Recovery from Addiction

Residential care for people with
Alcohol and Other Drugs Issues

A Handbook for Training
Addiction Recovery Workers

Volume 2

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Preface

As an educational resource, Recovery from Addiction (RFA) is designed to equip you to implement a successful model of treatment as a shift worker, caseworker, shift manager, and later as a senior case manager taking more complex cases. Although it was not the original intention, RFA has to some extent become a how-to manual for establishing recovery services.

This isn't an exercise in classroom theory. It is intended to support you to be trained and assessed on the job. It tells you how to perform the main duties of your role, and gives you enough to start exploring other resources. Wherever possible, I have divided roles into separate skills so that you can learn them more easily and quickly.

So far, students have generally handled the academic aspects very well, but find the practicum requirements more demanding. Even when they can perform their roles, some have difficulties in performing consistently for an extended period across the full range of their responsibilities.

Practicum students need to learn which incidents need to be referred to a supervisor and which they should handle themselves. One of the best signs of being ready for assessment is to be able to accurately discern the difference.

Despite the abundance of Internet information and published texts, I found no other resource that already gives this training, although I found several that suggest various theories in the hope that one of them might work. Some other texts and websites could be very helpful if students have already learned the basics and gained some hands-on experience.

Like most writings in this field, RFA follows a very clear philosophy. It follows the holistic, residential approach to treating addiction to alcohol and other drugs, and seeks to address best practice and professional competence standards. Unlike most sources, it promotes abstinence from substances of addiction.

The_house

RFA uses the metaphor of a fictitious organization called The_house, although it is based fairly closely on several real facilities. It has enabled me to take a much more "how to" approach than a general textbook that describes theoretical principles. As a reader, you might sometimes find yourself drifting between The_house and your own organization. RFA depends on you to ask the following questions: What can you learn from The_house? Can you do everything in The_house that suits your particular job? What adaptations do you need to make for your situation? How would you improve on the practices of The_house?

The order of contents

The order of contents is based on the following rationale.

Volume 1 gave a focussed orientation to skills for new workers, including what they should know coming onto the floor and a set of skills that would enable them to make a valuable contribution to everyday operations in a residential facility.

In the following stages you learn to work with less supervision as a shift manager and case manager overseeing the implementation of the holistic, residential approach to treatment. This includes applying current best practice in case-managing residents who have at least one other serious issue that negatively impacts them.

In "AR background," you'll look briefly at the wider context and examine some theoretical aspects needed for advanced skills, progressing systematically to more advanced assessment skills. "Treatment and case management," and "Further on" cover the senior staff member's role in case management and program improvement.

This sequence of objectives implies a particular pathway. Starting from the role of a general shift worker, one goes on to develop various skills, including leading activity groups, case management, advocacy, house leading, assessing applicants, overseeing detox, and medications. Workers then learn to become shift managers, and then supervisors of shift managers. They lead recovery groups, learn one or more supervisor portfolios and specialize as a counselor or as a senior case manager. The final stage is director of services, whose role includes leading staff meetings and overseeing evaluation and improvement.

Without such a framework, workers are caught in a professional no man's land between being nurses, clinical psychologists, and social workers.

Some tasks are clearly outside the scope of this book, for example, general management, specialized counseling, and some tasks requiring licensing in some jurisdictions. Some topics are omitted because the information is freely available on the Internet and need not be repeated. Usage patterns of different drugs and medications vary from place to place and from time to time. You will find good information on medications used in treatment, the symptoms of drug use, neurology, and the philosophies of different approaches. And would they actually benefit you as a practitioner? Perhaps, but probably not much.

In many US states, addiction recovery counselors are now licensed, and the competency standards1 are a useful reference point. Although this textbook at least touches on all of them, it is deliberately more international and has more emphasis on shift management and case management than on specialist counseling.

Choose the questions and activities that suit your students. I doubt that any instructor or college professor will use all of them for any one cohort of students.

You might not agree with everything that I have written, and that might be a good thing. Think about it and come up with better answers. That especially applies to anything where research has moved on from the time this was written to the time you use it.

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1
About the AR sector

The AR sector in our state includes organizations that provide a wide variety of services, for example:

- Some do street outreach and refer people to other organizations for longer-term help.
- Some are medical clinics with doctors who liaise with services to get ongoing complementary support.
- Some run short courses with no residential component.
- Some run long-term residential programs.
- Some run short-term residential programs.
- Some deal only with alcoholics.
- Some deal only with narcotics.
- Some deal only with young people.
- One deals only with gays and lesbians.
- Some have overnight "drying out" rooms for people intoxicated by alcohol.
- Some can treat mental health, family problems, and other kinds of issues.
- Some are awareness programs that provide community education programs.
- Some provide case management but rely completely on other organizations to provide services.

Not only that, they operate with very different philosophies.

- Some offer needle exchanges in an attempt to reduce the risks of harm from blood-born infections such as HIV and hepatitis. They believe that it is unrealistic to get people to abstain from addictive substances. By contrast, others agencies insist that complete abstinence is essential to long-term recovery.
- Some are Christian, some are secular, and some are quite anti-Christian.
- Some treat only the medical aspects of chemical addiction, and some are counseling services that deal only with related psychological and behavioral issues.
- Some have staff who are well-trained professionals, and some have staff who are well-meaning but unqualified.

Key bodies

The state government has a Drug and Alcohol Office. We don't have anything to do with it as it doesn't offer any kind of useful help, although its website is quite good.

The state association of AR organizations has a very diverse membership, which is probably why it doesn't have any firm views or favor any particular approach or philosophy. It seems to be a good organization, but The_house isn't a member.

Two large public universities have courses in addiction studies and one of them has a Drug Research Institute. Both train AR workers but their graduates can't do even basic tasks at The_house. The Institute claims to focus on prevention rather than treatment, although their list of research projects reflects an emphasis on describing various problems.

About registration and regulation

The AR sector is not currently regulated in our state. AR facilities do not come under the definition of a facility that needs to be registered.

The sector is difficult to regulate because it includes such a diverse range of organizations, services and philosophies. The government would probably introduce regulation and licensing if several organizations had deaths during detox or if there were a series of malpractice cases.

The closest regulated category is a private psychiatric hostel. At present, an organization is running a private psychiatric hostel if it cares for three or more people who are "socially dependent because of mental illness." In this case, the rules are similar to those of a private hospital. However, our AR residents are not "socially dependent because of mental illness" as they can look after themselves and don't need to be treated like patients. This is the case even if they have occasional psychotic episodes or sometimes exhibit antisocial behavior.

Tasks

1. Do an Internet search on the registration and regulation of AR agencies in your state.
2. Describe the current federal government policy on AOD.
3. Describe the current government policy on AOD in your state.
4. If your state has a system for licensing AR counselors, describe the requirements and procedure.

2
Policies and models

Most AR resources assume one or another particular policy orientation, which one must consider in order to interpret it.

Here's a simple map. You will notice that some of them perceive substance abuse is mainly a health issue and the terminology is not fixed. For example, the terms *medical model* and *public health model* are confusingly similar. Some organizations seem to exploit the confusion; one organization claimed to offer care on an "holistic" model, although it actually offered inpatient medical services in a hospital.

The legal model

The *legal model* is the idea that governments could eliminate unauthorized addictive drugs by making ownership or supply a crime. As a policy, it has had limited success in controlling supply. Of course, The_house still believes that dangerous addictive drugs should be illegal, and modern governments usually try to reduce demand as well as supply. However, the legal model offers no help to substance abuse victims or residential recovery facilities.

The medical model

In the *medical model*, substance addiction is seen as mainly a medical problem that can be solved by medical care, called *pharmacotherapy*. Medical practitioners run the program and make decisions on treatment. Other services might also be offered as ancillaries. Taken narrowly, the goal of this approach is to eliminate only chemical addiction. It is more likely the model when medical practitioners are the only health care professionals supervising recovery, and is most appropriate for higher-risk detoxifications that need medical supervision in hospital.

This view rightly points out that addiction is a disease of the brain and that medications can be very helpful, but it does not help residents to resolve their other non-medical issues, which can be more significant.

Except for high-risk withdrawals, we don't agree with this view at The_house because it is only a partial answer.

The public health model

The *public health model* includes proponents who go so far as to argue that addiction is *only* a medical issue, and that illicit addictive substances should be legalized and controlled by the medical

profession. It is linked to harm minimization. Several European countries have adopted this approach. Any evaluation of its success needs to include a discussion of the assumptions and criteria used to define success.

The counseling model

Individual counselors and clinical psychologists most often provide these services. They presume that addiction is primarily a psycho-social problem and that counseling is the main service to precipitate recovery. They might also get medical practitioners to prescribe pharmacotherapy.

Counseling programs might be helpful for people with mild addictions. However, counseling alone produces negligible benefit in people with more serious addictions who should be in residential care. Providing counseling alone has the same weakness as the medical model; both are trying to play a tune on a piano with only one note.

The harm minimization approach

The *harm minimization approach* grew out of frustration that many treatments were ineffective at promoting full recovery based on abstinence. They responded, "Instead of eliminating the problem, can't we just reduce the harm as much as we can?" This position evolved into programs that let people stay addicted by using clean needles with illegal drugs, or taking prescribed addictive drugs as replacements.

It gives limited help to people who don't want to recover from addiction and don't want to move into environments that would help them to do so. In agencies that advocate a harm minimization approach, the message has evolved into: "You don't need full recovery based on abstinence, so you don't need to move into an environment that would help you to do so."

Perspective is essential when evaluating this model. Governments find a harm minimization policy attractive because it is politically necessary to offer help to addicts who won't commit to full recovery and abstinence, which might be the majority of them. Besides, the harm minimization lobby group is quite powerful.

Ultimately, however, harm minimization is a compromise position, and it is questionable how much it helps. One major study indicated that most substance abuse victims would like to be completely free of substance abuse, that is, abstinent. Most AR agencies promoting harm minimization keep substance abuse victims addicted to substitute medications such as methadone. This is particularly counter-productive when residents can realistically expect to completely recover.

The holistic model

The *holistic model* certainly includes medical help, but it also looks at the whole person and their full range of needs. Case managers ensure that each resident gets the range of services that they need at their particular stage of recovery. Holistic programs include behavior management, counseling, community support, and anything else the resident needs to have a life: suitable housing, life skills, fitness, financial management, family reconciliation, legal support, education and training, etc. Medical practitioners who work in holistic programs still focus on their particular role but they become skilled at integrating their role with that of other AR staff.

It is unlikely that one organization can provide all these services in-house, so AR organizations often work with other agencies. Case managers often act as mediators between professionals who frequently assume that their particular profession is somehow more important that the others.

The holistic model has emerged as necessary to successfully produce full, long-term recovery based on abstinence, although it works best in a long-term residential program. The_house is committed to this model. Consider these versions of the holistic model:

PHREE holistic model from FreshStart[1]:

- **P**hysiology: treating the physical cravings of addiction
- **H**ousing: As a residential program, people can leave their potentially harmful environments
- **R**elationships: Rebuilding broken relationships
- **E**ducation: Education and training for a normal lifestyle
- **E**mployment:

The_house's model:

- complete abstinence from the substance of addiction
- emotional healing
- social readjustment
- behavioral change
- physical health
- preparation for life after recovery
- minimized risk that residents will revert to former behaviors.

The social model

The *social model* is rather similar to the holistic model. It presumes that support from a caring community is the most important element in achieving recovery, and concentrates on counseling, resocialization, and rebuilding relationships. Agencies that follow this model don't provide medical care and try to avoid pharmacotherapy. However, residential programs often outsource medical care and might have staff who can administer prescribed medication. They often don't have staff with the skills to manage higher-risk withdrawals from heavy dependence on alcohol or benzodiazapines.

Non-residential programs are social support networks of peers who give support and encouragement to each other. Alcoholics Anonymous and Narcotics Anonymous have adopted this approach, and it has shown some success for those who do not need residential care.

The recovery-focused approach

The *recovery-focused approach* grew out of frustration with a medical industry that lived off government funding, ticked boxes to get patients through as quickly as possible, and recited the mantra "Recovery works" even though patients didn't get better.

In essence, the advocates of the recovery-focused approach said, "Why don't we look at recovery instead?" The emphasis shifted away from medical treatment of symptoms, frequent crises, dependence on medical professionals, and recurring relapses. The emphasis moved toward early intervention, giving people peer support and self-worth, using non-professionals (especially former addicts) in providing treatment, empowering people to make changes, promoting a model of cultural change, and working with communities. William White is one of the most prominent writers on the recovery-focused approach. When the Philadelphia mental heath service adopted this approach, it reduced its costs and increased its effectiveness.

At The_House, we already know that volunteers are essential to a community-based service. One useful insight is that many agencies could make better use of the stories and support of recovered addicts in helping others to recovery. Most heroin addicts have never met a recovered heroin addict.

The idea of "recovery capital" is also helpful. Recovery capital takes the form of self-esteem, physical and mental health, money, somewhere to live, and social support. It makes recovery much

1www.freshstart.org.au.

easier even though it does not of itself result in recovery. People with addiction issues are often caught in a vicious cycle. Recovery is much more difficult without recovery capital, but the only way to get it is to have already recovered. It's like getting some jobs; you need experience to get the job, but the only way to get experience is to get the job.[2]

Otherwise, the recovery-focused approach is in many ways a variation of the social model and is quite compatible with the holistic approach.

The work model

The *work model* is the idea that an emphasis on work is helpful to recovery. This model works better in a residential situation where work and trust build self-esteem, for residents who benefit from physical exercise, and for activity-driven residents who have difficulty opening up and talking about themselves. It also makes programs more easily self-sustaining and reproducible.

In the work model, residents usually live together in community and the agency places residents in viable businesses where they earn enough to cover program costs. Many agencies pioneer their own new businesses, which generally fall into three broad categories:

- Some businesses give skills training, so they prepare residents very well for life after recovery. One chain of restaurants gives training to former street kids to become high-end chefs in major restaurants and hotels.
- Some businesses are vocational colleges. The training is free, and students' work covers their program costs.
- Other business must be easy to set up, require minimal start-up capital, and become profitable as quickly as possible. They generally involve low-skilled work in services, where residents work in teams with a skilled supervisor.

The work model: Advantages

Organizations often aim to be as financially self-sustaining as possible, with minimal dependence on donations, grants, and welfare. This is especially advantageous in developing countries, where external funding is often unavailable. Other advantages include:

- Neither residents nor agencies learn to depend on donated money, welfare, or foreign funding, which often brings its own kind of problems.
- Organizations often grow and reproduce more freely.
- Residents are very highly motivated if the work atmosphere is good, their standard of living is adequate, and they see hope for the future.
- The organization can spin off businesses to provide long-term employment for past residents.
- It also works well for some other kinds of recovery, especially from poverty.
- The organization has a remarkable opportunity to innovate by finding new market niches and developing services or products to fit them.

The work model: An ethical issue

The model, however, also faces its own ethical dilemma, even for programs that are run with complete honesty. Residents easily feel exploited, and this is justified when program managers use residents as a free labor force, control all spending, or divert money into other "needy projects" or vaguely-defined "overheads." Residents can even feel exploited if they want cash in hand but funds are used to provide them with goods and services.

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2 Clark, David, 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

The work model has a bad history. In the nineteenth century, many rehabilitation programs set up exploitative labor camps based on the rationale "Work is good for you."

If residents feel that they have earned money, they usually want to know how it is used and want to contribute to decisions. A transparent financial system minimizes many problems but it can invite others. When people don't understand business, they can be tempted to divide up the operating capital and pay it out as wages, not seeing that it will send the business broke.

Payment is problematical. The simplest approach is simply to pay a fair wage, although newly pioneered businesses can seldom afford it. In some kinds of projects, it is helpful to establish a profit-sharing system, but a flush of money, whether real or imagined, has a destructive effect on people who would use it to acquire debt, buy drugs, or gamble. In other cases, it creates taxation and legal problems.

The simple advice is, before you start, set up a clear decision-making structure and ethical guidelines about how funds will be used, and then educate people into the system.

The work model: Some suggestions

Make sure residents are accompanied if you send them out into the general public. If they go alone, they are tempted to relapse because they can very easily contact their dealers to buy illicit substances.

Select people for particular jobs and require that they apply. It is very hard to run a business if the staff feel like prisoners. Make sure that your staff want to be there and are suitable. Find out the skills each resident has, and especially what they are good at. Some are surprising; some highly qualified and experienced people go through personal difficulties that make them turn to recovery programs.

If you expect residents to eventually move on, build links with prospective future employers.

People will let you down, so don't be disappointed when it happens. It doesn't mean your program has failed.

Learn as much as you can about developing and managing new businesses. Registration in some countries is difficult, slow, or expensive. It can work better to run new businesses under the name of the recovery organization.

Newer residents need sheltered positions, usually in a team away from the general public. For example, some kinds of workshops are suitable. In one case, some residents in a food business were likely to be rude or lose their temper, so could not be given tasks involving customer contact. They were given kitchen tasks and barred from the dining room.

Other models

Prevention programs create awareness of substance abuse problems so that people do not start abusing substances.

Early intervention programs seek to identify substance abuse in its early stages and turn it around. This includes social users who use substances occasionally but have not yet become addicted.

About models

To make matters more confusing, proponents of each model produce statistics and research reports showing that their particular approach is effective.

It would be helpful to explore the balance and relationship between medical and non-medical treatments. The discussion so far seems inconclusive. Medical practitioners clearly take legal responsibility for diagnosing medical conditions and prescribing medication. Yet equally clearly, treatment needs to include socio-emotional care and a pathway to a fulfilling life free of addiction. Senior AR workers increasingly have a quite sound medical knowledge of addiction and its

treatment. They also have advanced but specific skills in counseling, managing people, preparing people for employment, and navigating the justice system.

Task

1. Which European countries have adopted a public health model of addiction treatment?
2. How have they implemented it?
3. How effective has it been?

Questions

1. What kinds of jobs and careers does the AR sector offer?
2. What kinds of problems do AR workers face through working in the AR industry?
3. In your area, what is the general community attitude to the use of alcohol and other drugs (AOD)?
4. Approaches:
    a. What ethical views and values are common across the AR sector?
    b. What recommended practices are currently controversial?
    c. Which currently controversial practices does your agency disagree with? Why?
    d. How do these issues affect your work in AR?
    e. What is a "holistic" approach?
    f. What is a "client-centered" approach?
5. Your organization's services:
    a. What services does your organization provide?
    b. What kind of services has your organization deliberately decided *not* to provide? (E.g. It might bring in specialists or refer clients because it does not have the expertise in-house, or it might view some kinds of controversial services as unethical.)
    c. How do you know that your agency's services are appropriate for its clients?
    d. How do you know its services are effective? It may be quite difficult to know whether it is effective if your service:
        i. is short-term, out-patient or non-residential,
        ii. does not have a longer-term follow-up system, or
        iii. has no definition of "effective."
6. What range of activities does your agency use to minimize harm to clients? (In this sense, harm normally means psychological and physical harm caused by AOD.)
7. What other kinds of services do AR agencies often provide that yours might not? (E.g. community development and education, working with families, advocacy)
8. Health:
    a. What does your organization specifically do to promote health and well being?
    b. What does your organization specifically do to early identify health problems early?
    c. When it identifies health problems, what does it do about them? (It will probably have different responses to different kinds of problems.) Make a list of the most common health problems and what it does next to each one.
9. Some clients seem to do well in one agency and not so well in another.
    a. From the client's viewpoint, finding an agency is a matter of "finding the right one for me." Is this true? Why?
    b. What client factors might affect the suitability of the agency?
    c. What agency factors might affect its suitability of a particular prospective client?
    d. Should your agency try to be a good fit for all prospective clients in your target group?
10. Is professional psychological counseling more effective than peer counseling from recovered addicts? Considerable evidence shows that that peer counseling from recovered addicts is

highly beneficial. It isn't as clear whether professional psychological counseling actually makes as much difference. (Of course, the professional psychologists normally think it is.)

Visiting other agencies

As part of your training you should get some exposure to other agencies to expand your thinking and better understand of the wider AR scene.

If you do it as a group of students or as a group doing a Professional Development activity, the first part of a visit is normally to meet the person assigned as your host, have them explain what they do, and explain the rationale of their approach. They will normally tell you that they are successful. They might allow questions and you should ask follow-up questions about anything they explained but is still unclear to you. They then show you around and introduce you to some of the staff and see the facilities.

What might you learn? In most cases, you'll notice the very different context, for example, the kind of organization, a different demographic, different kinds of client issues, different facilities, and the effects of a different funding model. You'll also see that most other organizations apply the same principles and systems as yours, with little that is really new. However, you might also notice some things that are either new or in sharp contrast to anything within your experience so far. This is most likely in programs that follow a contrasting treatment model, or are much smaller or much bigger that yours.

Before you go, brainstorm a list of questions. Here are my tips:

1. Start with questions that your host will find easy to answer, but haven't already been answered in the walkaround.
2. Don't feel compelled to ask every question on your list. It doesn't matter if you don't get answers to all questions.
3. Ask them about the most difficult kinds of decisions that have to make, and what are the arguments for and against each option.
4. Avoid embarrassing them. For example:
    a. They will probably be able to answer a question on "How does your system of case management work?" But they might be unable to debate the theoretical pros and contras of different models of case management.
    b. Even if they can answer a difficult question, they might not be able to give a satisfying answer in a short time and with no notice.

Debrief the visit afterward as a group and compare your observations. What is similar and what is different between the agency you visited and your current program? Why the similarities and differences? What did you learn that was new? What does it tell you about best practice?

3
Treatment at The_house

A core premise of holistic AR is that it needs to treat both health issues and the emotional-social issues that caused the substance abuse. Earlier chapters have already covered some core aspects of AR treatment at The_house: detoxification, behavior management (in *The shift worker's role*), medical liaison and pharmacotherapy (in *Medical aspects of substance abuse*), case management (*Starting case management*), and advocacy. Other core treatment approaches are resocialization, recovery groups, work, specialized counseling, and relapse prevention.

It is probably a mistake to ask whether this is a "one size fits all" approach. It is better to ask whether this range of treatments covers the range of needs of our residents, and whether it is flexible enough to cover each individual's needs. All our evidence so far is that it does.

This approach has been effective in different cultures. People are still social creatures. Programs have different governance, financing, and standards of behavior. What seems to be good discipline in one culture can be licentious or authoritarian in another. The tasks that residents are assigned and the educational opportunities are different. The culture and ethos of the community will probably be at least as important as the predominant ethnic culture. But the basic principles still apply.

Resocialization: The therapeutic community

"Socialization" is the idea that people naturally tend to become like the people around them. That is, they naturally tend to adapt their behavior to the demands of those with whom they socialize. For example, a new army recruit is cut off from civilian life and taught to relate to other recruits and officers in particular ways. Similarly, a student moving to a residential college needs to adjust to a different social group.

As a treatment, resocialization means taking people out of their existing social networks and putting them into a controlled social environment. It works on the principle that people tend to improve when they are surrounded by people who exert a positive influence and when they have no contact with people who exert a negative influence. Most residents have come from groups of friends whose influence is not good.

For some residents with social problems but no addiction problems, resocialization into a healthy environment is the main treatment.

Consequently, staff promote positive friendships and interactions between residents and discourage any kind of destructive relationship between them. It's important for new residents to feel accepted and valued. However, some new residents find it difficult to feel accepted and desperately seek attention to cover their low self-esteem.

Staff gradually reintroduce residents back into the wider world in a series of controlled, monitored stages. From a starting period of thirty days without visitors or phone calls, residents are then permitted visits from their parents (or guardian), then weekends at home and other visitors, then working outside.

A new culture

Our residents need at least three months to settle in, and might need up to six months before they can talk about themselves.

In this environment, they learn another culture; that is, they learn to think and behave differently. They learn to base their thinking on a new set of values and purposes. Cultural change is essential to recovery, and new residents are forced to make changes as a natural part of adjustment. David Clark has even suggested that people with substance abuse issues find it "more difficult to break away from the culture of addiction than the addiction itself."[3]

They learn a different set of habits; they learn new daily routines and new ways of relating to people. Their new habits don't include their substance of addiction, so they learn not to reach for a bottle when they wake up or feel anxious. Then they get enough long-term practice with their new habits to make them endure after they leave.

Gaining a new culture is also especially helpful for residents who have been victims of some of the problems associated with socio-economic disadvantage. They can learn that life can be different. They learn to manage their money rather than to spend it. They learn that they can succeed in the education system and that they can aspire to employment that suits their abilities.

Cultural adjustment

It is very enlightening to examine the kinds of emotions that residents often have during adjustment, although it would a mistake to presume that they have them all.

Almost all residents in adjustment go through some culture shock, even though they only recognize the symptoms in hindsight later on. Cultural adjustment tends to takes several stages:

- *The honeymoon phase.* New people play the tourist, enjoy meeting people, and have lots of new experiences. At this stage, it's all adventure.
- *The beginning of culture shock.* Somewhere between three and six weeks after arrival, new residents feel like they've had a good visit but it's not fun any more. The honeymoon is over. Even though they now live here, it doesn't quite feel like home yet and the temptation to leave is very strong. Even when their family home is a very destructive environment, they might still long to return to it. Some residents keep track of how many days, hours and minutes they have been in The_house.
- *Deep culture adjustment.* The resident is fitting in well, but they occasionally need to work through small problems that have been caused by cultural misunderstanding.
- *Belonging to the new culture.* The resident has now made the emotional move, and The_house is now home. Their worldview has changed and their emotional investment in making the adjustment is starting to pay off. The way people in The_house do things now seems sensible and right, and it gets harder to think in terms of the old ways. Some residents even start to forget the details of their previous life.

Culture shock has several elements:

- *Situation.* In the beginning, a new physical environment alone is daunting, especially for residents from out of town. They have to move house, learn their way around a new city, and adjust to a new diet.
- *Language.* Learning our particular jargon is a challenge when ordinary words have different meanings.

3Clark, David, 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

- *Interpersonal stress*. New residents have to make a whole new set of friends, but might be wary of what others expect of them and don't quite know what they should expect of others. Some are not accustomed to sharing a bedroom. Some are secretly very lonely and do not easily feel accepted.
- *Decision-making shock*. In a totally new situation, people can have great difficulty making even minor decisions. They feel, "How can I make good decisions when so much of the future is unknown?" Besides, their expectations are not necessarily realistic.
- *Organizational shock*. Coming into a new organization is quite stressful. Residents might find it difficult to come under authority, and think that the rules don't make sense.
  Organizational shock has another more serious consequence. It's not uncommon that someone on staff makes an innocent error when a resident is moving in. Look at it from their perspective: Even if you understand that organizations make mistakes, it's nearly impossible to be objective when they make mistakes with *your* life. Consequently, it can easily lead to blame, anger, frustration, distrust of motives, gossip, and communication breakdown. And some mistakes are only perceived; people can interpret your "maybe" statements as promises, and your "at least" statements to mean "no more than" (or vice versa).
- *Shock of discovering yourself*. Adult residents usually find new limitations and abilities within themselves and process the changes in their lives. Teenagers, however, are less self-aware and have difficulty understanding the changes.

Facing change

Another approach is to look at the range of emotions that people tend to go through when facing a significant change. The original form is called the Kübler-Ross cycle after the person who first studied these emotions, although they are conceived quite differently now.

The first stage of emotional reactions comprises:

- Shock: Initial paralysis.
- Denial: "This can't really be happening." "My cousin needs to be here more than I do."
- Resistance: "This change is bad and I'll fight it. Perhaps I could always go slow, be late, or skip my homework."
- Anger: "Why me? It's not fair!" They might be unable to identify whom they are angry at; it might be everybody or nobody in particular. They might feel like a guinea pig in your experiment, or a rat caught in your trap.
- Bargaining: "I'll do what you want but give me my space. When do I get out?"
- Depression: "This is terrible. Why bother?"

After that, people ask: "How will we do this?" They test the changes, explore the implications, and look for realistic solutions. They then slowly accept the change: "It's going to be okay. I can see a way forward."

The lifeline phenomenon

Many new residents suffer from severe loneliness, so you might find cases of the lifeline phenomenon. Consider this situation:

> Monica has been at The_house for six months. She is convinced she isn't good at anything and we suspect she is depressed. She doesn't make friends easily. She had been struggling emotionally and had hit her lowest point ever. She was afraid of asking for help, but she knew she really needed it. But whom could she ask?

She looked at Amanda and thought: "She's busy. She's always busy. I can't ask her." (It's irrelevant that Amanda wasn't actually very busy and quite willing to drop what he was doing to listen.)

Then Monica considered Debra and thought: "She cut me off last week when we were talking. I wanted to ask her but perhaps she's not listening. I can't ask her either."

She next wondered about asking Emily: "She's such a good person and she's so good with everybody else. They're better than I am; perhaps I'm not important enough."

She then considered Nikki, a visiting counselor who comes in once a week: "Nikki is helpful. She was thoughtful last time we spoke and seemed really interested in me. I'll ask Nikki. She's the one." Monica identifies Nikki as the lifeline and becomes convinced that Nikki is the *only* person whom she can ask for help.

The lifeline view can be quite disconnected from reality; in fact all the staff (Amanda, Debra, and Emily) were equally suitable people to ask and equally available to give help. But that's not how it looks from the perspective of a resident who is afraid to ask for help.

Resocialization largely depends on residents making friends. Especially in the case of younger people, the principle seems much like cultural adaptation—if they can make a good friend, anything works. If they can't make a friend, nothing works. Many residents need only one good friend to fit in and feel they belong, but if they cannot make friends, then they are at higher risk of leaving the program. The counselors and case managers try to make a strong personal link, but residents need to latch onto other residents, not only staff. It's good practice is to assign each new resident a buddy to be with them constantly.

Unfortunately, it isn't quite that easy. Many residents are so damaged that they don't have the social skills to make and keep friends. They might be selfish, defensive, angry, or suspicious. Some naturally tend to make friends who are a bad influence, while other look for someone to whom they can plug in their emotional umbilical cord. If they do make friends, they tend to make their own choices; staff can't really make that decision.

Questions

1. "Socialization" implies that if a person enters a detrimental social environment, they have little choice but to go with the predominant view as they adjust to a different social group.
   a. What can be wrong with this theory?
   b. In this context, what would you say to:
      i. A young person going back to live with a dysfunctional family?
      ii. A substance abuse victim leaving rehab?
      iii. A prisoner leaving jail to live at home?
2. How can you respond helpfully to residents looking for a lifeline, without letting them become emotionally dependent on you?
3. How does adjustment differ for different kinds of residents:
   a. Males and females?
   b. Singles, couples with children, couples without children, singles with children?
   c. Teens and adults?
4. What can you do to make adjustment smoother and less stressful for new residents?
5. To what extent are you simply training people to adopt middle-class values?
6. When is it ethical to inculcate new cultural values? When is it unethical? For example, you might be taking residents out of cultural poverty or criminality. But you might also be obliterating their ethnic culture or building barriers between them and their extended families.

A safe environment

The community needs to be a safe environment. Some kinds of organizations (and The_-house is one of them) need to create a very positive environment with built-in affirmation, encouragement, and mutual respect. To outsiders, this looks like an artificial bubble, but some residents have come from environments where they never feel safe or respected. Some have been homeless, bullied, threatened, or bashed. Others have been belittled, rejected, or sexually abused.

These residents need an environment that gives them a healthy self-image and enough confidence to set beneficial goals for their lives. In other words, we also need to create an *emotionally* safe environment. This kind of environment is also essential to good management; a wave of negativity can destroy a community where many people live very closely together.

Group dynamics

Good group dynamics is essential to good resocialization, so we monitor the group dynamics of our residents. Our staff break up any unhealthy cliques and reduce the negative influence of their ringleaders. Besides, a closed community becomes an emotional hot-house that creates its own kind of warped perceptions, so it is essential that those in charge can keep the social structures healthy.

Group dynamics is a fact of human nature as social beings. A group of people left together will naturally set up social structures where some people are leaders and others are followers. They will often divide into sub-groups, where each sub-group sets up unwritten rules for its members and gives some members more right to speak than others. This can happen in quite brief periods, because people naturally tend to drift to those they think are like them and look for people to lead them or follow them.

The group leaders exert power to decide what others will do. It might be by being "cool," coming from a more prestigious social grouping, bullying, offering better solutions to their shared problems, presenting opinions most persuasively, or offering something that the others want. The powerless members of the group can find their own ways to counterbalance those with power. For example, they can set up their own little sub-groups with different values, discuss their own ideas, agitate for change, or resist authority.

Besides, groups and their dynamics change over time. Their environments change, people change, leaders come and go, and group members come and go.

Young people are especially susceptible to perceiving an "in-group." They can believe that staff give preferential treatment to a particular group of residents, even when staff treat all residents the same. The perception most often derives from their own insecurity and need for acceptance.

We have tried to build a good core group among the residents. It is very helpful to have either the majority of residents or the most influential residents on side; it improves the social dynamics and reduces residents' antagonism toward staff. (Not much ruins a smooth operation more than an ongoing war between staff and residents.) However, it would have been unethical to discriminate; we had to avoid picking favorites to be the in-group and treating the others as second-class.

When studying a group's dynamics, you'll probably ask questions like these:

1. What kinds of people are in this group?
2. What do they have in common that holds them together?
3. Who are the most influential people in it? What kinds of power do they have? And how do they use it?
4. Who are the followers and the powerless?
5. What kinds of responses do the powerless make?
6. Do the powerless have ways of counterbalancing those with power?

7. How does the group naturally divide in subgroups? (e.g. similar backgrounds, age, newness to the group, socio-economics)
8. What are the rules for each sub-group?
9. How is the group changing? Why?

Family dynamics

You might find this approach useful to find out what happens in families and outside peer groups. Consider this example:

Mom runs the Mackintosh family. Dad basically does what he's told, but he isn't there much anyway.

She works in survival mode, thinking about what is the best for her family in general and her kids in particular. She controls discipline and hands out privileges.

Kylie, the oldest sister, has appointed herself as deputy mom. When Mom isn't around, she bosses Daniel and Rob, her two young brothers. She mainly does this by making up rules and nagging them to do whatever she thinks Mom would like. Kylie seeks Mom's approval and usually gets it. The boys are understandably rebellious to their older sister and enjoy making her angry. She gets frustrated and retaliates by being even bossier.

Daniel and Rob respect Mom whenever they are at home, but outside the house, they seem to demonstrate increasingly serious behavior problems.

Assignment

1. Do an Internet search on group dynamics. Then write a paper of 500 words describing group dynamics and the aspects most relevant to your particular role.
2. Write a case study of the group dynamics of a group of residents and the steps taken to manage them. This will be easiest to do as an observation rather than leading the group yourself.
3. Write a case study of the social dynamics of a family.
4. What would be the consequences if staff were to select a group of favorite residents in an emotional hot-house environment?

Recovery groups

In recovery groups, we discuss key issues that are essential for living a healthy and productive life. These topics are highly effective for a wide range of residents' issues; our residents seldom need as much issue-specific care as one would think. Topics include:

Identity and self-image
Family of origin
Anger management
Communication
Boundaries
Stages of change
What causes problems in my life
Managing conflict
Making decisions
Relationships: my family
Relationships: my friends
Building a positive vision
Unhelpful thinking
Overcoming fear
Overcoming the past
Overcoming performance-based acceptance
How to solve problems
Processing feelings
Abandonment, shame, loss, guilt
Handling anxiety
Keeping healthy
Handling my money
Using my time
Sorting my personal values
Setting life goals
My relapse dangers
Planning to prevent relapse

Specialized counseling

To fully recover from addiction, residents need to deal with the emotional issues that brought it about in the first place and to learn specific coping strategies. All residents have individual time with a specialist counselor during their recovery phase. It helps them work through their past experiences and to make progress on their paths to recovery.

About work[4]

Most residential recovery programs help residents to make the transition into work when they are ready. They often don't see work as a kind of therapy, but as preparation for live after recovery.

At The_house, we sometimes consider work to be a treatment, because we found that physical work gives people time to develop a routine, learn to trust others, and to reflect on and process the changes happening in their lives. It also had other benefits. All of them had to learn how to carry at least some responsibility and to get along with other people. It was the first time that some residents had ever had a regular job. For others, it was their first chance to feel successful at something and it helped to build their self-image. Some rediscovered past skills. Some eventually became successful entrepreneurs or used their business experience as a stepping stone to bigger things.

Work has been more necessary for our male residents, who tend to relate their self-image to their ability to work successfully. They find recovery groups very difficult; they have different expectations of friendships and have a lot more difficulty talking about their feelings. Females tend to be better at talking about feelings and focus more on relationships than work. But the girls also benefited greatly from purposeful work.

As soon as they have finished detox, new residents start doing the regular chores needed to live. Later on, many of them supervise teams doing different kinds of work around The_house. The step after that is to work in a real business.

For example, work in the training stage is one day a week of unpaid on-the job training. Later, residents might have paid work that gradually increases from two days to three and then three to four. In the final stage, residents might work outside five days a week and may use a cellphone, but must be back at the house by curfew time.

We generate our own businesses to maintain a controlled environment. We looked around the world and found that programs like ours had started many kinds of businesses: gardening services, home maintenance and renovation, car washes, door-to-door sales, furniture restoration, handicrafts, a fashion house, catering, coffee shops, restaurants, and steel fabrication. One group of small restaurants trained chefs who went on to work in top hotels and restaurants.

The skills required varied greatly; some businesses required simple skills that people could learn quickly, while others needed advanced skills. Some organizations found open gaps in the marketplace, while others had to push their way into highly competitive markets.

We didn't expect some things and learned a lot. Pioneering a new business is much more difficult than it looks, especially when facing stiff competition. Some residents were easily discouraged when a new start-up faced difficulty. Even if it succeeded (and not all did), it usually took considerable effort and time until it became profitable.

We didn't expect it would be so hard to run a business in the open marketplace with real customers. We didn't know it would be so difficult to work at a safe profit, but we also couldn't afford to run at a loss.

We found that residents value meaningful, purposeful work, such as paying the bills or helping people in need. They see through busywork, that is, useless tasks that only fill up time.

4Many thanks to Lindsay McKenzie and Candy Bollington for their contributions on this topic.

We took risks with people. Most rose to the challenge, but some absconded just when the business had started to depend heavily on them. They let us down and we had to overcome the temptation to become angry and bitter. This was even more unsettling when a business had to meet contractual obligations.

We found it difficult to find the right job for some residents. Residents' abilities and confidence levels were seldom the same. Some were quite capable but had little confidence, while some were overly confident about their quite meager skills.

We also didn't expect such difficult choices between good business practice and giving the highest priority to residents' recovery. For example, residents might become essential to the business running well, but then need to move to another role for the next phase of their recovery.

As a part of our approach to recovery, work has some limitations:

- Residents cannot work at all during detox, and some very damaged people have limited ability to work.
- Residents still need ongoing care, community support, and a recovery program; a work program alone is seldom successful. With a heavy work schedule, residents have less time for activities that are specifically recovery-oriented.
- Many staff in the non-profit sector lack the entrepreneurship skills to establish new businesses.
- Some residents find the idea of pioneering a new business to be strange and difficult. This is especially the case if they come from social classes that do not have entrepreneurial skills, such as working class wage-earners, long-term unemployed, and subsistence farmers.
- If residents come and go, each business usually has partially trained staff and finds it difficult to build organizational capacity.
- Dishonesty is often a problem. Residents are easily tempted to steal money or goods.

Question

When should residents start work? Could they start working full-time in businesses as soon as they have finished detox? Or should we let them make significant progress in recovery and then gently ease them into employment?

The_house: Preventing relapse

At The_house, we help residents to prevent relapse back into alcohol and other drugs issues. We usually discuss this in groups, but team leaders also help residents as individuals.

Relapse precipitants are often called *triggers*. They tend to be specific to the particular resident because they reflect the circumstances of their background of substance abuse. They can be particular places, groups of people, music, or sources of stress (e.g. job, relationships, social pressures, and financial issues). Stress is often the most important trigger.

Residents are less likely to encounter their triggers when they have moved from their original environments into the controlled residential environment at The_house. The risks are obviously higher after residents have left, but they have practiced some good strategies and habits for preventing relapse well before they graduate.

At The_house, our staff prevent relapses in two ways: Group meetings where the facilitator leads discussion, and one-to-one meetings between team leaders and residents.

Group meetings

1. Help group members to join in the discussion as much as possible. Foster their strengths and respect their insights into their own situation, their knowledge and their experiences. Apply strategies that match the resident's stage of change.

2. Make sure you notice any high-risk situations. If they are violent, follow the normal crisis management procedure.
3. Observe their level of commitment. Even after they have made plans and committed to them, you still need to follow them up in case they waver or become confused in some way. You might need to talk over the plan again to have something effective in place.

Individual case meetings

You will need to be client-centered and communicate very effectively. Listen empathically and be reflective. Ask open-ended questions, and summarize what they say to make sure both you and they understand what was meant. Assess any problems as you go and prioritize them; deal first with those that are most pressing for the resident.

Use the normal motivational interview approach to help residents develop skills in solving problems, setting and achieving goals, coping, monitoring and managing themselves, recognizing and managing cravings, and learning to think in new ways.

Choosing strategies to prevent relapse

Work with the resident to make a plan to prevent relapse, starting as soon as they come into The_house. If they've tried and failed, the goal is to make a plan that will work next time. Ironically, a relapse can be an opportunity for a resident to experience a drug-free life and perhaps realize that their own life could be different.

You need to cover all the topics in the list below, but you probably won't go through them one by one. Most likely it will be a series of conversations in which you work through them all over time, and go over some topics several times until you have something workable.

Here's the list of things you need to talk about:

1. Check what medications they should be taking. Besides, they might also take some medications especially for moving out (e.g. naltrexone).
2. Tell the resident that many people have relapse problems and ask them about any ways that they've tried to prevent relapse in the past.
3. Explain why it's good to have a plan and discuss with the resident the best way of doing it. You might want to write it down or keep it informal and ongoing.
4. In making a plan, do you need to include other people who are significant in the resident's life? If so, who?
5. What are this resident's relapse triggers?
6. How will they avoid their triggers? While they are in The_house, this should be fairly easy, but could be very difficult when they leave unless they have a plan. Talk over their strategies, and be specific to their unique situation and their stage of change. Consider options that will encourage them to be independent. For example:
    a. "How will you avoid trigger people and situations?"
    b. "Who do you need to hang out with the most? Where?"
7. "Should you move when you leave The_house? If so, where to? Another city? Another state?"
8. "What will you do if you unintentionally meet a trigger person from your old life?"
9. "What will you do if you need help when you're by yourself and can't ask for help?"
10. "What if you don't have the people around who could help you the most?"
11. "What can you do to become less stressed?"
12. "What suggestions do *you* have?" (They might know of useful things that have worked in other situations.)
13. Other strategies:
    a. Check what medications they should be taking. Besides, they might also take some medications especially for moving out (e.g. naltrexone).

b. Get the resident to agree to ask for help if they have a relapse or even feel in danger of it.
c. Make sure the resident has ways of contacting help as soon as they need it. While they are in The_house, their team leader is the first person they can go to for help.
d. When they leave, give them contact details of people who can help them.
e. Later on, they can keep in contact with you, and might also have family members and other friends, especially in their church.
f. How will you identify difficult situations and still make positive choices? (E.g. talk it over as soon as you can.)
g. Where's your extra safety net? The resident also needs a plan for what to do if things go wrong and they relapse. Work with the resident to make a suitable plan.

Review and documentation

- Review the plan if they have a relapse.
- Record your relapse management planning in a case meeting form. Record the resident's response, outcomes and identified problems.

Relating to former residents

At The_house, we noticed that most graduates regressed a little after they left, even though relapse was quite rare. Some of them occasionally dropped in for a visit and consistently attended our special events, but others stayed away and we heard through other people that they had become bitter and resentful about their time with us.

It became obvious that we needed a system of consistent follow-up, and appointed someone to a role with aspects of both case management and alumni relations. As part of the role, the person would inform our board of the causes of post-graduation dissatisfaction and propose solutions.

We realized that those conversations of our past residents would be often extremely private, and we had to find a way to report concerns without breaching their confidentiality. We're trying two approaches. The first is to report aggregations of feedback in a way that no individual could be identified. The second is to have specific permission for specific items of feedback, including to whom it could be made available.

Identity

A significant sign of recovery is change of identity; in fact, it might be the central aspect. A recovered addict is free to feel that they have become a different person. They can be free of their past, living a new and different life with completely different goals, and a different set of friends.

Even so, they face a paradox. On one hand they have a new life. But on the other hand, their old life still has long-term consequences. They probably bear some kinds of emotional scars and are still vulnerable to relapse triggers. They might be unable to restore some significant relationships, and might never be eligible for some kinds of employment if they have a criminal record.

Question

Some addiction recovery organizations believe: "Once an addict, always an addict." How would you respond to this notion?

Practical assessment

Guide three residents through relapse prevention. The assessor will ask what you did and why, and examine your case notes. He/she may also verify your cases with your supervisor.

Assignment

- What are the most common risk factors for substance abuse relapse?
- Explain your three most important strategies for supporting behavior change.
- What are the main obstacles that make it difficult for residents to change their behavior?
- What medications and other therapies are appropriate for relapse prevention?
- What agencies can you refer residents to if they relapse?

What would you do? #1

It's 3.00 p.m. and Billy calls you to the recreation room. He is bent over and feels sick. He says it only started half an hour ago and is already complaining of serious pain in his lower abdomen. A few minutes later, he can't even stand up and has to sit. You wonder if he's faking it, but you doubt it. Then he can't even sit up any more and wants to lay down. What do you do?

What would you do? #2

Brad is twenty-one and has now been a resident for three months. He's here on a court order, with a background of criminal violence.

For no obvious reason, he has taken a disliking to Kent, who is much smaller. It started a few weeks ago with snide comments that embarrassed Kent in front of the others. Then he started making threatening comments and giving an occasional punch in the arm.

You think that it's time to put a stop to it. It's bullying, and could become a fight if Kent argued back and felt a need to defend himself.

What do you do?

What would you do? #3

You are at the front desk managing a shift. Nicki, a new resident whom you have started mentoring, comes to the door and tries to get your attention. She is supposed to be in a meeting and it's obvious she has no particular need to talk to you.

You must decide how to react. You could ignore her in order to discourage attention-seeking behavior. However, she might be thinking of you as her lifeline and unconsciously checking to make sure the lifeline is still intact; in this case, any kind of rejection might seriously damage your relationship. What do you do?

What would you do? #4

The HIJ Center has a large community of young residents, most of whom are going through major personal transitions. They hear stories from other residents about "new rules," and often make their own interpretations about what staff expect of them. With so many unspoken expectations as well as the normal pressures of communal living, the HIJ Center has become an emotional pressure cooker. For some, the pressure could be causing emotional damage; a few residents have already left without giving their reasons.

When a few residents eventually talked about it with staff, the staff reaction didn't help. Some tried hard to stamp out negative gossip, while others tried to prove that those beliefs were unfounded and clarify that they were not imposing new rules and expectations. But residents have continued to talk and tend to believe each other rather than staff.

You have just been appointed to staff. Now that you know more about what is happening, what should you do to resolve it? How could it have been recognized it earlier? How could it have been prevented in the first place?

4
Social effects of substance abuse

Many social issues normally accompany substance abuse, and you need to learn to recognize their signs. It is a mistake to create caricatures of drug users as a whole. It is more accurate to create a range of the most common scenarios. Although some substance abusers are school dropouts from dysfunctional families, others are well-educated professionals, and some come from good homes. Some of them remain social users and don't become addicts.

The downward spiral

The downward spiral is a pathway into serious addiction. It is only a generalization; not everybody goes through all stages below or even in the same way.

One pathway onto the downward spiral is to experiment with an illicit substance, most likely marijuana, and use it socially. Another pathway is to use a perfectly legal substance socially until it becomes a bad habit. Alcohol and nicotine addictions tend to start this way.

The third pathway is to use a prescribed medication for so long that the patient becomes addicted to it. They then go doctor-shopping to get more through legal means. If it gets worse, they might then start giving false stories of their symptoms, steal a prescription pad to falsify prescriptions, or buy medication on the black market. They might eventually depend on the black market for supply when they can no longer get legitimate prescriptions. They can also trade any excess on the black market.

Whichever entry point they come in through, the pattern tends to be a downward spiral:

1. Their family relationships suffer.
2. They may develop co-dependent relationships.
3. They may either increase their consumption of the substance, add another substance of addiction, or switch to something stronger.
4. They try to hide their problem. They often tell lies and become manipulative to keep their secret.
5. Substance abuse takes more of their time and money:
6. The person starts going without necessities in order to pay for substances.
7. They are increasingly absent from work or study, and often become socially isolated.
8. They have financial problems and start selling possessions to raise money to buy substances.
9. They start engaging in dubious activities to pay for substances, such as dealing, prostitution, crime, etc.
10. They face some kind of serious crisis, for example:
    a. become bankrupt,

b. have their house mortgage foreclosed,
c. go through a divorce,
d. have their children taken from them,
e. are convicted and imprisoned,
f. have a medical emergency, or
g. see a friend die of an overdose or from AIDS.

11. They feel they have hit rock bottom when confronted with the consequences of the crisis. They may be in hospital, in prison, or homeless. They realize that they could die if they don't change. They might feel the need for rehabilitation, but might still be unwilling to commit fully to a recovery program. Being socially isolated, they are without the friends and family that could have given them the kinds of support that most people have. They might have lost the social skills to develop those kinds of relationships.

Accompanying social issues

Most substance abuse victims also suffer from one or more social issues, although it is unlikely that addicts ever suffer them all.

Behavioral problems

- *Manipulative*: They tend to "use" people and try all sorts of ploys to get their own way and to control people around them. They might become pre-occupied with control and power.
- *Lying*: They become clever liars to hide their problems.
- *Erratic*: They change their minds a lot and cannot stick to their decisions. They might have extreme mood swings and poor impulse control.
- *Self-centered* and *grandiose*. "Grandiosity" is an irrational belief that they have immense influence or power over others.

Denial

People with addiction issues tend to live in denial; they believe they are still in control and don't really have a problem. ("I can quit anytime I want.") They might also justify themselves by pointing to others who are in a worse condition than they are.

Codependency

Co-dependency is a relationship between two people, one of whom is typically ambivalent while the other is co-dependent. The co-dependent one, fixated on saving the other or their relationship, becomes dependent on their approval. The co-dependent one might be driven by a poor self-image, a desire to prove oneself, or a feeling of power.

Homelessness

Homelessness includes living in squats, charity accommodation, or cars, the latter being unexpectedly common. Homeless people also sleep on the street or move between friends' houses ("couch-surfing").

Lack of driver's license

Residents with no driver's license find it much more difficult to get employment. For them, one stage of recovery includes learning to drive, getting a driver's license, and buying a car.

Financial difficulties

They don't know how to use money. They are often broke, in debt, and have disputes with the welfare office and their banks. They might have fines that they can't pay.

Domestic issues

Their family or spouse might have kicked them out of home, or they might have left home after a disagreement. Their de facto relationship might have broken up, they might have suffered physical or sexual abuse, they might have children as a one-parent family, or they might be pregnant. Their children might have been taken from them, and they might suffer separation anxiety.

Employment issues

Due to absenteeism or poor performance, their job is in jeopardy or they have already been sacked. Alternatively, they might be long-term unemployed.

Disability

Disability can be physical, sensory, intellectual, neurological, or psychiatric.

Legal issues

They might be under court, protective, or statutory orders. They may be on bail or probation, or be under investigation.

Immigration issues

Some residents need visas to stay in the country and can easily become illegal. An advocate normally needs to work with the embassy to get new passports and with the immigration authority to ensure residents have visas. Illegal aliens are especially afraid of the police and vulnerable to exploitation.

Communication

They have communication needs, especially if they have poor social skills or have been socially isolated for a long time.

Post Traumatic Stress Disorder (PTSD)

They might suffer Post Traumatic Stress Disorder (PTSD) from a major incident or as a military veteran. They might have some kinds of dysfunction through growing up as a child of in a long-term PTSD culture.

Sexual abuse and lifestyle issues

1. They may be adult survivors of child sexual assault or another kind of sexual abuse.
2. If they have been raped, they might suffer from Rape Trauma Syndrome.
3. They might have gender identity issues.
4. They might have developed a promiscuity cycle, where they have frequently changed sexual partners. This brings risks of a damaged psychological disposition, unwanted pregnancy, and sexually transmitted diseases.
5. They might have worked as prostitutes, whether freelancers, employees, or slaves. They vary greatly in the level of psychological damage, and some have been raped and physically beaten.

Risk of self-harm and suicide

It is not uncommon for young people to think of suicide as the way out (called "ideation of suicide"). They may also try to self-harm, for example, cutting with razor blades. The_house's case management approach normally provides suitable care.

If a resident or applicant makes a comment implying they are considering suicide, you should take it seriously even if you suspect that they are seeking attention. Current good practice is to ask them clearly if they are thinking of killing themselves. It is quite unlikely that this will trigger a suicide, and people who are seriously contemplating suicide are less likely to enact their plan if their

secret is out. If you don't ask the question, the person might think that you are deliberately avoiding the topic and is more likely to enact their plan.

Issues related to social position

Many people with addiction problems are ordinary people. At The_house, we usually have some university graduates among our residents, and the average intelligence seems to be similar to (or perhaps higher than) the general population.

Some AR residents, however, come from a position of socio-economic disadvantage, and recovery often involves helping them out of a poverty mindset. Their disadvantage may be compounded if they come from a minority ethnic group or from a background of long-term unemployment. They might have lacked access to appropriate health care, and be unable to manage their own health and well being.

Educational wounding

They had a bad experience of school. Its causes are:

1. influence of parents and friends who also had a bad experience of the education system
2. employment prospects for which education was no advantage
3. the government encouraged them to take training programs that do not lead to employment
4. a poverty mentality where people don't aspire to much education (common in lower socioeconomic groups)
5. ethnic marginalization: middle class white school culture tends to marginalize people of other ethnic groups or who hold those ethnic values. Some ethnic minorities are at higher risk of educational wounding.

Educational wounding results in dropping out of school while quite young, a feeling that the education system has set them up to fail, and reluctance to take up training and education opportunities later on. Educational wounding also devalues the "school" kind of information that is taught and the way it is communicated.

Religious abuse

Some residents have been victims of abusive religious organizations and cults.[5] These groups tend to have an agreed, but often unspoken, set of rules that they use to control members and ensure group coherence. Members often feel under pressure not to leave or consult outsiders for advice, and certain donations, attendance, and participation in activities are compulsory.

If members show behavior or beliefs that the organization holds to be incorrect, the organization punishes them by denying permission to participate in activities or fellowship, resulting in emotional abuse and social ostracism.[6]

Cultural poverty

The long-term unemployed eventually become unemployable. They then pass on a non-work culture to their children, who grow up believing it is normal to be unemployed and living on welfare. Some of them grow up having no family members who have ever had a job.

Cultural criminality

Some children grow up seeing criminal activity as normal behavior. They tend to see theft as the way to acquire things and physical violence as the way to solve problems.

5Cult recovery is actually a specialized field.
6With thanks to Beth Roberton.

Many members of their extended family are repeat offenders and have been in jail. They treat some kinds of law-breaking as acceptable behavior, such as stealing from the rich or from strangers when they believe they will not get caught. They believe that the government in general has oppressed and marginalized them, and they see the police force as the enemy.

A drug culture

Some young people grow up in families that have become dysfunctional through drug use. Their parents, older siblings and friends consider alcohol, nicotine, and cannabis to be normal and harmless, even when their effects become serious. They might also use something with more immediate harmful effects, such as heroin, cocaine, or methamphetamine. Consequently, these young people are more likely to start drug use younger than their peers, develop their own dysfunctional relationships, and have poor physical and mental health. Heroin addiction is starting at elementary school age, with reports that their own heroin-addicted parents deliberately injected them.

Ethnic language and culture

Immigrants have a hard time fitting in. You will need to help residents who do not speak English well or have another cultural background. You will find that most of these differences diminish if they adjust well to living in a residential program.

Powerlessness

A mindset of powerlessness is quite difficult to understand if you aren't powerless. It leads people to accept an unfair lot in life, and has various symptoms:

1. People feel like victims. ("It's not fair but we can't do anything about it.")
2. People believe that they cannot influence "the system", which usually means that they don't know how decisions are made and implemented. ("The politicians and bureaucrats don't listen to us." "There's nothing we can do about it.")
3. People accept their powerlessness, and might even believe it should not change. That is, they become acculturated to their position. ("Everybody in our ethnic group is a slave. Always has been, always will be. We couldn't be anything else.")
4. People are controlled by others who deprive them of rights. ("The old men make all the decisions. We women just do as we are told.")
5. People have no knowledge of their rights, or they might know their rights but have no way of getting them.

Powerlessness is only perceived in some cultures; people simply need to be taught their rights and their role in the decision-making system. But powerlessness is real in cultures where marginalized people are deliberately kept in place by government law, bureaucrats, large companies, traditional law, or social stigma. When pimps want prostitutes to become slaves, they use a set of deliberate strategies to create a mindset of powerlessness.

The toxic mix

Quite obviously, a toxic mix of these problems destroys people. Imagine a community where young people grow up believing that being an unemployed criminal or an addict is quite normal, education won't help them, the government oppresses them, the police persecute them, and there's nothing they can do about it.

Causes, effects, and treatment

Looking at all the associated issues, it's not easy to see which are the substance abuse itself, which are causes, and which are effects. Perhaps the effects have other effects in a chain reaction. It's a classic chicken-and-egg situation.

The question then arises, "Is it futile to put patches on particular effects without treating causes?" Understanding the causes of substance abuse can be a distraction from the real business of recovery, but it still has some uses in treatment. It can help you to identify the particular social and emotional reasons that made people susceptible, specific character weaknesses, and particular symptoms requiring treatment.

On the other hand, instead of a set of cause-and-effect relationships, it might be more helpful to think of substance abuse as a vicious cycle that needs to be broken. The holistic approach to residential recovery includes management of all issues associated with substance abuse. By focussing on the recovery of the *whole* person, we treat all three (addiction, causes, and effects) and break the cycle. Put more specifically:

1. Resocialization and culture change treat all three simultaneously.
2. Behavior management doesn't need to differentiate between causes and effects; it only has to differentiate between acceptable and unacceptable behavior.
3. Medical interventions treat physical aspects of addiction.
4. Counselors identify the cause and effect relationships of addiction for the particular individual, especially drivers and relapse triggers.

Assignment 1: Social structures

1. Describe the dominant social structures in your area of the nation (e.g. aged care system, education system, family, health system, labor market, legal system, media, political systems, religious systems, work, private enterprise, religion, marriage).
2. What kinds of influence and effects to these institutions have on communities, families and individuals?
3. Describe how the "typical" family has changed in the last fifty years. Include both positive and negative effects, as well as changes that are neither particularly positive or negative.
4. Describe how gender roles have changed in the last fifty years, especially in relation to the workforce.
5. What is social stratification?
6. Describe different beliefs about various kinds of stratification in society? (For example, how do a minimum wage employee and a wealthy corporation owner see social structure differently?)
7. Describe three cohorts of different ages (e.g. teenagers, older people, the elderly) using the following questions:
    a. Who are they?
    b. Describe how each forms its own micro-culture.
    c. How does each group perceive society differently?
    d. How do stereotypes develop in each group? What kind of impact do they have?
    e. How do new beliefs develop in each group?
    f. What positive contributions can each group make to society?

Assignment 2: Social and cultural impacts

1. To what extent does the social environmental affect the general health and well being of a community, family and individuals? Can people gain general health and well-being free of their social environment? Explain your answer, and give reasons.
2. In the target group of your services, what are the current core needs in health, well being, etc.?
3. Draw up a table like the one below:

Factor	Description	**Effects and consequences**

Fill in the blanks with enough detail to be useful in community services: In the first column, list these factors:

- Kinds of inequality
- Long-term unemployment
- Factors related to age
- Socioeconomic background
- Ethnic/cultural background

In the second column, describe each factor

In the last column, describe the effects and consequences on individuals (e.g. health and wellbeing), families, wider society, and kinds of discrimination.

Assignment 4: Specific effects

1. Government has a changing role, with more power centralized in the national capital and many citizens now wary of excessive government control. How does the role of government power affect community services and their clientele?
2. What frameworks does the government have for social policy?
3. What influences affect the government's social policy? (E.g. views of major lobby groups, political pressures.)
4. What kinds of frameworks and influences currently underpin social policy? (Some are federal government, some state government, and some come from private organizations, mainly non-profits and lobby groups. Some might derive from political pressures.)
5. Describe the influence of government policy decisions on general health and well being. What other factors affect general health and well being?
6. How have specific government policy decisions affected your organization's community work? Your own community work?
7. The political and economic views of the major political parties significantly affect and their community services policies, which in turn affect you and your work. Keep in mind that the same political party might have different views at state and federal levels.
    a. What are the main differences in community services policies between the major parties?
    b. How do their political and economic views result in their community services policies? In your answer, make a list of political views and their resultant community services policies.

Assignment 5: Effectiveness

1. Does your organization have any policies and procedures for monitoring its effectiveness?
2. In responding to the problems caused by social and cultural factors on your target group:
    a. How effective have *community services in general* been?
    b. How effective has *your organization* been? How do you know?
    c. How effective has *your own role* been?
3. What changes would you or have you made to your community services work so that you can better address the social and cultural issues and get better outcomes?

Assignment 6: Perfect storm

Describe cases of two people who both suffered the "perfect storm" of negative social effects. However, their "perfect storms" needs to be different. In your analysis, identify each specific sociological cause. Describe what you should do to alleviate those effects.

Assignment 7: Case studies

Using the questions below, write three case studies of clients describing the effects of social and cultural factors on community work and client services. Each case study should be about 500 words and cover a period of at least six months.

1. Describe the demographic of the client and the social context (socioeconomic group, family, and community).
2. In the target group of your services, what are the current core needs in health, well being, etc.?
3. From the information available to you, what are the specific effects of social and cultural factors on the target group of your service?
4. What effect did those factors have on the effectiveness of services to clients?
5. Over the period, what were the effects of services on clients?
6. What decisions have you/your organization made to address their issues?
7. How have you implemented those decisions?
8. How effective were your organizations' services?

5
Medical aspects of substance abuse

Although the kinds of substance abuse vary from time to time and between states, our highest rates of incidence in the recent past are amphetamines (mainly speed), alcohol, and marijuana:

1. Alcohol is legal, easy to get, and relatively cheap. Estimates vary, but between five and ten percent of adults in this state are alcoholics, most of them undiagnosed. It is one of the most destructive of all addictive drugs.
2. Speed (methamphetamine or amphetamine sulphate) is fairly cheap and easy to get.
3. Ice, another form of methamphetamine, was popular but its use is now declining in some regions. It is sometimes cut with epsom salts.
4. Marijuana is also fairly cheap and easy to get. Modern cultivation methods have increased the amount of psychoactive substance, and it is now more addictive and destructive that it once was.
5. Ecstasy (MDMA) is fairly common in some circles. It is often spiked with other drugs or contaminants.
6. The_house has some residents who have been on opioids, usually heroin. Its popularity varies according to time and geography.
7. Cocaine is less common in this state because it is so expensive. It tends to appeal to wealthy people who have jobs, because the high is quite short and they can work next day. It is the drug of choice in other areas where it is fairly cheap and easy to get.
8. LSD has been making a comeback.
9. Barbiturates are only common in some regions; it's a prescription-only sleeping pill that gives a high by forcing oneself to stay awake.
10. Synthetic variants. To circumvent local laws, underground chemists can make minor changes to illicit substances. For example, cannabinoids are a family of drugs based on cannabis. The effects are often a little different from the original base drug and are normally unsafe.

What are amphetamine-type stimulants?

The term amphetamine-type stimulants (ATS) refers to a group of psychostimulant drugs that are related to the parent compound amphetamine (phenylisopropylamine, or 1-phenylpropan-2amine) (International Union of Pure and Applied Chemistry, 1993). This includes amphetamine sulphate, amphetamine hydrochloride, methamphetamine … and phenethylamines.

Phenethylamines include MDMA[7], commonly referred to as 'ecstasy', and, or MDA[8] (Kalant, 2001). Although produced by a different chemical process, these latter drugs are structurally similar to amphetamine.

ATS stimulate the central nervous system by increasing synaptic concentrations of three major neurotransmitters in the brain: dopamine, serotonin (5-HT) and noradrenaline (Rothman & Baumann, 2003). This has the effect of increasing alertness, accelerating physiological functions and can produce euphoric effects.

ATS are available in diverse forms and vary in purity. Methamphetamine or amphetamine can be powder ('speed'), paste ('base'), or crystalline ('ice', 'crystal') form. Ecstasy is usually in tablet form and contains MDMA in varying amounts combined with other drugs such as meth/ amphetamine1 and ketamine (a general dissociative anaesthetic).[9]

Polyaddiction

Polyaddiction is addiction to two substances at once. Addicts use one substance to lift them out of a downer after they've had a high on something else, or when their substance of choice is unavailable. Others take something to get them to sleep after using a stimulant.

Many substance abuse victims also use alcohol frequently without considering its effects as another drug. Amphetamine users do not notice the effects of alcohol even though they still lose their motor skills.

At The_house, most of our substance abuse victims are probably poly users, and many of them have a polyaddiction problem. For example, a heroin addict might drink alcohol but might or might not also be an alcoholic.

Poly drug use is complex and dangerous, and includes medical and physiological aspects. It can result in dehydration and increased heart rate, blood pressure, and body temperature. At its worst, it can cause heart seizures.

Nicotine

Lots of residents smoke when they come in. Our incoming heroin addicts would rather give up heroin than nicotine; nicotine is one of the most difficult of all addictive substances to give up. Part of the trap is that they don't see the health problems in the short term, so they presume that it is either harmless or that they are somehow immune from harm.

Until several years ago, we didn't require new residents to quite smoking straight away. We regulated their cigarette supply and only allow smoking in designated outside places. If they did decide to give it up, we treated it as any other drug and attempted to prevent relapses. All residents quite smoking during their stay here.

We then changed policy. It is now a normal part of detox and all incoming residents give up smoking.

Assignment

Interview two supervisors who have overseen detox from polyaddiction:

1. What drugs were involved?
2. What extra medical risks did the residents face?

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7 3,4-methylenedioxymethylamphetamine.

8 3,4-methylene-dioxyamphetamine.

9 Adapted from The National Amphetamine-Type Stimulant Strategy 2008-2011 http://www. nationaldrugstrategy.gov.au/ internet/ drugstrategy/ publishing.nsf/ Content/ ats-strategy-08-l.

3. In what way did the treatment differ from detox of residents who were not in polyaddiction?

Impaired judgment

You should learn to identify impaired judgment associated with drug use. Many drugs impair perception and response, so addicts cannot perceive dangers and respond appropriately in time. It is a serious risk to drive or operate machinery while operating under the influence.

Some substances make people feel they have normal or good judgment, even though it is seriously impaired and they are prone to making poor decisions. For example, some amphetamines create a high where addicts feel they are superhuman (invincible, highly intelligent, socially brilliant). In other cases, addicts continue drug use so they feel "normal." These risks are exacerbated if the addict is still employed; the person feels they are doing well but the employer notices the decline in performance.

Medical risks

In the short term, the major risks are as follows:

1. An increased risk of overdose is often caused by :
   a. increasing dosages to get the same effect. Some drugs have less effect after a time so addicts take more of them to get high.
   b. drugs with a low toxicity level. That means that they may be safe in low dosages but become poisonous in dosages not far above a certain threshold.
   c. unusually pure batches of illicit drug. People take the normal amount but get more substance than they expect. (Illegal distributors don't control quality.)
   d. release from a prolonged period of abstinence in jail.
2. Some pills are laced with contaminants. (Rat poison is one of the more common.) Some pills sold as ecstasy are solely contaminant and have no MDMA in them at all.
3. "Bad trips" are usually associated with LSD, which can create a horrible experience rather than euphoria.
4. Ecstasy has increased risk if consumed with alcohol. It can induce dehydration and increase body temperature to dangerous levels.
5. Liver damage (cirrhosis) can be caused by alcohol and intravenous drug use, and is fatal in its advanced stages.
6. Cocaine usage can precipitate heart damage.

In the longer term, substance abuse results in a range of basic health issues. Some are fairly common to many substances and some are substance-specific[10]:

1. Malnutrition, which affects general health.
2. Weight problems. They can be severely overweight *or* underweight. (E.g. speed is an appetite suppressant.)
3. Blood-borne diseases. Hepatitis C is the highest risk but HIV is still a risk.
4. Skin infestations: Ice makes people feel like they have something crawling under their skin so they pick sores.
5. Constipation.
6. Decalcified teeth. They become brittle and decayed, especially in places with unfluoridated water.
7. Cognitive impairment, including brain injury.
8. Mental health problems:
   a. Paranoia ("Everybody is plotting against me.")

10 The current research indicates that the one's genetics can determine some effects.

b. Depression
c. Schizophrenia
d. Psychotic episodes (e.g. hallucinations, uncontrolled erratic behavior that can be quite violent).

Medical liaison

At The_house, most residents are in the care of a doctor. Our staff work with medical practitioners to simplify medical oversight and medication. Residents can retain their own medical practitioner if they wish, but we prefer them to have AR experience.

Mental illness is a special case. While shift workers and case managers can refer residents, only a medical practitioner can make a formal diagnosis and prescribe treatment. Most residents can be successfully treated within the program, but we sometimes need to send residents out for care in a psychiatric hospital.

About methadone

The_house does not recommend replacement therapies with addictive medications. The most controversial addictive substitute is methadone, an opioid used to replace heroin. Its use is based on the harm minimization philosophy.[11] Some methadone users lead fairly normal lives as long as they have a medically-supervised dose each day and can live on a very short chemical leash.

However, methadone has many drawbacks:

- Patients are still addicted.
- The majority of patients live on welfare and are long-term unemployed.
- Patients have great difficulty getting off it, more difficult than from heroin. The risk of dying during methadone withdrawal is unacceptably high.
- It requires an adjustment period of several weeks during which patients develop some tolerance to it.
- If the dosage is too high, they have the same problems as if they were on heroin.
- As it does not block the effects of other drugs in any way, patients can easily become addicted to something else as well.
- It is a very long-term approach with no exit strategy, patients can remain on it for the rest of their lives. They stay addicted much longer than if they were left alone to get off heroin without help.[12]

About buprenorphin

Buprenorphin, a synthetic opioid, is another agonist treatment for heroin addiction. It is itself addictive and withdrawal is similar to withdrawal from long-term heroin addiction, although not as severe. Ironically, it can also be used for methadone addiction and for pain. It is used illicitly in some places.

While in some ways similar to methadone, it has not attracted such strong criticism for its drawbacks.

About naltrexone

At The_house, some residents are on naltrexone, which is a non-addictive drug that reduces cravings for opioids and makes detox easier. It works best as an implant because people forget to

11See the policy section in the Chapter "About the AOD sector".

12N. McKeganey, Recovery-focused Drug Treatment Seminar, August 21, 2010, Perth, Western Australia.

take tablets. It is now being used to treat other kinds of addictions, including gambling, smoking, and amphetamines. However, naltrexone is not a magic bullet; residents still need a holistic program to produce real, long-lasting change.

In the past, its use as an implant for treating heroin addiction was controversial, mainly because the harm minimization lobby group advocated methadone instead. However, recent research has confirmed the value of naltrexone implants as a safe and effective treatment.

Naltrexone is also used on release from residential care because, compared to the general population, former addicts are much more likely to die in the first six weeks after release. If they are free to return to familiar surroundings, they are easily tempted to try a shot of their substance of abuse and die of an overdose. Naltrexone not only reduces the desire to do so, but also blocks the effects of heroin.

A simple map of medications[13]

You can't prescribe medications but you will find it very helpful to know something about the medications you supervise:

Antidepressants ease the symptoms of depression. The most modern kinds of antidepressant are the Selective Serotonin Reuptake Inhibitors (SSRI). SSRIs work by changing the levels of chemical messengers (neurotransmitters) used to communicate between brain cells. In particular, they block the reabsorption (reuptake) of serotonin. They are called selective because they seem to affect mainly only serotonin. Examples include escitalopram, and valdoxan. Mirtazapine is similar, it is a Serotonin Non-specific Reuptake Inhibitor (SNRI).

The *atypical antipsychotics* are a group of antipsychotic tranquilizers used to treat psychiatric conditions. They are called "atypical" because they tend to have fewer side effects than older-style "typical" antipsychotics. Examples are zeldox and seroquel.

Mood stabilization medications include valproate, zeldox, and seroquel.

Some medications treat *cellular oxidative stress*. Many diseases involve oxidative stress, that is, too much oxidation or too little de-oxidation of tissues, resulting in a toxic effect on the cells. An example of medication is valporate.

Medications for *Adult Attention Deficit Disorder*, which is often associated with amphetamine use, include edranox and strattera.

Insomnia is the inability to sleep and *anhedonia* is the inability to feel pleasure. Medications include agomelatine.

Weight gain (metabolic syndrome) is a serious problem for some substance abuse victims. An example of medication is contrave, which is a combination of naltrexone and bupropion.

Benzodiazepines are tranquilizers that slow down the central nervous system. They are usually prescribed to reduce anxiety, to help people sleep, and to relax the body. There are about thirty different kinds, and the most well-known are diazepam, oxazepam, nitrazepam, temazepam, lorazepam, flunitrazepam, bromazepam, and clonazepam. They have a variety of commercial names. They can only be used for a short time as they are quite addictive, and are especially dangerous in cases of polyaddiction.

Anticraving medications include campral, gabaergic, and champix.

Painkillers that are not opioid-based (non-opioid analgesia) include ketamine and vldntx.

Antagonists either block the effects of the drug or make the patient feel sick if they take the drug. A patient on Naltrexone usually feels no effects from a shot of heroin. A patient on disulfram (Antabuse) feels sick if they take alcohol. There are now also antagonists for nicotine, cannabis

13Based on J. Currie, Recovery-focused Drug Treatment Seminar, 21 August, 2010, Perth Western Australia.

(although there have been concerns about side effects) and benzodiazapines (although it is a short-term option).

The following medications are available for maintaining alcohol abstinence:

Acamproaste
Naltrexone
Baclofen
Topiramate
Disulfram (Antabuse)
Ondansetron (only effective for a certain genetic subset)
Pregabalin, gabapentin and memantine.

Medications and your role

Many residents at The_house are on prescribed medication of some kind, mainly antidepressants and antipsychotics. As an AR worker, you need to make sure they all get them in correct doses. While it's obviously dangerous for them to get too much or the wrong kind of medication, it can also be dangerous to suddenly discontinue some kinds of medication.

You also need to know what the various kinds of medications do and the effects of prescribed drugs on the use of other drugs. It's good if you learn the indications (when a particular medication can be prescribed), contraindications (the conditions when a particular medication may not be prescribed), and side-effects of specific drugs as well.

Jurisdictions vary widely. In some states, AR workers can administer medications, while one must be a Registered Nurse in others. In our state, an AR worker has no more legal power than an unqualified person sharing a house.

Here's our procedure for overseeing medications:

The_house: Medications procedure

The_house normally only keeps oral medications (tablets) that people can legally take home and take themselves. Residents may keep routine non-prescription medications in their rooms, except benzodiasapines, paracetamol, and medications containing codeine.

Core responsibilities

1. Keep all medications in the safe.
2. Keep prescription medications in containers clearly labeled with the residents' full names.
3. Make sure residents take their prescribed medications in the correct dosages and at the correct times.
4. Hand residents their medication container and observe that they administer it on their own.
5. Some residents try to avoid taking prescribed medications. It is your job to handle residents who still refuse to take medication, spit it out, or vomit it up.
6. Keep systematic records of dispensing medications. Make the record *immediately after* dispensing medication. Do not trust it to memory to write down later. Similarly, do not do it beforehand, as it must be a record of what you actually did, not what you expected to do.
7. Administer approved non-prescription medications.

Reporting

Report the following incidents to the staff member in charge of medications: missed doses, missing doses, inconsistencies between actual medications and records. If a resident lies about medications, report it to the supervisor on duty at the time. You might need to check with the medical practitioner so that the resident gets correct prescriptions and dosages.

Serious side-effects

Immediately report to the supervisor any relevant circumstances or changes in the resident's condition that might affect their medication, and write it in the Day Book. E.g.:

- behavioral changes
- changes to breathing
- changes in person's color (e.g. pale, flushed, or bluish tinge)
- changes to circulation (e.g. unexpected drowsiness, loss of consciousness)
- rash, inflammation, redness, swelling, or skin tone
- headache, feelings of dizziness, slurring of speech
- nausea and vomiting
- blurred vision
- confusion
- anything that looks different from their usual state.

If the side-effects of a medication are serious enough to be a medical emergency, apply first aid and call an ambulance. Take the medication package with you in the ambulance to show the medical practitioner.

Assignment

Go through all medications currently being administered at your facility, both prescribed and over the counter. For each one, list:

1. Class of drug: analgesic, anti-depressant, etc.
2. Commercial names
3. Chemical name
4. Indication
5. Contraindication
6. Expected effects
7. Side-effects
8. Normal dosages
9. Toxicity levels
10. Can it be addictive? If so, under what circumstances?
11. Effects on the use of other drugs
12. Consequences of incorrect use

Questions

1. What's the difference between prescribed medication and over the counter medication?
2. What are the main reasons for errors in giving medication?

Further reading

"Appendix A—Pharmacotherapy" in *A Guide to Substance Abuse Services for Primary Care Clinicians: Treatment Improvement Protocol (TIP)* Series 24 (DHHS Publication No. (SMA) 08-4075) https://www.ncbi.nlm.nih.gov/books/NBK64827/pdf/Bookshelf_NBK64827.pdf

Complex medical needs

You don't need to be able to diagnose these issues, but you should be able to recognize their signs and refer the matter to someone else. You have extra duty of care, because these people are considered especially vulnerable.

Malnutrition

Residents with addiction issues are often unhealthy on admission and might have malnutrition or eating disorders.

Mental health issues

The most common signs of mental health issues are:

- extreme mood swings, especially between happy and sad emotions
- phobic behavior (strong, irrational fear of something)
- manic behavior (mentally hyperactive)
- temporary obsessions
- irrational, erratic or aggressive behavior
- random changes in pace or mood
- screaming or tantrums
- attacks of panic or anxiety
- agitated, confused, or hyperactive
- prolonged pessimism
- paranoia
- insomnia
- remembering things that didn't happen
- emotionally blank, unresponsive, or withdrawn
- ideation of suicide
- self-harm, which is often a way to manage painful feelings.[14]

ADHD/ADD

These two conditions have been fashionable diagnoses, but medication is helpful in some cases.

- ADHD (Attention Deficit Hyperactivity Disorder). People with ADHD can concentrate for only short periods, and their hyperactivity often disrupts other people. In some cases, medication brings substantial improvement. In many other cases, The_house doesn't focus on the condition, but treats it as a behavioral problem and seeks to retrain thinking.
- ADD (Attention Deficit Disorder). These people can concentrate for only short periods, but are not hyperactive. They simply appear to be easily distracted or daydreaming, so ADD can be difficult to diagnose. Treat it as a behavior problem until confirmed otherwise.
- AADD (Adult Attention Deficit Disorder) is associated with amphetamine abuse.

Contraband medications

Residents who go shopping might try to buy unsafe medications over the counter. In some jurisdictions, for example, codeine is sold in small dosages mixed with other medications. It is an addictive opioid and can be dangerous in some circumstances. Paracetamol is another easy-to-buy medication but potentially dangerous in the hands of the wrong person; it has a low toxicity level and could be used to commit suicide.

Acquired Brain Injury (ABI)

Physical changes to the brain are normal after heavy or long-term addiction. The brain tends to heal after detox and during abstinence from the substance of addiction, although some impairment is longer term and can be permanent. ABI affects cognitive function (the ability to think)

14 With thanks to A. Clatworthy and T. Gunter.

although the effects might be imperceptible.[15] ABI can also be caused by stroke, head injury, brain infection, lack of oxygen to the brain, and brain diseases like Parkinson's disease. Serious cases need medical advice.

Loss of some cognitive function can have one or more of the following signs:

- erratic
- forgetful
- poor concentration
- slow at figuring things out
- confused by uncomplicated information
- find it difficult to get things in the right order
- find it difficult to set priorities
- clearly less capable that they once were
- over-think everything (think something is very complex and don't identify that it's quite simple).

Do not presume that a resident has ABI; the symptoms can be cultural and not a result of ABI. For example, the resident might come from an environment where erratic, undisciplined behavior is acceptable and common.

If the resident is nearly normal, ABI can be difficult to diagnose and is probably inconsequential. By adjusting well to community life and responding well to the recovery program, residents make the best of their abilities anyway.

Autism

Autism is the inability to notice personal emotion in speech and body language, and limits the sufferer's ability to have personal relationships. It occurs along a spectrum from insignificant to a serious disability where sufferers cannot relate to people at all.

It was almost completely untreatable in the past and its treatment is still a major area of study. Treatments are now available. However, we don't accept applicants with serious autism at The_house because we cannot treat them.

Ausbergers syndrome

It is an "autism spectrum" disorder. Mild cases are often undetected but the effects can be significant.

Prader Willi syndrome

The most obvious effect of this rare congenital condition is serious learning difficulties. It also produces a distinct shape of the face, although you would only notice it if you saw many cases. Their learning difficulties prevent them from being accepted into The_house, but you might come across some people with this syndrome when assessing applicants. Refer the resident to medical help. They should be admitted only with a recent medical clearance.

What would you do? #1

MJ is twenty-three and has been a resident for three months. She has a history of depression and has been on a range of medications. Her general health is quite poor; she is thin and weak, and often takes days off sick. She doesn't enjoy healthy food or exercise.

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15 J. Currie, Recovery-focused Drug Treatment Seminar, 21 August, 2010, Perth, Western Australia.

Debra, the junior staff worker has found that MJ has taken twice the recommended dosage of a prescription drug for the last couple of days. MJ shows no effects yet. Debra doesn't know how she got extra pills, or exactly what kind they are. Debra feels out of her depth and wants to hand the case to you straight away. What would you do?

What would you do? #2

Billy is seventeen and has been a resident at The_house for a year. He sometimes goes to the shop to buy everyday items. One day you catch him with a couple of empty pill boxes and it looks like he has taken much more non-prescription medication than the recommended maximum dose. You take him aside and ask him about it. But he won't admit anything and is getting agitated. What would you do?

What would you do? #3

Emily, one of the staff, found that a rather large sum of money went missing from her wallet. Rather than make accusations, she has come to you for advice, and you discuss what happened. You investigate and, before long, Andy is your only suspect. He could be the thief; you have eliminated all other suspects and he could be lying. On the other hand, he could be innocent; his version of events is plausible and you don't really have any conclusive proof that he is guilty. Besides, if he is innocent, you figure that an unjustified accusation might set back his recovery. You wonder if you should confront Andy.

What would you do?

6
Legal aspects of substance abuse

Different kinds of substances have different legal statuses:

- Owning any quantity is a criminal offence.
- Owning a larger quantity is prosecuted as ownership with intent to sell or supply.
- Ownership incurs a penalty but is not recorded as a criminal offence.
- The substance is legally available but only by prescription through pharmacies.
- The medical practitioner needs external approval to prescribe.
- Some drugs are not eligible for insurance benefits.
- A few drugs are available only in limited quantities from pharmacies but do not require a prescription.
- Many drugs are freely available without a prescription, but only at pharmacies.

Blurred lines

There can also be legal and illegal versions of the same drug. For example:

- Heroin is illegal, but diamorphine is medical grade heroin. Its main use is in the UK to treat serious pain for advanced stages of terminal cancer.
- Morphine can be legally prescribed for relieving serious pain. "Street heroin" is black market morphine. Addicts obtain it legally to maintain heroin addiction by convincing a doctor that they are in serious pain.
- Cocaine is illegally imported and sold for illegal consumption. However, it is also is legally grown and imported for use as a medical anesthetic. Supply channels are quite secure so that legal cocaine does not make its way onto the black market.
- Dexamphetamine (Dexies) can be legally prescribed, but then re-sold as a recreational drug.
- Barbiturates are normally obtained by prescription. Addicts convince a doctor that normal sedatives do not help them sleep and that they need something stronger.

Some prescription medications are also quite addictive. For example, oxycodone is an addictive analgesic opioid similar to codeine and morphine. An increasing trend, it is obtained by convincing a doctor that one is in chronic pain.

Medical practitioners are trained to assess risks to the patient when prescribing addictive medications. In other words, does the benefit to the patient outweigh the risks of side effects and

addiction? They may prescribe a very suitable medication but later discontinue it because the risk of addiction increases with continued use. Diazepam and oxycodone are good examples. (Valium is the best-known brand of diazepam.)

The lines blur when medical practitioners prescribe addictive medications for their own use; they tend to believe that they understand the risks so cannot become addicted. Some, however, have serious addictions and are a niche addiction treatment clientele. Pharmacists hardly ever refuse a legal prescription.

Assignment

1. Report the legal status of all drugs that your organization's clients have abused.
2. Trends in addictive drugs vary from place to place and from time to time. Which drugs are increasing in use in your area? Which are decreasing? (Check the local statistics on government and academic websites.)
3. Which drugs are generating an increasing number of applicants to your organization? Which are decreasing?

What would you do?

You are alone looking after The_house at night. The live-in staff have gone out, the other staff have gone home, and the residents are watching TV.

A policeman comes in and asks about Kent. The policeman explains that they are conducting a major investigation, they have tracked him to The_house, and now want to speak to him.

Kent is twenty-four and has been a resident for four weeks. He's a recovering speed addict. Since being here, he hasn't made any friends and is usually a loner. He can be quite manipulative and tries to protect his "rights". He often behaves erratically. From what you know about Kent, the police inquiry probably means that they've just made a major drug bust and Kent was one of their low-level dealers.)

What would you do?

7
Prostitution recovery

At The_house, we occasionally have residents who have come out of prostitution. Although the recovery path is generally the same, many of their problems are quite different.

Definitions and categories

A strict definition is difficult due to various ambiguities. Prostitution might be defined as the provision of sexual services in exchange for money, but this is too simplistic. Sex slaves are normally unpaid and not free to leave. It is often not the prostitute who gets paid, and many are forced to provide occasional free services. Some are paid in ways other than money.

Strippers are paid to provide sexual entertainment but do not necessarily engage in sexual relations. Moreover, prostitution often offers "cover services" such as massage, escorting, acting, or modeling. Some are called "bar hostesses," "spa attendants," or "hotel maids." Japanese geishas mainly provide entertainment and hostess services, but the deflowering of a geisha fits the category of prostitution.

Categorization is difficult whenever it might create stereotypes. Nevertheless, at least for descriptive purposes, prostitution generally has the following kinds.

The first is *employees*. Some work full-time in brothels, bars, and massage parlors. If they are legal, the work can be fairly well-paid. Some girls are hired on a casual or drop-in basis, and they become accustomed to erratic work hours.

Second is *freelancers*. Some women are self-employed. Streetwalkers are willing to get into any car with a prospective client. Many are assaulted, raped, or unpaid for their services. Some set up one-room brothels in hired rooms and recruit their own clients. A small number of women work the glamour circle; they are more likely to be self-employed with a relatively small number of upper class clients who treat them well and pay high fees.

Third, *male prostitutes* are more likely to be bisexual and to be hired for both heterosexual and homosexual relations. Some live as transvestites, and can work as female prostitutes if they have hormone treatment before puberty. Some clients hire them to be human punching bags.

Fourth, *pornography models and actors* are employed on various terms. Some are employed based a script that discloses what will be expected of them. Others have contracts that require them to do anything in the scripts that will be provided by the employer. The great majority of actors in the latter category are discarded after about eighteen months.

Child pornography models start at about two years of age with fairly innocent nude photos, progress to hard-core porn, and then disappear from the publications when they reach puberty. Some are victims of violent crime, and the video sells for a higher price if the girl dies.

The fifth category is *rent-a-wife schemes*. For example, a middle Eastern tourist in Southeast Asia for a one-week vacation has a brief Moslem marriage ceremony with a local woman. At the end of the vacation, he pays her and gives her a brief Moslem divorce. The "marriage" component prevents the charge of adultery and maintains his requirements under religious law.

In another example, a foreign woman exchanges sexual services for an immigration status. She marries a local man and lives with him long enough to gain permanent resident status. She then leaves and files for divorce.

The final example of a "rent-a-wife" scheme is a worker on a three-year foreign assignment. He signs an agreement with a local woman to live with him as his loving wife on condition that she does not get pregnant. If her contraception is not effective and she becomes pregnant, the agreement requires her to abort the baby. At the end of the three-year commitment, he pays her and never sees her again.

Sixth, the *Devadasi* (Maids of God) are an hereditary Hindu sect of prostitutes, although the sect actively recruits girls. The local term differs across India. Their role varies greatly from place to place and time to time, and in some places is now indistinguishable from commercial prostitution. They are often forced into the sect, and some girls are forced to start work at only eight years old. They then find it very difficult to leave.

Seventh, *sex slaves* are not paid and are not free to leave. They cannot refuse to provide services and are not free to select clients. Slaves are usually locked up, kept addicted, and poorly fed. They are forced to work under threat of violence to themselves or to their family back home. Pimps use the same threats to enforce a code of silence so that they cannot be arrested and convicted. Pimps often use a live-in girlfriend as a prostitute.

Sex slaves are often trafficked from source countries to destination countries. Sources include China, South Korea, Thailand, Philippines, and Eastern Europe, while the main international destinations are USA, Western Europe, and Australia. Some are moved within their own countries to unfamiliar surroundings from which escape is more difficult.

In countries that allow child marriage and concubines, girls can be kept as sex slaves. If they are concubines rather than wives, they can also be lent out to other men without being seen as adulterous.

Eighth, in jurisdictions where prostitution is defined as sexual favors for reward, "sleeping with the boss" to get a promotion is legally classified as prostitution.

Blurred lines

Some lines between categories are quite blurred. The first is between consensual sex and sex work. Although there might be no agreement about payment, both client and sex worker expect that a payment will be made.[16]

The second blurred line is between sexual abuse and sex slavery. There is not much difference between being an incest victim and being forced to provide the same services to someone else.

The third blurred line is between being a slave and being free:

- When a live-in girlfriend is physically abused, at what point is she intimidated enough to be viewed as a slave?

16Guilfoos, 2014, p. 27.

- When sex workers are below the age of consent, sexual relations are legally deemed to be rape in some jurisdictions. In other words, the girl is legally a victim even if she is consenting and proactive in the relationship.
- Debt slaves are bound to work off a debt by providing their labor. It is doubtful that they are really paid. Wages are artificially low and they are charged interest and living expenses, so they usually cannot pay their debt. Their children inherit it and also become debt slaves.
- Some actors are duped into believing they are being employed by an independent film company as a pathway into mainstream film acting. Although some realize that the movies are pornographic, the scripts are much more violent or perverse than they anticipate. Contracts can be highly exploitative when they require commitment to unread scripts and include high penalties for noncompliance.

No way out?

Whether or not they are actually free to go, many sex workers believe that they cannot get out. The mindset can be quite complex, but the notion that they have no other way to earn money or have nowhere else to go is often fairly dominant. In some cases it is justified; many recovery facilities do not accept applicants with children.

In some places, pimps simply pay enough that girls do not want to leave. Even if the girls could find a job, the possible reduction in pay is a serious incentive to stay. Paying them enough to stay affects their mindset and their personal value system; it teaches them to over-value money and to become more materialistic.

In other cases, the pimp or madam knows of prostitute's participation in criminal activities, which is often part of the job. Even if the pimp or madam is more heavily involved, the girl could easily be reported and arrested with a good chance of prosecution. Fear of prosecution simply increases the "trapped" mindset.

Worthwhile jobs can be nearly impossible to get if they have a criminal record but no qualifications or employment experience. Most have such severe mental health issues that they never re-enter the full-time work force. For some, embarrassment and shame is a major barrier.[17]

Moreover, they have been socialized and acculturated to a particular culture and lifestyle, see themselves as prostitutes, and might not expect anything else even if they would like it.

Local culture can also play a big role. In cultures that are more fatalistic and offer no opportunity for social mobility, sex workers can have difficulty envisaging a different future for themselves. Some cultures place a high value on family as a basis for identity and acceptance, but former prostitutes are spurned and cannot get married.

Risk factors

Statistics on prostitution vary considerably, mostly because different definitions are used and because populations can vary greatly. The sex industry is generally illegal or viewed with disdain, so it is usually quite difficult even to identify populations. Some studies use such small samples that it is difficult to make any generalizations at all. Consequently, any generalizations, no matter how helpful as background information, need to be weighed against one's local situation and the case of the individual in recovery.

In a recovery situation, it is always unwise to start with generalizations, and always best to start with the resident's own situation.

People who become prostitutes tend to have a very high incidence of some risk factors, although a risk factor by itself does not mean that a person will enter prostitution.

Younger girls are easier targets. The average age of entry into prostitution in the US is quite young, after which life expectancy is often quite short. According to one source, forty percent of

17Guilfoos, 2014, p. 43.

Bangkok's prostitutes are under fourteen years old. Then again, some other populations have relatively few girls under seventeen.

Patterns of co-occurrence are easier to identify than cause-effect relationships. Some factors are often probably symptoms rather than causes, and causes and effects can form a vicious cycle, making escape and recovery more difficult.

Out-of-town young people are particularly vulnerable if they are alone, can't get work, and have nowhere to go.

Illegal immigrants are easily enslaved if they don't speak English, especially if they can be trafficked to a strange city. They can't speak to anyone, don't know anyone, don't know their way around, and are afraid of the government. Police are more likely to arrest them than to help them as victims.

Girls in dysfunctional families are more vulnerable if they have become runaways or throwaways living on the streets. Consequently, foster-care children are higher risk. Data is generally unreliable, but a high proportion of female prostitutes in the US reportedly:

- had run away from troubled, fatherless homes.
- were repeat victims of sexual abuse or incest, often starting young.
- had been physically abused.
- had been abandoned.
- were victims of childhood neglect.

Financial reward is often a major driving force. The drivers can take the form of poverty, financial problems, lack of employment, or materialism. In some countries, young widows and divorcees have few other economic options.

Addiction is a risk factor, but addiction and prostitution is a two-way street. Addiction was once more usually the cause; prostitution was a way to support an expensive habit. It is now common for prostitutes to use substances used to get a high in an otherwise unenjoyable lifestyle. Some pimps deliberately get prostitutes addicted so they cannot leave.

Other risk factors are:

1. Emotional problems
2. Poor education and truancy
3. Absence of positive role models
4. Susceptible to manipulation and feelings of dependence
5. Younger girls with much older boyfriends, for example, a 14 year old girl with a 25 year old man
6. Leaving prison or being released on bail with nowhere else to go
7. Pregnancy, including a history of abortions
8. Petty crime
9. Mothers were drug addicts and prostitutes themselves
10. Adventurism
11. Peer influence
12. Cultural factors and gender issues, e.g.
    a. View of family and the role of sex
    b. View of women
    c. Superstition (e.g. *devadasi*)
    d. Lack of information.

How do people get into prostitution?

In the U.S., the pathways into prostitution are fairly clear. The summary below represents the most common way that U.S. girls become prostitutes:

1. The pimp locates a vulnerable girl, for example, a foreign student who has run out of money or speaks very little English, an unemployed rural girl who is unsuccessfully seeking a job in the city, or a girl who has had many sexual partners. The trend is that pimps are increasingly brazen and now do not look for only the most vulnerable.
2. He entices her to become a girlfriend with promises of wealth.
    a. She moves in with him.
    b. He isolates her and convinces her that he is her best friend and that she cannot trust anyone else.
    c. They have a sexual relationship.
    d. He asks for kinky sex.
    e. He takes photos of her, making her a commodity for blackmail or sale.
    f. She is manipulated by his friends.
    g. He admits to financial problems and asks her to help out: "Do my friends a favor."
3. The boyfriend becomes the pimp and she becomes a slave. He puts her in a brothel with other girls and takes all money from her work.
    a. He might move her to another city where she doesn't know anybody and doesn't know her way around.
    b. He confines her to quarters, either by threats or by locking her up.
    c. He provides inadequate food.
    d. The pimp gives carefully monitored rewards and punishments.
    e. Beatings become common.
    f. He threatens to do something to her family back home.
    g. The pimp frequently rapes her (common) or organizes pack rapes (less common).
    h. He puts her on a chemical leash; he gets her addicted and becomes her sole supplier.

In other countries with large numbers of prostitutes, such as India, Thailand, Indonesia, and the Philippines, the pathway is often quite different.

1. In India, Thailand and Cambodia, some rural parents to sell a child to a pimp or an "Aunt" to be resold or hired out to a city brothel. In some cases, parents sell the youngest child to raise funds to educate the older children. One source even reported cases of husbands selling their wives.[18]
2. In Thailand, rural parents often put pressure on their children in the city to send financial support, or force an older child to work to support the younger siblings. Many are not too fussy about how the money is earned.
3. Even in the US, girls are sold to pimps, sometimes very cheaply.
4. Some children are simply kidnapped and then sold.
5. Some girls are duped into an overseas job, given documents to get through immigration, picked up at the airport, then driven to a location where they become slaves and from which they cannot escape. Escape is even more difficult when they become illegal aliens.
6. A few are pimped by a parent or guardian, although this is quite rare.
7. Some follow their mother in. This is deliberately done by the 'Maids of God' (*Devadasi*) in India, but even in the U.S., daughters of prostitutes are six times more likely to become prostitutes than other women in the general population.

Symptoms

Women in prostitution suffer from many different kinds of problems. The effects of addiction have already been described in a previous chapter.

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18 Wickham, 2009, p. 5.

Together, they create a perfect storm. Many people in recovery face a difficult family situation, addiction, low self-esteem, control/manipulation, and poverty.

Post-Traumatic Stress Disorder (PTSD)

PTSD is very common among prostitutes, and it is well founded. Most have a history of childhood sexual and physical abuse. U.S. prostitutes are reportedly raped on average once a week, with about 20% of rapes committed by their pimps. Although the rape of prostitutes is illegal, it is almost impossible to get a prosecution because it is difficult to prove in court that the prostitute is a credible witness and that she was not seeking a sexual relationship.

Prostitutes are frequently victims of physical abuse, which might vary from place to place. It includes beatings of many different kinds, sometimes resulting in broken bones, sleep deprivation, penetration by animals or objects, being stapled, being chained and whipped, and having cigarettes extinguished on their skin.

Most prostitutes have been threatened with murder, and prostitution is the most dangerous occupation in the U.S. Murder is actually rather likely; in one U.S. study, homicide was the leading cause of death among prostitutes, with nearly two thirds of the murders committed by clients. Prostitutes were nearly eighteen times more likely to be murdered than other women of their age and race.[19]

In many big cities around the world, murdering a prostitute is barely illegal; police normally invest minimal effort in investigating the death of an unidentified prostitute.

Many have psychological effects of abortions. "A fetus is just an inconvenient scrap of disposable flesh." "My little boy would be having his second birthday this month."

Prostitutes mentally detach from sexual activities, called dissociation. For example, "It's like working in a shop. There's no emotional attachment in selling a can of beans to a customer." One admitted to writing shopping lists during sex., and another was caught read comic books during sex.

Other emotional and mental health issues include:

- Low self-esteem
- Anger resulting from sexual abuse as a child
- Poor communication and social skills
- Self-harm and suicide attempts
- Child prostitutes often suffer from Rape Trauma Syndrome[20]
- Denial: "It's my body. I can do what I like with it and it doesn't affect me."

Their ability to have non-vocational heterosexual relationships varies. Most have difficulty with personal sexual relationships, and either refrain from them altogether or prefer lesbian relationships. In some populations, however, a minority of prostitutes cohabit in heterosexual relationships. Some used sex as a way to start a relationship with a man, not as a way to fulfill a relationship that was already emotionally mature.[21]

Physical effects

- Effects of beatings
- Sexually transmitted diseases, especially HIV. AIDS is common in some populations.
- Physical damage to the anal, vaginal and uterine areas

19Potterat et al., 2004.
20Robinson, 1997, p. 252.
21Collins, 2010, p. 5.

- Genital tract infections, pelvic inflammatory diseases[22]
- Unwanted pregnancies
- Effects of pregnancy during early adolescence
- Sterility resulting from abortions or STDs.

The recovery process

Perhaps for many, the first step is to seek recovery, although many believe they cannot leave the sex industry and have difficulty imagining themselves in another lifestyle.

Organizations that offer prostitution recovery often make the mistake of aiming primarily to get people out of the sex industry. Clients, however, mainly look for a pathway to a better lifestyle, including basic economic security. If the girl is expected to be a breadwinner, this can include a means of income for her family as well.

The recovery regime for former prostitutes is the same as it is for addicts and sexual abuse victims. As has been seen, addiction and sexual abuse tend to co-occur with prostitution. The time in recovery is often longer due to the amount of counseling they need, but the elements are generally the same: assessment, detox for those with addiction issues, medical care, resocialization, case management, group sessions, counseling, education, and employment readiness.

Other helpful aspects of recovery are often more closely related to the kind of personal mentoring from case managers, pastoral care or chaplaincy support, goal-setting as a means of motivation, and provision of role models[23]

A few kinds of recovery services are more specific:

- HIV and STD testing and education
- Suicide and depression screening
- PTSD recovery
- Psychological testing, psychiatric consultation, and psychotropic medication education
- Cognitive Behavior Therapy (CBT)
- Access to long-term housing, especially for residents who have children.

Residents in recovery from prostitution always need a radical change of self-image and aspirations. Like sexual abuse victims, some girls are afraid of men, and cannot associate with them until later in the recovery cycle. Some disdain men. When they are ready, they need to learn to associate with men who are not exploitative, and who are examples of the kind of person they might marry.

As so many of them come from dysfunctional families or have no families, they need to either reconcile with their families or establish another kind of beneficial long-term relationships. If they are to go on to establish their own families, they need to learn appropriate behaviors and attitudes.

Questions

1. What is the relationship between poverty and prostitution?
2. To what extent does local culture affect the incidence of prostitution?
3. Prostitution is all about "control and manipulation." What does this mean and what effect does it affect their mental state?
4. Prostitutes often feel unable to leave the sex industry, even if they are free to go. Why?

22Wickam, 2009, p. 6.
23Guilfoos, 2014, pp. 36, 42.

5. Design a community services program that prevents vulnerable people going into prostitution by creating a more attractive alternative. It needs to be more than awareness and education.

8
More ethics

As a case manager or counselor, you naturally inherit greater ethical responsibilities. Your duty of care for residents is called *vicarious liability*. You are responsible for any harm that results from negligent or incompetent treatment. The easy way to handle this is to work as a team; if you're not sure, ask for advice or give a referral.

You also have a duty of *professional disclosure*. First, residents are entitled to know your *approach to treatment*. This should be easy because your organization should have a clear statement of its treatment approach.

Second, residents are also entitled to know what *credentials and qualifications* you have. It is most relevant for licensed occupations, such as medical practitioners and clinical psychologists, and in states where addiction recovery counselors must be licensed.

Professional disclosure can be problematical for AR workers who have only on-job training and do not have formal qualifications. In practice, however, it has never been a problem at The_-house; some of our best staff have no formal qualifications and we have found that some qualifications are a poor indicator of skills.

As leaders

In a leadership role, you will need to take responsibility for influencing ethical practice. It includes being a personal example of ethical values, and of your organization's values, embedding ethical practice into the organization's culture and processes, and promoting ethical leadership and decision making at all levels of the organization. Be consistent in showing your commitment to the professionalism, ethical values and principles of your organization. This includes your personal dealings within the organization as well as the way you act on behalf of the organization.

In ethics, you can focus on the important issues, thinking them through, generating ideas, and solving them. Avoid unnecessary hair-spitting and the extremes of political correctness.

Counselors

Our state has no legal registration requirement for general personal counselors, although politicians sometimes suggest it when a malpractice case hits the headlines. Other than financial advisors, the only specific counseling professions that must by law be registered are clinical psychologists and psychiatrists. With no external oversight, it means that we work hard to make sure that our practices are sound.

As a case manager, you will often be the first line of intervention and might develop a significant counseling role, but try not to take on all the counseling needs of your residents. It's

unethical to take on counselees if you do not have relevant training or know you can't help them. You could also be legally liable if something goes wrong.

Let the specialist counselors and medical practitioners do their jobs. More complex cases require a clinical psychologist, sometimes working in liaison with a psychiatrist.

At The_house, we have various strategies to follow best practice and minimize risk of malpractice lawsuits:

1. We only use the term *counselor* for people who have suitable training. We use a different term for other one-to-one roles such as *mentor*, *team leader*, or *chaplain*.
2. We keep an up-dated register of what each counselor is trained to do.
3. We have a system of supervising our counselors.
4. We comply with the professional standards for case managers, although it is usually not difficult.
5. Counselors comply with a statement of ethics for professional counseling.
6. We train all staff in mental health first aid.
7. We normally refer cases of deep-seated, long-term issues to specialist counselors.
8. We have a policy of *always* referring:
   a. Residents in whom staff see signs of mental illness, and
   b. residents who put themselves or others in danger (e.g., suicide ideation and threats of harm to others).
9. We keep written contemporaneous notes of sessions.

As counselees, residents are vulnerable to exploitation and manipulation. Avoiding manipulation is essential to maintaining trust, honesty, and transparency. Ethical codes directly address these issues. (See below.)

You need their permission to go into their lives. If they do not feel emotionally ready to talk about something, you can offer to be available but it is unethical to push your way in unless it directly affects others.

The association of counselors in our state has a very long ethical statement, so we summarized it and adapted it for The_house. (Specific terminology is italicized.)

1. Set a good personal example, including when you're not working in your employed role.
2. Avoid relationships with residents that are *exploitative*, *manipulative*, or otherwise unethical.
3. Avoid *conflict of duty*. If staff are also employed by another organization, their loyalty to the other organization may not interfere with their employee role at The_house.
4. Avoid *conflict of roles*. Romantic entanglements and family relationships with counselees are always considered unethical.
5. Maintain *privacy* and *confidentiality*.
6. Respect the resident's right to make decisions.
7. Respect the resident's personal beliefs.
8. Honor the trust that the resident places in you.
9. Restrict your activities to your own area of competence. Refer cases if you have reason to believe that you can longer offer competent help.
10. Respect the competence of colleagues in other professions, and keep your counseling role consistent with their contributions.
11. Work under supervision.
12. Act in the interests of residents' long-term recovery. Do no harm and promote the greatest good. The benefits should outweigh costs or risks.
13. Inform counselees and get their consent. Using language they can understand, discuss their treatment options, as well as any possible side-effects, benefits, costs, and risks.

Question

1. How similar is your association's statement of counseling ethics to the summary above?
2. Compare the ethics statement with that of your agency. What's the same? What's different?

Recommending courses of action to residents

A few things should be fairly obvious in making decisions and recommendations. You shouldn't exploit or manipulate residents, and you should avoid unethical pressures, such as conflicts of interest and undue influence from third parties.

One core principle is *informed consent*. People should be fully and accurately informed about their treatment options in a timely way. Information needs to include benefits, possible side-effects, fees, risks, and their rights, commitments, and obligations. The decision is then theirs to make.

Consent means that, whenever possible and before providing services, you have a duty to seek the agreement of the resident using language that is easy to understand. If you use lots of complicated language, residents could legitimately claim that you used it to conceal essential information, thus preventing them from being able to make an informed decision. You might then be held responsible for any ill-effects of their decision.

Choices are ultimately the client's, and you need to respect them even if they would not be yours. Your role is to make sure that their choices are well informed. First, give equal weight to equally good options, although you should conceal options that are unethical. Second, if you give a recommendation, separate your recommendation from the information. Third, in some cases, the legal onus might be on you to ensure that residents understand their options, for example if you are dealing with the elderly, the young, or the mentally impaired. It is good practice to have a responsible family member present as well.

The term *dignity of risk* means to respect people's right to make their own decisions. It involves some risk because they might get it wrong, or at least not make the decision you prefer. Residents in a residential program are a captive audience, so staff easily fail to comply with dignity of choice and informed consent. If you are a case manager, it is also unethical for you to try to influence their choice of services or of case manager.

In some cases, you might need to actively support their freedom to make decisions. For example, they might feel unable to decide because they are controlled or manipulated by someone else. In some cases, their personal limitations could prevent them feeling free to choose. For example, they might avoid making decisions because they feel under pressure, are distrusting or fearful, or cannot understand different options.

The law gives you some protection from residents' poor choices. Imagine that you have explained the risks involved but have let the resident make the final decision. However, the resident's decision resulted in some kind of harm to them, so they now want to sue you or your organization. Your defense is that they knew that the activity involved risk and voluntarily decided to do it anyway. Unless there were other factors involved, their case would be unsuccessful. The legal term for this defense is *voluntary assumption of risk*.

See also the next chapter for *evidence-based practice* EBP.

The problem of two mindsets

We interviewed two staff, Rob and Emily, who have contrasting views on their roles. How would you harmonize these two contrasting viewpoints?

Rob's view: The compliance mindset

"Our staff must follow all policies and procedures exactly. One kind is the procedures, which are sets of steps for doing specific tasks. Then we have policies, which state the philosophy and

principles governing behavior and actions. We also have our training, so that we consistently apply policies and procedures.

"The rationale is as follows. First, The_house's policies and procedures are designed to anticipate all residents and situations that staff will encounter, and presume that they all have characteristics in common.

"Second, like any organization, the governance structure requires that we comply with its policies and procedures. I am accountable to my supervisor who is responsible up to the board. Staff are liable if they operate outside their authorization.

"Third, some policies and procedures are set according to legislation, court-defined precedents, organizational licensing codes, professional registration standards, and industry-based quality standards. If we fail to follow policy and procedures and it results in serious consequences:

- I could be sacked.
- I could be prosecuted and sued.
- My professional registration could be cancelled.
- The_house might be liable for negligence if it is found to provide inadequate training and supervision.
- If we were in a jurisdiction where services must be licensed, we might have conditions imposed on us, or even lose our license.

Emily's view: The unique situation mindset

"The way I learned my role is to understand the policies and procedures and see how they apply in many different situations. We've found that this kind of training is quite fast and very purposeful, because we've thought through our approaches to difficult situations.

"I find that compliance-driven staff blindly follow procedures without understanding their purpose and the way they support the purpose of the whole program. They can easily ignore problems that are outside their training; they don't say anything when the procedures don't exactly fit the situation, and they don't feel free to look for the best solutions to problems.

"It is better to presume that each person and situation is unique, so I interpret each one according to its individual merits. Ready-made solutions often don't work. Flexibility is essential, and I don't believe in pigeon-holing. When facing problems, I need freedom to create unique solutions for each case. This is true even when situations are essentially similar.

"We have various theories of what we do. By comparing them, we build a toolkit of approaches that we can use to better handle any situation."

"I learned my role by analyzing many specific cases and proposing solutions for each. I noticed that some themes came up very often and other cases were rare and unusual. I learned to differentiate between cases that I could handle myself and those that I needed to refer to someone with more training.

"The purpose statement of the program is just one way of expressing what we are trying to achieve. In reality, purposes are very complex and can be articulated in different ways. Policy and procedures are only guidelines so we don't always need to follow them to the letter. They need to be interpreted.

Rob's comments: "I think the 'unique situation' view results in lots of 'making it up as you go along,' practices that are inconsistent and haphazard, and legally high-risk. Training is slow and people make up all sorts of rationalizations for not complying with our standards."

Assignments

Write a 1000-word review of current literature on each of the following:

1. Industry, state, national and international trends in the development of ethical organizations.
2. Frameworks for making ethical decisions and solving ethical problems.

3. Frameworks for setting policy on ethical issues.

Questions

1. What are your organization's strengths and weaknesses in ethical conduct? What influences most threaten its ethical stance?
2. What influence can a leader apply to include ethical practice in the organization's culture, policies and procedures?
3. In your organization, what patterns, trends and issues should managers and staff give ethical consideration?

What would you do?

Chloe is attractive and friendly, and wants to be your friend, but is not clingy or dependent. She is trying to do well in recovery and is making good progress. You have no contact with her outside your role at The_house.

Ryan is a quiet loner. He does not like you, is sometimes argumentative, and frequently makes sarcastic comments to you. You've tried to be pleasant but it feels like you're failing. You figure that he wants some distance, so you give it to him.

During a visit from Ryan's parents, you get a complaint that you have favorites. Is it true? After all, you do give Chloe much more attention and it would be easy to blame Ryan. Perhaps Ryan really wanted your acceptance and you didn't give it.

What do you say?

9
Evidence-based practice

When you recommend any treatment, you are ethically responsible to be able to give some evidence to show that it will be effective. This is evidence-based practice (EBP). This principle is clearer in the negative. Imagine how residents feel when they realize that they are rats in a failed experiment.

Demonstrating effectiveness, however, is much more difficult than it looks. First, evidence is not just an attractive rationale and a collection of persuasive anecdotes. (Everybody has them, no matter how ineffective their program is.) Second, what is "effectiveness"? It would be unrealistic to expect that 100% of accepted applicants will completely recover and never relapse, so what percentage is "effective", and how do you define recovery and relapse?

The purpose of EBP is to make the best possible decision for a particular case in a particular set of circumstances. EBP is used in a various professional fields, including medicine, nursing, psychology, and allied health. It is also being used in teaching and social work, and now more generally in the social services sector. In AR, it is relevant to the roles of shift managers, whose task includes behavior management, and case managers, who oversee decisions on client cases.

In its simplest form, EBP comprises three main elements: (1) the client's values, culture and preferences, (2) research evidence, and (3) professional expertise, including experience, education, and skills.

Evidence-based practice has several variations, but they often incorporate the following elements:

1. Start with the client's question or symptom, and rephrase it as a well-built clinical question.
2. Consider the research evidence. What evidence is available? How good is it? What firm conclusions have been reached in the research literature? How well does it suit the case? How do we incorporate it into practice?
3. Consider a range of case-specific factors in making a decision, because individual cases often have other complicating factors, for example:
   a. "What are the specific characteristics of this case?"
   b. "What is the case history of this client?"
   c. "What do we know about the context, such as social relationships and accommodation?"
   d. "What are the client's personal preferences?"
   e. "What is client's cultural background?"
   f. "How do we put scientific evidence into practice in this particular case?"

4. Make a decision based on professional expertise and judgment, including experience, education, and skills. It is actually based on an informed opinion rather than a statement of fact.
5. Review. What was the outcome?
6. Cycle: How can we use what we learned in future?

By definition, EBP is different from policy-based decision-making, in which organizations make a policy statement based on a review of evidence, effectively making the decision beforehand. This pre-empts individual decisions on specific cases using professional judgment.

Some practitioners conduct research, using evidence to test aspects of treatment approaches. They usually express elements of the philosophy, rationale or methods as hypotheses and then use established methodologies to gather evidence to show whether or not their hypotheses are true.

Compared to practice-based expertise

EPB is quite different from practice-based expertise, which was discussed in previous chapters. Staff can develop their expertise by analyzing individual cases and risks, and by continually improving their policies and practices.

These, however, are only informed hypotheses: "I've had lots of experience with this. The problem is usually ... and the outcome is often ...." An accumulation of personal experiences and anecdotes does not necessarily comprise "evidence."

Practitioners can easily maintain a philosophy of treatment without objectively demonstrating its effectiveness. They can argue passionately for a set of values, rationales, and methods. They can sound very logical and can use their rationale to justify their successes and explain their failures. They offer anecdotes and persuasive stories as "evidence," and they can appeal to common sense and their experience.[24]

However, they find objectivity quite difficult. They have little or no unbiased evidence to demonstrate the effectiveness of their treatments, and the views of the organization might only reflect the opinions of strong leaders, or the organizational culture and its in-house "mythology."

Limitations of EPB

Evidence-based does not mean "absolutely proven." One study alone is not particularly conclusive; researchers normally want a variety of studies to build up a stronger case for any conclusions.

Evidence-based research has weaknesses. It is seldom conclusive; researchers tend to divide into groups with different theories and views. Some good ideas go out of fashion in academia when they no longer generate research topics. It is also not as objective as it intends to be. Researchers are influenced by their social networks of researchers in the way they think about their topics and generate hypotheses. Researchers can easily prefer research topics that support their own viewpoints, and, although not methodologically sound, sometimes import their personal assumptions.

On the other hand, it has great strengths. It can produce results that are counterintuitive; some notions appear to be clearly true but are shown to be false or simplistic. Methodologies are themselves open to examination, so the effects of any imported assumptions and errors are open to critique. Any community of researchers needs to keep exploring and evaluating the assumptions that it brings to its research.

Kinds of research methods

In addiction recovery, evidence-based research uses three main kinds of methods.

24Experience-based hypotheses can be worth testing with real evidence and a suitable research methodology.

Qualitative research methods are suited to exploring viewpoints, values, and perceptions. Some qualitative methods are not particularly objective, and are better characterized as intersubjective. Ethnographers seek to understand and describe the culture of people in a particular community. By gaining insight into their viewpoint and values, they understand aspects of life that do not make sense to outsiders. Researchers can also use interviews with relatively small numbers of interviewees in a defined population. Questionnaires comprise mostly open-ended questions and allow for spontaneous follow-up questions.

Although the results do not necessarily represent norms in the larger population, they are usually very insightful. They describe how addiction and prostitution present, the causes, and patterns of comorbidity. They are can forecast tendencies in long term outcomes if not treated, especially if they have statistical information.

Descriptive studies, however, offer little help in treatment; they tend to describe problems rather than to guide in formulating solutions or to give evidence on how effective it will be. That is, they are not prescriptive. Too often, it is like standing at the bottom of the cliff keeping accurate records of people falling onto the rocks below without trying to build a fence at the top of the cliff.

Population statistics. The study of population statistics is central to epidemiology, which is the study of the ways in which diseases occur and spread. For example, the father of epidemiology found that cholera was transmitted through polluted water in London. In the twentieth century, tobacco was shown to increase the risk of cancer.

Positivistic methods. Researchers compare two or more equivalent populations where the only difference is the variable to be tested. This is sometimes referred to as the "scientific method," although it is only one of many methods used across the sciences. Nevertheless, it is essential to some fields, especially medical studies, as it claims to be most "objective."

Different kinds of sources

Primary sources are materials that contain the thoughts of people as they originally thought them. That is, they are in the original form before a translator, reviewer, commentator, or editor interpreted them. They include journal articles, monographs (books written by one person), books of research articles, theses and dissertations, and unpublished sources, such as official records, and conference proceedings.

Secondary sources are materials that contain the thoughts of primary sources in a form that has been interpreted by a translator, reviewer, commentator, or editor. You can use secondary sources for EPB.

Do not use explanatory sources, such as textbooks and general reading, because they are not a substitute for research. The internet also has many blogs and personal opinion sites, which are usually quite unreliable because they lack factual information altogether or contain biased, unconfirmed, or out of date information.

Journals

Journals are published in several different categories.

Research journals contain reports of original research (or reviews of original research) and are intended for researchers. Articles in research journals are normally very specialized and have narrow topics. They add to theory in their field, based on the belief that theory develops through a large amount of specialized researches. These can then be reviewed to create more generalized conclusions. When articles are experimental in some way, they have particular methodologies and tightly defined populations. *Refereed* journals are those where one or more peer experts reviewed the article before it was published and recommended it to an editor as being worthy of publication. Some journals are not refereed and considered of lower quality.

Articles in professional journals can be helpful, but they are quite different from those in research journals. They are often less specialized, and more likely to consider practical issues. They

are intended for practitioners who are not doing research, but want to know how to improve practice and to apply new techniques and ideas in practice.

Finding journal articles

The simplest way to find articles is to search online using a specialized search facility such as Google Scholar or jstor.org.

It is easy to find out what a journal article is about. The title of an article usually describes the topic very precisely even if it sounds long and complicated. Many articles also have an abstract (i.e. a summary) at the beginning, with a summary of conclusions.

When you find an article that appears to be suitable to your needs, read the title and the abstract. If it is not relevant, don't waste any more time on it, even if it's interesting. Move on quickly.

If it *could* be relevant to your needs, skim-read the rest of the article. It will usually have a series of section headings. Keep a record of it so you can find it again if it turns out to be helpful. Keep a copy if copyright allows it, even if it is not useful now.

If the article **is** relevant:

1. Decide exactly how it is relevant, that is, to which particular aspect of your task it relates.
2. Read the whole article carefully and make notes of your thoughts.
3. Check for references to other publications; you might get some good leads.
4. How will the findings affect your decisions in AR practice?

Task 1: Evaluate your organization's ability to incorporate EPB:

1. How well suited to EPB are your current staff? Could they get interested in reading and discussing research results? How many have the academic skills to read and evaluate research?
2. Consider the current state of research relevant to AR. How much is directly helpful to the roles of AR professionals? How accessible is research?

Task 2: Design a system

Design a suitable EPB system for your organization so that practitioners will build up their knowledge of useful research evidence and keep it up to date. Keep it simple so that it could actually work.

Task 3: Generate hypotheses

Interview experienced workers on "Things I have learned from experience." Express each item as a declarative statement that relates two or more variables. Define any terms that might be unclear. (If you like, write the contradictory i.e. put "not" after the finite verb of each one.)

What you will probably get …

- All the statements will appear to be true, whether or not they are.
- Most of the statements will appeal to common sense or anecdotal evidence for justification.
- Some will represent a theoretical viewpoint, a set of values, or a particular model of recovery.
- A few might be tautologous. (A tautology is a statement that is true by virtue of only the meanings of its words. Tautologous statements are useless.)
- A few might be so jumbled that they actually don't make much sense when analyzed.

Upon testing experimentally, you will find that some true-looking statements will not be true; that is, the truth is counter-intuitive. Some will be true, and some might only be true in certain circumstances.

Questions

1. Which of the following statements reflect EBP, if any? Explain your answer.
   a. "I met a guy in a bar who's done this a lot and he thinks ..."
   b. "I've been doing this job for twenty years and my gut instinct is ..."
   c. "I've been doing this job for three weeks and but I read lots of good articles before I started here. In my opinion, ..."
2. What is a Cochrane review?
3. Should evidence be arranged into a hierarchy that ranges from "strongly confirmed conclusions" to "weakly confirmed conclusions"?
4. What is the difference between an anecdote and a case study of an individual?
5. What's the difference between an informed and an uninformed opinion?
6. How should you respond to research that might not be current or accurate?
7. How should you respond to research that seems to assume a particular ideology with which you can't agree?
8. Decisions can be handled in various ways. Under what conditions is each of these options suitable?
   a. The decision should be pre-empted by an organizational policy statement.
   b. It must be left to the individual practitioner.
   c. It could be referred to a more senior practitioner.
   d. It could be referred to someone in a different specialization.
9. You have a client with symptom X. You find some studies indicating that about nearly 70% of people with this symptom have the same particular outcome. (That's about twice as likely as the other possible outcomes.) Can you safely assume that your client is going to be one of the 70% with that outcome, or should you consider that he/she is one of the 30% who doesn't? Explain your answer.

What would you do?

You are looking for some research on a particular topic. What would you do in each one of these situations?

1. You find a very solid study but it was based on a population of people with different characteristics from yours.
2. You find a very well done study but it is quite old. You wonder if subsequent research might have come up with different conclusions.
3. You find several studies, but they are based on particular assumptions that you think are quite suspect.
4. You find several studies but you suspect that their research methods are flawed.
5. You find several very well done studies but they are descriptive. You realize that description does not directly transfer into prescriptive action. How useful are they?

Assignment: Completion rates of a recovery program

Do this assignment in your organization. Please note that it needs a big enough program to work, because one or two individuals can skew the statistics in a small program. It might not work if your organization has recently implemented major changes that will dramatically change retention.

It separates program completion from simple retention. Some residents progress through recovery more quickly than others, and some have fewer or less serious relapses than others. If a resident absconds and then comes back into the program after a short period, it is better counted as a kind of temporary relapse than an exit and then admission as a new resident.

1. What is your organization's definition of satisfactorily completing the whole program? How objective is it?
2. What percentage of admitted residents go on to satisfactorily complete the whole program?
3. How long do residents stay? Draw a graph of the length of residency of residents who satisfactorily completed the whole program in the last three years. Make the horizontal axis the length of stay and divide it into short periods (e.g. months). Make the vertical axis the number of residents who satisfactorily completed the whole program in that period.
    a. On average, how long does it take someone to complete the whole program?
    b. What shape is your graph? What does it tell you? Are residents in particular stages of residency at higher risk of non-completion?
4. What percentage of past residents has a relapse after satisfactorily completing the whole program?
5. Why do some residents fail to complete your program? Make a list of:
    a. The causes for non-completion.
    b. How often each cause was dominant in causing non-completion.
6. Do different causes of non-completion tend to affect different stages of residency? (For example, some might affect new residents much more than those who have been in the program for over six months.) Any patterns you see will indicate higher risk levels associated with particular stages of residency.
7. What do graduates do after leaving the recovery program? What percentage of them relapses? How many are fully employed, and how is "fully employed" defined?
8. Ask staff for their suggestions of ways to:
    a. remedy each cause for dropping out
    b. improve residents' outcomes after graduation.

Other questions

This assignment is longitudinal, that is, it studies events that occur over an extended period. Consequently, you need to ask these secondary questions give you further insight into validity of your conclusions:

1. Did the organization get the same kind of resident across the time span of the study? In other words, are we comparing oranges with oranges, or oranges with apples? It cannot be assumed that residents are an homogenous group. For example, the residents in one period might be of quite different age groups or have quite different issues from those in another period. These might have necessitated changes in the program. If these differentiations were not made, generalizations across different groups might be of doubtful or limited validity. However, by taking any group differences into account, you might be able to make such generalizations.
2. Have retention rates changed over time?
3. Have causes for dropouts changed over time?
4. Has the average period it takes a resident to complete the program changed over time?

Methodology

Interview long-term staff to compile a data set for each resident leaving the program during the period of the study. Interviewees should use residents' case files. However, you don't need to read them and it is not necessary to gather any data that identifies individuals, such as name or case details. The data required for each resident is below, and you can then present most of it as percentages.

1. Date of admission
2. Age in years on admission
3. Category of primary causes for admission

4. Category of other causes of admission
5. Date of departure from the program
6. Category of primary causes for leaving the program
7. Category of other causes for leaving the program
8. What graduates are doing now.

Complicating factors

The methodology and findings are complicated by various factors, many of which are longitudinal. You might notice other complicating factors as they arise during your study, and you should note them down. Here's my list so far:

1. Has the model of treatment in the recovery program changed significantly during the period?
2. Your results must be qualified, in that a theoretical model of service cannot accurately represent a living therapeutic community that includes an emotional ethos and a set of personal relationships. These human factors might contribute to program successes and failures more significantly than the actual model. Even if the actual model of treatment has not changed, the ethos of the organization might have changed, especially if a key leader was replaced. The effect of the change in ethos could have the same effect as a change in treatment model.
3. A single case of non-completion might not have only one cause, nor even only one dominant cause. It could have multiple causes with more than one dominant factor.
4. Some residents progress through recovery more quickly than others, and some have fewer or less serious relapses than others.
5. Applicants usually have multiple issues.
6. Risk levels vary between applicants. High risk applicants are those that will probably drop out and not complete the program. Policies on accepting higher risk applicants can change over time.
7. Current residents are still in the program, and have neither dropped out nor satisfactorily completed the program. All that can be said is that they are presently making satisfactory progress.
8. Some residents who do not satisfactorily complete the program are not dropouts. For example, they might have been transferred to a hospital or a jail. They might have been placed in the program for a limited time under agreement with a court, a government department (Justice, Child Protection), or their parents.
9. Some residents abscond and are then re-admitted to the program. If the absence is quite brief, count it as a kind of temporary relapse while within the program rather than an exit and then admission as a new resident.
10. Residents who drop out might still have made significant progress toward full recovery.
11. The actual cause of residents leaving the program is not necessarily known:
    a. Perhaps you can only describe the nature of departure. For example, you might know that a resident absconded but not their reasons for doing so.
    b. The resident might not understand their own motivations for leaving.
    c. Even if the resident did inform staff, the actual reason might be different from the reason given.
    d. Staff might be incorrect when drawing conclusions.
    e. An incident that triggers departure might not be the cause. It could be the straw that breaks the camel's back or something that precipitates a severe mood swing.
12. Information on graduates after graduation may be sketchy or unreliable if contact with them is infrequent.

13. A resident's causes for admission might not be the same as those of relapse. Unfortunately, the term *relapse* is not a perfect fit for this eventuality because it means reversion to a previous state. For example:
    a. An applicant might be admitted for addiction but drop out for reasons unrelated to addiction.
    b. An applicant might come into the program with an addiction issue, successfully graduate, then later have a serious issue that is not addiction-related.
14. The non-relapse of a majority of recent graduates tends to be significant. However, the non-relapse of an individual recent graduate is not necessarily significant; the graduate might simply have not yet had time to relapse.
15. The non-relapse of a majority of long-term graduates only tends to be significant if the recovery program had not changed during the intervening period and the characteristics of residents are comparable. Otherwise, the non-relapse of a long-term graduate would represent the program as it once was, not as it is now.

Other questions

1. Are triggers the main cause of dropouts? Could failure to socialize and acculturate be more significant causes than triggers? The two kinds of causes are fundamentally different. Factors causing failure to adjust are predominantly repellant in nature, while triggers are attractants.
2. What is the relationship between organizational culture and residents' personality types? For example, do particular recovery organizations attract particular personality types? Does the organizational culture of the particular recovery organization affect retention rates? How does organizational culture affect recovery?
3. What is the relation of treatment to recovery? Is it a direct cause-and-effect relationship or does the recovery program simply provide a conducive environment for it to happen spontaneously?

10
Advanced assessment

After admission, we need to fully assess each resident, as well as keep the assessment up to date. The last stage of admission is also the first stage of routine case management, discussed in later chapters.

Observation

The first phase is observation, which is done during the settling in period. In a closed residential community, staff have lots of opportunity to observe residents informally and to monitor their health and well-being. For many new residents, the first few weeks are an exciting time of new friends and experiences, so the observation phase needs to be long enough for cracks to show. Observation over time is a more reliable assessment than the interview because residents cannot easily hide issues for long. Besides, the members of the assessment team validate their results by comparing their observations.

You may freely meet with the resident, but do not make them feel observed or under pressure. As they have been informed of the observation process, they might ask how you think they are going. Respond constructively and encourage them. Avoid negative conversations that don't help. Only let negative issues be raised if you know it is your role and follow The_house's counseling protocols.

As a whole-of-life assessment, it includes anything that needs attention, such as family, housing, personal finances, health, and ability to do the activities of daily living. At this stage, we particularly look at these items:

- how they respond emotionally to people and situations (frustrated, withdrawn, angry, fake, etc.),
- personality characteristics,
- strengths and weaknesses,
- signs of issues needing treatment, especially those with increased risk.

A case conference

At the end of the settling-in phase, convene a case conference with other staff. First, assess the resident based on your observations and other information available to you. Second, assess whether the resident is ready to have a case manager. If they are, assign one with a compatible personality. Third, make an interim case plan. Fourth, if you assigned the resident a case manager, tell them and make sure the transition is smooth.

More about testing

Tests can be open-ended questionnaires or tests with specific multiple choice questions. Some are designed to be used in an interview and some are written. A few tests use systematic observation of behavior, sometimes with specific activities. All tests should come with a specific purpose and a set of instructions on how to give them and how to interpret the results, because these affect the quality of the results.

A huge number of specialized *multiple choice questionnaires* are available to identify particular psychological traits, although most are not particularly helpful in addiction recovery. These tests usually give measurements, that is, they give one or more numerical results and a means of interpreting the results. They have been tested for reliability and validity, and come with information on exactly how accurate they are and the extent to which you can draw conclusions from them. Some have already been tested with large numbers of people, so you can see how your clients rate against the general population of people for whom the test was intended. The tests are usually designed so that it is very difficult to cheat. Due to the amount of work that goes into their development, many are available only on license to approved users for a fee.

Open-ended questionnaires work very differently. They are usually designed to explore issues and let the client report their own information. They are fairly easy to write and, if already written, are usually free. Open-ended questions work well for things that cannot be predetermined. However, they tend to allow clients to cheat. For example, clients can lie or hide something to make themselves look good. Clients can sometimes cheat an observation by putting on a good face for a period of time. You can side-step cheating by using other corroborating sources of information, or by doing observations over a longer period.

Observation matrices are grids of characteristics. They tend to encourage observers to think in terms of categories rather than tendencies, and often depend on disciplined observers.

Possible improvements

Periodically review the assessment system in the staff meeting. Include both the actual procedure as well as staff observation skills. For example, at The_house, we'd like to eventually make the medical examination part of the assessment procedure for all applicants.

We might decide that the initial application only gets applicants into detox. After that, they would have to re-apply for the full recovery program. The reason for this approach is that residents have limited ability to understand their obligations if they are highly distressed or suffering the effects of a substance.

We're currently considering doing a more thorough interview using more comprehensive questionnaires during the settling in period, when residents are more alert and less likely to tell lies. It would include any of the following that are relevant to the resident:

- a more complete medical history
- practices of taking drugs and alcohol
- high-risk sexual practices
- financial health
- measures of social and employment dysfunction.

Some agencies use a quite complete list of questions. The point is to cover applicants' whole lives with a list of questions covering all important topics. HEEFISS is a good example, covering Health, Education, Emotional, Family relationships, Identity, Self-care, Social. For example some kinds of questions and topics are as follows:

Health	How would they describe their general health?
	What allergies do they have?
	Who is their current doctor?
	Who is their current dentist?

	Do they have any personal hygiene issues? Have they been diagnosed with a mental health issue or been in mental health care?
Education	How far did they get? Did they graduate or drop out? Are they currently enrolled in a program of study or training?
Identity	Self-care, domestic skills, housing, personal finance, time management, use of services

One of our recent improvements is to train staff to assess stages of development. Younger people are especially likely to be developmentally very different at the same age, and they can vary greatly in their development of personal identity, and in their abilities to empathize with others, take responsibility, be reflective, consider consequences, and be self-aware.

One set of competencies[25] requires the assessor to "Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic culture, and disabilities that includes but is not limited to:

- History of alcohol and drug use
- Physical health, mental health, and addiction treatment histories
- Family issues
- Work history and career issues
- History of criminality
- Psychological, emotional, and worldview concerns
- Current status of physical health, mental health, and substance use
- Spiritual concerns of the client
- Education and basic life skills
- Socioeconomic characteristics, lifestyle, and current legal status
- Use of community resources
- Treatment readiness
- Level of cognitive and behavioral functioning.

Questions

1. What kinds of risks might you have to manage to keep both yourself and the client safe when doing assessments?
2. What are your limitations in assessing? When do you need to ask for help from colleagues, senior staff and/or experts in the area?
3. What are your organization's limitations in addressing residents' needs?
4. Some competency standards treat screening and assessment as completely separate tasks. Do you agree or disagree? Give reasons for you answer.
5. Multiple organizations
    a. What are the roles, responsibilities and boundaries of other organizations and personnel providing assessment and related services to your clients?
    b. What is the best way to handle assessments involving multiple service providers?
    c. What should you do when you and another organization's case manager both want to be in charge of your client's assessment?
    d. What should be in inter-organization agreements on client assessments?

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25 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* Technical Assistance Publication (TAP) Series, No. 21 Substance Abuse and Mental Health Services Administration, 2011. (Rockville, MD). Competency 33, p. 46.

6. Validity and reliability
    a. What is "validity" and "reliability" in assessment?
    b. What are the validity and reliability requirements for assessment?
7. Explain how to identify, assess, and prioritize risks.
8. What kind of consent do you need to disseminate a client's assessment results to other parties? What are the relevant privacy and confidentiality principles and practices?
9. The policy and planning context especially affects government services and services that are government funded. Describe your organization's policy and planning context for using service and resource providers.

Questions: Assessment tools and processes

1. Explain your assessment tools, processes and protocol requirements.
2. How effective are your assessment approaches and practices for identifying needs for delivery of services and resources?
3. What gaps in your assessment tools, processes and protocol do you need to cover with "professional judgment"?
4. What assessment tool(s) are appropriate to determine:
    a. developmental status,
    b. family,
    c. social relationships,
    d. natural supports,
    e. housing,
    f. financial situation,
    g. health,
    h. literacy,
    i. ability to do the activities of daily living,
    j. cognitive capacity.

Task 1

Look through the assessment systems above and write a proposal for an improved assessment system. It needs to be short enough to be practical while still covering all the requirements. (You might feel like being very comprehensive is better. If that's you, resist the temptation to make a long list of questions that requires such a long interview that it will never work in practice.)

Task 2

Write a 2000-word review of current research literature on assessment practice. What are the trends, and what is current good practice?

What would you do?

Some parents have shown up with their fifteen-year-old daughter and her suitcase. They want to simply drop her and off and leave. You know the family very well; another daughter has been in the program for two years, and you have had frequent contact with the parents and the other daughter over that time. You already have detailed knowledge of the reasons why the parents want her admitted, and they are all very familiar with the program at The_house.

The procedures require you to do a full assessment, but you think you know the family so well that it would be a waste of time. Besides, the parents want to leave as soon as possible. Should you do a full assessment? If not, what do you do?

11
Leading recovery groups

At The_house, recovery groups help residents to develop life-skills to recover from their issues.

You'll need all the skills you learned for leading activity groups. You'll need to lead discussions and navigate residents' emotions and reactions. You'll set the topics and might provide information, but it's normal for group members to also learn from each other. If you've been through a recovery program yourself, you're probably quite familiar with this kind of group. If you haven't, then you should sit in as observer to see how they work.

When you do start leading, you'll be supervised by a senior staff member. It is better for you and the supervisor to start as co-leaders so that they can easily take over if you get stuck or out of your depth. Even when you get very good at leading this kind of group, you'll still usually work in liaison with others because someone in the group might need more specialized help than you can give.

We go through the series of topics in a continuous cycle. All first-semester residents are in the group, so there is no selection process. Most repeat the cycle at least once more before progressing to other kinds of activities. A few residents are permitted to be absent if they have outside appointments or must appear in court.

If a group has developed enough mutual trust, the Director allows it to be more like group counseling. These have less structure and more often work with individuals' specific issues.

Plan the group

Here's a framework for planning groups. The first time you plan each topic, you'll probably take a lot of time and find some things don't actually work when you try them. Don't worry; that's normal. As you go, you'll improve your session plans and become more confident in going with the flow of the discussion and the issues raised.

1. Before you start planning, ask yourself what is it about the group that attracts people to it? What kind of thing do they expect to learn?
2. You'll be assigned certain topics and days for each topic. The kind of topic and how you approach it will determine the kinds of activities you plan.
3. Focus your session. It's successful if group members learn only one thing that they actually apply afterwards. Don't expect them to learn everything.
4. Prepare for all four phases of each session:

a. *Tuning-in*. Prepare for everybody to straggle in, settle down, and get into the right mood for the group.
b. *Beginning*. Open with some kind of welcome, any housekeeping (e.g. reminders about any journaling and reading tasks), and your topic for that session.
c. *Middle*. Go through the activities that you planned.
d. *Close*. Wind it down, answer any remaining questions, mention any follow-up work (counseling, homework etc.), and leave them knowing what to expect in the next session.

Leading discussions

One of the more complex tasks is leading discussions and meetings. It is up to you to take the lead. Start by setting the objectives of the meetings and contributing agenda items, and then follow them yourself.

Give people any information they need to achieve the purpose of the meeting. In some cases, you could distribute it in writing before the meeting. In other cases, you might hand it around in the meeting. A word of caution: "information" isn't only written information. Sometimes verbal or visual information is more helpful.

In leading the discussion, give people opportunities to fully explore all relevant issues. Encourage everybody in the group to participate equally; ask them all to contribute and acknowledge them when they do.

As you go, evaluate the way the group is communicating, so you can adjust your approach to help everyone to keep participating. For example, you might give the group short bits of information, close down overly talkative people, give quiet people more say, and ask questions that refocus or redirect the discussion.

Planning your questions for group discussions

Your goal is to get the others doing all the talking with you only keeping it on track.

When you have a topic, put most of your planning thought into writing some good lead questions. They should be open-ended discussion starters. If you're not used to leading this kind of group, write some follow-up questions as well. When you become more skilled, you'll be able to produce follow-up questions spontaneously as the need arises.

There are basic kinds of questions:

1. Use *lead questions* to open a new topic of discussion.
2. Use *closed questions* to give participants a limited range of answers to choose from, such as "Yes" or "No." They are usually fairly easy to answer, and are best for getting people to provide an initial response when they are reluctant to speak.
3. *To get basic information, use open questions that only ask participants to report specific information*. Helpful to make sure they get basic information.
4. *Use open-ended questions to get participants to think or reflect*. There usually isn't a particular answer that you should look for, and when they give their answer, you can ask the reasons why and follow through to causes. They cannot answer this kind of question by only repeating information.
5. Use *clarifying questions* if someone has not explained something clearly.
6. Use *redirecting questions* to get people back on track when they have skirted past an important issue or are avoiding a sensitive topic.
7. *Use follow-up questions* to explore participant's answers further. With practice, you will be able to make them up as you go. For example:
   "James, that's a good opinion. Why do you think that?"
   "Thanks, Jess. How would you … ?"
   "Okay. But what would you do if … ?"

8. Use *balancing questions* to prevent extreme views. Every now and then, dominant group members push a quirky, off-balance opinion, and the quieter group members seem to be willing to accept it. It would be irresponsible to let the whole group unquestioningly accept such an off-beat view, so you need to bring back some balance. As discussion leader, you can simply question the extremist view. You can also ask students to respond to a strongly contrasting counterweight view.

Of these, balancing questions come with a few traps. In many matters of opinion, students should generally be free to reach their own conclusions. You should not indoctrinate or manipulate students into accepting your personal view. It is also unfair to create an extremist stereotype of a view that you dislike, and then present your own view as the only balanced view.

Questioning approaches

- Draw out their opinions.
- Play the devil's advocate (graciously, of course). Take the opposite view and get participants to defend their ideas. "How would you respond to someone who said …?"
- Identify issues that will make participants take different opinions and discuss the matter with each other.
- If participants are reluctant to talk, you have several options. You can ask specific individuals what they think. "What about you, Krissy? What do you think?" You can also simplify the question (all the way back to a simple yes/no question if need be) until they answer the blatantly obvious. Then build back up to the complexity of your original question.

Hints

- Make sure the points of your questions are clear. Ten words is a good maximum.
- Give students the right to their own opinions. Don't try to force them to agree with you.
- Pick up on good ideas that come up and explore them.
- Make students glad they contributed, especially when they have very good ideas or are usually shy.
- Don't play: "Guess what's on my mind."
- Explore paradoxes.
- Defend quiet or less articulate students, especially when they have good ideas.
- Make sure that everyone who wants a say gets a say.
- Control people who talk too much: "The people on that side of the room have been quiet; what do you think?"
- Use silence if they are finding speech difficult but need time to describe feelings; lots of talk from you can be a hindrance.

Activities

Question-based discussions are not your only possible option. You can also develop activities to suit the group's needs. Here's a list of examples:

- Fish-bowls: two or three people do an interaction activity while others watch, and then the group discusses it
- Written reflections
- Drawings/collages

- Dyads and triads (discussion in groups of two or three, usually with assigned discussion questions
- Fantasy reflections
- Reading reflections. Discuss their responses to a book or article.
- Experiential exercises
- Values clarifications. Give group members a hypothetical dilemma. They then make a decision or indicate a preference that reveals their unconscious values. You then explore the values.
- Discussing teachable moments: a group member brings up a real need and you take the opportunity to teach exactly what they need at the time.
- Watch excerpts from a video and then discuss it.
- Scenarios: situations that you analyze through discussion. It's important that group members can identify with the characters without feeling that you are deliberately targeting them as individuals.
- Critical incidents. Discuss particular non-routine incidents and learn what you can from them.
- Letter writing exercises.
- Scaling questions: "On a scale of 0 to 5, how much is the problem now affecting you?"
- Self-evaluation tests, such as temperament, or learning style.
- Miracle questions: 'You wake up tomorrow morning and a miracle has happened, [your problem] has less affect on you." "How will you know things have improved? What will be different?" "What will others notice is different?"
- You can also try a strength-based approach. This can make the group more positive than always dealing with negative issues:
- Have a starting point for change.
- Notice what is already working well. Identify group members' personal strengths and affirm them.
- Identify their barriers, limitations or challenges.
- Identify their potential for positive change.
- Set achievable goals.
- Get them to report their successes.

Lead the group

Basically, follow your plan. Re-read the earlier section on how to lead a discussion; it will guide you in what to do.

When you open the group, learn to recognize individuals and call them by name. This is easy in a residential program but more difficult in a once-a-week outside group.

Tips for effective facilitation

Work with the whole person. For example, group members bring to group the effects of other aspects of their lives, such as their family backgrounds, their education, their temperaments, their relationships, their social class, and their personal circumstances. You also have to consider all sorts of influences in their lives including personality, culture, language, religion, age, gender, learning abilities, health, disabilities, and issues. And you have to see how these factors relate to each other.

In other words, be sensitive, and value each group member as a unique individual. Look for ways to make your sessions relevant to group members in their particular situations. Take notice of other kinds of issues that come up and respond appropriately.

Protect yourself as well. Follow the ethical guidelines for appropriate self-disclosure.

In a residential program, you'll probably give regular homework, such as books to read, journaling, and worksheets. Remember that residents' have different learning styles; some will find written tasks very rewarding while others might find the same task frustrating or unhelpful.

Individuals will sometimes display distress or concern. You need to respond in a way that protects them. There is no single prescribed answer and you'll have to choose the right one for the situation. For example, you might steer away from discussing some topics, offer to see the person afterwards, or close down a discussion topic. In any case, don't let anybody feel humiliated in front of the others or suffer emotional harm. And respect their personal boundaries; don't pressure people into disclosing personal information about themselves against their will.

You need to apply the usual approaches if group members come into conflict with each other or if they are antagonistic to you in some way. In particular you have a toolkit of things you can do:

- Respond to strong emotional expressions.
- Cut off scape-goating, personal attacks, and gossip.
- Get group members to clarify their feelings.
- Address underlying issues.
- Challenge them if necessary.
- Speak to people after the group concludes.

After the group

If a member of the group has not responded well, you might be able to speak with them privately after the session. Discuss what they are feeling and learning, and find the blockage. You might need to refer them to someone else for extra help. Do any other necessary follow up. Do you need to write up program outcomes or an evaluation? Do you need to keep attendance records?

Review how the group meeting went:

1. How well do *you* think it went? Be tough on yourself.
2. Did group members make any progress toward achieving the group's goals?
3. As a program, is it still working? Do you need to make changes to stay relevant?
4. What have you learned that you could apply to groups that you'll lead in the future?
5. How did you cope emotionally? If a session is stressful, debrief the emotions with a supervisor afterwards.

Assignment

1. What kinds of recovery groups do you have in your organization? What role does each have to play?
2. How would you modify your existing group programs to better meet group members' needs? Explain:
   a. the current needs,
   b. the current activity,
   c. the improved activity, and
   d. why the new activity is better.
3. Explain how a group has changed over time.
4. What is current best practice for leading recovery groups? (Do some research to answer this one.)
5. What other kinds of recovery groups are used elsewhere?
6. What are the appropriate boundaries for groups?
7. What written records do you need to keep?

8. Make a list of ten group activities that are *not* already used in your program but would be good to start using.

12
Case management procedures

Annie was desperate when she arrived at The_house. A heroin addict, she was thin, sick, in debt, and emotionally erratic. She'd been kicked out of her rented room and had no money, no friends, and no family who wanted to know her. She was considering suicide.

Amanda started by telling her about The_house and our rules, assessing her, and getting an urgent appointment with our doctor. In the meantime, Amanda met with our contact person at the welfare office, found out what was going on with the family, and discussed Annie's huge credit card debt with a bank manager.

Within a day of arriving at The_house, Annie had somewhere to live and had started detox under supervision of our doctor. She even had hope of getting out of debt and reconciling with some of her family. And Amanda had made it happen.

Resident meetings

You'll need to meet regularly with your resident. The basic procedure above is the best guide.

Be a good listener. Although you can't usually waste time, you need to give enough time for people to tell their stories, especially if they are nervous or naturally inarticulate. In some cases, you have to go through it several times to get a coherent picture and the details. You can probe with questions, and it's a good idea to sum up what people have said so you both know that you've understood correctly.

In any case, you need to focus on solutions. Some residents want to wallow in problems and it takes a major effort to start them having hope and looking at solutions.

If other people are present and there is some tension in the group, start by deciding where people will sit in the room during the meeting. In some difficult situations, people often choose seating positions in order to exert power over others. For example, they might use their positions to control how much others can say, or to make sure that they can say more than others. They can also use positions to create, prevent, or avoid conflict.

Assessments

Case managers assess the residents in their care. Assessments are regular and the case plan should specify how often they are done. Most assessments are simple and rather routine, and little more than monitoring the resident's progress and checking that treatments are remaining effective. Occasionally, they are quite major and perhaps out of schedule when new aspects of the resident's

behavior emerge, their health changes, or they face personal crises. The main concepts of assessment were discussed in an earlier chapter, so are not discussed again here.

Case conferences

A case conference is a meeting to review a particular case. The main idea is that a variety of people will probably come up with a better understanding of the issues involved and propose better solutions than a single person acting alone. Case conferences are used in a variety of professions, such as medicine, education, law, psychology, business, and nursing.

The purpose is usually to review the client's progress, understand (or diagnose) the kinds of problems he/she is facing, and make any necessary changes to treatment. It is the right place to write or revise the resident's case plan.

At The_house, most staff think that the term *case conference* is a little grandiose, so we've always called them "case meetings," although we have sometimes used exactly the same term for client meetings. We give our staff the instructions below on how to run them. It covered all the main points that we needed.

1. Collate and compare the range of available information and look for consistent patterns. The information should include:
    a. Observations of people in the meeting
    b. Observations of other staff
    c. Incidents
    d. Information from regular resident meetings
    e. Information from original admission interview
    f. Medical practitioner's input.
    g. Other expert input (e.g. clinical psychologist)
2. Identify the resident's needs, especially urgent needs and high risks. Confer to ensure that you eliminate the individual biases of staff and draw the best conclusions possible with the information available.
3. Make a treatment plan.
4. Make notes of the meeting on a case meeting form.

Formats

Case conferences can be meetings where a group of experts from the same field contribute to a solution. Case conferences can also be multidisciplinary, where experts from several different fields of expertise bring different observations to contribute to a solution. In AR, it is good practice to have input from both medical practitioners and from AR staff who oversee behavior.

Specific meeting formats can vary. For example, each expert might interview the resident separately according the protocols of their own discipline and bring their findings to the group. Alternatively, one person might do the interview, give a presentation to the group, and then lead an open discussion. Another approach is for the whole team to have regular contact with the resident and compare their observations and interpretations.

Bigger and smaller versions

Smaller organizations simply do case conferences as part of regular staff meetings. When we were a small team at The_house, our staff meetings were the obvious place for them.[26]

As the team grew, however, we found that case conferences eventually took, in total, a huge amount of staff time. The staff meeting also became unsuitable for the more sensitive topics that came up and Amanda, the Director, would discuss them privately with several senior staff.

26We couldn't put our findings in staff meeting minutes for privacy reasons. Residents must have access to their own records, but not those of other residents or of staff business.

We decided to have a smaller meeting: the case manager (who led it), one or two supervisors, one or two junior staff who were learning case management, and resident experts as they were available. As Director, Amanda could always come but she usually did so for only the most difficult cases. The case manager also brought the medical practitioner's input.

As part of the change, we implemented some guidelines to get the most benefit for our time:

1. Have a clear statement of why you have case meetings in general.
2. The case manager is responsible to call meetings and make sure others can come. We had a schedule to pre-empt excuses.
3. Prevent interruptions. We shut the door and switched off all phones.
4. Start with a list of questions that you need answered.
5. Make meetings only as long as necessary and don't let them turn into chatter.
6. Make sure the way of documenting them is SUB (simple, useful, brief.) This was a form.

How often should we have them?

It's tempting to want to hold case conferences only when you think you need them, but it's easy to overlook people, especially quiet people who don't attract attention and appear to be doing satisfactorily. The system then defaults to a kind of crisis meeting. We found it better to have a guideline such as once a month for higher risk residents and at least every three months for residents who are stable or in advanced recovery.

How to set up a case conference

Setting up a case conference is very easy if it is a routine internal meeting. The temptation is to have them as informal chats in the corridor and forget to make notes. It works better to have a proper meeting. However, meetings are not routine and internal if you need to invite outside personnel, in which case you may need to inform participants about the meeting, its purpose, the agenda, who else is invited, the venue, date, and time.

You might need to prepare a case history and distribute it to participants far enough in advance for them to read it, which is usually at least a week. You should also appoint someone to take minutes.

Does the resident attend his/her case conferences?

This is an ethical question. On one hand, residents are ethically entitled to know what is being said and decided about them, so they have a right to be there.

You might be acting in the their best interests by not inviting them to the meeting. It can also be unethical to make them attend if they might feel bullied. Many residents might feel so intimidated that any questions feel like an interrogation, and it is easy for staff to unintentionally pressure them into giving any answer they think the group wants. Some discussion can provoke distress that hinders long-term recovery; for example, residents can become angry, frustrated, trapped, defensive, confused, or withdrawn. Perhaps their distress results from their imagined motives and attitudes of staff, but the distress is real none the same.

So can they attend? It's common in some kinds of work (e.g. child protection, abuse victims) and uncommon in others. In some cases, residents want to be there and there's no reason not to be. In other cases, the resident might attend part of the meeting, but not parts that would be distressing. And it is certainly not beneficial when it would make residents distressed.

If residents come to case conferences in your organization, you'll need to prepare them for the meeting. Tell them what will happen and why, make sure they will get there, and make sure they have someone to look after them on the day. Consider limiting the number of people present.

At The_house, we don't invite residents to case conferences (we tried it and discontinued it), but they can read the filed report. Instead, the team leader personally reports on the meeting to the

resident in a way that would most be most helpful. This is usually to cast the outcomes in a positive and encouraging light.

Leading the meeting

Our in-house meetings are usually quite informal. Meetings involving other agencies are usually quite formal, and sometimes even require a professional presentation.

Give clear leadership and keep the discussion focused so that the group uses conference time wisely. It's the leader's job to get the meeting back on track Otherwise, meetings can easily become boring and unproductive; people sometimes start to digress or just chat.)

It's your job to get participants to have a say and present their observations and suggestions. Draw out peoples' thoughts into an honest and frank discussion, while still maintaining a positive, collaborative atmosphere. Whatever the meeting is and whatever the size it is, it pays to observe how people behave and to collect their feedback afterwards.

The point is to make decisions to actually do something, not to discuss interesting topics and then defer any decisions. Aim for consensus among participants and draw useful, concrete conclusions. Ensure that all useful decisions get written in the minutes.

Make the meeting the real meeting. It should be where things are discussed, not where they are avoided. Some organizations have a politically correct culture that prevents people saying plainly and clearly what they really think. Others let the corridor discussions make all the real decisions. (The meeting then loses credibility when people realize that decisions are rigged.)

Case conferences can also have other uses. They are helpful as a collaborative research model, especially if used as a recurring meeting to track the development of a case.[27]

Case conferences are used in training, such as on-job staff training, Professional Development or as a general educational format. Students are assigned to give presentations on cases and lead the discussion. Participants deal with both the unique characteristics of particular cases, and also draw their own conclusions and make their own generalizations.

The case plan

A case plan (sometimes called a "care plan" or a "treatment plan") states what needs to be done to meet the resident's specific needs and who will do it. Some organizations draw them up in a meeting with the resident, and others draw them up in case conferences. Case plans are *always* written, usually by filling in a form. They can also say how you will:

- assess and support the resident
- handle difficult relationships, including families
- manage any significant risks
- manage difficult behavior.

Before the meeting

1. Check your organization's procedure and compare it with this one.
2. Your organization will probably have a case plan form, so get a copy of it. The form will generally follow the format of the meeting, so you will mostly be talking about what to write in the form.
3. Get the statement of the admission assessment from the admitting officer.
4. Who else needs to be in the meeting?

27The case conference approach is very similar to case study research methodology; they both focus on individual cases one at a time and look at the unique characteristics of each. In fact, a researcher could use case study theory to modify case conference approaches and use case conferences to conduct case study research.

5. Figure out what information you need to give the resident in the meeting, for example:
   - Your role and what you do.
   - How case management works and their role in it.
   - Their rights, including how to appeal and complain.
6. Clarify the purpose of the meeting and what you want to achieve in it.

The case plan meeting

Start by setting the tone of the meeting. Being friendly and fairly informal will make things go much more easily. It's then a matter of going through the topics on the form and making sure you both agree.

In some cases, such as behavior issues, you simply have to lay down the rules. But even then, take some time to get the resident to accept it.

Your homework after the meeting

Check that your plan covers everything that the resident needs.

Next, decide how you will monitor it. For example, how often will you check up? Who will you talk to? Sometimes it feels like you are chief cat-herder, but that's part of dealing with so many people.

Make a list of your reporting requirements. These may be quite complex if you are responsible to people other than your supervisor. In other words, who needs to get a copy of the case plan, and who needs to inform you of progress?

Define how you'll implement the plan. This is really about making sure that everything gets done. In any case, you might have to make practical arrangements. For example, it's probably your job to make appointments and make sure people can attend them. You might have to figure out how to change the plan if you might need to do so. What's negotiable and what isn't? If you have to deal with so many people with their own agendas, you will have to know when to discuss changes and when you must simply disagree.

What can you delegate? You can hand some jobs over and let people be free to get their jobs done in their own ways. Give only enough oversight to be sure that the job is being done satisfactorily.

This sounds rather complicated, but in The_house, this part is mostly quite simple. We asked Amanda and she replied, "Our facility is residential, so we only have to make sure that the staff who work with the resident know what's in the plan. And we keep a copy on file in the office. Monitoring is easy; our staff are trained to observe residents and ask the team leader about any thing that causes concern."

Behavior plans and crisis plans

In many agencies, case managers write up a specific behavior plan when a resident has behavior problems that cannot be managed with routine procedures. A behavior plan typically specifies goals for improved behavior, the consequences of continued unsatisfactory behavior, the rewards for good behavior, and how behavior will be monitored.

The case manager discusses the behavior plan with the resident so that all expectations are clear. The case manager usually has to adjust the communication style to the personality of the individual resident; some residents mainly need encouragement while others need a more direct approach. However, it is usually counter-productive to be perceived to be giving an ultimatum.

A few residents are at high risk of personal crises, and staff might decide to have a crisis plan. For example, you might want to put a resident on suicide watch or keep two people apart in case they start a fight.

Collaboration

Case managers normally need to communicate relevant aspects of case plans to the various people and organizations who provide the resident with care or treatment. Later, on you will need to coordinate services and keep them updated with current information to make sure the plan is implemented effectively.

Exit procedure

When the resident will leave your care, you should normally negotiate the case closure with them. They might not want to leave if they've settled into a long-term home in a residential community. At The_house, the staff keep an informal friendship with them after they leave. In the future, we will probably try to be more systematic in the way we maintain relationships with alumni.

Give them a transition to whatever care they will need afterwards. This is often a referral to another organization, so find out who you need to speak with in the new arrangement and negotiate for the resident to get anything they need (ongoing resources, services, programs and support activities). It is then up to you to make arrangements for your former resident to make the move. Of course, some residents don't need a transition because they don't need further care, or move away, or even abscond.

Transitions can be messy. Both the other organization and the resident can drop the ball. Sometimes the transition needs to be done in a way that allays the resident's anxiety and helps them to trust the other party. A personal introduction is often better than a phone call.

It is good practice to follow up later on, as long as you don't appear to tread on the toes of the other organization. Have a way of keeping in contact with your resident and their significant others in the new arrangement. Negotiate an appropriate level of ongoing contact so that you can be sure their needs continue to be met. Keeping up a friendship will be normal, natural, and easy in some kinds of organizations, such as those where people live in community.

In any case, your organization should have a procedure for closure. It probably includes:

- Who the resident was referred to
- Recording what happened that brought about closure
- What follow-up and ongoing contact you will have
- Anybody you need to inform, whether in writing or orally
- Negotiating the closure with other agencies involved
- Any bills left to be paid
- Archiving of records.

You might also want to keep statistics on former residents so you can track their long-term performance. Agencies often want to know how successful they have been in preventing relapses.

More complex cases

Some cases are more complex. When taking on new residents with more complex cases, you also need to discuss whether the client has any specific cultural needs (e.g. for ethnic minorities) and your organization's criteria for leaving the program.

It is quite possible that you will need to identify and resolve complex issues. Some will be legal and ethical, and others will relate to the funding of specialist services or resources. Some will require that you advocate for the resident solve problems at service delivery and policy-making levels. These normally require you to do extra research, which can be time-consuming, and you will need to decide on the limits to what you can do.

Assignment 1

Write a 1,500-word literature review of current research on models and practices in goal-directed AR planning.

Assignment 2

Write a simple diagram of your organization's procedure for case management and label all the components clearly. It needs to be clear enough for a new, untrained staff member to understand with no further explanation.

What would you do? #1

Carrie has been in The_house for two weeks. Although only sixteen, she already has a long history of marijuana addiction. She ran away from home about a year ago and lived on the street with a gang of some kind.

Her parents are divorced. She gets on well with her Dad, who has custody of her and has been very cooperative. He seems to be a nice guy. Carrie doesn't know where her Mom is now, but she was in jail the last Carrie knew. They don't get on and the mother doesn't have custody anyway.

It's 6.00 p.m. and you are sitting down to an evening meal with the residents. A lady comes to the front desk and you go out to meet her.

She asks if Carrie lives here. You explain that there is a policy of not providing information about residents. The lady seems a little upset.

She introduces herself as Carrie's mother and demands to see Carrie immediately. You then check with Carrie, who doesn't want to see her. You offer to make an appointment for the mother to come back to visit and you'll try to convince Carrie to at least meet her mother. You feel that's a good offer.

The mother starts to get angry. She charges through the door to the residents' area and looks for Carrie, who has quite wisely made herself hard to find.

The mother now totally loses it and becomes quite irrational. She demands to take Carrie away right now. Her arguments are:

- She is Carrie's mother, after all.
- Carrie is only sixteen and can't make her own decisions as a minor, so her mother should be consulted on everything.
- She accuses you of trying to hide Carrie from her.
- She didn't give permission for Carrie to be here.
- If Carrie has a problem, it must be her father's fault.

What would you do? #2

Michaela, a twenty-year-old single mother, has been a resident in The_house for a year. She is doing really well and has made lots of friends.

Her three-year-old son, Jason, has also adapted really well to life here. Michaela has custody and her ex-partner only has rights to supervised visits, although nobody has seen him for a year.

One Saturday afternoon, you are visiting some friends when you get a hurried phone call from Rob, the junior staff member who is on duty. Michaela's ex-partner has somehow tracked Michaela to The_house and demanded to take Jason.

When Rob didn't let him past the front desk, he started to get angry, charged through anyway, and looks like he could become violent. He is now trying to take Jason, who is distraught.

What do you advise Rob to do?

What would you do? #3

Michaela's ex-partner has come around several times. He's been angry and abusive, but staff have usually been in control of the situation.

Today is Sunday and Rob is looking after the front desk. You get a hurried phone call from Michaela on Rob's phone. Her ex-partner has come back, and today he's the worst ever. He is threatening to put Rob in hospital and looks close to violence.

What do you advise?

Case studies

Describe three residents in your facility using the Case Study form below. When you have finished, describe how various decisions affected each resident's progress in recovery. This assumes that your organization uses a recovery cycle similar to The_house's seven-stage cycle, and that recovery to some extent depends on a series of decisions.

Case study Confidential

Your name:	Pseudonym of resident:

Stage	What were the main issues facing the resident at this stage?	What kinds of decisions did your organization make about them?	How effective were those decisions? Give reasons for your answers.
Detox			
Settling in			
Recovery			
Increased responsibility			
Training			
Integration into work			
Re-entry			
Follow-up			

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Being a case manager

Being a case manager is more than a set of procedures. This chapter discusses some of the skills you need to develop at the next level up, both in personal skills and on handling some kinds of complicated cases.

As a person and a communicator

Being a case manager is mainly about relating to people. You'll need good communication and interpersonal skills. Your job will generally be easier if you can make friends of people, or at least keep relationships cordial. Part of your role is to establish relationships and networks and maintain them.

It's more than just being friendly. People can be difficult, angry, egotistical, fearful, or frustrated. Sometimes you'll need to be assertive and manage people's behavior, resolve conflicts, negotiate and mediate. Dealing with groups is more complicated; look at their group dynamics and find out the best way to navigate them.

One of our case managers recently said: "I found that I needed to do better at planning, making clear decisions quickly, setting goals, and supervising people. And I can't do everything myself. I'm learning my personal limits, and the limits of what I'm allowed to do in my role. I delegate more to others, and trust them to get on with it."

Some general principles for relating to residents are:

1. Put technical information into plain language (e.g. medical and legal).
2. Use age-appropriate language.
3. When you make decisions or inform residents of the decisions of others, explain the rationale for them. Don't just say what the decisions are, but say why.
4. Learn to convey factual, non-emotive information succinctly. Be concrete and specific. Vague generalizations don't help very much.

Complex situations

Case management procedures are quite simple. This next section looks at several factors that increase the complexity of the case manager's task. The difficult part of being a case manager is dealing with people in complex situations:

- The resident has multiple problems. (This is normal.)
- The resident might be uncooperative.

- The resident might be unable to help themselves.
- You might also need to work with a resident's family members.
- You might be liaising with a range of other professionals and agencies.
- You might need to advocate for residents who have problems dealing with other services.
- You might have to deal with other case managers that other agencies have assigned to your resident.

Involving families and children

Of those families we can work with, we generally interact in two ways. First, the case manager meets with parents or other close family. We start by learning as much about the family situation as we need to know, and inform them about The_house and our program. Later on, it's mainly about keeping a working relationship, keeping the family supportive, and picking up on any problems or possibilities of miscommunication. We deliberately address any conflicts but it usually takes a year to see any progress.

Second, a supervisor holds larger group meetings with other parents and family members. These are mainly information sessions where we explain why we do things the way we do, and answer any questions. Parents particularly like to know how "the rules" work. Its effect is mainly to maintain a working relationship.

At The_house, we have two kinds of cases involving children: some residents are under eighteen and some residents have small children of their own. The younger ones are very vulnerable and need extra care so we give their welfare very high priority.

We plan interventions with a clear purpose in mind and try to be as unintrusive as possible. We believe that the best way to protect and support children in the long run is prevention and early intervention.

If younger children cannot live with a parent, we try to place them in a positive, stable environment where they can continue significant relationships.

Diversity

At The_house, we only accept residents who speak English well enough to participate in the program. But diversity can still be complicated.

For example, some ethnic residents had trouble getting mainstream services. Polite, white bureaucrats gave them the runaround with good excuses, complicated rules, and lots of forms. Most of them just gave up and left without getting any help.

Dealing with ethnic families can also be quite tricky. They often have their own cultural expectations and don't quite know how to relate to us. Some parents want to punish their children, others are ashamed and want to abandon their children, others just want the children to stay at home and treat it as a private family matter. Some can't see the need, and others simply can't understand what has happened. It's even more difficult if their English is weak.

We also have to navigate their community protocols, sometimes with ethical implications. For example, some family members had decision-making power that I'd never expected. There can also be community politics, gender issues, parenting practice, family dynamics, and belief systems. Consider these examples:

- The twenty-five year old resident is now in detox from speed, and is also the youngest daughter in a large family. According to their ethnic tradition, the daughter should live at home with her parents until she is married. The father is angry that you have "harbored a fugitive," although she wants to be at The_house and was near death when she came in.
- The resident is a minor. The parents have left and the child is in the temporary care of a cousin. The cousin culturally has full authority over the child, but under our state law, she cannot

approve the child's admission to The_house. In other words, she believes she can authorize admission, but legally she can't.

We still have to respond to diversity, and we do extra to make sure those residents get the same treatment as anybody else. Here are four examples:

First, we try to explain our services simply, and we usually have to go over it several times before they get it. We usually have to get someone else to interpret culture or language. Depending on the case, their English, whether we have an interpreter, cultural factors and the resident's stage of recovery, we might say that The_house is a special kind of medical service, a training program, a kind of school, or a place to live with others.

Second, some residents take their case managers to their appointments to speak on their behalf and help with forms.

Third, we have to deal with people of very different levels of ability. We keep explanations very simple for some people who are poorly educated or have a mental disability. On the other hand, some well-educated family members are only satisfied with much more explanation.

Fourth, we found that some ethnic groups had their own associations around the place. Some were very helpful; they linked us to their members and helped prevent all sorts of misunderstandings. We asked them about cultural factors and gave each other referrals. For example, we learnt that some prospective applicants found our building very intimidating, so we did all applicant interviews on their own turf.

In another ethnic group, we adjusted our assessments when we learned that people were very suspicious whenever we pulled out a form and started to fill it in. They expected a personal discussion, so when they saw the form they either stopped talking or gave sanitized answers that would not be embarrassing. No matter what we'd say, they still believed we would give the information to someone else. In other words, they stopped telling us what we needed to know.

Factors increasing risk

You should be able to respond to all the issues in the list below, either by noticing the problem and giving a referral, or by overseeing treatment as the case manager. The_house's treatment approach covers most of them.

Drug related

1. History of combination depressant substance use: opiates, benzodiazepines, alcohol
2. High-risk drug injecting behavior (sharing needles, injecting below waist, injecting pills, buprenorphine (Subutex), etc.)
3. Recently witnessed a fatal overdose or be affected by one
4. Family-related problems
5. Families with multiple difficulties (including family or domestic violence)
6. Child care problems, being the responsible adult for dependent children
7. Codependent relationships
8. Family breakdown

Social problems

9. Homeless or have insecure accommodation.
10. Cultural poverty and unemployment, especially long-term unemployment.
11. Poverty, including poor housing, inadequate and limited educational, health and social facilities, and high risk communities/neighborhoods.

Physical health

12. Any physical condition requiring medical monitoring or treatment
13. Pregnancy
14. Risk of blood-borne diseases; any cases of HIV, Hep B, or Hep C sero-positive
15. Acquired Brain Injury (ABI)
16. ADD (Attention Deficit Disorder)
17. ADHD (Attention Deficit Hyperactivity Disorder)
18. Autism spectrum disorders, including Ausbergers syndrome and mild autism
19. Prader Willi syndrome
20. Disability (including developmental and intellectual disability)
21. Eating disorders
22. Malnutrition

Mental health

23. Mental health condition requiring diagnosis, monitoring or treatment
24. At risk of self-harm
25. Suicidal ideation or intentions
26. Post Traumatic Stress Disorder (e.g. Vietnam veteran)
27. Children of Vietnam veterans (effects of Vietnam PTSD)

Legal and institutional services

28. Problems with government agencies
29. Involved with a wide range of other agencies, e.g. community services, legal, medical and police agencies.
30. Debt, especially credit cards
31. Legal problems: on bail or parole, frequent offenders, involved with protective and custodial agencies over a long period
32. Prison releasees
33. Cultural criminality
34. Educational wounding

Victims

35. Recent trauma such as assault or accident
36. Rape and Rape Trauma Syndrome
37. Abuse, which may be child abuse, serious or sustained violence, or sexual abuse
38. Child protection cases

Other

39. Financial problems
40. Danger to others
41. Age-related special considerations (e.g. children, the elderly)
42. Cases that attract public attention or are politically sensitive
43. Gender identification issues
44. Promiscuity cycle, including prostitution recovery.

Assignment

Go through the list above and mark each one as either:

- Within your scope to treat without help
- Within your organization's scope to treat, but not yours

- Within your organization's scope to treat, but requires your collaboration with others
- Not within your organization's scope to treat; needs to be referred to another organization

Go through the list of factors above and decide how you would manage each one.

Models of case management

Different organizations use different models of a case manager's role for different purposes. Consider these:

1. The *mentor/counselor* meets often with the client to offer personal support and counsel. The personal relationship and time commitment of the case manager is critical. The case manager gains access to other more specialized services when necessary. Changing case managers is possibly stressful for both parties.
2. The *legal representative* sees their main job as implementing the policies and legal obligations of their organization. They do not meet with the client very often and the quality of the relationship does not need to be very good.
3. The *coordinator's* main role is to be the organization's contact person and coordinate a range of services given by other people or other agencies. The coordinator does not to provide any services directly. Their job is done when the client has all the services they need from elsewhere.
4. The *single-line* case manager's only objective is to move clients through a set of steps in a particular order toward a predetermined outcome. Clients only vary in what it might take to complete each step and the speed that they go though the steps. For example, an employment agency might take on clients with the single purpose of getting them suitable jobs, and take them through phases of initial assessment, developing skills, locating job vacancies, and doing job interviews.

In some agencies, medical practitioners case-manage all their own patients. This model can work when residents' issues are predominantly medical and if medical practitioners have some skills beyond medical care alone. It is not, however, well suited for residents whose needs are not primarily medical but behavioral, social, or psychological. In other words, it should probably not be viewed as a model of case management.

While you need to work within organizational and legal guidelines, you can't presume that your current case management system will always work for all your residents. You may need to adapt it to the unique needs of particular residents. First, discuss with the resident and relevant others the outcome you need to achieve and any cultural considerations, then figure out exactly what you need to do to reach that outcome. Finally, if you need authorization for changes in policy or procedure, negotiate it with your supervisor.

It's possible to combine some of the models. For example, whichever model you choose, you may have to offer personal support and counsel. Or your organization might have a single goal for residents.

It is also possible to modify some approaches to case management; for example, some kinds of services could miss out case conferences altogether, although it wouldn't be a good idea in AR.

At The_house, we lean heavily toward the counselor model, but also have a clearly defined objective of AR.

At The_house, we split case management into two separate roles. It changed how we delegate authority *Case managers* are more highly skilled and experienced; they oversee cases and are in charge of making all major decisions. *Caseworkers* do most of the routine work. Regular meetings with residences, and run errands..

We noticed some risks. It would mean that residents will have less access to their case managers. It could create power-plays, and perhaps make mentoring less effective. Some staff wondered if it would overly de-personalize and professionalize the role.

The change suits a bigger organization with more staff and more residents. We also think that, with more expertise, case managers make better decisions, and that it saved senior staff from running routine errands. It has helped new workers in casework because they will have a better training entry point and a better career pathway.

Questions

1. Describe these approaches to case management:
   a. client-centered
   b. evidence-based
   c. holistic
   d. inclusive
   e. strength-based
   f. needs-based
   g. rights-based.
2. National standards for case management
   a. Where can you get a copy of current national standards for case management practice?
   b. Briefly describe the main points.
   c. Which points are most difficult to comply with?
3. What should you do when you and another organization's case manager both want to be in charge of your client?
4. What should you do when a client takes much longer than planned in case management?
5. In some case management models, case managers often work in a one-to-one relationship and make many decisions alone. In other models, case management is primarily collaborative, and case managers seldom make decisions alone. Compare the models based on how collaborative they are.

Assignment 1

Do an Internet search of models of case management.

1. List and explain three models that are different from the one that your organization uses.
2. Case managers handle different kinds of needs and work in different kinds of organizations. Some approaches to case management tend to be more office-based and administrative. Approaches at the other end of the scale are more inclined to mentoring, engaging personal attitudes, and giving personal counseling.
   a. In what kinds of situations would a more administrative approach be best?
   b. In what kinds of situations would a more personal approach be best?
3. Perceptions:
   a. What do case managers perceive their role to be? Do they all have the same opinion?
   b. How do residents vary in their views of what a case manager does?
   c. How do perceptions vary between organizations?
4. Suggest five specific improvements in your organization's case management procedure.
5. Write a one-page best practice guide for AR case management.

Assignment 2

You have been appointed case manager for five residents, and each has one of the issues listed below. Describe what you'd do differently for each one:

- Malnutrition

- Bulimia
- Depression with suicidal ideation
- Acquired Brain Injury (ABI)
- Attention Deficit Hyperactivity Disorder (ADHD)

Assignment 2

During the stages of recovery, workers generally have a very different kind of relationship with residents. For example, while the resident is in the early stages of detox, workers are more like nurses caring for a patient. When the resident is preparing for re-entry back into the outside world, they are often more like colleagues and personal friends.

Your assignment is to interview some workers to make a map of the different kinds of relationship between workers and residents during the stages of recovery. Consider the possibility that there might be more than one kind of staff-resident relationship at the same stage. As a reminder, here's the list of the stages of recovery:

1. Detox
2. Settling in: Adjustment and resocialization
3. Recovery (e.g. groups and homework)
4. Taking responsibility for others at The_house (e.g. leading an activity)
5. Training and education
6. Integration into work.
7. Re-entry: Going back into the wider world
8. Follow-up.

What would you do? #1

You are on call and it's an ordinary Tuesday morning. You get a phone call from Emily, a senior staff worker, about a resident named Tanya. Emily has been Tanya's counselor since she came into The_house.

Apparently Tanya had a brief fling with her brother's friend during weekend stays at her parents' house last year. It got serious very quickly, and Tanya was very clever at keeping it secret. Tanya told Emily that she is now several months pregnant and can't hide it any more. Emily asks you for advice.

What do you say?

What would you do? #2

Shane, a seventeen-year-old, is here on a court order as a condition of bail. He's not allowed to leave and will be sent back to remand if he does.

It's 7.00 a.m. on Saturday morning and you are having breakfast with the residents. You notice Shane isn't there and look out the front window, to see him disappearing around the corner in the direction of the main road. You go straight out and catch him up.

What do you say? What will you report to the court?

What would you do? #3

Sophie's parents have lived on welfare for as long as she could remember. They both have long criminal records so perhaps they couldn't get jobs even if they tried.

Since running away from home at fourteen, Sophie lived on the street or in squats with a series of boyfriends. The last one was the worst; he'd got her addicted to speed and then pimped her. When he beat her up for keeping some of her earnings, she managed to escape to The_house. She is now nineteen.

You have been appointed Sophie's case manager. Describe what you might need to do.

What would you do? #4

Cleo, a speed addict, came into The_house with a four-month-old baby boy. The father had moved out of state and was no longer in contact. Cleo often used her son to justify special privileges and would often lie when questioned. Before long, staff realized it was simply a manipulative ploy to get her own way and that she was an habitual liar.

She had frequent changes of mood and seldom followed through on her promises, no matter how sincere she seemed when she made them. Sometimes she admitted that her life was a mess and said she wanted to really change. She was very convincing. But then she'd have angry outbursts at staff or housemates for no reason, giving the impression that she wasn't making any progress at all. We didn't know whether we were getting through or not.

You have been appointed Cleo's case manager. Describe what you might need to do.

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On counseling

At The_house, every resident has a case manager to give regular counsel, support and pastoral care at their point of immediate need, especially short-term crises. At least for our young people at The_house, it is much better than immediately professionalizing the relationship, which would not work as well. In an earlier chapter we touched upon the role of empathetic listening, and a little about how to hear calls for help.

As a case manager, it's your role to meet regularly with your residents, and to monitor and review their progress. You'll also work cooperatively with the resident's family, any colleagues who are involved, and other services. Before we go any further, we should point out that you are really a first-line counselor, not a specialist. You also need to know that if a resident has reduced brain function, any message might not get through very effectively.[28]

Postmodernism has had a couple of direct effects on counseling. Counselees are led to believe that they and their issues are unique.[29] Another effect is that the change process is often conceived as a journey, and the idea of discovery is usually not too far away.

In most contemporary counseling approaches, the counselor is a facilitator who guides the counselee to interpret their problem, find a solution, and make a decision for change. The strengths of this view are that the counselee takes ownership of their issue and finds their own pathway, and the counselor does not impose a value judgment. Giving advice is often a last resort; more likely, you'll ask them to consider a particular viewpoint or a course of action. In most cases, it's good practice to let the resident set the agenda and be available to journey with them as a caring, fellow human being.

Question

What if the resident's morals are highly questionable and perhaps destructive? How proactive can you be in introducing other values?

A basic counseling cycle

28Currie, Jon. 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

29 This is usually quite untrue, as counselees normally have much in common. However, it is poor practice to "put them in a box" that is, to make presumptions about them.

The basic cycle below will help you to handle most situations you will encounter as a case manager. It has limitations; it leans toward a goal-setting model and probably won't help you handle severe emotional trauma or hurts.

Are you the right person?

Start by checking the resident's assessment and case management plans, and asking questions like these:

- Can your organization help this resident? What are your limitations? Does the resident have social, emotional and other needs that cannot be met? Should they go somewhere else instead?
- Can you as a counselor personally help this resident? Do you have the skills and the time? Should someone else be the counselor instead?
- What are you allowed to do as case manager?

If you are not the right person, check whether someone else on site is a better fit for that particular resident. If you and your organization can't meet the resident's needs, review the case with a view to finding a particular service that can, and then refer the resident.

Make a start

If you start with a new resident, you'll probably want to start by briefly introducing yourself and setting some ground rules.[30] Unless the resident has an urgent presenting issue, it's a good idea to get the resident to tell a little about themselves and about their family.

If they came to see about a presenting issue, ask them about it and give them opportunity to clarify it. Listen actively and positively to them and their thoughts about accepting support. If communication becomes difficult, try again with a different approach.

Explore

Explore the issues, and direct the conversation by asking questions, but don't let the counselee feel interrogated. In the chapter on leading recovery groups, we looked at different kinds of questions:

1. Use *closed questions* to get an initial response when somebody is reluctant to speak.
2. Use *open questions* to get residents to report information.
3. Use *open questions* ask the resident to reflect.
4. Use *follow-up questions* to explore a comment or topic further.
5. Use *lead questions* to open a new topic of discussion.
6. Ask *clarifying questions* when the resident has not explained something clearly.
7. Ask *redirecting questions* to get them back on track when they have skirted past an important issue or are avoiding a sensitive topic.

Open-ended probing questions are more specifically related to counseling. Use them when the resident is having difficulty expressing something, especially feelings, and needs your prompt to go ahead.

You can also use silence if they are finding speech difficult but need time to describe feelings. Lots of talk from you can be a hindrance.

Observe the resident carefully during your discussion. Their story is not just the words they say. Watch their facial expressions and body language. Are they casually leaning back or earnestly dealing with feelings and memories? Is the resident's body language consistent with what they say?

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30 Your ground rules might include how available you are, how often you expect to meet, how long each time, emergencies, and what you'll do if you can't make a planned meeting.

Do they show signs of distress, anxiety, aggression or apathy? Are there signs of dysfunction as an individual or in their relationships?

Going further

If you need to go further than listening, locate and explore the core issues, which might be very different from the presenting issue. You can either seek the main causes of the problem, go deeper into more sensitive emotions, or go into the stories of watershed incidents. Ask about the factors that contributed to past behavior and explore them. Depending on the kind of issue, you might also need to ask your supervisor for advice, or explore any potential legal and health aspects.

Clarify needs

Check with the resident that you have all the facts and that they are accurate. Describe the nature and scope of the issues and get the resident to confirm your conclusions.

Then explain your role as case manager and what you can do to give help and support. If necessary, negotiate for other people to come in, such as the medical practitioner or a specialist counselor. At this stage, you might need to give the resident (and perhaps also their family) helpful information.

Help the resident to set goals and make plans

Encourage and support the resident to work out their own goals and priorities and to assess their feasibility. If it's appropriate, offer the resident further options, but don't impose them or put pressure on the resident. Negotiate if they are reluctant to take responsibility.

It's ideal to choose both long-term and short-term goals but residents in severe emotional distress might need very short-term goals; for them, "long-term" can be a day or even less.

As you go, evaluate the obstacles they face to achieving their goals. If they are pessimistic, give them simple things that they can do to evade the obstacles or to make progress in spite of them.

Either way, after they've chosen suitable goals, your next stage is to encourage the residents to say what they will do to achieve them:

- Prioritize their goals. If they feel that all of them are urgent and absolutely necessary, they will need your help to evaluate each one and assign a priority. Don't forget that achievement of some goals could be a prerequisite to achieving others.
- Choose only those goals with the highest priority so that they are achievable. (They will achieve nothing if they attempt too much.)
- Develop concrete strategies to act on their goals.

Of course, residents don't always get it right. Challenge any negative attitudes and unacceptable objectives. You might even need to re-negotiate their plans. If they make risky choices, explain the risks in a supportive way. If they have unrealistic expectations, revise the goals into something achievable. If their goals are too easy to reach, renegotiate them into something more challenging and worthwhile.

Depending on the kind of issue, the first step will often be some homework. Give the resident something to do so they can feel that they have started making some kind of tangible progress. It might be a question to reflect on, a pattern of behavior to practice, a journal to keep, a person to meet, or a letter to write. Ask how they went at the next meeting; they will be disappointed if they have made a serious effort and you ignore it. On the other hand, don't show disappointment if they don't do the task.

Closing

At the end of the each meeting, check that the message has got through and that they know how to take the next step.

Plan a way to give the resident ongoing support. In a residential facility, you can touch base with them briefly and often. However, you might need to allocate time for another private meeting about this issue, or have a regular time together. You can also hand them over to someone else for more specialized help, as long as you avoid giving the resident the impression that you have dumped them. As their case manager, you will meet with them regularly anyway, and you can ask them if it is going well.

By the way, debrief with a supervisor if you feel you are carrying a load of other people's issues. Don't forget to write counseling notes and file them.

Motivational interviewing[31]

Motivational interviewing is based on the idea that behavior and decisions are based on motivations. To make a decision, one should weigh up the arguments for and against the different options, considering the costs and benefits of each. Residents need to learn this strategy to continue making responsible make decisions, which might be difficult if they have been accustomed to making decisions impulsively.

In a residential facility, residents have already decided to discontinue substance abuse. But to build a new life, they still need to decide to stay clean and to make a wide variety of other lifestyle decisions.

Motivational interviewing can be used to:

- identify and explore existing motivations and feelings,
- encourage ambivalent residents to consider change,
- let the resident become uncomfortable about destructive behavior,
- let the resident become convinced they need to choose beneficial options,
- create direction and purpose, and
- reinforce motivation for change.

As an example, the series of stages below is deliberately intended to guide a counselee to evaluate a particular practice and get motivated to change.

Stage 1

Explore the good aspects of their current behavior with a question such as, "What are the good things about …"

Stage 2

Explore the "not so good" aspects:

"What are the not so good things about …"

"What don't you like about …"

Stage 3

Ask follow up questions to help the resident explore the "not so good" aspects so that they can see how destructive their negative behavior is. You don't have to tell them.

"How does this affect you?"

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31 Based on Ali Marsh, Ali Dale & Laura Willis, 2007, *A Counsellor's Guide to Working with Alcohol and Drug Users* 2nd ed. (Perth, WA: Drug and Alcohol Office).

"What don't you like about it?"
"Could you tell me a little more about that?"
"Could you give me a recent example of when that happened?"

Stage 4

You cannot presume that they are actually concerned about their destructive behavior, so your goal is to find out whether the resident is concerned about the not so good things. You can ask questions such as:

"Does that concern you?"
"How do you feel about that?"
"Is that a problem or does that worry you in anyway?"

However, do not give an opinion about what should be of concern or make a value judgment. Your goal is to help the resident make their own judgment.

Stage 5

Summarize the points you have discussed, trying to be balanced and non-judgmental.

Stage 6

Ask the resident for their opinion of your summary.

Stage 7

Ask the resident to compare their present life with what they would like their life to be like. What goals for their life did they have as a young person? Have they achieved them? Ask how they feel about that. Ask about what they would like to do in the future.

The point is to let them see the difference between what they are and what they would like to be. Finish by summarizing that discrepancy.

Stage 8

The resident is now faced with a decision to alter their destructive behavior. It is their choice and they need to make it themselves, usually as setting some kind of goal. You can then shape it into something realistic that will work in their situation.

Narrative counseling

Narrative counseling uses the resident's personal story as a counseling approach.

Step 1: Make a start

The first step is to establish a personal trust with the resident, and commit to personal friendship. Help the resident to feel free to speak openly, although they usually find it is difficult at first. Before you go much further, decide on a schedule and a non-threatening location.

Step 2: Start where they want

When you are ready to start, start wherever the resident wants. It will probably be the first time they have told their whole story to anybody. However they choose to describe themselves at this stage is the right way, because their choice of starting point will be easy for them and will tell you something about them. For example, they must choose either to include or to omit their family, signaling the role of their family in their thinking.

Many residents choose something easy and non-threatening, such as favorite memories, especially of childhood. The information might be sketchy at this stage, but they will get

accustomed to probing their memory and expressing recollections. Don't interrupt with questions unless they are stuck and need your help to make progress.

If they came to you to discuss a specific need, they may choose to describe the particular issue and describe how it came about.

In their first telling, they might manipulate the story to impress you, justify themselves, lay blame, or seek attention or sympathy. To achieve that purpose, they might exaggerate, misrepresent facts, or conceal inconvenient or unpleasant information. Even if they are quite honest, they interpret the truth according to their perspective or their side of the story. Don't easily believe what they say at face value; it will need verification.

However they do it, telling one's story is often emotionally intense and they will probably replay it over and over in their head after meeting with you. It might arouse unpleasant memories or remind them of past traumas, so do not be surprised if the resident becomes angry, discouraged, or defensive. The stories can be embarrassing to them or those they love. They might include information about other people that you must keep confidential.

Step 3: Add detail through retelling and questioning

It can be helpful to let the resident re-tell the story of significant incidents. They can add detail, insert different perspectives, or reveal inconsistencies. Ask questions so they can explore them.

Getting them to say more about what happened might not be difficult; their challenge is to say how they feel about it. If they try to keep the story to external facts, they might be trying to avoid talking about themselves and what they experienced during those incidents.

Step 4: Issues arising

It is now your role to sensitively help them understand their story and identify the issues arising. You can also discuss their viewpoint and what they should change. They might have already faced those issues by telling their story. The resident might immediately recognize some other issues and admit to them.

However, they might be unwilling to accept some issues that you identify, even if they are blatantly obvious in their story. They might deny their own exact words. Don't let it be a point of tension; let them think about it for a week and then follow up.

You can continue with a narrative approach and get them to create a narrative for their future. Alternatively, you can move on to another counseling approach.

Narrative counseling: How it works

Letting the resident talk about themselves gives you time to build a relationship where they are playing a major role. The interpersonal dynamics may become quite complex. For example:

- What personal expectations do you both bring to the process?
- How might those expectations change during the process?
- How involved do you expect to get in that person's life?
- What about the things they might not want to talk about or lack confidence to discuss?
- Could those hidden areas turn out to be the most important elements?

Incidentally, from the viewpoint of current popular culture, many people currently favor a narrative presentation of information. They might find it easier to tell a story than talk about themselves in other ways.

How they say something can be more important than what they say. They reveal how they see themselves and how they interpret their world, and in so doing define some aspects of their identity. During this process, they interrelate these five elements:

- Their background context, their socio-cultural world.
- Their perspective: their identity, values, mindset and breadth (or narrowness) of experiences that determine how they assign meaning to their story.
- Incidents: the events as they remember them.
- Their context at the time they tell the story.
- Their relationship with you; they may tell you what they think you want to hear.

Telling one's personal story is a reflective exercise. When you ask questions, you stimulate them to learn about themselves and their worldview. Their views can change or crystallize into something new.

Their story is an artificial construction; they select events and interpret them according to their purpose, their hearer (you), and the context. They have most likely never before systematically told them all to one person in one context, so they probably change their stories just by putting them together in one sequence. They can create patterns, gaps, apparent inconsistencies, and problems of chronology.

A resident's memories after events are not necessarily a reliable source of what actually happened. In all honesty, they might manufacture parts of stories by interpreting events from a particular perspective, or by comparing stories and events then generating similarities or differences. They might misremember events, reconcile apparent contradictions, or interpret events in hindsight rather than representing the viewpoint of the past. They can adjust their stories to get a particular reaction from you. Even so, the way they tell their stories tends to very reliably portray their identity and worldview.

Moreover, your questions can set certain directions. The whole process can go in unforeseen directions through the way one story can trigger another. Once you and they have put the stories together one way for the first time, neither of you can necessarily go back and start on a different direction because you may be unable to ignore a pattern that has been established. That is, by committing oneself to one path, other paths can become inaccessible.

As you can't be neutral and objective, your values and methods tend to influence the direction of the story. The best approach is to monitor their effects as they emerge.

Analysis of critical incidents (ACI)

ACI is a way of learning from incidents by analyzing what happened. The process is much like unpacking a suitcase. The closed suitcase might be full but you can't see its contents. By "unpacking," you lay out all the contents so that they are easy to see.

Choose your critical incidents to get maximum instructive value. They can be any kind of interpersonal encounter in which the resident is emotionally engaged and which is potentially instructive. They can be good, not only bad.

Apply ICA selectively, because it doesn't work well for everybody. People vary greatly in their intrapersonal knowledge and in emotional intelligence, so some naturally respond better than others. Some find it quite distressing and cannot handle ICAs very often. Others are adept in defensiveness, blame-shifting, interpreting events from perspectives that are exclusively to their benefit, and remembering only things that cast themselves in a good light. Some simply tell lies if they feel trapped.

Your residents tend to make more progress if they feel they are learning something helpful, and normally resist if they feel you are setting them up for criticism and blame.

A critical incident analysis goes through the key questions below, usually in this order. Under each key question are other questions that can be useful.

Stage 1: What was the context?

Cover the basics: Who? When? Where? Why?

Describe the setting and how the incident came about.

Did the people involved have prior dealings? What else do you need to know that will help to contextualize the encounter?

Stage 2: Exactly what happened in the incident?

Rebuild the interchange; get the facts and put them into chronological order. Describe words, actions, and any non-verbal communications, such as facial expressions and other body language.

Stage 3: How did you feel at each stage of the incident?

Next to each stage of the incident, get the resident to say how they felt or what they were thinking. Don't forget that they might have been concentrating on something else and relatively unaware of the unfolding incident.

Stage 4: What were the personal dynamics involved?

How did the people in the incident respond to each other? Why did they respond the way they did? What different viewpoints did they have? What do you learn by comparing them? What issues and themes emerge? Which are significant?

Stage 5: What were your weaknesses and strengths?

What did you do well? What did you find difficult?

Stage 6: What could you have done better?

Consider the implications and consequences of various options.

Stage 7: What can you learn about yourself?

How do you naturally respond in this kind of situation? Which strengths do you need to build on? Where do you need help with attitudes, insights, habits, seductions, etc.?

Set some personal goals. Consider small projects for homework. (Personal journals work well for some people.)

Question

What do ACI and the narrative approach have in common? What's different?

Problem solving

As a shift worker, you learned a strategy for solving problems. You can work through a very similar set of steps with a counselee:

1. What is the need or problem?
2. What factors make up the situation? (Consider the people and attitudes involved, the counselee's temperament, stage of recovery, group dynamics, location, legalities, risk factors, etc.)
3. Generate a range of solutions that are suitable for the situation.
4. Consider the consequences of each option.
5. Choose the solution that will work.
6. Implement the solution.
7. Follow-up and evaluate.

It works well with out-there kinds of problems. When the counselee's issues are more emotional, they need to go through the steps emotionally, not just logically. They might want to rush

toward a solution or grasp at several solutions. But no matter how obvious and correct the solutions are, they do little good if the counselee has avoided facing their real issues.

Cognitive Behavior Therapy

Cognitive Behavior Therapy (CBT) is a kind of counseling that helps people to change unhealthy thinking habits, feelings, and behaviors. It is used to treat problems such as anxiety, depression, low self-esteem, uncontrollable anger, substance abuse, eating disorders, schizophrenia, and even chronic pain.

It works on the principle that learning to think and behave differently will result in positive emotions, which in turn leads to more positive behavior and thinking. It aims to teach people how to challenge and overcome automatic beliefs, take control of their thought patterns, and use practical self-help techniques to change or modify their behavior. Put another way, clients will tend to change their behavior and feelings by changing from flawed thinking and beliefs to healthy thinking and beliefs. When clients change behavior, their feelings will tend to catch up.

In general, CBT has the following characteristics:

1. As a counselor, CBT is much easier to learn than many other counseling approaches.
2. The counselor and client establish a collaborative relationship so they can work together to solve a problem.
3. CBT emphasizes practical techniques to address problems.
4. CBT empowers clients by giving them skills, and often includes homework.
5. CBT is goal-focused and relatively brief.
6. CBT highly values Evidence Based Practice and scientific testing.
7. CBT does not emphasize lots of talking and long term therapy.

For example:

- A CBT therapist can break a large, intimidating task into small achievable tasks.
- A CBT therapist can teach simple, systematic strategies for making everyday decisions. The new strategies contrast with old behaviors of being afraid into inaction or making impulsive, destructive decisions.
- A CBT therapist can teach someone to write an emotional diary to process their thoughts.
- A CBT therapist can use a series of small steps to overcome a particular fear. (A therapist can start treating someone who fears spiders by taking them into a room where they can see a small, unintimidating spider on the far side of the room.)

Assignment 1

Get permission to sit on a counselor's sessions with several residents. Based on your observation, write a summary of each discussion in the same order it happened. Label each stage and say what the counselor was attempting to do. Debrief with the counselor afterwards. (N.B. The counselor will need to first get the counselee's permission and your notes will be confidential.)

Assignment 2

Do an Internet search of Cognitive Behavior Therapy and write a ready-to-use training manual that would work to teach trainee counselors a set of techniques that they could use with residents. Although it needs to be presented well, emphasize good content.

Assignment 3

During the stages of recovery, residents generally go through significant emotional and social changes.

Your assignment is to interview some workers and residents to make a map of the different kinds of emotional and social changes that residents experience during the stages of recovery. Consider the possibility of a range of emotional and social changes at the same stage. As a reminder, here's the list of the stages of recovery:

1. Detox
2. Settling in: Adjustment and resocialization
3. Recovery (e.g. groups and homework)
4. Taking responsibility for others
5. Training and education
6. Re-entry: Going back into the wider world.
7. Follow-up.

What would you do? #1

Clinton came into The_house as a withdrawn loner. He didn't make friends, and his attitude closed people out.

He was regularly angry and abusive to staff. He tried to protect his independence by claiming all sorts of imaginary rights and protesting any rule that he thought was unfair, which was nearly all of them.

You have tried to get him into a conversation several times. After a series of uncomfortable attempts, he hinted at something in his past, mainly by saying that "it" was none of our business. After several weeks of difficult, evasive discussions, you can see that it had clearly left a serious emotional scar. It seems that he is desperate to be accepted, but is afraid of being dominated and exploited again. His defensiveness shows in his inability to express his emotions. He has a poor self-image and does not expect anything to change. He seems to interpret any opportunity to change as a threat.

You have just been informed that you are now Clinton's case manager. What will you do?

What would you do? #2

Monica is twenty-four and has been a resident for six months. She comes from a nice home and her parents come regularly for visits.

It's 10.00 a.m. on Monday, and Monica's Mom phones asking to talk to Monica urgently. She isn't here (she's helping on a shopping run), but you take a phone message for her. It's a notice that her brother has suddenly died in a car crash.

When Monica gets back, you pass on the message as gently as you can.

Monica is at first stunned and doesn't believe you. She then starts to think about it and becomes distraught. She blames herself. Then she blames you and wants to do leave straight away. She seems to be quite irrational.

What would you do?

What would you do? #3

Seventeen-year-old Tanya has been a resident for eighteen months. She's attractive and stylish, and looks much older than she is. She's knows that men usually respond to her very positively and often uses it to manipulate them.

Tanya has been at a movie with Debra (a staff member) and two other girls. The phone rings and you answer. Tanya was sexually assaulted in the car park at the movie theater; she was grabbed and then groped. She's shocked and crying but physically okay.

What do you do?

What would you do #4

Tommy is still fairly new and a couple of months ago finished his initial no-contact period under close supervision. During this time, he appeared cooperative and Rob, his case manager, had no unusual causes for concern.

On a spot search in his room, you find a wad of money and half a dozen small plastic bags, each with several grams of white powder.

The pattern is then obvious. Tommy has obviously enjoyed his new freedoms and has stretched them as much as he could. While on outings, he tends to wander off very briefly by himself, but not long enough to be counted as missing. He tends to go to the shop to buy things he doesn't really need, and he makes many more phone calls than other residents. He is quite protective of his privacy and his personal property, but not so much that it appears odd. What do you do?

What would you do? #5

Tanya is seventeen years old. Over the last eighteen months, she was placed at The_house on a court order after a conviction for stealing. An habitual liar with a tendency to be a ringleader, she can be rebellious and manipulative.

Debra, a junior worker, was doing some cleaning and found some prescriptions in Tanya's stuff. She thinks they must be forged, as all medications are supervised closely. Debra comes to you for advice on what to do. You are the senior person on duty so it's your call. What do you do?

What would you do? #6

You are halfway through a regular meeting with Andy when he pauses, looks down, and asks, "Can I tell you something?"

It's obvious that he's been seriously thinking about this for a while and that he needs someone he can trust.

For the next forty minutes, Andy offloads some of his burden. He's not completely coherent, but he keeps talking and you keep listening. You're both intrigued and repulsed. Some of it is so dark and destructive that you don't know how to respond.

You realize that you're well out of your depth. According to the rules, you should refer him to someone better equipped, but there's nobody else close by. And you can't just dump him as if you didn't care. What do you do?

Assignments and discussions

Some of these are best suited to class discussions, assignments or assessment interviews. Some might be better as personal reflection questions.

Your organization's counseling approach

1. Explain the specific purpose of counseling in your organization. Is it written down anywhere?
2. How does your organization define what you can and cannot do as a counselor?
3. Does your organization have any particular goals as a counseling organization? If so, are they written down anywhere, and how well is your organization doing at achieving them?
4. Describe the range of typical counselees of your organization. For example, it might be defined in terms of a particular demographic, or a particular kind of issue.
5. Do you bring counselees through a set of distinct stages?
6. What is the place of counseling in the helping services?
7. Describe your relationships with the other kinds of helping services with which you work.
8. What do you do to help counselees set personal goals and progress markers?
9. How does your social context affect the way you do counseling?

Ethics: General

1. What extra ethical requirements does a counselor have when the counselee is a minor (i.e. under 18 years of age)?
2. When does it become unethical to continue with a counselee so that you should refer him/her to someone else?
3. What about people who are a danger to themselves or others? Should they be put in detention by force and against their will?

Ethics: Confidentiality

1. What confidentiality requirements apply specifically to counselors?
2. If a client gives you information indicating they are a danger to themselves or others, do you have to keep that information confidential?
3. What about administrative details? If someone tells you about a procedural problem in the admin of their case, can you discuss that with admin people?

Ethics: Rights

1. What rights do counselees have in the counselor-counselee relationship?
2. How are counselees informed of their rights?
3. On one hand, you need the residents' permission to go into their lives. On the other, you need to be proactive in offering assistance. Where is the balance between these two apparently conflicting duties?

Ethics: When principles raise questions

1. Respect the individual's right to make decisions. But what if they make self-destructive decisions?
2. Informed consent.
    a. What if you don't have full information of all side-effects, benefits, costs and risks?
    b. Will the counselee remember the information you provide?
    c. What about counselees who can't give full informed consent, such as children, people with a mental impairment, those under cultural pressure relating to a social stigma, or those under social pressure to conform to an unfair practice.
3. Benefits should outweigh costs.
    a. Whose view of benefits?
    b. How much "cost" should you tolerate?
    c. If you accept payment for providing a service, how sure can you be that your treatment offers benefit?
4. What about treatments that have harmful consequences? (They are *iatrogenic*.) For example, when treatments can have side-effects, the treatment is only given if the potential benefits outweigh the risks of side-effects. However, some treatments are the result of mistaken notions of human behavior or unacceptable risks and can cause considerable harm. In counseling, some kinds of harm are emotional dependence, manipulation, exploitation, etc.
    a. How can you be sure that your treatments do not cause harm, or that any risks of harmful effects are acceptable?

Ethics: Relationships

1. How intimate can you be in a counseling relationship?
2. As a counselor, where is the boundary on how much should you reveal about yourself?
3. How much physical contact is permissible between a counselor and client of the same gender? Of opposite gender?

4. If two people are in a counselor-counselee relationship, what other kinds of relationships may they have? (For example, could they share a house in residential recovery?) What ethical requirements of a counselor apply to those other relationships?
5. What kinds of counselor behavior can counselees easily misinterpret?

Counseling roles

1. Describe the counseling roles of:
   a. A case manager
   b. A counselor
   c. A chaplain or pastor
   d. A clinical psychologist
   e. A psychiatrist
   f. The general "people-helping" role of a worker who is not one of the above.
2. What is the difference between those counseling roles?
3. Which of them need licensing or professional registration in your jurisdiction? Which don't?
4. Which of them need special insurance cover? Which don't?
5. How does counseling evolve as a helping relationship?
6. Define the ethical difference between a counseling relationship and a non-counseling relationship (e.g. case manager/shift worker)? Is there a gray area between those kinds relationship?
7. Case managers do lots of frontline counseling, but are usually not trained as specialist counselors or clinical psychologists. What is the limit to what a case manager may do as a counselor?

Kinds of counseling

1. What is the difference between crisis counseling and other counseling?
2. What are the basic procedures of crisis counseling?
3. What are the basic procedures of mental health first aid?
4. What are the basic procedures of grief counseling?
5. What is the Kübler-Ross cycle? How is it applied in grief counseling at each stage?
6. Is professional psychological counseling more effective than peer counseling from recovered addicts? It is already clear is that peer counseling from recovered addicts is highly beneficial. It isn't as clear whether professional psychological counseling actually makes a difference. The answers are not yet final, but consider these possibilities:
   "Yes, it is very effective for all residents."
   "Yes, it is effective for residents with a psychiatric condition."
   "Yes, it is effective but only if we also have peer counseling from recovered addicts."
   "Yes, it can be effective but results are quite variable."
   "No, it isn't very effective at all."

Counseling records

1. What records do you have to keep? What must be included in them and what may not be included?
2. How long do you need to keep them?
3. In what circumstances might they be necessary?
4. What are the legal requirements regarding notes?
5. What are the requirements of your relevant professional association?

Counseling in case management

1. What are the observable signs that a client has something amiss (e.g. substance use, mental health, family issues)?
2. What does the counselee's body language tell you about their attitude to you and to counseling?
3. What are the main indicators of stress?
4. What steps can you take to alleviate stress in yourself and in clients?
5. How can case managers change clients' behavior? Describe three different models/approaches for doing so.
6. Well-being is often termed "recovery" in AR studies.
    a. What is well-being? Define it in terms such as psychological, physiological, social, economic, and spiritual.
    b. How are the different conceptions of well-being used to give and adjust treatment?
    c. What are the different levels of well-being? How do different ideas of well-being affect treatment?
7. What does the counselee's body language tell you about their attitude to you and to counseling?

Assessing family situations

1. Explain how to do an assessment of a resident's family situation. It should have a procedure or structure (i.e. not *ad. hoc.)* and should include the dynamics of family interactions.
2. What kinds of notes do you keep?
3. Why do you use this kind of assessment?
4. What kinds of things to you need to look for during assessments?
5. What kinds of things need urgent attention?
6. What kinds of things can you safely ignore (for now anyway) or put on hold?
7. Of the kinds of things to you need to look for, what do you do about each one?

Therapeutic teams

1. Describe a therapeutic team for addiction recovery.
2. If you work in a therapeutic team, describe the role of each team member and how the team members work together.

Theories of psychology

1. Describe three different theories of psychology that are currently used to support counseling. Evaluate each one in terms of its relevance to your organization's counseling model.
2. Describe the psychoanalytic, behavioral, humanistic, and cognitive approaches to counseling.
3. Who is the main proponent of each approach?
4. Describe the relevance of each to social welfare work.
5. Evaluate each one in terms of its relevance to your organization's counseling model.

Stages in human development

1. Describe the stages in human development as they relate to your organization's counseling model. In particular, mark the major watersheds and explain how they affect counselees.
2. Explain the central features of each of the following theories of lifespan development: Constructivism, Attachment theory, Jean Piaget, Lev Vygotsky, Erik Erikson, Lawrence Kohlberg.
3. Explain how the theory of lifespan development relates to the practical care for clients and how it relates to your organization's counseling model. In particular, mark the major watersheds and explain how they affect counselees.

4. Draw up a table with three columns:
    a. The first column is for the stage of development: Pre-natal, Infancy (birth to 1 year), Toddler (1 to 2 years), Early childhood (3 to 9 years), Early adolescence/ preteen (9 to 13 years), Mid adolescence (13 to 15 years), Late adolescence (15 to 18 years), Early adulthood (19 to 25 years), Middle adulthood (25 to 69 years), and Old age (70 and over)
    b. In the middle column, list the key factors that can impact on the individual during that stage of development.
    c. In the right column, list their potential effects.
5. Fill in the boxes, considering each of the following domains: social-emotional (psychosocial), cognitive, physical, and moral. Include enough detail to be a useful guide in practice. Be prepared to explain your table to your assessor and to answer any questions that he/she might want to ask.

Psychological approaches to human behavior

1. Describe the views of B.F. Skinner and explain their relevance to counseling.
    a. Describe an example from counseling practice where it is useful. Explain your answer and the factors that were critical to success.
    b. Give an example from counseling practice where it is *not* useful.
2. Describe Piaget's view and explain its relevance to counseling.
    a. Describe an example from counseling practice where it is useful. Explain your answer and the factors that were critical to success.
    b. Give an example from counseling practice where it is *not* useful.
3. Describe Cognitive Behavioral Therapy and explain its use in counseling.
    a. Describe an example from counseling practice where it is useful. Explain your answer and the factors that were critical to success.
    b. Give an example from counseling practice where it is not useful.

Personality theory

1. Describe each of the following and explain its relevance to counseling:
    a. The views of Jung and Rogers.
    b. Hyppocrates' four personality types (Sanguine, Choleric, Phlegmatic, Melancholic).
    c. Myer-Briggs conception of personality types.
2. Describe three examples from counseling practice where each approach is useful. For each example, explain your answers and the factors that made it useful.

Counseling in addiction recovery

1. How should you respond to professional counselees? They have already had lots of counseling, now derive some kind of pleasure or energy from it, and use it as an excuse to avoid making real changes in their lives. In a few cases, they have mastered the jargon, or become emotionally dependent on counselors.
2. Some counselees are habitual liars or professional counselees. Others rationalize serious inconsistencies in their lives. Why should you be empathetic when counselees are deceptive, evasive, manipulative, or defensive?
3. Some counselees find trust difficult, but, underneath, are desperate for help and emotionally fragile. How do you approach these people?
4. In a residential program, counseling can be very directive, that is, it takes on a confrontational aspect. (In old-fashioned language, it is giving "rebuke and correction.")
    a. What situations are suitable for being directive with counselees?
    b. At what point does directive counseling become bullying?

c. What are the potential beneficial and harmful effects of directive counseling? How do you ensure that is will be beneficial and not harmful?

5. Imagine an ordinary tin can lying on the table. From a side viewpoint, it has a rectangular outline, but, from an end viewpoint, it has a round shape. This is perspectival truth; the truth depends completely on one's viewpoint.
   a. What kinds of human situations need to be viewed this way?
   b. In what kinds of human situations is it inappropriate. For example, it can be a manipulative ploy to justify one's own viewpoint.

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Case management supervision

As a senior case manager, your role will normally include the supervision of caseworkers and junior case managers. This involves taking a leadership role, ensuring the quality of case management, disseminating information, and giving advice.

You will need experience as a case manager in AR because you will need to advise your staff when they get stuck. Make sure that, in the terms of appointment, your line manager is a senior manager, normally the CEO unless your organization is very big, in which case it should be the head of the site. This can be necessary when case management becomes very political and you need to navigate difficult pathways between competing interests.

Unless you've had experience in a case management team, you might feel a little overwhelmed at first. Evaluate your skills by consulting with peers and senior colleagues, and keep looking for areas where you could improve.

Standards

Your first role is the check that your organization has suitable case management standards. If it doesn't, it will be your job to research and write them. This will be very easy if you keep them simple and practical, and involve your staff in writing them. Of course, they need to be consistent with professional standards, the goals and work patterns of your organization, and any legislative requirements.

You will then need to promote them to your staff, so that everybody knows what is in them. People tend to forget and need reminding. One of the best approaches is to cycle through them regularly in staff meetings so that the whole team is reminded what they say and can change procedures that are out of date.

Decide on a strategy for continual improvement and integrate it into your work systems. At The_house, we simply discussed our cases in team meetings, identified what we learnt from the most difficult cases, and made any necessary changes to our systems.

We also used our staff meetings for training so that the whole team kept current with accepted best practice and changes to legislation, policy, and procedures. Perhaps if we were a bigger organization, we'd need to pull people out and have seminars or reading files, but we're a small team and this is very effective for now.

Supporting your staff

The most obvious part of this role is to meet regularly with your staff. The meeting can be very brief if you meet often, the staff member is doing well, and cases are quite routine. A quick word and a glimpse of their case notes might be adequate.

Otherwise meetings will need to be a little longer. Go through their case notes and give them feedback. Check that their casework plans and actions are up to date, based on evidence, follow procedures, and meet all requirements.

Affirm them in what they do well. They need to feel that you are supporting them in their role. You also have the opportunity to advise them on ways to do better and give direction. As you go, you should refer back to the standards of practice, so that your staff members meet the standards.

It is your role to give your team members support, direction, and advice. In most cases, it will be a brief question and answer in the corridor. In some cases, you will need to give personal encouragement and support; their needs might be primarily emotional.

In other cases, you will be asked to explain who is responsible for what. For example, "What the case manager is responsible for and what is at the counselor responsible for?" "What is or organization responsible for and what is an outside service provider responsible for?"

Check that all your staff are keeping their case plans and schedules up to date and correct. In particular, check that case plans are based on evidence, and are actually being used. Challenge staff if necessary, because case records can be used as legal evidence.

When team members come for advice, look through their case plans, draw your own conclusions, look for different options, and give feedback and advice. In most cases, you can present solutions that are clearly within existing procedures. In other cases, you might ask them to get more information so you can make a better decision. Monitor their progress and recommend any necessary changes to get the best results.

Your staff will probably vary on how much they are willing to ask for help. For those who ask too often, your role is to encourage them to be more independent and confident. If they need advice but don't ask for it, your role is to intervene as tactfully as possible and help out.

If you also get out of your depth, consult someone with specialist expertise to create options for future action.[32] (Alternatively, you can train caseworkers to do so.) Your choices in order are:

- Ask someone else in the organization who has that expertise
- Discuss it as a group of case managers
- Phone a friend in your personal network of AR professionals
- Check the professional literature, including industry standards
- Pay for external advice.

Your role includes giving advice on complex cases. Accept your limits. It's that familiar ethical principle: Don't work beyond your level of expertise. You don't have to master every specialization; you only need to have effective case plans. Be willing to find other experts from whom you can seek advice and information. If an issue is beyond your role or expertise, refer it to a relevant specialist or your manager.

If you think that a staff member is struggling in some way, your meeting will need to be longer. Some staff won't ask you for help no matter how much they need it, and might believe they are doing well. Some will be completely stuck. Some will do adequately but could do better. Some will have residents who face major turning points in their lives, and they should ask advice even if

32 Most organizations have a procedure for this kind of consultation, although phoning a friend is not in the list.

they are doing very well. Some might involve risk.[33] (Despite their strengths, our case managers at The_house are generally not so good at keeping case notes.)

Some hints:

1. If a complex issue arises, make an appointment to give you enough time to discuss it.
2. Some legislation, policy, and procedures are too obscure, complex, or frequently updated for most staff to maintain mastery all the details. Keep up to date so that you can explain them.
3. Consider getting your team members to collect more information, and then use it to improve your procedures for the whole team.
4. Have a strategy for team members to consult with other caseworkers. This is especially important when dealing with cultural patterns among minority ethnic groups.
5. When appropriate, refer matters for discussion in a staff meeting, where you can help team members to reflect on their practices and to explore ethical questions that arise.
6. Use any advice you get, not just to handle the particular case, but also to improve your systems and practices.

Improving and training

As a supervisor, you are integral to the professional development of your staff and the quality of case management. Your one-to-one meetings with them should help them develop their individual reflective skills. In other words, ask lots of open-ended questions so they can think through topics themselves and understand themselves better.[34]

Keep an up-to-date development plan for each of your staff so they can improve their skills and perhaps work toward a promotion. They need to see it as something that is helpful and useful, not as some kind of cumbersome or heavy-handed bureaucracy. On-job training can be very successful.

Your case management team should meet as a larger group.[35] Use it to hold case conferences and discuss questions on difficult cases. You also need to keep your team up to date on case management best practice, ethics, legislation, recent court precedents, and your organization's policy and procedures. It might also be necessary to further differentiate between the responsibilities of staff and the organization.

Practice standards

Your role includes developing practice standards and promoting them to your staff. In the simplest cases, your staff meeting looks for ways to improve on current case management practices, record them in your minutes of the meeting, and then check that staff are implementing them. In bigger programs, it might involve:

- revising polices, procedures, and documentation templates,
- consulting more widely
- getting board approval
- including them in formal program evaluation systems, and staff management systems

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33 You are entitled to require changes if the matter is critical, for example, if the resident is put in danger or your organization could be sued for negligence.

34This is called Socratic questioning.

35A word of caution. If people like the meetings and find them beneficial, they might gradually become very long. However, these are expensive and probably inefficient. To find out how expensive, count the hourly wages for all the people who regularly sit in the meeting over a year.

Assignment 1

Write a 2000 word review of current literature on the theory and practice of case management and supervision.

Assignment 2

What are the differences between "high quality" and "low quality" case management? How could you determine the quality of case management in an organization?

Assignment 3

Reflect on your own supervision and evaluate it by consulting with your peers and senior colleagues. Make two lists: a list of areas for improvement, and a list of your opportunities to learn more about supervision.

16
Professional development and clinical supervision

As an independent professional, you need to be able to sustain your professional effectiveness. This involves creating and managing your own Professional Development (PD) plan and participating in Clinical Supervision (CS). These two kinds of activities overlap considerably, and in some circumstances might be the same. In fact, CS can also be called Practice Development, Practice Reflection, Professional Supervision, or Supervised Field Education. This bridges the gap between CS and PD.

What do you need to learn?

Start by identifying your own needs. Your personal reflection can be helpful, and you can also ask other staff who have similar roles to you. Consider these questions:

1. What have you already achieved? What skills and knowledge did it involve?
2. What are your strengths?
3. What could you improve? What skills and knowledge do you need?
4. What are you curious about? Do you already have ideas about what you'd most like to learn?
5. What has your professional reading been telling you?
6. Have you been thinking about big-picture issues that affect your work?
7. Have you had a series of difficult cases and are not sure how well you responded?
8. Getting tired? Do you want a refreshing a new direction?
9. What do you need to maintain your well being as a practitioner?
10. What positive and negative effects has your job had on you?
11. How vulnerable are you to accumulated latent stress?
12. What are your personal values? Which of them are challenged by your role?
13. What are your personal goals as a professional? Do you have particular career goals?
14. How do your values and goals fit with your professional objectives? With your codes of ethics?
15. Are your values and goals consistent with your work?

Professional Development[36]

PD normally works off a written plan, and you should take the initiative to decide what to put in it. A PD plan needs enough details for you to evaluate whether or not it is effective. The outline is usually as follows:

1. Your name
2. The dates it commences and concludes
3. A statement of your main goals or career objectives
4. An implementation plan with specific activities that will help you reach your goals and maintain your professional well being
5. Any strategies to improve coherence and manage areas of conflict.

Start your planning by identifying your main goals and deciding how long the plan should go.

Then consider possible options for activities that suit your main needs. You would be wise to start by asking other professionals in your professional network for their advice and ideas and about available activities. Many kinds of PD are free; in some places so many good activities are free or nearly free that there is not enough time for any others.

Professional Development includes almost any intentional activity that helps you to learn. It can include study for further qualifications, CS (see below), informal training programs, specialized reading projects, research groups, writing projects, short courses, training sessions, meetings with visiting experts or practitioners, field visits, etc. It can include network meetings with professionals within and beyond your own practice area. If you are teaching a college course for the first time, your preparation could be so challenging and time-consuming that it is your main professional development.

Write your plan and keep accountable to your own goals. Besides, in some organizations, the quality assurance people might want to see it and ask how effective it is.

Your PD has to sustain your professional effectiveness. Put what you learn into practice and ask whether it works. Then frequently review your PD plan and make changes if it doesn't work.

Clinical supervision

As a senior practitioner in a therapeutic service role, you will participate in structured Clinical Supervision (CS). If you work as a team, your organization might already provide it as part of its duty of care to prevent brownout and burnout.[37] In many cases, however, you will need to be able to initiate it yourself.

CS is a regular meeting with one or more other professionals to discuss casework in a structured way so that participants can learn from their experiences.

Although different people have different needs at different times, the purposes and benefits are broadly as follows:

1. Professional Development and education: staff improve their skills and increase their confidence.
2. Staff have personal and emotional support, including the opportunity to debrief stress and transferance issues.
3. Services are effective, ethical, safe, evidence-based, and appropriate.
4. Services comply with professional and organizational standards.

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36 See the section on Professional Development in Chapter 2. The main difference in this chapter is that, as a senior professional, you are now more autonomous and need to be able to initiate it yourself.

37If so, you should have some kind of input from the wider AR sector to avoid becoming ingrown and insular.

5. Diagnose and treat the most difficult cases, essentially becoming a kind of case conference.
6. Reflection and evaluation of practice, both at individual and program level.
7. Set goals and solve problems.

The term "supervision" is not a used in a management sense; the supervisor and supervisee are often peers. If you are a student in a group with more experienced professionals, you might need to learn to see yourself as a peer professional. You will need to learn when to ask questions and when to listen, and how to view the strengths and limitations of others.

CS can take various forms. The supervisor can be either external or internal to the organization. CS meetings can be a group or a one-to-one. The supervisor could be a peer or could be much more experienced. It can be either scheduled or unscheduled; it is good practice for CS to follow a schedule, but you might also need unscheduled meetings from time to time.

Initiating CS

Many community service organizations do not arrange CS for employees and might not even have a policy. You need to be able to initiate CS arrangements yourself.

Finding supervisors is probably easier if you already have a good professional network. Of those available, you need to find one that is right for you. Compare your learning, experience and area of practice with those available. But don't look for someone who is just like you. While you wouldn't want someone you really don't like or whose views are quite incompatible with yours, you might learn more from someone who isn't exactly the same as you.

Meeting with your supervisor

In your first meeting with your new supervisor, tell them about your goals and expectations of CS. Make a formal written agreement that includes goal-setting and timeframes for supervision. It should say when, where, and how long sessions will go, and what will happen in them. Confidentiality of personal information is obvious but essential. The supervisor should keep records of when, where, and how long meetings went, including missed meetings.

Are you effective?

Use supervision to evaluate your practices and techniques and find ways to improve. While you can follow the lead of the supervisor, you also need to initiate opportunities to learn.

Expect to prepare for CS meetings. Keep records of your personal growth and professional learning, such as observation and reflective notes on cases, a reading journal, writing projects, or a journal of questions and ideas. Then put what you learn from supervision into writing, although this can vary according to your practice needs.

Some sessions take a more academic tone. You can use sessions to discuss current clinical literature, professional research, and program evaluations on the topics you most need. For it to be useful, you'll need to reflect on how to apply it in real situations. Some topics have specific legal and ethical implication that you should explore.

Most sessions, however, are given to discussing the difficult aspects of existing cases, analyzing yourself, and evaluating your responses to residents. Then put what you learn into practice, evaluate how it went, and bring it back to CS for discussion. Ask for feedback, both positive and negative. It can be difficult to respond to comments appropriately if you don't like them, but it is better to accept them and think about them. Consider these possible reactions:

- You find some positive comments very encouraging.
- You might give them thought then discard them; they were a mistake.
- You might dislike some comments, but find them very helpful after thought.
- Some might fire your imagination into new ways of thinking and new avenues of inquiry.

Assignment 1

Research current best practice and describe it as a coherent whole. What are the most likely future needs and trends? Explain your answers.

Assignment 2

Write a plan for your own professional development according to the instructions above.

Assignment 3

Consider these six different activities: Professional Development, Clinical Supervision, case conferences, general staff meeting, consultation on workplace health and safety, and the supervision of caseworkers and junior case managers. Although you still need to cover all these bases, you shouldn't unnecessarily multiply meetings.

1. To what extent do these activities overlap?
2. To what extent do they need to be kept in separate meetings?
3. How many can be safely and ethically combined into one meeting to have the minimum number of meetings? Explain your answer.
4. A very small organization would like to do all these activities in one staff meeting. Is this feasible? If so, under what conditions?
5. How do you ensure that you get optimal value for the time spent in meetings?
6. How do you set reasonable limits to the length of meetings?

Assignment 4

You are invited to lead the next supervision meeting of five senior AR case managers, to be held in two weeks time. Write an agenda for the meeting, and explain your criteria for success.

Hints: You might like to have a set of questions or hot topics for discussion, get participants' questions beforehand, have a PD activity that everybody in the group needs, or focus on personal reflection.

Assignment 5

Write a 2000 word review of current literature on concepts of conflict and cohesion in professional practice when working with complex issues, how these manifest, and how they can be managed and minimized.

Assignment 6

Write two case studies of 500-1000 words each show how critical thinking and problem solving techniques are used to analyze complex and conflicting information.

Assignment 7

Write a 2000 word review of current literature on current and emerging theories about professional practice and clinical supervision in area of work.

Questions

1. What kind(s) of clinical supervision do you use in your organization? How well does it work? What would you improve?
2. What factors should you consider when preparing for supervision?
3. What sources of professional support are available to you?
4. In counseling, what is transference and countertransference?
5. Explain the different communication modes that can be used in different kinds of clinical supervision.

6. What ethical guidelines apply to CS?
7. How much CS should people have? (Recommendations range from at least one hour every two weeks to one hour each month.) What about part time staff?
8. When should staff have more than the minimum?
9. What are the strengths and weaknesses of holding CS internally in the organization?
10. What are the strengths and weaknesses of having external CS?
11. How much homework is reasonable?
12. Should CS focus on client issues or on practitioners' personal issues? Or are both necessary in some kind of balance?
13. What training is recommended for clinical supervisors?
14. Compare two codes of conduct relevant to AR (e.g. social work, counseling, case management). What is the same? What is different?
15. How do the following ethical considerations apply to clinical supervision in organizations? In individual practice?
    a. continuing professional development
    b. possible compromise in duty of care
    c. ethical dilemmas in practice and processes for ethical decision-making
    d. human rights
    e. practitioner client boundaries
    f. confidentiality and disclosure
    g. records management
    h. stress management
16. How would you recognize the need for unscheduled supervision?
17. Explain each of these requirements for professional wellbeing:
    a. work-life balance
    b. emotional wellbeing
    c. physical wellbeing
    d. personal skills.
18. What is current best practice in your area of professional practice?
19. What trends in skills requirements are emerging in your area of practice?
20. Explain how to:
    a. Create a personal development plan
    b. Set personal goals
    c. Set realistic timeframes
    d. Measure progress and performance.
21. Your analysis of your values, goals, current practice must be "evidence-based." What comprises "evidence"?
22. What kinds of personal and professional development opportunities and options are available to you? How can you access them?
23. What kinds of work and practices can improve your personal performance?

17
Continual improvement

As a leader in a community services organization, you'll get the task of managing quality assurance to maintain the standard of service outcomes. The first stage of this is to review your program and implement improvements.

Here's what happened at The_house: In the beginning, program quality was not really an issue. We were all absolutely committed to doing the best we possibly could. We thought we could do better than other programs, and we often did. We made mistakes and learned as much as we could from them. I have to admit, though, that sometimes we didn't even realize that we'd made a mistake at the time, so some of our lessons came from hindsight.

Making changes was fairly simple. Anyone with a good idea could go to Amanda, the Director, and she might make a decision straight away. It was a lot about getting Amanda to say "Ummm, yeah. I think so. Let's do it."

Sometimes she'd take it to the staff meeting and we'd toss it around. As Amanda was a strong leader, she'd usually sum up the discussion and make the final decision. And while we were small, it worked very well.

But The_house became something bigger. Our staff become more experienced, and some of them did formal training. The decisions became more complicated and we found we didn't really know as much as we thought we did. The old way started to look quite haphazard. Besides, some of our most talented staff left after they saw ways of making major improvements but couldn't get a hearing for their ideas. They were very tactful and discreet, but they needed to find somewhere else where they could grow.

Amanda also found it more difficult to be sure that she'd made the right decision over a wider range of increasingly complex specialist skills. She was good at taking advice, but we needed a better, more systematic approach.

We started a continual improvement system with two strands: a review-and-improve cycle and a way of proposing and deciding on changes.

Managerialism

Managers generally impose their own kinds of values on organizations, such as effectiveness, efficiency, budgeting, Key Performance Indicators, policy, and the division of tasks into the most effective groupings. This is sometimes known as "managerialism." Consider this example:

Susan and Sam worked in a major AR clinic. They were highly committed to providing good care, and were not interested in becoming managers.

When the clinic became bigger and more complex, the owners decided to hire Jeff, a professional manager. When Jeff started, he listened carefully to all the staff and learned as much as he could about how the organization worked. He saw various problems and decided to resolve them. Most staff members agreed with his interpretation.

At first, people liked the changes. As things became better organized, it was a less frustrating place to work. Schedules were clearer and put up further in advance. Some vagaries in responsibilities were resolved.

Susan and Sam could see the benefits, but soon disliked many changes. First, Jeff was not a medical person, so they believed that he could not really understand how the clinic worked. Second, they did not like being accountable for expenditures. They reasoned that they should be free to spend money if it was for the patients' benefit. Third, they did not like the time limits that they often had to work with.

In short, they believed that Jeff had turned medical care into a commodity by lowering the standard of care and de-humanizing their patients.

Your questions

1. Is care a commodity that consumers can buy? Explain your answer.
2. When is professional management a necessity?
3. When is professional management problematical?
4. What advice would you give Jeff?
5. What advice would you give Susan and Sam?

Task: Minimum compliance

Does your organization meet all its minimum compliance requirements? Make a list of requirements and standards that apply to you. Ideally, you already have them all on file close by, but check anyway. You should also check for any other relevant external service and industry standards. Examples are:

- Legal/legislative requirements
- Licensing and accreditation requirements
- Professional association standards
- Existing quality assurance standards
- Service guidelines and policies
- Occupational health and safety standards
- Guidelines of funding bodies.

When you have a full set of relevant standards, check your compliance and write the results of your check. If you have any borderline cases or non-compliances, make a list and say what you will do about each one.

How effective is your organization?

If you state your service's goals and objectives for clients, you can use it to design criteria for evaluation. For example, here's how it looks for The_house's residents:

Stage of recovery	Evaluation criteria
Settling in	Successfully adjusted and fitting in socially; ready for a Team Leader
Recovery	Successfully completed the recovery course; ready for increased responsibility
Increasing responsibility for self and others	Successfully taking responsibility for self and for others; ready for training or education
Training and education	Successfully completed a course of training or education
Transition to employment	Increasing practicum and perhaps some paid work

Our list for graduation is as follows

1. Complete abstinence from the substance of addiction
2. Emotionally well and stable
3. Good relationships
4. Good behavior
5. Moral and spiritual health
6. Has a beneficial set of life-goals and the means to achieve them
7. Good teamwork skills
8. Developed leadership (as able)
9. Equipped to make good choices, including avoiding harmful circumstances
10. Takes responsibility
11. Keeps good physical health
12. Ready for employment, study, or other occupation
13. Minimal risk of reverting to former behaviors

And here are the criteria for follow-up surveys of our graduates:

The_house's definition of recovery	Evaluation criteria
Complete abstinence from the substance of addiction (not just reduced harm)	Complete abstinence from the substance of addiction
Emotional healing	Emotionally well and stable
Social readjustment	In good social environment, good relationships
Behavioral change	Exhibits behaviors learnt at The_house
Moral and spiritual health	Has good moral and spiritual health
Having a beneficial set of life-goals and the means to achieve them	Has a beneficial set of life-goals and is working towards achieving them
Developing their teamwork and leadership abilities	Good teamwork skills Developed leadership (as able)
Being equipped to make good choices, including avoiding harmful	Makes good choices, including avoiding harmful circumstances

circumstances	
Being equipped to take responsibility	Takes responsibility
Physical health	Keeps good physical health
Preparation for life after recovery	Suitably employed, studying, or other gainful occupation
Minimal risk that residents will revert to former behaviors.	Minimal risk that graduate will revert to former behaviors.

Client feedback

You need an ongoing way to get feedback from all your residents. Here are some of your better feedback options. First, collate the observations of staff members. It is easy to observe residents, even when other ways won't work. Second, talk about it with residents. (called *focused interviews*.) Third, hold discussions with groups of residents to review the program (called *focus groups*). Fourth, check any complaints that residents have made and use them as feedback. (Senior residents were quite helpful, but we had to ignore some habitual complainers.)

The challenge is to cover *all* your residents. You have several ways of doing so. You could get information on every one of them. This is easy for some kinds of data (e.g. observation), and very difficult for others. In a large program, you might get information on a sample of residents that is big enough and random enough to represent them all. This is also usually fairly easy.

You can also use feedback forms that have open-ended answers, but you probably won't get useful answers, especially from residents with behavioral issues.

Multiple choice feedback forms are not always very useful. They are sometimes sarcastically called "happy forms" because they often do little more than ask: "Are you happy?" Lots of organizations use them because they are quick and easy to use for both staff and clients, keep a paper trail of feedback, and are easy to convert into statistics. But they are often unreliable because people tend to give minimum answers with little thought, and tend to be either overly optimistic or pessimistic.

Feedback from other parties

You should get feedback from lots of people who aren't residents but are also stakeholders in the program. These might include carers and significant others of residents, your management committee, funding bodies, staff, and volunteers.

While you're at it, try to get input from community members, experts and other professionals. Again, there are various ways to get this kind of feedback (personal or telephone interviews, etc.)

Effects on residents

Investigate the effects of services on your residents and document them. A simple way to get information on *all* residents is to look through your existing resident records and find out what they say. It's probably all in the files if you have goal-directed care and you keep written records.

Be cautious in attributing success or failure to your program. It might not be a direct cause-effect relationship:

- People naturally change and mature over time anyway, so some good outcomes might not be the result of your program.
- You might have made mistakes in admitting some people who should not have been admitted.
- Some residents might have improved despite flaws in your program.
- Some residents might have done badly no matter how good your program is.

- Your program might have changed during the time period of the evaluation. Consequently, good or bad outcomes might not represent your program as it is now.
- It can be difficult to see a big picture in a smaller program; you only get a picture of a small number of individuals.
- People who know they are being evaluated behave artificially to make the program a success. This can warp your assessment of outcomes. (Called the Hawthorne Effect.)

Review resident service outcomes

By collating the above kinds of information, you should be able to see a clear pattern emerge, a summary of which is your conclusions.

Telling people

Have some way of informing residents and stakeholders of the results of the evaluation. Members of the public and most operational staff simply want a brief-easy-to-read summary. Some Board members and senior staff will need access to the full text.

We did all this at The_house, and here's a summary:

Evaluating The_house

1. We didn't have many minimum compliance requirements, and easily met those that we had. The main value was that we'd compiled a list of them.
2. We gained feedback quite easily:
   a. We collated the observations of staff.
   b. We discussed our effectiveness with senior residents and generally found them to be quite insightful.
   c. We discussed program effectiveness in our routine meetings with residents' parents and families.
3. Getting comment from the wider community was a little more difficult. We discussed current trends with some experts and it was helpful, but didn't necessarily suggest many ready-to-use improvements.
4. We mainly asked questions about the effectiveness of the program, but also asked staff about their long-term job satisfaction, because we know how easy it is for them to burn out.
5. We went through resident's records to look at their personal goal-setting and achievement. It took lots of boring work and we stopped as soon as we had a good sample.
6. We wanted to see how far through recovery residents went and how long they stayed in the program. We looked at retention rates and causes for dropouts. It wasn't straightforward; some residents graduate sooner than others do, so someone could stay in the program longer than someone who graduates, but then still not graduate.
7. We eventually decided to measure progress through our defined stages of recovery, with follow-up surveys taken at one, two, and three years after graduation. We didn't need to create comparative data with other programs. This is what it looked like:
   a. Settling in
   b. Recovery
   c. Responsibility for self and others
   d. Training and education
   e. Graduation
   f. One year after graduation
   g. Two years after graduation
   h. Three years after graduation.

8. When getting information on graduates, we considered asking about occasional drug use, but how often is "occasional"?
9. If they'd died, we'd ask about the cause of death, but nobody had.
10. How firm is the data on graduates? For example, they could say whatever they thought we wanted to hear in a telephone interview. Eventually we decided that we'd differentiate between categories. "Unconfirmed" meant that we'd got a response from the former resident. "Confirmed" meant that another credible person had confirmed it.

Results

1. The_house has a good retention rate for residents.
2. Residents make very good progress toward recovery while in residence.
3. At first, we found it difficult to measure the effects of our ethos even though it seems to be essential to our success. We eventually found that our interviews with residents relating to resocialization strongly indicated the effects of our ethos.[38]
4. Nearly all residents maintain their achievements after leaving the program, although data about them is harder to get and less reliable. Even so, re-entry is rather high risk; residents don't always cope well in an uncontrolled, unstructured environment.
5. It is very helpful to have one set of recovery stages for all kinds of residents, as long as they work for everyone. We don't need separate categories for residents who come in with different kinds of issues.
6. We should seek to improve our staff retention rate, although it is much better than retention rates at other residential AR facilities.
7. We had no objective way of determining how many staff we need.

Recommendations

1. Keep our graduation requirements high because they appear to translate directly into good results afterwards.
2. Define the achievement of each stage more clearly. We could use indicators of language acquisition as analogies to define achievement.
3. Improve the way that team leaders record residents' achievement of their personal goals so that we can better track residents' progress through the stages. We can more easily generate statistics from our forms if we standardize the form formats.
4. Divide the recovery stage into two or more smaller stages so we could measure retention more effectively. That stage has the highest dropout rate, but it's relatively long and it's where we seek most change in residents. In other words, the next set of goalposts after settling in needs to be closer and better defined.
5. Keep our resident retention rate under review. We looked at how long residents stayed and the reasons for leaving, and didn't see any obvious way of improving. Our retention rate is already very good, but that isn't much help to those who need be here but leave.
6. We need some kind of alumni relations system. It needs to be highly relational, not institutional:
7. We should match existing staff to their friends who are former residents. Most keep in contact anyway. We should use the same approach for other former residents.
8. We shouldn't expect much from those who left under a cloud (absconded, evicted, etc.).

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38 In other words, we need to distinguish between what staff hope to achieve by establishing an ethos, and the actual effects of the ethos on residents. At The_house, we found that these two correlate very well, but the correlation cannot be assumed.

9. We should consider including family members and significant others of former residents in our list of contacts who are agreeable to maintaining a relationship.
10. We need to define what the relationship should be, perhaps occasional phone calls, visits, invitation to events, or perhaps an annual reunion. An alumni association might be more attractive if its purpose were related to future aspirations than the past friendships.
11. We might need to navigate some awkward sensitivities. Former residents need to "move on" as part of re-entry back into the outside world. Some residents might view re-entry as inconsistent with keeping a relationship with The_house.
12. Define staff career pathways more clearly. Our new training and job description system is still on trial.
13. Find and implement an objective system for determining how many staff we need. The obvious analogy is the levels of nursing staff in hospitals, at least for shift leaders and shift workers. It will be a little easier now we have clearly defined staff roles, and might be easier when we define career pathways.
14. We should consider developing staff handbooks and training for each specialist portfolio, for example, legal advocacy, mental health services, medications.
15. We should consider offering longer term accommodation for graduates that is cost-neutral to the foundation. Most likely, a group of graduates would share a rented house, with each one paying a share of the costs. They'd need enough autonomy to avoid being dependent on The_house forever.
16. When we decide to set up more centers, we'll need a way to replicate our ethos, probably by using groups of core staff that we have trained. Replicating our systems alone won't replicate the ethos. However, new centers shouldn't all be exact copies of The_house; they will need to adapt to local conditions, and our ethos will evolve as well.

We then put a carefully edited summary in the newsletter, gave a full copy of the report to the board, and circulated another full copy to any staff who wanted to read it.

Planning improvements

By now, you know where you most need to improve and have made some concrete recommendations to get better outcomes.

You now need to put it into a plan. You might not put them in this order, but you need to cover the following:

1. What are the priority items for change?
2. What are your immediate goals?
3. What are your long-term goals?
4. How will you break larger tasks down into smaller tasks?
5. Who can you delegate tasks to?
6. How much will each task cost?
7. What resources and funding will you need and where will they come from?
8. What kinds of things could go wrong? (Make a list.) What will you do if it does?
9. What is your timeline?
10. What new policies and procedures will you need to write? And how will you get them approved?

Your plan needs a way of getting people's participation. Inform everybody who needs to know what changes you will make, how you want to do it, and get their support. This is potentially the most difficult aspect and will take some patience and tact.

Maintaining a quality focus

Your task at this stage is to keep your staff's and stakeholders' attention on the quality of outcomes for residents, your service standards, and your codes of practice.

You will probably find initial enthusiasm followed by fatigue that causes a slow decline. Only the best organizations always keep trying to improve, and they build it into their culture. Regularly remind all stakeholders (and especially your staff) of your service standards and your organization's expectations. You can also include quality information in newsletters and brochures.

The most common way to keep staff focused on quality is the staff meeting. It's common to regularly discuss quality topics, and to use them to review the program and suggest improvements. Promote examples of good practice to staff and be an example of good practice yourself.

You also need to establish procedures to check that staff are following appropriate practice. Your staff meeting is a straightforward way to monitor practice, although you will also need to observe what goes on. As you go, you'll gather feedback from all involved.

Your other main avenue is a quality audit. Audits give a more objective viewpoint of the strengths and weaknesses of the organization. They also give the board a separate view from that reported by the CEO.

- An *internal* quality audit is usually voluntary and done by a neutral contractor. You can use your own policies and procedures as a quality standard. It is good practice for organizations to do internal audits annually and before being externally audited.
- In an *external* quality audit, the auditor is usually appointed by a licensing or accreditation authority, which always has its own quality standards. A successful audit outcome is a condition for a license or accreditation.

Unfortunately, you will find cases of staff who do not meet your quality standards. It's your job to confront issues with workers and develop a plan for improvement. You will find it relatively easy to fix problems caused by a lack of training or organizational glitches.

Attitudinal problems are more complex. Some of them are solved by moving people to other teams or tasks. Some are solved by listening and encouraging, and some are solved by clarifying boundaries. But some can only be solved by letting people go.

Our quality system

We then had all we needed to implement a quality management system.

1. Written industry standards. As I said earlier, we looked for them, but didn't come up with much, although we found some clear legislative boundaries, some useful OHS guidelines, a few good practice guides, and some quite useful competency standards.

2. Organization's goals. We had defined our specific goals and philosophy. For some of the philosophy, we had to do some research to get a good idea of best practice.

3. Written policies and procedures. We came up with our own statement of best practice that suited our goals and philosophy. We wrote down our procedures, saying what we did and how we did it. In general, we tried to keep them very simple and easy to use, so they looked more like sets of instructions on what to do. Some procedures were forms with a set of instructions at the top. This made them all good training tools. By complying with recognized competency standards, we could easily assess staff for recognized qualifications.

4. Unwritten procedures. We didn't write procedures for some kinds of simple implementation matters. We just made sure we all understood what to do and trained new people consistently. Besides, we change these kinds of procedures quite often.

5. Written record of implementing the standards. The Day Book and the staff meeting minutes were most important, but we also had case meeting forms, case conference records and incident reports. We'll need them if we ever have a legal claim for malpractice.

6. Actual practice. We had to do it all too. We had to do follow our procedures and actually do what we had written in the records.

We used actual practice to review our procedures. We found that our actual practice reflected our organizational culture; if people had been generally slack, getting detailed paperwork right was not much help.

We tightened up procedures wherever people tried to cheat the system, and we updated the procedures when people had made improvements.

7. Feedback. We routinely collected and collated feedback from everybody involved. The most important source was observations, case conferences, incident debriefs, and staff meetings. Family members and visiting experts were also quite helpful.

The residents often gave their comments, and the senior residents were sometimes very insightful. Inevitably, a few grumpy ones complained regularly twice a week although there was never much substance to it.

8. Review. We regularly considered changing our practice, our policies and procedures, and even our review system. We considered all the feedback.

As we got bigger, we had more and more issues to look at. We found it helpful to compile a list of things that came up (i.e. an issues register) to keep track of all input, and to select specific priorities for improvement. Right now, it's an annual process.

The review included recommended improvements, so the Board, the leadership team, and the staff meeting could make decisions on what to improve. For bigger decisions, we needed a strategy for managing change, such as how we could get people to accept the change and learn to do something differently.

9. Implement improvements. We then had to put the improvements into practice. During implementation, we sometimes had to adjust the changes in ways we couldn't have foreseen. We didn't always get it right, but at least we learned a lot. In fact, we learnt most from really good, well-planned ideas that had looked very feasible but hadn't worked in practice.

Some people had regularly faced difficult decisions. Having good policies made these decisions much easier and less frustrating, gave us more legal protection, made our practices more consistent, and made training much easier.

Approving program improvements

As The_house grew bigger, we needed a clearer avenue for suggesting program improvements, getting them agreed on, and implementing them. We still used the staff meeting for smaller items, but The_house had grown and changed.

Like most organizations, we had lots of staff who had good ideas for small improvements, but nobody in management was listening. It was simply a matter of harvesting these ideas and evaluating them.

We adopted the "champion" model of change management. Although people can hijack it to push hobby-horse ideas, it also allows individual staff members to give more attention to what they're particularly good at and to take ownership of changes.

At The_house, the onus is now on the person (usually a staff member) making the suggestion to do their homework and show that it would work. We had a few people on the team who were good at coming up with new ideas, and they often needed to be matched with somebody else to filter out the best ones and figure out whether they'd work. So this is our system:

Develop a project proposal

Develop a project proposal that addresses a core issue or opportunity in a way that would improve The_house. Your proposal must directly support our overarching goals and ethos. Your project proposal must include:

1. A clear, simple, compelling definition of the need or opportunity.
2. A clear, simple, compelling statement of your solution or response.
3. A plan and rationale for making the change.
4. An assessment of significant risks. (That is, look at what might go wrong.)
5. An operational plan for your project that:
   - shows that your idea is feasible.
   - includes a detailed financial plan with firm estimates of costs.
   - proposes a realistic timeline for implementation.
6. A convincing business case with a clear dollar value. This may be savings and/or increased income.
7. A way of monitoring implementation to keep it on track.
8. A plan for coaching our staff through the changes as part of your change management.

About your project proposal:

1. The leadership team will need to approve your project, including any expenditure. Consequently, they need to see a convincing cost-benefit case.
2. Back up what you say with enough concrete, well-researched information.
3. Present information in a way that is easy to understand for non-specialists.
4. Check your financial information with the accountant.
5. Consult your leaders for comment early in the process. However, do not waste their time or get them to plan the project plan for you.
6. Ensure that your approach is sound; report your reading if your project involves significant theoretical aspects (e.g. an annotated bibliography).

Presentation

Give a half-hour presentation to gain approval for your plan. Your listeners will be other staff, your leadership team, and perhaps some board members.

- Engage your listeners and speak persuasively. Be tactful about existing weaknesses.
- Use suitable visual aids (e.g. *good* PowerPoint presentations).
- If you use handouts, make sure they don't go over two pages.
- Do not use gimmicks.
- Close with a clear challenge to accept your project.
- After your presentation, answer any questions.

After that …

The leadership team has several main options:

- Lead a full staff discussion and get a recommendation or decision.
- Discuss the proposal among themselves and decide what to do.
- Refer the matter to the Board with a positive recommendation.
- Send the proposal back to the presenter to solve specific problems, answer specific questions, or consider suggested extra improvements.

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The profession

Addiction Recovery (AR) work is closely akin to several other professions and fields of study, but has not yet become a clearly separate profession, leaving workers in AR caught in a no man's land between being registered nurses, clinical psychologists, and social workers. Universities offer courses in addiction recovery, but many do not lead to any kind of professional registration.

The emergent role of Addiction Counselor in the US is driven by licensing. The role is to some extent mis-named in that it also includes other roles such as case management. We chose to interpret the standard as the kind of counseling given by a case manager, in contrast to the kind of counseling given by a clinical psychologist.

It seems helpful to think of AR workers as having a significant clinical role; they are not simply community service workers. They process admissions, oversee detox, lead recovery groups, do most of the personal mentoring and counseling, supervise all medications, manage all resident behavior, and process discharges.

General degrees in nursing, clinical psychology, social work, and youth work do not give their students enough specialist skills to work unsupervised in AR. With minimal extra training, nurses are well equipped to oversee normal detoxification; in fact, it is legally necessary to have registered nurses to oversee some kinds of medicated detoxification regimes. Psychiatric nurses are better trained to handle specific mental health issues. Similarly, clinical psychologists bring useful skills in counseling individuals and families, and in working with psychiatrists, but need orientation to some of the more specialized demands of AR.

AR is arguably a specialization in social work. It fits well within the professional goals of social work and uses the same methods. AR workers assess clients, lead recovery groups, act as case managers and advocates, give counseling, and intervene in crises. They handle child protection issues and court liaison. They work with other professionals to provide networks of personal support, including financial counselors. For many addiction recovery workers, the most natural pathway to further education is a further degree in social work.

AR work, however, is quite hierarchical and has different skill levels. While some workers use the core skills of social work, others fill in support roles at a sub-professional level. Some do street outreach, and others are case assistants rather than case managers. That is, only senior AR workers are equivalent to senior social workers.

If social work is the father of AR, then AR has many grandfathers. Social work comes from a history of being a field of professional practice rather than a theoretical discipline. Its counseling role derives from psychology, and its social awareness is a kind of applied sociology. It also uses

anthropology, especially cultural and social anthropology. It has an educational role, the theoretical underpinnings of which are on loan from education.

As specialists, AR workers learn only as much of social work as applies to AR. They do not have specialist skills in other social work roles such as working with convicts, general hospital patients, or disabled people. They do not manage adoptions and fostered children, nor give much family therapy.

Other professions and fields of study

AR workers can take also take further education and professional development in other related fields with which AR has a close affinity. Moreover, AR researchers can often adapt the methods and theories of other fields to improve AR practices and theoretical underpinnings. These other fields are as follows:

- *Nursing, especially psychiatric nursing and mental health care*. Nurses and AR workers give a very similar kind of care. For example, the job description of a shift manager at The_house is nearly identical to that of a registered nurse in charge of some kinds of hospital wards, and their relationship with medical practitioners is also very similar.. The professional practice of caring for patients has developed its own body of theory, and most of it is relevant to addiction recovery. Like nursing, AR also has lower levels; some AR workers in residential care have roles that are analogous to nurse aide and nursing assistant.
- *Counseling*. Many AR workers have a substantial counseling role and further studies in counseling are frequently a natural progression.
- *Rehabilitation*. The underlying principles of rehabilitating recovered addicts back into the wider community are the same as those for rehabilitating criminals, the long-term unemployed, sex workers, mental illness patients, and persons suffering abuse trauma. For example, all these kinds of rehabilitation include resocialization, independence, training and transition to employment, and relapse prevention. The principles are probably parallel to those of cultural entry, integration of marginalized minority groups, and resettlement of displaced people.
- *Community development and public health*. The principles of community development and public health are particularly relevant to those instigating programs in the wider community.

Addiction recovery is also closely related to various academic disciplines:

- *Cultural anthropology*. Addicted persons tend to establish lifestyles and networks that are best researched as cultural patterns, for which ethnography (cultural description) is a suitable methodology.
- *Sociology*. Patterns of addiction are usually socially defined and, to some extent, socially determined.
- *Epidemiology* is the study of how diseases occur and spread. Addiction research often uses population statistics to describe addiction occurrence, to calculate risk, and to demonstrate the effectiveness of treatments.
- *Psychology*. Recovery workers depend on psychological principles in their roles in counseling and behavior management.
- *Pharmacology*. Most residents in recovery from addiction benefit from pharmacotherapy. AR staff benefit from knowing what medications they administer and how they work.
- *Neurology*. Addictive substances affect the central nervous system. While addiction recovery workers don't need to know much about neurology to do their job, many want to know what is going on behind the scenes and how medications work.

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How to start a recovery house

Start by getting a small team together and clarifying the vision of what you want to do. Try to be specific.

If your team members have never worked in a functioning AR facility, get some hands-on experience. Reading as much as you can is very helpful and will give you a head start, but you need to go through the experience yourself to make the mental and emotional adjustments. As you go, ask questions, evaluate what you see, and learn as much as you can. You can prevent some avoidable mistakes by being willing to learn from more experienced agencies that have an ethos similar to yours. This is especially so when a correct course of action is counter-intuitive and the obvious, sensible action is incorrect.

The business model

You'll need a viable business model to know how you are going to pay the bills. Circumstances vary greatly, so don't look for a perfect formula that will always work anywhere. You just need the right one for you. Whatever your funding, it normally evolves over time as old sources dry up and new ones become available.

Most AR programs need a supporting constituency of donors. Charities often designate specific personnel for fund-raising, whether by holding special events or by writing proposals for grants.

It is hard to underestimate the value of good volunteers. Although they don't appear in your financial reports, they can make the difference between financial survival and failure.

In some western countries, residents are often eligible for a welfare payment. It is usually a reliable way to cover all basic living costs and still leave residents with some pocket money, but it is does not usually cover the costs of the recovery program.

Some governments have health care programs that cover medical practitioners' fees, medications, and some kinds of counseling.

A few programs have fee-for-service, but fees are normally high. Only the wealthy can access the most expensive programs, which have facilities resembling resort hotels. Fees in other facilities are lower but still a heavy drain on the finances of a middle class family.

Some programs generate their own funds by running businesses. You'd need strong entrepreneurial skills. One particular program provides high-level chef training to make their restaurants highly competitive, but it usually works best if businesses require minimal capital expenditure, few or easily-learned skills, and simple hard work.

In some cases, you might be able to get external funding, whether from government or from health insurance, but it's not that easy.

First, insurance funding is very helpful but usually comes with a time limit that is too short for a full recovery program. Second, dependence on government funding can be very risky. Regardless of how good your program is, governments can suddenly change their policies and discontinue funding for their own political reasons, especially if a different party is elected. Third, external funding of any kind normally has strings attached, including much more record-keeping than you actually need. It might also require external audits and compliance with standards that are incompatible with your organization's mission, your philosophy of operations, or your core values. In the worst cases, a large proportion of the external funding is swallowed up in compliance costs.

The legal situation[39]

Then look closely at the legal situation. You probably should incorporate as a non-profit and consider the following aspects:

1. Make sure you get the right people on your board.
2. Manage your risks; consider what might go wrong and what you might do about it.
3. Figure out your tax obligations and exemptions.
4. Check the licensing requirements in your jurisdiction. There might be separate licensing for the organization, the site, the building, and for individual staff. Different categories of staff might need different licenses.
5. Check what insurance you will need. Getting full cover for everything can be very expensive, so do your research. Beware: some low-cost policies don't give adequate cover, while some specialist non-profit insurers give excellent value for money. Check these tips:
   a. Consider getting public liability insurance.
   b. Ask if you can get volunteer insurance at a lower rate.
   c. Vehicles and building contents need insurance.
   d. If you own the building, your building needs insurance.
   e. You might not need professional indemnity insurance, or perhaps only for counselors.

Starting small

Plan to start small with five or six residents. It's easier to correct your mistakes with a small group; just make an announcement. With a big group, it's harder to make changes and easier to fail. Besides, you'll need fewer staff, and a small team of three or four people might be enough for a house of five. As Tina Gunter says: "Get good before you get big."

Decide on your model of treatment. Decide exactly what you will do, what you won't do, and what you'll outsource. You can start by copying The_house and adjusting it later on as you get experience.

The main physical resource you will need is an ordinary residential house. (It's having the right people and systems that will make it work.) It needs to be quite big, with enough bedrooms and bathrooms, and in a fairly central location so that staff have an easy commute. It should also be in an area with minimal social problems so that residents can't easily contact drug dealers and undesirable friends.

You will have to buy food and pay utilities (electricity, phone), just like anybody else living in a house. You should have a vehicle that will hold the whole group, and transport will probably cost more that you anticipate. Activities will probably cost something and it is good practice to take the group of residents on annual vacations.

39Legal requirements vary from place to place and are a separate topic for which you need separate advice.

Education-related costs are a whole other question. You can outsource them for free in some places, while they could be very expensive in other places, especially if you do them in-house.

Your staff

Start with nearly all volunteers if possible; you won't be able to pay anyone real wages for a while unless you have institutional funding. Getting them adjusted and trained will be a big job.

Make some decisions on the number of staff, the role of each, whether they are paid or volunteer, their hours each, what specific resources you need, and any other costs.

While still small, you probably need only one shift manager on duty at any one time, as long as they know what they are doing and have someone for support at the end of a phone. You need someone on duty at all times, so you'll need a few. How many is a little more complex because they will also have other roles, and volunteers will probably be part-time. You can increase your training effectiveness by having two people on shift together.

The bigger problem is that you might easily become short-staffed, because people in general (and volunteers in particular) tend to drop out when their idealism crashes on the rocks of reality. They can be disillusioned and frustrated with erratic, ungrateful people who sometimes lose their tempers, tell lies, try to manipulate, or perhaps relapse. But that is exactly the job. (And when some of them turn into remarkable people whom you like very much, a lot of things become worthwhile.)

Decide what your staff need to do. Here's my list of core activities, although most staff will have more than one role:

1. Somebody to be in charge
2. A bookkeeper
3. Shift managers
4. Somebody to oversee activities, groups, and whatever residents do all day
5. Counselors
6. Case managers
7. Somebody to oversee detox
8. Somebody to oversee any training and education
9. Somebody in charge of food.

You also need a medical practitioner who knows about addiction recovery, or s at least willing to learn. He/she doesn't need to be an internal staff member; they can come, do their job, and then leave. Consider whether you also need a clinical psychologist on the same basis. It will depend on the abilities and training of your counselors.

Staff mix

Watch your mix. You should probably aim for a range of ages in your staff group, with some younger and some older. Each kind can make a contribution that the other cannot.

Similarly, it is ideal to have a mix of recovered addicts and others. Both tend to bring strengths and limitations.

It is helpful to have staff members who have gone through the kinds of experiences that residents go through. They are well informed as to what is "normal" in recovery. They demonstrate that recovery is possible, a valuable contribution when many addicts have never met a recovered addict. However, recovered addicts might still have emotional and relational scars from their pasts, might have more erratic behavior patterns, and can be less emotionally stable.

On the other hand, it is also helpful to have staff who have never been addicted, come from stable, normal families, and have backgrounds of emotional stability. If recovery is described as "becoming a normal person," residents in recovery benefit from close contact with them.

Moreover, as many tend have a stronger educational background, they tend to find it easier to participate in further training and education.

It seems that former residents who come onto staff at The_house tend to be good at examining themselves, but more easily preoccupied with their own issues. Some of them don't easily make the transition to a position of authority. Staff who are not former residents are the opposite. They are not so good at self-awareness and examining themselves, but find it easier to focus their attention on residents.

These tendencies are not stereotypes; some recovered addicts are more like those who have those who have never been addicts, and vice versa.

Where do staff live?

Full-timers probably shouldn't live with the residents any more than necessary. If they do, the stress accumulates because they feel they are they always on the job. They might also become the victims of excessive familiarity with residents. If you have suitable live-in staff accommodation (preferably somewhat separate from residents) and can manage it well, staff will tend to acquire skills faster than if they live outside at home and commute in.

On the other hand, one organization has students who live in but go out all day to study. The students cover the evening meals and night shifts, and get free room and board. The arrangement works well for them.

Work hours

How many hours each week will staff be on duty? My guess is that most staff will come in as volunteers for a couple of days each week. Some of them will do what they came to do during the day and then leave. For example, they might cook, run an activity, have some case meetings, lead a group, oversee chores, or give counseling.

It is a little more complex for shift workers. In one plan, which works quite well, the day is divided into two shifts. Day shift is from 8.00 a.m. to 5.00 p.m. Overnight goes from 5.00 p.m. to 8.00 a.m. but overnight shift workers can sleep unless they must attend to a problem.

Another plan works better if shift managers must be alert all night, but this is unlikely. Their days are divided into three shifts: morning, afternoon, and overnight. Morning shift goes from 7 a.m. to 3 p.m. Afternoon shift goes from 2.30 p.m. to 11.00 p.m., and overnight goes from 10.30 p.m. to 7.30 a.m.

Job descriptions

At The_house, we wanted a way to give job descriptions to each staff member in services. We wanted something very useful that would keep people on track for what they were supposed to be doing. It had to have simple, minimal paperwork, preferably no more than one page for each person. Our staff are very relational and would usually ignore a long document.)

Part of our procedures manual was required reading during induction. It included our organizational chart (to show lines of accountability) and details of each position, because they were always the same and we didn't want to repeat them in each job description.

A job description gives some legal protection when it defines what a staff member does. First, staff need to know the scope of their authorization to make decisions. Second, we asked, "Hypothetically, what if a staff member made a serious error when doing something for which they had not been trained and which we had not authorized? Could we be legally liable for any harmful effects?"

To that, we added the aspect of training. We wanted to track on-job training by showing how staff can progress through different roles and tasks, and through learning, doing, and then training someone else for specific roles. Our system also had to state whether they were either deemed

competent or still in training. They could work alone if considered competent, but could work only under supervision while still in training.

Perhaps our solution is a little too task-focused. Perhaps a little too brief. Perhaps it's so easy to use that people don't think about it enough. It's still on its trial run. In any case, these are the position titles for orientees, shift workers, shift managers, and case managers:

1. Orientee
    a. Be part of the community, show good teamwork, and communicate well
    b. Attend staff meetings and orientation sessions
    c. Help on shifts as rostered by doing chores and errands as asked
2. Shift worker roles
    a. Be shift worker on shifts
    b. Be a house leader
    c. Lead activity groups
    d. Be a team leader for residents (Caseworker)
    e. Advocacy in one area
    f. Conduct initial assessments of applicants
    g. Oversee detox
3. Shift manager
4. Case manager/ Clinical supervision coordinator
5. Other advanced roles: Lead recovery groups, Oversee urinalysis and medications

Your residents

You probably have a very good idea of how you will get residents. At first, you should accept only lower-risk applicants who are willing to be helped. You need to get the program running and to create a successful, positive atmosphere while you are still getting experience. Accept that you do not yet have the experience to take on higher-risk residents, and it would be unethical to accept applicants when you cannot give any assurance that you have the skills to lead them through recovery.

Unfortunately, reality might intervene. It is quite likely that some of your first group of prospective residents won't exactly fit your plan. But if they need help, you should probably accept them and let your recovery house evolve naturally from there.

So now you're open …

Unless you have already had lots of AR experience, you'll now hit a very steep learning curve. Keep discussing your experiences with your team and learn what you can from them. Your network should be able to give you good advice because others in your professional AR network have almost certainly faced the same problems.

Task

You have been asked to submit a proposal to set up a new addiction recovery program. If the proposal is successful, you will become its head of services. Your proposal must meet the following specifications:

1. Neatly typed and presented, no more than five pages
2. Propose a clear program purpose
3. Explain how it would work (admission, treatment, etc.)
4. What kinds of resourcing it would need (funds, building, staff)
5. How you will get clients
6. An implementation plan that demonstrate that your plan is feasible. It must comprise a set of stages with a set of key performance indicators for each stage.

7. Your proposal does not need to cover business administration aspects of the program (e.g. business registration and licensing, financial management, administration of employment obligations).

Your instructor will assign you one of the following scenarios:

- A non-profit organization works in a poor neighborhood in a large Asian city. It wants a program for local opium addicts of both genders. Language might be problematical, although most people speak at least basic English. The program will have to generate its own funds as much as possible. Proposed staff are willing and enthusiastic but have no specific training.
- A non-profit organization works in a poor neighborhood in another large Asian city. It wants a program for local prostitutes. Most have no families, but some are married and want to live at home where they can retain clients to keep earning extra cash. The program will have to generate its own funds as much as possible. Proposed staff are willing and enthusiastic but have no specific training.
- A local government authority has asked you to submit a proposal for a new drug rehabilitation program. The government will fully fund it as long as you can prove that funds are necessary to achieving the program's purpose, and are spent honestly. You will need to employ eligible staff on the open market based on transparent criteria. Your policy for accepting residents must also be seen to be non-prejudicial, although you can set admission criteria and determine admission procedures.
- A non-profit organization works with trafficked prostitutes in a large western city. Most of them have poor English and have become illegal aliens. Many of them are addicts and have mental health issues. The program will have to be as self-funding as possible. Proposed staff are willing and enthusiastic but have no specific training.

Hints

1. Plan to start small and simple.
2. Keep your paper objective. Your readers will easily see through empty rhetoric and overly idealistic optimism.
3. Make your proposal easy to read for decision-makers who are very literate but have no previous knowledge of addiction recovery or prostitution recovery.
4. You may use any procedures from The_house, as long as you adapt them for your particular situation.
5. You will be accountable for meeting key performance indicators if the proposal is accepted.

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Major project

Many senior undergraduates and most Masters students need to do a major project. It means taking on a major challenge, reviewing current best practice, planning what you will do, implementing it, and evaluating it. It is usually the culminating work in a professional degree. Its purpose is not primarily to build theory, so it is different from a research thesis or dissertation.

Part One: Develop a project proposal

Develop a project proposal that addresses a core strategic issue or opportunity in a way that would improve your organization. Your proposal must directly support your organization's overarching strategic plan. You might also have to comply with your college's regulations for proposals.

Your project proposal must include:

1. A clear, simple, compelling definition of the need or opportunity.
2. A clear, simple, compelling statement of your solution or response.
3. Results of consultations with significant stakeholders.
4. A literature review of current best practice.
5. A change management plan.
6. An assessment of significant risks.
7. A structural statement to the effect that it will function as a separate business unit, of which you will be the manager.
8. An operational plan for your project:
   a. It must demonstrate feasibility.
   b. It must include a detailed financial plan with firm estimates of costs.
   c. It must include other operational information (timeline, critical path, cost schedule, etc.)
   d. Include a Gantt chart.
9. A plan for coaching your staff through the changes as part of your change management.
10. A method for evaluating the project.

About your proposal

1. Your senior management will need to approve your project, including any expenditure. Consequently, they need to see a convincing cost-benefit business case.
2. Back up what you say with enough concrete, well-researched information.
3. Present information in a way that is easy to understand for non-specialists.

4. Consult your senior management for comment early in the process. However, do not waste their time or get them to plan the project plan for you.
5. Some shortcuts do not comprise suitable projects:
   a. Incremental development with no intentional strategic change.
   b. A simple across-the-board budget trim.
   c. A simple staff reduction (e.g. sack people, cut hours of casual staff).
6. You must ensure that your approach is sound. If significant theoretical concerns are identified, you must include a more detailed written section on it. A critical review or an annotated bibliography may be appropriate.
7. Write it up as a draft following the guidelines above. Later on, use any comments or insights from the presentation feedback to improve your draft.
8. You might need to apply for exceptions to your college's regulations at the proposal stage:
   - *Confidentiality*. If a project contains significant sections of an organization's internal knowledge, the whole project might be classified as confidential and have specific limitations on who might read it. This is relatively rare, but it is better to conceal information that cannot be made public. If a confidentiality arrangement is in place, it should have an expiry date so that others can eventually read your work. Any special arrangements need to be confirmed at proposal stage.
   - *Copyright*. Academic institutions normally have regulations on ownership of copyright, and any exceptions need to be approved at the proposal stage. For example, if all your work was done as part of your paid employment, your employer has a legitimate claim to ownership.

Part two: Project presentation

Give a half-hour presentation to gain approval for your plan. Your listeners will be other members of the class, your senior management, and your college professors.

- Engage your listeners and speak persuasively.
- Be clear and factual, and do not use gimmicks.
- Use handouts of no more than two pages and suitable visual aids (e.g. good PowerPoint presentations).
- Close with a clear challenge to accept your project.
- After your presentation, answer any questions.

Part three: Implement the project

As manager in charge, implement your project. As you go, keep records of what you do and what you learn.

You will probably need to adjust the plan on the way, because the operating context might change or you might encounter factors that you could not have anticipated during planning. This doesn't mean that your plan has failed. It usually means that you have learned something new and need to make adjustments or run another research cycle to achieve your goal. Make changes to the project, and get approval as necessary.

Part four: Review and evaluate the project

1. Review and evaluate implementation and outcomes.
2. Do the financial acquittal.
3. Compile your portfolio of documents.
4. What did I learn about myself?

You can apply for an extension if your project isn't finished by the end of the allotted time. You will have to make a convincing business case, showing that the project is making sound progress and is worth any extra investment of time and resources.

About the final format

A formal written submission is a very reasonable expectation at graduate level. The advantages are:

- Writing helps you develop your thoughts, especially the details.
- It can be useful elsewhere in your organization.
- It can be a stepping stone for future students to develop good projects too.
- It is evidence of what you have learnt so can be helpful if you choose to continue your education.

It needs to be clear enough to demonstrate what you tried to do and why, and what you learned from it. It need not be an unreasonable amount of extra work. The introduction and methodology sections will be a tidied-up version of your proposal and routine reporting.

Your institution might have a specified length, so check with your supervisor. Your institution will specify the number of copies. You will almost certainly need at least three: One for your college or university, one for the senior management of the organization where you did the project, and one for yourself.

Final format: Outline

Your institution will normally have a prescribed format, but the following guide might be helpful:

Preliminaries

The preliminaries are written last of all and comprise the title page and table of contents. They can also include a Preface and Acknowledgments if necessary.

Lists of tables, maps, graphs, diagrams or abbreviations (as appropriate). If you have more than one list and they are short enough, you can put them on the same page.

Main body of text

Chapter 1 Introduction	Explain the need for the project, the purpose or problem, assumptions, definitions, etc. Keep it fairly brief.
Chapter 2 Theory section	(If needed.)
Chapter 3 Methodology	Give the details of your plan and describe the implementation. As a rule of thumb, it needs to be clear enough for someone else to copy your project.
Chapter 4 Project outcomes	State what the project achieved and give your evaluation of the approach. It is your opportunity to state any specific learning.
Chapter 5 Conclusion	The conclusion reviews briefly what you have done, what you have found, and its general implications.

Some projects need a separate chapter to rxplore interesting wider implications. It might be the most important part of all, especially in a large organization. However, it's optional because some projects don't have enough implications for a separate chapter. If you write a separate chater for implications, it's chapter 5, place before the conclusion.

Final materials

Appendices. An appendix is the place for anything unexciting that you need to include but would distract your readers if put into the text. Appendices are placed before the bibliography, because they might include references to sources that are listed in the bibliography. Appendices are optional because you might not need them.

Bibliography. You'll need a bibliography for details of any books, journal articles, formal interviews, website materials, and unpublished materials.

On workplace projects

Most readers only need an executive summary. Put it at the beginning.

Managers need to know your recommendations for action. Include them in a section near the back, and make them clear and positive. Check that the are based on actual research.

Appendix: Websites

The Internet is an excellent source of information on AR treatment. It is in governments' best interests to make information publicly available to promote abuse prevention, early identification, and responsible treatment. The opportunity to commercialize is limited; technical information primarily benefits addiction researchers, the not-for-profit sector, and medical service providers.

Broadly speaking, Internet sources tend to fall into two main categories. The largest comprises information for the general public, whether to promote a particular service, prevent abuse, explain how medications work, encourage persons with addiction issues to seek help, or to inform families how to cope. The other category is information for professionals, including current practice standards, technical explanations of medications, and research.

It is more difficult to assess the value of the information. One of the main weaknesses is the influence of the harm reduction lobby group, and particularly methadone advocates who do not seek to get people free of addiction. The second main weakness is that so much research has been devoted to careful description of problems and so little to effective recovery.

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