The Family Solution Finder
Learning Seminars Workbook

Empowerment in the Substance Use Disorders Journey

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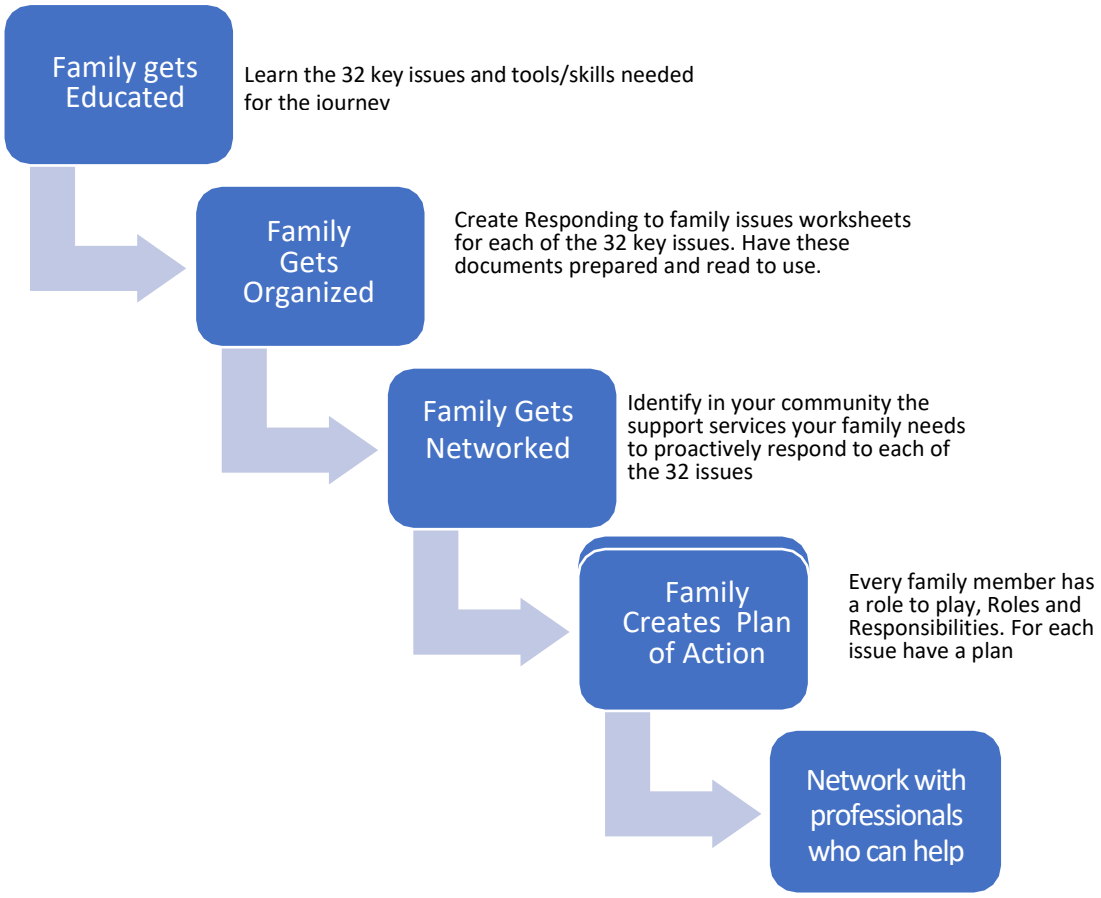

Family gets Educated
Learn the 32 key issues and tools/skills needed for the iournev
Family Gets Organized
Create Responding to family issues worksheets for each of the 32 key issues. Have these documents prepared and read to use.
Family Gets Networked
Identify in your community the support services your family needs to proactively respond to each of the 32 issues
Family Creates Plan of Action
Every family member has a role to play, Roles and Responsibilities. For each issue have a plan
Network with professionals who can help

Forward

This Workbook introduces how to become empowered throughout a family members journey living with Substance Use Disorder. This is a lifelong journey and there is a great deal to learn and prepare for in what will likely happen in the future.

The learning series material include:

1. *The Family Solution Finder Study Guidebook*

2. *The Family Solution Finder Workbook*

3. *The Substance Use Disorder Journey "It's Time to get Organized" Workbook.*

4. *The Substance Use Disorder Journey "It's Time to get Networked" Workbook.*

5. *E-Learning online seminars for each of the 32 key issues. https://www.familiesimpactedbyopioids.com/32-key-issues-learning-series-and-e-learning*

Instructions:

In using this book, the reader should read the learning session in The Family Solution Finder Study Guidebook first, then come back and read the correlated section in The Family Solution Finder Workbook and during their reading complete each sections practical exercises and the video link assignments. To extend the learning experience visit the e-Learning tab on our website and download all the buttons for that seminar topic. Take the time to view the power point presentation with narrator.

These assignments are designed to build a family members knowledge in how to use critical thinking, presented in each learning session to strengthen skills in dealing with these fast-moving issues, managing crises and effectively creating mid to long term plan.

Prior to having family members meet to address a specific issue, it is best if each member has reviewed this issue in the study guidebook and workbook. In this way, they all understand what certain steps are necessary. This will help to keep everyone in the family on the same page.

Please know, you don't have to go through this alone. You may contact us Families Impacted by Opioids (nonprofit) and we will answer your questions or walk you through each step. Call: 440.385.7605.

Each seminar is available on our website as a free PDF download. You can forward these PDF's prior to meetings for those who will attend your presentation.

Respectfully,

Roy P. Poillon
Executive Director/Founder
Families Impacted by Opioids
Direct Line: (440) 385.7605

Mr. Roy P. Poillon

In fellowship, I have written this material to benefit those who will read and learn. Please know that my prayer goes out to you, although you are unknown to me, but in understanding you are greatly loved and known to God. He has already won your battle, let him show you how. Roy P. Poillon

Table of Contents

Introduction

There are many different paths to take in this journey, yet no one single path can be defined as the absolute only way for your family members to travel. It is likely, this journey will involve many forks in the road and lots of decision making. Knowing the issues ahead of time, how to break it down into a solutions, make a values based family decisions, and have a process on how to respond to the issue, will be three very valuable tools for your family.

Just like a hiker on the trail; tools and skills are required to complete the journey safely and with success. However, the hiker typically will have a map, and a set destination they seek to achieve. This is not the case for a family living with one having a substance use disorder.

Up to now there was no map, no defined family skills and limited tools were given to a family. The family was not told what their destination would be, only that when each problem would arise, they would have to figure it out on their own. A come see us when it happens response. It is wrong for the family to be put in this situation, because as an industry, we know exactly what they are going to go through, and often the sequence they are likely to experience it.

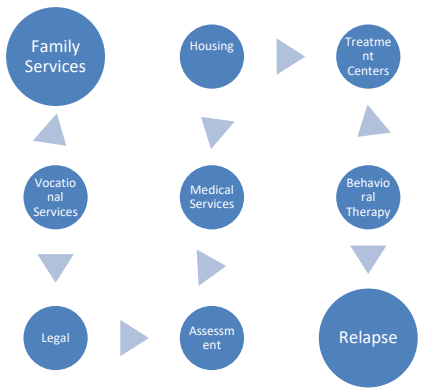
The Family Solution Finder Learning Series and Workbook is like a road map for your family to use during their journey. The work sheets in this workbook can be used as tools. The instructions and learned competences by completing the study guide, workbook and video's, will become an acquired capability to cope, for each member of your family. It is though knowledge that the family member will receive empowerment. And an empowered family is unstoppable.

By taking the steps outlined in this workbook your family members will be empowered to deal with most of the challenges that are in front of them. However, this is all balanced on one key axiom, "***Addiction is a disease of the brain", and "there is no final destination only a continuous journey".*** It is for this reason; we are applying the methodology of how chronic diseases are managed. For example, if this disorder was hypertension, you would take your medication, monitor your health with the advice and care of a physician, meet semi-annually or as needed to review your disease status, and make changes in your lifestyle.

All of these are normal measures which are taken when managing a chronic disease. Therefore, we will do the same with this life-long chronic disease. Substance Use Disorder is the name of the disease and creating an environment of support to effectively manage it is your family's primary focus. In "all" matters concerning this journey, always seek the advice of a licensed professional prior to taking any action on such topics such as medical, mental health, legal or personal life decisions. This book should only be considered as a reference, one way to think about a topic. This learning series is intended for the family member to know enough to ask the people for their assistance. First consult with a professional.

It is Complicated

Managing the Family Services, Child Care Services, Vocational Services, Mental Health, Housing, Medical Services, Education, Jail, HIV/AIDS Job Search, Legal Courts, Financial, Rehab, Housing, Transportation, Services, Assessments, Behavioral Therapy, Pharmacotherapy, Substance use Monitoring Clinical and Case Management, Self-Help, Continuing Care, Court System.



Our families have a lot to deal with, it is all very overwhelming. However, these families are not alone, they will benefit from professionals who are here to walk their journey with them. The question in managing the journey is when to use which service? That is why we are going to Get Educated, Get Organized and Get Networked.

So, learning in and by itself is not going to help you greatly. However, learning and applying what you learn will be empowering. Therefore, this workbook is designed to take what you have learned and provide you with exercise to put it into action, real world, your life issues. From these exercises the family will create their Family Plan of Action and have a reference as to why they are choosing to take each step in the plan. Take this work and review it with a drug counselor, attorney, M.D. or family therapist.

What is an empowered family?

Four Family Support Structures:
An empowered family will know the four support structures in their community. Where to find them, what to ask of these structures, and how to use their services to the family's advantage. The family being at its best will take ownership and responsibility in how well they manage support structure services from the city services, the healthcare systems and the local faith community. It is up to the family to manage. 1. The Family, 2. The Community Services and Agencies, 3. The Healthcare Systems Services, 4. Places of Faith Practice.

There are 32 key issues in the family's substance use disorder journey:
An empowered family seeks to educate themselves on the 32 key issues they are likely to face in their journey. They have the tools to apply in each issue, found in *"The Family Solution Finder Study Guide and Workbook*".

The community, agencies and providers need to understand the family journey by reviewing the 12 key core competency issues found in "*The Pathfinder Certificate of Completion Seminar"* . Please purchase book: www.amazon.com search Roy Poillon. These are 12 of the essential issues taken from the Family Solution Finder Learning Seminars for the purpose of educating those support structure that provide services to the family. Use these books to help train the community and their staff.

The Family Transformational Response Model (F.T.R.) is a tool to break an issue down into finding a solution:
To approach each issue a F.T.R. model is used. This tool is the Family Transformational Response Model (F.T.R.): 1. Define the Issue, 2. Identify how the issue impacts the family, 3. learn how to prepare for the issue, 4. meet with those who are here to help the family, 5. Gain a practical understanding of what some of the possible outcomes are. The F.T.R. is applied to each issue.

The Family Decision Making Model: is a tool used to standardize the process of making a decision. An empowered family uses a Family Decision Making Model to ensure decision made are in line with their family values and conducted in the most thorough and complete manner.

The Responding to a Family Issue Process: is a tool used to determine in advance the best process for responding to an issue faced by the family.

The Family Plan of Action: is a tool designed with the knowledge that change will happen and what steps the family will take and responsibilities assigned to family members can be determined in advance.

Introduction

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

The effects on the family may include:

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

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

The effects of SUD on specific family members or concerned significant other are determined by the severity of the disorder, and the possible presence of other serious problems such as psychiatric mental illness, Some family members are more resilient than others and less prone to the adverse effects of the SUD impact.

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

With empirical evidence as the proof to the effectiveness and usefulness of including the family members to the overall therapy plan, because the family is a system which needs to work together in support of each other, if one part is dysfunctional, it impacts the entire family system. So, both require their separate

and combined level of therapy. The loved one goes into treatment and the family members go into family therapy or counseling.

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

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

- Engage the family into and recovery timeline of care. The family helps to create the recovery environment.
- Engage the family in the assessment process and early in plan of treatment.
- Outreach efforts may be needed to engage families in treatment. The family might not know how to engage or what to ask.

Several effective interventions have been used with families to increase their rates of involvement as family members with a loved one who is in SUD treatment. But, the family will be the end decision maker in how involved they will be going forward.

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

Final Introduction Thought

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

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

- The family supports the person with the SUD by attending sessions together to learn ways to help their member with the SUD without "enabling" this individual.
    - Learning about potential relapse warning signs or actual episodes of substance use and how to intervene early in the relapse process can empower family members.
    - Help family members engage in recovery to meet their own needs.
- Focusing on children, families can be helped to understand the impact of SUDs on children and examining how their own children may have been harmed by the SUD in the family.
- Parents with SUDs, can be encouraged to talk with their children about their impact on their family and the children and maintain an open dialogue with kids to address their feelings, questions, or concerns. They can help kids learn about SUDs, treatment, and recovery.
- Establishing normal routines and rituals in the home, taking an active interest in the child's life, engaging them in family activities, and facilitating an evaluation for a child with a psychiatric or substance use disorder are other ways of helping the family.

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

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

  Families can help their loved one in several ways:

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

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

WHAT IF:

> **59%** reduction in cocaine/methamphetamine and opioid use was possible? It is found in multidimensional family member therapy.
>
> **46%** reduction in delinquency and criminal behavior related to drug addiction was possible? It is found in multidimensional family member therapy.
>
> **86%** started living at home during recovery. It is found in multidimensional family member therapy.
>
> **85%** started showing stable mental health functioning. It is found in multidimensional family member therapy.

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

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

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

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

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

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

#1 Tool for the Family

"Family Transformational Response Model" (F.T.R.)

FAMILY TRANSFORMATIONAL RESPONSE (F.T.R.) Model

Finding a solution for the 32 Key Issues can be addressed by using this model format.

Example, Take your issue and define what the issue is, then state how this issue will impact the family, then identify what steps your family can take to prepare for this issue, then find those organizations/professionals who can help the family in dealing with this issue**.**

The F.T.R. Model:

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?

The F.T.R. Model Worksheet

1. **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?

_____

_____

_____

2. **How does the issue impact the family?**

❖ Who in the family?

_____

_____

_____

_____

❖ In what way?

_____

_____

_____

❖ What is needed to move forward?

_____

_____

_____

_____

3. 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?

_____

_____

_____

_____

4. **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?

_____

_____

_____

_____

5. **What should the family expect as their outcome?**

❖ Timeline?

_____

_____

_____

_____

❖ The expenses/cost involved in this issue?

_____

_____

_____

_____

- Required changes to successful respond to this issue?

_____

_____

_____

_____

- Timeline?

_____

_____

_____

- Cost Involved?

_____

_____

_____

- Required changed to successful respond to this issue?

_____

_____

_____

2 Tool for the Family

"Family Value Based Decision-Making Model"

Value Based Decision-Making Model

In Values, we find ourselves taking a stance on how we will follow a certain way towards making a family value-based decision. It is therefore important to understand the family values, prior to making critical decisions about the lives of our loved one.

Values (ethics)

From Wikipedia, the free encyclopedia

In ethics, **values** denotes the degree of importance of some thing or action, with the aim of determining what actions are best to do or what way is best to live (normative ethics), or to describe the significance of different actions (axiology). It may be described as treating actions themselves as abstract objects, putting value to them.

It deals with right conduct and good life, in the sense that a highly, or at least relatively highly, valuable action may be regarded as ethically "good" (adjective sense), and an action of low in value, or somewhat relatively low in value, may be regarded as "bad.

What do you treasure the most that is without substitution for anything else?

Write yours down as an individual family member.

1.

2.

3.

Now discuss them together as a family, each person stating what they feel are their most important family values. (note: there is no wrong answer).

Our individual top Family Values Are:

1

2.

There are six steps taken to make a value-based family decision. Here we will identify these six steps, but in the Family Solution Finder Learning Series Workbook you will be asked in a practical exercise to use these steps along with your values.

SAY A DECISION BY THE FAMILY IS REQUIRED:

First Step: Identify Exactly What Happened

Exercise: What Happened?

Identify the details of the situation? (what happened, how did it happen, who was involved?)

What:

How:

Who:

Identify what you would have liked to have happened/happen?

Second Step: Analyzing the Situation

Every problem has a situation that surrounds it. Inside the situation is where you will find the solution to the problem. By analyzing the situation more closely, the solution will typically present itself. It will then be clarified and used in your decision-making process.

Exercise: We will look at the problem that impacts the situation. (what went wrong)?

1 Assessing the Problem: (Describe exactly what is happening that is not working?)

2 Identify, what is causing this to happen?

3 In "what areas" did this create an impacting or disruption?

Third Step: What is the number one contributing factor

What is (was) the number one contributing factor to this disruption or need for a decision?

Fourth Step: Gathering Information

It may seem unnecessary to have a segment that reviews "Gathering Information" however, this is a critical part of the decision-making process and can significantly impact the quality of your decision and its outcome.

There are three types of information to consider gathering:

1. The Primary Source information, The information comes from the person it happened too, or that was there.

2. The Secondary Source information, He Said She Said.

3. The Gut Feeling Source, no one person saw it happen, but I think this is what occurred.

All the above information gathering types are reasonable to include in the decision-making model.

The Primary Source: Prepare a list of questions and then go to the primary source for answers. At times you may not know which best questions to ask. So, research possible questions, then go ask them.

For Example: If you are considering a treatment center for your loved one, go to the facility and take a tour. Do not just read their website, listen to someone else's opinion about the facility or telephone them for a few answers. You will need to go directly to them as they are the "primary source" of information. You should come with a prepared list of questions in order to have an accurate understanding of their facility. Search online for how to assess a treatment facility.

The Secondary Source: This is also a good resource to consider using when deciding. The Secondary source is valuable because it allows others to provide information about your search for answers. From Secondary Sources you may find other topics or questions that need to be considered.

There are two areas that you need to be aware of; 1. The source of the secondary information. Who are they, what authority do they speak from, why are they providing this information. 2. Is this information a direct correlation to the topic that you are researching. Be careful, sometimes in secondary search it becomes tempting to seek out information that proves your premises to be correct. That is called bias. We want to avoid being bias, just the facts please.

INFORMATION GATHERING CARD

Gathered Information:

What did you learn?

Who did you learn it from?

Why do you feel it is creditable?

Use these answers to assemble your decision.

Fifth Step: Create a Criteria, what is most important

Exercise: Does your solution qualify for consideration? Use the Family Transformational Response Model (F.T.R.) to determine the solution.

CRITICAL CRITERIA, *Final Review (True or False)*

- Will this action ensure safety for your loved one?
- Do you have the resources needed to complete these tasks?
- Is your timetable realistic?
- Do you understand the negative impact(s) your actions may create?
- Would you want others to take this action on your behalf?

Sixth Step: Choose Best Solution

Exercise: Take your decision and place it here:

We will do the following:

_____
_____
_____

Our expected outcome is:

_____
_____
_____

Final decision are more useful when in writing, it helps you see them more clearly and you can easily share with others.

3 Tool for the Family

"The Responding to Family Issues Process"

Instructions in using
"The Responding to Family Issues Process"

Step One: Complete the "How Much Do We Know" by writing down the issues as clearly as you currently know it.

Step Two: Complete a "Family Transformational Response (F.T.R.) Model using the identified issue.

Step Three: Complete a "Family Values Base Decision-Making Model" using the identified issue.

Step Four: Complete the Functionality Practical Exercise #One worksheet in the Workbook.

Step Six: Complete the Potentiality Practical Exercise # Two worksheet in the Workbook.

Step Seven: Complete the Obstacles Practical Exercise #Three worksheet in the Workbook.

Step Eight: Complete the "Family Plan of Action" worksheet in the Workbook.

Example:
SEMINIAR #1: The Family is a System

	Purpose:	*The Responding to Family Issues creates a plan for future use in how the family will collectively respond to this particular issue.*
☐	Instructions	The "Responding to Family Issues" process provides a step by step path for a family to consider when developing their response in how to best create a solution to a specific family issue. Complete each step below to formulate your possible family course of action.
	Identify the Issue	First, identify what issue you are seeking to address. Write what you know about the issue. Then proceed.
☐	Complete Family Transformational Response (F.T.R.)	Second, complete each section in the F.T.R. worksheet using your identified issue. This seminar reviews the "Family is a System". Topics include: Achieving Balance with family members, functionality and potentiality issues, and addressing obstacles of Denial, Enabling and Codependency. Determine which part of this issue you are seeking to resolve.
☐	Complete Family Value Based Decision-Making Model	Third, in the Family Value-Based Decision-Making Model worksheet complete each section, then take that information and use it as your decision on what you will do collectively as a response to this issue. Include it to your family plan of action.
☐	Key Topic #1: Homeostasis in the Family	Your family will seek balance, by identify with a professional therapist, what areas the family needs to be adjusting, the skills required to make

		this adjustment and a plan with the therapist on how to develop this change. Complete the practical exercise in the workbook.
☐	Key Topic #2: Functionality and Potentiality	Your family members will seek to identify their level of functionality to act in response to an issue and increase their potentiality to contribute to the family dynamic. Complete the practical exercise in the workbook
☐	Key Topic #3: Obstacles	Your family members will seek to determine if any of these three obstacles are part of their contribution to the family dynamic: 1. Denial, 2. Enabling, 3. Codependency. Complete the practical exercise in the workbook
☐	Complete a Family Plan of Action Worksheet	Complete the Family Plan of Action.

4 Tool for the Family

"The Family Plan of Action"

Family Plan of Action:

I. SOLUTION:

The Identified Solution: (From the completed F.T.R. Worksheet):

II. DECISION:

The Decision-Making Process: (From the completed Family Values Decision-Making worksheet)

III. PLAN OF ACTION:

Priority # 1.

Task:

Task:

Task:

Priority # 2.

Task:

Task:

Task:

Priority # 3.

Task:

Task:

Task:

From these four tools:

1. The Family Transformational Response,
2. The Family Making Value Based Decisions,
3. The Family Plan of Action,
4. Responding to a Family Issue,

the family is prepared to learn about the 32 key issues they are likely to face in their journey with substance use disorders. To have addressed and learned about these issues without the having the needed tools to apply the lessons learned the education would have been useless.

The tools and your willingness to use them is the degree that you will have empowerment. Because empowerment comes from having knowledge and the tools to use the knowledge.

Now you can create a solution to an issue, make a family value-based decision and develop a shared family plan of action.

PART I

Learn about the family dynamic

Seminar # 1

"The Family is a System"

Seminar Objectives:

1. The attendee will be able to name the four (4) domain parts in the family system and the presence of Homeostasis.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. The family will identify any indicators of Denial, Enabling or Codependency.

Introduction

A family is a system, and in any system each part is related to all the other parts. Consequently, a change in any part of the system will bring about changes in all the other parts. *(Brodrick, 1993; Klein & White, 1996)*

It is important to note, the definition of what composes a family is much looser than what was assumed in the past. The household parent role might be a grandparent, aunt or neighbor.

Change is the new norm in the Family

When substance use disorder is introduced to the family system the one with the disorder becomes a subunit to the family system. The other parts adjust with constant adaptions in order to accommodate the new behavior. This is disruptive to the overall family system.

Because the goal of a family (realized or not) is to help each other, the family will seek to aid the one that has the disorder. These efforts take away from other parts of the functioning family system and create an in-balance. (Day et al, 2001)

Because the family system exists around the idea of well-being, overall the family goal is to help each other to "do better". The idea of subsystems is important in order to separate the needs of the family from the one experiencing substance use disorder. *(Minuchin, 1981)*

Therefore, within the family system is an ongoing stream of transitions requiring change and adjustments from each member of the family. *(Klein & White, 1996, p. 128)*

The Four Dominate Parts of the Family System

There are four primary domains to consider when looking at a family as a family system:

1. **The Child** – Is there an intrapersonal and relation development with the child.

2. **The Parent** – Are the parents individually functioning and can provide parenting.

3. **The Family Environment** - How well does the family transacts within itself, between family members.

4. **The Family External System** - How much is the family is influenced from outside the family system, i.e. Schools, work, faith organizations, legal issues.

These four need to be considered as you take this seminar training. Each domain needs to function at its best using its potential and being committed toward contributing to the outcomes of how the family responds to issues that are presented in their journey with addiction. Even though we seek balance in the

family system, what one family member is willing to contribute or give up, may be completely different from the other family member.

Homeostasis Theory Homeostasis Theory

is a fancy way of saying the family's natural way of seeking balance. The family understands (knowingly or not) their goal is to help each other in life and to keep the family as a system "in-balance". When family members' behavior becomes disruptive to the family unit, it causes imbalance in their roles, relationships and communication.

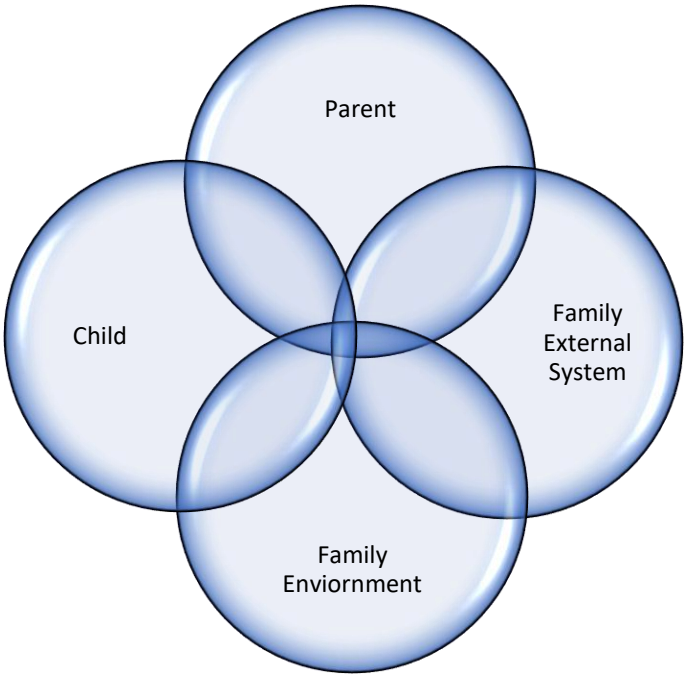
As the family responds to this undesired behavior, it compensates by adjusting. The greater the behavior, the greater the required adjustments.

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

This draws the attention from both parents to that one child, absorbing their time and resources. The second child is left on their own while years of attention, stress and worrying become the norm. From a development standpoint, the second child has been emotionally and in many ways physical abandon. The family system is out of its order and it will likely take therapy sessions to bring the family members back into alignment.

In family therapy, the unit of treatment is the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit—the person whose symptoms have severe repercussions throughout the family system. The therapist facilitates discussions and problem-solving sessions, often with the entire family group or subsets thereof, but sometimes with a single participant, who may or may not be the person with the substance use disorder.

KEEPING IT IN BALANCE



Where the <u>four overlap,</u>

is where the family system becomes one.

Practical Exercise # One: Your Family System, Homeostasis?

Take a moment to identify the members of your family, as it is currently:

Name: Relation:

1.

2.

3.

4.

5.

6.

Homeostasis Applied to your Family.

Have you noticed any new behavior patterns in the members of your family, now that substance use has been identified?

1. What Have You Notices?

2. What is the impact to the family system?

Functionality and Potentiality in the Family Dynamic

There is a theory worthy of consideration, functionality. This means to what level is a family prepared to deal with the impact of what has been presented as an issue. It starts as each family member has their own issues, but because there are many family members each (independently) they need to determine how they will collectively respond to a single issue, as a family. The family system consolidates these responses to achieve some combined outcome. Example: each member has their own way of addressing their loved one's incarceration, in a family system their combined responses are used to achieve some single outcome, i.e. "we will all help him navigate the legal system". Even though they come at it from different

perspectives (their own) , the result is a single combined outcome. They all showed up at drug court hearings in his support. This can present in the negative, also. The question is how well is the family EQUIPED to work together in a **FUNCTIONAL** manner? For many families they are not equipped functionally, although they seem to care about each other, and the family system starts to break apart.

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

The other theory is potentiality, whereby one issue impacts the family members and they all respond differently because they all have a different capacity to respond, thus creating several possible outcomes. In this case, the legal system is intervening in their loved one's life and each family member choose their own way to respond, creating many outcomes. i.e. one member chooses to ignore it, even though they have the potential to help. Another member shows up to drug court in support of him, a third member criticizes him and provides negative input. It's the same issue, with different outcomes. This can present in the positive, also. The question is how well the family is EQUIPED to use their **POTENTIALALITY** from each member in the family unit? Do they have the capacity of skills and ability as individual family members and *are they willing* to share them?

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

Therefore, the focus for the family is on "What has to be done, and How". Not why this issue has happened. When rafting down a stream, we don't ask why the rocks are there, we just determine what needs to be done to navigate around them and how to each paddle and steer our effort as a family to move forward.

Practical Exercise # One:

Instruction*: Take an issue, then apply it to your current family dynamic. Describe in your own words how well your family is likely to work as a system in addressing this issue: Consider Homeostasis (helping each other to keep the family balanced). Also consider, each family members functionality and potentiality. Using a numeric score rate their level of functionality and potentiality in the relationships between mother, father, sister brother, etc. This does not include the substance use disorder family member(s).*

SCORING KEY: (Good 5 pts, Fair 3 pts, Poor 1 pt.)

Choose an issue facing the family: (describe the issue "example, Enabling")

_____

_____

QUESTIONS:

The Families Ability to Respond to this issue example: "Enabling": (complete and score each question)

1. **Are the mother and father able to address this issue?**

Functionality (do they know what to do, as individuals and together as parents, regarding "Enabling")

_____

_____

Potentiality (are they willing to do it)

_____
_____

How well do you feel this is currently working? Good____ Fair ____ Poor ____

2. Parents to the other siblings?

Functionality (do they know what to do with the "other siblings", as individuals and together as parents, regarding "Enabling")

_____
_____

Potentiality (are they willing to do it, regarding "Enabling")

_____
_____

How well do you feel this is currently working? Good____ Fair ____ Poor ____

3. Parents and Siblings to the person with Substance Use Disorder?

Functionality (do they know what to do, as individuals and together as a family, regarding "Enabling")

_____

Potentiality (are they willing to do it)

_____

How well do you feel this is currently working? Good____ Fair ____ Poor ____

4. Parents and Siblings to those outside the family?

Functionality (do they know what to do, as individuals and together as a family, regarding "Enabling")

_____
_____

Potentiality (are they willing to do it)

How well do you feel this is currently working? Good____ Fair ____ Poor _

OVERALL SCORE: (take this worksheet to a family counselor for discussion)

Good 35pts – 22pts

Fair 21pts – 8pts

Poor 7pts – 0pts

Video One:

Instructions: Go To www.youtube.com

In the search field type this title: ADDICTION AND THE FAMILY SYSTEM: CODEPENDENCY

Or copy/type in this link:

https://www.youtube.com/watch?v=Nwd8pw5UdwE

Duration: 4:49 min Published on Mar 10, 2019 By Jim Savage

VIDEO WORKSHEET "Family Matters: Bowen Systems Thinking & Addictions

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In your world situation

1. In what way does the family circle itself around the persons substance abuse?
2. What is the impact to the family members?
3. What changes can be used to create a different family dynamic?
4. Why should the family seek "Family Therapy"?

_____

_____

_____

The Impact of Denial, Enabling, Codependency

Nearly every person in contact with an addict is impacted in some way. It's rare that the effects of an addiction are limited solely to the one who is abusing substances. Everyone around him or her is affected in some way. Frequently, the people who spend the most time around the addict are friends, family, and co-workers – therefore, these are the people who are likely to be most impacted by drug addiction or alcoholism.

Family members, especially non-addicted spouses, are forced to pick up the slack for the substance abuser, make excuses for his or her behavior, and potentially endure sexual, physical and emotional abuse. In many cases, extended family members and close friends must help financially and in other ways to account for the ignored responsibilities by the substance abuser. The children suffer in school and are more likely to be involved with drugs and alcohol as adults. Coworkers are not always as close to the addict, but they may also be affected by having to increase their workloads to make up for diminished job performance. Nearly every person in contact with an addict is impacted in some way.

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

Video Two: (Optional)

Instructions: Go To www.youtube.com

In the search field type this title: Exposing the Family Effect of Addiction | Sam Fowler | TEDxFurmanU

Or copy/type in this link: https://youtu.be/1qI-Qn7xass

Duration: 15:17 min Starting Instruction: Hit (skip ad) to start video**.**

VIDEO WORKSHEET: Exposing the family effect of addiction

In what way is getting educated on the brain disease of addiction helpful to the family system?

_____
_____

What can your family do to beat back the stigma of addiction?

_____

Is denial a healthy response, if no state why?

_____

In what can you relate to the speaker's life?

_____

How can you live a life of vulnerability?

_____
_____
_____

SEMINAR # 1 "FAMILY IS A SYSTEM"*: FAMILY PLAN OF ACTION*

Complete answers and move these to "Master Family Plan of Action" found It's Time to Get Organized Workbook.

1. Our family will identify the theory of Homeostasis in our family dynamic. *How does it present in the family?*

2. Our Family will need to first understand each member functionality and potentiality and agree that it is accurate then gather the resources which will empower each family member in dealing with their response to the issue. This will be done by using the *Self-Assessment of Family System Worksheet, Functionality and Potentiality found in Practical Exercise # One,*

3. We know as a family no one escapes addressing the obstacles in this journey. When issues present in this journey the obstacles will be even more prevalent. For this reason, the family chooses to address them now, so later they are not a contributor to the impact or a family issue. This will be done by using *The Obstacles Denial, Enable, Codependency will be included to the Master Plan of Action, from the study guidebook.*

Part I

Learn About the Family Dynamic

Seminar # 2

"Different Roles of the Family Members"

Seminar Objectives:

1. What you will learn:
    a. The 6 Characteristic Patterns of Interaction in the family dynamic.
2. How you will use it:
    a. The 7 roles family members have within the family system, how does this define your family dynamic?
3. What was learned:
    a. Apply this understanding of their behaviors for each role.
    b. Include this understanding in how you communicate with each other given their role.

Introduction

The family members play different roles inside the family dynamic. This becomes especially obvious during times when the family is most stressed or challenged. Knowing what these roles are, how they act out and impact other members of the family, can be an advantage when planning to achieve a common goal.

There is no blame or you're right – you are wrong. They are all dysfunctional to how the family links together. Because these roles exist it is best to learn how to identify them to work with them as expectations are set and impacts of behavior are created.

As we consider the Homeostasis theory learned in Seminar #1 "the Family is a System" take this information and consider how a role of your family member is working within the family dynamic. It is important to note, each member of the family wants to contribute to the family dynamic in a positive way. However, we are all different from each other and therefore we need to take time to see how our bias or way of approaching an issue, best meets our own needs, the persons need and the needs of the family.

If you have not taken Seminar #1, you may find it helpful to go back and learn those lessons first before continuing with this seminar.

6 Characteristic Patterns of Interaction

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

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

Alternately, the aging parents of adults with substance use disorders may maintain inappropriately dependent relationships with their grown offspring, missing the necessary "launching phase" in their relationship, so vital to the maturing processes of all family members involved.

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

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

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

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

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

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

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

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

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

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

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

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

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

Practical Exercise # One: 6 Characteristic Patterns of Interaction

---

Name each member of the family and the interaction pattern they are presenting.

1.

2.

3.

4.

Seven Dysfunctional Family Roles

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

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

The Substance Misuser:

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

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

The Enabler:

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

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

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

The Hero:

The Caretaker might make excuses for the Dependent, but the Hero is ultimately the one who does the best job of bringing esteem to the family. Heroes work hard to demonstrate responsibility, seeking achievement in any form possible. Younger Heroes will often find numerous extracurricular activities at school, while working in their free time. The family may rarely see the Hero due to the sheer amount of time they spend adding to their roster of accomplishments.

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

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

The Scapegoat:

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

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

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

The Mastermind:

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

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

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

The Mascot:

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

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

Much like the Hero, the Mascot's outward appearance masks deep-seated insecurities. They use their sense of humor as a defense mechanism to put off dealing with pain, fear, or any other sort of emotional discomfort that might cause them trouble. As a result, these feelings remain unprocessed and unresolved. Mascots find themselves in a state of arrested emotional development, unable to cope properly with

negative emotions. Their sense of humor becomes their most defining characteristic, and they fear that any failure on their part to maintain it may result in abandonment. And so while their antics may gain them some popularity (both inside and outside the family), this popularity feels cheap. The Mascot becomes isolated within a sea of people who enjoy their company, yet don't really know them as anything other than a walking laugh factory.

The Lost Child:

Each of the above dysfunctional family roles manifests through action. The Lost Child stands apart, in that we characterize this role primarily by inaction. Those who fit into this role try hard not to rock the boat. They may never mention the Dependent's behavior, perhaps even going out of their way to avoid family discussions about it. Introverted and inconspicuous, the Lost Child may take this role by choice. Many times, however, the Lost Child is as their title implies—someone needs were simply neglected.

Since we characterize the Lost Child by their neglected needs, they may easily fit into many of the other dysfunctional family roles. A Lost Child who gets fed up and angry with their role may wear the mask of Problem Child for a day, simply to take the spotlight for a short period of time. The Hero may identify as the Lost Child if they feel the rest of the family does not acknowledge their achievements. Sometimes the Lost Child plays the role of Scapegoat, disappearing from the family's radar until they become entangled in a family dispute against their will. Usually, however, the Lost Child simply stays out of the way. In a dysfunctional household, the Lost Child feels it safer to remain neither seen nor heard.

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

Practical Exercise # Two *Match the role with each family member*

The Substance Misuser: Family Member Name _____

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

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

What behavior are you observing that shows this is their role:

_____
_____
_____

The Enabler: Family Member Name _____

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

Common behaviors of the Caretaker may include posting bail after an arrest, making excuses for their addicted loved one's behavior, and looking after the Dependent's basic needs when intoxication prevents the Dependent from doing so themselves. Caretakers generally suffer from codependency, which affects their relationships with all members of the household.

They often facilitate—and sometimes encourage, whether purposefully or not—all dysfunctional family roles. Heaping praise upon the Hero, enabling the Problem Child's behaviors, falling prey to the Mastermind's manipulation, etc. We usually think of the Caretaker as a spouse or parent. In some cases, however, the chemical dependency of an adult in the household may necessitate that one of the children step up to fill this role. In such cases, the Caretaker may fit the roles of both Hero and Lost Child. They work to keep the family together but grow up feeling as if they never got to experience a true childhood.

QUESTION TO CONSIDER:

- Does the enabler facilitate the roles of other family members? If yes, how will you address this with them?
- What actions are they taking that create enabling?
- Do they blame themselves for the dependent's suffering?

_____

_____

_____

_____

_____

The Hero: Family Member Name _____

The Caretaker might make excuses for the Dependent, but the Hero is ultimately the one who does the best job of bringing esteem to the family. Heroes work hard to demonstrate responsibility, seeking achievement in any form possible. Younger Heroes will often find numerous extracurricular activities at school, while working in their free time. The family may rarely see the Hero due to the sheer amount of time they spend adding to their roster of accomplishments.

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

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

QUESTION TO CONSIDER:

- Is their volatility between the hero and other family members?
- Is there a sharing of the responsibilities or does the hero do it all? If Yes, how will you change this?

_____

_____

_____

_____

_____

_____

The Scapegoat: Family Member Name _____

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

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

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

In a dysfunctional way, the scapegoat will bring the entire family together. The addicted family system comes together so that they can feel better about whom they are in comparison to what the scapegoat is doing. Having a scapegoat to look at keeps everyone in the family from facing their own problems or addictions. Any anger or frustration that is felt over the addiction will be released onto the scapegoat inadvertently.

QUESTION TO CONSIDER:

- Is there misplaced blame for the dependent's behavior.
- Are they believing the unjustly assigned guilt?
- Are they showing trust issues?

_____

_____

_____

_____

_____

_____

The Mastermind: Family Member Name _____

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

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

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

QUESTION TO CONSIDER:

- Is this person showing signs of manipulation? If yes, how will you address this trait?

_____

_____

_____

_____

_____

_____

The Mascot: Family Member Name _____

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

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

Much like the Hero, the Mascot's outward appearance masks deep-seated insecurities. They use their sense of humor as a defense mechanism to put off dealing with pain, fear, or any other sort of emotional discomfort that might cause them trouble. As a result, these feelings remain unprocessed and unresolved. Mascots find themselves in a state of arrested emotional development, unable to cope properly with negative emotions.

Their sense of humor becomes their most defining characteristic, and they fear that any failure on their part to maintain it may result in abandonment. And so while their antics may gain them some popularity (both inside and outside the family), this popularity feels cheap.

The Mascot becomes isolated within a sea of people who enjoy their company, yet don't really know them as anything other than a walking laugh factory.

QUESTION TO CONSIDER:

- Are you observing traits of insecurities?
- Does this person make inappropriate, insensitive comments or jokes?

_____

_____

_____

_____

_____

_____

The Lost Child: Family Member Name _____

Each of the above dysfunctional family roles manifests through action. The Lost Child stands apart, in that we characterize this role primarily by inaction. Those who fit into this role try hard not to rock the boat. They may never mention the Dependent's behavior, perhaps even going out of their way to avoid family discussions about it. Introverted and inconspicuous, the Lost Child may take this role by choice. Many times, however, the Lost Child is as their title implies—someone whose needs were simply neglected.

Since we characterize the Lost Child by their neglected needs, they may easily fit into many of the other dysfunctional family roles. A Lost Child who gets fed up and angry with their role may wear the mask of Problem Child for a day, simply to take the spotlight for a short period of time. The Hero may identify as the Lost Child if they feel the rest of the family does not acknowledge their achievements. Sometimes the Lost Child plays the role of Scapegoat, disappearing from the family's radar until they become entangled in a family dispute against their will. Usually, however, the Lost Child simply stays out of the way. In a dysfunctional household, the Lost Child feels it safer to remain neither seen nor heard.

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

QUESTION TO CONSIDER:

- Does this person show signs of resentment?
- Do they seem inactive in the on goings of the family discussions?

_____

_____

_____

_____

_____

_____

The Story

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Dysfunctional Families 01

Link: https://www.youtube.com/watch?v=c8lQ6gDlgQs

Duration: 7:40min

Practical Exercise # One: Dysfunctional Families 01

1. What are the common family (shame bound) frailties in your family?
2. Are you seeing a power vacuum in your family? What does it look like?
3. What are your family rules?

The Story

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Codependency: The Chemical Dependent Family

Link: https://www.youtube.com/watch?v=h0e5gZfkVcg

Duration: 12:00min

Practical Exercise # Three: *How a family member is likely to respond to an issue given their role.*

State an example of a family wide issue being presented to the family unit. Use this issue for each family member and state how that family member is likely to respond to this family wide issue.

WHAT ISSUE IS OUR FAMILY IS FACING: _____

Mother: What role is she playing _____. How will she likely act when addressing _____ issue

_____

_____

Father: What role is he playing _____. How will he likely act when addressing _____ issue

_____

_____

Sibling One: What role are they playing _____. How will they likely act when addressing _____ issue

_____

_____

Sibling Two: What role are they playing _____. How will they likely act when addressing _____ issue

_____

_____

Extended Family System:

List Extended Members: What role are they playing ____. How will they likely act when addressing _____ issue.

_____

_____

Take this seminar content and apply it to the development of the "Family Master Plan of Action**".**

Family or Group Discussions (Ref: Study Guide & Workbook)

1. How would you describe the obstacles of Denial, Enabling and Codependency from Seminar # 1 (The Family is a System) created by the roles each family member assumes in responding to the impact in your family dynamic? (ref: study guidebook)
2. Why is knowing the roles of family members, valuable? (ref: workbook)
3. In what way are internal obstacles a part of your family system? (ref: study guidebook)
4. In what way can an issue impacting the family come from both internal and external sources be influenced by a role a family member is playing? (ref: workbook)
5. Attach an observed family members behavior to their assigned roles.

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

1. Identify which of the seven characteristic patterns of interaction may exist in your family.
2. Our Family will need to first understand each member role.
3. The family members will use an issue to then determine what will be the likely response from each member, given the role they play.

PART I

Learn About the Family System

Seminar # 3

"Childhood Trauma in the Family System"

Seminar Objectives:

1. Recognize the Signs of Childhood Trauma.
2. Get an Assessment and Diagnosis
3. The different scales used to evaluate childhood trauma.
4. Understand Trauma in School age Children.

Before beginning this seminar: A Link to a website worth reading:

www.giftfromwithin.org/html/cptsd-understanding-treatment.

Introduction

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

The devastating effects of child abuse on adult mental health morbidity has been well documented (e.g., *Edwards, Holden, Felitti, & Anda, 2003; Herrenkohl, Hong, Klika, Herrenkohl,& Russo, 2013; Horwitz,Widom,Mclaughlin, & White, 2001*).

One area of interest has been substance use disorders (SUDs) because substance use often emerges as a maladaptive strategy used to manage the negative results of trauma exposure, including posttraumatic stress disorder (PTSD) and depression.

Childhood abuse has been linked to substance use problems, including both alcohol and illicit drug use. Exposure to traumatic experiences, especially those occurring in childhood, has been linked to substance use disorders (SUDs), including abuse and dependence. Up to 59% of young people with PTSD subsequently develop substance abuse problems.

The ACE study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relationship to adult health a half-century later. The study confirmed earlier investigations that found a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease.

The Impact of Childhood Trauma

The impact of child traumatic stress can last well beyond childhood. In fact, research has shown that child trauma survivors may experience:

- Learning problems, including lower grades and more suspensions and expulsions
- Increased use of health and mental health services
- Increased involvement with the child welfare and juvenile justice systems
- Long-term health problems (e.g., diabetes and heart disease)

TRAUMA is a risk factor for nearly all behavioral health and substance use disorders. Traumatic experiences can set in motion a cascade of changes in children's lives that can be challenging and difficult. These can include changes in where they live, where they attend school, who they're living with, and their daily routines. They may now be living with injury or disability to themselves or others. There may be ongoing criminal or civil proceedings.

Traumatic experiences leave a legacy of reminders that may persist for years. These reminders are linked to aspects of the traumatic experience, its circumstances, and its aftermath. Children may be reminded by persons, places, things, situations, anniversaries, or by feelings such as renewed fear or sadness. Physical reactions can also serve as reminders, for example, increased heart rate or bodily sensations. Identifying children's responses to trauma and loss reminders is an important tool for understanding how and why children's distress, behavior, and functioning often fluctuate over time. Trauma and loss reminders can reverberate within families, among friends, in schools, and across communities in ways that can powerfully influence the ability of children, families, and communities to recover. Addressing trauma and loss reminders is critical to enhancing ongoing adjustment.

Neglect:

- Psychological, physical, or sexual abuse
- Witnessing or experiencing domestic violence
- Community or school violence
- Physical or sexual assault
- Commercial sexual exploitation
- Sudden or violent loss of a loved one
- Serious accidents or life-threatening illness

Treatment awareness's, acceptance and coordination by the family

Trauma-Informed Services—Basic principles of trauma-informed services include the following *(see Harris & Fallot, 2001, for a more complete discussion):*
Take a moment to see trauma as a defining and organizing experience that can shape a survivor's sense of self and others. Such programs understand that many problem behaviors originate as understandable attempts to cope with abusive experiences and that the effects of trauma may be seen in life domains not obviously related to experiences of violent victimization (for example, in substance abuse, eating disorders, or relationship difficulties).

Create an open and collaborative relationship between healthcare providers and your loved one and place priority on safety, choice, and control. A good program is designed with these goals in mind and are welcoming to trauma survivors, minimize the possibility of revictimization, and support consumer empowerment and skill development

Trauma-informed substance abuse service settings do the following:
Providers should be able to recognize the multiple, complex interactions between alcohol and drug use and interpersonal violence; understand that drugs and/or alcohol are often a part of children's physical, sexual, and emotional abuse (either because the perpetrator is using substances or induces the child to ingest alcohol or drugs); are aware that survivors often use substances to manage the emotional distress that follows from trauma; and understand that substance abusers become more vulnerable to

revictimization through risks associated with addiction-related behavior. If this is not the case, then you are dealing with a group that may not be fully qualified to meet your needs.

The practice should be able to simultaneously address trauma and substance abuse. In contrast, parallel models offer two distinct sets of services—one for trauma and one for addiction—often in different settings with different providers, and sequential approaches argue that the substance abuse problems must be addressed before turning to trauma-related difficulties. Both parallel and sequential approaches underestimate the realities of the close and often mutually reinforcing relationships between trauma and substance use. Helping people in recovery understand the range of possible connections between trauma and substance abuse is a key process in integrated services. The family needs to help the clinical team get this duality right, through the applied plan of care.

Ensure the loved ones' physical and emotional being is safe. This means the practice should provide an atmosphere that is hospitable, engaging, and supportive from the outset, avoiding practices that may be physically intrusive and potentially retraumatizing (e.g., urine sample monitoring and strip searches), and avoiding shame inducing confrontations that may trigger trauma-related responses of avoidance, withdrawal, depression, or rage. Again, move on if they are not doing this.

Focus on empowerment by empowering the loved one to engage in collaborative decision making for themselves during all phases of treatment. This means that the consumers choose where, how, and when they will receive services, and they have a voice in deciding on the specific provider of the services.

Recognize that ancillary services are necessary components of comprehensive, whole-person interventions. Vocational and educational services, safe housing, parenting and other life skills training, health care, and legal services are among essential supports.

Without treatment, repeated childhood exposure to traumatic events can affect the brain and nervous system and increase health-risk behaviors (e.g., smoking, eating disorders, substance use, and high-risk activities). Research shows that child trauma survivors can be more likely to have long-term health problems (e.g., diabetes and heart disease) or to die at an earlier age. Traumatic stress can also lead to increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems. Adult survivors of traumatic events may also have difficulty in establishing fulfilling relationships and maintaining employment.

FOR MORE INFORMATION ABOUT:

THE NATIONAL CHILD TRAUMATIC STRESS INITIATIVE

(you are the consumer; you are the family)

visit http://www.samhsa.gov/child-trauma or call (240) 276-1880

THE SUBSTANCE ABUSE AND MENTAL HEALTH

visit http://www.samhsa.gov or call (877) SAMHSA-7

THE NATIONAL CHILD TRAUMATIC STRESS NETWORK: visit http://www.nctsn.org

The Story

1st ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Tim Fletcher's Talk Complex Trauma 1

This is a four-part series. The instructor may want to divide them into two sessions.

Link #1: https://www.youtube.com/watch?v=6IxEwPMqB-c

Link #2: https://www.youtube.com/watch?v=tfr-jBjQ9Wk

Link #3: https://www.youtube.com/watch?v=8Sfd0IEiVWw

Link # 4: https://www.youtube.com/watch?v=1UyAzcS7epc

Extra Assignment

2nd ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Complex Trauma: Understanding and Treatment Education Published on Jan 21, 2016

Link: www.youtube.com/watch?v=otxAuHG9hKo

Duration: 45:38 min

Practical Exercise # 1 Childhood Trauma in Substance Use Disorder Worksheet

This worksheet is for the family to understand the types of questions asked in an assessment screening for childhood trauma. We strongly recommend that the family members **not attempt to deal with any of these topics** without the instructions and oversight of a profession licensed therapist. It is critical that these topics be handled by a professional.

Childhood Traumatic Events Scale

For the following questions, answer each item that is relevant. Be as honest as you can. Each question refers to any event that they may have experienced prior to the age of 17.

1. Prior to the age of 17, did you experience a death of a very close friend or family member? If yes, how old were you?_____

If yes, how traumatic was this? (using a 7-point scale, where 1 = not at all traumatic, 4 = somewhat traumatic, 7 = extremely traumatic)_____

If yes, how much did you confide in others about this traumatic experience at the time? (1 = not at all, 7 = a great deal) _____

2. Prior to the age of 17, was there a major upheaval between your parents (such as divorce, separation)? _____ If yes, how old were you? _____

If yes, how traumatic was this? (where 7 = extremely traumatic) _____

If yes, how much did you confide in others? (7 = a great deal) _____

3. Prior to the age of 17, did you have a traumatic sexual experience (raped, molested, etc.)? _____ If yes, how old were you? _____

If yes, how traumatic was this? (7 = extremely traumatic) _____

If yes, how much did you confide in others? (7 = a great deal) _____

4. Prior to the age of 17, were you the victim of violence (child abuse, mugged or assaulted other than sexual)? ____ If yes, how old were you? _____

If yes, how traumatic was this? (7 = extremely traumatic) _____

If yes, how much did you confide in others? (7 = a great deal) _____

5. Prior to the age of 17, were you extremely ill or injured? ____ If yes, how old were you? _____

If yes, how traumatic was this? (7 = extremely traumatic) _____

If yes, how much did you confide in others? (7 = a great deal) _____

6. Prior to the age of 17, did you experience any other major upheaval that you think may have shaped your life or personality significantly? _____ If yes, how old were you? _____

If yes, what was the event? _____

If yes, how traumatic was this? (7 = extremely traumatic) _____

If yes, how much did you confide in others? (7 = a great deal) _____

Recent Traumatic Events Scale

For the following questions: Again, answer each item that is relevant and again be as honest as you can. Each question refers to any event that you may have experienced within the last 3 years.

1. Within the last 3 years, did you experience a death of a very close friend or family member?_____

If yes, how traumatic was this? (1 = not at all traumatic, 7 = extremely traumatic) _____

If yes, how much did you confide in others about the experience at the time? (1 = not at all, 7 = a great deal) _____

2. Within the last 3 years, was there a major upheaval between you and your spouse (such as divorce, separation)? ____

If yes, how traumatic was this? ____

If yes, how much did you confide in others? ____

3. Within the last 3 years, did you have a traumatic sexual experience (raped, molested, etc.)? ____

If yes, how traumatic was this? ____

If yes, how much did you confide in others? ____

4. Within the last 3 years, were you the victim of violence (other than sexual)?_____

If yes, how traumatic was this?_____

If yes, how much did you confide in others?_____

5. Within the last 3 years, were you extremely ill or injured?_____

If yes, how traumatic was this?_____

If yes, how much did you confide in others?_____

6. Within the last 3 years, has there been a major change in the kind of work you do (e.g., a new job, promotion, demotion, lateral transfer)?_____

If yes, how traumatic was this?_____

If yes, how much did you confide in others?_____

7. Within the last 3 years, did you experience any other major upheaval that you think may have shaped your life or personality significantly?_____

If yes, what was the event?_____

If yes, how traumatic was this?_____

Family or Group Discussions (Ref: Study Guide & Workbook)

1. **How would you describe the obstacles created by complex trauma for your family?**
2. **Why is knowing the trauma important towards moving forward as family members.**
3. **Given that the trauma may have happened to a different family member than the one who is abusing substances, how do they impact the other family members? Consider the family is a system.**
4. **In what way can family therapy for the family members help to identify other types of mental health conditions in each family member, as the family tries to work together.**

Consider purchasing the organizing workbook on Prime Amazon.com

The Substance Use Disorder Journey, It's Time to get Organized. By: Roy P. Poillon

https://www.amazon.com

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

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

1. **Our family should consider a complex trauma may be a part of the family system and family therapy will assist in bringing this forward.**
2. **What is the best way to get the family to agree on a session with a family therapist?**

PART I

IT'S ABOUT THE FAMILY DYNAMIC

Seminar # 4

"Different Types of Family Therapy"

Seminar Objectives:

1. To identify the eight foundations of family therapy.

2. Identify the different types of family therapy.

3. The difference between Multidimensional Family Therapy and other family therapies.

Introduction

In therapy we learn about protective as well as corrective factors. Protective factors are conditions or attributes of individuals, family's members, communities, or the larger society that reduce or eliminate risk and promote healthy development and well-being in a family. These factors help ensure that children and family members function well at home, in school, at work, and in the community today and into adulthood. Protective factors also can serve as safeguards, helping parents to find resources, support, or coping strategies that allow them to parent effectively—even under stress.

Research has found that successful interventions can reduce risk factors and promote healthy family wellbeing. However, the family needs to know where to go for these resources, what to request, how to use the resource and what to expect as an outcome.

There is growing interest in families towards understanding the complex ways in which these a family can use family therapy in their journey with substance use disorder. This search for protective factors interacts within the context of a family's ability to gain access from the community, and society. By knowing the different types of family therapy available to the family, each member can benefit by participating in sessions that will strengthen their resolve to cope with the demands and issues that present in a journey with substances use disorder.

Lesson One: Eight Concepts of Family Therapy

There are Eight major concepts of family therapy, they occur in no particular order:

1. **Differentiation of self,** the core concept of approach, refers to the way a person is able to separate thoughts and feelings, respond to anxiety, and cope with the variables of life while pursuing personal goals. An individual with a high level of differentiation may be better able to maintain individuality while still maintaining emotional contact with their family. A person with a low level of differentiation may experience emotional fusion, feeling what the family feels, due to insufficient interpersonal boundaries between members of the family. Highly differentiated people may be more likely to achieve contentment through their own efforts, while those with a less-developed self may seek validation from other people in the family.
2. **An emotional triangle** represents the smallest stable network of human relationship systems (larger relationship systems can be perceived as a network of interlocking triangles). A two-person dyad may exist for a time but may become unstable as anxiety is introduced. A three-person system, however, may provide more resources toward managing and reducing overall anxiety within the group. Despite the potential for increased stability, many triangles establish their own rules and exist with two sides in harmony and one side in conflict—a situation which may lead to difficulty. It is common for children to become triangulated within their parents' relationship.
3. **The family projection process,** or the transmission of a parent's anxiety, relationship difficulties, and emotional concerns to the child within the emotional triangle, may contribute to the development of

emotional issues and other concerns in the child. The parent(s) may first focus anxiety or worry onto the child and, when the child reacts to this by experiencing worry or anxiety in turn, may either try to "fix" these concerns or seek professional help. However, this may often have further negative impact as the child begins to be further affected by the concern and may become dependent on the parent to "fix" it. What typically leads to the most improvement in the child is management, on the part of the parent(s), of their own concerns.

4. **The multigenerational transmission process**, according to professionals, this depicts the way that individuals seek out partners with a similar level of differentiation, potentially leading to certain behaviors and conditions that are passed on through generations. For example: a couple where each partner has a low level of differentiation may have children who have even lower levels of differentiation. These children may eventually have children with even lower levels of differentiation. When individuals increase their levels of differentiation, according to Bowen, they may be able to break this pattern, achieve relief from their symptoms of low differentiation, and prevent symptoms from returning or occurring in other family members.

5. **An emotional cutoff** describes a situation where a person decides to best manage emotional difficulties or other concerns within the family system by emotionally distancing themselves from other members of the family. Cutting emotional connections may serve as an attempt to reduce tension and stress in the relationship and handle unresolved interpersonal issues, but the end result is often an increase in anxiety and tension, although the relationship may be less fraught with readily apparent conflict.

6. **A sibling position** describes the tendency of the oldest, middle, and youngest children to assume specific roles within the family due to differences in expectation, parental discipline, and other factors. For example, older children may be expected to act as miniature adults within the family setting. These roles may be influenced by the sibling position.
7. **The societal emotional process** illustrates how principles affecting the emotional system of the family also affect the emotional system of society. Individuals in society may experience greater anxiety and instability during periods of regression, and parallels can be noted between societal and familial emotional function. Factors such as overpopulation, the availability of natural resources, the health of the economy, and so on can influence these regressive periods.
8. **The nuclear family emotional process** reflects the belief that a nuclear family tends to experience issues in four main areas: intimate partner conflict, problematic behaviors or concerns in one partner, emotional distance, and impaired functionality in children. Anxiety may lead to fights, arguments, criticism, under- or over-performance of responsibilities, and/or distancing behavior. Though a person's belief system and attitude toward relationships may impact the development of issues according to relationship patterns.

Practical Exercise # 1 Ten Concepts of Family Therapy

Your Observations: (these are not to be used in a dialog with other family members without a professional therapist present). This is for your self-examination only, take this to your next therapy session and review your findings with a professional.

ONE: Differentiation of self, the core concept of approach, refers to the way a person is able to separate thoughts and feelings, respond to anxiety, and cope with the variables of life while pursuing personal goals. What is your differentiation of self? Google "Differentiation of Self"

_____

_____

_____

TWO: An individual with a high level of differentiation may be better able to maintain individuality while still maintaining emotional contact with their family. Highly differentiated people may be more likely to achieve contentment through their own efforts, while those with a less-developed self may seek validation from other people in the family.

From your observations, what traits does each family member have?

_____

_____

_____

_____

THREE: An emotional triangle represents the smallest stable network of human relationship systems (larger relationship systems can be perceived as a network of interlocking triangles). A two-person dyad may exist for a time but may become unstable as anxiety is introduced. A three-person system, however, may provide more resources toward managing and reducing overall anxiety within the group. Despite the potential for increased stability, many triangles establish their own rules and exist with two sides in harmony and one side in conflict—a situation which may lead to difficulty. It is common for children to become triangulated within their parents' relationship.

What (if any) emotional triangles are present in your family dynamic?

_____

_____

_____

_____

_____

FOUR: The family projection process, or the transmission of a parent's anxiety, relationship difficulties, and emotional concerns to the child within the emotional triangle, may contribute to the development of emotional issues and other concerns in the child.

Has this occurred in the family?

_____
_____
_____

FIVE: The parent(s) may first focus anxiety or worry onto the child and, when the child reacts to this by experiencing worry or anxiety in turn, may either try to "fix" these concerns or seek professional help. However, this may often have further negative impact as the child begins to be further affected by the concern and may become dependent on the parent to "fix" it. What typically leads to the most improvement in the child is management, on the part of the parent(s), of their own concerns.

Has this occurred in the family?

_____
_____
_____

SIX: The multigenerational transmission process, according to professionals, this depicts the way that individuals seek out partners with a similar level of differences, potentially leading to certain behaviors and conditions that are passed on through generations. For example: a couple where each partner has a low level of differentiation may have children who have even lower levels of differentiation. These children may eventually have children with even lower levels of differentiation. When individuals increase their levels of differentiation, according to Bowen, they may be able to break this pattern, achieve relief from their symptoms of low differentiation, and prevent symptoms from returning or occurring in other family members.

Has this occurred in the family?

_____
_____
_____

SEVEN: An emotional cutoff describes a situation where a person decides to best manage emotional difficulties or other concerns within the family system by emotionally distancing themselves from other members of the family. Cutting emotional connections may serve as an attempt to reduce tension and stress in the relationship and handle unresolved interpersonal issues, but the result is often an increase in anxiety and tension, although the relationship may be less fraught with readily apparent conflict. Bowen believed emotional cutoff would lead people to place more importance on new relationships, which would add stress to those relationships, in turn.

Has this occurred in the family?

_____
_____
_____

EIGHT: A sibling position describes the tendency of the oldest, middle, and youngest children to assume specific roles within the family due to differences in expectation, parental discipline, and other factors. For example, older children may be expected to act as miniature adults within the family setting. These roles may be influenced by the sibling position of parents and relatives.

Has this occurred in the family?

_____
_____
_____

NINE: The societal emotional process illustrates how principles affecting the emotional system of the family also affect the emotional system of society. Individuals in society may experience greater anxiety and instability during periods of regression, and parallels can be noted between societal and familial emotional function. Factors such as overpopulation, the availability of natural resources, the health of the economy, and so on can influence these regressive periods.

How this occurred in the family?

_____
_____
_____

TEN: The nuclear family emotional process reflects the belief that a nuclear family tends to experience issues in four main areas: intimate partner conflict, problematic behaviors or concerns in one partner, emotional distance, and impaired functionality in children. Anxiety may lead to fights, arguments, criticism, under- or over-performance of responsibilities, and/or distancing behavior. Though a person's belief system and attitude toward relationships may impact the development of issues according to relationship patterns, Bowen held them to be primarily a result of the family emotional system

_____
_____
_____

Lesson Two: Different Types of Family Therapy

I. Multisystemic Family Therapy

Theoretical basis

This model originated in the simple observation of high treatment dropout rates among adolescents in family therapy for their substance abuse. Programmatic features that seemed to lower dropout rates were identified and implemented to maximize accessibility of services and make treatment providers more accountable for outcomes (Henggeler et al. 1996).

Techniques and strategies

Multisystemic therapy has proven useful as a method for increasing engagement in treatment in a study in which adolescents randomly assigned to this treatment were compared to a group receiving treatment as usual (Henggeler et al. 1996).

Features of this therapy that are designed to make it successful include the following:

• Multisystemic therapy is provided in the home.

• Low caseloads allow counselors to be available on an as needed basis around the clock.

• Family members are full collaborators with the therapist.

• It has a strengths-based orientation in which the family determines the treatment goals.

• It is responsive to a wide range of barriers to achieving treatment goals.

• Services are designed to meet individual needs of clients, with the flexibility to change as needs change.

• The counselor and other members of the treatment team assume responsibility for engaging the client and using creative approaches to achieve treatment goals (Henggeler et al. 1996).

Multisystemic therapy has influenced the development of other therapies, including functional family therapy, a brief prevention and treatment intervention with delinquent youth with substance abuse problems (Sexton and Alexander 2000).

II. Multidimensional Family Therapy

Theoretical basis:

The multidimensional family therapy (MDFT) approach was developed as a standalone, outpatient therapy to treat adolescent substance abuse and associated behavioral problems of clinically referred teenagers. MDFT has been applied in several geographically distinct settings with a range of populations, targeting ethnically diverse adolescents at risk for abuse and/or abusing substances and their families. The majority of families treated have been from disadvantaged inner-city communities. Adolescents in MDFT trials have ranged from high risk early adolescents to multi-problem, juvenile justice involved, dually diagnosed female and male adolescents with substance use problems.

As a developmentally and ecologically oriented treatment, MDFT takes into account the interlocking environmental and individual systems in which clinically referred teenagers reside (Liddle 1999). The clinical outcomes achieved in the four completed controlled trials include adolescent and family change in functional areas that have been found to be causative in creating dysfunction, including drug use, peer deviance factors, and externalizing and internalizing variables. The cost of this treatment relative to contemporary estimates of similar outpatient treatment favors MDFT. The clinical trials have not included any treatment as usual or weak control conditions. They have all tested MDFT against other manualized, commonly used interventions. The approach is manualized (Liddle 2002), training materials and adherence scales have been developed, and have demonstrated that the treatment can be taught to clinic therapists with a high degree of fidelity to the model (Hogue et al. 1998).

promising interventions for adolescent drug abuse in a new generation of comprehensive, multicomponent, theoretically derived and empirically supported treatments (Center for Substance Abuse Treatment [CSAT] 1999c; NIDA 1999a; Waldron 1997).

MDFT has demonstrated efficacy in four randomized clinical trials, including three treatment studies (one of which was a multisite trial) and one prevention study. Investigators have also conducted a series of treatment development and process studies illuminating core mechanisms of change.

Techniques and strategies

Targeted outcomes in MDFT include reducing the impact of negative factors as well as promoting protective processes in as many areas of the teen's life as possible. Some of these risk and protective factors include improved overall family functioning and a healthy interdependence among family members, as well as a 1.Reduction in substance abuse, 2. Drastically reduced delinquency and 3. Involvement with antisocial peers, and 4. Improved school performance.

Objectives for the adolescent include transformation of a drug using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains, including positive peer relations, healthy identity formation, bonding to school and other prosocial institutions, and autonomy within the parent adolescent relationship. For the parent(s), objectives include increasing parental commitment and preventing parental abdication, improved relationship and communication between parent and adolescent, and increased knowledge about parenting practices.

Core components

MDFT is an outpatient family-based drug abuse treatment for teenagers who abuse substances (Liddle 2002). From the perspective of MDFT, adolescent drug use is understood in terms of a network of influences (i.e., individual, family, peer, community). This multidimensional approach suggests that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. The therapeutic process is thought of as retracking the adolescent's development in the multiple ecologies of his or her life. The therapy is organized according to stage of treatment, and it relies on success in one phase of the therapy before moving on to the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions. Sessions are held in the clinic, in the home, or with family members at the court, school, or other relevant community locations. Change for the adolescents and parents is intrapersonal and interpersonal, with neither more important than the other. The therapist helps to organize treatment by introducing several generic themes. These are different for the parents (e.g., feeling abused and without ways to influence their child) and adolescents (e.g., feeling disconnected and angry with their parents). The therapist uses these themes of parent child conflict as assessment tools and as a way to identify workable content in the sessions.

The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT ranges between 16 and 25 sessions over 4 to 6 months, depending on the target population and individual needs of the adolescent and family. Sessions may occur multiple times during the week in a variety of contexts including in home, in clinic, or by phone.

The MDFT approach is organized according to five assessment and intervention modules, and the content and focused sessions vary by the stage of treatment.

III. Structural/Strategic Family Therapy

Theoretical basis

Structural/strategic family therapy assumes that (1) family structure—meaning repeated, predictable patterns of interaction—determines individual behavior to a great extent, and

(2) the power of the system is greater than the ability of the individual to resist. The system can often override any family member's attempt at nonengagement (Stanton 1981a; Stanton et al. 1978).

Among the models in the above list, several have demonstrated effectiveness in treating substance use disorders: structural/strategic family therapy, multidimensional family therapy, multisystemic therapy, and behavioral and cognitive–behavioral family therapy. The others have not demonstrated research-based outcomes for substance abuse treatment at this point, but appear to have made inroads into the substance abuse treatment field.

Roles, boundaries, and power establish the order of a family and determine whether the family system works. For example, a child may assume a parental role because a parent is too impaired to fulfill that role. In this situation, the boundary that ought to exist between children and parents is violated. Structural/strategic family therapy would attempt to decrease the impaired parent's substance abuse and return that person to a parenting role.

Whenever family structure is improperly balanced with respect to hierarchy, power, boundaries, and family rules and roles, structural/strategic family therapy can be used to realign the family's structural relationships. This type of treatment is often used to reduce or eliminate substance abuse problems. As McCrady and Epstein (1996) explain, the family systems model can be used to (1) identify the function that substance abuse serves in maintaining family stability and (2) guide appropriate changes in family structure.

Techniques and strategies

In this treatment model, the counselor uses structural/strategic family therapy to help families change behavior patterns that support substance abuse and other family problems. Because these patterns in dysfunctional families are typically rigid, the counselor must take a directive role and have family members develop, then practice, different patterns of interaction. Counselors using this treatment model require extensive training and supervision to direct families effectively.

One modification that flows from structural/ strategic family therapy is strategic/structural systems engagement (SSSE). In SSSE, the family is helped to exchange one set of interactions that maintains drug use for another set of interactions that reduces it. SSSE targets the interactions linked to specific behaviors that, if changed, will no longer support the presenting problem behavior. Once the family, including the person with a substance use disorder, agrees to participate in therapy, the counselor can refocus the intervention on removing problem behaviors and substance abuse.

Another modification, brief strategic family therapy (BSFT), also flows from structural/ strategic family therapy. In BSFT, structural family therapy "has evolved into a time limited, family based approach that combines both structural and strategic [problem focused and pragmatic]

interventions"(Robbins and Szapocznik 2000). BSFT is known to be effective among youth with behavioral problems and is commonly used for that purpose among Hispanic families (Robbins and Szapocznik 2000).

BSFT is used to help counselors attract families that are difficult to engage in substance abuse treatment (Szapocznik and Williams 2000). In Hispanic families with adolescents using drugs, Szapocznik and colleagues reported that 93 percent of families were brought into treatment using standard BSFT, versus 42 percent in a control group. Treatment completion rates were higher among those receiving BSFT (Szapocznik et al. 1988). To achieve this improvement, BSFT was modified to a oneperson family technique. The technique is based on the idea of complementarity (Minuchin and Fishman 1981), that is, when one family member changes, the rest of the family system will respond. Szapocznik and Williams (2000) used the one-person family technique with the first person in the family to request help. Once the whole family was engaged, they refocused attention on problem behavior and drug abuse.

While structural/strategic family therapy has been shown to be effective for substance abuse treatment, counselors must carefully consider using this approach with multi-problem families and families from particular cultures. Some points to consider are

• Culture. Counselors should become familiar with the roles, boundaries, and power of families from cultures different from their own. These will influence the techniques and strategies that will be most effective in therapy.

• Age and gender. Cultural attitudes toward younger people and women can affect how the counselor can best assume the directive role that structural/strategic family therapy requires.

• Hierarchies. certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until the parent notices they are not there.

The professional needs to be attentive to who is who in the family. Who is revered? Who are friends? What is its history? Place of origin? All these are clues to understanding a family's hierarchy.

Counselors who use structural/strategic family therapy need to appreciate how a particular intervention might be experienced by family members.

If family members experience the intervention as duplicitous, manipulative, or deceitful, the counselor may have broached a possible ethical line. As discussed in the section on informed consent in chapter 6, family therapists or substance abuse counselors might wish to explain in advance that such interventions could be part of the therapeutic process and obtain the client's informed consent for their possible inclusion. If you have questions about the use of such interventions, they should be answered ahead of time and included as part of the informed consent. For more detailed information about structural/ strategic family therapy, refer to Charles Fishman's manual Intensive Structural Therapy: Treating Families in Their Social Context (1993) and Szapocznik and colleagues' Brief Strategic Family Therapy (in press). The case study on p. 89 demonstrates how structural/strategic family therapy might work with a client from the criminal justice system.

Practical Exercise # 2 Different Types of Family Therapy

In what say is MDFT Different from Structural Family Therapy?

_____
_____
_____

In Multisystemic Family Therapy, describe the approach in how the therapist focuses on the family needs.

_____
_____
_____

Which of the three types of family therapy presented here, are a good place to discuss with a Family Therapist as where to start, and Why?

The Story

ASSIGNMENT VIDEO: www.youtube.com/

Title/Search: Multidimensional Family Therapy, An Introduction (1 of 2) - See www.mdft.org

Link: https://www.youtube.com/watch?v=FiOiOERc82o

Duration: 10:16 min

ASSIGNMENT VIDEO: www.youtube.com/

Title/Search: Structural Family Therapy

Link:

www.youtube.com/watch?v=TfPiGr41mow&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=10&t=0suration: 13:46 min

Practical Exercise # 3 Difference of MDFT to Other Therapy Models

Which is not a foundational structure of Multidimensional Family Therapy?

1. Reduction in substance abuse

2. Drastically reduced delinquency

3. Involvement with antisocial peers

4. Improved school performance

5. Improved skills for sports

Family/Group Discussion: What is the objective in Structural Family Therapy? How can it help?

EXTRA LEARNING: This video could be its own session, or as homework.

ASSIGNMENT VIDEO: www.youtube.com/

Title/Search: MDFT Illustrated: Evidence-Based Treatment for Youth Substance Abuse and Delinquency

Link: www.youtube.com/watch?v=wWSaebHdsS0&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=7

Duration: 59:53 min

This video gives a living example of how the therapy works. Note: the different areas that the therapist includes to each therapy session. Group discussion is encouraged. Because this is a long video it may be best to split this topic into its own sessions one following the other.

Family/Group Discussion: How is using a multi-level approach more inclusive to the world of the family and the one who is a substance abuser.

Family or Group Discussions (Ref: Study Guide & Workbook)

1. How would you describe the obstacles created by not seeking family therapy?
2. Which are the two most likely best choices for your family? State Why?
3. Given the family is a system, each member plays a role, there may be childhood trauma can you list three more reasons that family therapy will benefit the family members going forward?
4. In what way can family therapy for the family members help to identify other types of mental health conditions in each family member, as the family tries to work together.

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

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

1. Our family considers the family system to be complex and family therapy is likely the best path to take. State how each member will assist in bringing this forward.

PART I

IT'S ABOUT THE FAMILY DYNAMIC

Seminar # 5

Four Primary Family Support Structures

SEMINAR GOALS:

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.

Introduction

We see the family is a system, and in any system each part is related to all the other parts. Consequently, a change in any part of the system will bring about changes in all the other parts. (Brodrick, 1993; Klein & White, 1996)

Even if you have not seen the statistics, you've likely felt a shifting of the sands. A change is underway that is reshaping the landscape of the mental health and addiction services industry: a rapid rise of consumerism in healthcare. But what will be the impact of consumerism on the Substance Use Disorder healthcare industry? If families begin to see themselves as a system worthy of preventive maintenance, then they will need to understand what services are available. The problem is most mental healthcare services are not set up for consumerism.

According to The IHC, Healthcare consumerism is defined as, "transforming an employer's health benefit plan into one that puts economic purchasing power—and decision-making—in the hands of participants. It's about supplying the information and decision support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and healthcare purchasing behaviors."

No longer content to let others make their decisions, and emboldened by the freedom of choice they enjoy in an ever more consumer-centric economy, consumers have emerged as the fastest growing payer in the industry. They are many. And they are powerful. But they are also confused and frustrated, creating one of the major issues in healthcare today. And that's a situation no one can afford to ignore. (Primarily because the family are the ones who need to use it.)

Families are increasingly prepared to interact with the medical industry as consumers rather than as passive patients. Through interactions with other services industries, a family's expectations about healthcare experiences have changed, we expect more transparency, accountability, performance reporting and greater-more timely access.

4 Primary Support Structures

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

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

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

4. The Healthcare Systems Support Structure: The healthcare industry in each community is a support structure for the family unit. They have the capacity to create treat, care, build resiliency.

Get Organized:

It is important for the family to see this journey as "requiring a sense of organization". The areas that can be organized will be assembled and placed into a family organization binder. This is where all critical documents are held. Using Tab Dividers, the binder can contain, Legal, Medical, and Support Network contacts. Take the time to get organized by using the Families Impacted by Opioids "worksheets" for each issue and place them into this binder. When addressing the 12 Key Stress Issues and determining what the family is likely to need, the family will have organized their journey and be better prepared to face each issue. This is empowering. This is the families responsibly. Empowerment = Responsibility.

Get Networked:

The family needs to see the value of those who are here to help, and have these resources proactively listed in their organization binder. This list of contacts with names, title, phone and email will be valuable when created ahead of the time.

The 4 Primary Support Structures

The family cannot go through this journey alone. They will require extensive support during their loved one's road towards recovery. This support will come from four primary resources. Unfortunately, there is no single resource structure that provides all four, (i.e. a case management company). In this journey although the family will learn they are not alone, just the same, they will need to become their strongest advocate. The family needs to see themselves as a consumer of services with purchasing power. This is a consumer type environment where the family is the consumer with purchasing power and the primary support structures (as resources) are selling their services for what the family will need.

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

Lesson One: The Family is the Consumer

The nation is responding to the opioid epidemic by pouring money and resources into increasing access to addiction treatment. But these consumers of services are not examining the providers accountability of addiction providers to deliver quality of care. There are more than 14,000 specialty addiction treatment programs in the US. Although addiction can be treated with the same effectiveness as other chronic diseases, there is significant variability in how treatment services offer their addiction services.

Most of these programs are group counseling. We want to see providers offering a more comprehensive set of treatment types. For example: less than 20 percent of provider programs prescribe any of the four medications approved therapies to treat opioid or alcohol use disorders. As a result, families as the consumer/payor do not find these services available: The outcome is often, a third of patients discontinuing their treatment within two weeks of treatment initiation—this is far less than what is recommended. But no one is accountable, there is no structure to support adherence to a plan of treatment.

A Family Report Card

The concept of consumer report cards is documented effective in providing the accountability and quality of health care providers services. It gets measured, it gets reported, it becomes available. The opposite is also true. These initiatives provide immediate value to the family in helping them to select the right level of care from the right provider.

Public rating systems for mental health and addiction providers are used in other parts of the world, such as in the UK; however, not in the US.

What should consumers expect from purchasing addiction treatment services?

The first question a family needs to ask is "does the facility or treatment service provider view addiction and a chronic disease". It is the position of most healthcare providers "*all addictions are best considered chronic illnesses affecting many organ systems but particularly the motivational, inhibitory, and reward circuits of the brain*". In turn, it is reasonable to apply the same expectations of structure and support for addiction treatments as are commonly applied to the treatments of other chronic illnesses**:**

1. **Reduction in key symptoms.**
2. **Improvement of general health and ability to function.**
3. **Education for both patient and family.**

The provider should be able to demonstrate their results in a quarterly outcomes report for your family to review. If not, you may want to consider a different provider. If they can not measure it, it is likely they do not manage it, come prepared to walk away.

The family will benefit providers are who are most likely to help them progress across these three areas of services: 1. Substance Use Disorders Assessments, 2. Mental Health Assessments and Medical Health Assessments. Their programs should state how this is included to their services. They should also be prepared to demonstrate how well they perform in this area.

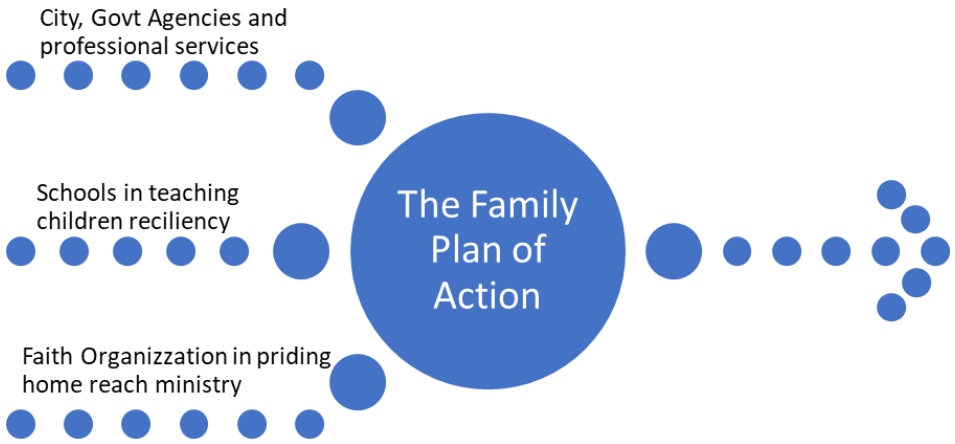
Here are some areas for reporting by providers, ask for them:

Family Required Performance Measures:

- Screening for substance use disorders (SUDs) across medical care settings.
- Rapid access to appropriate SUD care.
- Personalized diagnosis, assessment, severity of disease level and a treatment plan.
- Engagement in continuing long-term outpatient care with monitoring and adjustments to treatment.
- Concurrent, coordinated care for Medical, Addiction and Mental Health illnesses.
- Access to fully trained and accredited behavioral health professionals.
- Access to FDA-approved medications.
- Access to non-medical recovery support services, (i.e. Peer to Peer, Housing, Job finding services).

Four Primary Support Structures

Four Primary Support Structures feed into the family plan of action



It is through the family "*getting educated*" about what each structure offers, *organized* around how to approach these organizations to use these services and *networked* to put these services into action according to their family plan. We need to consider for the benefit of the family members, there are non-medical services which are important in supporting the family in their journey.

But the family first must know what it needs, prior to asking for help. An evaluation of family needs, by take an inventory of needs will be a helpful exercise.

Practical Exercise One: What are your family needs?

1. **What is your need?**
   _____
2. **Prioritized: Urgent (now), Immediate (12-36 hrs), Soon (this week), In the future (month or more).**

   Priority: _____.
3. **Category of Organization Type (who can help)**
   _____

Category of Organization (who can help)

CATEGORY)	Point of Contact	Phone Number	Email Address	Website
Medical Needs				
Mental Health Needs				
Addiction Treatment Needs				
Legal Needs				
Financial Needs				
Employment Needs				
Foster Care Needs				
Elder Care Needs				
Housing Needs				
Transportation Needs				
Child Care Needs				
Spiritual / Faith Needs				

Family Support Structure Needs (Worksheet)

I. Where to go to for help?

The City:

- Police
- Prosecutors Office
- Court System,
- Emergency Medical Services

County:

- Sheriff's Office
- Prosecutors Office
- County Jail system
- Family Services
- Job Services and Family Welfare
- Department of Mental Health Services
- ADAMHS Board
- Child & Human Health Services**.**
- Community Service Centers

Professional Services:

- Addiction Treatment Centers (Detox, Residential, IOP)
- Medical Professionals and Specialist
- Addiction Counseling
- Peer to Peer**.**
- Mental Health Family Therapy Networks

II. School Services

III. Faith Organizations

Practical Exercise Two: Take an Inventory of Available Services

City Departments: Inventory

CATEGORY ()	Point of Contact	Phone Number	Email Address	Website
Police Department				
Fire Department				
Quick Response Team Medical Service				
Legal Defense				
Prosecutor's Office				
Clerk of Courts Office				
City Jail				
City Social Workers Services				
Drug Court judges Office				
City Hospital				
Other				
Other				
Other				

County Agencies: Inventory

CATEGORY ()	Point of Contact	Phone Number	Email Address	Website
Sheriff Department				
Department of Mental Health				
Department of Human Health and Family Foster Services				
Job and Family Services				
United Way				
Clerk of Courts Office				
County Jail				
City Social Workers Services				
Drug Court judges Office				
Other				
Other				
Other				

Professional Services: Inventory

	Point of Contact	Phone Number	Email Address	Website
Medical Needs				
Mental Health Needs				
Addiction Treatment Needs				
Legal Needs				
Financial Needs				
Employment Needs				
Foster Care Needs				
Elder Care Needs				
Housing Needs				
Transportation Needs				
Child Care Needs				
Spiritual / Faith Needs				
Other				

The School Systems: Inventory

CATEGORY	YES	NO	MAYBE/Sometimes	To Coordinate with a Ministry
Teacher				
Police Service Office				
Guidance Counselor				
Mental Health Social Worker				
Family Therapist				
District School Board Members				
PTA Association				
Coaches and Coaching Staff				
Librarians				
After School Program Directors and Staff				
Adult Supervised Clubs (at school)				
Peer to Peer Groups				

The Faith Organizations: How you practice faith

CATEGORY	YES	NO	MAYBE/Sometimes	To Coordinate with a Ministry
Do you attend church weekly				
Do you pray by yourself				
Do you pray with others				
Do you read the Bible				
Do you attend church events (non-retreats)				
Do you have close ties to a senior citizen family member				
Are your children engaged with church education or events				
Are you volunteering in a church ministry				
Would you allow a church member to come to your home				
Do you attend spiritual retreats				
Do you or have you participated in a bible study group				
Have you had a church ministry come to your home				

Lesson Two: Community Support Structures and the Family Plan of Action

Identify What is Happening

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

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

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

3. The Services inventory will help the family identify what services are available where they can be found and how to access these providers.

4. The Family Plan of Action and Needs Matched to Services, this exercise will allow the family to act on the collected information. This knowledge will then be applied to a plan and become a source of empowerment. An empowered family is a powerful force as they seek to resolve their issues.

Create a plan by using a planning guide

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

• List of their services most likely found on their website.

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

• A point of contact that will answer questions, usually provide upon your request.

• A program application typically requires the applicant provide documents of proof based on their qualifying criteria.

All the above should be included to the family plan of action.

Family Plan of Action

SOLUTION:
The Identified Solution: (From the completed F.T.R. Worksheet):

DECISION:
The Decision-Making Process: (From the completed Family Values Decision-Making worksheet)

PLAN OF ACTION:

Priority # 1.

Task:

Task:

Task:

Priority # 2.

Task:

Task:

Task:

Priority # 3.

Task:

Task:

Task:

Prior to taking any action it is important to review your families plan of action with a professional therapist, counselor or licensed State/Federal professional. This step should not be ignored and will ensure safety, continuity and bring about the best results for your loved one and your family.

Preparation is about taking baby steps

As in building a house, it is important to have a good plan, hire the right people to help and prep. Your work before starting.

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

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

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

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

Share your plan

• Set up a meeting to review with the organization how their services fit into your family plan of action. You will likely find them to be helpful in making other suggestions and may be in addition to your original thought, now that they are empowered by knowing what you plan to accomplish.

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

Use the family Plan of Action

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

The Story

In this seminar the video's is the most valuable of what we are presenting.

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Road to Recovery - Recovery Support (Full Episode)

Link: www.youtube.com/watch?v=4LX5VD19oSI

Duration: 59.53 min

Road to Recovery - Recovery Support (Full Episode)

Published on Feb 11, 2016

Recovery Support: Collaboration, Coordination, and Recovery Management Wednesday, June 1, 2011

This show addresses the elements that contribute to long-term recovery and how advances in improved collaborations, service coordination, and recovery management have led to more effective systems of support. The show also highlights effective models for providing this support, such as recovery-oriented systems of care (ROSC), peer-to-peer support, and recovery-related resources.

Call SAMHSA's National Helpline, 1-800-662-HELP (4357) or visit http://samhsa.gov/treatment for free and confidential information on prevention and treatment referral. Please visit http://www.recoverymonth.gov for more information. This video can also be viewed on the Recovery Month website: http://www.recoverymonth.gov/road-to-... Comments on this video are allowed in accordance with the HHS and Recovery Month comment policies: http://www.recoverymonth.gov/about/so...

Practical Exercise Three: A NINE by ONE, Primary Support Structure Form

Nine Questions to One Issue

Questions to ask the organization:

1. **Who are you:**
   _____

   Address:
   _____

   Phone:
   _____

   Website:
   _____

   Primary Point of Contact Name & Title:
   _____

   _____

   Phone:
   _____

   Email:
   _____

2. **What do you offer:**

   Medical Services:
   _____

   Mental Health Services:
   _____

   Addiction Services:
   _____

   Social Services:
   _____

   Family Services:
   _____

Legal Services: _____

Child Services: _____

3. When do you offer it?

Hours: _____

Episodic: _____

Continuous Care: _____

Required Physician's Referral/orders: _____

4. To whom do you offer it:

Gender: _____

Age: _____

Economic Status: _____

Geographic Boundaries: _____

Bi-Lingual _____

5. Where do you offer it?

Facility/Residential: _____

Home Based: _____

Out-Patient: _____

6. How do you offer it?

Initial Intake, Start of Care or Application: _____

Delivery Process, (step by Step): _____

Discharge Requirements: _____

7. **How does one qualify for it?**

Qualify:

Acceptance criteria:

_____

_____

Documents required for qualifying:

_____

_____

Cost:

Amount charged for each service:

_____

_____

_____

Frequency of charges:

_____

Types of payments:

_____

8. **How will I use it?**

What part of the family Plan of Action does this belong in:

_____

_____

Assign to for action steps:

_____

_____

Timeline for Start & Finish:

_____

_____

9. **What should we expect from using it?**

1st Expectation:

_____

_____

2nd Expectation:

_____

_____

Needs Matched to Organization & Services

Category of Service Need	**Organization Name:**	**Service Provided:**	**Assigned to Family Member:**	**Completed By:**
Medical Needs				
Mental Health Needs				
Addiction Treatment Needs				
Legal Needs				
Financial Needs				
Employment Needs				
Foster Care Needs				
Elder Care Needs				
Housing Needs				
Transportation Needs				
Child Care Needs				
Spiritual / Faith Needs				
Other				

Part II

Learn About the Disease

Seminar # 6

"Getting the Diagnosis"

Seminar Objectives:

1. The attendee will be able to name the three (3) primary Assessment tools used in creating a diagnosis. These diagnoses are for Medical, Mental Health, and Addiction.

2. The attendee will be able to identify their family member symptoms and match them with the selected part of the Assessment of Severity survey tool (A.O.S.) for addiction, the xxx-survey tool for medical condition diagnosis, and xxx for Mental Health diagnosis.

3. Using the information, identify within these exercises the family will complete their family plan of action with information needed to further develop their understanding to their loved one's diagnosis and determine what impact this will have on the family members.

Introduction

Understanding the extent and nature of an individual's substance use disorder and their interaction with other life areas is essential for careful diagnosis, appropriate case management, and successful treatment. This understanding begins during the screening and assessment process, which helps match the client with appropriate treatment services. To ensure that important information is obtained, providers and family should use standardized screening and assessment instruments and interview protocols, some of which have been studied for their sensitivity, validity, and accuracy in identifying problems.

Hundreds of screening instruments and assessment tools exist. Specific instruments that are available to help counselors determine whether further assessment is warranted, the nature and extent of a client's substance use disorder, whether a client has a mental disorder, what types of traumatic experiences a client has had and what the consequences are, and treatment-related factors that impact the client's response to interventions.

Assessment drive the course of selected treatment, therefore, getting an assessment is critical towards getting the right level of care. All families need to understand what assessment tool is being used, how it is applied to the development of the treatment plan and in what ways the family can be supportive.

Each member in the family plays a role and identifying this characteristic will allow the family to better understand what they can expect in each member.

Likewise, childhood trauma may have been a factor in the family unit and through therapy this can be identified in the assessment and included to the therapy work. It is when the family gets educated on the family role in supporting the use of assessments, the disease, gets organized and the families get networked, so they can begin to expect a more positive and useful results from their family plan.

The first step in diagnosis relies on a friend, family member, or the person with addiction themselves acknowledging a need for treatment.

This can often be the most difficult step and might sometimes involve a personal or group intervention if an individual with substance use disorder is not aware of the extent of the problem. 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.

Lesson One: When to Get an Assessment

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.

Lesson Two: The primary indications of addiction

The primary indications of addiction are:

- uncontrollably seeking drugs
- uncontrollably engaging in harmful levels of habit-forming behavior
- neglecting or losing interest in activities that do not involve the harmful substance or behavior
- relationship difficulties, which often involve lashing out at people who identify the dependency
- an inability to stop using a drug, though it may be causing health problems or personal problems, such as issues with employment or relationships
- hiding substances or behaviors and otherwise exercising secrecy, for example, by refusing to explain injuries that occurred while under the influence
- profound changes in appearance, including a noticeable abandonment of hygiene
- increased risk-taking, both to access the substance or activity and while using it or engaging in it

Psychological symptoms

Symptoms of addiction that because mental disorders include the following:

- An inability to stop using: In many cases, such as a dependence on nicotine, alcohol, or other substances, a person will have made at least one serious but unsuccessful attempt to give up. This might also be physiological, as some substances, such as heroin, are chemically addictive and cause withdrawal symptoms if a person stops taking them.
- Use and abuse of substances continue despite health problems: The individual continues regularly taking the substance, even though they have developed related illnesses. For example, a smoker may continue smoking after the development of a lung or heart disease. They may or may not be aware of the health impact of the substance or behavior.
- Dealing with problems: A person with addiction commonly feels the need to take the drug or carry out the behavior to deal with their problems.
- Obsession: A person may become obsessed with a substance, spending more and more time and energy finding ways of getting their substance, and in some cases how they can use it.
- Taking risks: An individual with an addiction may take risks to obtain the substance or engage in the behavior, such as trading sex or stealing for illicit drugs, drug money, or the drugs themselves. While under the influence of some substances, a person with substance use disorder may engage in risky activities, such as fast and dangerous driving or violence.
- Taking an initial large dose: This is common with alcohol use disorder. The individual may rapidly consume large quantities of alcohol in order to feel the effects and feel good.

Lesson Three: Substance use disorder can impact the way an individual socializes with and relates to other people.

- Sacrifices: A person with substance dependence might give up some activities that previously brought them joy. For example, a person with alcohol use disorder may turn down an invitation to go camping or spend a day on a boat if no alcohol is available. A person with nicotine dependence may decide not to meet up with friends if they plan to go to a smoke-free pub or restaurant.
- Dropping hobbies and activities: As an addiction progresses, the individual may stop partaking in pastimes they enjoy. People who are dependent on tobacco, for example, might find they can no longer physically cope with taking part in their favorite sport.
- Maintaining a good supply: People with substance use disorders will always make sure they have a good supply, even if they do not have much money. They may make sacrifices in their home budget to ensure the availability of the substance.
- Secrecy and solitude: In many cases, a person with a substance use disorder may use the substance alone or in secret.
- Denial: A significant number of people with substance use disorder are not aware that they have a problem. They might be aware of physical dependence on a substance but deny or refuse to accept the need to seek treatment, believing that they can quit "anytime" they want to.
- Excess consumption or abuse of substances: Some types of substance use disorders, such as alcohol or opiate use disorders, can lead an individual to consume unsafe amounts of a substance. The physical effects of abusing a substance can be severe and include overdosing. However, for a person with substance use disorder, these effects will not be enough to prevent future overuse.
- Having stashes: A person with an addiction may have small stocks of a substance hidden away in different parts of the house or car, often in unlikely places, to avoid detection.
- Legal issues: This is more a characteristic of some alcohol and illicit drug dependences. Legal problems may occur either because the substance impairs judgment or causes the individual to take more risks to the extent of causing public disorder or violence or breaking the law to get the substance in the first place.
- Financial difficulties: An expensive substance can lead to sizeable and regular financial sacrifices to secure a regular supply.

Lesson Four: Repeatedly using a substance can impact a range of bodily functions and systems.

- Withdrawal symptoms: When levels of the substance to which a person has dependence drop below a certain level, they might experience physical symptoms, depending on the substance. These include cravings, constipation, diarrhea, trembling, seizures, sweats, and uncharacteristic behavior, including violence.
- Appetite changes: Some substances alter a person's appetite. Marijuana consumption, for example, might greatly increase their appetite while cocaine may reduce it.
- Damage or disease from using a substance: Smoking substances, for example, tobacco and crack, can lead to incurable respiratory diseases and lung cancers. Injecting illicit drugs can lead to limb damage and problems with veins and arteries, in some cases leading to the development of infection and possible loss of a limb. Regularly consuming excessive amount of alcohol can lead to chronic liver problems.
- Sleeplessness: Insomnia is a common symptom of withdrawal. Using illicit stimulants, such as speed or ecstasy, might also encourage a disrupted sleep cycle, as a person might stay up late for several nights in a row to go to parties and use the substance.
- A change in appearance: A person may begin to appear more disheveled, tired, and haggard, as using
- the substance or carrying out the addictive behavior replaces key parts of the day, including washing clothes and attending to personal hygiene.
- Increasing tolerance: The body experiences reduced effects of the substance over time, so a person feels the need to take more to achieve the same effect.

A person might experience a few of these symptoms or many of them. Substance use disorder can have a drastically different impact on every individual.

Choose evidence-based screening tools and assessment resource materials

Other Validated Assessment Tools

- https://www.asam.org/docs/default-source/education-docs/cows_induction_flow_sheet.pdf?sfvrsn=b577fc2_2 Clinical Assessment Opioids, PDF
- McCaffreyInitialPainAssessmentTool.pdf - Tool to assess pain-related outcomes and document long-term pain management.
- **Patient Health Questionnaire-9 (PDF, 131KB)** - Nine-item self-report tool to assess depressed mood in the past 2 weeks.

CRAFFT screening Device:

Orally administered brief screens are usually targeted at substance abuse alone and can be administered by the physician as part of the general health interview or while performing the physical examination. To be practical, they must be easy to administer, score, and remember. Simple yes or no questions that lend themselves to mnemonic acronyms are ideal. The CAGE questions, which are widely used in medical settings, are a good example of this type of brief screen.16 The CAGE test has been shown to have good validity among adult medical patients.17 However, studies among adolescents have not provided adequate evidence of the CAGE test's sensitivity or reliability.18,19 In addition, some of its items (eg, "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover [eye-opener]?") are not developmentally appropriate for adolescents.

One brief screening device, the CRAFFT test, was developed specifically for use among adolescent medical patients.20 Like CAGE,16 CRAFFT is verbally administered, simple to score (each yes answer = 1 point), and easy to remember. Its name is a mnemonic of the first letters of key words in the test's 6 questions. (Figure 1)

CAGE Substance Abuse Screening Tool

Directions: They will ask you these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?

2. Have people annoyed you by criticizing your drinking?

3. Have you ever felt bad or guilty about your drinking?

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?

2. Have people annoyed you by criticizing your drinking or drug use?

3. Have you felt bad or guilty about your drinking or drug use?

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders.
A number of other screening tools are available.
CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener
CAGE Source: Ewing 1984

SEVERITY LEVELS OF SUBSTANCE USE DISORDER

The American Psychiatric Association diagnoses the severity of Substance Use Disorders by identifying the presence of problem patterns using the criteria below occurring over a 12-month period.

A M O U N T

Take the substance in larger amounts & for longer than intended.

C O N T R O L

Want to cut down or quit but are unable to**.**

T I M E

Spend large amounts of time obtaining the substance**.**

C R A V I N G S

Experience cravings or strong desires to use the substance**.**

O B L I G A T I O N S

Repeatedly unable to carry out major obligations at work, school or home due to substance use.

S O C I A L

Continuing to use the substance despite persistent or recurring social or interpersonal problems or harm to relationships.

A C T I V I T I E S

Stopping or reducing important social, occupational or recreational activities due to substance use.

H A Z A R D

Continually using the substance in physically hazardous situations such as driving under the influence.

H A R M

Consistently using the substance, despite knowledge of the substance causing persistent or recurrent physical or

psychological problems.

T O L E R A N C E

Building a tolerance — the need for markedly increased amounts of the substance to achieve the desired effect, or a markedly diminished effect with continued use of the same amount of the substance

W I T H D R A W A L

Feeling withdrawal symptoms – as either a characteristic

syndrome or when the substance is used to avoid withdrawal

From the above list, how many do the individual match:

M I L D Stage

MEETS 2 to 3

MODERATE Stage

MEETS 4 to 5

SEVERE Stage

MEETS 6 or MORE

NOTE:

Just because you have a diagnosis does not mean you have identified the underlying problem that caused the to occur. There will be many assessments, each will tell how to best deliver care and make changes to the plan of treatment. You will find the diagnosis may not change but the assessment will cause the plan of treatment to make changes.

Assessment should be given quarterly to ensure time responses to changes. Discuss this strategy with your primary care physician.

The Story

The problem is not the problem! It runs deeper than the initial diagnosis.

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Psychology of Drug Addiction & Substance Abuse Disorder, Causes & Solutions

Link:
https://www.youtube.com/watch?v=8NaHepAgoSg&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=22&t=0s

Duration: 16.28 min

Psychology of Drug Addiction & Substance Abuse Disorder, Causes & Solutions IN this video psychiatrist Dr. Colin Ross, M.D. discusses the psychiatric diagnosis of Substance Abuse Disorder and

discusses its treatments, underlying causes and diagnostic criteria. Visit Dr. Ross' website at; http://www.rossinst.com/ Full List of Dr. Colin Ross Videos; https://www.youtube.com/playlist?list...

The Problem is not the problem, Worksheet?

What you your words does this mean?

_____

_____

With your loved one, what might be the "Problem that caused the Problem?

_____

_____

What are the underlying problems?

1.

2.

3.

What are they avoiding facing?

Family Plan of Action

1. The family members will identify which of the three (3) primary Assessment tools is being used to create a diagnosis. These diagnoses are for Medical, Mental Health, and Addiction.

2. The family members will identify their loved ones symptoms and match them with the selected part of the Assessment of Severity survey tool (A.O.S.) for addiction, for medical condition diagnosis, for Mental Health diagnosis.

3. The family will identify which stage in the disease is their loved one, anticipate the behavior commonly associated to this state and consider what their role can be in their loved ones plan for sustained recovery.

Part II

Learn About the Disease

Seminar # 7

"Substance Use Disorder is a Brain Disease"

Seminar Objectives:

1. The attendee will be able to name the three (3) primary parts of the brain that deals with the reward system.

2. The attendee will be able to identify in their family triggers that can cause relapse.

3. Using the information, identify within these exercises the family will complete their family plan of action with information needed to further develop their understanding to their loved one's diagnosis and determine what impact this will have on the family members.

Introduction

What is drug addiction? Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting and can lead to the harmful behaviors seen in people who abuse drugs.

The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction. Brain areas affected by drug abuse include: 1. The ***brain stem***, which controls basic functions critical to life, such as heart rate, breathing, and sleeping. 2. The ***cerebral cortex***, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.3. The ***limbic system***, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life-sustaining activities such as eating and socializing— but it is also activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

The brain is a communications center consisting of billions of neurons, or nerve cells. Networks of neurons pass messages back and forth among different structures within the brain, the spinal cord, and nerves in the rest of the body (the peripheral nervous system). These nerve networks coordinate and regulate everything we feel, think, and do. 1. **Neuron to Neuron** Each nerve cell in the brain sends and receives messages in the form of electrical and chemical signals. Once a cell receives and processes a message, it sends it on to other neurons. 2. **Neurotransmitters**—The Brain's Chemical Messengers The messages are typically carried between neurons by chemicals called neurotransmitters. 3. **Receptors**—The Brain's Chemical Receivers The neurotransmitter attaches to a specialized site on the receiving neuron called a receptor. A neurotransmitter and its receptor operate like a "key and lock," an exquisitely specific mechanism that ensures that each receptor will forward the appropriate message only after interacting with the right kind of neurotransmitter. z Transporters—The Brain's Chemical Recyclers Located on the neuron that releases the neurotransmitter, transporters recycle these neurotransmitters (that is, bring them back into the neuron that released them), thereby shutting off the signal between neurons

Drugs are chemicals that affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, such as marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. This similarity in structure "fools" receptors and allows the drugs to attach onto and activate the neurons. Although these drugs mimic the brain's own chemicals, they don't activate neurons in the same way as a

natural neurotransmitter, and they lead to abnormal messages being transmitted through the network. Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message, ultimately disrupting communication channels.

We know that the same sort of mechanisms involved in the development of tolerance can eventually lead to profound changes in neurons and brain circuits, with the potential to severely compromise the long-term health of the brain. For Long-term drug abuse impairs brain functioning. Example, glutamate is another neurotransmitter that influences the reward circuit and the ability to learn. When the optimal concentration of glutamate is altered by drug abuse, the brain attempts to compensate for this change, which can cause impairment in cognitive function. Similarly, long-term drug abuse can trigger adaptations in habit or non-conscious memory systems. Conditioning is one example of this type of learning, in which cues in a person's daily routine or environment become associated with the drug experience and can trigger uncontrollable cravings whenever the person is exposed to these cues, even if the drug itself is not available. This learned "reflex" is extremely durable and can affect a person who once used drugs even after many years of abstinence

Chronic exposure to drugs of abuse disrupts the way critical brain structures interact to control and inhibit behaviors related to drug use. Just as continued abuse may lead to tolerance or the need for higher drug dosages to produce an effect, it may also lead to addiction, which can drive a user to seek out and take drugs compulsively. Drug addiction erodes a person's self-control and ability to make sound decisions, while producing intense impulses to take drugs.

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Cognitive Behavioral Therapy seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.

- Contingency Management uses positive reinforcement such as providing
rewards or privileges for remaining drug free, for attending and participating in counseling sessions, or for taking treatment medications as prescribed.

- Motivational Enhancement Therapy uses strategies to evoke rapid and internally motivated behavior change to stop drug use and facilitate treatment entry.

Family Therapy (especially for youth) approaches a person's drug problems in the context of family interactions and dynamics that may contribute to drug use and other risky behaviors.

Behavioral treatments help engage people in substance use disorder treatment, modifying their attitudes and behaviors related to drug use and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive use. Behavioral therapies can also enhance the effectiveness of

medications and help people remain in treatment longer.

Did you know that a family system has direct impact on the environment of the person with substance use disorder. If this person is in treatment and then discharged from care, back into an unchanged family environment, it is likely the triggers which were present before treatment are still present in the family, after treatment. The family members will benefit from seeking Multidimensional Family Therapy while their loved one is in the treatment center. Doing this, has proven to reduce the likelihood of relapse by 69%.

The Story

The bi-chemical signature tells the truth. The dopamine rewiring in our brain, creates a new condition stimulation. Prediction of stimuli creates a new channel towards reward and our memory stores it for retrieval.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Brain Reward: Understanding How the Brain Responds to Natural Rewards and Drugs of Abuse?

Link: https://www.youtube.com/watch?v=7VUlKP4LDyQ

Duration: 9:11 min

VIDEO TWO

Search Title: Addiction Neuroscience 101

This is an overview of the neurobiology of addiction

Link: https://www.youtube.com/watch?v=bwZcPwlRRcc&t=930s

Duration: 23:29min

VIDEO Three

Search Title: Matrix Pt II TRIGGERS AND CRAVINGS FOR MORE

LINK: https://www.youtube.com/watch?v=kqZak9ctzGo

Comprehensive kit provides substance abuse treatment professionals with a year-long intensive outpatient treatment model for clients with dependence on stimulant drugs such as methamphetamine and cocaine. Includes family education sessions and handouts.

Duration: 35:17 min

The triggers at home with the family?

What are your words that might become triggers?

_____
_____

What visual stimuli are present in the home environment?

_____
_____
_____

What activities does the family do that might create triggers?

1.

2.

3.

What are the roles of each family member and how might they create triggers?

_____
_____
_____

Reference Publications:

NIDA's Special Initiatives for Students, Teachers, and Parents Heads Up: Real News About Drugs and Your Body—A drug education series created by NIDA and SCHOLASTIC INC.

for students in grades 6 to 12. www.headsup.scholastic.com

NIDA for Teens: The Science Behind Drug Abuse—An interactive Web site geared specifically to teens, with age-appropriate facts on drugs. www.teens.drugabuse.gov Drug Facts Chat Day— A Web chat between NIDA scientists and teens, held through school computer labs once a year during National Drug Facts Week (below). www.drugabuse.gov/chat

National Drug Facts Week— A week-long observance that encourages community-based events and dialogue between teens and scientists during National Drug Facts Week (below). www.drugfactsweek.drugabuse.gov/

Publications on Prevention and Treatment Principles Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community

Leaders—NIDA's research-based guide for preventing drug abuse among children and adolescents provides 16 principles derived from effective drug-prevention research and includes answers to questions on risk and protective factors as well as on community planning and implementation.

Principles of Drug Addiction Treatment: A Research-Based Guide—This guide summarizes the 13 principles of effective treatment, answers common questions, and describes types of treatment, providing examples of scientifically based and tested treatment components.

Family Plan of Action

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1. The family members will name the type of rewards in the brain that are most likely to trigger a relapse with their loved one.

2. The family members will identify the types of triggers the family creates that can cause relapse.

3. Using the information, identify within these exercises the family will complete their family plan of action of the changes they will make to create as much of a trigger free environment for their loved one, as is reasonable for them to complete.

Part II

Learn About the Disease

Seminar # 8

"The disease progresses in stages"

Seminar Objectives:

1. The attendee will be able to name the three (3) stages of SUD disease progression in the brain.

2. The attendee will be able to identify the four behaviors in SUD disease progression

3. Using the information, identify within these exercises how the family will respond to these behaviors. What steps can the family take to learn more about their role in the disease progression.

Each member of the family contributes to the family system. Their contribution to these exercises can help to create a more successful environment for their loved one to maintain recovery.

The Addiction Cycle: Addiction can be described as a repeating cycle with **three stages**. Each stage is particularly associated with one of the brain regions described above—basal ganglia, extended amygdala, and prefrontal cortex. But first, it is necessary to explain four behaviors that are central to the addiction cycle: impulsivity, positive reinforcement, negative reinforcement, and compulsivity.

For many people, initial substance use involves an element of impulsivity, or acting without foresight or regard for the consequences. For example, an adolescent may impulsively take a first drink, smoke a cigarette, begin experimenting with marijuana, or succumb to peer pressure to try a party drug. If the experience is pleasurable, this feeling positively reinforces the substance use, making the person more likely to take the substance again. Another person may take a substance to relieve negative feelings such as stress, anxiety, or depression. In this case, the temporary relief the substance brings from the negative feelings negatively reinforces substance use, increasing the likelihood that the person will use again. Importantly, positive and negative reinforcement need not be driven solely by the effects of the drugs. Many other environmental and social stimuli can reinforce a behavior. For example, the approval of peers positively reinforces substance use for some people. Likewise, if drinking or using drugs with others provides relief from social isolation, substance use behavior could be negatively reinforced.

The positively reinforcing effects of substances tend to diminish with repeated use. This is called tolerance and may lead to use of the substance in greater amounts and/or more frequently to experience the initial level of reinforcement. Eventually, in the absence of the substance, a person may experience negative emotions such as stress, anxiety, or depression, or feel physically ill.

This is called withdrawal, which often leads the person to use the substance again to relieve the withdrawal symptoms. As use becomes an ingrained behavior, impulsivity shifts to compulsivity, and the primary drivers of repeated substance use shift from positive reinforcement (feeling pleasure) to negative reinforcement (feeling relief), as the person seeks to stop the negative feelings and physical illness that accompany withdrawal.15 Eventually, the person begins taking the substance not to get “high,” but rather to escape the “low” feelings to which, ironically, chronic drug use has contributed. Compulsive substance seeking is a key characteristic of addiction, as is the loss of control over use. Compulsivity helps to explain why many people with addiction experience relapses after attempting to abstain from or reduce use.

The three stages:

Binge/intoxication,

Withdrawal/negative affect,

Preoccupation/anticipation

Four Behaviors in the disease progression:

Impulsivity: An inability to resist urges, deficits in delaying gratification, and unreflective decision-making. It is a tendency to act without foresight or regard for consequences and to prioritize immediate rewards over long term goals.

Positive reinforcement: The process by which presentation of a stimulus such as a drug increases the probability of a response like drug taking.

Negative reinforcement: The process by which removal of a stimulus such as negative feelings or emotions increases the probability of a response like drug taking.

Compulsivity: Repetitive behaviors in the face of adverse consequences, and repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that the behaviors are harmful, but they nonetheless feel emotionally compelled to perform them. Doing so reduces tension, stress, or anxiety.

Treatment Stages for Substance Use Disorder

Overview

- Adjustments to Make Treatment Appropriate
- The Early Stage of Treatment
  - Condition of Clients in Early Treatment
  - Therapeutic Strategies in Early Treatment
  - Leadership in Early Treatment
  - The Middle Stage of Treatment
  - Condition of Clients in Middle-Stage Treatment
  - Therapeutic Strategies in Middle-Stage Treatment
  - Leadership in Middle-Stage Treatment
  - Leadership in Late-Stage Treatment

Adjustments to Make Treatment Appropriate

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

Any discussion of intervention adjustments to make treatment appropriate at each stage, however, necessarily must be oversimplified for three reasons. First, the stages of recovery and stages of treatment will not correspond perfectly for all people. Clients move in and out of recovery stages in a nonlinear process. A client may fall back, but not necessarily back to the beginning. "After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become pre-contemplators again, temporarily unwilling or unable to try to change . . . [but] a recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change" (Center for Substance Abuse Treatment 1999b , p. 19). See chapters 2 and 3 for a discussion of the stages of change.

A return to drug use, properly handled, can even be instructive. With guidance, clients can learn to recognize the events and situations that trigger renewed substance use and regression to earlier stages of recovery. This knowledge becomes helpful in subsequent attempts leading to eventual recovery. Client progress-regress-progress waves, however, require the counselor to constantly reevaluate where the client is in the recovery process, irrespective of the stage of treatment.

Second, adjustments in treatment are needed because progress through the stages of recovery is not timebound. There is no way to calculate how long any individual should require to resolve the issues that arise at any stage of recovery. The result is that different group members may achieve and be at different stages of recovery at the same time in the lifecycle of the group. The group leader, therefore, should use interventions that take the group into account.

Third, therapeutic interventions, meaning the acts of a clinician intended to promote healing, may not account for all (or any) of the change in an individual. Some people give up drugs or alcohol without undergoing treatment. Thus, it is an error to assume that an individual is moving through stages of treatment because of assistance at every point from institutions and self-help groups. To stand the best chance for meaningful intervention, a leader should determine where the individual best fits in his level of function, stance toward abstinence, and motivation to change. In short, generalizations about stages of treatment may not apply to every client in every group.

The Early Stage of Treatment

Condition of Clients in Early Treatment

In the early stage of treatment, clients may be in the precontemplation, contemplation, preparation, or early action stage of change, depending on the nature of the group. Regardless of their stage in early recovery, clients tend to be ambivalent about ending substance use. Even those who sincerely intend to remain abstinent may have a tenuous commitment to recovery. Further, cognitive impairment from substances is at its most severe in these early stages of recovery, so clients tend to be rigid in their thinking and limited in their ability to solve problems. To some scientists, it appears that the "addicted brain is abnormally conditioned, so that environmental cues surrounding drug use have become part of the addiction" (Leshner 1996, p. 47).

Typically, people who abuse substances do not enter treatment on their own. Some enter treatment due to health problems, others because they are referred or mandated by the legal system, employers, or family members (Milgram and Rubin 1992). Group members commonly are in extreme emotional turmoil, grappling with intense emotions such as guilt, shame, depression, and anger about entering treatment.

Even if clients have entered treatment voluntarily, they often harbor a desire for substances and a belief that they can return to recreational use once the present crisis subsides. At first, most clients comply with treatment expectations more from fear of consequences than from a sincere desire to stop drinking or using illicit drugs (Flores 1997; Johnson 1973).

Consequently, the group leader faces the challenge of treating resistant clients. In general, resistance presents in one of two ways. Some clients actively resist treatment. Others passively resist. They are outwardly cooperative and go to great lengths to give the impression of willing engagement in the treatment process, but their primary motivation is a desire to be free from external pressure. The group leader has the delicate task of exposing the motives behind the outward compliance.

The art of treating addiction in early treatment is in the defeat of denial and resistance, which almost all clients with addictions carry into treatment. Group therapy is considered an effective modality for …overcoming the resistance that characterizes addicts. A skilled group leader can facilitate members' confronting each other about their resistance. Such confrontation is useful because it is difficult for one addict to deceive another.

Because addicts usually have a history of adversarial relationships with authority figures, they are more likely to accept information from their peers than a group leader. A group can also provide addicts with the opportunity for mutual aid and support; addicts who present for treatment are usually well connected to a dysfunctional subculture but socially isolated from healthy contacts (Milgram and Rubin 1992, p. 96).

Emphasis therefore is placed on acculturating clients into a new culture, the culture of recovery (Kemker et al. 1993).

Therapeutic Strategies in Early Treatment

In 1975, Irvin Yalom elaborated on earlier work and distinguished 11 therapeutic factors that contribute to healing as group therapy unfolds:

Instilling hope—some group members exemplify progress toward recovery and support others in their efforts, thereby helping to retain clients in therapy.

Universality—groups enable clients to see that they are not alone, that others have similar problems.

Imparting information—leaders shed light on the nature of addiction via direct instruction.

Altruism—group members gain greater self-esteem by helping each other.

Corrective recapitulation of the primary family group—groups provide a family-like context in which long-standing unresolved conflicts can be revisited and constructively resolved.

Developing socializing techniques—groups give feedback; others' impressions reveal how a client's ineffective social habits might undermine relationships.

Imitative behavior—groups permit clients to try out new behavior of others.

Interpersonal learning—groups correct the distorted perceptions of others.

Group cohesiveness—groups provide a safe holding environment within which people feel free to be honest and open with each other.

Catharsis—groups liberate clients as they learn how to express feelings and reveal what is bothering them.

Existential factors—groups aid clients in coming to terms with hard truths, such as (1) life can be unfair; (2) life can be painful and death is inevitable; (3) no matter how close one is to others, life is faced alone; (4) it is important to live honestly and not get caught up in trivial matters; (5) each of us is responsible for the ways in which we live.

In different stages of treatment, some of these therapeutic factors receive more attention than others. For example, in the beginning of the recovery process, it is extremely important for group members to experience the therapeutic factor of universality. Group members should come to recognize that although they differ in some ways, they also share profound connections and similarities, and they are not alone in their struggles.

The therapeutic factor of hope also is particularly important in this stage. For instance, a new member facing the first day without drugs may come into a revolving membership group that includes people who have been abstinent for 2 or 3 weeks. The mere presence of people able to sustain abstinence for days—even weeks—provides the new member with hope that life can be lived without alcohol or illicit drugs. It becomes possible to believe that abstinence is feasible because others are obviously succeeding.

Imparting information often is needed to help clients learn what needs to be done to get through a day without chemicals. Psychoeducation also allows group members to learn about addiction, to judge their practices against this factual information, and to postpone intense interaction with other group members until they are ready for such highly charged work. Attention to group cohesiveness is important early in treatment because only when group members feel safety and belonging within the group will they be able to form an attachment to the group and fully experience the effects of new knowledge, universality, and hope.

Therapeutic factors such as catharsis, existential factors, or recapitulation of family groups generally receive little attention in early treatment. These factors often are highly charged with emotional energy and are better left until the group is well established.

During the initial stage of treatment, the therapist helps clients acknowledge and understand how substance abuse has dominated and damaged their lives. Drugs or alcohol, in various ways, can provide a substitute for the give-and-take of relationships and a means of surviving without a healthy adjustment to life. As substances are withdrawn or abandoned, clients give up a major source of support without having anything to put in its place (Brown 1985; Straussner 1997).

In this frightening time, counselors need to ensure that the client has a sense of safety. The group leader's task is to help group members recognize that while alcohol or illicit drugs may have provided a temporary way to cope with problems in the past, the consequences were not worth the price, and new, healthier ways can be found to handle life's problems.

In early-stage treatment, strong challenges to a client's fragile mental and emotional condition can be very harmful. Out of touch with unmedicated feelings, clients already are susceptible to wild emotional fluctuations and are prone to unpredictable responses. Interpersonal relationships are disturbed, and the effects of substances leave the client prone to use "primitive defensive operations such as denial, splitting, projective identification, and grandiosity" (Straussner 1997, p. 68).

This vulnerable time, however, is also one of opportunity. In times of crisis, "an individual's attachment system opens up" and the therapist has a chance to change the client's internal dynamics (Flores 2001, p. 72). Support networks that can provide feedback and structure are especially helpful at this stage. Clients also need reliable information to strengthen their motivation.

A Note on Attachment Theory and Substance Abuse Treatment

Attachment theory provides a comprehensive meta-theory of addiction that not only integrates diverse mental health models with the disease-concept, but also furnishes guidelines for clinical practice that are compatible with existing addiction treatment strategies including an abstinence basis and alignment with 12-Step treatment philosophy.

Attachment theory (Bowlby 1979) and self psychology (Kohut 1977b) provided the first compelling theories that offered a practical alternative rationale for the addiction cycle that is not only compatible with the disease concept, but expands it by providing a more complete and intellectually satisfying theoretical explanation why Alcoholic Anonymous (AA) works as it does.

According to the theory, attachment is recognized as a primary motivational force with its own dynamics, and these dynamics have far-reaching and complex consequences (Bowlby 1979). In clients with substance use disorders there is an inverse relation between their substance abuse and healthy interpersonal attachments. A person who is actively abusing substances can rarely negotiate the demands of healthy interpersonal relationships successfully.

Using this theoretical model, substance abuse can be viewed as an attachment disorder. Individuals who have difficulty establishing intimate attachments will be more inclined to substitute substances for their deficiency in intimacy. Because of their difficulty maintaining emotional closeness with others, they are more likely to substitute various behaviors (including substance abuse) to distract them from their lack of intimate interpersonal relations.

The use of substances may initially serve a compensatory function, helping those who feel uncomfortable in social situations because of inadequate interpersonal skills. However, substances of abuse will gradually compromise neurophysiological functioning and erode existing interpersonal skills. Managing relationships tends to become increasingly difficult, leading to a heightened reliance on substances, which accelerates deterioration and increases abuse and dependence. Eventually, the individual's relationship with substances of abuse becomes both an obstacle to and a substitute for interpersonal attachments. If problems in attachment are a primary cause of substance abuse, then a therapeutic process that addresses the client's interpersonal relations will be effective for long-term recovery (Flores 2001; Straussner 1993). Treatment

concentrates on removing stress-inducing stimuli, teaching ways to recognize and quell environmental cues that trigger inappropriate behaviors, providing positive reinforcement and support, cultivating positive habits that endure, and developing secure and positive attachments.

Currently, clients are solidifying their "new identity as an alcoholic with the corresponding belief in loss of control." They develop "a new logical structure" with which to assail their "former logic and behavior." They also can develop a "new story . . . the Alcoholics Anonymous drunkalogue," which recalls their experiences and compares previous events.now

Whether information is offered through skills groups, psychoeducational groups, supportive therapy groups, spiritually oriented support groups, or process groups, clients are most likely to use the information and tools provided in an environment alive with supportive human connections. All possible sources of positive forces in a client's life should be marshaled to help the client manage life's challenges instead of turning to substances or other addictive behaviors.

Painful feelings, which clients are not yet prepared to face, can sometimes trigger relapse. If relapses occur in an outpatient setting—as they often do, because relapses occur in all chronic illnesses, including addiction—the group member should be guided through the regression. The leader encourages the client to attend self-help groups, explores the sequence of events leading to relapse, determines what cues led to relapse, and suggests changes that might enable the client to manage cravings better or avoid exposure to strong cues.

For some clients, chiefly those mandated into treatment by courts or employers, grave consequences inevitably ensue as a result of relapse. As Vannicelli (1992) points out, however, clinicians should view relapse not as failure, but as a clinical opportunity for both group leader and clients to learn from the event, integrate the new knowledge, and strengthen levels of motivation. Discussion of the relapse in group not only helps the individual who relapsed learn how to avoid future use, but it also gives other group members a chance to learn from the mistakes of others and to avoid making the same mistakes themselves.

Leadership in Early Treatment

Clients usually come to the first session of group in an anxious, apprehensive state of mind, which is intensified by the knowledge that they will soon be revealing personal information and secrets about themselves. The therapist begins by making it clear that clients have some things in common. All have met with the therapist, have acceded to identical agreements, and have set out to resolve important personal issues. Usually, the therapist then suggests that members get to know each other. One technique is to allow the members to decide exactly how they will introduce themselves. The therapist observes silently—but not impassively—watching how interaction develops (Rutan and Stone 2001).

During early treatment, a relatively active leader seeks to engage clients in the treatment process. Clients early on "usually respond more favorably to the group leader who is spontaneous, 'alive,' and engaging than they do to the group leader who adopts the more reserved stance of technical neutrality associated with the more classic approaches to group therapy" (Flores 2001, p. 72). The leader should not be overly charismatic, but should be a strong enough presence to meet clients' dependency needs during the early stage of treatment.

During early treatment, the effective leader will focus on immediate, primary concerns: achieving abstinence, preventing relapse, and learning ways to manage cravings. The leader should create an environment that enables clients to acknowledge that (1) their use of addictive substances was harmful and (2) some things they want cannot be obtained while their pattern of substance use continues. As clients take their first steps toward a life centered on healthy sources of satisfaction, they need strong support, a high degree of structure, positive human connections, and active leadership.

> In process groups, the leader pays particular attention to feelings in the early stage of treatment. Many people with addiction histories are not sure what they feel and have great difficulty communicating their feelings to others. Leaders begin to help group members move toward affect regulation by

labeling and mirroring feelings as they arise in group work. The leader's subtle instruction and empathy enables clients to begin to recognize and own their feelings. This essential step toward managing feelings also leads clients toward empathy with the feelings of others.

The Middle Stage of Treatment

Condition of Clients in Middle-Stage Treatment

Often, in as little as a few months, institutional and reimbursement constraints limit access to ongoing care. People with addiction histories, however, remain vulnerable for much longer and continue to struggle with dependency. They need vigorous assistance maintaining behavioral changes throughout the middle, or action, stage of treatment.

Several studies (Committee on Opportunities in Drug Abuse Research 1996; London et al. 1999; Majewska 1996; Paulus et al. 2002; Strickland et al. 1993; Volkow et al. 1988, 1992) have observed decreased blood flow and metabolic changes rates in the brains of subjects who abused stimulants (cocaine and methamphetamine). The studies also found that deficits persisted for at least 3 to 6 months after cessation of drug use. Whether these deficits predated substance abuse or not, treatment personnel should expect to see clients with impaired decision making and impulse control manifested by difficulties in attending, concentrating, learning new material, remembering things heard or seen, producing words, and integrating visual and motor cues. For the clinician, this finding means that clients may not have the mental structures in place to enable them to make the difficult decisions faced during the action stage of treatment. If clients draw and use support from the group, however, the client's affect will re-emerge, combine with new behaviors and beliefs, and produce an increasingly stable and internalized structure (Brown 1985).

Cognitive capacity usually begins to return to normal in the middle stage of treatment. The frontal lobe activity in a person addicted to cocaine, for example, is dramatically different after approximately 4–6 months of nonuse. Still, the mind can play tricks. Clients distinctly may remember the comfort of their substance past, yet forget just how bad the rest of their lives were and the seriousness of the consequences that loomed before they came into treatment. As a result, the temptation to relapse remains a concern.

Therapeutic Strategies in Middle-Stage Treatment

In middle-stage recovery, as the client experiences some stability, the therapeutic factors of self-knowledge and altruism can be emphasized. Universality, identification, cohesion, and hope remain important as well.

Practitioners have stressed the need to work in alliance with the client's motivation for change. The therapist uses whatever leverage exists—such as current job or marriage concerns—to power movement toward change. The goal is to help clients perceive the causal relationship between substance abuse and current problems in their lives. Counselors should recognize and respect the client's position and the difficulty of change. The leader who leaves group members feeling that they are understood is more likely to be in a position to influence change, while sharp confrontations that arouse strong emotions and appear judgmental may trigger relapse (Flores 1997).

Therapeutic strategies also should take into account the important role substance abuse has played in the lives of people with addictions. Often, from the client's perspective, drugs of abuse have become their best friends. They fill hours of boredom and help them cope with difficulties and disappointments. As clients move away from their relationship with their best friend, they may feel vulnerable or emotionally naked, because they have not yet developed coping mechanisms to negotiate life's inevitable problems. It is crucial that clients recognize these feelings as transient and understand that the feeling that something vital is missing can have a positive effect. It may be the impetus that clients need to adopt new behaviors that are adaptive, safe, legal, and rewarding.

As the recovering client's mental, physical, and emotional capacities grow stronger, emotions of anger, sadness, terror, and grief may be expressed more appropriately. Clients need to use the group as a means of exploring their emotional and interpersonal world. They learn to differentiate, identify, name, tolerate, and communicate feelings. Cognitive–behavioral interventions can provide clients with specific tools to help modulate feelings and to become more confident in expressing and exploring them. Interpersonal process groups are particularly helpful in the middle stage of treatment, because the authentic relationships within the group enable clients to experience and integrate a wide range of emotions in a safe environment.

When strong emotions are expressed and discussed in group, the leader needs to modulate the expression of emerging feelings, delicately balancing a tolerable degree of expression and a level so overwhelming that it inhibits positive change or leads to a desire to return to substance use to manage the intensity. It also is very important for the group leader to "sew the client up" by the end of the session. Clients should not leave feeling as if they are "bleeding" emotions that they cannot cope with or dispel. A plan for the rest of the day should be developed, and the increased likelihood of relapse should be acknowledged so group members see the importance of following the plan.

Leadership in Middle-Stage Treatment

Historically, denial has been the target of most treatment concepts. The role of the leader was primarily to confront the client in denial, thereby presumably provoking change. More recently, clinicians have stressed the fact that "confrontation, if done too punitively or if motivated by a group leader's countertransference issues, can severely damage the therapeutic alliance" (Flores 1997, p. 340). Inappropriate confrontation may even strengthen the client's resistance to change, thereby increasing the rigidity of defenses.

When it is necessary to point out contradictions in clients' statements and interpretations of reality, such confrontations should be well-timed, specific, and indisputably true. For example, author Wojciech Falkowski had a client whose medical records distinctly showed abnormal liver functions. When the client maintained that he had no drinking problem, Falkowski gently suggested that he "convince his liver of this fact." The reply created a ripple of amusement in the group, and "the client immediately changed his attitude in the desired direction" (Falkowski 1996, p. 212). Such caring confrontations made at the right time and in the right way are helpful, whether they come from group members or the leader.

Another way of understanding confrontation is to see it as an outcome rather than as a style. From this point of view, the leader helps group members see how their continued use of drugs or alcohol interferes with what they want to get out of life. This recognition, supported by the group, motivates individuals to change. It seems that people who abuse substances need someone to tell it like it is "in a realistic fashion without adopting a punitive, moralistic, or superior attitude" (Flores 1997, p. 340).

In the middle stage of treatment, the leader helps clients join a culture of recovery in which they grow and learn. The leader's task is to engage members actively in the treatment and recovery process. To prevent relapse, clients need to learn to monitor their thoughts and feelings, paying special attention to internal cues. Both negative and positive dimensions may be motivational. New or relapsed group members can remind others of how bad their former lives really were, while the group's vision of improvements in the quality of life is a distinct and immediate beam of hope.

The leader can support the process of change by drawing attention to new and positive developments, pointing out how far clients have traveled, and affirming the possibility of increased connection and new sources of satisfaction. Leaders should bear in mind, however, that people with addictions typically choose immediate gratification over long-range goals, so benefits achieved and sought after should be real, tangible, and quickly attainable.

The benefits of recovery yield little satisfaction to some clients, and for them, the task of staying on course can be difficult. Their lives in recovery seem worse, not better. Many experience depression, lassitude, agitation, or anhedonia (that is, a condition in which formerly satisfying activities are no longer pleasurable). Eventually, their lives seem devoid of any meaningful purpose, and they stop caring about recovery.

These clients may move quickly from "I don't care" to relapse, so the group leader should be vigilant and prepared to intervene when a client is doing all that should be done in the recovery process, yet continues to feel bleak. Such clients need attention and accurate diagnosis. Do they have an undiagnosed co-occurring disorder? Do they need antidepressants? Do they need more intensive, frequent, adjuncts to therapy, such as more Alcoholics Anonymous or Narcotics Anonymous meetings and additional contacts with a sponsor?

Leaders need to help group members understand and accept that many forms of therapy outside the group can promote recovery. Group members should be encouraged to support each other's efforts to recover, however much their needs and treatment options may differ.

The leader helps individuals assess the degree of structure and connection they need as recovery progresses. Some group members find that participation in religious or faith groups meets their needs for affiliation and support. For long-term, chronically impaired people with addictive histories, highly intensive participation in 12-Step groups is usually essential for an extended period of time.

The Late Stage of Treatment

Condition of Clients in Late-Stage Treatment

During the late (also referred to as ongoing or maintenance) stage of treatment, clients work to sustain the attainments of the action stage, but also learn to anticipate and avoid tempting situations and triggers that set off renewed substance use. To deter relapse, the systems that once promoted drinking and drug use are sought out and severed.

Despite efforts to forestall relapse, many clients, even those who have reached the late stage of treatment, do return to substance use and an earlier stage of change. In these cases, the efforts to guard against relapse were not all in vain. Clients who return to substance abuse do so with new information. With it, they may be able to discover and acknowledge that some of the goals they set are unrealistic, certain strategies attempted are ineffective, and environments deemed safe are not at all conducive to successful recovery. With greater insight into the dynamics of their substance abuse, clients are better equipped to make another attempt at recovery, and ultimately, to succeed.

As the substance abuse problem fades into the background, significant underlying issues often emerge, such as poor self-image, relationship problems, the experience of shame, or past trauma. For example, an unusually high percentage of substance and alcohol abuse occurs among men and women who have survived sexual or emotional abuse. Many such cases warrant an exploration of dissociative defenses and evaluation by a knowledgeable mental health professional.

When the internalized pain of the past is resolved, the client will begin to understand and experience healthy mutuality, resolving conflicts without the maladaptive influence of alcohol or drugs. If the underlying conflicts are left unresolved, clients are at increased risk of other compulsive behavior, such as excessive exercise, overeating, or gambling.

Therapeutic Strategies in Late-Stage Treatment

In the early and middle stages of treatment, clients necessarily are so focused on maintaining abstinence that they have little or no capacity to notice or solve other kinds of problems. In late-stage treatment, however, the focus of group interaction broadens. It attends less to the symptoms of drug and alcohol abuse and more to the psychology of relational interaction.

In late-stage treatment, clients begin to learn to engage in life. As they begin to manage their emotional states and cognitive processes more effectively, they can face situations that involve conflict or cause emotion. A process-oriented group may become appropriate for some clients who are finally able to confront painful realities, such as being an abused child or abusive parent. Other clients may need groups to help them build a healthier marriage, communicate more effectively, or become a better parent. Some may want to develop new job skills to increase employability.

Some clients may need to explore existential concerns or issues stemming from their family of origin. These emphases do not deny the continued importance of universality, hope, group cohesion and other therapeutic factors. Instead it implies that as group members become more and more stable, they can begin to probe deeper into the relational past. The group can be used in the here and now to settle difficult and painful old business.

THE THREE STAGE OF DISEASE PROGRESSION:

The binge/intoxication stage: of the addiction cycle is the stage at which an individual consumes the substance of choice. This stage heavily involves the basal ganglia and its two key brain subregions, the nucleus accumbent and the dorsal striatum. In this stage, substances affect the brain in several ways.

The withdrawal/negative affect stage: of addiction follows the binge/intoxication stage, and, in turn, sets up future rounds of binge/intoxication. During this stage, a person who has been using alcohol or drugs experiences withdrawal symptoms, which include negative emotions and, sometimes, symptoms of physical illness, when they stop taking the substance. Symptoms of withdrawal may occur with all addictive substances, including marijuana, though they vary in intensity and duration depending on both the type of substance and the severity of use. The negative feelings associated with withdrawal are thought to come from two sources: diminished activation in the reward circuitry and activation of the brain's stress systems.

Preoccupation/Anticipation Stage: The preoccupation/anticipation stage of the addiction cycle is the stage in which a person may begin to seek substances again after a period of abstinence. In people with severe substance use disorders, that period of abstinence may be quite short (hours). In this stage, an addicted person becomes preoccupied with using substances again. This is commonly called "craving." Craving has been difficult to measure in human studies and often does not directly link with relapse. This stage of addiction involves the brain's region that controls executive function: the ability to organize thoughts and activities, prioritize tasks, manage time, make decisions, and regulate one's own actions, emotions, and impulses. Executive function is essential for a person to make appropriate choices about whether or not to use a substance and to override often strong urges to use, especially when the person experiences triggers, such as stimuli associated with that substance (e.g., being at a party where alcohol is served or where people are smoking) or stressful experiences

The Story

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Matrix Pt III ROADMAP FOR RECOVERY

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=ZA14YwKQ-f0

Duration: 32:11 min

VIDEO TWO

Search Title: Roadmap for Recovery (Part 1): Recovery Begins With Withdrawal

This video presents the four stages of recovery—withdrawal, early abstinence, protracted abstinence, and adjustment and resolution. It explains what people in recovery and their families, friends, and loved ones can do during each stage to make the journey more successful

Link: https://www.youtube.com/watch?v=dkAY8m-uJI0

Duration: 5:23 min

The stages of progression to ask

What is the diagnosis?

_____
_____
_____

What assessment tool was use and what were its findings?

_____
_____
_____

What is their current stage? (for each diagnosis, medical, mental health and addiction)

_____
_____
_____

What is the current plan of care? (Coordination between the different discipline)

_____
_____
_____

What is the current plan of treatment? (For each diagnosis, medical, mental health and addiction)

_____
_____
_____

Plan of Care and Plan of Treatment are interchangeable. However, we are asking about the plan of care and we want to know what steps are being taken to coordinate the plan between the medical team with what is being done by the Mental Health team and what is being done with the Addiction treatment team. How well are they collaborating to create a holistic level of care, because all three disciples are involved.

Reference Publications:

NIDA's Special Initiatives for Students, Teachers, and Parents Heads Up: Real News About Drugs and Your Body—A drug education series created by NIDA and SCHOLASTIC INC. for students in grades 6 to 12. www.headsup.scholastic.com

NIDA for Teens: The Science Behind Drug Abuse—An interactive Web site geared specifically to teens, with age-appropriate facts on drugs. www.teens.drugabuse.gov Drug Facts Chat Day— A Web chat between NIDA scientists and teens, held through school computer labs once a year during National Drug Facts Week (below). www.drugabuse.gov/chat

National Drug Facts Week— A week-long observance that encourages community-based events and dialogue between teens and scientists during National Drug Facts Week (below). www.drugfactsweek.drugabuse.gov/

Publications on Prevention and Treatment Principles Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community

Leaders—NIDA's research-based guide for preventing drug abuse among children and adolescents provides 16 principles derived from effective drug-prevention research and includes answers to questions on risk and protective factors as well as on community planning and implementation.

Principles of Drug Addiction Treatment: A Research-Based Guide—This guide summarizes the 13 principles of effective treatment, answers common questions, and describes types of treatment, providing examples of scientifically based and tested treatment components.

The Family Plan of Action

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1. The family members will name which of the three (3) stages of SUD disease progression in the brain is current for their loved one.
2. The family members will identify which of the four behaviors in SUD disease progression their loved one is currently presenting.
3. The family will identify which of the brains thinking skills are being compromised by the disease as seen from their current behavior.

Part II

Learn About the Disease

Seminar # 9

"Relapse is part of the Brain Disease journey"

SEMINAR GOALS:

1. The attendee will be able to name the three (3) stages of relapse.

2. The attendee will be able to identify parts of a family plan that can help to prevent relapse.

3. Using the information, identify within these exercises.

    a. What the family will do, to complete their family plan of action.

    b. What steps can the family member take in the life of their loved one after a relapse.

Introduction

Current research suggests that relapse is a gradual process wherein a person in recovery returns to his or her drug abuse. This means relapse can begin weeks or even months before an individual first takes a drug again [7]. A good relapse prevention program helps individuals identify those early signs of relapse and develop tools and techniques for coping, so they can stop relapse early in the process. Researchers believe this significantly reduces a person's risk of returning to drug addiction [7].

Drug relapse warning signs can be broken down into three categories: emotional, mental, and physical signs. During **emotional relapse**, individuals are not consciously thinking about using, but they are setting themselves up for it. They remember what relapse feels like and are in denial about the possibility of it happening again.

During **mental relapse**, individuals are thinking about using drugs again, but they are at war with themselves. Part of them wants to use, and part of them doesn't. Eventually, this internal struggle wears them down. **Physical relapse** is when an individual finally returns to drug use. Some clinicians divide this phase into **lapse** (initial drug use) and **relapse** (returning to uncontrolled using). Either way, this final stage is the hardest to come back from [7].

Recent drug relapse statistics show that more than **85% of individuals relapse** and return to drug use within the year following treatment. Researchers estimate that more than 2/3 of individuals in recovery relapse within weeks to months of beginning addiction treatment [6].

Why are these drug relapse statistics so discouraging? Without a long-term drug relapse prevention plan, most people will be unsuccessful in their attempts to remain sober, so having a solid plan is place is essential.

The goal of **drug relapse prevention programs** is to address the problem of relapse by teaching techniques for preventing or managing its reoccurrence. Drug addiction relapse prevention models are based on the idea that high-risk situations can make a person more vulnerable to relapse. A high-risk situation can include people, places, or feelings that lead to drug-seeking behavior [4].

Lesson One: Stages of Relapse

Drug and alcohol addiction relapse prevention requires identifying the following warning signs:

Emotional

- Isolating oneself
- Not going to treatment or meetings
- Going to meetings but not sharing
- Bottling up emotions
- Poor eating and sleeping habits
- Not taking care of self mentally or physically
- Denial
- Relaxing of self-imposed rules

Mental

- Drug cravings
- Thinking about people and places associated with past drug use
- Romanticizing past drug use
- Minimizing consequences
- Bargaining with self
- Lying to others
- Thinking about how to better control drug use next time
- Planning a relapse or looking for opportunities

Physical

- Using drugs “just once”
- Returning to uncontrolled use

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Relapse Prevention: Early warning signs and important coping skills

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

Duration: 5.35 min

Dr. Steven Melemis

Practical Exercise # 1. What can the family do to prevent relapse?

The Three stages of Relapse?

What can be done to prevent emotional relapse?

How can you help them Practice?

Mindfulness:_____
_____

Help them Keep in Gratitude.

Journal:_____
_____
_____

What can be done to prevent mental relapse?

How can you help them Practice?

Mindfulness:_____
_____

Journal:_____
_____

What can be done to prevent Physical relapse?

In what ways can you use K.I.S.S. to simplify their life:_____
_____

How can each member of the family contribute towards creating Good Orderly Direction for their loved one:
_____
_____
_____

1.

2.

3.

What has worked in the past?

Lesson Two: The Three Stages of Drug and Alcohol Relapse

For many, *relapse is part of recovery from addiction*. In fact, according to DrugAbuse.gov, it is believed that 40 to 60 percent of addict's relapse at least once during their recovery.

However, just because someone relapses, it does not mean they failed at recovery. Many view relapses as a learning experience and take into account what not to do the next time around for their recovery. *Though relapse is often unplanned and impulsive, there are certain warning signs that can point to the danger of a potential drug or alcohol relapse.*

In fact, often relapse is thought to have three separate stages – emotional, mental and physical. The following are a more in-depth explanation about the stages of relapse and include what to watch for in yourself or in others.

1. Emotional relapse

During this stage, a person is not actively thinking about using a drug or drinking alcohol. However, their behavior and actions may be setting them up to head down that road.

Emotional relapse can be detected through symptoms such as anxiety, intolerance, anger, defensiveness, mood swings, isolation, failing to attend meetings and poor sleeping and eating habits. It is believed that this stage of relapse aligns with Post-Acute Withdrawal Syndrome (PAWS), during which an addict

experiences emotional and psychological withdrawal rather than physical ones. Physical withdrawals only last a few weeks whereas PAWS can last up to two years after an addict stops using. PAWS episodes tend to last a few days at a time and include the symptoms listed above.

2. Mental relapse

During this stage, the mind is battling between using and not using. Part of the addict wants to use, while the other part of them wants to continue with their recovery.

Signs of mental relapse may include reminiscing about the people and places associated with your past life, glamorizing your past use, lying, spending time with people you used with, thinking about relapse and even planning relapse.

Often, recovering addicts are the only ones who can really pinpoint these symptoms of mental relapse as internal battles are harder for others to pick up on.

3. Physical relapse

Unfortunately, the techniques in stage two do not work for everyone and some people do resort to acting on their urges to use. This stage of relapse includes the actual physical decision to use.

When an addict hits this stage of relapse, some will continue to use for months, but others realize what they have done and the focus becomes recovery.

Lesson Three: 4 Techniques That Prevent Mental Relapse

When the process of mental relapse begins, there are some techniques an addict can use in order to regain control of their thinking and make the choice to not drink or use.

1. Call someone. Whether this be a sponsor, friend, or family member, talking your urges through with another person can help in determining why you want to use and why you should not.

> Talking your thoughts through with another person makes them seem less intimidating and even less logical when it comes to reasons for wanting to use.

Being able to talk to someone about your urges may bring you some clarity as to why using will not solve any problems but only create more.

2. Make yourself wait 30 minutes. Before impulsively acting on an urge to use, wait half an hour and reevaluate your urges and your reasoning behind them. Sometimes the passing of time can help clear things up in the mind.

3. Think about what would happen if you had one drink or used once. Likely it wouldn't stop there, and you'd eventually find yourself at the same bottom you previously hit, if not a deeper one. Thinking about actions and their consequences can curb the desire to use.

4. Don't think about every day. Think about today. Even people who have been sober for decades take their sobriety one day at a time. Thinking about it in terms of years or forever is too intimidating for anyone and will likely result in feeling overwhelmed and wanting to use.

Instead of thinking about forever, focus on making it through one day without using. Then focus on that again the next day and repeat. Before you know it, the days will add up.

Take time to go on-line and search the word: *Drug addiction relapse*. Also, do the same on www.youtube.com

Practical Exercise # 2. What can family member do to help prevent triggers for physical relapse?

List next to each trigger, what the family will do to help your loved deal with this in their lives.

People:

- Former drug dealers: _____
- Unhealthy Friends: _____
- Past/Present Co-workers: _____
- Employers: _____
- Family members: _____
- Spouses or partners: _____
- Neighbors: _____

Places:

- Neighborhoods:
  _____
- A friend's home:
  _____
- Bars and clubs:
  _____
- Hotels:
  _____
- Worksites:
  _____
- Concerts:
  _____
- A freeway exit:
  _____
- Bathrooms:
  _____
- Former drug-stash locations:
  _____

- Schools:

  _____

  - Downtown:

    _____

Items:

- Paraphernalia:

  _____

- Furniture:

  _____

- Magazines:

  _____

- Movies:

  _____

- Television:

  _____

  - Cash:

    _____

  - Credit cards:

    _____

  - ATMs:

    _____

  - Empty pill bottles: _____

Happenings:

- Meeting new people:

  _____

- Listening to a particular music genre

  _____

- Recovery group meetings:

  _____

- Going out to dance or eat:

  _____

- Parties hanging out with friends:_____
- Being around substance-using peers: _____
- Payday: _____
- Driving: _____
- Calls from creditors: _____
- After paying bills: _____
- Before, during and after work: _____
- Before or during a date: _____
- Going out: _____
- Alone in the house: _____
- Before, during and after sex: _____
- After an argument: _____
- Anniversaries: _____
- Talking on the phone: _____
- Holidays: _____
- While eating lunch or dinner: _____
- Family gatherings: _____

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5. Marlatt, A.G., Donovan, D.M. (2005). **Relapse Prevention, Second Edition, Maintenance Strategies in the Treatment of Addictive Behaviors**. (1-50).
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8. Gorski, T. (2001). ***Understanding relapse***.

We Strongly Suggest:

https://www.smartrecovery.org/smart-recovery-toolbox/

Take their courses, get a certification to run a meeting with their materials.

The Story

The bi-chemical signature tells the truth. The dopamine rewiring in our brain, creates a new condition stimulation. Prediction of stimuli creates a new channel towards reward and our memory stores it for retrieval.

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Relapse Prevention for Addiction & Mental Health: Counselor Toolbox Episode 115

Link: https://www.youtube.com/watch?v=OMQHUAmj3Cw

Duration: 60 min

The Pathfinder

Certificate of Completion Seminar

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.

This is especially true when we look at the family using the support of an external organization. The organization typically will have a stated process that guides the family through their organization's services. It is for this reason that many families will have in some way a similar path.

Because the addiction process is known to include critical Categories i.e. The Legal System, and issues "Drug Court", and the Drug Court has a specific design in how a family is processed, this information can be presented and learned in advance of needing it for necessary actions the family to take.

Learning these issues in advance reduces stress of the unknown, save time, allows the family to budget their expenses, and gives them room to gather the needed resources.

This next 12 seminars will address each of the 12 key issues a family faces in their journey with addiction. It is our goal to break these issues into three parts for each issue:

Issues the Family Faces

This 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 Addresses

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

Solutions to Issues & Obstacles

Each of these will be presented to the 12 Key Family Issues.

The 12 Key Issues a Family Faces

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

GOAL: To use this seminar content as a foundation towards *building communication techniques* that do not enable substance misuse. Also learn how to avoid communication that disables the positive habits of successful recovery. How communication makes a safe place for the family.

ISSUE #2. Addiction Behavior (30-minute session)

GOAL: To learn the *behavior traits of substance use disorder*. To understand how the behavior progresses and changes over time. Also, learn how to responds to these behaviors.

ISSUE #3. Family Intervention (30-minute session)

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.

ISSUE #4. The Police Intervention (30-minute session)

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.

ISSUE #5. The Emergency Medical Services Intervention (30-minute session)

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.

ISSUE #6. The Legal System Intervention (30-minute session)

GOAL: Learn how to navigate the court system. What is the requirement for drug court and other options?

ISSUE #7. The Treatment Center Intervention (30-minute session)

GOAL: Learn what the treatment center will do and what it will not do. How to select the right treatment center using a criteria check list.

ISSUE #8. The County, State, Federal Agencies (30-minute session)

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.

ISSUE #9. Relapse (30-minute session)

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.

ISSUE #10. Successful Life Long Recovery (30-minute session)

GOAL: Learn how to create a supportive and safe space for the family and the loved one in recovery.

ISSUE #11. Bereavement (30-minute session)

GOAL: Learn how to navigate the journey of grief and all that life give us in these times.

ISSUE # 12. Faith, Spiritual Practices (30-minutes session)

GOAL: How to create a new State Certified Addiction Counselor position at your place of worship. Open Doors to Open Hearts May 5th call for universal inter-faith prayer across NE Ohio. 2-4pm

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)**

FAMILY TRANSFORMATIONAL RESPONSE (F.T.R.) Model

The 12 Key Stress Issues can be addressed by using this model format.

Example, Take your issue and define what the issue is, then state how this issue will impact the family, then identify what steps your family can take to prepare for this issue, then find those organizations/professionals who can help the family in dealing with this issue**.**

The F.T.R. Model:

Define the Issue?

How does this issue impact the family?

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

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

What should the family expect as their outcome?

The F.T.R. Model Worksheet

6. **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?
7. **How does the issue impact the family?**
   - ❖ Who in the family?
   - ❖ In what way.
   - ❖ What is needed to move forward.

8. **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?
9. **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.
10. **What should the family expect as their outcome?**
    - ❖ Timeline.
    - ❖ The expenses/cost involved in this issue.
    - ❖ Required changes to successful respond to this issue.

PHASE III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 10

Issue # One: Enabling vs. Consequences

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.

Introduction

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 really 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

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 of 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?

The Story

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

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?

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

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.

PHASE III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 11

Issue # Two of 12 key issues: The Addiction Behavior

Seminar Two Objectives:

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

Introduction

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.

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 hope that you will be unable to keep boundaries. 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

FAMILY WORK SHEET How to clinician's assess behavior

It is empowering to know the tools being used in the care of your loved one. This is a list of evidence-based screening tools and assessment resource materials. Search internet for these documents.

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.

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 this is long video and is optional. However, it is valuable.

> 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

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 ____**

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

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 ____**

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" found in back of workbook.

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 Clinicians Assessment of Behavior scales to determine what to expect.

3. 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.

PHASE III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 12

Issue # Three of 12 key issues: Family Intervention

Seminar Objectives:

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

Issues the Family Faces

Introduction

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 behaviour 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

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Introduction to Motivational Interviewing

Published on May 4, 2018
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.**

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

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

3. 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.

4. Our Family will use the Clinicians Assessment of Behavior scales to determine what to expect.

5. 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.

PHASE III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 13

Issue # Four of 12 key issues: The Police Intervention

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

Issues the Family Faces

The Police Intervention

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.

How to Report a Missing Person

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.

There were 20,101 fatal overdoses related to prescription painkillers and 12,990 stemming from heroin, according to ASAM.

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

Published on May 4, 2018

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:

_____

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Business Phone Number:

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Employer: Name, Address Phone

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Residence Address, City, State, Zip Code:

_____

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

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Business Address, City, State, Zip Code:

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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:

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_____

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:

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_____

Past or Current Girlfriend/boyfriend: Name, Cell Phone

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Other Comments to Disclose:

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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 you 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: "FAMILY IS A SYSTEM"

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

1. The family will identify the have a plan on who will follow through with the booking and release process for their loved one.
2. The Family will complete a missing persons report now for use as needed later.
3. Next steps need to be considered and planned, in order the right documents and people are included.

PHASE III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 14

Issue # 5 of 12 key issues: Emergency Medical Services Intervention

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.

Introduction

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

An Introduction to S.B.I.R.T.

Because emergency medical services are an intervention and assessment is a matter of course and procedure, 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 decisions that need to be made.

The family being included is a matter of advocatory activist. Your family members need to become Advocatory Activist in order to address your family needs in a manner that will make a difference. We are sorry to tell you this, but you will need to stick up for yourself and make this industry do for your, that which needs to be done.

Therefore, you will need to know more about "best practices" that are being provided elsewhere and set up the same model to serve you and your family. This may seem un-necessary in going to such extremes, but consider the alterative, you know nothing, your being told nothing and therefore you can do nothing. If nothing is not an option you want, then learn what is possible, that is 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.

SBIRT stands for Screening Brief Intervention and Referral Treatment. Nothing gets done in this industry until an Assessment Tool is given stating the treatment is needed. Therefore, get the assessment screening completed and move forward to the referral for treatment phase.

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.

Foundations of SBIRT is a 1.5-hour course developed by the **Pacific Southwest ATTC** that helps familiarize health professionals with the SBIRT process.

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.

The Substance Use in Adults and Adolescents: Screening, Brief Intervention and Referral to Treatment (SBIRT) **free online SBIRT course** through Medscape addresses the basic principles of SBIRT as well as coding and reimbursement for the implementation of SBIRT in practice.
** A free membership to Medscape is required to view the training.

An extension of SBIRT - Implementing Care for Alcohol and Other Drug Use in Medical Settings.

GENERAL RESOURCES The **SBIRT App**, developed at Baylor College of Medicine to support the use of SBIRT by physicians, other health workers, and mental health professionals is free to download. The app provides evidence-based questions to screen for alcohol, drugs and tobacco use. If warranted, a screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient based on motivational interviewing.

The Annals of Internal Medicine journal article **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement** provides a good overview of ways to improve long-term health outcomes, the harms of screening and behavioral health counseling interventions, and influences from the health care system that promote or detract the effectiveness of screening and counseling interventions for alcohol misuse.

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.

SBIRT in a Radically and Rapidly Changing Environment is a power point that highlights SBIRT in the context of healthcare reform. The webinar which was conducted by the Altarum Institute for SAMHSA can be found below.

The Addiction Technology Transfer Center (ATTC) created an guide: **SBIRT: A Resource Toolkit for Behavioral Health Providers to Begin the Conversation with Federally-Qualified Healthcare Centers.** This resource provides behavioral health providers with information to engage their local FQHC and community health centers in conversations around implementing SBIRT.

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**.

NIAAA's **Helping Patients Who Drink Too Much: A Clinician's Guide** focuses on implementing alcohol screening and intervention in any healthcare setting. A SAMHSA Treatment Improvement Protocol (TIP), **TIP 24: A Guide to SA Services for Primary Care Clinicians** provides guidelines to primary care clinicians for caring for patients with alcohol and drug abuse problems. TIP 24 discusses screening, assessment, brief intervention, medication-assisted treatment, and legal issues of patient confidentiality.

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 referred 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: 5:17hrs.

So why view this video? The answer is just because your hospital does not provide the Behavioral Referral does not mean your family con 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.

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 together 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.

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

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

lcohol screening questionnaire (AUDIT)

Patient name:
Date of birth: _
One drink equals: 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: "FAMILY IS A SYSTEM"

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

1. Our family will identify the steps of receiving emergency medical services as an intervention of our loved one.
2. Our Family will use the workbook: The Substance Use Disorders Journey, It's Time to Get Organized and complete it now, in advance of needing it during an emergency.
3. As part of the Master Family Plan of Action we will complete the review of setting boundaries and seek professional counseling, legal advise and financial advice depending on our findings in organizing these documents. We want to be assured to have all the necessary documents in an easy to find binder.

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 15

Issue # Six of 12 key issues: The Legal Court System Intervention

Seminar Objectives:

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

Introduction

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

Incarceration Diversion

Issues the Family Faces

Introduction to 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.

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

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. 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

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.

Each day in the U.S. more than 115 people die from an opioid overdose. Whether it's by abusing

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

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

1. Your family will identify the steps of a legal Court System Intervention of your loved one.
2. Your Family will use the workbook: The Substance Use Disorders Journey, It's Time to Get Organized and complete it now, in advance of needing it during an emergency.
3. Be prepared to request an assessment and become familiar with these tools.
4. Pre-Screen an attorney while there is time and less stress. The family will likely need this service at some point in the journey.
5. As part of the Master Family Plan of Action you will complete the review the needed points of contact in the practical exercises and gain a diagram level of understanding the court process.

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 16

Issue # Seven of 12 key Issues: Treatment Centers Intervention

Seminar Objectives:

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

Introduction

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

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
- extensively 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
- Other mental health services

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.

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 members, 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

COMPLETE A FAMILY Against Medical Advice Discharge Prevention Plan

2. **Do they live in the area, do they know where to find drugs?**
3. **Risky Peers, Boyfriend, girlfriend, spouse, drug friends that will help them leare treatment?**
4. **Logistical Means, Access to money, car, transportation, place to live?**
5. **Are there members of the family and distant relatives who will provide the person with emotional cover for learning treatment?**

Complete the above questions and discuss with the persons therapist at the facility and your family counselor.

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.					

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: "FAMILY IS A SYSTEM"

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1. Your family is to complete a diagnosis and assessment with severity of stage.
2. An interview of the treatment facility will be planned and implemented by the family members.
3. The organization chart for the facility will be recorded for future reference.
4. The family members will seek family therapy during the time the loved one is in treatment.

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.

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 17

Issue # Eight of 12 key Issues: Support Agencies Mapping

Seminar Objectives:

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

Introduction

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

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 stakeholders/organizations 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 stakeholders/organizations, 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 stakeholders/organization? 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 an Family Master Plan of Action is a matter of detailing the action the family will take to build their system so it meets the families 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, in light of 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, stakeholders/organizations in one patient's outcomes stand at cross-purposes with each other. Programs must seek a mutually satisfactory response, for example, when courts and departments of corrections, whose primary interest is public safety, mandate lengthy residential treatment in secure settings, while health plans require brief treatment in the least intensive environment. Or when a treatment center excludes the family from understanding how to support sustainable recovery after the discharge from services, the family is not well served.

Programs confront the issues of stakeholder/organization conflict most commonly, perhaps, when treating clients with co-occurring mental health and substance use disorders. These cases tend to involve the most from stakeholders/organization because of the exceptional number of community services these men and women require. Moreover, substance abuse 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."

The incentives should be based on three factors: (1) identification of difficult-to-treat clients based on analysis of differential outcomes and clients' characteristics, (2) analysis of the additional average costs of serving these clients, and (3) provision of either explicit incentives for serving these clients or a more equitable approach.

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

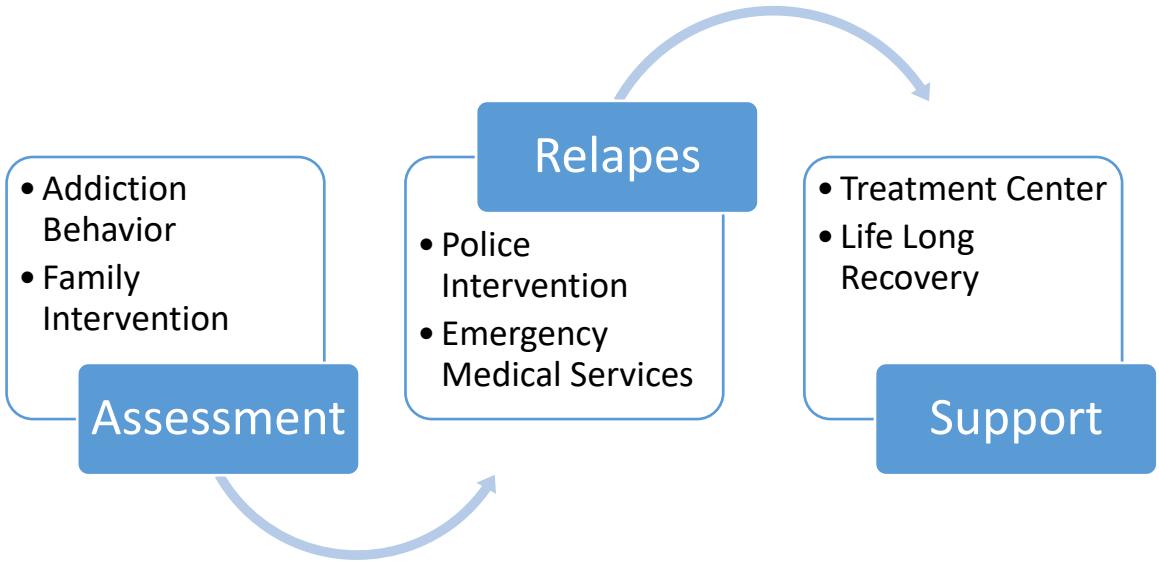
People live in different environments, and service providers have a responsibility to understand the contexts in which their clients operate. Client-focused treatment and referral needs to be based on an understanding of the family relationships, cultures, and communities of the clients. Culture can 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 primary focus.

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.

Distinct from a traditional model is one where collaborations are fostered and maintained among agencies providing services to clients with overlapping needs, such as substance abuse treatment, employment, housing, education, and child care. In this context, the multidisciplinary team approach comes into play, but rather than coexisting under one roof, team members work within the various agencies engaged in collaboration. Referrals are negotiated among interlinked and interdependent agencies that share mutual goals and outcomes.

Practical Exercise # One



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:

The 12 Key Issues a Family Faces

#11
Bereavement (Learning how to move forward)

#12 **Faith, Spiritual Practices**

STEP THREE

1. **Define the Issue?**
    a. Clearly State what happened or will happen.

    _____
    _____

    b. Identify who is involved or should be involved.

    _____
    _____

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

    _____
    _____

2. **How does the issue impact the family?**
    a. Who in the family?

    _____
    _____

    b. In what way?

    _____
    _____

    c. What is needed to move forward?

    _____
    _____

3. **What steps can the family take to prepare and then respond to the issue?**
    a. What needs to be done, prioritize the list.

    _____
    _____

b. Who needs to be involved?

_____
_____
_____

c. What will it look like when completed?

_____
_____

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

a. How to search for an organization to help.

_____
_____
_____

b. What to ask from them?

_____
_____
_____

c. What to expect?

_____
_____
_____

5. What should the family expect as their outcome?

a. Timeline.

_____
_____
_____

b. The expenses/cost involved in this issue.

_____
_____
_____

c. Required changes to successful respond to this issue.

_____

_____

_____

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

GOAL: To build a foundation *denial coping technique* 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.

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:

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.

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.

4. Your family is to complete a diagnosis and assessment with severity of stage.
5. An interview of the agencies by selection of the 12 key issues list.
6. The organization chart for the facility will be recorded for future reference.
7. The family members will seek family therapy during the time the loved one is in treatment.

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.

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 18

Issue # Nine of 12 key Issues: The Relapse

Seminar Objectives:

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

Introduction

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 [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. 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 [6]. It begins weeks and sometime months before an individual picks 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 [7]. Gorski has broken relapse into 11 phases [6]. 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 [4].

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.

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

Helping clients avoid high-risk situations is an important goal of therapy. Clinical experience has shown that individuals have a hard time identifying their high-risk situations and believing that they are high-risk. Sometimes they think that avoiding high-risk situations is a sign of weakness.

In bargaining, individuals start to think of scenarios in which it would be acceptable to use. A common example is when people give themselves permission to use on holidays or on a trip. It is a common experience that airports and all-inclusive resorts are high-risk environments in early recovery. Another form of bargaining is when people start to think that they can relapse periodically, perhaps in a controlled way, for example, once or twice a year. Bargaining also can take the form of switching one addictive substance for another.

Occasional, brief thoughts of using are normal in early recovery and are different from mental relapse. When people enter a substance abuse program, I often hear them say, "I want to never have to think about using again." It can be frightening when they discover that they still have occasional cravings. They feel they are doing something wrong and that they have let themselves and their families down. They are sometimes reluctant to even mention thoughts of using because they are so embarrassed by them.

Clinical experience has shown that occasional thoughts of using need to be normalized in therapy. They do not mean the individual will relapse or that they are doing a poor job of recovery. Once a person has experienced addiction, it is impossible to erase the memory. But with good coping skills, a person can learn to let go of thoughts of using quickly.

Clinicians can distinguish mental relapse from occasional thoughts of using by monitoring a client's behavior longitudinally. Warning signs are when thoughts of using change in character and become more insistent or increase in frequency.

Physical Relapse:

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 Two

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 Three

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.

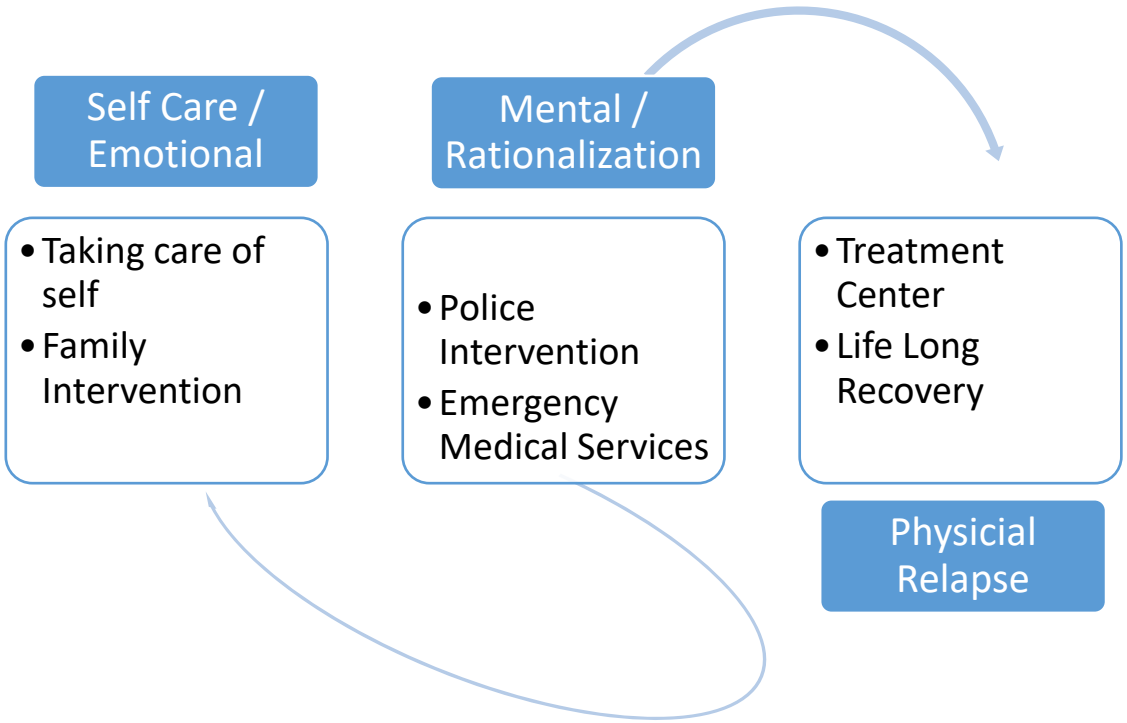
After emotional relapse comes physical relapse – this is when the person actively returns to substance use and a pattern of dysfunctional behaviors. It is a complete reversal of the progress made so far.

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 Four

1. **Define the Issue?**
    a. Clearly State what happened or will happen.

    _____

    _____

    b. Identify who is involved or should be involved.

    _____

    _____

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

    _____

    _____

2. **How does the issue impact the family?**
    a. Who in the family?

    _____

    _____

    b. In what way?

    _____

    _____

    c. What is needed to move forward?

    _____

    _____

3. **What steps can the family take to prepare and then respond to the issue?**
    a. What needs to be done, prioritize the list.

    _____

    _____

    b. Who needs to be involved?

    _____

    _____

    c. What will it look like when completed?

    _____

    _____

4. **Who can help and assist the family in their response?**
    a. How to search for an organization to help.

    _____

    _____

    b. What to ask from them?

    _____

    _____

    c. What to expect?

    _____

    _____

5. What should the family expect as their outcome?

a. Timeline.

_____

_____

b. The expenses/cost involved in this issue.

_____

_____

c. Required changes to successful respond to this issue.

_____

_____

Practical Exercise Five: 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 Six: After Relapse

FAMILY RESOURCE MAP

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

Practical Exercise Seven: 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:

VIDEO THREE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: "Recovery and The Family" by Father Martin.

Published on Dec 17, 2012

Link: https://www.youtube.com/watch?v=b8RkLRxMinY

Duration: 1.28 hrs.

Father Martin talks about "Recovery and The Family" like no one else. He speaks about how important it is for the whole family to recover from their loved one's addiction. You will enjoy listening and learning from Father Martin.

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To speak to an addiction professional please (888)381-6994

or visit us online at www.BeginningsTreatment.com

ASTER FAMILY PLAN OF ACTION FOR: "The Relapse"

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1. Your family is to complete an Assessment of Severity to understand the indicators of relapse stage.
2. A family action plan will be written on how the family will respond in stages Mild and Moderate for the three stage of a relapse.
3. The Support Agencies Map will be used to set into place where the family will turn to for assistance in the stages of relapse.
4. The family members will seek family therapy during the time the loved one is in treatment.

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.

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 19

Issue # Ten of 12 key Issues: Successful Lifelong Recovery

Seminar Objectives:

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

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 begin 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 commit ting 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"

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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:

Search 

ASSIGNMENT VIDEO: On www.youtube.com/

Title: Six Skills for Families Affected by Addiction

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?

2. **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. Google how to practice mindfulness. www.youtube.com
- **Journaling** - Daily reflection and affirmation.

3. **Self-Care** – Doing the things that are necessary to maintain and improve your physical, emotional, and mental health.

Q: What can the family member do for themselves:

_____

_____

4. **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 member do for themselves:

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.

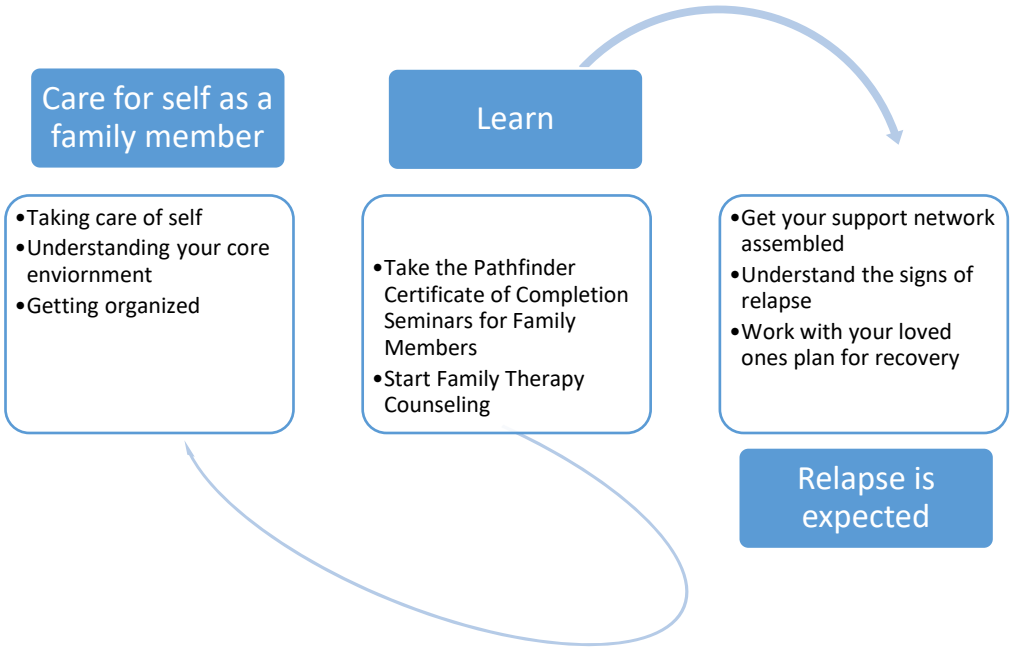
Q: What can the family member do for themselves:

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 member do for themselves:

5. **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 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.

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.

8. Your family will use the elements of supporting the loved ones plan of care in recovery/
9. A family action plan will be written on how the family will respond in stage of emotion, for potential relapse. Early intervention
10. 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.

REF:

Differ from major depression associated with other forms of stressful events? Am J Psychiatry. 2008;165:1449–1455. [PMC free article] [PubMed] [Google Scholar]

36. Zisook S, Shear K, Kendler KS. Validity of the bereavement exclusion criterion for the diagnosis of major depressive episode. World Psychiatry. 2007;6:102–107. [PMC free article] [PubMed] [Google Scholar]

37. Wakefield JC, Schmitz MF, First MB. Extending the bereavement exclusion for major depression to other losses: evidence from the National Comorbidity Survey. Arch Gen Psychiatry. 2007;64:433–440. [PubMed] [Google Scholar]

38. Karam EG, Tabet CC, Alam D. Bereavement related and non-bereavement related depressions: a comparative field study. J Affect Disord. 2009;112:102–110. [PMC free article] [PubMed] [Google Scholar]

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

SIDNEY ZISOOK1 and KATHERINE SHEAR

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: When to Treat Grief and Bereavement

TEDx Talks

Sidney Zisook, MD, Phd, describes the circumstances when bereaved patients may benefit from treatment. Duration: 5:08 min

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

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 20

Issue # Eleven of 12 key Issues: Bereavement

Seminar Objectives:

1. Stages of Grief Your family members will seek identify what level of grief they are in and how the family environment impacts that stage, both negative and positive. Determine can this environment change or circumstance change to meet the family members needs?

2. Complicated Grief Each family member will seek clarity as to if complicated grief is a part of their journey and who is in their lives to support them, and what level of support is likely to be shared.

3. Self Care in Grief Your family members will seek professional tools are used to assess, develop their response to the how one takes better care of themselves. Each will be different.

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 have to 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.

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. You might even experience suicidal thoughts – thinking "what's the point of going on?"

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 every day 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

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" found in back of workbook.

1. The family member will have a working knowledge of the Kubler-Ross Grief Cycle.
2. The family will understand the difference between, Uncomplicated Grief, Complicated Grief and Grief Related to Major Depression.
3. The family members will use the "Self Care" steps for care for themselves in managing the stress of grieving.

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

PERSONAL NOTES: (in passing, how to be kind to myself and the ones we love)

Part III

"The Pathfinder Certificate of Completion Seminar"

Seminar # 21

Issue # Twelve of 12 key Issues: Faith, Spiritual Practices

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.

Introduction

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.

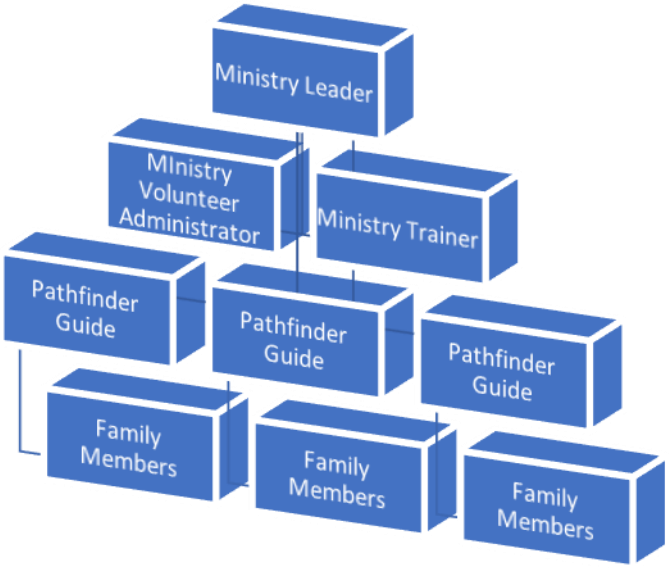
The first step is to develop the ***culture*** from which the "Invest in the Family Ministry" will operate. This is done when leadership gathers those who will volunteer and asks them, "What are your **VALUES**, what are your **BELIEFS**"? Once this is out in the open, the leadership can ask, "*how do 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

Is leadership right for you?

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.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: How to Start a Church Ministry | Mission, Ideas, Organizing, Leadership, and Money

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

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

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.

SOLUTION TWO: Developing personal spirituality and faith practices

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SP~ARK'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 (Member Organizing Resources Evaluation)

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.

MASTER FAMILY PLAN OF ACTION FOR: Spirituality, Faith Practices

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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.

Part IV

"Creating a Family Plan of Action"

Seminar # 22

Elements of a Family Plan of Action

Seminar Objectives:

1. What Change to Expect Your family members will seek identify What Changes will take place. Determine What impact will it have on the family and each family member?

2. The Family Meeting Each family member will seek clarity as to if complicated parts of the decision and how a plan will include them or others to create a solution to an issue. Gathering and creating a unified response will require the family to communicate together in a family meeting.

3. Making a Family Decision Having family members who understand a standard way the family will make decision is an advantage for everyone. Learn and decide as a family how decisions will be made, what are the steps? Each family member may have a different way to approach decision making and yet this is a family action that unites all members of the family.

Issues the Family Faces

Developing a Family Strategy

Family Strategy: Planning is about assessing what's likely to change?

This strategy will include the behavior and known issues which are likely to present in the next stage.

1. **Changes to Expect with Your Family Member or Friend?**
    a. Now:

    b. Future:

2. **Currently used family Strategies?**
    a. Future:

3. **Your Role and How you will Cope in the next stage**
    a. Now:

    b. Future:

4. **Orientation, What Change to Expect**
    a. Now:

b. Future:

5. **The loved one's communication and language changes to expect**
    a. Now:

b. Future:

6. **Independence and Basic Care**
    a. Now:

b. Future:

7. **Travel and Movement**
    a. Now:

b. Future:

8. Finances and Shopping

a. Now:

9. Managing Medication

a. Now:

b. Future:

10. Reasonable Housing

a. Now:

b. Future:

11. Work and Leisure

a. Now:

b. Future:

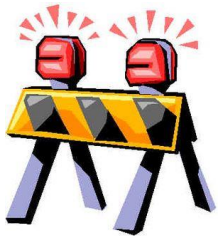
12. Summary of Information About This Level Change

a. Now:

_____

b. Future:

_____



An Obstacle is the time it takes for a family to meet.

Family Initial Meeting

Strengthening the family bond can prove to be challenging even for the most dedicated parents. One of the best tools to achieve this goal is holding a family meeting. This has proven to be one of the most effective in bonding families and can create greater harmony and with more depth and connection with those they love.

The goal of the family meeting is to help you communicate better, bring everyone closer together, and to have some fun. Here are some simple guidelines to help you get started. Remember that all families are different and not every step is exactly right for yours, so be creative and add to these guidelines when necessary.

1. Keep it upbeat. Just talking together as a family is something that will make everyone involved feel better. Talk about the good things that happened during the month and ask the kids about the funniest thing that happened at school or around the neighborhood. Remember to keep your sense of humor and don't be afraid to laugh out loud. The family meeting is about communication, which will lead to better connections between family members, and it's much easier to communicate when you're having a good time.

2. Don't try to control participation. Let everyone in the family join in, while encouraging attendance for teenagers, don't make it compulsory. In a very short time, they will attend just to see what they may be missing—and make a bit of a fuss when they do attend. Also, make sure you don't talk over the heads of your kids by keeping things simple.

3. Encourage every person who lives in the home to join the meeting. If you live with in-laws, other relatives or a nanny, they are all part of the family and so they need to be part of the meeting. Make sure everyone involved gets some airtime. If one member is not talking use some gentle questioning to get him or her to open up. For example, you could simply ask the person, "What was the best thing that happened to you this month?"

4. Give everyone a chance to lead/record the meeting. This will help your kids feel validated and realize that what they think matters. Make a record of the decisions reached so you can refer to agreements made if you need to. You can also post the minutes of the weekly meeting on the refrigerator so everyone can be reminded of plans for the week. Remember to make sure you follow through and do what you say you're going to do as parenting is best done by example.

Here is an example of some typical family meeting agenda topics:

- What happened last month
- What's happening this week and future/holiday plans
- Old stuff
- New stuff
- Money stuff (There's always money stuff)
- Something wonderful my family did for me
- Something wonderful I did for my family
- Questions/comments about anything that anyone needs or wants to talk about

5. Help each other resolve any issues. Remember that this is a bonding tool designed to teach as well as inspire everyone that being close as a family is the best thing for all concerned. Keep talking about things until everyone agrees or at least agrees that it's OK to disagree. Getting support and talking about choices will teach your children about fairness and about being a family. In areas where there have been difficulties, point them out gently and don't be punitive. This will encourage everyone to ask for help where he or she needs it. Remember that win-lose is the same as lose-lose when it comes to your family.

9. Consult a therapist when necessary. If you are having trouble navigating some of the deeper issues you might want to consider bringing in a professional or counselor. Therapy isn't just for families that are breaking up or having problems with conduct. Most families have moments of difficulty or confusion as well as problems with communication. Being comfortable with getting some advice when needed will make your life a whole lot easier.

Setting Goals

For many people setting a goal is a difficult task, especially if the goal includes several family members.

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: SMART Goals - Quick Overview

Duration: 3:57 min

Link: https://www.youtube.com/watch?v=1-SvuFIQjK8

Solutions to Issues & Obstacles

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: How to Create and Implement Effective Action Plans

Duration: 11:30 min

Link: https://www.youtube.com/watch?v=ztIYASw-tCc

The Family Needs to Meet

MEETING AGENDA

RE: "Family Meeting"

Location: Time:

1. Identify the stage and what was discovered in the most resent assessment.
2. Gain a consensus of the work that is needed for the next 4 months.
3. Review Family roles and current projects/tasks.
4. Use the Decision-Making Model for the family, what decisions are needed.
5. Review a list of known Critical Issues to consider.
6. Discuss action items that may be required soon.
7. Roles and Responsibilities Assignments, progress report.
8. Create a Plan of Action for the next 4 months.
9. Determine date for follow up meeting.

Family Decision Making Model

"15. Let the peace of Christ rule in your hearts, since as members of one body you were called to peace. And be thankful. 16. Let the message of Christ dwell among you richly as you teach and admonish one another with all wisdom through psalms, hymns, and songs from the Spirit, singing to God with gratitude in your hearts. 17. And whatever you do, whether in word or deed, do it all in the name of the Lord Jesus, giving thanks to God the Father through him." Colossians 3:15- 17New International Version (NIV)

PURPOSE: The purpose of a family meeting is multi-faceted. It can serve to communicate information regarding the loved one's situation, or the status of family members. The meeting can also be used to make critical decisions or to determine role responsibilities. In many cases it is all of these.

TASK: In order to make effective decisions as a group, an agreed upon process is important to ensure participation and success in making the best decision. As a family, you are tasked to make many decisions in the Substance Use Disorders journey. This model will provide a framework that when used will be helpful to gain the best insight to the problem, create a criteria of importance, consider the options and weigh the possible outcomes.

CONDITION: By gathering as a group to learn about the Substance Use Disorders disease and its related progression, and dementia behavior, the family has taken the first step in making strong decisions. The second step is to understand the stages and Substance abuse related behavior that will occur. In the final step by gathering as a family, review the family values, understand how to use a "Family Decision Model", assigning Roles and Responsibilities. Then set-up a strategy for the next few months. These are all great steps towards self-empowerment.

STANDARD: The standard is that each person will participate. The individual family member will take on an assigned role and be responsible to achieve that assignment in that role to their best ability. They will seek assistance when needed and give willingly when asked. Each family member will proactively be involved in decisions and communication with respect, dignity and a positive, "Can Do" attitude.

Identifying Your Family Values

Family Values

In Values, we find ourselves taking a stance on how we will follow a certain way towards making a decision. It is therefore important to understand the family values, prior to making critical decisions about the lives of our loved one.

Values (ethics)

From Wikipedia, the free encyclopedia

In ethics, values identify the degree of importance of some thing or action, with the aim of determining what actions are best to do or what way is best to live (normal ethical life), or to describe the significance of different actions. It may be described as treating actions themselves as abstract objects, putting value to them. It deals with right conduct and good life, in the sense that a highly, or at least relatively highly, valuable action may be regarded as ethically "good" (adjective sense), and an action of low in value, or somewhat relatively low in value, may be regarded as "bad.

What do you treasure the most that is without substitution for anything else? Write them down as individual family members.

1.

2.

3.

Now discuss them together as a family, each person stating what they feel are your family values. (note: there is no wrong answer).

Our Family Values Are:

1.

2.

3.

Combine Family Values with Decision Making Process

In Value Based Decision Making, we find ourselves taking a stance on how we will follow a certain way towards making a decision. It is therefore important to understand the family values, prior to making critical decisions about the lives of our loved one.

Practical Exercise # One: In a family meeting

Write down your top three values and those you feel are the families.

Each family member reads what they wrote down.

Where there were alike values, make a list.

Determine, which of this list are the top three values for your family? Open discussion

Write down which the family agrees are your families top three values. Prioritize them 1-3.

Our Family Values Are:

1.

2.

3.

Take the final list of the families top three values and use them in the “decision Making Model”

FAMILY DECISION MAKING MODEL

First Step: Identify Exactly What Happened

Practical Exercise # Three: What Happened?

Identify the details of the situation? (what happened, How did it happen, Who was involved?) What:
How:

_____
_____

Who:

_____
_____

Identify what you would have like to have happened?

_____
_____

Second Step: Analyzing the Situation

Every problem has a situation that surrounds it. Inside the situation is where you will find the solution to the problem. By analyzing the situation more closely, the solution will typically present itself. It will then be clarified and used in your decision-making process.

Exercise: We will take a look at the problem that impacts the situation. (what went wrong)

1 Assessing the Problem: (Describe exactly what is happening that is not working?)

_____
_____

2 Identify, what is causing this to happen?

_____
_____

3 In what areas did this create an impacting or disruption?

_____
_____

Third Step: What is the number one contributing factor?

_____
_____

Fourth Step: Gathering Information

_____
_____

It may seem unnecessary to have a segment that reviews "Gathering Information" however, this is a critical part of the decision-making process and can significantly impact the quality of your decision and its outcome.

There are three types of information to consider gathering:

1. The Primary Source information, the person it happened to, or from someone that was there.

2. The Secondary Source information, He Said She Said.

3. The Gut Feeling Source, no one person saw it happen, but I think this is what occurred.

All the above information types are reasonable to include in the decision-making model.

The Primary Source: Prepare a list of questions and then go to the primary source for answers. At times you may not know which questions are best to ask. So, research possible questions, then go ask them.

For Example: *If you are considering moving your loved one into a facility, go to the facility*

and take a tour. Do not just read their website, listen to someone else's opinion about the facility or telephone them for a few answers. You will need to go directly to them as they are the "primary source" of information. You should come with a prepared list of questions in order to have an accurate understanding of their facility.

The Secondary Source: This is also a good resource to consider using when making a decision. The Secondary source is valuable because it allows others to provide information about your search for answers. From Secondary Sources you may find other topics or questions that need to be considered.

There are two areas that you need to be aware of; 1. The source of the secondary information. Who are they, what authority do they speak from, why are they providing this information? 2. Is this information a direct correlation to the topic that you are researching. Be careful, sometimes in secondary search it becomes tempting to seek out information that proves your premises to be correct. That is called bias. We want to avoid being bias, just the facts please.

The Gut Feeling: This is a combination of your past experiences, your family upbringing, your spiritualty, and your cultural values and beliefs. They are all wrapped into one feeling of an emotional response. It should not be ignored, and rarely should it be the only information feedback that is used in making an informed "Values Based Decision".

Third Step: Identifying Reasonable Options

The process of identifying reasonable options can only come after you understand the problem, considered your values, reviewed some of the considerations and circumstances as you continue to gather more information.

Once you completed the information gathering phase of decision-making process, it is at this point when you will eliminate ideas that are not a good fit and consider only those ideas that will work best. Use your values when considering options, use prayer for guidance, let the Holy Spirit take charge and follow what you believe God would have you do. It is our will to do His will.

Practical Exercise # Four: What are the top three pieces of gathered information?

INFORMATION GATHERING

Gathered Information:

_____

_____

_____

Fifth Step: Criteria for Solution

Practical Exercise # Four: Does your solution qualify for consideration?

CRITICAL CRITERIA, final Review

1. Will this action ensure safety for your loved one?

_____
_____

2. Do you have the resources needed to complete these tasks?

_____
_____

3. Is your timetable realistic?

_____
_____

4. Do you understand the negative impact(s) your actions may create?

_____
_____

5. Would you want others to take this action on your behalf?

_____
_____

Sixth Step: Choose Best Solution

Practical Exercise # Five: Take your decision and place it here

Our decision is:

_____
_____
_____
_____
_____
_____

We will do the following:

_____
_____
_____
_____
_____

Our expected outcome is:

A book designed to help your family get organized and make quality decisions: It's Time to get Organized, in the Substance Use Disorders Journey. www.Amazon.com

Also, The Pathfinder Certification of Completion Seminar. This book contains the 12 key issue seminars pulled from the 32 learning seminars in the Family Solution Finder Study Guide and Workbook. These are essential for the family to learn.

Part IV

Create a Family Plan of Action

Seminar # 23

Roles and Responsibilities in the Family Plan of Action

Seminar Objectives:

1: Healthy vs. Unhealthy Characteristic,s Your family members will seek identify What Characteristics of both healthy and unhealth relations between members. This is the responsibility of each family member to determine what impact this will have on the family and their loved one?

2: Treatment Strategies for Family Members, Each family member will seek clarity as to if complicated parts of the journey. Finding the right therapist and using the correct therapy model is a joint effort between the therapist and family member. Become an educated consumer of mental health services, before it is needed.

3: Triangulation Relationships, Having family members who understand a standard way the family will relationships and should be to everyone's advantage. Learn and decide as a family how triangulation may present in some form within family members.

Issues the Family Faces

Practical Exercise One: Family Plan of Action, Issue Role Assignment and Responsibility Description

12 Key Issues	Role Assignment: Who.	Responsibility Description for this Role: Will do What.
Enabling		
Addiction Behavior		
Family Intervention		
Police Intervention		
Emergency Medical Services		
Legal Court Intervention		
Treatment Centers		
Community Mapping		
Relapse		
Successful Lifelong Recovery		
Bereavement		
Spirituality, Faith Practices		

To create a list of resources needed to successfully complete a task.

RESOURCE REQUIREMENT WORKSHEET

The required resource:

_____
_____
_____

The source of this resource:

_____
_____
_____

The steps or criteria for receiving the resource:

_____
_____
_____

The budget needed for this resource:

_____
_____
_____

The timeline for secure:

_____
_____
_____
_____

Who needs to be involved in this project:

1.
2.
3.

An Obstacle is the time it takes for a family to meet.

Triangles

A triangle is a three-person relationship system. It is considered the building block or "molecule" of larger emotional systems because a triangle is the smallest stable relationship system. A two-person system is unstable because it tolerates little tension before involving a third person. A triangle can contain much more tension without involving another person because the tension can shift around three relationships. If the tension is too high for one triangle to contain, it spreads to a series of "interlocking" triangles. Spreading the tension can stabilize a system, but nothing gets resolved.

People's actions in a triangle reflect their efforts to assure their emotional attachments to important others, their reactions to too much intensity in the attachments, and their taking sides in others' conflicts. Paradoxically, a triangle is more stable than a dyad, but a triangle creates an odd man out, which is a very difficult position for individuals to tolerate. Anxiety generated by anticipating being or by being the odd man out is a potent force in triangles.

The patterns in a triangle change with increasing tension. In calm periods, two people are comfortably close "insiders" and the third person is an uncomfortable "outsider." The insiders actively exclude the outsider, and the outsider works to get closer to one of them. Someone is always uncomfortable in a triangle and pushing for change. The insiders solidify their bond by choosing each other in preference to the less desirable outsider. When someone chooses another person over oneself, it arouses particularly intense feelings of rejection.

If mild to moderate tension develops between the insiders, the most uncomfortable one will move closer to the outsider. One of the original insiders now becomes the new outsider and the original outsider is now an insider. The new outsider will make predictable moves to restore

closeness with one of the insiders. At moderate tension levels, triangles usually have one side in conflict and two harmonious sides. The conflict is not inherent in the relationship in which it exists but reflects the overall functioning of the triangle.

At a high level of tension, the outside position becomes the most desirable. If severe conflict erupts between the insiders, one insider opts for the outside position by getting the current outsider fighting with the other insider. If the maneuvering insider is successful, he gains the more comfortable position of watching the other two people fight. When the tension and conflict subside, the outsider will try to regain an inside position.

Triangles contribute significantly to the development of clinical problems. For example, getting pushed from an inside to an outside position can trigger a depression or perhaps even a physical illness, or two parents intensely focusing on what is wrong with a child can trigger serious rebellion in the child.

NUCLEAR FAMILY TRIANGULATION SCALE FOR CHILDREN

For each of the questions, please choose one of the following answers that

best describes your family. There are no right or wrong answers.

(0) never (1) rarely (2) sometimes (3) often (4) very often

____1. When your parents disagree, how often do you feel “caught in the middle”

between them?

____2. How often does your mother “butt in” to disagreements between you and

your father?

____3. Do you ever do things to try to keep your parents apart?

____4. Does your father share secrets with you that he doesn’t share with your mother?

____5. Do your parents ever try to involve you in their fights or problems?

____6. Do you ever think that your father would rather spend time with you than with your mother?

____7. When your parents are fighting or are unhappy with each other, do you tend to misbehave?

____8. How often do you feel the need to take sides when your parents disagree?

____9. When you are spending time with both of your parents, do you wish your father would not be there?

____10. Do you find it difficult to feel close to both of your parents at the same time?

____11. Do you ever feel that your mother cares more about you than she cares about your father?

____12. Do you feel your parents need your help in order to get along with each other?

____13. How often are your parents' discussions about you?

____14. When your parents are fighting or are unhappy with each other, do you tend to get sick (stomach aches, headaches, etc.)?

____15. Do you ever think that your mother would rather spend time with you than with your father?

____16. How often does your father "butt in" to disagreements between you and your mother?

____17. Is it ever difficult to feel friendly toward both of your parents at the same time?

____18. Does your mother share secrets with you that she doesn't share with your father?

____19. Do you try to solve your parents' problems when they are not getting along with each other?

____20. Do you ever feel that your father cares more about you than he cares about your mother?

____21. When you are spending time with both of your parents, do you wish your mother would not be there?

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: authors. Beck, A.T., Emery, G., & Greenberg, R.L. (1985). Anxiety disorders and phobias: A cognitive perspective. USA: Basic Books. Black, B. (1995). Separation anxiety disorder and panic disorder. In J.S. March (Ed.), Anxiety disorders in Children and Adolescents (pp. 212-234). New York: The Guilford Press. Bowen, M. (1978). Family therapy in clinical practice. New Jersey: Jason Aronson. Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. USA: Basic Books. Bray, J.H., Harvey, D.M., & Williamson, D.S. (1987). Intergenerational family relationships: An evaluation of theory and measurement. Psychotherapy 24(35): 516-529. Compton, S.N., Nelson, A.H., & March, J.S. (2000). Social phobia and separation anxiety symptoms in community and clinical samples of children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry 39(8): 1040-1046. Guerin, P.J., Fogarty, T.F., Fay, L.F., & Kautto J.G. (1996). Working with relationship triangles: The one-two-three of psychotherapy. New York: The Guilford Press. Jellinek, M.S., & Kearns, M.E. (1995). Separation anxiety. Pediatrics in Review 16(2): 57-61. Johnson, P., & Nelson, M.D. (1998). Parental divorce, family

Solutions to Issues & Obstacles

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Family Roles in Addiction

Families for Depression Awareness

Duration: 51.52 min

Link: https://www.youtube.com/watch?v=VdvDa4j-ZX8&t=16s

FAMILY PLAN OF ACTION

The Issue: _____

CURRENT SITUATION

Describe what has happened or is likely to happen:

_____
_____
_____
_____
_____

COMPLETE A FAMILY TRANSFORMATIONAL RESPONSE (F.T.R.)

State the Solution from the F.T.R. worksheet:

_____
_____
_____
_____

COMPLETE A FAMILY DECISION MAKING MODEL

State the Decision to be Acted Upon from the Family Decision Making Model:

_____
_____
_____

Part IV

Create a Family Plan of Action

Seminar # 24

"Getting Networked in Advance "

Seminar Objective:

1. Getting Organized Your family members will seek identify what the past 32 seminars and place the Responding to a Family Issue completed worksheet in the respective numbered tab for each seminar.

2. Getting Networked Each family member will seek the M.O.R.E. Card worksheet for each of the 32 seminars and place them into the respective numbered tab for each seminar.

3. Create a Binder System Your family members will purchase the supplies to create a tabbed binder system for both the It's Time to Get Organized and It's Time to Get Networked Binders.

The Seminar Goals:

1. The attendee will be able to name the four (4) domain parts in the family system.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. Using the "Functionality & Potentiality Worksheet", the attendee will be able to provide their understanding of each family members role in working to meet a desired family outcome.

Issues facing the family

The best way to approach building a network in advance of when you will need it, is to consider what is likely to happen, how will you respond to what is happening and who is here to help your family in addressing this issue.

Family Evaluation Card

CATEGORY	**Website**	**Point of Contact Name and Phone** **Email address**	**Required Admission Criteria**	**Date to connect with this group**
Behavior Health Therapist for Family Members				
Attorney's list for Drug Court				
Peer to Peer Organizations				
Treatment Center's				
Department of Human Health and Services (Foster Care) Point of Contact				
Food Bank				
Woman's Rape and Suicide Center				
OTHER:				

Obstacles is the time to set up

There are three primary obstacles the family will face when creating their family referral network. These include:

1. Determining the issue and response
2. Finding those who will help, the right organization and right level of services
3. Determining what about this group needs to be known and what needs to be prepared in advance.

Solution to the Issues and Obstacles

Creating an Evaluation Card

Creating an evaluation card is the second step in building a family referral model. To do this the family will want to consider the 32 key issues and design a referral resources from within their church, school system, city and local community services which will best meet the needs of a family when they are addressing that issue. For an evaluation to be thorough, several areas will need to be takin into consideration.

Pre-Evaluation to address an issue

CATEGORY	YES	NO	Date completed	Coordinated within the organization?
Did you complete an F.T.R. worksheet for this issue?				
Have you discussed the F.T.R. solution with the family members?				
Have you determined your timeline for completing each task?				
Have you reviewed this issue with your Pathfinder Guide?				
Do you have a list of potential obstacles?				

Are there organization which have already been used with satisfaction?				
Do you have recommendations from others?				

In this section the family will create the list of organizations, reference which issue this group will assist the family in addressing, and obtain the organizations contact information. These Categories apply to what do you might consider, the family will need to generate their own list.

Create a Family Referral Network List

CATEGORY	**ISSUES**	**1st Organization**	**2nd Organization**	**Date included to the family referral network**
Family Therapy	Enabling, the family system			
Medical Diagnosis	Emergency Medical Services			
Mental Health Diagnosis				
Addiction Diagnosis				
Detox and Treatment	Treatment Centers			

Peer to Peer Coaching	Successful Lifelong recovery			
M.A.T.	The Relapse			
Drug Court or Jail	The Legal Court System			
Employment and housing	Jobs and Family Services			
Foster Care	Foster Care Services in SUD			
Developing Support	Create a Family Solution Finder Learning Center			

Family Plan of Action

The family will follow through with these next steps:

A Pre-Evaluation Card will be completed.

1. Family Referral Network Worksheet will be completed.
2. Organizations will be reviewed on site to determine the correctness of their fit in the family referral network.

And if you think that financial problems end when an addict is in recovery, you're mistaken: 72% of the survey respondents said no matter how well someone manages money during their addiction, managing money during recovery is even harder.

"Treatment is extraordinarily expensive, and it often takes a couple of tries," said Kai Stinchcombe, True Link's founder. Stinchcombe has a family member who has dealt with substance abuse issues. "It was emotionally fraught for us," he said.

Part V

Other Possible Situation

Seminar #25

"Suicide Prevention"

Seminar Objectives:

1. The attendee will be able to name the four (4) domain parts in the family system.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. Using the "Functionality & Potentiality Worksheet", the attendee will be able to provide their understanding of each family members role in working to meet a desired family outcome.

Issues a family face

Worried about Suicide? Learn the Facts

Are you concerned that someone you know may be at risk for suicide? Your first step in helping may be as

simple as learning the FACTS or warning signs. The following signs may mean that a youth is at risk for

suicide, particularly if that person attempted suicide in the past.

FEELINGS

- Expressing hopelessness about the future.

ACTIONS

- Displaying severe/overwhelming pain or distress.

CHANGES

- Showing worrisome behavioral cues or marked changes in

behavior, including withdrawal from friends or changes in

social activities; anger or hostility; or changes in sleep.

THREATS

- Talking about, writing about, or making plans for suicide.

SITUATIONS

- Experiencing stressful situations including those that

involve loss, change, create personal humiliation, or involve

getting into trouble at home, in school or with the law. These

kinds of situations can serve as triggers for suicide.

Suicide is a preventable problem.

By taking the time to notice and reach out to a peer, you can be the beginning of a positive solution.

Don't Forget - Youth Suicide Prevention is Everyone's Business!

If you notice any of these warning signs, you can help!

---

1. Express your concern about what you are observing in their behavior

2. Ask directly about suicide

3. Encourage them to call the National Suicide Prevention Lifeline at 800-273-TALK (8255)

4. Involve an adult they trust

Remember, if you have IMMEDIATE concern about someone's safety, call 911 right away!

Obstacles a family is likely to face

Should I talk to my child about suicide?

A lot of people get confused by this. Just like you would want to talk about drug or alcohol use with your child, it's important to address the issues of suicide. It's a myth that talking about suicide can plant the idea in someone's mind. Kids hear about suicide from a variety of sources and this is nothing new to them. In fact, talking about it can be a real relief. It's like having a secret you feel no one will want to hear; once you can talk about and expose it to reality, you have a much better chance of figuring out what to do about it.

School counselor suggested mental health counseling.

Usually school counselors base these kinds of referrals on their professional experience. This recommendation was most likely developed in response to concerns from your child's teachers or a conversation the counselor had directly with your child. First, talk to the counselor to find out why she's concerned. Try not to be defensive. Remember that the school is obviously concerned that something you may not be aware of is going on and that your child may benefit from professional help.

It's important for you to understand why the counselor is making this referral because you'll need this information when you speak with a mental health professional. Most mental health agencies will have releases you can sign that give them permission to talk with the school directly. The school's input can be critical to make sure that your child gets the services needed. It may be helpful to know that those releases only go one way. What that means is that the school has permission to share information with the counselor, but unless you specify, the counselor does not have permission to share information with the school.

Solutions to Issues and Obstacles

Suicide can happen… it's a real danger for adolescents. It is important to educate yourself about the things that may signal your child could be at risk. A good way to organize your thinking about youth suicide's warning signs is the acronym FACTS:

F-stands for feelings. Feelings of hopelessness, anger, worthlessness, emptiness, anxiousness, or excessive worry are examples of feelings that should really concern us. Talking about being a burden on the family or being trapped in a horrible place from which they can't escape should also get our attention.

A-indicates actions. Actions include things like trying to get access to a gun or pills, risky or dangerous behaviors, increasing drug or alcohol use, or getting into fights. Bulling someone else or being bullied are also actions of concern. Self-harm behaviors also fit into this category as do looking online for ways to die or hurt one's self. Your child may suddenly stop going to school or ask to leave school early. Schools have told us that some of the actions they pay attention to during the school day are frequent visits to the school nurse or to the restroom, and problems at lunch or in the cafeteria.

C-indicates changes in moods, attitudes or behaviors. For example, kids who were active may

become withdrawn, quit athletic teams, stop paying attention to personal appearance, daydream more, or start to cut class. It would be impossible to list all the potential behaviors you might see… so concentrating on simply recognizing changes in your child's behaviors, from as little as two weeks ago, is the real key.

T-shows that some kids "Talk" about suicide or actually make "Threats. These can be specific verbal statements, like "I don't want to live anymore" or "I'm thinking of killing myself" or worrisome innuendos in text messages, blogs, or school assignments. When these statements or messages aren't in sync developmentally with your child's peers, you may want to explore their meaning. For example, for a 7-year-old to be preoccupied with bombs and superheroes is developmentally appropriate; if a 12-year-old shares those same preoccupations, you would be wise to see what's going on. Whether the statements are specific or vague, what these threats tell us is that a child is thinking about death or suicide – and that's why we need to be concerned.

S-refers to "Situations" that may serve as triggers for a suicide or suicide attempt. These are situations where your child's coping skills are really challenged… and he or she may not think they have a way out. These can include circumstances like getting into trouble at home, in school, or experiencing the loss of something or someone important like a death, the end of a relationship or something less concrete like the loss of a hope or a dream. Some children are very undone by changes in their environment. Being exposed to the death of a peer or a role model is also a situation you want to talk about. (You'll find a handout under the 'parent tab' that can give you some help with that conversation.)

Scales for Assessing Suicide

See also: Assessment of suicide risk § In practice

- Beck Scale for Suicide Ideation
- Nurses' Global Assessment of Suicide Risk
- Suicidal Affect–Behavior–Cognition Scale (SABCS)[9]
- Columbia Suicide Severity Rating Scale

We strongly recommend visiting this site: https://www.sptsusa.org/not-my-kid/

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Suicide Assessment of Client with Initially Subtle Warning Signs of Suicide

Duration: 22:01 min

Link: https://www.youtube.com/watch?v=P2a9102jifM

Part V

Other Possible

Seminar # 26

"Financial Management in the Substance Use Disorder Journey"

Seminar Objectives:

1. What you have to financial manage, Your family members will seek to identify their own level contributing to the financial management challenges to be faced in each issue of the SUD Journey.

2. Create an Expanse Budget for each issue, Each issue is likely to have an expense of some type to the family. Determine in advance what that expense will possible amount to and complete the Budgeting Aligned with the Key Issues in the SUD Journey. .

3. Identify where are the financial support services, Your family members will purchase the on line training or attend the half day seminar. It's Time to Get Organized and It's Time to Get Networked Binders.

Practical Exercise One:

Insurance your policy allow coverage for:

- **Inpatient care in an approved facility:**
    1. **Outline plan benefits.**
    2. **Identify Cost, out of pocket.**
    3. **Are their treatment limitations in time?**
    4. **Are their treatment limitations in dollars charged to health plan?**
- **Outpatient care with an approved provider:**
    1. **Outline plan benefits.**
    2. **Identify Cost, out of pocket.**
    3. **Are their treatment limitations in time?**
    4. **Are their treatment limitations in dollars charged to health plan?**
- **Medical detox, including medications:**
    1. **Outline plan benefits.**
    2. **Identify Cost, out of pocket.**
    3. **Are their treatment limitations in time?**
    4. **Are their treatment limitations in dollars charged to health plan?**
- **Co-occurring mental health conditions:**
    1. **Outline plan benefits.**
    2. **Identify Cost, out of pocket.**
    3. **Are their treatment limitations in time?**
    4. **Are their treatment limitations in dollars charged to health plan?**
- **Follow-up counseling:**
    1. **Outline plan benefits.**
    2. **Identify Cost, out of pocket.**
    3. **Are their treatment limitations in time?**

4. **Are their treatment limitations in dollars charged to health plan?**

- **Maintenance medication**

1. **Outline plan benefits.**
2. **Identify Cost, out of pocket.**
3. **Are their treatment limitations in time?**
4. **Are their treatment limitations in dollars charged to health plan?**

There are other costs for the family to budget:

- **Legal fee's are expensive:**

1. **Down Deposit**
2. **Other expenses, labs, testing, etc.**
3. **Other legal cost such as court fee's, filing fee's, etc.**

- **Housing costs, if shared.**
- **Transportation costs, if shared.**

Other Expenses related to long term recovery:

- **Entertainment of a responsible type.**
- **Recreation and physical fitness of a reasonable type.**
- **Diet requirements sometime cost more to eat healthy.**
- **Attending social events supportive of recovery.**

Other Medical Diagnosis related to substance use disorders, have costs:

- **Diabetes**
- **Cardiac**
- **Pulmonary (respiratory)**
- **Allergies**

Soft Expenses:

- **Caregivers lost time at work..**
- **Caregivers lost commission wages if on commission salary.**

- **Caregivers medical and mental health costs related to stress from substance use disorders in the family.**

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: How Much Does Addiction Treatment Cost? Does Insurance Pay For rehab?

Duration: 9:56 min Link: https://www.youtube.com/watch?v=7KMejQtjm3s

Family Plan of Action

USING THESE TWO WORKBOOKS:

The Substance Use Disorder Journey, It's Time to Get Organized

The Substance Use Disorder Journey, It's Time to Get Networked Binders

1. Using the "Lets Get Organized Workbook, Your family members identify their own level contributing to the financial management challenges to be faced in each issues of the SUD Journey.

2. Using the "Let's Get Organized Workbook, Your family members will create their Expanse Budget for each issue, Each issue is likely to have an expense of some type to the family. Determine in advance what that expense will possible amount to and complete the Budgeting Aligned with the Key Issues in the SUD Journey. What we want to achieve is that everyone consider the cost of the disease by the segments of issues that might occur and therefore be ready to help with the financial burden if needed.

3. Using the Let's Get Networked Workbook, Your family will Identify where are the financial support services,

Part V

Other Possible Situations

Seminar # 27

"Foster Care Services in Substance Use Disorder"

The Seminar Goals:

1. The attendee will be able to name the eight (8) Criteria point for reunification.

2. Create a plan in how they will work with the case worker on each of the eight points.

3. Have a working understanding of the Family Level and Child Level factors involved with reunification.

Introduction

Parental substance use is particularly relevant to child welfare as children whose parents misuse or abuse substances are disproportionately the victims of neglect or abuse, which may lead to placement in a foster home (Christoffersen & Soothill, 2003; Cunningham & Finlay, 2013; De Bortoli, Coles, & Dolan, 2013; Dunn et al., 2002; Young, Boles, & Otero, 2007).

Further, parental substance use has been linked to other poor outcomes including lower probability of reunifying with a caregiver (Courtney & Hook, 2012),

As one strategy for addressing parental substance use for families involved with child welfare, most states have implemented family drug treatment courts (FDTCs) (American University School of Public Affairs, 2012). Evidence from prior studies suggests that children of adults who enroll in FDTCs spend less time in foster care and experience higher rates of reunification with parents than children of similar adults not enrolled in FDTCs (Bruns, Pullmann, Weathers, Wirschem, & Murphy, 2012; Chuang et al., 2012;

Understand Their Criteria, then meet it

These are a set of criteria used by some Foster Care Agencies. They have goals, your goal is to help them meet their goal. To work in the opposite direction will ensure failure.

1. **Because they are:** Examining multiple interrelated factors that influence your child's neglect

   You will want to: Know exactly what those factors are, take steps to improve them. Work with your case manager on each issue. You will want them to record where you start from, what you will do to correct it, on record how these steps created a measurable change. The change is recorded and is satisfactory to them.

2. **Because they will:** Identify the parents' (your) needs.

   You will want to: Know what they are recording as your needs. Then make a plan with your case working to take steps in fulfilling those needs. Typically, these are critical needs they want to see in place before reunification.

3. **Because they will:** Identify stressors that contribute to difficulty.

   You will want to: Know what the recorded stressors for their list. Then make a plan with your case working to work on resolving these stressors. Be sure as each is resolved it gets recorded in you record to their satisfaction.

4. **Because they will: Identify your existing strengths and resilience of parents.**

   You will want to: Have them list for you these strengths and create a plan in how to make them stronger. Make sure your starting point is recorded and the follow up progress review is recorded.

   Allow them to set up longer periods of contact when meeting with you.

   Accept their educating you about the culture of the child welfare system, ask good questions.

   Be clear about their expectations for the you. Ask for clarification, it shows you care.

   State you appreciate their empathy when they give it.

   Allow hope by you when interacting with them

   Let them know you see this as a partnerships, you as the parent with them as an agency who is trying to help.

5. **They will always be evaluating you with a "Needs Assessment" tool.**

   a. Be aware of how they assess your and the families strengths and needs

   b. Ask for a copy of the blank standardized assessment tool they are using

   c. They are focused on the three domains of parenting influences: (Ask them to review with you)

      i. Developmental history

      ii. Child characteristics

      iii. Sources of stress and support

6. **They will be reviewing progress in goal setting**

   Develop and set goals with them that are tailored to the unique strengths and needs that were identified

   in the need's assessment process,

   Identify smaller goals with them that may be achieved in the process of reaching the larger end goal

   in order to instill hope and empowerment in families.

7. **They will measure "Assessment of Progress" (this is very important)**

   Ask them to review with you their assess of progress.

   Understand the baseline measurement of the problem area (where you started) and review with them their notes on progress made when taken as a daily or weekly assessment. This is how your progress gets recorded

8. **Goal achievement**

   Utilize individual or team of child welfare workers to determine if the outlined goals have been achieved and if reuniting the child and family is appropriate.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Children of Addicted Parents

Duration: 28:59 min

Link: https://www.youtube.com/watch?v=2Ajuw8YImIM

Part V

Other Possible Situations

Seminar # 28

NARCAN Intervention(s)

Seminar Objectives:

1. The attendee will be able to name the four (4) domain parts in the family system.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. Using the "Functionality & Potentiality Worksheet", the attendee will be able to provide their understanding of each family members role in working to meet a desired family outcome.

Introduction

Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

A doctor can prescribe naloxone to patients who are in medication-assisted treatment (MAT), especially if the patient is taking medications used in MAT or considered a risk for opioid overdose. Candidates for naloxone are those who:

- Take high doses of opioids for long-term management of chronic pain
- Receive rotating opioid medication regimens
- Have been discharged from emergency medical care following opioid poisoning or intoxication
- Take certain extended-release or long-acting opioid medications
- Are completing mandatory opioid detoxification or abstinence programs
- Pregnant women can be safely given naloxone in limited doses under the supervision of a doctor.
- A doctor or pharmacist can show patients, their family members, or caregivers how to administer naloxone. Intravenous injection every two to three minutes is recommended in emergencies.
- Patients given an automatic injection device or nasal spray should keep the item available at all times. Medication should be replaced when the expiration date passes.
- Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. It is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines. SAMHSA Naloxone

Responding to Opioid Overdose

Some trainers/educators find the SAVE ME acronym helpful for teaching the steps involved in

responding to an opioid overdose. Instruction on how to recognize and respond to overdose

can be found on the insert inside the naloxone kit. The steps involved in responding to an

opioid overdose will now be described in greater detail.

Stimulate: If Unresponsive call 911

If you suspect someone is having an opioid overdose, start by stimulating them to confirm that

they are unresponsive. Shout at them – use their name if you know it. Next do a sternal rub (make a fist and rub your knuckles along the person's breast bone). You should always tell

someone what you are going to do before you touch them. If the person does not respond to sound or pain, then it is a medical emergency.

Calling 911 (or your local emergency response number)

If you are alone, you can put the phone on speaker. 911 dispatchers will walk you through the

steps of managing an overdose – including how to perform CPR. The Good Samaritan Drug

Overdose Act protects people who experience or witness an overdose and call 911 for help.

The Act provides immunity from charges for simple drug possession, breach of parole, pre-trial

release and conditional sentences. The Act does not protect those involved in drug trafficking,

drug production, or those with outstanding warrants.

Airway

Next, check the person's mouth for any obstructions. Items like gum, dentures, or a syringe cap could be preventing the person from breathing properly. Remove any obstructions. Once you've confirmed the mouth is clear, tilt the person's head back – this opens their airway.

Ventilate: Rescue Breathing

The next step is to breathe for the person. Opioid overdoses slow

breathing decreasing oxygen to the brain. By doing rescue breathing

throughout the overdose response, you help keep oxygen going to the

person's brain until the naloxone takes effect. A mask is available in the Take Home Naloxone kit to provide a barrier – you can use a piece of clothing instead if you do not have a mask. To give breaths, keep the person's head tilted back, pinch their nose, and give them 2 normal

sized breaths. You should be able to see their chest rise with each breath.

Evaluate

Sometimes giving a few breaths is enough for the person to regain consciousness. If they are

still unresponsive, it is time to give naloxone if you have it. If they are barely breathing (less

than 1 breath every 5 seconds) or not breathing, you should commence CPR. If you do not have

naloxone, you may still save the life of someone who has overdosed on opioids with CPR and

calling 911 if the overdose was very recent. You should give chest compressions and rescue breaths until first responders arrive [cycles of 30 compressions: 2 breaths]. 911 will instruct you how to give CPR.

Chest Compressions: To give chest compressions, place the heel of one hand on

the breast bone in the center of the chest between the nipples, place your other hand on top of the first hand, push hard and fast 30 times, about 2 inches deep, and let the chest come all the way up between pumps. If there is an Automated External Defibrillator (AED) nearby it should be used. The AED can tell if the person's heart is still beating, and can shock the heart if required. If you do not have naloxone, you may still save the life of someone who has overdosed on opioids if the overdose was very recent.

Stimulate to confirm they are not responsive, and call 911.

- Check their airway, and provide CPR [30 chest compressions: 2 breaths] until first responders arrive. Breaths are crucial in an overdose response. Oxygen keeps the brain alive.
- Monitor the person for 3-5 minutes (7 cycles of CPR) after each dose is given. If the person does
- not regain consciousness, repeat the same process with a 3rd dose of naloxone, and continue
- with further doses (if available) until you run out of Naloxone.
- Most overdoses will be reversed with one or two doses of naloxone, but occasionally a very strong overdose may require more naloxone than is in the kit. Overdoses that are not caused by opioids will not respond to naloxone. Calling 911 is important for these reasons.

While naloxone is a safe medication, individuals that are dependent on opioids may experience

unpleasant withdrawal symptoms like pain, sweating, agitation and irritability. For this reason, it is important to give the lowest dose of naloxone required to reverse the overdose.

The Recovery Position

If you have to leave an unconscious/unresponsive person at any point, put them in the recovery position. This helps to keep the airway clear from their tongue or vomit allowing them to breathe properly. During an opioid overdose, slowed breathing can cause the lungs to fill up with excess fluid – if you are not actively working on an individual (giving CPR or administering naloxone) put them in the recovery position.

To put someone in the recovery position, hold the leg and arm on the side of their body closest to you and roll them away from you. In the picture above it is the right leg and the right arm that get bent.

Aftercare

It is important to stay with someone who has overdosed after giving naloxone because:

- When the person wakes up they may have no memory of overdosing or receiving naloxone – gently explain to them what happened
- The person may experience withdrawal symptoms and want to take more drugs. The person should be discouraged from using more opioids or other drugs for at least 2 hours. Symptoms of withdrawal sickness will start to wear off in half an hour. Using more opioids will be a “waste”. While naloxone is in their system it blocks opioids from getting to receptors and they will continue to feel sick; using more opioids will also make the overdose more likely to return
- It is helpful to be there to tell the emergency response team as much as you know – what drugs the person took, and what actions you have taken so far

Responding to a non-opioid depressant overdose

Non-opioid depressant overdoses (e.g. Xanax, alcohol, GHB) look like opioid overdoses (since

opioids also act as depressants). If you are certain that someone has not taken opioids, support

the person similarly to an opioid overdose without the administration of naloxone. In other

words, call 911 or your local emergency number and provide CPR. Naloxone has no effect on

depressant overdoses that do not involve opioids. However, if the overdose involves multiple

substances including opioids, it will temporarily take opioids out of the picture and if opioids are not involved, administering naloxone will not be harmful (it will have no effect).

Training Manual: Overdose Prevention, Recognition and Response 14

Chest Compressions and Rescue Breathing:

Most overdose response programs recommend giving rescue breaths in an opioid overdose

because opioids affect breathing first. If a person stops breathing, the heart will eventually stop.

Therefore, getting oxygen into the body is the first priority (rescue breathing) but circulating

that oxygen through the body (chest compressions) is also necessary. In an overdose that is

potentially fatal, the best way to prevent death is to provide chest compressions and rescue

breathing, in addition to naloxone. For these reasons, this training manual introduces rescue

breathing and chest compressions as part of a comprehensive response to opioid overdose.

Videos Recommended

Watch any or all of the following instructional videos to review the content covered in this

manual. Please note that chest compressions may not be included in the overdose response

steps covered in these videos:

- Naloxone Saves Lives (12:49 min) https://vimeo.com/164669763
- Naloxone Wakes You Up (youth focused) (6:29 min) https://vimeo.com/180116125
- SAVE ME Steps to Save a Life (3:21 min) https://vimeo.com/185012011

Introduction to the Manitoba Take-Home Naloxone Program

The Manitoba Take-Home Naloxone kits contain:

- Instruction sheet (French and English)
- Alcohol Swabs
- Gloves and a breathing mask to protect the

Let's start with a video, this will speed up your learning several areas when administering Nalozone.

Acknowledgements: The above training tip was adapted from the Toward the Heart Training Manual (www.towardtheheart.com) from the British Columbia Centre for Disease Control. Updated: July 2017 Manitoba Health, Seniors and Active Living Population Health and Health Equity

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Administering Naloxone

Duration: 11:27 min

Link: https://www.youtube.com/watch?v=nurz9qPGKws

Part V

Other Possible Situations

Seminar # 29

"Peer to Peer Service's"

Seminar Objectives:

1. What is Peer to Peer Services, Your family members will seek to identify their own level of functionality in regards to addressing the involvement of peer to peer services by first understanding what this service includes.

2. How Peer to Peer Service works, Understanding what the specialist will be doing, what they are not doing and how it will be done.

3. What are the Expectations of Peer to Peer Services, Because they will be working together each week the family will need to understand to to expect from this service and what not to expect.

The Seminar Goals:

1. The attendee will be able to name the four (4) domain parts in the family system.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. Using the "Functionality & Potentiality Worksheet", the attendee will be able to provide their understanding of each family members role in working to meet a desired family outcome.

Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Type of Support Description Peer Support Service

The Peer Support Specialist will:

Emotional Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.

Conduct Peer Mentoring: Peer-led support groups.

Informational Relationships: Share knowledge and information and/or provide life assistance in getting to vocational skills training.

Parenting class and Job readiness training.

Wellness seminar is instrumental in recovery.

Provide concrete assistance to help others accomplish tasks.

Child care and Transportation Help to access community health and social services

Affiliationally Facilitate: contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.

Attend recovery centers sports league participation Alcohol- and drug-free socialization opportunities.

Mental Health Diagnosis with Addiction:

Mental health treatment and addiction treatment have historically and continue to be separated systems of care. While many research studies have been performed on mental health and addictions separately, it has only been within recent years that studies have emerged on people who struggle with both conditions in tandem. This emerging research identifies that traditional separated systems of care not only alienate the consumer from treatment, but they also result in much poorer outcomes that those experienced by people with single disorders. More surprising, we are now learning from these studies that programs predominantly designed to treat a specific disorder are actually only capable of treating the minority of those in need where, In fact, up to 65.5% of people with a substance dependence disorder had at least one mental disorder and 51% of people with a mental disorder had at least one substance abuse disorder. A physician prescription is required.

TO MAKE A REFERRAL FOR PEER TO PEER SERVICES

Referral Source Information: Peer to Peer requires a doctors referral.

- Name
- Organization
- Phone of person making referral
- Email of person making referral

Patient Information:

- Name
- Date of Birth
- Gender
- Patient Home Phone
- Patient Cell Phone
- Address:
- County
- **SSN # :**
- **Insurance Provider:**
- **Policy Number:**
- **MMIS Number**

Diagnosis Information:

- Does patient have a substance use disorder?

Substance use diagnosis (ICD-10 #)

Patient Uses what type of drugs or substance?

Has client had previous criminal justice involvement?

- Type of Court
- Probation Officer

Does patient have a history of mental illness?

- Mental Health Disagnosis (ICD-10 DMS-5 #)

How much Peer Support is being requested (hrs per week)

As peer supporters, one of our most important jobs is to focus on the whole person first. Our unique ability to connect and develop relationships with people, seeing more than the diagnoses or stigmatizing labels, allows us to guide people to reconnect with their own abilities, strengths, talents, and lessons learned from their own stories of survival.

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: 2/7/2019 Addiction Recovery Channel - Emergency Department Peer Recovery Coaching Program

Duration: 30:11 min

Link: https://www.youtube.com/watch?v=k5Jdxz9_OZs

Part V

Other Possible Situations

Seminar # 30

"Medical Assisted Treatments (M.A.T.)"

The Seminar Goals:

1. The attendee will be able to name the four (4) domain parts in the family system.

2. The attendee will be able to identify how the degree of functionality and potentiality of each family member will impact the outcome of dealing with a family issue.

3. Using the "Functionality & Potentiality Worksheet", the attendee will be able to provide their understanding of each family members role in working to meet a desired family outcome.

Introduction

There are two phases to a NARCAN event, the administration of NARCAN and the Quick Response Team follow up in the days to follow. One should always come with the other.

Introduction The National Institute on Drug Abuse (NIDA) endorses medication in treating substance use disorders, and especially combining it with counseling and other behavioral therapies.

Medications that have emerged in recent decades have transformed lives. Ongoing research efforts are testing additional medications that show promise for treating alcohol and cocaine addiction. The National Quality Forum has developed consensus standards for addressing substance use illnesses.

Four of the eleven standards focus on the use of medications. Specifically, they state that everyone receiving detoxification or treatment for opiate, alcohol, or nicotine dependency should be offered medications. “Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment,” a report issued by the Institute of Medicine in 1998, discusses the gap between what scientific research has found to be effective treatment for substance use disorders and the type of care delivered in substance-abuse treatment settings.

Since then, NIDA and SAMHSA have been working to bridge the gap identified in the report. Source: Doug Denton, Executive Director, Homeward Bound, Dallas Texas Substance Abuse Treatment Case Management Wrap-around Services Aftercare and Peer Support 12-step Program and Sponsor Physical Health Assessment Treatment Follow-up Mental Health Evaluation Counseling Case Management Addiction Medication Physical Health Medications Mental Health Medication Element.

ELEMENTS OF SUCCESSFUL RECOV ERY

1. Addiction Medication Physical Health Medications Mental Health Medication
2. Substance Abuse Treatment Case Management Wrap-around Services Aftercare and Peer Support 12-step Program and Sponsor
3. Physical Health Assessment Treatment Follow-up
4. Mental Health Evaluation Counseling Case Management

Categories of mental illnesses include: Dual Diagnosis

- Anxiety disorders: General anxiety disorder, panic disorders, specific phobias, social phobia, and post-traumatic stress disorder all fall into this category.
- Depression: Major depression, dysthymic disorder, clinical depression, postpartum depression, and unipolar depression are all forms of depressive disorders.

- Bipolar disorder: There are three primary forms of bipolar disorder – bipolar disorder I, II, and cyclothymic disorder. However, the DSM-5 also recognizes unspecified bipolar disorder, and many clinical psychologists are debating the place of seasonal affective disorder, which is a mood disorder like both depression and bipolar disorders.

- Personality disorders: These disorders involve a rigid, uncompromising view of the world and the inability to deal socially with others. These include:

- Cluster A: schizoid personality disorder, paranoid personality disorder, and schizotypal personality disorder

- Cluster B: antisocial personality disorder, borderline personality disorder, and narcissistic personality disorder

- Cluster C: avoidant personality disorder, dependent personality disorder, and obsessive-compulsive disorder

- Psychotic disorders: This is a broader, vaguer category for mental health compared to other listed mental illnesses, and they are primarily characterized by psychotic episodes. Some conditions that fall under psychotic disorders include postpartum psychosis, schizoaffective disorder, and schizophrenia.

Medical Impact to the Body:

Using cocaine can damage the heart's smallest vessels, but this problem doesn't show up on routine medical tests, according to a new study. "We see many emergency room admissions because patients experience chest pain following cocaine use," said study researcher Dr. Varun Kumar, an internist at Mount Sinai Hospital in Chicago.

EXAMPLE OF FAMILY RECORD KEEPER: MEDCIAL ASSISTED TREATMENTS

Category	Product/Strength	Frequency/Date Started	Contra Indications	Titration Required
Mental Health Diagnosis: Anxiety	**Xanax**	**PRN** **2/2/2020**	**Yes, see prescribing information.**	**Yes**
Medical Diagnosis: Diabetes				
Addiction Diagnosis: **Methamphetamine**			**Yes, see prescribing information**	**Yes**
Other				

YOUR FAMILY RECORD KEEPER: MEDICAL ASSISTED TREATMENT

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Medication Assisted Treatment for Alcohol and Opiate Use Disorder

Duration: 12:36 min.

Link: https://www.youtube.com/watch?v=LOXnrld_eIw&t=211s

VIDEO TWO: (optional deeper understanding)

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Opioid Use Disorder: Breaking the Barriers in Medication-Assisted Treatment

Duration: 1:03 hrs.

Link: https://www.youtube.com/watch?v=NUj9sAtuWDE

Part V

Other Possible Situations

Seminar # 31

"Creating a Family Solution Finder Learning Center"

The Seminar Goals:

1. Understand the Learning Series, Your family seeking to start a family solution finder learning center will first need to understand the Learning Series of the 32 key issue seminars in the study guide book and workbook, Organizer workbook, and Networking Provider Community Directory. Complete the practical exercise in the Seminar Workbook.

2. The Four Levels of a learning center, Your family members will need to understand the four levels of a learning center and how Level One is book distribution, Level Two is Providing Family Member Seminars, Level Three is Providing Community and Provider learning seminars, Level Four to provide church and places of faith practice the "Invest in the Family Ministry" manual. Complete the practical exercise in the workbook

3. A place to meet, Your family members will need a place to meet for Level Two, in order to provide family member seminars. Complete the practical exercise in the workbook

Knowledge is Empowerment

The fact is, we know what the family will experience. The problem is we are not telling them what they need to know. There is no payor organization that will provide reimbursement to providers for educating the family in preparing them for their journey.

This problem is now solved, The Family Solution Finder learning seminars, is available for family education on most topics the family will need to know.

There are four key learning tracks: 1. The Family Dynamic, 2. Getting educated about the disease, 3. Getting the family life organized around the disease, 4. Creating a proactive family plan of action.

Each seminar is supported with a Seminar Study Guide and Seminar Workbook with practical exercises and video links for extended learning. These seminars do not require training or experience in the topic being presented. Therefore, any person can prepare and present each seminars.

Inside these 1.5hr sessions the family will learn about themselves, their situation, the disease, how to make family decisions, how to breakdown an obstacle, the best way to proactively network, how to get the most out of government agencies and the list goes on.

There are two models an organization can choose from:

1. The Family Solution Finder Learning Seminars
2. The Family Solution Finder Learning Center

The Family Solution Finder Learning Seminars

The Family Solution Finder Learning Seminars, are an adjunct resource to the value proposition of any organization that is in the substance use disorder treatment and recovery services industry.

Think of this program as being yours, flexible to design around your services, your organization process, your family's and community needs.

- Opportunity: This solves the problem of educating the families, so they are included to the care and self-management of their loved one's recovery. By offering this program, your families will be included and empowered.

- Mission: The Family Solution Finder Learning Seminars provides program learning content for other organizations and groups to use in educating families on a journey with substance use disorders. It is not just for families because many different types of people will benefit from knowing these lessons.

- Your Solution: By representing each stage of a typical family's journey and identifying the issues they are likely to face, the family will have the advantage of knowing what is coming next and can take the time to prepare for what will be required of them.

- Market Focus: An ideal group providing their community with a Family Solution Finder Learning Seminars would have the resources needed to consistently offer the programs in a location which is conducive to gathered learning, sustained with a person assigned to lead the education initiative, and the channels to help families become aware of the program and its value.

- Expected Returns: For those organizations providing a Family Solution Finder Learning Seminars, they will be seen as a group or organization that is progressive in searching and providing real world solutions to this epidemic and one who cares about the community and families it serves.

Who can provide these learning seminar's?

Anyone can provide these seminars: from a treatment facility, behavioral health center, small or large support groups, county library, association meetings, government agency, school PTO's, Churches and place of faith practice, wellness programs and community meeting places. The list is endless.

The family can take the seminar and view it in the comfort of their home, at a pace that meets their needs.

A specific situation many occur, and a person can view just that signal topic for the issue they are facing. For example, before going to court they will benefit to know more about the legal system. This family would want to review "Seminar Fifteen, Issue # 6: Legal System Intervention". These seminars are not sequential and can be chosen on an as needed criteria.

The Seminars are self-administrated, meaning the presenter does not need to have prior knowledge of the topic to present each session. Although for quality of

presenting to a group, they will want to take the seminar for themselves prior to a meeting where they are presenting.

A person could go around their community and provide these seminars at different locations.

CREATE A FAMILY SOLUTION FINDER LEARNING CENTER:

In order to assure access to these learning tracks, groups like yours can take this program and make it your own to present through your established infrastructure and services. You will then have a Family Solution Finder Learning Center at your organization. The F.I.O. team will support your center with the materials for your learning sessions.

To start a Family Solution Finder Learning Center, go on-line to our website: famliesimpactedbyopioids.com and register as an F.S.F. Learning Center. We will send you a starter packet with easy to follow start-up instructions.

Faith organizations can use it in their monthly ministry meetings, small or large support groups, treatment centers, library's, City and County Departments, Drug Courts, Behavioral Health groups, Hospitals and community organizations, the list goes on.

We know what they will experience, So let's tell them.

The Family Solution Finder: This is an education learning program of 32 seminars 1.5 hours each with Study Guide, Workbook and Video used to educate the family about all the aspects of their journey with substance use disorders. It is Self-Administered.

We are asking you to register on www.familiesimpactedbyopioids.com in order that we can provide updates to content, support to your organizations learning center and allow others to find you in their community. These materials can be copied with permission for the purposes of marketing and training. All these materials are available as free downloads on our website.

It may be best to start one level down from where you want to be, in order to get comfortable with the material, the set up and functioning of the seminars. We recommend most organizations start at Level One, Book Distribution and determine how in the future they will provide learning seminars at their location. Then move into Level Two from a base of family members who have received from you the Pathfinder books. include those who or were past clients, are current clients and invite the public community for those who are interested in learning more and may be future clients.

a. Use the books:

Our books help to drive the learning experience, but your presentation and presence is what will matter even more to these family members. The operation for The Family Solution Finder Learning Center is the same as any other scheduled list of seminars you may have provided in the past. There is nothing specific or special steps needed for the center itself, other than making people aware of your sessions.

RESOURCES:

There are sites on the internet which provide good content to support learning and instruction. Here are a few worth looking through:

1. www.samhsa.org
2. www.adaa.org
3. www.drugfree.org
4. www.psychologytoday.org
5. www.Relink.org
6. www.drughelp.cares
7. www.nichq.org
8. www.apa.org
9. www.drugabuse.gov
10. www.nacoa.org

b. Free On-Line Download Presentation and Handouts:

Each of the 32 Issues has a power point presentation, where each slide has an audio speaker presenting the slide. In the presentation are several video links to professional content used to refine the topic (internet access required). This makes providing a seminar as easy as ordering the books and turning on the projector. The presentation also has seminar handouts PDF, practical exercises and video worksheet PDF, Family Best Practice and Plan of Action worksheet PDF. You are fully supported to offer a turnkey presentation for each of the 32 issues, from which the community will be better serviced by your organization. www.familiesimpactedbyopioids.com

Each session has a suggest "Meeting Agenda" PDF and this can be modified to meet your specific needs.

c. Room set-up:

This can be in what ever design you choose. We recommend circle tables because in helps to facilitate conversation and sharing between family members.

d. Audio/Visual:

Be sure to have access an internet WiFi for the extended learning video's, included in these seminars. Laptop, speakers, and TV or screen.

e. Meeting Agenda:

It is helpful to have the next meeting's agenda as a handout in each monthly meeting. Also, keep a calendar updated as to time, topic, location and point of contact on a page in your organization's website.

f. Which issue to present:

Some choose to start with Seminar #1 and proceed as it is numerically set up. Others ask their attendees, which topics they want to view. In either case, it is helpful for the attendee and the presenter if a schedule is set up going out six months.

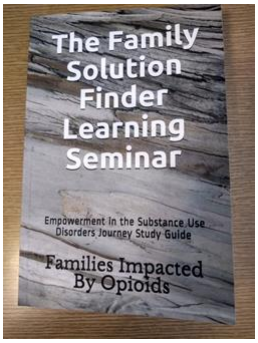
g. Issue of the Month:

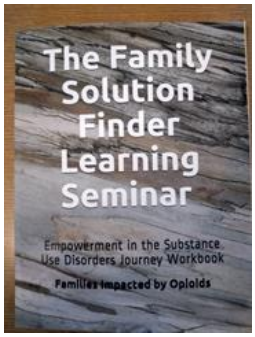
You might want to select an issue as the "T*opic of the Month".* Where, the seminar (issue) is presented in the first week. A speaker from the community is invited to speak for the next session. In the third session a personal testimony is presented from that person's experience with this topic. In a fourth session a general discussion covering how to use the lessons learned this month.

h. Duration:

- It is more effective to have one single topic (issue) in a meeting. Try <u>not</u> to mix one subject with another in the same meeting. For example, don't mis seminar # 1 The Family is a System with Seminar # 2 The Different Roles Family Members Play.
- There should be 40 minutes for slides and video's, 20 minutes for practical exercises, 20 minutes for group discussion.
- The video sessions are more valuable when there is a discussion to follow, so others can gleam important points from the person next to them. **And again, circle tables work best.**

Educate the Family





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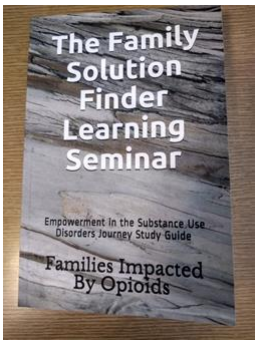
32 Seminars, Study Guidebook & Workbook

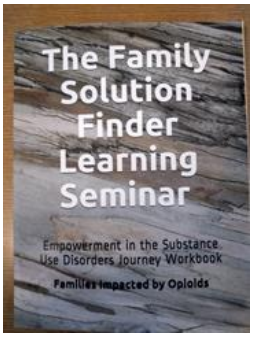
(family study curriculum course content)



The Family Solution Finder Study Guidebook: (Primary learning center book)

This book introduces the issue as a topic of learning. The topic is presented as to the top issues that a reader needs to understand about the issue. Then the following chapters develop how the issue impacts a family and identifies some of the parts to the issue that when broken down into pieces becomes clearer in how to create a solution in responding to this issue. There are 32 issues in this Study Guidebook each are likely to present in a family's journey with substance use disorder and each can be known and prepared for in advance. All four category levels (I-IV) of the Family Solution Finder Learning Centers use this book.

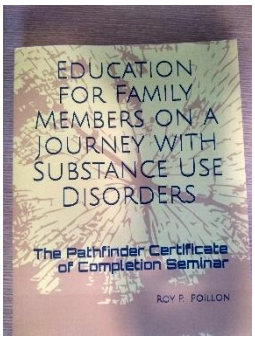
The Family Solution Finder Workbook: (Primary learning center book)

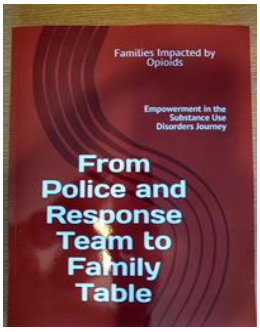


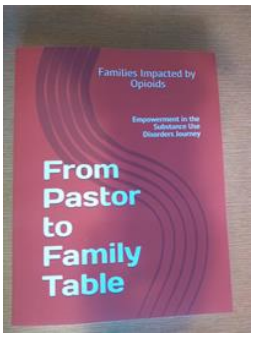
This book has practical exercises, extended video links and work sheets for each video. The issue is aligned with the same issue provided in the Family Solution Finder Study Guidebook. A family member will first read the issue in the study guidebook, then take the practical exercise, watch the video and complete the video work sheet in the Family Solution Finder Workbook. There are 32 issues in this workbook each are likely to present in a family's journey with substance use disorder and each can be known and prepared for in advance. All four Family Solution Finder Learning Centers use this book.

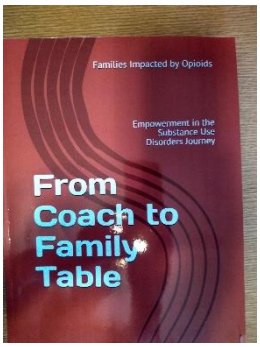
To order any of these books: Go on-line to www.amazon.com search Roy Poillon.

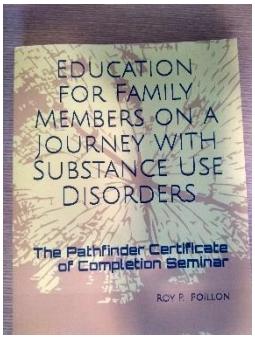
VI. Educate the Providers & Community.









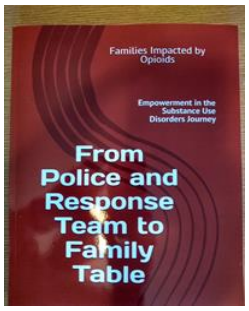


"The Pathfinder Certificate of Completion Seminar" books can be used as a marketing tool:

This book is used in developing clinical and non-clinical support staff to increase their awareness of the "Family Members Whole Journey" with substance use disorders. Also, this is a great book to offer those who refer clients to your services and programs. These 12 key issues provided a core competence for the family members, providing strength in their daily lives. The contents of this book is The Pathfinder Certificate of Completion Seminar and the 12 issues are pulled from the 32 issues found in the Family Solution Finder

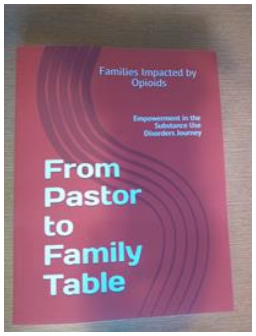
Learning Seminars books. This book can be given to your organizations staff, other organization's staff members and the Family members. All audiences will benefit from taking these seminars. Your organizations contact information can be placed inside. All four category levels (I-IV) of the Family Solution Finder Learning Centers use this book.

From Police and Response Team to Family Table, can be used as a marketing tool:



This book is used by your organization, to give to your local police and first responder teams, for them to give to the family members during or after an intervention with a family that they have identified as experiencing the impact of substance use disorders. The police and first responders can also use it to train their own staff members on the family's whole journey with this epidemic. It gives our first responders a community engagement resource for caring for the family members as well as the individual. Your organizations contact information can be placed inside. All four Family Solution Finder Learning Center Category Levels (I-IV) use this book

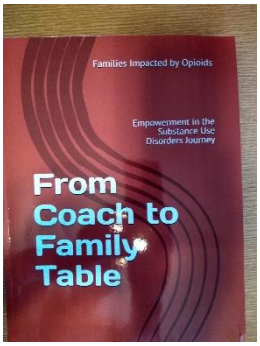
From Pastor to Family Table, can be used as a marketing tool:

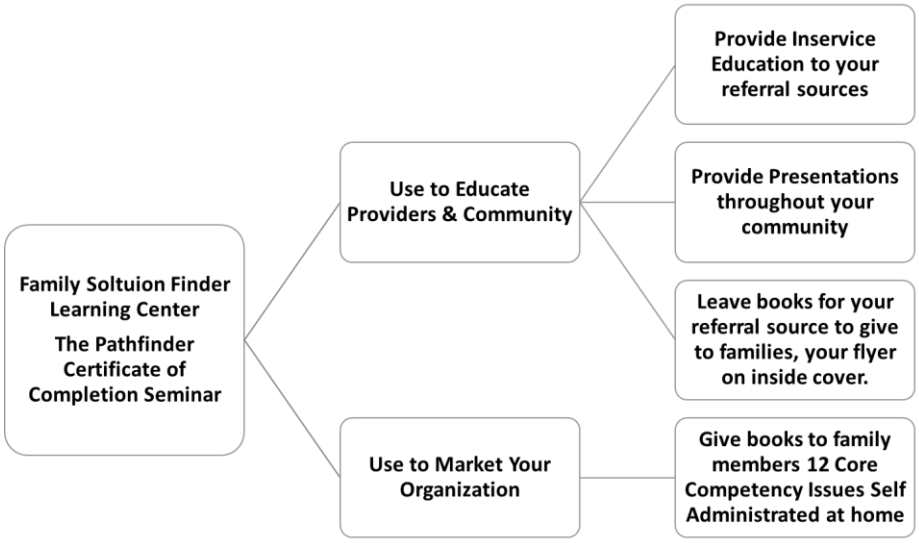


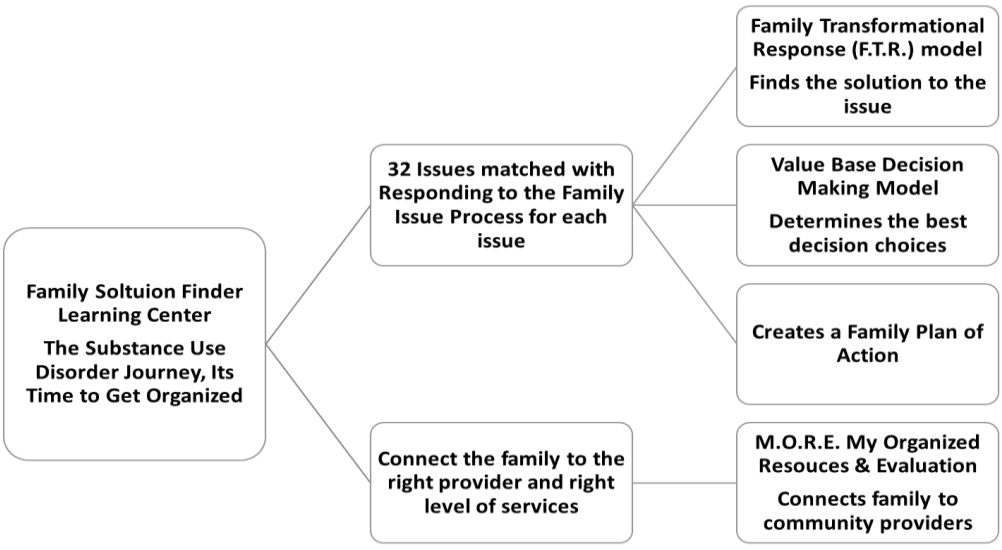
This book is offered to the Pastor and Ministry Leaders of a faith organization to give to the family members within their church who are on a journey with substance use disorders. Often, Family members especially mothers will seek advice from a minister or priest. This book can be given by the Pastor as an act of kindness and caring for the family. Your organizations contact information can be placed inside. All four Family Solution Finder Learning Center Category Levels (I-IV) use this book

From Coach to Family Table:

This book is offered to the sports coaches to give to a player when they identify a family who is going through a journey with substance use disorders. In many communities our coaches are looked up to for their advice and guidance. They are on the front line of our families (children) and will be able to pass this book through a player to the family members. This will empower coaches to have a way of contributing to the value of our community by being an asset towards empowering our families. Your organizations contact information can be placed inside. All four category levels (I-IV) of the Family Solution Finder Learning Centers use this book.




Family Soltuion Finder Learning Center
The Pathfinder Certificate of Completion Seminar
Use to Educate Providers & Community
Use to Market Your Organization
Provide Inservice Education to your referral sources
Provide Presentations throughout your community
Leave books for your referral source to give to families, your flyer on inside cover.
Give books to family members 12 Core Competency Issues Self Administrated at home



Substance Use Disorder Journey, It's Time to get Networked

Social Media:

You can build a Facebook group page for your Family Solution Finder Learning Center. It can be private or public. Instagram and Twitter accounts can also be set up.

The www.eventbrite can help to provide a place for new members to find and register for your seminars.

Local Community Education Sessions:

The local newspaper will often have space for your seminar announcements, announcement flyers can also be placed at referral source locations.

Public, private clubs and associations will often welcome a speaker from your learning center as part of their meetings agenda.

Employers "Lunch and Learn" brief seminars:

A lunch and learn session can be scheduled through large employers HR Department. Also, local unions.

Current, Past and Future Client Family Education Learning Schedule:

This is a great way to keep your community up to date with your organization, by having them connected to your family learning schedule of seminars.

VII. **Budgeting for a Family Solution Finder Learning Center**.

There is no fee to register your Family Solution Finder Learning Center. The Study Guide and Workbook for each issue (seminar) are provided free as a download on our website, or can be purchased as books at www.amazon.com search Roy Poillon. Typically, the family members are the ones who purchase their books.

To provide books as a part of your organization marketing program, we recommend buying them by the case to reduce shipping costs. It may help if you are an Amazon Prime member.

Most organizations' when offering a Level II, III & IV Family Solution Finder Learning Center will have the family member pay for their books, and each seminar.

Book Purchase Budget

Family Four Pack Books

The Family Solution Finder Learning Seminar Study Guide	$15.00
The Family Solution Finder Learning Seminar Workbook	$15.00
The Substance Use Disorder Journey, It's Time to Get Organized	$10.00
The Substance Use Disorder Journey, It's Time to Get Networked	$10.00
TOTAL:	$50.00

$50.00 Family Four Pack Books / 32 seminars = $1.56 per seminar

That is less than a chocolate milkshake at McDonalds ($3.35)

Part V

Other Possible Situations

Seminar # 32

"Harm Reduction"

Seminar Objectives:

1. Understand the Learning Series, Your family seeking to start a family solution finder learning center will first need to understand the Learning Series of the 32 key issue seminars in the study guide book and workbook, Organizer workbook, and Networking Provider Community Directory.

2. The Four Levels of a learning center, Your family members will need to understand the four levels of a learning center and how Level One is book distribution, Level Two is Providing Family Member Seminars, Level Three is Providing Community and Provider learning seminars, Level Four to provide church and places of faith practice the "Invest in the Family Ministry" manual.

3. A place to meet, Your family members will need a place to meet for Level Two, in order to provide family member seminars.

Introduction

Psychologists, social workers, counselors and addiction specialists can provide a number of innovative therapies to help people overcome their brain chemistry deficiencies so they can live a life that's free of drugs. But even so, many people who have addictions simply don't want to pursue a life of abstinence. For example, in the 2010 National Survey on Drug Use and Health, of those illicit drug users who didn't enter treatment, 30.1 percent stated that they simply weren't ready to stop using drugs.[2] Even if treatment was available, these people didn't want to take part.

Those who regularly engage in non-suicidal self-injury (NSSI) say that it offers temporarily relief from overwhelming emotions and negative thoughts as much as 90 percent of the time, as reported by *Current Psychiatry*. It is important to understand that although this seems like it might be helpful, it is not a healthy outlet for relieving stress and should be treated. It can be a symptom of a greater issue and many who suffer from NSSI also may have substance abuse problems as well. Some of the warning signs of this condition are:

- Noticeable wounds that aren't easily explained
- Wearing long-sleeved clothing at inappropriate times in an attempt to hide wounds
- Avoidance of social situations
- Isolation or a lot of time locked in a room or bathroom
- Impulsivity
- Feelings of worthlessness or hopelessness
- Personal identity issues
- Tools such as razors, bits of glass, lighters, knives or scissors in places they don't belong and usually in easily accessible places

Typical locations for cuts and burns are on the arms, legs and stomach; all of which are places that are easily accessible and can be covered up. Social media sites are also flooded with cases of self-harm, and some even glorify it. Cases of celebrity self-mutilation continue to pop up, and self-harming behavior seems to be rising everywhere. Excessive visits to pro-self-harm websites could be a warning sign for a bigger problem. If you or someone you know is presenting these warning signs, it is time to get help.

Self-harming behavior can be difficult to notice, diagnose and treat. Only recently has

the disorder really hit the public eye. Many times, episodes of self-harm are indicative of an underlying psychological disorder, but not always. When self-injurious behavior is coupled with addiction, treatment can be even more difficult. Those who struggle with addiction as well as self-harming behaviors need specialized treatment that simultaneously addresses both afflictions.

Dual diagnosis treatment understands the unique pressures that can lead individuals to want to harm themselves. Cognitive Behavioral Therapy may be an effective tool along with group, family and individual therapies. If someone suffering from self-harming behaviors has a traumatic event or trigger in their past or current life, dual diagnosis treatment can work to uncover the issues and help patients to cope in a healthier way.

Psychology Today explains what mindfulness is: actively paying attention to the present moment, taking stock of what you're thinking and feeling, and offering no criticism or judgment. Mindfulness is simply making a neutral, comprehensive inventory of what you're experiencing. The idea of "living life in the moment" comes from the idea of being mindful.[1]

There are three primary components of mindfulness:

It is intentional. The patient has to make a conscious effort to catalog what he is going through, from one moment to another.

It is accepting. The patient cannot deny what she is sensing.

It is nonjudgmental. A patient who criticizes himself for what he is feeling is not being truly mindful, in the same way that a patient who thinks highly of his emotions has not achieved actual mindfulness.[2]

By achieving this sense of balance, patients learn how they can regulate their emotions and thoughts. While this has a number of applications in everyday life, mindfulness can play a very important role in substance abuse recovery: patients learn how to rethink the nature of stressful situations and stimuli that may otherwise trigger a harmful train of thought that leads to drinking or using. Prior to a mindfulness intervention, patients may have been oblivious to the various factors that start the chain reaction of negative thought and unhealthy behavior. Mindfulness treatment gives them the chance to examine those factors on a level playing field, in a calm, supportive and safe environment. In time, the triggers become less daunting and more manageable.

A Comprehensive Harm Reduction package:

What is the Comprehensive Package of Interventions?

An effective and evidence-based response is required to curtail the rapid spread of HIV among drug using populations, but also to prevent transmission to the general population. In order to achieve

these goals, according to UNODC, WHO and UNAIDS, the implementation of a 'comprehensive

package' of nine interventions for the prevention, treatment and care of HIV among people who inject drugs is essential. This package – also widely referred to as the 'harm reduction' approach consists of interventions for which there is a wealth of scientific evidence supporting their **efficacy in** preventing the spread of HIV2:

Comprehensive Package:

1. Needle and syringe programs (NSPs) - access to clean injecting equipment.

2. Opioid substitution therapy (OST – e.g. Methadone Maintenance, Buprenorphine, Suboxone, Naltrexone...) and other drug dependence treatment.

3. HIV testing and counseling.

4. Antiretroviral therapy (ART).

5. Prevention and treatment of sexually transmitted infections.

6. Condom distribution programs for people who inject drugs and their sexual partners.

7. Targeted information, education and communication for people who inject drugs and their sexual partners.

8. Vaccination (as available), diagnosis and treatment of viral hepatitis (HBV, HCV).

9. Prevention, diagnosis and treatment of tuberculosis (TB).

A broader view – especially for young people?

The nine components above grew out of concern for the link between HIV and IDU. What about other aspects that can impact on risk, and/or make prevention and treatment more difficult for young people who use drugs?

For young people, and those who do not inject their drugs, it is important to add:

For example:

 Unstable or unsuitable accommodation

 Poor physical health, including

nutrition

 Poor mental health

 Poor child care

 Inadequate education

 Poor access to training

 Poor access to employment

 Poor access to legal assistance

 Parenting

 Reducing transitioning to IDU

 Building community intervention

capacity to enhance diversion from

closed settings

 IEC - information, education and communication (IEC) programs on HIV, drug use and other blood-borne infections for people who inject drugs Community mobilization and outreach to reach people who inject drugs who do not or cannot access health services

“Opening Doors” A toolkit

Enhancing Youth-Friendly Harm Reduction 2011

30

 Advocacy for harm reduction and access to services

A study in the journal Clinical Psychology Review found that constant worry or stress directly leads to depression and anxiety (which in turn can lead to substance abuse); and mindfulness therapy is effective in reducing the worry that many depressive and addicted patients feel.[3],[4]

VIDEO ONE:

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: The harm reduction model of drug addiction treatment | Mark Tyndall

Duration: 16:32 min

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

Why do we still think that drug use is a law-enforcement issue? Making drugs illegal does nothing to stop people from using them, says public health expert Mark Tyndall. So, what might work? Tyndall shares community-based research that shows how harm-reduction strategies, like safe-injection sites, are working to address the drug overdose crisis. Check out more TED Talks: http://www.ted.com

APPENDIX(S)

Appendix A: Family Solution Finder Learning Center, Start-Up Check List

Appendix B: Inventory your market.

Appendix C: Create your brand strategy, Marketing Mix (4 P's).

Appendix D: Support the Selling process for sustain ability and brand equity.

Appendix E: Your Best Practices Matching with The Families Members Best Practices.

Appendix F: To include the Church and Places of Faith Practices.

Appendix G: The Family Solution Finder Learning Seminars vs. The pathfinder Certificate of Completion.

Appendix A: Family Solution Finder Learning Center, Start-Up Check List (The Product Development)

Step One: Complete the request for starting a Family Solution Finder Learning center application on our website and submit this to register your organization. We will send you a welcome packet with instructions.

Step Two: Purchase the Family Solution Finder Study Guidebook, Workbook and Pathfinder Certificate of Completion Seminar Book. Become familiar with the chapters in these publications. This is the content for each seminar**.**

Step Three: Have access to a laptop, internet, TV or Projector w/Screen. Allocate a room with day and time for seminar**.**

Step Four: Create your "education Seminar" schedule.

Step Five: Make announcements to your targeted audience.

Step Six: Upon registration, sell the attendee's the learning books, make copies for seminar handouts, order refreshments, set up room. Turn on the lights, empower the family members with knowledge about the 32 issues they are likely to face in their journey with substance use disorders.

Appendix B: An Inventory of your market

Your referral sources are also a place of support structure for Family members. Each of the 32 key issues has a community resource for families, and they depend on these organizations to understand their needs to match their services. When you provide these support resources the Pathfinder Certificate of Completion Seminar book, their staff can then learn more about the clients they are serving. This same book can be given by the referral source to the family members, with a flyer inside announcing your organizations services.

This is where you want to plant your organizations message as an awareness campaign with their staff and the families they serve. As a referral source you want them to see your services as preferred. Therefore, differentiating yours from your competitor, the Family Solution Finder Learning Seminars and Pathfinder Certificate of Completions will be a great bolt-on to your existing brand image. This increases your organizations sustainability in the market.

In the concept of selling there are three primary reason for sales failure: 1. Spending time talking with the wrong person in the organization. 2. Providing this person the wrong selling message. 3. Not providing the right time frequency to redeliver the message through consistent follow up. (Person to person message and frequency).

Territory Management: By dividing a set geographic area into four quadrant the representative will spend on week in each territory. This territory management ensures that each call point receives your message, the representative picks up on new trends and new programs can be launched more effectively. This also makes it easier to monitor sales activity, respond to needs timelier and create performance incentives.

Territory Inventory: Determine your most important referral source and list them in the form below. Then expand that list, be creative.

Territory Administration: Keep track of the activity by quadrant. Match the number of referrals from each referral source with the number of sales calls. Also consider the time lag between visits. If greater than four weeks, consider it starting all over again.

Appendix C: Create your brand strategy, Marketing Mix, (The Message)

Product: This product (the Family Solution Finder Learning Center) is an add on to your existing products. Consider how one flows into the other. Example: A treatment center might consider how the family knowing more about their entire journey is a complement to their services. This is how the product should be explained. "*our services include ongoing Family Solution Finder Learning Seminars" which help your family know what is likely to happen next*".

Price: Although there is not a great cost in providing these seminars because the attendee pays for the book or downloads the session free from our website, there is what is called an "Opportunity Cost" and that is what it cost your organization if you choose not to provide these services. The fact that your competition is providing the Family Solution Finder Learning Seminars from a Category level III Family Solution Finder Learning Center means, families identify with their brand as being concerned for the entire family and the referral sources in the market sees this organization as offering more than the basic services.

Place: When an organization is providing a Category Level III or IV they are in the community presenting family member education, at their referral source sites providing the staff education about the family journey and in the churches helping to set up the Invest in the Family Ministry which has as it primary meeting content the 32 key issues, 2.5 years of monthly meetings.

Promotion: Because very few if any organizations provide education to the family members that covers the family entire journey with substance use disorders, your organization promotion of this program as your program, offered by your organization, the choice of channels is very broad. In social media, let everyone know you are providing the Family Solution Finder Learning Seminars, is like a laptop having an "Intel Inside" sticker on it. The buyer identifies the quality that goes into the brand, by the service they provide their customers. Your promotion will identify that your organization is a well thought out provider that sees the bigger picture of this epidemic and that you are showing community engagement in the services you provide.

Appendix D: Support the Selling process for sustain ability and brand equity, (The Place)

Your location: Many do not know where the organizations that service these needs are located. By providing these learning centers at your location, a level of identify is increased within the community as to where you provide your primary services.

Their location: When your brand is presented inside another organization location, it extends awareness that you are in the community, active part of the healthcare delivery system and a group that supports the needs of other organizations.

Mobile Location: When your brand is seen in unexpected locations like the public library or at hotel weekend seminars to the public, your organization will be identified as being everywhere they are and the family and referral sources will more readily identify your organization as being present in the community.

Family Home Study Support Location: Few organizations have the reach to show up at home, in the family, at the family table. When you provide a learning seminar for the family to take home and learn about their entire journey, your brand is now embedded into the awareness of these family's members. Consider, this same image is also embedded in the minds of your referral sources, the community at large, the churches, the ER social worker, the sports coaches, the school guidance counselors, public officials. The list is endless. All because you are taking care the family learning their entire journey. All because you provide a "Family Solution Finder Learning Center.

Appendix E: Your Best Practices Matching with The Families Members Best Practices

Because each issue ends with the family member creating their own best practice protocol for that issue, the family has identified up front how they plan to respond should this issue present. It would be your organization taking them through this exercise. Therefore, you would be the service they are most likely choose because your can show how your services best match their best practice needs.

Therefore, by modeling the communication in how your organization provides its services so it does in fact match the typical family best practice needs, you are lining up a more successful, seamless continuity of care for our community and the family members.

It is from within a space between organization in the continuity of care where the healthcare industry fails the greatest, in helping the family members transition with their loved one who is misusing substances.

By matching their best practice with your best practice, a greater community communication bridge will exist and thereby create a more successful match of the right type and level of care is obtained by the family.

Plus, there is an added advantage from having a knowledgeable and prepared family to work with when they arrive at your front door. This saves your organization money and reduces the staff experience of unnecessary follow up with family's who are uninformed and getting frustrated by what they do not understand.

Appendix F: To include the Church and Places of Faith Practices

It is not that your organization will be telling a faith group how to ministry to their congregation, but rather this model will show the church team how to incorporate family learning seminars on the substance use disorders journey, into their monthly meeting. The Invest in the Family Ministry provides all the needed set up instructions for the church volunteers to set up and run monthly meetings. Your role will be to help them turn on the material for that meeting, Once introduced, the volunteers will only be calling you to come in for specific presentations when it is your type of services being reviewed.

However, your organizations name will be a part of this content. Therefore, this church will become a community resource for better understanding and identifying with your services.

In effect, by helping the faith groups understand how to support their family's members, you are helping the family members to understand how to access your services. While at the same time, doing our community a great service in reducing stigma and increasing empowerment through the sharing of knowledge.

Appendix G: The Family Solution Finder Learning Seminars vs. The pathfinder Certificate of Completion

The Family Solution Finder Study Guidebook and Workbook provider the reader 32 key issues family will experience in their journey with substance use disorders. It can be self-administered by the family in the comfort of their home or presenting in a meeting type forum at a specific location in a group seminar.

Everyone can benefit from taking these 32 key issue seminars. All of the seminar materials needed for a meeting and power point presentation are on the www.familiesimpactedbyopioids.com website as a free download, to include the meeting agenda. Everything is there.

However, this is a great deal of work to consider. By its design, there are 48 hours of material being presented. If it were given as one topic per month equals 2.5 years of meeting content, 128 meetings and each is approximately 1.5hrs in duration.

This is a shortened version take out of the 32 key issues, by having only the core competency issues presented, the top 12 key issues a family and provider need to understand about the family journey is what the reader will find in the Pathfinder Certificate of Completion seminar.

The Pathfinder Certificate of Completion Seminar provides 12 key issues of 1.5 hours each for the providers to train their staff, and for families who only want to learn the essential topics about what they are likely to face in their journey.

These same issues are found in the list of 32 key issues from the Family Solution Finder Learning Seminar Study Guidebook and Workbook. They are identical.

Concept and Brand Image

The Family Solution Finder Learning Center (FSFLC) is to be marketed as a place where families can learn, find ways to solve problem, network and find resources. Given there are no services for family member counseling in this specific area, the FSFLC will be a unique offering to the community.

That has both it advantages and disadvantages. The advantages are when a family needs this level of empowerment, yours likely be the only place within the community where this can be found. Another advantage, your community will see you as a positive contributor doing what is most needed.

The disadvantages include:

1. Few will understand what you provide, because it is new to the market
2. Most will not know in advance what to expect.
3. Few will be able to project the outcome of using this learning center to their advantage.

Therefore, you will be identified as being different, more inclusive and a step above those who are not providing a Family Solution Finder Learning Center. And your communication about your brand will be enhanced as an image of a company that care about the whole family and your community overall health.

Brand Management

In brand management we look to see the name of the organization, what it offers and who it serves all rolled up into one concept.

The Name: If you are providing this education outside your primary brand, you can rename your organization whatever is best for you and those you will serve. The program is the Family Solution Finder Learning Seminars and this name should not change. Example: The center's name might match the name of the county, Boone County Family Learning Center for Substance Use Disorder, provided by your organizations name. We provide The Family Solution Finder 32 Learning Seminars throughout the year to family members.

Product Image: The way the product is described is best by its outline of subjects covered. But here is where creditability will apply. The attendee needs to be reassured this material is founded by professionals (which it is) and presented by professional, when possible. However, one does not have to be a professional to present these topics, because the seminar is designed to be administered by anyone choosing to learn more.

Organization Brand Integration: The Family Solution Finder Learning Center is designed to be a stand-alone brand or a program that fits inside an existing brand as a product offering. It can be promoted as a part of your organization to give your existing market presence a greater audience reach.

New Audience Type, Family Members: It is important to consider the family member as a decision influencer, as a separate audience type with unique needs and will require communication through channels that specifically reach them.

Families Impacted by Opioids owns both brands: 1. The Family Solution Finder Learning Centers and 2. The Family Solution Finder Learning Seminars.

Sales Training

Families Impacted by Opioids recommends the sale of this program be fit into your existing sales process as another product/program offering.

The easiest place to begin is with past, current and future clients. A telephone call and mailer to this audience with the purpose of inviting them to attend a family member learning seminar would be a great first step. Likely as is true with other starting programs, expect smaller numbers for attendance. However, by asking this group key questions of what brought them to the meeting can be a valuable step in developing the correct messaging to this audience.

This step may take "cleaning up| your contact data, but in doing so you will likely use this list in the future for similar programs and announcements.

The organizations and people who referral clients to your organization are also good call point for selling this program. In doing this type of call, you are asking the referrals source to pass to a family member on a journey with substance use disorder, the Pathfinder Certificate of Completion Seminar book. Your advertising needs to be in the book, in order to for the family member to know where to call.

The Pathfinder Certificate of Completion book can also be used by the referral source to train their internal staff using these 12 key issues seminars. Or in Category Level III of The Family Solution Finder Learning Center you can go to these organizations and provide their internal staff a presentation of a selected seminar.

Your liaison team can also go directly to support groups, probation officers, behavior therapy groups, selected social workers, Child and Family Services case managers can also be a sale call point and future referrals sources.

Use the Pathfinder Certificate of Completion Seminar books as a marketing tool. These books can be used to market the program to other potential program referral points:

1. From Pastor to Family to Table Book
2. From Police and Response Team to Family Table Book
3. From Coach to the Family to Family Table Book

Conclusion

We are nationwide, as Families Impacted by Opioids can support you in whatever way you need, where ever you are located, whatever type of organization or as a single person, just contact us and let's review what you are considering. We will show you how to best approach it and what resources are available. This is all new to us and as well as it is new to you, but together we can achieve many things that most thought not possible. We are all part of one body and when one suffers, we all feel a certain level of their pain. The pain is real and so is our commitment to find a way to do better.

On our website for each issue you will find: (Free Downloads)

1. The Family Solution Finder Study Guidebook in sections of each issue, PDF.
2. The Family Solution Finder Workbook in sections of each issue, PDF.
3. Power Point Presentation for each issue (used by the presenter) w/audio option.
4. The issue Practical Exercise and Video Worksheets, PDF.
5. The Family Best Practices and Plan of Action worksheet for each issue, PDF.
6. A (suggested) Monthly Meeting Agenda, PDF.
7. All our books available for on-line purchase www.amazon.com

We are a nonprofit 501(C) 3 organization, Tax Deductions for you donations.
see our website for certification documents

To Start your Family Solution Finder Learning Centers Today.

1st Visit our website: www.famliiesimpactedbyopioids.com

2nd ORDER BOOKS: www.amazon.com Search Roy Poillon.

3rd Download the presentations and material handouts.

4th Practice a presentation.

5th Set up the room.

6th Make an announcement of date, time location.

7th provide your first Family Solution Finder Learning Center Seminar.

CONTACT US:

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DISCLAIMER:

Again, this book is only a suggestion to the options you may have available and steps you may want to consider. We strongly encourage you to find a licensed professional family therapist or Drug Counselor and review any plans with them for their guidance and assistance. None of the information provide in these learning series should be acted on without first talking with a professional.

YOU ARE NOT ALONE, KEEP LEARNING, STAY HOPEFUL, PRAY OFTEN.

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