


2026 Free Webinar Series 

Unseen, Unheard, Untreated: A Disconnected System's Call for the Medicine of Connection

Presented by: Kenneth J. Martz, PsyD, MBA

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Webinar Facilitator:

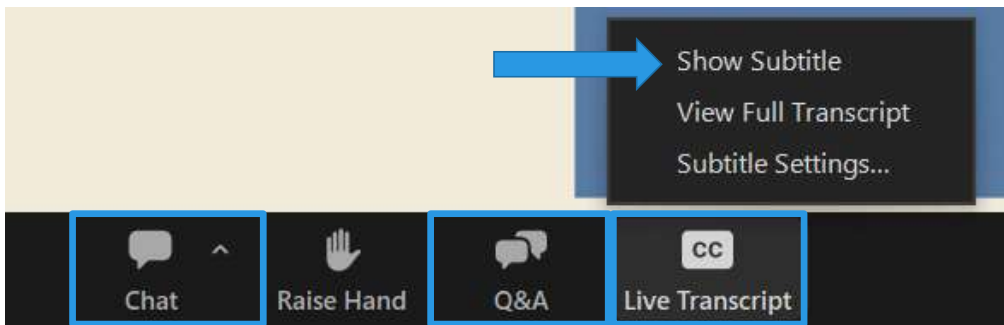
Jessica O'Brien, LCSW, CASAC
Director of Training & Professional Development

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- jobrien@naadac.org



www.naadac.org/webinars NAADAC, the Association for Addiction Professionals 2

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The screenshot shows the Zoom webinar control bar. The 'Live Transcript' button is highlighted with a blue box. A blue arrow points from the 'Live Transcript' button to a menu that is open, showing options: 'Show Subtitle', 'View Full Transcript', and 'Subtitle Settings...'. Below the control bar, there is a text box with the following content:

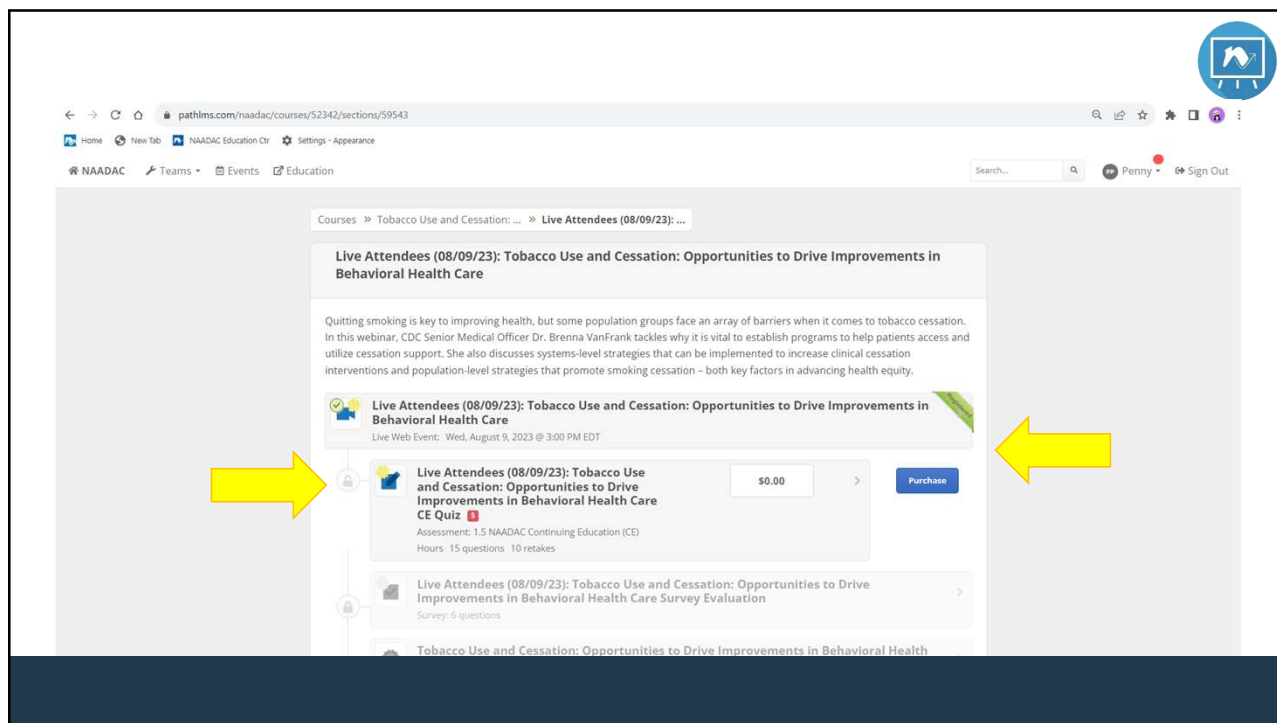
Using Zoom Webinar (Live participants only)

Chat:
Allows you to send chat messages to the host, panelists, and attendees (if permitted).

Question & Answer:
Open the Q&A window and you can ask questions to the host and panelists. They will either reply to you via text in the Q&A window or answer your question live.

Live Transcript
Click on Live Transcript and select "show subtitle."

3



The screenshot shows a web browser displaying a course page on pathlms.com. The page title is 'Live Attendees (08/09/23): Tobacco Use and Cessation: Opportunities to Drive Improvements in Behavioral Health Care'. The page content includes a description of the webinar and a list of items for purchase. A yellow arrow points to the 'Purchase' button for the 'Live Attendees (08/09/23): Tobacco Use and Cessation: Opportunities to Drive Improvements in Behavioral Health Care' item. The price is \$0.00. Other items listed include a 'CE Quiz' and a 'Survey Evaluation'.

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Webinar Presenter:

Kenneth J. Martz, PsyD, MBA

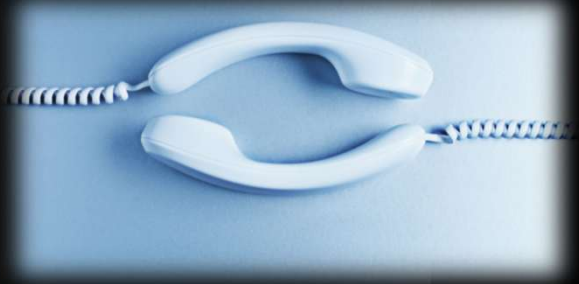


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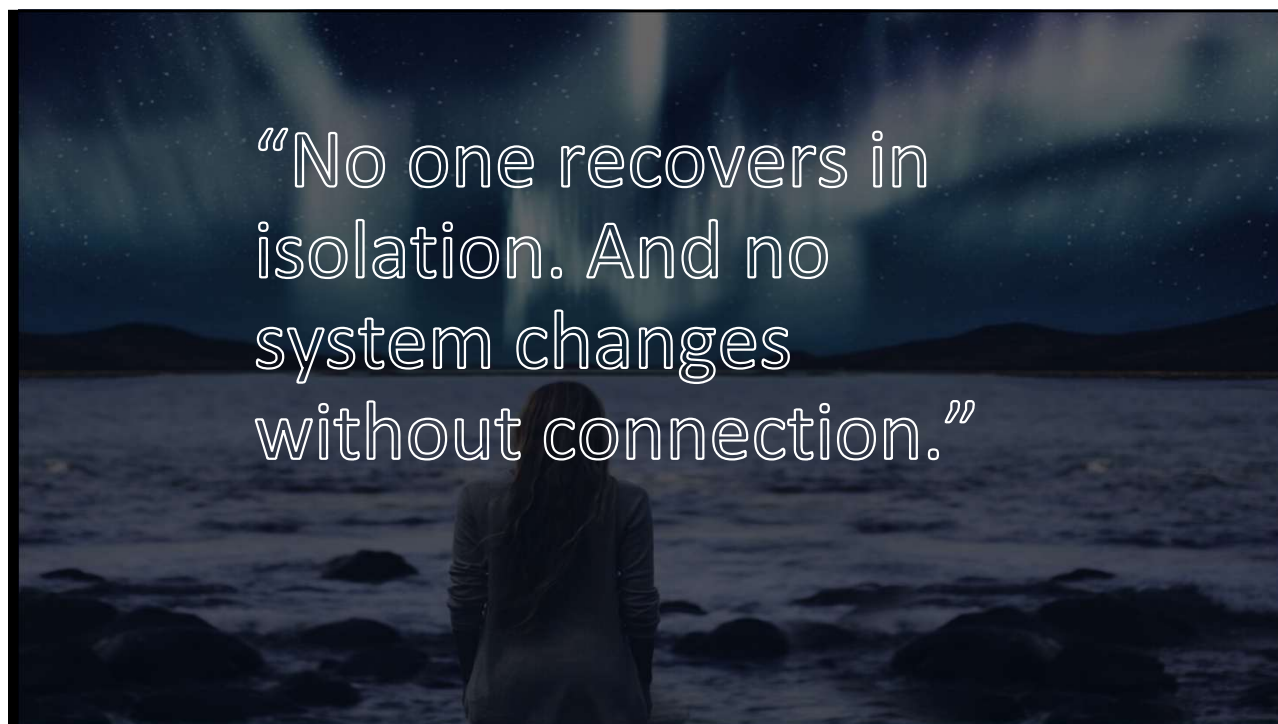
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Unseen, Unheard,
Untreated
A Disconnected
System's Call for the
Medicine of Connection

Ken Martz, PsyD



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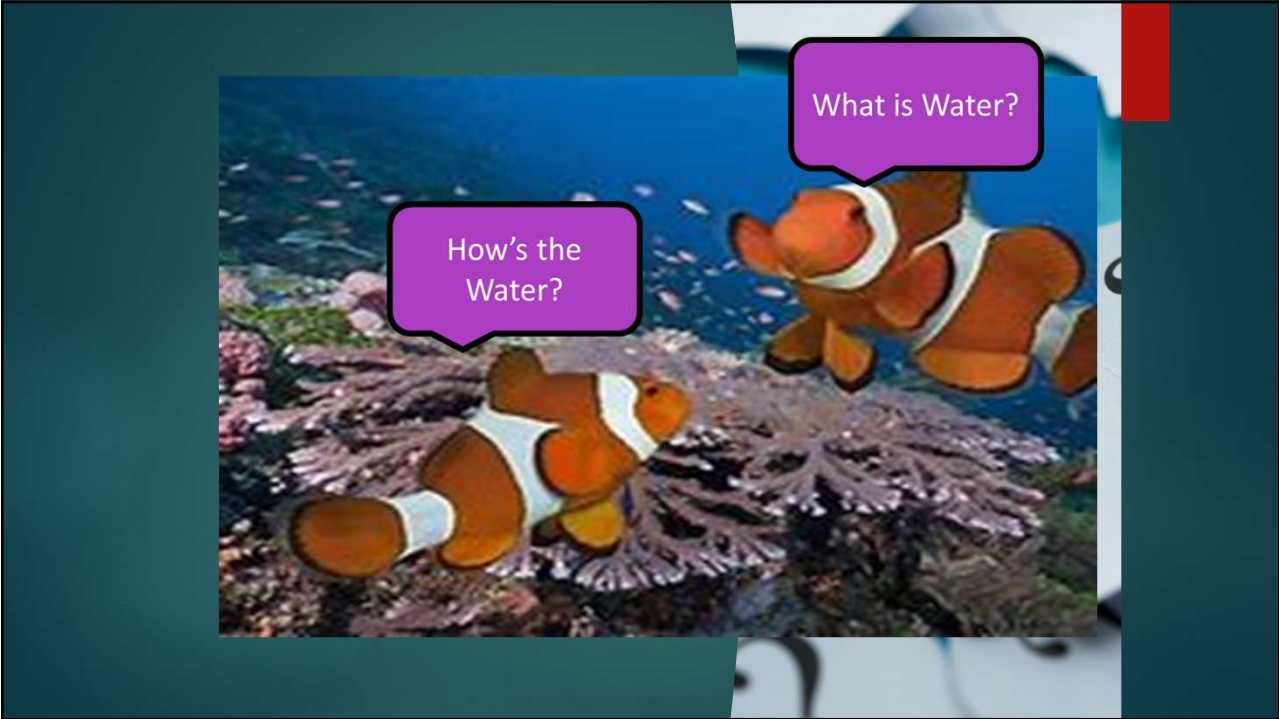


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A dark background with a white box containing the text "The Central Problem" and a list of bullet points.

- Addiction is a disease of isolation and disconnection
- Fragmentation within individuals, across services, and systems
- Populations left unseen, unheard, untreated

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Ken Martz, Psy.D.

- Licensed Psychologist
- 30 Years experience in gambling disorder, substance use disorder and mental health treatment
- Worked across sectors and across states
- Former Special Assistant to the Secretary for the Pennsylvania Department of Drug and Alcohol Programs
- Co-Chair of NAADAC's Policy Committee
- International bestselling author in addiction and mental health
- www.DrKenMartz.com
- DrKen@DrKenMartz.com

Download PowerPoint HERE



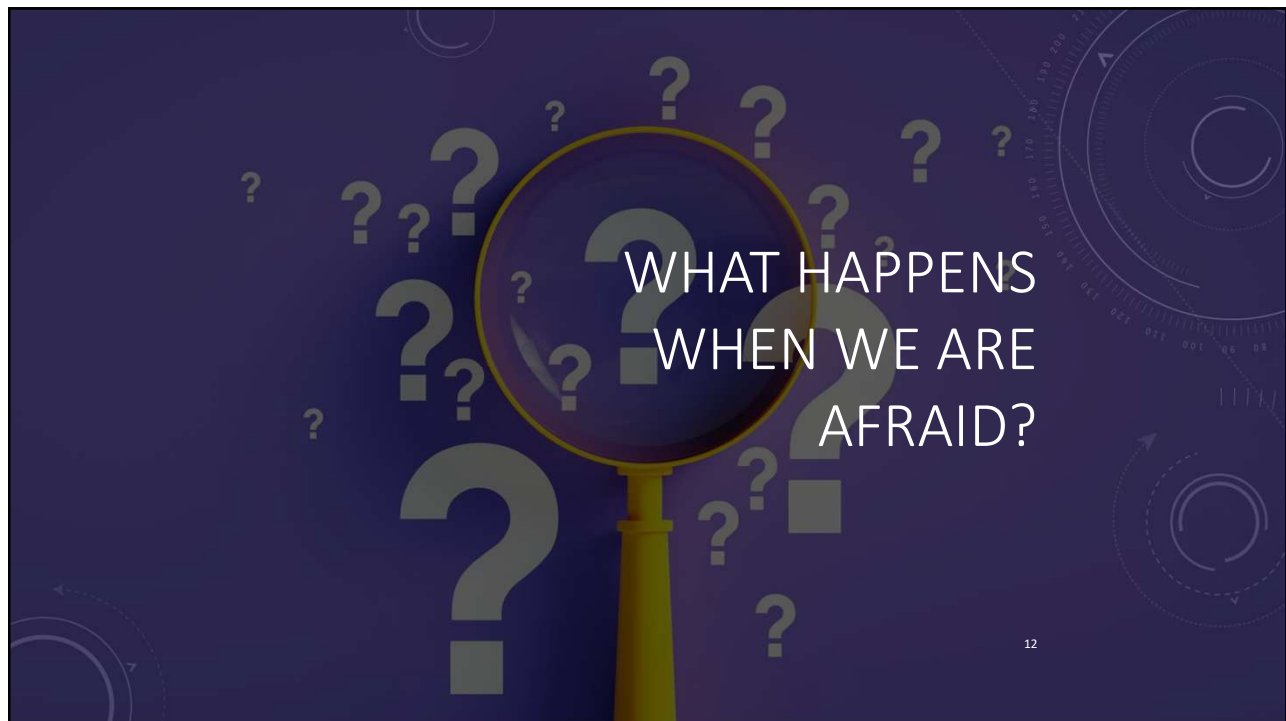
10

A photograph of two hikers standing on a rocky mountain peak, reaching their arms up in triumph against a blue sky with light clouds. The hiker in the foreground is wearing a red jacket and a backpack. The background shows a range of snow-capped mountains under a clear sky. The image is framed by a dark teal border on the left and right, with a small red rectangle in the top right corner.

Goals

- **Understand how disconnection creates treatment gaps**
- **Explore cross-sector collaboration strategies**
- **Apply connection-based care principles**

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A dark blue background featuring a large magnifying glass with a yellow handle and frame. The lens of the magnifying glass is focused on a large white question mark. Numerous other smaller white question marks are scattered across the background. In the bottom right corner, there are faint, light-colored circular patterns resembling a clock face or a technical diagram.

WHAT HAPPENS
WHEN WE ARE
AFRAID?

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COMMON COUNSELOR FEARS

- Fear of lack of funding
- Fear of relapse in clients
- Fear of client resistance or hostility
- Fear of not being able to help clients effectively
- Fear of burnout or compassion fatigue
- Fear of making mistakes or providing incorrect information
- Fear of encountering ethical dilemmas
- Fear of personal safety in working with clients who have a history of violence or aggression
- Fear of negative feedback or criticism from colleagues or supervisors
- Fear of losing one's job or professional reputation
- Fear of personal issues or biases interfering with work performance
- Fear of being judged or stigmatized for working in the addiction field
- Fear of relapse in oneself or colleagues
- Fear of not having enough resources or support to help clients
- Fear of being overwhelmed by the emotional intensity of the work
- Fear of not being able to maintain boundaries with clients
- Fear of being sued or facing legal repercussions
- Fear of encountering clients with complex mental health issues
- Fear of encountering clients with trauma or abuse histories
- Fear of encountering clients with multiple or severe addictions
- Fear of encountering resistance or lack of support from family members or loved ones of clients

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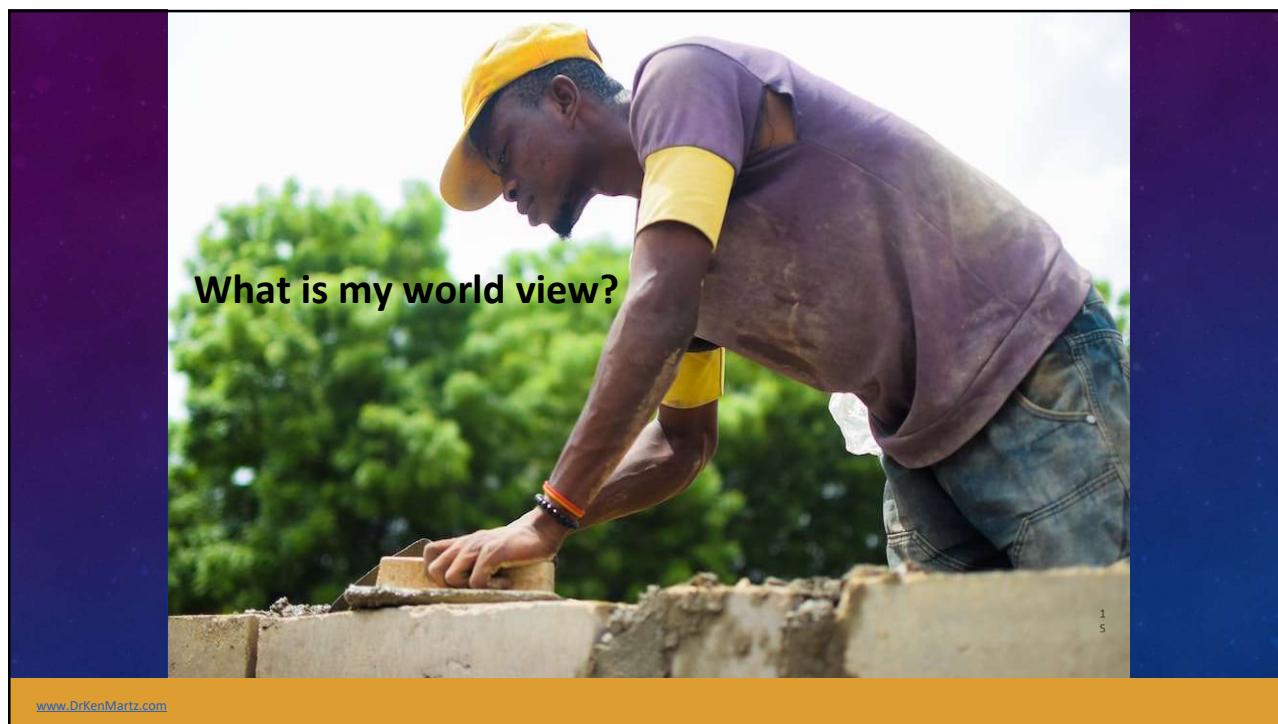
Self-Awareness

1. Where am I a bridge, and where might I be a barrier?
Am I facilitating connection between clients and resources, or unintentionally contributing to disconnection?
2. Do I treat the system as static or shapeable?
Am I passively navigating institutional limitations, or actively advocating for change and integration?
3. How do I respond when the system fails my client?
Do I offer repair, advocacy, or creative alternatives, or do I retreat into protocol?
4. Am I building trust or reinforcing mistrust?
Do my words and actions signal safety, consistency, and respect, or do they echo past traumas?
5. Do I collaborate across silos—or stay in my lane?
Am I engaging with medical teams, peer supports, housing advocates, and families, or working in isolation?
6. How do I model connection in my own professional relationships?
Do I practice what I preach in supervision, team dynamics, and community partnerships?
7. What legacy of connection am I leaving behind?
Will clients and colleagues remember me as someone who stitched the system together—or someone who watched it fray?

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Real-World Example

- Story of "Anthony":
 - Bounced between providers,
 - Discharged without follow-up
 - Back in crisis
- Who is responsible?
 - Blame the client?
 - The counselor?
 - The case manager?
 - The clinical supervisor?
 - The program director?
 - The funder?
 - The County addiction agency?
 - The State addiction agency?
 - The US Congress?
 - SAMHSA (Federal addiction agency)?
 - The president?
 - The voters?
 - The "system"?
 - The culture?
- Invisible in the data, unheard by the system

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Learning Objective 1

- Understand how disconnection creates treatment gaps:
 - Missed handoffs
 - Internal disconnection
 - Cultural disconnects
 - Programmatic silos

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Where are we?

9/10 individuals in need don't get treatment

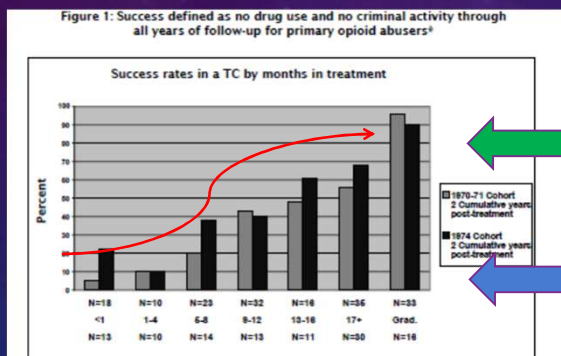
Untreated addiction leads to healthcare costs, criminal justice costs, human services costs and more.

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RESEARCH LENGTH OF STAY

Almost 50 years of studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment, for 90 days minimum and appropriate continuum of care.

1970's



Do we want:

80% success rates?

Or

20% success rates?

Deleon (2010) *Is Therapeutic Community an Evidence Based Treatment? What the Evidence Says*

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RESEARCH LENGTH OF STAY

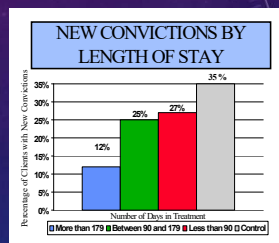
Almost 50 years of studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment for 90 days minimum and appropriate continuum of care.

1990's

Overview of 1-Year Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)

Robert L. Hubbard, S. Gail Craddock, Patrick M. Flynn, Jill Anderson, and Rose M. Etheridge
National Development and Research Institutes, Inc.

The Drug Abuse Treatment Outcome Study (DATOS) collected 1-year follow-up outcomes for 2,966 clients in outpatient methadone (OMT), long-term residential (LTR), outpatient drug-free (ODF), and short-term inpatient (STI) programs in 1991-1993. LTR, STI, and ODF clients reported 50% less weekly or daily cocaine use in the follow-up year than in the preadmission year. Reductions were greater ($p < .01$) for clients treated for 3 months or more. Clients still in OMT reported less weekly or daily heroin use than clients who left OMT. Multivariate analysis confirmed that 6 months or more in ODF and LTR and enrollment in OMT were associated with the reductions. **Reductions of 50% in illegal activity and 10% increases in full-time employment for LTR clients were related ($p < .01$) to treatment stays of 6 months or longer.** The results replicated findings from 1979-1981 for heroin use in OMT and illegal activity and employment for LTR but not for illegal activity in OMT and ODF.



Source: Pennsylvania Department of Corrections (1997) *Pennsylvania FIR Evaluation*

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Research Length of Stay

Almost 50 years of studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment for 90 days minimum and appropriate continuum of care.

2000's

Source: Greenfield et al. (2004). *Effectiveness of Long Term Residential Treatment for Women: Findings from 3 National Studies*

Source: Zhang (2002). *Does retention matter? Treatment duration and improvement in drug use. (4,005 clients)*

Figure 1 Overall improvement by treatment duration by modality

	Medication maintenance			Outpatient non-medication			Short-term residential		Long-term residential			
	<= 3 months n = 100	> 3 months n = 341	Raw P-value	<= 3 months n = 780	> 3 months n = 923	Raw P-value	<= 2 weeks n = 229	> 2 weeks n = 441	P-value	<= 3 months n = 530	> 3 months n = 653	Raw P-value
Specific drugs												
Heroin	0.59	1.12	0.0001***	0.10	0.07	0.25	0.19	0.51	0.0001***	0.11	0.26	0.0004**
Cocaine powder	0.41	0.53	0.37	0.29	0.27	0.62	0.43	0.61	0.07	0.46	0.62	0.01
Crack cocaine	0.16	0.11	0.66	0.52	0.62	0.10	0.73	0.62	0.25	0.99	1.24	0.0009**
Marijuana	0.52	0.39	0.27	0.50	0.39	0.03	0.56	0.74	0.06	0.69	0.97	0.0001***
Overall drug use	1.67	2.33	0.03	1.41	1.33	0.51	1.91	2.47	0.01*	2.24	3.07	0.0001***
Primary drug use	1.02	1.71	0.0005**	0.82	0.79	0.67	1.14	1.38	0.09	1.36	1.83	0.0001***

Significance tests (*p < 0.05, **p < 0.01, ***p < 0.001) were conducted to test the mean difference of the improvement scores between the group with shorter treatment duration and the group with longer treatment duration, for each type of substance within each modality. For the improvement on the five types of substances used as the components of the general drug use improvement, the significance level symbols reported in the table were adjusted with bootstrap method to control for multiple tests by means of Bootstrap through SAS PROC PLM TEST.

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[Does Retention Matter? Treatment Duration and Improvement in Drug Use \(Zhang, 2003\) 4005 clients across 62 programs](#)

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NIDA RESEARCH

Decades of studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.

1-year outcomes for shorter and longer stays in TC treatment

Outcome	< 90 days	90+ days
Cocaine (any use)*	55%	28%
UA+ (any drug)*	53%	19%
Alcohol (daily use)*	15%	9%
Any jail*	54%	24%

*p < .01 for all four measures.
Cocaine use, alcohol use, and being jailed are self-report measures for the 12 months after treatment. UA+ indicates a positive urinalysis test at the follow-up interview.
Source: Simpson et al., *Psychology of Addictive Behaviors*, 11:264-307, 1997.

“Therapeutic community treatment shows improvements in recidivism and relapse rates, as well as engagement in employment. These improvements are correlated to length of treatment, with highest rates of improvement among those with 9 months of treatment, and reduced effectiveness for treatment of less than 90 days.”

[NIDA\(2002\) Research Series: Therapeutic Community](#)

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NIDA RESEARCH

Decades of studies consistently find length of stay as the primary predictor of outcomes, along with intensity of treatment and continuum of care.

NIDA (2018) Principles of Drug Addiction Treatment

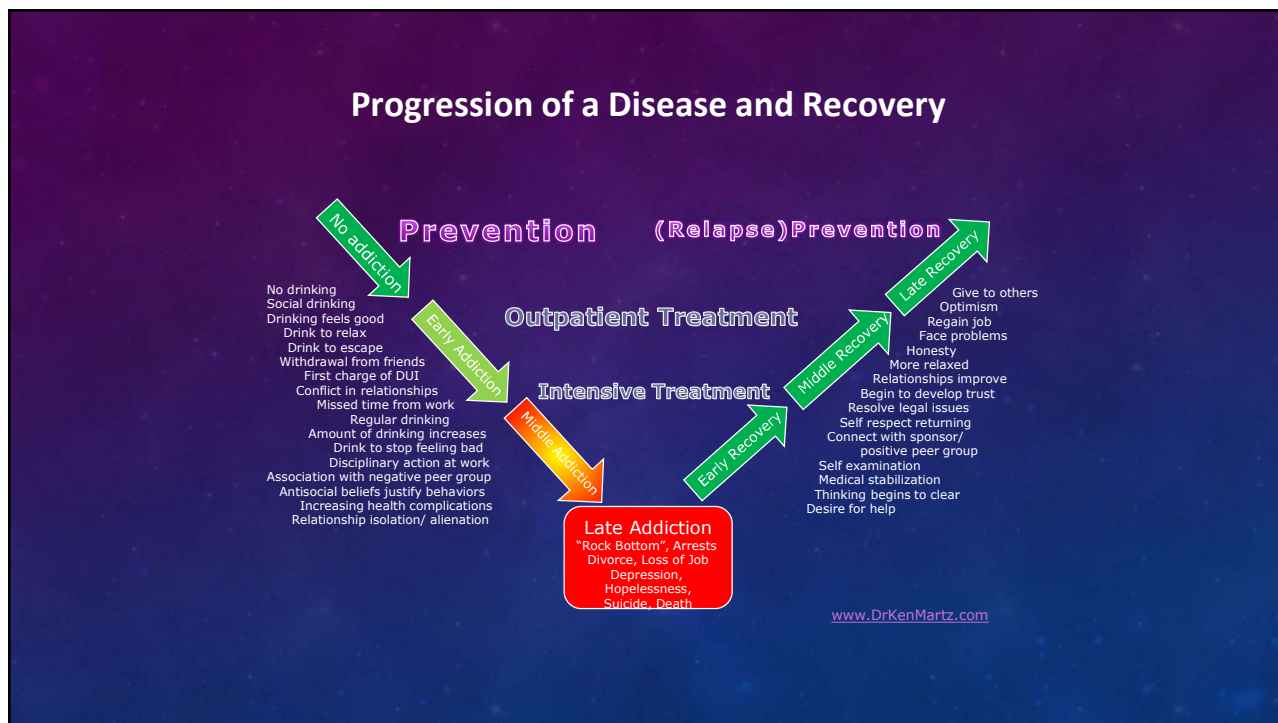
"Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and the best outcomes occur with longer durations of treatment." p. 5

"Research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. p. 14

"The best known residential treatment model is the therapeutic community (TC), with planned lengths of stay between 6 and 12 months." p. 29

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Let's Apply It

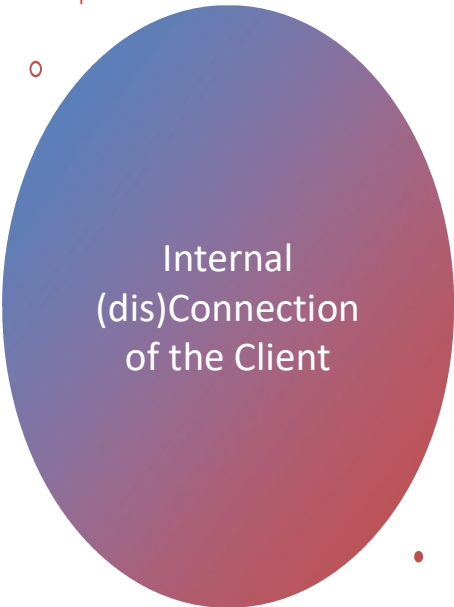
Brainstorm 1 minute:

- The Disconnection Map:
 - Map a client's journey
 - Identify drop points

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<u>Step</u>	<u>Challenge</u>	<u>Drop Point</u>
Primary Prevention	Risk factors, Isolation	Roots of addiction develop
Intervention	Risky behavior, "I can control it", I don't have a problem	Death, harm to others, progression of illness
Initial Crisis / Rock Bottom	Overdose, arrest, hospitalization, or "emotional breakdown"	Lack of immediate intervention or trauma-informed response
Emergency Services / First Contact	Interaction with police, EMTs, ER staff	No referral to addiction specialists or peer support
Detox / Short-Term Stabilization	Medical detox or brief inpatient stay	Discharge without a warm handoff to long-term care
Assessment & Treatment Planning	Evaluation by clinicians or case managers	Plans made without client input or cultural sensitivity, Plans made by "what insurance will approve" rather than by what is clinically necessary
Residential / Outpatient Treatment	Structured therapy, group work, medication-assisted treatment, Client treatment/work balance	Inconsistent attendance, lack of transportation, or insurance lapses/challenges
Transition to Community Support	Sober living, peer mentorship, outpatient follow-up	Isolation, stigma, or absence of wraparound services
Reintegration / Employment / Relationships	Rebuilding life skills, reconnecting with family, seeking work	Relapse triggers, lack of coping tools, or unsupportive environments
Long-Term Recovery Maintenance	Ongoing therapy, 12-step programs, spiritual or personal growth	Burnout, complacency, or loss of purpose

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Internal (dis)Connection of the Client

- “I don't have a problem”
- Clients may feel “split” between wanting help and fearing vulnerability
- Internalized stigma leads to self-blame and secrecy
- “If I admit I need help, I confirm I'm broken”
- Past experiences with judgment, neglect, or coercion
- Services are seen as punitive, not restorative
- Disconnection from feelings = disconnection from needs
- Seeking help requires emotional presence many clients don't yet have
- Survival mode overrides long-term planning or self-care
- Fear of change competes with desire for healing
- “I want to get better—but I don't believe I deserve it”

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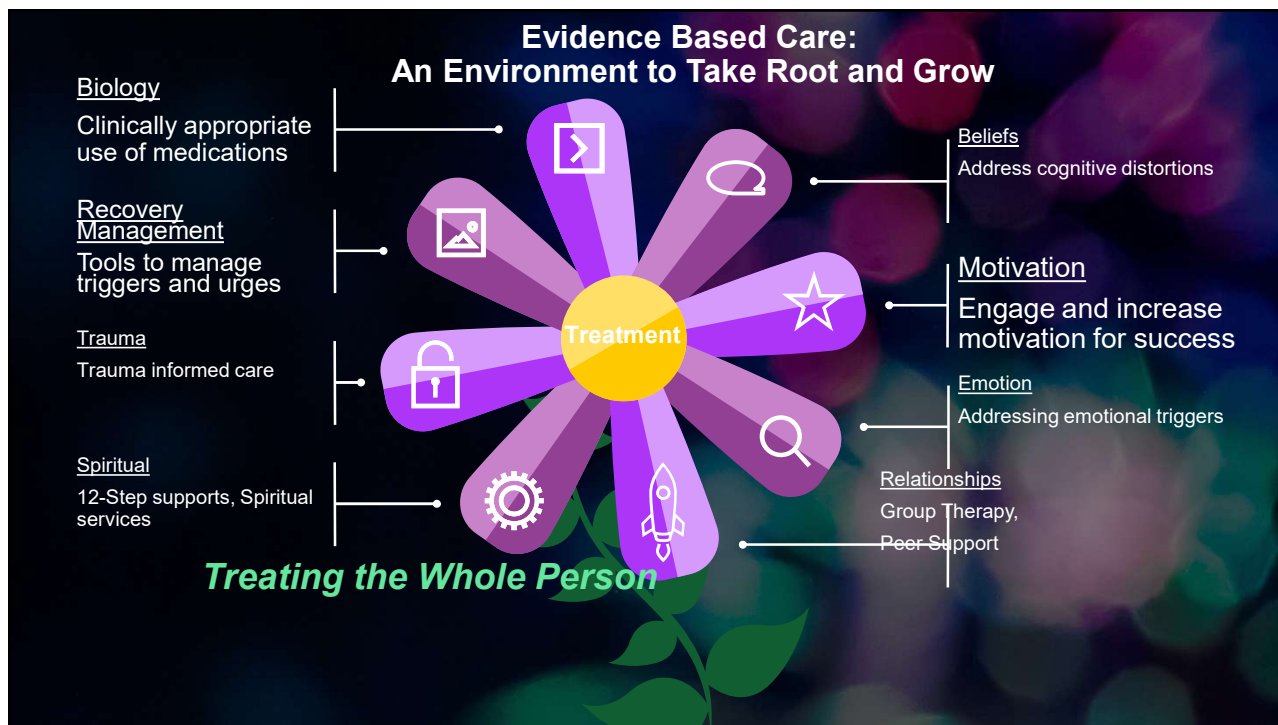
Cultural (dis)Connection

- Services ignore or minimize race, gender, sexuality, or spiritual identity
- Lack of culturally competent staff or multilingual resources
- Clients feel unheard, misinterpreted, or silenced
- Shame amplified by community norms or religious beliefs
- Seeking help may be seen as weakness or betrayal
- Normalization of behaviors (e.g. marijuana use, alcohol use in college)
- Few staff or peers who share the client's background
- Cultural expressions of distress may be pathologized or dismissed
- Emotional language and coping styles are misread by clinicians

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Learning
Objective
2

- Explore cross-sector collaboration strategies:
 - Justice + Treatment
 - Schools + Prevention
 - Peer Support + Clinical Care
 - SUD Treatment + Others

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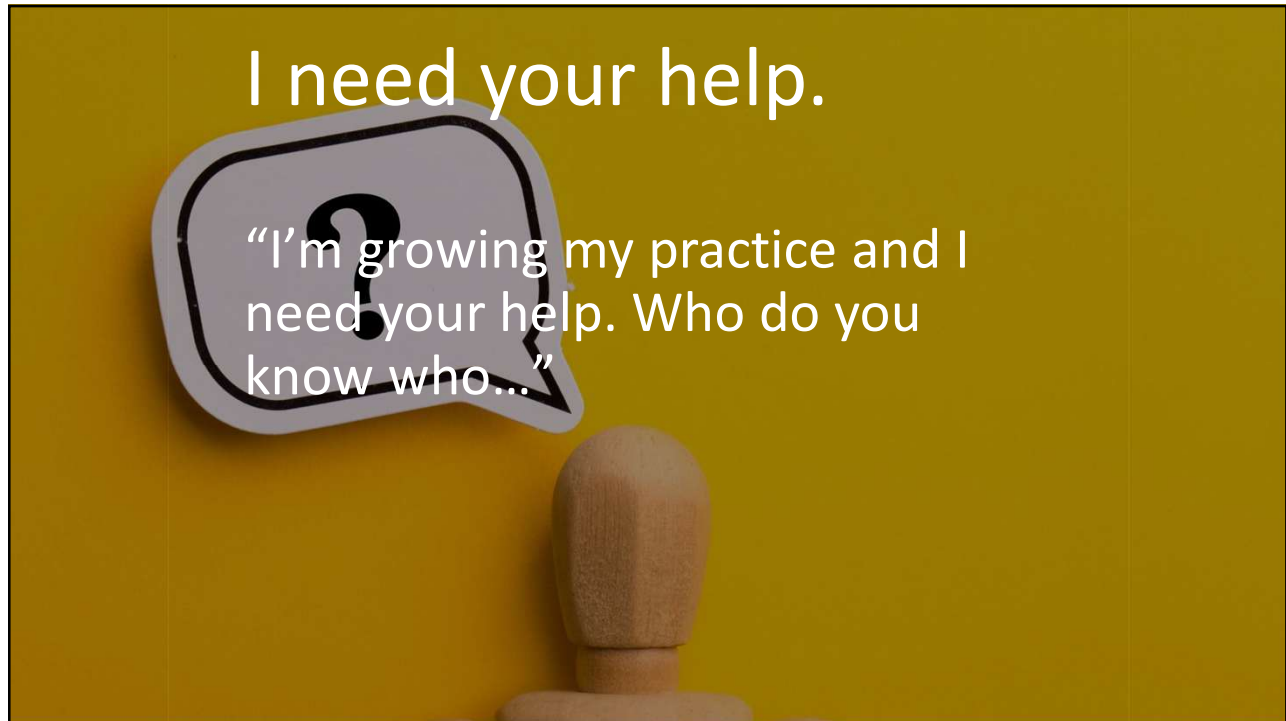
Reframing
Our
Models

Justice +
Treatment

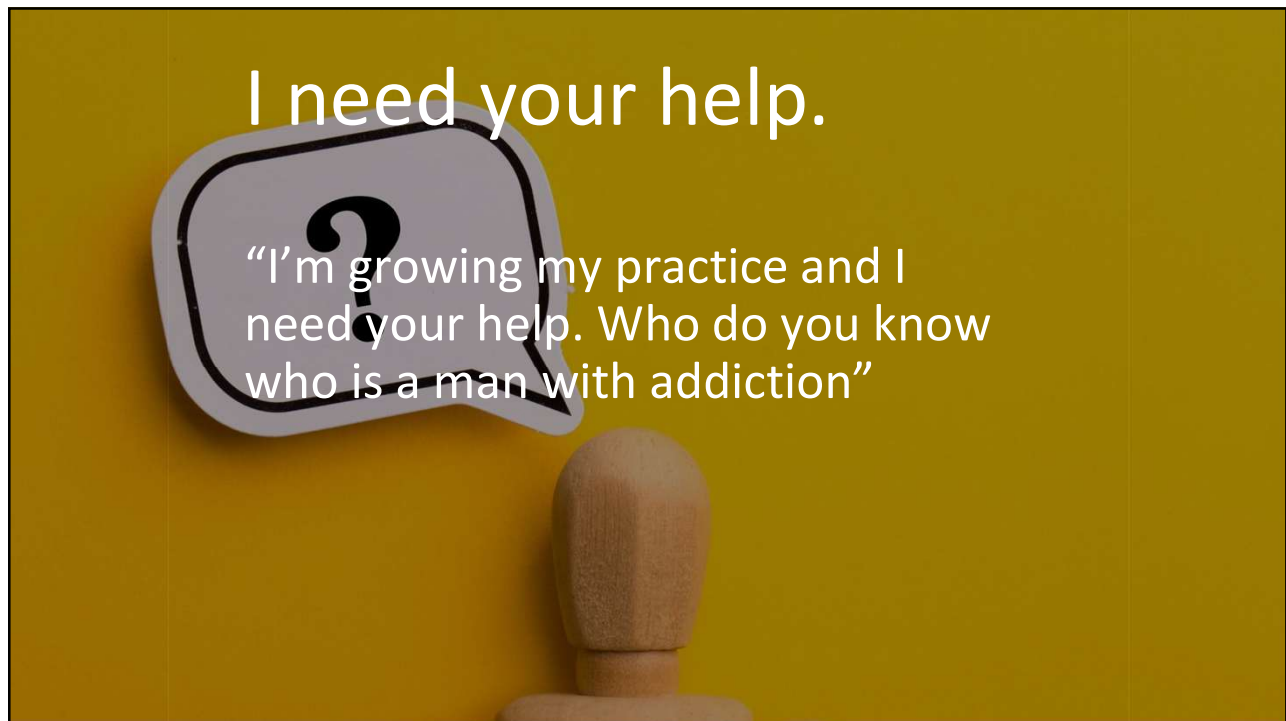
Schools +
Prevention

Peer Support +
Clinical Care

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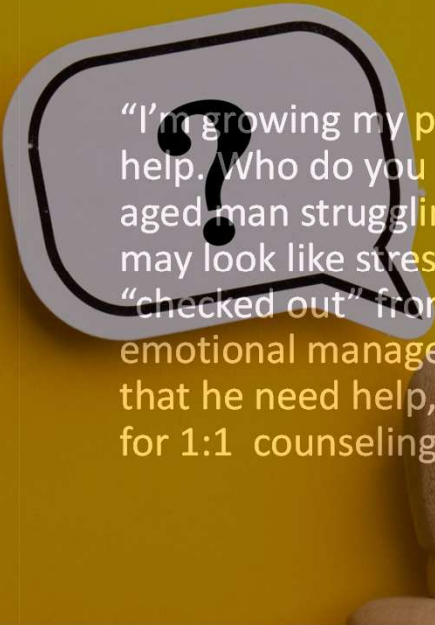


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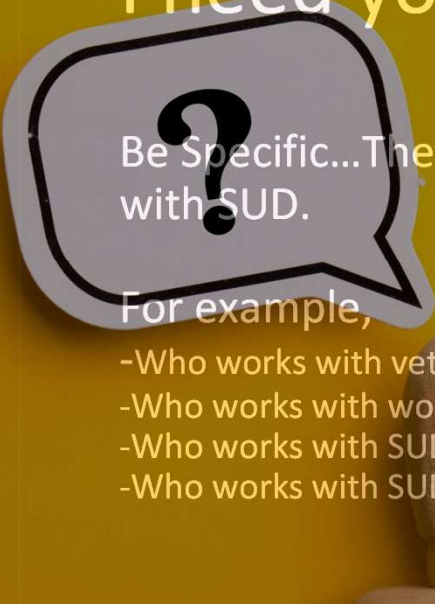
I need your help.



"I'm growing my practice and I need your help. Who do you know who is a middle-aged man struggling with anxiety which may look like stress at work or being "checked out" from his spouse. He needs emotional management tools but denies that he need help, but needs a safe space for 1:1 counseling and men's group"

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I need your help.



Be Specific...The left-handed carpenter with SUD.

For example,

- Who works with veterans?
- Who works with women with children?
- Who works with SUD and eating disorder?
- Who works with SUD and gambling disorder?

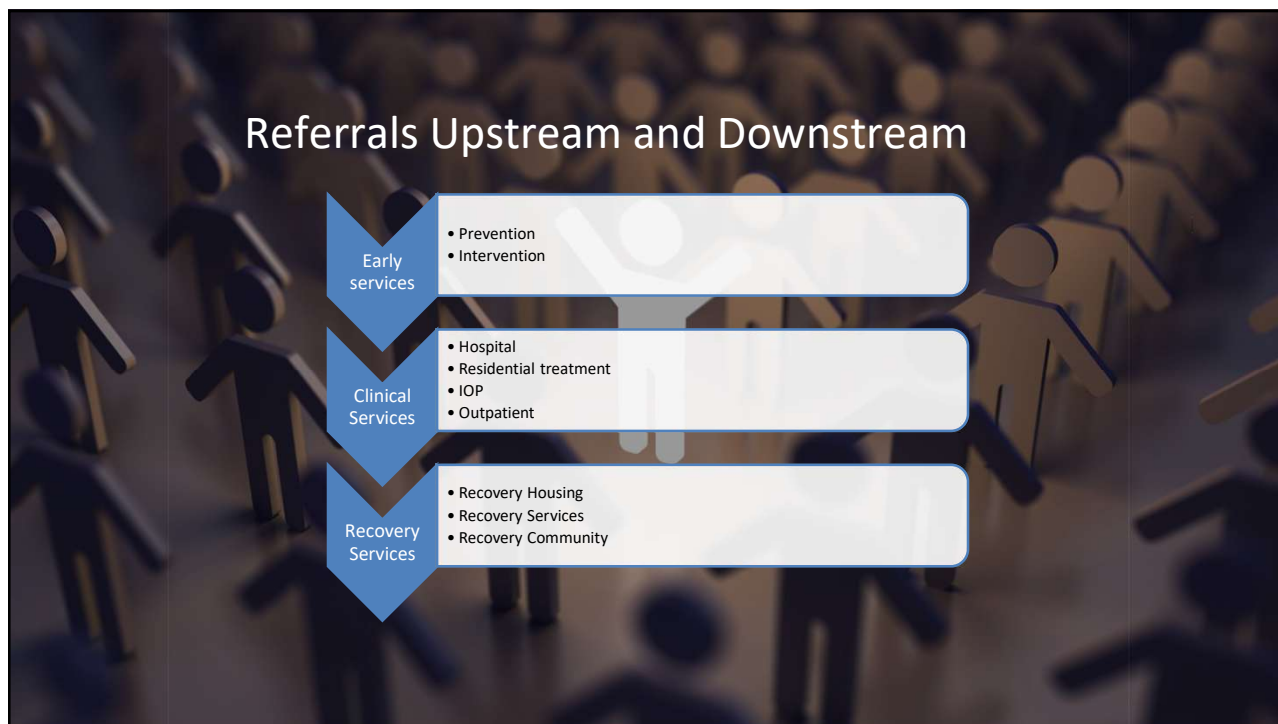
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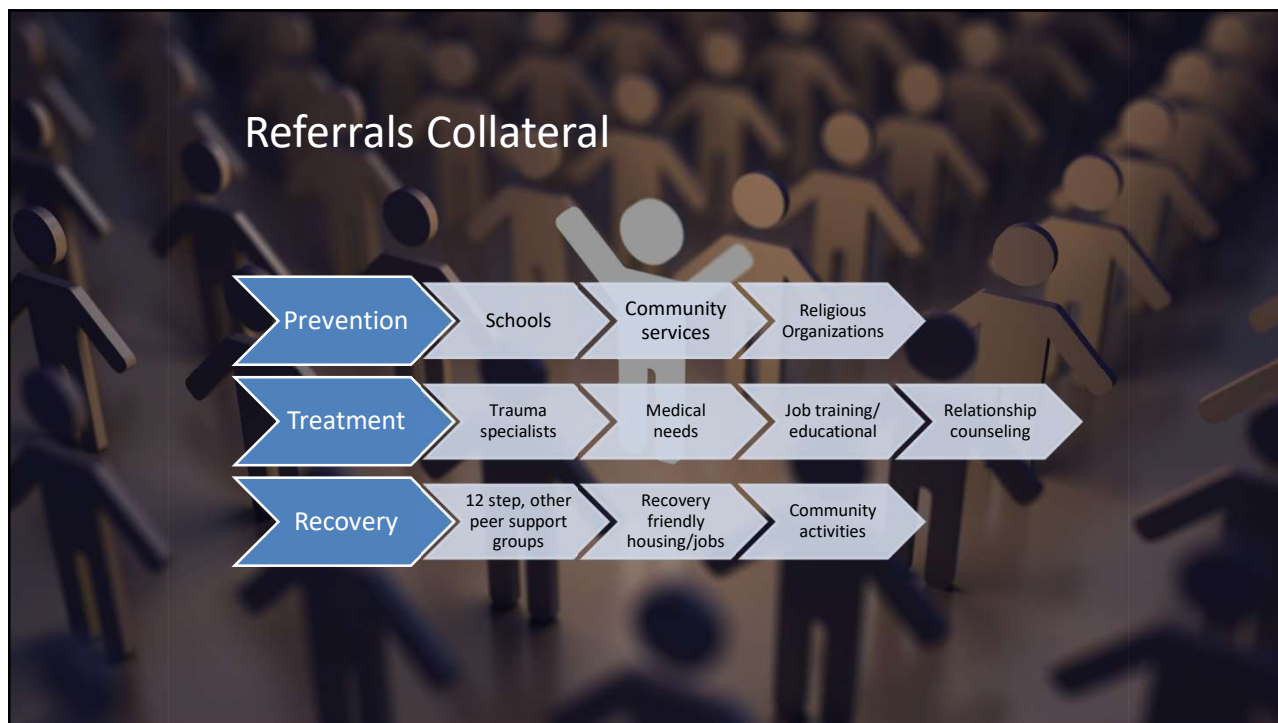
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Referrals

Brainstorming
1 minute

How many things can I think of that
are upstream to refer to me?

How many services can I think of that
are downstream that I refer to?

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Learning Objective 3

- Apply connection-based care principles:
 - Assess for disconnection, not just diagnosis
 - Engage whole communities, not just individuals

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Relationships

Addiction is a
disease of
isolation....



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Relationships

- Consider:
 - My beliefs influence the treatment
 - Attitudes of others around the individual influence treatment
 - Relationship issues of isolation, connection, and judgement influence treatment

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Recovery Capital



Citizenship	<ul style="list-style-type: none">• Sense of Belonging• Social Contribution
Social Support	<ul style="list-style-type: none">• Positive Relationships
Global Health-Psychological	<ul style="list-style-type: none">• Confidence
Recovery Experience	<ul style="list-style-type: none">• Life Purpose, Optimism
Substance Use and Sobriety	<ul style="list-style-type: none">• Achieving Abstinence

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Recovery Capital (William White)

- Isolation/Connection
 - I feel like I have meaningful positive communication in my family and community
 - I have friends who are supportive of my recovery process
 - I have established close affiliation with a local recovery support group.
- Hopelessness/Hope
 - My personal values and sense of right and wrong have become clearer and stronger in recent years
 - I now have goals and great hopes for my future
 - I know that my life has a purpose


Hanauer et al. (2019)

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Therapeutic Alliance

- As counselors, our role is to:
 - Foster individual change
 - Model a safe and trusting relationship
 - Facilitate development of these relationships in the individual's system of recovery supports
 - Maintain cultural competency and context



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Therapeutic Alliance

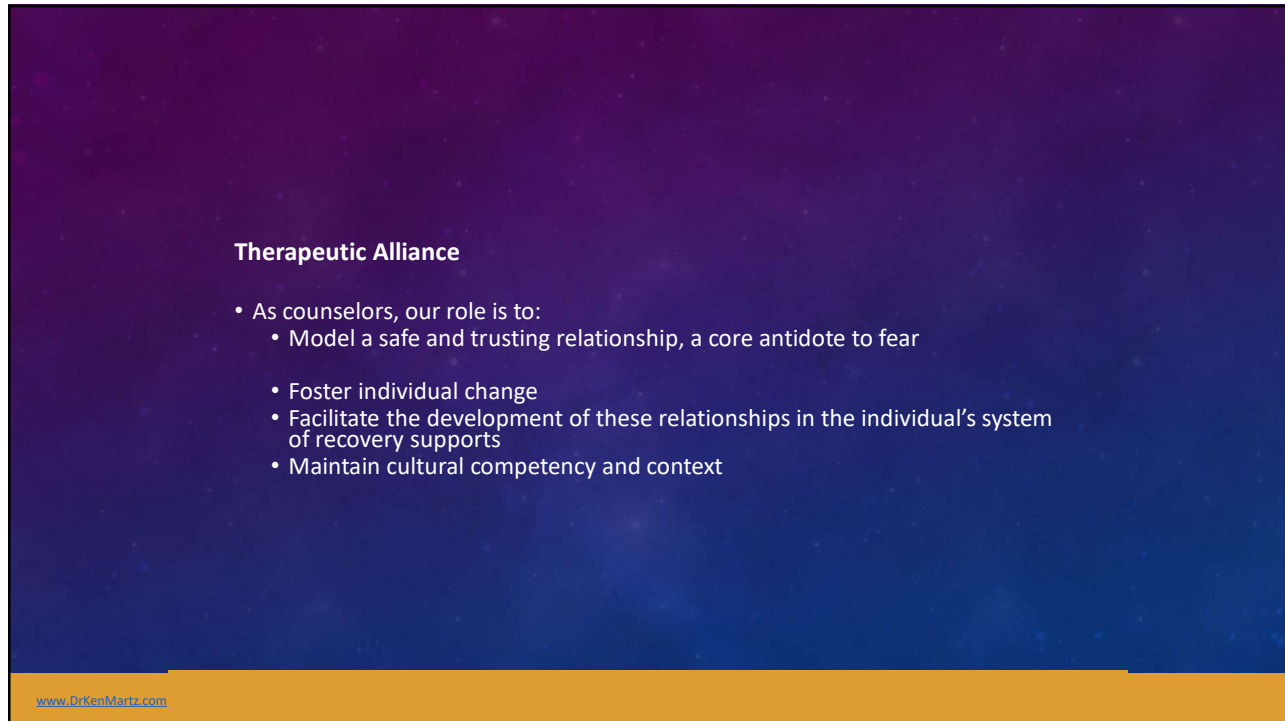
What is it about relationships that are healing?

- As counselors, we can do many things to help such as:
 - Empathy
 - Warmth
 - Genuineness
 - Open communication
 - A safe space to explore difficult emotions
 - Balance support, with courage to alter difficult emotions
 - Time and consistency

Peterson et al. (2019)

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Therapeutic Alliance

- As counselors, our role is to:
 - Model a safe and trusting relationship, a core antidote to fear
 - Foster individual change
 - Facilitate the development of these relationships in the individual's system of recovery supports
 - Maintain cultural competency and context

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Therapeutic Alliance

- As counselors, we can do many things to help such as:
 - A safe space to explore difficult emotions
 - Time and consistency
 - Empathy
 - Warmth
 - Genuineness
 - Open communication
 - Balance support, with courage to alter difficult emotions

Peterson et al. (2019)

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Therapeutic Alliance Apply It Now

What is it about relationships that are healing?

- Choose one important person in your life. Rate them on a scale of 1-10 on how much you show them:
 - Empathy
 - Warmth
 - Genuineness
 - Open communication
 - A safe space to explore difficult emotions
 - Balance support, with courage to alter difficult emotions
 - Time and consistency

And can they share these with you?

What about one other person that you do not like?

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Your Role in System Change

- Provider
- Administrator
- Advocate

“The system isn’t broken. It was built this way. And we can rebuild it.”

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Invitation to Action



Make one
connection you
haven't been making



Create one
collaboration you've
resisted



Start one
conversation in your
agency

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Action Planning Activity

The 90-Day Connection Plan:

- Write one actionable change
- Name one colleague to share it with
- Define success and invite support

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THANKS!

CONTACT INFORMATION
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www.DrKenMartz.com

Healing is a team sport
Don't just feel inspired. Go home with tools for change.

**Meditation for inner connection
HERE**

**Download Posters
HERE**

**Download PowerPoint
HERE**

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Accessing the CE Quiz

Courses >> Haley and Jessie Test the C... >> Live, Interactive Webinar: ... >> NAADAC - CE Instructional P...

NAADAC - CE Instructional Process

Overview

THANK YOU

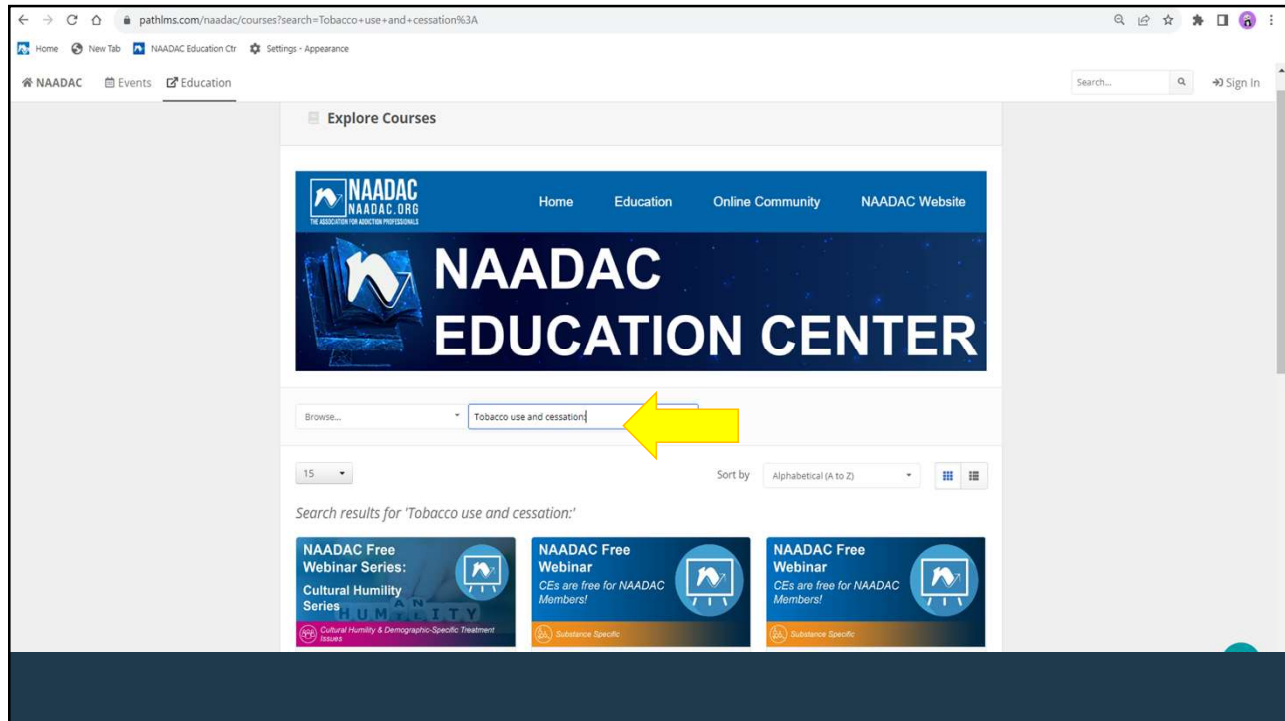
Thank you for attending this webinar! In order to get your CE certificate, you will need to pass the content knowledge quiz with a score of 80% or higher and complete the survey evaluation. [Click here to access the CE quiz.](#)

CONTRIBUTORS

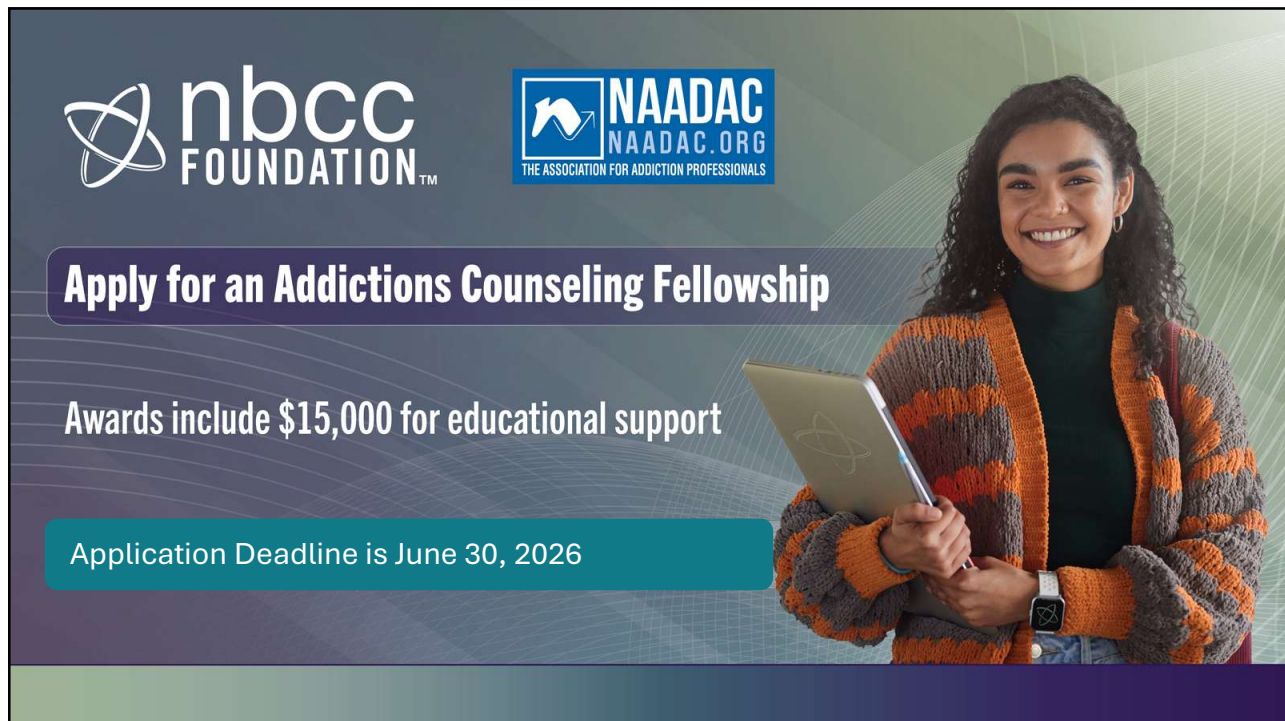
November 28, 2022
Mon 9:30 AM EST

DURATION 0H 30M
This live web event has ended.

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UPCOMING FREE WEBINARS

<p> April 29, 2026 @ 12:00 PM ET <i>Ethical Issues and Best Practices in Substance Use Disorder Treatment</i> Presented by: Malcolm Horn, PhD, LCSW, MAC, SAP</p>	<p> May 13, 2026 @ 12:00 PM ET <i>Supporting Individuals Engaged in Opioid Use Disorder Treatment for Peer Professionals, Recovery Coaches, Mentors, and Related Helpers</i> Presented by: Chris Allende, CPSS</p>
<p> May 6, 2026 @ 12:00 PM ET <i>The New Vape Landscape: Dual Use and What to Know</i> Presented by: Kristina Fenn Silver, MA</p>	<p> May 20, 2026 @ 12:00 PM ET <i>The Skill of Taking Steps: Using DBT In Conjunction with 12 Steps</i> Presented by: Laura Goldstein, LCMFT and Sara Varga, LCSW-C</p>

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Restoring Balance: Mindful and Holistic Practices in Addiction and Recovery

A six-part specialty online training series designed for addiction professionals, exploring mindful, spiritual, and holistic approaches to support recovery and long-term wellness.

On-Demand	Soulful Steps: The Spiritual Path to Recovery
On-Demand	Mindfulness in the Addiction Field: Sitting with Discomfort
On-Demand	Breaking Addiction with Breath: A Transformative Framework
On-Demand	Thriving in Sobriety: Building Emotional Resilience & Daily Wellness Practices
On-Demand	A Philosophy of Self-Care
On-Demand	Nourishing Recovery: Plant-Forward Nutrition & Faith-Informed Support

Each webinar is 1.5 hours | \$25 per session (includes CE hours)
Participants who complete all six webinars are eligible for a Certificate of Achievement.

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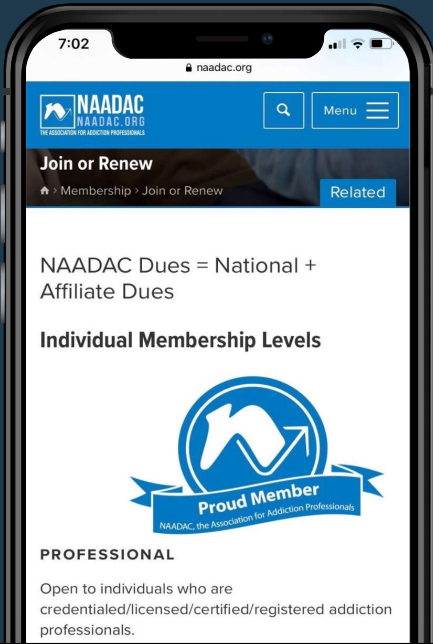
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Empowering Addiction Service Providers: Best Practices for HIV, HCV, and HBV

- 1 HIV Screening and Prevention
- 2 Supporting Clients With HIV: What You Need to Know
- 3 Viral Hepatitis: HCV and HBV Screening and Treatment Support
- 4 Optimizing Protocols for Care of Clients with SUD with or at Risk for Viral Infections

Designed for addiction service providers to strengthen knowledge and care strategies related to HIV, HCV, and HBV.



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Thank You

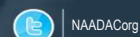


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