

California Social Work Education Center

C A L S W E C

**ASSESSMENT, INTERVENTION, AND
RECOVERY SUPPORT FOR
SUBSTANCE-ABUSING PARENTS IN
THE CHILD WELFARE SYSTEM**

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation's largest state coalition of social work educators and practitioners. It is a consortium of the state's 19 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is "to facilitate the integration of education and practice." But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become "educated" and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, and worldwide, curriculum sections are made available online or at cost through the CalSWEC Child Welfare Resource Library (www.csulb.edu/projects/ccwrl).

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.

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Thanks to David Hurley for his editing assistance.

EDITOR'S PREFACE: THE CURRICULUM COMPETENCIES

The California graduate schools of social work have been educating public child welfare workers using the Competency Based Child Welfare Curriculum since 1992. The Curriculum was modified in January 1996 based on input from all constituent members of CalSWEC, including deans and directors of social work programs, directors of county welfare agencies, professional organizations such as NASW, field liaisons, classroom faculty, students, graduates, and community members throughout the state. Our coalition now includes 12 graduate schools of social work and plans are underway for the graduate curriculum to articulate with the statewide training academy in-service curriculum for child welfare workers.

The competency-based approach is designed to encourage schools to infuse child welfare content into already existing resources, to develop new courses addressing a specialization in public child welfare, and to create guidelines for consistency in field placements in public child welfare. It is intended to allow for maximum decision-making opportunities on the part of the schools while still paying attention to the provision of a consistent experience for the pre-service student of child welfare.

The material in this manual specifically addresses the issues of assessment, treatment, and recovery for substance-abusing parents. There is an Appendix on websites for information on organizations concerned with helping persons addicted to drugs and/or alcohol which includes links to other sites.

The instructor can use this material to address a combination of the following public child welfare competencies. The four competencies that address parental substance abuse most directly are highlighted:

Ethnic Sensitive and Multicultural Practice

- 1.4 Students can develop relationships, obtain information, and communicate in a culturally sensitive way.
- 1.5 Student considers the influence of culture on behavior and is aware of the importance of utilizing this knowledge in helping families improve parenting and care of their children within their own cultural context.

Core Child Welfare Skills

- 2.1 Student understands that child abuse and neglect are presenting symptoms of social and family dysfunction.
- 2.2 Student is able to assess the interaction of individual, family, and environmental factors which contribute to abuse, neglect, and sexual abuse, and identifies strengths which will preserve the family and protect the child.
- 2.4 Student gathers, evaluates, and presents pertinent information from informants, case records, and other collateral sources to support or refute an abuse or neglect allegation.
- 2.6 Student understands the dual responsibility of the child welfare caseworker to protect children and to provide services and support to enable families to care for their children.
- 2.7 Student recognizes signs and symptoms of drug and alcohol abuse in children and adults and assesses the impact on families and children; understands individual and family and cultural dynamics in substance abuse.**
- 2.9 Student accurately assesses the initial and continuing level of risk for the abused or neglected child within the family while ensuring the safety of the child.

Social Work Skills and Methods

- 3.3 Student demonstrates the ability to evaluate and incorporate information from others, including family members and professionals in assessment, treatment planning, and service delivery.
- 3.4 Student conducts effective casework interviews.

- 3.5 Student understands the importance of and demonstrates the ability to work with the client in the community, including home, school, etc.
- 3.6 Student is aware of his or her own emotional responses to clients in areas where the student's values are challenged, and is able to utilize the awareness to effectively manage the client-worker relationship.
- 3.7 Student assesses family dynamics, including interaction and relationships, roles, power, communication patterns, functional and dysfunctional behaviors, and other family processes.**
- 3.8 Student understands crisis dynamics, identifies crises, and conducts crisis intervention activities.
- 3.11 Student can engage clients, especially nonvoluntary and angry clients.**
- 3.20 Student understands and knows how to plan for and implement home-based services whenever possible to prevent removal of children from their homes.
- 3.21 Student effectively and appropriately uses authority, while continuing to use supportive casework methods to protect children and engage families.
- 3.22 Student is able to evaluate the need for removal and placement of a child by weighing the risk to the child of continuing to remain in the home against the potential trauma of separation and placement.
- 3.23 Student understands and conducts an ongoing process of reassessments and makes appropriate modifications to the case plan.

Human Development and Social Environment

- 4.9 Student understands the impact of adult/parental substance abuse on child development and family functioning.**
- 4.10 Student understands the impact of adult/parental psychopathology on child development and on family functioning.

Sherrill J. Clark, PhD, MSW
Curriculum Specialist
January 1998

INTRODUCTION

This manual was commissioned by the California Social Work Education Center to provide substance abuse curriculum modules for child welfare students and social workers. These modules can be utilized by both social work faculty and field instructors. Each module is separate and distinct and can be utilized alone or in conjunction with the other modules. This manual has been used in short workshop trainings with child welfare social workers as well as with graduate students.

This manual was integrated into a three-credit substance abuse course for graduate social work students, taught by the author, at San Diego State University. Although the material is written specifically for child welfare, many of the social work students who were not in child welfare found the material relevant as well.

Students were assigned to attend at least two self-help meetings (one being AA) and to write about their experiences and feelings for later discussion in class. One student, a CPS worker, shared that he saw a former client at a meeting but he did not acknowledge her nor did she acknowledge him. At the closing prayer, she came and stood next to him and took his hand, then vanished as soon as it was over. He told the class he wasn't sure what it meant. The class responded that it was probably intended to say, "Thank you." We all felt moved. Students' acknowledgment of their feelings of fear and anxiety in attending these meetings gave some insight into what clients may experience.

Students were also asked to interview someone in recovery, and write this up as a clinical narrative. The primary student feedback from this assignment was that it "gave me hope." We too often see the negative side of addiction. Yet we must remember that recovery is possible.

It is hoped that this manual will be useful and can serve as a foundation to which new material can be added as we grow in our knowledge of addiction and the recovery process.

Melinda Hohman, PhD
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December 1997

MODULE I

ASSESSMENT AND INTERVENTION

MODULE I

ASSESSMENT AND INTERVENTION

Objectives (Slide 1)

1. Describe the components of *Motivational Interviewing*, including the *Stages of Change*, and how these are utilized by the nonspecialist.
2. Demonstrate through role play the skills needed for *Motivational Interviewing*.
3. Describe the difference between screening and assessment for substance abuse.
4. Describe several types of screening tools for both substance abuse and for demonstrating the Stage of Change.

MOTIVATIONAL INTERVIEWING

We will begin with *Motivational Interviewing* as it is an intervention style that can set the stage for assessment as well as intervention.

Objective #1: Describe the components of *Motivational Interviewing*, including the *Stages of Change*, and how these are utilized by the nonspecialist.

Motivational Interviewing is a *style* or technique developed for therapists to help motivate their clients to seek help for an addiction problem.

- Motivation is seen as something that develops in the interaction between therapist and client.
- This technique has been used in a variety of settings: with sex offenders, heroin addicts, smokers, and alcoholics (Miller & Rollnick, 1991; Garland & Dougher, 1991).
- Used by addiction professions as well as nonspecialists, particularly in brief therapy settings.

- This technique is very similar to client-centered counseling. It is based on social values, such as working as a partner with client, client self-determination, client empowerment, and respect and dignity of all humans.

Classroom Discussion Questions

How many people here have ever been on a diet, or have tried to or have actually quit smoking?

Think about the process you went through. Would anyone care to describe it?

(Encourage participants to think about when they started to think about changing, how they prepared to change, and then how they went about it.)

Before we can use *Motivational Interviewing*, we need to assess a client's readiness to change. Most people pass through five stages in the process of change.

Stages of Change Model (Slide 2) (Prochaska, DiClemente, & Norcross, 1992)

- Model based on studies of self-changers, variety of problems
- People tend to recycle through the stages several times

Stage 1 **Precontemplation:** The person does not see that there is a problem, or if, has a vague awareness of it, and has no intention of changing. Therapists tend to see a lot of denial, defensiveness, minimization, and projection.

Stage 2 **Contemplation:** The person becomes aware of the problem, and needs a period of contemplation to think about change, what it means, what is involved (usually about 6 months). Person may appear ambivalent, anxious, fearful of changing, depressed. Premature action in changing usually leads to failure. (Have class give examples from their own experiences.)

Most social workers see clients who are in either of these first two stages (Barber, 1995).

Stage 3 **Preparation:** The person is thinking about changing within the next month. The person decides that the problems with the addiction outweigh the benefits of continued use. He or she may decide that

change is too difficult and return to Stage 1 (show how the person recycles out in diagram **[Slide 3, then back to slide 2]**).

- Stage 4 **Action:** The person takes concrete, behavioral steps to change, and carries through with these actions for at least 6 months.
- Stage 5 **Maintenance:** The person thinks about the differences between stopping and staying stopped. The person continues to apply the behavioral steps learned in Stage 4.
- Stage 6 **Relapse:** Relapse is usually part of the change process; few persons terminate behaviors first time around the wheel. A *lapse* is not necessarily a *relapse*—depends on how it is handled.

Classroom Discussion Questions

What do you think is the difference between action and maintenance? (Encourage participants to tie in with their own examples.)

- The person sustains all changes that are made, lasts from 6 months to a lifetime.

What is relapse?

We will look at specific reasons why people relapse and ways to handle it in another session.

Assessing Stages of Change

In order to assess the stages of change the social worker needs to know:

- The stage the person is in, in order to use the correct motivational techniques,
- That pushing into action too soon is a set-up for failure, as client is seen as resistant or in denial,
- How to use specific measuring tools: SOCRATES (see p. 15).

Objective #2: Demonstrate, through role play, the skills needed for *Motivational Interviewing*.

SKILLS NEEDED FOR MOTIVATIONAL INTERVIEWING

Common Elements of Successful Outcomes (Slide 4)

Miller and Rollnick (1991) studied various types of brief counseling and based *Motivational Interviewing* on six elements they found that were common to successful outcomes (FRAMES acronym):

Feedback: Information about how drug/alcohol use is affecting the client.

Responsibility: Responsibility to change ultimately rests with the client.

Advice: Yes, clients do often want advice, but it must be given with caution.

Menu of choices: Therapists need to know about several different kinds of treatment.

Empathy: Clients respond to a counselor who is warm, understanding. Old style drug/alcohol counseling of heavy duty confrontation has been shown to be ineffective.

Self-efficacy: The counselor should support the client by building the self-efficacy of the client, that is, his/her belief that he/she can make the needed changes.

Five General Principles of Motivational Interviewing (Slide 5)

Taking these elements, Miller and Rollnick developed *Motivational Interviewing*, which follows five general principles:

- 1. Express empathy:** It is important to convey acceptance of the person. This principle involves active/reflective listening techniques.

Classroom Discussion Questions

Does anyone remember studying these principles? How would you describe active listening?

(Active listening is a technique whereby one listens for the feeling content (which can be the actual content) and reflects that back to the client, with the expectation that the client feels listened to and continues to clarify his/her problem.)

Classroom Exercise

Give an example: Ask a volunteer to role play active listening with you. Ask a volunteer to share with you how he/she felt about coming to this training/class.

Share with participants that active listening is actually a tricky skill to master and usually takes some practice.

Why do you suppose that Miller and Rollnick highlight empathy and active listening as their first principles? How do you feel when you know someone is really listening to you?

- 2. Develop Discrepancy:** Clients need to understand that drugs/alcohol are impacting their lifestyle and relationships with children.

Help clients with a "decisional balance"—whereby the client sees how the problems of using outweigh the benefits.

Arguments for change should be elicited from the client, not the counselor.

- 3. Avoid Argumentation:** Argumentation only increases resistance.

It is important not to label the client. She may say, "Are you telling me I'm a drug addict?" Avoid arguing by telling her it is not up to you to label her; labels don't mean much anyway; what is important is for her to discuss with you her concerns about her drug use.

- 4. Roll with Resistance:** Miller and Rollnick define resistance as "signals that the client is not keeping up" (1991, p. 101). They believe that many times resistance is not a personality characteristic but a product of client-therapist interaction.

- **Signs of Resistance** (Miller & Rollnick, 1991)

- Arguing
- Interrupting
- Denying
- Ignoring

Classroom Discussion Questions

What does resistance feel like? Can you give me an example of client resistance?

How do you handle resistance? What do you suppose it means to “roll with it?”

- **Handling Resistance (Slide 6)**

Simple Reflection: Respond with nonresistance: use reflective statements to let client know you heard what he or she said. Example: Client says, "It's none of your business how much I drink!" The social worker responds, "You feel that the amount you drink does not impact your parenting, and thus my role as your social worker."

Amplified Reflection: The therapist reflects the content or emotion of the client to a greater degree than what was meant. However, Miller and Rollnick (1991) warn against sounding sarcastic. Example: Client states, "A little pot now and then never hurts anyone." The social worker replies, "Your drug use has absolutely no impact on you or anyone in your family."

Double-Sided Reflection: Like the simple reflection, the therapist reflects the content or emotion of the client's statement, but also reflects his or her ambivalence by reminding him or her of what has been previously stated. For example, as noted above, the client indicates she sees no problem with smoking marijuana. The social worker replies, "Your drug use has no impact on you and your family, yet you may not be sure, because you know how much your mother's drinking impacted you when you were little."

Shifting Focus: Miller and Rollnick (1991) define this as taking a "detour" (p. 107) around a stumbling block. Example: Client states, "Hey, you're not going to take my kids away from me, are you?" The social worker replies, "No one has said anything about that! That would really be jumping the gun! What I am interested in is you and what you think about your marijuana use."

Emphasizing Personal Choice and Control: The client is reminded that it is up to him or her to make a decision about whether or not to quit drugs/alcohol; no one else can do that.

Reframing: This is when the social worker takes some of the client's statements and reframes them by putting them in a different light or by giving them a different meaning. Miller and Rollnick (1991) indicate that

a perfect example of this is when a client thinks that he or she is doing okay because he or she can drink even more than his or her friends and not show the effects. In actuality, this is indicative of tolerance which is a warning sign of alcoholism.

Paradox: Miller and Rollnick (1991) write that this is a tricky method and should be used carefully, perhaps even as a last resort. Again, you don't want to sound sarcastic; the goal is to put the pressure on the client to tell you why they need to change. Telling them they probably can't change may push them to argue for it.

Miller and Rollnick (1991) give a great example:

You remember we talked about all the pros and cons of drinking, and although you told me quite a few reasons why alcohol is causing you trouble, I think what I'm hearing is that for you the pros still outweigh the cons. You're quite happy drinking as you were, and don't really want to change. That choice is yours to make *[emphasizing personal choice and control]* and perhaps that's what you should do. Clearly, it would be hard for you to change your drinking—maybe too hard for you. Maybe you couldn't even do it if you tried. It sounds like what you really want is to go on drinking as much as you were before, or more. Maybe that's what you need. Maybe you need alcohol to cope with life (p. 110).

4. Support Self-Efficacy (back to Slide 5):

- Support, encouragement
- Convey belief that client can change, that things can be different
- Client is responsible, with your help, to make the change.

Tools for Use by the Nonspecialist (Slide 7)

Question: So how do we put this all together? Rollnick and Bell (1991) give specific guidelines for the “nonspecialist” that help provide a framework:

Format for a Client Interview

Ask about substance use in detail. Ask about:

- A typical day
- Lifestyle and stresses
- Health, then about substance use related to health
- The good things about using, then the “less good” things
- Substance abuse in the past and now
- Clients’ concerns directly and specifically
- The next step

Throughout: Provide information—summarize what you have heard—and ask “What do you think?”

[Go over list, then go back and ask class for feedback about each step. For example, ask what kinds of questions you would use to get someone to describe their substance use in detail, while still utilizing the principles of *Motivational Interviewing*. Examples: Tell me about your use of marijuana. How often do you get high? What are its effects? Do you use more than you need to, to get the same effect? How do you think your marijuana use affects your family? What do your children say to you about it? Write questions on big sheets of paper if possible, and tape up around room. Do same for steps 2 through 6. Then role play the following scenario (or use own), with the instructor as the counselor.]

Demonstrate through role play the skills utilized in *Motivational Interviewing*.

Role Play [Read to class]

Cindy is a 28-year-old white female who was anonymously reported to CPS for being “out to all hours” and leaving two children, a boy 8, and a girl 6, home alone. The emergency response worker found the home to be messy, with piles of clothes everywhere, and there was only orange juice in the refrigerator. Cindy denied the allegations and said she is always home with her children. She has never been married and receives AFDC. On a second visit to the home, the emergency response worker found the clothing picked up and food in the refrigerator. The case was turned over to voluntary services.

Before interviewing her, the voluntary services social worker learned that Cindy had previously been in drug counseling for methamphetamines, and had told the ER worker that she “had quit.” Despite this statement, Cindy’s hands shook as she explained this to the ER worker, and she appeared quite agitated and jittery. Although beer cans were stacked in a window, Cindy has stated that she only drank occasionally with her friends.

Question: Knowing this little bit of information, where would you start, on this list? Cindy has already given answers (minimally) to #1.

[The instructor may want to ask a colleague who has a background in working with clients with drug problems to play Cindy. You will need someone who can realistically answer the questions. Integrate motivational interviewing techniques throughout, while following the non-specialist’s list; stop the role play periodically to ask students to comment on the process, and to point out what techniques they have seen you use.]

THE DIFFERENCES BETWEEN SCREENING AND ASSESSMENT

Objective #3: Describe the differences between screening and assessment for substance abuse.

Classroom Discussion Question

What do you think is the difference between screening and assessment?

[Have students generate ideas and list on board.]

1. Screening

- Intention is to determine whether alcohol and drugs are actually being used.
- And, if they are being used, to determine if the client is at high risk for problems.
- Screenings generally focus on actual use and related behaviors or problems.
- Usually are brief, easy to administer and score, and can be given by non-substance abuse specialists.
- Seen as a place to begin, to refer for further assessment (Cooney, Zweben, & Fleming, 1995.)

2. Assessment

- Assessments are more in-depth.
- Looks at drug/alcohol use in more detail, as well as other psychosocial concerns.
- Can lead to ranking regarding client's drug or alcohol use (mild, moderate, or severe) as well as to diagnosis.
- Lead to a detailed understanding of the individual client, and a specific treatment plan (Cooney, Zweben, & Fleming, 1995). Can be used to focus on specific issues, such as to determine the client's Stage of Change, motivation to change, presence of a psychiatric disorder, etc., (Miller, Westerberg, & Waldron, 1995).

3. Problems With Screenings/Assessments

- The caseworker should establish some rapport with the client before attempting to ask even screening questions; drug and alcohol use are sensitive issues, particularly if the client is afraid of losing custody of children; scale questions can feel depersonalizing.
- Closed-ended questions on the scales do not allow room for discussion or probing; however, a social worker can use these questions as jumping-off points for later, further discussion.
- Many of the scales focus on later stages of drinking/drug use problems, and do not pick up early stage issues.
- Sometimes the questions are perceived as accusatory (CSAP Curriculum Modules, 1995), and clients may be resistant.
- Still screenings and assessment questionnaires can be valuable tools.

Objective #4: Describe several types of screening tools for both substance abuse and for determining the stage of change.

EXAMPLES OF SCREENING AND ASSESSMENT INSTRUMENTS

The following descriptions of several types of screening tools and assessment questionnaires, for both substance abuse and determining stages of change can be used as handouts.

1. TWEAK (Russell, 1994) (Slide 8)

- This screening tool was developed specifically for pregnant women.
- It is brief, easy to administer, and easy to score.
- While it cannot be used to measure for substances other than alcohol, it is a good place to start; people are less threatened by discussing their alcohol use than their drug use.

TWEAK (Slide 8)

(Russell, 1994)

- T Tolerance:** How many drinks can you hold?
- W** Have close friends or relatives **Worried** or complained about your drinking in the past year?
- E Eye-Opener:** Do you sometimes take a drink in the morning when you first get up?
- A Amnesia:** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- K (C)** Do you sometimes feel the need to **Cut Down** on your drinking?

Scoring:

- The tolerance question scores 2 points if a woman reports she can hold more than five drinks without falling asleep or passing out.
- If “yes” to the Worry question, score 2 points.
- If “yes” to other questions, each scores 1 point.
- A total score of 2 or more points indicates that the woman is likely to be a “risk drinker.”

Four Ps (Screening tool) (Slide 9)

(Ewing, 1992)

- P** Do your **P**arents have an alcohol or drug problem?
- P** Does your **P**artner use alcohol or drugs?
- P** Have you had an alcohol or drug **P**roblem in the past?
- P** Have you used any drugs, alcohol, or cigarettes during your **P**regnancy?

A positive response to one or more of the questions would merit a further assessment. This instrument is still under validation, but clinicians in health clinics like it because it addresses both drugs and alcohol and family issues.

AUDIT (Alcohol Use Disorders Identification Test)

(Babor, de la Fuente, Saunders, & Grant, 1992)

(Slides 10-13 and Handout 2)

This is a structured screening tool developed by the World Health Organization for use by physicians. It is multicultural and is designed to screen for early identification of problem drinkers (Cooney, Zweben, & Fleming, 1995). This could be incorporated into an assessment packet used by social workers. It can be asked in an interview situation or given as a pen-and-paper questionnaire.

AUDIT scoring: A score of 8 or greater may indicate the need for in-depth assessment.

DAST (Drug Abuse Screening Test)

(Skinner, 1982)

(Handout 3)

This screening tool is similar to the MAST (Michigan Alcoholism Screening Test), which is for screening alcohol problems (See Hohman, 1996). It has 20 “yes” and “no” items. The total score then can range from 0 to 20, which provides an index of problem severity. A score of 5 or above indicates a problem. The test has been shown to be reliable, have good internal consistency, concurrent validity, and be little influenced by social desirability and denial in clients’ responses, unless the client has some motivation to underreport drug use (Skinner). Since many child welfare clients are likely to underreport drug use, the results from this screen should be considered carefully.

Copies of the DAST must be purchased from the Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1 (1-800-463-6273), at a minimal cost. Go to the Centre for Addiction and Mental Health website for full information:

http://www.camh.net/Publications/CAMH_Publications/drug_abuse_screening_test.html

SOCRATES

(The **S**tages of **C**hange Readiness and Treatment **E**agerness **S**cale)

(Miller & Tonigan, 1996)

This assessment tool was originally designed to assess the stage of motivation, according to the model developed by Prochaska, DiClemente, and Norcross (1992).

Analysis of the scale revealed that it measured three stages, which Miller and Tonigan (1996) have identified as Recognition, Ambivalence, and Taking Steps. The authors indicate that this scale measures different stage constructs from Prochaska et al., but it is still useful in the clinical setting. Feedback from the scale's results can provide an opportunity to discuss the motivation a client may have about change, or a test/retest can measure change from an intervention.

Test-retest reliability scores range from .82 to .93, and internal consistency scores range from .87 to .96. The scale is scored by summing the indicated subscales, and transferring them to a profile sheet. Clients can then be ranked as high, medium, or low in each of the three constructs (Miller & Tonigan, 1996).

This scale is in the public domain and may be reproduced and used without cost. It can be found at: <http://motivationalinterview.org/library/socrates8.pdf>

MODULE II

TREATMENT MODELS, PRINCIPLES, PROGRAMS, AND PROGRAM COMPONENTS

MODULE II

TREATMENT MODELS, PRINCIPLES, PROGRAMS, AND PROGRAM COMPONENTS

Objectives (Slide 14)

1. Describe the Patient Placement Criteria-2 (PPC-2), including the six assessment dimensions, and the Treatment Levels of Service.
2. Demonstrate, through the use of vignettes, the ability to use the Patient Placement Criteria-2.
3. Describe two models of alcoholism/drug abuse and their implications for treatment, including the components of treatment.

Objective #1: Describe the Patient Placement Criteria-2 (PPC-2), including the six assessment dimensions, and the Treatment Levels of Service.

Now that we (hopefully) have a client who is ready to enter some kind of treatment, which kind of substance abuse or alcoholism treatment is best?

- Sometimes the most pragmatic answer to that question is whatever treatment program they can afford that has an opening!
- Hopefully, there is some menu of options available. How do you, as the caseworker, match your client to the treatment that is best for him or her?
- One way is to have a good understanding of the different "levels of care," as they used to be called. This is now known as the Patient Placement Criteria-2 (American Society of Addiction Medicine, 1996).

PATIENT PLACEMENT CRITERIA-2

- Developed in 1991 by the American Society of Addiction Medicine in order for physicians, nurses, social workers, managed care caseworkers, and other health care professionals to have a standardized language and format for assessment, referral, case monitoring, and discharge.

- The original Patient Placement Criteria-1 was based on input from 130 organizations and was revised in 1996 to become the PPC-2. Some of its guidelines are:
 - The severity of the patient's problems should be matched to the type of treatment needed.
 - Patients should be started at the least intensive treatment that is appropriate.
 - Patients should be assessed on all dimensions (as will be noted) to see what "went wrong" if there is a treatment problem. Treatment "failure" may have less to do with the patient than with being matched incorrectly.
 - Treatment should always be individualized according to the patient's needs.

The Six Dimensions for Assessment (Slide 15)

While these dimensions are more geared toward health care professionals' assessments, caseworkers should be able to incorporate these dimensions into their assessments as well.

1. Acute Intoxication and/or Withdrawal Potential:

- How much medical supervision might the client need?
- What is the client using?
- What are the withdrawal problems the client might have that would need medical supervision?
- What has the client's withdrawal history been?
- Has he/she had seizures or other kinds of symptoms?
- Is the client in withdrawal now?

2. Biomedical Conditions and Complications:

- Are there any other medical conditions of which you might be aware that would impact treatment?

3. Emotional/Behavioral Conditions and Complications:

- Do you suspect that your client might have a "dual disorder," that is, an emotional or personality disorder along with the addiction?

- Does the client's depression seem to be separate from the addiction? This is often hard to evaluate until the client is detoxified; however, you may have a "sense" of this, or have concrete indications, such as prior psychiatric treatment.

4. Treatment Acceptance/Resistance: Hopefully, the use of *Motivational Interviewing* has motivated your client into treatment. Some are more open to it than others, however!

- How willing is your client to enter into treatment?
- Is he or she being forced into it by court order?
- Is your client more of a contemplator or in determination to take action?

5. Relapse/Continued Use Potential:

- Does your client have at least "good enough" social skills to participate in some sort of a self-help program or to reach out to other sober people for support?
- Does your client have any insight as to warning signs of relapse?
- Does your client have "good enough" coping skills to deal with stressful situations and other potentials for relapse?

6. Recovery Environment:

- Is the environment around the client supportive of staying sober? Are there any other family members in sobriety?
- What are the client's other resources, such as a place to live, employment, and social supports?
- Are there other social services available to the client that can provide support?

Class Discussion Question

Think about your caseload, and your "typical" drug-addict client. How would you describe him or her, using these six dimensions?

[Get class to discuss how they see their clients, using each of these dimensions. Most will identify #5 and #6 as being the most problematic for their clients...the "sequelae of poverty" (lack of resources, exposure to crime and violence, etc.) makes for additional problems for substance abusers. The class may want to discuss this at length.]

Now, let's look at the Levels of Service...

Levels of Service (Otherwise Known as the Continuum of Care) (Slides 16-17)

- Level 0.5:** Early Intervention: (not sure if abuse or dependence; educational or assessment screening, such as Driving Under the Influence Classes)
Opioid Maintenance Therapy (OMT): Methadone treatment (may be more than just outpatient).
- Level I:** Outpatient Treatment (weekly therapy)
- Level II:** Intensive Outpatient/Partial Hospitalization Services
- II.1:** Intensive Outpatient Treatment (about 9 hours/week)
- II.5:** Partial Hospitalization Treatment (about 20 hours/week)
- Level III:** Residential/Inpatient Services
- III.1:** Clinically managed, low intensity residential (halfway house, sober living home)
- III.3:** Clinically managed, medium intensity residential treatment (Extended Care)
- III.5:** Clinically managed, medium/high intensity residential treatment (Therapeutic communities, such as Phoenix House)
- III.7:** Medically monitored, intensive inpatient treatment (hospital based)
- Level IV:** Medically managed intensive inpatient treatment (hospital based, sees physician daily)

Objective #2: Demonstrate the ability to use Patient Placement Criteria-2 through the use of vignettes.

EXERCISES FOR PPC-2

Classroom Exercise

Putting it all together: Go to handouts or overhead and review categories. Students can be asked to meet in small groups to discuss vignettes (Handout 4) and determine which level of treatment is appropriate. Have students discuss their rationale for each decision.

Vignette #1

Sam is a 45-year-old male who has had three prior treatments for alcoholism. Currently he is drinking about one case of beer per day. He reports that he awakes in the morning shaking and drinks two to three beers to stop his tremors prior to going to work. Sam is currently being told by his boss that he either seeks treatment or he loses his job due to excessive tardiness. Sam lives alone in a rooming house as his wife has thrown him out. At this point, Sam reports he is feeling suicidal due to his impending job loss.

[Answer: Vignette #1: Level IV – Medically managed intensive inpatient services]

Vignette #2

Suzanna is a 29-year-old female who was in treatment as an 18-year-old for cocaine. She has remained abstinent from cocaine but still drinks. She was reported to CPS for neglect, for leaving her sleeping infant locked in a car while she was in a bar drinking with her friends. When the social worker interviewed her, Suzanna cried and said she wants to change, that she never really realized the impact her drinking has had on her.

[Answer: Vignette #2: Level I – Outpatient services]

Vignette #3

Gloria is a 35-year-old woman who has been involved in a Family Reunification program. Her children were removed due to her and her boyfriend's drug use. Gloria had attended outpatient treatment but failed a drug screen (positive for marijuana), which she claimed was due to her live-in boyfriend and friends—they just used drugs around her all the time making it really hard for her to quit. She is willing to work on her drug problem and wants to have her children home with her but needs a structured sober living setting to help her accomplish these goals.

[Answer: Vignette #3: Level III.1 – Low intensity residential services]

Objective #3: Describe two models of alcoholism/drug abuse and their implications for treatment, including the components of treatment.

- There are many different models of alcoholism/substance abuse and different types of treatment modalities.
- Two of the more common models will be presented; however, class members should feel free to discuss models and programs with which they have some familiarity as well.

MODELS OF ALCOHOLISM/SUBSTANCE ABUSE AND IMPLICATIONS FOR TREATMENT

The Disease Model

- This is probably the most widely used model in alcoholism treatment centers today. It is implemented in a modality called the Minnesota Model (Littrell, 1991), which was developed at treatment centers such as Hazelden in Minnesota in the 1970s.
- Alcoholism has been officially designated as a disease by the American Medical Association, The World Health Organization, The National Council on Alcoholism and Other Drug Dependencies, and the National Association of Social Workers (Brower, Blow, & Beresford, 1989).

Components of the Disease Model

- Alcoholism or drug dependence has biological components. It is considered a disease in that one is not morally responsible for "getting it."
- It is a disease because it is progressive in nature, with predictable outcomes. This progression was outlined by Jellinek in 1952 and included the psychological, behavioral, and physical symptoms.
- Once one is an alcoholic or addict, he or she will always have the disease, just like a diabetic will always have to live with diabetes. There is no cure at this time for either disease.
- While the alcoholic or addict is not responsible for getting the disease, he or she is responsible for getting treatment.
- Complete abstinence from all drugs is necessary for recovery. One is never "recovered," the alcoholic is always "recovering" due to the chronicity of the disease.
- The alcoholism or drug addiction is the primary problem; treating underlying pathology or problems will not eliminate the disease (Brower et al., 1989).
- Recovery is more than just abstinence; it involves taking on the identity of being an addict or alcoholic and becoming involved in a recovery program, which is

usually a 12-step group with a focus on spirituality. Spirituality is important because it involves changes in how the addict views him or herself, his or her relationships with others and with humankind in general (Miller & Kurtz, 1994).

- Treatment involves breaking through the defense mechanisms that are manifestations of the disease, such as denial and rationalization, so that the alcoholic/addict can begin to recognize the damage that substance abuse has caused, and to motivate him or her to begin a recovery program (Chernus, 1985).
- Many times, programs also use a model called the Biopsychosocial Model (Nunes-Dinis & Barth, 1993). This model utilizes the Disease Model but also looks at psychological and social factors in the alcoholic/addict's substance abuse.
- The addict must explore feelings and emotions that resulted from the addiction, such as guilt, shame, low self-esteem, anger, and learn new ways of handling these emotions (Wallace, 1996).
- Social problems, mainly relationships, must be addressed, as well as employment problems, arrests, etc. (Wallace, 1996).
- The family is considered to have a disease as well, in that they were impacted by the disease and the behaviors of the alcoholic, and they too need to get into recovery. Recovery for family members also means attending 12-step groups (such as Al-Anon, for family members of the alcoholic) and learning new communication and interaction styles (Rivers, 1994).
- Relapse prevention is a key component of alcoholism treatment (as will be discussed in Module III) since the alcoholic must learn to self-identify thoughts and behaviors that could lead to a return to drinking. Family members are helped to develop a contingency plan of what they will do if the alcoholic does relapse.

Goals of Treatment in Disease Model Programs (Slide 18)

(Morgenstern & McCrady, 1993)

These programs seek to have the client:

- Recognize his or her problem and commit to abstinence.
- Understand the loss of control over alcohol/drugs (of drinking and lifestyle problems).
- Accept chemical dependency as a disease.
- Believe in a Higher Power (accept that there is help “out there”).
- Identify with others in recovery.
- Make a commitment to AA.

Components of Treatment Programs Utilizing the Disease Model (Slide 19)

(Specifically inpatient. Other treatment programs may utilize same components but not necessarily all of them.)

- Detoxification
- Biopsychosocial Assessment
- Comprehensive Treatment Planning
- Drug Testing
- Group Therapy
- Individual Therapy
- Recreational Therapy/Activity Groups
- Psycho-Educational Groups (on the nature of the disease, family disease, relapse prevention, etc.)
- Family therapy; usually Multi-Family Groups
- 12-Step group attendance
- Case management: psychiatric, medical, legal, financial, housing, vocational, educational (Bachrach, 1996)

The Social Learning Theory/Model

Components of the Social Learning Theory/Model

- Addiction is a "maladaptive habit" (Brower et al., 1989, p. 150) that is learned from experiences in the environment and in relationships with others.
- People with alcohol problems have "learned" that alcohol will provide certain effects, that is, the effects of the alcohol are more a product of cognitive beliefs than actual pharmacological interactions (Brown, Christiansen, & Goldman, 1987).
- The alcoholic or addict can gain self-control through learning new cognitions about alcohol or drugs and through learning coping skills to deal with high-risk situations (Marlatt, 1985).
- It is up to the client to determine the treatment goal; it can be abstinence or it can be controlled drinking. Most therapists do not recommend the latter goal, however (Brower et al., 1989).
- Social support is important in treatment. Social skill training is used to teach coping skills for dealing with interpersonal conflicts and other stressful situations (Marlatt, 1985).
- Relapse prevention is a key treatment component. Clients need to understand triggers, cues to using, relationship issues, and develop strategies to cope with these problems.

Components of a Program Utilizing the Social Learning Model (The Neurobehavioral Model [Rawson, Obert, McCann, & Ling, 1991]) **(Slide 20)**

- This model is not a "pure" social learning model in that it does focus on the neurological effects of cocaine use, but many of its components are based on social learning principles.
- This model is administered in an intensive outpatient setting and the program lasts for 12 months.
- **Individual Therapy Sessions.** Specific content is covered, including:
 - Rating withdrawal symptoms
 - Teaching thought-stopping techniques to deal with drug-using cues and triggers; dealing with drug-using friends and developing a non-drug using support network
 - Monitoring personal behavior and lifestyle changes

- Monitoring exercise and nutrition
- Dealing with "the Wall"
- Dealing with emotions in recovery, including pleasant memories of drug use (Nunes-Dinis & Barth, 1993)
- **Educational Group.** Content covered includes:
 - The biology of addiction
 - Conditioning and addiction, including cues
 - Medical impacts of cocaine use
 - Addiction and the family
- **Stabilizing Group.** Held on Friday nights to focus on getting through the weekend without using:
 - Dealing with free time and structuring time
 - Coping with triggers
 - Positive activities to fill leisure hours
- **Relapse Prevention Group.** Called a "central component" (Rawson et al., 1991, p. 105). The content is specific to relapse.
 - Signs and symptoms of relapse
 - Dealing with fatigue
 - Dealing with holidays
 - Coping with cocaine dreams and other involuntary thoughts of using
 - Sex and recovery
 - Leading a balanced lifestyle
- **Family Group.** While family members are given a chance to discuss issues, therapists present a topic for group discussion:
 - Communication
 - Co-dependency
 - Family roles and rules
 - Healthy relationships
 - Relapse and family responses
- **Conjoint Sessions.** Marital therapy or family therapy for individual families, based on needs. While individual concerns are covered, the focus is on:

- Communication about positive areas of change
- Identifying problem areas
- Identifying strategies for dealing with problems
 - Drug testing
 - AA Meeting one night per week
- Relapse Analysis: this is rehearsal for what to do if relapse occurs. The client maps out what would be likely to cause a relapse and works with the therapist to design strategies of how to handle it to prevent it from becoming a bigger problem.

Which Model is Best?

Miller (1990), in reviewing research regarding different treatment models, drew several conclusions:

- Most research has found that no one approach is better than others, even when patients have been “matched” to specific treatment modalities. It is still important, however, to tailor treatment to the individual’s needs.
- Amount of treatment does not seem to make a difference whether it is inpatient or outpatient. This is interesting in that other studies have found that time in treatment is the biggest predictor of positive outcome (Bell, Richard, & Feltz, 1996).
- The style and personal characteristics of the therapist do seem to have an impact on how clients respond to treatment. These characteristics include “an empathetic and supportive style” (Miller, 1990, p. 261).

Overall, treatment is effective as reported in clinical trials, but some models, such as the disease model, have had little empirical investigation.

Suggested Components of Treatment for Women (Slide 21) (Beckman, 1994; Rhodes & Johnson, 1994; CSAT, 1994)

- Medical treatment, including treatment for reproductive health, sexual problems, HIV, STDs, and reproductive counseling.
- Sexual assault and physical abuse counseling: Women who have abused alcohol and other drugs have high rates of sexual abuse, incest, and domestic violence (Beckman, 1994).

- Substance abuse counseling that focuses on issues of low self-esteem, shame and guilt due to stigmatization of women alcoholics, feelings of helplessness, lack of identity, eating disorders, and depression.
- Social support skill training: Often women in treatment have limited social support from friends and family. They may have few skills in forming friendships with other women. Learning how to develop friendships and relationships not connected with drugs or alcohol is important.
- Parenting skills development.
- Other life skills development: Educational assessment, training or referral, vocational counseling.
- Other social services: Child care assistance, legal services, transportation services, etc.

MODULE III

SELF-HELP GROUPS, THE RECOVERY PROCESS, AND RELAPSE PREVENTION

MODULE III

SELF-HELP GROUPS, THE RECOVERY PROCESS, AND RELAPSE PREVENTION

Objectives (Slide 22)

1. Describe the characteristics of self-help groups, including Alcoholics Anonymous (AA), Women for Sobriety, Rational Recovery, and the role of social workers with these groups.
2. Describe the recovery process for both alcohol and drugs, factors that enhance the chances of recovery, how recovery impacts parenting, and implications for social workers.
3. Define relapse, describe the causes of relapse, and examine two models of relapse prevention.

SELF-HELP GROUPS

Objective #1: Describe the characteristics of self-help groups, including AA, Women for Sobriety, and Rational Recovery

Classroom Discussions Questions

What do you think of, when you think of self-help groups?

If you have ever attended a self-help group (as an observer), what was that like for you?

Why do self-help groups work for some people? What do they do for our clients? (Brainstorm answers, list on board)

[If possible, prior to this session, assign students to attend one or two self-help meetings of their choice to facilitate discussion.]

Common Characteristics of All Self-Help Groups (Powell, 1987)

- They help to restructure beliefs about the problem: Cognitive messages learned through the slogans, readings, steps, etc. help members reframe the problem (e.g., as a disease) by providing an explanation and by giving new cognitions about themselves (e.g., as having the ability to change).
- They provide examples of skills/alternative behaviors: Many provide specific plans for the types of changes that are needed. Members are living examples of how these changes can be implemented. Advice about changing can include going to meetings, getting a sponsor, and staying away from drinking with friends and hangouts. Members also self-disclose problems they may be faced with and how they handled them.
- They provide emotional support:
 - *Positive reinforcement*: Clapping or tokens for lengths of sobriety time.
 - *Sharing*: Members speak of concerns, problems, and feelings.
 - *Offering feedback*: At some meetings, members may offer advice on how they have handled similar situations.
 - *Reassurance*: Members give support to other members regarding their abilities to handle problems. For example, that it gets easier with time.
 - *Justification*: Members can provide feedback that the person is feeling or behaving "as they should" in response to a given situation or problem.
 - *Mutual affirmation*: Members give support to each other that they are valuable and worthwhile persons.
 - *Empathy*: Members communicate to one another that they understand feelings.
 - *Normalization*: Members indicate that the negative feelings someone may be experiencing are normal and that they are part of the process.
 - *Instillation of hope*: Members can reassure one another that problems do get worked out and one can remain sober in the face of temptation, etc.
 - *Catharsis*: Seeing or hearing other members let out emotions can be healing for group members.
- They provide a place for personal disclosure: Usually groups are confidential and anonymous. They provide a place for members to discuss personal issues or feelings in an atmosphere of acceptance and nonjudgmentalism.
- They provide a place for socialization: Many times groups offer social activities as well as meetings. Usually all members are peers in these groups where no

one is the "leader" and all are accepted. Some groups, including AA, may offer childcare during the group meeting. They promote group cohesion which can decrease isolation. The groups give a place to "belong" and to feel as though they are a part of a bigger organization.

- Self-help groups can build self-esteem and self-reliance: As members are able to solve problems through their interactions, this promotes a sense of self-confidence and self-esteem.

Alcoholics Anonymous (AA)

- Membership:
 - Started in 1935 by two alcoholics, "Dr. Bob" and "Bill W."
 - In 1990, there were 87,000 groups in 150 countries, 1.7 million members worldwide. There were almost one million members in the U.S. and Canada (Alcoholics Anonymous, 1990).
 - About 9% of adults in the U.S. report having attended an AA meeting at some point during their lives, and 3.4% reported having gone to a meeting in the past year (Room, 1993).
 - About 30% of the members of AA are women (Beckman, 1993).
 - The only requirement for membership is "a desire to stop drinking" (AA, 1953, p.143).
- AA Principles:
 - There are 12 Traditions and 12 Steps of AA that are the basis for the group. [Pass out the 12 Traditions and 12 Steps (Handout 5) or use as an overhead, and review, starting with Traditions first. Emphasize that each group is autonomous, has no hierarchical relations, has no affiliation with any group or program, is totally self-supporting, and that membership is anonymous.]
 - Each group sets itself up however it wants. Usually meetings are either open (open to anyone in the community) or closed (open to only those who identify as AA members or have a desire to stop drinking). The meetings can be speaker meetings where the group listens to a speaker, or discussion meetings, where a discussion is led around a specific topic (McCrary & Delaney, 1995).
 - Meetings usually open with announcements, a reading from AA literature, and recognition of "anniversaries" of sobriety dates. After the speaker or discussion, the meeting may close with the Serenity Prayer or the Lord's Prayer (McCrary & Delaney, 1995).

- AA defines alcoholism as primarily a problem of spirituality with genetic and social factors (Miller & Kurtz, 1994). Change comes about through a relationship with a "higher power," which is something outside of oneself that is more powerful than the individual. It is up to the individual to define what this is.
- It is the function rather than the form that is significant...acceptance and active construction of a higher power sustain individuals in a complementary frame, which then provides a new foundation for relationships with self and others. The individual is dependent on a higher power and is equal with others. The work of recovery involves the development of autonomy, grounded in acceptance of one's basic human dependence, and the development of mature interdependent relationships with others. Paradoxically, by relinquishing a belief in a self-power, people in recovery experience themselves as autonomous and empowered from within (entire bullet is a quote from Brown, 1993, pp.150-151).
- An important part of the program is getting a sponsor. A sponsor in AA is someone who has at least one year of sobriety and is the same gender as the person. Usually a person approaches someone he or she has gotten to know and asks them to be his or her sponsor. The sponsor helps the person understand how to work the steps and is available to deal with problems and emergencies (McCrady & Delaney, 1993).
- The 12 Steps of AA are the principles of how to "work the program." [Review 12 Steps here. Discuss aspects of loss of control, powerlessness, surrender, making amends, reaching out to others, etc.]

Homework Assignment

Prior to this class, the instructor or field supervisor may ask students to attend two or more self-help groups, with at least one being AA. Have students discuss how they felt before and during the meetings. List these feelings on the board. Most will state they felt nervous, anxious, afraid, intimidated, etc. Relate that these may be similar to the feelings that clients experience when asked to attend.

Have students discuss what they observe at the meetings and write these comments down as well. Several different themes will emerge, ranging from the variety of experiences the students had to the lack of uniformity among different meetings. This, too, is an important concept in that not all meetings appeal to all people or are equally beneficial.

- AA and Minorities:
 - A criticism of AA is that it is designed for middle-class white men and it may be biased against minorities (Powell, 1987).
 - There are no large-scale epidemiological studies that break down membership by race, but some studies of the general population have found that proportionally, Hispanics had a higher utilization rate of AA than whites or African Americans (Caetano, 1993).
 - Humphreys, Mavis and Stoffelmayr (1994) followed a group of patients post-treatment and found that racial minorities had the same rates of attendance as the white members. When African American AA attenders were compared to non-attenders from the sample, the attenders had better outcomes on employment, alcohol, drug, and legal problem measures.
 - Beckman (1993) reviewed AA outcome studies, and found that AA is as effective for women as it is for men, if not more so. Women prefer the emotional disclosure and sense of collectivity found at meetings, and may even integrate into AA more quickly because of this (Denzin, 1987).
- The Efficacy of AA
 - There are few controlled studies of AA and its outcomes and there are many methodological problems in the studies that have been conducted. Design issues include the immense variability between meetings, meaning that not everyone is experiencing the same thing. Subjects in an experiment may choose to attend more meetings than assigned or may decide to increase their involvement. The tradition of anonymity also makes research difficult (Miller & McCrady, 1993).
 - Emrick, Tonigan, Montgomery, and Little (1993) conducted a meta-analysis of 107 studies of AA and found:
 - Those who had better drinking outcomes were more actively involved and seemed to follow the principles of AA closely.
 - Those who attended AA after some sort of therapy or treatment had better drinking outcomes.
 - Weak but positive associations with AA involvement and employment, family, and marital adjustment.
 - A strong relationship was found with AA involvement and psychological adjustment.

Women for Sobriety

Some participants of AA, as well as researchers and clinicians, have felt that AA's emphasis on powerlessness and dependency only further perpetuates traditional gender role stereotypes for women. Many professionals and participants believe that women alcoholics should instead receive messages of empowerment and worth (Wilke, 1994). Some women do participate in all-female AA meetings, but the steps and traditions are still the same. It was because of these issues, however, that Jean Kirkpatrick founded Women for Sobriety (Kirkpatrick, 1978).

- Membership of Women for Sobriety (WFS)
 - All members need a "desire to stop drinking and a sincere desire for a new life" (Women for Sobriety, 1976, as cited in McCrady and Delaney, 1995, p.171).
 - Meetings are led by a certified moderator who is in recovery herself.
 - Meetings are structured, usually open with readings, followed by a discussion around a specific topic (McCrady & Delaney, 1995).
- Principles of Women for Sobriety (WFS)
 - Abstinence is necessary for recovery.
 - Women are competent and can choose to stop drinking, with support.
 - Drinking has been a way to cope with feelings of loneliness, powerlessness, helplessness, and this can lead to a physical addiction.
 - Women can create new identities as competent adults through positive thoughts and attitudes.
 - New behaviors come about as a result of these new thoughts and attitudes.
 - Interpersonal relationships are important in recovery.
 - Members need to focus on personal and spiritual growth as well as self-responsibility (McCrady & Delaney, 1995).

- 13 Statements and *Affirmations* of Women for Sobriety¹
 -- the “New Life” Acceptance Program (also **Handout 6**)
 1. I have a life-threatening problem that once had me.
I now take charge of my life. I accept the responsibility.
 2. Negative thoughts destroy only myself.
My first conscious act must be to remove negativity from my life.
 3. Happiness is a habit I will develop.
Happiness is created, not waited for.
 4. Problems bother me only to the degree I permit them to.
I now better understand my problems and do not permit problems to overwhelm me.
 5. I am what I think.
I am a capable, competent, caring, compassionate woman.
 6. Life can be ordinary or it can be great.
Greatness is mine by a conscious effort.
 7. Love can change the course of my world.
Caring becomes all important.
 8. The fundamental object of life is emotional and spiritual growth.
Daily I put my life into proper order, knowing which are the priorities.
 9. The past is gone forever.
No longer will I be victimized by the past, I am a new person.
 10. All love given returns.
I will learn to know that others love me.
 11. Enthusiasm is my daily exercise.
I treasure all moments of my life.
 12. I am a competent woman and have much to give life.
This is what I am and I shall know it always.
 13. I am responsible for myself and my actions.
I am in charge of my mind, my thoughts, and my life.
- Efficacy of WFS: As of this writing, no research has been conducted with this group.

¹ <http://www.womenforsobriety.org/>

Rational Recovery

Also called SMART (Self-Management and Recovery Training), Rational Recovery was founded by Jack Trimpey, a social worker, as a different approach from the disease concept of alcoholism and the focus on the need for spirituality in recovery. Rational Recovery is based upon reason; the belief that people can use their rational minds to choose not to drink.

- Principles of Rational Recovery
 - It is more useful to not drink or use drugs as you respect yourself—people choose not to use because they have self-esteem.
 - After the person chooses to stop drinking, he or she can use his/her rational mind to choose a plan for change. Change is based on reason, not faith.
 - Irrational thoughts (The Beast) about drinking may lead to relapse, and RR can help provide ideas of how to deal with The Beast. Trimpey (1992) calls this *addictive voice recognition training* (A VRT) to recognize how the voice is the enemy in that it tells the person to drink.
 - Abstinence is the best choice; however, some members may choose to drink in moderation.
 - Usual attendance is 6-12 months; most people are able to move on with their lives and get their drinking under control.
 - Most groups are peer-led but a professional therapist may be involved (McCrary & Delaney, 1995).
- Rational Recovery Ideas (Trimpey, 1992)²
 - I have considerable voluntary control over my extremities and facial muscles (instead of being powerless over what is put into the body).
 - It is because I am worthwhile to myself that I will decide to stop drinking and build a better life.
 - Some discomfort is necessary, inevitable, and entirely harmless part of becoming and remaining sober.

² www.rational.org

- I feel the way I think, and so have enormous control over my emotions, sorrows, and disturbances.
- I am a fallible human being. While I may feel regrets, remorse, or sadness for my alcoholic behavior, I need not conclude that I am a worthless person.
- As time goes by, drinking appears increasingly stupid because of the obvious selfish advantages of sobriety, but if I ever stupidly relapsed by drinking, it wouldn't be awful because I would very likely recover again.
- Because rational sobriety is self-fulfilling, and because there is so much more to life than a constant struggle to remain sober, I can gradually close the book on that sorry chapter in my life and become vitally absorbed in activities and projects outside of myself that are unrelated to my former alcoholism.

Practice Issues for Social Workers

- Social workers should have a fairly strong knowledge of the various support groups and how they operate before referring clients to them.
- With this knowledge, you can refer clients to the kind of group you think he or she would find most helpful.
- Also with this knowledge, you can explain what the group would be like, that is, what your client can expect. Some people are very intimidated about going to a group by themselves for the first time and having some information is helpful.
- Address the concerns that your client might have. Some groups, such as AA, can send someone to take your client if they are fearful of going somewhere where no one knows them.
- Having tools such as meeting lists and introductory pamphlets are helpful (McCrary & Delaney, 1995).
- Understand some of the principles of the groups so that your counseling sessions can work around these (i.e. discuss "the Beast" with someone who is attending RR, perhaps "turning it over" with someone in AA).

Objective #2: Describe the Recovery Process for both alcohol and drugs, factors that enhance the chances of recovery, how recovery impacts parenting, and implications for social workers.

Classroom Discussion Questions

How would you define recovery? (Generate several answers)

- Recovery: usually (not always) is defined as abstinence plus the building of a new life (Morgan, 1995).
- It has only has been since the late 1970s that recovery was viewed as a separate clinical process. It used to be once the alcoholic/addict got sober, that was all that was needed to be done.
- Recovery must receive as much attention as intervention and treatment (Brown, 1985).

Why do you think that is?

What kind of issues do you think your clients face?

MODELS OF THE RECOVERY PROCESS

Developmental Model (Slide 23)

The Developmental Model of Recovery for alcoholism was developed by Stephanie Brown (1985).

- Recovery involves **three major components**:
 1. **Role of alcohol**: "continual, organizing role." Even if the alcoholic is sober, even for a long time, has to recognize that he or she cannot return to drinking.
 2. **Environmental changes**: major life changes and adjustments.
 3. **Intra and interpersonal changes**: new identity and new interpretation of self and others.
- There are **four stages** in the recovery process:
 1. **Drinking**: Consumption of alcohol with loss of control, impacts on family, work, self, etc. Sometimes defined as "hitting bottom."
 2. **Transition**: The person becomes abstinent, may enter treatment and may choose to return to drinking.
 3. **Early**: Abstinence plus the assumption of identity of "alcoholic," mostly focused on environmental changes.
 4. **Ongoing**: Integration of all three components:

- Alcohol: desire is lessened but client still needs to remember that he/she cannot return to social drinking.
- Relationships start to become more important.
- Externalized behaviors become internalized; habits are formed, such as exercise, avoiding "high risk" situations, friends, etc.
- May begin to explore past life events, such as family of origin issues to gain knowledge about self.

The Process of Recovery

The process of recovery for drug addiction developed by Mim Landry (1994) is very similar to Brown's (1985) model **(Slide 24)**.

- **Psychosocial Crisis Management:** Stabilizing the client. It is usually a crisis that propels someone into treatment or quitting. The client may feel intense shame or guilt. There may be problems at home, such as children being removed. Management usually involves detoxification, medical management, and emotional and family management.
- **Post-treatment Restructuring:** Beginning of building a new identity and viewing oneself as an addict in recovery who is taking care of oneself. Does well with structure of 12 Step groups. Again, like in Brown's model, emphasis is on external rules and following guidelines from others in recovery. The client seeks approval and feedback from others.
- **Mature Recovery:** Begins to internalize behaviors and values learned in 12 Step meetings, such as honesty and openness. Landry calls this "a restructuring of the personality" (1994, p. 165). The lifestyle becomes more balanced and may not need to attend 12 Step meetings as frequently.
- **Late Recovery:** Landry (1994) indicates that this comes a year or two after treatment. This is similar to Brown's ongoing recovery stage whereby the person works on resolving psychological issues, particularly those that may hamper recovery.

Landry (1994) indicates that for both alcohol and drug recovery, there are several characteristics of those who experience a healthy recovery.

Stages of Cocaine Addiction Recovery (Slide 25)

Stages of Cocaine Addiction Recovery was developed by Richard Rawson et al. (1991) and is specific to cocaine addiction. According to this model, there are five stages of recovery:

1. **Withdrawal:** (0-15 days post-cocaine): Rawson et al. (1991) describe this as a time when clients first come off cocaine. They are very tired, depressed, anxious, afraid, confused, and have difficulty concentrating. Clients during this time need a lot of structure and direction in their recovery program.
2. **The Honeymoon:** (16-45 days post-cocaine): The client starts to feel better, perhaps confident that he/she is now okay and energy returns. Because clients are starting to feel better, many during this time feel that they don't have a problem or that it is licked and may want to leave treatment. They may turn to drinking at this point, have difficulty recognizing the need to stay abstinent, and do not think that relapse is an issue. Cognitively, clients during this time are still "scattered" and have difficulty focusing.
3. **The Wall:** (46-120 days post-cocaine): During this stage, clients begin to experience depression and fatigue again. They may become bored with treatment and recovery. Because they feel so awful, many at this point think that this stage will last forever, that they will never feel good again, and become discouraged. The relapse potential during this stage is quite high. Clients may want to drop out of treatment because they think it is not working. Cravings for cocaine return. Clients may spend a great deal of time thinking about using or may actually relapse. Rawson calls this period the "major hurdle in the recovery process," (1991, p. 103).
4. **The Adjustment Stage:** (121-180 days post-cocaine): Clients who have made it through "the Wall" stage start to feel a sense of accomplishment, and their depression and anxiety is reduced. They are beginning to integrate the behavioral/lifestyle changes (having been taught new skills), and have reduced cravings and thoughts about cocaine. Sometimes taking on new lifestyle changes means looking at destructive relationships. Clients during this stage begin to recognize the relationships in their lives that have been destructive, and may return to cocaine to cope. This can still be a period when addiction is questioned, as clients are feeling somewhat "normal."
5. **The Resolution Stage:** (181+ days post-cocaine): Clients during this time have fairly well integrated the lifestyle changes and have a more balanced lifestyle.

They still need to monitor themselves for relapse. Sometimes other problems emerge that need to be dealt with, such as gambling or alcohol use. As in Brown's (1985) model, this begins a stage when underlying intrapsychic issues emerge that get in the way of a satisfying recovery and need to be discussed in individual therapy. Rawson et al. (1991) indicate that for many women in this stage, these issues may include sexual abuse, relationships, and self-esteem.

Characteristics of a Healthy Recovery

How do you know if your client is actually in recovery and is doing what is called "working a program?" The following was developed by Mim Landry regarding drug abuse recovery. Landry states that the recovery client:

- Accepts addiction as a treatable disease
- Acknowledges the loss of control over drug use
- Abstains from all psychoactive drugs (not just the one addicted to)
- Eliminates all drug paraphernalia (keeping anything around can be a visual reminder, these become "powerful triggers for drug hunger"; Landry, 1994, p. 170).
- Participates in all phases of treatment
- Includes entire family in treatment process
- Family involvement in Al-Anon and Nar-Anon
- Early recovery: 90 meetings in 90 days (typical treatment recommendation, helps fill time and builds structure)
- Regular 12 Step group attendance and participation
- Obtains a 12 Step sponsor during early recovery
- Works the 12 Steps (making amends, etc.)
- Creates a healthy and sober social network (New friends who are not in the drug scene are important. Many women have never had friends before recovery [Hohman, n.d.]).
- Avoids new intimate relationships during early recovery
- Avoids and defuses triggers for drug hunger
- Avoids self-medication of emotional and social problems

- Seeks professional help for psychosocial problems
- Develops healthy leisure and recreational life
- Tendency toward trust, openness, and honesty
- Tendency to talk about personal feelings
- Shows concern for thoughts and feelings of others

Characteristics of Those Who Recover

Who is most likely to go into recovery? (The characteristics are mainly of women in research studies.)

- Those who have a longer time in treatment (Simpson, 1993). Length of time in treatment is positively correlated with successful outcomes. Many times in substance abuse treatment evaluation, "successful outcomes" is defined as abstinence or using less than they were prior to treatment.
- Participation of the spouse/partner in treatment (Higgins & Budney, 1993).
- Those who are employed, married, have higher SES, and have some kind of church or community involvement (Macdonald, 1987).
- Those who had close, supportive relationships prior to treatment and had fewer life stressors (Macdonald, 1987).
- Those that have a relationship with a sponsor or someone who has had similar experiences and is able to accept the 12 Step concept of powerlessness (Huselid, Self, & Gutierrez, 1991).
- Similar to accepting powerlessness, Sandoz (1991) found that those with external locus of control had better outcomes.
- Those that were able to leave destructive, substance abuse-centered relationships and build new and positive ones (Hunt & Seeman, 1990).
- Those that attended AA (Hoffman, Harrison, & Belille, 1983) and identified themselves as being alcoholic (Denzin, 1987; Maracle, 1989).
- Those that did it for themselves rather than for someone else (Smith, 1986).
- Those who were able to establish a relationship with a "Higher Power," that is, have some sort of spirituality which allowed them to redefine themselves as "lovable and worthwhile" (Morgan, 1995, p. 68).

In sum:

- Women who recover have to want to do it for themselves. Those that do better generally have psychosocial supports, income, and a spouse.
- Recovering women are able to reach out to form connections with other women and men in some sort of a recovery program. They are able to restructure their lifestyles, take on a new identity, and utilize spirituality as part of their growth. All this is very similar to the two recovery models presented.

Recovery and Parenting

Classroom Discussion Questions

How does recovery impact parenting?

Most of you are aware of how drug abuse/alcoholism impacts parenting skills. What have you seen with your clients? (Generate answers).

Research has found:

- Using parents are unaware of the child's developmental status and tend to expect children to be more mature than they are (Fiks, Johnson, & Rosen, 1985).
- Using parents seem unaware that a child has difficulty regulating emotions and take emotional outbursts personally (Kaplan-Sanoff & Rice, 1993).
- Usually parents with substance abuse problems have poor attachment histories, both with their families of origin and with their own children (Davis, 1994, Sandoz, 1995).
- There is little research on parents and recovery. Most professionals agree that parenting classes should be incorporated into substance abuse treatment, especially for women (Peterson, Gable, & Saldana, 1996).

Early Recovery

Usually the mother experiences a lot of guilt and shame (Eliason & Skinstad, 1995; Kane-Cavaiola & Rullo-Cooney, 1991).

- She may possibly be noticing children's misbehavior for the first time (Hohman, n.d.).
- The child may be reacting to change in the family system (Johnson, 1995).

- The mother may develop a strong over-identification with the child and find developmental milestones threatening (not know how to perceive autonomy, etc.) (Watkins & Durant, 1996); may feel that the child should love her (Haller, 1991).
- She may view already born children as "children of my addiction" (a negative view) and any children born in recovery may be viewed positively (Watkins & Durant, 1996).
- Many times mothers in early recovery feel a need to make up for "lost time" by being the "perfect" mother by having high expectations for themselves and their children (Finkelstein, 1994).

Ongoing Recovery

- The mother deals with psychological issues and her own personal growth. She is able to utilize support systems such as parenting classes.
- She seems more able to allow children to develop their own identities (Watkins & Durant, 1996).

Social Workers and the Support of Recovery

What can social workers do to provide support to parents in recovery?

- Understand the 12 Step process and be able to discuss it with your clients. Ask them about characteristics listed in healthy recovery (above; i.e., how frequently and what types of meetings they have attended, if they have a sponsor, etc.). Morgan (1995) advocates that therapists and social workers should be willing to hear about clients' spiritual experiences. If clients are not in a 12 Step group, you still want to focus on what kind of behavioral restructuring changes they are making.

Classroom Discussion Question

How do you come to understand how 12 step programs work? What do you do if you are uncomfortable in hearing about "spiritual experiences?" (Generate answers)

- Attend AA, Al-Anon,³ and other 12 Step meetings.
- Read 12 Step literature and familiarize yourself with some of the lingo.

³ Al-Anon is the 12 step program for persons whose lives have been affected by family members' use of alcohol and/or drugs. It was started by Lois W., wife of AA founder Bill W.: <http://www.al-anon.alateen.org/>

- Form relationships with other people in recovery and get them to tell you "their story" so that you have a personal account.
 - Read biographies of people who are in recovery, such as *Getting Better* by Nan Robertson (1988) or *Drinking: A Love Story* by Caroline Knapp (1997).
 - Think about professional collaboration with treatment agencies, such as teaching a child development class for them. Perhaps they would let you sit in on a treatment group.
 - As for spiritual experiences, understand that AA is not about religion and does not advocate formal religion. Spirituality is a major concept in AA and in many treatment programs and it is also the focus of research on how it is used in therapy. Reading and discussions with others will help in this area.
- Utilize the developmental models presented; that is, remember that early recovery involves behavioral changes and ongoing recovery involves more "core" issues. You want clients to be very structured when they first get sober. It is okay if they seem to have transferred dependency to AA by attending all the time and may seem overzealous. This will level out.
 - The dependency court's timeline and the time it actually does take to recover can be very different, particularly when we see stages such as "the Wall" in cocaine recovery (Azzi-Lessing & Olsen, 1996). Clients need time to integrate and consolidate the growth they have made. Social workers may have to advocate that children not be returned home as quickly (if they are removed) or that a family stay longer in a treatment program.
 - As we also saw, having environmental support also helps a great deal. Most child welfare clients do not have the psychosocial support we would prefer; therefore, it is necessary to help link them with support from the community. You may also want to work with substance abuse counselors in this support-building (Finkelstein, 1994).
 - Finally, work to convey hope. Not every family problem will be, or must be, solved immediately. Family problems occur in every family and some take more time than others to deal with.

Women need to understand that all family problems will not disappear immediately with sobriety and that they must be prepared for the long haul, especially with their children. The attitudes and assistance of caregivers will make an enormous difference in a woman's ability to face her guilt and shame regarding her children and to deal with ongoing parenting concerns (Finkelstein, 1994, p. 11).

Objective #3: Define relapse, describe the causes of relapse, and examine two models of prevention/intervention.

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RELAPSE PREVENTION

Rates of Relapse

- A classic study (Hunt, Barnett, & Branch, 1971) of treatment outcomes for alcoholics, smokers, and heroin addicts showed that 66% relapse within the first 3 months of post-treatment.
- Advances in treatment methods have reduced relapse rates, but not perceptibly.
- Relapse is a common problem for anyone working with addictions.

Definition of Relapse (Marlatt, 1985, gives several definitions)

- The resumption of drug use after a period of abstinence.
- The return to previous levels of drug use.
- A return to addiction.
- The unfolding process in which the resumption of substance use is the last event in a long sequence of maladaptive responses to internal or external stress or stimuli.
- Relapse is different from lapse: a lapse (or a slip) is a single incident of substance use that can be a learning process. Daley (1989) calls this a "therapeutic relapse" as it can help the person in the recovery process.

Causes of Relapse (Daley, 1989) **(Slide 26)**

There are affective, behavioral, cognitive, environmental, relationship, physiological, psychological, and treatment-related issues that can cause relapse.

Classroom Discussion Question

What do you think would make people relapse after they have received some kind of treatment or have been involved in a self-help group for a while?

- Have students meet in groups to brainstorm reasons. Write these on the board in the various categories listed below.
- Relapse can be an interactive combination of different variables such as environmental, relationship, physiological, psychological, spiritual, treatment related, affective, behavioral, or cognitive (Daley, 1989).

- Affective-Negative emotional states and positive emotional states
 - Anger
 - Boredom
 - Anxiety and nervousness
 - Depression
 - Loneliness
 - Guilt and shame
 - Painful memories
 - Self-pity
 - Happiness
 - Self-confidence
 - Feeling like this problem is “licked”

Classroom Discussion Question

Why would positive emotional states be a problem? (Persons can let their guard down, drink to celebrate something, etc.)

- Behavioral
 - Limited coping skills
 - Difficulty with stress management
 - Poor problem-solving skills

- Difficulty with managing leisure time
- Spending time with people who drink or use and/or socializing in bars
- Isolating self from others
- Other compulsive behaviors, such as gambling and/or overeating
- Allowing oneself to get overly hungry or tired
- Not going to AA meetings or therapy
- Cognitive—attitudes toward substance use and recovery
 - Denial: thinking there is no problem
 - Thinking alcohol or drugs are needed to have fun
 - Belief that recovery program isn't progressing fast enough or be the way it should be
- Environmental and relationships
 - Being in situations where there are drugs
 - Feeling social pressure to use
 - No friends who do not use drugs or alcohol
 - Family members in addiction themselves
 - Family members not supportive of recovery
 - Argumentativeness and conflict with others
 - Difficulty meeting new people
 - Sexual problems
- Physiological variables
 - Cravings and urges to use
 - Cue reactivity: certain cues can bring about urges or cravings
 - Pain, surgery, illness
 - Poor diet
- Psychological issues
 - Undiagnosed mental illness or personality disorder
 - Unresolved physical or sexual abuse issues
 - Other unresolved trauma

- Treatment-related variables
 - Social worker attitudes: expect relapse
 - Social worker fails to address warning signs of relapse
 - Poor aftercare planning; treatment did not address all issues
 - Failure of treatment providers to gain support or participation from family members
 - Agency counselors do not understand relapse

Relapse Prevention Planning

Social Support Approaches: focus on clients' needs for emotional support from family and friends to help reduce interpersonal stress.

- Family therapy and education
 - Helps family members be aware of problems the client can face in recovery.
 - Helps family members eliminate enabling behaviors that could increase the risk of relapse.
 - Helps family members plan on how to respond if a relapse occurs.
 - Helps family members identify own issues and concerns that recovery in client can bring out.
- Social support network/AA involvement
 - Involvement in 12 Step program helps in meeting new friends and creating new social networks.
 - The principle in AA that a person is only one drink away from a relapse, and helps to remind that recovery is a daily process.
 - Activities in AA are centered around events that do not include drinking.
 - Working the AA steps can help identify threats to recovery and unresolved feelings or issues.

Cognitive Behavioral Approaches (Marlatt, 1985): Emphasizes identifying internal and external cues associated with craving and relapse and developing ways to avoid them.

- Principles
 - Abstinence—not controlled use—must be ultimate goal.
 - Clients are helped to recognize that one or more temporary lapses are likely to occur (yet do not give permission to use).
 - Clients should be taught skills for anticipating, avoiding, and coping with their personal high-risk situations.
 - Clients are taught constructive responses to cope with lapses when they occur.
 - Any positive expectations that clients have about drug use should be countered with reminders about the lows that follow the highs and about long term negative consequences of substance use.
 - Helping clients manage their own lives being drug-free is the essence of prevention, giving them a lifestyle of "balance and moderation" (Dimeff & Marlatt, 1995).
- Theoretical concepts in relapse prevention
 - People in recovery must cope with **urges and cravings about using**, may rationalize these away, or deny they are happening. Unless the addict recognizes thoughts and desires to use, he or she is in denial that this is happening. The addict then may make what Marlatt (1985) describes as "apparently irrelevant decisions," but it is these decisions that puts the person into a high risk situation for relapse. An example Marlatt gives is that the alcoholic drives home another way, one which takes him past his old bar hangout.
 - Once the addict/alcoholic finds him or herself in a high-risk situation, he/she needs to have coping skills to deal with the situation. If the person has limited skills or has not thought these out ahead of time, he or she may feel decreased self-efficacy to not avoid drinking or using. **Self-efficacy**, or the belief that one has the capacity to execute a certain behavior, is a key concept in Marlatt's work.
 - **Outcome expectancies** are another key concept. How a person expects alcohol to act (provide relief, take away stress vs. get me into all kinds of problems) will also predict relapse. Part of relapse prevention is having the alcoholic review what he or she thinks of alcohol and how she or he expects it to impact her or him, both positively and negatively. Marlatt uses a strategy called a "decision matrix" that helps the person analyze what would happen if they resumed drinking (Dimeff & Marlatt, 1995).

- If the person does lapse, he or she may be prone to the **Abstinence Violation Effect (AVE)**. This is what the client experiences when he or she lapses:
 - Knowledge of use contradicts self-image as a recovering person who has vowed to stay abstinent.
 - Client may feel helpless, hopeless, and continue to use.
 - Relapse prevention helps to reframe relapse as a lapse, and to strategize with the client in advance ways that he or she will deal with a lapse.
- **Skill training** is an important component. Alcoholics are taught to identify urges, high risk situations, and prepare for them in advance. Some skills are behavioral: avoiding certain places, removing drug paraphernalia, and finding leisure time activities. Others are more cognitive: thinking through the effects of drinking, reminding oneself that an urge to drink will pass if given time, and focusing on the benefits of staying sober.

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APPENDIXES

OPTIONS TO AA

S.M.A.R.T. (Self-Management And Recovery Training)
(Formerly Rational Recovery) *An Alcohol and Drug Abstinence Education Group*

M.M. (Moderation Management)
An Alcohol Education Group for Early Stage Problem Drinkers ONLY

FOR PROFESSIONAL TREATMENT IN THE LOS ANGELES AREA
CONTACT

Marc F. Kern, Ph.D.

Certified Addictions Specialist and Certified Rational Addictions Therapist
(310) 275-5433

FOR FREE SELF-HELP GROUPS IN LOS ANGELES & ORANGE
COUNTY CALL

(310) 478-0776 OR (714) 550-9311

FOR NATIONAL INFORMATION CONTACT

S.M.A.R.T. (216) 951-0515

M.M. (313) 930-6446

VISIT **WWW.SMARTRECOVERY.ORG** AND
WWW.MODERATION.ORG FOR IN-DEPTH INFORMATION AND
LOCAL GROUP MEETINGS

GUIDE TO SELF-HELP WEBSITES

The Christian Recovery Network has links to several self-help recovery sites.	www.12steps.org
Alcoholics Anonymous	www.aa.org
Al-non Family Groups	www.al-anon.org
Cocaine Anonymous	www.ca.org
Marijuana Anonymous	www.marijuana-anonymous.org
Rational Recovery	www.rational.org
Women for Sobriety	www.womenforsobriety.org

ASSESSMENT, INTERVENTION, AND RECOVERY SUPPORT FOR SUBSTANCE-ABUSING PARENTS IN THE CHILD WELFARE SYSTEM

PRE/POSTTEST

Circle the correct answer.

- | | | |
|--|---|---|
| 1. According to the Stages of Change, contemplators are those who are aware of their problems, but need about 6 months to think through what they are going to do. | T | F |
| 2. Relapse is a normal part of recovery, according to the Stages of Change. | T | F |
| 3. The best way to break through denial is to confront it head on. | T | F |
| 4. Motivation to change drinking or drug use is a characteristic that rests solely within the client. | T | F |
| 5. Resistance from a client means that the social worker may be addressing the wrong Stage of Change. | T | F |
| 6. Discrepancy is the difference between what the client says and does. | T | F |
| 7. Screening tools are to determine the client's ranking of drug use and diagnosis. | T | F |
| 8. Screening tools are to be quickly given and easy to score. | T | F |
| 9. According to the Patient Placement Criteria, residential treatment can be appropriate for someone who is open to recovery and understands relapse. | T | F |
| 10. "Medically managed" hospital services means the patients see the physician daily. | T | F |

- | | | |
|--|---|---|
| 11. According to the disease model of alcoholism, it can be cured. | T | F |
| 12. According to the disease model, all family members should be involved in treatment as well. | T | F |
| 13. According to the social learning model, alcoholism is a "bad habit" that needs to be changed. | T | F |
| 14. A key component of the social learning model is relapse prevention. | T | F |
| 15. The research is contradictory regarding the time in treatment impacting outcome. | T | F |
| 16. No one treatment model is best, according to research. | T | F |
| 17. Alcoholism treatment for women should include sexual abuse counseling. | T | F |
| 18. Only AA members can attend AA meetings. | T | F |
| 19. AA has shown to not be effective for women. | T | F |
| 20. AA defines alcoholism as a problem of spirituality. | T | F |
| 21. Rational Recovery advocates controlled drinking for everyone. | T | F |
| 22. Social workers should attend different self-help groups, to learn about them and experience them. | T | F |
| 23. The Development Model of Recovery states that alcohol only plays an important role in early recovery. | T | F |
| 24. In cocaine recovery, "The Wall" comes 2-3 months into recovery, when the client becomes depressed and discouraged. | T | F |
| 25. Parenting behaviors can be disrupted once a parent gets into recovery. | T | F |

- | | | |
|--|---|---|
| 26. Feeling "too good" can sometimes lead to relapse. | T | F |
| 27. Social support approaches in Relapse Prevention Planning tend to focus totally on AA involvement. | T | F |
| 28. In the Cognitive Behavioral approach to Relapse Prevention Planning, denial of urges or cravings to use is a cue of beginning of a relapse | T | F |
| 29. The Abstinence Violation Effect causes the alcoholic to say, "I might as well keep on drinking since I had a slip." | T | F |
| 30. Removing all drug paraphernalia from the home is important in Relapse Prevention. | T | F |

PRE/POST-TEST ANSWERS

1. T	11. F	21. F
2. T	12. T	22. T
3. F	13. T	23. F
4. F	14. T	24. T
5. T	15. T	25. T
6. F	16. T	26. T
7. F	17. T	27. F
8. T	18. F	28. T
9. T	19. F	29. T
10. T	20. T	30. T

HANDOUTS

ASSESSMENT, INTERVENTION, AND RECOVERY SUPPORT FOR SUBSTANCE-ABUSING PARENTS IN THE CHILD WELFARE SYSTEM

PRE/POSTTEST

Circle the correct answer.

- | | | |
|--|---|---|
| 1. According to the Stages of Change, contemplators are those who are aware of their problems, but need about 6 months to think through what they are going to do. | T | F |
| 2. Relapse is a normal part of recovery, according to the Stages of Change. | T | F |
| 3. The best way to break through denial is to confront it head on. | T | F |
| 4. Motivation to change drinking or drug use is a characteristic that rests solely within the client. | T | F |
| 5. Resistance from a client means that the social worker may be addressing the wrong Stage of Change. | T | F |
| 6. Discrepancy is the difference between what the client says and does. | T | F |
| 7. Screening tools are to determine the client's ranking of drug use and diagnosis. | T | F |
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| 10. "Medically managed" hospital services means the patients see the physician daily. | T | F |
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- | | | |
|--|---|---|
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| 30. Removing all drug paraphernalia from the home is important in Relapse Prevention. | T | F |

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Begin the AUDIT by saying: "Now I am going to ask you some questions about your use of alcoholic beverages during the past year." Explain what is meant by alcoholic beverages (i.e., beer, wine, liquor [vodka, whiskey, brandy, etc.]). Circle the score for each question in the bracket on the right side of the question.

How often do you have a drink containing alcohol?

- | | |
|------------------------|-----|
| Never | (0) |
| Monthly or less | (1) |
| 2 to 4 times a month | (2) |
| 2 to 3 times a week | (3) |
| 4 or more times a week | (4) |

How many drinks containing alcohol do you have on a typical day when you are drinking?

- | | |
|------------|-----|
| None | (0) |
| 1 or 2 | (1) |
| 3 or 4 | (2) |
| 5 or 6 | (3) |
| 7 to 9 | (4) |
| 10 or more | (5) |

How often do you have six or more drinks on one occasion?

- | | |
|-----------------------|-----|
| Never | (0) |
| Less than monthly | (1) |
| Monthly | (2) |
| Weekly | (3) |
| Daily or almost daily | (4) |

How often during the last year have you found that you were unable to stop drinking once you have started?

- | | |
|-----------------------|-----|
| Never | (0) |
| Less than monthly | (1) |
| Monthly | (2) |
| Weekly | (3) |
| Daily or almost daily | (4) |

How often during the last year have you failed to do what was normally expected from you because of drinking?

- | | |
|-----------------------|-----|
| Never | (0) |
| Less than monthly | (1) |
| Monthly | (2) |
| Weekly | (3) |
| Daily or almost daily | (4) |

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

How often during the last year have you have a feeling of guilt or remorse after drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

Have you or someone else been injured as the result of your drinking?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

Has a relative, friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

Record the total specific items. A score of 8 or greater may indicate the need for a more in-depth assessment.

(Source: Developed by the World Health Organization, AMETHYST Project, 1987)

THE DRUG ABUSE SCREENING TEST (DAST)

The following questions concern information about your involvement and abuse of drugs. Drug abuse refers to:

- The use of prescribed or “over the counter” drugs in excess of the directions, or
- Any non-medical use of drugs.

Carefully read each statement and decide whether your answer is yes (Y) or no (N). Then circle the appropriate response.

- | | | |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | Y | N |
| 2. Have you abused prescription drugs? | Y | N |
| 3. Do you abuse more than one drug at a time? | Y | N |
| 4. Can you get through the week without using drugs (other than those required for medical reasons)?* | Y | N |
| 5. Are you always able to stop using drug when you want to?* | Y | N |
| 6. Have you had "blackouts" or "flashbacks" as a result of drug use? | Y | N |
| 7. Do you ever feel bad about your drug abuse? | Y | N |
| 8. Does your spouse (or parents) ever complain about your involvement with drugs? | Y | N |
| 9. Has drug abuse ever created problems between you and your spouse? | Y | N |
| 10. Have you ever lost friends because of your use of drugs? | Y | N |
| 11. Have you ever neglected your family or missed work because of your use of drugs? | Y | N |
| 12. Have you ever been in trouble at work because of drug abuse? | Y | N |
| 13. Have you ever lost a job because of drug abuse? | Y | N |
| 14. Have you gotten into fights when under the influence of drugs? | Y | N |

- | | | |
|--|---|---|
| 15. Have you engaged in illegal activities in order to obtain drugs? | Y | N |
| 16. Have you ever been arrested for possession of illegal drugs? | Y | N |
| 17. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? | Y | N |
| 18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Y | N |
| 19. Have you ever gone to anyone for help for a drug problem? | Y | N |
| 20. Have you ever been involved in a treatment program specifically related to drug use? | Y | N |

* These items are scored in the “no” or false direction.

Purchase through the Addiction Research Foundation, as noted in the text.

LEVEL OF SERVICE VIGNETTES

Vignette #1

Sam is a 45-year-old male who has had three prior treatments for alcoholism. Currently he is drinking about one case of beer per day. He reports that he awakes in the morning shaking and drinks two to three beers to stop his tremors prior to going to work. Sam is currently being told by his boss that he either seeks treatment or he loses his job due to excessive tardiness. Sam lives alone in a rooming house as his wife has thrown him out. At this point, Sam reports he is feeling suicidal due to his impending job loss.

Vignette #2

Suzanna is a 29-year-old female who was in treatment as an 18-year-old for cocaine. She has remained abstinent from cocaine but still drinks. She was reported to CPS for neglect, for leaving her sleeping infant locked in a car while she was in a bar drinking with her friends. When the social worker interviewed her, Suzanna cried and said she wants to change, that she never really realized the impact her drinking has had on her.

Vignette #3

Gloria is a 35-year-old woman who has been involved in a Family Reunification program. Her children were removed due to her and her boyfriend's drug use. Gloria had attended outpatient treatment but failed a drug screen (positive for marijuana), which she claimed was due to her live-in boyfriend and friends—they just used drugs around her all the time making it really hard for her to quit. She is willing to work on her drug problem and wants to have her children home with her but needs a structured sober living setting to help her accomplish these goals.

ALCOHOLICS ANONYMOUS THE 12 STEPS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

ALCOHOLICS ANONYMOUS THE 12 TRADITIONS

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
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.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

WOMEN FOR SOBRIETY
13 Statements and Affirmations
The “New Life” Acceptance Program

I have a life-threatening problem that once had me.
I now take charge of my life. I accept the responsibility.

Negative thoughts destroy only myself.
My first conscious act must be to remove negativity from my life.

Happiness is a habit I will develop.
Happiness is created, not waited for.

Problems bother me only to the degree I permit them to.
I now better understand my problems and do not permit problems to overwhelm me.

I am what I think.
I am a capable, competent, caring, compassionate woman.

Life can be ordinary or it can be great.
Greatness is mine by a conscious effort.

Love can change the course of my world.
Caring becomes all important.

The fundamental object of life is emotional and spiritual growth.
Daily I put my life into proper order, knowing which are the priorities.

The past is gone forever.
No longer will I be victimized by the past, I am a new person.

All love given returns.
I will learn to know that others love me.

Enthusiasm is my daily exercise.
I treasure all moments of my life.

I am a competent woman and have much to give life.
This is what I am and I shall know it always.

I am responsible for myself and my actions.
I am in charge of my mind, my thoughts, and my life.

www.womenforsobriety.org