SHIFT SUPPORT NETWORK

How to Talk to Someone You Love About Substance Use Treatment

A guide for the family member, partner, or close friend who is doing the hardest part of this. Published May 2026. Reviewed by Oren S. Raphael, MD, Medical Director.

SHIFT SUPPORT NETWORK

How to Talk to Someone You Love About Substance Use Treatment

A guide for the family member, partner, or close friend who is doing the hardest part of this. Published May 2026. Reviewed by Oren S. Raphael, MD, Medical Director.

Published by Shift Support Network. Reviewed by Oren S. Raphael, MD, Medical Director.

What this guide is, and what it is not

If you are reading this, you are probably the person in the room who is most worried, who is most informed about what is happening, and who has the least power to fix it. That is a brutal place to stand. We wrote this for you.

This is not a script. It is not a five-step formula. It is not a manipulation playbook. It is not a promise that if you say the right words in the right order, your loved one will agree to treatment by the end of the conversation.

There is no such script. Anyone selling you one is selling you something else.

What this is: a frame. A clinically grounded way to think about what is actually going on, what the evidence says works, and how to take care of yourself while you do this. It draws on three bodies of work that have held up over decades of research and practice: Community Reinforcement and Family Training, which has the strongest evidence of any family-side intervention for substance use; Motivational Interviewing, developed by William Miller and Stephen Rollnick, which is the clinical standard for talking to people with ambivalence about change; and trauma-informed care, which recognizes that the family member is often carrying their own load of fear, grief, and exhaustion.

You will see things in here that contradict what you have been told, especially if you have watched the TV version of an intervention or sat in a meeting where someone said “they have to want it.” Both of those framings are partly right and mostly wrong, and we will get into why.

A note before you start: take this in small pieces. You do not need to read this in one sitting. You do not need to act on it today. The person you love did not get here in a week and is not going to be reached in a single conversation. Pacing yourself is part of the work.

Why most “interventions” do not work the way TV depicts

The image most people carry of an intervention comes from a single source: the Vernon Johnson model, popularized in the 1960s and 1970s and dramatized on the A&E show of the same name. A surprise gathering. The family reads letters. An ultimatum gets delivered. The person breaks down and agrees to go.

It is dramatic. It tests well on television. And it has a real problem, which is that the published evidence on the Johnson model is weak, and the evidence on what actually happens after the cameras leave is worse.

A few specific issues:

The dropout rate in published Johnson-model studies is striking. In one of the only randomized comparisons, only about 30 percent of families who were trained in the Johnson model actually went through with the confrontation. The rest backed out. That is not a failure of the family. That is a sign that the model asks something most families correctly intuit is too much.

For the families who do go through with it, the intervention can rupture the relationship in ways that take years to repair, whether or not the person enters treatment. A surprise confrontation with a circle of the people you love most is, by clinical definition, a traumatic experience. If the goal is long-term recovery and a relationship that can survive into it, starting with trauma is a hard opening move.

And the comparison evidence is now decades old. In head-to-head studies, the Community Reinforcement and Family Training approach, called CRAFT, has consistently outperformed the Johnson model on the only metric that ultimately matters: the proportion of loved ones who actually enter treatment. CRAFT shows engagement rates in the range of 60 to 70 percent across multiple trials, compared to about 20 to 30 percent for Johnson-model interventions that families actually complete. CRAFT also produces better outcomes for the family member’s own mental health, regardless of whether the loved one enters treatment.

So what is CRAFT.

CRAFT is a structured set of skills taught to family members over several sessions, usually with a therapist trained in the approach. It teaches you how to communicate without escalating, how to recognize and reinforce the small movements toward sobriety that are happening even now, how to set limits that protect you without weaponizing the relationship, and how to time the conversation

about treatment for the moments when the person is most likely to hear it. It treats the family member as a co-therapist, not as a bystander who must be coached through one big emotional moment.

There is a directory of CRAFT-trained clinicians and a national family support organization called Allies in Recovery that offers CRAFT-aligned coaching. We include links at the end.

What about Sober Coaches and "recovery coaches." This is a newer and less regulated category. Some sober coaches are CRAFT-trained, ethically grounded, and add real value. Others are well-meaning people in recovery themselves who are reproducing the patterns they learned in their own treatment, which may or may not fit your situation. If you go this route, ask about training, ask about credentials, ask whether they have a clinical supervisor, and ask what they will and will not do. A coach who promises a specific outcome is making a promise no one can keep.

Validating without enabling

This is the section that trips people up the most, so we want to say it directly.

Validation does not mean agreement. Validation means acknowledging that the other person's experience makes sense from where they are sitting, without endorsing the choices they are making.

"You have had a brutal year and I can see how exhausted you are" is validation. "It is fine that you are drinking a fifth a day" is not validation. It is minimization.

People with substance use disorder are not lying when they describe how unbearable their inner state is. The drinking, the using, the late nights, the missed shifts, those are real responses to real pain, even when they are also making the pain worse. If you start the conversation by trying to argue them out of the reality of their suffering, you will lose them in the first sentence.

A working frame: you can hold two things at the same time.

One: the pain is real, the stress is real, the trauma is real, the medical or psychiatric thing underneath it is real.

Two: what they are doing about it is hurting them and is hurting you, and that has to change.

Both can be true. Both have to be true. If you only validate, you are enabling. If you only confront, you are doing the Johnson-model thing that does not work. The skill is holding both.

A few specific moves that help:

Reflect what you hear before you say anything new. “What I am hearing is that work has been impossible since the layoff and you do not know how to slow down at night without a drink. Is that right.” This is a Motivational Interviewing move. It is disarming. It signals that you are not preparing a counterargument.

Name the change you want without naming the person as the problem. “I am scared about what is happening to your liver” is different from “you are an alcoholic.” The first is a statement about your experience of the situation. The second is a label, and labels invite defenses.

Resist the urge to inventory every incident. The list of every late night, missed event, broken promise, and slurred phone call is in your head. You have rehearsed it. Most family members feel that if they can just present the evidence convincingly enough, the person will finally see. They will not. People with substance use disorder know what they have done. The list does not move them. It hardens them.

What does move them: a specific, recent, concrete thing the person already cares about. “When you did not pick up Mia from soccer practice last Thursday, she cried in the car when I got there. She thought you forgot her.” One incident. The person they love. A real consequence. Not the indictment.

Specific conversation openers

Below are starting points for five common situations. These are not scripts. They are first sentences. The conversation goes wherever it goes from there.

A note on logistics. Have these conversations sober, on both sides, ideally in the morning or middle of the day. Not after a fight. Not after a using episode. Not when one of you has just come home from a hard day. The right time is rarely the urgent time.

Opening 1: The ambivalent loved one

This is the person who knows something is off, who has half-tried to cut back, who is open to a conversation in the abstract but has not committed to anything.

You might start with: “I wanted to talk to you about something I have been thinking about. I have noticed you have been trying to cut back, and I have noticed that some weeks it works and some weeks it does not. I am not asking you to do anything today. I just want to know what you are noticing about it from the inside.”

The work here is to draw out their own ambivalence rather than supply your conclusions. Ask them what is working, what is not, what they want, what they are scared of. Ambivalent people pull away from arguments and lean toward curiosity. Be curious.

Opening 2: The in-denial loved one

This is the person who insists everything is fine, that the drinking or using is under control, that the problem is everyone else's reaction to it.

The hardest thing here is not to try to win the argument about whether there is a problem. You will not win it in this conversation. They are protecting something, often a sense of self that cannot survive admitting the truth out loud.

You might start with: "I am not going to argue with you about how much you are drinking. You know what is going on and I know what is going on, and arguing about it has not helped either of us. What I want to tell you is what I have decided I am going to do, regardless of what you decide."

Then you tell them. You tell them you are going to stop covering for them at family events. You are going to stop calling their boss with excuses. You are going to move money out of the joint account. You are going to take the kids to your sister's on weekends. Whatever you have decided. The point is to shift the conversation from "is there a problem" to "here is what is happening." You are not asking permission. You are giving information.

This is hard. It almost always provokes a response that is louder and angrier than anything you have heard before. That is the point. The information lands even when the response is denial.

Opening 3: The in-crisis loved one

This is the person who is in real and immediate trouble. Recent overdose. A medical episode. A DUI. A workplace incident. An episode of self-harm.

A crisis is a clinical window. It is the moment when the wall around the substance use is thinnest. It is also a moment when the person is scared, ashamed, and physically depleted, which means they are more likely to accept help than they were a week ago, and also more likely to bolt if the conversation goes badly.

The opener here is short. It is not the time for the list. It is not the time for the ultimatum.

"I am scared. I love you. I want us to figure out what comes next, together. Will you let me help you find a program before this gets worse." Then you stop talking. You let them think. You do not fill the silence with persuasion.

If the crisis is medical, the priority is medical stabilization first. A person in acute withdrawal from alcohol or benzodiazepines needs medical care, not a program. Call 911, go to the ER, or get them to a medically managed detox. Outpatient treatment, including ours, comes after that. We have a section below on what to expect from the levels of care so you can tell which is which.

Opening 4: The post-relapse loved one

This is the person who completed treatment, maybe more than once, and is using again. This is one of the most demoralizing conversations a family can have, and one of the most important to get right.

Relapse is part of the natural course of substance use disorder for many people. The National Institute on Drug Abuse cites relapse rates of 40 to 60 percent within a year of treatment, in line with relapse rates for other chronic illnesses like hypertension and asthma. That is not an excuse. It is context. The first relapse is not the end of recovery. It is information about what was missing the first time.

The opener: “I am not going to pretend this did not happen, and I am not going to pretend this is the end. What I want to know is what was different this time. What were you up against. What were you missing. Because the version of treatment that did not stick the first time is not the version we should send you back to.”

The work here is to take relapse as a clinical event, not a moral one. Different level of care, different therapist, treatment for the depression or anxiety or trauma that was not addressed the first time, a step up from outpatient to a higher level of care, a step down from residential to outpatient with better long-term structure. Something has to change. The conversation is about what.

Opening 5: The loved one who already tried treatment and quit

This is the person who agreed to go, started a program, and walked out. Maybe they could not stand the group format. Maybe the therapist was wrong for them. Maybe the schedule was incompatible with their work. Maybe they thought they were fine and they were not.

The opener: “I know that program was not right for you. I am not going to talk you back into it. What I want to figure out, together, is what would actually fit. Because going back to the same thing that did not work is not the plan, and doing nothing is not the plan either.”

The work: a different modality, a different level of care, a different format. Virtual outpatient instead of in-person residential. Evening cohort instead of daytime. A program that integrates the medication they are already on. A clinician who specializes in their specific situation, like first responders, healthcare workers, working parents, or trauma survivors. The first try gave you information about what does not fit. Use it.

What to do if they refuse

You do not get a vote.

We mean that gently and clinically. You can talk to them, you can structure your own life in a way that makes their substance use harder to sustain, you can offer to walk into the intake call with them. You cannot, in the end, decide for an adult what they will or will not do with their body and their choices. Civil commitment laws for substance use exist in some states but are narrow, hard to invoke, and clinically uneven in their results.

What you can do is decide what you will do.

Boundaries are about your behavior, not theirs.

A boundary is “I am not going to drive you home when you have been drinking.” That is a statement about what you will do. You control it.

An ultimatum is “if you do not go to treatment by Friday I am leaving you.” That is a statement about what they have to do, with a consequence attached. You may mean it, you may have to mean it, and there are situations where you do have to leave. But the ultimatum-form puts the decision and the consequence in their hands in a way that often hardens the refusal rather than softening it.

If you are going to deliver an ultimatum, deliver it for one reason: because you have actually decided, and you will follow through. Do not bluff. People with substance use disorder are sensitive to bluffs. They will call them every time, and the cost of an uncashed ultimatum is your credibility with them for years.

Detaching with love is not abandonment.

This phrase comes from the Al-Anon and Nar-Anon traditions, and it is one of the most useful frames family members have. Detaching with love means stepping back from managing the consequences of someone else's substance use, without stepping back from caring about them. You can stop covering for them at work and still love them. You can stop bailing them out and still be in their life. You can take care of yourself first and still want them to get well. These are not opposites.

When you can step away.

There is a difference between standing by someone through a hard recovery and putting yourself in physical, financial, or psychological danger to manage someone else's illness. If your safety is at risk, leave. If your children's safety is at risk, leave. If your financial survival is at risk, separate the accounts. If your mental health is collapsing, get your own treatment. None of these are betrayals of the person you love. They are the conditions under which you can be present at all in the long arc of recovery, which is often longer than the initial crisis.

The role of co-occurring depression, anxiety, and trauma

You will hear, at AA meetings and from well-meaning relatives, "they have to want it." That is partly true. People with substance use disorder do better when they have some internal motivation, and motivation usually grows over the course of treatment rather than appearing in full before it.

It is also partly false, and worth understanding why.

Substance use disorder rarely exists alone. The Substance Abuse and Mental Health Services Administration estimates that more than half of adults with a substance use disorder also have a co-occurring mental health condition. Depression, generalized anxiety, post-traumatic stress, ADHD, bipolar spectrum conditions, and unprocessed grief are the most common. For many people, the substance use is the layer that became visible. The thing underneath is what is actually keeping them sick.

Why this matters for the conversation about treatment.

If the underlying depression, anxiety, or trauma is not treated, the person can complete a program, leave with their substance use under control, and slide back within months because the original pain is still there. This is one of the most common reasons people relapse after a successful first treatment. The substance is gone and the thing it was managing comes back.

A program that treats substance use disorder without simultaneously treating the co-occurring mental health condition is treating half the problem. When you are evaluating programs, ask specifically whether they treat co-occurring conditions in-house, whether the same clinical team manages both, and whether the medications for the mental health condition are coordinated with the substance use treatment. The answer should be yes to all three.

This is also why “they have to want it” is too narrow. A person with severe depression often cannot generate the kind of motivation the phrase implies. Treating the depression makes the motivation possible. The order of operations matters.

Costs and logistics

We are going to be specific in this section because vagueness is what makes families freeze.

Insurance and benefit verification

Most commercial insurance plans cover substance use treatment, including outpatient and intensive outpatient programs and higher levels of care. The Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act require most plans to cover behavioral health at parity with medical and surgical benefits. That does not mean coverage is automatic, and it does not mean any program is in-network with your plan.

What to ask the program before you commit:

Are they in-network with your specific plan, or are they out-of-network. There is a meaningful financial difference. An out-of-network program may still be a great clinical fit and your benefit may still cover it well, but the cost to you can be different and you should know before you start.

Will they run a verification of benefits and tell you in plain English what you would owe before you commit. The answer should be yes, same day or next business day. If the program will not give you a written estimate of your out-of-pocket cost before admission, treat that as a warning sign.

Does the program offer single case agreements with out-of-network plans. A single case agreement is a one-time agreement between the program and the insurer to cover treatment as if the program were in-network. It is common for specialty programs and is worth asking about.

What is the prior authorization process and how long does it take. Most insurers require pre-authorization for intensive outpatient or higher. The program should know how to navigate this with your specific plan.

Virtual versus in-person

The evidence on virtual intensive outpatient treatment for substance use has matured considerably since 2020. Published studies during and after the pandemic show comparable outcomes between virtual and in-person intensive outpatient for many populations, with the caveats that virtual is best suited to people who are medically and psychiatrically stable, who have a private space to attend sessions from, and who have a reasonable internet connection.

Virtual is not equivalent to in-person for everyone. People who need the structure of leaving the house, who have unstable housing, who have severe co-occurring conditions that benefit from in-person observation, or who are in early ambulatory withdrawal may do better with an in-person program at least at the start. A good intake clinician will help you figure this out.

When virtual works well, it works for specific reasons. The person can keep their job, their housing, and their custody arrangement. They do not have to disclose to an employer or take leave under FMLA. They can integrate treatment with the rest of their life rather than stepping out of life to get it.

What to actually expect during week one of an intensive outpatient program

If your loved one enrolls in a virtual intensive outpatient program, here is roughly what week one looks like, so you can normalize it for them and for yourself.

Days one and two: intake paperwork, a full clinical assessment, medication review, and meeting with a primary therapist. There will be a lot of forms. There will be a lot of questions about substance use history, mental health history, family history, and current safety. This is normal. The assessment is what produces the treatment plan, and the treatment plan is what makes the rest of the program coherent.

Days three through five: the first group sessions. Group therapy is the spine of intensive outpatient treatment. It is also the part most people are most anxious about. The first few sessions are usually mostly listening. Your loved one will not be put on the spot. They will be allowed to share what they want to share, when they want to share it.

Throughout the week: individual therapy, family programming if clinically indicated, medication management appointments, and check-ins with case management about logistics like work and benefits and family communication.

What to expect from yourselves, as the family: this is harder than people anticipate. The relief of starting treatment is real, and so is the grief and exhaustion that comes up when the immediate crisis is no longer absorbing all of your attention. Some families describe the first two weeks of their loved one's treatment as the hardest emotionally, not the easiest. That is normal. It does not mean the treatment is not working. It means you are finally allowed to feel everything you have been pushing down.

Confidentiality, in plain language

There is a federal law called 42 CFR Part 2 that governs the confidentiality of substance use treatment records. It is stricter than HIPAA. Here is what it means in practice.

A substance use treatment program cannot release information about your loved one's treatment to anyone, including you, without their written consent. That is intentional. The law exists because of decades of evidence that fear of disclosure, especially to employers, courts, and family members, is one of the largest single barriers to people seeking treatment. The protection is meant to make it safer to ask for help.

For you, as the family member, this means a few specific things.

If your loved one is over 18, the program cannot tell you whether they showed up, whether they completed the program, or what is in their treatment plan, unless your loved one signs a release form authorizing the program to share that with you. This can feel painful, especially if you are paying for the treatment. It is also part of how the system is designed to work. Your loved one may sign a release. Many do. But it is their decision, not yours.

If you are paying and want some basic accountability about whether the program is being attended, the cleanest path is to ask your loved one directly to sign a limited release that authorizes the program to confirm attendance and treatment status to you, without sharing clinical content. Most programs have a form for this and many people in treatment are willing to sign it because the alternative is constant questions from family that they would rather not field directly.

For your loved one, the protection means that their employer, their licensing board, their family, and even law enforcement cannot generally access their treatment records without their consent or a specific court order. There are narrow exceptions, mostly related to medical emergencies and crimes committed on program premises.

If they are involved in a drug court or treatment court, the court typically requires them to sign a release as a condition of court participation. That is a separate situation and is usually clearly disclosed up front.

Resources

These are the resources we point families to most often.

SAMHSA National Helpline. 1-800-662-HELP (4357). Free, confidential, 24/7. They will help with treatment referrals and basic information. They do not provide treatment themselves. They are the right starting point if you do not know where to begin.

Al-Anon. For family and friends of people with alcohol use disorder. Meetings in most areas, virtual options widely available. The frame is twelve-step adjacent and focuses on the family member's own recovery, separate from whether the loved one gets sober. al-anon.org

Nar-Anon. Same model for families of people with drug use disorder. nar-anon.org

SMART Recovery Family and Friends. A secular, evidence-based alternative to Al-Anon, drawing on cognitive behavioral and motivational interviewing principles. Often a better fit for families who do not connect with the twelve-step frame. smartrecovery.org

Allies in Recovery. A CRAFT-aligned online coaching and support community for family members. Subscription-based. Offers the most accessible introduction to CRAFT skills outside of in-person therapy. alliesinrecovery.net

The CRAFT-trained clinician directory. Maintained by the Center for Motivation and Change. cmcffc.org has a search tool for CRAFT-trained therapists in your area.

988 Suicide and Crisis Lifeline. Call or text 988 if your loved one is in immediate danger of self-harm or suicide. This is a crisis service, not a treatment service. Use it for the acute moment.

Substance Abuse and Mental Health Services Administration treatment locator. findtreatment.gov. The most complete federal directory of treatment programs, searchable by location, level of care, and population served.

Faces and Voices of Recovery. facesandvoicesofrecovery.org. A national peer-support organization for people in recovery and their families. Useful for finding recovery community organizations near you.

Taking care of yourself

This is the section most family members skip and the one we want you to read most carefully.

You are also experiencing trauma.

The medical literature is clear that family members of people with substance use disorder show elevated rates of depression, anxiety, sleep disturbance, hypervigilance, and somatic stress symptoms that meet criteria for what clinicians call secondary or vicarious trauma. The body keeps the score on what you have been living with. The chronic worry, the broken sleep, the bracing for the next phone call, the silent surveillance of their breathing in the next room, the way you can read their face in the first half-second of a conversation. That is not normal stress. That is what living adjacent to a chronic illness looks like.

It is also not free.

A few things to consider.

Get your own therapist. Not the program's family therapist, although that may be useful too. Your own. Someone whose job is to take care of you, not to take care of the family system. This is not optional if you are going to be in this for the long haul. Look for someone who has experience with families affected by substance use, and ideally with the CRAFT or family systems approach.

Sleep. Eat. Move your body. These sound trivial and they are not. The single largest predictor of whether a family member can stay present through a long recovery is whether their own physical system holds up. You cannot pour from an empty cup, and the cup gets emptied faster than you think.

Find peers. Al-Anon, Nar-Anon, SMART Family and Friends, Allies in Recovery, your church or your community center. The people who actually understand what you are going through are the people who have been there. Their wisdom is not equivalent to clinical care and is not a substitute for it, but it is something a therapist cannot give you, which is the experience of not being alone.

Remember that recovery for the family is its own arc, not a derivative of theirs. You can recover, in the clinical sense, from the experience of loving someone with this illness, regardless of what happens to them. That recovery has its own pace and its own milestones. Many families describe the recognition that they get to have their own life back, separate from the management of someone else's illness, as one of the most important shifts of the whole experience.

You are allowed to want things for yourself that do not depend on what they decide. You are allowed to make plans. You are allowed to be happy on a Tuesday in March without it being a betrayal.

The person you love is sick. They are not, by virtue of being sick, the only person in the room whose life is allowed to matter.

If you want to talk

Shift Support Network is a virtual outpatient program for substance use and co-occurring mental health, headquartered in California, expanding to additional states. We treat working adults and their families, including union members, first responders, healthcare workers, professionals, college students, and adolescents 14 to 17 with parent consent. We are not residential. We do not have beds. We are where patients go after the bed, and where many people go before they ever need one.

If you would like to talk to someone about your specific situation, including whether Shift is the right fit and what other options exist if it is not, here are three ways to reach us.

Call (805) 815-6777. Book a 20-minute call with our Medical Director, Oren S. Raphael, MD, at calendly.com/admin-shiftsupportnetwork/intro. Email admin@shiftsupportnetwork.com.

We will run a benefit check the same day and tell you, in plain English, what your specific plan covers and what you would owe. We will do a short clinical screen to confirm the right level of care. If we are not the right level of care, we will help you find who is.

We do not pay for referrals. We will not promise outcomes we cannot guarantee. We will tell you what we measure, what we do well, and what we do not do.

You did not cause this. You cannot cure it. You can love them through it, and you can take care of yourself while you do.

Reviewed by: Oren S. Raphael, MD, Medical Director, Shift Support Network. **Published:** May 2026. **About Shift Support Network.** Vanguard Labs LLC d/b/a Shift Support Network. DHCS Certification 191663AP. Type-2 NPI 1043190226. HIPAA-compliant. Substance use treatment records protected under 42 CFR Part 2. We are an outpatient program. We are not residential. We are out-of-network with the commercial carriers as of publication; in-network credentialing is in progress. We do not pay for referrals.

Not an emergency service. If you or someone you are with is in immediate danger, call or text **988** or call **911**.