted by Opioids

The Family Solution Finder

Educate, Organize, Network

LIVE AND LEARN SERIES

Continue your learning with THE FAMILY SOLUTION FINDER IN SUBSTANCE USE DISORDERS, 32 LEARNING SEMINARS. The Family Solution Finder learning seminars has 32 issues of 1.5 hrs. each with Study Guide and Workbook. These issues cover the entire journey of the family in substance use disorder. Two Books: The Study Guide and The Workbook

ALSO:

Purchase for your resource library THE SUBSTANCE USE DISORDER JOURNEY, IT's TIME TO GET ORGANIZED. This book provides the family the forms, tools and worksheets that enhance and help the family to apply new skills in breaking down issues, making family decisions, and other valuable worksheets.

To purchase books: www.amazon.com search: Roy Poillon

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