 Recovery Coaching Training Manual

Presented by Cali Estes of the Addictions Coach
And Diversified Intervention Group.

www.theaddictionscoach.com
www.diversifiedinterventiongroup.com
FORWARD

We, the educators, hope that you enjoy this training course and that it helps your career to go to new levels with respect not only to education, but also for the amount of value that you are able to charge for your professional services for clients once completed.

The Diversified Intervention Group and Master Therapist Cali Estes would like to expressly thank our major sponsor: Aurora Charter Oak Hospital. Thank you for your support. It is very much appreciated.

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Definitions

**Therapist/Counselor:** Psychotherapy is a general term referring to therapeutic interaction or treatment contracted between a trained professional and a client, patient, family, couple, or group. The problems addressed are psychological in nature and of no specific kind or degree, but rather depend on the specialty of the practitioner.

Psychotherapy aims to increase the individual’s sense of his/her own well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family).

Psychotherapy may also be performed by practitioners with a number of different qualifications, including psychiatry, clinical psychology, counseling psychology, clinical or psychiatric social work, mental health counseling, marriage and family therapy, rehabilitation counseling, school counseling, play therapy, music therapy, art therapy, drama therapy, dance/movement therapy, occupational therapy, psychiatric nursing, psychoanalysis and those from other psychotherapies. It may be legally regulated, voluntarily regulated or unregulated, depending on the jurisdiction. Requirements of these professions vary, but often require graduate school and supervised clinical experience. Psychotherapy in Europe is increasingly being seen as an independent profession, rather than being restricted to being practiced only by psychologists and psychiatrists as is stipulated in some countries.

**Sponsor:** Alcoholics Anonymous (AA) is an international mutual aid movement founded in 1935 by Bill Wilson and Dr. Bob Smith (Bill W. and Dr. Bob) in Akron, Ohio. AA states that its “primary purpose is to stay sober and help other alcoholics achieve sobriety.” With other early members Wilson and Smith developed AA’s Twelve Step program of spiritual and character development. AA’s Twelve Traditions were introduced in 1946 to help AA stabilize and grow. The Traditions recommend that members and groups remain anonymous in public media, altruistically help other alcoholics, including all who wish to stop drinking, and do not affiliate AA with any other organization. The Traditions also recommend that AA members acting on behalf of the fellowship steer clear of dogma, governing hierarchies and involvement in public issues. Subsequent fellowships such as Narcotics Anonymous have adopted and adapted the Twelve Steps and the Twelve Traditions to their respective primary purposes.

Sponsors are unpaid, untrained individuals that have completed the program and are sober for a length of time.

**Life Coach:** Life coaching is a practice that helps people identify and achieve personal goals. Life coaches assist clients by using a variety of tools and techniques. Life coaching draws inspiration from disciplines such as sociology, psychology, positive adult development and career counseling. Specialty life coaches may have degrees in psychological counseling, hypnosis, dream analysis, marketing and other areas relevant to providing guidance. However, they are not necessarily therapists or consultants; psychological intervention and business analysis may be outside the scope of some coaches’ work.
Critics contend that life coaching is akin to psychotherapy without restrictions, oversight, regulation, or established ethical policies. These concerns have been dealt with on a state-by-state basis. In 2009, the State of Tennessee issued a memorandum emphasizing that life coaches may be subject to discipline if they perform activities that could be construed as personal, marital, or family counseling. Other states have made no formal statement but have legal statutes that broadly define mental health practice. (Hawaii, for example, defines the practice of psychology as any effort aimed at behavior change or to improve "interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, [or] mental health." Although such states usually provide some exclusion to licensure requirements, such as for ordained clergy, life coaches usually fall under such statutes. More favorably to life coaches, in 2004 the Colorado General Assembly specifically exempted trained life coaches from licensure requirements that apply to other mental and behavioral health professionals in the state.

On August 14, 2012, the word Life Coach was listed for the first time in the mainstream Merriam-Webster’s Collegiate Dictionary.

Types and Styles:

1. Business Coaching
2. Personal Coaching
3. Christian Coaching
4. Executive Coaching
5. Career Coaching
6. Financial Coaching
7. Health and Wellness Coaching
8. Sports coaching
9. Dating and Relationship Coaching
10. Recovery coaching

**Sober Companion**: A sober companion works “full-time” with the client: full work days, nights, weekends or extended periods where the coach is by the client’s side 24 hours a day. Some recovery coach roles have evolved from a travel or sober escort to a Long Term Recovery Coach or Sober Companion. A Long Term Sober Companion works “full-time” with the client: full work days, nights, weekends or extended periods where the coach is by the client’s side 24 hours a day. This long term option can begin with treatment discharge, the client’s first day or weekend home and may develop into a coaching relationship that continues for several weeks, months or longer.

Returning home from treatment, the client trades a secure, drug-free environment for a situation where they know there are problems. A Long Term Recovery Coach or Sober Companion will provide the symbolic and functional safety of the treatment center. A Long Term Sober Companion will introduce the client to 12 step meetings; guide them past former triggers (e.g. liquor stores or strip clubs) and support the client in developing their recovery plan. A Long Term Recovery Coach or Sober Companion
will help the client to make lifestyle changes in order to experience a better quality of life in the first crucial days after discharge from a treatment center. Sometimes a recovery coach is necessary to keep a client sober in order to regain custody of their child.

**Recovery support specialist (RSS)** - a recovery support specialist (RSS) or a peer recovery support specialist (PRSS) is a non-clinical person who meets with clients in a community-based recovery center, or goes off sight to visit a client. The Recovery Support Specialist will receive no monetary reimbursement for these coaching services. The recovery support specialist ensures there is a contract for engagement, called a personal recovery plan. A key component of the Recovery Management model that all RSS follow is this personal recovery plan. Peer Recovery support specialists (PRSS) are sometimes called "recovery coaches" but that term has been dropped by William L. White in favor of "recovery support specialist" to avoid confusion with the professional life recovery coach. Other terms used to describe peer recovery support specialist is a peer mentor.

**Family Recovery Coach** - The family plays such an important role for a person in recovery, yet is so often neglected by traditional models of recovery. Specially trained Family Recovery Coaches strive to create a calm, objective, non-judgmental environment for the family of a recovering addict. These coaches are knowledgeable in specific models that aid the family coping with the changes that they have gone through living with an active addict or living with a recovering addict. Regardless of an addict’s choices, working with a Family Recovery Coach helps a spouse; partner; or loved ones avoid the mental obsession that plagues so many families affected by addiction and learn to lead sane and productive lives.

**Recovery Coach**: Recovery coaching is a form of strengths-based support for persons with addictions or in recovery from alcohol, other drugs, codependency, or other addictive behaviors. Recovery coaches work with persons with active addictions as well as persons already in recovery. Recovery coaches are helpful for making decisions about what to do with your life and the part your addiction or recovery plays. Recovery Coaches help clients find ways to stop addiction (abstinence), or reduce harm associated with addictive behaviors. Recovery coaches can help a client find resources for harm reduction, detox, treatment, family support and education, local or online support groups; or help a client create a change plan to recover on their own.

Recovery coaches do not offer primary treatment for addiction, do not diagnose, and are not associated with any particular method or means of recovery. 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.

Recovery coaching is unlike most therapy because coaches do not address the past, do not work to heal trauma, and there is little emphasis on feelings. Recovery coaches are unlike licensed addiction counselors in that coaches are non-clinical and do not diagnose or treat addiction or any mental health issues.
Telephone or Virtual Recovery Coach - A Telephone or Virtual Recovery Coaching relationship may be established to continue beyond the face to face meeting of a client and a recovery coach, sober escort or a sober companion coach. The prior face to face coaching relationship was built on trust and re-established honesty for the client, so the Telephone or Virtual Recovery Coach relationship can continue in the same light, with daily or weekly telephone or web based conversations.

Today, many treatment centers are embracing virtual recovery coaching and linking Telephone or Virtual Recovery Coaches to clients prior to leaving treatment as a way to continue the connection to the treatment center, as well as meeting guidelines of an ‘aftercare’ program. On line virtual coaching programs has also sprung up recently, either fee based or for free, that will help anyone apply the methods of recovery (e.g. developing a recovery plan and building recovery capital) whether the person has departed from a 30-day stay at a treatment center or relapsed many months after treatment.

Legal Support Specialist - Recovery Coach - Recently, lawyers dealing with criminal drug cases or drug courts have been requesting a type of recovery coaching to ensure a client, (perhaps under house arrest, enrolled in a drug court outpatient program or pending trial) stays sober as per the law’s mandate. Recovery Coaches with the required certification and legal knowledge are contracted for this purpose. Coaches licensed as a Licensed Clinical Social Worker or Certified Alcohol and Drug Counselor with training in assessments can perform these tasks. The courts request them to perform a client assessment. The coach will then draft a letter to the court and offer suggested placement in a residential alcohol/drug treatment center, an outpatient treatment program and/or a sober living facility. A Legal Support Specialist - Recovery Coach can also appear in court with the client and provide transportation to or from courthouse.

History of Recovery Coaching

In 1984, the rock group Aerosmith was attempting a comeback; but it was not working, just as their newest album Back in the Saddle was not climbing the charts. There were a lot of things that were not working for Aerosmith, Joe Perry and Steven Tyler, front men for the group, are referred to as the “Toxic Twins” for their heroin habits and other behaviors on and off the stage. In fact, the entire band was heavily drinking or taking drugs.

That summer, while touring for the new album, co-manager, David Krebs, hired a psychiatrist to tour with the band. After a month, the doctor claimed the band was "unfixable". Krebs left the band. Aerosmith denied drugs were dragging down the tour and the album sales.

Tim Collins told the group that in order to survive they had to get sober, claiming that of they stopped using alcohol and drugs, and he could take them “platinum” again. Band members Joey Kramer and Tom Hamilton both became sober and by the fall of 1986. Steven Tyler went to an in-treatment drug rehabilitation center, followed by Joe Perry. By the end of 1986, the final band member Brad Whitford had accepted sobriety. Even so, Aerosmith’s sobriety commitment to Tim Collins was only partially completed. Collins still had to get these heavy metal rockers on the road, with roadies, groupies,
opening acts and exposure to more drugs and alcohol, in order to promote their newest album, Permanent Vacation. Tim was able to help the group, maintain sobriety throughout the tour by contracting a recovery coach, Bob Timmons to stay with the band through the tour. A new era in recovery coaching had begun.

Recovery Coaching became more developed and professional in 2003 as a professional life-coaching niche. Alida Schuyler, a coach credentialed by the International Coach Federation (ICF) and a woman in recovery from addiction wrote the first recovery coach certification training program specifically aimed at training students to coach persons with addictions. She also created the first special interest group for recovery coaches, and she co-founded the nonprofit Recovery Coaches International with Andrew Susskind.

William L. White used the term "recovery coach" in his 2006 paper Sponsor, Recovery Coach, Addiction Counselor but later changed adopted the term "Peer Recovery Support Specialist" to emphasize a community-based peer model of addiction support. Many recovery coaches use different recovery approaches adapted from the Minnesota Model. White's Recovery Management model adapted from the Minnesota Model includes recovery coaching (peer recovery support specialist) and was developed by William White in 2006. Alida Schuyler developed a professional model of life coaching for addiction recovery by blending the Minnesota Model and Harm Reduction model with the core competencies of the International Coach Federation (ICF).

** Information gathered from Wikipedia. **
Differences

Hours: 24/7, on call, nights, weekends, holidays. Hourly, daily, weekly, monthly or per job.

Education: None required.

State Requirements: None at this time

Continuing Education: None at this time

Private and Public Sectors: Private only, public does not recognize Recovery Coach

Ethics (attend meetings): Can attend meetings as a Recovery Coach

HIPPA: Not an issue but for ethical reasons should follow

Insurance: Not accepted or covered at this time

NOTES:
MODELS OF ADDICTION

1. Minnesota Model of Addiction is what our country bases addiction on. Utilization of:
   a. Relapse Prevention
   b. Denial
   c. 12 Step
   d. AA/NA
   e. 30 day rehab
2. Florida Model utilizes Halfway and ¾ housing for aftercare
3. 12 step Models (used in Minnesota and Florida Model)
   a. Utilize ‘surrender’ and “giving your will up to God”
   b. Meetings/Ego
   c. Belief that you are ‘sick’ and cannot recover
   d. Disease oriented with expected relapses
4. Non 12 Step Models
   a. SMART RECOVERY “self-reliance and self-empowerment”
   b. Holistic
      i. Fitness and Nutrition
      ii. Mediation
      iii. Activities
      iv. Healing body and mind
5. Disease Process vs. Disorder
   a. Argument sick vs. empowerment

NOTES:
MODELS OF TREATMENT

1. Abstinence -- zero tolerance

2. Moderation Management -- some but not primary drug of choice

3. 12 step NA/AA -- abstinence with meetings, steps

4. Holistic – fitness, wellness, health, alternative therapies

5. Faith Oriented—specific religious

6. Medication Management (suboxone, methadone, vivitrol)

Notes:
STYLES OF TREATMENT

1. **Detox**: removal of the drugs from system or placement on a medication management program. $20,000 + Insurance

2. **Rehab 30 or 28 day**: goal is to remain sober 28 or 30 days. $12,000-$63,000
   Insurance and Private Pay

3. **PHP: Partial Hospitalization Program** – day treatment. Usually 30 days. $10,000-$30,000
   Insurance and Private Pay

4. **IOP: Intensive Outpatient Program** – 6 week evening program 3x a week for 3 hrs. $8,000-$30,000
   Insurance and Private Pay

5. **Halfway House**: usually 6 months with a curfew and zero tolerance, drug testing offered. $150-500 a week. Cash only.

6. **Meetings AA/NA**: Sponsorship, zero tolerance. FREE.

7. **Recovery Coach**: Daily, weekly, hourly or longer stays with client, can go with them to location, work school etc. $125 hourly, $650-1500 a day. Cash only

8. **Sober Companion**: Similar to Recovery Coach usually hired for specific event or a minimum of 30 days. Cash only $350-1500 a day.
DUTIES AND RESPONSIBILITIES

As a Recovery Coach you have to adhere to certain responsibilities and duties to assist the client.

1. Client Centered: If you are in ‘recovery’ it is imperative to remember that this all about the client and not at all about you. Sharing some of your experiences is natural but keep it short and only relevant to them.
2. If you can’t help - do no harm. Know when to turn a client down and refer them out to someone that can handle the situation.
   a. Eating Disorders
   b. Excessive using and Detox
   c. Psychiatric Issues: bipolar, schizophrenia, etc.
   d. Medical professionals
   e. Cutting and Self Harm
3. Do not discuss other client’s issues with your current client.
4. Work alongside professionals: therapists, MD, psychiatrists etc. remember it is or the client’s best interest.
5. Check your own baggage at the door and take your own inventory.
6. Transference and Countertransference. By the same token do not pick up their issues and defects.
7. Use Contracts with clients as a rewards system
8. AA/NA meetings are acceptable but remember this is about them.
9. Use a mentor if you need one.
10. You cannot ethically sponsor your Recovery coach client.
11. Motivation to Change. Learn what their motivators are and utilize them on an hourly or daily schedule.
12. Nutrition
13. Fitness
14. Spiritual Side of Recovery

Make sure you are a good fit for your client. If you are into 12 step and AA/NA and they are not it is not ethical for you to force it on them or tell them it is ‘the only way’.
ETHICS AND RESPONSIBILITIES

1. Show respect and regard for the laws of the communities in which they work.

2. Recognize that violations of legal standards may damage their own reputation and that of the agency that they may work for.

3. Not physically or verbally abuse their clients.

4. Not abuse alcohol or illegal substances.

5. Not financially exploit their clients.

6. Not abuse legal drugs, preferably not be taking any mood altering medications that could compromise the client.

7. Not engage in any sexual relationship of any kind with the client and or family/relatives/friends of the client.

8. Ensure that services are offered in a respectful manner in an appropriate environment.

9. Not charge or collect a private fee or other form of compensation for services to a client who is charged for those same services through any agency.

10. Not use their relationship with clients to promote personal gain or the profit of an agency or commercial enterprise of any kind.

11. Avoid continuing a clinical relationship (maintaining a case) for personal gain or satisfaction beyond the point where it is clear that the client is not benefiting from the relationship.

12. Not accept a fee, gift or other donation of any kind for referral to treatment, therapy or any other service.

13. Refer out of scope clients to appropriate sources.


16. Do not offer, pretend to offer or otherwise assume to offer any services outside the scope of a Coach unless otherwise trained, licensed or certified.

17. Establish and maintain professional relationships characterized by respect and mutual support.
18. Establish and maintain professional relationships with their clients.

19. Respect the confidences shared by other colleagues/ professionals with respect to clients.

20. Not knowingly solicit the clients of other colleagues/ professionals.

21. Not knowingly withhold information that has been appropriately released by the client, from colleagues/ professionals that would enhance their treatment effectiveness.

22. When working within a treatment team, work to support, not damage or subvert the decisions made by the team.

23. Respect professional status and standing and not misrepresent their professional qualifications and affiliations.
LEGAL ISSUES OF A RECOVERY COACH

1. We do not have a DUTY TO WARN YET.
2. We are not bound by HIPPA Yet (laws of privacy and confidentiality).
3. We are bound by all laws of crime and criminal acts.
4. We are not permitted to touch our clients.
5. You can give your clients a ride in your car, buy insurance to cover them.
6. Buy liability or malpractice insurance. HPSO is recommended.
7. You can meet your clients in a public place, beach, coffee shop, park etc.
8. You can drug test your client.
9. You can be asked to testify what was said by your client.
10. You do not need to keep records and or take notes
11. If you choose to over nights with your client, get BONDED.
12. You can search a client’s car, home or purse with permission.
13. You can deny service to a client if they are not a good fit.
14. You cannot deny service for race, religion, creed, political view or sexual orientation.
15. You can deny service for sex of client (i.e.: you are male and do not want to work with a female for liability purposes)
16. If you see adolescents take on extra insurance and get permission of parent in writing.
   Also just because the parent pays DOES NOT MEAN THEY ARE PRIVY TO WHAT IS DISCUSSED UNLESS IT IS AGREED UPON. (GREY AREA).
CONFIDENTIALITY

Preserve, protect and respect their clients' right to confidentiality.

Comply with the federal and state laws, rules and regulations pertaining to client confidentiality, including current HIPPA law.

Guard professional confidences and shall reveal such confidences only in compliance with the law or only when there is a clear and imminent danger to an individual or society.

Inform the client and obtain written agreement in areas likely to affect the client's participation (working with other professionals, legal issues).

PAYMENT

Accept payment and charging for services.

Recovery Coaches charge by the hour, ½ day, day, week or month. We go to the client and can live in with them. Rates vary by location and can run $350 to $2000 a day. Deciding what to charge depends on going rate in the area and your unique experiences.

You can accept cash, check, PayPal, charge etc. Generally it is ½ down and half in the middle for longer stays. We can negotiate meals, travel etc.

Payment should be negotiated prior to the stay and collected upon meeting the client.

We are not covered by insurance at this time.
Day in the Life of a Recovery Coach

1. Wake up
2. Meditation/prayer/set the tone for the day
3. Fitness
4. Breakfast-proper nutrition
5. Work/school/volunteer
6. Meditation/prayer
7. Proper Lunch
8. Meeting
9. Event
10. Sober activities
11. Proper Dinner
12. Meditation/prayer
13. Bed proper rest
Goals of a Recovery Coach

* You may need to pre search your client’s apartment, house, condo, car, jackets, boots pockets etc. to locate and remove any drug paraphilia prior to client coming home from treatment, going out, or after use. You may need to continue to sweep for any drugs or ‘works’ the client may hide or conceal.

1. Teach Life skills
   a. Fitness
   b. Nutrition
   c. Mediation/prayer
   d. Balance
   e. Stressors
   f. Staying Sober
   g. Sober activities
   h. Outdoor fresh air activities

2. Assist the client in remaining sober

3. Allow room for growth
   “Progress not perfection”

4. Celebrate the wins

5. Encourage forming friendships and partnerships

6. Avoid isolation

7. Assist at work (on set, on tour, in meetings, wedding, and parties)

8. Get the client through the stressful event and allocate for triggers

9. Community Involvement

10. Daily activities sober
Building Relationships and Qualifying the Client

Building relationships and trust with the client is paramount if you plan to work with them for any length of time. Key points to remember:

1. If you cannot HELP, do NO HARM
2. Have Referral Resources Ready
3. Set Boundaries Early On
4. Establish the Alpha Role
5. Clarify Expectations
6. Be Consistent in Actions, and Verbiage
7. Be Thorough in Use Follow Through at all times
8. Do not take on a client you cannot help
9. PRE QUALIFY ALL Clients

Pre Quality Process:

1. Phone Call Questions –WHAT DO I ASK?
   a. Age?
   b. Type of Use...What substances?
   c. Length of use....How Long?
   d. Have you been to rehab? How many times?
   e. Have you been arrested? How many times?
   f. Do you have legal issue spending?
   g. Is this court ordered?
   h. What is your goal or goals for this time we spend together?
   i. When did you use last?
2. ASSESS for detox
   a. IF USING ALCOHOL AND BENZOS DETOX IS HIGHLY RECOMMENDED.
3. ASSESS for mental health
   a. Do you have a history of mental health?
   b. Are you on any prescribed meds now? What are they? Does?
   c. Have you been in any psychiatric facilities? How many times? When was the last time?
   d. Have you been diagnosed with a mental health disorder?
4. ASSES for self-harm and Eating disorders
   a. Do you cut or burn yourself?
   b. Do you have issues with eating? DO you restrict or binge and purge at all?
Personalities versus Mental Health

a. **Controlling:** I am in charge. I must be in charge. You are all doing what I want and expect. If I am out of control I may get angry and nasty.

b. **Narcissist:** Life revolves around me. I am the center of my family. No one can exist without me. I get what I want.

c. **People Pleaser:** I want to make others happy and like me. If they are happy, I am happy; even if what I am doing to make them happy does not make me happy.

d. **Egotistical/Entitled:** I come from money, therefore others treat me well. I hired you, or my family hired you and therefore you do what I say. I may treat wait staff and those that I feel are beneath me unfairly.

e. **Social Anxiety:** I fear social situations/people/interaction but that which I fear I crave.

RATIONAL VS IRRATIONAL ANXIETY

f. **Manipulation and Lying:** I have been getting my way for so long it is intrinsic to lie. Sometimes I do not even realize that I am lying. Then I might tell another lie to cover up the first lie.

g. **Grandiosity:** I am dramatic. I enjoy being dramatic and boast about all of my accomplishments even if some of them are lies.

h. **Victim Role:** I am an addict because of all the things that happened to me. I am a victim, it condones my behavior and I act this way because people have done me wrong. They always do me wrong.

i. **Anger Role:** I am angry. I am always angry, I am not sure why or maybe I am but everything annoys me and I am comfortable I anger mode. I do not show many other emotions.

j. **Codependency:** I can’t exist in life without a certain person or thing. I could not imagine being alone and must continue doing what I am doing even if it is not working (common with spouse of the addict)

k. **Bipolar:** I am happy. I am sad. I am angry. I don’t know why, I can’t tell you why. I just am. Can be a product of drug induced psychosis or can lead to drug use to quell the symptoms.
I. **Borderline:** I will use anger, tears, sex laughter or whatever means I can to get you to do what I want. I desire to have many friends and be liked, but also to control everyone. If I cannot control you, I will turn the circle of friends against you and cast you out. There is no drug to fix this, it is a personality disorder.

m. **Depression:** I am sad. I am very sad; I can’t get out of bed. Can be drug induced psychosis or true depression. If it persists for more than a week or two refer out.

n. **Schizophrenia and shizo affective:** I may hear voices or see things that are not there. I may symptoms of paranoia. Commonly induced after the drugs Bath salts, Spice or Wet are used. Medication will alleviate some symptoms.

**Notes:**
PHARMACOLOGY

Currently Illegal Drugs (without a script)

1. **HEROIN** - This highly addictive OPIATE comes in a number of quantities, but we will focus on the individual dose, or “BAG” and the “BUNDLE”. The “BAG” in almost every situation is $10.00 worth of Heroin. To an active user 2-3 “BAGS” are needed per dose to give the user his/her desired high. The “BUNDLE” is when the user buys “BAGS” in multiples of 10 to usually get a better price per bag. Heroin can be ingested in 3 different ways: Snorting the drug is the least potent way to ingest Heroin and usually has the weakest withdrawals, which in turn makes it easier to hide the usage. Next, is Smoking the drug. Much like Cocaine, smoking Heroin gives the user a much more intense and rapid high. Last is the most potent and dangerous way to ingest Heroin and that is by injecting the drug directly into the bloodstream. The potency of Heroin varies so much that this makes injecting the drug extremely dangerous and the toll that injecting takes on the body makes it almost impossible to hide the usage.

2. **COCAINE** - this highly addictive narcotic comes in a variety of different quantities as well, but we will focus on the individual doses that would relate to an “everyday user” as opposed to a dealer or trafficker. There are 3 very common quantities for the average Cocaine user and these would be a half gram, a gram and an 8-ball (3.5 grams). The price of these vary, but on average we are talking 25.00/30.00 per Half Gram, 50.00/60.00 per Gram and 150.00/200.00 per 8-Ball. Much like Heroin, Cocaine can be ingested in 3 different ways: Snorting is again the least potent way to ingest the drug and easiest to hide. It is also the most cost efficient way for the user to do the drug. Next is Smoking Cocaine. This way of ingesting the drug gives the user a much more intense and rapid high than snorting and causes the user to go through much more of the drug in a short amount of time. And finally, there is injecting Cocaine. This way definitely gives the most intense high and is by far the most dangerous. Much like Heroin, the wear and tear that shooting Cocaine takes on the body is vicious and is extremely hard for the user to hide.

3. **METH** - this drug is an extremely addictive amphetamine and comes in various amounts which are much smaller in quantity than Heroin or Cocaine. Meth, known as “the poor man’s Cocaine” is extremely potent and is only needed in smaller amounts. The smallest is the “POINT” which is actually only 1/10th of a gram and costs the user about $10.00. Next is the “QUARTER” which is exactly that….a ¼ gram and usually costs the user $25.00. A “GRAM” of Meth runs about $100.00 and a “TEENER” costs about $175.00 and is 1/16 of an Ounce. All of these prices are easily attainable for the average person, but the use of this drug is the hardest
to hide from friends and family because of the toll that it takes on the body, especially the skin. Once of the biggest signs of Meth abuse is open sores appearing on the body (especially the face) from the user picking obsessively while being high.

4. ROXICODONE/OXYCONTIN- This section should be a seminar all on its own. The newest EPIDEMIC is actually prescribed by Doctors at an alarming rate and sold illegally on the streets in large amounts. These pills can be swallowed, snorted or injected. Not only are these pills single handedly destroying lives, they are also directly responsible for a “spin-off” HEROIN epidemic. With the government cracking down and restricting the manufacturing of these pills the illegal street price had gone from $8.00 a pill (30 mg) to $25.00 a pill (30mg) in less than 1 year. Before we get into the quantities and signs of abuse, let’s make sure we know the difference between the two widely abused pills. Roxicodone pills come in 15mgs and 30 mgs and are IMMEDIATE RELEASE pain pills used to fight severe pain. The 30 mgs are usually baby blue in color, but new lighter blue (almost white) are starting to surface. The 15mgs are always light green in color. The 15mgs are now $12.00 while the 30mgs run $25.00. To the average user (2) 30mg pills are needed to obtain the “abusers” high. Now, OXYCONTIN is a “controlled release” pill meaning that OXYCODONE is time released into the body over a long period of time...OXYCODONE is the shared opiate between the two pills we are discussing, ROXICODONE AND OXYCONTIN. Many people think they are the same pill but remember, ROXICODONE(ROXY) is IMMEDIATE RELEASE while OXYCONTIN(OXY) is TIME RELEASED...So you can see where the “immediate need addict” usually prefers the ROXY. We mentioned earlier that these pills were contributing to a “spin off” Heroin epidemic. Like we stated before, in less than one year the illegal street price of a Roxy has gone from $8.00 to $25.00 due to new restrictions by the government on prescriptions and manufacturing of the pill while the cost of a single bag of Heroin has stayed at $10.00. Both Heroin and Roxicodone are Opiates and produce the same effect and feeling for the user. So with the cost of a Roxy skyrocketing, users are beginning to revert to the more cost efficient Heroin. Which, in turn, is creating a whole new Heroin epidemic.

5. XANEX/KLONOPIN- The benzodiazepine crowd of drugs is usually prescribed from a doctor and starts off with a client’s chief complaint of ‘anxiety that not which is specified.” A PHD or MD will give a client a dose of these to ‘calm them’ with instructions usually before bed and Per Diem, meaning as needed. What happens with a client is the ‘anxiety’, real or imagined gives the addict a crutch or excuse to get high. “Because the doctor gave it to me and it is legal it is OK “is what most clients rely on when wanting to use. The drugs are physically and mentally addictive and the client begins to use more then what was originally given and seek them on the street. Can be taken orally but more commonly crushed and snorted or shot with a needle. Sometimes paired with cocaine to remove the paranoia. Pills can sell for as low as $7.00 a pill up to $15 or $20 depending on the area.
6. **ADERALL/PAXIL** – These uppers are usually given to clients with ADD or ADHD and the client will usually take them orally or crush them and snort them or even shoot them. If a client has ADD or ADHD the drugs will calm them down and help them focus. If the client does not, the client will get a rush or feel a speed effect. Sometimes these drugs are paired with Benzos or opiates for a ‘speed ball’ effect.

7. **Ecstasy’s and Molly** - “E” and Molly are known party drugs. Clients will go to clubs or Rave’s or Ultra Music Fest and take these party drugs to ‘roll’. The drugs give the client a warm fuzzy happy feeling and increase the sense of touch, sight, smell and sound. The client is fairly docile and will ingest or snort the drugs. They sell anywhere from $10.00 a pill to $20.00 depending on location and event. Clients usually do not overdose or die on these drugs, they usually dehydrate because they forget to drink water and can end up in the ER or dead.

8. **Special K (Ketamine)** – Horse Tranquilizer. Usually snorted or mixed with other assorted drugs. Sometimes shot. Usually bought on the black market. Pill is sold on market value.

9. **PCP/LSD/Mushrooms** – Can be on paper, in pill, liquid or other forms. Mushrooms ‘shrooms’ look like freeze dried mushrooms and can be eaten or make into a tea to drink. Psychedelics, cause a ‘trippin’ effect. Price varies depending on location. Usually as cheap as 10.00 and can last up to 12 hrs.

*****FISH BOWL PARTIES*****

Currently LEGAL drugs

1. **BATH SALTS** - A legal substance that heats the brain up and clouds it at the same time. Can be bought at local gas stations for $5.00 and lasts all day. Designed to mimic cocaine. Snorted, cooked and smoked or shot.

2. **Smiles** – Designed to mimic Meth, again totally legal and sold at gas stations, head shops. Snorted, cooked and smoked, or shot. $3-5 lasts all day.

3. **Spice**- Similar to Marijuana, can be rolled with or without tobacco and smoked. DOES NOT SMELL LIKE MJ. This label on the package says “potpourri’ and not for human consumption. Yet the clients will take it. $5.00 lasts all day.

4. **Strawberry Quick or pop rocks- looks** like pop rocks candy and smells like strawberry Quick. Another version of meth. For cooking. Runs 10-15.00 per baggie. Lasts 6 hrs. roughly.

***** THESE DRUGS GO BY MANY NAMES:  POW, K-POW, JUMP, CIRCLE ETC....  *****
Life skills

a. **Job and Career:** Can the client maintain a job? Can the client find a suitable career path that does not afford them the opportunity to use drugs and alcohol or does not stress them out so much that they use drugs and alcohol to cope? What advice can I give that is productive?

b. **School:** have they dropped out of school repeatedly and can’t seem to finish a semester? Do they have a short attention span and want things now?

c. **Purpose and Passion:** Most addicts lack purpose in their life and passion for something. Investigate and assist them in utilizing their potential.

d. **Relationship issues:** Are they in a stuck in negative relationship and is the negativity adding to the drug use?

e. **Children:** Kids can be major stressors. Addicts do not deal well with stress. Stress leads to using. How can you assist your client in reducing childcare burdens and stress?

f. **Social Events:** Require a lot of dedication and can be high stress. Sometimes a family or work event with expectations can cause a high stress or high expectation and pressure on the addict to not only stay clean and also be social at the same time. Most addicts are used to using to handle high stress situations and situations that require a specific amount of talking and interacting. Knowing how to handle the client and how to teach them to socialize sober is a task.

g. **Community tie in and sober events:** Events that are not focused around alcohol and drugs are key. Most house parties, picnics and social events are surrounded around alcohol and this can play into a stressor for your client. Chose events and encourage them to choose events that are not alcohol or drug focused.

h. **Budget and Finances:** Most of your clients will be in poor financial shape and need to learn to budget. With the ‘immediate need’ mentality of your clients and ‘I will fix it later’ mentality they end up borrowing money, going into debt usually have one person (the enabler) that picks them up every time. You will need to identify this person and work with them to stop giving money to the client.

i. **House Chores:** Most clients will struggle with keeping their living quarters clean and doing simple tasks such as cooking, cleaning and laundry. They may not have ever had to do these tasks (family did them or they had a maid) or they simply haven’t been doing them for so
long that they are used to not doing them. You will need to reeducate and hold them accountable.
Stress Reduction

a. **Nutrition and Fitness**: Better eating and higher grade food choices will increase the serotonin in the brain and fuel the body to make the client feel better.

b. **Meditation and Yoga**: Both Yoga and Meditation calm the body and relax the mind. Teaching the client to relax and learn how to reduce stress and breathe in a stressful situation can be a key into overcoming the need to use drugs and alcohol when the going gets tough.

c. **Calming activities**: fishing, snowboarding, surfing, skiing, etc. Things that the client enjoyed prior to use should be explored and encouraged.

d. **Religion**: for some clients that are religious, ‘going to church’ is considered calming and peaceful. Speak to your client and encourage makes them relax.

e. **Talking**: sometimes just ‘venting’ and allowing your client to discuss what is stressful and bothering them may allow them to relax. Addicts usually don’t call someone when things get stressful and bother them; they reach for the drug or alcohol to soothe their emotions. Teaching them how to text you or call you as the feeling arises is key.

*Remember: Feeling ---Thought---Action:

If you can break the cycle between feeling and thought or thought and action you can stop them from using. Teach them the tool.

Feel it (any uncomfortable emotion), call me. Think it (get high) call me. Action (on way to cop drugs) call me.

****PLAY BY PLAY FOR WRITTEN USE (DEMO)*****
Coping Skills

a. **Anger Management:** clients get angry at themselves when they can’t stay sober and they can get angry at others when they don’t get their way. Working with your client to understand the root of the anger and how it is really repressed hurt manifesting itself can be a crucial turning point in their sobriety.

b. **Relapse:** Clients are sometimes trained to expect to relapse. They may make an excuse for it and they may use while in your care. Be prepared for it and talk them through it. The shame and guilt after the fact can be overwhelming and allowing them to know you are there and on their team is beneficial.

c. **Craving:** Check in with your client at least 2x per day for craving levels. Craving and moods swings and craving and triggers are similar. Knowing what fuels the fire is important so you can discuss ways to handle the cravings as they arise.

d. **Sending someone to rehab:** if your client is using and needs to go detox or rehab you can ask them to go. You may need a trained interventionist to assist you and you should have a few on hand to call if need be.

e. **Couples Coaching:** As a Recovery Coach you may have a couple that uses together and wants to become sober together. Meet with them individually and then together to determine if you are going to be a good fit. Sometimes the dynamic may be skewed and you want to be sure you can help both of them. You may also recommend them for therapy or counseling if different marital issues are at stake.

f. **Fear Based Thinking:** Clients can make decisions from a place of fear and not a place of understanding. Work with your client to ‘weigh all the options’ before making a decision and running or hiding behind substances. Clients will dwell on issues and sometimes over analyze them to the point of talking themselves out of or into a situation that they may not have gotten into with the proper thought process.

g. **Triggers:** Ask your client early on what triggers them. They maybe visual, auditory dominant, olfactory or tactile in nature so be sure to include sights, sounds, feelings, colors, vibrations, smells etc.

h. **Transference and Countertransference:** “Checking your own baggage at the door” is paramount. The client does not need to know what is wrong or stressful in your life and it is highly inappropriate to discuss it with your client. Also it is imperative to not take on their stressors and issues.
i. **Lying and Manipulation:** Clients will lie and manipulate, even with you. Start listening in between what is said and begin to look for clues of the lies so you can assist them in learning to tell the truth. Clients will manipulate you (or try to), again look for clues and signs and be prepared to handle these in your conversations with the client.
Medication Management

**Release for the Psychiatrist:** it is imperative that there is a release on file for you to discuss medication with the psychiatrist. Sometimes an addict will not disclose their addiction and can be on meds that are considered habit forming or narcotic. Ask your client to sign a release of information for you.

**Release for the Therapist:** If you client has a therapist to counselor you want to know what the treatment plan is and how you can assist. Again ask for a release from your client and verify with the therapist that she/he has one as well.

*It is imperative to educate yourself on what medications the client is taking and prescribed. Familiarize yourself with doses and amounts. You may have clients that are insulin, depression meds, anxiety meds, anti-psychotics etc.*
Ego List

1. Need to win
2. Need to be right
3. Need to be in control
4. Need for immediate gratification
5. Need for total satisfaction
6. Need to be Superior
7. Constantly being offended or wronged by others behaviors
8. Desire to have more stuff: money, clothes, Car
9. Desire to have the best stuff
10. Need for making others happy at cost to self.
Treating the Family Dynamic

*Understating the unit*: Understanding what roles each family member plays is an invaluable tool in understanding how to handle your client.

*Understanding the family roles* (Claudia Black):

**The Addict** (your client): Family life revolves around this person.

**Hero** (usually oldest child) tries to make it look perfect on the outside but inside he or she isolates, will become a workaholic and has trouble with relationships.

**Scapegoat** (usually second child) this person identifies with addict and may act out in criminal, sexual or deviant ways and may even dabble in drugs or alcohol himself or herself.

**Mascot** (usually the youngest child) they try to make everyone laugh and make the situation seem better. They like to be busy and usually run from problems, using humor to solve them.

**Lost Child** This person seems to disappear. They avoid conflict, interaction and appear to be ‘lost in the crowd’. They have trouble forming lasting relationships and may have physical maladies to gain attention.

**The Enabler** (usually the mother or the wife of the addict): this person will minimize the addict’s behavior, make excuses for him or her and provide money, services (meals, laundry etc.) for the addict. This person plays the martyr role and usually complains that the addict is not getting better but will be the first person to refuse to cut off ties with the addict and continues to send money or items to allow the addict to continue using substances.
Defense Mechanisms

Primitive Defense Mechanisms

1. Denial

Denial is the refusal to accept reality or fact, acting as if a painful event, thought or feeling did not exist. It is considered one of the most primitive of the defense mechanisms because it is characteristic of early childhood development. Many people use denial in their everyday lives to avoid dealing with painful feelings or areas of their life they don’t wish to admit. For instance, a person who is a functioning alcoholic will often simply deny they have a drinking problem, pointing to how well they function in their job and relationships.

2. Regression

Regression is the reversion to an earlier stage of development in the face of unacceptable thoughts or impulses. For example, an adolescent who is overwhelmed with fear, anger and growing sexual impulses might become clingy and start exhibiting earlier childhood behaviors he has long since overcome, such as bedwetting. An adult may regress when under a great deal of stress, refusing to leave their bed and engage in normal, everyday activities.

3. Acting Out

Acting Out is performing an extreme behavior in order to express thoughts or feelings the person feels incapable of otherwise expressing. Instead of saying, “I’m angry with you,” a person who acts out may instead throw a book at the person, or punch a hole through a wall. When a person acts out, it can act as a pressure release, and often helps the individual feel calmer and peaceful once again. For instance, a child’s temper tantrum is a form of acting out when he or she doesn’t get his or her way with a parent. Self-injury may also be a form of acting-out, expressing in physical pain what one cannot stand to feel emotionally.
4. Dissociation

Dissociation is when a person loses track of time and/or person, and instead finds another representation of their self in order to continue in the moment. A person who dissociates often loses track of time or themselves and their usual thought processes and memories. People who have a history of any kind of childhood abuse often suffer from some form of dissociation. In extreme cases, dissociation can lead to a person believing they have multiple selves (“multiple personality disorder”). People who use dissociation often have a disconnected view of themselves in their world. Time and their own self-image may not flow continuously, as it does for most people. In this manner, a person who dissociates can “disconnect” from the real world for a time, and live in a different world that is not cluttered with thoughts, feelings or memories that are unbearable.

5. Compartmentalization

Compartmentalization is a lesser form of dissociation, wherein parts of oneself are separated from awareness of other parts and behaving as if one had separate sets of values. An example might be an honest person who cheats on their income tax return and keeps their two value systems distinct and un-integrated while remaining unconscious of the cognitive dissonance.

6. Projection

Projection is the misattribution of a person’s undesired thoughts, feelings or impulses onto another person who does not have those thoughts, feelings or impulses. Projection is used especially when the thoughts are considered unacceptable for the person to express, or they feel completely ill at ease with having them. For example, a spouse may be angry at their significant other for not listening, when in fact it is the angry spouse who does not listen. Projection is often the result of a lack of insight and acknowledgement of one’s own motivations and feelings.

7. Reaction Formation

Reaction Formation is the converting of unwanted or dangerous thoughts, feelings or impulses into their opposites. For instance, a woman who is very angry with her boss and would like to quit her job may instead be overly kind and generous toward her boss and express a desire to
keep working there forever. She is incapable of expressing the negative emotions of anger and unhappiness with her job, and instead becomes overly kind to publicly demonstrate her lack of anger and unhappiness.

**Less Primitive, More Mature Defense Mechanisms**

Less primitive defense mechanisms are a step up from the primitive defense mechanisms in the previous section. Many people employ these defenses as adults, and while they work okay for many, they are not ideal ways of dealing with our feelings, stress and anxiety. If you recognize yourself using a few of these, don’t feel bad – everybody does.

**8. Repression**

Repression is the unconscious blocking of unacceptable thoughts, feelings and impulses. The key to repression is that people do it unconsciously, so they often have very little control over it. “Repressed memories” are memories that have been unconsciously blocked from access or view. But because memory is very malleable and ever-changing, it is not like playing back a DVD of your life. The DVD has been filtered and even altered by your life experiences, even by what you’ve read or viewed.

**9. Displacement**

Displacement is the redirecting of thoughts feelings and impulses directed at one person or object, but taken out upon another person or object. People often use displacement when they cannot express their feelings in a safe manner to the person they are directed at. The classic example is the man who gets angry at his boss, but can’t express his anger to his boss for fear of being fired. He instead comes home and kicks the dog or starts an argument with his wife. The man is redirecting his anger from his boss to his dog or wife. Naturally, this is a pretty ineffective defense mechanism, because while the anger finds a route for expression, it’s misapplication to other harmless people or objects will cause additional problems for most people.
10. Intellectualization

Intellectualization is the overemphasis on thinking when confronted with an unacceptable impulse, situation or behavior without employing any emotions whatsoever to help mediate and place the thoughts into an emotional, human context. Rather than deal with the painful associated emotions, a person might employ intellectualization to distance themselves from the impulse, event or behavior. For instance, a person who has just been given a terminal medical diagnosis, instead of expressing their sadness and grief, focuses instead on the details of all possible fruitless medical procedures.

11. Rationalization

Rationalization is putting something into a different light or offering a different explanation for one’s perceptions or behaviors in the face of a changing reality. For instance, a woman who starts dating a man she really, really likes and thinks the world of is suddenly dumped by the man for no reason. She reframes the situation in her mind with, “I suspected he was a loser all along.”

12. Undoing

Undoing is the attempt to take back an unconscious behavior or thought that is unacceptable or hurtful. For instance, after realizing you just insulted your significant other unintentionally, you might spend the next hour praising their beauty, charm and intellect. By “undoing” the previous action, the person is attempting to counteract the damage done by the original comment, hoping the two will balance one another out.

Mature Defense Mechanisms

Mature defense mechanisms are often the most constructive and helpful to most adults, but may require practice and effort to put into daily use. While primitive defense mechanisms do little to try and resolve underlying issues or problems, mature defenses are more focused on helping a person be a more constructive component of their environment. People with more mature defenses tend to be more at peace with themselves and those around them.
13. Sublimation

Sublimation is simply the channeling of unacceptable impulses, thoughts and emotions into more acceptable ones. For instance, when a person has sexual impulses they would like not to act upon, they may instead focus on rigorous exercise. Refocusing such unacceptable or harmful impulses into productive use helps a person channel energy that otherwise would be lost or used in a manner that might cause the person more anxiety.

Sublimation can also be done with humor or fantasy. Humor, when used as a defense mechanism, is the channeling of unacceptable impulses or thoughts into a light-hearted story or joke. Humor reduces the intensity of a situation, and places a cushion of laughter between the person and the impulses. Fantasy, when used as a defense mechanism, is the channeling of unacceptable or unattainable desires into imagination. For example, imagining one’s ultimate career goals can be helpful when one experiences temporary setbacks in academic achievement. Both can help a person look at a situation in a different way, or focus on aspects of the situation not previously explored.

14. Compensation

Compensation is a process of psychologically counterbalancing perceived weaknesses by emphasizing strength in other arenas. By emphasizing and focusing on one’s strengths, a person is recognizing they cannot be strong at all things and in all areas in their lives. For instance, when a person says, “I may not know how to cook, but I can sure do the dishes!” they’re trying to compensate for their lack of cooking skills by emphasizing their cleaning skills instead. When done appropriately and not in an attempt to over-compensate, compensation is defense mechanism that helps reinforce a person’s self-esteem and self-image.

15. Assertiveness

Assertiveness is the emphasis of a person’s needs or thoughts in a manner that is respectful, direct and firm. Communication styles exist on a continuum, ranging from passive to aggressive, with assertiveness falling neatly in between. People who are passive and communicate in a passive manner tend to be good listeners, but rarely speak up for themselves or their own needs in a relationship. People who are aggressive and communicate in an aggressive manner tend to be good leaders, but often at the expense of being able to listen empathetically to others and their ideas and needs. People who are assertive strike a balance where they speak up for themselves, express their opinions or needs in a respectful yet firm manner, and listen
when they are being spoken to. Becoming more assertive is one of the most desired communication skills and helpful defense mechanisms most people want to learn, and would benefit in doing so.

**********NEED VERSES WANT**********

Notes:
Scenarios:

1. Becky has been using Roxy to get through the tough days at work. She can barely keep her head off her desk where she is a secretary at a large accounting firm. She has 2 write ups and her job is in jeopardy. She can’t go to detox because she can’t afford the time off and she called you for help. How do you proceed?

2. Michael’s father is a famous musician and he lives in his shadow. He can’t seem to finish college or hold a job and his dad has hired you to ‘fix him’. Michael is 25 and using heroin and Roxy. He has no girlfriend and few friends; he has social anxiety and low self-esteem. What do you do with Michael?

3. Jordan is 53 and an ex alcoholic. He has 10 years clean and his partner of 25 years has just left him. Jordan is distraught and upset. He fears turning to the bottle and has asked you to come stay with him for a period of time. He was in AA actively and has gone to a few meetings but tells you ‘it has changed’ and he really doesn’t want to go. He is at the point where he isn’t going to work and has taken a leave of absence because he is so depressed he can’t get out of bed. How do you handle Jordan?

4. Cindy is 21 and lives at home. Her mom and dad work long hours and until now thought Cindy was attending community college for the past two years. Her parents pay her car payment, insurance, school bill, food and health expenses. They even give her spending money so she can concentrate on her studies. Recently her father found her passed out in her room and she was rushed to the ER with a cocaine and Roxy overdose. She survived and was sent to detox. After detox she went to a 28 day rehab and comes home this week. Her parents want to hire you to handle her. How do you proceed?
5. Jack used Spice laced with Wet and has been ‘hearing voices’ and thinks his parents are trying to kill him and the FBI is chasing him. His parents sent him to rehab and he lives in a monitored halfway house. They are hiring you to stay with him and help him with daily tasks. What do you do? He does have a psychiatrist and is on Seroquel. However, he still hears voices.

6. Robert is a cardiac surgeon. Recently he and his new wife starting using cocaine to increase their sexual pleasures. She is able to use here and there and Robert found himself using from once over the weekend to daily. He fears using while at work, and that has begun. What do you suggest for Robert?

7. Melanie calls you to set up a treatment plan for her daughter ‘to take care of her probation’. Upon speaking to her daughter you learn she is 17 and on probation for ‘smoking weed’. The probation requires she have a treatment plan and discharge summary. What do you do?

8. Linda is a 48 year old married woman that found out her husband of 20 years has been cheating on her with 5 different women even before their marriage. She is financially dependent on her husband and has no college education. She has raised 3 grown daughters that all live out of state. Recently Linda has sought counseling for her issues and confronted her husband whom told her to ‘either find a boyfriend’ or leave. Linda aught solace in the comfort of wine. She drinks 3-4 bottles a day and is recently had a mild heart attack. Her daughter is calling you for help because she fears her mother may die. What do you do?

9. Grant is 22 and used to play sports. His father pushed him into hockey at age 5 and Grant got to the junior leagues at age 14. Grant hurt himself on the ice and had to have his shoulder rebuilt. His father began to treat him horribly and called him a ‘loser’ and an ‘idiot’ and forced him to play injured. Grant tore the other shoulder and the surgeon
told him he can no longer play hockey. His father was devastated and shunned the boy. Grant turned to drugs, specifically heroin, at age 16 to cope with both the loss of his purpose and passion in life and his father’s shunning. To this day he does not speak to his father. He has been in 10 different rehabs and jail 2 xs for selling and buying drugs. His mother called you in tears, he just got out of detox again and she doesn’t know what to do. How do you handle it?

10. Andrea grew up with a crack addict for a mother and father. She learned the paranoia of hiding behind the barricaded doors at age 5 and used to help her mother to bed. Andrea left at age 14 and ended up being a prostitute. Between rehab and jail she learned that the fast life was not for her. At age 25, with countless track marks and an addiction to heroin and Roxy, she started to get clean. She found God and feels ‘he saved’ her. She fully believes in NA and goes 2x a day. She lives in a halfway house for women and the owner has called you to assist Andrea with moving forward in her life, as Andrea doesn’t want to leave the safe haven of the halfway house and has been there for 2 years. What do you do?
Community Resources

*Build a network of local people in your area to network with and rely on to refer your clients to. Investigate your resources and learn which ones are the best in their field.

a. Medical professionals (MD, PHD)
b. Therapists
c. Interventionists
d. Psychologists vs. Psychiatrists
e. AA/NA community
f. Alternative medicine
g. Attorneys
h. Advocates
Activities

a. Life story
b. Journaling
c. Circle of Influence
d. Bucket List
e. Who am I?
f. Positive and Negative traits
g. Contracts
h. Activities List
i. Timeline
j. Obituary
k. Gratitude list
l. 3, 6, 9 month goal list
m. People places and things (change phone friends etc.)
n. Level of stress list (GAF Scale)
o. Goodbye Letter to Addiction
p. Letter to Mom, Dad, Loved Ones
q. Impact Letter
FORMS:

1. Contract for payment
2. Substance Abuse Evaluation
3. Confidentiality
4. Cancellation Policy
5. Self-Harm (cutting contracts)
6. Additional contracts (Ad Hoc or per event)
7. Assess for Mental Health
8. Assess for Eating Disorder
Contract for Addiction Coaching

This is a contract entered into by XXX, (hereinafter referred to as “the Provider”) and __________________ (hereinafter referred to as “the Client”) on this date, June 6, 2012.

The Provider’s location of services includes: mobile, via Skype, phone or in person services, as dictated by the location and proximity of the client and provider.

The Client hereby engages the Provider to provide services described herein under “Scope and Manner of Services.” The Provider hereby agrees to provide the Client with such services in exchange for consideration described herein under “Payment for Services Rendered.”

Scope and Manner of Services

Services to Be Rendered by Provider: Addiction and Life coaching for a 3 month period, at 1 x per week, for a total of 12 (1) hour sessions. Intake (initial session to last approximately 1 ½ to 2 hrs.). Provider offers unlimited text, email and availability via phone for emergencies. Provider and client may increase the number or duration of sessions in frequency as needed and dictated by both parties, at any time, to total 12 sessions, in accordance with payment.

Payment for Services Rendered

The Client shall pay the Provider for services rendered at $XXX for initial consult. 3 months of services at $XXX per hour (total 12). Total amount due at signing of contract is $XXX for services.

Applicable Law

This contract shall be governed by the laws of the County of USA in the State of XXX and any applicable Federal law.

Signatures

In witness of their agreement to the terms above, the parties or their authorized agents hereby affix their signatures:

_________________________________  ______________________________________
(Printed Name of Client or agent)       (Printed Name of Provider or agent)

_________________________________  ______________________________________
(Signature of Client or agent) (Date)    (Signature of Provider or agent) (Date)
# DRUG AND ALCOHOL QUESTIONNAIRE

**Name:**

**Date:**

## Part I. Substance Abuse History

<table>
<thead>
<tr>
<th>Substance</th>
<th>Ever Used?</th>
<th>Ever a Problem?</th>
<th>Age of 1st Use</th>
<th>When last used?</th>
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<tbody>
<tr>
<td>Alcohol</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Barbiturates or other sleeping pills</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Benzodiazapines</td>
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<td>No</td>
<td>Yes</td>
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<td>(Valium, etc)</td>
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<td>Caffeine</td>
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<td>No</td>
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<td>No</td>
</tr>
<tr>
<td>Ephedra</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Gasoline</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Glue</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heroin</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other inhalants</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>(paint, white-out)</td>
<td></td>
<td></td>
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<tr>
<td>LSD</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marijuana or hashish</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Methadone</td>
<td>Yes</td>
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<td>Methamphetamine</td>
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<tr>
<td>Drug</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>-----------------------</td>
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<tr>
<td>Mescaline</td>
<td></td>
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<td>Yes</td>
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<td>Mushrooms</td>
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<td></td>
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<tr>
<td>Nicotine</td>
<td></td>
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<tr>
<td>Nitrous Oxide</td>
<td></td>
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<tr>
<td>Opiates (pain pills)</td>
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<td>No</td>
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<td>Opium</td>
<td></td>
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<td>PCP</td>
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<td>Poppers</td>
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<td>Prescription drugs</td>
<td></td>
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<td>No</td>
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<tr>
<td>Psilocybin</td>
<td></td>
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<tr>
<td>Quaaludes</td>
<td></td>
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<td>Seconaol (Reds)</td>
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<tr>
<td>Speedballs</td>
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<td>Steroids</td>
<td></td>
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<tr>
<td>Tuinol (Yellows)</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>

Please put a circle around any of the drugs above that you feel you are addicted to or dependent upon.

Part I Continued:

How did you get started using drugs/alcohol?

When you consume alcohol, what do you usually drink (circle)? Beer  Wine  Vodka  Gin  Tequila  Whiskey  Scotch  Rum  Other:
How many drinks do you usually have per day? Per week?

How much (name of drug) do you usually have per day? Per week?

How have you ingested (the drug)? Swallow Smoke Sniff Inject Mix with other

What is the best thing about getting high?

What is your favorite thing to do when drinking or using drugs?

Are there any times you tend to use these substances less? More? When?

Are there any times you have successfully stopped? When? For how long?

How much do you spend each week on your drugs/alcohol?

Do you usually drink/use drugs alone or with others? At home or elsewhere?

What time of day do you usually start using drugs/drinking? Is there a pattern to your use?

What effects does drinking/using drugs have on you? (circle)

Feel happier Feel more important Feel more alert Reduces physical discomfort

Increased irritability Less shy Think more clearly More creative Have more fun

Reduce stress/tension Help to sleep Relax socially Express self more easily

Avoid negative emotions (depression, anger, grief, boredom)

Forget something that happened Concentrate better
Have you ever experienced any of the following symptoms when you use drugs or alcohol (circle)? Seizures  Blackouts  Hallucinations  Paranoia  Personality changes

Decreased need for sleep  Increased aggression  Increased sexual arousal
Severe weight loss  Ulcers or other stomach problems  Headaches
Excessive bleeding  Sinus problems  Heart palpitations  Suicidal thoughts
Panic attacks  Memory problems  Depression  Loss of sex drive
Sex with strangers  Other:

Do you or have you ever experienced any physical symptoms when you try to stop drinking or use drugs? Yes  No  If so, which ones?  Shakes/tremors  Sweating  Seizures
Continuous vomiting  Sleeplessness  Disorientation  Hallucinations  Depression  Hypersomnia  Increased appetite
Other:

Do you gamble when you drink or use drugs?  Yes  No
Is your gambling out of control or excessive?  Yes  No
Have you ever had an eating disorder (bulimia, anorexia, obesity)?  Yes  No

Part II: Family History

Which family members have had a drug or alcohol problem (circle)?
None  Mother  Father  Brother(s)  Sister(s)  Stepparent  Grandparent  Uncle/Aunt
How were you affected by your family member’s drug abuse?

Does in anyone in your current household use drugs or drink?  Yes  No
If so, who?
Do most of your friends drink or use drugs?  Yes  No
Part III: Consequences Related to Alcohol or Drug Use

Please circle any problems that have persisted following your use of drugs or alcohol:

Hepatitis or liver problems  Persistent cough  Hallucinations  Strange thoughts
Congestion or wheezing  Heart problems  Depression  Mania  Loss of sex drive

Please circle any social or relationship problems that have resulted from your use of alcohol or drugs:

Arguments with spouse or partner  Thrown out of house  Social isolation
Arguments with parents or siblings  Loss of friends  Spouse or partner left you

Other:

Please circle any job or financial problems caused or worsened by your use of drugs or alcohol:

Lost a job  Less productive at work  Behind in paying bills  Late to work  In debt
Missed days at work  Missed opportunities for raise or promotion

Other:

Please circle any legal problems caused or worsened by your use of alcohol or drugs:

Arrest for possession  Arrest for forging prescriptions  Auto accident while intoxicated
Arrested for assault  Arrested for embezzlement or forgery  Arrested for selling drugs
Arrested for driving under the influence  Arrested for theft or robbery

Part IV: Treatment History

Have you ever attended a 12-step program?  Yes  No

Have you ever attended an outpatient program for drugs or alcohol?  Yes  No

Have you ever been treated in an inpatient facility for drugs or alcohol?  Yes  No

Have you ever been given a medication to help you abstain from drinking or using drugs?  Yes  No

Have you ever been treated in an emergency room for a drug overdose or alcohol poisoning?  Yes  No
Have you ever made a suicide attempt while intoxicated or using? Yes  No

What is the longest you have been able to stop drinking/using drugs?

How were you able to remain abstinent or sober this long?

Why do you want to stop drinking or using drugs?

What do you think will happen if you do not stop drinking or using drugs?

Part V: True-False Questions

1. T  F   I drink/use drugs when I feel anxious.
2. T  F   I often try to hide or minimize my drinking/drug use.
3. T  F   Many of my friends drink or use drugs.
4. T  F   I sell, or used to sell drugs.
5. T  F   I would never consider going to a 12-step program.
6. T  F   Drinking or using drugs has never really caused me any problems.
7. T  F   I have tried to stop using drugs/drinking in the past.
8. T  F   I drink/use drugs when I feel depressed.
9. T  F   When I drink, I usually get drunk.
10. T  F   I feel more confident when I drink or use drugs.
11. T  F   Sometimes I use drugs or drink in the morning.
12. T  F   Friends or family have told me I should stop drinking or using drugs.
13. T  F   I spend too much time thinking about drinking or using drugs.
14. T  F   I become very anxious if I am unable to have a drink or do drugs.
15. T  F   I have never stolen in order to buy drugs or alcohol.

16. T  F   I am an alcoholic.

17. T  F   I am a drug addict.

18. T  F   I have experienced the need to use more drugs to get the effect I had the first time I used them.

19. T  F   If I stopped using drugs or drinking, I would lose many of my friends.

20. T  F   I am not a religious person.

21. T  F   I think better when I have a few drinks or use drugs.

22. T  F   I enjoy sex more when I’m high.

23. T  F   Drinking or using drugs helps me forget about my problems and relax.

24. T  F   I have never used drugs and alcohol at the same time.

25. T  F   I have sometimes alternated taking uppers and downers.
Confidentiality Agreement

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client’s Parent/Guardian if under 18)

________________________________

Today’s Date____________________

Recovery Coach Signature___________________________________________
Cancelation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

__________________________________

Client Signature (Client’s Parent/Guardian if under 18)

________________________________

Today’s Date
These are the original Twelve Steps as published by Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory, and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
12 Traditions

Tradition 1

Our common welfare should come first; personal recovery depends upon A.A. unity

Each member of Alcoholics Anonymous is but a small part of a great whole. A.A. must continue to live or most of us will surely die. Hence our common welfare comes first. But individual welfare follows close afterward.

Tradition 2

For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

For our group purpose, there is but one ultimate authority - a loving God as He may express Himself in our group conscience.

Tradition 3

The only requirement for A.A. membership is a desire to stop drinking.

Our membership ought to include all who suffer from alcoholism. Hence we may refuse none who wish to recover. Nor ought A.A. membership ever depend upon money or conformity. Any two or three alcoholics gathered together for sobriety may call themselves an A.A. group, provided that, as a group, they have no other affiliation.

Tradition 4

Each group should be autonomous except in matters affecting other groups or A.A. as a whole.

With respect to its own affairs, each A.A. group should be responsible to no other authority than its own conscience. But when its plans concern the welfare of neighboring groups also, those groups ought to be consulted. And no group, regional committee, or individual should ever take action that might greatly affect A.A. as a whole without conferring with the trustees of the General Service Board. On such issues our common welfare is paramount.
Tradition 5

Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.

Each Alcoholics Anonymous group ought to be a spiritual entity having but one primary purpose - that of carrying its message to the alcoholic who still suffers.

Tradition 6

An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.

Problems of money, property and authority may easily divert us from our primary spiritual aim. We think, therefore, that any considerable property of genuine use to A.A. should be separately incorporated and managed, thus dividing the material from the spiritual. An A.A. group, as such, should never go into business. Secondary aids to A.A., such as clubs or hospitals which require much property or administration, ought to be incorporated and so set apart that, if necessary, they can be freely discarded by the groups. Hence such facilities ought not to use the A.A. name. Their management should be the sole responsibility of those people who financially support them. For clubs, A.A. managers are usually preferred. But hospitals, as well as other places of recuperation, ought to be well outside A.A. - and medically supervised. While an A.A. group may cooperate with anyone, such cooperation ought never to go so far as affiliation or endorsement, actual or implied. An A.A. group can bind itself to no one.

Tradition 7

Every A.A. group ought to be fully self-supporting, declining outside contributions.

The A.A. groups themselves ought to be fully supported by the voluntary contributions of their own members. We think that each group should soon achieve this ideal; that any public solicitation of funds using the name of Alcoholics Anonymous is highly dangerous, whether by groups, clubs, hospitals or other outside agencies; that acceptance of large gifts from any source, or of contributions carrying any obligation whatever, is unwise. Then too, we view with much concern those A.A. treasuries which continue, beyond prudent reserves, to accumulate funds for no stated A.A. purpose. Experience has often warned us that nothing can so surely destroy our spiritual heritage as futile disputes over property, money and authority.
Tradition 8

Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

Alcoholics Anonymous should remain forever non-professional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform those services for which we might otherwise have to engage non-alcoholics. Such special services may be well recompensed. But our usual A.A. "12th Step" work is never to be paid for.

Tradition 9

A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

Each A.A. group needs the least possible organization. Rotating leadership is the best. The small group may elect its secretary, the large group its rotating committee, and the groups of a large metropolitan area their central or inter group committee, which often employs a full-time secretary. The trustees of the General Service Board are, in effect, our A.A. General Services Committee. They are the custodians of our A.A. Tradition and the receivers of voluntary A.A. contributions by which we maintain our A.A. General Services Office at New York. They are authorized by the groups to handle our over-all public relations and they guarantee the integrity of our principal newspaper, the A.A. Grapevine. All such representatives are to be guided in the spirit of service, for true leaders in A.A. are but trusted and experienced servants of the whole. They derive no real authority from their titles; they do not govern. Universal respect is the key to their usefulness.

Tradition 10

Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.

No A.A. group or member should ever, in such way as to implicate A.A., express any opinion on outside issues - particularly those of politics, alcohol reform or sectarian religion. The Alcoholics Anonymous groups oppose no one. Concerning such matters they can express no views whatever.
Tradition 11

Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

Our relations with the general public should be characterized by personal anonymity. We think A.A. ought to avoid sensational advertising. Our names and pictures as A.A. members ought not be broadcast, filmed or publicly printed. Our public relations should be guided by the principle of attraction rather than promotion. There is never need to praise ourselves. We feel it better to let our friends recommend us.

Tradition 12

Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles above personalities.

And finally, we of Alcoholics Anonymous believe that the principle of anonymity has an immense spiritual significance. It reminds us that we are to place principles before personalities; that we are actually to practice a genuine humility. This to the end that our great blessings may never spoil us; that we shall forever live in thankful contemplation of Him who presides over us all.

Working your own program and assisting others you need to know boundaries and not push your recovery and ideas off onto your client.