enCompass:

A Comprehensive Course on Navigating Addiction

Participant Manual

ADDICTION POLICY FORUM

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CHAPTER 1
INTRODUCTION

Family members of people struggling with addiction are often at a loss for how they can help their loved ones.

It's an overwhelming, frightening, and helpless situation that countless families confront each year. Further complicating matters, addiction is a misunderstood disease that is frequently stigmatized in a way that other chronic diseases, such as diabetes and heart disease,
are not.

enCompass: A Comprehensive Training on Navigating Addiction

is a curriculum designed to help family members, friends, and community members navigate addiction treatment and recovery. The interactive, multidisciplinary training teaches participants about the science of addiction and equips them with the knowledge and tools to understand and address it. The curriculum and manual were developed and written by Jessica Hulsey, founder of the Addiction Policy Forum, and reviewed by an expert review panel composed of prominent researchers and physicians in the addiction field.

OBJECTIVES

This training provides practical content to help you understand the prevention, early intervention and treatment of substance use disorders, as well as how to engage someone struggling with addiction and develop an action plan.

WHAT WILL YOU LEARN?

- The signs and symptoms of addiction
- How to start the conversation
- Getting an assessment and treatment options
- How to set healthy boundaries
- How to access recovery support
- Medications that are available to treat addiction

ABOUT ADDICTION POLICY FORUM

Addiction Policy Forum aims to eliminate addiction as a major health problem by translating the science of addiction and bringing all stakeholders to the table. The organization also works to elevate awareness around substance use disorders and help patients and families in crisis. Founded in 2015, Addiction Policy Forum empowers patients and families to bring innovative responses to their communities and end stigma through science and learning.

ADDICTION
POLICY FORUM

CHAPTER 2
UNDERSTANDING ADDICTION

Addiction is a complicated disease. Individuals are often at a loss for how to help their loved ones, employees, friends, or community members who are suffering.

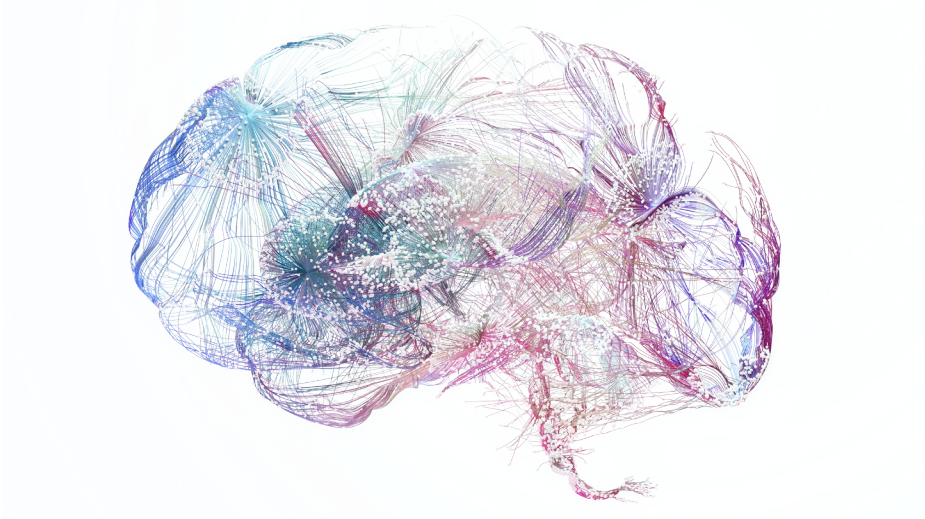
Navigating treatment and recovery can feel like a daunting process, but that doesn't have to be the case. This course will simplify the science of addiction and offer strategies for how best to respond to someone in crisis. Addiction impacts the entire community, and we have to work together to properly address this disease.

WHAT IS ADDICTION?

Addiction is a medical condition that affects the brain and changes a person's behavior. The medical term for a drug or alcohol addiction is a substance use disorder (SUD).

PEOPLE CAN DEVELOP AN ADDICTION TO:

alcohol;	cocaine, methamphetamine, and other stimulants;
nicotine;	PCP, LSD, and other hallucinogens;
opioids, such as heroin, fentanyl, or prescription painkillers;	inhalants; and
marijuana;	sedatives, such as sleeping pills and benzodiazepines.



Many people start using substances to feel good, to feel better, to do better, or out of curiosity. However, an SUD affects brain function as it develops and progresses, making it harder for a person to control their use. The impairment in self-control is the "hallmark of addiction," according to the National Institute on Drug Abuse (NIDA, 2020). What was once a decision to use turns into a compulsion. This is why engaging with treatment as soon as possible is so important.

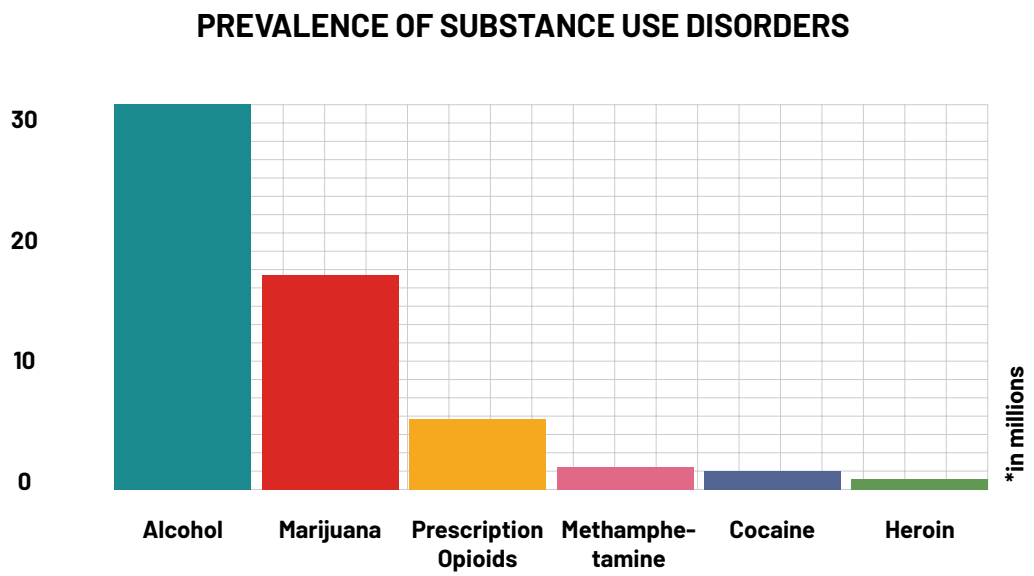
ADDICTION IS A MEDICAL CONDITION THAT AFFECTS THE BRAIN AND CHANGES BEHAVIOR.

Addiction is characterized by a loss of control over a person's behavior, as well as continued use despite consequences—such as loss of a job, arrest, damaged relationships, or other significant negative outcomes. It can happen to anyone regardless of race, age, or socioeconomic status.

PREVALENCE OF ADDICTION IN THE U.S.

Addiction is a very prevalent illness in the United States. More than 46.3 million people aged 12 or older—16.5 percent of the U.S. population—met the diagnostic criteria for a substance use disorder (SUD) in 2021 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). More than 60 percent of those with an addiction struggle with an alcohol use disorder (AUD), making alcohol the primary type of SUD in America. The next most common type of SUD is marijuana use disorder (16 million people), followed by prescription opioid use disorder (5 million), and methamphetamine use disorder (1.6 million). In addition, 29 million Americans are in recovery, proving that a person can be treated and recover from this illness (SAMHSA, 2022).

Figure 1.



Source: 2021 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.

ALCOHOL USE DISORDER IS THE MOST PREVALENT ADDICTION IN THE U.S., FOLLOWED BY MARIJUANA AND PRESCRIPTION OPIOIDS.

DIFFERENT TYPES OF SUBSTANCE USE DISORDERS

Patients are diagnosed with a specific type of disorder based on the primary substance that they misuse, such as an alcohol use disorder, opioid use disorder, stimulant use disorder, marijuana use disorder, or sedative use disorder. However, many patients diagnosed with SUD misuse more than one kind of substance—also known as a polysubstance use disorder.

Figure 2.

TYPES OF SUBSTANCES

ALCOHOL	MARIJUANA	OPIOIDS	NICOTINE
Beer	Marijuana	Heroin	Nicotine
Wine	THC	Fentanyl	Tobacco
Spirits		Prescription Pain Killers	
STIMULANTS	**SEDATIVES**	**SYNTHETICS**	**HALLUCINOGENS**
Cocaine	Benzodiazepines	Synthetic Cannabinoids	MDMA (Ecstasy/Molly)
Methamphetamine	GHB	(K2/Spice)	LSD
Prescription		Synthetic Cathinones	PCP (Phencyclidine)
stimulants (Adderall,		(Bath Salts)	Peyote (mescaline)
Vyvanse)		Ketamine	Psilocybin
		GHB	

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ADDICTION AND THE BRAIN

In the early 1990s, scientists began to understand how repeated substance use affects the brain. Brain scans showed that, like other diseases, SUD affects tissue function. An SUD affects two main parts of the brain: the limbic system and the cortex.

The limbic system is located deep within the brain and is responsible for our basic survival instincts. When we exercise our survival instincts—by doing things like eating, drinking, finding shelter, having sex, or caring for our young—the limbic system in our brain reinforces those behaviors by releasing dopamine, a chemical that makes you feel good. That reward for surviving is also transmitted to the amygdala and hippocampus, which record a memory of that feeling so we seek it again. This is our survival hardwiring. Addiction also affects the prefrontal cortex, which is where decision-making and impulse control live, and what separates us from other animals.

When we use drugs or alcohol, they activate the very same dopamine process in our survival center. With repeated use, the substance can compromise or damage that part of the brain. The SUD changes the brain and weakens this system to make it believe that the primary need for survival is the drug. The reward system is damaged and the survival instinct re-wired as the brain recodes those primary survival instincts. Suddenly, getting that substance rises higher on the scale of the things necessary for survival—higher than food, water, shelter, sex, and protecting our young.

According to top scientists, "Brain imaging studies of people with addiction show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control" (NIDA, 2020).

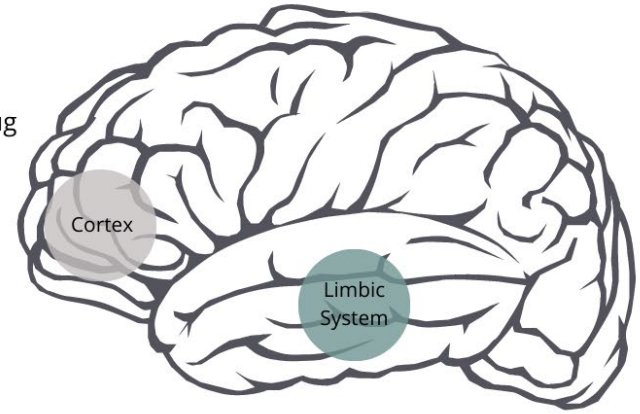
As time goes on, the brain will also need more and more of the substance to activate that same level of reward or feeling of pleasure. As a result, the brain tissue will become increasingly damaged with continued drug use.

Figure 3.

HOW ADDICTION HIJACKS THE BRAIN

Addiction and the Brain

There are two main parts of the brain affected by drug use: the limbic system and the cortex. The limbic system, located deep within the brain, is responsible for our basic survival instincts. The cortex is where decision making and impulse control live.

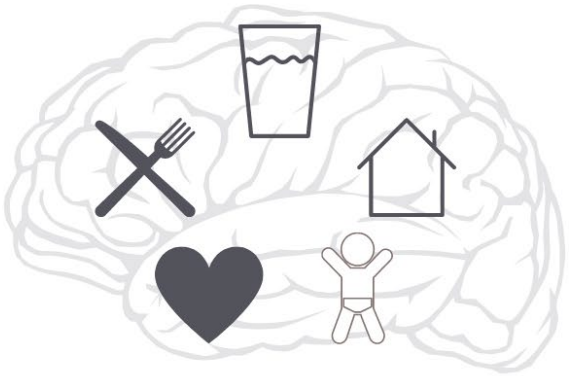


Alcohol and Drug Use

Alcohol and drug use can affect these important areas of the brain.

Our Survival Hardwiring

The limbic system controls our survival instincts.



When you do essential things to stay alive, like eat, drink, find shelter, have sex, or care for your young, your brain reinforces behaviors that cause the release of dopamine from this region.

Dopamine is the the feel-good neurotransmitter responsible for feelings of pleasure and satisfaction.

Hardwiring Hijacked

When drug or alcohol use is repeated, that substance can hijack the survival hardwiring in the brain. This hijacker changes the brain and weakens this system to make it believe that the primary need for survival is the drug.

In hijacking the brain, it can compromise those primary motivations: food, water, shelter, sex and protecting our young.

And the hijacker needs more and more of the substance to activate the same level of reward or feeling of pleasure, causing the brain tissue to become increasingly damaged with continued drug use.

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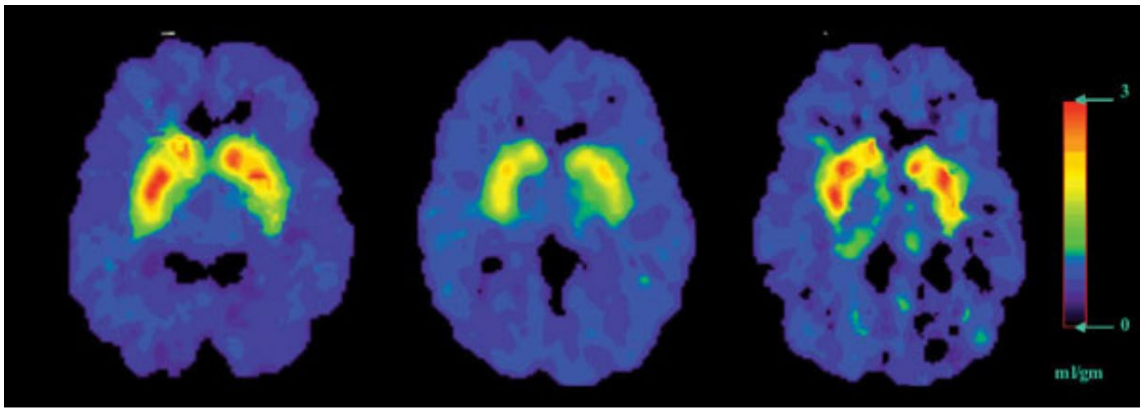
THE BRAIN CAN RECOVER

Science also shows that the brain can recover from a substance use disorder. Brain scans show the survival circuit in a healthy brain compared to the brain of someone with a methamphetamine use disorder after one month of abstinence, and then 14 months of abstinence. The activity in the survival circuit starts to regain normal levels through recovery and, over time, can return to its previous state.

Figure 4.

BRAIN SCAN SHOWING BRAIN RECOVERY WITH PROLONGED ABSTINENCE



No Substance Use Disorder	Individual with Methamphetamine Use Disorder (1 month abstinence)	Individual with Methamphetamine Use Disorder (14 months abstinence)

Adapted from NIDA. (2020) Drugs, Brains, and Behaviour: The Science of Addiction.

BIOPSYCHOSOCIAL MODEL OF ADDICTION

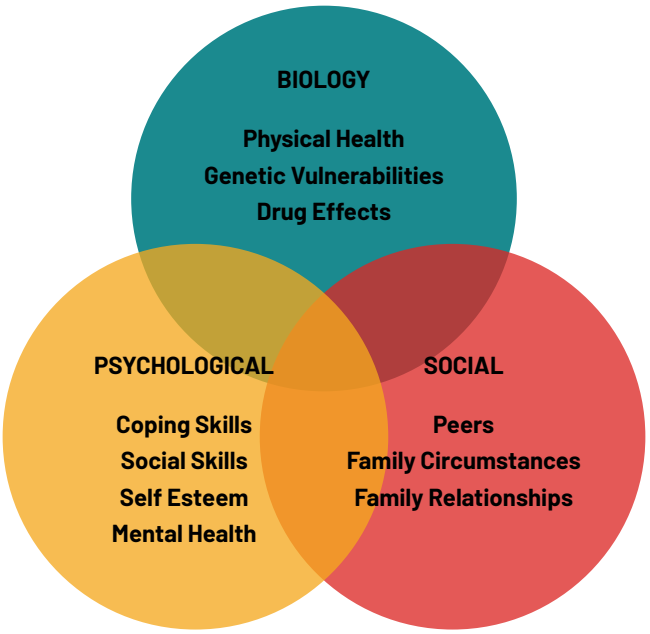
While addiction is categorized as a brain disease, it has other components as well. You may hear about the biopsychosocial model, which comes from combining the biological, psychological, and social factors that contribute to many chronic illnesses, including addiction. Biopsychosocial recognizes that there are multiple pathways to addiction, such as genetic predisposition, psychiatric and psychological factors, and unhealthy coping skills. The significance of these individual pathways depends on the individual.

Biopsychosocial was one of the first models to recognize the importance of treating the whole person and not just the disease. It was conceptualized in 1977 by psychiatrist Dr. George Engel, who proposed that the treatment should consider psychological and social factors in addition to biological ones.

The goal of a biopsychosocial response is to work together with the patient to discover the different underlying causes and introduce appropriate treatment models to create a unique pathway to recovery. Two patients with the same diagnosis may differ greatly in physical, social, and psychological composition. Placing addiction patients into the same "one-size-fits-all" treatment program will not produce the best results compared to an individually tailored treatment regimen.

Figure 5.

BIOPSYCHOSOCIAL MODEL OF ADDICTION



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LEVELS OF SEVERITY

Like other illnesses, addiction gets worse over time. And similar to stages of cancer, there are levels of severity to describe a substance use disorder. These levels are detailed in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, or DSM-5, which is the American Psychiatric Association's gold-standard text on mental health (American Psychiatric Association, 2013).

The DSM-5 has 11 criteria for substance use disorders based on decades of research that includes symptoms related to impaired control, social problems, risky use, and physical dependence:

SYMPTOMS INCLUDE

01 Using for longer periods of time than intended, or using larger amounts than intended.

02 Wanting to reduce use, yet being unsuccessful doing so.

03 Spending excessive time getting and using the substance, and/or recovering from the substance use.

04 Cravings that are so intense it is difficult to think about anything else.

05 Using despite problems with work, school, or family/social obligations.

06 Continued substance use despite interpersonal problems because of the substance use. Spending less time with friends and family.

07 Giving up or reducing time spent on social and recreational activities because of substance use.

08 Repeated use of substances in physically dangerous situations.

09 Continued use despite worsening physical and psychological problems.

10 Needing more of the substance to have the same effect (developing tolerance to the substance).

11 Experiencing withdrawal symptoms when the substance isn't used

Figure 6.

11 SYMPTOMS ACROSS FOUR CATEGORIES

CATEGORIES OF SUD SYMPTOMS Symptoms of substance use in the DSM 5 fall into four categories: 1) impaired control; 2) social problems; 3) risky use, and 4) physical dependence			
Impaired Control	Social Problems	Risky Use	Physical Dependence
• Using more of a substance or more often than intended • Wanting to cut down or stop using but not being able to • Spending excessive time getting, using, or recovering from the substance use. • Intense cravings	• Neglecting responsibilities and relationships • Giving up activities they used to care about because of their substance use • Inability to complete tasks at home, school or work	• Using in risky settings • Continued use despite known problems	• Needing more of the substance to get the same effect (tolerance) • Having withdrawal symptoms when a substance isn't used

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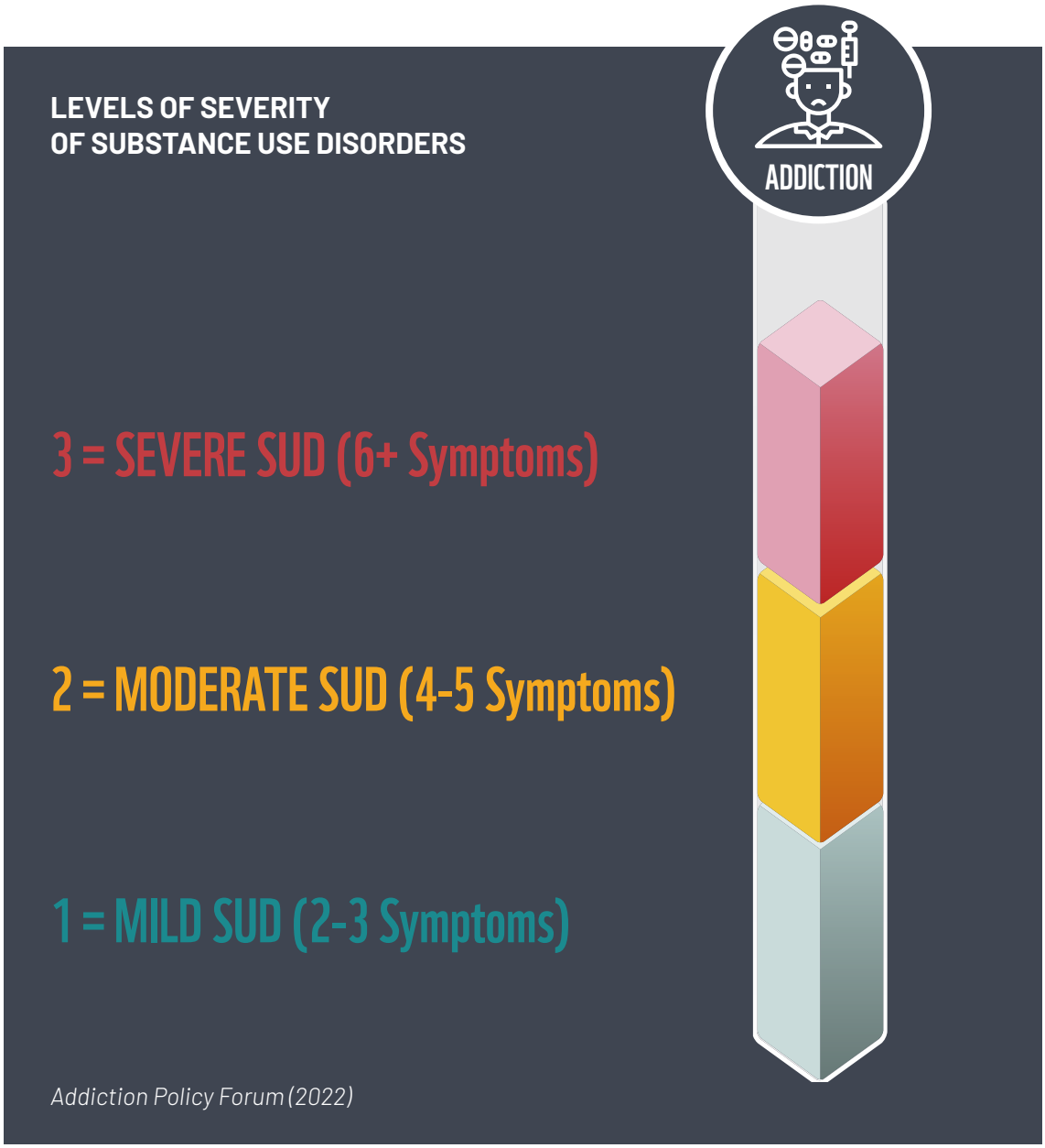
The DSM-5 includes guidelines for clinicians to determine the severity of a substance use disorder. The presence of two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder. A severe SUD is also known as having an addiction.

Doctors determine the severity level of the substance use disorder to help develop the best treatment plan. The higher the severity, the more intensive the level of treatment needed. Most patients are likely to need ongoing treatment and recovery support using a chronic care model for several years. A doctor should monitor progress and adjust the plan as needed.

Figure 7.



NOTES

CHECKLIST

SYMPTOMS OF A SUBSTANCE USE DISORDER

IMPAIRED CONTROL:

- ☐ Using for longer periods of time than intended, or using larger amounts than intended.
- ☐ Wanting to reduce use, yet being unsuccessful doing so.
- ☐ Spending excessive time getting and using the substance, and/or recovering from the substance use.
- ☐ Cravings that are so intense it is difficult to think about anything else.

SOCIAL IMPAIRMENT

- ☐ Using despite problems with work, school, or family/social obligations.
- ☐ Continued substance use despite interpersonal problems because of the substance use. Spending less time with friends and family.
- ☐ Giving up or reducing time spent on social and recreational activities because of substance use.

RISKY USE

- ☐ Repeated use of substances in physically dangerous situations.
- ☐ Continued use despite worsening physical and psychological problems.

PHYSICAL DEPENDENCE

- ☐ Needing more of the substance to have the same effect (developing tolerance to the substance).
- ☐ Experiencing withdrawal symptoms when the substance isn't used

ADDICTION IS A CHRONIC DISEASE

Too often substance use disorders are treated like an acute issue instead of a chronic disease in the United States. Movies, TV, and commercials often reference "rehab stays" or one-month treatment programs that sound like a cure. But unlike a common cold, the flu, or pneumonia, addiction does not resolve quickly or just disappear.

A chronic disease or illness is persistent or otherwise long-lasting. While they often don't have a cure, you can live with them and manage their symptoms. According to the Centers for Disease Control and Prevention (CDC), chronic diseases are defined as conditions "that last one year or more and require ongoing medical attention or limit activities of daily living or both" (CDC, 2021). Common chronic diseases include heart disease, asthma, and diabetes.

Top researchers note that "drug addiction shares many features with other chronic illnesses, including a tendency to run in families (heritability), an onset and course that is influenced by environmental conditions and behavior, and the ability to respond to appropriate treatment, which may include long-term lifestyle modification" (NIDA, 2005). Common chronic diseases include heart disease, asthma, and diabetes.

ACUTE VS. CHRONIC DISEASES

Healthcare providers often categorize conditions as either chronic or acute. So what's the difference?

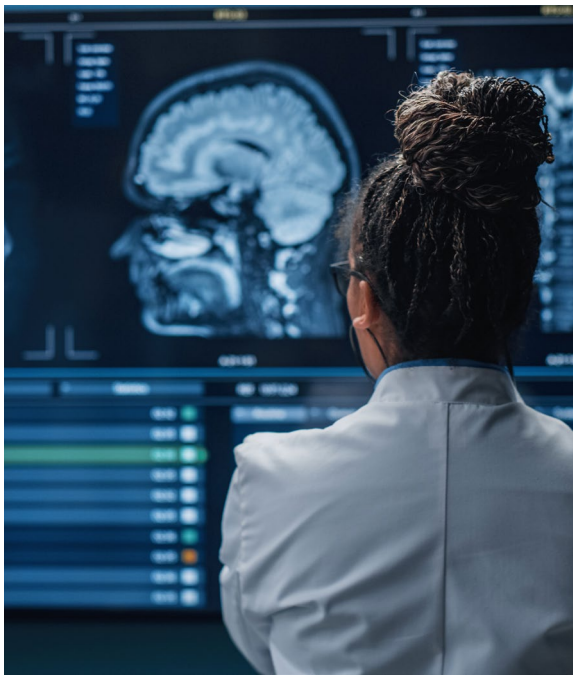
Acute illnesses generally develop suddenly and last a short time, often only a few days or weeks. Examples include the common cold, flu, bronchitis, pneumonia, strep throat, or a heart attack. Chronic conditions develop slowly and require a longer term treatment and management strategy. Examples include Alzheimer's disease, depression, diabetes, heart disease, and obesity.

Figure 8.

Acute	Chronic
Generally develop suddenly and last a short time, Often only a few days or weeks.	Develop slowly and require a longer term treatment and management strategy.
Examples include the common cold, flu, bronchitis, pneumonia, strep throat or a heart attack.	Examples include Alzheimer"s disease, depression, diabetes, heart disease and obesity.

CHRONIC DISEASE MANAGEMENT FOR SUDS

Our current system of care for addiction is often fragmented and not coordinated to provide chronic disease management. Because of this, family members or the individuals themselves often must piece together each of the needed components to create an adequate care plan for a chronic SUD. Efforts are underway to change this in our healthcare system, but progress is slow.



Learning from models of other chronic diseases will help providers, patients, and caregivers understand better approaches.

For example, a chronic care plan for a patient with type 2 diabetes (diabetes mellitus) may include: insulin, medication monitoring and adjustment by the physician, control of blood glucose levels through regular testing and glucometers, consulting with a nutritionist on healthy eating habits, physical exercise, and modified eating habits. And diabetes patients are taught that long-term adherence is key. When a patient is stable or has managed their symptoms, it doesn't mean they are cured or can discontinue their treatment regimen. In other words, normal blood sugar levels don't mean a patient can discontinue their medication, diet, and exercise regimen. They must still continue their care plan and have regular physician visits to monitor their symptoms.

For chronic disease management for addiction, many care plans will include the use of medication, psychiatric counseling, and support groups, and will recommend abstinence from alcohol and drugs.

Experts recommend that care plans include treatment and management of other diagnoses or health concerns (comorbidities).

Many patients with an SUD also struggle with depression or an anxiety disorder. Others have experienced trauma, have post-traumatic stress disorder (PTSD), or have physical health disorders ranging from diabetes to infectious diseases that also require attention. Treatment and management of these conditions should be built into the care plan to treat the whole patient.

Addressing social needs is another critical component of a care plan. Building positive relationships with peers—and others in recovery who abstain from alcohol and drug use—creates a significant protective factor for the patient. Addressing coping skills and alternate social skills is also helpful to patients, from mindfulness training (dialectical behavioral therapy) to retraining behavior patterns (cognitive behavioral therapy) to developing new social skills.

HOW TO RESPOND TO A RELAPSE

Managing slips or relapses is also a key component of a chronic care plan. Though addiction has similar relapse rates to other chronic health conditions, like asthma and diabetes, there is a general lack of understanding about how to address relapses and understand their occurrence as part of a chronic health condition (McLellan, 2000). For a person recovering from addiction, returning to drug or alcohol use after a period of remission does not mean that the patient or the treatment has "failed" (NIDA, 2018).

Relapse—or "recurrence of use"—is better understood as an important indicator that the care plan needs adjustment to better align with the patient's needs. Setbacks should be met with a modification in the care plan to help the patient restabilize and continue their chronic disease management course.

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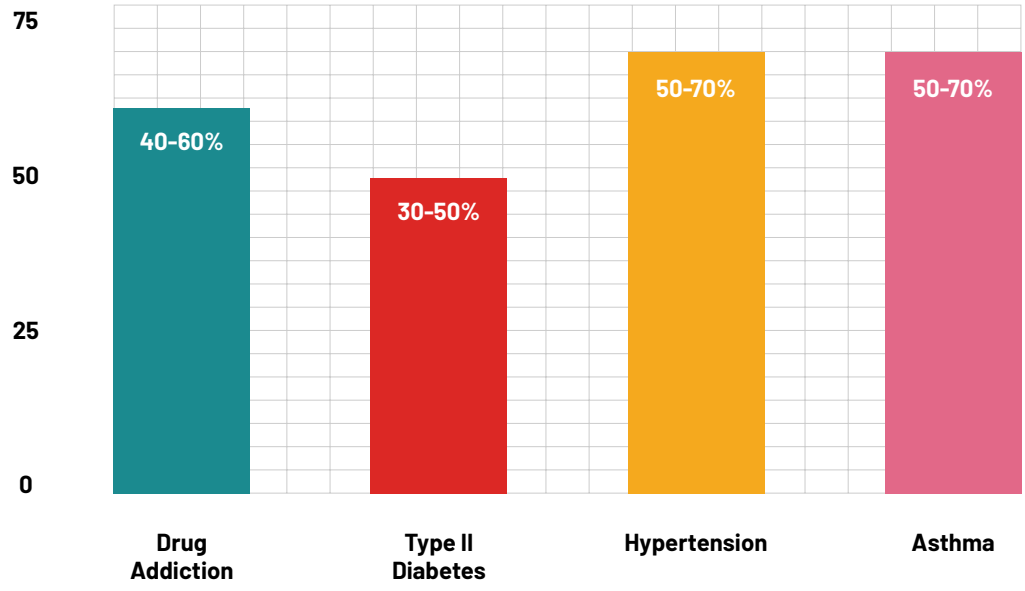
Figure 9.

RELAPSE IS COMMON IN ADDICTION AND OTHER CHRONIC DISEASES



Adapted from McLellan A. T., et al. (2000). Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation. JAMA.

If your loved one experiences a relapse, don't be discouraged. The treatment of chronic diseases involves changing deeply embedded behaviors. Healing the areas of the brain and body affected by substance use takes time.

Patients are at the highest risk of relapsing during the first 90 days after their initial treatment intervention as they are experiencing major changes within their body, mind, and social context.

Often, people start misusing substances as a way to cope with life's challenges. When substance use is stopped, individuals may lack the skills needed to cope with everyday stress.

As patients progress through treatment, they develop these skills and become more confident in their ability to handle stress without using substances. It's important to remember that people being treated for an SUD require extra support

during the period of early recovery.

Patients are also at risk when specific triggers occur, whether a job loss, relationship change, loss of a loved one, or physical injury. These stressors should be met with open dialogue with your loved one and engagement with the care team to determine whether more wraparound support is needed.

RISK AND PROTECTIVE FACTORS

Risk factors are characteristics that make an individual more susceptible to substance use disorders.

The age someone starts using alcohol or drugs is a significant risk factor. The earlier someone starts using substances, the greater their chances of developing a substance use disorder, and the more severe their illness is likely to be. Individuals in recovery from addiction report an average age of first use of 14 years old (Addiction Policy Forum, 2022).

Research also suggests that genetic factors account for about half of a person's likelihood of developing a substance use disorder. While we can't change our genetics, knowing about a family history of addiction should empower us to make different decisions about our substance use.

Other factors that put a person at risk for an addiction include parental substance misuse, trauma, and a lack of social attachments. These are called individual factors and they're part of the "big three" in areas of risk: individual, environmental, and genetic. Environmental factors include high drug availability, poverty, a lack of laws and enforcement, and social norms.

For every risk factor, there is a protective factor to counter-balance it. Strengthening the protective factors that we can control is important both for preventing the illness in other family members and relatives as well as supporting an individual recovering from a substance use disorder.

SIGNS, SYMPTOMS, AND EARLY INTERVENTION

Because substance use disorder is a progressive disease, intervening in the early stages greatly improves outcomes. Families should take warning signs seriously. Concerned significant others may report these signs and symptoms:

- A change in behavior for no apparent reason—such as acting withdrawn, frequently tired or depressed, or hostile
- Disinterest in activities that were previously enjoyable
- Loss of money, missing valuables, or borrowing behavior
- Change in daily routine
- Loss of interest in overall health, hygiene, preventative, and dental care
- Change in mood
- Change in weight or appearance
- Change in sexual behavior
- Change in weight, eating, or sleeping habits
- A decline in performance at work or school
- Change in peer group
- Secrecy regarding phone
- A tendency to disappear for hours at a time
- Deteriorating relationships
- Inability to be present when in conversation

THE MYTH OF WAITING FOR ROCK BOTTOM

Substance use disorders get worse over time. The earlier treatment starts the better the chances for long-term recovery. Many families are wrongly told to "wait for rock bottom" and that their loved one needs to feel ready to seek treatment in order for it to work. The idea that we should wait for the disease to get worse before seeking treatment is dangerous. Imagine if we waited until stage 4 to treat cancer.

Belief in this "rock bottom" can keep people who are struggling from reaching out for help. It can also keep family, friends, and care providers from addressing the issue because they have been incorrectly told that the disease has to "run its course" and that they should practice "tough love" until a person hits bottom. You shouldn't wait for the worst to happen before seeking treatment or helping a loved one, even if they don't feel "ready." Often the "moment" that helps someone get help can simply be a conversation, a letter, or a series of conversations.

Decades of research has proven that the earlier someone is treated, the better their outcomes—and that treatment works just as well for patients who are compelled to start treatment by outside forces as it does for those who are self-motivated to enter treatment.

USING NON-STIGMATIZING LANGUAGE

Research has shown that the words we use to describe SUD and recovery have a significant impact on those struggling and how they are treated. While evidence shows that SUDs are medical illnesses, it is still too common for SUDs to be characterized as a moral failing or due to lack of willpower. Disparaging words are unfortunately still used to describe SUDs and the individuals suffering from them (NIDA, 2019).

When words are used inappropriately to describe individuals with an SUD, it not only negatively distorts societal perceptions of their illness but also feeds into the stigma that can prevent individuals from seeking help. In 2014, over 22 percent of individuals with an SUD did not seek out treatment because they felt that it would have a negative impact on their employment or the way in which their neighbors and community would view them (SAMHSA, 2017). The constant inundation of negative terminology surrounding SUDs in our own communities, as well as among health professionals, educators, policymakers, and the media, reinforces these barriers that prevent individuals from seeking help. Research suggests that aligning our language to describe addiction with the prevailing research improved outcomes for the individuals.

Figure 10.

PERSON-FIRST LANGUAGE

Language Matters	
Say This	Not That
• Substance Use Disorder	• ~~Substance Abuse~~
• Individual with a Substance Use Disorder	• ~~Addict, Junkie, Druggie, Drug Abuser~~
• In Recovery	• ~~Clean~~
• Positive Drug Test	• ~~Dirty Drug Test~~

For example, when referring to people who have an SUD (or any medical illness), it's best to use person-first language—emphasizing the person before the disorder ("a person with a substance use disorder")—which restores and empowers the humanity of individuals rather than defining them by their illness.

Family members can remove words that may reinforce shame, prejudice, and discrimination from their vocabularies and replace them with more compassionate and accurate language.

HOW ADDICTION AFFECTS THE FAMILY

Family members impacted by a loved one's addiction are not alone and shouldn't be embarrassed to seek out help and support. A Pew Research Center report found that almost half of Americans report having a family member or close friend with an SUD (Gramlich, 2017).

Many families face significant challenges in responding to a loved one's addiction, including:

» **Frustration**. Information on the disease can be confusing, frustrating, and conflicting, and it can be hard to find helpful resources. It can also be difficult to watch a loved one struggle with their addiction and not take suggestions.

» **Emotional challenges**. The presence of addiction in the family often leads to taxing emotional challenges for family members. Families, naturally concerned for their loved one's well-being may become depressed, angry, withdrawn, or afraid.

» **Financial problems and lost connections**. The negative effects of addiction in the family extend to practical considerations like financial problems and loss of social connections. Caring for an impacted loved one demands time, energy, and effort, which can be expensive between medical bills and lost jobs or savings. It can also become harder to see friends, go to religious services, or participate in clubs or other community groups.

» **Increased risk for other family members**. Growing up in a family with a member who has an SUD puts an individual at greater risk of developing one and extending cycles of addiction across generations (SAMHSA, 2019). This does not just constitute a genetic risk, but is also an environmental factor that can increase the risk of developing an SUD.

» **Exhaustion**. Caring for an impacted loved one for extended periods of time can be exhausting. Relapses, general concern for the loved one and family unit, and sadness and isolation can easily give way to depression. Family members often express concerns about an impacted loved one's resistance to treatment and occasional disappearances, and can feel powerless, revolted, humiliated, and even hateful.

» **Poor self-care**. Addiction-related stressors are also associated with declines in reported well-being among family members. Time constraints can interfere with personal health practices, such as maintaining a good diet and finding opportunities for physical activity. Research shows that family members may also have problems with eating and sleeping, increased substance use, headaches, indigestion, hypertension, asthma, and other health conditions.

Figure 11.

Effective coping strategies include making time for yourself and your personal interests while practicing self-care. Awareness of the specific ways in which addiction affects the family is also helpful, as well as learning a new set of skills that must be practiced on an ongoing basis. Family therapy and family support groups (SMART Recovery Friends and Family, Alanon, Families Anonymous, and others) are also a resource for family members with a loved one struggling with addiction.

CHAPTER 3
UNDERSTANDING TREATMENT

As with most other chronic diseases, addiction is treatable. Research has confirmed many treatment modalities that help people stop using drugs and live full, healthy, and productive lives.

Today we have a wide variety of evidence-based approaches for treating a substance use disorder (SUD), from behavioral therapies to medications to wraparound recovery support. There is no "one-size-fits-all" option for treating addiction. The treatment plan will be tailored to the unique needs of your loved one and will vary depending on the types of substances used, any co-occurring health conditions, and the severity of their illness.

To better understand addiction treatment, there are five key areas to consider, including:

- the setting where treatment will occur;
- the services (interventions) that will be received by the patient, including medications;
- the clinicians and providers best suited to provide treatment;
- the assessment; and
- the length of care and follow-up.

There is a tendency to overfocus on the place—the where—when it comes to treatment. But it's important to understand the what—the services and treatment options—and the who—the type of clinician—when determining a treatment plan. We will also cover what the science tells us about getting an assessment and the length of service necessary for treatment.

GETTING AN ASSESSMENT

When you or your loved one decide to take the important step toward seeking treatment, the next critical step in the process is to determine the appropriate level of care via a professional assessment, which will help identify evidence-based services and programs and what setting is best suited for your loved one.

An assessment is when a professional—like a psychiatrist, counselor, or social worker—checks to see if a person has an SUD. This assessment, sometimes called an evaluation, is a clinical tool to determine what is going on with your loved one. Experts recommend a comprehensive assessment to determine whether there is an addiction, the severity of the SUD, and co-occurring physical or mental health disorders. The assessment may be conducted by a variety of professionals, including a board-certified psychiatrist, a board-certified addiction medicine physician, or professional counselors (CADC, MSW, LPC, LSW, LPCP, or LCSW) who look at the whole person. The setting for the assessment could be an outpatient or residential treatment program, an opioid treatment program (OTP), or an office-based opioid treatment program. No matter what, it is important to ensure that an evidence-based assessment tool is utilized.

The assessment should include:

- complete medical history;
- psychiatric assessment;
- a comprehensive interview to understand behavior; and
- a physical exam to assess health conditions.

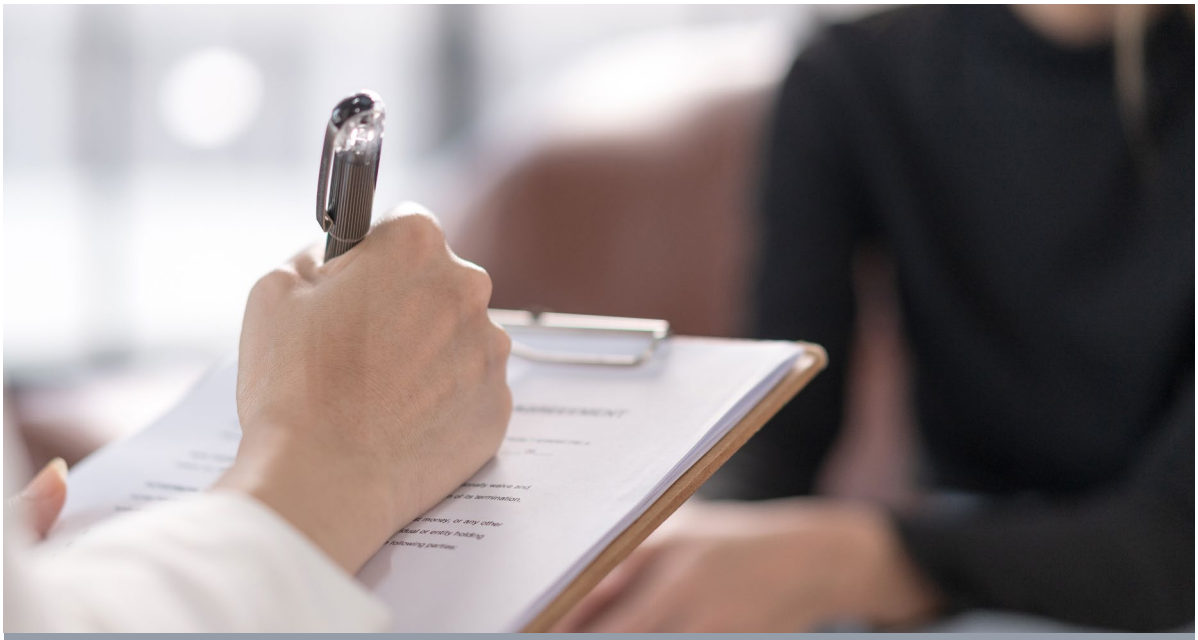
The provider may use a validated screening tool in the assessment process. A validated screening questionnaire is an instrument that has been tested for three things: reliability, validity (the ability of the instrument to produce true results), and sensitivity to ensure it correctly identifies a patient.

Two of the highest recommended assessment tools are the Diagnostic Interview Schedule-IV (DIS-IV) and Addiction Severity Index (ASI).

The *Diagnostic Interview Schedule-IV (DIS-IV)* assessment tool determines the presence of a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

The *Addiction Severity Index (ASI)* interview examines seven potential areas of concern, including medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.

The completed assessment will then be used to develop an individualized treatment and recovery plan.



Ask the Expert

Is it important to intervene early?

Dr. Mark Gold

Substance use disorders are chronic, progressive, and can be fatal. The progressive nature of this disease means that the earlier in the vicious cycle the diagnosis is made and treatment begins, the better for the person with an SUD, their brain, and their life. Family members, colleagues at work, and health providers encourage seeing a professional or going to rehab. But, it is often very difficult to know how far to go. We recommend that they try to intervene early in the course of the disease.

In the early days, their relationship to the individual is stronger than the individual's relationship to the drug or drugs of misuse. This is the best time for an intervention. Get an evaluation, see the full scope of the SUD and any other co-occurring or acquired medical problems or infectious and psychiatric diseases. Treatment works, but it is best to initiate treatment early and to monitor for many years.

Dr. Mark Gold

Dr. Gold is a University of Florida College of Medicine Teacher of the Year, translational researcher, author, mentor and inventor. He is best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food.

TREATMENT SETTINGS

There are several treatment settings available for SUD treatment, including:

01 **Intensive outpatient programs/outpatient programs.** Outpatient and intensive outpatient programs (IOPs), are traditionally recommended for patients with less severe addictions, few additional mental health problems, and a supportive living environment. Evidence suggests that more severe cases can be treated in outpatient settings as well, especially if combined with other interventions like medications for addiction treatment (MAT). Low- or moderate-intensity outpatient care is generally delivered once or twice a week. Intensive outpatient services are delivered more frequently, typically more than twice a week for at least three hours per day.

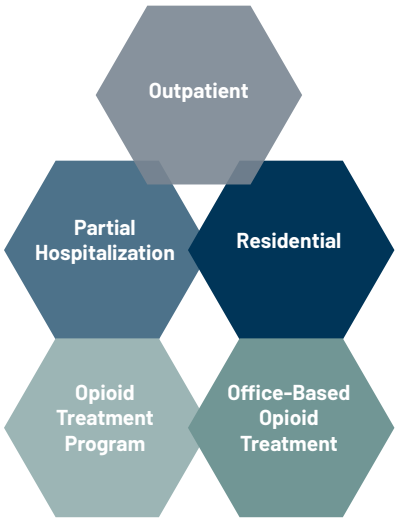
02 **Partial hospitalization programs.** Partial hospitalization or "day treatment" offers treatment for individuals who have more severe SUDs, but who can still be safely managed in their home living environment. Patients commute to a treatment center for at least 4–6 hours of treatment a day at least five days a week.

03 **Inpatient/residential programs.** Residential treatment is a more intense level of care. It is generally reserved for individuals with severe levels of addiction who require a 24-hour structured environment or who would otherwise benefit from this setting.

04 **Opioid treatment programs.** Opioid treatment programs offer supervised assessment and treatment using methadone, buprenorphine, or naltrexone for individuals who have opioid use disorders. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other supportive care.

05 **Office-based opioid treatment.** Office-based opioid treatment, or OBOT, provides treatment for opioid use disorder within a regular medical practice that can prescribe buprenorphine.

Figure 12.



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CLINICIANS

The personnel or providers best suited to provide treatment are also important components of a treatment plan. According to NIDA, addiction can be treated "in physicians' offices and mental health clinics by a variety of providers, including counselors, physicians, psychiatrists, psychologists, nurses, and social workers." Addiction is a health condition best treated by trained and licensed health professionals. Peer support specialists and recovery coaches are additional emerging professions that may be able to work with particular individuals with SUDs. These are professionals who have lived experience with an SUD and have undergone training to receive a certification.

INTERVENTIONS

Interventions and services can be delivered in any setting and include:

- cognitive behavioral therapy,
- dialectical behavioral therapy,
- counseling,
- group counseling,
- contingency management,
- medications for addiction treatment,
- mutual aid support groups (AA/NA or other 12-step support groups), and
- family therapy.

COGNITIVE BEHAVIORAL THERAPY (CBT) was developed as a method to prevent relapse when treating problem drinking, and was later adapted for individuals with cocaine use disorder. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug use and to address other problems that often co-occur with it. CBT usually involves 12 to 24 weekly individual sessions. These sessions typically explore the positive and negative consequences of substance use, and they use self-monitoring as a mechanism to recognize cravings and other situations that may lead the individual to relapse. They also help the individual develop coping strategies.

DIALECTICAL BEHAVIORAL THERAPY (DBT) was developed by Dr. Marsha Linehan in the 1980s as another approach to therapy. The main components of DBT are mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. These components can help individuals regulate their emotions, be present in the current moment, implement new coping skills, and work on relationships with other people. One of the overarching ideas that is woven into each of these components is the idea of "wise mind." When we are thinking and behaving there are three types of minds that we may be utilizing: emotional, rational, or wise mind. The emotional and rational minds are the two extremes, while the wise mind is the middle, desired path.

INDIVIDUAL COUNSELING OR THERAPY is delivered in structured sessions to help patients reduce substance use and improve function by developing effective coping strategies and life skills. Individual counseling has been extensively studied as an effective intervention for individuals with SUDs.

GROUP COUNSELING is a standard part of most SUD treatments. It complements individual counseling or other forms of individual therapy. A big part of treating addiction is learning new behaviors and changing old behaviors.

CONTINGENCY MANAGEMENT is the use of positive rewards or incentives to aid in the behavior change process. Contingency management involves giving tangible rewards to individuals to support positive behavior change, and has been found to be effective in treating SUDs. In this therapy, patients receive a gift card or voucher when they exhibit desired behavior such as drug-free urine tests or participation in treatment activities.

Clinical studies have shown that contingency management results in better treatment engagement for patients and longer periods of abstinence. Studies have shown effectiveness for individuals with cocaine use disorder, as well as those struggling with alcohol, opioid, and methamphetamine use disorders. Contingency management may be combined with other therapies or treatment components like CBT.

Figure 13.

Understanding Settings, Clinicians and Interventions		
Settings	Clinicians	Interventions
• In patient/Residential Programs • Partial Hospitalization Programs (PHP) • Intensive Outpatient Programs (IOP) • Outpatient programs • Detoxification • Opioid Treatment Programs • Office-Based Opioid Treatment	• Psychiatrists • Psychologists • Nurses • Social Workers • Physicians • Counselors	• Assessment • Cognitive Behavioral Therapy • Counseling • Group Counseling • Contingency Management • Medications for Addiction Treatment • Mutual aid support groups (AA/NA, Other 12 Step support groups) • Family Therapy

MEDICATIONS FOR ADDICTION TREATMENT (MAT)

Medications for addiction treatment (MAT) is the use of medications in combination with behavioral counseling to treat SUDs (Oesterle, 2019). There are FDA-approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder.

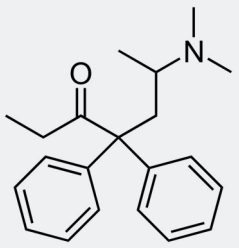
> MEDICATIONS FOR ADDICTION TREATMENT (MAT) IS THE USE OF MEDICATIONS IN COMBINATION WITH BEHAVIORAL COUNSELING TO TREAT SUBSTANCE USE DISORDERS.

Research has shown that patients who receive these medications remain in therapy longer than those who don't, and are less likely to use illicit drugs (Bell, 2019). In addition, MAT dramatically reduces the risk of overdose death as well as the transmission of infectious diseases, including HIV and hepatitis C. Medications can also be referred to as medication assisted treatment (MAT).

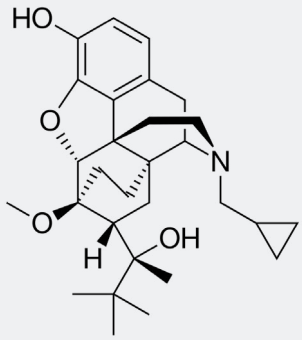
MEDICATIONS FOR OPIOID USE DISORDER

Medications used to treat opioid use disorders are considered the "gold standard" of treatment. Medications for opioid use disorder (MOUD) help stabilize brain chemistry, reduce or block the euphoric effects of opioids (the "high"), and relieve cravings so that the patient can engage in other aspects of treatment such as counseling.

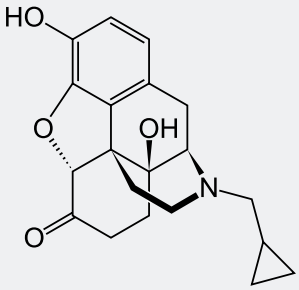
Medications should be combined with behavioral counseling for a "whole patient" approach. Types of MOUD include methadone, buprenorphine, and naltrexone.



Methadone is an agonist medication—an opioid that binds to the same opioid receptors in the brain and body as other opioids. Its longer stay in the body prevents withdrawal. Methadone for the treatment of opioid use disorder can be dispensed only through federally-regulated opioid treatment programs (OTPs) (LaRochelle, 2018).



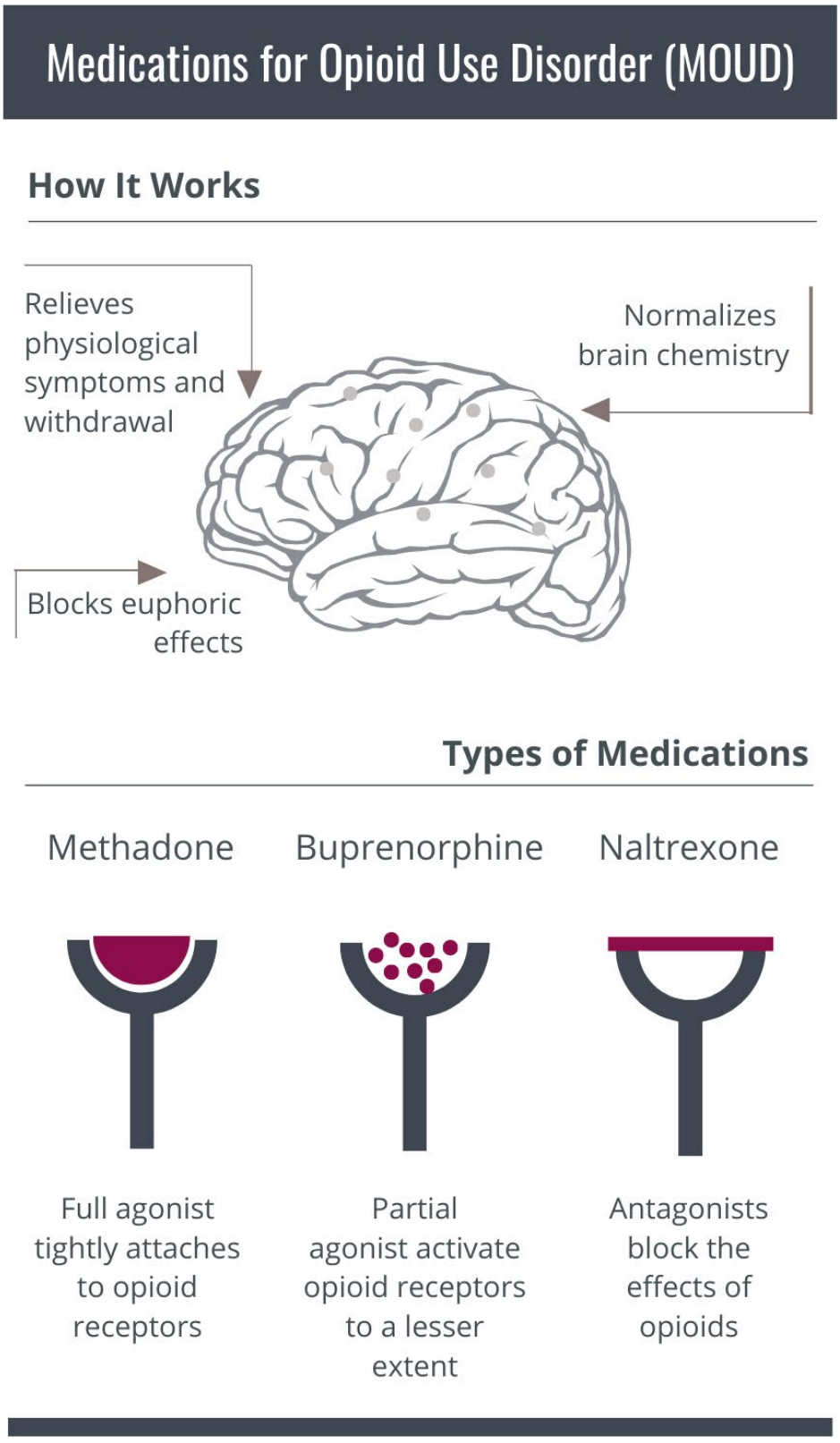
Buprenorphine is also called "bupe" and is distributed under various brand names. A partial agonist, it binds to the same receptors as methadone and other opioids, but produces a less intense effect. It can be dispensed by an OTP or prescribed by physicians, nurse practitioners, or physician assistants in an office-based setting if the prescriber has completed required training and obtained a waiver from the Drug Enforcement Administration (DEA). Brand names Subutex® and Suboxone® (a combination of buprenorphine and naloxone) are available, as well as an implant (Probuphine®), or a long-acting injectable (Sublocade®).



Naltrexone is an antagonist that prevents opioids from binding to opioid receptors in the brain. Patients do not develop a dependence on naltrexone and it cannot be misused (SAMHSA, 2019). Physicians, nurse practitioners, and physician assistants can prescribe and administer naltrexone without an additional license. A long-acting injectable naltrexone formulation is available under the brand name Vivitrol®.

Figure 14.

HOW THE MEDICATIONS WORK TO TREAT OPIOID USE DISORDER



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LONG-ACTING INJECTABLES AND IMPLANTS

Another medication option for opioid use disorder is a long-acting injectable. Often patients receive a daily dose of buprenorphine, which was approved by the FDA in 2002 and has had effective outcomes for those suffering from opioid use disorder. However, it can often be challenging for individuals to commit to taking medications every day. Another issue is that cravings will often return after the 24-hour cycle. More recently, the FDA has approved extended-release injectables which have had positive results in recent studies.

Three long-acting medication options include:

Sublocade™ a once-monthly buprenorphine injection for adults with an opioid use disorder;

Probuphine® an implantable buprenorphine formulation that eliminates the need for daily dosing and improves treatment retention; and

Vivitrol® a long-acting injectable formulation of naltrexone for the treatment of opioid use disorder and alcohol use disorder.

ALCOHOL USE DISORDER MEDICATIONS

There are three FDA-approved medications to treat alcohol use disorder:

Acamprosate (Campral®) supports patients in recovery from alcohol use disorder by lessening some of the negative symptoms of extended abstinence, such as insomnia, anxiety, restlessness, and depression. It is a pill taken three times per day. It may be most effective for patients with severe addiction.

Disulfiram (Antabuse®) interferes with the body's breakdown of alcohol and causes unpleasant symptoms when a person drinks, such as nausea, irregular heartbeat, and face flushing.

Naltrexone reduces cravings for alcohol and rewards from drinking by blocking certain receptors in the brain. It is available as a pill taken daily or as a monthly injection.

NICOTINE USE DISORDER MEDICATIONS

Nicotine replacement therapies have several forms, including the patch, nasal spray, gum, inhalers, and lozenges. These products are available over the counter.

In addition, there are two FDA-approved medications for the treatment of nicotine use disorder:

Bupropion (Zyban®) helps reduce withdrawal symptoms. It is also approved for the treatment of depression.

Varenicline (Chantix®) blocks the effects of nicotine to help reduce cravings and withdrawal symptoms.

ADDRESSING MYTHS ABOUT MEDICATIONS

A common misconception associated with MAT is that it "substitutes one drug for another." That is not the case. Instead, these medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT provides a safe and controlled level of medication to help in the treatment of an SUD. Research has shown that, when provided at the proper dose, these medications have no adverse effects on a person's intelligence, mental capability, physical functioning, or employability.

- **Does MAT get a person high?** No. For patients being treated for opioid addiction with MAT, the dosage used does not get them "high." It reduces cravings and withdrawal symptoms and rebalances the key circuits in the brain affected by addiction.
- **Isn't buprenorphine sold on the street?** Research has shown that, when diversion of buprenorphine occurs, it is primarily used for self-management of withdrawal symptoms.

WORKSHEET

TREATMENT AND RECOVERY PLAN

Timing	Setting	Services
1 - 2 months		
3 - 12 months		
Year 2 - 5		

Ask the Expert

When should you consider long-acting injectables?

Dr. Brian Fuehrlein

Long-acting injectable medications serve a variety of purposes and can have significant advantages over medications taken by mouth. It is often very difficult for patients to be compliant with daily medications. Patients have busy, sometimes chaotic lives. Some may be homeless with poor social supports, many travel frequently, etc. Long-acting injectable medications are typically given one time per month with no worry about compliance during the remainder of the month. They also have an advantage for patients who are not motivated for sobriety.

Many patients stop taking oral medications due to lack of motivation. This often leads to a relapse. Injectable medications are good for the entire month. Oral medications may become lost or stolen as well.

Dr. Brian Fuehrlein

Associate Professor of Psychiatry, Yale University School of Medicine; Director, Psychiatric Emergency Room, VA Connecticut Healthcare System

Ask the Expert

Is MAT just moving from one drug to another?

Dr. James Berry

This is a common question that I'm asked by a variety of people ranging from patients, patients' family members, other doctors, judges, etc. In most instances, I believe the motivation behind the question is a sincere desire to protect vulnerable people from harm. It seems counterintuitive that a doctor would give a patient with "a pill problem" a pill to solve the problem! Add to this the understandable distrust of pharmaceutical makers whose policies helped fuel our opioid epidemic and certainly engendered suspicion about medications in general.

However, my own experience using medications to treat addiction is that they prevent harm and foster well-being. This experience is supported by solid evidence demonstrating that people who are appropriately treated with FDA-approved medications for addiction have much better outcomes than those who are not. A significant reason why these medications can be so helpful is that they minimize the persistent cravings and sickness which overwhelms one who suffers from addiction. It is very difficult to focus on taking care of yourself and participate in healthy activities while every fiber in your body is screaming to satisfy the craving and feel better.

Medications approved for Opioid Use Disorder, for instance, rest on the receptors in the brain responsible for opioid cravings to the point that these cravings are manageable. Over and over again, I have found that once these cravings are under control, patients are much more likely to build recovery tools into their lives. They are more likely to attend mutual support groups, individual therapy, practice wellness and follow up with healthcare appointments. The evidence is also very clear that these medications decrease risk of overdose and minimize the spread of infectious disease such as HIV.

When I have conversations with loved ones who express reservations regarding a patient's decision to utilize medications as part of their treatment, I ask them to be patient and consider the goals of treatment.

I propose the two most important goals are: number one, keep the person alive and number two, increase the quality of the life lived. I encourage them to not focus so much on the medication, rather focus on the outcomes. Over time, is he looking stronger? Has she been able to keep a job? Is she attending family functions? Is he parenting better? Is he less irritable? Does she still appear intoxicated? If the patient doesn't look or sound any different and is still engaging in unhealthy behaviors, then it is possible that he or she has simply moved from one drug to another. The patient may need a different type of treatment or escalation in care. However, for many, there is a dramatic and palpable difference in well-being which makes it obvious that the treatment is contributing to positive changes rather than the harm of ongoing substance use.

Dr. James Berry

Dr. Berry is an associate professor and Chairman of the West Virginia University Department of Psychiatry and is board certified in both general psychiatry and addiction psychiatry

PATIENTS NEED MULTIPLE INTERVENTIONS AND SERVICES

Addiction Policy Forum conducted a large-scale study to map the patient's journey through treatment and recovery in 2022, *Patient Journey Map: Substance Use Disorder Treatment and Recovery Experiences*. The mapping underscored the need for layered interventions across three critical domains: 1) biological, or physical health, 2) psychological, and 3) social (Addiction Policy Forum, 2022).

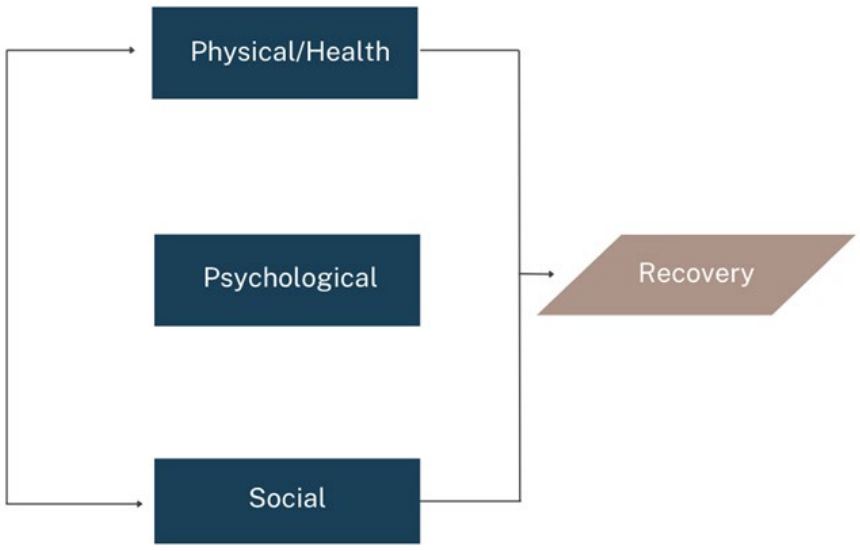
Biological interventions include MAT, medical care for other health conditions, prescriptions for mental health disorders and other chronic conditions like heart disease and diabetes, as well as self-care priorities that include sleep, exercise, and proper nutrition. Forty-seven percent of participants in the study utilized an intervention or service to address physical health.

Three out of four patients required psychological interventions. Psychological interventions include mental health counseling, group counseling, CBT, building a relapse prevention plan, identification and awareness of triggers for substance use (such as high risk people, places and things), and resource-focused strategies like learning new coping skills.

Ninety-five percent of patients required social interventions. Social components include building a positive social network, commonly through support group participation and new hobbies and activities. This also includes cutting out old friends and the individual's using network.

Figure 15.

THREE LAYERS OF SERVICES NEEDED IN TREATMENT



LENGTH OF TREATMENT

Like other medical conditions, SUD treatment must be strong enough and long enough to effectively treat the disease. NIDA uses the analogy of a bacterial infection, which requires antibiotics taken at a high enough dose and for a long enough period of time to kill all the bacteria. This means that patients might need to continue taking medication even after their symptoms are gone—otherwise the infection might come back and be harder to fight.

The same is true of SUDs. Insufficient treatment increases the risk that individuals will return to substance use, leading them to feel hopeless about their condition and the benefits of treatment.

We often hear of 28 days being the standard of care for addiction treatment. We see it in TV shows, movies, and even advertised by some treatment providers. However, research has shown that the longer a patient receives treatment, the better the chance of long-term recovery.

The best outcomes for substance use disorders come from systems of care management that include quality treatment, close monitoring, and engagement in community-based recovery support for up to five years—not 28 days. While 28 days is a start, it is only the beginning of a treatment plan that should last much longer.

WHAT TO LOOK FOR IN QUALITY TREATMENT

Treatment works. We do not have genetic or other tests like they do for cancer or other medical diseases that individualize and predict which treatment will work for which patient with an SUD. We have determined how to match a person to a treatment or program by trial and error and years of experience.

After determining the best treatment categories for an individual based on the severity and specific type of substance use, the next step is to research the available offerings to make informed choices on the best treatment plan. Finding a treatment program can seem daunting. There are many factors to consider when choosing a program that is right for those with SUDs and their loved ones, including the quality and affordability of the treatment program. There are 15 quality criteria to look for in a treatment program.

15 QUESTIONS TO ASK WHEN LOOKING FOR A TREATMENT PROVIDER

Addiction Policy Forum recommends the following 15 key questions and criteria to consider when choosing a treatment provider:

01 Is the program licensed and accredited?

02 Do they have a full time addiction physician, more than one, or a part-time MD?

03 Do they use urine and other drug testing and validated assessment tools to determine what level of care their patients need?

04 How do they develop a patient's treatment plan? Is it personalized?

05 Does the patient play a role in developing the plan?

06 Do they regularly monitor the patient's progress and adjust the treatment plan if needed? How do they motivate patients to remain engaged in treatment?

07 Do they screen for co-occurring medical, infectious, and mental health problems such as depression, anxiety, hepatitis C, and trauma? Do they provide mental health treatment as needed?

08 Do they provide medications for patients with opioid or alcohol use disorder?

09 What types of providers will be providing you or your loved one's care? What are their credentials?

10 What is the ratio of patients to staff?

11 Do they provide the levels and types of care you think you or your loved one will need (such as trauma-informed care or family counseling)?

12 Do they have experience working with patients who have different backgrounds and needs (adolescents, LGBTQIA+, American Indian, veterans)? Can they provide culturally competent care?

13 How do they respond to a relapse? Do they develop a plan for continuing care when the patient leaves their program?

14 Do they coordinate with the patient's other healthcare providers?

15 Do they help engage patients in ongoing recovery support services?

CHECKLIST

QUALITY TREATMENT

- ☐ Is the program licensed and accredited?
- ☐ Do they have a full time Addiction Physician, more than one, or a part-time MD?
- ☐ Do they use urine and other drug testing and validated assessment tools to determine what level of care their patient needs?
- ☐ How do they develop a patient's treatment plan? Is it personalized?
- ☐ Does the patient play a role in developing the plan?
- ☐ Do they regularly monitor the patient's progress and adjust the treatment plan if needed? How do they motivate patients to remain engaged in treatment?
- ☐ Do they screen for co-occurring medical, infectious, and mental health problems such as depression, anxiety, hepatitis C, and trauma? Do they provide mental health treatment as needed?
- ☐ Do they provide medications for patients with opioid or alcohol use disorder?
- ☐ What types of providers will be providing you or your loved one's care? What are their credentials?
- ☐ What is the ratio of patients to staff?
- ☐ Do they provide the levels and types of care you think you or your loved one will need (such as trauma-informed care or family counseling)?
- ☐ Do they have experience working with patients who have different backgrounds and needs (adolescents, LGBTQIA+, American Indian, veterans)? Can they provide culturally competent care?
- ☐ How do they respond to a relapse? Do they develop a plan for continuing care when the patient leaves their program?
- ☐ Do they coordinate with the patient's other healthcare providers?
- ☐ Do they help engage patients in ongoing recovery support services?

ASAM LEVELS OF CARE

The American Society of Addiction Medicine (ASAM) has established five main levels in a continuum of care for substance use disorder treatment that a provider may reference. They include:

Level 0.5: Early Intervention Services

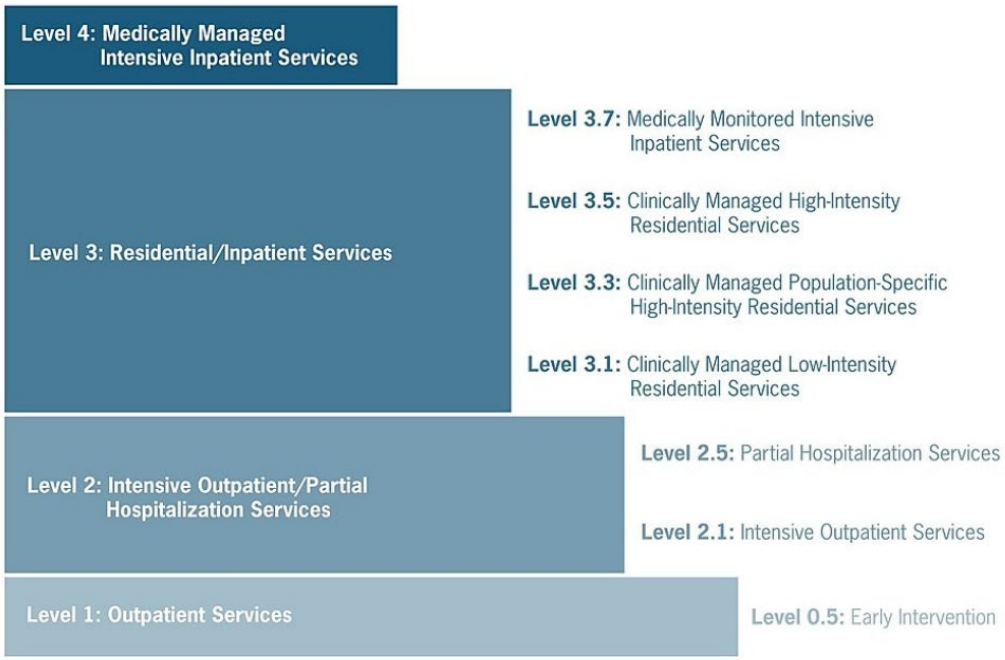
Level 1: Outpatient Services

Level 2: Intensive Outpatient/Partial Hospitalization Services

Level 3: Residential/Inpatient Services

Level 4: Medically Managed Intensive Inpatient Services

Figure 16.



Source: American Society of Addiction Medicine

PAYING FOR TREATMENT

When considering treatment options, it is important to determine how to pay for it. Typically, health insurance provides at least partial coverage for addiction treatment. Check to see whether you or your loved one will have coverage from any of the following:

- private, employer sponsored health insurance;
- plans purchased on the Health Insurance Marketplace;
- government insurance; and
- Medicaid or Medicare.

In the absence of health insurance, there still may be options for paying for treatment, including:

- state or local government programs (sometimes referred to as state funding);
- employee assistance programs;
- loans or other financing; and
- scholarships.

PARITY

The passage of the Mental Health Parity and Addiction Equity Act (2008) and the Affordable Care Act (2010) provided significant help in making treatment for SUDs more accessible and affordable. Now, health insurance providers through employers, the Health Insurance Marketplace, and government plans like Medicaid and Medicare are required to cover addiction treatment services at the same level as any other medical treatments.

Here are steps an individual can take to find out what services are covered and at what level.

Look online or contact the individual's insurance provider to obtain a summary of benefits and coverage for mental health and addiction treatment.

» For Medicare coverage information, visit Medicare.gov or call 1-800-633-4227.

» For Medicaid information, find your state on this website (https://www.medicaid.gov/state-overviews/index.html) and then search for benefits and coverage.

Review the summary of benefits and coverage, or ask a representative to get answers to the following:

» Are healthcare providers required to get prior authorization from the insurance company before treating SUDs?

» What, if any, out-of-pocket expenses (deductibles or copays) will apply? How are they estimated?

» Are there limits on the number of days or episodes of treatment that are covered?

» Which treatment providers are in my insurance network?

Ask the Expert

How do you treat methamphetamine use disorder?

Dr. Jean Lud Cadet

The treatment of individuals who suffer from methamphetamine use disorder is very complex. There is, at present, no FDA-approved medication for methamphetamine use disorder.

During the past decades, many pharmacological agents have been tried with different populations of methamphetamine users, with very little or no success. These medications, which are available for other neurological or psychiatric conditions, include aripiprazole, baclofen, bupropion, ibudilast, mirtazapine, modafinil, naltrexone, perindopril, and several antidepressant medications. Because ketamine is effective in some patients who suffer from major affective disorders, clinicians may be tempted to try it in the case of methamphetamine users. This is not advisable in view of the potential toxic interactions of these two drugs.

Because there is no effective FDA-approved medication, the clinician will need to devise a treatment program that is focused on the needs of each individual user. Such a program should include an initial hospitalization for a complete neurocognitive assessment.

Non-pharmacological approaches should then include cognitive behavioral therapy, contingency management, and exercise. The addition of cognitive enhancers, especially in users who show cognitive deficits on comprehensive evaluation, is paramount to help improve cognitive functions.

A program should include an initial hospitalization for a complete neurocognitive assessment. Non-pharmacological approaches should then include cognitive behavioral therapy, contingency management, and exercise.

Because there are no magic bullets, the treatment team will need to try different medications under the supervision of a very skilled psychopharmacologist. This approach is important because the nature and magnitude of cognitive deficits and medical problems associated with chronic methamphetamine use increase the risk of poorer health outcomes, unemployment, high-risk behaviors, and treatment non-adherence and repeated relapses. For example, during treatment, drug-seeking behaviors are maintained to a higher level in patients who exhibit deficits in executive function and memory and these patients end up with poor treatment outcomes.

Finally, interventions with repeated transcranial magnetic stimulation may be added to the armamentarium against methamphetamine use disorder.

Dr. Jean Lud Cadet

Dr. Cadet is a neurologist and also a psychiatrist who is a senior National Institutes of Health (NIH) investigator and the chief of the Molecular Neuropsychiatry Research Branch.

Ask the Expert

My daughter has an eating disorder and an opioid use disorder. What do I do?

Dr. Nicole Avena, PhD, Princeton University

It is actually more common for those with eating disorders (EDs) to misuse substances than those without an ED. According to the National Center on Addiction and Substance Abuse, around 50 percent of women with eating disorders struggle with some kind of SUD. The relationship between these disorders is multifaceted. Studies have shown that both EDs and SUDs can arise from the same set of personality traits or past experiences. Both kinds of disorders can be ways of coping with trauma in the past. Substance use can also be an enabler for the ED. Drugs can speed up metabolism or suppress appetite, which is desirable specifically for those suffering from anorexia (Killeen, 2015).

It is important, while seeking treatment, that individuals acknowledge that the same underlying issues for their disorders can be expressed in multiple ways. Post-traumatic stress disorder (PTSD) is seen as a common underlying factor in women suffering from both EDs and SUDs (Cohen, 2010).

Certain personality traits have also been cited as indicators for the propensity to develop multiple disorders. However, it is important to note that these personality traits, including self-destructive and erratic behavior, are much more consistent and obvious when comparing subsets of ED sufferers with and without the comorbidity of an SUD. Conversely, comparing ED sufferers with substance use sufferers leads to a much less significant correlation. This indicates that there is a very specific set of traits that intersect in individuals with both SUDs and EDs.

The exact type of ED and SUD is also important to consider, as it can help make a more specific diagnosis and a more highly-tailored treatment plan. For example, according to Clinical Psychology Review, a substance use comorbidity is more often seen with bulimia nervosa and binge/purge anorexia than with restrictive anorexia (Wolf, 2000). This occurs because of the similar physiological effects of using drugs and purging.

Opioids offer a rush of endorphins to the user, an effect that is also mimicked by the action of purging. Examining the differences between eating disorders—and why they often coexist with other substance use disorders—can lead to answers about how to treat these disorders.

According to the National Eating Disorder Association, it is important to distinguish between the types of substance an individual is misusing. Most eating disorder clinics are familiar with abuse of laxatives, diuretics, and other over-the-counter drugs, but if serious addiction to illicit drugs is involved, treatment must involve professionals trained in that field (National Eating Disorders Association, 2018).

In terms of what parents can do, the best thing is to make sure that you are working with a practitioner who has experience in treating both conditions, so that there is a coordination of care. The ED and the substance use problem need to be addressed concurrently.

Nicole Avena, PhD

Dr. Nicole Avena is a Mount Sinai Medical School research neuroscientist and Princeton University expert in the fields of nutrition, diet and addiction

TREATMENT NOTES

CHAPTER 4

NALOXONE AND HARM REDUCTION

It is important for family members to understand harm reduction, or how to reduce the negative consequences of substance use. For our loved ones, we want to prevent misuse, addiction, and various negative health consequences, from infections to injuries to overdose.

We understand this concept well when we consider other risky behaviors. For driving, which is risky, we want drivers to follow speed limits and wear seatbelts. For sexual activity, we want individuals to practice safe sex by using condoms and getting tested for sexually transmitted diseases. For riding a bicycle or motorcycle, we want people to wear a helmet. For alcohol use, we have social guidance that instructs individuals not to drink before 5 p.m., to avoid drinking alone, and not to drink and drive.

For substance use, from alcohol to nicotine to illicit drugs, harm reduction should begin when the use of the substance begins. There is a broad spectrum of harm reduction strategies, including safer use and managed use, disease prevention strategies, and overdose reversal medications, among other things. The frequency and duration of substance use play an important role in whether an SUD develops. For example, frequent binge drinking increases the likelihood of developing an alcohol use disorder. Therefore, one harm reduction strategy is to encourage individuals to control the frequency and amount of use to reduce the likelihood of developing an SUD.

DISEASE PREVENTION

There are specific harm reduction strategies that help prevent infections and infectious diseases, particularly for IV drug use. Syringe service programs (SSPs), also called needle exchange programs, are a harm reduction approach to reduce infectious diseases and overdose death, and improve access to treatment for individuals with substance use disorder. SSPs have been shown to reduce human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other infectious disease transmissions. Research shows that people participating in SSPs are three times more likely to stop or reduce injection drug use and five times more likely to enter SUD treatment programs than those not participating in SSPs (Ruiz, 2019).

REVERSING OVERDOSE

A person may experience an overdose if they take in a toxic amount of alcohol or another substance that interferes with their body and brain's normal functioning. Drug overdoses may be deadly, but even when they are not, the toxicity associated with them can have detrimental short- and long-term effects on one's health.

Many substances can cause an overdose, including:

- alcohol;
- opioids;
- benzodiazepines; and
- stimulants, such as cocaine and methamphetamine.

Symptoms of an **opioid overdose** include:

- loss of consciousness, nodding off;
- pinpoint pupils;
- breathing difficulties (slowed, labored, and/or irregular breathing);
- choking, gurgling, or snoring sounds; and
- blue or purple lips or fingertips.

Signs of **alcohol poisoning** include:

- confusion;
- vomiting;
- seizures;
- slow breathing or irregular breathing;
- blue-tinged skin or pale skin;
- low body temperature (hypothermia); and
- passing out (unconsciousness) where the individual can't be roused.

Signs of a **benzodiazepine** overdose may include:

- slurred speech and confusion;
- drowsiness and loss of consciousness;
- shallow or slowed breathing;
- uncoordinated movements; and
- seizures.

NALOXONE

Naloxone is a medication to treat an opioid overdose. It works by reversing the effects of opioids on the brain and nervous system so the individual can breathe again. It has been used in emergency rooms for decades to treat people who have overdosed on opioids like heroin or prescription painkillers.

Naloxone is available in two forms: intramuscular and nasal. The intramuscular form is injected into the muscle, while the nasal spray is sprayed in the nose. After administering naloxone, it is imperative that you call 911 and seek immediate medical attention, because an individual can go back into an overdose once the naloxone has worn off. You may also need to administer more than one dose of naloxone due to the type of opioid or amount of opioids within someone's system. It is also important to seek medical attention to help with the connection to care and addiction treatment to prevent another overdose and to address the underlying SUD.

Having naloxone on hand is a critical step for family members who have a loved one with an opioid use disorder. You can't connect a person to treatment if they overdose and die, so life-saving naloxone is a necessity. Naloxone is to an opioid overdose as a tourniquet is to a gunshot wound or automated external defibrillator (AED) paddles are to a heart attack.

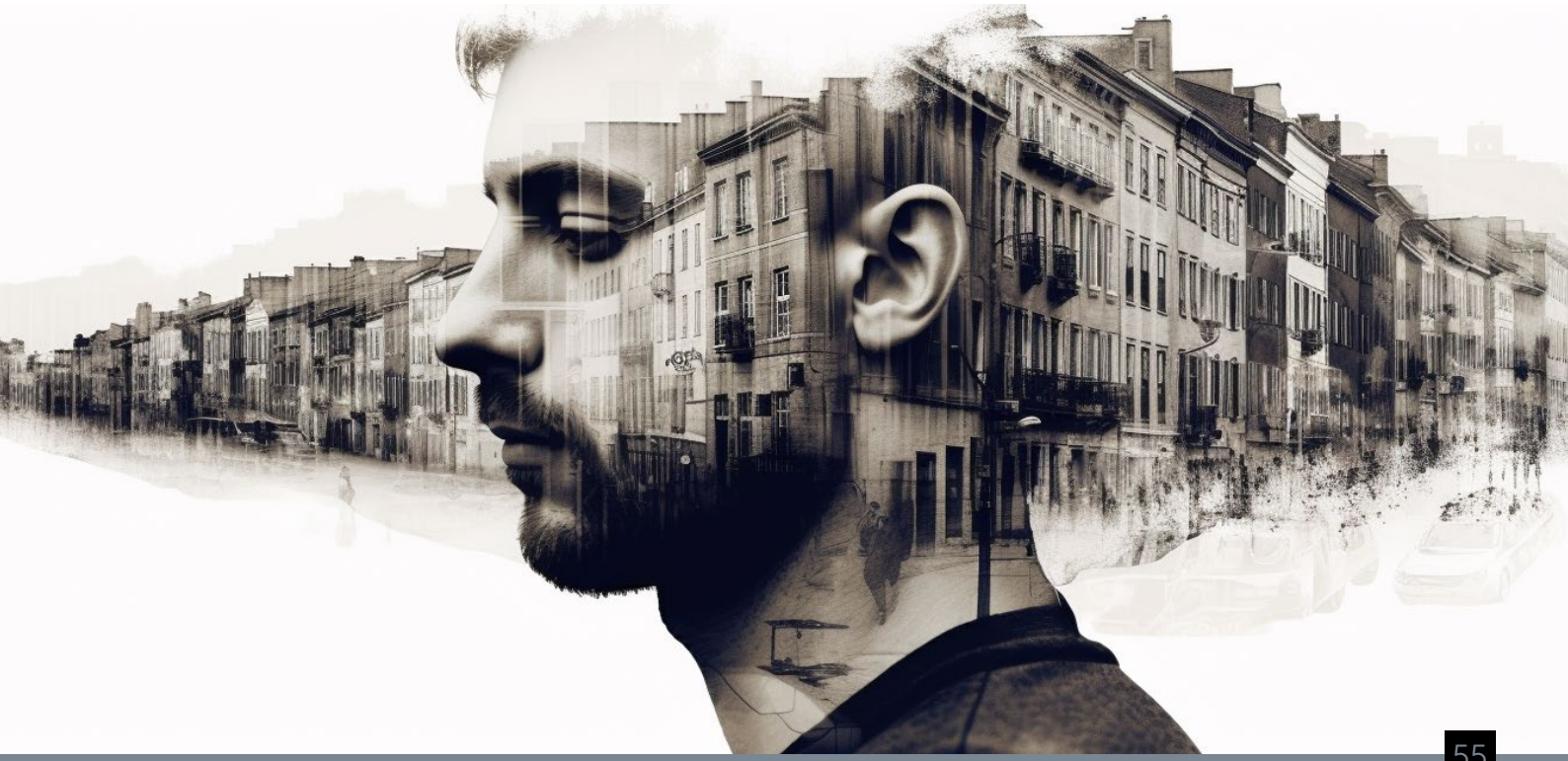
Naloxone only works on opioids. To date, we do not have medications to reverse stimulant, alcohol, or benzodiazepine overdoses.

FENTANYL TEST STRIPS

Fentanyl is a powerful synthetic opioid found in many illicit drugs. It is a synthetic opioid that's 50 times stronger than heroin and 100 times more potent than morphine. It's used to treat severe, chronic pain after surgery or in people with conditions like cancer or Crohn's disease. It's often mixed with other substances, which makes it difficult to detect. Fentanyl exposure is currently the largest driver of overdoses in the U.S.

Fentanyl test strips are a type of harm reduction tool used to identify the presence of fentanyl in drugs and other substances. They enable an individual to test for the presence of fentanyl in any drug, including heroin, cocaine, methamphetamine, and counterfeit prescription opioids and other medications made to look like legitimate medications.

Fentanyl test strips are a tool to help protect people from overdoses caused by fentanyl. They can help identify what kind of substance you have before using it, and they're easy to use at home or anywhere else. It's important to note that these tests are not 100% accurate and don't check for all possible contaminants or harmful substances.



CHAPTER 5
RECOVERY

People can and do recover from addiction. Like other chronic diseases, such as cancer or heart disease, recovery support for SUD helps patients manage their condition.

Recovery is a process—different for each person—that often begins with addiction treatment but lasts well after the treatment period is over. Most people recovering from severe SUD need ongoing monitoring and long-term recovery support.

> **LIKE OTHER CHRONIC DISEASES, SUCH AS CANCER OR HEART DISEASE, RECOVERY SUPPORT FOR SUD HELPS PATIENTS MANAGE THEIR CONDITION.**

There are many different types of recovery options available. It is important that people seeking recovery from SUD are given guidance from care providers and are empowered to choose a path that will work best for them.

BIOPSYCHOSOCIAL AND RECOVERY

As you learned earlier, there are three components in the biopsychosocial model of addiction and other chronic diseases. As such, there are three domains of recovery support needed—the biopsychosocial needs in recovery.

Biological components include improvements to physical health and well-being, which may involve medications to treat addiction and other mental health conditions, exercise, mindfulness training, and improvements to diet and sleep.

Psychological components can include individual counseling, group counseling, and learning new coping skills.

Social components involve building new and supportive relationships, cutting out old friends or using networks unhelpful to recovery, and developing new hobbies.

CHECKLIST

BIOPSYCHOSOCIAL NEEDS IN RECOVERY

BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
☐ Medications	☐ Counseling	☐ Friends and family supportive of recovery
☐ Exercise	☐ Group therapy	☐ New hobbies
☐ Nutrition	☐ Positive coping skills	☐ Support group
☐ Sleep	☐ Sense of meaning and purpose	☐ Volunteer activities
☐ Health insurance	☐ Daily routine	
☐ Regular physicals/ healthcare		
☐ Basic needs (housing/ food)		
☐ Transportation		

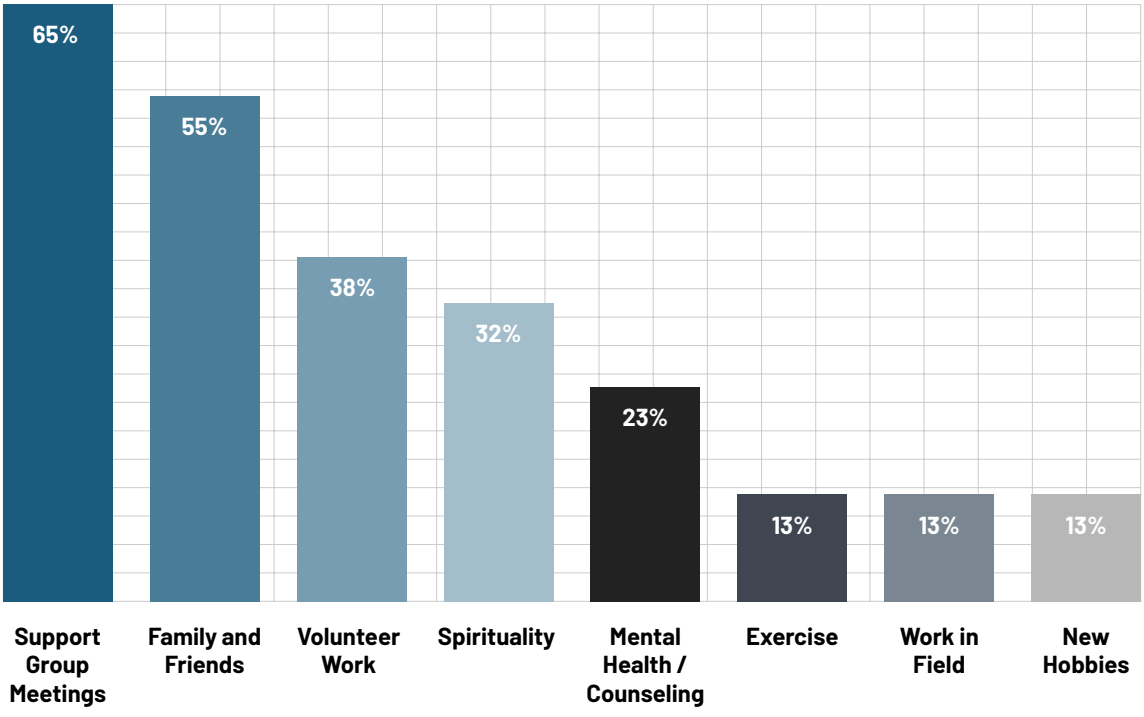
MULTIPLE SERVICES NEEDED FOR RECOVERY SUPPORT

Addiction Policy Forum's 2022 mapping project highlighted that individuals rely on multiple supports in long-term recovery, using an average of three different ones. The most common were support groups (65%), family and friends (55%), volunteer and service work (38%), and mental health/counseling (23%). Patients in recovery from SUDs continue supports specific to their needs for years or even decades. Just as a treatment plan should be individualized to a patient, these recovery supports are also individualized.

INDIVIDUALS IN RECOVERY UTILIZE AN AVERAGE OF THREE SEPARATE SERVICES OR SUPPORTS.

Figure 17.

ACTIVITIES AND SERVICES UTILIZED IN LONG-TERM RECOVERY



This information shared by individuals in recovery is a reminder that multiple strategies or interventions are necessary in long-term recovery.

IDENTIFYING TRIGGERS

One of the most challenging aspects of recovery is avoiding triggers. A trigger is something that brings back feelings from a past experience with an SUD or makes an individual think about wanting to use a substance, which can lead to relapse. An important component of recovery is being aware of triggers and building strategies to address them.

Triggers can be people, places, things, or emotions and often include:

- being around people an individual drank/used with or bought substances from during active addiction;
- feelings of stress, anxiety, and depression;
- places like bars or clubs;
- a difficult social situation;
- loneliness or isolation from others;
- boredom and restlessness;
- holidays or specific anniversaries;
- a certain beverage an individual frequently drank while using substances; and
- items an individual may have used while using substances, like needles, tin foil, a lighter, etc.

There are several tools and resources individuals in recovery can use to identify and manage triggers, including cognitive behavioral therapy, counseling, and specific strategies like creating a HALT plan (see more information about this in the next section) and relapse prevention plan.

TRIGGER WORKSHEET

PEOPLE, PLACES, AND THINGS

Self-awareness of triggers and strategies to address them are a key component of recovery. An individual in recovery can use this worksheet to record triggers

PEOPLE	PLACES	THINGS

List coping skills to combat triggers.

PEOPLE	PLACES	THINGS

HALT PLAN

The HALT method is a four-part system that helps an individual check in with their emotional state and spot triggers that may lead to unhealthy decisions. It was originally developed by addiction counselors as a way for people in recovery from SUDs to recognize their own personal triggers for relapse.

> **HALT IS AN ACRONYM FOR HUNGRY, ANGRY, LONELY, AND TIRED.**

HALT is an acronym for hungry, angry, lonely, and tired. These four emotional states render individuals more sensitive and are common triggers that can cause them to make unhealthy decisions.

An individual in recovery can build a plan for these four key stressors by answering the following questions:

- What action steps can you take to try to avoid experiencing these four triggers?
- In what ways will you manage these triggers to try to avoid making poor decisions?
- How will you tell whether you are feeling one of these triggers?
- What will you do if one of these triggers starts to pop up?

The HALT method encourages people in recovery from SUD to build a plan for these four key stressors—helping them stay on track so they can reach their goals of health and wellness.

WORKSHEET

HALT PLAN

Check in with each of these when you are feeling off to see if you are expericing any of the HALT triggers.

H	Hungry. Are you hungry? Are you eating three meals a day? Do you need a snack?	☐
A	Angry. Are you angry? Are you anxious? Take time to assess how you're feeling and construct a plan to express your emotions in healthy ways.	☐
L	Lonely. Feeling disconnected can be difficult. Assess your feelings and check in with your support system. Don't hesitate in letting your friends and families know you need support.	☐
T	Tired. Being tired can take a big toll on your health and wellness and affect your decision-making abilities. Get the right amount of sleep for you. Rest when you need it.	☐

Fill out the following worksheet to determine how you can be proactive and avoid the HALT triggers.

H

» Hungry
» What can you do to prevent being hungry?
» When and where do you find yourself experiencing hunger?
» What are warning signs that you are experiencing hunger?

A

» Angry
» What are your triggers for experiencing anger?
» What are warning signs that you may be experiencing anger?
» What coping skills can you implement when you are feeling angry?

L

» Lonely.
» When do you tend to feel lonely?
» What are warning signs that you may be feeling lonely?
» What can you do when you are feeling lonely?

T

» Tired
» When do you usually experience feeling tired?
» What are warning signs/markers the indicate you are tired?
» How can you proceed when you are feeling tired?

RELAPSE PREVENTION PLAN

A relapse prevention plan is an essential component of addiction treatment and recovery. It is a cognitive-behavioral therapy tool developed by psychologist Alan Marlatt in the 1980s. The plan is a document that outlines what an individual can do if they start to experience thoughts of using, uncomfortable moments, challenges, triggers, symptoms of depression, or anxiety. It can help an individual in recovery be prepared for stressors and prevent a relapse. Having a relapse prevention plan is a critical tool in the toolbox that can help protect recovery.

A relapse prevention plan has six key components:

01 **Recovery goals.** Write down your recovery goals and what motivates you to make positive changes to your health and wellness. Make sure to write your goals in the SMART goal format (specific, measurable, achievable, relevant, and time-bound).

02 **Identify triggers.** Identify triggers: the people, places, things, and emotions that create the feeling or urge to want to use drugs or alcohol. Triggers range from things like a certain song that comes on the radio, to feeling the urge to drink to decompress from work or a stressful experience, to navigating a social situation with alcohol or drugs present.

03 **Managing triggers and cravings.** What tools do you have to manage stress and triggers? New activities, support group meetings, stress-management ideas, and coping strategies can be included in your plan. Healthy coping skills help us respond to stress, anxiety, frustration, or other triggering feelings. If you do not replace old coping skills, you may revert to old behaviors, which could include using substances. It is also important to develop healthy routines, like getting quality sleep, good nutrition, and exercise, to help manage stress.

04 **Daily Routine.** Building a daily routine that covers essential self-care needs is critical. There are five key items needed in a daily self-care plan: sleep, nutrition, exercise, positive content, and social connection.

05 **Support system.** A strong support system around you is important, so that when tough times come, you have backup: family members, friends, coworkers, and professionals (therapists, counselors, and recovery coaches or peer support specialists).

06 **Communication strategies.** Include ways to communicate and ask for help from your support system when you need it. Write down the phone numbers for counselors, recovery coaches, psychiatrists, physicians, friends, and family, and don't hesitate to reach out.

WORKSHEET

RELAPSE PREVENTION PLAN

Your recovery goals	
List your triggers	
Plan to manage triggers and stress	
Your daily self-care plan	
Your support system and contact information	
Communication strategies	

RECOVERY SUPPORT PROGRAMS

There are many types of recovery programs available nationwide, including:

Mutual aid support groups: Free peer support provided in a community setting (such as AA, NA, and SMART Recovery).

Recovery housing: Living environments that promote abstinence-based, long-term recovery. After treatment for SUD, many patients return to high-risk environments or stressful family situations. Returning to such settings without a network of people to support recovery increases the chances of recurrence of use. Recovery housing can provide abstinence support, guidance, and information that may reduce the probability of a relapse.

Peer support services: These services provide mentorship, coaching, and connection to others in recovery. Because peer support services are designed and delivered by peers––persons who have experienced an SUD and have recovered––they embody a powerful message of hope, as well as a wealth of experiential knowledge.

Recovery community organizations: Local nonprofit organizations that support recovery through services, education, and outreach. Recovery is facilitated by a continuum of comprehensive, community-based services that can be tailored to individual needs and help people recover "in place."

Activity-based recovery: Therapeutic activities to support recovery. Research shows physical activity is an effective recovery support as well as a healthy way to build community.

Recovery high schools: Research has shown a significant reduction in both substance use and mental health issues among students attending a recovery high school during their recovery from SUD.

Collegiate recovery: Designed to support college-age students in recovery. Supporting young people in recovery to handle the personal and academic stress of college life in healthy ways and succeed in achieving and/or maintaining recovery and building supportive communities.

Faith-based programs: Programs informed and/or guided by faith-based practice. Research has shown that, for some individuals, spirituality is an important component of recovery.

Online support: The number of Americans who have access to the internet is increasing. Proven telehealth and other online resources help to ensure that more people have access to resources.

SUPPORT GROUPS

Support groups are instrumental to recovery for many people. Support groups can provide a range of opportunities to grow within recovery and learn how to live without drugs and alcohol. They also provide steps to take to change old behaviors, build healthy coping skills, and address cognitive processes unhelpful to recovery. At meetings, individuals can connect with others who have had the same experiences, which imparts hope and strength. Meetings connect individuals with others who have been there, or who are currently there.

Research has shown that AA (a support group) was more effective than psychotherapy alone or non-treatment when it comes to maintaining sobriety. Dr. John Kelly from Harvard University and Dr. Keith Humphreys from Stanford University completed a meta-analysis of 35 studies of AA involving 10,000 participants that showed that people who attended Alcoholics Anonymous (AA) meetings had a 20% to 60% better abstinence than those in other treatments (Kelly, Humphreys and Ferri, 2020).

There are many different types of support groups, including:

Alcoholics Anonymous (AA): A 12-step based program that focuses on alcohol addiction. However, many people who have struggled with other substances attend this program as well.

Website: https://www.aa.org/

Celebrate Recovery: Christian 12-step recovery program for anyone struggling with hurt, pain, or addiction of any kind.

Website: https://www.celebraterecovery.com/

Cocaine Anonymous: A fellowship of people who share their experience, strength, and hope to solve their common problem and help others recover from their addiction.

Website: https://ca.org/

Crystal Meth Anonymous (CMA): A fellowship of people who share their experience, strength, and hope to solve their common problem and help others recover from addiction to crystal meth.

Website: https://www.crystalmeth.org/

Harm Reduction Works (HRW): This program was created to fill the need for a harm reduction-based alternative to abstinence-only self-help/mutual aid groups. This is NOT in opposition to abstinence-only groups. HRW is for anyone who wants to know more about harm reduction and how it might hel. This includes people who are involved in long-term, abstinence-based recovery with other groups such as 12-step programs.

Website: http://heroinanonymous.org/

Heroin Anonymous (HA): A fellowship of men and women who have found a better way of life, free from heroin addiction.

Website: http://heroinanonymous.org/

In the Rooms: This website where people can access a range of online support groups. Some of the support groups they have are affiliated with Narcotics Anonymous, Dual Diagnosis, Marijuana Anonymous, Codependency Anonymous, Alcoholics Anonymous, and many more.

Website: https://www.intherooms.com/home/

Life Ring: Organization of people who share practical experiences and sobriety support.

Website: https://lifering.org/

Marijuana Anonymous (MA): A fellowship of people who share their experience, strength, and hope to solve their common problem and help others to recover from marijuana addiction.

Website: https://marijuana-anonymous.org/

Medication-Assisted Recovery Anonymous (MARA): A support group of people who believe in the value of medication as a means to recovery.

Website: https://www.mara-international.org/

Moderation Management: A behavioral change program and national support group network for people concerned about their drinking and who desire to make positive lifestyle changes.

Website: https://moderation.org/

Narcotics Anonymous (NA): A fellowship or society of people for whom drugs had become a major problem.

Website: https://na.org/

Nicotine Anonymous (NicA): A non-profit 12-step fellowship of people helping each other live nicotine-free lives.

Website: https://www.nicotine-anonymous.org/

Recovery Dharma: Peer-led organization that supports individuals on their path of recovery from addiction using Buddhist practices and principles.

Website: https://recoverydharma.org/

Refuge Recovery: An abstinence-based practice, process, set of tools, treatment, and path to healing addiction and the suffering caused by addiction. It offers individuals a mindfulness approach to understanding causes for addiction and remedies for future health.

Website: https://www.refugerecovery.org/

Secular Organizations for Sobriety (SOS): Non-religious, sobriety-based group that welcomes anyone who is seeking sobriety from alcohol, drugs, or compulsive eating. An alternative to the 12-step model of recovery.

Website: http://www.sossobriety.org/

SMART Recovery: An abstinence-based organization with a sensible self-help program for people having problems with drinking and using.

Website: https://www.smartrecovery.org/

Women for Sobriety: Organization dedicated to helping women discover recovery from SUDs.

Website: https://womenforsobriety.org/

CHECKLIST

SUPPORTING YOUR LOVED ONE'S RECOVERY

Family support is an important part of the recovery journey. Recovery is stronger when all family members understand the nature of drug addiction and are involved in the healing process.

Research supports family involvement to be a significant factor in predicting long-term recovery.

YOU CAN SUPPORT YOUR LOVED ONE IN A VARIETY OF WAYS, INCLUDING:

- ☐ helping your loved one remember to take all prescribed medications;
- ☐ offering to attend their treatment appointments;
- ☐ staying engaged with their treatment team and being a resource;
- ☐ going "meeting shopping" with your loved one to help find the right meeting;
- ☐ helping to establish a sober peer network;
- ☐ knowing the signs of relapse and removing substances that could trigger a relapse;
- ☐ being loving, patient, and non-judgmental;
- ☐ learning about addiction;
- ☐ attending your own support group meetings; and
- ☐ working on your own healing and wellness journey.

CHAPTER 6
DEVELOPING AN ACTION PLAN

Talking to a loved one about their alcohol and drug use can feel uncomfortable and awkward. Many are afraid of overstepping their bounds, or that bringing it up will hurt their relationship.

While it's natural to try to avoid the discomfort of addressing these issues with a family member or friend, the longer someone waits to seek help for an SUD, the worse the condition can become. This information is designed to help you support a loved one in crisis by breaking the process down into small steps. This can help you think through how to communicate with your loved ones even if they don't feel "ready."

COMMUNICATING WITH YOUR LOVED ONE

Every conversation counts. In a research study that Addiction Policy Forum conducted, it was found that on average individuals experienced three trigger events that led them to make a decision to change their substance use. Most of the 60 study participants shared that these events generally involved a conversation with a concerned friend or family member (Addiction Policy Forum, 2022). Even if this conversation or comment did not have an immediate impact, it contributed to a decision to get help later on. It's clear that these are important conversations to have. Think of the conversation as having four distinct components:

- planning and preparation for the conversation;
- starting the conversation (or an "opener");
- providing feedback; and
- exploring options together.

If your loved one isn't open to the conversation, you may only get through the first step, but that's ok. Each of these discussions can help further the conversation and let the individual know that you are there for them.

FOUR-STEP ACTION PLAN

1 PLAN AND PREPARE

Think about what you want to say beforehand. The old adage of "think before you speak" is especially important when we are feeling emotional or worried about someone. Managing your emotions and staying calm and compassionate is very important. You may feel anger, betrayal, or even shame, but being aware of how you are feeling and planning for the conversation in advance will help.

It's also important to consider timing. Find a calm moment without interruptions. Do not attempt to have the conversation when they are under the influence, when they are more likely to react negatively and less likely to understand you fully.

> **FOCUS ON SHOWING EMPATHY AND LISTENING WITHOUT JUDGMENT.**

The language you use around addiction is also important. Remember to avoid labels like addict, junkie, and alcoholic. Instead, use phrases like "trouble with drug use" or "problem with drinking/ alcohol use." Problems and troubles are fixable and treatable, whereas labels make a person feel "less than" and blamed.

2 STARTING THE CONVERSATION

Always begin the conversation with love and concern and try to avoid making any kind of accusations. Starter talking points may look like:

» I've noticed you've been drinking a lot lately and I'm worried about you.

» I've noticed you've been using heroin again and I'm worried about you.

Listen and be patient. Make sure you give time for their response and listen carefully to what they're saying. Focus on empathy and listening without judgment. It is important to be mindful of your body language and tone, such as:

» staying seated

» using a soft, calm tone of voice

» leaning into your loved one to show you are engaged and present

Avoid things like:

» standing

» crossing your arms

» pointing your finger or making any aggressive gestures with your hands

» using a loud voice or curse words

After you have started the conversation and are aware of your visual cues and body language, offer encouraging words, such as:

» I want you to know that you are not alone.

» It may not seem like it right now, but you can be in control of your life again.

» I love you and want to help.

3 PROVIDE FEEDBACK

Once you've started the conversation, it's helpful to provide specific examples. You can share your concerns about their behavior or your worries about their substance use and its effects on their health. Try to use non-blaming language. Do not raise your voice or get angry; instead share specific behaviors or incidents and how they worried you.

Try and use pronouns like "I" or "we" to avoid making your loved one feel defensive. "I am concerned about the methamphetamines you are using."

Feedback talking points may include:

» I'm worried that your behaviors change when you drink. Last night, for example _____ .

» Your overdose on opioids has me worried that you will have another overdose.

» I'm concerned that your drug use is affecting your relationships/children/job/health. For example, _____ .

» How are you feeling about your drinking? I've noticed you've been drinking more than usual.

4 DEVELOP AN ACTION PLAN

The third step in the conversation is to ask if they would be willing to seek professional help and develop an action plan together. If your loved one is willing, offer to help find a nearby health care provider who can conduct an assessment.

Then, develop an action plan:

» Let's talk about getting an assessment, which would help find the right treatment and recovery plan.

» I am here for you, and I want to help in any way that I can.

» We are here for you and in this together. I think we all might benefit by going to family counseling.

WHAT IF THEY'RE NOT READY?

Don't give up hope if this conversation doesn't "work" the first time. Every conversation counts. They may not be open to the topic and may become defensive. If this happens, let it go for the time being.

Sample talking points if you are met with resistance include:

» I understand you're not feeling ready to take steps today. Let's pause this conversation and revisit at another time.

» I understand you need more time, but I want to make clear my expectations and boundaries when it comes to your alcohol/drug use, including:

  » You cannot drink/use around me;

  » I don't want alcohol/drugs in my home; and

  » I will not provide money to purchase alcohol/drugs, etc.

» I'm here to help when you're ready and want to get help.

Figure 18.

FOUR STEPS TO PLANNING THE CONVERSATION

PLAN AND PREPARE	Prepare your talking points and find the right time for the conversation.
CONVERSATION STARTER	I've noticed you've been using heroin again and I'm worried about you.
PROVIDE FEEDBACK	I'm worried that your behaviors change when you drink. Last night, for example _____ .
DEVELOP AN ACTION PLAN	Let's talk about getting an assessment and find the right treatment and recovery plan.

Ask the Expert

I want to engage my son and talk about getting help but I'm afraid of the angry outbursts and the backlash. What do I do?

Dr. Brian Fuehrlein

The brain of a person addicted to a substance becomes completely and irrationally focused on obtaining the substance over and over—often to the detriment of everything else that the person cares about. As a result, there are recognizable symptoms that are often very frustrating. For example, denial is a common manifestation of the disease of addiction. The person may not recognize that a problem exists, even when it is incredibly obvious to everyone else around. This denial serves to protect the addiction and to allow it to continue, despite many adverse consequences. Denial frequently presents as anger and frustration towards those asking questions.

Firstly, it is important to recognize that these angry outbursts are likely a symptom of the illness, much like a fever may be a symptom of an infection. The angry outbursts serve to deter you from asking questions and thus allow the addiction to continue more easily.

How forceful you should be with your questions and interventions depend upon many factors. Primarily it would depend upon the severity of the substance use and likelihood of imminent and severe adverse consequences. For example, if your son is injecting heroin and has had prior near-lethal overdoses, despite the possible angry outbursts, it is very important to discuss treatment with your son right now. If your son is drinking excessive alcohol but with no major consequences with no obvious imminent risk, more time is available to you to connect with your son in a less forceful and direct way.

Dr. Brian Fuehrlein

Associate Professor of Psychiatry, Yale University School of Medicine; Director, Psychiatric Emergency Room, VA Connecticut Healthcare System

WORKSHEET

FOUR-STEP COMMUNICATION PLAN

It's challenging to help a loved one struggling with addiction, and while you cannot fix the problem by yourself, there are important steps you can take. Start with a frank conversation expressing your concerns and offering support.

1. Plan and Prepare

Prepare your talking points and find the right time for the conversation.

2. Conversation Starter

To begin the conversation with your loved one, start by raising the subject, using sample talking points like: "I've noticed you've been drinking a lot lately and I'm worried about you."

3. Provide Feedback

For example: "I'm concerned that your drug use/alcohol use is affecting your relationships/ children/ job/ health. For example, _____."

4. Develop an Action Plan

Let's talk about getting an assessment to help determine the right treatment and recovery plan.

Ask the Expert

What to do when your loved one doesn't want help?

Dr. Brian Fuehrlein

Sometimes an honest, frank conversation can prompt the path to recovery, but when it comes to SUDs, it can be difficult for people struggling to see or acknowledge the extent of harm their substance use is causing to themselves and to others. Know that your support matters and try to be patient—even if a loved one doesn't want to get help when you offer it. He or she will remember what you said and may be ready to engage in treatment at another time.

Try to respond to resistance with compassion and optimism—keeping in mind that your loved one may be feeling ashamed, afraid, hopeless, and isolated. When possible, continue to offer your support in finding help and reminders that addiction is treatable.

Remember, severe SUDs "hijack" the brain, making the person who is struggling think that the substance is more important than anything else and thus fearful about what could happen if that substance is taken away. By the time an SUD has progressed to addiction, living without the substance feels impossible—like being told you aren't going to be able to breathe air anymore. Because of the way addiction impacts brain function, it is common for patients to rail against the idea of going to treatment.

What to do next depends heavily on your relationship to the person. For example, if your teenage son is resistant to getting help, the course of action will look very different from a coworker or friend not being open to your concerns.

If a friend doesn't want help:

Stay in touch and know that there are other ways to show your concern and support, such as suggesting activities that do not involve alcohol or drug use.

Don't offer alcohol when they visit and/or encourage meetings, etc., that don't involve alcohol.

Don't continue to lend money if that's an ongoing problem. Don't accept late-night calls if you suspect your friend is using.

If the person hesitates or says he or she drinks a lot but doesn't have a problem, suggest a formal assessment by a professional who is trained and knowledgeable about SUDs.

Just because your loved one doesn't want help or treatment now doesn't mean they never will. If you want to be the person that your loved one reaches out to when they are ready to accept help, you will need to maintain a supportive, loving relationship, letting them know you are there for them when they are ready. It is important that you prepare and plan ahead. This might mean researching treatment and payment options and meeting with counselors or treatment facilities. When and if the time comes when they ask for help, you will need to act quickly. Having all of the resources prepared in advance will enable you to swing into action.

Dr. Brian Fuehrlein

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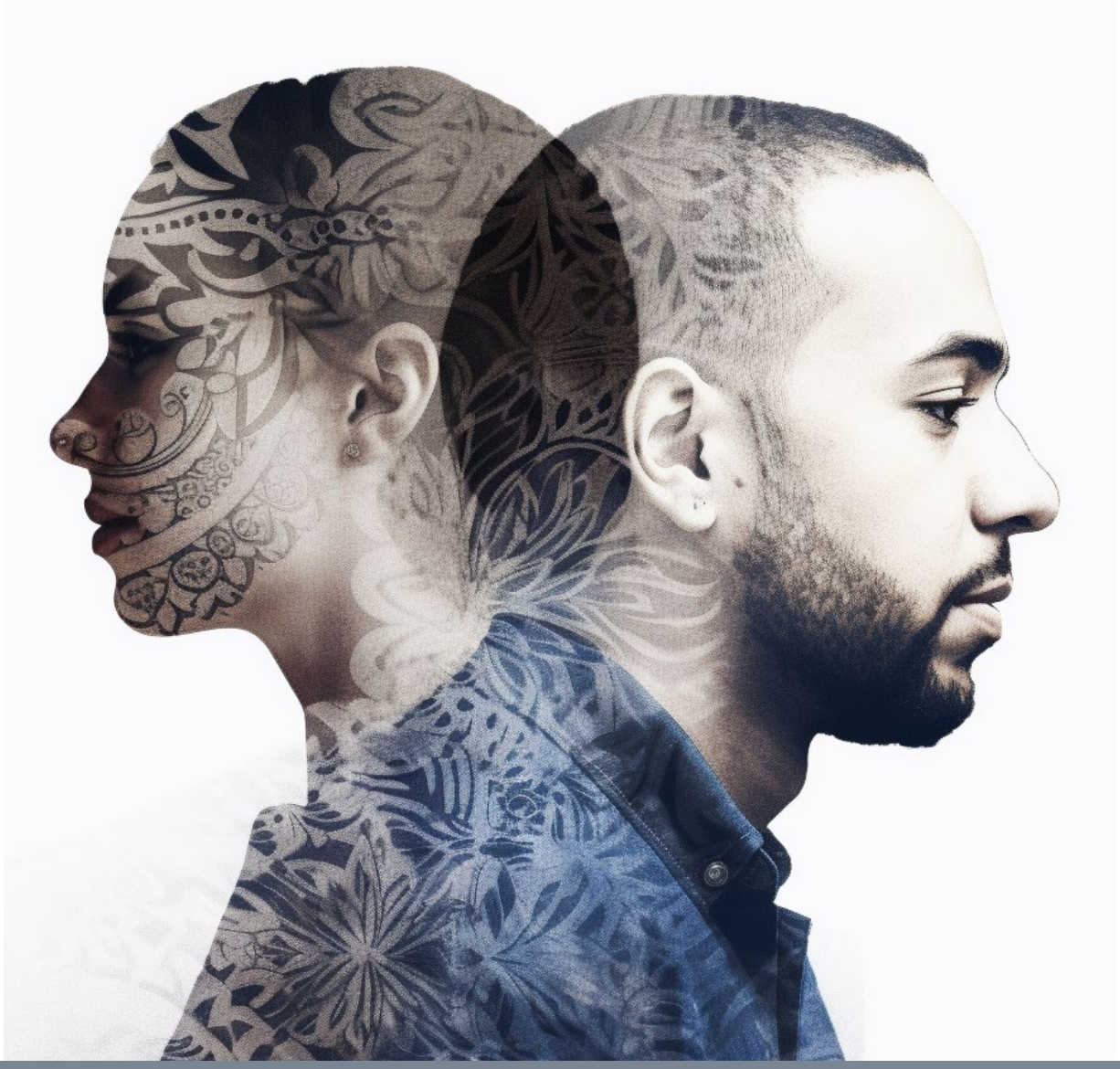

CHAPTER 7

ENABLING VS. HELPING AND HOW TO SET BOUNDARIES

ENABLING VS. HELPING

Having a family member or loved one with a substance use disorder is difficult, and it's not always clear how best to help them. Parents want to protect and help their children. Siblings don't want their brothers or sisters to get into trouble. And as friends, we don't want to overstep our bounds.

According to the American Psychological Association, enabling is "a process whereby someone (i.e., the enabler) contributes to continued maladaptive or pathological behavior (e.g., child abuse, substance abuse) in another person. The enabler is typically an intimate partner or good friend who passively permits or unwittingly encourages this behavior in the other person; often, the enabler is aware of the destructiveness of the person's behavior, but feels powerless to prevent it" (American Psychological Association).

> **ENABLING BEHAVIORS CAN REMOVE THE DESIRE TO SEEK TREATMENT.**

Put simply, enabling behaviors can remove the desire to seek treatment. Enabling behavior can range from pretending there isn't a problem to providing money to your loved one for drugs or alcohol to taking on their responsibilities.

If you apply enabling, versus helpful, behavior to other chronic diseases, the delineation becomes clear. If your loved one has diabetes, are you helping with positive physical exercise routines and healthy eating habits, or are you providing meals and foods not in line with your loved one's diet restrictions?

With chronic substance use disorders, examples of enabling behavior include:

- ignoring the problem or downplaying its severity;
- allowing substance use;
- providing money not earned;
- protecting the individual from the consequences of their behavior;
- keeping secrets about their behavior from others;
- making excuses for their behavior to criminal justice authorities, employers, friends, and other family members;
- fixing their problems, from paying debts to hiring lawyers to providing jobs; and
- completing tasks that the individual is expected to do for themselves.

SETTING BOUNDARIES

If you recognize enabling in your own behaviors, the next step is to decide how to modify the ways you support your loved one. Mental health experts recommend you begin by having a clear conversation about your concerns around their substance use and go over the boundaries you are setting from that point forward.

Boundaries are a critical step in addressing enabling behavior. You don't have to accept bad behavior, and while you can't control the behavior of your loved one, you do have choices when it comes to what you find unacceptable.

> **BOUNDARIES ARE RULES AND GUIDELINES THAT WE ESTABLISH TO PROTECT OUR OWN WELL-BEING.**

They draw lines in the sand to ensure that you are not unknowingly shielding your loved one from the consequences of their own actions. It is important to determine what boundaries you are comfortable setting and will uphold. For example, one family may say, "if you live in our house and use substances you will have to move out." If this family sets this boundary and then does not uphold it, their loved one with the SUD will know that the boundaries mean nothing and they will not experience consequences for their actions. Therefore, it is imperative to set boundaries that you can stand by. Also, remember that boundaries are different for each family and individual.

Figure 19.

ENABLING VS. HELPING, DOS AND DON'TS

ENABLING VS. HELPING	
Do	**Don't**
» Support treatment and recovery	» Make excuses for the person
» Set boundaries	» Take over personal responsibilities
» Let the individual deal with consequences of their SUD	» Save from legal consequences

SAMPLE BOUNDARIES TO SET

01 Be clear they cannot drink or use around you.

02 Do not allow drugs, alcohol or drug paraphernalia in your home.

03 Do not lend or give them money or pay off their debts.

04 Do not lie for them.

05 Do not allow for abusive behavior, whether verbal or physical.

06 Let them know you will help them get better.

07 Always follow through with set consequences and boundaries.

FOR PARENTS AND CAREGIVERS OF TEENAGERS

For parents and caregivers of teenagers, boundaries and expectations can be more complicated to set and follow through on. But even if there have been issues with consistency, you can begin to set expectations and boundaries:

01 Set clear expectations about no alcohol, tobacco, or drug use.

02 Establish clear boundaries and consequences for alcohol, tobacco, or drug use. For example, a teen may be grounded (for what period of time?), or lose usage of their car, cell phone, and/or electronics. Be clear and be consistent.

03 Do not provide alcohol or drugs to your children. Parent-condoned use or supplied alcohol can promote binge drinking and unsafe behaviors.

04 Monitor your teen(s). Stay involved in the lives of adolescents while setting clear expectations. Be "that parent" and ask to speak to other parents. Ask them about alcohol or marijuana use within their household and be clear about your expectations.

05 The research is clear—talk early and often, even tackling tough questions about your own alcohol use.

06 Assert your expectations for the appropriate age of drinking alcohol.

07 Discuss possible genetic risk factors if family members have struggled with an SUD.

NOTES

Ask the Expert

If I talk to my son or let him come home, is that enabling his addiction?

Dr. James Berry

I was recently reminded by a wise mentor that the word "enable" has both a positive and a negative connotation. To enable in a positive sense is to help one become more "able" to accomplish something good. For instance, I enabled my 6-year-old daughter to successfully ride a bike by walking alongside her and keeping her from falling. On the other hand, to enable in the negative sense is to support another's self-destructive behavior, either by directly contributing to the means of the behavior (e.g. giving money to buy drugs) or shielding from negative consequences (e.g. bailing out of jail). You should try to encourage the former and discourage the latter form of enabling when it comes to his addiction.

It is important to recognize that there are no easy answers and sometimes it is unclear how best to proceed. Whenever possible, try to get the support of others, preferably people who know you both and are able to clearly see how your behavior has either helped or may have harmed in the past. Learn from past decisions; the best predictor of future outcomes is past outcomes. You may want to find a counselor who can be objective or make use of mutual support groups such as Al-Anon. As much as possible, I would always support keeping the lines of communication open with someone suffering from addiction.

Rarely would I counsel cutting off contact unless there are instances of abuse and potential harm to you by not doing so. You can always be available to talk and offer support, but with clear expectations such as not while he is intoxicated. Letting him come home may be a different matter. I recommend being very clear about the limits of returning home and the consequences for crossing the limits. For instance, you may determine that a condition of him living at home is that he attends weekly therapy for his addiction. You would need to decide what the consequences would be if he failed to do so and be certain to follow through with the consequences. I also encourage you to consider a reward system for successfully meeting certain targets while at home, such as negative urine drug screens.

Try to have an open conversation with him to find out the reasons why he is using. Be honest about the likelihood that some of these reasons make sense to you, such as helping him feel more calm or making him more social. This can provide a platform where the two of you can have a constructive dialogue. You can express your commitment to helping him as he works through these issues, but in order for him to continue to live with you, he needs to be committed to working through them and you need to have indicators that he is doing so.

Dr. James Berry

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CHAPTER 8
CAREGIVER SELF-CARE

CAREGIVER SELF-CARE

During safety demonstrations, flight attendants will remind you to put on your safety mask before helping others. The same thing applies to caring for a loved one suffering from an SUD. You can't help another person if you aren't taking care of yourself. Your loved one may not recognize the negative effects his or her behavior has on others, including you, but addiction impacts the entire family.

Whether or not your loved one is willing to seek help, remember to take care of yourself. You can't control the actions of a loved one struggling with SUD, but you can control how to treat yourself. Prioritize self-care. Eating a balanced diet, exercising, and getting a full night's sleep are important aspects of self-care. You may find it helpful to practice meditation, take up yoga, or do mindfulness exercises.

> YOU CAN'T CONTROL THE ACTIONS OF A LOVED ONE STRUGGLING WITH SUD, BUT YOU CAN CONTROL HOW TO TREAT YOURSELF.

The following are self-care recommendations:

» Make sure you are getting at least seven hours of good, quality sleep on most nights. This is one of the key foundations for good health. However, sleeping over nine hours or extended napping can sap your energy and drive.

- Healthy meals are another key foundation for good health. Food is fuel and our brains need healthy building blocks from wholesome meals to function well. A Simple Meal Planning can help you to get on track.
- Whether you can exercise for 10 minutes or 30 minutes, every minute counts! Set reasonable goals and remember that getting outside in the sunshine can have lots of mood-lifting benefits and can help a person feel calm and focused.
- Make sure to include positive content in your life from people, reading, music, and TV. Try decluttering the negative content from your life while adding positive sources.

Don't isolate. What you are going through is very difficult. Seek out the strength and wisdom of others who have been in your position by attending a support group for loved ones impacted by addiction (Roozen, Waart, & Van Der Kroft, 2010).

There are also support groups and programs for friends and family of people with active use disorders and in recovery. Some examples of these support groups include Al-Anon, Narcotics Anonymous, Families Anonymous, Parents of Addicted Loved Ones, and SMART Recovery Friends and Family. These support services can be a great place for impacted families to connect with others who've been through what you're going through. Additionally, individual and family therapy can be incredibly helpful for families healing from the trauma of addiction. Finally, please remember that you are not alone and there is hope.

Ask the Expert

How does a family, caregiver and loved ones avoid burnout?

Dr. Jessica Gold, Assistant Professor of Psychiatry, Washington University in St Louis, School of Medicine

When we take care of others, it is often hard to remember we have to take care of ourselves, too. We think if we stay up just one minute more, skip a meal to help the other person, or stay with them a moment more and sacrifice time for ourselves, we will be able to help just that much more. But, in reality, if we would actually take some time away for ourselves to reset, we would actually be better caregivers. There is a reason that airplanes tell you to put your mask on first before putting on the mask of your child. It is because you can't help someone else if you are not yet cared for yourself.

The most important things you can do for yourself are the basics: sleep, eat, and exercise. Sleep is entirely essential to you being able to not burnout. You may be able to survive on the adrenaline of no sleep for a bit, but it catches up to you and it affects your mental and physical health quickly.

Eating, too, is important to maintaining your energy throughout the day. Exercise, even if it is just getting some fresh air and a walk outside, also has known effects on mood and allows you a good break. Something like yoga, might also allow you to relax if you are feeling particularly overwhelmed or stressed by caregiving.

Besides the basics, it can help to think about what other things in your day give you enjoyment that you can add as part of your self-care routine. This can be something as simple as taking a bath to relax, or reading a book, or could include journaling or mindfulness.

Some people like to do mindfulness with an app and actually doing meditations before bed, for example, but others do simple tasks like naming all the objects in the room of a certain color, or listing off items in a category they like, like classic cars. No matter what you do, it should be something YOU like and not something someone tells you to do or add in your day. It should also be a priority and not be put aside when you think you need to be doing something else.

Therapy is also a key component of avoiding burnout and there is never a "wrong time" to seek it out. It is helpful to have a place to go and process that is outside of your family and typical support system and is neutral. Therapy is a safe space and allows you to really be heard. Medication additionally can be helpful if it is warranted, as sometimes when we think we are burned out, we are actually just depressed.

Dr. Jessica Gold

Assistant Professor of Psychiatry, Washington University in St Louis, School of Medicine

SOCIAL SUPPORT

While a common reaction to a loved one's SUD is to isolate from other family and friends, one of the best things you can do for yourself is to increase your social support system. Finding support for yourself and other family members is vital whether or not your loved one chooses to engage in treatment or recovery. Support can come in different forms, from friends and family, church, neighbors, coworkers and others.

Almost all of us benefit from social and emotional support. Though it may seem counterintuitive, having strong social support can actually increase your ability to cope with problems on your own by improving your self-esteem and sense of autonomy. A strong support system helps us develop resilience and self-esteem.

Types of social support:

Emotional: Helping to manage emotions, including listening to problems and showing empathy.

Tangible: Helping with practical problems such as finances, childcare, or transportation.

Informational: Providing information, advice, or valuable resources.

Social: Fulfilling of basic social needs like love, connectedness, belonging, and security.

Identify everyone currently in your social network, including those you may have lost touch with. Once you determine what types of support you need, refer to your list to determine who might be able to provide it. You can also identify places or ways you can increase your social support network.

PEER SUPPORT

Self-help groups specifically for families impacted by addiction are becoming more commonplace. There are both structured and informal groups led by experienced family members or in combination with professional clinicians.

Types of peer support:

Mutual aid (12-step) groups. These groups, such as Al-Anon and Nar-Anon, give family members the opportunity to learn from the experiences of others who have faced similar challenges. Al-Anon members come to understand problem drinking as a family illness that affects everyone in the family. By listening to Al-Anon members speak at Al-Anon meetings, you can hear how they came to understand their own role in this family illness. This insight puts them in a better position to play a positive role in the family's future. Mutual aid groups include:

- Adult Children of Alcoholics: https://adultchildren.org/
- Al-Anon: https://al-anon.org/
- Ala-Teen: https://al-anon.org/for-members/group-resources/alateen/
- Co-Anon: https://co-anon.org/
- Co-Dependents Anonymous: https://coda.org/
- Families Anonymous: https://familiesanonymous.org/
- Learn to Cope: https://learn2cope.org/
- Nar-Anon: https://www.nar-anon.org/
- Parents of Addicted Loved Ones: https://palgroup.org/
- Recovering Couples Anonymous: https://recovering-couples.org/

Self-Management and Recovery Training (SMART) Family & Friends groups. SMART Groups provide effective, easy-to-learn tools to help both you and your loved one. They are based on the tools of SMART Recovery Methods. Meetings are available both in person and online and provide concerned significant others the tools they need to effectively support their loved one without supporting the addictive behavior. These tools also help family and friends better cope with their loved one's situation, and regain their peace of mind. (https://www.smartrecovery.org/family/)

The Community Reinforcement and Family Training (CRAFT): This is a skills-based program that addresses self-care, activities, problem solving, and goal setting. CRAFT also addresses a loved one's resistance to change and teaches families behavioral and motivational strategies, including positive reinforcement. Positive communication skills are also a focus in CRAFT.

Many of these skills are valuable for the family even if their loved one does not enter treatment or has already begun the treatment process. Additionally, the skills remain essential over the long run in navigating and maintaining a positive trajectory for all family members.

ADDRESSING FEELINGS OF GUILT AND SHAME

It is not uncommon for family members to feel both guilt and shame over a loved one's substance use. However, understanding the difference between them may help you better address and process your feelings.

Many people use the terms "guilt" and "shame" interchangeably, but they are psychologically different and may require different responses. Guilt is when we realize that something we said or did was harmful to others, while shame arises from a negative evaluation of ourselves. Guilt acknowledges "I did something bad." On the other hand, shame says, "I am bad."

Without guilt, we would have no reason to change. Guilt allows us to take responsibility for our actions, strive to repair any damage done and do better in the future. Shame keeps us feeling isolated, fearful, and helpless.

As a family member, being able to label your feelings appropriately and determine their root cause will go a long way in helping you cope with and manage the stressors that come from life with someone with an addiction.

There is nothing wrong with feeling guilty about things you may have done that could have contributed to your loved one's addiction. This is different from taking the blame for another's choices and actions.

If you are experiencing feelings of guilt:

- strive to correct any wrongs;
- practice self-forgiveness;
- develop greater empathy for your loved one;
- seek out support to help process these feelings; and
- let go of what you cannot control.

There is no need to feel shame over having a family member with an SUD. As we have learned, addiction isn't a moral failing on the part of the individual, nor is it a reason to be ashamed as a family member. One in three people in the U.S. are affected by substance use, so you are not alone. Taking control over your feeling of shame can empower you to make positive changes for yourself, the rest of the family, and even to help your loved one.

FAMILY THERAPY

Family therapy consists of counseling with a number of goals, including:

- reducing substance use in both youth and adults;
- helping families heal from strained relationships and family conflict;
- improving communication within the family;
- helping with school and employment attendance and performance; and
- improving the overall behaviors of individuals in the family unit.

Family members can attend therapy while their loved one is in treatment or even if their loved one hasn't chosen to seek their own treatment.

HOW DOES IT WORK?

Family therapy generally begins soon after an individual enters substance use treatment and has begun to make progress. The persons involved in the therapy will depend on the makeup of the individual's family dynamic. Because every family is different, the therapist should help the patient determine who to engage in therapy by identifying the most important influences in his or her life.

In family therapy, you can expect to work on things like behavioral changes, life skills, communication, conflict resolution, and goal setting. Family therapy doesn't automatically solve all of the issues or make the problem go away, but it can help members to better understand and change their own behaviors and reactions that may be contributing factors.

It is also important to mention that family therapy can be beneficial for the family even if the individual with the SUD is not involved. Addiction impacts everyone in the family. Healing and growth for other members of the family can take place without the participation of the patient.

If your loved one is involved in treatment for their SUD, the treatment provider may offer family therapy as part of the treatment. They will likely have staff professionals who are trained in both addiction and family therapy. Otherwise, they may refer you to an outside provider. If family therapy isn't offered as part of the treatment plan you can still inquire about options or ask for a referral.

Additionally, your insurance provider may have a list of providers, or you can check with your state department of health services for local options.

CHAPTER 9
NATIONAL RESOURCES

HELPLINES

SAMHSA NATIONAL HELPLINE

1-800-662-HELP (4357)

https://www.samhsa.gov/find-help/national-helpline

ALCOHOL AND DRUG HELPLINE

Addiction Policy Forum

301-200-3658

https://www.addictionpolicy.org/

SUICIDE PREVENTION LIFELINE

Call or text 988

or

1-800-273-TALK (8255)

TTY: 1-800-799-4889

https://suicidepreventionlifeline.org/

VETERANS CRISIS LINE

Dial 988, then press 1

or

1-800-273-TALK (8255)

https://www.veteranscrisisline.net/

TREATMENT RESOURCES

SUBSTANCE USE TREATMENT LOCATOR

https://findtreatment.gov/

BEHAVIORAL HEALTH TREATMENT SERVICES LOCATOR

https://findtreatment.samhsa.gov/

BUPRENORPHINE PRACTITIONER AND TREATMENT PROGRAM LOCATOR

https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator

OPIOID TREATMENT PROGRAM DIRECTORY

https://dpt2.samhsa.gov/treatment/

FAMILY SUPPORT GROUPS

» Adult Children of Alcoholics (ACoA): https://adultchildren.org/

» Al-Anon: https://al-anon.org/

» Ala-Teen: https://al-anon.org/for-members/group-resources/alateen/

» Co-Anon: https://co-anon.org/

» Co-Dependents Anonymous (CoDA): https://coda.org/

» Families Anonymous (FA): https://familiesanonymous.org/

» Learn to Cope: https://learn2cope.org/

» Nar-Anon: https://www.nar-anon.org/

» Parents of Addicted Loved Ones: https://palgroup.org/

» Recovering Couples Anonymous: https://recovering-couples.org/

» Smart Recovery: https://www.smartrecovery.org/family/

GRIEF SUPPORT

Camp Mariposa: https://elunanetwork.org/camps-programs/camp-mariposa/

Compassionate Friend: https://www.compassionatefriends.org/

GRASP (Grief Recovery After a Substance Passing): http://grasphelp.org/m/

CHAPTER 10

ADDICTION POLICY FORUM RESOURCES

Video: Is Addiction a Disease?

This video from the Addiction Policy Forum featuring Dr. Nora Volkow, Director of the National Institute on Drug Abuse, shares more information about addiction as a disease.

Video: Addiction and the Brain

This Addiction Policy Forum video breaks down the science of how addiction hijacks the brain and explains changed behavior and priorities.

Video: Brain Imaging Reveals What Causes Drug Addiction in Humans

Dr. Nora Volkow discusses what goes on in the human brain when an individual is addicted to drugs.

Video: The Myth of Rock Bottom

This Addiction Policy Forum change to video on the myth that we should wait for the disease to hit "rock bottom" before seeking treatment or helping a loved one. Science tells us that, like for other illnesses, the sooner we intervene, the better the outcomes for the patient.

REFERENCES

Addiction Policy Forum. (2022). Patient Journey Map: Substance Use Disorder Treatment and Recovery Experiences. Addiction Policy Forum. https://www.addictionpolicy.org/post/patient-journey-map

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (n.d.). Enabling. Dictionary of Psychology. https://dictionary.apa.org/enabling

Bell, J., & Strang, J. (2019). Medication Treatment of Opioid Use Disorder. Biological Psychiatry. www.biologicalpsychiatryjournal.com/article/S0006-3223(19)31485-4/fulltext#articleInformation

Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.439.783&rep=rep1&type=pdf

Centers for Disease Control and Prevention. (2021). About Chronic Disease. https://www.cdc.gov/chronicdisease/about/index.htm

Cohen, L. R., Greenfield, S. F., Gordon, S., Killeen, T., Jiang, H., Zhang, Y., Hien, D. (2010). Survey of eating disorder symptoms among women in treatment for substance abuse. The American journal on addictions, 19(3), 245–251. https://doi.org/10.1111/j.1521-0391.2010.00038.x

Daley, D. C. (2013). Family and social aspects of substance use disorders and treatment. Journal of Food and Drug Analysis, 21(4), S73-S76. https://doi.org/10.1016/j.jfda.2013.09.038

Fowler, J.S., Volkow, N.D., Kassed, C.A., &Chang, L. (2007). Imaging the addicted human brain. Sci Pract Perspet 3(2):4-16.

Gramlich, J. (2017). Nearly half of Americans have a family member or close friend who's been addicted to drugs. Pew Research Center.

Horta, A. L. de M., Daspett, C., Egito, J. H. T. do, & Macedo, R. M. S. de. (2016). Experience and coping strategies of family members of dependents. Revista Brasileira de Enfermagem , 69 (6), 1024-1030. https://doi.org/10.1590/0034-7167-2015-0044

Kelly, J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics Anonymous and other 12-step programs for alcohol use disorder. The Cochrane database of systematic reviews, 3(3), CD012880. https://doi.org/10.1002/14651858.CD012880.pub2

Killeen, T., Brewerton, T. D., Campbell, A., Cohen, L. R., & Hien, D. A. (2015). Exploring the relationship between eating disorder symptoms and substance use severity in women with comorbid PTSD and substance use disorders. American Journal of Drug and Alcohol Abuse, 2015. 41(6): 547-552. www.ncbi.nlm.nih.gov/pmc/articles/PMC4689437/

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

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA, 284(13), 1689–1695. https://doi.org/10.1001/jama.284.13.1689

National Eating Disorders Association. (2018). Substance Abuse and Eating Disorders. Retrieved from www.nationaleatingdisorders.org/substance-abuse-and-eating-disorders

National Institute on Drug Abuse. (2019). Genetics and Epigenetics of Addiction DrugFacts. https://nida.nih.gov/publications/drugfacts/genetics-epigenetics-addiction

National Institute on Drug Abuse. (2018). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). Treatment. www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/

National Institute on Drug Abuse (2005). Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems

National Institute on Drug Abuse (2020). *Drug Misuse and Addiction*. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction.

National Institute on Drug Abuse. (2020). Drugs, Brains, and Behavior: The Science of Addiction. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface

Oesterle, T. S., Thusius, N. J., Rummans, T. A., & Gold, M. S. (2019). Medication-

Assisted Treatment for Opioid-Use Disorder. Mayo Clinic Proceedings. www.mayoclinicproceedings.org/article/S0025-6196(19)30393-3/fulltext

Orford, J., Copello, A., Velleman, R., & Templeton, L. (2010). Family members affected by a close relative's addiction: The stress-strain-coping-support model. Drugs: Education, Prevention and Policy, 17(sup1), 36–43. https://doi.org/10.3109/09687637.2010.514801

Roozen, H. G., de Waart, R., & van der Kroft, P. (2010). Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment. Addiction (Abingdon, England), 105(10), 1729–1738. https://doi.org/10.1111/j.1360-0443.2010.03016.x

Ruiz, M. S., O'Rourke, A., Allen, S. T., Holtgrave, D. R., Metzger, D., Benitez, J., Brady, K. A., Chaulk, C. P., & Wen, L. S. (2019). Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia. Journal of acquired immune deficiency syndromes (1999), 82 Suppl 2(2), S148–S154. https://doi.org/10.1097/QAI.0000000000002176

Saitz, R., Larson, M. J., Labelle, C., Richardson, J., & Samet, J. H. (2008). The case for chronic disease management for addiction. Journal of addiction medicine, 2(2), 55–65. https://doi.org/10.1097/ADM.0b013e318166af74

Seljamo, S., Aromaa, M., Koivusilta, L., Rautava, P., Sourander, A., Helenius, H., & Sillanpää, M. (2006). Alcohol use in families: a 15-year prospective follow-up study. Addiction, 101(7), 984–992. https://doi.org/10.1111/j.1360-0443.2006.01443.x

Substance Abuse and Mental Health Services Administration. (2022). Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report.

Substance Abuse and Mental Health Services Administration. (2018). The Power of Perceptions and Understanding: Changing How We Deliver Treatment and Recovery Services.www.samhsa.gov/power-perceptions-understanding

Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment. www.samhsa.gov/medication-assisted-treatment/treatment

Substance Abuse and Mental Health Services Administration. (2017). Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016/NSDUH-DR-FFR2-2016.htm

Substance Abuse and Mental Health Services Administration. (2019). Supporting

A Loved One Dealing With Mental And/Or Substance Use Disorders: Starting The Conversation. Retrieved from www.samhsa.gov/sites/default/files/samhsa_families_conversation_guide_final508.pdf

Substance Abuse and Mental Health Services Administration. (2019). Risk and Protective Factors. https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment. Retrieved from www.samhsa.gov/medication-assisted-treatment/treatment.

Volkow, N. (2020). Drugs, Brains, and Behavior: The Science of Addiction [preface].. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/prefaceWhitley, R. & Drake, R. E. (2010). Recovery: A Dimensional Approach. Journal of Psychiatric Services. https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2010.61.12.1248

Wolfe, W. L. & Maisto, S. A. (2000). The relationship between eating disorders and substance use: Moving beyond co prevalence research. Clinical Psychology Review, 2000. 20(5): 617-631. Retrieved from www.sciencedirect.com/science/article/pii/S0272735899000094

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