

An Overview of Policy



At Sunshine Coast Health Center, an intentional effort is made to simulate real-life situations by getting clients to actively work through their issues rather than just talking about them in a hypothetical way as part of a therapy session. Clients at Sunshine Coast are asked to experience the real world as much as possible by challenging clients to:

1. have fun through off-site programming and activities i.e.) clients are often challenged in real life to learn to have fun and bond with others without mood-altering chemicals.
2. interact with family members outside of family program with leaves and during the Sunday afternoon portion of program so that they can practice the new communication skills they have learned. If clients are triggered and upset, then they have some “real-life material” which is reflective of where they are currently at emotionally in their recovery to work through with their Masters level trained therapist.
3. work through down-time by confronting their issues of boredom and restlessness. We want them to be bored and do not overschedule them particularly on the weekends because this is a huge emotional trigger and high risk situation that clients will have to work through especially if they are in a career with long hours or overtime followed by down time in places that lack recreational opportunities.

The experiential-focused program at Sunshine Coast is something that has taken a lot of time and consideration to design. This has involved more staffing time to work through teachable moments and the upset that clients have facing real-life emotional triggers and high risk situations. Also we have had to increase our counsellor competency with the multi-dimensional, complex issues that our clients are working through in their lives. We also have a motivational element in which we want clients to feel empowered working through real-life issues so that the goal is to develop skills that will serve them well in life well beyond the immediate treatment experience.

1. How do you deal with clients who have relapsed while still in treatment?

There are two guidelines. First, if the client used on site, then there is a good chance of his being discharged. Second, we determine if the client is motivated to work on himself. The relapse may have been an isolated incident, thus providing a teachable moment to work through. Such opportunities have great therapeutic value, which can help the client in real life when he faces similar emotional triggers and high risk situations. On the other hand, if the client is not motivated to work on himself, then there is no purpose being at SCHC.

2. Why do you allow cell phones and laptops? Isn't that a distraction?

A large part of the SCHC program is to help clients gain control of their lives. Cell phones and laptops are now considered part of the modern culture. If the client is being distracted, then this is a therapeutic opportunity to help the client recognize the distraction.

The key principle involved is that we operate therapeutically for an individual client. Therapeutic value, not fairness, is the issue.

3. Why do you give clients day passes? How do you deal with relapses that occur during a day pass?

Day passes and leaves of absences provide, as mentioned above, opportunities to practice recovery. There are minimum criteria, which a client must meet for a pass, such as having completed a specific number of days at SCHC.

Because we are concerned with the individual client, we may not grant a pass to a client who does not meet the requirements. Decisions are made therapeutically for an individual case.

4. How do you discipline clients who are habitually sleeping in and missing programming? Do you discharge them?

We do not ‘discipline’ because research has shown that the ‘carrot-and-stick’ approach has little therapeutic value. In cases such as this, we adhere to a principle of solution-focused therapy: If what you’re doing as a counsellor isn’t working, then stop it and do something else’. In the past

we have used various methods and approaches on an individual client.

If we threaten to discharge a client for sleeping in, then we have to carry out the threat. A client cannot benefit if he is not in treatment.

It should be noted that we occasionally have to deal with a ‘military’ narrative summed up by a statement from one CF member: ‘The military owns me until 3 p.m.; after that I’m free to do with I want. Occasionally, a CF member adheres, consciously or non-consciously, to this idea and tells himself that since he is in a health care setting, then he is not in a military, and thus may have a tendency to ‘do what I want.’ This way of thinking provides therapeutic opportunity.

5. How do you integrate CF, VAC and RCMP members into the rest of the peer group?

CF, VAC, and RCMP members become part of the regular groups, our primary addiction program. Because SCHC’s approach is to see the addict as a whole person who uses substances, then there is no distinction between a client who is a physician, a police officer, a lawyer, an oil-patch worker, an unemployed person, or a military man. CF clients have the same rights and responsibilities as any other client.

In addition to taking part in the primary program, CF members suffering from PTSD attend an adjunct, closed, CF group with our trauma therapists.

6. How do you manage a client whose primary diagnosis is PTSD rather than addiction when the rest of the peer group has addiction as a primary disorder?

Occasionally, we deal with clients who meet the criteria for “substance abuse” but not “substance dependence” (as defined in the DSM-IV). This may be true for a CF, VAC or RCMP member who is using substances to medicate.

This is not a problem at SCHC because our program puts the focus on the struggles of the individual client—in fact a common comment from clients is that “anyone would benefit from SCHC.”

We routinely design individual programs for clients. In the case posed, we would spend more time helping the client to develop new coping skills.

7. Why aren’t 12 step meetings mandatory? Why don’t they go to more meetings? Are you anti-12 step?

Again, with an experiential-focused program, we want clients to work through real-life issues. We do not want clients to pretend they are interested in 12 step meetings and tell us what they think we want to hear. We want them to experience the meetings especially in a small community that has lots of members with long term sobriety. If clients do not connect with a 12 step experience, then we want to challenge them to look at what this is about. We ask them to design an intensive recovery program as they assemble the members of their recovery support team and complete aftercare planning that matches where they are emotionally in their recovery. We are not anti 12 step and are instead 12 Step Informed.