Meeting Clients Where They Are At
and other fairy tales

(or, the credibility crisis in the SUD prevention, treatment & recovery industry)

Jeffrey Quamme, MS, AADC, CCS, CNE, CNC
Executive Director
Connecticut Certification Board

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DISCLAIMER

The views expressed come from over 30 years in the field from entry level positions to executive leadership. They do not necessarily represent the views of the Board of Directors of the CCB.

If you were in any way offended, don't blame them, blame me.

2

A special thanks to…

Dr. Carl Hart	Maia Szalavitz	Dr. Bob Lynn
Dr. Hart takes a very adversarial position against the treatment and criminal justice systems.	Ms. Szalavitz openly challenges the overall mindset of the field as it relates to dependence and recovery.	Bob demands outcome data from providers that make claims of a more effective treatment experience.
		

And also to…

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Critical thinkers everywhere!

The truth is…

We must be honest that the field needs continuous improvement and we must also be honest about our challenges.

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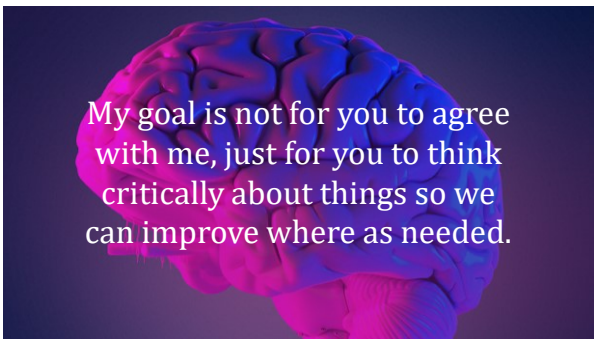

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Additionally

We need to partner with other behavioral health providers to address the multiple needs of those we serve and **recognize that their view of us as a profession is not especially positive.**

Most of this is our own fault!

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"The great enemy of truth is not the lie – deliberate, contrived and dishonest, but the myth – persistent, persuasive and unrealistic."
John F. Kennedy

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What evidence says

The industry has not had a significant improvement in outcomes in 45 years. That's 1976

(more to follow)

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In the same amount of time…

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Credibility Concern #1

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EGO

Our most pressing issue

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Unchecked Ego can be destructive

Materialism
Trap one in the past
Inferiority complex
Limitations and scarcity
Self-sabotage
Stoicism
Reaction versus response
Limits abilities and productivity

Nguyen, 2014

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- Personal opinions become fact
- Boundary issues
  - Believing that the role fills some sort of reciprocity of need
  - Self disclosure of recovery status
- Professional's moral system supersedes that of the service recipient
- Biases against other forms of service (medications, drug courts, harm reduction, etc.)
- Measurement of client against the self
- Uninformed/unskilled use of self
- Lack of awareness/rejection of research and emerging models of care
- Belief that one's personal experience (and response) is universal
- Equate personal experience with expertise or omnipotence

The Trap of Ego on the Individual

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- Lack of interest in learning about other organizations
- Outdated policies and procedures
- Lack of support of the professional development of staff
- Failure to coordinate with other service providers
- Adversarial community relations
  - "We're here, get used to it"
  - Become bad neighbors
  - Failure to respond appropriately to NIMBY issues
- "We've always done it this way"
- Clinical supervision as administrative supervision OR as therapy
- Lack of response to client-presented issues
- Poor staff treatment
- Organization focused as opposed to recovery focused
- One size fits all

The Trap of Ego on the Organization

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CHANGE IS SCARY. PERHAPS ESPECIALLY WHEN IT IS GOOD FOR US.

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The organization is a role model for those served: willingness to change must be present before asking others to change.

Change management matters.

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The focus on doing it "our" way makes it nearly impossible to meet the client "where they are at."

Actual examples I have witnessed:

- "I've been there, I know how to do it right."
- Discrediting the work of other leaders based on personality or individual point of view
- Libelous commentary
- Claiming work that is not their own
- Exaggeration of impact and self importance
- "My view is not only better, but the only right one"
- Focus on their legacy rather than service
- Greed
  - Financial
  - Appreciation
  - Power
- Assumes and expresses pre-eminence with peers
- Myopic view of issues
- Cult of personality
- Belief that they can actually get back what was lost

The Trap of Ego on Leadership

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Examples of problems with EGO

- Focus on one's legacy instead of what is the right thing to do for the client
- Defensiveness or criticism when differing opinions are offered
- Feeling threatened when an individual chooses a different route than what we prefer.
- Failure to learn from mistakes because it's never our fault: "The client just isn't ready" or "They haven't hit rock bottom."

What others do you see?

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Healthy Ego: Yale Professor Dr. Kathleen Carroll (1958-2020)

- Significant research on the effectiveness of Cognitive-Behavioral Treatment (CBT) on many populations, including several specific to those with SUDs.
- Strong advocate of CBT in SUD treatment
- Recently completed a study where the use of CBT with certain population showed little or no efficacy
- Published the research although it put into question some of her previous work and beliefs
- Stands by the study done by she did with her colleagues, and wants to understand the findings better

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Recovery Humility

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Real game changers don't need to brag, their work speaks for them.

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The focus on ourselves and our accomplishments makes it nearly impossible to meet the client "where they are at."

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Credibility Concern #2: Separation of Personal & Professional Roles

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"Does the work I do support my recovery?" (Reciprocity of need)

"Do I use my recovery as a (primary?) tool to build a therapeutic relationship?

"Do I downplay the power differential?" ("are my clients my peers?")

"My story is important to my clients." "I know just how you feel?"

Separation of Personal & Professional

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If those are things we say, then our boundaries stink!

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"Does the work I do support my recovery?" (Reciprocity of need)

- That applies to a sponsor in a 12-step fellowship, not to a professional role, be it clinical or non-clinical
  - We are helping people follow the path that they choose, it is not our path – the experience is theirs through their eyes
  - That is not to say that we don't learn about ourselves by doing this work, but it must happen organically and not be part of our focus
- Our job description does not say "work on [your own] recovery!

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Do I use my recovery as a (primary?) tool to build a therapeutic relationship?

Similar experiences do not equal sameness

Relying on this shortcuts the therapeutic relationship:

1. We fail to build the relationship based upon your interactions in the here and now;
2. Our clients don't learn to effectively build relationships

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"Do I downplay the power differential?" ("are my clients my peers?")

Bottom Line: The power differential exists as long as we are in the role of the professional, whether we recognize it or not. The client sure does!

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"Do I downplay the power differential?" ("are my clients my peers?")

- Look at all the hoops they have to jump through just to see us
- Do we have appointments with your peers?

30

"Do I downplay the power differential?"
("are my clients my peers?")

Those of us who recognize and accept this differential can manage it better than those of us who fail to see it (or even deny it)

THOSE WE SERVE ARE NOT OUR PEERS – IF THEY ARE, THEN WE HAVE NO BUSINESS SERVING THEM AS A PROFESSIONAL.

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"My story is important to my clients."

You'd be surprised at how disinterested our clients are about us, especially early in our relationship. When do so many tell clients their stories? The first session!

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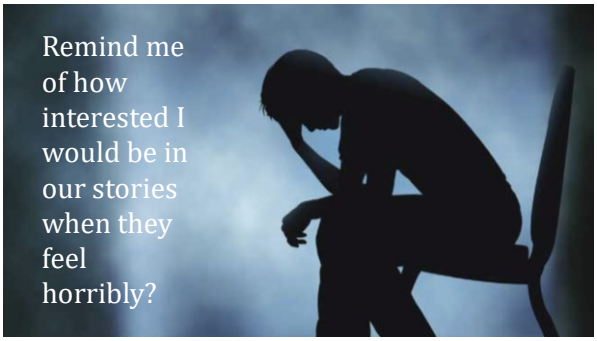

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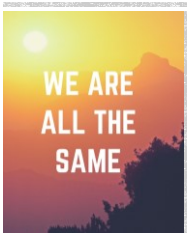

Universality of Experience

Credibility Concern #3

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Who are these women and why are they here?

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Jessica	Jacqueline
Easygoing until she has had enough…	*Driven, planful, aware of emotions in the moment*
Couldn't wait to marry her spouse	*Put off marriage as long as she thought she could*
Content to let her spouse be head of household	*Absolutely the head of her household*
High school teacher and coach	*MBA in Business Analytics*

They are my nieces, so be nice!

- Monozygotic twins
- Parents married 40+ years
- Grew up doing everything together
- Both played basketball in college
- They live 1/4th of a mile from each other

NATURE AND NURTURE ARE THE SAME

37

"I know just how you feel?"

NO WE DON'T!

We all experience emotions and physical sensations differently.

To assume anything else is disrespectful.

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The focus on ourselves (whether conscious or not) makes it nearly impossible to meet the client "where they are at."

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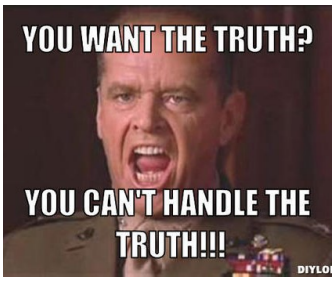

Our lived experience only tells us about how WE dealt with specific issues and situations

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Misrepresenting

Credibility Concern #4

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Fact:

Self care is crucial to remaining effective in the work that we do

HOWEVER

The way we go about it is often problematic

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We often talk about self care like there is some magical procedure that we do…we even cancel appointments because "I need time for self care."

Misrepresentation and Exaggeration of Self Care

43

We are willing to put part of our client's recovery process ON HOLD to meet our wishes…yet we won't admit that we struggle with issues like countertransference.

Misrepresentation and Exaggeration of Self Care

44

Emotional Intelligence Allows Us to Manage Our Stress ALL DAY/EVERY DAY!
(and it doesn't interrupt our client's recovery process)

45

Emotional Intelligence

It also helps us become better role models for our clients as we are aware of where we exist in the moment…

Weisinger (2006)

46

Emotional Intelligence

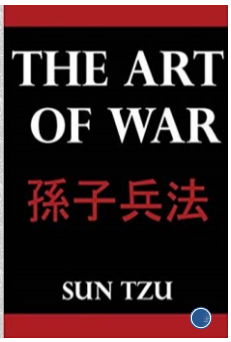
Takes into account that you are unique in your needs and is not a prescribed set of rules or a to-do list.

Weisinger (2006)

47

"If you know your enemy as you know yourself, you will not fear defeat in a thousand battles."

1. The enemy is the substance use disorder (not the individual suffering)
2. Knowledge of SUDs and treatment is not enough
3. To be successful in this battle, you must know yourself - or as Dirty Harry has said "A man's got to know his limitations" (yes, he said man, of course it's sexist, its from the 70s!)
4. Skilled and emotionally intelligent professionals perform better.



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Credibility Concern #5

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Failure to Respect Job Roles

The ridiculous ongoing "battle" between 2 sectors of the industry:

Those with advanced education

"There's more than telling someone to do 90 in 90"

Those with recovery histories

"You can't learn this in a book."

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In Reality

Both statements are true, so let's clarify roles and cross train so that we respect each other and work together for the good of the client. The finger pointing has got to ***stop.***

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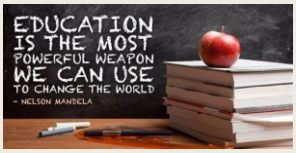
Education System

There are very few graduate clinical education programs that address the needs of the SUD workforce, and what's worse, the field isn't demanding more.



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Advanced Education

Even with graduate level education, competency in working with individuals with SUDS is absolutely necessary – but many of those professionals balk at that requirement.

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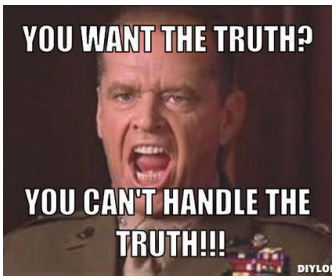

Lived experience does not itself qualify someone to be a substance use disorder professional.

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No job description lists "be a person in recovery" as its sole responsibility.

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Job Responsibilities

- Establishes positive, trusting rapport with patients.
- Diagnoses and treats mental health disorders.
- Creates individualized and measurable care plans according to patient needs and circumstances.
- Meets with patients regularly to provide counseling (using appropriate evidence based practices), treatment and adjust care plans as necessary.
- Conducts ongoing assessments of patient progress using measurable standards.
- Involves and advises family members when appropriate.
- Refers patients to outside specialists or agencies when necessary.
- Maintains thorough records of patient meetings and progress in an objective manner.
- Follows all safety protocols and maintains client confidentiality.
- Contributes to practice by accomplishing related tasks as needed.

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The Advocacy Perspective Credibility Concern #6

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The Advocacy Perspective

It is nearly impossible to advocate for an industry when we can't even figure out what needs to be done or who should do it!

58

There are few consistencies in what specific roles require or even the terms used (Recovery Coach, Peer Specialist, Recovery Navigator)

Clinical roles do not require a Master's degree (unlike other behavioral health fields)

There are battles between roles (most recently, the American Society of Addiction Medicine has pushed for physician driven treatment)

There are few consistencies in what specific roles require or even the terms used (Recovery Coach, Peer Specialist, Recovery Navigator)

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And most importantly

We ignore research and are content with the status quo.

We'll get back to this…

60

We Need to Get Our House in Order

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In God we trust, All others bring data.

W. E. Deming

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And our data either:
1. Is non-existent, or;
2. Flat out sucks

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Credibility Concern #6

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Stigma Marginalizes

Both

&

65

Putting a face on recovery is just the beginning and not sufficient to elicit change

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This is one of my heroes, Larry Kramer

He started by putting a face on those who have AIDS, but didn't stop there. He fought for money for research, laws against discrimination. Increased prevention efforts and better treatment options.

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He is responsible for millions of individuals with HIV being alive and healthy today. For those who died from the disease, he fought for their dignity. He did most of his work during the Reagan and Bush eras, when the rights of LGBT persons were ignored and the common belief was those with HIV were dispensable.

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He planted a tree from which he would never enjoy the shade. Even when things improved, he demanded better.

We share that responsibility for our field.

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Outcomes haven't changed in 45 years, but we continue to do the same thing

71

What does the basic text of Narcotics Anonymous (1981) call doing the same thing over and over and expecting different results?

72

So it's somewhat ironic that…

73

74% of all treatment programs worldwide are 12-Step based.

(Do you see the irony?)

74

The fellowships…

- were never designed as treatment.
- are impossible to get an accurate set of outcomes from (why? They aren't treatment or designed to be professionally led)
- work for some people some of the time.
- do not meet people where they are at
- Are self sufficient and an outstanding option for someone who chooses that recovery path
- Don't ask treatment providers to serve as "boot camps" for them

75

The fellowships as treatment:

Violate at least 3 traditions:

7. Every AA group ought to be fully self-supporting, declining outside contributions. (Treatment centers are paid for with insurance and client fees)

8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers. (Clinicians running 12 step groups as part of their job; or as part of their own recovery as well)

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

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So if the treatment world hasn't had significant outcome improvements in 45 years, and 74% of treatment facilities across the world are 12-step based organizations

WHY HAVEN'T WE CHANGED HOW WE DO THINGS???

77

BECAUSE (some reasons)

- Slogans are more important that research.
- Who is developing and operating so many of these organizations? *Individuals who found their own recovery through a 12-step fellowship.*
- Failure to fully grasp the idea of multiple pathways or the value in meeting people where they are at

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To be clear

- **12-step fellowships are fine as they are – as fellowships**. Any words to the contrary are incorrect. They are not for everyone nor were they designed to be.
- "It works if you work it", so what's the big deal if someone doesn't want to?
- "If it ain't broke, don't fix it" – the fellowships ain't broke but the treatment system is. Bastardization of the fellowships for treatment purposes have not worked for most people.

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We don't do a good job of measuring outcomes for a very simple reason

We (at present) don't have to.

- Neither of the two major accrediting bodies (JCAHO or CARF) have standards that require outcome measurement, only a follow up tool. There are no consequences for those with lousy outcomes.
- Shatterproof, which has developed its own "National Treatment Quality Initiatives" designed to "transform the addiction treatment system" make no mention of outcomes.

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This is by no means a complete list nor is it meant to offend. It's just reality. We need to work hard to establish our credibility in the field.

We have to change our narrative so that when you identify your profession, the first question is not "Are you in recovery?" We have to put the work in on our professional development.

However, if something I said did offend you…

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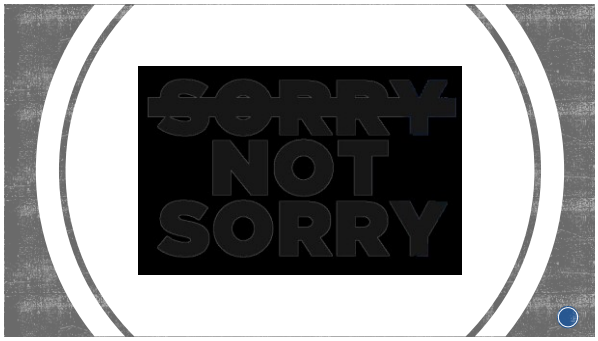

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Again, I don't expect or want you to agree with me…I simply want you to look from a different perspective.

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When clients struggle, do we ask "what could I do differently?"

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Thank you all for allowing me this opportunity

Jeffrey Quamme, MS, CNE, CNC
Executive Director, Connecticut Certification Board
JQuamme@ctcertboard.org

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Coming in July

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