



How We Work & Why It Works

A Manual for Clinical Staff
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Things to always keep in mind...

Our Mission: ...helping put lives back together again

Our Vision: A healthy community---one made up of individuals and families of every background, empowered to live, work and enjoy life to the fullest, with esteem for themselves and respect for others.

Our Values:

- *Diversity:* every sort of person is welcome at Vitanova
- *Inclusivity:* everyone who comes is allowed to participate in meaningful ways
- *Equity:* everyone is treated fairly
- *Professionalism:* everyone is treated with the respect expected from trained staff
- *Accountability:* confidentiality is respected, decisions are responsible and transparent
- *Service Excellence:* programs and services are effective
- *Collaboration:* teamwork is valued by staff and volunteers, as are partnerships with other community organizations
- *Accessibility:* individuals and groups facing systemic barriers to health care are especially welcome at Vitanova
- *Innovation:* Vitanova is creative when it comes to meeting client and community needs in a cost effective manner.

Whom we work for

Even if our pay cheque says “The Vitanova Foundation”, the fact is we work for a very particular subset of the population---substance users, abusers and addicts (and their family members and friends). And these clients have certain rights (see the inside back cover of this manual) of which staff must always be cognizant. Clients also have a whole range of interim and long-term goals they seek to achieve as they participate in Vitanova’s programs---goals enumerated in the clients’ code of conduct, developed by the clients themselves in 2014. (By the way, the code is a fount of topics for discussion by clients and their primary counsellors). Lastly, our work is informed by a mission, a vision, and a set of values shaped by our entire stakeholder community.

The clients of the Vitanova Foundation range from the pre-teen children of adult users to the latter’s aging parents, with the bulk being non-recreational habitual users, abusers, and addicts.

The typical client is male, around thirty years of age, a user of a succession of illicit drugs for between eight and ten years. Depending on his drug of choice at entry, he evinces a range of feelings and attitudes. Heroin users tend to be unaggressive, apparently seeking relief from a usually unspecified pain. Cocaine users are given to grandiose thinking and posturing. Crack cocaine use has different effects on different people---but in most every case it brings out the worst in them, full of anger and sometimes an almost savage hatred. Alcohol users seem to lack courage to face the world; if drinking doesn't give them such courage, it certainly lowers their inhibitions in confronting it. The ecstasy user seems to have little of real accomplishment in his life, and less hope for the future; so he looks to have fun "right now". Hence, the association of ecstasy and "raves". Marijuana use seems to blur reality slightly, making it commensurately more acceptable to those who often find it otherwise.

The typical client, at entry, will---readily or with not too much probing---provide a reason for his substance use/abuse/addiction. Whether that reason is physical or sexual abuse, parental disinterest or hostility, flight from "boredom" or pursuit of "excitement", this information must be noted, and be the point of departure for any program of treatment and rehabilitation. The client has to unlearn the behaviour that has sustained him up to entry and, at some point, decide how it is he wishes to live the rest of his life.

Getting Started

The initial interview provides a number of opportunities to assess a potential client's readiness for recovery by way of:

- evidence that the interviewee is "tired of being tired" due to homelessness, lack of money, trouble with the law, damaged interpersonal relationships---particularly with family members or significant others of long standing
- evidence of mental or physical disorder (e.g., schizophrenia masked by illicit drug use, violent tendencies, serious liver damage due to alcoholism---all of which might require referral to alternative settings, better suited to addressing these issues)
- evidence suggesting where the prospective client sits along the substance use/abuse/addiction continuum. Thus an occasional user might best be served by a course of outpatient counselling; an abuser (whose family can be enlisted in monitoring his activities while he remains resident in the family home) by attending our day-treatment program. A homeless individual who is seriously addicted would necessarily require domiciliary shelter on the premises.
- evidence of readiness for recovery. This includes the desire to

lead a drug-free life, to “belong” somewhere, to “connect” to one or others who care about them, along with some degree of “mobilizable guilt”----a conscious sense of genuine regret for the consequences to himself and others of his past behaviour.

- evidence of a lack of readiness for recovery. This includes being forced into a recovery program by family or the courts, the absolute inability to resist any form of “temptation” to use again, extensive history of crime-driven street life.

The tone of the interview as set by the interviewer should be calming to the prospective client. Addicts don’t respond to hysteria, but to a level, caring voice. Swearing at them, belittling them, scolding them is counterproductive. Insults directed at the interviewer on the other hand should be noted, but any engagement of the client at this level of his defenses will suggest what the interviewer has to offer is no better than what the client gets from most everyone else. The fact is most addicts rationalize their behaviour by saying no one cares for them. Emphasis must be placed on the fact that future, not past behaviour will be the basis of any judgment made of the client once admitted.

Staffing for Success

The initial interview is designed to collect the sorts of evidence listed above. If, on balance, admission is advised, the client’s connection to the agency will in future be marked by dealings with a variety of individuals in a range of staff positions. Selection of staff members is thus a key consideration in ensuring that connection is productive of recovery.

Working at Vitanova is not just a job. It requires a particular attitude on the part of staff to the client populations, because such populations are by definition not accustomed to abiding by rules. They cannot be “handled” by merely demanding that they conform to a set of rules. They have to be educated to such respect of the rules, and there is nothing magical about that. It takes time, it requires patience, and yes, at times it means being flexible in the application of rules, because the process of building respect for rules is difficult at best, and extremely difficult when dealing with individuals who have been breaking rules for most of their lives.

Potential staff must first demonstrate clinical knowledge, augmented by training in the field. The latter is critical in providing staff with a repertoire of appropriate responses to the wide variety of behaviours which can be expected from this client population. Experience teaches that inflexible responses often result in the “pressing of the wrong buttons”. Thus, if a crisis arises at 5 p.m., at the end of a staff member’s shift, he cannot go home without dealing with the matter. This requires an empathy for the client who, by virtue of his addictive personality (including attendant shame and guilt), will act in ways which do not encourage empathy. These clients can be quite unreasonable and eminently untimely in their

demands, but the staff member must be able to see the human being behind the behaviour. We are not working with a human being who acts that way naturally, but one who is, by virtue of his addictive past, given to such behaviour, and we have to reach behind the behaviour to touch the person inside, underneath, buried beneath that behaviour.

Thus, the most basic quality needed by staff in this setting is a belief that the client can recover---a belief that the client might not at first share. And this is of critical importance: as long as staff believe in the possibility of recovery for the client, the latter will cling to that belief as if it were a lifeline---sometimes without even being conscious of the attachment.

For this reason, the so-called treatment approach known as “tough love” is highly problematic. Tough love---“breaking” the client by threatening them with discharge---is not treatment in the sense of improving the client’s commitment to positive change. As an alternative, at Vitanova we offer genuine care with firmness, an iron hand in a velvet glove. The problem comes in interpreting rules as laws rather than guidelines. The breaking of rules is to be expected from addicts who are by definition rule breakers. Do we expel them for infraction of the rules, or do we work with them, to promote understanding of the patterns of their behaviour and why such behaviour is inappropriate?

By way of example, let us suppose that an accomplished thief comes into treatment and within a week steals two quarters. Are we to be surprised that he stole? Are we to expel him for breaking the rules---even in so minor a way, when he’s been breaking the law in major ways for years? How many such people can we really help if we are not prepared to accept them for what they are and work with them.

Indeed, on what grounds would any staff member think that our threshold is so sacred that simply by crossing it our clients would recover? If that were the case, would it not make more sense to employ only a doorkeeper, to charge a fee for the right to cross that magical threshold, which money could then be dedicated to some other worthy cause?

Intake and Assessment

The first staff member that the client meets upon acceptance into the agency at the end of the initial interview is an intake and assessment worker whose task is to collect every sort of information on the client. On the basis of information collected at intake and assessment every client---in cooperation with the intake/assessment worker---creates an individualized treatment plan which he signs, as evidence of his commitment to it. Treatment plans specify in which program or programs the client will participate, the sequence of such participation, and the individualized options to be pursued within each. Thus, for example, a teenager who has entered the program because his parents

refuse to permit him to live any longer in the family home, may be admitted to the domiciliary program and the day treatment program simultaneously, on the understanding that when he has made sufficient progress he will be permitted to return home, that he will continue in the day treatment program thereafter, and that he will, once he has gained a full-time job, attend an evening relapse prevention group (i.e., aftercare) on a once-a-week basis for a minimum of eighteen months. Furthermore, while in the domiciliary program he will take on progressive responsibilities in one or other area (to develop generic life and job skills), and while in the day treatment program as well---perhaps leading a group of clients in the preparation of one lunch each week. As should be clear from the above, effective treatment cannot be provided in 21 or 28 days; it depends on the unique needs of each client.

Ensuring Recovery in Day Treatment

Constancy, punctuality, and a willingness to “stay with the program” over evenings and weekends are all signs of successful recovery-in-progress among day treatment clients who, by definition, reside elsewhere than on the premises. These qualities speak to an ability to maintain a secure footing in two worlds without losing one’s way, to take direction about time away from our premises---including instructions for reconnecting with family, doing chores with them, socializing with them (perhaps---by way of example---visiting married siblings rather than going to a bar). Choosing new friends--people with whom you have something in common other than drugs is, of course, a critical indicator of success in the day treatment program.

It is important to teach day clients how to focus their energies on productive activities, in order that they not have time to focus on their residual cravings. Hence, time left over in the treatment program after weekly individual counselling sessions and daily group sessions is devoted to activities which generate clear results---a garden bench built in the woodworking shop, a lawn mowed and nicely trimmed, a room painted. Order is constructed on the outside, to reinforce the new order being built inside.

Alternatively, certain behaviours raise warning flags, questions whether the client is making any progress in day treatment recovery. Among these we can include bringing in drugs for those in the domiciliary program, and using drugs themselves. Day clients caught doing this (after urine testing) are immediately suspended and referred to a detox centre, as a condition for readmission. If they used “just a little” between daily visits and aren’t high on arrival, they are counseled, any privileges they may enjoy are suspended, and they are assigned some less-than-pleasant task as a consequence. We still insist on detox for the sake of other clients. They can usually tell that the client in question has used, and such awareness can very well threaten relapse in the others.

Ensuring Recovery in Outpatient/Evening Treatment

Signs of success are slower in manifesting themselves in outpatient/evening treatment clients (those who come on average once a week for a group meeting and perhaps an individual counselling session). These clients tend to be occasional “bingers”, and given their more tenuous connection to the treatment process, relapses are much more common. The goal of treatment is to reduce the frequency of relapse and increase the length of time between each occurrence. Thus, for instance, progress can be seen if a client returns within a week of relapse instead of a month, if he binges for only one night instead of an entire weekend. Key to changes in this case is again the choice of new friends who do not use drugs.

If bingeing continues without any of the incremental improvements mentioned above, due to a refusal to make use of any of the suggested strategies, referral to some other treatment centre might be advisable.

Ensuring Recovery in Domiciliary Shelter

Ideally, the domiciliary client is prepared to detach himself from the outside world and ready to focus on his recovery twenty-four hours a day, seven days a week, for a minimum of three months. While a shorter length of time may be sufficient to complete a full “detox” (ridding the body of the physical addiction to a drug), it is insufficient to effect and solidify changes in lifestyle and attitude sufficient to preclude future relapse. Key to this process is the ability to forgive oneself of the harm done to one’s own life and the lives of significant others by serious drug use. To achieve such change, clients must spend time in an environment which accepts them for what they have the potential to become rather than for what they have been until then. This is the foundation for the building of the degree of self-esteem which will prevent relapse. As with day clients, it is important that the client focus on productive activities which are sufficiently engaging to preclude sustained periods of craving.

The most difficult domiciliary client is one who undermines the safety of his peers through real or threatened violence, and he is best referred elsewhere, to a facility equipped to handle such individuals. Those who threaten domiciliary clients in other ways need not be, providing the situation they present is workable. For instance, a client who brings in drugs to share with others must be confronted, penalized, and assuming he accepts the penalty (and after being detoxed off-site), he does not repeat the offense. If the offense is repeated, discharge is advised with the offer of readmission at a future date when the client is prepared to accept direction. Attendance at day treatment might be acceptable on a provisional basis, or if success is not a reasonable expectation, outpatient counselling may be advisable. An example of a workable situation would be one in which the client evidences an

understanding of the danger he has posed to others, and is prepared to accept the loss of privileges.

The nature of addiction is to want drugs, and at early stages many domiciliary clients---denied access to the “outside world”---will do anything to obtain them. Hence, an extra effort must be made to see the signs of potential relapse and deal with the matter before relapse is attempted. An example is perhaps instructive, one which occurred during the course of one of our annual open houses---a day when our facility is open to the public, including the families of clients and the local community, a day of games and entertainment. I happened to notice that one domiciliary client was listening intently to the performance of some musicians. As I looked at him from a distance, the expression on his face told me he was “jonesing”---experiencing cravings and thinking who from the public could get him some drugs. I walked over to him and asked him how he felt. He said he didn’t feel grounded. So I asked, “If I put my arms around you and pull you down with all my weight, will that ground you?” He hugged me and told me it would. The jonesing ended.

Rules, Relapse, and Readmission

Relapse is, of course, a violation of the rules. It is also a phenomenon one must reasonably expect given the addictive nature of drugs (both physical and psychological). What is important is to understand that losing a battle (seeing an addict relapse) is not the same thing as losing a war (seeing an addict give up entirely on recovery and return to the drug life). What is critical is the judgment that must be made as to whether a relapse is a step backward on the road to recovery or an indication that the client is permanently pointed in the opposite direction. It is important to acknowledge that the client who decides to relapse does so because he is still addicted to drugs (in the psychological, if not the physical sense) and thus is not capable of making an entirely free choice. This inability evidences itself in most areas of the client’s life. For example, when to go to bed. Left to his own devices, the client will go to bed at 4 a.m. as readily as 11 p.m., or 11 a.m. for that matter! The need for rules and regulations thus reveals itself: order must first be imposed from without, before it can be exercised from within. And hence the requirement that changes be made in the client’s physical appearance---no body-piercing jewelry, short rather than long hair, etc., so that when he looks in the mirror in the morning he does not see the person he was when he was using drugs.

What Constitutes Recovery

When has a client recovered? When is a client ready to leave the program (in the case of Vitanova, when is the aftercare provided in the outpatient/evening treatment program complete?). When he has healed. That is, when he has learned to live according to life’s rules, when he demonstrates that he can apply what he has

learned; and when he can apply what he learned by teaching it to others. The risk of relapse is reduced when the client understands his own reality---just as the diabetic knows that his insulin must be balanced. The addict needs to know that one relapse is too much, a thousand is never enough. He must accept the reality that he cannot test himself, and that he must avoid all the triggers which formerly led to drug use. Memory is thus the key mental function in recovery, to prevent the client from returning to those situations which led to drug use; and to know that he must replace those voids with real things.

In this regard, he may be clean for a year but still have what is called a “using dream”. That may be a daydream of sticking a needle in their arm, of remembering the euphoria and not the attendant consequences (loss of wife, family, or job).. In a very real sense, the client cannot be drug free until he learns to hate what it cost him. He needs to associate drugs with the worst experiences he had when he used. Sometimes he cannot reason it through; he must just use his willpower---if only for ten minutes or maybe even an hour. His brain is like a television set and he has to know when to change the channel.

General Conclusions

Successful treatment must provide both discipline and healing, with an emphasis on the latter. But without discipline, healing is impossible. By nature the addict lacks self-discipline. He lives in a world in which physical and psychological needs are not filtered by rational choice. He is oblivious to the system and what it requires. He does not question his actions, nor think of their consequences. Put a plate of pastries in front of an addict and he will eat them all. The concept of sharing, having had enough of a good thing, stopping short, does not occur to him.

Healing is what solidifies recovery, and ends the need for an imposed discipline. It is however the most difficult part of the process. Once off of drugs, the client begins to “remember” his past, and he must begin to deal with those issues which he could not face at one time, and which he avoided by turning to drugs. Depending on his “roots”, the healing process will vary. If the addict comes from a “good” family, which taught the “right” lessons before the child went to drugs, he’ll have a lot easier recovery, all other things being equal. If the client’s parent engaged in unethical, immoral, or illegal behaviours, and if that was a model the parent provided to the client as he grew up, the clients must be taught another model, making the healing process lengthier. It is particularly lengthy for those clients who made money by pushing drugs on others.

The Secret of Success

The secret of success in treating an addict is to have the strength to endure him, until he begins to understand that strength and wants

to make it his own. Enduring him means being his mirror, reflecting him to himself, until he begins to understand his situation, and knows that he need no longer be a prisoner of that situation.

Putting This Manual Into Practice

- Remember, Vitanova exists to serve its clients, not to provide us with employment
- Our client-centred, holistic, “wrap-around”, “whatever-it-takes” approach is what distinguishes us in our field
- Our reputation for dedication---as acknowledged by United Way awards and the comments of the 2016 accreditation review team---should be demonstrated each day.
- Our work is to build on our clients’ strengths, to help them conquer their weaknesses. Rather than simply “coming down hard” on one who breaks a rule (surely the easiest of responses), we need to make that extra effort to create teaching moments for our clients, perhaps around some specific direction in the clients’ code of conduct (after all, they wrote it) that applies when a specific rule is broken.
- The goal is always to deepen each client’s sense of personal autonomy and responsibility, the conviction that he---and not his addiction---is in control of his life. That, after all, is the proof of recovery.