Introduction

Who will use this manual?

This manual has been written for therapists working with adults affected by familial substance use. To use this manual, you should be skilled in providing marriage and family therapy and group therapy, particularly from a cognitive-behavioural perspective. You should also have knowledge about the treatment of, and recovery from, substance use problems and concurrent disorders.[1]

Because the program described here is designed as a group treatment, the manual will be most useful to therapists working with groups of family members. Nonetheless, we hope that it can be adapted for use as a structured treatment approach, with either individuals or families, when it is not possible to offer group treatment.

This manual is not a self-help guide. We anticipate that as clients work through this program, they will benefit from the knowledge, teaching, advice, support and encouragement of the facilitators and of other participants.

1. In the most formal sense, *concurrent disorders* (or co-occurring disorders) are defined as the presence of at least one diagnosed mental health disorder and at least one diagnosed substance use disorder. Less formally, the term is used to describe co-occurring substance use and mental health problems, whether or not a formal diagnosis has been made.

Why offer programs for family members?

Traditionally, service providers have offered treatment to people with mental health or substance use problems, and have often neglected to involve their family members. We believe strongly in the importance of involving family members in treatment, because:

- family members themselves often need treatment
- family members benefit from treatment
- family members can influence the behaviour of their relatives who have substance use problems, and the outcome of their treatment.

FAMILY MEMBERS NEED TREATMENT

Problematic substance use has an impact far beyond the person who uses substances (Csiernik, 2002). Partners, children, other family members, friends, neighbours, colleagues and associates of a person with a substance use problem all may experience stressful consequences of the person's behaviour. The 2004 Canadian Addiction Survey (Adlaf et al., 2005) revealed that many adult Canadians perceived that in the past 12 months, they had been harmed in some way by others' substance misuse. Of the almost 14,000 respondents to this survey:

- 22 per cent reported having been insulted or humiliated
- 16 per cent had experienced serious arguments or quarrels
- 16 per cent had experienced verbal abuse
- 11 per cent had experienced family or marriage problems
- 11 per cent had been pushed or shoved
- three per cent had been hit or physically assaulted.

In a study conducted in England (Velleman et al., 1993), 50 partners or close relatives of people who misused substances noted ways that they or their families had suffered as a result:

- 94 per cent reported relationship problems such as more arguments, less sex, and less trust and communication
- 88 per cent reported practical problems such as financial difficulties, social isolation and work difficulties
- 82 per cent reported negative emotions such as loneliness, isolation, anxiety, guilt, fear and confusion

- 82 per cent reported mental or physical health problems such as depression, panic attacks, eating disorders, ulcers and raised blood pressure
- 52 per cent reported an increase in their own addictive behaviours such as drinking, smoking, and eating.

Studies in England, Mexico and the United States have found similar negative consequences reported by parents and other relatives of people with substance use problems (Butler & Bauld, 2005; Lewis et al., 2004; Orford et al., 1998).

Nor do the negative consequences disappear—or, necessarily, even decrease—when the person with a substance problem seeks treatment. Despite their wish for the person to recover, family members often experience anxiety and confusion as they deal with the changes and difficulties that occur during the recovery process (Lewis et al., 2004).

It is clear from these data that family members encounter stress from their involvement with the relative with a substance use problem, and that they need help in coping with the negative consequences. Despite this reality, most drug treatment resources in Canada and elsewhere neglect the needs of partners, other family members and friends (Csiernik, 2002; Howells & Orford, 2006). When treatment programs involve family members, they often do so only to help engage the person with a substance use problem in treatment.

FAMILY MEMBERS BENEFIT FROM TREATMENT

In a recent review of studies, researchers concluded that:

- family members who receive family treatment (e.g., family coping skills treatment, behavioural therapy, Al-Anon) have reduced emotional distress
- those who receive coping skills treatment experience improved coping
- partners who receive behavioural couples therapy experience happier relationships, fewer separations, a lower risk of divorce and less domestic violence than those whose substance using partners receive no family treatment (O'Farrell & Fals-Stewart, 2003).

In a recent study, researchers in England found that spouses who received individual counselling aimed at improving coping, safety, relational skills, problem solving and emotion management showed significant decreases in psychological symptoms over the course of treatment, and that these changes were maintained for 12 months after treatment (Howells & Orford, 2006).

Another study demonstrated that children affected by familial substance use can benefit from their parents receiving treatment—as evidenced by improved

functioning—even when they themselves receive no treatment (Kelley & Fals-Stewart, 2002).

FAMILY MEMBERS INFLUENCE THE PERSON WITH A SUBSTANCE USE PROBLEM

Research has demonstrated that family involvement in treatment both increases the rate of treatment initiation and improves treatment outcomes for the person who uses substances (Stanton, 2004).

Family treatment can help to increase the likelihood of a person with a substance use problem entering treatment, for example by helping to change family patterns or problems that are impeding the person's motivation to enter treatment (Hser et al., 1998). One successful model is Community Reinforcement and Family Training (CRAFT; Miller et al., 1999).

Family treatment can also help those who are already in treatment. Rowe & Liddle (2003) found that these people demonstrate less substance use, better medication compliance and better family and relational functioning than those whose families are not involved in treatment. One form of family treatment, behavioural couples therapy, has been studied extensively and has proved effective in reducing substance use and improving relationships (O'Farrell & Fals-Stewart, 2003). Another study showed that when family members attended Al-Anon, their relative with a substance use problem was significantly more likely to continue attending Alcoholics Anonymous (McBride, 1991).

No matter how they behave or what choices they make, partners, other family members and friends do influence the person who has a substance use problem, and receiving treatment themselves can help increase the positive impact of their influence. Family members can provide consequences for the person's behaviour, exert appropriate pressure, encourage and support the person, and provide information. For example, they can:

- learn how to avoid reinforcing problematic substance use (e.g., avoiding telling the person that he or she is more fun after a few drinks) and how to set limits around this behaviour
- learn how to avoid enabling the person's substance use (e.g., avoiding calling the person's employer with a story that covers up the fact that he or she can't make it to work because of substance use) and how to allow the person to experience the full consequences of his or her use
- learn about the recovery process and how to reinforce the person as he or she takes steps toward recovery
- improve their skills in problem solving, regulating their emotions, resolving

conflicts and communicating, all of which can improve their relationship with the person who has a substance use problem.

The Families CARE program

WHAT IS FAMILIES CARE?

Families CARE is a program that aims to help family members **C**ope **A**nd **R**elate **E**ffectively with the person who has a substance use problem, not only to support the person's recovery but also to enhance their own well-being. The program offers education, support and skills development. Though eclectic, Families CARE is rooted in a cognitive-behavioural approach. Family members learn about, discuss and practise such skills as coping, grieving, dealing with emotions, solving problems, setting goals, communicating, setting limits, supporting and responding to the person with a substance use problem, and helping children affected by a family member's substance use.

Families CARE is not an "intervention." There has been a great deal of publicity about intervention approaches, particularly the Johnson Institute Intervention, and many family members ask about this method. We do not use or recommend this approach for several reasons:

- The research data do not support the intervention method, which engages only 20 per cent of potential clients in treatment, a significantly lower percentage than other approaches (Stanton, 2004). This low rate of success seems to derive from the fact that most family members who begin the process are not able to follow through on the intervention.
- Research suggests that clients who do engage in treatment following an intervention are at higher risk of relapsing than are clients who engage in treatment through less confrontational methods (Loneck et al., 1996).
- The intervention approach focuses on getting the person with a substance use problem into treatment, and may do nothing to help family members reduce their distress or cope better with their situation. (In fact, if the intervention is aborted prior to completion or if it fails, family members may actually become more emotionally distressed.) In addition, a treatment designed only to get a person into treatment does not help family members support the person and deal with issues arising from the person's treatment and recovery.
- While the goal of the intervention approach is only to help a person begin treatment, Families CARE helps family members of people who may be at various stages of treatment and recovery, not just pre-treatment. (This is also true of

other documented and researched treatment methods for family members, such as CRAFT and behavioural couples therapy, which—though otherwise successful models—are not relevant to groups of family members who may have differing needs with regard to the person in their respective families who has a substance use problem.)

WHO CAN BENEFIT FROM FAMILIES CARE?

Families CARE is intended for adult family members—including partners, adult children, parents, siblings, or even friends or ex-partners of people who are engaging or have engaged in problematic substance use, and who may or may not be in treatment. For the sake of simplicity, we will refer to these concerned others as "family members" or, in the context of the treatment sessions, as "group members" or "participants."

Relationship of family members to the person with a substance use problem

Family members may vary in their level of current involvement with the person who uses substances, ranging from living with the person to having little contact with him or her. Given this, the Families CARE program may be offered by a substance use treatment agency to families of its clients (though the person with a substance use problem does not participate in the group), or may be offered as a service for family members even when the person with a problem is not a client of the agency.

Mental health of family members

Many family members may be struggling with mental health issues, often in part because of the stress of their relationship with the person who has a substance use problem. Prior to beginning the program, family members should be screened to determine their mental health status. If they have serious mental health problems (e.g., severe depression or anxiety, bipolar disorder, a personality disorder or an eating disorder), have substance use problems, or are at risk of violence or suicide, they will need additional services and should be given appropriate referrals before beginning the program. They may need to increase their level of stability in order to participate successfully in the group treatment. Family members who have mental health problems may also be helped by treatment from an individual therapist while completing the Families CARE program.

Involvement of the person with a substance use problem

The Families CARE program is intended only for family members, and not for the person in the family who has a substance use problem. This is because the treatment of family members should not depend on:

- the willingness or ability of the person who uses substances to participate in treatment (some people with substance use problems may not co-operate or may not be ready to engage in treatment; others may not be able to attend treatment because they live far away, are in jail or a residential treatment facility or hospital, or have schedule conflicts)
- the amount of contact the family members currently have with the person who has a substance use problem (family members who have ended their relationship with a person who uses substances may still need and benefit from treatment)
- where a person who uses substances is in his or her substance use or recovery (family members may benefit from treatment when a family member is just beginning to exhibit symptoms of substance use problems, is experiencing severe problems, is beginning treatment, is in early or later recovery, or has relapsed).

As mentioned earlier, family members themselves typically struggle to cope and may be experiencing mental health difficulties. Consequently, their treatment is important: it may help to reduce their preoccupation with the difficulties, needs and goals of the person who has a substance use problem, and may enable them to identify their own difficulties, needs and goals. Further, as we have noted, their treatment—with or without the involvement of the person who uses substances—may lead to positive changes for that person (Miller et al., 1999; Stanton, 2004).

Family therapy including the person with a substance use problem can be helpful, but should be done outside of this program.

When running the program, you may discover that the family members themselves vary in their use of substances, from no use ever, to past use, to current problematic use. Some family members use substances themselves to cope with their relationship to a person who has a substance use problem. Although the program can help family members learn healthier methods of coping, family members who have significant substance use problems should be excluded from the program and be directed instead to substance use treatment.

The development of Families CARE

BACKGROUND

In 1997, the Centre for Addiction and Mental Health (CAMH) opened the Family Addiction Service (FAS) to meet the needs of family members of people with substance use problems. Since then, FAS therapists have worked with family members both individually and in groups.

Initially the group program was primarily supportive, but over time it began to address particular topics, such as self-care, boundaries and hope. Various groups were run at different sites, by different therapists, with different topics and in different ways. Following most educational evenings or series of groups, staff elicited written feedback from the clients.

In March 2006, the FAS hired a psychologist to help review, refine, consolidate and manualize the group programs being offered. This psychologist:

- observed some of the educational evenings and groups, as well as similar groups offered in other programs
- read the feedback forms from family members, which provided information on what they believed was helpful about their treatment and what they wished could have been different
- solicited feedback from the therapists who facilitated the groups and educational evenings (through surveys, interviews and group discussions) and from FAS board members
- reviewed research articles and books on treatment relevant to the support offered in the FAS, looking specifically for empirically validated approaches that could be adapted to the needs of the FAS's clients.

PRIORITIES

For a year after this initial process, the FAS team expanded the program, incorporating material from a variety of sources. This program development was based on the following priorities:

- using empirically validated treatment
- meeting the needs of our diverse clientele
- providing support
- facilitating skills development
- providing education.

Each of these areas is discussed below.

Using empirically validated treatment

Two of the treatments best validated by empirical data are Community Reinforcement and Family Treatment (CRAFT; Stanton, 2004), a cognitive-behavioural treatment program designed to help partners or other family members to enter treatment; and behavioural couples therapy (O'Farrell & Fals-Stewart, 2003), a behavioural treatment program for both partners.

Like these two programs, we chose to use a cognitive-behavioural approach with our family members.

Meeting the needs of our diverse clientele

We had to develop a program that could be useful for various types of family members (e.g., partners, adult children, parents, siblings, close friends, ex-spouses), with varying levels of involvement and contact (ranging from living with the person who has a substance use problem to having no current contact), and whose family member may be at varying points in the recovery process (ranging from denial of a substance use problem to maintenance of recovery). The program also had to be flexible enough to be used for family members of different ethnocultural and religious backgrounds and in different settings.

Providing support

Research has long shown that support plays an important role in helping people cope with difficult circumstances. Unfortunately, due to the stigma of substance use and mental health problems, some family members become isolated and do not receive support from others. Treatment offers family members the opportunity to experience professional support and so to reduce their isolation and shame.

Research has demonstrated that family members who take part in group programs such as Al-Anon experience decreased emotional distress and personal problems, due perhaps in part to the support they receive (O'Farrell & Fals-Stewart, 2003). These findings are supported by the feedback from the FAS's clients, which demonstrated an appreciation of the group's providing validation and support. The clients also appreciated the fact that they were accountable to the group for the changes that they had agreed to make. We decided to offer our program primarily through a group format not only because it is cost- and resource-effective, but also because it is an effective intervention. A recent review of treatment studies demonstrated that there was no difference in outcomes between group therapy for family members and family therapy (Stanton & Shadish, 1997).

Facilitating skills development

As well as demonstrating the benefit to family members of education and support, research has also shown benefits from skills training through family, couples or family group therapy, including greater decreases in emotional distress, increases in coping skills, and greater positive changes in the behaviour of the person with a substance use problem (O'Farrell & Fals-Stewart, 2003; Rychtarik & McGillicuddy, 2005; Smith & Meyers, 2004; Stanton & Shadish, 1997). Treatment programs that help family members learn new ways of behaving seem to be the most successful in helping both the family member and the person with a substance use problem.

Al-Anon has long emphasized the importance of family members identifying their powerlessness over those who engage in problematic substance use, and accepting that they cannot change another person. However, research has demonstrated that family members do influence one another and can support the recovery of another person (Meyers & Wolfe, 2004). CRAFT has been designated the most effective program for concerned others of adults who have problems with alcohol or other drugs and who are not in treatment (Stanton, 2004). CRAFT is a highly structured cognitive-behavioural treatment approach that helps concerned family members learn new skills in dealing with the person with a substance use problem, with the result of improving their own functioning and that of the person who uses substances (e.g., at least 64 per cent of those identified in the study as "drinkers or drug users" entered treatment) (Miller et al., 1999). Behavioural couples therapy is another intervention that helps clients make behavioural changes in how they respond to each other. It too has demonstrated improvements in the functioning of both spouses (O'Farrell & Fals-Stewart, 2003).

We built on this evidence by incorporating a skills development component into our model.

Providing education

In response to frequent requests from family members for information on a variety of topics, we incorporated an educational component into our model. We believe that when family members are provided education, they are more knowledgeable about their relative's situation, about substance use and concurrent disorders, and about treatment options; more realistic in their expectations; more firm in setting limits with the person who has a substance use problem; more supportive of the person's positive gains; and more able to make informed decisions about their own behaviour and responses. A recent study in Sweden demonstrated that spouses of alcoholics exhibited improved coping and decreased distress after receiving one individual information session

in which they were educated on coping strategies, alcohol dependence and its effects on the alcoholic partner and the family, and on addiction treatment and social services (Zetterlind et al., 2001).

PILOT STAGE

Stage 1

After the first draft was completed, the revised program—now called Families CARE—was offered by six therapists at two of CAMH's facilities. The program comprised three elements.

The first component was a two-hour educational evening for family members that covered substance use and concurrent disorders and their effects on families; the stages of change; the process of recovery and its effect on families; and treatment options for families and for people using substances. Most of the material for this seminar came from modules 2 and 14 of this manual. This educational evening was presented twice, each time by at least two therapists, to 69 family members (24 at one session and 35 at the other). Participants were told at this educational evening that if interested and if they had not already done so, they could contact a therapist and schedule a screening and assessment interview for further services (including individual, couple or group therapy within the Family Addiction Service).

The second component of the program was the screening and assessment interview to determine family members' eligibility for and interest in participating in the group program.

The third component consisted of eight weeks of group treatment, whose topics were determined by the interest of group members and which are contained within this manual. The group was offered three times, and each was facilitated by two therapists. A total of 31 people participated (25 women and six men), whose relationship to the person with a substance use problem varied.

Stage 2

After the second draft of the program was completed, Families CARE was again offered at CAMH, by seven therapists at two sites over a period of 18 months. This time, 457 people took part in 11 large educational sessions (an average attendance of 42). Of these people, 148 (114 women and 34 men) subsequently took part in a Families CARE group, and 124 completed the program. While each group began with an average of 10 members, the average number of participants per session was seven.

Families CARE was also offered outside of CAMH, in conjunction with Addiction Services for York Region, in order to determine whether our materials could be used successfully in another setting and by someone who was not part of our team, and with a different group of family members. The participants and facilitator of this pilot provided feedback to help us refine the materials.

FEEDBACK

At various points in the development of Families CARE, many professionals and clients provided feedback on the program.

During the first stage of the development process, we asked every family member who attended an educational evening or small group session to fill in our feedback form. We used the information received to help us revise the respective sessions. During the second stage, we asked for feedback from family members who attended an educational evening and then, if they went on to participate in a group, upon completion of the program. Unfortunately we did not obtain written feedback from participants who did not complete the group program.

Educational evening

Family members who attended the educational evenings rated their satisfaction level with the content and presentation on a seven-point scale, with 1 being "not at all satisfied" and 7 being "very satisfied." The average rating for content was 5.8, and for presentation 5.7. Most participants responded positively about the content, indicating that they found it informative, comprehensive, relevant and practical. Almost as many people mentioned particular topics that they found helpful, such as the stages of change. Other respondents said they found the presenters knowledgeable, caring, understanding and responsive, and skilled in creating an open, relaxed, positive and comfortable atmosphere. A large number expressed their appreciation for the interaction and the social support they experienced during the discussions and the question and answer periods. The participants said they most liked the educational evening because they felt validated, affirmed, supported and encouraged.

When asked what they liked least about the educational evening, family members indicated that it was too short and did not cover enough information, or that the information was not specific to their situation. Many wanted to know more about concurrent disorders, types of drugs and their effects, harm reduction, substance use treatment, recovery and maintenance. Many people

also wanted to spend more time learning how they could respond and relate to the person in their lives with a substance use problem. (For those who went on to attend the group sessions, these issues were dealt with in much greater detail in that context.) Some participants said that the group was too big (attendance was as high as 60) and involved too much interaction (this was sometimes defined as other participants asking inappropriate or personal and over-specific questions). Others felt that the format did not allow enough time for questions.

After the educational evening, family members shared their reactions to the evening. The most common responses were that family members had:

- learned new ways of responding to the person with a substance use problem
- developed a greater understanding of addiction, treatment, recovery (including realistic expectations), relapse prevention and the experiences of families and of people with substance use problems
- learned about resources for themselves and for the person with a substance use problem
- started to focus more on their own needs; and to feel less alone and more supported, reassured, and more hopeful.

Group sessions

Group members rated the teaching and discussion component and the homework exercises on a five-point scale, with 1 being "not at all helpful" and 5 being "very helpful." The average rating for the teaching and discussion was 4.8, and for the homework 4.3. Most participants liked the social aspect of the group, including the social support and their interaction with other group members. Others mentioned the warm and safe environment created, and the skilled facilitation of the leaders. Many expressed appreciation for the content and the educational component, noting how much they had learned and grown, and how much they had appreciated the topics, handouts and homework exercises.

When asked to identify what they had not liked about the program, participants' comments generally centred on their opinion that the sessions were too short and too few, and that the program did not include a "reunion" session.

How to use the Families CARE manual

The Families CARE program comprises 18 modules, including sample introductory and closing sessions. Different treatment settings and different populations have distinct resources, needs and structures, so the manual and materials are designed to be tailored your program—you do not need to offer all 18 modules.

For example, some facilities or programs may offer full day or weekend workshops, others might offer a time-limited series of individual or group sessions, and yet others might offer ongoing long-term groups.

In describing the program, we will assume that you are offering time-limited outpatient group sessions, which is probably the most common and beneficial way in which family treatment is offered. Weekly sessions offer family members ongoing support and guidance for an extended period, without saturating them with too much information at once, while providing opportunities to practise what they are learning at home between sessions.

CHOOSING MODULES

We recommend that the group program run for at least 10 sessions, to enable the participants to develop supportive relationships and to change the ways they cope and deal with their situation. At CAMH, as noted earlier, we start with a two-hour educational evening (the equivalent of two sessions), open to all, in which we present information on substance use problems and recovery, and their effects on families. This is followed by eight closed group sessions for attendees of the educational evening who would like additional support and education. We then offer optional workshops on specific topics that may not be relevant to all the group members.

There is enough material in the manual for at least 18 sessions. However, many modules could be extended over multiple sessions, so if you are able to offer a longer-term or ongoing group you will have plenty of material to do so. Feedback from the pilot stage suggests that some family members appreciate receiving treatment beyond 10 weeks so, if you offer a time-limited group, you may choose to provide one or more booster or reunion sessions at a later date. It is becoming increasingly evident that booster sessions can help clients sustain gains in the longer term (Connors & Walitzer, 2001; Eyberg et al., 1998).

If you provide only short-term treatment it will not be possible to cover all 18 modules, so the facilitators will need to determine which modules are the most relevant (a pre-treatment survey, through which you can obtain clients' input on the topics they would like to be addressed, is included as Appendix 1 of this introduction). We recommend that you devote at least one session to each module (excluding the final session), because covering more than one module in a single session would be difficult and may overwhelm participants. However, as noted above, you may wish to dedicate more than one session to a particular topic if it is particularly salient or problematic for the participants.

There is no set order in which to provide the sessions. However, we recommend that, after introducing the program in Module 1: Starting Out, you

present Module 2: Understanding Substance Use Problems and Their Effect on Families, which is the most informational session and the least demanding for group members. We cover this session in our educational evening.

We suggest that you then choose at least two modules that are designed to improve family members' well-being and to prepare them for later topics that may be more emotionally demanding. These modules are:

- Module 3: Taking Care of Yourself
- Module 4: Finding Support
- Module 5: Managing Stress
- Module 6: Using Religious and Spiritual Resources.

We strongly advise you to then deal with crisis management and safety (Module 7: Staying Safe and Managing Crises). Participants must be able to maintain their safety if they are going to deal with their emotions, make changes in their relationships and be successful in treatment.

You can then move on to one or both of two modules that involve deeper emotional processing and the learning of emotion management skills:

- Module 8: Grieving and Coping
- Module 9: Managing Emotions.

We suggest that only after providing information, helping to bolster family members' well-being, ensuring safety, and dealing with emotions do you begin tackling the change-oriented modules and those specifically related to the person with a substance use problem. We recommend that you begin with one of the modules that cover communication, because these modules offer family members tools to help them make changes in their relationship with the person who has a substance use problem. The relevant modules are:

- Module 10: Communicating Effectively with a Person Who Has a Substance Use Problem
- Module 11: Problem Solving
- Module 12: Setting Goals and Making Change Happen
- Module 13: Responding to a Person Who Has a Substance Use Problem
- Module 14: Supporting the Recovery of a Person with a Substance Use Problem
- Module 15: Setting Limits with a Person Who Has a Substance Use Problem.

Module 16: Helping Children Affected by Substance Use in the Family may go anywhere in the cycle or can be offered as a standalone workshop. At CAMH, we have provided it as a workshop that family members who have attended our groups can attend if it is relevant to them.

Finally, we recommend that if you have a time-limited group, you end with Module 17: Finding Hope, and Module 18: Next Steps. Even if your program is ongoing, you may wish to periodically incorporate some of the components of

Module 18 to help family members evaluate what they have done and to determine next steps.

This information is summarized in the table below.

Order of modules*

A. PROVIDING BASIC INFORMATION

Module 1: Starting Out

Module 2: Understanding Substance Use Problems and Their Effect on Families

B. IMPROVING FAMILY MEMBERS' WELL-BEING

Module 3: Taking Care of Yourself

Module 4: Finding Support

Module 5: Managing Stress

Module 6: Using Religious and Spiritual Resources

C. ENSURING SAFETY

Module 7: Staying Safe and Managing Crises

D. DEALING WITH EMOTIONS

Module 8: Grieving and Coping

Module 9: Managing Emotions

E. COMMUNICATING AND MAKING CHANGE

Module 10: Communicating Effectively with a Person Who Has a Substance Use Problem

Module 11: Problem Solving

Module 12: Setting Goals and Making Change Happen

Module 13: Responding to a Person Who Has a Substance Use Problem

Module 14: Supporting the Recovery of a Person with a Substance Use Problem

Module 15: Setting Limits with a Person Who Has a Substance Use Problem

Module 16: Helping Children Affected by Substance Use in the Family†

F. ENDING

Module 17: Finding Hope

Module 18: Next Steps

* It is recommended that at least one module from each lettered section be completed before moving on to those in the next section. Within most sections, the modules may be completed in any order. Certain modules may be omitted, depending on time available (see page 15 for details).

† May be offered anywhere in the cycle, or as an optional standalone workshop.

COMPONENTS OF THE MANUAL

For each module, we provide objectives and a session outline, teaching points and a discussion of key topics, and handouts.

Objectives and session outline

The module objectives help facilitators to quickly see what each module covers. They will also help you to stay focused during the sessions on what you hope clients will learn. The session outline provides an at-a-glance guide to the format of each module.

Teaching points and discussion

This part of each module will help you prepare for the session and guide you in conducting the sessions. The material was developed by therapists who have facilitated the program and contributed to this project. It includes suggestions for how to cover topics, such as:

- ways to explain or define concepts
- questions to ask to promote discussion
- exercises to help clients reflect on a topic.

These session protocols also provide advice and background information to help you handle topics knowledgeably and effectively. Ideally you will have the opportunity to become comfortable with this material prior to each session, and will need to refer to it only occasionally during sessions.

Handouts

Each module includes handouts that provide information, clinical exercises and home practice for clients to use during the sessions and at home. The teaching points sections provide instructions for when and how to use the handouts. The home practice assignments are important, so you should emphasize the need for family members to complete the assignments.

We have found it helpful to give the group members binders in which to keep their handouts. Once you have decided what modules you will cover, you can fill the binders with all the material you will use. Alternatively, you can distribute hole-punched handouts each week. If you fill the binders at the beginning of the group, it avoids the need to distribute handouts during each session, which can be distracting, and it enables participants who miss a session to look over the material at home and do the home practice.

NOTE: This manual is intended only as a guide, and should not supersede the perceptions and judgment of the facilitators. We expect that you will adapt the procedures, exercises, information and handouts to make them relevant and helpful to the family members you work with.

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