RECOVERY COACHING WORKBOOK

A Training Guide to Provide Peer Support and Navigation for Addiction

Face It TOGETHER®

WHAT'S INSIDE

GRATITUDE

Since 2009, Face It TOGETHER has been working with individuals and families suffering from drug and alcohol addiction to get the help they so desperately need.

Thousands of individuals and families have been comforted, guided and supported by hundreds of peers who once struggled with this horrible disease, but have found recovery and wellness. People, like you, who have committed themselves to giving back and helping others. It is through this extension of peer support that we have been able to help so many people.

Thank you for taking this step to learn about being a Recovery Coach. We have compiled the best teaching and learning for peer-based addiction and recovery supports from all around the country.

Through this workbook and our training, you will be given the tools to engage people where they are, move them through the stages of change and find lasting wellness.

Like you, I got well with the help of others who suffered like I once did. The process of getting well from the disease of addiction is, unfortunately, scary and confusing. With compassionate and supportive peers, getting well can be less difficult and more successful.

Again, thank you for joining our mission to get drug and alcohol addiction sufferers well.

With gratitude,

Kevin Kirby
Co-Founder and CEO
Face It TOGETHER

INTRODUCTION

WELCOME! With this workbook and our in-person training, you will be armed with the best tools available to help others get well from the disease of addiction. Paired with your lived experience, the Face It TOGETHER Recovery Coach training program will give you everything needed to ensure success.

This workbook and training program will expose you to the following:

- Basic understanding of addiction as a disease and the continuum of care required to get well and stay well.
- A definition of recovery that promotes multiple pathways to recovery and wellness.
- The role of recovery coaching in the initiation, treatment and recovery phases of addiction wellness.
- The difference between a Recovery Coach, Sponsor and Counselor.
- The power of the peer and shared lived-experience in getting well from addiction.
- The skills and techniques to effectively meet people where they are and assist them through the recovery and wellness process.
- Full understanding of the confidentiality and ethical standards required of a Recovery Coach.
- Introduction to Face It TOGETHER's mission, as well as the work of the Face It TOGETHER Affiliate in your community and its resources.

The greatest gift we can give as survivors of this disease is our compassion and experience to others who suffer as we once did. With Face It TOGETHER's training and guiding principles, you will transform lives by helping individuals get well and stay well.

LEARNING OBJECTIVES

- Describe the roles and functions of recovery coaching
- List the components, core values and guiding principles of recovery
- Build skills to enhance relationships
- Describe stages of change and their applications
- Address ethical issues and boundaries
- Experience wellness planning
- Practice newly acquired skills

PART 1
BACKGROUND

ABOUT FACE IT TOGETHER

We're a nationally focused 501(c)(3) not-for-profit organization dedicated to fundamentally transforming the way communities deal with the chronic disease of addiction.

We believe that like anyone suffering from a serious illness, the 22 million Americans facing drug and alcohol addiction deserve world-class health care and support.

Through our community Affiliates, we work with health care, employers and other key stakeholders to remove barriers to seeking help and to improve lifelong addiction care, so more people get well and stay well.

Our **Vision** is a nation that has solved the disease of drug and alcohol addiction.

Our **Mission** is to get drug and alcohol addiction sufferers well.

Achieving our Vision will mean that:

- No one fears seeking help, and people get care before problems are so severe.
- There is connectivity to addiction management supports throughout the community, via health care providers, employers and other organizations.
- Evidence-based treatment and peer support are easily accessed over an extended period to help people successfully manage their disease.
- Chronic disease management programs for addiction are broadly embedded in the workplace.
- New social norms ensure that the language of medicine and public health is applied to addiction.
- The disease of addiction is understood the same as any other chronic illness.
- Value is created for all stakeholders, leading to measurably lower economic, social and human costs of the disease.

Our first Affiliate organization, Face It TOGETHER Sioux Falls, was established in 2009. We're currently developing new Affiliates in Fargo-Moorhead, Bismarck-Mandan, Grand Forks and Bemidji, with plans to expand to other communities.

You can learn more about what we do at **www.wefaceittogether.org,** and see our first Affiliate in action at **www.faceitsiouxfalls.org.**

WHAT OUR AFFILIATES DO

Our Affiliates are called Community Addiction Management Organizations™ (CAMO). The CAMO™ provides information; navigation to care and other resources; awareness and education; and addiction management and recovery supports and works collaboratively with multiple community sectors to help individuals and families get well from the disease of addiction. Face It TOGETHER Affiliates are led by a team of peers in recovery and volunteers who have gotten well and are giving back to help others.

Our Affiliates work with all sectors to build a chronic disease community model for alcohol and drug addiction. The goal of the model is to remove barriers to care and create the community architecture to support long-term wellness around addiction.

COMMUNITY ADDICTION MANAGEMENT SYSTEM™

Each community is unique, and local leaders tailor our model to meet demonstrated needs. However, each Affiliate carries out its mission in six primary ways:

1) Whole Community Advocacy

Our Affiliates work to facilitate system-wide transformation to improve the quality and accessibility of addiction management supports and services community-wide. This means reaching into and changing every sector.

2. *Community Awareness and Education*

These initiatives are designed to remove psychological and physical barriers that keep people from getting well. Our Affiliate's awareness efforts help eliminate stigma, shame and fear around addiction and increase understanding of the disease, so more people seek help.

3. *Mainstream Addiction Care Into Health Care*

These efforts include the implementation, together with local health care partners and treatment providers, of our Addiction Chronic Care Model, a continuum of disease management care that is patient-centered and based on successful approaches for other chronic illnesses.

4. *Mainstream Addiction Wellness Into the Workplace*

In our Employer Initiative, our Affiliates engage in strategic partnerships with community employers to build an infrastructure for addiction wellness in the workplace. These partnerships deliver value by educating the workforce about addiction, removing barriers to getting well and providing Addiction Management Services to affected employees.

5. *Provide Clearinghouse & Peer Addiction Management Support Services*

Our Affiliates provide a wide range of peer-to-peer, non-clinical services to help individuals and family members access the right care and stay well from addiction. These services fill gaps in the community and are provided by our Affiliates to clients at no charge. These services include peer-to-peer recovery coaching, telephone recovery support and recovery clearinghouse/navigation services to connect people to resources in the community.

6. *Prove Results by Measuring Outcomes*

Face It TOGETHER Affiliates also implement our Recovery Capital Evaluation Model™, which uses leading research methods and tools to measure the effectiveness of their peer support services on behalf of individuals and the community.

WHY PEER SUPPORT?

Research shows that peer support can improve health and functional outcomes by:

- Linking people to others with shared knowledge and experience
- Providing health education at the individual and community levels
- Providing emotional and social support to help individuals cope with stressors that accompany health problems
- Helping people stay connected to clinical care and other needed social services
- Assisting in navigating the health care (and addiction treatment) system
- Building relationships and advocating for patients when needed

Source: Peers for Progress and National Council of La Raza. (2014). *Evidence to Action: An Expert Report of the National Peer Support Collaborative Learning Network.* Washington, D.C. Retrieved from: http://peersforprogress.org/wp-content/uploads/2014/04/20140402_peer_support_in_health_evidence_to_action.pdf

POWER OF THE PEER

The peer Recovery Coach is the driving force for addiction recovery and wellness for all Face It TOGETHER Affiliates. *Peer Recovery Coaches are personally experienced in recovery, having either gone through it themselves or been close to someone who has.*

When providing peer supports, Recovery Coaches **focus on building the quality and quantity of "recovery capital"** – the internal and external resources that are shown to play a major role in successfully initiating and sustaining recovery, such as life skills, knowledge, stable housing, health care, family support and linkage to the community, among others.

Evidence shows that recovery from drug and alcohol addiction is more successful when aided by peer support (White). In a 2014 evaluation of services at our first Affiliate, Face It TOGETHER Sioux Falls, 90% of our clients reduced risk factors for a recurrence of the disease and 88% remained well and in recovery after 12 months.

Recovery Coaches provide individuals seeking to enter or sustain recovery with informal, personalized support over an extended period of time. At our Affiliates, all of our peer support services are offered at no charge to anyone, for any length of time. We also provide support to those impacted by the disease, such as family members and friends.

SOURCE: White, W., Cloud, W. (2008). *Recovery Capital: A Primer for Addictions Professionals*. Counselor, 9(5), 22-27.

Coaches must recognize the gravity of their position. They are essential to helping others escape the terrible disease that once affected the coach. They oftentimes are the first person available to begin the recovery and wellness process – meaning that the individual has chosen that very moment to get help.

A Recovery Coach helps individuals and families identify and remove the personal and environmental barriers to recovery and increase the quality of recovery capital.

Because of the fragmented treatment system, finding help and getting to the right help is confusing and frustrating for many impacted by the disease.

Our trained Recovery Coaches learn the system and how to overcome some of the barriers to treatment, such as finding providers available to do assessments, finding providers who accept the individuals' insurance and shrinking the amount of time an individual must wait before getting into treatment. Our coaches also provide ongoing support to help strengthen recovery and reduce the risk of recurrence.

Addiction can be a manifestation of estrangement from the community or generate such estrangement over time. Peer recovery support provides a framework for reconciliation in the person-community relationship. (White, 2009)

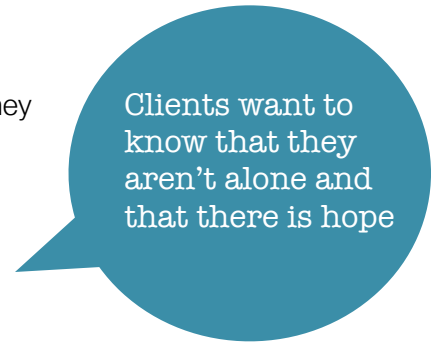
"I'm a 28-year survivor of addiction. I believe everyone deserves support and a chance to share with a peer to help them stay well. We help others find strength and new energy in recovery."

--Mel Harrington, Recovery Coach, Face It TOGETHER Sioux Falls

SOURCE: White, W., Cloud, W. (2009). *Peer Based Addiction Recovery Support*. Great Lakes Addiction Technology Transfer Center.

RESPONSIBILITIES AND SKILLS OF A RECOVERY COACH

RESPONSIBILITIES



- Supports individuals and family members in their recovery journey with non-clinical, personalized support without dictating what recovery will look like for that individual;
- Supports a wide variety of recovery pathways;
- Offers choices of available services in the community and links the individual to the recovery community;
- Supports with recovery check-ups, telephone support and active linkage to recovery support systems following treatment;
- Empowers the individual and makes him or her accountable for his or her recovery and wellness process;
- Acts as a role model, mentor, advocate and motivator to recovering individuals and their loved ones;
- Assists individuals to navigate any stage of the recovery process;
- Demonstrates an ability to share personal recovery experiences, developing authentic peer-to-peer relationships;
- Treats all individuals, volunteers and staff with dignity and respect;
- Maintains high standards of conduct to represent people in recovery at all times as our actions influence how the community see the recovery movement.

SKILLS NEEDED

- Personal belief in recovery;
- Ability to suspend personal judgments about people;
- Optimism that the recovering individual has the ability to succeed;
- Sincere interest in the welfare of the recoveree, including the ability to see each person as a unique individual;
- Willingness to share their own recovery experience when applicable;
- Ability to engage people based on their level of receptivity and individual needs;
- Acknowledging the same person may need different types of peer-based resources and services at various points in their recovery;
- Respect for the privacy of all confidential information;
- Willingness to walk by the individual and loved ones' sides with trust and respect;
- Personal experience in recovery: A minimum of one year of continuous personal recovery or experience with a close friend or family member in recovery;
- A commitment to work a regular schedule that is consistent to ensure an individual's progress, accountability and goals.

OUR VALUES

Our Recovery Coaches must understand and agree to uphold the Face It TOGETHER values in all that they do.

- We have **REVERENCE** for those we must reach.
- We are committed to **EXCELLENCE**, based on the proposition that anything less is an insult to those we serve.
- Steadfast commitment to vision and mission.
- **INTEGRITY** trumps everything.
- **DIGNITY** and **RESPECT** for each other and for those we serve.
- We challenge and encourage each other to **OPTIMIZE OUR OWN GIFTS**.
- We have high expectations of **PERFORMANCE**.
- We embrace being held **ACCOUNTABLE** for that which we agree to be accountable.
- We embrace with humility our leadership role in this **REVOLUTIONARY SOCIAL MOVEMENT.**
- We exist to **SERVE COMMUNITIES** and are committed to helping them discover their potential.
- Given the universality of the problems we will solve, we embrace an obligation to develop and disseminate **BEST PRACTICES**.
- We relish our role as **PROVOCATEURS** and **DISTURBING INNOVATORS**, working **COLLABORATIVELY** but constantly challenging entrenched practices of the past.

ADDICTION IS A DISEASE

Addiction is our nation's largest and most devastating health crisis. An estimated 22 million Americans age 12 and older suffer from addiction, about one in every 11 people.

- In the United States, one in four children is exposed to addiction at home.
- More than 50% of adults have a close family member with a problem.
- More than 11% of full-time workers have an alcohol problem in a given year.
- Among those suffering from addiction, 70% are employed; about half are employed full-time.
- Addiction is an equal-opportunity disease. It affects people from every age, income and ethnic group.

Many fail to get well because of stigma, shame and fear, and serious shortcomings in the traditional way we treat the disease of addiction

TOO FEW GET WELL AND STAY WELL

- Only 10% of those with addiction receive any form of treatment in a given year.
- Only one out of three will recover over a lifetime.
- Less than 10% remain in recovery one year after their first treatment.
- Among those few with the disease who do get help, they will receive treatment between 4 to 7 times over a lifetime.
- Half of those who complete treatment will start using drugs or alcohol again within thirty days of leaving treatment.

WHAT SCIENCE SAYS ABOUT ADDICTION

Addiction is a disease that affects both the brain and behavior. Decades of research in neuroscience, behavioral science and brain imaging clearly show that addiction is a disorder of the reward center of the brain.

A Vulnerable Brain

Research points to structural and functional differences in the brain and to genetic factors that may predispose some individuals to this disease.

When a person does something that satisfies a need or fulfills a desire, dopamine is released in the brain and produces pleasure. It serves as a signal that the action promotes survival. The brain records this experience and we are likely to do it again.

In nature, rewards usually only come with effort and after a delay. But addictive substances shortcut this process and flood the brain with dopamine.

This isn't about making bad people good, it's about getting sick people well.

Loss of Control

In a person who is suffering from addiction, the natural reward circuits get hijacked, while the need to use the drug strongly persists.

The changes that occur include interfering with the brain's natural chemical systems and over-stimulating the "reward pathway" of the brain. Once this happens, the substance activates the same circuits linked to survival, driving powerful urges no different from those driving the need to eat or drink water.

When the disease takes hold, these changes in the brain erode a person's self-control and ability to make sound decisions, while sending highly intense impulses to take drugs. Taking drugs becomes a matter of survival. These changes help explain the compulsive, destructive and often baffling behavior around addiction.

The behaviors associated with addiction look to healthy people like a lack of willpower because the primary symptom of addiction is irrational compulsivity. Someone who is sick with this disease will engage in risky and dangerous behaviors despite serious consequences because of these profound changes in the brain.

"…addiction is not about drugs, it's about brains. It is not the substances a person uses..; it is not even the quantity or frequency of use. Addiction is about what happens in a person's brain when they are exposed to rewarding substances or rewarding behaviors, and it is more about reward circuitry in the brain and related brain structures than it is about the external chemicals or behavior that "turn on" that reward circuitry."

--American Psychiatric Association

WHAT IS ADDICTION?

Addiction is a chronic but treatable brain disorder in which people lose the ability to control their need for alcohol or other drugs.

The American Society for Addiction Medicine uses the following definition:

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

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.

Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

WHAT CAUSES ADDICTION?

Addiction is caused by a combination of biological, environmental and behavioral factors. No single factor can predict whether or not a person will develop addiction. The risk for addiction is influenced by a person's biology, influences in their social environment and development. The more risk factors an individual has, the greater the chance that using drugs or alcohol can lead to addiction.

Genetics, in combination with environmental influences, account for about half of someone's addiction vulnerability. Other factors such as gender, quality of life, peer pressure, physical and sexual abuse, stress, parental involvement and age of first use can also influence the development of this disease.

SOURCE: National Institute on Drug Abuse. (2014). *Drugs, Brains and Behavior: The Science of Addiction*. Washington, D.C. Retrieved from: http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface

A CHRONIC DISEASE

Research also shows that addiction is a treatable *chronic* disease, with similarities to other chronic illnesses such as type II diabetes, heart disease and asthma.

Chronic diseases are long-lasting conditions that can be controlled but not cured. Most can be effectively managed with proper treatment and support. They are different from acute illnesses, which usually have an identifiable cause and can be treated in the short term and often cured.

Chronic illnesses are usually caused and influenced by a complex set of personal, family, environmental and genetic factors. Chronic diseases often have a genetic component and tend to run in families. In addition, behavioral elements, such as lifestyle habits, may also play a strong role in the development and course of chronic illness.

All chronic treatments, regardless of disease, share three important features:

First, treatment for chronic disease can usually remove or reduce the symptoms of the illness, but cannot "cure" or influence the root cause of the disease. People suffering from chronic illnesses will usually have to live with and manage their disease over a lifetime.

Second, chronic treatments often require significant changes in lifestyle and behavior. This might include changes in diet, exercise and other lifestyle habits, such as substance use.

Lastly, ongoing care is needed. Because of the important role of self-management, relapse – or recurrence of chronic disease – is somewhat common for all of these illnesses. In fact, rates of disease recurrence are about the same for addiction as they are for other chronic illnesses.

SOURCE: White, W.L. & McLellan, A.T. (2008). *Addiction as a chronic disease: Key messages for clients, families and referral sources*. Counselor, 9(3), 24-33.

CHARACTERISTICS	ACUTE DISEASE	CHRONIC DISEASE
BEGINNING	usually rapid	slow
CAUSE	usually one, identifiable	complex, often uncertain, especially early on
DURATION	short	usually for life
DIAGNOSIS	commonly accurate	sometimes difficult
TESTS	give good answers	often of limited value
ROLE OF PROFESSIONAL	select and conduct treatment	teacher and partner
ROLE OF PATIENT	to follow orders	partner of health professionals, responsible for daily management

SOURCE: Stanford Education Research Center. Better Choices, Better Health Chronic Disease Management Program.

TREATMENT CRITERIA

It's important to emphasize that as a coach, you are not a clinician. In other words, you are not qualified to assess whether or not someone needs treatment or what type they should have. At the same time, because you may be working in partnership with a clinical team, it's important to have an understanding of how a clinician might evaluate the severity of a person's addiction and make recommendations for treatment.

The American Society of Addiction Medicine has developed specific criteria for treatment. The ASAM criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. You can review these criteria in the Appendix.

THE CHRONIC CARE MODEL

Our approach to addiction follows a "chronic care" model to match the nature of the disease. As you know, there are too many gaps in service in the world of addiction care today. Even when individuals and families seek help, the care is fragmented, uncoordinated and short-term in nature, which fails to provide the support necessary to sustain wellness.

Addiction is a chronic disease, but it's not treated like one in today's world of health care. Our Addiction Chronic Care Model™ (ACCM) mainstreams addiction care into primary care. In the health care setting, by utilizing a Peer Support Advocate, we coordinate addiction care services from the clinic, to the addiction treatment provider, and to the community Face It TOGETHER Affiliate. The ACCM is patient-centered with a coordinated, team-based continuum of care that enhances the patient's addiction treatment experience, and improves recovery and wellness.

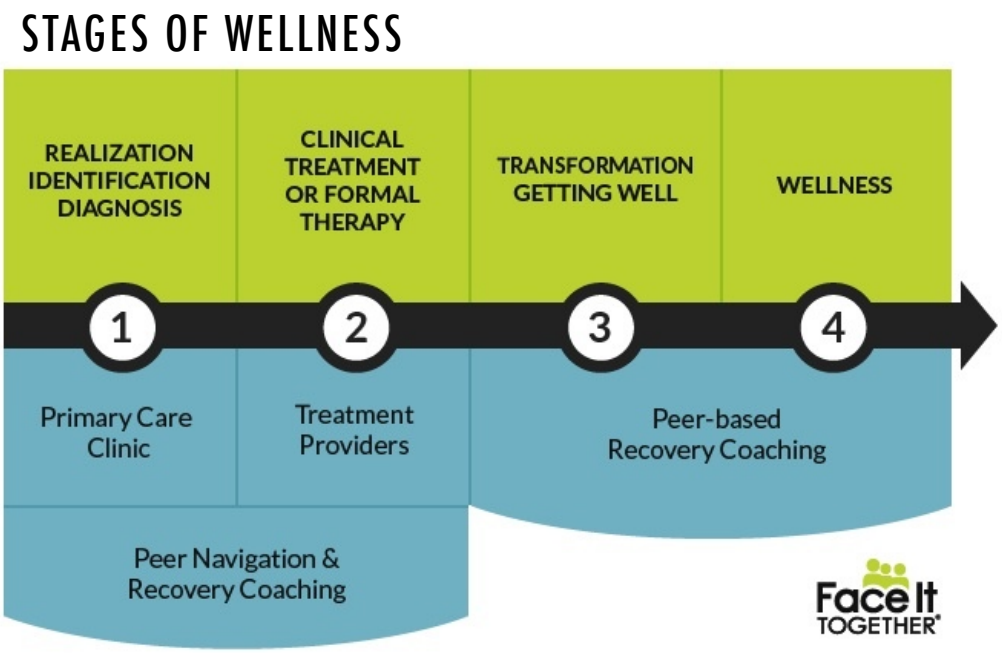
> The ACCM is based on the principle that people suffering from drug and alcohol addiction are ill and should be able to receive expert health care delivered or coordinated by their doctors.

Face It TOGETHER, because it is an integral part of the patient's treatment plan, will be able to coordinate and track the addiction health care of a patient outside the four walls of the clinic because it will use its own Electronic Health Record system (Addiction Health Record) in concert with customized Customer Relations Management software. This will allow our Peer Support Advocate and Recovery Coach to independently track interventions and outcomes in a secure health record, while using technology to monitor and coordinate the patient's care both inside and outside the primary care clinic.

Primary care doctors and supporting personnel should be equipped to help addiction sufferers by making accurate diagnoses, referring them to appropriate care, and measuring outcomes across a continuum of care that extends beyond the clinic.

The ACCM reflects the stages of wellness:

- **Realization, identification and diagnosis should be done inside the primary care clinic.** Doctors can refer high need patients to clinical care or formal therapy, which is of limited duration.
- **The getting well process can take many months, and sometimes years.** The patient's transformation from illness to wellness depends on the patient's family, social, community and cultural resources.
- **Someone to guide the patient through the complexity of clinical and community addiction** care can improve the patient experience, improve patient wellness, and reduce the number of doctor visits and admissions effectively lowering health care costs.
- **So, clinical resources connected to community resources provides a continuum of care for those with chronic diseases.** This is the heart of the ACCM, which is based on the Wagner Chronic Care Model. (http://content.healthaffairs.org/content/28/1/75.short).



The ACCM is designed to reduce care fragmentation and ensure high quality referrals and transitions to enhance care. It incorporates the following elements of a successful care coordination model: clear accountability for care; effective patient support; well-defined relationships with all partners; and strong connectivity for seamless information flows.

STIGMA AND LANGUAGE

One of the reasons many of those suffering struggle to get well is because of shame and a fear of being stigmatized. Stigma is linked to myths and misconceptions about what causes addiction and the people who suffer from it.

In addition, stigmatizing language we've inherited around addiction perpetuates bias by conveying the idea that someone is to blame for their addiction, is a bad person and should be punished. This language is so punitive and prejudicial that people and families whose lives are being torn apart by addiction are literally scared to death to affix these labels to themselves and don't seek help.

- About one-third of Americans continue to see addiction as a sign of lack of willpower or self-control.
- 63% of the general public see addiction as a personal or moral weakness and only 34% see it primarily as a health problem.
- 60% of those with an alcohol problem would not seek help because of fear of stigma.

Much of the existing language around addiction perpetuates stereotypes and fuels the psychological barriers, such as stigma, shame and fear, that keep 90 percent of those who need treatment from coming forward for help.

We choose to reject the "poisoned language" we've inherited around the disease and are very intentional about replacing it with language that:

- Is based on the fact that addiction is a chronic disease.
- Is firmly established in the fields of medicine and science.
- Eliminates inconsistencies between the language of addiction and the language of other chronic diseases.
- Promotes the Vision of a nation that has solved the disease of drug and alcohol addiction.

Stigma is often reinforced by the words we use to talk about and describe this disease and the people who have it. We avoid the use of objectifying labels, preferring "people-first" language instead.

EXAMPLES OF POSITIVE, NON-STIGMATIZING LANGUAGE

Instead of this	Try this
addict, alcoholic, substance abuser junkie, doper, drunk, lush	person suffering from addiction person with addiction
chemical dependency, substance abuse, habit	addiction substance use disorder alcohol or drug problem
person who got sober	survivor of addiction person who is well person who has recovered
clean, sober	remission, wellness, recovered, survived the disease, symptom-free
relapse	recurrence of the disease experiencing symptoms
rehab	addiction treatment

RECOVERY - SURVIVORSHIP

SOBRIETY VS. RECOVERY/WELLNESS

What does it mean to "recover" from addiction? Face It TOGETHER uses the definition of recovery that has been adopted by the U.S. Substance Abuse and Mental Health Services Administration -- **"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."**

We focus on defining recovery, or "addiction wellness," as **much more than sobriety** (the absence of consuming a substance). Getting well from addiction is about healing the body, mind and spirit. Recovery:

- Is self-directed and empowering
- Involves personal recognition of need for change and transformation
- Is holistic and multifaceted
- Has cultural dimensions
- Emerges from hope and gratitude
- Is a process of healing and self-redefinition
- Involves transcending shame and stigma
- Is supported by peers and allies
- Is rebuilding and rejoining a life in the community

We also adhere to the following foundational principles:

- **Holistic view.** Recovery means a multifaceted process of getting well for the body, mind, spirit and relationships.

- **Multiple pathways.** We respect all pathways to wellness and styles of recovery. Every individual has unique needs and circumstances that will determine what works for them. The priority is finding ways to build up recovery capital to strengthen their overall wellness. The process of getting well can include a combination of many paths, including mutual support groups, therapy, faith-based programs, self-help strategies, medical treatment and other medical interventions, among others.

SOURCE: U.S. Substance Abuse and Mental Health Services Administration. *Guiding Principles of Recovery.* Retrieved from: http://www.attcnetwork.org/learn/topics/rosc/whatisrecovery.asp.

- **Client-centered.** Clients are at the center of the process, empowered to guide and provide self-direction for managing wellness and being responsible for his/her own recovery.

- **Harm reduction.** Harm reduction is focused on reducing negative consequences and risky behaviors associated with addiction. It doesn't mean "anything goes." This philosophy is based on respect and trust and about helping clients effect positive changes in their lives. Harm reduction is not opposed to total abstinence from chemicals, but rather includes it as a possible goal over a continuum of strategies. Harm reduction does not condone drug use; however, it only seeks abstinence if that is the goal of the individual.

- **Evidence-driven.** We have a commitment to proven practices as identified through evaluation and outcomes measurement.

BUILDING RECOVERY CAPITAL

As a Recovery Coach, you will focus on increasing the quantity and quality of recovery capital of every individual seeking addiction recovery and wellness. By becoming part of a support system for individuals with addiction, recovery coaches are part of that person's recovery capital.

> Recovery Capital is "… the breadth and depth of internal and external resources that can be drawn upon by an individual to initiate and sustain recovery." (White, 2008)

Further, by connecting individuals with other resources, our coaches continue to expand that capital in many important ways. As recovery capital continues to grow, so do the chances of getting and remaining well.

By consistently using these tools and following our training guidelines, Recovery Coaches will be best equipped to help individuals and families increase the quantity and quality of recovery capital.

Recovery Capital Index™. The basic architecture of the Recovery Capital Index is premised on three core dimensions -- Personal Recovery Capital, Family/Social Recovery Capital and Cultural Recovery Capital (see next page).

SOURCES: Harm Reduction Coalition. *Principles of Harm Reduction.* Retrieved from: http://harmreduction.org/about-us/principles-of-harm-reduction/. Addiction Technology Transfer Center Network. Principles of Recovery Management. Retrieved from: http://www.attcnetwork.org/learn/topics/rosc/recoverymanagement.asp

Within each core domain – Personal Recovery Capital, Family/Social Recovery Capital, Cultural Recovery Capital – are key health, social and living components that make up the disease of addiction from illness to wellness.

These components are based not on an individual's relationship to the use of a substance but based exclusively on functional and other outcome indicators. Each subcomponent of our Recovery Capital Index questionnaire is individually scored and weighted for components and domain. So, individuals and recovery coaches will be able to measure and monitor an individual's progress through wellness across multiple outcomes indicators.

RECOVERY CAPITAL INDEX: AN EXAMPLE

PERSONAL RECOVERY CAPITAL DOMAIN SCORE:	**48.03**
Physical Wellbeing	**65.75**
General Health	60.00
Employment Survey	60.00
Financial Survey	33.33
Housing Survey	72.50
Nutrition Survey	25.00
Health Care Survey	100.00
Transportation Survey	100.00
Clothing Survey	80.00
Safety Survey	56.67
Education Survey	20.00
Mental Wellbeing	**30.00**
Emotional Health Survey	23.33
Mental Health Survey	36.67
Spiritual Wellbeing	**48.34**
Spirituality and Sense of Purpose Survey	30.00
Hopefulness and Optimism Survey	66.67
FAMILY AND SOCIAL RECOVERY CAPITAL DOMAIN SCORE:	**38.33**
Family Relationships and Issues	**38.33**
Family Support Survey	50.00
Family Support - Significant Other Survey	10.00
Social Support General Survey	55.00
CULTURAL RECOVERY CAPITAL DOMAIN SCORE:	**96.66**
Beliefs and Values	**93.33**
Beliefs and Values Survey	93.33
Culturally Relevant Recovery Supports	**100.00**
Culturally Relevant Recovery Supports Survey	100.00

WHAT HELPS PEOPLE STAY WELL?

This is a complex question and the answer depends in good part on the individual. Because of the chronic nature of addiction, a key to sustaining wellness is ongoing, long-term support.

"Recovery capital" also plays a major role in determining the success of someone's ability to get well and stay well. Recovery capital includes the internal and external resources that someone can bring to bear on their recovery. It includes everything from physical resources, such as health insurance or housing, to human capital including education, problem-solving capabilities and social and family supports. Increases in recovery capital help sustain wellness and improve quality of life.

SOURCE: White, W., Cloud, W. (2008). *Recovery Capital: A Primer for Addictions Professionals*. Counselor, 9(5), 22-27.

COMPARISON OF ROLES

	Addiction Counselor	Recovery Coach	Sponsor
Training and Knowledge	Emphasis on formal education; credentialed or licensed by profession	Emphasis on personal experience and knowledge; training by experienced coach	Emphasis on personal experience; no training
Organizational Setting	Usually works in a treatment or health provider setting	Variety of organizational settings, formal and informal	No formal organization or supervision
Service/Support Framework	Usually follows a particular organizational treatment philosophy or modality	Supports many different paths to wellness, led by client needs and preferences	Follows beliefs and practices of 12 step or mutual aid community
Service/Support Relationship	Led by the expert/professional	More of a partnership and generally client-driven	Informal and support is reciprocal
Style of Helping	Formal and professional	Generally personal and informal but structured	Informal and spontaneous
Role of Self	Self-disclosure or focus on self usually discouraged	Strategic use of own story and experience; role model expectation	Strategic use of own story and experience; role model expectation
Duration of Relationship	Usually time-limited	Measured in months or years	Varied but can span years
Time Focus	Typically a considerable focus on past experience	Focus on today and future planning	Varies by fellowship and stage of recovery
Support Emphasis	Emphasizes intrapersonal and interpersonal issues	Emphasis on building personal and environmental recovery capital; linking to resources; problem-solving skills	Intrapersonal and interpersonal focus; minimal focus on the environment
Documentation	Extensive	Moderate	None
Funding	Works as paid support professional, client or third party pays	Provided by paid staff or volunteers; service is usually available at no cost to client	Provides support voluntarily as part of one's service work

CODE OF ETHICS

Your commitment to Face It TOGETHER comes with the responsibility of positively representing recovery. Promoting community trust, honesty and integrity is essential. Our actions influence how the community perceives addiction recovery and wellness. The following guidelines are in place to protect you and the individuals we serve:

- Be responsible for your own recovery before you commit to serving others through the organization;
- Be knowledgeable about recovery coaching;
- Encourage physical, emotional and spiritual growth;
- Be positive about recovery;
- Treat everyone with dignity and respect;
- Follow the confidentiality agreement;
- Respect cultural diversity;
- Hold individuals and organization accountable to the organization's mission;
- Report any real or perceived conflicts of interest to your supervisor;
- Report anything that interferes with your responsibilities to the organization;
- Report anything that raises a question about the integrity of the organization;
- Protect the integrity of the recovery community;
- Involve community stakeholders in support of the recovering individual.

CAUTION

- Do not exploit personal relationships for personal gain
- Do not sexually exploit or harass others
- Do not violate any civil, legal or ethical rights
- Do not gossip

Face It TOGETHER Recovery Coaches must:

- Read and comply with the Face It TOGETHER Code of Conduct;
- Report conflicts of interest or violations of the Face It TOGETHER Code of Conduct; and
- Report illegal or unethical activities.

PRIVACY & CONFIDENTIALITY

As a Recovery Coach, you may have access to personal and/or patient health information. Individuals have the right and expectation to have their confidentiality respected. Recovery Coaches will not during or after their employment use or disclose any confidential or private information about an individual receiving coaching services, volunteer or staff member. All Face It TOGETHER Recovery Coaches are required to sign a Confidentiality and Privacy Agreement.

Face It TOGETHER Recovery Coaches are NOT mandatory reporters. This means that even if some sort of abuse is suspected, you are not legally required to report it. Further, unless the Recovery Coach knows that abuse is ongoing or observes some sort of emergency that requires intervention for the safety of the client or any other person, confidentiality must be protected.

The reasoning behind this is simple: addicted persons come to us at a time of great vulnerability. If they cannot trust that we will protect their privacy to the highest level possible, they will not trust us and seek our help. If they do not, they will likely remain in the clutches of the disease that is killing them. We cannot allow this to happen. As such, confidentiality must be of the utmost importance to our recovery coach program.

Our trained Recovery Coaches must:

- Understand and agree to keep information confidential;
- Only access information and systems required to efficiently execute your recovery coaching function;
- Understand that health information is protected by state and federal laws and the policies of Face It TOGETHER;
- Understand that violations may be subject to civil or criminal legal action and the termination of any and all Face It TOGETHER recovery coaching responsibilities;
- Refrain from sharing confidential information;
- Understand that this agreement will survive the Face It TOGETHER employment or volunteer termination;
- Face It TOGETHER Confidentiality & Privacy Agreement is only void in crisis such as child abuse or suicide situations (applies only to Face It TOGETHER Sioux Falls employee Recovery Coaches and volunteers).

Confidential information includes but is not limited to any individual's individually identifiable personal or health information, whether as printed information (manually or automatically generated), oral communications and electronic information.

HIPAA COMPLIANCE

By now, you've probably heard of HIPAA, or the Health Insurance Portability and Accountability Act of 1996, from your other training or when you filled out forms at your doctor's office. HIPAA implements privacy rules to ensure that health information is protected.

SOURCE: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

"A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed"

WWW.HHS.GOV

Health plans, health care providers and health care clearinghouses are all entities covered by the Privacy Rule, as well as business associates of these entities. With the implementation of the Addiction Chronic Care Model, Face It TOGETHER does business with health care providers. The data collected and shared between health care providers and Face It TOGETHER Recovery Coaches is protected information.

So What's Protected?

The Privacy Rule calls it "protected health information," or PHI. PHI is any individually identifiable health information (including identifiers such as name, address, DOB and Social Security number) held or transmitted by a covered entity or its business associated. PHI is in any form or media—electronic, oral or paper.

Individually identifiable health information is information, including demographic data, that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. This information relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present or future payment for the provision of health care to the individual.

De-identified Health Information

There are no restrictions on the use or disclosure of de-identified health information.

> *"De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual."* (http://www.hhs.gov)

This is how information pertaining to the use of services is disseminated to organizations such as the United Way or to Employer Initiative partners.

Failure to Comply

The Department of Health and Human Services, Office for Civil Rights enforces these standards and investigates violations. Covered entities that fail to comply may be subject to civil money penalties from $100 to $50,000 or more per violation with a calendar year cap of $1,500,000.

A person who knowingly obtains or discloses information in violation of the Privacy Rule may face a criminal penalty, including imprisonment and fines.

BOUNDARIES

Boundaries can get blurred when someone is sick with their addiction. When a person is suffering, there is a tendency to develop unreasonable intimate relationships with others who are addicted or who enable his or her addiction. Someone who is suffering may also push away or become angry with those who care about him or her.

The individuals you coach will be working on re-establishing healthy boundaries in their lives. It's important to recognize that recovery coaching is all about building healthy relationships with your clients.

Coaches will use good judgment in building relationships with individuals and families who utilize our services. It is imperative while working in the human services that coaches recognize that dual or multiple relationships with the individuals and families we serve may be harmful to the recovery and wellness of the individual AND the Recovery Coach.

"Boundary management" encompasses the decisions that increase or decrease intimacy within a relationship. This is an area of potentially considerable conflict between Recovery Coaches and traditional service professionals.

Where traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize hierarchical boundaries and maintaining detachment and distance in the service relationship, peer-based services rely on reciprocity and minimizing social distance between the helper and those being helped (Mowbray, 1997).

IMPORTANT!

Coaches will not provide clients with housing, transportation or financial support. Romantic relationships with individuals we serve are considered dual relationships and are prohibited.

While addiction professionals and peer-based recovery support specialists both affirm boundaries of inappropriateness, they may differ considerably in where such boundaries should be drawn.

We could view the relationship between the Recovery Coach and those they serve as an intimacy continuum, with a zone of safety in which actions are always okay, a zone of vulnerability in which actions are sometimes okay and sometimes not okay, and a zone of abuse in which actions are never okay. The zone of abuse involves behaviors that mark too little or too great a degree of involvement with those we serve.

"My role is to assist people on the road to a happy life. For me, being well is all about freedom. I tell my clients that they don't have to do this alone, and that our past does not define us. I focus on helping people develop the tools needed to sustain a healthy recovery."

---Terri Brown, Recovery Coach, Face It TOGETHER Sioux Falls

SOURCES: White, W. (2007). Ethical Guidelines for the Delivery of Peer-Based Recovery Support Services. Retrieved from: http://www.bhrm.org/recoverysupport/EthicsPaperFinal6-8-07.pdf. Mowbray, C.T. (1997). Benefits and issues created by consumer role Innovation in psychiatric rehabilitation. In: Mowbray, C.T., Moxley, D.P., Japser, C.A., Howell, L.L. eds. (1997) Consumers as providers in psychiatric rehabilitation.. International Association of Psychosocial Rehabilitation Services, Columbia MD, pp. 45-63.

EXERCISE

Examples of behaviors across these zones are listed in the chart below. Place a checkmark for each behavior based on whether you think this action as a Recovery Coach would be always okay, sometimes okay but sometimes not okay, or never okay.

Behaviors of Recovery Coach	Zone of Safety (Always OK)	Zone of Vulnerability (Sometimes OK)	Zone of Abuse (Never OK)
Giving gift			
Accepting gift			
Lending money			
Borrowing/accepting money			
Giving a hug			
"You're a very special person"			
"You're a very special person to me"			
Invitation to holiday dinner			
Sexual relationship			
Sexual relationship with client's family member			
Giving cell phone number			
Using profanity			
Using drug culture slang			
"I'm going through a rough divorce myself right now"			
"You're very attractive"			
Addressing person by first name			
Attending support group meeting together			
Hiring client to do work in your home			

From http://www.bhrm.org/recoverysupport/EthicsPaperFinal6-8-07.pdf

PROPER USE OF YOUR STORY

Although you are a peer, using your personal experience as a tool to help others, it's important to be mindful that the process is not about you. This is often a key difference between a Recovery Coach and a traditional 12 step sponsor. Use your story carefully for strategic purposes. Think about:

- Who is being served by your disclosure?
- Are you using empathy in telling your story?
- Is sharing your story helping to build your clients' recovery capital? How?
- Will parts of your story cause emotional discomfort for the client?
- Are you taking time away from your client's coaching opportunity?

PART 2
PEER SUPPORT TECHNIQUES

As a Recovery Coach, your job is to help clients get through what will likely be one of the most difficult things they've ever done. We know that this is a confusing time for those suffering as well as for their loved ones. You are there to help them navigate the process and provide support along the way.

Everything we do is to help families and those who suffer connect with the right resources at the right time and to maintain that connection as long as it takes to achieve wellness. We take the mystery out of understanding the disease, its symptoms and the options available. This section is intended to help you be as successful as possible in helping others on their journey to wellness and a healthier, more fulfilling life.

ADDICTION HEALTH RECORD

An Addiction Health Record is an organized record of an individual's addiction treatment and recovery plan information in one place. The Recovery Coach assists the client in creating, updating and following the plan. It's a document where clients can maintain their short and long-term wellness goals as well as their RCI score. There is a template of an Addiction Health Record in the Appendix.

SPECTRUM OF ATTITUDES

The Spectrum of Attitudes focuses on the nature and quality of relationships between and among people. The three attitudes making up the spectrum might prevail in any kind of relationship—between parent and child, between manager and subordinate, between teacher and student, between elected officials and citizens, between husband and wife.

People Viewed as Objects

The basis of this attitude is that one person or group of people "knows what's best" for another person or group of people. Or the first person or group may decide they have a right to determine the circumstances under which the second person or group will exist. The person being viewed and treated as an object usually knows it.

People Viewed as Recipients

Here the first person or group still believes they know what is best for the other, but they "give" the other the opportunity to participate in decision-making because it will be "good" for the other person or group. Thus, the other is supposed to receive the benefits of what the first person gives to them.

Understanding people as resources – leaders in their own healing process – will give you a strong foundation for success in working with clients as they strive to get well from addiction

People Viewed as Resources

Here there is an attitude of respect by the first person or group toward what the other person or group can do. This attitude and the behaviors that follow it can be closely associated with two matters of great concern: self-esteem and productivity. Creating a culture in which people are viewed as resources is a worthy goal.

ACTIVE LISTENING

Active listening is a remarkable skill for letting others know you are paying attention, for encouraging them to open up and for understanding others. Simply stated, active listening is "putting into words your understanding of what others have said."

Some of the **benefits** of active listening:

- Active listening helps you to understand others.
- Active listening helps to keep a conversation going.

FIVE STEP FORMULA FOR ACTIVE LISTENING

1. Pay careful attention to the other person.
2. Ask yourself, "What is this person feeling?' or "What is this person saying?"
3. Briefly share your answer to one of the questions in Step 2 (Example: "you sound angry." Do not be judgmental.).
4. The other person will probably tell you if you are right or wrong.
5. If your original statement is inaccurate, you may try again or return to Step 1 to wait for another opportunity.

Challenges:

- Not identifying feelings (practice identifying with feelings if you have had a similar experience or even a distant experience that might have produced similar feelings-focusing only on content).
- Simply repeating message.
- Offering criticism or advice.

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a collaborative, goal-oriented style of communication that we use to elicit behavior change with recovery coaching clients. It's client-centered, meaning the client is the one who drives the process. The coach's focus is to help the client achieve goals by helping him or her explore and resolve ambivalence. This is considering the person as much as the disease.

We use Motivational Interviewing as the heart of the coach's method of peer-to-peer support. It is a collaborative style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the individual's reason for change within an atmosphere of acceptance and compassion.

OVERALL APPROACH TO MOTIVATIONAL INTERVIEWING

ENGAGING Used to involve the client in talking about issues, concerns and hopes, and to establish a trusting relationship with a counselor.	**FOCUSING** Used to narrow the conversation to habits or patterns that clients want to change.
EVOKING Used to elicit client motivation for change by increasing clients' sense of the importance of change, their confidence about change, and their readiness to change.	**PLANNING** Used to develop the practical steps clients want to use to implement the changes they desire.

SOURCE: Sanford One Care. *Motivational Interviewing to Engage Patients in Their Lives and Health* (training video). Dr. Leichter, Sanford Health.

While there are as many variations in technique as there are clinical encounters, the spirit of the technique can be characterized in the following ways:

- Motivation to change is elicited from the client, and is not imposed from outside forces.
- It is the client's task, not the coach's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence. The style is generally quiet and elicits information from the client.
- The coach is directive, in that they help the client to examine and resolve ambivalence.
- Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction.
- The relationship resembles a partnership or companionship.

It's normal for clients to have contradictory feelings about making behavioral or other changes. Motivational Interviewing is a method of communication for exploring and resolving any ambivalence they may have.

SKILLS FOR MOTIVATIONAL INTERVIEWING

During a recovery coaching session, skilled coaches utilize **OARS**: **O**pen-ended questions, **A**ffirming statements, **R**eflecting statements and **S**ummarizing statements.

The goal in using the OARS is to move the person forward by eliciting change talk, or self-motivational statements.

OPEN-ENDED QUESTIONS cannot be answered with a simple yes or no. You could ask a client to describe how he or she has been feeling or what he or she would like to accomplish today. It's a very conversational style that allows for more client involvement. Remember to only ask one question at a time and use the client's own words when possible. **Using open-ended questions builds rapport with clients.**

Watch out for the "Yeah, but" answers in your questions. This is sustained talk and our goal is change talk. You may have asked the client to tell you about his or her drinking and the client says, "I do want to quit drinking, but there are times when it is fun." The skilled coach replies, "You say you do want to quit, tell me more about that."

SOURCE: Sanford One Care. *Motivational Interviewing to Engage Patients in Their Lives and Health* (training video). Dr. Leichter, Sanford Health.

EXERCISE

Your first job. Get into pairs and have one person play the speaker and the other play the listener. The listener will ask open-ended questions to the speaker to have him or her describe his or her first job. Any closed-ended question stops the conversation.

Examples of open-ended question starters

To what extent...
How often....
Tell me about...
Help me understand...
What are your thoughts about...
What, if any.....

AFFIRMATIONS are direct statements of support such as:

- You have quite a gift for...
- I am really impressed with how you…
- Thank you for making your appointment on time today.
- You have really thought a lot about….

These statements recognize the client's strengths and continue to build rapport. This is a space to reframe behaviors and for encouragement. As a coach, you are not a cheerleader, but you are helping the client see him or herself in a more positive light. Be genuine and specific with your clients. Those suffering from addiction may have low self-esteem and not have received much praise or affirming comments, perhaps in their entire lives. Sincerity is key.

EXERCISE

Practice affirmations. Get into pairs. Review the sample Recovery Capital Index profile on page 23. With your partner, brainstorm affirmations you could share with this client.

SOURCE: This section adapted from http://motivationalinterview.net/clinical/interaction.html

Reflection at its core is simply repeating an element of what the individual said. Reflection is a chance to express empathy and guide an individual toward change. Reflection is important because it is the primary way we demonstrate listening. Too many people just listen to respond; skilled recovery coaches listen to reflect.

The listener must listen carefully and think reflectively, then form reflections back on what the listener thinks he or she heard. Think of it like holding a mirror up for your client. This allows clients the chance to correct and re-direct a coach. There are several ways a coach can offer reflection. First, rephrasing - the listener stays close to what the speaker said, substituting synonyms or slight rephrases what was offered.

Second, paraphrasing – this is a restatement in which the listener infers the meaning in what was said and reflects this back in new words. This adds to and extends the dialogue. In artful form, this is like continuing the paragraph that the speaker has been developing, saying the next sentence rather that repeating the last one.

Finally, reflection of feeling - often regarded as the deepest form of reflection -- this is a paraphrase that emphasizes the emotional dimension through feeling statements or metaphor.

CASE STUDY: "FRANK"

Frank is an ambitious young man who is outwardly quite successful. He drinks daily and smokes pot several times a week. He came to the CAMO at his wife's suggestion. Over the course of your conversation, Frank makes the following statements:

"My wife really wants me to quit."

"I go to the doctor, but I don't talk to him about this. This isn't a disease. I don't want to get locked up in treatment."

"I am willing to go to AA meetings."

"This is all my fault."

ACTIVITY: Brainstorm two or three reflections for each of Frank's statements.

SUMMARIZING is specialized reflective listening. It highlights important aspects of the conversation and helps structure the coaching session. The structure of the summary is straightforward. Begin with an announcement that you are about to summarize, list specific pieces of the conversation, invite the client to correct or add anything you may have missed, and then finished with an open-ended question.

If we were considering Frank from the reflection case study, you might say, "Let me stop and summarize what you've shared. You really only came today because your wife wanted you to and you aren't comfortable discussing your drinking or smoking with your doctor, but you are willing to try an AA meeting. You feel like the way you feel is all your fault. Am I missing anything? What are you willing to do today to help feel better?"

SUCCESSFUL MOTIVATIONAL INTERVIEWING

Resist the "righting reflex"

- Tolerate incorrect information that is irrelevant or useful. Don't jump right in; let the individual feel like the expert.
- Ask permission before educating or informing.
- Be strategic about when to educate, first find out what the individual already knows.
- Remember that many people already know which behaviors are healthy and which are not.

Demonstrate empathy. Empathy means understanding the individual's thoughts and feelings. It does not necessarily mean you feel what the individual feels or think what he or she thinks. To show that you understand how he or she feels, reflect back to what he or say is saying to you, and make him or her feel understood. To demonstrate empathy you must verbalize your understanding of the individual's thoughts and feelings.

Find opportunities for change. When an individual seems unmotivated to change or to take the sound advice of recovery coaches, it is often assumed that something is the matter with the individual and that there's not much you can do about it. That assumption is FALSE. Motivation for change is actually quite malleable and is particularly formed in the context of building a strong relationship.

Support your client's expertise. Listen to what they have to offer. People have substantial personal expertise and wisdom regarding them and tend to develop in a positive direction if given proper conditions of support.

NOTES PAGE

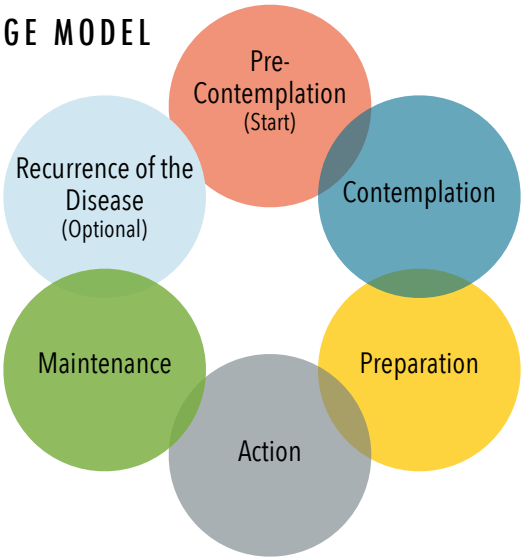
STAGES OF CHANGE

Change is cyclical, not linear

You may have heard that Recovery Coaches meet the individuals they coach "where they are at." Getting well is a process on a continuum. As a coach, you will meet individuals at different points on their journey to getting well from addiction.

James Prochaska and Carlo Diclemente developed a model of change called "Stages of Change" that complements the spirit of Motivational Interviewing and recovery coaching.

STAGES OF CHANGE MODEL



Most successful self-changers will go through the stages 3-4 times before they make it through the cycle without a recurrence of symptoms.

The authors explain that it's normal for people to require several trips through the five stages (six, including possible recurrence) to make long-term, lasting change. Relapse, or recurrence of symptoms, is a normal part of the process of managing a chronic disease like addiction.

Let's take a closer look at each of the stages:

1. **Pre-contemplation** is when a client is not thinking about change or considering the benefits of changing. We wouldn't even be able to start a client file at this point. The individual is not likely to present for help on his/her own. A friend or family member may make a call regarding a person in this stage. This individual may see another's concern as a lecture and will not respond to it. Working with an individual in pre-contemplation stage is a time to use your Motivational Interviewing skills to help move him/her to the next stage. Clients may be **unaware** or **resistant**.

SOURCE: Prochaska, J.O. (2007). *The Transtheoretical Model of Health Behavior Change.* American Journal of Health Promotion, Sept-Oct (12)1, 38-48.

2. **Contemplation** is when an individual is taking a serious look at the pros and cons of behavior change. This is a stage of ambivalence and conflicted feelings. The individual may see the need for change or want to change, but is not taking the active steps to make a change. Key words for this stage may be **awareness** and **openness.**

STAGE MATCHED LEARNING

Identify what stage of change the client is in, and provide support accordingly using Motivational Interviewing and other techniques

3. **Preparation** is when an individual may be influenced by emotionally salient events. An individual in preparation is not quite ready for the commitment to change. For example, someone who wants to lose weight might join a gym, but not actually go there to exercise. Key descriptors for this stage may be **anticipation** or **willingness**.

4. **Action** stage is when the ambivalence is gone and action is initiated. The client is working on change, although not always successful. This stage often occurs after a few months of actually implementing new behaviors. Key words may be **enthusiasm** or **momentum**.

5. **Maintenance** is when the client, with the help of a coach, has developed a workable change plan. Action has been maintained for several weeks. The client accepts barriers to change and identifies a support system to overcome them. Characteristics may be **perseverance** and **consolidation**.

6. **Recurrence** of symptoms (or relapse) is a normal part of managing addiction. It is a return to previous behavior. This should never be looked at as a failure, but rather a chance to learn and discover what can be done differently next time. Most self-changers who suffer a recurrence of symptoms will return to the contemplation stage. Coaches are an excellent resource in this part of the process to help clients develop coping strategies and help them understand that they haven't failed, but that new approaches or techniques may be needed. This stage is all about **risks** and **opportunity**.

PUTTING IT INTO PRACTICE

MOTIVATIONAL INTERVIEWING & STAGES OF CHANGE

PRE-CONTEMPLATION CLIENT

This would be described as a non-recovering client. In this case, someone made the client come in or someone told them to talk to you. The client may be there because of a DUI or domestic violence charge - they are coming to satisfy their lawyer or court, or even a loved one.

QUESTIONS TO ASK:

- What would you like to happen?
- How can you get the court or your wife off your back?

TIPS:

- Help them understand the mission of Face It TOGETHER and what services we offer. It may be the client will use this information later.
- If the client is just "fishing," it may be they'll utilize our services at a later date, and it is important they know what we do and they are welcome to come back.
- Pre-contemplation clients respond to honesty, not pressure to give up drinking or using.

CONTEMPLATION CLIENT

This person would still be in non-recovery, but have flashes of wanting to get well. Oftentimes these clients are in mandatory treatment or just coming out of mandatory treatment. Somewhere inside they know something is wrong.

TIPS:

- Peer coaching is invaluable at this point. It gives the client a chance to get to know a happy and healthy individual in recovery.
- Let the client sort out what they are ready to do next. Gently offer them options and help them think through the alternatives in more depth.
- The presence of a peer Recovery Coach lets the client know they will be safe when they take the next step. "The Recovery Coach took this path and survived."
- Push gently and non judgmentally. Education on addiction and resources can start at this phase.
- Start to introduce the concept of hope. Life doesn't have to be that miserable.
- In the Pre Contemplation and Contemplation phase it's important for the Recovery Coach to have a thick skin. Clients may have periods of trying to push the Recovery Coach away as they go back and forth moving into getting well.

PREPARATION STAGE CLIENT

This client is getting ready for recovery.

TIPS:

- Heavy doses of recovery coaching including Clearinghouse support at this phase are important. Clients need to be connected to resources for a variety of needs.
- Start with some concrete goals, but don't overwhelm the client. Make them short term and achievable. Examples include which treatment centers they will consider, which support meeting they will try, how specifically they will take steps to deal with their spouse/partner or employer.
- Help the client start visioning longer-term goals.

ACTION STAGE CLIENT

This client is in early recovery. This may or may not be the first time the client is in this stage.

TIPS:

- They are ready to take the beginning and ongoing steps to deal with addiction and problems in their daily living.
- The client is more willing and often welcoming suggestions or teaching skills.
- Offer lots of supportive talk with the client for the efforts and actions they are taking.
- Introduce new support systems during this period. "It takes a village of support to build your recovery capital." The Recovery Coach should resist the inclination to go it alone with the client.
- Plan on six months of active work during this phase. Behavior changes take time and problems pop up for clients as they enjoy their early stages of recovery.

MAINTENANCE STAGE CLIENT

This client is working on maintaining and strengthening his/her recovery.

TIPS:

- This client continues to need ongoing support, but needs may vary.
- At this point you can introduce the concept of preventing recurrence of addiction and how to manage risks to recovery.
- Be ready in times of stress. Teach new and improved ways of managing stress.
- At this point coaching often turns into mutual peer support. You may also help the client find meaningful ways to give back to recovering community.

DEALING WITH AMBIVALENCE

Ambivalence is the state of having mixed feelings or contradictory ideas about something or someone. Understanding ambivalence is important so you realize how a brief interaction can trigger a lasting change in behavior. People usually feel ambivalent about change—they are pulled between a desire to change and a fear to change. Ambivalence means being stuck between completing motivators.

The fear of not using drugs and alcohol is very real. For many who are suffering, alcohol is tied to social activities like softball leagues and gatherings with friends, as well as functions of their employment, like entertaining customers. The fear of doing something new or not being accepted by friends and family can be extreme. The biggest fear is usually the fear of failure. Change can be frightening, but your work with clients to help them work through their fears can help them not get stuck.

A sign of ambivalence is the "but" in the sentence, as in, "I want to stop drinking, but if I miss after work drinks, I won't hear everything that happened at the office that day." Ambivalence can also be more subtle, like "My wife said I needed to come talk to you." That spouse is resistant, but did come to the appointment.

EXERCISE

Speaker/Listener Challenge

Find a partner. The speaker will focus on his or her own life and talk about things he or she has wanted to change, but hasn't. Identify the "buts" in each statement. The listener will offer a reflection for the "buts."

Remember, reflection is repeating an element of what the individual said. Reflection is a chance to express empathy and guide an individual toward change. Be mindful of your communication style—a directing style is most likely to invite ambivalence (see next page for more on communication style).

ELICITING CHANGE TALK

Change talk statements will tell you how likely the client is to change. **When you hear change talk, you know you are on the right track.** If you find yourself arguing for change and the client is defending the status quo, you are off course.

Change talk refers to the client's mention and discussion of his or her Desire, Ability, Reason, and Need to change behavior.

"DARN" statements are made in preparation for change:

Desire: I want to change.

Ability: I can change.

Reasons: I should change because _____.

Need: I have to change.

DARN statements lead to CAT statements:

Commitment: I will change.

Activation: I am ready to change.

Taking steps: I am doing/have done.

Together, these steps result in behavior change. It is crucial to respond to DARN statements. When eliciting change talk, ask open-ended questions for which the answer is change talk. Look forward and have the client tell you how life might be different after a change.

COMMUNICATION STYLES

DIRECTING - You take charge

- Ask what the client would like to know
- Provide non-judgmental suggestions
- Get client's interpretation

GUIDING - Listen carefully and ask about options

- Help individual solve for self
- Patient decides what the agenda will be

FOLLOWING - Avoid offering suggestions

- Use active listening
- Important when dealing with difficult issues

SOURCE: Sanford One Care. Motivational Interviewing: Helping People Change, Session Four (training video). Dr. Ulven, Sanford Health.

EXERCISE

Eliciting Change Talk. The following questions could be utilized by a recovery coach to elicit change talk from a client. One person plays the coach and the other the client. Coaches, be mindful to offer reflections for the clients' answers.

Desire
If you were going to change your pot use, why would you do it?

Ability
I understand you are not ready to stop drinking, but if you were, what are some things you would do?

Reason
What are three good reasons you would consider to not abuse your prescriptions?

Need
How important is changing your drinking right now?

OVERCOMING SUSTAIN TALK

"Sustain talk" is what clients use to justify not changing. When ambivalent, individuals naturally voice sustain talk. It is a response for both their own and others' arguments for change. An ambivalent client is likely to use both change and sustain talk, so it's critical to respond to sustain talk. If a client is verbalizing sustain talk more and more, he or she is likely to talk him or herself out of changing. Using reflection is the Motivational Interviewing response to sustain talk.

Be aware that discord will happen in your coaching relationships. Discord is when there is a disturbance between the client and the coach, such as arguing, ignoring or discounting. These are times when you both aren't on the same page. It is the coach's responsibility to recognize and address discord. You can address discord by:

Reflection – "This isn't resonating with you."
Apologizing – "I'm sorry, I feel like I am missing something. What do you think I am missing?"
Affirming – Affirm the strength in a positive choice the client made.
Shifting focus – Try a different approach.

SOURCE: Sanford One Care. Motivational Interviewing: Helping People Change, Session Four (training video). Dr. Ulven, Sanford Health.

MANAGING A CHRONIC DISEASE

Managing a chronic disease is an ongoing process. Part of recovery is learning to respond to the disease to solve day-to-day problems. Learning self-management skills is crucial to solving addiction. The best self-managers are those who think of their disease as a path and are willing to utilize a coach as a navigator.

Attitude counts! Attitude can't cure a chronic disease like addiction, but a good attitude and good self-management skills are vital to getting well.

Good self-managers need these skills:

- **Skills needed to deal with the disease.** The client needs to find the proper supports to deal with his or her addiction. This can range from different types of treatment, medical care and medications to therapy to 12-Step groups or support groups to recovery coaching.
- **Skills needed to continue normal life.** Your client needs to rebuild or maintain family and work life.
- **Skills needed to deal with emotions.** Clients need skills to deal with negative emotions that may surface when dealing with a chronic condition.

THINGS TO REMEMBER

Your client is not to be blamed for his or her addiction. A client is not responsible for causing the disease or not curing it, but is responsible for taking action to manage it.

Connecting with others, like a recovery coach, is vital to good self-management. Addiction is a very isolating disease, so maintaining connection with others in the recovery community reminds the client he or she isn't alone.

Your client is more than his or her addiction. Drinking or using was the center of his or her life for a long time, so you don't want the client to feel like being an addiction patient or a person in recovery is the definer of who he or she is. Focus on his or her strengths and abilities.

Addiction is an opportunity for wellness. Wellness is a chance to shift priorities and re-evaluate life.

SOURCE: Lorig, K, et al. (2007). *Living a Healthy Life with Chronic Conditions.* Bull Publishing Company.

COGNITIVE BEHAVIORAL THERAPY

While you won't be providing formal therapy to clients, it's important to understand some of the key principles of cognitive behavioral therapy (CBT) because of its value for eliciting change. CBT builds a set of skills that enable an individual to be aware of thoughts and emotions; identify how situations, thoughts and behaviors influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors.

CBT emphasizes collaboration and active participation, is goal-oriented, problem-focused and emphasizes the present. CBT values and empowers the individual to take control of his/her life through a variety of techniques. Examples of different techniques include:

- Setting specific, attainable goals from week to week
- Reading about the problem to better understand it
- Role playing and visualizing to overcome negative or distorted thinking
- Doing homework exercises or "action steps" and keeping records between appointments to track progress
- Identifying and changing inaccurate negative thoughts
- Behavioral activation, such as engaging more often in enjoyable activities and developing or enhancing problem-solving skills

PUTTING IT INTO PRACTICE

USING THE "ABCs" TO REDUCE RISKS TO RECOVERY

The ABC process is way to identify and dispute our irrational thoughts, beliefs and feelings. By doing this we can come up with new rational beliefs, thoughts and feelings, which helps clients resist urges and regain control.

What you need to know: There are three basic elements to human functioning -- thoughts, feelings and behaviors. People or events don't make us feel bad, its our perceptions of them that make us feel good or bad. Our perceptions then influence our behavior.

This approach is based on using self-motivation, self-responsibility and self-discipline to engage in healthier behaviors.

THE BASIC A-B-C

A - **Activating event.** *What do you think happened? What would a camera see?*
B - **Beliefs about activating event.** *What did you tell yourself?*
C - **Consequences.** *How did you act? How did you feel?*

EXAMPLE:

Activating event: I'm at a party.
Beliefs: I feel left out if I'm not drinking. I need a drink to relax and have fun. This is awful and I can't stand being here. I'm a bad person because I want a drink.
Consequence: I feel anxiety. I have a drink.

Types of irrational beliefs to be aware of:

- Dogmatic demands (must, should, etc)
- Awfulizing (it's terrible, awful, horrible)
- Low frustration tolerance (I can't stand it, I need it)
- Self/other rating (I'm bad, worthless, weak)

STEP ONE: Identify A-B-C
STEP TWO: Dispute irrational beliefs. Ask yourself:

- Is this belief helpful or self-defeating?
- Where is the evidence to support my belief? Is it consistent with reality?
- Is my belief logical? Does it follow from my preferences?
- Is it really awful? Why is it so terrible? What's the worst that can happen?
- How do I know I can't handle it? Must I always get what I want?
- Is this belief going to lead to my desired behavior and goals?

STEP THREE: Identify new rational beliefs:

- This is difficult, but I can have fun without drinking
- I can handle being here
- It may be upsetting, but it's not life threatening
- While I want a drink, I can survive without one

STEP FOUR: New behaviors

- I abstain
- I stay at the party and have fun
- I move closer to my goal of staying well

SOURCE: SMART Recovery, Introduction to the ABCs. Retrieved from: http://www.smartrecovery.org/resources/library/Tools_and_Homework/Quick_Reference/abc_crashcourse.htm

HARM REDUCTION – GUIDING PRINCIPLES

Harm reduction can be a valuable step in getting clients on a path to long-term wellness. The Harm Reduction Coalition considers the following principles central to harm reduction practice:

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and wellbeing – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

"In practicing harm reduction, we do not give up on abstinence - on the contrary, we may hope to encourage that possibility by helping people feel better, bringing them into therapeutic relationships with caregivers, offering them a sense of trust, removing judgement from our interactions with them, and giving them a sense of acceptance. At the same time, we do not hold out abstinence as the holy grail, and we do not make our valuation of addicts as worthwhile human beings dependent on their making choices that please us." ---G. Mate, MD, "In the Realm of Hungry Ghosts"

TRANSFERENCE

Sometimes situations arise in a recovery coaching relationship that can undermine its effectiveness. Transference in psychotherapy (or any other counseling-type relationship) is typically an unconscious process where the attitudes, feelings and desires of our very early significant relationships get *transferred* onto the therapist. The feelings can be negative or positive.

Transference is normal but becomes inappropriate when patterns of transference lead to maladaptive thoughts, feelings or behaviors. If transference is causing issues in your recovery coach relationship, it's important to talk about it openly and discuss whether it is interfering with the progress of your client. If so, it's important to refer the client to another coach.

Related to this issue, counter-transference is defined as redirection of a therapist's (or recovery coach's) feelings toward a client, or more generally, as a therapist's emotional entanglement with a patient. If you're experiencing counter-transference with a client, it's important to refer that client to another coach.

MAINTAINING YOUR OWN HEALTH

As a peer Recovery Coach, you will be working with clients on complex, difficult issues that could cause emotional stress and wear you down. That's why it's so important to take care of yourself first. Here are some tips on making sure you keep your wellness a priority:

- If you have a challenging client session, debrief with another coach. Other coaches can be a good sounding board to gain perspective and feedback, and to help you work through your own emotions.

- Don't neglect your own physical, spiritual and mental self-care. If you're not well, it will get in the way of your service to clients. You need to take care of yourself if you want to help others find their own paths to lifelong wellness.

- Pay attention to warning signs that your own wellness may be suffering. This could include irritation with clients, a feeling of burden, or even sloppiness or disorganization. Do periodic self-checkups, such as updating your RCI. Don't be ashamed to ask for support if you need it.

- Find healthy ways to de-stress and connect with others on a regular basis.

- Set and honor your own boundaries. Don't sacrifice your own wellbeing in order to always be there for your clients. Make room for your own life!

SPECIAL SITUATIONS

Challenging Clients

Along with the clients that are quite easy to work with, we will have our challenging clients. Among these clients are clients that signed up for the service but don't really want to follow through. It can get frustrating for the Recovery Coach to make several calls without actually connecting with the client.

Clients can also start out and be quite resistive or suspicious of the motives of the call. It is important to try to work through those attitudes. It is part of the addiction disease and it can be viewed that the client is testing us out based on their disease and past experience with helping professionals.

Clients with Suicidal Statements

If a client should make a suicidal statement during a discussion or call, it is necessary to follow established guidelines (either the policy of the Face It TOGETHER Affiliate or Sanford Health). As a Recovery Coach, you are not a mental health counselor, but it is important to listen to what your client has to say and make sure you get the client to the help he/she needs.

If you have an uncomfortable feeling about what the client is trying to tell you, it is appropriate to ask, "Are you having bad thoughts about wanting to hurt yourself?" The client can then tell you, which in itself is very helpful to the client and can relieve the suicidal risk of the client. Always consult with another Recovery Coach when you get a client which makes some suicidal statement. The old adage "two heads are better than one" is significant in dealing with this critical issue.

Clients that Disappear or Have Recurrence of Symptoms

One of the challenges for recovery coaching is having a client that becomes difficult to reach or relapses. This can bring up many personal feelings with the Recovery Coach. It is hard to have clients that "disappear" without notice or let you know they are in a relapse.

We all know that this can happen in the recovery journey and accept this challenge when we make the commitment to recovery coaching. It helps tremendously to share your personal feelings with another Recovery Coach. You need to stay personally healthy to be effective to the clients we serve.

Clients that Challenge Your Own Recovery or Core Beliefs

Some clients can be challenging to your own sobriety beliefs or your overall core beliefs. When dealing with clients such as this it is important to keep to the core tasks and goals of recovery coaching. Examples of this could be a client that challenges your own recovery program (e.g., "AA is a stupid program") or makes a racist or sexist statement.

A constructive way to deal with this is to try your best to stick to the basic recovery coaching goals and not engage in a "battle" with the client. Also, the statements a client can make really aren't about you, but more a reflection of their own problems. If you find yourself dreading a call to or meeting with a particular client that is a good time to discuss the client with another Recovery Coach.

Threats to Staff or Others

This is a serious situation that requires immediate action. The first step is to stay calm and alert. Attempt to get the individual to a quiet and confidential space, such as one of the offices. Ensure you have a safe escape route should the individual become violent. Use a calming voice and tone to de-escalate the situation, if possible. Please refer to the full crisis policy included in the Appendix.

PROVIDING NAVIGATION SUPPORT

In addition to recovery coaching, you will be helping your clients navigate the process of getting well. Oftentimes this means helping your clients identify needs and connecting them with appropriate resources and services in the community.

It's important to remember that there's a lot of confusing information out there about drug and alcohol addiction. It can be overwhelming trying to figure out what to do. We're here to help clients navigate the process and provide support along the way.

Everything we do is to help families and those who suffer connect with the right resources at the right time and to maintain that connection as long as it takes to achieve wellness.

ROLE OF THE CAMO

The CAMO serves as the hub for the local recovery community, connecting people and families to treatment information, resources and services to help initiate, foster and sustain long-term wellness from addiction. This includes serving as a call center, operating a drop-in Recovery Center and information clearinghouse, including a comprehensive website, and providing navigation support for clients and partners.

Our goal is to take the mystery out of understanding the disease, its symptoms and the options available for families and those who suffer. We are here with one purpose – to help individuals and families navigate the process of getting well from this illness.

Navigation includes providing information about and linking clients to a wide range of resources related to recovery, including treatment options and availability, housing, transportation, employment issues, health care, employment support and peer recovery support groups.

This will also include answering questions about the kinds of help available in the community for people and family members who are struggling.

Some of the most common areas you may be asked to help with in terms of navigation are treatment options and health insurance for addiction treatment. Here are some things to consider.

UNDERSTANDING TREATMENT

Every addiction treatment program is unique. But many use a variety of therapeutic approaches to help clients get on a strong path to wellness. Here are some common examples.

Individual Counseling

One-on-one counseling helps your clients through individual issues related to the disease. If intervened in the early stages, some individuals find success in managing their diseases through this type of treatment. ALL reputable treatment programs, whether inpatient or outpatient, will include one-on-one sessions as a component.

Family Counseling

Since addiction is a disease affecting the entire family, family counseling is an important part of treatment. Family-involved therapy can help educate loved ones about the disease, improve family functioning and communication and resolve conflict.

Group Therapy

This is a form of psychotherapy in which a group of patients meet to describe and discuss their problems together under the supervision of a therapist.

Motivational Interviewing

As we covered earlier, Motivational Interviewing is a collaborative counseling method designed to strengthen a person's own motivation for and commitment to change.

Cognitive-Behavioral Therapy

This is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. The therapy aims to help people develop the tools to change these thoughts, recognize cues and break the link between them and using substances.

Medication-Assisted Treatment

This is when medications are used, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of addiction to certain substances. Medications are usually used to reduce cravings and block the effects of certain drugs.

12-Step Philosophy

Many formal in-patient, residential and out-patient treatment providers rely on traditional 12-step programming in their approach. These principles are most commonly associated with AA and related programs.

Some treatment programs have programs for specific addictions, such as opioids or methamphetamines. There are also programs for people struggling with addictions in addition to other health issues such as mental illnesses or eating disorders. Other programs have a strong spiritual focus. It's important to stay abreast of different options that treatment programs provide so you can help navigate the individual to the best fit. The "Recovery Coach Resource" file at the CAMO maintains a listing of available facilities in your area.

Not everyone needs formal addiction treatment. In fact, for those with less severe problems, many often resolve them without any professional medical help. They may rely on structured peer support or other options.

However, some form of treatment is likely needed for a person with fully developed addiction. Treatment comes in many forms and your treatment plan will be determined by an assessment and consultation with a health care provider.

It's also helpful to understand the difference between inpatient and outpatient treatment.

Outpatient Treatment. Outpatient treatment programs allow someone suffering from the disease of addiction to learn to manage his or her disease while still functioning in day-to-day life in the community. This may not be a high-enough level of care for some sufferers, as they are not isolated from the day-to-day situations in which recurrence of symptoms may be more likely. Outpatient treatment may include individual and group therapy, with the intensive group portion lasting six to eight weeks, depending on the program. Many outpatient programs offer some type of family therapy or mental health counseling as well.

Inpatient Treatment. These are residential programs in which a sufferer stays at a facility for a minimum of 28 days, while some programs last 90 days or longer. Some sufferers need medical detox services to deal with withdrawal symptoms safely at the beginning of their treatment. Some inpatient programs have the staff to handle a safe, medical detox on site, while other programs ask that the sufferer complete a medical detox prior to admittance. Some providers offer programs that combine a residential stay with an intensive outpatient program.

Inpatient or Outpatient? This is a decision that should be discussed between the client and health care provider, addiction specialist or with one of our recovery coaches. The answer usually depends on the person's needs and circumstances plus the quality of the programs that are available. An outpatient program may be appropriate as a first step for someone who seems to be at a low risk of relapsing, symptoms are mild, who don't have serious psychological disorders and live in relatively stable environments.

Other things to consider:

- **Encourage clients to get an assessment first.** Before delving in too much on treatment issues it's helpful to encourage clients to seek an assessment. No one is obligated to go to treatment after they have had an assessment. But with an assessment, you will be in a better position to discuss the options available for the treatment that insurance is going to pay for.

- Help clients understand that unless they are in a position to pay for whatever services they might want or need, the assessment will be a necessary and critical part of the insurance process.

- Once they've agreed to have an assessment, you can work with them to make the calls and help with scheduling.

- **Help clients understand that they have options when it comes to treatment.** Most clients have unrealistic or irrational beliefs regarding "treatment" and what that means. Many have a 30-day stay in a "rehab" facility locked into their brains. Most are resistant to this and it can be a significant barrier to getting help.

- Help clients understand that this form of treatment MAY not be what the assessment indicates is best for them. For example, intensive outpatient is not necessarily less effective and may work better for the client -- it depends on the individual. Many clients are relieved to hear this and are unaware of all of their options. The realization that they may be able to remain at home and work while receiving therapy appeals to many because it is far less disruptive to their lives.

THINKING THROUGH TREATMENT

- What type of things have you tried so far to stop drinking/using?
- Have you been to treatment before?
- How has that worked for you?
- What made you decide about seeking treatment?
- Do you have any preferences about inpatient or outpatient treatment and why?
- Do you want a program with a 12-Step focus?
- Do you have insurance? (If so, this is a great time to explore what in-network options are available. If not, this is the time to set up an assessment if a request for state funding is needed.)
- Any other issues such as medical issues or medications that you are taking that might have to be dealt with in treatment?
- Do you want to stay in the area or are you willing to go somewhere further away?
- Do you have any friends/family issues with going to treatment?
- How are you going to communicate this to your employer and what issues can we help you with?
- What are your expectations of treatment?

If there are barriers, you could ask:

- What have you tried before and how did it work?
- If you have tried treatments or programs before what did you like or not like about them?
- What are measures for success to tell us your current program is working?
- What are you willing to do to get well?

Getting Quality Treatment

Selecting treatment for addiction to alcohol and other drugs may be one of the most important decisions someone will make. Unfortunately, sometimes the best treatments are hard to find and sometimes even harder to access.

Treatment centers are not all the same, and will differ greatly in program options, staff qualifications, credentials, cost and effectiveness. Here are some questions to ask or consider when looking at treatment programs:

- **Do they use "evidence-based practices"?** Find out what treatment therapies and approaches they use.

- **Is their treatment philosophy based on "tough love" or other punitive approaches?** Treatment therapies based on shaming, beratement, "breaking people down" or confrontation often do more harm than good.

- **Do they have physicians on staff who are specially trained in addiction medicine?** If so, find out how involved they are in treatment therapies. Ideally, these physicians should be available daily.

- **Do they offer individual counseling?** Individualized counseling is an essential part of an effective treatment program.

- **What are their outcomes?** Do they have evidence that their clients get well and stay well? Is their program evaluation done by an outside expert?

- **Do they offer continuing care programs after discharge?** A structured program of post-discharge checks ups, telephone or other recovery support is needed for ongoing disease management. If these are not offered, contact us and we'll set you up with a recovery coach to provide free, ongoing support.

- **Do they take a patient-based, team approach to treatment?** Ideally, staff should include a range of specialists, including licensed psychologists, licensed clinical social workers or licensed therapists, in addition to medical professionals.

- **Is the treatment approach individualized for each person or is it "one size fits all"?** Given the complexity of addiction and related problems, treatment plans should be individualized and tailored for each patient's needs.

SOURCE: Sheff, D. Clean.

HEALTH INSURANCE

Issues around health insurance will depend on the client's insurance plan and the state in which they live. However, in general, some points to consider include:

- The first step is to sit down and have a conversation with your client about what insurance he/she has.
- Coverage and its limitations will vary from plan to plan based on what product they've purchased. Not all insurance plans are the same, even when it's the same insurer.
- Some form of addiction treatment should be covered based on current law, but there are nuances to this so each situation needs to be evaluated independently.
- If your client is considering treatment, you should encourage them to call up their health plan to learn more about exactly what will be covered.
- A formal assessment is almost always necessary as a first step to securing treatment and ensuring it's covered by insurance.

COMMUNITY RESOURCES

Navigation will also include providing linkages to community resources, supports and services to help clients sustain recovery and address potential risks to a recurrence of symptoms. Each community has its own set of resources that you should become familiar with. The CAMO should have a comprehensive listing.

TYPES OF USEFUL COMMUNITY RESOURCES

- Basic needs (clothing, food/grocery, utilities)
- Conflict resolution
- Employment support, job skills and training
- Faith community
- Family support and childcare
- Financial education/money management
- Health care
- Housing
- Interpreters
- Legal support
- Mental health resources
- Recovery support group meetings
- Senior services
- Transportation
- Veterans support
- Youth programs

PART 3
WORKSHOP

SCENARIOS FOR PRACTICE AND DISCUSSION

SCENARIO #1: CHRIS

Chris is 40 years old. He admits to occasionally drinking too much and has struggled with some health and relationship problems, including conflict with his wife. He enjoys going out to bars most nights of the week, drinking heavily, even though his wife asks him to stay home and cut back. He's resistant to admit that he has a problem, but came in because his wife threatened him with an ultimatum.

SCENARIO #2: BRENDA

Brenda comes in with a long medical history, including a recent visit to the ER. She is obviously not well, as she appears very frail. She's been to enough treatment centers, she's pretty sure she could teach a class at one. Finances are not an issue, as she has even been to a well-known, nationally respected treatment provider. Her overall health is deteriorating. She states that her doctor is not helpful.

She likes him but senses frustration to the point they have even discussed ending their doctor-patient relationship. He knows alcohol is her issue but offers little concrete assistance other than to tell her she needs to quit. When she does not, he admonishes her. Brenda is divorced and has three grown children, all of whom live in other states. She does have a teaching degree, but is currently unable to work. She is resistant to going to 12-Step meetings, but is open to new ideas. She isn't sure how we can help her, but she is willing to listen and engage.

SCENARIO #3: JEROME & AUDRE

Jerome comes in because he is concerned about his friend, Audre. She is a single mother of four and has been using meth for quite some time. He describes her as looking like "walking death" and is very concerned for her health and her safety. Her teenage children are also concerned about her and not sure how to help. They have contacted him to assist in getting their mother some help. She has no health insurance but seems to be willing to get into treatment, although funding is an issue. He says that he thinks she would be willing to come to the center and meet with a recovery coach.

SCENARIO #4: ISABELLA

Isabella comes in for a doctor's appointment, is screened and meets the criteria for additional support, so she meets with the Peer Support Advocate. She is 25 years old and her primary addiction is alcohol. She has previously completed an outpatient treatment program, but hasn't been able to get into an aftercare program due to program size restrictions. She stayed away from alcohol for the two months that she was in outpatient, but is worried about what's going to happen now that she's not going to the classes anymore. She is a single mother. Her mother lives in the same town, but her mom also suffers from addiction.

SCENARIO #5: SHERRY & MAX

Sherry comes in to meet with you after mentioning to the nurse that she's worried about her 28-year-old son's drinking. He denies that he has an addiction to alcohol, but Sherry thinks otherwise. He has received three DUIs in the past three years and still continues to drink. He is no longer drinking and driving (as much as she is aware), but he still drinks to the point of being "black out drunk." His drinking has caused him thousands of dollars in legal fees and fines, and due to this he is still living at home with his parents. The situation is stressing Sherry out and she's not sure what to do. She wonders if she is "enabling" him.

SCENARIO #6: KRIS

Kris has been smoking pot almost every day for the last eight years. Kris denies that he has a problem and claims he can stop at any time. However, he has already been arrested twice for marijuana possession and is on probation, so he has to take UAs whenever his court services officer wants. Instead of quitting, he purchased a bulk order of cleaning agents so that he could continue to smoke and pass UAs.

SCENARIO #7: SARA

Sara comes in after she learned about Face It TOGETHER at the halfway house, where she is currently staying due to a sentence on a DUI 3rd conviction. She has a long history of alcohol use, but no other drugs have been problematic. She has recently completed nursing school and is waiting to take her Boards. She has a job waiting for her at a local hospital if she successfully completes her Boards. She is VERY concerned about how the Board of Nursing and the hospital will react to her DUI convictions. She has an infant child, who is currently in her mother's custody in another city. Her mother filed the complaint with social services. This has strained an already difficult relationship with her mother. She was raised Catholic. She does not resonate with AA or the 12-Steps. Sara is very confused, angry, and frightened.

SCENARIO #8: KAREN & TONY

Karen is worried about her husband's alcohol use. Tony is 35 year-old. He's been drinking since high school. He did get into harder drugs for a while in his 20s, but now only smokes pot a couple times a week. He does drink every day, but always figured that "it wasn't that much of an issue since I go to work every day and we pay the mortgage." He got a second DUI and has an assessment scheduled. He isn't sure what is going to happen with treatment and work, since he does travel out of town often for his job. Karen is tired of it. She has threatened to divorce him if he doesn't quit drinking. Both of Tony's parents suffer from addiction and mental health issues.

SCENARIO #9: JOHN

John is a 25 year-old, single man. He is a father of a 6-month-old boy. John is a Certified Nursing Assistant at a local health care facility. He loves his work but says it does not pay enough to cover his bills. John was diagnosed with ADHD as a youth and has been taking medication for it ever since. He states that the medicine helps him focus and be successful at his daily tasks, but also makes him jittery. Lately John has been drinking way too much. John says he started to relieve stress. He also says that His ADHD medicine and his drinking don't seem to mix. John came in for a doctor's appointment because he wasn't feeling well. He describes himself as being miserable. He has a dysfunctional family and doesn't seem to have too many support systems. John is not opposed to other helping services but says he can't afford any type of professional treatment.

SCENARIO #10: KATHERINE

Katherine is a 45 year old woman living at the local homeless center. She is currently clean from her meth for about 3 months. She had been in recovery for 8 years but relapsed after her husband relapsed. They are separated. Katherine sought out a recovery coach because she is a strong believer in her 12 step program and wanted to seek any recovery individuals available to talk with about her newfound sobriety. Katherine has indeed lost everything: her husband, her job, she has one plastic sack of clothes and personal possessions. In addition she is in a homeless center 75 miles from her home base because there wasn't space anywhere else.

SCENARIO #11: NATHAN

Nathan is a 55 year old single male who has been seeing a recovery coach for two months. After his 5th DUI, he was ordered in 24/7 sobriety monitoring and his attorney suggested getting recovery support. He has tried some previous outpatient programs. Nathan also struggles with gambling and his last two DUIs have happened on his way home from the casino. Nathan has a good job and is a respected supervisor at work. He puts in long hours and enjoys getting overtime. He has reduced his gambling debts in half with this overtime and is proud of this accomplishment, although he still has five figures in gambling debts. Nathan realizes he has made some significant mistakes, but does not believe himself to be dependent on alcohol. He says he can quit without withdrawal symptoms anytime he wants. Currently he complains of no withdrawal or craving symptoms and says that his abstinence from alcohol during his probation is no issue. Nathan is bright and eager to participate, but his recovery coach is concerned with Nathan's lack of anxiety about his 5th DUI and the money he still owes on his gambling debts.

SCENARIO #12: EMILY

Emily believes that she has a problem with alcohol because while she has been able to stop on a few occasions, she is never able to stay completely sober for a period of time longer than a couple weeks. She is a single mom with two young kids and has had the same job for five years. She says, "I go to work hung over sometimes, and I know it has an effect on my performance. I drink when the kids are in bed so they don't see me drinking." She has never had any legal trouble or lost a job due to her drinking and wonders if maybe having something bad happen would spur her to finally change. Emily hints at having suffered some childhood trauma, but quickly says that it is something she has never been able to talk about. Her mother was never there for her as a child because of her own disease of addictions, her dad was absent from her life on most occasions so she never had a father figure.

SCENARIO #13: CARLOS

Carlos admits to recently having a heavy binge drinking episode. He is visibly shaken and frightened. Carlos drank a little in high school, but was more focused on sports. He started drinking more heavily, but not every day, while in college. Although now in his 40s, he still is not a daily drinker, but he does binge drink very heavily went he is out of town, which is usually 10 or 12 times a year. He blacks out every time he drinks. He is divorced, but in a serious relationship and his partner is concerned. She worries when he leaves town, primarily because he is non-communicative. He takes *benzos* to self-detox after binges. His two teenaged children are not aware of the extent of the problem.

SCENARIO #14: JOY

Joy just turned 21. She has lived in the United States since she was 12 years old. Along with most of her family, she was given refugee status due to a decade-long struggle in her home country. This is the third city her family has lived in in the United States. Joy is very reserved and quiet. She says that she drinks because it helps her talk to people and that's what everyone her age does here. Her family is upset because she is going out and drinking almost every day, which caused her to be repeatedly late for work and lose her job. Her mother suggested she talk to someone and find out if this is a problem.

APPENDIX

ATTACHED SEPARATELY

Addiction Health Record
ASAM Criteria for Treatment
Recovery Capital Index Survey
Emergency or Crisis Situation Response Plan

COMMON QUESTIONS ABOUT ADDICTION

Is someone addicted if they drink too much?
Not necessarily. Alcohol and other drug problems range greatly in severity, from mild problem drinking to severe, life-threatening chronic medical conditions. Many people with less serious problems are able to resolve them on their own, without formal treatment or recovery support groups. Those with more severe addictions often have co-occurring conditions – other medical or psychiatric problems – and greater problem severity and complexity.[2(1)]

How is addiction diagnosed?
To be diagnosed with addiction, you must meet criteria spelled out in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This manual is published by the American Psychiatric Association and used by doctors, mental health professionals and other health providers to diagnose mental health conditions.

For each disorder included in DSM, a set of diagnostic criteria indicate what symptoms must be present (and for how long) as well as symptoms, disorders, and conditions that must not be present in order to qualify for a particular diagnosis.

The current version of the manual, referred to as the DSM-5, refers to addiction as a "substance use disorder." The illness is defined on a continuum from mild to severe based on the criteria. Each specific substance is addressed as a separate use disorder but nearly all substances are diagnosed based on the same overarching criteria. Mild substance use disorder requires two to three symptoms from a list of 11.

How do you treat addiction?
Like other chronic diseases, addiction can be effectively treated and managed with the help of a qualified medical professional. Treatment approaches need to be tailored to each individual, given the wide variations in problem severity and related medical and psychiatric issues and social supports. There are many paths to recovery that can help individuals and families get well.

What is an assessment?
When someone seeks or is referred for help for a potential alcohol or drug problem, the first step is often an assessment by a professional, such as a health provider or social worker. An assessment is typically a standard set of questions, criteria or checklist that help the professional evaluate the person's condition and determine the right level of treatment.

What is a relapse?
A relapse is a return to alcohol or drug use after a drug-free period. It is essentially a recurrence of symptoms. Many people who suffer from addiction will experience a relapse given the chronic nature of this disease. However, relapse is not inevitable. In addition, rates of reoccurrence of the disease of addiction are similar to other chronic diseases, such as diabetes or hypertension.

Why do people relapse from addiction?
The chronic nature of addiction means that relapse is often possible. Relapse can be caused by a number of factors, including "reminder cues" that can trigger craving, emotional challenges and other issues. Vulnerability to relapse may depend on brain circuitry, social support systems and other factors. However, relapse rates (how often symptoms recur) for addiction are similar to those for other chronic medical conditions such as diabetes, hypertension and asthma, which also have both physiological and behavioral components.[2]

Why can't some people just stop using on their own?
For someone with an addiction, the urge to use alcohol or drugs can be as powerful as the need for air or water. The initial decision to take drugs or drink is mostly voluntary. However, when the disease takes hold, changes in the brain erode a person's self-control and ability to make sound decisions, while sending highly intense impulses to take drugs. This helps explain the compulsive and destructive behavior around addiction.[3]

Do people have to "hit rock bottom" before they can successfully recover?
No. In fact, research shows that the sooner someone gets help, the more likely they are to have the tools and motivation to successfully recover, get well and stay well.

What's the difference between physical dependence and addiction?
Addiction is characterized by *compulsive* alcohol or drug use despite serious harmful consequences. As part of addiction, a person usually also experiences physical dependence. Physical dependence includes tolerance to the substance (needing more of the drug to experience the same effects) and withdrawal symptoms when they cut back or abruptly stop using.

However, physical dependence can exist without addiction. It means that a person's body has developed tolerance to a drug and may experience withdrawal symptoms. A natural physical dependence can develop with the chronic use of many types of drugs—including many prescription drugs, even if taken as instructed.

What are the signs of addiction?

Signs and symptoms of addiction can be emotional, physical, behavioral, social and spiritual. According to the American Society of Addiction Medicine, addiction is characterized by an:

- Inability to consistently abstain;
- Impairment in behavioral control;
- Craving or increased "hunger" for substances;
- Diminished recognition of significant problems with one's behaviors and relationships; and
- A dysfunctional emotional response.

Some behavioral signs of addiction, primarily due to impaired control, can include:

1. Excessive use, at higher frequencies and/or quantities than the person intended, often with a persistent desire for and unsuccessful attempts at behavioral control;

2. Excessive time lost in substance use or recovering from the effects of use, with negative impact on relationships or the neglect of responsibilities at home, school or work;

3. Continued use, despite persistent or recurrent physical or psychological problems caused or worsened by substance use;

4. A narrowing of behaviors focused on rewards that are part of addiction; and

5. Lack of ability and/or readiness to take consistent action to make things better, despite recognition of problems.

Cognitive or thinking changes can include:

1. Preoccupation with substance use;

2. Altered evaluations of the relative benefits and detriments associated with drugs or alcohol; and

3. The inaccurate belief that problems are because of other causes rather than a consequence of addiction.

Emotional changes in addiction can include:

1. Increased anxiety, dissatisfaction and emotional pain;

2. Increased sensitivity to stressors such that “things seem more stressful” as a result; and

3. Difficulty identifying feelings, distinguishing between feelings and bodily sensations of emotional arousal, and describing feelings to other people.

MYTHS AND REALITY ABOUT ADDICTION

Almost everything we think we know about addiction is wrong. These myths hurt families, friends and our community – and they make it harder for people to get well.

Myth: Using drugs or alcohol is a choice, so if someone gets addicted, it's their fault.
Reality: No one would choose to get addiction, any more than they would choose to get cancer. It's not the substance a person uses – it's not even the quantity or frequency of use. Addiction is about how a person's brain is wired. Brain imaging studies show that differences in the brain are both a cause and effect of the disease of addiction. Addiction is more about the reward system in the brain and how it responds to certain chemicals.

Myth: If someone just uses willpower, they should be able to stop using.
Reality: For people who are vulnerable to addiction, use of drugs or alcohol can lead to profound changes in the brain. These changes hijack the natural "reward pathway" of the brain. In nature, rewards usually only come with effort and after a delay. But addictive substances shortcut this process and flood the brain with chemicals that signal pleasure.

When the disease takes hold, these changes in the brain erode a person's self-control and ability to make sound decisions, while sending highly intense impulses to take drugs. These are the same circuits linked to survival, driving powerful urges no different from those driving the need to eat or drink water.

These overwhelming impulses help explain the compulsive and often baffling behavior around addiction. The person will keep using, even when terrible things are happening to them.

Myth: Addiction mostly affects certain types of people.
Reality: This disease does not discriminate. Addiction can affect anyone. No matter your age or income, ethnicity or religion, family or profession. In the Sioux Falls area, an estimated 20,000 people are suffering from addiction. That's about 1 in 10 people ages 12 and up.

Myth: If someone has a stable job and family life, they can't be suffering from addiction.
Reality: Many people live in denial because they're successful in their professional lives, or because they don't drink until after 5 pm, or because they come from a "good" home. The reality is that anyone can be vulnerable to addiction. Many people hide the severity of their illness, or don't get help because of stigma and shame. If drinking or using drugs is causing any kind of conflict or problem in your personal or professional life, it's worth seeking support.

Myth: People have to hit "rock bottom" before they can get well.
Reality: This simply isn't true, and it's dangerous. The longer you wait, the sicker the person gets, and this can have deadly consequences. Studies show that people forced into treatment have an equal chance of success as people who decide to go on their own. Also, people who get help before their illness is so severe have more resources to draw upon, such as supportive family or a job, to help them successfully recover. So the sooner someone gets help, the better.

Myth: Going to treatment will fix the problem.
Reality: Addiction is a chronic disease, which means it is a long-lasting condition that can be controlled but not cured. Treatment can be the first step toward wellness but it's just the very beginning. Many people need more than one treatment visit to get on a stable path to wellness. More importantly, staying well requires a lifelong commitment to personally managing the disease.

Myth: If someone relapses, they're a lost cause.
Reality: Try not to be too discouraged by a relapse, which is a recurrence of symptoms of the disease. Addiction is a chronic illness very similar to type II diabetes or hypertension, meaning it requires lifelong management. Relapse is no more likely with addiction than it is for these other chronic illnesses. Getting well involves changing deeply imbedded behaviors, which takes time and effort, and sometimes there are setbacks. This doesn't mean that previous treatments failed, because the person with the disease still made progress overall in getting well. A recurrence of symptoms may be a sign that the treatment approach or other supports need to reevaluated or strengthened, or that other treatment methods are needed. There is hope. Keep in mind that most people with addiction who suffer a reoccurrence of symptoms will return to recovery.

Myth: People with addiction are bad and need to be punished.
Reality: Sometimes, after prolonged substance use, people with addiction do horrible things. These bad acts are often impossible to understand. They are due to profound changes in the brain that compel them to lie, cheat, steal or worse, in order to keep using. While this behavior can't be condoned, it's important to understand that they do it because they are deeply sick and need help. Sick people need treatment, not punishment, to get well.

Myth: Addiction is treated behaviorally so it must be a behavioral problem, not a disease.
Reality: Human behavior begins in the brain. Because of this, for certain people whose brains are not properly wired, negative behaviors are linked to the impacted brain's inability to discern between good and bad behaviors. Moreover, advanced brain studies show that different types of treatments, such as psychotherapy and medication, can both change brain function. This is true for depression and other illnesses, including addiction. Sometimes behavioral treatments, like counseling, are enough. Sometimes medication may be required as well. But the fact that behavioral treatments can be effective does not mean addiction isn't a real illness.

TELEPHONE RECOVERY SUPPORT/FOLLOW UP -- BEST PRACTICES

WHAT IS TELEPHONE RECOVERY SUPPORT?

One of our Affiliate's core services is Telephone Recovery Support (TRS). In this service, our trained peers in recovery make weekly telephone calls to individuals at any stage of the wellness process.

In the clinic setting, TRS calls may be referred to as patient "follow up"

The calls are an opportunity to check in, identify any issues and connect clients to resources to keep them well and prevent a reoccurrence of symptoms. Clients are enrolled for an initial 12-week program but can continue receiving calls as long as they wish.

Weekly calls to interested clientele that are moving toward a good recovery or clientele that are in a good recovery can benefit from weekly telephone calls from a trained and supportive telephone recovery coach. The weekly telephone calls can provide clients with:

1. A weekly reminder that someone is interested in their health and wellbeing.
2. A weekly way for clients to share their concerns and successes with a non-judgmental fellow peer in recovery.
3. Ask questions about needed resources.
4. Add one additional concerned support person into their life.

Goals of TRS will vary based on the client, but they can include helping individuals initiate and sustain recovery, as well as harm reduction, to encourage clients to take steps toward long lasting wellness.

The typical weekly call is short in duration, usually five to ten minutes. It is important to clearly identify yourself, and that you are making a telephone recovery support call. Often for the first few calls the clients are rather cautious about the nature of the calls. Getting the essential required information in a gentle way, letting them very briefly know that you too are in recovery can pave the way for developing a positive relationship.

Asking how things are going for them is a gentle way to start. If they don't get around to mentioning issues in their recovery it is appropriate to ask. Our clients don't often have people in their lives that are actually interested and willing to listen to how things are going for them. As clients reveal things about themselves and their recovery it gives us good information to follow up with them at a later time.

Giving advice can be appropriate but early on clients can react based on all the advice they have been given along their path to recovery. Asking if they have any resource needs (housing, meetings, job seeking, is good on each and every call.

Including the benefits of the above service offered by the TRS Recovery Coach, the most important benefit is the relationship and trust that develops over time on the calls. It is a little different that face-to-face recovery coaching. Really all it is that develops the relationship is the client becoming more comfortable with the calls and the developing trust with the Recovery Coach that he/she is indeed interested in them and their recovery, that the Recovery Coach is listening to them in a personal/professional way and it not just a job to the Recovery Coach and the consistency of the calls. Many clients are very used to professionals not hanging with the client as they struggle with their commitment to sobriety. They often expect that they will hear from us once or twice and that we will not have any follow through.

Keeping good boundaries/personal disclosure. One of the strengths of the Face It TRS program is the peer support that takes place in the telephone call. Often the positive relationship between the client and the Recovery Coach is enhanced by the clients understanding that the Recovery Coach has personal commitment to the recovery process. While personal disclosure of the Recovery Coaches own recovery/sobriety journey is part of the peer coaching process, too much disclosure can detract from the clients need to share their complete story. We have to remember that the coaching is about the client telling their story and dealing with their recovery issues. Personal disclosure is good but in small doses.

Clients that want to meet you face to face –occasionally clients have wanted to come in to meet their TRS recovery coach. Clients may also run into their TRS coach at 12 step meetings or support groups. The only important thing to remember is to not inadvertently disclose any personal information the client has given you over the phone in a non-TRS setting.

BENEFITS FOR THE RECOVERY COACH

For people working to get well, giving your experience, strength and hope can be as beneficial to you as it to the client. By visiting and sharing with another person in recovery, it can cement your own security in your recovery and can remind you of the priorities you need to keep in your own life and your own recovery. Gratitude for you own recovery builds with each and every telephone call you make.

DEVELOPING YOUR TELEPHONE COACHING SKILLS

Although the same principles apply to TRS coaching as they do to face to face Recovery Coaching, there are some differences. Both the client and the recovery coach don't have access to one another visually, so you need to rely on the sense of hearing. Your voice and voice tone is more important than ever. To someone who has never had the opportunity to do telephone counseling it might seem like telephone counseling is less than a real live face to face conversation.

The strength of the telephone calls are it puts you into the client's personal life space. You may be talking to the client in their home, their work, or in a car. It could be that is exactly the most important place they receive a supportive message. It is also clear that some individuals are willing to disclose more of themselves when they feel they are not face to face with a counselor. One way of becoming aware of the issues in effective voice presence in telephone counseling is to be attentive to people that talk with you over the telephone. Being aware of good telephone presence or bad telephone presence is one way of becoming conscious of things you might do to make your own telephone skills improve. Role playing with another recovery coach or taping you own voice can be one way of improving your skills over time.

BOTTOM LINE ON GOOD TELEPHONE RECOVERY SUPPORT SKILLS

1. Know the TRS goals and follow them.
2. Be yourself.
3. Don't take things too personally.
4. It isn't all about you. Remember to listen. Most people don't have many people who listen to them!
5. What you are doing is significant in the lives of people struggling to be successful in recovery.

OUR HISTORY

Our story began in 2007, when Kevin Kirby, a seasoned business executive, connected with Charlie Day, a lawyer, CPA and health care finance expert.

Kirby, a survivor of addiction, had been active in the community of Sioux Falls, S.D., establishing a network of sober living homes and a residential, non-medical addiction treatment program. These made a difference, but he felt something more fundamental had to change for more people to get well from addiction.

Day had recently served as a senior finance officer in one of the nation's largest regional integrated health care systems. He was an experienced start-up strategist and business innovator and ready to give back to the community.

The two met, and began crafting a vision for a community-wide transformation around the disease of addiction. They quickly engaged some of the nation's leading experts. Very soon they could see that those with the most "skin in the game" – employers, health care organizations and others – needed to play a leading role.

Their work led to a seven month community town hall process that enlisted the private, public and social service sectors to identify shared solutions to addiction in the community.

These meetings led to the creation of a new nonprofit "Community Addiction Management Organization," Face It TOGETHER Sioux Falls. The organization was charged with implementing an innovative community model designed to foster system-wide change and eliminate barriers to addiction wellness while reducing costs.

Face It TOGETHER Sioux Falls opened its doors in 2009. In 2011, the success at the local level in Sioux Falls served as the catalyst for the creation of Face It TOGETHER, a nationally focused social enterprise dedicated to advancing the model in communities nationwide.

VOICES - INTERVIEW

An interview with Shelly Berg, former Face It TOGETHER Sioux Falls' Director of Recovery Coaching.

How does recovery coaching help a client?

As a recovery coach, I help remove personal and environmental obstacles, barriers to recovery by providing free peer-to-peer support. I link individuals and family members in recovery to services, supports, agencies, organizations and other community resources to strengthen and help sustain and maintain their recovery.

I serve as a personal guide, navigator and advocate in their management of personal and family recovery. I'm first and foremost interested in promoting recovery by assisting individuals to help identify and overcome the century old barriers and shame and stigma by developing recovery capital, but firstly building the human capital.

I'm loyal, I respect their privacy and confidentiality, and I'm trustworthy, approachable and treat each and every individual and/or their family member with the dignity, respect and grace of which they are entitled.

Recovery coaches support any positive change, helping persons coming home from treatment to avoid relapse, build community support for recovery, or work on life goals not related to addiction such as relationships, work, education etc. Recovery coaching is action-oriented with an emphasis on improving present life and reaching goals for the future.

How does a recovery coaching relationship work?

Recovery coaching can help individuals with drugs, including alcohol addiction, advance beyond the limitations of living only "one day at time" without jeopardizing one's recovery and or sobriety. Coaching individuals learn how to plan ahead, how to set goals, and how to achieve them. While working with a Recovery Coach like me, one can learn the art of breaking things down into small, attainable steps. I want individuals to know they are not alone and that they don't have to take on big projects, challenges or steps alone.

As recovery coaches, we walk by their side, meet them at the point at which they are as well as we are here to cheer them on, brainstorm new solutions, encourage and challenge in a positive and up-lifting way. Together we are able to accomplish so much more. Recovery becomes the joy of purposeful living. This is a principal I live by both one-on-one with individuals and or talking with individuals or family members over the phone.

Who are the recovery coaches and how are you matched up with one?
We have a variety of volunteers and staff members that are peers in recovery or have family members impacted by the chronic disease of addiction. All of our recovery coaches – staff or volunteers – who have had recovery coach training meet with individuals and family members that may walk-in to the center, call in for appointments are referred to us from other treatment facilities, transitional living situations, etc. If there is an individual whose addiction matches one of our recovery coach staff or volunteers we will accommodate that.

How do you know that recovery coaching works?
We are in the process of developing procedures and data to measure outcomes. From a professional standpoint, as recovery coaches as we see more and more individuals that are continually increasing longer time of recovery and sobriety we measure that as success. We also measure success by the weekly visit, the TRS calls, and the individuals that pop in to visit us after several years of working with us.

What do you like about being a recovery coach?
Witnessing the individuals that come back who have recovered. I personally have grown so much, and learned so much from all of the many wonderful people and family members I have had the privilege to meet and work with.