Family Support and Addiction Management for Long-Term Success

Using Leverage to Support Sustained Recovery

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Overview

This article explains how we modify the highly successful pilot/physician recovery programs to apply to other groups, with an emphasis on affluent addicted and dysfunctional family members. For pilots and physicians, maintaining their license to fly or practice medicine is an obvious incentive to comply with treatment recommendations. For others, the task is to find something similar in their lives that they value, such as access to funds, resources, employment, relationships, or status. We find this process – the use of pressure or therapeutic leverage – can be a very effective tool to encourage compliance with treatment recommendations during and after in-patient treatment.

High Recovery Rates for Pilots and Physicians

This article is the second in a series of twenty articles on improving recovery outcomes for affluent addicts. These articles describe our experience in using the pilot/physician programs as models for our work with our client families and their advisors facing addiction in a family member.

- The pilot and physician programs have proven recovery outcomes ranging from 85% to 92%, outcomes achieved by no other treatment program.

Such high success rates set a new standard for treatment results and provided us with the inspiration to improve recovery outcomes for other groups. That is why, after eight years of assisting clients, we now write these series of articles so families, their advisors, and professionals in the field can benefit from our work in applying the pilot/physician model to affluent family members suffering from alcoholism, drug dependence, and other addictions.

Reducing Risk to Family Well-Being from the Predictable Disease of Addiction

Alcoholism, drug dependence, other addictions, and significant mental health disorders are statistically probable and will occur in affluent families at an estimated minimum rate of 20%; often much higher.

- These disorders will undermine the best family mission statements and succession plans and result in the loss of both wealth and cohesiveness.

Family leaders and their advisors need an effective "game plan" for addressing these diseases. We offer not only that "game plan." but also the reasoning underlying our recommendations. In our experience addiction and mental health disorders are the leading cause of harm to families due to the combined monetary, personal, and inter-generational damage generated by these diseases.

Cancer Comparison

In our way of thinking, if similar statistics applied to cure rates for pilots and physicians with cancer or diabetes, families would be beating down the doors of hospitals and doctors' offices demanding the same programs for their relatives. *But not the families of alcoholics!*

- Addicts and alcoholics are sick people. They need educated, active family members to help them find effective treatment and encourage them to engage in post-treatment recovery activities, just like relatives who are sick with other chronic, life-threatening diseases.

Families must insist that treatment centers provide the same programs for their addicted loved ones as are provided physicians and pilots. Addiction is one disease where many family members have different opinions – whether it exists in a loved one, and if so, what to do about it. The pilot/physician model, as applied to the affluent, provides a coherent, understandable, and results-oriented structure for all concerned persons to rally around.

Leverage – A Technique to Encourage Change

One of the key elements leading to outstandingly successful outcomes for pilots and physicians is the use of therapeutic leverage or pressure to encourage the addict to comply with treatment recommendations.

The focus in this article is on how we adapt and modify the pilot/physician program to use similar leverage or pressure to encourage affluent addicts to:

- Enter treatment,
- Engage in treatment, and
- Follow post-treatment recommendations until recovery is stable – usually a year or more.

The fundamental concept is that outside pressure is needed so the addict remains in treatment long enough to become self-motivated (internalizes the desire) to learn to live a sober lifestyle.

To this end, *leverage is a process; it is not a treatment program*. Using leverage to encourage a loved one to enter an inadequate treatment program – leading to a subsequent relapse – means the family has "burned a bridge" with no long-term positive results. That is why we emphasize the need for families to locate clinically appropriate treatment centers.

The Pilot/Physician Model Provides Insight into Highly Effective Treatment Programs

By describing this model and how we apply and adapt it to affluent families, our hope is that we can achieve the following:

First, convince families and their advisors that treatment does work.

- Many advisors and family members believe treatment does not work. By understanding how we modify the pilot/physician programs to use the same principles for the affluent addicts, we hope more families will be willing to seek help for their loved ones.

Second, help families understand the treatment process.

- For almost all families, treatment is opaque. Our model provides an experience-based rationale for recovery, providing affluent families with a clearer understanding of what works for successful recovery.

Third, when relapse occurs, have a better idea as to what is needed for recovery.

- For families experiencing the treatment-relapse cycle, this article should be helpful in identifying flaws in previous treatment attempts and areas for improvement in the next treatment.

Fourth, explain to family leaders and professionals how we think about recovery and treatment.

- This article will provide the reader with a general understanding of our process and how we work with families and their advisors.

The pilot/physician model is highly successful and you, as a family member or advisor, need a good understanding of why it is so successful and how you can adapt their model to the unique circumstances of your family.

Articles One Through Seven Constitute a Comprehensive Approach to Improve Outcomes

Of our twenty articles, the first seven cover core components of a comprehensive program to improve recovery rates. Because *Article Two* on Leverage is part of this comprehensive approach, it may be helpful to the reader to briefly describe the other six articles so as to put in proper perspective the importance of creating leverage in governance documents:

A. *The Successful Pilot/Physician Programs: Proven Standards for Recovery Outcomes*

1. Leverage First: Using Family Resources as a Positive Influence for Recovery

- Overall discussion on applying the ideas underlying the pilot/physician programs to other groups, with an emphasis on affluent addicts and reducing risk due to addiction. Proposes that families view and plan for addiction as a predictable and treatable disease.

B. *Encouraging and Inducing Change*

2. Using Leverage to Support Sustained Recovery

- Discusses how we modify the pilot/physician program when applying leverage to affluent alcoholics and addicts to improve outcomes. Describes fifteen differences between programs for pilots/physicians and programs for the affluent.

3. Change Strategies For Advisors with Low Leverage or Low Interest Families

- Advice on change strategies for advisors facing reluctance to address difficult problems in their families. Ranges from educational and risk protection to using family momentum or addiction-related incidents to promote change.

4. Building Leverage in Governance Documents for Earlier Intervention and Stable Recovery

- Discusses a problem-solving approach in dealing with family members exhibiting addictive or other dysfunctional behavior. Suggests language for family documents and explains from a "stages of recovery" perspective why leverage must remain in place for many months.

C. *Systems Transformation to Improve Outcomes*

5. The New Treatment Model: Systems Transformation to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived from the pilot/physician programs. Looks at family relationships in affluent family systems. Describes 12 Core Concepts to think about regarding recovery in affluent families.

D. *Improving Treatment for the Affluent:* ***Substantive Program and Clinical Issues***

6. Practical Advice on Achieving High Recovery Rates for Affluent Alcoholics and Addicts

- In-depth review of the clinical needs of the affluent in treatment and in the context of applying the pilot/physician program model to the affluent.

7. Families, Wealth and Addiction

- A new clinical approach to addiction, treatment, and recovery for wealthy families. Discusses barriers to finding and receiving effective treatment (four page overview).

Leverage, Quality Treatment, Systems Transformation, and Change Strategies

These topic areas compose a comprehensive, innovative and effective treatment model for affluent addicts, their families, advisors, and trustees. While these topics are discussed in separate articles, it is their integration, individualized for each family and their addicted loved ones, which leads to improved outcomes.

Be Persistent, Be Pro-Active

We hope our ideas about improving outcomes will encourage advisors to take a pro-active approach in addressing addiction in their client families, knowing that successful outcomes can occur for the affluent. In cases where addiction is not currently present in families or is too difficult to confront or arrest, our additional hope is that our articles will provide a platform for advisors to help their clients adopt measures to effectively address dysfunctions in future generations.

Using Leverage to Support Sustained Recovery

Article Summary: Five Topics on Using Leverage

Section A. Leverage: Applying the Pilot/Physician Programs to Affluent Addicts and Alcoholics

- In this article we explain how we adapt the pilot/physician model to the affluent by first addressing fifteen (15) differences to consider when comparing the two programs.

These differences are primarily due to the fact that the pilot and physician programs are government-mandated.

Section B. Modifying Behavior Through Leverage

- We then discuss leverage as an effective "behavior change technique" and an often-necessary component of an intervention strategy aimed at cutting off continued use.

Many treatment centers are opposed to using leverage and view it as "anti-therapeutic." Other groups, such as Al-Anon and family programs, advocate "letting go." In this section, we explain why we oppose these positions and believe an activist approach is the much-preferred course for the affluent addict whose resources limit consequences from use.

Section C. Six Prerequisites for Effective Program Implementation

- These prerequisites discuss the importance of the family in the recovery process.

The reason for the success of the pilot/physician programs is the involvement of their oversight boards in managing their recovery programs. This section discusses how families and their advisors can operate in the same manner as the airline and medical oversight boards.

Section D. If Not Abstain, Attempt to Contain and Manage

- The fourth section addresses containment strategies for situations where leverage is ineffective or unavailable and the addict continues to drink or goes through cycles of abstinence and use.

Not every addict or alcoholic responds to treatment, even with pressure. The question then becomes how to protect that person and others from the effects of continued use, while providing a lifestyle that is commensurate with that person's means and position in the community. (Assuming the use of addictive substances is such that the person has periods of abstention and can function in society or a home environment.)

Section E. Limitations and Cautions on Using Leverage

- Important advisory warnings on the use of leverage, including, "Never cut off an addict without putting a support system in place" and "Never terminate communication."

Discusses how the lack of leverage impacts intervention and relapse after treatment.

Leverage: Most Effective if in Governance Documents

Leverage can be a very effective tool in dealing with an addict, but many families either do not have the necessary governance provisions in place to address addiction, or, if addiction is referenced in documents, the process is inadequate to contain the addict (See Articles 4, 13, 14 and 15). Some families do have leverage provisions in place but prefer to use a less pressured or softer approach, as we discuss in Article 3.

SECTION A:
Leverage: Applying the Pilot/Physician Programs to Affluent Addicts and Alcoholics

In Section A we describe our approach to helping families and advisors address addiction in a family member, based on using leverage similar to the highly successful recovery programs for airline pilots and physicians. These programs are government-mandated. Thus, the employer usually has much more power over pilots or doctors to obtain compliance with treatment recommendations than families have over the affluent addict.

- Lacking a similar mandate means families must be much more patient, nuanced, and sophisticated when following the pilot/physician model for their addicted loved ones.

Accordingly, we discuss fifteen important elements of the pilot/physician programs and how we adapt their model to the affluent by contrasting their programs with modifications made for affluent addicts. These program differences are derived from our experience working with affluent families for the past seven years. *Keep in mind that the greater the degree of affluence and prominence, the more complicated the problem and intensity of resolution strategies.*

The remarkable feature of the pilot/physician programs is the high degree of compliance generated by control over license to fly or practice medicine. An intriguing facet of our work is attempting to locate similar control sources in families, particularly family businesses or families with multiple trusts. This process can be much less straightforward than for a pilot or physician, because families may be reluctant to talk about these complex structures or identify the real decision-makers.

- The key here is not so much the intervention as it is developing effective strategies to implement treatment and post-treatment plans.

How the intervention process is structured is important because it helps set up the long-term recovery plan. As mentioned, this means not overusing leverage in the initial interactions, when the emphasis may be on expressing concerns about the addict's health or behaviors.

1. Use Therapeutic Leverage to Encourage Compliance

- *Regulatory boards with licensing-revocation power govern pilots and physicians.*

Regulatory boards govern pilots and physicians. When a pilot or physician is found to be using on the job, his or her license to fly or to practice medicine is dependent on compliance with the requirements of these boards relating to treatment and recovery activities. In the counseling profession, such job-dependent compliance is known as "therapeutic leverage" or "pressure" to encourage people to change their behaviors. It is effective, particularly if used early on in the disease process.

For the affluent, leverage, or pressure, comes from controlling money, participation in family businesses, access to family resources, and relationships. Therapeutic leverage, or pressure to enter treatment and comply with post-treatment recommendations, is needed because it is very difficult for people to change harmful behaviors on their own.

- To be effective, leverage must be used with sophistication and discretion and is much more

a "carrot and stick" proposition, rather than raw force.

Leverage is most effective if senior family members, trustees, or others in positions of power support its use and are united when dealing with an addicted family member.

Some treatment centers, therapists, and addicts assert that leverage is coercion and "anti-therapeutic" because it forces the addict to enter treatment against his or her will. However, the addict always has the choice not to comply. Also, evidence supports leverage as an effective treatment tool in improving outcomes. For example, judges overseeing DUI programs using a model similar to airlines and medical boards are reported to achieve higher outcomes than treatment centers (see discussion in the footnote in the preceding paragraph and the discussion on "Enforced Behavior Modification" below).

2. Timing of Leverage

- *The pilot and physician regulatory bodies revoke licenses the first time there is an indication of a rule violation regarding the use of alcohol or drugs.*

Many families wait to apply leverage until their loved one has tried and failed several treatments or the disease has progressed to later stages. By the time it is applied, it is often too late to be effective because the addict is treatment-savvy, figures out how to minimize leverage, believes treatment does not work, or is too ill to recover.

In non-emergency situations, we believe an evaluation process is an effective tool for increasing self-awareness in addicts who have lost control over their use of alcohol or drugs. This process may require several months of monitored attempts by the addict to stop before the addict agrees to enter treatment. Thus, pressure by the family to comply with an evaluation or monitoring procedure may increase over time.

- The time frame is different than that of pilots and physicians who enter treatment as soon as the problem is identified, because the focus is on how to best set up the intervention process to encourage compliance by the affluent addict with post-treatment recommendations.

In addition, there can also be family conflict about whether or not the addict is indeed an addict and what to do about it. This may take time and unkept promises to resolve. In the pilot/physicians' model, there is no debate and procedures and processes are set forth very clearly.

3. Release of Information and Confidentiality Issues

- *Pilots and physicians are required to sign complete releases of confidential information so that their treatment and recovery program is transparent.*

Affluent patients often will sign only partial releases and will withhold information about post-treatment recommendations, if the recommendations run contrary to the patient's wishes.

It is much more difficult to obtain these waivers from the affluent alcoholic or addict, although it is essential that there be complete transparency regarding treatment and post-treatment options. One challenge is finding treatment centers that will cooperate in the effort to obtain full releases. Some treatment centers don't believe in it; others do not have the time. One way to counteract "game-playing" by addicts regarding the scope of the release is to request the

treatment provider to send a copy of the signed release to the professional hired by the family.

4. Post-Treatment Recovery Activities

- *Pilots and physicians are required to actively engage in post-treatment and recovery activities including attending approved counseling sessions, attending AA meetings, complying with observed drug testing, meeting with assigned sponsors, and agreeing to written relapse plans.*

The affluent addict will often try to negotiate out of post-treatment recommendations and refuse to comply with agreed-upon recommendations.

- However, the best outcomes occur when a long-term disease-management plan is in place, including a list of recovery activities and drug monitoring.

Professional literature now focuses on the importance of post-treatment recovery activities in improving outcome rates. For an example of the type of document DWI court participants are required to agree to, see **Article 4** on Governance, Appendix, Exhibit E.

5. Choice of Treatment Center

- *Pilots and physicians have no choice regarding the treatment center that they attend or the length of the program.*

Affluent addicts will try to pick their own treatment center and negotiate the duration of treatment.

- The family, on the other hand, should select treatment centers that cooperate with family-hired professionals, provide a supportive treatment environment for affluent patients, and are firm on the time and post-treatment programs needed for recovery.

Drug and DWI courts also select their treatment providers to assure quality treatment, as judges are outcome-focused – they want results, not slick ads or unfulfilled promises.

6. Quality of Treatment Professionals

- *Treatment centers contract with pilot and physician oversight bodies to assign their patients to the most qualified treatment personnel who specialize in helping doctors and pilots.*

For all other groups, it is "luck of the draw," meaning it is unlikely an affluent patient will be assigned to an experienced counselor or one with special skill sets in understanding the connections between money and addiction.

- The quality of the counselor-patient relationship is an important factor in improving outcomes, but most treatment centers are indifferent to matching counselor strengths with patient needs.

In addition, staff bias against the affluent – "wealthism" as Joanie Bronfman named it – is a big problem in treatment centers and needs to be taken into account when selecting a treatment center.

7. Family Systems Issues

- *For pilots and physicians, there is an unambiguous workplace message regarding support for recovery.*

Unlike the recovery environment establishing unequivocal guidelines for pilots and physicians, family members may be in conflict and some family members may be inadvertently or unintentionally supporting the addict's use.

- Also, as we discuss in **Article Five** on systems, below, there are many relationship issues that need to be looked at in terms of identifying changes that are required to support recovery.

If knowledge about entering treatment is limited to one or two close family members, other parts of the system will not understand the need for change nor be in support of requests to modify existing practices to support recovery.

8. Control the Environment

- *Oversight boards for pilots and physicians "strongly suggest" that their employees avoid relationships and environments that could negatively affect their recovery.*

Families have far less influence over their loved one's activities in early recovery, meaning the risk of relapse is much higher. That is why it is critical to have in place a monitored post-treatment recovery plan.

- Some addicts leave treatment, wanting to show their friends and family that the only thing that has changed for them is they no longer drink alcohol or use drugs.

They will attend social events or hang out with friends where alcohol is present to show off their new abstinence, failing to understand how vulnerable they are to relapse due to embedded emotional memories. If the addict in early recovery has a support plan in place, and is actively participating in the plan, then he/she is less likely to return to old friends and entertainment sites.

9. Knowledge of the Problem

- *Colleagues and administrators of pilots and physicians know that they have been through treatment. There is no attempt to hide their status as individuals in recovery.*

Families and their alcoholic or addict will try to cover up or minimize the addiction and recovery, keeping it all a "secret" until disaster strikes.

- It is almost impossible for one or two family members to face these problems on their own because addiction is such a powerful disease. Also, addictions and other dysfunctions flourish in secrecy, making the situation worse as the disease progresses.

Help from the larger community of family, friends, and professionals is needed to provide immediate relatives with a proper perspective on the urgency of taking action and to reduce the shame and anxiety generated by addiction or mental illness. It is, after all, a disease. Also, it is easier for the addict to adjust to and feel safe with his or her identity shift after treatment when there is open acceptance of the recovery process by family members.

10. Communication Among All Interested Parties

- *All advisors and professionals communicate and discuss ALL aspects of the physician or pilot recovery process with the chemical dependency (CD) professionals.*

Advisors and professionals working with affluent families will often restrict or limit information

to the CD professional about key family relationships, documents, and current or past events. This compartmentalizing of information may be done in order to protect and maintain relationships and privacy or it may be done due to the misguided belief that chemical dependency is not affected by other aspects of family life.

- However, in order to effectively implement the behavior modification tools we advocate using, the chemical dependency professional must be kept aware of all contemporaneous communications or other contacts between the addict, family members, family office, and advisors.

Failure to follow this rule can undermine our advice on using leverage, because the addict establishes side communication channels designed to ease pressure, or there are other resources or funds being made available to the addict that we are unaware of.

11. Professional Help

- *Highly qualified addiction professionals, acting on behalf of the two respective oversight boards and their employers, oversee addicted pilots and physicians.*

We find that families and their advisors have difficulty using leverage effectively on their own because they are too close to the addict, leading to inconsistency and conflict, which the addict exploits. In addition, addictive thinking is incomprehensible to non-addicts.

- Moreover, one advantage in hiring the addiction professional is that the family and advisors can tell their dysfunctional family member they are following the advice of a professional advisor who knows addiction.

This advisor can then take some of the heat when funds or access to other resources are terminated as per the family's request in seeking help. Another reason for using a licensed professional is that treatment centers will not send diagnostic and program information to unlicensed persons.

Affluent families rarely turn to <u>qualified</u> help until there have been a number of failed attempts at recovery. This is not their fault, as treatment centers often refer callers to non-licensed "interventionists" lacking academic credentials from recognized institutions. Be sure to ask about the academic credentials and state licenses held by your interventionist or counselor. Check with state authorities to see if the license is valid.

12. Length of Recovery Oversight

- *Oversight boards often require pilots and physicians to be under their supervision for two or more years.*

Families usually end their relationship with a professional advisor within one or two months after their loved one enters treatment or some other significant event.

- Addicts must stay in an active recovery program until external motivation to enter treatment (leverage) is replaced by internal motivation to abstain and seek a sober life.

In addition, it takes **several months, and often longer** (depending on the progression of the disease), **for brain cells to reduce their need for alcohol/drugs and susceptibility to using impulses,** returning to a less reactive state.

Because the emotional and mental impact of addiction on personality is so severe, it also takes time for the addict to stop blaming others for his or her problems, stop believing that he or she can't live without drugs or alcohol, and lose his or her self-centered focus.

- The desired personality conversion wherein the addict accepts responsibility for his or her problems and addiction, engages in regular self-examination, and learns to access the benefits of the "spirituality" of recovery requires much more than 28 days.

Recognizing that *"I am the problem vs. You are the problem,"* and similar awakenings are the hoped-for outcomes. But these take time (and an active recovery program)!

13. Recovery Program Costs

- *Employers and the government fund oversight boards. Pilots and physicians pay for their post-treatment costs as a condition of licensing.*

Professional advice and ongoing oversight on behalf of families is much more expensive because there is less leverage and also because affluent family and business/economic dynamics are far more complex.

In our experience the amount of money can be an issue for some families – not because they don't have it, but because many have already spent multiple thousands on treatment.

- However, this is an area where families need to understand that treatment "failed" not because of the addict, but because treatment was not effective.

That is, treatment did not take into account the addict's clinical needs nor was there an explanation of how treatment works, as there is for the pilot/physician programs. See **Articles Six, Seven, and Eight**, listed in the Appendix, on improving outcomes for affluent addicts, referenced above for more on this topic, including sustaining positive family engagement with the addict.

14. Disease Concept

- *The pilot/physician programs are grounded in the disease concept, abstention from all mood-altering chemicals, and AA participation. There is no debate.*

Affluent addicts will challenge the disease concept, argue that limited use or use confined to one substance is permissible, and will reject AA. ("*They told me at treatment I needed to stop using cocaine, but drinking alcohol was still OK.*")

- The role of the professional is to advise the addict on behalf of the family about treatment programs that are known to be effective, as well as unfounded statements like the one in the preceding sentence.

Overwhelming evidence supports the disease concept, including brain-imaging studies. Other claimed ideas about addiction or how to treat addiction are based on unsound scientific evidence and bogus success rate claims.

In addition, although many families are reluctant to acknowledge it, addiction is a primary disease affecting the **entire family system**. This means that family members, their support systems, and family entities must work together to focus on addressing and resolving the addiction. It cannot be "compartmentalized" with the focus on the addict.

15. Traditional Chemical Dependency Treatment

- *Pilots and physicians attend traditional treatment programs where the emphasis is on listening to the advice of counselors, being open to self-examination, and taking personal responsibility for actions. The goal for recovery is abstention.*

Many treatment centers, therapists, and educators believe that engaging the addict in discussions as to the benefits and drawbacks of being addicted, in conjunction with the experience of continued use or relapse, will eventually result in long-term abstention. This form of treatment is based on "Motivational Interviewing" theories developed twenty-five years ago in regards to smoking cessation efforts.

Because this form of treatment regards relapse as part of the counseling/recovery process, we take issue with it, especially in cases where an addict has underage children. Also, affluent addicts simply do not experience enough consequences from relapse to make relapse a "learning tool." Another fatal flaw in this approach is that it is very difficult to encourage a using family member to enter treatment once, let alone a second, third and fourth time after each successive relapse.

More importantly, the rationale/discussion form of addiction counseling advocated in "Motivational Interviewing" and used by many treatment centers has suspect data to support its effectiveness. In fact, the data that does exist identifies emotional factors and external pressure as important influences on an addict's willingness to seek help and stay in recovery. For more discussion in this area, see *Flawed Family Assumptions* and *Achieving High Recovery Rates for Affluent/Prominent Alcoholics and Addicts,* listed on page 21.

In summary, these fifteen recovery principles are a set of both ideas and services to encourage alcoholics and addicts to enter treatment and participate in post-treatment activities until they are motivated to continue on their own. The addiction-trained therapist must be wise enough to apply them with sophistication and discretion, and in partnership with families and advisors. On their own, however, these principles are insufficient to lead to and assure stable recovery without changes in the family system discussed in Article Five, *The New Treatment Model and Family Systems Transformations to Improve Recovery Outcomes*.

SECTION B:
Modifying Behavior Through Leverage

After discussing the significant program differences in Section A, we now address in Section B the obvious point that one major goal is to modify behavior by encouraging the affluent addict to seek effective treatment and follow post-treatment recommendations. Since the recovery field has differing views on the use of leverage to encourage behavior change, we will provide our reasoning for advocating leverage in this section on enforced behavior modification. (Note that in *Article Three* on **Change in Families**, we offer alternatives to using overt leverage, including The Family Systems Workshop.)

1. Some Parents Fear Using Pressure

Some parents are reluctant to use pressure, saying, "It will never work" or, "My son or daughter will be so mad he/she will never talk to us again."

- However, the disease has often progressed to the point where families are almost always unaware of the drug combinations being used. Example: alcohol, Valium and Ambien. These are all "legal," the latter two when prescribed by a physician, but almost always supplemented by doctor shopping or Internet purchases.

These are extremely dangerous combinations (substitute heroin, cocaine and other benzos to the same effect). Doing nothing and waiting for a serious enough consequence *is not a choice*. The risks are too great. Anger, rejection, and threats are transitory attempts by the addict to preserve the status quo. A good counselor will help you manage these responses (and will take some of the heat).

In addition, the addict almost always has support mechanisms in place to permit continued use at dangerously high levels. These include spouses, friends, relatives, employees, lawyers, therapists, physicians, and managers – the longer the use history and the larger the wallet, the larger the protective entourage.

- It can be extremely difficult to obtain accurate information about the health of your loved one or even visit him or her for a sufficient length of time to see what is actually going on.

This is not only an argument for early action, but also for the idea that cutting off funds or access to other resources may be the only effective way to neutralize the support mechanisms.

The pilot and physician model is, in essence, forced behavior modification in which the addict is required to engage in recovery activities until he/she internalizes the desire to remain sober. As mentioned, many treatment programs, therapists, and chemical dependency counselors reject leverage or behavior modification as a means to encourage compliance with treatment protocols.

- An added danger is that therapists and counselors tell family members and their advisors to "let go" and not try to affect or "control" an addict's use or recovery.

This is erroneous advice because the affluent addict can continue to use with few consequences, producing results in direct contrast to the outcomes of the highly successful programs for pilots and physicians. Leverage is needed and it works! (See footnotes 8-16.)

2. Drug Courts

Other groups that use leverage are DWI and drug courts. Judges obtain better outcome rates than treatment centers. They, too, use leverage to encourage behavior change.

- As one judge said to a newly enrolled participant in a DWI sentencing program, *"Drink and drive and a ton of bricks will come down on your head."*

The threat of jail time for non-compliance, coupled with highly structured conditions of probation and close judicial supervision, results in remarkable success for offenders sentenced to these programs. One interesting facet is that participating offenders do not have the option of quitting. They either graduate from the program or do their jail time, similar to pilots and physicians who either comply or lose their licenses to fly or to practice medicine.

One reason why we emphasize the need for continued pressure on addicts to stay in an active treatment program for much more than 28 days has to do with the nature of addiction. Addiction resides in the limbic area of the brain, which is an area similar to the brains of lower animals (those who just react, not think). The limbic system controls motivation, emotions, sex drive, and other areas that are automatic and occur without thought input. Similarly, the brain contains deep-seated emotional memories and stress/craving centers beyond rational control. It takes months for the brain to modify these memories and restructure pathways to cravings.

SECTION C:
Six Prerequisites for Effective Program Implementation

Following our discussion on behavior change, in Section C, we identify six prerequisites for effective implementation for our model based on the pilots and physicians programs:

- The Family is the Client
- Use a Professional
- Information Repetition
- Accessibility and Coordinated Communication
- Patience, Persistence and Flexibility
- An Addict Recovers with Support

It is very helpful to understand why these six prerequisites are important for successful outcomes, because without such understanding, family members can find the pilot/physician model difficult to adapt and apply to their individual situation (this is an understatement).

1. The Family is the Client

The first precept is that our client is almost always the family, family office, advisor, or trustee. Families need help and are the missing link in the recovery process. We work with our families over the long term. The addict receives the focus of attention in treatment. Families may attend a family program for a few days or so, at most. Families can be very influential regarding an addict's recovery, but have difficulty being effective without professional help (see **Article Eight**, *Flawed Family Assumptions About Addiction* for more on this topic).

We also work with families for the practical reason that the addicted family member will fire us the first time we tell him/her something he/she does not want to hear. Then professional and confidentiality rules prohibit us from discussing the situation with the family without a signed release by the addict.

2. Use a Professional

Families and advisors are very unlikely to achieve optimal success using the ideas in this paper without high-quality assistance. A professional advisor is someone with an advanced degree and/or a state-issued license or certification, and vast experience working with affluent families. It helps if the professional is in recovery and grew up in a family business. It is not easy, but it is necessary to find the right support early on when addiction first arises in your family.

Some advisors, trustees, and lawyers do not want to bring in outside assistance because they are threatened by the idea of another professional becoming close to their client or do not want to lose the billing hours.

- However, it is our experience that these people are outside their scope of expertise and training when dealing with addicted clients and often they do not have the emotional demeanor or skill sets to be effective with addicts.

Also, be aware when looking for help that there are many non-licensed, undereducated interventionists and others in the chemical dependency field who are not capable of successfully working with affluent families.

3. Repetition
Many people reading our articles are doing so because they are worried or concerned about a loved one who is active in their use of alcohol or drugs. The anxiety or fear this generates in family members cannot be overstated or overestimated, in our experience. Due to these heightened emotions, we find that many readers need to be reminded of the core messages in our article because they forget what they have read or have selective memories. Some of the information provided is deliberately redundant so that if the reader is experiencing anxiety or fear, she/he has an opportunity to gain a better understanding of our advice and to remember the basic ideas underlying our approach to recovery.

4. Accessibility and Coordinated Communication are Keys to Success
Key family members must make themselves available to communicate with the professional expert. Our preferred client-professional relationship is one where the professional is available in the evening and on weekends (within reason). This is because our clients – parents, siblings, children, and advisors – often have the time to talk to us when they are not busy tending to family and business. Evenings and weekends are times when the client has free space to think about concerns or questions and also when a loved one will call, resulting in the need to consult with us. In the first stages of implementing our approach to recovery, access to helpful conversation is crucial. Normal "office hours" will not suffice.

Where two or more family members are the clients and want to be involved, coordinated communication helps avoid misunderstandings, because separate conversations usually result in multiple follow-up calls. When one family member says, *"I am too busy to speak with you. Talk to my sister and she can make the decision. I will talk to her later to see what she said,"* inevitably that family member will be e-mailing or on the phone to provide input on the decision.

Similarly, delegating authority to communicate to a family advisor or office executive does not work well because, again, inevitably the client will call and be upset because he/she was not directly informed. It is better to have the advisor or office person handle administrative matters or be party to the substantive calls with the client(s). Even for very busy family members, ultimately, the stakes are too high for them to allow communications to be delegated to a non-family member.

5. Patience, Persistence and Flexibility: Advice to Professionals
In working with families, an overarching and fundamental principle is to respect where each family member is in his/her ability to deal with addiction. Expect that things will not go smoothly or as planned. We embrace the client's inability to make decisions, failure to follow through, or backtracking.

- Professionals have the skill set and demeanor to support their client families and advisors as they go through the very difficult process of evolving to a recovery mode.

The expert must not be rigid or demanding. *The expert can set limits and make demands on the addict, but with family members and advisors, flexibility and support are crucial for successful engagements.* And the expert must understand that some of the negative emotional energy

generated by the addict and carried by the family will be transferred to the professional.

6. An Addict Recovers with Support

We fully recognize that alcoholics and addicts are responsible for their own recovery. However, families can help them achieve sobriety by creating a supportive environment. Evidence shows that outcomes improve when families positively engage with their addicted loved ones. Professional counselors help by developing a close working relationship with their client families when applying the principles of the pilot/physician protocols, paying particular attention to modifying them to fit individual circumstances unique to each engagement.

SECTION D:
If Not Abstain, Attempt to Contain and Manage

In Section D, we offer suggestions on how to contain and manage the problem when a family member is unable or unwilling to quit drinking or using. Unfortunately, some families reach the point where they must accept that despite their best efforts, the ongoing user will continue to be at risk. Some addicts/alcoholics are either unable to recover or choose not to recover despite the best efforts of all concerned persons.

1. Containment Strategies

One approach in this situation is to provide support for the addict to stop or reduce use so he/she can participate meaningfully in family, social, and business settings. We work with families and their advisors to isolate the disease (the active user) and contain the damage resulting from use of alcohol or drugs. We do recognize that at some point, if use continues, the family member may become so physically or mentally disabled that a nursing home or other confinement is the only alternative. How this is accomplished is too complex a topic to discuss here, but it does require the active involvement and cooperation of all advisors and key family leaders.

We have been involved in cases where the active user has lost parental rights, been fired, or bought out at a reduced price from the family business, had an inheritance reduced or placed in perpetual trust, or has been prevented from using family resources. While these outcomes were not easy to accomplish, it is far better to confront the active user than to passively absorb his/her abuse and ongoing disruption of family activities and enterprises.

2. Protective Services

In other situations, the goal is to protect the active user from harm to self or others while at the same time helping relatives and advisors regain their emotional stability and develop a healthier perspective on the situation.

- These "Protective Services" may be appropriate for senior family members who are in control of their assets, are unable to stop drinking, but are not yet candidates for guardianship or commitment.

Often, these individuals are still able to experience days and weeks without drinking or using with the ongoing help and support of trained companions, leading to an improved quality of life and interaction with family members.

An added benefit to isolating or providing protective services for the active user is that by facing the addict head-on, a positive message is sent to the rest of the family (including the next generations) as to what is acceptable behavior in the family.

- It helps establish a family "culture" that supports health rather than dysfunction – the explicit message given to families where the active addict is tolerated or ignored.

The up-and-coming generation notices how their senior members confront or accept addiction. The senior generation's response does affect the next generation's attitudes about drinking and behavior! If "Uncle Snuffy" regularly becomes inebriated at family functions – whether social or business-related – the younger generations take notice.

SECTION E:
Limitations and Cautions on Using Leverage

While leverage is effective in the right circumstance, there are at least four important cautions and limitations to keep in mind when thinking about leverage as means to encourage compliance.

1. Leverage is a Technique

- It can be a very effective technique, but it is not a treatment program.

Simply obtaining agreement to enter a treatment program means the addict is entering the existing inadequate treatment system with very low recovery rates and will likely relapse. That is why we discuss a new treatment model to improve recovery and treatment services that actually address the clinical needs of the affluent patient (see Section C below for an overview of this model).

2. This Model Assumes Leverage Exists

If it does not exist, we find it is often very difficult for families and their advisors to persuade an addicted family member to enter treatment and remain engaged in recovery activities long enough to achieve and maintain stable sobriety.

- Lack of leverage leads to the treatment/relapse cycle common for affluent addicts and so frustrating, frightening and discouraging to those who love them or are in fiduciary relationship (yes, bankers and lawyers do care).

If the family does not now have leverage provisions in its documents, reading this article on leverage will demonstrate why it is necessary to create leverage by adding governance provisions to all family succession and enterprise documents. (Trust "decantation" may be the only option available for existing documents. See your trust lawyer on this topic.)

For situations where there is low – or no – leverage or the family wants to try a less forceful approach, see our *Change Strategies for Advisors with Low Leverage or Low Interest Families*. This "change" article includes a description of our "Family Systems Workshop" where the family convenes in a non-confrontational process, an alternative to the traditional surprise intervention. However, these change strategies are poor substitutes for document leverage, because the problem is how to encourage the addict to engage in recovery activities over the long term, not merely to agree to attend treatment or change a behavior.

3. Surprise Intervention Ineffective in Low Leverage Situations

We caution the reader on using the traditional surprise intervention model in low leverage situations because it is unlikely the addict will comply with the request to enter and complete treatment, leading to a deterioration in relationships and jeopardizing the ability to use other change strategies. Accordingly, families and their advisors should be aware of the degree of leverage available to encourage the addict to enter treatment and not be forced by interventionists into using the surprise model when there is low leverage or the family preference is for a different form of intervention.

4. Using Leverage Never Means Cutting Off an Addict from Support

Families Must Always Remain Engaged with their Addict, Even When "Cutting Off" Access to Funds or Other Resources. While we discuss using pressure, such as limiting access to funds, the family and its assisting professionals must always stay engaged with the addict, particularly for the out-of-control addict who is on the loose or overdosing. We emphasize the need to maintain professionally directed contact because we continue to hear of tragic outcomes when families "cut off" a family member who is addicted (and often has co-occurring mental health problems) and fail to simultaneously put into effect an action plan to monitor and support their loved ones. (See this footnote for more information on remaining engaged.) As a recent article states:

> *Families are often told by addiction counselors that their loved one must "reach their bottom" before they can get sober, so families think they should not intercede after a certain period of time. Brad Lamm disagrees: "Don't buy into the myth of letting the person bottom out," he says. "If your loved one was drowning, you wouldn't think, okay, we need to let her get a little farther underwater and gasping before we throw her the life preserver."* (Brad Lamm, author of *How to Change Someone You Love*.)

We agree completely and wholeheartedly with this statement. While remaining engaged with the addict is a major theme in our articles, we find we need to repeat this information over and over again because many families continue to be ill-advised on recovery tactics regarding their loved ones. Publicity about the recent deaths of newsworthy young adults prompts us to again warn parents against using this tactic without putting a support system in place.

Never Use Terminating Communication as a Threat

We recently heard of another instance of bad advice given to parents, when they were told to write a letter to their young adult child telling him that unless he complied with their requests to enter and complete treatment, the parents would never speak to him again. This is absolutely the incorrect message to send to anyone, let alone a twenty-something-year-old child.

CONCLUSION

While this article is about using leverage, it is important to keep several key concepts in mind when reading all our articles:

Family Support and Education are Critical to Improve Outcomes

- The focus of all our articles is on helping families and their advisors.

Competent, professional and ongoing help for families is one of the missing pieces in a successful recovery strategy for an addicted family member.

- To improve recovery rates, families must become knowledgeable buyers of treatment services.

Most families know little about what constitutes effective treatment even though they are often paying the bill and locating the treatment center to help their loved ones.

Concepts Apply to Other Groups

Many of the ideas discussed in this article apply across the board to any family, regardless of economic status, including small business owners, professional groups, non-profits, and similar entities. However, the more resources a family has, the greater the complexity of the problem, as there will be family members, employees, and friends dependent on the addict who will help him/her resist the use of leverage. Also the disease very likely has progressed to the point that recovery may be difficult unless the addict is in long-term treatment.

You Can Make the Difference

Through our professional, recovery, and personal lives we know many members of affluent families who struggle to abstain and find meaningful lives without alcohol and drugs. You, as parent, sibling, advisor, trustee, family leader, or business owner have the power to collaborate with professionals to insist your family members afflicted with alcoholism and drug addiction start down the path to recovery. You can make the difference.

We have seen far too many members of affluent families suffer unnecessarily from the disease of addiction. It is time to take a new approach to addressing addiction in our families, an approach based on the highly successful programs for pilots and physicians.

In ending this article on leverage, as we state, leverage is a means to encourage compliance with requests for professional evaluations and treatment recommendations. Leverage by itself does not constitute a substantive or effective recovery program. However, at a minimum, leverage does provide the means to move discussions about problematic behavior beyond the talking or surface compliance stages to active recovery. Without leverage, in most cases, the addict will always quit "tomorrow," as pointed out in Vern Johnson's book *I'll Quit Tomorrow*.

Improving Recovery Rates for Affluent Addicts and Alcoholics

TWENTY ARTICLES

Introduction

A. *The Successful Pilot/Physician Programs: Proven Standards for Recovery Outcomes*

1. Leverage First: Using Family Resources as a Positive Influence for Recovery

- Contrasts the high success rates for pilots/physicians with the low (and misleading) outcome rates promoted by treatment centers. Discusses addiction as a statistically probable disease to be anticipated and planned for by families, as well as different intervention strategies and an overview on improving recovery rates by adapting the pilot /physician model to other groups.

B. *Encouraging and Inducing Change*

2. Using Leverage to Support Sustained Recovery

- Explains how we modify the pilot/physician program when applying leverage to affluent alcoholics and addicts to improve outcomes. Describes fifteen differences between programs for pilots/physicians and programs for the affluent.

3. Change Strategies For Advisors with Low Leverage or Low Interest Families

- Advice on change strategies for advisors facing reluctance in client families to address difficult problems. Strategies range from education and risk protection to using the momentum generated by addiction-related incidents to promote change.

4. Building Leverage into Governance Documents for Earlier Intervention and Stable Recovery

- Discusses a problem-solving approach in dealing with family members exhibiting addictive or other dysfunctional behavior. Suggests language to include in family documents, the reasons underlying these suggestions, and explains from a "stages of recovery" perspective why leverage must remain in place for many months.

C. *Systems Transformation to Improve Outcomes*

5. The New Treatment Model: Systems Transformation to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived from the pilot/physician programs. Reviews family relationships in affluent family systems. Describes 12 Core Concepts to consider in promoting recovery in affluent families.

D. *Improving Treatment for the Affluent:* ***Substantive Program and Clinical Issues***

6. Practical Advice on Achieving High Recovery Rates for Affluent Alcoholics and Addicts

- In-depth review of the clinical needs of the affluent in treatment and in the context of applying the pilot/physician program model to the affluent. Explains why current treatment is inadequate and describes strategies to improve outcomes.

7. Families, Wealth, and Addiction

- A new clinical approach to addiction, treatment, and recovery for affluent families. Discusses barriers to finding and receiving effective treatment (four page overview).

E. *Advice for Families*

8. Flawed Family Assumptions about Addiction and Treatment: Information for Families

- Misconceptions by parents about treatment impede recovery for their adolescents and young adults.

9. Fifty-Seven (57) Things I Wish I Had Told You When First Becoming Aware Your Loved One Has "A Problem"

- Written after a friend's child died five months after leaving treatment. This tragedy motivated the author to enroll in addiction studies school and become an advocate for improved treatment outcomes, using the pilot/physician model as a prototype for services to other groups*.

10. Advice for Parents of Adolescents and Young Adults

- A parent's perspective on the developmental impact of addiction and recovery issues*.

F. *Individual Blocks to Change: Childhood Experiences and Counseling Inadequacies*

11. How Childhood Experiences in Affluent Families Impede Change as Adults

- Counselors and family members must understand how these experiences negatively influence the addict's ability to benefit from treatment, including lack of trust and inability to connect with peers*.

12. Counselor - Client Relationship and Conditions Promoting Change

- Identifies blocks to recovery for the affluent in the treatment and counseling setting*.

G. *For Family Offices, Family Businesses, Trustees, Lawyers, Accountants, and Advisors*

13. Trustees and Beneficiaries*

- *The Demise of Trustee Discretion and Ascertainable Standards as Effective Controls on Dysfunctional and Underperforming Beneficiaries*". Discusses ways beneficiaries access funds despite restrictions on distributions. Suggests language to include in trusts and other governance documents to address addictive behavior in family members (See Article 4, above).

14. Advisors, Trustees, Account Managers, and Family Offices

- *Solutions for Dealing with Alcoholism and Drug Addiction in Affluent Families: What Advisors, Account Managers, Trustees, and Family Offices Need to Know*

15. Financial Managers and Dysfunctional Clients

- *Financial Managers and Dysfunctional Clients: Addiction's Effect on Staff Morale and Fiduciary Responsibilities in the Family and Wealth Management Office*

16. Family Integration Services: the Key to Successful Succession Planning for the Family Business, Foundation, and other Enterprises (with Larry Hause)*

- Families need much more than sound legal and financial planning; they also need to make sure their relationships and roles are on a sound footing for the business to survive.

17. Functional Alcoholism: Distinguishing Between Safe and Potentially Dependent Use of Alcohol and Drugs*

- Reducing risk to family wealth and well-being by understanding contemporary medical definitions of safe drinking, at risk drinking and prescription medicine use, and definitions of abuse of and dependence on addictive substances.

18. Core Needs in Wealthy Families

- *The Advisor's Role in Helping Wealthy Families Meet Their Core Needs*
  Part 1: A Developmental and Experiential Model for Advisors and Consultants
  Part 2: An Alternative Model for Planners and Consultants

H. *Lawyers and Law Firms*

19. Law Firms

- *Achieving High Recovery Rates for Addicted Attorneys, What Every Law Firm and Lawyer Needs to Know (Based on the Highly Successful Recovery Programs for Physicians and Airline Pilots)*

20. Bench and Bar Article

- *Lawyer Seeks Treatment, Boss Seeks Assurance* by Todd Scott, *GPSolo* Magazine October/November 2009

* Articles marked with an asterisk are in progress or being revised

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Author Information

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Bill is the author of a series of articles for families on improving treatment outcomes. He emphasizes the effectiveness of the highly successful pilot and physician (PHP) recovery model when applied to other groups. Bill is also an expert on the intersection of addiction and family wealth, including modifications of trust documents to account for addiction. These articles educated family members on the treatment and recovery process and clinical issues unique to affluent addicts, as well as advice for family offices, advisors and trustees. Bill is a graduate of Yale University, University of Minnesota Law School, and the Hazelden School of Addiction Studies.

The National Network of Addiction Professionals, LLC

Established by William Messinger, we specialize in working with families and their advisors facing alcohol, drug and other addictions in loved ones. We model our program after highly successful programs for pilots and physicians. Our extensive experience and training translate into unique and individualized consulting and case management services that ensure our client families receive the highest standard of care available and have the best opportunity for positive change.

We provide our clients with comprehensive support thorough assessment services, selecting and utilizing the right interventions, referral and placement with the treatment providers, and post-treatment care and monitoring. Our clients include law firms, family businesses, family business advisors, and family offices. We are available 24 hours a day to respond to your questions. Please visit our web address to review our articles for family advisors, trustees, attorneys and family leaders.

For more information, please email us at info@billmessinger.com, or call us directly at 651.209.7670. Bill Messinger can also be reached directly at bill@billmessinger.com.
Find us online at www.billmessinger.com (www.NNAP.com is currently under development).

Footnotes

[1] Readers of previous articles combining several topics on how we apply the pilot/physician model to affluent addicts have asked me to "unbundle" these articles and address one topic per article.

[2] Since pilots and doctors are required to follow all the recovery program mandates of their oversight boards, their programs can also be described as "airline and medical board recovery programs."

[3] Here is what Dr. Robert DuPont, former Director of the National Institute on Drug Abuse, said about a nation-wide review of outcomes for physicians' programs:

> *"The results: 78 percent of the physicians did not have a single positive test for any drug or alcohol use over five years of testing. Of the 22 percent who did have at least one positive test, 65 percent did not have a second positive test.* ***Where else in the addiction treatment field can you find results like that? Those results set an entirely new standard for recovery outcomes, one that every treatment program should aspire to."*** (Emphasis added.)

Why does the doctor say it sets a "new standard for recovery outcomes"? Because all other programs have long-term recovery rates at thirty percent (30%) and below. *(See Dirty Little Secrets: Why Rehab Programs Must Come Clean*, Consumers Digest, p. 20-24, May/June 2008)

- 95% success rate for NWA pilots Airline pilots soar to success in recovery. *Hazelden Voice* Vol. 3, Issue 1. THIS LINE LOOKS LIKE AN ARTICLE TITLE BUT IS NOT CLEARLY MARKED WITH PUNCTUATION

78% continuous abstinence rate at **7.2 years** for 904 doctors in Physicians Recovery Programs, *Addiction Professional*, online, 8/24/10) DITTO, NEEDS PUNCTUATION FOR CLARITY

[4] In our years of living and working with affluent families, we know of no extended family system (including in-laws) with addiction and significant mental health problems at rates of less than 20%. Many families have rates exceeding 30% to as high as 70%. However, these numbers are based on anecdotal and personal experience. The overall addiction rate is said to be 10% of the population.

[5] Family Firm Institute Brochure excerpt for 2010 Annual Conference

> "Addiction: the Achilles Heel. Preliminary research indicates that 52% of family businesses utilizing business consultants have an acute addiction issue embedded in the family business system"

[6] Satel, M.D., Sally. 2006. For Addicts, Firm Hand Can Be the Best Medicine. *The New York Times*, Aug.15.

> *A myth is that the addict must be motivated to quit – that, as it is often put, "You have to do it yourself." Not so. Volumes of data attest to the power of coercion in shaping behavior. With a threat hanging over their heads, patients often test clean.*

Goodman and Levy. Biopsychosocial Model Revisited. p. 3. IF BOOK TITLE, SHOULD BE ITALICIZED

> *Chemically dependent patients, free of co-existing mental illness, with intact jobs and family, tended to do well in rehabilitation programs if families and employers applied therapeutic leverage and support.*

Susan Merle Gordon. Relapse & Recovery: Behavioral Strategies for Change. Caron Found. Rept. 2003: p. 18.

> Internal motivation is a more powerful predictor of recovery than external motivation. Moving from external motivation to internal motivation is a long process. Therefore **it is critical for external pressure to continue** until this transition is fully underway, if not complete. The failure to follow this advice is a major cause of relapse (paraphrased from report).

Chuck Rice. Impaired Lawyers Overcome Denial, Stigma to Achieve Road to Recovery. *Hazelden Voice*. Vol. 9, No. 2. Summer, 2004.

> *My experience with attorneys tells me that long-term outcomes are dramatically improved when lawyers can be monitored and when there is an accountability system with a fair amount of external support.*

Alan I. Leshner, Former Director, National Institute on Drug Abuse. National Institute for Mental Health. *Science and Technology*. Spring, 2001: p. 2.

> *Treatment noncompliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction.*

[7] Taleff PhD, CSAC, MAC, Michael J., Irvine AA, Jamie. Continuing Care: Late Breaking News. *Counselor*. October 2009.

> *Continuing care interventions that use more direct and active attempts to bring treatment to the client through aggressive outreach (i.e., taking the treatment to the client by visiting the home, or inviting a spouse to session, or through lower burden delivery systems such as using the telephone) all had clear advantages over the old traditional approaches.*

White MA, William L. Peer-Based Addiction Recovery Support. *Counselor*. October 2009.

> *Specialized addiction treatment grew out of the failure of the mainstream health and human service system to provide effective solutions for individuals and families experiencing alcohol and other drug problems. Today, peer-based recovery support services are growing out of the failure of professionally-directed addiction treatment to provide a continuum of care that is accessible, affordable and capable of helping*

people with the most severe and complex AOD problems move beyond brief episodes of recovery initiation to stable long-term recovery.

Obernauer PhD, Lorie. Improving Alumni Relations. *Addiction Professional*. September/October 2009.

The alumni program can offer opportunities to participate in a variety of events all designed to enhance the recovery process. Recreational and social activities help the recovering addict learn to cooperate with others in new, healthy relationships and environments. Educational events, workshops and retreats can nurture critical skills not usually addressed at 12-Step meetings: getting a job (interviewing, networking, communicating with colleagues or a boss), pursuing an intimate relationship (how, when and where to meet new people, how to define and set boundaries), and getting the most out of life (learning to cook, paint or do any of those activities that always seemed so elusive). If geography poses an obstacle, these educational events can be carried out on the Web.

Hazelden Foundation Brochure

At Hazelden, we've learned from years of experience and research that patients who follow continuing care plans after treatment have better recovery outcomes than those who don't. In an extensive, multi-year patient outcomes survey conducted by Hazelden's Butler Center for Research, more than 4,000 discharged adult patients were surveyed at their one-month follow up, and over 2,000 surveyed at their six-month follow up. The data from this research show that patients who followed all or most of their continuing care recommendations were at least 30% more likely to be abstinent.

[8] The Experience of Inherited Wealth: A Social-Psychological Perspective, p. 6, Dissertation Outline, By Joanie Bronfman. This outline summarizes issues in Ms. Bronfman's 406-page thesis. For more complete understanding, refer to the thesis, The Experience of Inherited Wealth: A Social-Psychological Perspective. UMI. 1987. All rights reserved. Copyrighted material. (To order: UMI 1-800-521-0600)

[9] **The Brain Holds on to Memories of Use Long After Active Drinking or Drugging**

New research on the brain is showing that addiction is a matter of memories, and recovery is a slow and hesitant process in which the influence of those memories is diminished. It's now becoming clear that neurons (brain cells) themselves change in the course of addiction. Long-term memories are formed by the activity of transcription factors—substances that switch on the genes that manufacture proteins, establishing new and strengthening old neural connections.

Researchers are only beginning to explore the differences and similarities between drug addiction and other consuming habits. It is possible that drug addiction differs only in degree from "addictions" to television, shopping, computer games, or even biologically natural rewards like food and sex. The new brain studies are beginning to show how the capacity for choice is impaired by addiction, and why it must be regarded—and treated—as a chronic relapsing disorder of learning memory. ("Addiction and the Problem of Relapse" Harvard Mental Health Letter, January 2007)

[10] Robinson, Mary. Discipline and Disability; When is Disease a Defense? *GPSolo*. October/November 2009, presents a good summary of addiction and what is needed for recovery:

(Alcoholism has) *physiological attributes*, (and is*) also listed as Axis I mental disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association (1994). Alcoholism is often associated with a disruption of brain chemistry. Alcohol and other drugs target the brain's reward system by flooding circuits with dopamine, a neurotransmitter present in regions of the brain that regulate movement, emotion, cognition, motivation, and feelings of pleasure. The brain has inhibitory systems that can mute the stimulation of the dopamine flood, but for someone addicted to alcohol or another drug, the natural damping circuit appears to be faulty. Overstimulation by the flood of dopamine produces euphoric effects, which the addict seeks to repeat again and again, setting up a cycle of uncontrollable craving.*

Over time, the flooding causes the brain to produce less dopamine or to reduce the number of receptors that can receive and transmit signals, thereby reducing the person's natural ability to experience pleasure. Then the person has to use drugs just to bring dopamine function back up to normal, and as the disease progresses it takes larger and larger amounts of the drug to create a dopamine high. It is believed that some people have a genetic predisposition to addiction, but anyone can become an addict if sufficiently exposed to drugs or alcohol.

Brain scans of individuals addicted to alcohol or other drugs show significantly reduced activity in the areas of the brain that control reasoning and judgment, leaving the person impulsive and often unable to follow a rational course. Although there are pockets of disagreement in the field, most professionals accept that treatment for alcohol or drug dependence requires total abstinence from all intoxicants, and most prescribe long-term participation in Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or some other 12-step program. Research shows that after a period of abstinence, some areas of brain activity can return to pre-drug states.

For many drugs, including alcohol, the brain resets itself and shakes off the immediate influence of the drug within 90 days, and a gradual re-engaging of proper decision-making and analytical functions in the brain's prefrontal cortex will be seen after at least 90 days of abstinence. ***Nevertheless, it takes considerably longer than 90 days for sobriety to be considered stable.***

[11] See also, *Flawed Family Assumptions About Addiction*

[12] Stephen Davis. What I Learned About Recovery. *COUNSELOR*, The Magazine for Addiction Professionals. Vol. 6, No. 2. April 2005.
William L. White, MA, and Mark Godley, Ph.D. Addiction Treatment Outcomes: Who and What Can You Believe? *COUNSELOR*, The Magazine for Addiction Professionals. Vol. 3, No. 3. June 2006: p. 52.

[13]Bevacqua PsyD, Tony. A Dangerous Infatuation. *Addiction Professional*. September/October 2009.

As treatment professionals, we're committed to helping our clients identify their adaptive and maladaptive behaviors, understand the consequences for both, and learn self-responsibility. In this regard, whether explicitly or not, we're emulating the authoritative parenting style first delineated by Diana Baumrind in her influential approach to family dynamics. She contrasted the authoritative style with the authoritarian (obedience-oriented/punitive) and permissive (lax or indulgent) styles, both associated with weaker outcomes for fostering autonomy, self-efficacy and psychological well being in youthful development. Over the ensuing decades, the authoritative style has been consistently linked to better social adjustment and fewer behavioral disorders in teens and adults. In contrast, both the authoritarian and permissive parenting styles have been repeatedly tied to greater frequencies of problem behavior, including substance abuse. In a variety of ways, celebrity addiction culture undermines the I THINK THERE IS SOME TEXT MISSING HERE!

Little, L., & Girvin, K. (22). Stages of change: A critique. *Behavior Modification,* 26, 223-233.

...it is important to distinguish readiness for change from readiness to participate in a particular treatment; …. Indeed, some barriers to treatment participation are not related to client motivation or readiness for change. Ryan, Plant and O'Malley showed that intrinsic and extrinsic motivation for alcoholism treatment have different relationships to treatment participation and outcome…. Feelings connected with behavioral problems and with the prospect and processes of change (depression, anxiety, fear, etc.) are likely to influence readiness for change and the change process. Ripple, Alexander, and Polemis described motivation as a balance between discomfort and hope…

…Rather than a progression through stages, change can come about swiftly, often as a result of life events or external pressures. The change process is likely to vary, depending on whether motivation for change is internal or external and whether a pharmacological dependence is present.

From, Flores, Not God IF 'NOT GOD' IS A BOOK TITLE, ITALICIZE

Therapists must learn that treatment of addicted individuals requires the recognition that they cannot treat these patients alone – "that addiction is too deeply entrenched, the patient too alienated." "Unlike traditional forms of psychotherapy… addiction treatment requires an "emphasis on groups and the self help movement." p. 382….

An important aspect of relapse prevention is finding effective and influential ways to persuade addicted individuals it is not in their best interest to return to drugs and alcohol. ***Logic and reason alone will not accomplish this task.***

….This requires more than just appealing to the addicts and alcoholics to give up alcohol and drugs; it demands they relinquish old sets of attitudes, behaviors and even friends associated with addictive lifestyles. p. 387

[14]There is the concept of "homeostasis" for an addict, meaning that an addict will establish a stable environment for his/her drinking or using that allows for a functioning lifestyle. An event may occur to destabilize the situation, such as near overdose, death of a using friend, DWI, or obviously unacceptable behavior in a family, social or business setting. Even if the addict enters treatment, because recovery is so difficult, the addict's goal will be to return to homeostasis. The family's goal must be to prevent that – keep the pressure on to stay the course.

[15] Hennepin County, MN DWI Court, Jan. 2010

[16] See, *Achieving High Recovery Rates for Affluent Families* and *Addiction-Treatment-Recovery Basics*

[17]See, White, William L., MA. Recovery Management and Recovery-Oriented Systems of Care. *Counselor Magazine.* February 2002.
Kelly, Dr. Tim. Recovery Management Tools Help Prevent Relapse. Highlights of the American Bar Association Commission on Lawyer Assistance Programs. Volume 9 Number 1 Winter 2006.
Pedersen, James M. Erasing Misconceptions About Enabling. *Addiction Professional*. January/February 2007.

[18] Financial Managers and Dysfunctional Clients.

[19]For out of control addicts on the loose, families must stay engaged with these addicts and not wait for them to "hit bottom" on their own (the latter advice given by many interventionists, family programs, and Al-Anon, is not a successful strategy). Instead, families must do what is necessary to remain in contact and find ways to encourage the addict to get help. For affluent families, this may mean assembling a group that includes a knowledgeable addiction

professional, private detectives, lawyers (to use the legal system, if feasible), sober companions, and a "go to person" in the family who can authorize expenditures and actions. If the addict is holed up in a hotel room or resort drinking and using, living or driving around town with her dealer, smoking crack at the crack house, or wandering the streets, using heavily, overdosing or otherwise at risk, **the family must go after the addict** (or hire professionals to do so). We emphasize this point in every article because too many families are being given misinformation about what to do under the circumstances described in this footnote. No family has regretted doing too much when a loved one dies from addiction or addiction related complications. Many regret doing too little.

[20] Black, R. (2010, January 07). Casey Johnson, Redmond O'Neal, IS SOMETHING MISSING HERE? YOU MAY WANT TO CHECK THIS FOOTNOTE, IT DOESN'T SEEM TO MATCH UP TO THE REFERENCE IN THE TEXT other drug, alcohol addicts fail rehab more often than not: experts. *NY Daily News*. www.nydailynews.com/lifestyle/health/2010/01/07/2010-01-07_why_dont_rehabs_work_for_drug_and_alcohol_addicts_like_casey_johnson_redmond_one.html

[21] Available on our website, at www.AureusInc.com)