EAP & ORGANIZATIONAL

Employee Assistance Programs and Organizational Ethics

William L. White — Selected Papers, Volume VII

29 Papers

White's writings on Employee Assistance Programs, organizational leadership, professional ethics, and the culture of addiction counseling organizations.

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RELAPSE AS A PHENOMENON OF STAFF BURN-OUT AMONG RECOVERING SUBSTANCE ABUSERS

By

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TO THE READER

The following paper is the second of a series of HCS monographs developed to further our understanding of occupational stress and professional burn-out in health and human service fields. While this study focuses on the substance abuse field, both the concepts and proposed tools for organizational analysis are broadly applicable to the entire range of human service organizations.

Special thanks and acknowledgements are due the persons who shared with me the intimate details of their personal and organizational histories. This paper would not have been possible without their courage and honesty.

It is my hope that the following pages will serve as a stimulus to further discussion and concern. I would welcome the opportunity to receive your comments, your criticisms, and your ideas. Correspondence can be sent to:

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RELAPSE AS A PHENOMENON OF STAFF BURN-OUT AMONG RECOVERING SUBSTANCE ABUSERS

BY WILLIAM L. WHITE

ABSTRACT

This study is based on interviews with recovering substance abusers (RSAs) who returned to the abuse of alcohol and/or drugs while working as counselors in alcohol and drug abuse treatment programs. Case histories and role analysis are utilized to illustrate the contention of the author that relapse is one of the most tragic apsects of staff burn-out in the substance abuse field. Ten (10) role stressors are identified that characterized the high stress work environment at the time of relapse.

The issue of burn-out will be addressed when we begin defining it as an organizational process and stop defining it solely in terms of the personalities of our casualties.

I. THE CONTEXT OF THE STUDY

This author in an earlier study on staff burn-out utilized a family systems model to conceptualize the process by which staff members become dysfunctional in and are extruded from human service organizations. It was contended that staff casualties increase as the "organizational family" becomes progressively closed. Three incestuous dynamics (professional, social, and sexual) were described which often result in staff burn-out and extrusion in small direct service organizations. Speculation was also made on the staff casualty process (identified as staff fall-out) in the large human ser-

vice bureaucracy. Staff burn-out was defined as an interactional problem that requires modification of both the high stress work milieu and the individual victim's style of stress management.

This study continues the author's interest in exploring the way in which internal relationships within an organizational group and the group's relationship with its outside professional and social environment effects the physical and emotional health of group members. The current study focuses on the alcoholism and drug abuse treatment field and was initiated to assess the extent to which relapse to alcohol/drug abuse by recovering substance abusers (RSAs)[2] working as counselors is a response to the high stress work environment. To initiate this study, the author communicated to a large number of alcoholism and drug abuse treatment programs, professional associations of alcoholism and drug abuse counselors, and self-help groups his desire to interview RSAs who had relapsed while working in the field. Twenty (20) individuals subsequently contacted this author and, following assurances of confidentiality, explanations of the purpose of the study, etc., agreed to in-depth interviews. Each of the interviews was conducted utilizing a format which approximated the following outline:

1. Family and social network history (during the section of the interview on relapse, I returned to this first area and diagrammed the family and social network at the time of relapse.)
2. Brief health history
3. Stress/Defense history

4. Alcohol/drug use history including treatment history.

5. Employment history (both general and in the substance abuse field).

6. History of employment in agency in which relapse occurred (including hiring process, initial orientation and training period, role clarity, supervisory supports, staff interrelationships, group process, etc.)

7. The relapse period (including areas of stress in work, social, and personal setting, the process of extrusion from the agency, etc.).

8. The Post-relapse period (extent of alcohol and drug usage, attempts at treatment, contacts with self-help groups, contacts with prior agency of employment, etc.).

9. Current activities and perspectives on the employment period and the relapse.

Six (6) individuals further gave permission to the author to contact family members, Alcoholics Anonymous (AA) sponsors (with the sponsors' prior permission so as not to violate anonymity), and staff members who were working with the individuals at the time of the relapse. An average of four (4) additional persons were interviewed from the social network of each of these six individuals. In addition to the above, staff from two programs were interviewed (at the program's request) where an RSA who had worked for the program relapsed and subsequently died in an alcohol or drug related incident.

In total, twenty-two (22) personal/organizational histories were constructed. Tapes from interviews on each personal/organizational history were reviewed to determine what organizational factors, if any, contributed to the individual's relapse either by failing to provide sufficient supports or by inadvertantly sabotaging the in-

dividual's recovery via administrative decisions and policies, organizational structures, interpersonal processes, etc. In eight (8) of the twenty-two (22) cases, no organizational sources of stress could be identified which could have contributed to the relapse. In these eight (8) cases, factors influencing the relapse were primarily attributed to personal and interpersonal crises outside of the work setting. In the remaining fourteen (14) cases, there were clearly identifiable stressors in the work environment that could have played a contributing or major role in the individual's relapse. An analysis of the stressors identified in these fourteen (14) cases will be the primary focus of this paper.

I have chosen to organize the information and insights gained from this study in the following manner. Section II will summarize a number of concepts about the phenomenon of staff burn-out and serve to place the conclusions of this study within a broader context. Section III will summarize three case histories and offer a straightforward analysis and interpretation by the author with a minimum of theoretical tools. Section IV will utilize a theory of role dynamics to conceptualize the aggregate results of the study.

II. STAFF BURN-OUT: SOME PRELIMINARY UNDERSTANDINGS

The following understandings about staff burn-out, stated in the form of propositions, have been developed by the author during the past three years. Some of the propositions summarize conclusions

of earlier research studies; others were developed out of the experience of conducting workshops on staff burn-out for human service workers. The purpose of this section is to develop a conceptual framework for understanding how high levels of organizational stress may produce dysfunctional behavior that has previously been described only in terms of the idiosyncrasies of personality or psychopathology.

Proposition 1: Staff burn-out is a deterioration of personal and interpersonal functioning directly attributable to continued contact with high stress work environments. Although the term "staff burn-out" has been primarily utilized in literature on the staff casualty process in the human services field[3,4,5], numerous concepts from management research and theory have been developed on the impact of the organization upon the individual which are directly applicable to this phenomenon.[6]

Corollary 1: Indicators of this deterioration of functioning can be categorized into the following areas:

1. Health indicators,
2. Excessive behavior indicators,
3. Emotional adjustment indicators,
4. Attitude indicators, and
5. Relationship indicators.

The table on the following page summarizes some of the frequently mentioned symptoms under each of these indicators.

Indicators of Staff Burn-Out*

Health Indicators	Excessive Behavior Indicators	Emotional Adjustment Indicators	Attitude Indicators	Relationship Indicators
Fatigue and chronic exhaustion	Increased consumption of caffeine, tobacco, alcohol, over-the-counter medications, psychoactive prescription drugs, illicit drugs	Emotional distancing	Grandiosity	Isolation from or overbonding with other staff
Frequent and prolonged colds	High risk taking behavior, e.g., auto/cycle accidents, falls, "high risk" hobbies, general proneness to accidents and injuries	Paranoia	Boredom	Responding to clients in mechanical manner
Headaches	Extreme mood and behavioral changes	Depression, e.g., loss of meaning, loss of hope	Cynicism	Increased isolation from clients
Sleep disturbances	Increased propensity for violent and aggressive behavior	Decreased impulse control	Sick humor--aimed particularly at clients	Using clients to meet personal, social, sexual needs
Ulcers		Increased feelings of guilt	Air of righteousness	Increased interpersonal conflicts with other staff
Gastro-intestinal disorders		Martyrdom	Hyper-critical of program and/or peers	Increased anger at clients
Sudden losses or gains in weight		Fear of "going crazy"	Expressions of hopelessness and frustration	Increased problems in marital and other interpersonal relationships away from work, including relationships with ones children
Flare-ups of pre-existing medical disorders, e.g., diabetes, high blood pressure, asthma		Increased amount of time day-dreaming/fantasy		
Injuries from high risk taking behavior		Constant feelings of being trapped		

* This table summarizes the indicators of staff burn-our most frequently mentioned by individuals who were interviewed during this author's studies. It is essential that these indicators be viewed as emerging from a breakdown in the relationship between the individual and the organization and not be viewed as a matrix of symptoms to be used for the clinical diagnosis of individual staff.

Corollary 2: The severity of the symptoms of staff burn-out are in direct proportion to the severity of organizational stress.

Corollary 3: Staff burn-out is experienced by human service workers as a very primitive and devastating process. At the beginning of a recent workshop, I asked thirty human service workers their free associations to the words "staff burn-out." Their associations included: "trapped," "cornered," "hopeless," "death," "robot," "castration," "loss of meaning," "loss of energy," and "betrayal." I have frequently used the metaphor of "impotence" to describe the burn-out process because the term emotionally communicates one's loss of power and the loss of one's ability to impact his or her environment.[7]

Proposition 2: Although the term "burn-out" is primarily applied to the experience of indidivuals, organizations may also be said to burn-out when the aggregate level of stress within the work milieu prevents the completion of tasks essential to the survival of the organization.

Proposition 3: There are aspects to the burn-out process that are unique to individuals, to programs, and to particular professions.

Corollary 1: There are unique aspects to the phenomena of staff burn-out in the substance abuse field which may require different response strategies than those utilized in other fields of human service. This uniqueness comes from the nature of our clients, the nature of our service providers, and the short history of our field.[8]

Corollary 2: The fact that large numbers of workers in the substance abuse field have prior histories of stress management which include the excessive abuse of alcohol and drugs makes the study of relapse essential to an overall understanding of burn-out within the field.

Proposition 4: The experience of burn-out occurs along a continuum from minimal to maximal loss of individual functioning and from minimal to maximal repercussions on overall organizational effectiveness.

Corollary 1: The burn-out process may be described as both situational (acute) and cumulative (chronic).

Corollary 2: Experiencing early stages of burn-out is inevitable and is, in fact, endemic to the nature of human services work. This is due to the unavoidable incongruency between the needs of individual staff and the demands of the organization, and is also an inevitable consequence of prolonged confrontation with the emotional pain and turmoil in the lives of our clients.

Corollary 3: Although the burn-out experience is usually spoken of in negative terms, the early stages of burn-out may be extremely important in indicating to ourselves areas of needed change and development. The experience may indicate:

- areas of needed skill development;
- a need for time out periods (vacations, etc.);

- our need to take the next step in our professional development, e.g, school, job change, etc. (in response to feelings of boredom, being trapped, etc.);
- personal needs outside the work setting which are being neglected; or
- the need to re-establish a more equitable balance between one's work life and one's personal life.[9]

Proposition 5: While early stages of burn-out are inevitable, we can take responsibility for and control over our organizational structures and group processes to reduce the number of staff casualties resulting from the high stress work setting.

In the next series of propositions, I will summarize three approaches to staff burn-out in the substance abuse field and attempt to further define burn-out as an organizational process. These models are particularly important to understanding the response of our field to relapse by the RSA. The three models to be discussed include the clinical approach, the training approach, and the systems approach.

Proposition 6: The clinical approach to burn-out utilizes a process that is remarkably similar to the response of a family system to an acting-out adolescent, e.g., the worker is diagnosed as ill (becomes the identified patient); the illness is characterized as emerging from the personality of the victim (psychopathology); the victim is "worked with" to alter his or her inappropriate behavior (offered a treatment plan); or the victim is extruded (institutionalized) from the organization. In short, the problem of burn-out is defined as intrapsychic and responses involve treating the

personality (referring the individual for outside treatment or turning a supervisory relationship into a treatment relationship) or extruding the person from the agency.

Corollary 1: The clinical approach is marked by a number of severe deficiencies:

1. The approach individualizes what is essentially an interactional problem.
2. The approach fails to address the possible need to modify the high stress work environment, particularly the role conditions under which the person is working.
3. The stigma of the diagnostic process decreases rather than increases the worker's ability to mobilize needed external resources.
4. The approach increases the worker's feelings of isolation, paranoia, and loss of control and, in short, escalates the symptoms of burn-out.

Corollary 2: While the clinical approach is the most frequent response to the loss of functioning by workers, relapse in the substance abuse field is approached both clinically and punitively. The relapse victim is most frequently immediately extruded (our anger at the victim) and the postmortem is conducted as a sophisticated clinical case review (our need to define the problem as individual rather than interactional).

Proposition 7: <u>The training approach to staff burn-out defines burn-out as a problem of skill deficiency rather than one of psychopathology</u>. Prevention and remedial approaches to staff burn-out that emerge from this model rely on teaching workers more effective styles of stress management.

Corollary 1: The training approach to staff burn-out avoids most of the more detrimental aspects of the clinical approach but still does not adequately address the environmental causes of high stress levels. In spite of this limitation, the training approach is an essential element in any comprehensive response to the problem of staff burn-out.[10]

The systems approach to burn-out which is advocated by the author focuses on the manner in which organizational structures, internal organizational relationships, and the organizational group's relationship with its outside environment effects the physical and emotional health of group members. The etiology of burn-out is thus described as a problem of relationship rather than a problem of psychopathology. The role of the individual and the role of the organization in this relationship problem is elaborated in the following propositions.

Proposition 8: Each person brings to the work environment a unique system/or style of defenses to protect his or her self-esteem in response to high stress.

Corollary 1: This unique history of stress management determines the potential for burn-out in a high stress work environment.

Corollary 2: The particular type of burn-out an individual is most vulnerable too can also be predicted by reviewing this unique history of stress management, e.g., individuals with a history of somatatizing stress are likely to develop psychosomatic symptoms in response to high stress work situations, etc.

Proposition 9: As the individual enters and works in a particular organization, there exists a number of role conditions and factors which will effect the individual's physical and emotional health. These can be summarized through the use of the following terms:

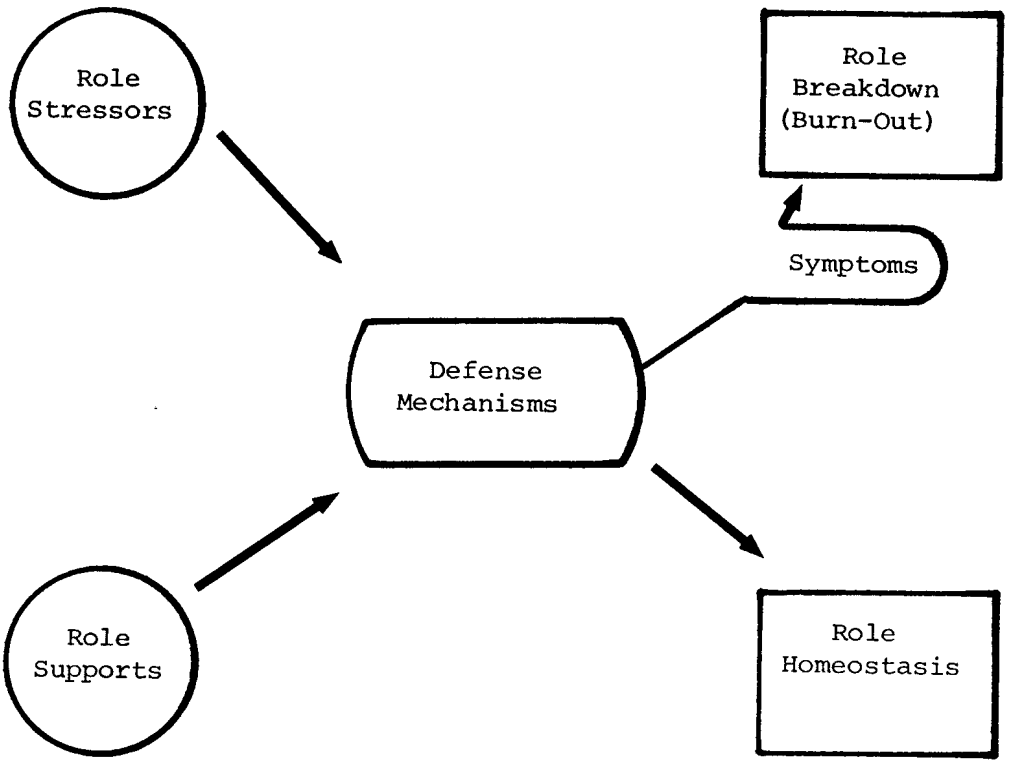
1. Role stressors can be described as the number and intensity of role conditions which threaten and decrease one's self-esteem and decrease one's ability to perform organizational tasks. Ten such role stressors will be described in detail in section III of this paper.

2. Role supports can be described as the number and intensity of role conditions which increase self-esteem and increase one's ability to perform organizational tasks.

3. Role homeostasis exists when the individual experiences a relative balance between role stressors and role supports. The defense mechanisms of the individual operate constantly to maintain this balance. When this equilibrium is maintained, the individual performs tasks adequately and suffers no stress related disruption in physical or emotional health. In short, the individual functions without symptoms.

4. Role breakdown exists when there is a concurrent loss or deficiency in role supports and an overload of role stressors. When this condition occurs, the defense system fails resulting in the appearance of symptoms (charted earlier as indicators of burn-out) and task performance deteriorates.[11]

These factors can be summarized graphically as follows:



Proposition 10: The above model illustrates three levels of system intervention that can be utilized to reduce the staff casualty process:

1. We can teach individual staff (via the training system model) more effective stress coping techniques.
2. We can manipulate the work environment to reduce role stressors.
3. We can manipulate the work environment to increase role supports.[12]

Proposition 11: The overall character of the organizational system greatly influences the intensity of role stressors and the availability of role supports for individual staff. In an earlier study the author described the tendency for small direct service organizations to become "closed organizational families" marked by increasing numbers of staff member's personal, professional, social, and sexual needs being met within the staff group. It was emphasized that as the group became progressively closed, role stressors increase and role supports significantly decrease.[13] It is still the author's contention that the staff casualty process is highly influenced by the degree to which the organization is "open" or "closed."

I have attempted in the above propositions to take the issue of staff burn-out out of the realm of psychopathology and place it in its organizational context. Section II presents three case studies of RSAs who relapsed while working as counselors in substance abuse programs.

The organizational analysis of each of these three cases is meant to set the stage for a detailed discussion in Section IV of the particular role stressors which appear to play a contributing role in the relapse of the individuals interviewed in this study. Two major propositions will become apparent in the remaining pages:

1. Numerous cases of relapse by RSAs working in the substance abuse field can be viewed as a tragic and dysfunctional response to a particularly high stress work environment.

2. As long as the substance abuse field utilizes a manpower strategy that calls for the employment of large numbers of RSAs, the field has a concomitant responsibility to shape and influence program policies, administrative decisions, supervisory supports, etc., that are at best supportive and at a minimum not destructive to the recovery process.

III. A SELECTION OF CASE HISTORIES

Case #1: "Everyone in the community used to tell us 'If you get Lee sober, it'll be with magic 'cause nothing else has worked.'"

Lee was a notorious alcoholic and lifelong resident in this predominately rural county. His alcoholism had led him through the revolving doors of the local hospitals, jails, welfare agencies, ministers, social workers, and members of Alcoholics Anonymous (AA), all to no avail. During one of Lee's sojourns in the local jail, he was interviewed by a social worker from a new mental health center which had just started in the county and was offered the opportunity to check into a 90 day detox program at a nearby state hospital. Being an obvious way to extricate himself from jail, Lee immediately agreed and was subsequently admitted to the detox program. While in the detox program, Lee participated in minimal unit activities but did attend AA meetings. The social worker visited Lee on a number of occasions during the 90 days and brought back glowing reports to the other staff on Lee's progress. Upon Lee's return to the community he immediately con-

tacted the local AA group and maintained both contact with the group and sobriety during these first few months of his return. During the second month back in the community he was approached by the new mental health center staff and offered a job as a paraprofessional to work with alcoholics. Lee accepted this job assuming that working with alcoholics would decrease the odds of his drinking again. During the next 8 months there appeared to be no limits to Lee's energy on the job. His personal charisma made him a natural for recruiting large numbers of clients into treatment and made him a popular staff member at the agency. The explosion occurred during a weekend of the tenth month when it was discovered that Lee was drinking again and that he was sexually involved with a married client. Within 48 hours Lee was fired and left the community. Knowledge of the event rapidly spread into the community and affected the agency's reputation for a number of years. Lee drank almost constantly for several months following this incident, felt overwhelmed with remorse, and contemplated suicide on numerous occasions. Lee subsequently became re-involved with AA, obtained employment in a small business enterprise, and at the time of the interview with this author had maintained four continuous years of sobriety.

Organizational Analysis

This analysis is based on interviews with Lee, with two staff members who worked with Lee during the period described earlier, one board member of the agency, and Lee's AA sponsor at the time

of his initial hiring.

A. The Hiring Process: The probabilities of Lee encountering difficulties managing job related stress were very high from the outset considering the decision to hire Lee was impulsive and blatantly exploitive. Recalling the staff meeting in which the hiring of Lee first came up, the social worker who first interviewed Lee in jail recalled the following: "There was a lull in the meeting and somebody mentioned that all kinds of people in the county thought the center had magic because we had got Lee sober. I said half joking that we could turn Lee into a staff member and really show people what kind of magic we had. Before you knew it, we had decided to hire Lee--as a matter of fact he was offered a job the following day. . . It's horrible looking back but I guess we wanted Lee as a walking advertisement of our center. We did everything but put him in a picture window." The essential elements missing from this process include:

1. No assessment was made of the potential impact of the job on Lee's continued recovery.

2. No assessment was made of the need to prepare both Lee and the staff for difficulties encountered in integrating a paraprofessional into a staff of professional social workers and psychologists.

3. No assessment was conducted of Lee's skills in the area of human services nor was any assessment made of Lee's capability of handling the stress implicit in such work, particularly giving his short period of sobriety.

4. No plan was implemented which could have provided for a smooth transition between the status of client and staff nor was there an assessment of what services Lee himself might have needed to continue from the agency for his own personal health.

5. No plan was implemented to effectively orient and integrate Lee into the agency. The message was essentially: "Now you're on staff; go out and work with alcoholics."

B. The Employment Period: Lee functioned for months with no formal training provided and with minimal supervision. The importance of these two areas can't be emphasized too much. Lee reports of this period: "I don't know what the hell I was doing most of the time. But I figured whatever I lacked in quality I could make up for in quantity. I was working 75-80 hours a week and I figured if everyone was saying, 'Look at Lee, he works so hard,' no one would take the time to figure out how scared I was. I guess I also thought that if I kept busy all those hours, I wouldn't have time to think about drinking." The feeling that all Lee had to offer was his energy could have been addressed by:

1. the provision of formalized training in alcoholism counseling,

2. the provision of close clinical supervision as both a supportive and teaching process,

3. arranging for Lee's affiliation with a professional alcoholism counselor's alliance, and

4. arranging for Lee to meet regularly with other RSAs working in the field for purposes of mutual support and information exchange.

Lee's relapse to active alcoholism did not emerge from a vacuum. Numerous signs and symptoms of stress could have been responded to during the months preceeding the relapse. Lee's "workaholic" syndrome had begun to produce a number of health related problems and all persons interviewed agree in retrospect that Lee had been emotionally and physically exhausted for at least two months prior to his relapse. At least two AA members had expressed concern to staff of the center that Lee had stopped attending AA meetings and appeared well on his way to a "rip roaring dry drunk." In response, the director suggested to Lee that maybe he needed to hit a couple of AA meetings for "P.R. purposes." Lee's entire social network and nearly every waking hour revolved around work, and yet no mention was made to Lee of the need for separation between one's personal and professional life nor was any mention made of the need for Lee to have outside relationships and activities that could nourish and replenish himself from work related stress.

C. The Extrusion Process: The organizational process which was involved in Lee's extrusion from the agency is illustrative due to its similarity to a number of cases interviewed for this study. The organizational process was remarkably similar to the process by which acting out adolescents are extruded from the family system. Lee was immediately identified as the problem of the organization (the identified patient), defined as pathological

(we're o.k.; he's not o.k.), and extruded. A board member reflecting back on this period stated: "They (the center staff) were so concerned about what Lee's drinking would do to the agency's reputation and so concerned about getting Lee out of the community before he became a further embarassment, they fired him and didn't even ask if he wanted to get into treatment somewhere or wanted an AA contact."

Case #2: <u>The Super Ex-Dope Fiend Folk Hero Set-Up</u>

Randy had been addicted to heroin for nearly six years prior to entering a therapeutic community (T.C.) for treatment. He had followed the usual career of the urban addict until an arrest for armed robbery had forced him into treatment. Randy responded well to the structure of the T.C. and within fourteen months had entered a training job to eventually move into a staff position within the program. At this same time the program was contacted by the director of a youth agency in a rural part of the state who was looking for a potential staff person to work with adolescent drug abusers. The T.C. was particularly interested in helping fill this position with one of their graduates since it would open up a new area for client admission and funding procurement. Randy was approached by the T.C. staff and arrangements were made to interview for the job. Within a month, Randy had been interviewed, accepted for the position, and had relocated to this small rural community. Randy was immediately caught up in a whirlwind of

activity in the new job. He was in constant demand for speaking engagements at local schools and community groups. The local drug using adolescents almost immediately turned Randy into a folk hero and there was a steady progression of these young people through Randy's office in the daytime and his home at night. Although the community responded warmly to Randy's initial entrance into the community, criticism began filtering back to the agency regarding such things as Randy's "swearing" in groups, his suggestion to some adolescents that they confront their parent's alcohol abuse, etc. Randy became embittered at some of this criticism particularly when rumors began which hinted that he was selling drugs to his clients. (These events occurred at a time in this state where anyone working in drug abuse was simultaneously suspected of dealing drugs and being a narcotics agent.)

The job related stress experienced by Randy peaked between the fourth and sixth months on the job. He began to experience problems relating to other staff and his expressed feelings toward the community became increasingly confrontive and negative. By the sixth month Randy was drinking to intoxication at least three to four nights a week and becoming increasingly isolated from the rest of the staff. On a weekend during the sixth month, Randy visited his home city and was found dead in a hotel room on the following Monday morning. He died of an overdose of heroin while under the influence of alcohol. It was never determined whether the death was accidental or suicide.

Organizational Analysis

This analysis is based on an interview with the entire staff group which worked with Randy and on interviews with two staff members of T.C. in which Randy was in treatment.

Both the T.C. and the agency in which Randy worked admitted significant omissions in the process by which Randy was placed in the job. One of the T.C. staff said of this process, "We really screwed up. All we saw was a chance to open up another area of the state for (the program); we didn't take the time we usually do to find out if this makes sense as far as the person staying straight. There were things we knew about Randy's progress which should have prevented us from encouraging him to take a job out in the boondocks where he would be almost totally isolated . . . his death hit us really hard. We now have a review committee of senior staff that must agree as a group before we recommend one of our people to work either here or in some other program." Omissions by the agency in the hiring and employment period included the following:

1. An adequate assessment was not made of Randy's skill level nor of his ability to sustain himself emotionally in an isolated area.

2. There was no clear orientation and training process. No job description was provided (which set Randy up to be all things to all people around drug abuse issues) and only minimal supervision was provided.

3. The agency did not provide an administrative/supervisory buffer between Randy and the community. This support and protection was needed to keep Randy "grounded" during both the euphoric period of his

early work period as well as the period of depression and anger which followed it.

4. No supervisory review occurred in response to Randy's decreased job performance, increasing problems with alcohol, and his increasing isolation from other staff.

In addition to the above, the agency staff modeled excessive alcohol consumption as a method of stress management to any incoming staff. Randy was rapidly pulled into the practice of joining staff after work to drink for several hours. While this method of stress management later proved deterimental to other staff (at least two other staff later developed significant problems with alcohol), it was particularly devastating to Randy.

Another practice of this agency, which was not atypical of the agencies involved in this study, was the extreme stereotyping of the RSA within the agency. Assumptions about Randy's expertise were made which were never checked out. Staff automatically assumed any RSA knew about pharmacology, laws pertaining to drugs, and how to handle medical/psychiatric emergencies precipitated by drugs. An illustrative example of this was the assumption by the agency that Randy did not need further training in drug abuse (in spite of the fact that Randy's prior history of heroin addiction and prior treatment experiences in a program developed almost exclusively with heroin addicts had only minimally prepared him to effectively deal with the hallucinogenic and stimulant drug abuse which was prevalent among the youth seen at the agency.) The constant reinforcement of the "ex-dope fiend" role and the failure

to provide access to training and supervison which could have broadened Randy's professional identify and skill was also part of this stereotyping process.

Case #3: "It's them (AA) or us (agency)."

Beth had developed a severe alcohol abuse problem following the sudden death of her husband in a traffic accident. After more than a year of almost constant intoxication, Beth was hospitalized and subsequently referred to a private alcoholism treatment program. She actively participated in AA during her course of treatment and became actively involved in AA upon her return to her community. She attended numerous AA meetings and most of her social network consisted of persons she had met within the fellowship of AA. During Beth's third year of sobriety, she took a job as a counselor in a halfway house for alcoholic women and worked there for almost a year until the program was forced to close due to funding problems. During this period Beth participated in numerous alcoholism counselor training programs and developed an excellent reputation as a counselor.

Shortly following the closing of the above program, Beth was hired as a counselor in a year old outpatient alcoholism counseling center. Her early impressions of the program were extremely positive as the staff seemed both dynamic and committed. The first signs of problems occurred during her third month of work following an intensive in-service training program for all staff. This week long training emphasized psychological approaches to treating alco-

holism, spoke of "curing" alcoholism, and was extremely critical of the "illness concept of alcoholism" in general and the approach of AA in particular. The program staff with the exception of Beth experienced a type of group conversion to the model advocated by the trainers. Over the next several months a number of significant events occured:

1. A large number of staff training events were scheduled for evenings and weekends to train the staff in the new ideology. These sessions were primarily growth groups which emphasized a high level of staff disclosure. These sessions decreased the amount of time Beth could spend in AA activities and were very stress producing as there was a great deal of pressure for her to "deal with the emotional traumas which caused her alcoholism."

2. Beth's affiliation with AA and her use of AA principles and philosophies with clients was subtly but continually discounted and criticized during this period.

3. As Beth began to experience increased stress concerning her own personal and professional beliefs, she came to increasingly rely on the emotional support of her supervisor. This eventually led to a romantic and sexual involvement which for a period of time provided a welcomed reprieve from the increasing stress experienced on the job. Beth recalling this period says: "I really believe if it hadn't been for (supervisor), I would have resigned. I knew my thinking was getting screwed up, but that relationship felt so good I didn't believe anything could throw me off balance and I still felt great about the work I was doing with my clients."

During the eleventh month of Beth's employment, the relationship with the supervisor ended bitterly (at the instigation of the supervisor) and Beth began drinking immediately. Although Beth made numerous AA contacts during the early months following her return to drinking, she had great difficulty maintaining sobriety. At the time of my interview with her, Beth had re-established her-

self within the AA program and had maintained continuous sobriety for the last year. She has not and reports she will not return to work in the alcoholism field.

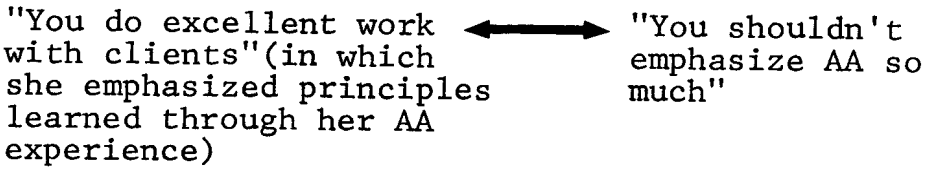
Organizational Analysis

This analysis is based on interviews with Beth and with three staff persons who worked with Beth during the period described earlier. None of the three staff interviewed still work for the program, and in fact report that the entire staff of the center has turned over. Beth was the first of many casualties which resulted from the very serious internal organizational problems that were to plague the agency.

The probability of Beth functioning effectively within the agency described should have been very high. She had four continuous years of sobriety, formal training in alcoholism counseling, a year's experience in counseling alcoholics, and an extensive network of personal support outside the agnecy. And yet within eleven months she had become victim to the very problem she was hired to address in her clients. The stresses placed on Beth within this agency can be catalogued as follows:

A. Contradiction in Personal/Program Beliefs: Beth experienced continuing contradictions between those personal beliefs which supported her continuing sobriety and those beliefs espoused by the program on the nature of alcoholism and the recovery process. This stress was in-

tensified by the following double message received from other program staff:



B. Breakdown of Personal Supports for Sobriety: The program's subtle disapproval of AA and the increasing time demands on evenings and weekends both decreased Beth's ability to maintain her previously active participation in AA. This was further exacerbated in later months by the time spent with the supervisor and an increasing expectation for socializing with staff away from work.

C. Breakdown of Personal Defenses: The mandatory participation in staff growth groups which required that Beth verbalize the emotional traumas of her life severely weakened the defenses that had served Beth well in her period of sobriety. This breakdown of defenses left Beth very emotionally vulnerable.

D. Bonding to the Agency: Beth's relationship with the supervisor marked her final bond to the organizational group and her loss of outside supports. Beth's increased reliance on the supervisor for support in the face of increased stress allowed the supervisor to easily exploit the relationship for sexual purposes. (The supervisor had also been sexually involved in a similar

manner with other women staff).

E. Replication of Earlier Emotional Trauma: The sudden termination of the relationship with the supervisor replicated emotionally Beth's earlier loss of her husband and came at a time when she had few defenses left to cope with such a loss. Having lost other sources of coping, Beth regressed to the use of intoxication to medicate her emotional pain.

Beth had unknowingly entered what the author has in an earlier study called a "closed organizational family" marked by:

- the propagation of a rigid treatment ideology;
- the homogenization of staff;
- the reduction in professional and social contacts outside the program;
- the extrusion of staff who challenge program ideology;
- a shift in focus from the treatment of clients to the personal and interpersonal problems of staff; and
- the development of problematic social and sexual relationships between staff.

Beth's participation in the "closed organizational family" set up an "It's them (AA ideology/fellowship) or us (agency ideology/fellowship) decision." Her relapse was an inevitable consequence of a decision which brought increased acceptance in the organizational group but cut her off from the belief system and supports which had been the foundation of her recovery.

IV. ROLE STRESSORS ASSOCIATED WITH RELAPSE OF RSAs WORKING IN THE SUBSTANCE ABUSE FIELD

The three case histories presented in the previous section have hopefully prepared the reader for a more in-depth analysis of high stress situations endemic to the work environment of substance abuse programs which may inadvertantly sabotage the recovery of the RSA. In this section, ten role stressors will be identified:

- Role/Person Match
- Role Conflict
- Role Integrity
- Role Ambiguity
- Role Feedback
- Role Overload
- Role Boundary Position
- Role Connectedness
- Role Deprivation
- Role Termination

Each role stressor will be defined and examples will be given which are drawn from the author's experience and interview material upon which this study is based. I am particularly indebted in this section to the work of Kahn, Wolfe, Quinn, Snolk, and Rosenthal[14] whose classic work on organizational stress convinced me that a modified version of role theory would be an effective framework for summarizing the results of this study.

Role/Person Match

Role/person match is the congruency between:

a. An individual's knowledge and skill level and the knowledge and skill level required to perform tasks of a given role (e.g., counselor);

b. an individual's level of stress tolerance and the stress endemic to a particular role; and

c. an individual's style of stress management and the methods of stress management that are officially and informally sanctioned within an organization.

Several cases of Role/person mismatch were identified in this study. This mismatch took the following forms:

1. A favorite client was rescued. The author has noted this phenomenon in a number of alcohol and drug abuse treatment modalities, e.g, halfway houses, detox centers, therapeutic communities, methadone programs. In the absence of a viable aftercare plan, the client is moved into an entry level staff position. What initially appears as a way to continue to provide a client with a nurturing support system may prove disastrous due to the stress generated from the discrepancy between skill level and skill demands.

2. The treatment needs of the clients were sacrificed for the immediate staffing needs of the program. This was particularly evident in one program that was studied which recruited most of its staff from clients who had gone through the program. Following a period of high staff turn-over, the program "shortened" the treatment of several clients and moved them into staff positions to fill the void created by the loss of more experienced staff. These individuals possessed neither the skill nor the current level of adjustment to assume high stress roles within the organization.

3. The RSAs were assumed to possess a level of skills and knowledge by virtue of their prior status of addiction. This extreme stereotyping of the RSA, which was noted in case study #2, seems to be particularly prevalent in professional agencies (mental health centers, family service agencies, etc.) which are hiring paraprofessionals for new substance abuse services, outreach programs, etc. The level of stress for the RSA escalates as the discrepancy between real and assumed skills becomes increasingly evident.

4. The commitment of the RSA to help others in the recovery process was confused with competence in substance abuse counseling. The most committed RSAs may find themselves hired for their commitment and yet hopelessly overwhelmed with feelings of incompetence due to their lack of knowledge and skills to sustain their work with clients.[15]

The above examples indicate role/person mismatch based on knowledge and skills. The level of stress produced from this mismatch is further exacerbated by a failure on the part of the progrm to provide the RSA adequate training, access to professional organizations, and access to other professional development resources.

Another type of mismatch involves the individual's history of stress management and the stress involved in the particular role they are hired to perform. Two examples of this type of role/person mismatch will be summarized.

1. The RSA may be hired into an admittedly high stress role without an assessment of whether he or she could adequately respond to this stress over prolonged periods of time.[16] The RSA by definition has a stress management history that has included the excessive consumption of alcohol/drugs. Also by definition the RSA has developed through the recovery process a system of defenses that allows them to manage stress without the use of psychoactive drugs. What is critical in avoiding role/person mismatch is an assessment of the strength and flexibility of the defense system of the RSA. Many programs have set specific time periods of continual sobriety before an individual may be considered for a staff position.[17] While the existence of such a guideline and the differing periods of time proposed continue to be a subject of controversy, the fact that more than

half of the RSAs interviewed in this study relapsed with less than three years continuing sobriety adds some credence to the use of such guidelines. It is the author's contention that the strength and flexibility of the RSAs defense system is a time dependent process. The greater the period of continual sobriety the stronger the defense system becomes and the greater the repertoire of defenses against stress. To place an RSA with minimal sobriety time in a high stress role within a substance abuse program is to invite disaster, particularly when elements of the program structure may inadvertently violate the already fragile defense system of the RSA (see Role Integrity).

2. It is equally important that the individual's stress management abilities be compared to the specific role within the program. Different roles have varying degrees of stress and allow varying degrees of flexibility in responses to stress. It is not simply a question of whether a particular applicant can make a contribution to the field. The question is whether this specific applicant (skills, knowledge, coping abilities, personal supports, etc.) can simultaneously perform the tasks and maintain their personal health in this specific role. Examples of failure to ask this question were detailed in case histories 1 and 2.

Role Conflict

There are numerous areas in which the RSA may experience role conflict. I wish to focus on one particular type of role conflict that appears most problematic. This conflict occurs when the expectations placed on an individual in one role (e.g., counselor in a substance abuse program) are incongruent with expectations placed on the individual in another role (e.g., member of self-help group). To be in compliance in one role places one in conflict in the other role and vice versa. Three sets of conflicting roles will be summarized below.

1. Client Role--Staff Role

   As was discussed earlier, a number of individuals in this study moved suddenly from the role of client in treatment to the role of staff member/counselor within the same program. The lack of a clear transition, or "rite of passage" from one role to another left these individuals simultaneously in the role of client and in the role of staff. The behavioral expectations inherent in the respective roles were different and frequently in direct conflict. These individuals found themselves in a limbo status between roles, unable to fulfill either role adequately and unable to be fully accepted by either the client group or the staff group. Relapse provided a simplistic escape from the stress and conflict surrounding this limbo status.[18]

2. Staff Role-- Self-Help Group Member Role

Both the staff group and the self-help group may have mutual ambivalence if not hostility regarding the RSAs role in the "other" group. The conflict between these two roles was particularly significant to the RSAs interviewed in this study, as was evident in case study #3. The importance of this area is also well indicated by the fact that conflict between these roles often resulted in the RSA being split off from the self-help group. The role of the organizational group in driving a wedge between the RSA and the self-help group has been grossly overlooked. A number of programs subtly discount the RSAs continued need for self-help participation. Other programs, which are somehow threatened by the need of a staff person to look outside the program for help in the recovery process, attempt to blatantly discourage the RSAs participation in such groups.

The professional substance abuse field has contributed very little assistance to the RSA in developing a balance between their own personal recovery on the one hand, and their role as a substance abuse professional on the other. Alcoholics Anonymous has undoubtedly made the most significant contribution to the RSA working in the substance abuse field through its continuing dialogue on the "two hat problem."[19,20] This dialogue has helped large numbers of RSAs bring greater clarity and delin-

eation to what are ideally distinct but complementary roles.

3. Staff Role--Family Member Role

The excessive time and emotional demands of work in substance abuse programs frequently places the worker in conflict with the emotional and time demands placed upon them by their families. Unfortunately this situation is often polarized to the point that either the family or the job are sacrificed. This is particularly true in programs which encourage rather than confront overproduction by staff.

In summary, role conflict may result in two behavioral patterns that may prove equally devastating to the RSA:

- The RSA may withdraw through decreased personal involvement in the job.
- The RSA may escalate his or her time and emotional commitment to the job while cutting off outside supports (self-help groups, families) which may leave the RSA particularly vulnerable to the high stress work environment.

Role Integrity

Role integrity, as applied in this study, is the congruence between the values and belief system of a program (regarding the nature and treatment of addictions) and the belief system of the RSA (regarding his or her own personal recovery). Role integrity also involves a program's respect for the unique defense structure the RSA has developed to maintain his or her continuing sobriety.

While the ideology of a treatment program may be open to intellectual debate, the belief system of the RSA is a matter of personal survival. For a program to consistently undermine this belief system and to place the RSA in a role that demands espousal of beliefs contrary to their personal beliefs is to risk disrupting the very foundation of the RSA's recovery. This is particularly true for the RSA early in the recovery process. Dr. John Wallace has described the importance of this belief system for the recovering alcoholic as follows:

> "The Sober member of AA needs his ideological base. He can ill afford the dispassionate, disinterested, and, indeed, almost casual play upon words and ideas of the inquiring academic intellectual. He recognizes intuitively that he needs a stable and enduring belief system if he is to stay sober."[21]

Dr. Wallace has also proposed the existence of a "Preferred Defense Structure" (PDS) which the recovering alcoholic utilizes to maintain sobriety during the first three to five years of recovery. The PDS utilizes the same defenses that maintained drinking (e.g., denial, rationalization, projection, etc.) to maintain sobriety. For example, the blatant denial of numerous problems confronting the recently sober alcoholic may be essential if relapse is to be avoided. Dr. Wallace further contends: "Therapeutic efforts that confront the alcoholic PDS prematurely and too heavily will increase the probability of further drinking

rather than reduce it."[22] I concur with Dr. Wallace on the existance of the PDS and contend that program practices which undermine the PDS of staff who are RSAs increase the probability of relapse by these particular staff.

In case #3, which was described earlier, Beth had developed a PDS which had helped maintain her sobriety for four years. The program described forced Beth into a series of encounter groups under the auspices of required staff training which grossly violated her PDS, leaving her without the emotional mechanisms to support her sobriety. Within the framework of AA Beth had:

1. identified the single thread that had made such havoc of her life (First step of AA: "We admitted we were powerless over alcohol--that our lives had become unmanageable," [23] the disease concept of alcoholism, etc.);

2. developed a belief that the pieces of her life could be reassembled (second step of AA)[24];

3. set aside much of the emotional pain and feelings which had fueled her drinking until she had maintained some period of sobriety, (third step of AA, "Let go-let God," "Turn it over to God--you can't handle it," "First things first," "One step at a time," etc.)[25]; and

4. taken on a framework of recovery which would allow her at her own speed ("Easy does it") to deal with her past emotional traumas, defects of character, etc. (Fourth, Fifth, Sixth, Seventh, Eighth, Ninth and Tenth Steps of AA).[26]

Beth's PDS was violated in the "training groups" by both contradicting the above (e.g., disease concept of alcoholism) and by disrupting the crucial sequence of the above steps. This process could be stated rhetorically as follows: How long would the

fellowship of AA have lasted if the fourth, fifth, eighth, and ninth steps of AA had been collapsed into a single step and made the recommended beginning of the recovery process?[27]

Dr. Wallace in his discussion of the PDS goes on to note the paradox that:

> "the very same defenses that enabled the alcoholic to drink, as well as achieve abstinence, must ultimately be removed if long term sobriety is to be maintained. However, in many cases such growth must take place over periods of time ranging from two to five years of abstinence."[28]

The existence and possible fragility of the PDS adds a note of warning to our early discussion on the practice of hiring RSAs with relatively short periods of abstinence.

There is an African proverb which says: "Before a man is asked to give up a thing he cherishes and holds most dear, he must be given something of value to take its place."[29] While this proverb has obvious reference to the treatment of clients within our programs, I suggest that it articulately summarizes the proposition that if we are to tamper with the PDS of RSAs working in our programs, then we had better have something of value to take its place.

Role Ambiguity

Role ambiguity refers to the lack of clear and consistent information necessary to perform one's role in the organization. Role ambiguity may involve a lack of:

1. knowledge of role expectations (what tasks are to be performed),

2. knowledge of the degrees of importance to the organization of varying tasks (priorities),

3. knowledge of the steps necessary to satisfactory completion of tasks (methods, style),

4. knowledge of the accountability structure (who is the person directly responsible to), and

5. knowledge of the consequences of satisfactory and non-satisfactory role performance (rewards and punishments).

Role ambiguity consistently emerged as a source of stress for the RSAs in this study. This was particularly true for those persons with minimal training and experience in the field. A common pattern was for the RSA to produce a large quantity (measured by hours on the job) of work in a number of task areas--hoping that this shotgun approach to role performance would meet the undefined expectations of their supervisor.[30] The stress generated from role ambiguity was closely related to problems in two other areas (role feedback and role overload) which will now be discussed.

Role Feedback

Role Feedback refers to the availability of regular information from one's supervisors and peers on:

1. the adequacy of role performance,

2. methods of improving role performance, and

3. the adequacy of the personal and interpersonal adjustment to the total work milieu.

The most critical communications are those which enhance self-esteem, those which support role adequacy, and those which provide the worker with an early warning of stress related symptoms.

When continuing role feedback was not available to the RSAs in this study, they tried to make up for their lack of confidence in the quality of their work by increasing the quantity of their work (number of hours on the job). In short, they traded confidence in their competence for confidence in their commitment. The long term consequences of this were an inevitable chronic exhaustion and deterioration in both task performance and personal self esteem.

Perhaps one of the most critical aspects of this study concerns the availability of feedback to the RSA on his or her overall adjustment to the work setting. Relapse rarely occurs in a vacuum. Numerous early warning signs were exhibited by the individuals in this study. In most cases there was a slow deterioration of functioning which occurred over months, and yet supervisors and peers sensitized to such symptoms in clients seemed blind to such symptoms in other staff or there were no permissions in the program to convey feedback to one another on such an issue. The lack of availability of regular "strokes" in the work setting and the lack of personal feedback on stress management (responsible concern) were two of the supports missing in the programs in which the RSAs in this study were employed.

Role Overload

Role overload, as stated earlier is a frequent consequence of role ambiguity and an inadequate level of role feedback. Role overload may be the result of organizational role/task assignments that are humanly impossible to complete within ascribed timelines or it may be a method of over-compensation by the individual due to fears concerning adequacy of job performance. The personality of the overachiever (workaholic) has been extensively noted in literature on staff burnout. I wish to identify in the following discussion some of the organizational factors that contribute to the overextension of individual workers.

Role overload or the overextension of the individual is frequently a by-product of the over-extension of the organization. Limits are not set on workers because no limits have been set on what the agency can and cannot realistically accomplish. An agency which tries to be all things to all people is inevitably filled with staff who must do the same.

The stress from role overload is often intensified by double bind communications to the worker. The double bind communication has been studies extensively by family systems theorists for its potential role in the etiology of schizophrenia.[31] An example of an extreme double bind communication within the family could be illustrated by the following double message from a mother to her eighteen year old son:

"You need to leave home, get a good job, and develop a life for yourself." ⟷ "If you leave, I'll die."

Double bind communications to the RSAs in this study that tended to reinforce role overload are illustrated below:

1. "You need to slow down and take it easy."	⟷	-Increased work responsibilities. "Give it to ____. She'll get it done." -Promise of promotions if the quality of her work continues.
2. "Why don't you get away for a weekend and visit some friends."	⟷	-I'm sorry ____, but can you cover the house this weekend--Bob has to go out of town for a funeral."
3. "You need to get a boyfriend and some friends that don't work here."	⟷	-Scheduled hours and responsibilities leave little time, let alone energy, to develop outside of work relationships.

That over-extension of the RSA may emerge from the organization itself is further noted by the following two points:

1. In several of the programs studied, professional staff had clearly defined (in some cases over-defined) their territory in the work area leaving the paraprofessionals (frequently RSAs) to manage all tasks not assumed by the professionals.

2. In three of the residential programs studied, I found the following situation:

   - Professionals worked a 40-45 hour week, working weekdays on an approximate 8:30 - 5:00 schedule.
   - The RSAs interviewed from these three programs

were routinely scheduled from 60 - 70 hours per week, worked primarily evenings and nights, and regularly worked weekends. The scheduled evening and weekend hours left little time for the RSAs to develop outside of work social relationships and scheduled hours also conflicted with their attendence at AA meetings and in one of three cases, Narcotics Anonymous meetings.

Role overload has two disastrous effects upon the RSA. It produces a state of chronic exhaustion which weakens the defense structure of the RSA and it cuts the RSA off from outside sources of nurturing which may be essential to the RSA's continuing recovery.

Role Boundary Position

Boundary refers to the line which separates an organizational system from its outside environment. An individual may hold a boundary position within the organization which places them in contact primarily with members of their own organization. An individual who functions quite well in an interior role may function poorly in a boundary role and vice versa.

The importance of this relative position emerged from two of the individual histories in this study. In both cases (case #2 summarized earlier is one of the two), the individuals moved from an interior role in a therapeutic community (TC) to a boundary role in a community agency. The boundary role produced an initial period of euphoria (the super ex-dope fiend folk hero set-up) but was followed by a period of intense conflict and rejection. Within the TC there had existed a structure to keep these individuals "grounded" in response to both elation and rejection.

The checks and balances of the TC were missing in the boundary role within the community agency and, in short, each RSA was given enough rope to hang themselves.

It is important that the RSA who has come through treatment in a TC or halfway house and moved into a staff position in that setting, should not be placed in a boundary role in a community setting without substantial supervisory supports. This is particularly true for the RSA who has moved from the relatively closed world of addiction to the equally closed world of the addiction treatment culture. Boundary roles demand skills beyond those required to operate within either of the above cultures.

Role Connectedness

Role connectedness refers to the degree of attachment between organizational members. This area will be discussed only briefly since the author has written extensively on this area in two other papers on staff burn-out.[32]

Role connectedness can be viewed as a continuum from over-attachment (the closed organizational family) to an almost total absence of attachment (the too open organizational family). Both ends of this continuum may present problems to the RSA.

The over-attachment between organizational members breaks down the balance between ones personal and professional life and leads to members meeting increasing numbers of their personal, professional, social, and sexual needs within the boundaries of the staff group.

Loyalty to the group, expressed by agreement with group values and the amount of time spent with group members, becomes the primary criteria for group membership. The danger of over-connectedness for the RSA is that it frequently cuts off outside sources of replenishment that have both supported the recovery process and served as a reprieve from job related stress. When these outside sources of replenishment are cut off, the RSA becomes highly vulnerable to the stress endemic to the work setting.

The isolation and detachment of the RSA from organizational group members may also be problematic. Two cases in this study (one in an outreach role, the other in a satellite office) had minimal contact with other staff. Although they were both in fairly high stress roles, neither had the supervisory and peer supports available to other staff of their agencies.

Role Deprivation

Role deprivation refers to the process by which significant role responsibilities are either suddenly or progressively taken away leaving the person with minimal or in some cases no responsibilities. The person is, in effect, retired while on the job. That such a move would create a loss in status, a loss of self-esteem, and increased isolation from other staff is obvious.

Given the self-esteem needs of the RSA, such forced retirement may precipitate a personal crisis where the RSA is overwhelmed with feelings of worthlessness, rejection, or bitterness at the experi-

ence of having been used. As the RSA struggles to regain his or her esteem, mini staff meetings occur to decide "what to do" with them. The exagerated efforts of the RSA to maintain his or her visability and personhood are construed as further evidence of the RSA's inability to handle responsible job assignments. The character in Ralph Ellison's The Invisible Man could have been speaking for the RSAs in this position when he said:

> "I can hear you say, 'What a horrible, irresponsible bastard'? And you're right. I leap to agree with you. I am one of the most irresponsible beings that ever lived. Irresponsibility is a part of my invisibility; any way you face it, it is a denial. But to whom can I be responsible, and why should I be, when you refuse to see me."[33]

Role Termination

Role termination refers to the process by which the organization brings to a close an individual's responsibilities in a particular role or brings to a close an individual's membership in the organization.

The author, in another study,[34] has detailed the importance of providing permissions, procedures, and processes by which individuals can leave our organizations with their self-esteem intact and carry with them a sense of fulfillment about their past work. The aspect of permissions for early exit from the agency which the author discussed in that earlier study is particularly applicable here. Two of the individuals in this study had attempted to resign from their agencies within the first three months of their employment but were talked into staying by affirmations of the

quality of their work, promises of training and increased supervision. I feel it is essential that our agencies respect the RSA's judgement on what I have called "Role Person Mismatch" and that we allow the RSA permission (guilt-free) to exit from the field. We need to operationalize the often stated belief that "not everyone is cut out to do this work."

The discussion of role termination would be incomplete if I did not mention the termination process surrounding the relapse of the individuals in this study. Three of the programs responded, in this authors view, in an admirable manner. They dealt with the RSA in a firm but caring manner. They responded to the relapse both as a personal and program issue offering support to the RSA and dealing with the relapse in an honest and straightforward manner. The personal but firm support of staff contributed to the fact that the relapse period in all three cases was relatively short. Two out of three of the programs also processed the level of stress all staff had been functioning under and implemented a number of changes to reduce the causes of stress and increase staff supports.

In most of the other programs, the RSA was responded to administratively (fired), but not personally. The communication to staff and clients occurred through the rumor mill and not through direct communication. Staff were discouraged from having any contact with the RSA and there was an unwritten rule that the incident was not to be talked about. Some of the individuals interviewed had had no

contact with program staff since the day they were fired. The program seemed most concerned about the impact of relapse on the program's reputation in the community.

It should not be surprising that most programs flounder helplessly in response to the relapse of one of their staff when one considers that as a field we have not even publicly opened dialogue on this issue. It is my hope that this paper will in a small way provide an opening for that dialogue to begin.

Summary

This paper has attempted to heighten the reader's awareness of forces within the work milieu which may play a contributing role in the relapse of RSAs who are employed in the substance abuse field. Ten sources of role stress were identified and applied to the RSA based on the author's understanding of the addiction recovery process. Relapse was viewed as a potential response to continued contact with high stress work environments that subvert the individual's defense structure and cut off sources of support that are critical to the recovery process. This view significantly broadens the most common conceptualizations of relapse which are based primarily on the notion of the "addictive personality." The view proposed in this paper is that sources of stress endemic to the work environment may play a contributing and a critical role in the relapse process. Relapse is thus identified as one of numerous dysfunctional responses to work related stress that have been included within our understanding of "staff burn-out." The implication of this study to the substance abuse field is obvious: as long as

the field continues to utilize a manpower strategy that calls for the employment of large numbers of RSAs, the field has a concomitant responsibility to shape and influence program policies, supervisory structures, etc., that are at best supportive and at a minimum not destructive to the recovery process.

The second major implication of this paper which is broadly applicable to the human services field is that an analysis of role supports and role stressors can serve as an excellent vehicle to identify organizational factors which contribute to staff burn-out. The ten role stressors described in this paper produce staff burn-out among the whole range of human service workers. They are by no means unique to the RSA working in the substance abuse field. The unique tragedy of relapse is that the victim falls prey to the very process her or she has commited themselves to help eliminate in the lives of their clients.

It has long been my contention that the ability of a human service organization to effectively nurture its clients can only be as good as that organization's ability and willingness to promote the health of its service providers. It is my hope that this paper will help support the movement to build service systems that promote the health of both staff and clients.

Notes and References

1. William L. White, Incest in the Organizational Family: The Unspoken Issue in Staff and Program Burn-Out. (Rockville, Maryland: HCS, Inc., 1978).

2. The terms "Ex-Addict," "Recovered Alcoholic," and "Recovering Alcoholic" have been lumped into a more generic term of "Recovering Substance Abuser (RSA)." Unfortunately we have no term which brings together all those in the recovery process irrespective of their particular drug choice.

3. Herbert J. Freudenberger, The Staff Burn-Out Syndrome. (Washington, D.C.: Drug Abuse Council, Inc., 1975.) (Hereinafter "Freudenberger, 1975.")

4. Christina Maslach, "Burned-Out." Human Behavior. Vol. 5, No. 9, pp. 16-22, September, 1976.

5. Seymour Shubin, "Burn-Out: The Professional Hazard You Face In Nursing." Nursing. 78 Vol. 8, No. 7, July 1978.

6. See the following:

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   C. Robert Golembiewski, Behavior and Organization. (Chicago, Rand McNally & Company, 1962.)
   D. Robert L. Kahn, Donald Wolfe, Robert Quinn, J. Snoek, and Robert Rosenthal, Organizational Stress. (New York: John Wiley & Sons, Inc. 1964.) (Hereinafter "Kahn, 1964.")

7. The metaphor of impotence not only captures the loss of passion and energy produced by burn-out, it helps explain the power games and problematic sexual relationships that occur when programs experience a high rate of staff burn-out. These behaviors are, in fact, attempts to re-establish potency in the exact arena where one feels impotent--in the work setting.

8. These three aspects are discussed in more detail by the author in the following:

   William L. White, A Systems Response to Staff Burn-Out. (Rockville, Maryland: HCS, Inc., 1978.) (Hereinafter "White 1978B")

9. I am indebted to Mr. Ron Arkin, Center for Education and Manpower Resources, Ukiah, California for my understanding of

the importance of the early burn-out experience as a vehicle for personal and professional growth.

10. Training approaches to staff burn-out could be even more essential if management courses placed greater emphasis on systems approaches to burn-out, e.g., how to structure the agency environment to promote the health of workers.

11. These symptoms which I have described in the aggregate as staff burn-out are both symptomatic of a breakdown of coping mechanisms and are, in fact, a further attempt at defense against the high stress situation. While excessive alcohol usage is on the one hand a possible symptom of high stress, it is at the same time an attempt to medicate that stress, an attempt to return the individual to psychological homeostasis. The symptom will not dissipate until either the environmental stressor is alleviated or the individual discovers alternative defenses which provide relief from stress.

12. A number of these strategies are identified in White, 1978B.

13. White, 1978A

14. Kahn, 1964

15. Many members of Alcoholics Anonymous and Narcotics Anonymous have learned that successful Twelfth Step work does not in and of itself provide the necessary skills to sustain oneself in the full time profession of addiction counseling.

16. For additional comments on the need for screening of RSA's for both skill level and stress management abilities, see:

    James McInerney, "Alcoholics Anonymous members as Alcoholism Counselors" in The Paraprofessional in the Treatment of Alcoholism, edited by George Staub and Leona Kent (Springfield, Illinois: Charles C. Thomas, 1973.)

17. See AA Guidelines for AA Members Employed in the Alcoholism Field. (New York: General Service Office of Alcoholics Anonymous, N.D.) (Hereinafter "AA Guidelines); "Several years of good, uninterrupted AA sobriety should be behind you before you tackle any paid alcoholism job. AA's who answered our questionnaire agreed. Five years was mentioned most frequently, but a couple of people said three." p.1.

18. A careful reading of Dan Waldorf's Careers in Dope (Englewood Cliffs, New Jersey: Prentice-Hall, Inc. 1973) provides some added insight into the issue of role conflict. We could oversimplify and say that there is an addict career, an addict in treatment (client) career, a professional ex-addict career (staff), and the possibility of an alternate career

following treatment. The limbo status between client and staff career may force the individual back into the addict career. Relapse is then viewed as not simply a resumption of chemical intoxication but a reversion to a previous career that the individual was able to perform. This reversion in the face of role conflict could only be checked by the effective integration into a staff role or "re-entry" into a new career.

19. AA Guidelines

20. Vera L. "AA's Employed in the Alcoholism Field: The Two Hat Problem" presented at the 49th AA Anniversary International Convention, July 4-6, 1975, Denver, Colorado.

21. John Wallace "Tactical and Strategic Use of the Preferred Defense Structure of the Recovering Alcoholic" (New York: National Council on Alcoholism, 1974) p. 7 (Hereinafter "Wallace, 1974.")

22. Wallace, 1974. p. 6.

23. See either:

    A. Alcoholics Anonymous (New York: Alcoholics Anonymous World Services, Inc., 1955) (Hereinafter "AA, 1955.")
    B. Twelve Steps and Twelve Traditions (Alcoholics Anonymous Publishing, Inc., 1953).

24. AA, 1955 "2 - Came to believe that a Power greater than ourselves could restore us to sanity."

25. AA, 1955 "3 - Made a decision to turn our will and our lives to the care of God as we understood Him."

26. AA, 1955 "4 - Made a searching and fearless moral inventory of ourselves.
    5 - Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
    6 - Were entirely ready to have God remove all these defects of character.
    7 - Humbly asked Him to remove our shortcomings.
    8 - Made a list of all persons we had harmed, and became willing to make amends to them all.
    9 - Made direct amends to such people whereever possible, except when to do so would injure them or others.
    10 - Continued to take personal inventory and when we were wrong promptly admitted it."

27. My statements on AA here apply equally to NA (Narcotics Anonymous.) Although a full discussion is beyond the scope of this paper, I am convinced there exists a preferred defense structure for the recovering addict that is strikingly similar to that Wallace describes for the recovering alcoholic.

28. Wallace, 1974, p. 6.

29. Cited in Stephen Pittel, "Addict Aftercare: Essence or Afterthought?" Contemporary Drug Problems. Winter, 1977, p. 511.

30. For additional discussions that have applicability to the area of role ambiguity for the RSA, see:

    A. Alexander Bassin, "Taming the Wild Paraprofessional," Journal of Drug Issues. Fall, 1973.
    B. Arthur Pearl and Frank Riesman, New Careers for the Poor. (New York: The Free Press, 1965.)

31. See Virginia Satir's Conjoint Family Therapy (Palo Alto, Ca: Science & Behavior Books, Inc., 1967 pp. 35-37) for a concise description of the double-bind communication.

32. White, 1978A
    White, 1978B

33. Ralph Ellison, The Invisible Man (New York: Signet Books, 1947) p. 16.

34. White, 1978B

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THE STAFF BURN-OUT PAPERS

William L. White

HCS, Inc. is pleased to announce the availability of three (3) monographs concerning the phenomena of staff burn-out in the field of human services. These monographs were prepared by William L. White, M.A., following more than three years of research on the topic.

> "The issue of burn-out will be addressed when we begin defining it as an organizational process and stop defining it solely in terms of the personalities of our casualties."

INCEST IN THE ORGANIZATIONAL FAMILY: THE UNSPOKEN ISSUE IN STAFF AND PROGRAM BURN-OUT

This monograph looks at the inter-relations between members of an organizational group as one would look at a family system. Family systems theory and family incest literature is utilized to describe three incestuous organizational dynamics (professional, social, and sexual) which produce staff burn-out and extrusion. Individual/organizational case histories are included.

RELAPSE AS A PHENOMENA OF STAFF BURN-OUT AMONG RECOVERING SUBSTANCE ABUSERS

This monograph is based on interviews with recovering substance abusers who returned to the abuse of alcohol and/or drugs while working as counselors in alcohol and drug abuse treatment programs. The interview material is utilized to further explore the organizational context of staff burn-out. Ten (10) role stressors (role/person mismatch, role conflict, role ambiguity, role overload, role deprivation, role boundary position, role integrity, role connectedness, role feedback, and role termination) are identified that produce high levels of burn-out in human service organizations.

A SYSTEMS RESPONSE TO STAFF BURN-OUT

This monograph utilizes the conceptual models in the above monographs to describe mechanisms of stress reduction that can be implemented programmatically to reduce the staff casualty process. The way in which persons enter an agency, potential mechanisms of on-going staff support and the manner in which persons leave an agency are examined in detail. Specific strategies are recommended for preventing the over-extension of staff; providing "strokes" and re-energizing experiences for staff; preventing the professional, social, and sexual closure of the staff group, and preventing the isolation of members from the group. Suggestions are also offered on how supervisory staff can respond effectively to severe staff casualties resulting from burn out.

The monographs may be ordered by writing to: HCS, Inc., Attention: Burn-Out Monographs, 1370 Piccard Drive, Rockville, Maryland 20850. Each monograph costs $6.00 per copy. Please allow three weeks for delivery.

STAFF BURN-OUT WORKSHOPS

William L. White has developed a number of workshop and training designs based on the material in the monographs. The most frequently utilized design is a two day workshop which is aimed at acquainting participants with factors which contribute to staff burn-out and individual and organizational strategies that can reduce the burn-out process. The workshop methodology includes didactic presentations, small group exercises, and a number of individual and organizational assessment instruments.

William L. White has presented workshops during the past year for a wide variety of human service organizations, including:

Illinois Dangerous Drugs Commission
Indiana Dept. of Mental Health
Oklahoma Health and Welfare Assoc.
Eagleville Hospital & Rehab. Center
West Virginia Dept. of Health
Wisconsin Bureau of Alcohol & Other Drug Abuse
The National Manpower & Training System (National Insitute on Drug Abuse) Staff Development Workshop
Minnesota Chemical Dependency Program
Ohio Dept. of Mental Health and Mental Retardation
Virginia Dept. of Mental Health and Mental Retardation
The Alcohol and Drug Problem Assoc. of North America
Minnesota Education and Training Consortium

If your organization is interested in the delivery of a workshop, please complete the form below and send to: Attention: Burn-out Workshop
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1370 Piccard Drive
Rockville, Md. 20850

We will forward additional information on workshop design, costs, etc.

- -

STAFF BURN-OUT WORKSHOP

Agency _____ Contact Person _____

Address _____ Title _____

_____ Phone _____

_____

Primary purpose of agency _____

_____

# of staff in agency _____ Problems which you wish to see addressed in the workshop _____

_____

Sick Systems In Treatment: The Impact on Staff and Clients

John Du Cane interviews Bill White, author of Incest and the Organizational Family

How did you come to develop the ideas that are found in your book "Incest and the Organizational Family"?

The seeds to both ideas were from personal feelings of failure. I had been in the CD field for a number of years and had moved into supervisory positions, where I had a lot of responsibility. I often felt very powerless. Something was happening with the team dynamic. People that I cared deeply about were disintegrating right before my eyes. Not only could I not prevent it or intervene, I couldn't even make sense of what was happening. I had a real sense of futility, frustration and incompetence.

At the same time, I was doing clinical consultation with other agencies dealing with organizational issues. We would go in only to hear sick and cynical comments such as: **"We don't need a consultant, we need thorazine".** We had many of these cryptic comments that indicated that what I was experiencing wasn't an isolated phenomenon.

The Casualties of Counseling

There are stages that organizations get into where there is an incredible deterioration in team health, that is also reflected in the quality of client services. In 1978, I started to research these casualties. I wanted to understand why some people not only left their agency but just walked away from the field completely, often under very negative circumstances. I was working for the National Institute for Drug Abuses' regional training centers. I was in a lot of states and interviewed a lot of people who not only left their job site under high stress but also walked out of the field. I started to interview casualties and as I interviewed them, I also asked what was going on in the life of the organization at the time they left.

Patterns Began To Emerge

As I got into it and patterns began to emerge, I began to request permission to go and interview other people that had worked with them at those times. I began to put together not only individual histories but also some organizational histories. With a lot of family systems training, it was natural to begin to organize all of this data within a family systems concept. I began to look at it in terms of open and closed systems.

When one of the women who was a casualty used the phrase "It's just like I was back in my family, its like organizational incest", what she was referring to was her own incest experiences being replicated within the organization. As a staff person, she had been involved in a very abusive sexual relationship with the Executive Director of this agency.

Incest is the final stage in the closure of family systems. The same kind of sexual dynamics in organizations represent the last stage of closure in the same way as they do in family systems. That became the beginning of this concept of organizational incest, of progressive closure, of progressive violation of personal and professional boundaries. The latest stages of this result in the violation of sexual boundaries inside the organization. In broad terms, I started out looking into individual casualties and was led into exploring and understanding organizations. I ended up at a very different place from where I had started.

Would you talk a little more about the differences between closed and open systems in relation to the family and the organization?

With family systems, we look at a continuum in family structure based on the ease with which members can have transactions with people outside, the flow of ideas and people across the family boundary. At one extreme, we have total isolation, of us against the outside world, at the other extreme we have a chaotic, disengaged, boundary-less type of family.

In family systems, we know that there is a fairly high casualty process at both ends of the continuum. The health of a family is determined by its flexibility, its ability to move back and forth between openness and closure according to its real needs.

Stuck

Organizations are much the same. There is a time when organizations need closure and in fact sometimes extreme closure. You probably can't start an organization from scratch without closure. You can't respond to crises without closure.



The danger point that is highlighted in my work focuses on what happens when an organization closes up. The organization responds to a crisis by closing but they get stuck there. What I mean by stuck is that week by week, month by month, they continue that isolation from the outside world. By isolation, I mean that they decrease the flow of ideas and people that cross their boundary. It is harder for outside people to make contact inside. It is harder for staff to make contact outside.

In that kind of situation, what I found in my studies was that week by week, month by month there is a very predictable process of closure, in fact, almost developmental stages of closure. In the late stages, it is just horribly disruptive. Not only does the health of individual staff members suffer, but entire organizations literally self-destruct. You can think about Watergate and other public events which we can conceptualize as closed systems in the latest stages breaking out with these acts that would normally be unthinkable. How could somebody do these kinds of things? And yet inside this closed system they appear a whole lot more sane. To sustain health, organizations need to be in the middle range of the continuum.

"The key word is flexibility, the ability to move back and forth, to move towards closure or openness based on changes in the outside world, based on internal changes or on the changing needs of clients."

The Key is Flexibility

The key word is flexibility, the ability to move back and forth, to move towards closure or openness based on changes in the outside world, based on internal changes or on the changing needs of clients. What happens if over a period of time the characteristics of those clients radically change? In essence, the questions is "Is the organization healthy enough to take the data related to the changing characteristics of clients, and do we have the technology and philosophy to fit that?" Healthy systems can adopt. Closed systems can't. Closed systems will continue to pound round clients into square holes or vice versa.

The High Priest

What have you seen in the leadership of organizations that are heading toward major problems?

The term that I use a lot with closed systems is "high priest". Sometimes it may be based on personality style, sometimes a person gets thrust into that role and can't quite figure out how they got there or how to get out of it, but the high priest role really is an extremely centralized authority figure within the organization. The power and decision-making is centralized. They tend to have a more charismatic style of management.

Again, there are times where that kind of leadership style is extremely appropriate. I am not sure you can start an organization from scratch without some of that style. I don't know if you can come in and respond to crisis or an organization that needs to completely re-organize without some elements of that style. It raises a fascinating question. Are there unique leadership styles that need to be used very selectively to come in and build or re-organize a program and then get out before they screw everything up? Other people may be able to shift their style from year one to year four. But the same skills that can guarantee success in year one may later destroy a closed system. Not that this style is wrong, but it is wrong in the sense that it can be devastating when sustained for long periods of time.

So there isn't any one correct style of leadership?

It's not an issue of a correct style as much as: what is the style needed for each developmental stage in the life of an organization? The kind of styles needed to respond to an organization in crisis are very different from maintenance styles. The key is the ability of the leader to adapt their style to move between closure and openness. Can they tolerate more decentralized decision making? Can they tolerate more delegation and decentralization of power within the organization? Can they make that shift? Healthy organizations can make the shift. With closed systems, you tend to have leaders that find it difficult to do that.

The danger is that there is an extremely high causality rate. Our entire field has been built from the blood of some of these people. I'm talking not only about national people but if you look at local programs, there is probably a high priest associated with the initiation of many of these programs. If we look 15 years later, what we see in many cases is the fall of the high priest in a late stage because we haven't figured out a way to salvage and sustain the health of some of the most powerful and charismatic people in our business.

Is there a lack of care toward the leadership or is it a matter of a power imbalance?

If you compare the 12 step movement with Synanon, you get a radical difference of understandings of the nature of desired leadership. AA, NA and CA in particular represent the 12 step model. What would happen if we personalized their leadership? They understand that given the nature of the beast, in terms of grandiosity and narcissism, to push people to centralized power would absolutely guarantee destruction of the movement because almost every other movement preceding that year did in fact self-destruct when it became a personality cult. Synanon, in contrast to AA, centralized enormous power within the top three personnel.

We need to figure out a way to sustain leadership over time and support the health of our leaders and keep them out of high priest roles, keep them out of those extreme isolated roles in which they are almost immune from feedback. In those high priest roles, they can go crazy because they are so isolated from the field. There is absolutely nothing keeping them grounded, whereas there are built in mechanisms within those 12 step structures which guarantee them to keep grounded in that kind of way - the principle of anonymity for example, and the principle of rotating leadership.

The Warning Signs

If you are a counselor, what are the kinds of warning signs that would tip you off that something is going wrong with your organization?

What you would see if you looked collectively across large numbers of individuals in the organization, are systems closing simply by decreased boundary transactions. That is the principle. You will have increased isolation, decreased access to outside training, loss of learning, tremendous fear in terms of any ideas from outside coming inside and penetrating the organization.

You will have increased homogenization of staff, you will begin to hire or fire people in terms of who talks likes us or walks like us rather than for their competence or skill. Training shifts from issues of knowledge and skill acquisition to indoctrination into whatever that particular philosophical or treatment dogma is. People who challenge the belief system are in high danger so we start scapegoating members out of the organization.

Stagnation, Boredom, Loss of Faith

Probably, the earliest stage is a sense of stagnation and a sense of boredom and a sense of a loss of faith. Probably what that is from, is simply a loss of learning as we decrease the flow of ideas from outside. When nobody is giving you ideas from outside, you reach a point of diminishing returns in terms of what you learn from one another. So there is this sense that we have lost something, a feeling of being trapped, not individually, but collectively. This is not a individual phenomena. It is literally a collective developmental stage in the life of an entire organizational group.

Are there things that people can do when they see things happening to their organization without having to go outside? My impression is that you do have to go outside to receive this help.

A lot of organizations reach an instinctive sense of warning and they instinctively begin to act. They bring in outside consultants or trainers, or they get people out or they do

"The ecosystem, not only in Minnesota, but around the country, is changing so rapidly...is so turbulent that we're all in culture shock trying to catch up with the kinds of things that are confronting us."

retreats and kind of assess where people are at. They can do this with planning, marketing, thinking how they will respond to clients with new characteristics. There are all kinds of formats but the result of all those is that they begin to re-open the system in a very healthy way without even realizing it.

When the system is extremely closed, we need to be aware of the personal risk for the person that steps out and begins to attempt organizationally to open that system back up. We just need to be aware that anything they do in that regard can be dangerous, particularly saying things like "We need to get together as a staff and assess where we are at." The staff member who voices that opinion is doing some very healthy things by trying to get that organization to assess itself and move to its next developmental stage, but they are taking a definite risk.

Networking As a Health Tool

A second level that staff has to operate at is to figure out where they are at personally. What is this closed system doing to them at a personal level? Because they are more restricted in that closed system, there is increased role integrity problems/conflicts between personal values and beliefs. If people are needing to stay in closed systems, the best personal advice I could give based on my research is that no matter where the rest of the organization is at, they have to cultivate an outside personal and professional network outside the organization to sustain them. Without that, as that closure continues, their health will continue to deteriorate.

Burnout and the Organization

One of the terms strongly associated with chemical dependency counselors is burnout. I have usually heard this term in relation to individuals and their clients. Here, it sounds like it is the result of something more.

There are particular issues that each worker brings with them that can either increase or decrease their vulnerability to burnout. By burnout, I am talking about a deterioration of work performance and an equal deterioration of emotional and physical health in that process. Historically, what we have done is we have defined the phenomena of burnout within the personality characteristics of our victims and simply failed to look at the environmental context in which that occurs. We defined it as bad morals, by saying that there is no such thing as burnout, but rather a staff that doesn't want to work and we define it as laziness, we define it as psychopathology.

Or we can define it as job efficiency and we can bring people like me in and have people lay on the floor and teach them to breathe deep and learn great techniques for relaxation. I'm not saying that any of those approaches may not be appropriate in some circumstances. What I'm really saying, what the whole message from most of our research says, is this is an extremely complex phenomenon, it springs from multiple etiologies. For example, what if you teach people all the stress management techniques in the world and they're in a horribly toxic organizational environment? What in essence we are doing is teaching them to sustain themselves longer in a toxic environment, asking them to last three years instead of 18 months before they become a casualty.

Training As a Health Tool

I've been struck by your emphasis on the need for training in order to remain healthy.

I'm an avid supporter of training for two reasons. One is just for all the knowledge and skill acquisition that naturally comes with training. My second reason for training has very little to do with knowledge and skill acquisitions. When individual supervisors send line staff out to workshops, I think the fact that they learn something should be looked on as a perk or as a plus, but not the most important point.

One of the primary reasons for that is for the boundary transaction impact of outside training - that people begin to interact with other professionals, develop a professional identity that transcends the organization of what they are a part. They see that the CD professional is something other than somebody tied to this specific organization, that there's a sense of values and ethics across the field, that transcend any individual agency. That's a benefit of training that far transcends to me simply the issues of giving people specific knowledge and skills. The knowledge and skills, they're going to need to keep coming back for, but the transactions begin to shape a maturity and a professionalism that go way beyond the issue of knowledge and skill adequacy.

Minnesota: Stigma and Status

Can you identify certain underlying assumptions in what you've seen in Minnesota that have stymied health or growth in the profession?

The very success of Minnesota at some levels can be a curse. I love the state of Minnesota, I love it for it's innovation, I've loved it for 20 years, I mean every field in health and human services that I've been involved in, it's like all roads lead to Minnesota, in terms of an incredible history of innovation. The danger of that kind of history is that suddenly models get cast in cement and become unchangeable and you find yourself out selling this Minnesota model or that Minnesota model and in the process of defending it as you move across the country and market it. It may be that the world has changed and the model needs to move and grow, but in the process of selling it, it can't.

One issue that triggers closure is stigma. Alcoholism and addiction is stigmatized. We've often thought about the impact of that stigma in terms of its impact on the client, but I would suggest to any of us who work with highly stigmatized clients that stigma drives us into closed systems.

Ironically, another thing that creates closure is status or an incredibly high level of staff. Now what's interesting, is what happens when you have a situation like Minnesota where you're dealing with what historically was a highly stigmatized client population and you created some incredibly innovative models for that and get so well known for that, you combine both stigma and status at the same time. You have both of those elements coming together to create what can be a very high level of isolation, which is what I mean by the concept of models getting cast in concrete.

In any healthy field or healthy organization, for any point in time, there needs to be a set of values and beliefs and philosophies that for this date make sense out of what we're doing. From the standpoint of the health of the entire system, that belief system has to be open every day to negotiation. The same philosophy and belief system has to be open for constant refinement and evolution. If we get stuck with it at any point, we're probably

in trouble, in a field like ours.

Let me give you a classic example. Let's suppose that we took an entire philosophy and understanding of addiction that emerged over 25 or 30 years, but let's assume that philosophy as it evolved was based on an incredibly homogenized population, and for that population, not only was this philosophy and technology effective, it was unbelievably effective. It was like a revolution compared to 300 years of history. But let's say that philosophy and technology fit people who were white and who were men and who were adult, who were in late stages of alcoholism and let's say that model was so successful that we have replicated it all over the United States.

We've spawned Minnesota models in every 28 day program from here to Florida to California and as long as people look like the people that model was designed for, it's an incredible model. What happens the first time we start bringing kids into that model unchanged? What happens the first time we start bringing large numbers of women into that model? What happens when we bring people who present serious psychiatric illness concurrent with that? Suddenly we've got clients failing in that model.

What we do then to maintain the holiness of the model is to blame clients for their failure in treatment. That's what I'm talking about with frozen models. It's not to say that old philosophies are bad at all. It's just to be extremely clear about the nature of the world and the clientele that the models were designed to fit. As soon as those characteristics change the belief system has got to evolve. That's the difference between open and closed.

Every two years we can say: how are our clients different today than they were two years ago? We're getting younger kids. What's that really mean? Let's think that through. What's it mean that kids are using between 9 and 12 at onset, compared to 17? But what's that mean in terms of what we do? Healthy systems can think those things through and day by day they adapt their systems. Closed systems are basically back selling the product and the product remains unchanged.

Have you seen some examples of that in your work in Minnesota?

> ***"Values and morals work really well when all of your needs are taken care of. But, what do you do when those needs aren't getting met?"***

Yes, but I wouldn't want to pick out Minnesota particularly. The ecosystem, not only in Minnesota, but around the country, is changing so rapidly.There are radical changes in drug consumption patterns and the characteristics of users, and in issues of violence and HIV infection. The ecosystem is so turbulent that we're all in culture shock trying to catch up with the kinds of things that are confronting us. Has there been that kind of closure in Minnesota? One indication of that is simply been the responsiveness to the research that I've done. I've come in and worked with a lot of programs in the state of Minnesota around how not to be closed in this way.

Are people handling these changes?

What I am particularly excited about in the state of Minnesota is the state's openness to look at these issues. There is a hunger for models to help identify these problems. The first three or four years after my early papers were done, the majority of work I did in Minnesota was with organizations in a horribly late stage of closure. Some had literally been bordering on organizational death. There were severe casualties among the high priests, horrendous issues of abuse and neglect of clients.

The difference today is not that I don't still occasionally do some late stage work in Minnesota with those organizations, but I get a lot of requests from Minnesota to look at organizations that are basically healthy organizations, in very early stages of closure, and part of their health is they recognize that fact early and even recognize that they may need some freshness from outside to come in and help facilitate the entire process of moving back towards openness.

From that standpoint, there's some tremendous health in terms of the openness in that system to look at problems. When I first began talking some these concepts, it was real scary for people to want to hear some of those ideas and also to apply some of those ideas to their own organizations and to their own roles. I have been in high priest roles in organizations, believe me, I empathize with what it's like to kind of stumble into a workshop and hear somebody describe in intimate details this role you've been in and have not fully articulated, that's some pretty scary stuff to look at.

I think the difference in Minnesota compared to some other places, is some states can get so terrified they don't want to confront any of those issues. I go into places for example who will invite me in and what they want to do is to control what parts of the book that I talk about. That's not unusual at all!

Abuse and Neglect of Clients

Can you enlarge a little bit on the abuse and neglect of clients that follows from the system closing?

In the late stages of closure, two things are happening. One, the intensity and frequency of stressors on staff escalates dramatically. You've got an organization almost always horribly overextended that hasn't even begun what it can and can't do with x-number of people. You've got these overloaded, depleted staff with incredible levels of demands in terms of quantity and quality of work demanded on them at one level.

The supports in the system have deteriorated radically over the months or years so you've got this combination of extremely high stressors, you've got extremely low supports and you've got a system that's lost all clarity internally around appropriate and inappropriate boundary issues both in terms of staff-staff and staff-client relationships. You've got all these incredibly needy staff, you've almost lost any appropriate sense of professional and personal boundaries to guide relationship-building. In this situation, we almost always find an incredibly high incidence of client neglect. Part of this is that the organization internally is getting so crazy there simply isn't enough staff time and emotional energy to respond to the needs of the clients. At a minimum, we have client neglect.

Unmet Needs

More frequently, we'll go beyond neglect and begin to see conditions of abuse where staff begin to violate boundaries with clients, to meet their own high level of unmet needs. If you look an incest in family systems, not as an event but a process, the sexual violation here is simply one of numerous steps in a general violation of boundaries. It is simply the end of the continuum. It is the ultimate violation, but in fact there have been many

violations before that.

If we look at sexual exploitation of clients, or financial exploitation, or friendships with clients, what we see in closed systems from year one to year five, is a progressive deterioration in and violation of those boundaries. If you've been in a closed system in the last few years, you've basically sacrificed or had a casualty in whatever marital or intimate relationship you've had outside and we've cut off your social relationships outside this organization. For all practical purposes, you have almost no life outside this organization. Where else are your sexual needs going to get met if not inside the organization? You have no other world.

That's where you begin to get not one but multiple episodes of sexual exploitation or other abuse of clients in this stage. We often go in because there are allegations that the Executive Director has been involved with sexual exploitation of clients. When we begin to interview clients, staff and board members, what we find is not one but multiple episodes of sexual exploitation.

One incident is likely to be just the tip of the iceberg.

In closed systems, any single incident of sexual exploitation of clients should always trigger the suspicion that there may be multiple perpetrators involved inside the system. You often see sexual exploitation in predatory terms and I don't want to discount that. There are certainly sexual predators out there, but you may have people in closed systems that in other circumstances would not have been involved in sexual exploitation of clients. Some of the people that we've interviewed in our studies literally found it inconceivable that they could ever be involved in a sexual relationship with a client.

Values and morals work really well when all your needs are taken care of. Maybe it's not even particularly a virtue that one is ethical and moral when all your needs are taken care of. But, what do you do when those needs aren't getting met? Now let's see what happens to ethics and morals and professional boundaries. It is not under normal conditions, but under these sort of bizarre organizational conditions, that these problems happen.

The organization is involved with finding ways to help prevent those sort of situations from arising, and in having have some kind of system of accountability for people when that situation has developed. As you know, we're involved in looking at the possibility of licensing counselors to help that process. Have you seen ways in which a credentialing process or major licensing process has helped deal with these problems that surface in closed systems?

There are things that can be done both in terms of certification and licensing systems for individual workers or programs. One of the things that has helped break down some of that closure in a lot of states is the high level of training demands that come out of licensing. Historically, closed systems begin to shut down external contact through training. It is always in the name of money. We're so smart, that we don't need those people out there. We can do our own training. Licensing and credentialing insists that there has to be legitimate training outside the agency.

Those training needs cannot be met through inservice training which tends to be more like indoctrination sessions. You are in fact sure that there really is skill building, and maybe even more importantly, relationship building, with other people in the field so that somebody has a professional idea that is not tied to a program. There are values and ethics that transcend the job site. Some states have begun to actually integrate some training related to open and closed systems into their counselor training programs. Training related to ethics, boundary issues and therapy, all of those are things that quickly send up warning flags to people once they have been trained. The most vulnerable people in the world are people who stumble into these systems and these processes who don't understand what is happening.

Part of what I have done with my research is that once people have experienced really looking at middle and late stages of closed systems, they will never experience it the same way again without consciousness and an awareness of what is going on. People really should be trained in this business before they go to work. People often come in with no training. Minnesota was one of the first states to develop this idea that people really have to be trained before we walk them in. This is a radical concept.

Minnesota: A Model for Professional Training

Have you seen this making a difference?

Absolutely. In fact, in a lot of ways, Minnesota has been the model for this professional training. I think that this has helped other states speed up with what was, in fact, constituting a horrible abuse of recovering people. The Minnesota experience really began to show this. They said "Hey, we really need to talk about the inappropriate abuse of recovering people in this field and see what kind of preparation and support they need."

Do you think that our field of chemical dependency is more vulnerable than most to this kind of health problem?

The chemical dependency field is more vulnerable to problems related to closed systems for a couple of reasons: One is the issue of stigma. In spite of all of the changes that have gone on, the destigmatization in this culture, there still is substantial stigma. There is this clustering phenomena. We tend to socialize with this stigma still. There are people with alcoholics in their family who want free counseling. All of these things tend to drive us into closed systems.

The second is that I firmly believe that many of us are forever replicating family experiences. Many of us come from closed families, dysfunctional families, alcohol and drug dependent families and all of the co-dependency issues that spill out of that. It is possible that many of us seek out organizations which replicate the emotional flavor of those families. ■

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Chestnut Health Systems
Lighthouse Training Institute

The Ethics of Competition *

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The Ethics of Competition

William L. White

I. Introduction

It is a privilege and a pleasure to be here this morning. My research and consulting activities have been bringing me to Minnesota since 1978. The fact that the people and programs of this state have been instrumental to the development of my most seminal work always adds a special pressure when I come to speak here--a pressure born from the desire to repay a special gift. I was very excited when I received an invitation more than 18 months ago to speak on the subject of the ethics of competition in the CD field at last year's fall conference and I was quite disappointed when health problems prevented me from making that address. But as I was flying here last night I was struck by how different the address I will present today is from the one I would have presented just 12 months ago. Words I would have spoken tentatively last year I will speak with more boldness today. Last year I wanted to sound a warning of what could happen; today I wish to discuss what has happened and is happening.

I am speaking to you at a critical juncture in our history--a time that many are characterizing as crisis. We have entered a period in which a growing number of persons and organizations are suggesting that the treatment field itself may need treatment. And yet this crisis follows two decades of unfathomable success in our field. Who could have predicted 20 years ago that explosive growth within the field would bring hundreds of thousands of untreated clients and families into the recovery process? Who could have predicted president's wives on television talking openly about their addiction and recovery? Who could have predicted how far we would come in placing early intervention programs in our schools and work places? Who could have predicted the force and spread of the COA movement? Who could have predicted how far we could come in stigmatizing driving while intoxicated? Who would have predicted just a few years ago that we would go through a period where people proclaimed their

alcoholism publicly with great boldness but hesitated shamefully to admit that they smoked cigarettes? Who could have predicted that our prevention efforts would see a decrease in the number of illicit drug consumers in the United States? We have brought doctors and nurses and scientists and others back into what is now a legitimate component of our culture's health care system. What crisis could threaten such unprecedented success?

The crisis of which I will speak comes out of our success. It has come out of our growth. It comes out of the industrialization of the CD field. Signs of this crisis can be seen in many quarters. Following a period of explosive expansion, we are seeing programs close in unprecedented numbers. Occupancy rates are dropping in many CD programs/modalities across the country. The public as a whole and referral resources are looking at CD programs with a more critical eye. Talk of "treatment rip-offs" among active users fuels continued use and poses an obstacle to seeking services. Staff with history in the field grieve a loss of focus and loss of passion in the business; newcomers are overwhelmed by the sheer volume of paper. Morale has suffered during this decade of rapid change. Annual turnover of frontline workers in some portions of the U.S. has reached 40%. Much of the field seems to have lost control over its own destiny--reactors to market and regulatory forces. There is a growing sense that the forces shaping our identity and character are coming from outside rather than within the field. The integrity of the field is being increasingly challenged because of the abuses of some and the silence of many. We are experiencing an identity crisis now that will likely dictate the nature of the field for many years to come. While the crisis will be seen by many as a crisis of dollars, I would like to suggest that it is primarily a crisis of values and ethics.

Let me share a brief story that can perhaps serve as a metaphor of this crisis. You can tell a lot about a field by its storytelling. This is one of the most popular stories on the CD lecture circuit during the past year. It seems that two neophyte hunters had gone to the north country to hunt bear. Neither of them had hunted anything before, let alone bear. On the afternoon of their second day hunting, they were becoming quite tired from a prolonged trek up a mountain trail. Rounding a sharp bend, the two

hunters suddenly found themselves staring into the face of a bear whose size, close proximity and sudden ill-temper caught them so off guard that they dropped their guns and began tearing down the mountain trail for their very lives. There terror was intensified by the sounds of breaking branches coming from behind them. Suddenly as if inspired one hunter threw himself on the ground, tore off his boots, reached frantically into his back pack and began tying on his tennis shoes. His standing partner screamed at him in disbelief: "Those shoes aren't going to help you outrun the bear!" Jumping from the ground into full stride, the tennis-shoed hunter shouted back, "I don't have to outrun the bear; I just have to outrun you!"

There are a lot of us in the CD field who have felt the breath of the bear and reached for our tennis shoes during the last decade. I believe there is nothing inherently unethical about competition. There are many areas within which the field has benefitted from increased competition of the past decade. This escalating competition within the field has, however, pushed many programs into practices that create ethical vulnerability. In the next hour I'm going to explore with you some of these areas of collective vulnerability and propose some broad strategies and directions to address ethical issues in our clinical and business practices.

The perspective I wish to speak from today is not that of the ethicist, but that of a clinician, manager and organizational consultant whose tenure in the CD field spans more than two decades. The perspective is based on assisting individual workers and programs respond to the growing number and complexity of ethical issues within our field. The areas of ethical vulnerability which I will review are those which are systemic across the country rather than those which are idiosyncratic to program or locality. Addressing the ethical vulnerability of the field is picking up momentum across the country in spite of the fact that these can be very painful issues to explore and resolve. There must be certain risks associated with raising such issues; I have noticed conference organizers always bring someone from out of state in to conduct this ethical inventory.

II. Ethics in the Chemical Dependency Field

There are a number of factors that make addressing ethical issues in the CD field qualitatively different than in sister professions.

History: The short history of the field as it exists today has not provided a well developed and well transmitted body of ethical values or models of ethical problem solving. We have no single set of codified standards that defines the boundaries of ethical and unethical conduct. We have no single casebook of ethics or model of ethical decision-making that spans geographical and modality boundaries. Our technology for articulating and transmitting ethical values is under-developed.

Growth: The rapid growth and industrialization of the field moved so quickly that standards related to the ethical conduct of our business practices have not yet evolved. The rapid growth has diluted the ability to transmit those historically shared values and ethics. We have operated historically as a guild system, with new members taught skills and values through mentor relationships. The explosive growth of the field led to a scarcity of mentors that overwhelmed this system.

Diversity: The enormous diversity of personal and professional backgrounds of persons within the field brings multiple perspectives on ethical questions. There is a richness and a depth to this diversity--an untapped resource--but there has been no process within the field to synthesize from this diversity shared values and standards that are of sufficient specificity to guide professional decision-making.

Turnover: The overall turbulence of the field is reflected in the instability of the workforce. High annual staff turnover regularly bleeds out our oral history making it very difficult to transmit core values to new generations of workers and managers.

These conditions have intensified our vulnerability to breaches in ethical and professional conduct. Our history of addressing ethical issues is not a notable one. What work we have done has focused primarily on the counselor role and has not been fully extending to all roles within the CD agency or to the agency as a whole.

We seem to have been afraid of dealing with ethical issues head-on. Ethical issues fester in the denial of silence until they detonate into humiliating exposes of our personal and institutional shortcomings. Those of us on the sidelines of these explosions react with self-righteous indignation seeing ourselves and our institutions as immune from such a fall. And yet the explosions continue, setting up the climate through which outside institutions paternalistically promulgate regulations to legislate our moral and professional conduct. The time for self-inventory is now. Now is the time to expose ourselves to the harsh light of reality and to identify and address our areas of ethical vulnerability.

III. A Collective Inventory

There are at least five broad areas within which the forces of competition have influenced our ethical vulnerability. These are areas of self-inventory being examined by CD programs across the country. Some represent areas under which we are already under attack from persons and institutions external to the CD treatment field. Some represent practices which have led to the restructuring of reimbursement for CD services, e.g., restrictions on coverage, pre-admission approvals, external utilization review, preferred provider arrangements, and managed care systems. The five areas include:

1. Planning and initiation of CD services,
2. Marketing of CD services,
3. Costing and billing of CD services,
4. CD assessment and treatment practices, and
5. Professional peer/agency relationships in the CD field.

My goal in this review is not to shame or demean persons or programs, but to stimulate a process of self-inventory that can protect and nurture our future. My goal is to elevate values and ethics to the same level of consideration as financial survival and to suggest that our values and ethics may well determine this survival.

IV. The Ethics of Planning

We have seen across the United States a disregard or manipulation of planning bodies to oversaturate an area with substance abuse service providers. We have seen the initiation of services, not in response to unmet need, but to capture a portion of market share (profits) from an existing program. The long range needs for a coordinated continuum of care are sacrificed for short term profits. The number of institutions providing CD services with no roots in the field and only superficial commitments to the long range development of the field have increased. This veneer-thin commitment to the treatment of alcoholics and addicts is cast aside the minute more profitable services are discovered leaving in their wake severely weakened or closed agencies with a long historical commitment to this mission.

There is an emerging profile of the profiteers who spring up to drain our resources and then disappear in search of more profitable pastures. The characteristics often seen within this profile include:

- Weak ties to the local community.
- Skeleton staffing patterns.
- Excessive rates for services.
- Aggressive marketing via print and visual media.
- Extended lengths of stay (referred to internally as "maximizing the value of the admission").
- Treatment by "recipe."
- Propensity to frequently recycle chronically relapsing clients.

- Superficial links to local self-help groups.
- Propensity to abandon clients/community when profit levels fall below acceptable levels.

One can speak of "institutional predators" and "profiteers" in 1990, but the story I wish to unfold for you is not a story of good guys and bad guys. It would be easy to launch into Biblical rhetoric demanding that we drive the moneychangers out of the temples and reclaim our field--for the good guys. But such rhetoric is much too simplistic. The ethical issues catalogued here represent a much more pervasive problem than the practices of our most unconscionable and exploitive members. Much of our ethical vulnerability springs not from the blatant abuses of the few but the moral drift of the mainstream. I am not suggesting unethical decision-making by the mainstream as much as suggesting that the mainstream is making decisions without an awareness that they are even in ethical terrain. If we expelled the bad guys, there would still be a lot of good guys who have drifted into uncharted ethical terrain.

The pressure of competition can alter and contaminate the way we make decisions whether they be planning decisions or clinical decisions. We need to define ethical standards that should govern the process of planning,initiating and terminating CD services.

V. *The Ethics of Marketing*

It has become fashionable this last decade to posit that CD agencies must become businesses, that we must apply business technologies in planning, marketing, public relations, financial management, personnel management, and service operations. Many have said this is the only way to save the field. I would suggest that the danger lies in saving the field but losing touch with our historical mission.

The competition of the last decade has spawned the aggressive application of marketing technology within the CD field. These programs are most often designed, implemented and evaluated without the input of direct service staff. The only criteria

for appropriateness and effectiveness is whether they fill beds. The marketing campaigns--marketing wars, in some communities--have pushed some programs to the brink of bad taste and unethical conduct. There are growing concerns about a number of marketing practices through which CD programs promote themselves through radio, television and print medias. These practices include:

- The misrepresentation of the scope, intensity or quality of services.

- Targeting of expanded client base through superficial specialization, e.g. women, adolescents, cocaine, dually diagnosed, etc.

  A traditional inpatient alcoholism unit, facing pressure from a deteriorating daily census, launches a media campaign announcing their new "specialized cocaine treatment track." Upon close examination, one would find only superficial changes in the program--a daily exercise period was added to the program schedule, a small amount of cocaine literature was purchased for patient education, etc. The medical and clinical protocol of this program has not been re-examined in light of the needs of the newly targeted clients nor have staff knowledge and skills been enhanced to address cocaine-specific treatment issues. The "success" of the new cocaine track will be measured in admissions and patient days of billable services, not in the impact of this program on the lives of these new clients.

- Exaggerated and unsubstantiated claims of program success, conveying public perception that recovery is easy.

  Some of the inebriate asylums on the late 1800s proclaimed success rates of 95% based on the fact that only 5% of their clients returned for additional treatment; the assumption was "no news is good news." Some of our modern programs are claiming success rates of similar proportions using evaluation procedures about as sophisticated as the inebriate asylums of yesteryear.

- Exploitive adds that seek to manipulate the shame and guilt of family members.

  The 30 second television spot for the newly opened substance abuse unit in a local hospital opens with a physician proclaiming that alcoholics and addicts are blinded by a disease of denial that makes it nearly impossible for them to initiate their recovery spontaneously. It is the family, the physician exhorts, not the alcoholic, that must initiate the change process. It is the family's responsibility! Panning through scenes of wrecked cars, then moving into a scene of a graveyard and finally a focused shot of an unnamed gravestone, the commercial ends with the words, "If you don't call us today, you may have no reason to tomorrow." Is this an effective tool to penetrate family denial or is it exploitive sensationalism? Is this good advertising or poor taste? Do such aggressive media campaigns unduly exploit and manipulate family guilt and emotional pain? What standards of ethics and taste should govern the design of marketing programs?

- Aggressive adds that reflect poor taste and tarnish the professional image of the field.

  We have seen an aggressiveness in the marketing of CD programs that in my home town we usually reserve for the promotion of cars, carpet, replacement windows, and exotic kitchen gadgets. Are we on the verge of blue light specials, rebates, 2 for 1 sales, seasonal discounts?

- Exploitive use of clients in program promotion.

  A growing number of programs are questioning the historical use of active clients to conduct facility tours and to participate in community/school speaking engagements (sometimes referred to internally as "dog and pony shows").

- Misuse of information/entertainment forums for marketing purposes.

  How many times have you seen someone interviewed for their substance

abuse expertise exploit this opportunity to promote the special interests of their program?

We need to define standards or principles that can guide the presentation of ourselves to the public.

VI. The Ethics of Service Costing and Billing

There is increased ethical scrutiny of service costing and billing practices within the CD field. Areas in which we seem to be most vulnerable to attack include the following.

- Misrepresentation of costs or hidden costs, e.g., inflation of overhead to support other units of a hospital, "free assessments", "free aftercare", etc.
- Failure to provide comparative costs as part of the informed consent process.
- Fee-splitting--sharing portion of client fees to referral sources by agreement or coercion--creating conflicts of interest in contamination of objectivity in the referral process.
- Double billing--billing two or more parties for the same services.
- Setting service fees high with routine writing off of client copayment (accepting insurance portion as full payment) opening ourselves to charges of deception and fraud.
- Abandonment of client when insurance benefits or personal resources are exhausted.
- Violation of confidentiality via use of collection agencies without informed consent of client.

VII. The Impact of Competition on Assessment and Treatment Services

The intensity of competition within the field and our growing preoccupation with occupancy rates, program income, bad debt write-offs, etc., can spill into the clinical

decision-making process. Major shifts in the structure of CD service reimbursement have grown out of abuses in this area. Areas of ethical vulnerability in this area include the following.

- Providing free EAP/SAP services as a case-finding mechanism.

  Such practices violate the objectivity of the assessment and referral process through conflicts of interests that range from the subtle to the blatant.

- Conducting client screening as a recruitment (sales) process rather than an assessment process.

  Principle: Client pathology is in direct proportion to family resources; the greater the resources, the greater the pathology.

- Manipulation of diagnosis according to payor source; preference for "billable diagnoses."

  The current shift from CD diagnoses to psychiatric diagnoses--to escape limitations on reimbursement for CD services--offers a classic example of such manipulation.

- Placement of clients in treatment (particularly adolescents) without clinical data to justify a CD diagnosis.

  There is growing concern about "the ethics of diagnosis"--the labeling of both children and adults with a CD diagnosis without appropriate clinical justification and for the financial gain of the practitioner or the institution.

- Modality bias--admitting clients needing more or less restrictiveness.

  There is a well-documented tendency for programs to assess clients as appropriate for whichever modality they provide, e.g., residential programs consistently assess persons as needing residential services. The lack of independent judgement regarding modality placement and the bias toward more restrictive levels of care have tarnished the professionalism of the field.

- Misuse of treatment settings for purposes other than active treatment.

  There is a danger, for example, that locked units and long term treatment settings could become surrogate jails used as respite for families or as quarantine units (AIDS), losing their active treatment focus.

- Misdiagnosing and misplacing clients in treatment for financial gain raises risk of ineffective treatment and iatrogenic effects of treatment.

  Chronically relapsing clients, for example, may be recycled through precisely the same treatment structure and sequence of treatment activities that have failed repeatedly--until the client's financial resources are drained. We say, in essence, "you must go through this same program again because you didn't get it right the last time." Such shame-based treatment systems misapply treatment technology then blame the client for failure--leaving the clients original problem intact and adding iatrogenic effects of treatment failure: increased passivity, helplessness, hopelessness, and dependence.

- Making length of stay decisions based on insurance benefits rather than the clinical needs of the client.

Our concern here is the integrity of the assessment and treatment process. This is true whether we have a system that financially profits from placing and keeping clients in treatment or an alternative system that profits by keeping clients out of treatment. Both systems can exclude the needs of the client and the voice of the client from the clinical decision-making process.

VIII. Professional Peer Agency Relationships

Our response to escalating competition has often been isolation and grandiosity. Competition has fueled professional arrogance. It forces us into self-aggrandizing statements when we should be asking questions. It forces us to close in when we

should be reaching out. It prevents us from seeing ourselves as part of a broader treatment community--part of a growing culture of recovery in the United States. Amid such isolation and animus have come such practices as gossip-mongering--the spreading of unsubstantiated rumors that detract from one's competitors--raids on the staff of one's competitors, and the open solicitation of clients already in treatment within other agencies.

IX. Where do We go from Here?

I think there are three broad directions we need to go to contain our growing vulnerability. These directions include 1) developing internal standards of ethical conduct, 2) developing mechanisms of internal discipline and 3) refocusing our vision and our values.

X. Internal Standards Development

There is a desperate need for us to come together to develop our own standards of professional practice. We are letting external agents define who we are, what we do, when we do it, to whom and for how long. We need to look internally rather than externally. We need client and community centered values and standards that decrease the need for our regulation by external agents. In the 1940's AA went through a turbulent period shaping the traditions that would govern its organizational life. Those traditions were heavily shaped by the belief that money, power, politics and property could destroy AA by diverting its attention from its primary mission--carrying the message of hope to still suffering alcoholics. Fifty years later,we may be learning the same lesson. In the same way that the traditions have governed the group life of 12 step programs, we need to develop codes of professional practice that govern the life of our organizations--both our clinical practices and our business practices. We must stop reacting and complying and shape our own identity and destiny.

I believe this standards development can occur at multiple levels. It can spring from professional organizations seeking to identify standards of ethical and professional conduct. It can spring from local service agencies who through the development of an agency code of professional practice seek to define the values and standards that will govern day-to-day business and clinical practices within their organizations. It can come also from persons sharing specialty roles whose functions fall outside the parameters of existing standards development. At all levels we need to define and say: These are the limits beyond which we will not be moved; these are the core values which will not be compromised.

XI. Mechanisms of Internal Discipline

We need to challenge programs and people who care more about profits than people, who care more about occupancy than recovery, and who are more concerned with private and institutional wealth than with public welfare. We need to explore mechanisms through which we can discipline ourselves so that the fate of the field is not shaped by the abuses of the few. We need to find forums from which to confront breaches in ethical conduct so that the fate of the field will not be shaped by the silence with which we have historically confronted our shortcomings.

XII. Refocusing

I think one of the most positive developments in the field is the growing number of programs, overwhelmed by rapid changes, who are taking an opportunity to step back and get themselves recentered and refocused. Whether in retreats or in staff meetings, this self-examination process is occurring across the country. Programs are re-examining their historical mission, refining or changing this mission when necessary, and providing for rituals of recommitment. Whether programs approach from a planning framework or a problem-solving (e.g., stress, team-functioning), they are collectively beginning to get back to fundamental issues of defining organizational values and organizational culture. Some of the major themes emerging from this self-examination process include the following.

A. Vision and values - Many programs have observed the push from external forces to shift from a people-changing to a people-processing focus. In the former, responsiveness to client need--facilitating change in the client's quality of life--is the highest institutional value. With the latter, the highest value is procedural efficiency with the focus on process rather than outcome. How many times has a counselor confronted with overwhelming paperwork thought: "If I could just get rid of all these clients wanting to come in and tell me their problems, I could get my work done!?" Many of us have drifted into people-processing. We must redefine why we exist and recommit ourselves to those service values.

B. Defining Success - A growing number of programs are beginning to define success not in terms of profit but in terms of service accessibility, service affordability, responsiveness to client need. They are refocusing on the mission of service. They want communities and families to feel the agency has served them, not used them.

The values that drive our business practices must be congruent with the values that drive our clinical practices. If not, there will be a war within the institutional identity that can compromise both service quality and financial viability.

C. Stewardship of Resources - A growing number of programs are assessing their overall management of resources in light of their revisited mission and their newly clarified organizational values.

D. Networking - A growing number of programs are intensifying their relationships with other health and human service agencies and exploring innovative multi-agency, multi-disciplinary models of serving multiple problem client/families.

E. Creativity - There is a desperate need for creativity. Our obsession with regulatory compliance and financial survival or growth has numbed our imaginations and our ability to perceive and respond in original ways. A growing number of programs are exploring how to revive creativity as an organizational value.

F. Spirituality - There is a spiritual component of this revitalization movement. Spirituality is being approached not as some ephemeral and mystical concept. It simply suggests that there are values and accountabilities that transcend personal and institutional self-interest. It is a concept that can temper our institutional appetite for power and profit. To cultivate spirituality within an organization is a recognition that there are external resources and relationships that can empower the organization. It is the experience of internal congruity and external connectedness. It is the experience of an ethically united professional community, full membership in the culture of recovery.

We need to tap our spiritual traditions to forge business ethics for our field. I fear most a future history where the driving motive will be profit--a field that saves itself but loses its soul--a field where once vibrant programs become empty carcasses changing identities through seasonal reorganizations, mergers and hostile takeovers. I don't think this future will come because we lack moral integrity, but it could come because of our passivity, our dependence on external institutions, and our failure to be morally assertive in the face of financial threat.

I am not proposing a retreat into the past, but I am suggesting that the best of our past can keep us grounded through what is likely to be a turbulent future. I am also suggesting that our ability to stay ethically grounded and to stay value focused may very well dictate our financial future.



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The Ecology of Sexual Harassment and Sexual Exploitation: A Systems Perspective

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Efforts to address sexual harassment in the workplace have often been initiated with a microscopic definition of the problem and required remediation strategies. The problem is investigated and defined within the "accused perpetrator" and "alleged victim" dyad. The etiology of harassing behavior is seen as springing exclusively from the character of the individual perpetrator(s) and internal redress seeks to correct the problem by re-education, punishment or expulsion of the offending member. Defense of the accused perpetrator often involves an attack on the veracity or character of the alleged victim, a process that poses risks of further emotional violation. Organizational responses all too often involve isolated elements of action—a policy is written, a speech is made, a group of supervisors is trained—that could be part of an effective response but prove ineffectual in their lack of comprehensiveness.

A systems perspective on sexual harassment can provide a framework to integrate divergent perspectives into a coherent and coordinated framework for understanding and correcting sexual harassment and broader abuses of power within the organization. Beginning premises to illustrate this perspective might include the following.

- Sexual harassment can be more aptly described as a process rather than an event. Sexually harassing behaviors often exist on a continuum of disrespectful, demeaning, exploitive and/or discriminatory behaviors. Harassment is often the breaking into light of what has been a progressive violation of intimacy barriers in the worker-to-worker relationship. Remediation strategies will be ineffective if they attempt to address the sexually harassing behavior in isolation from this broader continuum.
- Sexual harassment, while exhibited by individuals, is ecologically nested within organizational, community and cultural environments that can either elicit or suppress the presentation of such behavior. Prevention and remediation strategies must target

multiple sites within this person-environment ecosystem.

- While usually defined in perpetrator-victim perspectives, acts of sexual harassment can be elicited from (for example, as part of a broader scapegoating process) and be symptomatic of disruptions in group process and organizational health.
- A strong organizational culture can promote sexual harassment if aberrant values have been incorporated into the culture that legitimize disrespect and abuse towards a targeted group of workers. Weak organizational cultures can promote sexual harassment by failing to socialize members with values, attitudes, standards and taboos that would inhibit harassing and exploiting behavior.
- As organizational systems grow in size, their units become more independent, creating the danger of renegade cultures which violate values of the parent organization. Repeated incidence of sexual harassment from a particular work unit involving multiple perpetrators may reflect such a renegade process and may require interventions targeted at group culture as well as interventions targeted at individual perpetrators.
- Harassing behavior while environmentally influenced, in turn, feeds back into the process of the work group. The strong emotion generated by the perception or knowledge of harassing events emotionally galvanizes the work group leaving little energy left for productivity and system maintenance. The organizational response to harassing events is experienced by other organizational members in ways that will increase or decrease worker fear/security related to physical and psychological safety and will increase or decrease worker feelings of identification and loyalty to the organization. The organizational response is experienced by other organizational members in ways that will either increase or decrease the likelihood of future incidents of sexual harassment and exploitation.
- Ismsc sexism, racism, ageism, classism, homophobiac constitute powerful forces that can influence many aspects of sexual harassmentc its incidence, how it is perceived, its effect on the work group, the outcome of legal or administrative redress. Isms constitute powerful undercurrents of emotion, the consequences of which must be actively managed to protect individuals and assure system health and vitality.
- A change in one part of a system produces accommodating changes in all other parts of the system. Implementing change (strategies to address sexual harassment) in dynamic systems must anticipate the emergence of unforeseen problems created by corrective action.

Principles and observations like the above can assist in understanding the complexity of the defined problem as well as in helping avoid the development of simplistic, ineffectual or problem-generating remediation strategies.

System perspectives can aid in strategy development by helping identify the multiple etiological roots of a problem, by targeting desirable targets of intervention, and by elucidating the potential interaction of strategies simultaneously or sequentially implemented at multiple levels within a dynamic system. The problem of sexual harassment and exploitation can, for example, be placed within an ecological model. A harassment incident involving a single harasser and person being harassed, is viewed as occurring within an environment that is itself nested within a large environment and so forth. This model places the interaction of these two individuals at the center of this ecological onion. There may be things at each layer that contributed to the unfolding of this event and resources and strategies at each layer which may contribute to problem resolution.

The center of this model is ontogeny—the unique developmental histories of the harasser(s) and the person(s) being harassed that brought them to this exact point in time. The systems model seeks to identify any characteristics or circumstances that contribute to either role. The purpose of such inquiry is not to psychologically excuse the harasser or blame the victim for his or her own victimization. Knowledge of the characteristics of the harasser and situational cues related to when, where and how the harassment occurred may help develop policies and structures that decrease the likelihood of such behavior. By better understanding persons targeted for harassment, we may discover strategies to reduce vulnerability. If the lack of knowledge of sexual harassment policies and procedures for grievance and redress increases vulnerability, then more effective employee orientation to such issues become a preferred strategy. If it is discovered that passivity increases risk of victimization, then employee access to assertion training, empowerment training, and related mediums become strategies to reduce worker vulnerability. If it is discovered that persons in certain roles, certain shifts, certain sites are being targeted, special systems of intervention, protection, and support can be designed and implemented.

The harassing event occurs within a physical, professional and social environment. This second layer of our ecological onion is the microsystem—the smallest unit of the organization that surrounds each worker. The microsystem is a shift, a physical plant, a work team, a supervisor, a job description. The point of inquiry in the microsystem is an examination of forces or conditions in this environment that influence positively or negatively the incidence of sexual harassment. By conducting this kind of force field analysis, we are able to generate a series of microsystem intervention strategies. The strategies seek to reduce those promoting forces identified and strengthen the identified inhibiting forces. Microsystem strategies include such areas as unit-level employee orientation programs, supervisory training programs, supervisory access to technical consultation, immediate accessibility to harassment reporting, accessibility of internal support resources (employee assistance program), and linkage to external resources (personal/legal consultation, counseling, support groups).

Each microsystem is ecologically nested with the mesosystem—the total organization that embraces and links all of the organizational unit and defines their relationships with one another and the outside world. At the mesosystem level, one can examine how broad organizational processes and structures either enhance or inhibit sexual harassment and exploitation of workers. Mesosystem issues include things ranging from the existence, clarity, accessibility and enforcement of sexual harassment policies to the attitudes, values and behaviors modeled by organizational leaders. Mesosystem strategies to address sexual harassment are encompassed within quality of work-life committees, joint labor management committees, and planning processes that seek to consciously shape the culture of the organization. In a moment, two particular mesosystem issues will be explored in detail—the sexual culture of the organization and the propensity for abuse within closed organizational systems. The examination of microsystem and mesosystem influences on sexual harassment recognizes that there is a dynamic relationship between what the individual worker brings to the organization and what the organization brings to the worker. In the chemistry of this interaction, the propensity to harass/exploit and the vulnerability to be harassed/exploited can be either decreased or increased. This step neither blames the organization nor exculpates the harasser from responsibility for his or her actions. It does acknowledge that organizations can play a contributing role by promoting or tolerating conditions that nurture harassment or by failing to serve as an active restraining agent to workplace harassment.

Each organization (its microsystems and its workers) are nested within a broader geographical, social, political and economic

environment (exosystem). There is a complex and continuing relationship between the organization and this immediate environment that influences the internal values and behavior within the organization. It is important for an organization to have some understanding of the degree to which the values, attitudes and entrenched behaviors within this exosystem will serve to enhance or inhibit sexual harassment within the workplace. Where enhancing factors exist in great strength, the organization may choose to link itself with other organizations in a campaign of community education designed to weaken such forces, or, having an awareness of such external factors, intensify their internal programs to prevent sexual harassment. Through its political voice and through its trade associations, the organization may also contribute to weakening such enhancing factors in the broader culture (macrosystem).

In these two days you will hear detailed strategies targeted at various layers of this ecosystem. The issue is not which one of these strategies is preferable. The issue is how can these strategies be integrated with existing resources into a coordinated program that targets these multiple levels of intervention.

In many organizations the struggle is to bring the implicit and real culture into compliance with the culture defined aspirationally in policy. Incongruencies between aspirational and real values within the organizational culture provide a breeding ground for abuse. Well written sexual harassment policies and procedures are rendered meaningless in an environment where organizational leaders are practicing or openly condoning the exact behaviors tabooed in the policy statement.

What many of the recommended strategies you will hear about over these two days do is define and transmit organizational values and standards that define appropriate and inappropriate behavior. These strategies define the organizational etiquette governing relationships between workers. They define the behaviors and values to which we are to aspire and they define behaviors which are tabooed within the organizational family. By consciously examining our organizational cultures we can seek to remove abuse-condoning elements and replace them with elements more conducive to worker and organizational health.

Incest in the Organizational Family

I have often been asked whether there are any types of organizations or particular stages in the life of an organization that generate a greater incidence of sexual harassment and sexual exploitation problems. There are two such circumstances that I have noted from my consulting experience. The first is an increased incidence of harassment and exploitation in organizations going through periods of turbulence and rapid change. The second is the great potential for the abuse of power—including sexual harassment and sexual exploitation—in what I have described as closed incestuous systems.

Rapid change within an organization disrupts the psychological homeostasis of all workers. Workers at all levels who have lost their sense of personal and professional value may seek a variety of channels through which to reassert and affirm their value and potency. The increased incidence of sexual harassment, sexual exploitation and voluntary sexual intimacy between workers during such periods probably has little to do with sex, but is a means of seeking fulfillment for other needs. Attempted sexual contact between workers during such turbulent periods may have more to do with aggression and violence or desperate needs for self-affirmation than what Joseph Campbell has referred to as the "zeal of the organs for one another."

In the mid-1970s I began publishing articles and monographs on the propensity for abuse within a particular kind of organizational setting and process. Applying family systems theory to organizations, I described the extreme disruption of personal and organizational health associated with sustained organizational "closure." The concept of organizational incest was used to describe a stage in the life of an organization marked by increasing numbers of staff

meeting most, if not all, of their personal, professional, social and sexual needs inside the boundary of the organization. The progressive (spanning years) closure of such organizations was marked by such predictable elements as the following:

- the emergence of organizational dogmaCa rigid, and unchallengeable belief system,
- the centralization of power and preference for charismatic styles of leadership,
- the progressive isolation of the organization and its members from the outside professional and social world,
- the homogenization of the workforce by age, race, sex, religion or values via a tendency to isolate and expel that which was different,
- excessive demands for time and emotional energy of workers,
- the development of a work-dominated social network by organizational members,
- the intense focusing on the personal and interpersonal problems of staff,
- the disruption of team functioning from problems arising in worker-worker social and sexual relationships,
- the projection of organizational problems on an outside enemy or scapegoating and extrusion of individual workers,
- the escalation of interpersonal and inter-group conflict to include staff plots, conspiracies, or coups against organizational leadership,
- the emergence of a punitive, abusive organizational culture, and
- the fall of the "high priest/priestess" and a contagion of staff turnover (break-up of the system).

Sustained closure of organizational systems disrupts both the health of workers and undermines the health and survivability of the organization. It is my experience that closed organizational systems have a high incidence of sexual harassment and sexual exploitation and that the intensity and duration of abuse incidents tends to be greater and more debilitating to victims than incidents in more open systems. The potential and intensity for abuse in closed systems is intensified through:

- the violation of the boundary and balance between one's work life and one's personal life,
- the loss of outside sources of personal, professional and social replenishment,
- the progressive depletion (physical and emotional exhaustion) of personal and group health resulting from excessive demands on worker time and emotional energy, and
- the distortion of organizational values resulting from the loss of external feedback and mechanisms for reality-testing with the outside social and professional community.

At its worst, sexual harassment and exploitation can be institutionalized as an element of the culture of a closed system. In such circumstances the abusive episodes are large in number, occur over extended periods of time, and involve large numbers of perpetrators and harassed/exploited workers. In service organizations, harassing and exploitive behaviors may be extended beyond the workers to encompass the organizations service consumers. I have found, for example, human service organizations experiencing numbers of sexual harassment episodes are also likely to be experiencing a concurrent problem of sexual exploitation of clients seeking services at the agency. The high level of unmet needs within the closed system makes anyone interacting with this system high risk for exploitation.

The vulnerability of workers in closed systems to sexual harassment, exploitation and other forms of abuse is so great and yet potentially more subtle in its manifestations that the traditional definitions of sexual harassment may need to be expanded for these settings.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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A Commitment to Ethical Action

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This article was excerpted from Mr. White's book, ***Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment****, published by Lighthouse Training Institute (1993).*

The alcoholism and drug abuse counseling profession is at a turning point, facing threats that fundamentally could alter the character of this field. While some see health care reform and financial concerns as topping the list of challenges; many others depict a spiritual crisis—a crisis in values. This crisis has emerged out of two decades of unprecedented success in our field. Ironically, this very same success set the stage for our current crisis, which has emerged out of the excesses of our explosive growth and industrialization. The following examples are signs of this crisis:

- Occupancy rates in private and hospital-based chemical dependency units have dropped precipitously in many areas, while waiting lists in public sector programs treating clients less financially blessed are unconscionably long.
- After the explosive proliferation of new substance abuse programs, private sector programs are being closed, reorganized, or merged in unprecedented numbers.
- Staff morale in the field has eroded over the past decade, contributing to excessively high rates of staff turnover for direct service workers.
- There is a new form of staff turnover—older, historically committed workers with significant tenure in the field are leaving professional roles. When interviewed, they speak of something being lost in the field. Some paradoxically say they are leaving to try to recapture the original spirit of service that brought them into the field.
- There is a crisis of public confidence in our field. Exposure of financial exploitation and other client abuses have led those in our communities to look at us with a more suspicious eye. Talk of "treatment ripoffs" among active alcoholics and addicts adds another obstacle to entry into treatment and damages our image in the minds of our most important constituents.
- There is a growing feeling among workers that the identity and character of our field is being

shaped externally rather than internally—that we do not control our own fate.

Special Concerns of Ethical Issues in the Substance Abuse Field

Few fields have ever brought within a professional umbrella individuals so diverse in terms of age, race, culture, religion, sex, sexual orientation, education, professional training, and life experience. Such diversity is a source of vulnerability as well as a source of enrichment. The vulnerability of such diversity springs from the lack of a shared value system guiding personal/professional decision-making and conduct. No health care field has ever existed in which so many service recipients have evolved into professional roles of service providers. This phenomenon has raised new and more complex ethical issues for which there are no precedents to be gained from other helping professions.

In the more traditional fields of psychiatry, psychology and social work, elaborate systems and rituals have evolved to define standards and values of professional practice and to internalize these values in new generations of professionals. The short history and rapid turnover of staff within the substance abuse field has resulted in an ambiguity of professional values and a regular bleeding out of the field's collective wisdom and expertise. While our short history has prevented the full evolution of formal systems of professional indoctrination, high staff turnover is a wound from which escape our informal systems of technology transfer, e.g., the professional values imbedded within oral history, professional etiquette transmitted through story telling, and the collective wisdom channeled through mentor relationships.

The genesis of professionalism in the field can be tied to the founding of the American Association for the Study and Care of Inebriety in 1870. However, the full industrialization of the field has occurred only within the last two decades. Our most recent history has included the legitimization of addictive disorders via their inclusion in public and private health care reimbursement systems, the rapid proliferation of substance abuse treatment programs, the emergence of substance abuse services as popular and profitable business ventures, the intensification of competition within the field, and the explosion of legal and regulatory controls governing the delivery of substance abuse prevention and treatment services. For the first 100 years of our profession, ethical issues were addressed within the umbrella of our medical and clinical practices. Events of the past twenty years have forced us to extend the topic of ethics to cover our business practices.

The dramatic increase in drug-related predatory crime, the increased violence within the culture of addiction, the emerging spread of HIV infection among drug consumers and the growing threat to public safety posed by drug impaired workers are among the many changes in the context of substance abuse in the United States that are raising infinitely complex legal and ethical issues for substance abuse prevention and treatment professionals.

The Goal of Ethical Sensitivity

Ethics must be addressed as a personal-professional issue. The substance abuse field needs to develop what Biggs and Blocker (1987) have called ethical sensitivity. Ethical sensitivity is the ability to step outside oneself and perceive the complexities of a situation through the needs and experiences of the client, the agency, allied institutions and the public. It is the ability of the staff member to project the potential consequences of his or her action or inaction on these various constituency relationships. It is the ability of the staff member to recognize when he or she is in ethical terrain. It is the ability to identify and analyze the precise ethical issues involved in a particular situation and to isolate and articulate conflicting duties. It is the ability to weigh the advantages and disadvantages of various actions and to formulate ethically appropriate resolutions to complex situations.

Ethics and the Profession

Ethical and professional practice dilemmas are occurring with increasing frequency within the substance abuse field. Workers in a broad spectrum of roles are frightened and overwhelmed by their lack of preparation in ethical decision-making. Our organizations have tended to define ethics as an individual rather than institutional issue. Ethical issues fester in the silence of denial until they detonate into humiliating exposés of our personal and institutional short-comings. Those of us on the sidelines of such explosions all too often react with self-righteousness indignation, seeing ourselves and our institutions as immune from such a fall. And yet the explosions continue, setting up the climate through which outside institutions paternalistically promulgate regulations to legislate our moral and professional conduct. It has become painfully evident that the field has not developed a paradigm or process for ethical problem-solving nor has it developed a fully articulated set of ethical standards to guide professional practice. The field—as represented by the majority of its agencies—does not have an ethical framework that can consistently protect our consumers, our workers, our organizations and the public.

If there is any message that emerges from our history, it is that individuals and individual programs of excellence can have a profound impact on the evolution and advancement of our field. Having that kind of impact requires both technical knowledge and skills and a passionate commitment to service.

Systematic Approaches to Professional Practice Issues

Ethics must be addressed as a systematic issue. A comprehensive approach to promoting high standards of ethical conduct within a substance abuse agency requires interventions at multiple levels of the organization. Such interventions and levels are reflected in the following checklist which may be used as an inventory of potential strategies to promote an ethical organizational culture.

Knowledge and Skills

Yes	No	
__	__	Are education, experience and certification/licensure requirements for positions within the agency set at such a level as to increase the likelihood that staff have prior knowledge and skills in ethical decision-making?
__	__	Have ethical issues been addressed within the in-service training schedule, not just as a special topic, but integrated as a dimension within a broad spectrum of training topics?
__	__	Are there opportunities for staff at all levels to explore ethical issues with other professionals within and outside of the agency?
__	__	Does the agency have access to outside technical expertise for consultation on complex ethical-legal issues?

Ethical Standards

__	__	Does the agency have a code of professional ethics integrated within its personnel policies?

__ __ Have agency staff had the opportunity to participate in the development or episodic review of the professional practice standards?

__ __ Are the ethical standards and values written with sufficient clarity and have they been discussed sufficiently to allow their application in daily decision-making and problem solving?

__ __ Are violations of ethical conduct addressed immediately and consistently?

__ __ Could staff, if asked, define the core values of the agency?

Organizational Culture

Yes No

__ __ Are ethical issues raised within the context of employee hiring and new employee orientation?

__ __ Do organizational leaders talk about ethical issues in their communications with staff?

__ __ Is adherence to ethical and professional practice standards a component of the performance evaluations of all staff?

__ __ Does ethical conduct constitute a core value of the organization as reflected in agency history and mythology, the designation of heroes, agency literature, storytelling, symbols and slogans?

__ __ Are rituals built into the cycle of organizational life that help identify practices that undermine or deviate from our stated values and which provide opportunities to celebrate and recommit ourselves to those values, e.g., staff meetings, retreats, planning processes?

__ __ Are there mechanisms in place through which agency leaders can identify and rectify environmental stressors (role overload, role conflict, etc.) that can contribute to impairment in ethical decision-making?

__ __ Does the agency have an active, aggressive Employee Assistance Program to address areas of personal impairment that could affect the ethical judgment and conduct of staff?

Ethical Decision-making

Yes No

__ __ Have staff been oriented to the multiple parties whose interests must be reviewed in ethical decision-making?

__ __ Are the forums clearly defined within which ethical issues can be explored, e.g., individual supervision, team meetings?

__ __ Are the potential consequences of breaches of ethical conduct clearly defined and communicated to staff?

__ __ Are the procedures through which ethical violations are addressed at the agency clearly defined and communicated to staff?

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CHAPTER 4

THE ORGANIZATIONAL FAMILY: A SYSTEMS PERSPECTIVE

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REDUCTIONIST MODELS

In my involvement in professional organizations over the past thirty years, I have observed six reductionist models that have explicitly or implicitly guided attempts to prevent or intervene in episodes of misconduct of a sexual nature by professional helpers.

1. Perpetrator Morality Model
2. "Victim" Morality Model
3. Clinical Model
4. Anomie Model
5. Training Model
6. The Environmental Model

After sharing the origins and intervention strategies of each of these reductionist models, I will outline the systems model, which integrates the best of these reductionist models into a whole, so that a framework for such wholeness can be sought and achieved.

In the **Perpetrator Morality Model** the misconduct is viewed as emerging from the evilness of the perpetrating clergy. It is assumed that only a person totally lacking superego controls, in short, a psychopathic predator, could so exploit the sacred trust. Our task is to screen out these evil people and help them from entering the clergy and our churches. Our further task is to find these persons who fooled us and remove them from positions of responsibility in the church.

This model has general appeal because these persons can occasionally be found, and when we label and treat these persons as

sexual psychopaths, it magnifies the distance between ourselves and the perpetrator. It allows us to believe, for example, that, because we see no such exploitive tendencies in ourselves, we are not vulnerable to sexual involvements with parishioners—a belief that probably increases our chances of being involved in just such a relationship. It also allows organizations, such as the church, to believe that they have addressed the problem of misconduct of a sexual nature solely by removing an identified sexual predator.

The second model is closely related to the first but defines the source of evilness not within the alleged perpetrator but within the alleged victim. The **"Victim" Morality Model** denies the reality of the misconduct and casts the problem within the character of the victim. It is believed that the victim/complainant misinterpreted the intentions or actions of the perpetrator or is retaliating with false allegations out of personal animosity. Another version of this model portrays the complainant as seductive and manipulative and one who overwhelms the otherwise ethical clergy.

If this belief permeates the Church, then the Church will be notorious for scapegoating the complainant. Even if the Church has clear policies and grievance procedures related to misconduct of a sexual nature, hearings are often turned into a systematic indictment of the complainant. It becomes a vehicle for revictimization. Like children breaking silence about sexual abuse, the dangers of revictimization are great. The scapegoating and revictimization of persons who have broken silence deepens the silence of other victims and also protects perpetrators from experiencing the consequences of the actions. It is a way to ignore the call to justice and compassion.

In the **Clinical Model**, the origins of misconduct of a sexual nature are defined in terms of psychopathology. The misconduct is viewed as transient aberrations in judgment that have emerged from chronic or transient emotional disturbance. The model is seen in religious leaders—when efforts to escape charges fail—running off to alcoholic or psychiatric treatment centers with the underlying explanation that the abuses of power resulted from a crisis.

The Clinical Model dictates one of two responses to the identified perpetrator. Where such emotional disturbance is validated by clinical assessment and is adjudged to preclude the clergy's ability to perform their ministerial office, the person is either removed from the ministry setting through suspension or surrender of credentials. In other cases, when the clergy's impairment is not so severe or enduring as to preclude professional performance, the person is restricted to only particular types of professional activity and is mandated to continue in some form of treatment. The clinical model applied to the ministry posits that persons must screen out those whose emotional instability precludes their ability to work with vulnerable persons. It also posits that effective programs of early intervention must be in place to intervene at an early stage before the health and safety of the parishioners are involved. There is also an assumption that some perpetrators can be treated and returned to ministerial roles with minimal risks of future exploitive incidents. This model, like some of the others, may contain elements of the true story of misconduct of a sexual nature, but fails to capture the whole story.

There is a variation of the Clinical Model that defines the problem in terms of the complainant's psychopathology. The misconduct is interpreted as delusion, fantasy, a transference problem, or as retribution for "imagined slights by the borderline personality." In some complaints, the initial presentation of the allegation is framed more as a clinical case study of the victim/survivor than an administrative hearing to determine fact regarding an allegation. One problem in this regard is that the most insidious sexual predator is going to select victims that include those persons who have the greatest vulnerability and whose complaint would be most easily discounted.

The fourth reductionist model of sexual exploitation is the **Anomie Model.** This model, which is often found in new emerging disciplines and organizations (or those going through turbulent changes), defines the origin of misconduct of a sexual nature as the absence of clear ethical standards for defining appropriate and inappropriate conduct. The source of the problem is the lack of definition of standards of appropriateness in service relationships. With this model, our task is to generate codes of conduct that define appropriate and inappropriate behavior within these relationships.

When organizations have created standards and continue to have problems with misconduct, it is time to redefine the problem. The **Training Model** defines the origin in terms of the knowledge and skill deficiency of the clergy—it is a problem of inadequate professional socialization. The solution for helping clergy is to provide preparatory and ongoing training in ethical standards and ethical decision making for all clergy and targeted training designed to rehabilitate the clergy who have been involved in poor boundary maintenance in their relationship with parishioners.

The sixth reductionist model, **The Environmental Model** defines the origin as an isolated aberration (abnormality) of chemistry between the perpetrator and the environment at a particular point in time. The model argues that since this event was idiosyncratic and unlikely to ever occur again in a different context, the best strategy is to move the perpetrator to another role, department, church, or geographical location. The same logic could justify transferring the victim's membership to another church. While the church has been visibly criticized for moving pedophile priests from parish to parish, many other organizations have been involved in the same practice.

Reductionist models of explanation and intervention, which are central in the early stages of exploring any problem, must eventually give way to models that can encompass complexity and diversity. All of the models described above tend to define the problem of misconduct of a sexual nature in ways that narrow our view of its origins and restrict our vision of prevention and intervention strategies. Some are based on errors of fact. Others describe an element of the problem but do not encompass the problem. Our task is to integrate the best within these models into a coherent whole. The goal of the systems model outlined below is to provide a framework through which such wholeness can be sought and achieved.

SYSTEMS MODEL

The systems model begins by defining the problem of misconduct of a sexual nature as a breakdown in a relationship. It is a breakdown in the fiduciary (trust) relationship that exists between the clergy/church and parishioner. This breakdown occurs when certain elements necessary to the success of the relationship get lost and certain new elements get injected. What gets lost in the minister-parishioner relationship is respect and integrity; what gets injected into the relationship is the manipulation and abuse of power. The factors and conditions that lead to both the loss and the injection are multiple and synergistic in their interaction. Prevention and intervention strategies must understand and target these multiple influences. *A systems model provides a conceptual map within which the existing data and viewpoints can be linked together and within which understandings of new complexities can be integrated.*

Four propositions can help introduce this systems perspective.

Proposition One Misconduct of a sexual nature can best be viewed as a process rather than an event.

Proposition Two The process of misconduct of a sexual nature is ecologically nested (interrelated) within professional, organizational, community, and cultural environments. These elements of influence can serve to promote or inhibit boundary violations in the clergy-parishioner relationship.

Proposition Three Strategies and programs to address the misconduct must reflect an in-depth understanding of dynamics through which organizations resist and experience change over time.

Proposition Four A change in one part of the system produces accommodating changes in all other parts of the system, raising the potential for unforeseen problems created by an attempt at problem resolution.

Proposition One:
Misconduct of a sexual nature can best be viewed as a process rather than an event.

Sexually exploiting behaviors often exist on a continuum of disrespectful, demeaning, and/or discriminatory behaviors. Misconduct of a sexual nature is often the last stage of what has been a progressive violation of intimacy barriers in the clergy-parishioner relationship. Allegations are often a breaking into light of what has been a progressive deterioration in the integrity of the relationship. The helping

relationship could be displayed on a continuum of intimacy. At one end of this continuum is the complete physical and emotional disengagement; at the other is a high level of emotional and physical intimacy. Somewhere in the middle, depending on the nature of the organization, our role, and the nature of those we serve, a zone of appropriateness will mark the boundaries of appropriate intimacy.

This concept can help us first develop a deeper understanding of the experience of victimization that results from misconduct. The trauma from sexual exploitation results from the entire continuum of boundary violations, not just the overt sexual acts. Where boundary violations have been sustained and accelerating, but stop short of sexual acts, the parishioner may be traumatized, but lack the ability to clearly label his or her exploitation. In family and therapeutic relationships, this is sometimes described as emotional incest. The concept of continuum also suggests that violations that may also be traumatic can occur at the other end. Many case studies of exploitation, in fact, involve violation at both ends of the continuum—sexual exploitation followed by precipitous termination and abandonment of the parishioner. Clergy should be held as accountable for the latter as for the former.

The understanding of this proposition is also critical to effective strategy development. The fact that sexual exploitation is often preceded by a progression of other boundary violations provides a window of opportunity to both identify boundary problems at an early stage and potentially prevent more severe transgressions in the ministerial relationship. Sexual exploitation of parishioners cannot be dealt with in isolation but must be addressed within the broader context of abuses of power that occur at both ends of the intimacy continuum.

Proposition Two:
The process of misconduct of a sexual nature is ecologically nested (interrelated) within professional, organizational, community, and cultural environments. These elements of influence can serve to promote or inhibit boundary violations in the clergy-parishioner relationship.

There are two major implications of this proposition. The first is that the identification of forces at all levels of this ecosystem that promote or fail to inhibit the misconduct must be identified. The second implication is that our prevention and remediation strategies must target multiple sites within the ecosystem. The layers of this ecosystem will be described shortly.

Proposition Three:
Strategies and programs to address the misconduct must reflect an in-depth understanding of dynamics through which organizations resist and experience change over time.

Organizations tend to respond to crises and demands for change with responses that minimize real change. If boundary problems with parishioners, and misconduct of a sexual nature in particular, become an issue generated internally or through the decree of some external body, the organization's first efforts are likely to be superficial and mechanistic. An individual worker is removed. Something extra is added—a policy, a person, a training seminar—none of which is intended or likely by itself to alter the nature of the organizational culture.

In the cases of clergy misconduct of a sexual nature, one church/conference acquires another church/conference ethics policy, then replaces their name and with minimal involvement from anyone sticks it in a policy manual that few will ever read. The complaint procedure and mechanism is quickly manufactured in a similar manner and an outside trainer is brought in to do one-shot training for a group of clergy. The church feels it has responded to the problem of clergy misconduct of a sexual nature. This is not how a church changes; this is how a church avoids change.

This inherent resistance to change in most human systems suggests that efforts to address serious problems often result in superficial rather than systemic change. Our response is to take some singular action or add some appendage to the system rather than change the culture *within* the system. It is easier to remove one sexual predator than to confront an entire organizational (church) culture that has lost its mission and ministry focus or has become toxic and abusive.

Proposition Four:
A change in one part of the system produces accommodating changes in all other parts of

the system, raising the potential for unforeseen problems created by an attempt at problem resolution.

This proposition demands that organizations take extreme care in avoiding strategies that, while designed to protect parishioners, end up re-victimizing or otherwise harming parishioners. In a similar manner, we must avoid policies or procedures that in protecting parishioners fail to also protect the procedural rights (fair process) of clergy.

THE ECOLOGY OF SEXUAL EXPLOITATION Microsystems, Mesosystems, Exosytems, and Macrosystems

Systems perspectives can aid in strategy development by helping identify the multiple etiological roots of a problem, by setting a focus of intervention, and by elucidating the potential interaction of strategies at the same time or sequentially implemented within a dynamic system. The problem of misconduct of a sexual nature can, for example, be placed within a ecological framework. An event of misconduct involving a single perpetrator and a single complainant is viewed as occurring within an environment that is itself nested within a larger environment and so forth. This model places the interaction of these two individuals at the center of this ecological onion. There may be things at each layer that contributed to the unfolding of this event and resources and strategies at each layer that may contribute to problem resolution.

The center of this model is ontogeny—the unique developmental histories of the perpetrator and the person(s) being exploited that brought them to this exact point in time. The systems model seeks to identify any characteristics or circumstances that contribute to either role. The purpose of such inquiry is not to psychologically excuse the perpetrator or blame the victim for his or her own victimization. Knowledge of the characteristics of the perpetrator and the victim and situational cues related to when, where, and how the misconduct occurred may help develop policies and structures that decrease the likelihood of such behavior. Perpetrator profiles may help remove persons with predatory proclivities from being appointed or may tell us the circumstances under which they may be high risk for intimacy violations in their ministry. A better understanding of persons targeted for harassment could lead to the discovery of strategies to reduce parishioner vulnerability. If, for example, it is discovered that the lack of knowledge of what is and is not appropriate within a ministerial relationship contributes to parishioner vulnerability, programs of parishioner orientation to such issues become a potential prevention strategy. If it is discovered that particular types of parishioners are being targeted, special systems of prevention, intervention, protection, and support could be designed and implemented.

In addition to examining what each individual brings to the exploitive minister--parishioner relationship, the presence of any special chemistry in the relationship that seems unique to the exploitive event can also be explored. It seems that some clergy are vulnerable to boundary violations with only a particular type of parishioner. A greater understanding of such chemistry could help reduce minister and parishioner vulnerability by influencing how ministers are assigned to work with particular persons. It would also reveal particular types of minister-parishioner combinations that might be worthy of much more frequent and rigorous supervision.

The exploiting event occurs within a physical, professional, and social environment. This second layer of our ecological onion is the **microsystem**—the smallest unit of the organization that surrounds each worker. The microsystem is a church, a ministry setting, a work team, a supervisor, a job description. The point of inquiry in the microsystems is an examination of forces or conditions in this environment that influence positively or negatively the incidence of misconduct of a sexual nature. Conducting this kind of analysis can generate a series of microsystems intervention strategies. The strategies seek to reduce the promoting forces and to strengthen the inhibiting forces. Microsystems strategies include such areas as:

- parishioner education about boundary issues in the ministerial relationship;
- parishioner access to grievance/complaint procedures;
- training programs on ethical and

boundary issues;
- clergy access to clinical supervision of pastoral counseling;
- access to internal resources of ministerial support; and,
- access for the parishioner to external resources of support (advocacy services, personal/legal consultation, counseling, support groups).

Microsystems strategies also target the alleviation of roles stressors that may have contributed to the deterioration in boundaries, e.g., role overload, role-person mismatch, role ambiguity.

Each microsystem is ecologically nested with the **mesosystem**—the total organization that embraces and links all of the organizational units and defines their relationships with one another and the outside world. At the mesosystem level, one can examine how broad organization processes and structures either enhance or inhibit misconduct of a sexual nature. Mesosystem issues include things ranging from the existence, clarity, accessibility, and enforcement of policies and standards governing the ministerial-parishioner relationships to the attitudes, values and behaviors modeled by organizational leaders. Mesosytem strategies to address misconduct of a sexual nature are encompassed within ethics committees, quality improvement committees, and planning processes that seek to consciously shape the service culture of the organization. In the next section, two particular mesosystem issues will be explored in detail—the sexual culture of the organization and the propensity for abuse within closed organizational systems.

The examination of microsystem and mesosytem influences on misconduct recognizes that there is a dynamic relationship between what the minister and the parishioner brings to the organization and what the organization brings to these relationships. In the chemistry of this interaction, the propensity to exploit and the vulnerability to be exploited can be either decreased or increased. This step neither blames the organization nor removes the blame of responsibility from the clergy for his or her actions. It does acknowledge that organizations can play a contributing role by promoting or tolerating conditions that nurture misconduct or by failing to serve as an active restraining agent to misconduct of a sexual nature.

Each organization (its microsystems and its workers) is nested within a broader geographical, social, political, and economic environment (**exosystem**). There is a complex and continuing relationship between the organization and this immediate environment that influences the internal values and behavior within the organization. It is important for an organization, the church, to have understanding of the degree to which the values, attitudes, and entrenched behaviors within this exosystem will serve to enhance or inhibit misconduct within the ministerial setting. Where enhancing factors exist in great strength, the church may choose to link itself with other organizations in a campaign of community education designed to weaken such forces, or, having an awareness of such external factors, intensify their internal programs to prevent misconduct. Through its political voice and through its trade associations, the church may also contribute to weakening such enhancing factors in the broader culture (macrosystem).

The issue is not which one of these strategies is preferable. The issue is how can these strategies be integrated with existing resources into a coordinated program that targets these multiple levels of intervention.

MESOSYSTEM AND MICROSYSTEM PROBLEMS

Organizational Culture: Boundaries Controlling the Expression of Power, Aggression Sexuality

With this broad overview in place, I will focus on three mesosystem and microsystems problems that have been a focus for my work:

- Shaping non-exploitive organizational sexual cultures
- Creating an organizational code of Professional Practice as the centerpiece of a value-driven, service-oriented organizational culture, and
- Addressing the special problem of sexual exploitation of clients within closed organizational systems.

One dimension of the microsystem and mesosytem environment that influences misconduct of a sexual nature is the culture of the organization and its work units. Every organization can be said to have a culture. Each organization's culture can be described in terms of its history, traditions, heroes and heroines, values, symbols, slogans, rituals, taboos. Some can be described in terms of particular customs related to dress, food, leisure, music, and art. In a similar manner it can also be said that each organization has a sexual culture. The sexual culture defines the customs and etiquette that will guide professional and personal relationships between organizational members and between members and their constituents. The sexual culture of an organization shapes a climate of respect or disrespect that can serve to either inhibit or nurture misconduct.

Strategies to discourage abusive behavior in the church can examine how member values and behaviors are shaped by such cultural elements as:

Language, e.g., customary use of disrespectful, profane, exclusive, or derogatory language; racial epithets; demeaning humor; labels that objectify and depersonalize; or verbal threats and intimidation.

Artifacts and symbols, e.g., paintings, sculptures, books, magazines, posters, articles of clothing, or other objects in the work environment that may contribute to a climate of disrespect.

Ethics and values, e.g., the absence or lack of clarity in values defining proper and improper behavior in minister-parishioner relationship, work practices that devalue particular groups of workers such as gender inequity in salaries, work assignments, or promotions.

Modeling of relationships, e.g., the values and behavior modeled by organizational leaders in clergy-clergy, clergy-parishioner relationships in both formal and informal settings.

In many churches the struggle is to bring the implicit and real culture into compliance with the culture defined in the church's mission and core values. Incongruence between these values provides a breeding ground for misconduct. Well written sexual ethics policies and procedures are rendered meaningless in an environment where organizational leaders are practicing or openly condoning the exact behaviors tabooed by our aspirational values.

Through the conscious examination of our church cultures, we can seek to remove abuse-condoning elements and replace them with elements more conducive to parishioner health, clergy health, and church health.

Organizational Code of Professional Practice

The centerpiece of any response to misconduct of a sexual nature is the clear definition and monitoring of the boundaries of appropriateness and inappropriateness within the ministerial relationship. Our ability to prevent abuses of power and our response to persons who commit such abuses are both contingent upon the clear articulation of these boundaries. *(See Section I, Chapter I on Policies and Procedures)*

A core value that is often embedded in policies and procedures is the presumpive vulnerability and innocence of the client. Many organizations declare unequivocally that the responsibility for setting boundaries in helping relationships is always that of person with the greater ascribed power—the clergyperson. The parishioner's interest in, initiation of, or compliance with sexual intimacy has no relevance and in no way diminishes the clergy's total responsibility for maintaining boundaries of appropriate conduct in the ministerial relationship. Such responsibility is the very essence of the fiduciary relationships—the special duty and obligation taken on by the clergy to protect the interests and well-being of the parishioner.

Developing policies and operating with a highly visible policy are powerful tools for shaping and monitoring values within a strong parishioner-centered organizational culture. Such policies articulate clear standards and a body of aspiration values that can serve as inhibiting influences to boundary violations and misconduct.

Organizational Turbulence and Parishioner/Clergy Vulnerability

Are there any types of organizations or particular stages in the life of an organization that generate a greater incidence of misconduct

of a sexual nature? There are two such circumstances I have noted from my consulting experience. The first is an increased incidence of harassment and exploitation in organizations going through periods of turbulence and rapid change. The second is the great potential for the abuse of power in what I have described as closed incestuous systems. In both contexts, clergy-parishioner boundary violations can be elicited from and be symptomatic of aberrations in group process and organizational health.

Rapid change within an organization disrupts the psychological homeostasis of all members. Members at all levels who have lost their sense of personal and professional value may seek a variety of channels through which to reassert and affirm their value and potency, including increased incidence of voluntary sexual intimacy between members. Incidence of misconduct of a sexual nature during such periods probably has little to do with sex, but is a means of seeking fulfillment for other needs. Attempted sexual contact in clergy-clergy and clergy-parishioner relationships during such turbulent periods may have more to do with power, anger, aggression, physical depletion, loneliness, or desperate needs for self-affirmation than with sexual attraction.

During periods of organizational turbulence there is a weakening of organizational culture and values. The organization loses its power to shape, monitor, and self-correct boundary problems within clergy-parishioner relationships. Weak organizational cultures lose the capacity to define boundaries of appropriateness in ministerial relationships. Weak organizational cultures exert little influence or control on individual practitioners. Rapid member turnover or growth opens up the possibility of emergent subcultures that deviate from the church's historical values. Turbulence within organizational systems, just as in family systems, marks a period of great vulnerability for role boundary violations. Strategies to address boundary violations amid such turbulence must include the active management of change and the strengthening of the organizational culture and the values guiding clergy-parishioner relationships.

Incestuous Systems

Applying family systems theory to organization, I have described the extreme disruption of personal and organizational health associated with sustained organizational "closure." An incestuous dynamic can result from this closure—a stage in the life of an organization marked by increasing members meeting most, if not all, of their personal, professional, social, and sexual needs inside the boundary of the organization. The progressive closure of such organizations over a number of years was marked by such predictable elements as the following:

- the emergence of organizational dogma—a rigid, and unchallengeable belief system;
- the centralization of power and preference for charismatic styles of leadership (the emergence of high priests/priestesses);
- the progressive isolation of the organization and its members from the outside professional and social world;
- the homogenization of the members by age, race, sex, religious doctrine or values via a tendency to isolate and expel that which was different;
- excessive demands for time and emotional energy of members;
- the development of a closed social network by organizational members;
- the intense focusing on the personal and interpersonal problems of members;
- the disruption of church functioning from problems arising in clergy/clergy, clergy/parishioner social and sexual relationships;
- the projection of organizational problems on an outside enemy or scapegoating and extrusion of individual members;
- the escalation of interpersonal and intergroup conflict to include plots, conspiracies, or coups against church leaders;
- the emergence of a punitive, abusive organizational culture; and
- the fall of the "high priest/priestess" and a contagion of member turnover (breakup of the system).

Sustained closure of organizational systems (or subsystems) both disrupts the health of members and undermines the health and survivability of the organization. It is my experience that closed organizational systems have a high incidence of misconduct of a sexual nature and that the intensity and duration of these incidences tend to be greater and more debilitating to victims than incidents in more open systems. The potential for abuses of power in closed systems and the intensity of abuses in such organizations is magnified by:

- the violation of the boundary and balance between one's work life and one's personal life;
- the loss of outside sources of personal, professional, social, and sexual replenishment;
- the progressive depletion (physical and emotional exhaustion) of personal and group health resulting from excessive demands on member time and emotional energy;
- the distortion of organizational values resulting from the loss of external feedback and external mechanisms for reality-testing with the outside social and professional community.

At its worst, misconduct of a sexual nature can be institutionalized as an element of the culture of a closed system. In such circumstances the abusive episodes are large in number, occur over extended periods of time, and involve large numbers of perpetrators and exploited members. This misconduct often emerges out of the same abuses of power within such organizations. The high level of unmet needs and the distortion of values within the closed system makes anyone interacting with this system high risk for exploitation.

In such circumstances, issues of misconduct are inseparable from broader issues of organizational health. Parishioners cannot be protected without intervention into basic problems of structure and process within closed systems. Intervening in such systems requires action targeted at multiple layers of the ecosystem.

THE BROADER VIEW

In summary, when we speak of clergy misconduct of a sexual nature, we are speaking of the abuse of power. We must eventually link our internal organizational efforts with broader movements seeking to confront the whole spectrum of abuses of power, in general, and the institutionalized violence against disempowered persons, in particular. If we only see misconduct of a sexual nature in terms of psychopathology or skill deficiency of the perpetrator, we miss the broader social milieu, which incites or fails to inhibit such behavior. Misconduct of a sexual nature is part of a broader continuum of aggression and violence toward the culturally disempowered, particularly women and children. As we understand sexual exploitation within these broader frameworks, we can link ourselves to parallel resources and movements seeking to enhance the health of our parishioners, our churches, our communities, and our culture.

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The Ethics of Affiliation

The Relationship between Alcohol, Tobacco and Other Drug Prevention Agencies and the Alcohol, tobacco and Pharmaceutical Industries

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Executive Summary: The Ethics of Affiliation

The Ethics of Affiliation summarizes the work of 33 professionals who attended a policy forum titled *Building a Solid Foundation: A Symposium on Ethics in Prevention.* The symposium was conducted to examine the relationship between alcohol, tobacco and other drug (ATOD) prevention agencies and the alcohol, tobacco and pharmaceutical (ATP) industries. Throughout the event the participants were deeply engaged in discussing the ethical issues surrounding the funding and management of prevention programs and the circumstances under which program administrators may be tempted to accept ATP monies – circumstances such as, the competition for shrinking financial resources that support substance abuse prevention programs.

The scarcity of resources could act as a catalyst for many substance abuse prevention agencies to begin to look for non-traditional funding sources. The question of ethics arises when the standards and goals of the substance abuse prevention agencies are compromised due to their monetary or other (than funding) relationships with industries that harbor interests contrary to those held by the prevention community. The stated goals of the policy forum were to:

1. Identify the ethical and professional practice issues involved in the question of accepting funds from the alcohol, tobacco and pharmaceutical industries to support prevention programs and services.

2. Identify the ethical and professional practice issues involved in other (than funding) areas of affiliation and collaboration with the alcohol, tobacco and pharmaceutical industries.

3. Seek areas of consensus that could constitute guidelines and recommendations on the management of the interface between prevention programs and the alcohol, tobacco and pharmaceutical industries.

It is often assumed that a relationship between ATOD prevention agencies and the alcohol and tobacco industries is unlikely because of the potential conflict between agency and industry missions. It was under this premise that policy forum participants engaged in a discussion that compared the core interests of the ATP industries with the interests of the prevention field and public health and safety institutions. Participants worked to identify areas where there may be common ground, however, participants soon realized that there are very few areas in which public interest and the alcohol and tobacco industries share a common goal. It is important to note however, that participants felt that there might be some shared goals between pharmaceutical companies and prevention agencies. An example of this is the collaboration of pharmaceutical companies and prevention organizations to stop the abuse of prescription drugs by the elderly.

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Participants were asked to use an ethical decision making model to assess the amount of harm that could be caused by creating an alliance with the alcohol and tobacco industries. The majority of participants found that significant harm would befall service consumers, individual workers, agencies, the professional field and the community as a whole if alliances with these industries were formed.

Participants worked together during round table discussions to answer five questions related to the appropriateness of accepting funds from ATP companies to be used in prevention programming and the circumstances surrounding other types of collaboration. Participants discussed the role that ATP representatives should and should not be allowed to play in decision-making positions on prevention agency boards and advisory councils.

The final question asked participants to make recommendations about what guidelines prevention agencies should follow in their potential relationships with the ATP industries. Participants made the following three recommendations:

1. Prevention agencies should educate themselves about the history of the ATP industries in the United States and where the interests of these industries may conflict with or align with prevention agencies. More specifically, these agencies should review some of the historical strains that have existed between ATP companies and the fields of substance abuse prevention and treatment.

2. Administrative and fiscal agents of prevention programs need to be educated about the problems that can arise in the relationship between prevention agencies and ATP companies. There needs to be a high level of value congruence on these issues from the bottom to the top of prevention agencies.

3. Prevention agencies should develop a foundation upon which they can make ethical decisions regarding their relationship with the ATP industries. This foundation is made up of a clear mission statement, the delineation of core values of the organization, and the development of an agency code of ethics whose standards can help delineate acceptable and unacceptable prevention partnerships. This foundation needs to be in place BEFORE the issue of accepting funds from, or collaborating with, ATP companies arises.

The policy forum was an initiative to engage the substance abuse prevention field in conversations regarding the critical ethical issues that will ultimately affect prevention programs. This paper was developed to outline possible guidelines and solutions to this important ethical issue as well as act as a catalyst for further action regarding this issue.

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The Ethics of Affiliation

The Relationship between Alcohol, Tobacco and Other Drug (ATOD) Prevention Agencies and the Alcohol, Tobacco and Pharmaceutical (ATP) industries

I. Introductions

During the past 25 years, the concerns about the relationship between the alcohol, tobacco and pharmaceutical (ATP) industries and ATP-related research, publications, and public health initiatives have intensified. (For samples, see: Mason, 1993; Edwards, et. al., 1996; Babor, et. al., 1996; Perkins, 1997; Hurt, 1997) Particularly contentious has been the debate over the question of whether it is ethically appropriate for alcohol, tobacco and other drug (ATOD) abuse prevention agencies to accept funds from or otherwise collaborate with the ATP industries. This paper will summarize the work of more than thirty prevention professionals brought together to look specifically at the ethical issues involved in this question. We will begin by setting this issue in its historical context.

A. Historical Background: A Synopsis

The strain between institutions whose primary goal is the manufacture, distribution, promotion and sale of psychoactive drugs and institutions whose goal is to control, reduce or eliminate particular patterns of psychoactive drug use is deeply rooted in American history. This strain emerged following an era (1780-1830) that saw a dramatic increase in per capita alcohol consumption. Alcohol as "Good Creature of God" and the tavern as a central colonial institution gave way to "Demon Rum" and the emergence of the saloon as a threat to community stability and morality (Rorabaugh, 1979). It was in this era that the concept of addiction was born in America and that an emerging temperance movement began to encourage Americans to moderate their relationship with alcohol. When these efforts to moderate community drinking standards were perceived to be failing, the temperance movement shifted its methods from "moral suasion" (education) to advocacy of legal prohibition of the sale of alcohol (Levine, 1978). By the mid-19th century, the forces of alcohol promotion and alcohol prohibition were waging open battle with one another to shape the role of alcohol within the American culture. The 19th century also saw growing concern about the use of drugs other than alcohol. There were sporadic anti-tobacco campaigns (often led by temperance organizations) and there were conflicting efforts to both promote and control opium, morphine, cocaine, and chloral hydrate.

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The temperance organizations that fueled anti-alcohol and anti-tobacco legislation at local, state and national levels viewed the alcohol and tobacco industries with such antipathy that the idea of soliciting or accepting funds or otherwise cooperating with these industries would have been unthinkable on moral as well as ethical grounds. This was not necessarily the case with late-19th and early 20th century treatment institutions. Many of those who advocated the creation of specialized institutions for the treatment of alcoholism called upon the state to allocate a portion of the alcohol tax revenues to support alcoholism treatment. The Chicago Washingtonian Home, for example, received 10% of a saloon tax until alcohol interests were successful in getting the law that provided such support declared unconstitutional. Treatment institutions in the era advocated that alcoholism treatment should be subsidized by the alcohol industry.

The principle upon which this support was advocated was a simple one: "Every business should be obligated to provide for the accidents which grow out of it." The strain between inebriate homes and asylums who wanted laws allocating a portion of alcohol revenue to treatment and the manufacturers, distributors and sellers of alcohol who resisted such taxation began in the mid-19th century as does the practice of some treatment institutions receiving support indirectly (through state and municipal governments) from the alcohol industry (White, 1998).

During the decades that preceded and spanned national prohibition of alcohol, antagonism between "Wets" and "Drys" became so polarized that the idea of any cooperation let alone accepting funds from the alcohol industry would have been unthinkable. But the repeal of prohibition opened up opportunities to redefine the relationship between alcohol organizations and prevention and treatment organizations. While Wet and Fry forces were still clearly identifiable, there was a growing desire to escape this dichotomy. Alcohol representatives were ever present in post-repeal meeting about alcohol problems and it is during this period that we see the first direct relationships between the alcohol industry and what today would be defined as prevention agencies.

Finding middle ground between Wet and Dry interests was not an easy task. Everett Colby organized the Council on Moderation to prevent alcohol misuse and to promote responsible use of alcohol. The organization solicited funds from both the alcohol industry and from post-repeal temperance groups but failed to sustain itself financially when it was viewed as too dry be Wet interests and too wet by Dry interests (Roizen 1991b). The post-repeal period in America witnessed the founding of Alcoholics Anonymous in 1935 and the rise of a "modern alcoholism movement" out of which emerged some of the core beliefs and the organizational infrastructure of 20th century prevention and treatment agencies. The story of the modern debate about the ethics of affiliation between alcohol organizations and prevention organizations begins in this era within the Research Council on Problems of Alcohol (RCPA).

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The RCPA, from its inception in 1937, brought together some of America's leading scientists to study alcohol problems and to make recommendations of how such problems could be best resolved. Following a two-year struggle to get funding, the RCPA resolved to focus, not on alcohol, but on alcoholism. Where RCPA leaders believed the former would preclude accepting money from the alcohol industry, they felt the latter focus would allow them to ethically accept contributions from the alcohol industry. While the RCPA did accept funds from the alcohol industry following this 1937 decision, the decision generated considerable controversy and funds from the alcohol industry were never large enough to really launch substantial research or educational efforts. In the face of continued struggles and criticism, the RCPA folded in 1949 (Roizen, 1991c).

Two other relevant milestones come from this period. The Yale Center of Alcohol Studies and the National Committee for Education on Alcoholism provided the core of national leadership to de-stigmatize alcoholism and launch the creation of grassroots prevention and treatment efforts. Formally organized in 1943 by E.M. Jellinek, the Yale Center, while being highly critical of RCPA for accepting alcohol industry funds, itself accepted funds from the alcohol industry-donations masked behind the fine distinction between contributions to the university versus contributions to the Center of Alcohol Studies. Yale's actions raised another ethical dimension: the failure to publicly disclose a financial connection to the alcohol industry. A second story comes from the National Committee for Education on Alcohol (NCEA) which was founded in 1944 by Marty Mann. NCEA experienced enormous financial struggles just to stay alive during much of its early history and did accept contributions from the alcohol industry until its later recognition that this practice could compromise the organization's judgment on key alcohol-related policy issues (Roizen, 1991a; Johnson, 1973; NCADD, 1991).

We do not know the total amount of funds the alcohol industry provided to RCPA, Yale and NCEA, the timing of these contributions, nor the effect such contributions had on the policies of these organizations or the extent to which the reputations of these organizations may have been damaged by these decisions. It does not appear that the industry acted with "one voice and one checkbook" during this or subsequent periods. There does not appear to have been any unified strategy, as this funding appeared more haphazard and piecemeal than conspiratorial. This is not to say there was no influence, e.g., liquor-industry representatives dislike constant references to alcoholism – a disorder named after their product – and were successful in getting RCPA to use their preferred term, "problem drinking." (Room, 1978)

Many national and local prevention and treatment agencies followed NCEA's lead in accepting funds from the alcohol industry, and industry representatives continued to participate in national and local alcohol/alcoholism councils in the middle decades of the twentieth century.

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Advocates of newly emerging alcoholism treatment programs between 1950-1975 again asked that some portion of alcohol taxes be allocated to support alcoholism treatment. Some states concurred while others ran voluntary fund-raising efforts in bars to support alcoholism treatment. (Michigan's campaign asked for contributions in bars under the banner, "Give the price of a drink to the victim of drink.") Whether through tax revenues or voluntary contributions, these dollars went to state or municipalities that in turn directed the funds to support local treatment programs.

During the 1980s, a number of grass roots advocacy and prevention organizations were created around special issues or special populations. Mothers Against Driving Drunk (MADD) was founded by Candy Lightner and was followed by groups like Students Against Drunk Driving (SADD), Remove Intoxicated Motorists (RID). Alliance Against Intoxicated Motorists (AAIM), and Boost Consciousness Concerning the Health of University Students (BACCHUS). Many of these groups accepted funds from the alcohol industry during their founding years but later reversed this position and refused to accept such contributions. The acceptance of funds by prevention agencies during the 1970s and early 1980s was done with little awareness by board members of staff of the potential conflicts surrounding the acceptance of such practices. That awareness dramatically increased in the 1980s and 1990s.

In 1983, the Center for Science in the Public Interest release its influential report, *The Booze Merchants: The Inebriating of America* and a follow-up report, *Marketing Booze to Blacks.* These studies documented the aggressiveness with which the alcohol industry had targeted, and were continuing to target, youth, women, people of color, and heavy drinkers via industry marketing campaigns. Such studies stirred debate within the prevention field regarding how prevention organizations could collaborate with agencies that put their own corporate profit above that of the public welfare. This debate intensified when groups like the Partnership for a Drug-Free America accepted contribution from tobacco companies.

In 1994 James Mosher and Ellen Frank conducted a study on the impact of not-for-profit agencies accepting or refusing to accept money from the alcohol industry. They found that agencies that refused such moneys were more likely to support public health measures controlling alcohol (including restrictions on alcohol industry marketing practices) than were organizations that accepted money from the alcohol industry. More specifically, agencies that received money from the alcohol industry were less likely to support administrative licensure revocation for drunk driving; lowering blood alcohol content driving impairment laws; product warning labels and health warning ads.; bans on alcohol billboards, restrictions on sales of alcohol in gas stations, grocery stores, movies, and sports events; and limitations on density of alcohol sales outlets (Mosher and Frank, 1994; Paying the Piper, 1996).

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In 1995, the National Association of Prevention Professionals and Advocates (NAPPA) released an issue paper on "Prevention Program Funding from Controversial Sources." The paper did not take a definitive position on the question of prevention programs accepting funds from the ATP industries but did suggest questions that programs should consider in making such a decision, e.g., the motivation of the funder, potential injury to agency reputation, threat to other sources of agency funding, and conditions of funding that may interfere with freedom of agency action (NAPPA, 1995).

The fact that issues were raised about the ethics of prevention organizations accepting money from alcohol companies does not mean that there was clear agreement on this issue. The debate about the appropriateness of accepting such funds left organizations like the National Organization of Student Assistance Programs and National Association of Leadership for Student Assistance Programs (NALSAP) on completely opposite side of this issue, with NOSAPP accepting funds from the alcohol industry and NALSAP refusing to accept such funds (Hicks and Hammond, 1990).

The broader issue of how prevention organizations should relate to ATP industries was heightened in the 1990s when 1) representatives of the major tobacco companies stood before Congress in 1994 to deny that a) tobacco (nicotine) is addicting, b) addiction has a causal relationship to smoking, and that c) the tobacco industry targeted youth in their marketing campaigns, 2) subpoenaed internal documents from tobacco companies revealed that the industry was long aware of nicotine's addictive properties, understood the cigarette as a drug delivery device, manipulated nicotine levels via genetically altered tobacco, and consciously targeted young people (as young as 12) in their advertising campaigns, and when 3) a proposed "tobacco settlement" included provisions through which the tobacco industry would contribute millions of dollars toward the prevention of tobacco use among young people. The intensified debate about how prevention agencies should relate to what was being viewed as increasingly predatory alcohol and tobacco industries stirred heated debate among board members and staff of local prevention agencies.

Three trends are evident in the brief history; First, prevention and treatment organizations tend to accept funds during their organizational birth and emergence only to later reject such contributions and relationships as they move into organizational maturity. This suggests that ethical sensitivities evolve as professional fields mature and as their financial infrastructures become more stable. Second, there seems to be distinctions between the ethics of accepting money directly from the alcohol industry versus accepting money from the alcohol industry that has been routed through an independent governmental or public health body. Third, ethical sensitivities regarding organizational affiliation and acceptance of contributions have evolved dynamically through the 20th century. The trend has been from one of little awareness or regard for the ethical implications of such relationships to growing concerns that there are serious problems inherent in such relationships.

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B. Current Concerns and Issues

The organization and funding of prevention services continues to lack consistency and reliability. As ATOD prevention initiative (and organizations) come and go, the very desperation to initiate and sustain some of these efforts increases the likelihood that prevention agencies find themselves operating on the boundary of ethical appropriateness in both their collaborative relationships and the sources of their funding. Prevention agencies need a clear understanding of the ethical issues involved in such affiliations and clear ethical guidelines to define when, and when not to, enter into relationships with other organizations. It was in this context of heightened concern and debate about ethical issues regarding the relationship between the ATP industries and preventions organizations that a policy forum was hosted by Prevention First, Incorporated. The aim of the forum was to create opportunity for discussion and formulation of recommendations for how local prevention agencies should best respond to these issues.

C. Policy Forum: Goals, Participants

Prevention First, Inc. proposed to coordinate a meeting of executive level prevention professionals to define the critical ethical issues in funding and managing prevention programs. The event titled "Building a Solid Foundation: A Symposium on Ethics in Prevention," sought to bring together a group of individuals representing a variety of disciplines, who have an interest in the issues of funding of substance abuse prevention programs. The stated goals of the policy forum were to;

1. Identify the ethical and professional practice issues involved in the question of accepting funds from the alcohol, tobacco and pharmaceutical industries to support prevention programs and services.

2. Identify the ethical and professional practice issues involved in other (than funding) areas of affiliation and collaboration with the alcohol, tobacco and pharmaceutical industries.

3. Seek areas of consensus that could constitute guidelines and recommendations on the management of the interface between prevention programs and the alcohol, tobacco and pharmaceutical industries.

The intent of symposium organizers was to deep the number of attendees to a minimum so that all participants could be actively engaged in the discussion. In accordance with the desire to limit the number and scope of participants, registration for the event was by invitation.

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Invitations were sent to individuals in a number of disciplines to ensure that persons from a variety of professional backgrounds were in attendance. The disciplines of government, medicine, substance abuse prevention, mental health, youth service and education were represented at the meeting.

Although the majority of invitations were sent to the recognized leader of the prevention field in Illinois, an effort was made to include individuals from other states. In order to capture the perspectives of prevention leaders from across the nation, invitations were sent to prevention professionals who are a part of the National Prevention Network (NPN). Four states including, Arkansas, Ohio, Wisconsin and Illinois were represented at the symposium.

There were a total of 33 participants who contributed their time and energy to the task of discussing the possible implications that accepting funds from the alcohol, tobacco and pharmaceutical industries may have on their programs. The following is a list of professionals who contributed to this paper through their work at the policy forum.

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The symposium began with a historical perspective of the ethical issues surrounding the interface between the alcohol, tobacco, and pharmaceutical (ATP) industries and the prevention field. Participants were then led in a discussion that compared to core interests of the ATP industries with the interests of the prevention field and public health and safety institutions. Using an ethical decision-making model, participants assessed the amount of harm that could be caused by creating an alliance with the ATP industries.

The afternoon session of the symposium consisted of round table discussions during which participants worked together to answer 5 questions related to the appropriateness of accepting funds from ATP companies to be used in prevention programming and the circumstances surrounding other types of collaboration. Participants also discussed the role that ATP representatives should and should not be allowed to play in decision-making positions on prevention agency boards and advisory councils. Lastly, participants were asked to make recommendations about what guidelines prevention agencies should follow in their potential relationships with the ATP industries.

Throughout the event the 33 participants were deeply engaged in discussing the ethical issues surrounding the funding and management of prevention programs and the circumstances under which program administrators may be tempted to accept ATP monies. The discussions that occurred have been summarized in the pages that follow.

It is important to note that during much of their discussion participants made a distinction between accepting money from the pharmaceutical industry and accepting funding from the alcohol and tobacco industries. Participants were more inclined to concede that it was acceptable to take direct funding from pharmaceutical companies than from the alcohol or tobacco industries. The reason for this distinction is that many participants felt that the mission and goals of the pharmaceutical industry were more congruent with those of the prevention field. Because of this distinction specific mention of the pharmaceutical industry has not been noted in portions of the following participant discussion summaries.

II. The Ethics of Affiliation: General Analysis of Ethical Issues

A. Two Industries: Mission Compatibility versus Mission Conflict

The discussion of ethical issues in affiliations between prevention organization and ATP organizations began with a discussion of the missions of the two industries. The premise of this discussion was that prevention agencies should enter into financial and programmatic collaborations only with organizations whose missions are compatible with their own. Mission congruity can help prevention organizations, through their partnering relationships, avoid problems of “double agentry”: pledging loyalty to one party (the community) while knowingly or unknowingly making decisions that serve the interests of another party (the alcohol industry).

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When comparing the missions of the alcohol and Tobacco (AT) industries to that of the prevention field, many areas of potential conflict were identified. Perceived areas of similarity and differences regarding institutional goals included the following.

Who consumes AT Products?

The AT industries have historically sought to expand their markets by lowering legal age of consumption and by targeted marketing to special populations: youth, women, people of color, and heavy drinkers; the prevention field has sought to constrict overall consumption, raise the legal drinking age, and to focus prevention efforts toward many of the same populations targeted by AT industries.

Where AT products can be purchased/used

The AT industries have sought to expand the number and variety of culturally approved places to purchase and use AT products while the prevention field has sought to constrict the number and variety of such places.

Quality Control

Both the AT industries and the prevention field have supported some degree of quality control to reduce product adulteration of licit substances.

Product Labeling

The AT industries have opposed product labeling while many prevention organizations have supported truth in labeling and mandatory health warning labels.

Product Potency

The AT industries have expanded their markets by both increasing and decreasing doses of alcohol/nicotine in their products. Lowered potency has been aimed at expanding the AT market by catering to broader consumer taste and by responding to consumer health concerns.

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AT industries have also increased product potency to maximize drug effects, to enhance brand identification and to reduce the probability of maturing out (through increased odds of physical addiction). Prevention advocates have long attacked high potency products such as 100+ proof distilled spirits, fortified wines and high alcohol-content malt liquors.

Unit Dose of Product

AT industries have provided products that tend to mask drug dependency behind ever increasing dose sizes, e.g., ever lengthening cigarettes, 40 oz. Beers-a practice bitterly attacked by many prevention organizations.

Event/Daily Dose

AT industries have worked to weaken cultural definition of "excessive" while prevention organizations have tried to limit dosage of use per episode both as a means of lowering threats to public safety (drunk driving) and as a means of reducing personal and social costs that rise progressively with lifetime dose. The alcohol industry has lobbied against lowering level of legal intoxication to .08 – a measure strongly supported by most prevention and public safety advocates.

When Use Occurs

AT industries have attempted to increase use by normalizing use in ever-expanding times and circumstances (e.g., champagne brunches, "Put a little weekend in your week.") while prevention organizations have sought to reduce daily/lifetime dose and to disentangle alcohol and tobacco from cultural rituals, (e.g., sober proms/graduations; "First Night Celebrations").

Perception/Promotion of Product

AT industries have aggressively sought to glamorize and promote their products while prevention organizations have sought to de-glamorize these products. AT industries have bitterly fought prevention efforts to define their products as drugs (and potentially addictive drugs).

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Illicit Markets

Both the AT industries and prevention organizations have voiced strong opposition to illegal drug markets (both illegal [untaxed] sales of AT products and sales of legally prohibited psychoactive drugs).

Product Taxation

The AT industries strongly oppose efforts to increase AT-related taxes while many preventionists support increased AT-related taxation as a way to lower per-capita use and particularly use among young people.

ATP-related Injuries and Fatalities

The AT industry has sought to reduce A-related morbidity and mortality but in ways that don't damage the image of their product or its profitability, e.g., low tar cigarettes, filters, "know when to say when" campaigns, non-alcoholic beer. The prevention field has been quite aggressive in its efforts to reduce AT-related morbidity and mortality, e.g., educational programs on harmful effects of smoking, drunk driving, FAS, etc.

ATP-related Social Costs

The AT industries tend to deny the reality or scope of AT-related social costs whereas the prevention field has been a strong advocate of research and public education related to such social costs. Many prevention programs are also designed to specifically lower personal and social costs of AT use, e.g., FAX/FAE educational campaigns, server training.

Paraphernalia

The AT industries have long used images and logos as marketing devises for their products while the prevention field has attacked many such products and images (Joe Camel) for their use in the targeting of vulnerable populations.

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Heavy Use

Where heavy use is a core of AT industry profits, the reduction of heavy use is a major goal of many prevention initiatives.

Alcoholism

The alcohol industry has been quite concerned about the damage alcoholism could do to its product's image but has been reasonably comfortable with a view of alcoholism as a disorder not caused by their product but by the unique biological vulnerability of a small population of drinker. There is potentially much greater goal incongruence between the alcohol industry and the prevention field in the arena of alcohol abuse than the arena of alcoholism.

B. What gains are possible in this relationship?

Given the large number of areas listed above in which the goals or methods of the AT industries are in direct conflict with those of the prevention field, one must ask: Why would any prevention agency want to enter into a direct relationship with AT companies? When posed with that question, prevention program representatives quickly answered, "Money!" but were hard pressed to find any other benefits of such collaboration. The only other benefits noted were convincing the alcohol industry that preventionists weren't all "neo-prohibitionists" and the potential to influence AT companies to assume more responsible marketing practices. Discussion of this latter point, however, emphasized that the David-Goliath nature of any such relationship would make improbable any such influence on AT corporate policies.

When asked what AT companies could expect to get out of giving money to ATOD prevention organizations, prevention workers perceived varied motivations for such contributions: 1) tax write-offs, 2) the ability to monitor and anticipate prevention strategies, 3) the ability to manipulate prevention agendas toward programs least threatening to the industry, 4) improved public image, and 5) suppression of effective prevention messages.

C. What harm could unfold from this relationship?

The questions of what harm could unfold and who could be harmed as a result of prevention agencies entering into collaboration with AT industries triggered lively debate at the policy forum. It was generally agreed that the ethical question of potential harm involved multiple parties: individual prevention consumers, the community or society as a whole, individual prevention workers, prevention agencies, and the broader prevention field. It was argued that the potential harm to each and all of these parties needed to be carefully evaluated, as part of any decision to accept funds from the ATP industries.

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D. Universal Values and the Question of Affiliation

Policy Forum participants were asked to review a list of universal values that tend to be consistently reflected in the values of professional helpers and to identify which of these values were relevant to the discussion of the relationship between prevention programs and the ATP industries. The universal values reviewed included the following:

Autonomy (Freedom over one's own destiny)
Obedience (Obey legal and ethically permissible directives)
Conscientious Refusal (Disobey illegal or unethical directives)
Beneficence (Do good; Help others)
Gratitude (Pass good along to others)
Competence (Be knowledgeable and skilled)
Justice (Be fair; distribute by merit)
Stewardship (Use resources wisely)
Honesty and Candor (Tell the truth)
Fidelity (Keep your promises)
Loyalty (Don't abandon)
Diligence (Work hard)
Discretion (Respect confidence and privacy)
Self-improvement (Be the best that you can be)
Nonmaleficence (Don't hurt anyone)
Restitution (Make amends to persons injured)
Self-interest (Protect yourself)
(Source: Reproduced from White, 1993)

This portion of the Policy Forum discussions focused on four primary concerns.

1. The *freedom and autonomy* of prevention organizations to advocate on key alcohol policy questions could be undermined by financial linkages with and potential financial dependence upon organizations that manufacture, distribute, market and sell ATP products.
2. The values of fidelity and loyalty demand that prevention organizations not weaken their fiduciary promise to serve their communities. Forum participants expressed fears that this promise could be compromised for personal/institutional self-interest via acceptance of money from the ATP industries.
3. There was concern that accepting money from ATP industries in support of prevention initiatives could potentially do more harm and injury to the community than the good that could be potentially achieved through such monies. In short, there are potential iatrogenic effects from collaborations that undermine the prevention message and inadvertently empower ATP companies to more effectively promote their products. *(Nonmaleficence)*

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4. Soliciting/Accepting funds from ATP industries, while helping prevention organizations in the short run, could injure these same organizations in the long run. *(Self-interest)*

III. Policy Forum Questions, Issues and Recommended Guidelines

A. Should community-based prevention agencies accept funds that come directly from AT companies?

Of the five focus groups, four reached clear consensus that it was never acceptable for a community-based prevention agency to accept funds directly from AT companies. The primary expressed concerns were: 1) that the ability of the agency to fulfill its prevention mission could be compromised as a result of damage to its reputation and credibility resulting from perceived collusion with AT interests, and 2) that acceptance of such funds, by masking company policies and practices that undermined public health, could contribute to a positive image of AT companies. It was contended in these discussions that the potential for damage to prevention agencies from such relationships was minimized by the public's lack of knowledge about objectionable AT company practices such as the conscious targeting of minors in their advertising campaigns. However, with recent disclosures of such practices, public opinion of these companies and those who collaborate with them has rapidly shifted. There was particular concern that financially strapped prevention agencies because of their fiscal vulnerability might unconsciously shape prevention policies and practices to avoid conflict with their AT benefactors and, as a result, weaken the effectiveness of prevention programs.

The one focus group that believed accepting funds from AT companies was sometimes acceptable, defined the following four conditions under which the acceptance of such funds would be acceptable:

- The history of the particular AT company and its current operating principles would not pose a gross conflict with the prevention message of the agency.
- AT representatives would not receive access to policy-making positions on the prevention agency's board as a result of their contribution.
- The AT company would not be able to impose restrictions on what could and could not be done within the prevention activities of the agency.
- The AT company's name would not appear on any prevention programs materials distributed to the community.

B. Should community-based prevention programs accept AT dollars that are routed through an independent public health authority?

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There was considerable disagreement regarding this proposition. One focus group took the position that prevention agencies should never accept AT funds under these circumstances. They argued that all such contributions or levies on the AT industry should be devoted to media-based public service campaigns that could offset the promotional activities of the AT companies. There was a concern that by filtering token amounts of funds to local prevention efforts, the AT industries could avoid broad environmental strategies that could threaten their financial interests. A second group argued that AT funds coming through an independent public health authority would always be acceptable and that such arrangements would become commonplace in the future with the growing propensity for "sin taxes" and negotiated settlements of lawsuits targeting the AT industries. [1] Three focus groups felt that accepting AT dollars through an independent public health authority would be acceptable if:

- The money comes in the form of institutional restitution (tax/legal settlement) rather than a gift from AT companies.
- The source of the money and the mechanism through which it is delivered is openly communicated (not kept secret) from the community.
- The money supported prevention policies and programs through guidelines developed by the public health authority and without the involvement and influence of the AT industry.

C. Should AT representative be allowed to sit in decision-making positions on prevention agency boards and advisory councils?

Four of the prevention focus groups took the position that it would never be acceptable to have AT representatives sitting on prevention agency boards or advisory councils. The groups argued that such inclusion would be impossible given what they perceived as inherent conflict of interests on issues that could come before such boards and councils, e.g., prevention representatives sitting on AT boards. The fifth group stated that, while including AT representatives on a prevention board would be unacceptable, that there might be roles for such representatives on advisory councils or on a specialized committee, e.g., drunk driving task force.

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[1] Alan Markwood, an independent reviewer of this document suggested the following in reference to this issue:

"I would contend that the key distinction is not whether alcohol or tobacco money flows through an intermediary but, who controls the distribution of those funds. Taxation, in which an elected government makes the decisions of whether funds are raised as well as how they are spent, is qualitatively different than any other situation in which industry representatives own the decision to give, irrespective of who the money goes through for distribution. Taxation is ethically 'clean' vis-à-vis the industry. The only concern is the government unit becoming dependent on alcohol or tobacco taxes. The best protection against this is to earmark the proceeds of these taxes to ATOD prevention and treatment."

D. Should prevention agencies collaborate with AT companies in the planning or delivery of prevention services, e.g., co-sponsorship of events, collaboration on prevention campaigns?

Four focus groups contended that collaboration with the AT industries would never be acceptable while one group suggested that such collaboration might be acceptable as long as there was an unequivocal no-use message for youth under age 21 and that all elements of the prevention message were supported by mainstream research. There was further criteria suggested to judge any such collaboration: "Can this arrangement pass the "60 Minutes" Test? What questions would Mike Wallace ask about this collaboration?" Those groups that universally opposed such collaboration felt that collaboration with the AT industries in local prevention activities would send a mixed message that would dilute the power and effectiveness of any prevention activity.

E. What other recommendations would you make to prevention agencies regarding their relationship with the ATP industries?

Focus group discussions of this question acknowledge that many prevention agencies had received funding from or otherwise collaborated with the ATP industries sometime during their history. It was further acknowledged that some prevention agencies, in a search for greater financial stability, were looking at ATP industries as a potential future funding source. Based on these realities, the focus groups made the following three recommendations.

1. Prevention agencies should educate themselves about the history about the history of the ATP industries in the US and where the interests of these industries may conflict with or align with prevention agencies more specifically, these agencies should review some of the historical strains that have existed between ATP companies and the fields of substance abuse prevention and treatment.

2. Administrative and fiscal agents of prevention programs need to be educated about the problems that can arise in the relationship between prevention agencies and ATP companies. There needs to be a high level of value congruence on these issues from the bottom to the top of prevention agencies.

3. Prevention agencies should develop and foundation upon which they can make ethical decisions regarding their relationship with the ATP industries. This foundation is made up of a clear mission statement, the delineation of care values of the organization, and the development of an agency code of ethics whose standards can help delineate acceptable and unacceptable prevention partnerships. This foundation needs to be in place BEFORE the issue of accepting funds from, or collaboration with, ATP companies arises.

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IV. Where do we go from here?

It is undeniable that the controversy surrounding the relationship between the ATP industries and ATOD prevention agencies will continue for some time to come. We will most likely hear more and more discussions regarding shrinking resources for prevention programs, tobacco settlements, sin taxes, etc. It is becoming increasingly important for individual prevention agencies and the prevention field as a whole, to take a position on this issue. The following are some suggestions as to what next steps we, as a field, should take in order to continue to develop an ethical framework from which we practice our profession.

1. It is important that we continue to heighten ethical sensitivities in this arena. This can be achieved through orientation and training of prevention professionals. As was recommended by the policy forum participants, all sections of prevention agencies, including administrative staff and fiscal agents should educate themselves about the history of AT companies in the US, the potential conflict of interest and the problems that can arise from the acceptance of AT industry funding.

2. As a field, we must develop a collective model of ethical decision-making. This model must go beyond the ATP issue and address the whole spectrum of ethical issues that arise within the prevention arena. We need a body of ethics literature that is specific to prevention. Senior professionals must be encouraged to write about ethical issues, and to help the field formulate an ethical decision-making model and a casebook of ethical dilemmas faced in the prevention field.

3. We must develop, as a field and as individual agencies, ethical codes that can guide the field in constructing its relationship with ATP industries. It is important to move beyond aspirational values to operational standards of practice. We recommend that state prevention certification bodies push for the further evolution of codes of ethics that are tied to certification and we recommend that development of local agency codes of professional practice.

4. We recommend that each agency develop a clear statement regarding its position on the issues discussed in the paper, in order to have their policy in place prior to a time when these issues arise.

5. As a field, we should recommend that our state substance abuse and public health authorities explore how they might serve as the clearinghouse through which any funds from the ATP industries would flow. Authorities should develop guidelines regarding the acceptance and reallocation of funds to community agencies. This process would assure that the interests served by those funds would be those of the public at large and not exclusively those of a proprietary industry.

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6. Ethical sensitivities in prevention have evolved considerably throughout the 20th century. We must allow these sensitivities and standards to continue to evolve as we move forward as a culture and as we progress as a professional field. To assess the current status of those sensitivities and standards, we would call for a national prevention forum to specifically explore the issues addressed in this report.

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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Listening to History: Lessons for the EAP/Managed Care Field[1]

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Introduction

The twentieth century witnessed the rise of occupational alcoholism programs, the explosive growth and evolution of these programs into employee assistance programs (EAPs), and the more recent evolution of many EAPs into managed behavioral health care organizations. Like the addiction treatment industry with which it is historically linked, the EAP field is confronted with unparalleled threats and opportunities. This paper recounts three episodes in the history of addiction treatment and recovery in America and reflects on what these episodes might teach us about the vulnerabilities and challenges facing the EAP/managed care field. This presentation is intended as a platform for reflection about the roots, evolution, and future of a field that is undergoing rapid transformations in its mission and character.

Three Episodes in History

Our first episode is drawn from the history of alcoholic mutual aid societies in America. There many such societies organized by and for alcoholics between the late 1700s and the early 20th century. There were the Native American temperance societies, the Washingtonians, the fraternal temperance societies, the reform (ribbon) clubs, the Ollapod Club, the Keeley Leagues, the Business Men's Moderation Society, the United Order of Ex-Boozers, and the Jacoby Club. None of these organizations outlasted their founding generation.

When Alcoholics Anonymous emerged out of the Oxford Group in the late

[1]First presented as a keynote address at the 20th anniversary conference of the Northern Illinois Chapter of EAPA, June 2, 1998, Oakbrook Terrace, Illinois and at the 1999 Annual EAPA Meeting, Great Detroit Chapter, March 10, 1999. I would like to acknowledge David Sharar and Randall Webber for their thoughtful critiques of this paper:.

1930s, it had little more prospects for survival than did its predecessors. AA faced threats of professionalization and commercialization--Bill Wilson's offer of employment to work as a lay therapist at Towns Hospital. Explosive growth--from less than 100 members in 1939 to 8,000 in 1941--threatened to overwhelm and dilute AA's program of recovery. (Members of a new AA group in Richmond, Virginia, for example, regularly drank beer at their meetings.) There was dissension over plans for AA missionaries and AA hospitals and the operation of AA clubhouses. Local AA groups struggled with the inclusion of women and African Americans. Jealousies abounded over who could speak for AA. There were even rumors that AA was a scam to make AA's co-founders rich. Issues of ego, money, property, and sex threatened to tear AA apart. By all accounts, this self-described "neurotic fellowship" should have shared the premature death of its predecessors. We will explore what sources of resiliency prevented that demise and what those sources have to teach us today.

For our second episode, we will visit the rise of addiction treatment during the second half of the 19th century. An elaborate network of medically-oriented inebriate asylums, religiously-oriented inebriate homes, private addiction treatment franchises, and proprietary bottled addiction cures rose in the second half of the 19th century. In 1895, the future of addiction treatment could not have looked brighter. Significant strides had been made to destigmatize alcoholism and other addictions via a well-articulated disease concept of inebriety. The American Association for the Study and Cure of Inebriety was celebrating its 25th anniversary. The *Journal of Inebriety* was about to enter its 20th year of publication. Care for inebriates was emerging as a legitimate specialty within medicine and religion. Treatment institutions were growing in number, and the proprietary home cures were reporting record profits. All seemed bright, and yet within 25 years this multi-branched field of addiction treatment had all but disappeared from the American landscape. We will try to identify the sources of this demise and what this chapter in history has to teach us today.

For our third episode we will visit the modern field of addiction treatment and one particular treatment system known as Parkside. The roots of Parkside can be traced to Dr. Nelson Bradley, Dr. Jean Rossi and Rev. John Keller who took what they had learned at Willmar State Hospital (and from Pioneer House and Hazelden) in Minnesota and refined that model within Lutheran General Hospital in Park Ridge, Illinois. In 1980, a plan was implemented to replicate this successful alcoholism treatment program throughout the country via a newly created entity, Parkside Medical Services (PMS). PMS went on to become the largest provider of addiction treatment services in America: 100 separate treatment sites, more than 2,000 inpatient beds, 2,500 staff, and annual revenues of more than $220 million.

Addiction treatment institutions, including many treatment franchises like PMS, grew almost explosively during the late 1970s into the mid-1980s, but then began to encounter threats to their existence. If there was one organization that should have survived the turbulence of this period, it was Parkside. It had bright and long-tenured addiction treatment professionals and deep roots in the mainstream Minnesota Model of chemical dependency treatment. It should have survived, but it didn't. By the end of 1993, Parkside as a Lutheran-affiliated national network of addiction treatment centers had collapsed. We will explore some of the factors that contributed to Parkside's demise.

From the above three episodes in the history of addiction treatment and recovery in America, eight lessons will be identified that can help assure that the EAP field does not share the fate that befell many addiction treatment institutions in the in the 1890s and Parkside in the 1990s. In trying to apply these lessons to the EAP field, it is important to acknowledge the difficulty in talking with any clarity about an "EAP field" or an "EAP/Managed Care field." A growing variety of organizational configurations and rapidly expanding service menus are stretching the boundaries of the term

Employee Assistance Program and making it difficult to make sweeping statements about what EAPs are and how they are evolving. But this rapid transformation in the character of EAPs is itself part of the story we will explore.

1. Monitoring and Shaping the Social, Economic and Political Ecosystem

The first lesson suggested from our three episodes in history is the importance of rigorously monitoring the ecosystem that constitutes a field's operating environment. America's first network of addiction treatment programs fell in part because of dramatic shifts in the social, economic and political climate within which they had been birthed. The medicalized view of inebriety--the proposition that inebriety was a treatable disease--began to fade in the late 1890s within a growing climate of therapeutic pessimism. A redefinition of addiction in moral and criminal terms led to a bold new social strategy: let the existing inebriates die off and prevent the creation of new inebriates by prohibiting the non-medical sale of alcohol and other addictive drugs. State and federal prohibition laws temporarily dried up the demand for addiction treatment services, and prohibition advocates discouraged the continuation of the financial support that had sustained addiction treatment institutions for more than a half a century.

The effects of this political shift were further magnified by several simultaneous and equally unanticipated economic depressions. Widespread economic distress forced a rapid reallocation of private and public funds away from inebriate asylums and toward what were perceived as more important personal and community needs. Many inebriate homes and asylums simply did not see these environmental changes coming quickly enough to position themselves for survival. In a similar manner, errors in reading the external environment prevented Parkside from recognizing the fundamental changes that were transforming addiction treatment in the United States. At a time when most addiction treatment leaders were recognizing that the days of inpatient addiction treatment were numbered, Parkside's leaders pursued an aggressive expansionist strategy of purchasing inpatient treatment programs. When inpatient census plummeted across the country, Parkside collapsed under the weight of its own size and debt.

AA also faced political and economic threats in the Wet-Dry polarization of post-Repeal America. Several organizations interested in alcohol problems during this period collapsed from lack of financial support because they were seen as too wet by Drys and too dry by Wets. The Council for Moderation, the National Committee on Alcohol Hygiene, and the Research Council on Problems of Alcohol were among the casualties of AA's organizational peers in the 1930s and 1940s. AA's solution to this potential entrapment in political turmoil and financial dependence was reflected in two fundamental decisions. The first was to take a position of uncompromising neutrality on all outside social and political issues. The second was to minimize its financial needs by pledging itself to corporate poverty and economic self-reliance. The decisions that contributed to AA's survival emerged out of AA's own internal turmoil and out of AA's recognition of the environmental threats to its existence.

So what implications can be drawn from all of this for our current situation? First, it is important to point out that challenges to the modern addiction treatment and EAP fields have unfolded within the most robust economy in American history. We must ask ourselves the question: How would we fare if there was a sudden economic downturn that forced difficult choices in the allocation of public and corporate resources? The addiction treatment and EAP/managed care industries are vulnerable to any precipitous economic decline, but vulnerable for different reasons.

Addiction treatment institutions are vulnerable because of a broader cultural shift in the perception of addiction and addiction treatment. As happened in the late 19tn century, we are again shifting from medical to moral and criminal models of viewing those addicted to alcohol and other drugs. Therapeutic pessimism is again on

the rise as treatment is increasingly cast as a place where bad, irresponsible people are coddled and protected from the consequences of their behavior. The ideological foundations for treatment and the treatment system's claim to cultural ownership of alcohol and other drug problems is weakening.

EAPs are vulnerable because of a fundamental change in the relationship between organizations and their employees. The day is passing when company presidents saw themselves as the paternalistic heads of their own organizational families--a day in which employers and employees were bound by an implicit covenant of mutual loyalty. Today, employees are more likely to be viewed as replaceable commodities whose potential risks/costs to the company must be actively managed. When workers get so redefined, the organizational culture that birthed industrial alcoholism programs and EAPs is in danger of crumbling.

The grass roots movement that birthed industrial alcoholism programs is all but gone and needs to get rebirthed if addiction treatment and addiction-inclusive EAP's are to sustain their viability as cultural institutions. That survival hinges on the re-instillation of four simple messages that birthed the rise of a modern alcoholism movement in the 1940s: 1) The alcoholic is a sick person, 2) The alcoholic can be helped, 3) The alcoholic is worth helping, and 4) Alcoholism is a public health problem worthy of public resources.

I believe that the EAP field needs to participate in the rebuilding of this grass roots recovery movement and renew its relationship with employees in general and organized labor, in particular. To do that, we must move back into full partnership with recovering people in our local communities. We need to help re-instill the cultural belief in the potential for permanent recovery. Many members of our field who are in personal recovery have come to mask that history behind an expanding array of professional credentials. The time has come for those among us in recovery to climb back out of the closet and reassert that permanent recovery from alcoholism and other addictions is not only possible but a living reality, the best evidence of which is our own transformed lives.

It is not enough to simply monitor threats and opportunities in the external social, political and economic environment. We must counter the growing sense that the field is being shaped almost exclusively by outside forces. We must shed our chameleon-like character, define who we are and where we are going, and then pursue that identity and vision through a rebirth of professional and social activism. None of us would be here today if it were not for the Marty Manns, the Lefty Hendersons, the Harold Hughes, the Will Fosters. They and many more unnamed heroes spent decades of their lives as activists creating fields now threatened by professional passivity. We need a new generation of activists.

2. Singularity of Purpose

The second lesson to be drawn from our historical vignettes is that we must not lose touch with our founding mission. Organizations operating within turbulent environments often encounter diversions from their primary missionBdiversions that are frequently masked as golden opportunities. Many 19th century alcoholic mutual aid societies lost their sustaining passion (their focus on the alcoholic) when they got caught up in broader political agendas of the temperance movement. Nineteenth century inebriate asylums and many of their 20th century counterparts became similarly diverted when they moved beyond into activities far beyond the boundaries of their founding missions.

AA avoided the threat of such diversions through Bill Wilson's almost single-handed advocacy of what members at the time referred to as "Bill's damned traditions." The Twelve Traditions saved (and continue to save) AA from self-destruction by detailing a core set of values and operational principles to manage the dangers of distraction. As a field and as individual organizations, we have yet to evolve such a clear delineation and utilization of our core mission and values.

Their creation and use would dramatically enhance our future resilience as a field.

We have seen the mission of the EAP field get redefined in ever-extending concentric circles: from occupational alcoholism programs, to employee assistance programs, to drug free workplace programs, to managed behavioral health organizations, to "work-life" programs. The privatization of EAPs via the shift from internal company-operated to external vendor-operated programs has been marked by a shift from a service orientation to a sales orientation. Profit and proprietary self-interest have emerged as potential sources of corruption of EAP clinical decision-making processes.

The Drug Free Workplace Movement brought a new level of invasiveness and coerciveness to many EAPs, shifting their focus from one of personal recovery for occupationally impaired *addicts* to one of apprehension, containment, control, and punishment of *drug using* employees. EA professionals in many companies became perceived more as behavioral police than professional helpers.

The metamorphosis of EAPs into managed behavioral health organizations with a primary focus on risk management and cost containment marks the latest shift in the redefinition of the EAP "client" from the corporate employee to the corporation. We now have a most unusual situation: the short-term profits of EAP organizations and the organizations for whom they work are suddenly linked to denying or rationing rather than maximizing services to employees. The field of employee assistance needs, for technical accuracy, to be renamed the "employer assistance" field in order to reflect the field's redefinition of its primary client.

Organizations within turbulent operating environments are often confronted with the need to adapt rapidly or become extinct, but it is important that we filter our strategies of financial survival through our mission. A lesson from both the inebriate asylums and Parkside is that strategies of financial support that work in the short term may not work in the long term and may weaken the long-term integrity of a professional endeavor. We must be very careful that we do not financially survive in terms of our institutions and our personal careers only to discover that we have become something else--that the field that it took decades to build is gone while its institutions and its workers have changed their essential mission and character. We must be very careful not to justify our existence solely based on cost savings, only to later discover that we achieved such savings not by managing care but by altering the quality and access to care.

The question, "What is the future of EAP?" needs to be answered not as a question about the future of EAP as a profitable market, the future of EAP organizations, or the future of career opportunities within EAP. The question that calls for an answer is, "What is the future of the need and the vision out of which EAP was born?" History suggests that professional disciplines that do not remain cognizant of their core reason for being do so at their own peril. Such cognizance can come by achieving broad consensus in answering four questions:

1. What is our **primary** purpose for being?
2. If we have more than one purpose, are these multiple purposes mutually compatible? (Are there any inherent conflicts through which pursuing one purpose fundamentally compromises our ability to pursue another defined purpose?)
3. When one purpose is in conflict with another, which will take precedence?
4. What core values will help us determine when we say "yes" and when we say "no" to EAP-related service and business opportunities?

We all need to revisit our organizational missions and participate in some serious discussion of who and what we are and who and what we are not. Once that vision is clear, we must let this recrystallized mission drive decision-making at all levels within our organizations.

3. The Divergent Dangers of Isolation and Absorption

Mutual aid societies and addiction treatment organizations have long faced twin threats related to boundary transactions with their operating environments. These organizations often faced demise either from isolating themselves from their professional, political and social environments or by being coopted and absorbed into these environments.

Organizations whose missions involve them with stigmatized issues and stigmatized groups of people have a long history of becoming what I have described as "closed incestuous systems." Such systems can rise to remarkable levels of achievement only to stagnate and then implode. The first medically-oriented addiction treatment institution in the United States--The New York State Inebriate Asylum in Binghamton, New York--self-destructed from precisely such a process and many of its historical progeny have suffered similar fates.

Many addiction treatment providers of the 1980s no longer exist today. Some of these organizations lacked any defining membrane to separate and protect themselves from a rapidly evolving behavioral health care environment. They expanded their identities from alcoholism to addiction to behavioral health or behavioral medicine, only to be gobbled up by more powerful forces within their operating environments. This is a death masked in the process of rapid growth, diversification, loss of identity, loss of passion, and, finally, closure or absorption.

EAPs at both of these poles will not survive the next decade. Those isolationist EAPs will be swept away by forces they didn't see, let alone understand. Those EAPs that chase unlimited market opportunities or are gobbled up in serial mergers may discover somewhere in this process that they have survived as managers of behavioral health services but that they have lost their souls in the process.

There are two related issues within this theme of dilution, diversion, and absorption that are worthy of discussion: 1) the changing status of the alcoholic within the EAP field, and 2) the rapid integration of EAP into broader behavioral health organizations.

The EAP field is rooted historically in the industrial and occupational alcoholism programs that rose up in the early and mid-20th century. When the window of opportunity presented itself for these programs to move towards a broadbrush model, it was done with two rationales: 1) that a broader range of services with a less stigmatized label would result in even larger numbers of alcoholic employees receiving help, and 2) that this broader service would extend the benefits of this program to a wider population of employees with problems other than alcoholism. The second of these anticipated benefits has been achieved, but as the field's mission has moved outward in ever-widening circles, there are real questions about the degree to which EAPs are now fulfilling their core historical mission of returning alcohol-impaired workers to full health and productivity.

In my more than three decade career, I have witnessed a rise in the expertise in EAP practitioners regarding problems other than addiction, but a deterioration of the ability of EAP practitioners to recognize alcohol and other drug-related problems and to effectively intervene in these problems. What was supposed to be an extension of services beyond the alcoholic is in many quarters turning into a transfer of focus to other areas. As the EAP environment has expanded its embrace to encompass all employees, it has become a less friendly place for the impaired alcoholic.

If we survive as organizations at the sacrifice of our founding mission; then we will have recreated the conditions--the unmet needs--out of which the field was originally born. We will have come full circle and will need to rebirth ourselves. I envision a day in the coming century when enlightened employers will tire of losing some of their best workers to the ravages of alcoholism and will call for a program to intervene in the lives of these employees. Perhaps such a program could go by a name fitting to its form and function: perhaps we could call these new programs *occupational*

alcoholism programs. We must maintain fidelity to the field's founding mission by reasserting addiction knowledge and expertise as a central and critical core of EAP services.

The current epidemic of organizational mergers within addiction treatment and EAP is part of a broader shift in the character of American organizations. Such merger frenzy is underway in all sectors of the American economy. It is also, more specifically, part of the current movement out of categorical segregation in health and human services toward cross-disciplinary service integration. As a result of these changes, we are seeing fewer but larger organizations in these arenas, and we are seeing core service of addiction treatment and EAP fields shrink at the same time there is dramatic growth in new and peripheral services. The danger in this trend is that whole arenas of professional endeavor could disappear clouded in the illusion of continued service availability. The names may still be there, services could theoretically exist on paper, while the reality is that the core services that took decades to build could be gone.

History tells us that much can be lost in these integration frenzies. Mergers of addiction treatment and psychiatric units in hospitals, for example, have all too often been more analogous to hostile takeovers than carefully planned integrations. I regularly visit such units following such so-called mergers and I am hard pressed to find the core addiction treatment technology that once existed there. This is a death masked in the rhetoric of service integration. I think a major challenge entering the new century will be that of maintaining a core identity for the addiction and EAP fields amidst what will be an unquestionable wave of service integration initiatives.

There is also an implied business assumption within this frenzy of mergers of behavioral health organizations that bigger is better and safer. This assumption has yet to be tested over time. We have yet to determine which of these many new EA configurations best serves the needs of individual employees and their families. We must ask ourselves what is being lost in this frenzy to affiliate and merge and be careful that responsiveness to local needs and tastes will not be sacrificed by homogenizing EAP services into the professional equivalent of fast food franchises.

4. Toward a Definition of Core Clinical Technology

Inebriate asylums fell in part because of poorly defined clinical technology--no unifying theory, no codification of treatment methods, and a preference for anecdotal case study as opposed to the use of scientific methods to test theories and evaluate treatment methods. The inebriate asylums possessed clinical folklore but not a science of addiction treatment. When they were suddenly put under a cultural microscope as a result of broader political and economic forces, they had no scientific data that they could use to justify their existence.

The modern fields of addiction treatment and EAP have likewise advanced more by ideological proclamation than by science. But scientific research is beginning to play an increasing role in the evaluation of our services. As we progress, we need to continually define our core technologies and use rigorous methods of evaluation to determine what those technologies are and are not capable of achieving (and defining with whom that technology does and does not work). If it turns out that we have no defensible technology, then there is no justification for the field's future. If on the other hand, as I suspect, the research confirms that this technology works with some employees but not others, then we must vigorously work to bridge the gap between this clinical research and our clinical practice--a process that will inevitably focus on the sharper delineation of clinical subpopulations, improved intervention matching, and the continual expansion and refinement of service menus.

5. Continua of Care

The 19th century inebriate asylum's struggle to compete with inebriate homes and proprietary addiction cure institutes was due in part to the asylum's fixation on a single

modality--long-term (1-4 years) institutional care. This made it difficult to compete with the much shorter, less restrictive, and less costly modalities of their competitors and assured that the asylums would see only those addicts in the latest stages of deterioration. The modern addiction treatment field has been similarly prone to modality biases that have been increasingly challenged by research findings that confirm: the existence of multiple etiological pathways for addictive disorders, the presence of multiple clinical subpopulations, the need for rigorous assessment and carefully differentiated treatment interventions, and the existence of multiple styles and long term pathways of recovery.

Clinical research confirms the need for community-based continua of services spanning primary prevention through various levels of primary treatment and sustaining care. It has taken more than a century for the addiction field to construct and implement this notion of differential diagnosis and the strategic use of a continuum of care for each client. The backlash against the one-size fits all (28-day inpatient) “Minnesota Model” of addiction treatment threatens to erode this emerging concept of continuum of care and replace it with a one-size fits all low-dose outpatient therapy intervention. We must carefully protect and elevate this continuum of care concept. We are increasingly treating chronic diseases characterized by remission and relapse that unfold within still poorly understood developmental stages of recovery. The issue is not only that different EAP consumers need different types of treatment, but that the same person often requires different types of treatment during different stages of his or her addiction/recovery careers.

Welfare reform initiatives and the current trend toward full employment have contributed to the growing numbers of multiple problem clients/families seeking and being referred for EAP and addiction treatment services. This new generation of clients who present with multiple problems of great acuity and chronicity and with numerous personal and environmental obstacles to stable recovery are often not amenable to the brief outpatient therapies that are becoming the prescriptive norm for everyone seeking EAP/behavioral health services. Only a continuum of care can respond to these changing needs. We must continue to champion this concept. Multiple episodes of low dose therapies that meet cost-containment goals in the short run may not do so in the long-run and our rush to unquestionably embrace these brief interventions may create a backlash that could threaten the future existence of both the EAP and addiction treatment fields. Such brief interventions should be embraced as part of a continuum of care, not as financial or clinical panaceas.

We must continue to generate outcome data to evaluate elements within this continuum of care at the same time we need to be cautious about a political setup in which we are given decreasing resources to work with clients presenting with greater problem chronicity and intensity. When evaluation studies then confirm that low dose treatments have minimal impact in either inciting personal recovery for most of these clients or reducing their long-term social costs, the inevitable outcome will be the conclusion that treatment doesn’t work and the extrusion of these individuals from the workforce. Such a conclusion could lead to the abandonment of workplace counseling, diminished support for community-based treatment, and the emergence of more coercive and punitive interventions into the lives of those who fail to respond to brief outpatient therapy. We need as a field to be able to look back in future years and say that we spoke out about such issues and that we refused to be part of such processes.

6. Ethical Vulnerability

Ethical abuses within 19th and early 20th century inebriate homes and asylums hurt their image with the public and contributed to the erosion of support for their continued existence. Those ethical breaches included unethical marketing practices (particularly claims of excessive cure rates), corruption in the award of contracts (particularly to trustees and family members),

the financial exploitation of patients/families, unsanitary conditions and improper care, excessive use of restraints and solitary confinement, cruel and immoral treatment of patients by attendants, and charges that an inordinate percentage of the financial resources were being devoted to support the extravagant lifestyles of the superintendents. Public exposés did great damage to these institutions and the field=s image was further damaged when many of the proprietary cures were revealed to contain alcohol, opium, morphine and cocaine.

The addiction treatment field has been similarly hurt in the past decade by exposés of personal and institutional shortcomings. There is little doubt that the aggressive managed care that is decreasing accessibility and altering the character of addiction treatment in the U.S. grew out of abuses within the treatment industry itself: inappropriate admissions and re-admissions; inappropriate lengths of stays; excessive fees, and unethical marketing practices, to name just a few.

The EAP field is moving into a period of heightened ethical vulnerability. These vulnerabilities, which have historically focused on clinical issues, include innumerable ethical complexities involved in the field's business practices: issues involved in the sale, acquisition, and merger of EAP providers; the duality and inherent conflicts in simultaneously provided EAP and managed care services; unethical marketing and sales tactics, including lowball bids for EAP contracts that inevitably lead to service erosion; the troublesome relationship between profit margins and the duration and intensity of service utilization (profit-driven rationing of care); excessive profit margins; misrepresentation of utilization rates; "free" EAP services (the illusion of EAP linked to a 1-800-Tape Recorder or a 1-800-Say No@ hotline); vendor contracting and referral practices; lack of geographically accessible referral sources; the replacement of comprehensive employee behavioral health benefits with low-dose EAP services, and the movement of EA practitioners into areas far beyond their education, training and experience. Conflicts of interests and conflicts of loyalties abound in the emerging EA environment.

We now have a window of opportunity to prevent the ethical abuses that could spawn a backlash against EAP in the coming decade. To avoid this backlash, we need to get ourselves ethically re-centered. I think we can do that by enhancing our ethical sensitivities in light of this changing environment, creating or updating organizational codes of professional practice, and by exerting greater disciplinary control over those in our profession who violate the boundaries of ethical practice. The ethical standards development within the EAP field that has to date focused primarily on clinical ethics needs to be expanded to encompass a rigorous scrutiny of ethical issues and potential ethical standards related to the field's business practices.

7. Leadership Challenges

Developing fields (and organizations) face three fundamental leadership challenges: 1) surviving the character foibles of their charismatic founders, 2) managing the transition between the creators and the sustainers, and 3) implementing long-term structures for leadership development and leadership succession.

Very few addiction-related mutual aid societies have outlived their founding generation, and the history of addiction treatment is replete with stories of institutions achieving great acclaim only to fall into disrepute behind the fall from grace of their charismatic leader. John Hawkins, John Gough, and other key leaders within the Washington Movement contributed to the demise of this movement by pursuing their own career agendas as paid temperance lecturers. Reform clubs sprang up in the 1870s around local charismatic leaders, sustained themselves for years, and then quietly died out alongside the relocation or death of these local leaders. The man most responsible for the founding of inebriate asylums in America--Dr. Edward Turner--created such animosity within his own organization and in his professional peer relationships that he was expelled from his own facility and precluded from

membership in the first professional association of the field that he himself had helped create. Most of the leaders of 19th century inebriate asylums and homes birthed these organization, maintained them for years, and then collectively retired or died without cultivating new leaders to take their places. The environmental threats to this field were significant in the early 20th century, but in many ways this field died as much from old age as from these external threats.

AA used its Steps, Traditions, and the sanction of "group conscience" to minimize the ability of AA to be mortally wounded by the character defects of its leaders. AA took a minimalist approach to organizational structure, chose not to place its founders in positions of centralized power, defined a core set of principles through which all organizational decisions were to be filtered, decentralized decision making within the lowest level of the organization, and created constantly rotating cycles of leadership.

Today many of the remaining founding leaders within the addiction treatment and EAP fields are poised to leave in mass within the next decade. This rapid bleeding out of the history and professional culture of these fields poses a significant threat to their future. This situation calls for: 1) the development of leadership succession plans inside individual agencies and for the field as a whole, 2) the development of mechanisms and rituals through which we can honor the service of these exiting leaders and capture their experience in ways that can be passed on to new generations of workers, and 3) the creation of one or more leadership institutes to prepare tomorrow's leaders within the EAP and treatment arenas.

8. Unity and Statecraft

Perhaps the saddest element of the story of America's first network of addiction treatment providers is the lack of certainty regarding the field's death. We know that the last issue of the *Journal of Inebriety* was published in 1914, but the exact time of the demise of the American Association for the Study and Cure of Inebriety is unknown--sometime in the 1920s. It is noteworthy that no one remained who cared enough to document the collapse of a field that had provided addiction treatment in America for more than sixty years. Two final factors that contributed to the demise of that field was the lack of unity of the field (bitter debates raged for years between competing branches) and the lack of statespeople who could speak for the field out of a reputation of unquestionable honesty and integrity.

I think a lesson of this period is that we must come together and find a way to speak with one voice. We need strong advocacy organizations that can guide the long-term evolution of the field and protect the integrity of the field from internal and external challenges. We need statespeople whose pronouncements about the needs of employees and their families transcend issues of personal and institutional self-interest. We need statespeople who have the courage to make decisions that are based more on principles than popularity or profitability. We need statespeople who are viewed by all as truthtellers and not hustlers pursuing their own personal or institutional agendas.

The Lessons of History

In closing, let me recap what I think are the eight historical challenges that I believe are important in shaping the future of the EAP field.

1. We must rigorously monitor the social, political and economic ecosystem within which we operate and sustain an activist stance in shaping social, economic and political agendas that support hope-infusing interventions into the lives of impaired workers.

2. We must not be diverted from our primary purpose. We must sustain fidelity to our historical mission.

3. We must monitor our boundary transactions with the extra-professional environment in order to avoid the threats of isolation and implosion on the one hand and dilution and absorption on the other.

4. We must define core clinical and management technologies and practice only within the boundaries of that technology.

5. We must continue to construct continua of care that can respond to behavioral health problems of varied intensity, complexity and duration.

6. We must find ways to elevate the level of our ethical practices, both in the business arena and the clinical arena.

7. We must find ways to survive the character flaws of our charismatic founders. We must implement strategies of leadership development and succession that will allow us to survive our founding generations with our mission intact.

8. We must come together, rise above our parochial personal and institutional interests, and find a way to speak as one voice. We must find the courage to be truthtellers.

A Personal Note

As I interact with EAP professionals in my travels around the country, it is clear that this is a time of great strain. Many EAP professionals report that it is getting harder and harder to draw personal satisfaction from their day-to-day duties. The transition from company counselor to fiscal gatekeeper and contracts manager has not been an easy one for many. Some are taking an activist stance to more positively shape the future of their organizations and the field. They are trying to re-seed their organizations and the broader field with what they believe are our most important core values. Others are practicing a policy of self-containment--creating pockets of hope within which they can actualize the historical values that originally drew them to EAP. Still others are exiting the field in search of arenas that offer greater levels of personal and professional satisfaction. What all three of these groups share is the experience of strain in trying to reconcile their own personal and professional values with those they encounter within our evolving field.

In this time of great strain, I think we can sustain ourselves through the same four daily rituals that have long been the hallmark of addiction recovery. We need to find *centering rituals* that provide us time alone to set aside distractions and help us "keep our eyes on the prize"--keep ourselves focused on what is most important within this thing called EAP. We need time to reflect, meditate, pray and stay focused. We need *mirroring rituals* through which we can interact with like-minded spirits for mutual support. The worst threats of this period we need to face together, not in isolation. We need regular *acts of self-repair* to heal ourselves and our most intimate relationships. We must guard against the danger of carrying light to others while leaving our own homes in darkness. Finally, we need to cultivate unpaid *acts of service* in our communities--acts that help affirm the nobility of public service and remind us of why we chose to devote our lives to helping others.

The future health and vitality of our field will only be as strong as the health of our individual service organizations and the health of each of us. I have completed more than thirty years of involvement with these imperfect instruments we call intervention and treatment but I pass this milestone still believing that at their best these instruments can transform individuals, families, organizations and communities. It is that power that is the soul of our field, that power that can nurture each of us and our organizations, and, if the field should lose its way, that power that will have to be rediscovered in the future. I wish each of you and your organizations Godspeed on your journey into that future.



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Developing a SAP Code of Ethics and Professional Standards

Barbara Fafaglia and William L. White

Introduction

Integration of Student Assistance Programs (SAP) into the field of education has created a new role for school districts that is without historic precedence. Staff members who fill SAP positions are encountering complex ethical dilemmas for which they and their districts are often ill prepared. This article will describe how one Illinois school district has addressed these dilemmas through the development and implementation of a code of ethical standards and professional practice (CPS).

Context

District 186 is an urban K-12 school in Springfield, Illinois, encompassing thirty-five schools and serving approximately 15, 000 students with a faculty and staff of more than 2000. Under the leadership of a Safe and Drug-Free Schools Program (SDFS) Director hired in the 1990-1991 school year, an SAP was developed and implemented. Utilizing a Core Team model with an average of 10 team members per site working under the leadership of a full-time SAP building coordinator, the program has expanded from one staff member in one building to fifteen staff members in twenty-four buildings over the last nine years.

While the process of implementing SAP's within a growing number of our schools was exciting and fulfilling, we became increasingly aware of the growing number of ethical issues our SAP faced daily. As our fledgling SAP grappled with these sensitive issues, we sought outside assistance in the hope we could find existing ethical standards and training specific to the SAP experience. To our surprise, we found few resources that could guide staff through some of these most difficult situations. Following introductory training sessions on ethical issues in prevention and early intervention, we committed ourselves to develop a CPS that would provide consistent professional guidance to all SAP staff and Core Team members. We became convinced that developing these standards would be essential to the successful operation of the District's SAP.

We assumed that developing these ethical standards would tax our mental energy and require hard work. But, little did we know that we were about to undertake a process that would challenge us and compel us forever to question our assumptions and rethink the way we did business in the SAP. In the end, our work of nearly three years was time well spent. It generated a document that addressed ethical standards to guide staff through complex and sensitive

situations, and it set clear boundaries for appropriate and inappropriate professional and personal conduct.

The process used to generate the CPS included the six critical steps that follow.

The Process

Getting Organized

Developing a CPS requires considerable up-front organization. We began by convening a working group of SAP building coordinators and a scribe, and we used SDFS money to procure a consultant to facilitate the development process. At the first meeting, we defined our goals, outlined the steps we would use to formulate the document, and established meeting dates and agenda formats for the year. We also brainstormed what we thought were the most critical ethical issues SAP staff faced and addressed them in the development of our CPS. Leaving our first gathering with a sense of where we were going and approximately how long it would take to get there, we were ready to apply our organizational plan and to learn about ethics.

Perusing Available Ethics Codes

Our first step was to identify ethical standards drawn from other arenas of the health and human services field that we though might be applicable to the SAP program and staff. We pored over these documents, culling what we could use or adapt for our own needs. In short, we went shopping for existing ethical standards that we thought would be applicable to SAP. This process generated initial standards that would eventually be incorporated into the first draft of the CPS.

Exploring Ethical Issues in SAP

Our next step consisted of providing staff a crash course on ethical issues is SAP. First we defined and distinguished issues of ethics, morality, professional appropriateness, and relevant legalities. We focused on how each SAP member's personal and professional conduct could affect and potentially harm the student/family, SAP staff person, SAP program, District, SAP field, and community and public safety. This process brought discomfort and fear along with enlightenment as our discussions helped us refine a mission statement that would guide the specific development of ethical codes. It allowed us to create a shared context and vision for our team and clarified the need for a paradigm of ethical problem-solving. It was a critical step that propelled the value of the process.

Reviewing Critical Incidents

During our next few meetings we moved SAP staff into small working groups and presented them with ethical vignettes of critical incidents drawn form a broad spectrum of categories, ranging from personal conduct to conduct in relationships with students, families, and professional peers. In response to each vignette, the working groups identified the ethical issues within each situation; the parties that could be potentially harmed by the actions or "inactions" of staff response; and any universal values (e.g., honesty, loyalty, justice) that might apply to the ethical dilemmas.

The groups then determined how they would respond to each ethical vignette presented. Finally, each group generated a draft standard that could guide SAP staff when they found themselves in similar ethical situations.

The following critical incidents were typical of the ones used for this exercise.

Incident #1: *An SAP staff member is arrested (on non-work time but in her local community) for DUI.*

This situation, which applies to personal conduct, generated some interesting discussions. We had to ask

ourselves these difficult questions: Is this behavior subject to professional and/or ethical scrutiny or is it a matter of personal privacy? What potentially harmful consequences could unfold from such an event? What standards, if any, should guide the conduct of SAP staff during non-work hours?

Incident #2: *A student discloses to the SAP Coordinator that he has been selling and using cocaine for the past year. He wants to quit using and selling and wants the SAP staff to help him*.

This example raises the boundary between confidentiality and duty to report. We asked ourselves these questions: Would an SAP professional be ethically or legally bound to report this situation? If so, to whom would this information be reported? What parties could potentially be injured in this situation?

Incident #3: *One of your SAP coordinators is a "toucher." She hugs and pats friends, fellow staff members, and students. This coordinator has worked with students in SAP for three years, and so far, there have been no know incidents in which a student had misinterpreted or taken offense at her physical style of expressing support. And yet, some staff members have worried that her effusive touching might one day create a problem*.

This vignette forced us to ask some complex questions: What are the ethical issues involved in physical touch between SAP staff and the students they serve? Is touch always okay, never okay, or sometimes okay? What parties might be vulnerable to injury in this situation? What are the boundaries between ethical and unethical touch? This is a tough one, isn't it?

These are just a few of the many incidents we addressed. The more we worked, discussed, and struggled for appropriate responses, the clearer it became that we needed ethical standards to effectively and sensitively deal with issues such as these.

Developing a Draft Document

Developing the draft document took about nine months of writing, editing, and re-writing. We incorporated all information from our review of various codes of ethics and the draft standards that had been generated during the group training and working experiences. Hours were spent deciding what categories we needed to address and the critical components for each category. Comprehensiveness and clarity were our top priorities. This task was rather tedious, but we found a couple of writers in our group who helped pull it together.

Implementing the Final Document

Our final document, The Code of Professional SAP Standards, Practice and Ethics, was the result of nearly three years of hard, rewarding work. We then presented the document for review and comment to the Superintendent, Director of Personnel, Board of Education, the school's legal counsel, and SAP Core Team members. Following approval from the board, the SAP code was implemented effective the 1996-1997 school year. Today all new staff members are oriented to the code, and all staff uses the code to guide them in daily ethical decision-making.

The Product

The purpose of the CPS is to assure that all decisions and actions of SAP personnel are filtered through the SAP's mission, core values, and professional practice standards. It includes five elements: 1) the mission statement of SAP; 2) the core aspirational values of the SAP; 3) the service components of the SAP; 4) professional

standards for the delivery of SAP services; and 5) the procedures through which the CPS is linked to district-wide policies and disciplinary procedures.

Several types of statements in the CPS set forth standards of practice for those working in the SAP. There are traditional ethical standards (Thou shall…and Thou shall not…statements). There are standards that capture the folk wisdom of those who have worked in SAP (It has been our experience that…statements). And there are procedural directives that define not what to do in a particular situation but the process that must be followed (e.g., seeking consultation with the SAP Director). Procedural directives usually apply to situations of such intensity and complexity that no universally applicable standard could be generated. Also included are standards that reflect mutually agreed upon practices of professional and organizational etiquette (This is how we do things around here…statements).

The District 186 CPS articulates standards related to six areas of professional practice:

1. personal conduct outside the workplace (e.g., standards regarding breaches in morality/law, personal drug use/impairment)
2. conduct related to business practices (e.g., standards regarding conflicts of interests, vendor/consultant relationships, ownership and promotion of proprietary products)
3. general professional conduct (e.g., standards regarding representation of credentials, secondary employment, speech, and attire)
4. conduct in relationships with students and families (e.g., standards regarding confidentiality, dual relationships, boundaries of competence, gifts to/from students/families)
5. conduct in professional peer relationships (e.g., standards regarding sexual harassment, conflict resolution, allegations of professional misconduct)
6. conduct in response to threats to public safety (e.g., standards delineating the boundary between rights to confidentiality and duty to report)

Reviewing and Training

Since the code of ethics is a living document, it needs to be reviewed and refined on an ongoing basis. Yearly review is prudent. We have combined this step with continual training on the subject of ethics and boundaries in SAP. This regular review and training process have contributed greatly to the professionalism of our staff.

*Anyone who would like to receive a copy of the District 186 CPS may contact the senior author:

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Workshop Exercise Handout
Ethical Vignettes in Training Delivery

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1 Use of Proprietary Materials

Jamie attends a workshop on dual diagnosis to prepare himself for a workshop on this same subject that he is scheduled to give in two months. The workshop he attends is an excellent one that includes a wealth of information and handouts. Provide examples of both ethical and unethical ways that Jamie could utilize information and materials from this workshop in his own delivery of this subject.

2 Marketing/Delivery

A brochure marketing a workshop on family counseling clearly outlines learning objectives and notes that the learning methodologies used in the workshop will include lecture and discussion of videotaped vignettes from family counseling sessions. During the workshop, the trainer alters the agenda and learning methodologies without negotiation with the trainees. Workshop participants find themselves suddenly "volunteered" to play key roles in psycho-dramatic recapitulations of their own families of origin. Discuss the ethical issues involved in this situation? What universal values would apply to this situation?

3. Confidentiality

Disclosures in treatment are protected by such mechanisms as informed consent and confidentiality requirements. Is there an assumed contract of confidentiality in the training environment?

Robert, an addictions counselor for the past four years, disclosed in a workshop on staff burnout that he had relapsed and had been secretly drinking for the past two months. Following this brief disclosure, he refused to discuss the issue and left the training early. One of the training staff felt ethically obligated to contact Robert's supervisor to notify her of Robert's disclosure and the trainer's fear of what Robert's relapse may mean for Robert, his clients and his agency. Robert later filed a complaint with the agency sponsoring the training alleging that that his confidentiality had been violated--that information he

shared in training had been disclosed outside. Discuss your thoughts on the ethical issues involved in this situation.

4. Self-Disclosure

Betty, a recovering alcoholic who works for a substance abuse prevention training institute, spends the majority of her time speaking to professional audiences about various dimensions related to the assessment and treatment of addiction. Under what conditions would it be appropriate or inappropriate for Betty to self-disclose her status as a recovering person? What factors should be considered in this decision? Betty is an active member of a 12 step program such as Alcoholics Anonymous, how can she speak to professional groups about AA without inadvertently violating AA's tradition of anonymity? What standards should guide the professional trainer (recovering and non-recovering) to avoid the appearance that they represent or speak for a 12 Step Program or other mutual aid society?

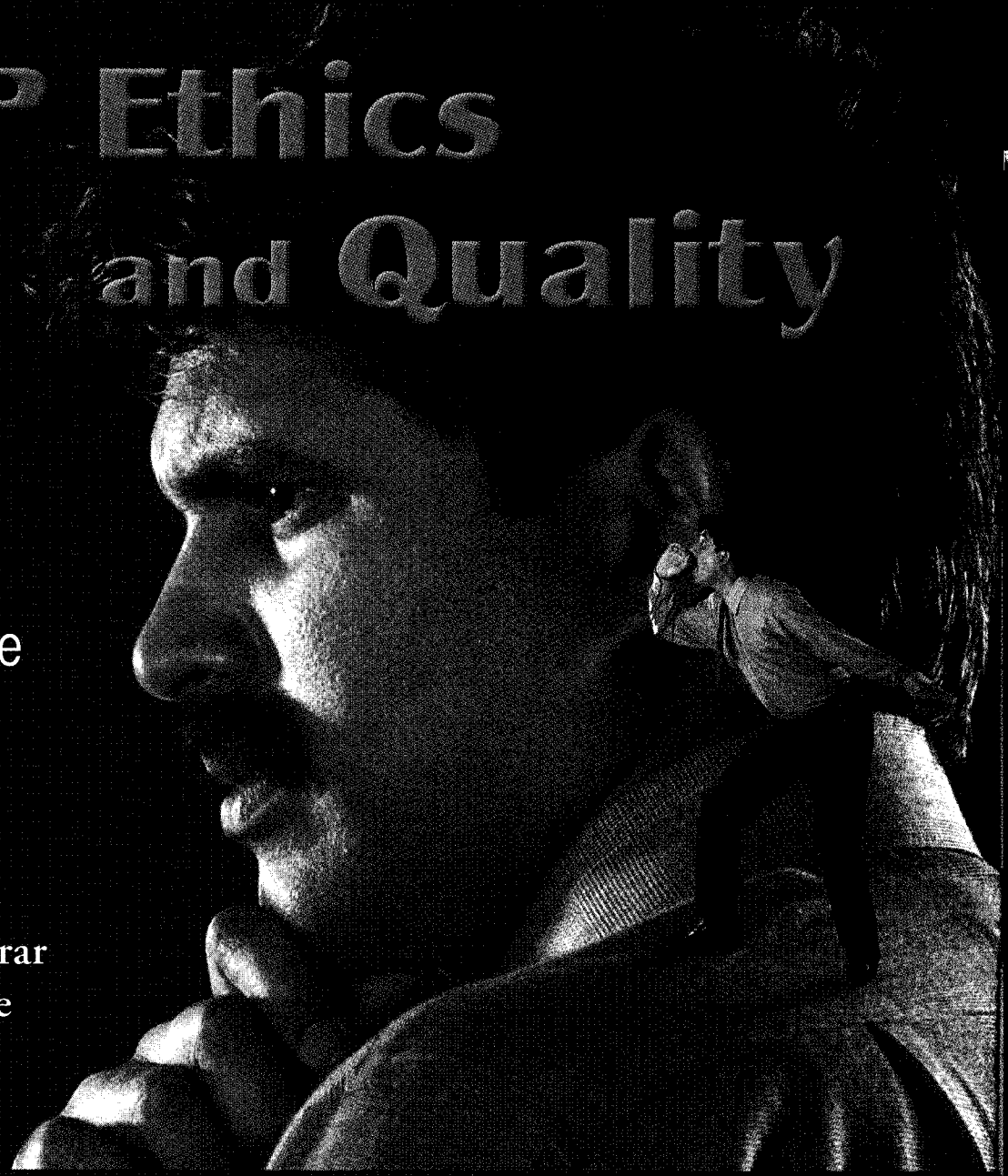
5. Duty to Intervene: The Impaired Trainee

You are facilitating process-oriented training on adolescent substance abuse to 25 professional participants, all of whom are involved in addiction treatment except one who, does DUI evaluations. The behavior of this latter person over the first 90 minutes includes the following: inability to follow the conceptual material, incoherent speech-making, excessive and inappropriate self-disclosure, anger toward group member challenges to her comments, and threats to leave if the group won't listen to her ideas. The participant in question appears to be in her late sixties or early seventies and also exhibits clearly observable tremors in both hands. You have deduced from various disclosures that the participant works in an independent practice that consists almost entirely of conducted DUI evaluations. Describe your potential responses to this situation.

6: Relationship Boundaries

Mark is a part-time counselor in an addiction treatment program who spends the remainder of his professional time working contractually as a trainer on addiction-related topics. Most of his training activities involve 3-5 day residential training experiences that bring together trainees from throughout his state. Mark has developed over the past two years a fairly consistent pattern of sexual involvement with trainees during these training retreats. Do the ethical boundaries that preclude counselor-client sexual involvement extend to the trainer-trainee relationship? If a fundamental difference in the therapist-client and trainer-trainee relationship is the duration of power inequity and the duration of vulnerability, could a trainer get involved with a trainee after a training event without being suspected of a breach in ethical conduct? Would a trainer who was attracted to a trainee be ethically prohibited from pursuing that relationship after the training event was over? Where the prohibition against a therapist-client sexual relationship might last forever, might any prohibition against a trainer-trainee sexual relationship be relatively time-limited? Discuss ethical issues and standards related to this situation.

EAP Ethics and Quality



Does national vs. local service delivery make a difference?

By David A. Sharar and William White

Professionals say they're concerned about quality erosion as a result of the recent trend toward national vendors dominating administration of local employee assistance programs, according to a recent U.S. survey that measured differences in perceptions of ethical problems between respondents working for national and local/regional EA firms.

The survey found, among other things, that a majority of EA professionals say that quality of service is compromised by subcontractors who may lack knowledge and competence, that out-of-state administration may constrain local response time, and that enrolled local companies may lack elements of a comprehensive EAP, such as adequate training of supervisors to identify troubled workers.

Over the past few years, a series of mergers has yielded a tremendous concentration of U.S. employees covered by for-profit, nationally based EA vendors. In fact, 10 vendors now manage 75 percent of EAP enrollment in the country — with Magellan Behavioral Health, Managed Health Networks and Value Options comprising the Top Three.

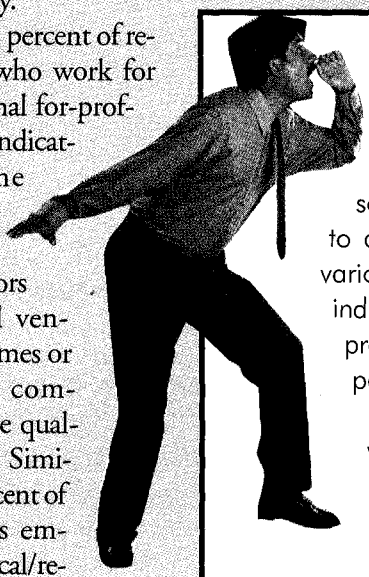
As EA service control becomes concentrated and structured into massive delivery networks, examining ethical perceptions of professionals who work for national, local and regional vendors may offer some insights on this market trend.

National firms tend to be vendors based in private, for-profit stockholder or investor-owned corporations that offer programs throughout the United States as well as internationally. Local/regional firms tend to be based in not-for-profit behavioral health agencies or health systems as a division or specialized program, or based in local proprietor-owned programs, either

as a stand-alone EAP or an extension of a private group practice.

Concerns over service quality

Interestingly, 71 percent of respondents employed by national vendors — who arguably have some duty of loyalty to their employers — say they are concerned that EA service quality is compromised when national vendors assume control of local aspects of service delivery.



Some 71 percent of respondents who work for large, national for-profit EA firms indicated that the "shift from local/regional vendors to national vendors sometimes or frequently compromises the quality of care." Similarly, 82 percent of respondents employed by local/regional EA firms expressed the same concern.

Surveyed professionals alluded to two primary related concerns: First, they questioned the degree of knowledge and sophistication among subcontracted EA providers. Most national vendors contract with "network providers," affiliates or independent contractors who can be used on an as-needed basis to provide services in locations where national vendors do not have staff members or offices.

Respondents suggested that these subcontractors, while licensed, sometimes lack competence and experience in the distinguishing aspects of EA practice. Respondents cited examples of subcontractors who lacked rudimentary understanding of EA core functions, such as conducting a screening for chemical dependency, managing a supervisory referral, or having some knowledge of the relationship between personal issues and workplace productivity.

Secondly, surveyed professionals cited a missing connection to the local workplace when communications, decisions and account management migrates to an out-of-state headquarters. The local subcontractor, they said, is "unaligned and non-integrated with the local employer" and has little motivation to build a close and consultative relationship with the local employer, particularly when the subcontractor has signed a non-compete clause with the national vendor.

One respondent commented that "I'm essentially a bottom feeder in my own market, waiting for the occasional referral. I've never even been to the local employer's work site or had a conversation with their human resources staff."

Another respondent remarked "Basically, I'm the local problem assessment/ counseling resource on behalf of [national vendor] and provide no real work-based services to the local company. I don't think I've ever had a supervisory referral."

Frequently, the subcontractor is not even known to the local employer. If subcontractors wish to be utilized and paid, they must wait for a request for service from the national EA vendor headquarters and "adhere to an array of telephone authorizations and paperwork requirements," respondents said.

Critical incidents in the workplace were referenced as one example of this "unalignment" in action. A rapid and intense local response by a subcontractor is severely constrained when the incident is being coordinated by an out-of-state account manager whose "primary objective is to contain the cost of subcontractor's intervention." Another example cited is the large number of supervisors among geographically diverse multi-location employers who rarely or never receive EA training on how to identify and refer troubled employees.

When the scope of the subcontractor's involvement is limited to the occasional EA assessment of an employee, essential elements of an effective and comprehensive EAP are missing. The emergence of national models of EA delivery, with the "convenience of a single-point-of-contract," distances the concerns of the local employer from the local EA provider and dilutes the workplace emphasis that EAPs historically bring to the table.

The delineation of roles between the local subcontractor and the national vendor is not simply a technical one. Without all parties, local and national, involved in the implementation and delivery of a complete program, without all the key players receiving incen-

How the Survey Was Conducted

The survey questionnaire used rating scales and open-ended questions and was sent to a random sample of EA professionals from various regions of the United States. Respondents indicated perceived frequency of various ethical problems based upon direct observation and experience over the past five years.

A total of 272 questionnaires out of 632 were returned, a 43 percent return rate.

The survey focused on identifying ethical issues perceived as occurring "frequently" — more than 10 observations — and "sometimes," between four and 10 observations. Findings here focus on the differences between local/regional and national EA players, with some interpretation and commentary regarding related environmental and financial issues.

tives to integrate the EAP with the work site, the claim of a comprehensive and integrated program may merely be, in some cases, a liberal form of puffing and spinning, under the guise of marketing and contract retention.

Low-ball rates

Among professionals employed by national vendors, 42 percent of respondents said that "low-ball rates and bids frequently lead to quality erosion." This compares to 26 percent of local/regional players who responded similarly.

Most EAPs are priced using "capitation," or a fixed sum per month or year for each covered employee of a defined workforce. With that sum, EA vendors are responsible for providing all services as agreed upon — as well as for paying all legitimate claims from EA subcontractors — in order to fulfill contractual obligation to the employer or customer.

The ethical breach here, as noted by respondents, was to knowingly put forth a bid that was insufficient to fund the program as proposed.

The concern with this finding is that the current pricing scene is filled with sometimes amazing examples of bids so low that under-service and under-promotion is practically guaranteed. The data also indicates that national vendors are, reportedly, experiencing this ethical problem at a higher frequency than local vendors.

Perhaps intense competition for increased market share (for example, making up loss by gaining volume) and slim profits or operating losses among many EA firms has contributed to a climate where the field is vulnerable to ethical breaches in pricing practices. Several respondents mentioned experiences of bidding strategies that could probably be termed "predatory." Unlike the general healthcare industry, EA vendors have not been successful in negotiating substantive increases in their rates over the past several years.

Price competition among the big firms and fighting for dominance in the national market, is fierce. Local and regional players attempt to justify why their bid is higher or else scrap for market share by competing with the nationals on price.

Instead of finding ways to adequately fund what EAPs do — or propose to do — the field has ceded leadership to the invisible hand of market forces, in effect, becoming its own worst enemy. Despite the acrimonious nature that frequently exists in the competitive bidding process, the field needs to find ways to converge mutual interests so that funding structures do not — at their best — support what some respondents called "cheapened" mediocre EAPs, and — at their worst — "programs camouflaged as EAPs," such as strictly telephone services that call themselves EAPs but have very limited value or workplace emphasis. There is an ethical obligation to carefully assess the adequacy of a capitation rate to make sure that basic EA services to both the employer and employee are not threatened by rates too low to do the job.

Instead of finding ways to adequately fund what EAPs do — or propose to do — the field has ceded leadership to the invisible hand of market forces, in effect, becoming its own worst enemy.

Deception in marketing

Some 21 percent of national vendor respondents report that "service features and capabilities are frequently misrepresented in marketing materials, presentations, and proposals," compared to 8.5 percent of local and regional respondents. Respondents referred to a variety of misrepresentations in EA vendor promotional materials and proposals, ranging from outright false claims of capacity to putting positive spins on certain practices.

Analyzing what this finding means is difficult because the general practice of marketing/sales, like politics, is a social context in which the normal rules about truth telling are commonly relaxed. For example, the EA sales representative is at a heavy disadvantage in her sales presentation if she admits to a potential purchaser that, "Unfortunately we do not have credentialed and contractual EA affiliates in your Midwest locations, but I'm sure our provider relations department could build that network in the next 120 days."

The example of grossly exaggerating the scope, coverage, availability

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and quality of an EA vendor's affiliate network in marketing materials was referenced in the survey as a common form of misrepresentation. Another was the degree to which some national vendors claim to be workplace-focused and involved, as though a telephone counselor at the end of an anonymous 1-800 number has an understanding of a local employer's personnel policies and procedures, work environment, absenteeism and other issues.

The finding suggests that an unknown number of EA vendors, like other competitive business organizations, employ deceptive mechanisms to win contracts. Deception, in this context, refers to the different ways sales representatives refrain from telling the truth about their products and services.

Given the perception by local and national vendors that ethical problems related to EAP pricing and models of service delivery are increasing, it is counterintuitive to believe that the quality of EA services is improving.

The degree to which employers and their employee families are being victimized by deceptive market tactics is unknown, although national EA vendors view it as a more frequent phenomenon than do local/regional vendors.

The quality gap is alive and well

Given the perception by local and national vendors that ethical problems related to EAP pricing and models of service delivery are increasing, combined with an extended period of restraint on premium growth, it is counterintuitive to believe that the quality of EA services is improving. The more likely scenario is that EAPs could progressively deteriorate in the midst of these pricing wars and centralization of service models. Despite the fact that EA administrators, account managers and sales staff are quick to pledge their heart and soul to quality goals and services, the quality gap may be alive and well.

While the recent short-term growth of the EA field has been fueled, in part, by low-ball bids, marketing prowess and even ethically questionable marketing practices, the long-term health of the field can only be founded upon a commitment to sustained service quality and a high level of ethical conduct in both our clinical and business practices. ■

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***William White, MA**, is the senior research consultant with Chestnut Health Systems and has worked in the addiction treatment field for more than 25 years. He is nationally recognized as a trainer, consultant, and ethicist and has authored more than 60 articles, research reports and books, including* Slaying the Dragon: The History of Addiction Treatment and Recovery in America, *and the latest edition of* Critical Incidents: Ethical Issues in Substance Abuse Treatment and Prevention. *He can be reached at bwhite@chestnut.org or (309) 827-6026, ext. 3403.*

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Elevating Business Ethics in Employee Assistance / Managed Behavioral Healthcare: Recommendations from a National Field Survey

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The employee assistance (EA) field has gone through many transformations in its history: from the emergence of formal occupational alcoholism programs in the 1940s, their evolution into the "broadbrush" EA programs in the 1970s, and their growing integration with managed behavioral health care services, worklife benefits, organizational development, and other ancillary products. Through those transitions, the bulk of EA services have moved from internally to externally programs and from small, local EA service providers to ever-enlarging, regional and national EA service vendors. It is not uncommon to hear concerns expressed by EA professionals about the ethical and professional practice issues raised by such changes.

In an effort to measure such concerns, the authors surveyed a random sample of the combined membership of the Employee Assistance Professionals Association (EAPA) and the Employee Assistance Society of North America (EASNA) between October-December, 2000. The purpose of the survey was to determine how EA professionals currently perceived the state of ethical conduct related to business practices within the EA/managed behavioral healthcare field.

Of the ten percent (632 of 6,317) of EAPA and EASNA members who were surveyed, 272 (42%) responded--a rate well within the 25-45% return rate normally seen in ethics surveys. Respondents included a diverse mix of professional roles (administrators, EA counselors, account managers, trainers), tenures in the EA field, organizational configurations (internal and external EA providers), organizational ownership structures (for-profit and not-for-profit), and organizational sizes (national, regional, local service vendors). Survey respondents were asked to identify the most significant issues related to business practices in the EA field and to make recommendations about how the field could elevate ethical conduct in this area.

Areas of Ethical Vulnerability: A Summary

Two methods were used to ascertain the type of ethical issues that are arising in

the current EA environment. First, survey respondents were given a list of fifteen ethical issues (developed by expert informants) and were asked to rank on a five-point Likert Scale the degree of frequency with which they had observed each of the listed ethical problems in the past five years. The major ethical problems and concerns (those with highest combined reported incidence of "frequently" and "sometimes") identified included:

1) erosion of EA service quality in the shift from local to national EA vendors,
2) poor understanding and performance of EA functions by EA subcontractors,
3) erosion of quality resulting from intense competition and low-ball rates,
4) biased referral patterns created by parent organizations of EA providers,
5) compromised core EA functions resulting from service integration,
6) low dose service recommendations by cost-containment gatekeepers,
7) misrepresentation of organizational capabilities and service outcomes, and
8) EA professionals practicing beyond boundaries of their competence.

The second method used to identify ethical issues facing the EA field was the following open-ended survey question: "Of all the business related ethical issues facing the EA field, which three do you believe are most important or critical?" The responses were topically coded with the following seven categories generating the highest percentages of responses:

1) Competence of EA practitioners/contractors,
2) Shift to cost containment/managed care,
3) Loss of boundaries around EA functions and competencies,
4) Ethics of referral and ownership,
5) Bidding and fee-setting practices,
6) Shift from local to national vendors,
7) Misrepresentation of marketing/ advertising.

Field Recommendations

Each of the 272 survey respondents were asked the following open-ended question: "What steps should the EA field take to enhance business-related ethical sensitivities and ethical practices?" Each respondent could list up to three recommendations. The authors reviewed the survey responses, organized them into topical categories, coded each survey response within the categories, and then tabulated total response frequencies within the categories. Figure One displays the top ten categories of recommended actions. These recommended strategies fall into the following five broad categories.

Education and Training EA professionals called for the education of EA service consumers (both corporate and employee) about the "core technology" of EA and the ethical issues that are arising in the EA marketplace. Respondents recommended disseminating information on ethical issues in EA through the major business and human resource conferences, journals and newsletters. Several respondents suggested the development and routine dissemination of an EA client rights statement that would include a "digest" of the ethical issues that arise in the EA arena. There were also many recommendations for baseline and continuing ethics education and training for EA professionals. Most focused on the need for baseline "core technology" training for everyone working within the EA field, particularly those working as subcontractors. More specifically, there were suggestions for the development of a specialized ethics training module for delivery at local EA professional meetings. One respondent called for the better packaging and marketing of ethics workshops under such slogans as, "If you're getting rich, you're doing something wrong! Or is it right? Pick one!" There were repeated calls to "cuss, discuss, confer, debate, renegotiate" the whole topic of ethics in the EA field. There

were also calls for the regular publication of ethical case studies in the EA professional journals and trade magazines.

Standards Development and Revision The two most frequent standards-related recommendations involved the call to establish educational and certification/licensure standards for all EA professionals and the formal accreditation by all EA programs. There was some divergence of opinion among respondents regarding where the field should place its energy and resources: on the quality of the EA program itself, or on the competence of individual practitioners. Some respondents expressed dismay that EAPA and EASNA, in their opinion, are "fractured on this issue" and lack a unified approach. There was agreement among respondents that defining minimum standards for both individual practitioners and programs are ethical matters of extreme importance.

Other recommendations included the expansion of ethical standards involving business practices, particularly related to marketing practices, the use of a uniform methodology for calculating and reporting service utilization rates, the practice of "self-referral," and the integration of EA and managed behavioral health care into a single program. One respondent called for a commission of EA professionals, business and human resource representatives, and benefits consultants to formulate ethical standards related to EA business practices.

Standards Enforcement Enforcement recommendations included a centralized hotline to lodge ethical complaints, an auditing/monitoring process through which a comparison could be made of marketing claims and quality and accessibility of service products, and a more assertive process in publicizing, encouraging, and utilizing the ethical complaint processes of EACC. Several respondents recommended the use of a peer-review consultation mechanism for resolving areas of great ethical ambiguity.

Research Survey respondents called for research that could help establish an empirical baseline for standards of professional practice. One element of such research should be service satisfaction surveys of EA clients (purchasers and consumers of EA services). Another recommendation was to improve the rigor of research in the field prior to making claims about the cost and outcome effectiveness of nearly every EA model. Most studies of EA effectiveness employ a case study, single group pre- and post-test or quasi-experimental design, lacking in long-term follow-up or legitimate comparison groups.

Leadership and Advocacy Respondents recommended that the field's professional associations take a stronger leadership role in ethics education and in generating discussions and standards of practice related to the number of ethical issues that are arising in the field=s business practices. There were calls for EASNA and EAPA to take a courageous lead in protecting the future of the field by stirring ethics dialogue (particularly on new ethical issues that are arising in the integration of EA and managed care functions) and enhancing the field's ethical sensitivities and capacity for ethical decision-making. A few respondents remarked that EAPA and EASNA, on their own, do not carry the influence or member base to substantively raise the level of awareness regarding ethics and quality standards among employer purchasers. These respondents suggested the field's leaders initiate dialogue and collaboration with the Society for Human Resource Management (SHRM) to ascertain how our professional associations can work together to collectively improve EA programs.

Closing Observations

Caution should be taken in over-interpreting the findings of the survey summarized in this article. It is a survey of perceptions of ethical problems and vulnerabilities rather than a survey of the actual prevalence of ethical breaches. We did not embark on this survey so that we could proclaim like a modern-day "Chicken Little" that the EA sky is falling, but we did want to validate or invalidate our own perceptions of growing ethical vulnerabilities

within the business practices of the EA field. The survey responses provide an important source of information regarding potential areas of ethical vulnerability and potential strategies to elevate the level of ethical conduct in the EA field.

The recommendations generated within this survey call for the use of three basic strategies to elevate the level of ethical conduct within the business practices of the EA field: 1) the design and delivery of ethics education and training for EA purchasers, providers and consumers, 2) the development, refinement, and enforcement of ethical standards, and 3) ethics-related advocacy by the leadership of the EA field.

We need to enter into dialogue with each other and with our EA service consumers on these issues. We need to find ways to curtail marginal and egregious areas of ethical conduct BEFORE a backlash dramatically alters the reputation and future of the EA field. This national survey of EA professionals offers a window of opportunity and some suggested directions on how we may proceed in our quest of this goal.



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A Lost Vision:
Addiction Counseling as Community Organization

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Abstract.

Addiction counseling in the modern era has been practiced as an essentially clinical activity, but this has not always been the case. There have been key points in the history of addiction treatment when the functions of community organization and social activism competed with, or complemented, this clinical orientation. The first section of this paper draws on nine episodes in this history to explore the relationship between addiction recovery and the addict's identification with, and participation in, a community of recovering addicts. The second section utilizes the work of John McKnight to explore how professionalized and institutionalized services can inadvertently undermine the development and vitality of indigenous community support systems. The third section outlines a series of recommendations that would shift the focus of addiction recovery from something that happens exclusively in the context of professionally-directed treatment to a process that unfolds within the larger community. It is argued that the professionalization (medicalization and psychologization) of addiction treatment needs to be balanced by a re-emphasis on recovery as a connection with indigenous resources and relationships beyond the self. The paper closes with a discussion of the potential pitfalls of this shift in focus from clinical technique to community resource mobilization.

Keywords. Community organization, social model, mutual aid, consumer involvement, history of treatment, role of addiction counselor.

We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.

-Sandra Bloom, Creating Sanctuary

The Lessons of History

There are several critical episodes in the history of addiction treatment and recovery in America that offer an opportunity to examine the ways in which personal recovery is nested within, or occurs independent of, a larger experience of connectedness to a recovering community.[1] Each of the following episodes provides a different perspective on the question of whether recovery is something that *emerges from within* the individual, something that *happens to* the individual within professionally-directed treatment, something that *is experienced in the context of the addict's identification and relationship with* a recovering community, or something that results from unique combinations of these experiences.[2]

1. Abstinence-based Cultural Revitalization Movements Alcohol-related problems rose in tandem with the physical and cultural assault upon Native American tribes during the 18th and 19th centuries. Three approaches typified tribal responses to these problems. First, there were individual solutions: Native medicines used to treat alcoholism, Christian conversion, and pledge signing initiations into Native American temperance societies. Second, there were environmental solutions. Native leaders-Little Turtle, Tecumseh, Sitting Bull, and Crazy Horse, to name just a few-voiced strong opposition to the use of alcohol as a tool of exploitation, advocated laws prohibiting the sale of alcohol to their tribes, and sometimes attacked and destroyed the supplies of predatory whiskey sellers (Lewis 1990; Apess 1833). A third approach framed the source and solution to alcohol-related problems in cultural terms.

Leaders of abstinence-based cultural revitalization movements (Wagomend, known as the Assinsink Prophet; Papoonan, a Unami Delaware; Kenekuk-The Kickapoo Prophet; the Delaware Prophet; and Handsome Lake), many in personal recovery from alcoholism, portrayed alcohol as a symbol of the worst of what happened when Native Peoples abandoned their own traditions and cultures for less noble ones (Waldman 1988; Francis 1996; Herring 1988; Custer 1918). Alcoholism was framed as a consequence of colonization and cultural dispossession, and abstinence was framed as an act of resistance and a step toward repossession of Native culture and identity. The later ritual use of peyote by some Native American alcoholics provides yet another example of a cultural framework of recovery from alcoholism. Here it was not the peyote experience alone that enhanced recovery from alcoholism but the Peyote Way-an ethical code that helped one live sacredly and soberly in relationship to family and tribal community (Albaugh and Anderson 1974).

Within Native American cultural revitalization movements, the healing of those addicted to alcohol occurred first through a renewed tribal community and then through personal fidelity to one's tribal traditions.[3] An important principle undergirded these early abstinence-based movements: *personal sobriety and survival may be inseparable from the sobriety and survival of a larger community. The individual draws nourishment from the sobriety of the community just as the sobriety of the individual feeds the community. Addiction recovery for members of a besieged group is best framed within a message of hope for a people as well as the individual.*

2. Nineteenth Century Mutual Aid Societies Three major alcoholic mutual aid structures grew out of the 19th century temperance movement: the Washingtonians, the fraternal temperance societies, and the reform clubs (Maxwell 1950; Temple 1886; Ferris 1878).

The most vibrant and viable recovery movements are both visible and accessible to addicted members living within the wider community. Alcoholics and addicts are most attracted to appeals for participation that are free of moral condescension and which maximize the process of addict-to-addict identification. The Washingtonians actively recruited alcoholics from their own social network as well as on the streets and in the

bars. When the Washingtonians stopped such recruitment and shifted from a closed (alcoholics only) to open meeting structure, class distinctions prevailed, the percentage of "hard cases" declined, and the focus on the reclamation of the confirmed drunkard was lost (Blumberg 1991). *Mutual aid societies lose their vitality when their members become disconnected from the people who most mirror their own pre-recovery histories.*

The Washingtonian experience-sharing meeting was able to elicit a sobriety decision (the act of signing the pledge), but did not provide a framework or a context for long term recovery. The fraternal temperance societies and reform clubs sought to counter this failure by moving beyond the pledge decision to a focus on building a sober life in the community. By providing food, shelter, clothing, sober fellowship and help restoring the family, these support structures helped to re-integrate the alcoholic into the community. An important lesson learned in America's earliest alcoholic mutual aid societies was that *what works to initiate sobriety may be insufficient to sustain sobriety*.

Addiction mutual aid societies face risks at two extremes in their relationship to the wider community. When they move towards extreme isolation from the community, such societies risk becoming therapeutic cults dominated by and exploited by their charismatic leaders. When they interact too freely with the outside community, such societies risk being colonized by those with agendas other than helping the addict. The emotional power of the Washingtonians was used to re-energize the larger temperance movement, just as this power was being depleted by Washingtonian leaders who used their new status as reformed drunkards to pursue paid careers as temperance lecturers/missionaries (Blumberg 1991). *Recovery-focused service organizations can be hijacked and exploited for ideological, institutional, and personal gain.*

3. 19th Century Addiction Treatment The first formal treatment institutions in the country emerged in the 1860s and 1870s and represented quite different views on the relationship between recovery and community (Baumohl, Room 1987; White 1998).

Small inebriate homes grew out of temperance groups and mutual aid societies, and the boundary line between these homes and societies was virtually invisible. The homes provided food, shelter and mutual support while involvement in religious and temperance meetings worked their transformative influence. Brief, three- to four-week voluntary stays in such homes focused on morally strengthening the inebriate's pledge of abstinence and on helping the inebriate initiate a sobriety-based lifestyle within the wider community (MacKenzie 1875). Support groups-such as the Godwin Association of the Appleton Temporary Home-were organized within these homes to provide inmates and graduates weekly meetings for sober fellowship and opportunities for service to new members (*Twelfth...*1884).

The medically-oriented inebriate asylums saw the cure of addiction as something that occurred to the addict in the context of a prolonged (months if not years) process of physician-directed, legally-coerced institutional treatment. The inebriate asylums isolated the addict from the negative (and potentially positive) influences of the community and focused on the addict's detoxification and physical and psychological renewal. When mutual-benefit associations did rise within these institutions (such as the Ollopod Club of the New York State Inebriate Asylum), they were not defined by professional staff as an essential element of addiction recovery (Parton 1868).

The for-profit addiction cure institutes combined the brief treatment period of the inebriate home with the physical methods of treatment of the inebriate asylum. The most well-known of such cure franchises-the Keeley Institutes-supported the development of the Keeley Leagues, a mutual aid society of 30,000 former Keeley patients, but the Leagues disbanded in the late 1890s amid charges that Dr. Leslie Keeley was trying to turn the Leagues into

an advertising medium for the Keeley cure (Barclay 1964; White 1998).

We see in the three styles above how *the leaders of treatment institutions can encourage the development and use of indigenous mutual aid societies, virtually ignore such mutual aid societies, or co-opt such societies to further their own interests.*

4. The Urban Mission Movement Jerry McAuley, an alcoholic ex-con who became a born-again Christian, launched the urban mission movement in the United States when he opened the Water Street Mission in New York City in 1872. What this movement did for the alcoholic was provide a message of warm invitation ("Everyone welcome, especially drunkards!" boasted the weekly newspaper advertisements) and a message of hope (the potential for recovery through rebirth) (Bonner 1967). Both this invitation to fellowship and this promise of hope were couched in an offer of immediate services (food, shelter, clothing, work) that the suffering alcoholic desperately needed. Those who worked in these missions went into the streets and bars to find alcoholics in need and introduced these alcoholics to a larger Christian community. For the alienated and marginalized alcoholic, the urban mission provided a bridge from the physical and cultural world of Skid Row to the mainstream churches and wider community to which these churches were connected. The spark of alcoholism recovery was seen as originating in a highly personal conversion experience that could only be sustained by living in fellowship within a Christian community. The job of 19th century mission workers was threefold: to remove the barriers (hunger, homelessness, sickness) that stood between the alcoholic and God, to use themselves as instruments of the Holy Spirit to touch the heart of the alcoholic, and to link the newly reborn alcoholic to fellowship with a wider Christian community. *What the religious revivals, urban missions and religiously-sponsored inebriate colonies provide (at their best) is a milieu of hope and an invitation for the isolated addict to live in a community of shared experience and belief.*

5. Alcoholics Anonymous Five historical milestones collectively shaped the relationship between Alcoholics Anonymous (A.A.), professionally directed alcoholism treatment, and the wider community (Kurtz 1979). These milestones include:

1) A.A. co-founder Bill Wilson's 1936 refusal of an offer of employment as a lay therapist at Towns Hospital. (The acceptance of this position could have led to a professionalization of AA and resulted in AA becoming merely an extension of the earlier lay therapy movement.)
2) The crystallization of the Twelve Steps in 1938. (The Steps provided a framework of long term recovery that placed responsibility for recovery, not in the hands of professionals, but in the hands of alcoholics living in relationship to a Higher Power and a community of recovering people.)
3) The decision in the early 1940s that AA would not have paid missionaries to carry its message and would not operate hospitals for the treatment of alcoholism. (This decision rendered support within AA mutual rather than professional, and emphasized that AA and professional treatment were different entities.)
4) The formulation of the Twelve Traditions in 1946. (The Traditions insulated AA from the diversions of outside political and religious issues, prohibited AA's affiliation with outside causes and organizations, and protected alcoholic-to-alcoholic identification by restricting membership in AA to those who possessed "a desire to stop drinking.")
5) The on-going definition of the boundary between AA and "treatment." (This boundary, drawn through AA's experience in its relationship to hospitals and alcoholic "retreats" and "farms," defined AA not as a "treatment" for alcoholism but as a way of living within a spiritual community [Harbaugh 1994, 1995].)

AA, by instinct and circumstance, forged solutions to the problems that had mortally wounded its predecessors: How to construct a framework of mutually-supported long term recovery while protecting the organization from external colonization and the foibles of its own leaders and members. AA placed itself and the recovery process squarely within the fabric of community life but progressively delineated itself from professionally-directed alcoholism treatment (by admonitions against use of AA language within addiction treatment, e.g., "Twelfth Step House," "AA Counselor"). AA and its Twelve Step children (Narcotics Anonymous, Cocaine Anonymous, ...) avoided the problem that had long-plagued institutional addiction treatment: the transfer of learning from the environment of the treatment center to the home environment of the person being treated (Patrick 1965; Stone 1997). No transfer was needed: *Twelve Step recovery, rather than being linked to a treatment institution, became imbedded within the community itself*.

6. The Early Industrial Alcoholism Programs Occupational alcoholism programs, the forerunners of today's employee assistance programs, began to flourish in the 1940s when sober and grateful AA members working inside various companies began reaching out to their fellow alcoholic workers. Initially, these AA members provided support and counsel on an informal basis while continuing to work full time in their regular job assignments. Then AA members were re-assigned to full or part time roles in which their exclusive responsibility was to counsel alcoholic employees. This transition brought a new job title (occupational alcoholism counselor) and specialized training. When occupational alcoholism programs were later redefined as "broadbrush" employee assistance programs (EAPs), the former occupational alcoholism counselor was forced to acquire academic credentials and certification or be replaced by traditionally trained professional helpers. The "Drug Free Workplace" movement of the 1980s further shifted the focus of many EAPs from one of helping drug-impaired employees to one of detecting, controlling and extruding drug-using employees-a move that led many workers to view these former indigenous helpers as behavioral police. More recently, those working in employee assistance services have been moved outside the companies as a result of the trend toward company outsourcing of employee assistance services. As a consequence, these services are now provided by people who are not part of the internal web of relationships inside the organization and who often have weak or even non-existent ties to the local community. At the same time, the focus of EAPs further shifted from a focus on enhancing the recovery of impaired employees to one of aggressively managing the financial costs of such impairment (Bickerton 1990; White 1999). *Social movements organized by and for addicts are often diverted from this mission by the forces of professionalization and industrialization. Addiction recovery is enhanced when encased within a commitment to singularity of purpose and when the source of recovery is placed within the addict's natural environment.* In the face of this changing character of EAPs, unions are again organizing their own counseling programs with a returned emphasis on salvaging those members impacted by alcohol and other drug addictions. *When professional structures of care collapse or lose their responsiveness to the needs of the addicted and their families, new indigenous structures eventually rise to fill this void of unmet need*.

7. The Implosion of Synanon Only a few times in American history has a totally new approach emerged for the treatment of narcotic addiction, but such was the case in 1958 when Synanon rose as the first ex-addict directed therapeutic community. Synanon created an alternative, closed community within which the addict was isolated, broken down, and then habilitated in a process that sought the fundamental reconstruction of the addict's character. Widely acclaimed in the 1960s, Synanon became the model for virtually hundreds of

therapeutic communities and residential treatment programs. But in the 1970s, Synanon abandoned its goal of rehabilitating and returning addicts to the community and took on the tenor of a militaristic religious cult. All but the most loyal of Synanon's members were driven out of this community and Synanon's founder and leader, Charles Dederich, was criminally indicted for an incident in which a live rattlesnake (with the rattles removed) was placed in the mailbox of a lawyer that had just won a suit against Synanon. In spite of its positive contributions to the evolution of addiction treatment, Synanon today stands as a morality tale about the abuses of power and breaches of ethics and law that can emerge when an historically stigmatized group isolates itself from the larger community and places itself under the control of a charismatic leader and his or her inner circle (Yablonsky 1965; Mitchell, Mitchell, Ofshe 1980).

Synanon also provides a powerful lesson about the relationship between recovery and community. The experience of Synanon and the second-generation therapeutic communities that followed suggest several crucial principles. *Institutions whose founding goal is to rehabilitate and return addicts to the community often end up further isolating addicts from the community. Recovery doesn't occur inside an office or an institution; it occurs within the larger context of life within a community. It must be anchored within the family, extended family, neighborhood and community institutions. The more complete and enduring a client's isolation from this natural web of relationships during his or her treatment, the greater the difficulty in transferring institutional learning to post-institutional life in the community.*

8. Grassroots Organizations to Formal Organizations During the 1950s and 1960s, several types of grassroots organizations were founded to address growing concerns about juvenile drug use and addiction. Those in the 1950s grew out of alarm over rising juvenile narcotic addiction and were typified by such programs as St. Mark's Clinic in Chicago and the East Harlem Protestant Parish's Exodus House in New York City. These religiously-sponsored, neighborhood-focused programs constitute the modern beginning of community-based addiction treatment. In the 1960s and early 1970s, the same youth culture that celebrated marijuana, and to a lesser extent, LSD, spawned a whole genre of drug-related service institutions: crisis lines, "Acid Rescue" teams, street drug analysis programs, free health clinics, and walk-in counseling programs. Counterculture agencies were organized by members of this culture to provide support to their peers. There were also a wide variety of programs that emerged from the larger community to respond to youthful polydrug use. Most of these grass roots organizations of the 1950s and 1960s were eventually absorbed into formal prevention and treatment agencies following the infusion of federal treatment dollars in the 1970s, or they faded into obscurity and died. In this transition, there was a shift from caring for addicts by the community itself to passing this responsibility along to a new class of professionals and new institutions within the community. *Indigenous community organizations often change their essential character as they migrate toward the status of formal, professionalized service organizations. Addiction treatment institutions tend to emerge through the efforts of grass roots movements and then become divorced from such movements and the wider community as they mature. Services that emerge out of a "we" position often evolve toward services provided by "us" to "them."*

9. The Early Professionalization of Addiction Counseling Before passage of the Hughes Act in 1970 and the establishment of the National Institute on Alcohol Abuse and Alcoholism, some of the most innovative alcoholism initiatives at the federal level came out of the Office for Economic Opportunity's (OEO) Alcoholism Counseling and Recovery Program, under the leadership of Matt Rose (McGovern 1992). The earliest national effort to organize

and professionalize alcoholism counselors occurred when Rose brought together leaders of the OEO alcoholism programs in Atlanta in 1972 to found the National Association of Alcoholism Counselors and Trainers. Robert Waymer of Georgia, one of the founding members describes the core idea behind this seminal event:

> *Our original idea was to have counselors train people in communities to deal with the growing alcoholism problem. The training we taught was not based on clinical skills; it was based on a community development model with emphasis on AA.* (NAADAC... 1992)

OEO's involvement in poor communities, particularly poor African-American communities during the vibrant days of the civil rights movement, gave these programs both a grass roots orientation and an activist temperament. What the core of OEO alcoholism leadership brought to this initiative was a belief that: "*Helping systems had to be built on the needs of, and be ultimately controlled by, the alcoholics and their families* (Renaud 1982)." The grassroots programs funded by federal, state and local funds that sprang up in the 1950s, 1960s and early 1970s emerged from deep roots within their communities. Members of those communities-many themselves in recovery from or impacted by alcoholism-devoted years of effort before the first grants created formal local service organizations and the first paid alcoholism counselors. When voluntary efforts alone proved to be inadequate to the magnitude of local problems, there were inevitable calls for greater organization, greater skill, and greater financial resources. In this rising tide of professionalization and industrialization, voluntarism within the addiction problem arena declined and was replaced by an emerging class of paid helpers. *Grass roots movements that spawn treatment agencies tend to dissipate as the leaders and members of these movements are professionalized or extruded during the rise of formal service organizations.*

The Present: A Field In Search of its Soul

It would not be an overstatement to suggest that the field of addiction treatment is in a state of crisis as the 21st century opens. Most define that crisis in terms of an aggressive system of managed behavioral health care that for the past decade has altered the availability and character of addiction treatment in both the private and public sectors. Others depict this crisis in terms of the cultural demedicalization and restigmatization that has moved large numbers of alcoholics and addicts from hospitals and treatment centers to jails and prisons during the 1980s and 1990s. But there is another much more fundamental crisis that is revealed in listening to the words of addiction counselors across the country.

Tenured addiction counselors are suffering from increased disenchantment in their professional lives. They regularly lament that it is getting harder and harder to feel good about what they are doing. This deep dissatisfaction comes from a feeling that treatment institutions have become places where addicts are billable commodities more likely to be repeatedly processed than changed. There is a sense among "oldtimers" that something indefinable has been lost as the field has matured. Many are referring to the field's crisis as spiritual in nature-a crisis in values. There are suggestions that the field has become disconnected from its roots and even suggestions that the treatment field needs to conduct its own fearless and searching moral inventory. There is an emerging consensus that new clinical technologies cannot make up for a lost sense of mission and core values. Paramount among such dissatisfactions is the sense that *addiction treatment has become disconnected from its historical roots, detached from the larger and more enduring process of addiction recovery, and divorced from the grass roots communities out of which it was born.*

This is not the first time such sentiment has emerged among professional helpers. Lubove and Specht and Courtney

have separately described similar processes through which social work shifted from a focus on resource mobilization in their clients' environments to engaging clients in psychotherapy (Lubove 1965; Specht, Courtney 1994). The shift from psycho-social casework to psychotherapy marked a relocation of service delivery-from the community to the consulting room-and a shift in the target of such services from the environment of the client to the unique developmental history and mental/emotional processes of the client. In response to this change, there were charges that social work, in its search for professional status, had forsaken social and political action for the mastery of clinical technique and charges that social workers were selling out the community for the higher salaries of the consulting room. This shift from the social to the clinical has for addiction therapists, like the psychiatrists, psychologists and social workers before them, led to a pre-occupation not only with their client's emotional life but also their own. The new addiction counselors of the 1970s and 1980s discovered their own emotional life as a rewarding area of study and as a potential diversion from their focus on the needs of the client. Addiction counseling, perhaps under the impact of the larger culture in which it is imbedded, shifted to a focus on the "self" (Lasch 1978; Bellah 1985). What got lost in this shift were the functions of community education, social action, resource development, resource mobilization, and resource linkage: in short, the field's role as an active agent in enhancing the healing power of the community. The current preoccupation with "case management" in addiction treatment is in many ways a piecemeal attempt to compensate for this loss.

II

Community, Treatment, and Recovery

> *Ultimately, it is the community that cures....To cure the wounded, one need only return them to their community or construct a new one.* (Philip Rieff 1987)

We can see from these historical vignettes many variations on the role of community in addiction recovery. Addiction is often depicted as a disorder that has biological, psychological, social, cultural, and spiritual dimensions, but individual addiction treatment therapists/agencies and addiction mutual aid societies differ widely in their emphasis of one element over the others. This emphasis also evolves cyclically; so-called "new" approaches in the addiction arena often have a musty quality to them. And so it will be with the discussion that follows. What follows is as much a call to recapture roots as it is a call for bold innovation.

In 1995, John McKnight wrote a book, *The Careless Society: Community and its Counterfeits*, with a most provocative premise. McKnight suggested that the proliferation of helping agencies and paid helpers inadvertently undermined the natural web of supportive relationships provided by families, extended families, neighborhoods, churches, labor unions, other voluntary associations and whole communities. McKnight concluded that as a country we suffer not from a lack of professionally-directed service agencies but from a lack of community (pp170-172). He suggests that we need to "distinguish between services that lead people out of community and into dependency and those activities that support people in community life" (p.123). An example from the addiction/recovery arena illustrates McKnight's point. To the extent that the interventions of addiction counselors have replaced Twelfth Step calls, the "culture of recovery" has been weakened rather than strengthened (White 1990, 1996).

McKnight proposes a new role, that of the "community guide," whose function is to move clients, not toward enmeshment with professional helpers and their institutions, but toward deeper involvement in the problem-solving and healing resources within the community itself. The goal of the guide is to "reduce dependence on human

services by increasing interdependence in community life..."(p. 122)." McKnight contends that equal relationships of shared experience are infinitely superior and more sustainable than relationships that are hierarchical, professionalized, and commercialized (p. 119).

McKnight's analysis provides a fresh way to view the earlier reviewed milestones in the history of addiction treatment and recovery. Since the days of the inebriate homes and asylums, there has been disagreement about whether treatment of addiction requires moving addicts deeper into the life of a community or isolating them from the community. There are deep biases

We are in an era of potentially landmark clinically advances: psychopharmacological adjuncts that promise to help quiet the siren call of the addict's drug of choice (Kranzler, et.al., 1999); sophisticated models of understanding the stages of addiction recovery (Prochaska, DiClemente 1986; Prochaska, Norcross, DiClemente 1994); improved strategies and techniques of client engagement (Miller, Page 1991; Miller, Rollnick 1991); empirically-validated and manual-guided individual, group and family therapies (Carroll, Nuro 1996); and research-based relapse prevention tools (Marlatt, Gordon 1985). The era of professionalized addiction treatment (1970-2000) has been built more on the promise of medical, pharmacological and psychological treatments than on the role the wider social milieu can play in initiating and sustaining recovery from addiction. The following discussion is a call for the rediscovery of the power of community in the recovery process. It is not a call for the abandonment of medical and psychological interventions, but a call to for balance between medical, psychological and socio-cultural approaches to addiction treatment and recovery. It is most importantly a call to shift the delivery of these interventions into the natural environment of the client.

Addiction treatment must always adapt to the evolving context in which it finds itself. Such redefinition may push treatment toward the experience of retreat and sanctuary in one period and toward the experience of deep involvement in the community in another. I would suggest that the focus of addiction counseling today should not be on addiction recovery: that process occurs for most people through maturation, an accumulation of consequences, developmental windows of opportunity for transformative or evolutionary change, and through involvement with other recovering people within the larger community. The focus of addiction counseling today should instead be on eliminating the barriers that keep people from being able to utilize these natural experiences and resources. Our interventions need to shift from an almost exclusive focus on intervening in the addict's cells, thoughts and feelings to surrounding and involving the addict in a recovering community.

toward sequestration of the addict: the inebriate asylums, the federal narcotics farms, Synanon, and many of today's residential programs and religiously-sponsored alcoholic retreats. Treatment professionals have long viewed the client's natural environment as an enemy rather than an ally in the recovery process. And yet there are other threads in this history that have invited the addict into the experience of community and sustained that experience in the community: the inebriate homes, the urban missions, and mutual aid societies from the fraternal temperance societies and reform clubs to AA and NA and the new societies that have followed.

The recognition of limitation-according to Ernest Kurtz the very foundation of Twelfth Step recovery (Kurtz 1979; Kurtz, Ketcham 1992)-is also an essential foundation for addiction counselors and addiction treatment agencies. Such a recognition is crucial in defining the boundaries of what treatment can and cannot do and in understanding why treatment agencies must move into the community to compensate for this limitation. To the extent that a treatment program expends resources in support of this community-based culture of recovery, they address dimensions of recovery that cannot

be addressed directly within the treatment environment. To the extent that addiction treatment professionals attempt take the place of these natural resources, they are practicing beyond the boundaries of their professional training and usurping, and potentially weakening, structures in the community that are better equipped to perform this task.

Addiction counselors need to help create and support voluntary communities of recovering people and enhance the involvement of others who are willing to enter into sobriety-based fellowship with this community. Our focus should be not on what professionalized services we can offer members of this community, but on how we can support the development of resources within this community that diminishes its members' needs for professionalized services. In short, the goal is to replace relationships that are transient, hierarchical, and professionalized with relationships that are enduring, equal, and reciprocal. For fear of being misunderstood, let me say again that I am not calling for the destruction of professionally-directed addiction treatment services. (I have spent more than 30 years helping develop such services.) But I am calling for a redefinition of these services. In many communities, professionally-directed addiction treatment needs to be reduced to its most critical dimensions; it needs to become smaller, not larger. What does need to become larger is the web of support in the community itself for recovering addicts and their families. Treatment should not be the first line of response for addiction but a safety net for those individuals facing special problems in their ability to find and utilize these larger and more natural support networks. The job of treatment is to do what the community at any given moment cannot do. If one believes that recovery involves a transcendence of self-an experience of relationships and resources beyond the self-then the most legitimate role for addiction treatment providers is that of removing barriers that stand in the way of connection to such resources and helping enhance the variety and viability of such resources.

What does a treatment institution do when there are few indigenous recovery support systems in their community and they face a growing number of their clients who are isolated from families and disenfranchised from the mainstream community? The treatment center's role in such circumstances is to help build and mobilize resources within the community that such clients can rely upon. Its role is to create space within the larger community where such resources can grow, sow seeds in that space, and to nurture the emerging indigenous resources until they can flourish on their own. Under some circumstances, a treatment institution will have to take on the roles of surrogate family, surrogate extended family, and compassionate community in the lives of their most alienated clients until more natural and enduring resources can be developed. Both barriers to and incentives for recovery exist in the community space surrounding the client and it is that space that must become the arena of activity for the addiction treatment professional.

Recovery Community

When we hear the word "community," we tend to think of a city or neighborhood. Community can imply a geographical boundary, but it can also imply the boundary of what Ferdinand Toennies (Toennies, 1957) has called a "reciprocal, binding sentiment," e.g., the "African American community," the "faith community." Communities of experience are generated and sustained by shared history, hopes, beliefs, language, rituals, and folkways. There is in the experience of community a sense of identity-a "we-ness," a sense that we are with "our own." Here one's estrangement-the experience of *self detached* from others different than me—turns into the experience of *self among* others like me.

There is in the concept of community a sense of linkage, belonging, and acceptance and a connection to place. There is a sense of *being at home*-of being at the one place where one's absence would be missed. With communities traditionally

defined by kinship, residence and workplace dissipating, a new kind of community-a community of recovery-has emerged that can offer sanctuary and healing to those who have been stigmatized and marginalized by their addiction careers. This "community" is one defined not by neighborhood but by shared experience, shared identity, shared need, shared hope, and shared support.

When we speak of "recovery community," these qualities take on added significance because of the shared wounds its members bring to their membership in this community. It is here that those who have never experienced sanctuary often discover a place where they feel physically and psychologically safe for the first time. Here one is accepted not in spite of one's imperfectness but because of the very nature of that imperfectness. It is this shared "torn-to-pieces-hood" (as William James called it) that turns "people who normally would not mix" into a "fellowship" (Perry 1935, p.679; *Alcoholics ...* 1955, p.17). It is here that, in discovering one's self in the stories of others, people discover themselves and a "narrative community" whose members not only exchange their stories but possess a "shared story." Within such a community, one can find a deep sense of fit-a sense of finally discovering and connecting to the whole of which one is a part. The recovery community is a place where shared pain and hope can be woven by its members into life-saving stories whose mutual exchange is more akin to communion than communication (Kurtz 1997a; Kurtz 1997b). This sanctuary of the estranged fills spiritual as well as physical space. It is a place of refuge, refreshment and renewal. It is a place that defies commercialization-a place whose most important assets are not for sale.

The Varieties of Community Experience

To speak of the "recovery community" today requires an understanding that this community actually constitutes an ever-growing variety of sobriety-based support structures and styles of recovery. First, there is not only the growth and expansion of AA, NA and other Twelve Step recovery programs but the ever expanding varieties of AA/NA experience (Kurtz, 1999). There are what might be called Eleventh Step groups-groups such as the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS) -that are used as adjuncts to AA. There are the abstinence-based alternatives to Twelve Step programs that include Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery, and Rational Recovery. There are groups like Alcoholics Victorious, Alcoholics for Christ, Mountain Movers, High Ground, and an ever-growing number and variety of other religiously-sponsored addiction recovery support groups. There are cultural pathways of recovery ranging from Afrocentric frameworks (Williams 1992) to Native American frameworks-the Peyote Way, the Red Road, Circles of Recovery, and Firestarters (Bordewich 1996; *A Report...*1998). There are a growing number of moderation-based support structures (Moderation Management, DrinkWise, SMART) for those who wish to temper their drinking but who are not addicted to alcohol. There are a large number of people attempting "solo recovery," some aided by manuals that promise a self-engineered resolution of alcohol and other drug problems without the requirement for treatment or support group affiliation. And nearly all of these resources can be reached via the Internet, creating a virtual recovering community that no longer has geographical boundaries.

How do we make sense of such diverse structures and styles of recovery in the community and their relationship to professionally directed addiction treatment? Four key understandings could guide this relationship:

1. There are success stories to be found in almost all advocated approaches to addiction recovery, including some that probably reflect little more than a well-timed placebo effect.
2. If we assume that alcoholics and addicts are not a homogenous population, then it follows that no one

approach will meet the needs of all addicts and that any particular approach will vary in its degree of success with different clinical subpopulations.

3. If we agree that addiction is a chronic disease (or "condition") characterized in the lives of many addicted people by reoccurring episodes of remission and relapse, then we have to consider that such individuals may require different types of interventions and support structures at different stages of their addiction/recovery careers.

4. We are likely to discover that, for some addicts, the most successful approach to treatment/recovery is one that involves serial experiments in sobriety, sobriety monitoring, early re-intervention and combinations (accumulated effects) of interventions and support structures over time. (The operative motto-"different strokes for different folks"-has long marked the most successful and clinically-nuanced addiction treatment programs.)

These understandings constitute a foundation from which a counselor can both help organize the community and "work the community" for the benefit of his or her clients. What we need to move toward within the arena of addiction treatment is the creation of the broadest possible menu of words, ideas, support structures, rituals, and experiences from which diverse clients may select those particular menu items that pull them toward positive change. Addicts have all kinds of coercive forces pushing them toward recovery; what we need are expanded forces of attraction that pull the addict into recovery. This latter force often occurs in the dynamic interaction between a support group, its evolving stew of conceptual and experiential ingredients and the addict.

How do we understand how various support structures incite change in some addicts and resistance to change in others? It is in the unique match between the ingredients of such groups and particular individuals that we find the transformative power of mutual aid. To have this effect, the elements of group culture must strike cords of resonance at both personal and cultural levels. Where resonance exists, these elements become the raw materials used by the addict to reconstruct a sobriety-enhancing life story. The elicitation of this resonance involves an almost electrical mutuality of fit. There is in this dynamic interaction as much a sense of having been chosen as there is a sense of choosing a particular framework of recovery. It is both a "you belong with us" connection between the group and the individual and a "this is where I belong" connection between the individual and the group. The job of the guide is to help expand the community menu of such resources, to warmly introduce each client to these resources, to help eliminate the obstacles that stand between the client and his or her involvement in such resources, and to then witness and validate the potential power of these special connections between individuals and indigenous groups. The emergence of "guides" or "recovery coaches" could re-capture the best of what has been lost in the professionalization of the role of the addiction counselor.

III

A Renewal Movement: Some Beginning Goals and Prescriptions

> *We have resources. Can we mobilize them?*
> (Selden Bacon, 1947)

The field of addiction treatment is in deep need of a process of renewal that allows it to get back in touch with its historical mission and values and redefine its service technologies. I believe the heart of that re-centering process will be a conceptual redefinition of where and how recovery occurs-a shift in focus from the institutional setting to the community setting. To achieve this redefinition of treatment, addiction treatment agencies will need to achieve six goals.

<u>Knowledge Development</u> The first goal is to expand the agency's knowledge of and application of the concept of "culture of recovery." We must recognize different

styles and pathways of long term recovery. For most addicts, addiction and recovery occur and progress in relationship to addicted and recovered people. In addiction, and for some in early recovery, that progression involves an isolation form the larger community and an enmeshment in either a culture of addiction or a culture of recovery. Both cultures have their own language, values, symbols, career milestones, roles and rituals of daily living. We need to recognize and respect the variations in how addicts and those in addiction recovery relate to these cultures. There are acultural, bicultural and culturally enmeshed styles of addiction: addicts who sustain their addiction in isolation from other addicts, addicts who move in and out of the mainstream community and drug-saturated subcultures, and addicts whose whole lives are consumed within subterranean cultures of addiction. There are similarly acultural, bicultural and culturally enmeshed styles of recovery (White 1996).

Many treatment agencies have lost touch with local cultures of addiction and recovery. We have lost much in the transition from grass roots community organizations to behavioral health businesses. The practice of alcoholism counselors who are not in recovery attending open AA meetings and Al-Anon meetings, for example, seems to have virtually died out. The tentacles of our agencies that once reached deep into our communities have been replaced by paid specialists who venture into the community for public relations and marketing purposes. The beautiful buildings that many of our agencies have constructed have for too many of us become professional prisons that have diminished our interactions with the actively addicted and those in long term recovery. Too many agencies have become "closed incestuous systems" isolated professionally and socially from the wider community (White 1997). All of us-physicians and nurses, addiction counselors, researchers and teachers, supervisors and managers-need to leave our offices and rediscover the social ecology within which both addiction and recovery are nested within our communities. We need to be meeting with the service committees of local addiction mutual aid societies. We-those in recovery and those not in recovery-need to get to know the recovering community by attending (within the prescribed guidelines for participation) meetings and social events of such organizations. We need to be visiting with the leaders of religious and cultural revitalization movements in our communities. We need to break bread with those working within our local union counseling programs. Rather than waste our lives obsessing about managed care, we need to relearn the cultural terrain outside our agencies and help create spaces within our communities that can serve as sanctuaries and places of renewal for recovering addicts and their families. And most importantly, we must enter into relationship with these indigenous resources as students rather than as teachers.

Role Redefinition The second goal is to expand the definition of addiction treatment and addiction counseling to include and emphasize the functions of community organization and community development. I am proposing that the clinical dimensions of the role of addiction counseling be balanced with dimensions that focus on organizing sobriety-based support structures and then linking clients to such structures. This added function or new position would combine both the role of community organizer and what McKnight calls the "community guide." The purpose of the organizer/guide is to help build enduring sobriety-based support structures that stand, not as time-limited, contractual services provided by an agency, but as an enduring part of the fabric of local community life. McKnight describes five characteristics of such roles/persons:

- They have a capacity to see possibilities and potentials where others see problems.
- They are themselves well-connected to what might be called the "communities within the community."
- They can make things happen because they are trusted within these communities rather than because they have letters or titles linked to their name.

- They believe that the community as a whole is a "reservoir of hospitality" that needs only be tapped.
- They know that a client's engagement with the community doesn't begin until the guide whose with them disengages (McKnight 1995, pp120-122).

The guide, recognizing and celebrating the enormous variety in recovery styles, simply serves as a source of introduction and encouragement for continued experimentation until the client finds a suitable pathway of long-term recovery (Borkman 1997).[4]

One very concrete way that an addiction treatment agency could begin this process is to experiment with:

- adding community organization functions into existing addiction counselor role responsibilities,
- seeking financial support to hire community organization specialists, and
- providing training to staff to enhance their skills to perform community organization/guide functions.

Increasing community involvement can be achieved in a variety of ways: collaborating in multiagency models of service delivery, launching aggressive programs of outreach, moving satellite service offices into the community, experimenting with neighborhood-based service delivery, entering into partnership with such emerging resources as addiction ministries, and strengthening the agency's relationship with indigenous sobriety-based support structures. This goal can involve everything from carrying institutional services to the community to shifting the whole focus of recovery to the natural environments in which clients live. To achieve the latter, we need carefully constructed and rigorously evaluated experiments in moving the "therapeutic community" into the community. The question of "how do we get addicts to come into treatment at our agency?" needs to be reframed: "How can we move treatment (the professionally-guided initiation of recovery) from our agency into the community?" By

<u>Community Involvement</u> The third goal is to increase the agency's involvement in the community. The first step in achieving this goal is for a treatment institution to honestly evaluate its historical commitment and relationship to the community it serves. When the board and staff of Dawn Farm, a traditional long-term therapeutic community located in Ann Arbor, Michigan, conducted such a self-inventory, they were forced to make some bold admissions on their way to redefining their role in the community. The Board members and professional leaders of Dawn Farm called a large meeting of community stakeholders and acknowledged that with the best of intentions Dawn Farm had inadvertently implemented policies and procedures that had become barriers between the Farm and those it sought to serve as well as to the wider community. Following this courageous declaration, the leadership of Dawn Farm invited community stakeholders to participate in reshaping Dawn Farm's involvement in, and responsiveness to, its local community.

creating seamless and flexible transitions between levels of care, we can move clients toward the least restrictive environments and into those environments that are closest to the natural supports in the community. Dawn Farm, in redefining its mission, formulated a simple principle to guide its selection of service activities: "Will this help our clients join the recovering community?" Taking such a position requires a fundamental redefinition of the relationship between an addiction treatment agency and the world outside itself.

Benjamin Bowser, in his excellent analysis of what it means for an addiction treatment program to be "community-based," predicts a future shift from professionalized to indigenous recovery resources.

> *When the current generation of drug treatment programs declines far enough, we may very well witness the emergence of another generation of drug treatment initiatives which may not be so ready to compromise their*

missions for government funding. (Bowser 1998).

New generations of programs will boldly respond to service needs rather than passively accepting the limitations of various funding guidelines. These new programs are arising as indigenous institutions (neighborhood organizations, schools, churches, labor unions, cultural revitalization movements, recovery groups) respond to needs that they see not being addressed by mainstream addiction treatment providers. That new generation could also include existing treatment agencies who move forward by reconnecting with their founding missions.

Addiction treatment professionals need to be part of these rising movements not out of a position of professional arrogance but as fellow members within the local culture of recovery. The goal is not to colonize these indigenous initiatives by using this movement to get referrals for treatment, by pushing these indigenous movements toward professional models of care, or by manipulating these organizations into lobbying for enhanced funding for treatment. Instead, the goal is to support these churches and labor unions and neighborhood organizations in the development of ideas, metaphors, and rituals that can move people from addiction to recovery within the cultural context in which they live. We must serve these new support structures rather than lead them, co-opt them, or compete with them.

Consumer Involvement The fourth goal is to increase the community's involvement in the agency. This can involve building a strong alumni association, creating a feedback loop between former/current service consumers and agency supervisors and managers, developing linkages to newly emerging recovery consumer alliances, or, most significantly, bringing recovering people and service consumers into policy-making positions on agency advisory and governing boards.

What addiction treatment will have to address in the 21st century that it has never had to deal within its history is a strong consumer movement that, like its mental health counterpart, will demand increased accountability and responsiveness (*Brief ...* 1998). We must find meaningful venues of participation for consumers and eschew the current propensity to use consumer involvement manipulatively as a device to market treatment programs or to generate political support for political agendas related to treatment reimbursement policies. If professionals fail to enter into legitimate partnership with the recovering community and fail to significantly involve consumers in decision-making regarding their own care, then the ownership of the problem of alcoholism and other addictions needs to be wrested from the professional and returned to the community itself.

Resource Development The fifth goal is to take an active role in the development and support of local sobriety-based support groups. Rather than lament the absence of such structures, treatment institutions need to create the physical and cultural space within which such movements can grow and nourish the seeds of such movements that arise within this space. This strategy involves reducing environmental obstacles to recovery while expanding resources and opportunities within the client's environment. This can be done by promoting no-cost, or low-cost transportation and child care to get people to support meetings and sober social activities, developing job banks and volunteer job-coaching programs, developing housing programs (drug free zones in public housing, recovery homes), entering into partnership with other sobriety-based organizations to help develop drug free recreational activities. Recovery-themed radio programs are appearing locally and through national syndication and Internet recovery resources are growing so prolifically as to render any directory of such resources instantly out-of-date. In Lubbock, Texas, the Texas Tech Center for Addiction Studies at Texas Tech University is involved in an "addicts-to-scholars" program through which private funds are used to provide scholarships to recovering addicts to attend college (White, 2001). Treatment programs

need to both stimulate such activity and reach out into partnership with such indigenous community efforts. When White Bison, Inc. of Colorado Springs, Colorado trains Firestarters—persons in recovery-who agree to facilitate Circles of Recovery in their tribal communities for three years, the focus of recovery shifts from a treatment institution to the community itself (*Brief...*1998). Treatment institutions have for more than 140 years served as sober sanctuaries-places for personal, social and spiritual renewal, but some have also served as a hub of numerous activities that reach out into the community to extend and nourish the culture of recovery. The motifs that should guide our own work in this latter area are:

- stewardship (Is this the best possible use of these resources?),
- simplicity (Is this the least amount of organization required to achieve this goal?),
- transferability (Can this function be transferred from the agency to the community in a reasonable period of time?), and
- sustainability (If other elements in the local culture of recovery cannot sustain this function, is this something that the agency will be able to sustain over time as one of its contributions to the culture of recovery?)

There are brief developmental windows of opportunity for change that open in the life of every addict, and, in the midst of such a window, one's life can be forever changed or a rare opportunity missed-the difference for some between recovery and death. Addicts "hit bottom" many times and often continue their self-destruction. Pain in the absence of hope will not incite a recovery process. Our goal is to assure the presence of personally and culturally meaningful resources (hope) when those windows of opportunity briefly open.

Identity Reconstruction The sixth goal is to redefine the implications of this new agency-community partnership on everything from the agency's mission, its core values, its primary service modalities, its role definitions for paid and volunteer workers, and its ethical standards governing relationships between staff and service consumers. To focus on barriers to recovery rather than recovery itself requires a reframing of traditional clinical roles, but this broader focus continues to call for the use of new breakthroughs in clinical technology to aid the client. Adding community organization and community advocacy does, however, mark a dramatic change in the current role definition of the addiction counselor-a change that calls upon the counselor-like the Native American leaders of 19th century abstinence-based cultural revitalization movements-to confront forces in the community/culture that promote excessive alcohol, tobacco and other drug use.

Potential Pitfalls

The shift in focus advocated in this paper is not without its pitfalls.

1. *Skill Demands* The knowledge and skill requirements of the community organizer/guide are not part of the current preparation of addiction counselors nor may some addiction counselors be characterologically suited to take on these functions. Any shift toward expanding the functions of the addiction counselor would have to be reflected in changes in the content of addiction counselor training programs as well as national and state addiction counselor certification programs.

2. *Funding* Most reimbursement mechanisms for addiction treatment do not pay for community organization and advocacy. While some publicly funded agencies may be able to embrace such activities within the rubric of outreach, case management, early intervention, or primary prevention; funding guidelines will continue to narrowly define addiction treatment. The agency today seeking to become truly community-based must swim against the powerful current of these funding strictures. I think the trend will be for agencies to respond to the criticism inherent in this

article by placing these functions within a specialty role. Such a move would mark not a positive indication of organizational change, but one of the most frequent strategies used by organizations to avoid change. At a practical level, I believe the desired strategy is to begin integrating resource development, resource mobilization and client advocacy functions within the rubric of case management and counseling and to seek additional reimbursement for these newly expanded functions. The potential role of community resource mobilization in improving clinical care outcomes will need to be rigorously evaluated before these activities are compensated within existing service reimbursement systems.

3. *The Limits of Community Support* The approach called for in this paper is applicable to a wide spectrum of human problems, but its proposed solutions all hinge on whether there is a reservoir of support available within local communities. There is little doubt that the traditional safety nets of nuclear and extended family, value-homogenous neighborhoods, stable occupational networks, and other social institutions (schools, churches, labor unions, local civic groups) are weakening. While one could argue that we need an ever-growing professional infrastructure to compensate for this loss of natural supports, I would argue with McKnight that proliferation of the former could inadvertently speed the demise of the latter. But tapping indigenous resources and spiritual and healing traditions within a community is not a panacea for addiction recovery (Brady 1995). There are communities that lack much of the natural supports idealized in this paper. In such communities, such resources will need to be rebuilt before they can perform their healing functions. We need to extend the medical models and even social model programs farther into the heart of our communities (Borkman et al. 1998)

4. *Resistance and Conflict* The expansion of the counselor role will provoke resistance among counselors for whom this transition will be difficult and who will likely interpret this expansion as an implied attack on the value of therapy in the treatment of addiction. Some counselors could feel a loss of status and prestige in the diminished clinical emphasis suggested in this paper. Social activism could also bring agencies into conflict with other community institutions regarding such environmental factors as poverty, racism, zealous and targeted alcohol marketing campaigns or the oversaturation of alcohol sales outlets. There is also a risk that focusing on environmental factors that contribute to addiction could divert focus from service to the treatment/recovery needs of individual addicts. This very process happened to many of the 19th century mutual aid societies. Community-oriented activities will need to be monitored to assure that they stay client-focused.

5. *Charisma* The function of community organization attracts charismatic leaders whose character foibles can, rather than moving the organization into the community, create organizations that progressively isolate themselves and move into adversarial relationships with the community. These leader-dominated, cult-like systems often drift toward ideological extremism and eventually implode amidst charges of internal abuses of power and breaches in ethical and legal conduct. At its best, the heightened community-orientation advocated in this paper should help flatten the hierarchies of treatment organization, but the potential long term consequences of the charismatic leadership characteristic of such models requires close monitoring.

6. *Ethical Quandaries* The new role functions of the community organizer/guide force the counselor to shed the safety of the office and the execution of highly codified clinical functions. As the newly defined counselor/organizer/guide moves into the community, he or she does so without clear ethical and boundary definitions. Traditional standards which safeguard the therapeutic relationship often smack of emotional disregard and professional elitism when moved into the community and into different cultural settings. Professional standards that discourage/prohibit counselor self-disclosure (particularly self-disclosure of the therapist's own recovery

status) and prohibit involvement in any type of dual relationships may work well in the office but not in the arena of community outreach and community organization. New standards will have to emerge and evolve to guide these expanded functions, and these standards will need to simultaneously protect clients and community members, individual workers, and addiction treatment agencies. The community guide will need to find middle ground between the potentially detached impersonality of the therapeutic relationship and the complete absence of boundaries that originally created a call for increased professionalism and ethical standards.

7. *De-professionalization* There is a danger that professionals could become so infatuated with indigenous cultures of recovery that they abandon medical, pharmacological, and psychological interventions that could be of great benefit to some addicts (Van Dusen, Sherman 1974). There is also some danger that professionals could use this approach as an escape from the demands to develop and sustain traditional technical competencies in addiction counseling.

8. *Care versus Control* The most painful aspect of this role transition may be a forced examination of the difference between the professional support offered in addiction counseling and the more natural support that clients can experience in the wider community. Any relationship of unequal power, any relationship in which one party is professionally pledged to serve the other, is a relationship that in its essence involves as much (or more) control as care. The history we have reviewed suggests that addiction recovery is best nurtured within a network of mutually caring and enduring relationships in which mutual vulnerability, reciprocity, and collective strength, not fiduciary responsibility of one party for another, is the primary bond of the relationship. That is precisely what traditional addiction treatment cannot provide. To experience care without control, one must move out of the professional arena and enter the natural web of support that exists within communities. This realization is not an easy one for those of us who have dedicated our lives to the profession of addiction counseling.

9. *Potential Iatrogenic Effects* Misguided efforts at community organization could undermine the very indigenous supports they purport to build. Anything done *for* or *to* (as opposed to *with*) the recovery community is likely to undermine the growth and health of that community and replace it with structures and relationships that are hierarchical, professionalized, and eventually commercialized. The recovery movement itself will need to find a way to separate the healers from the hustlers who will be drawn to the energy of this movement. There will be problems with double-agentry: people who step forward to speak on behalf of recovered people but whose words and deeds reveal the hidden institutional and financial interests that they represent. Misguided efforts at community organization could undermine the very indigenous supports they purport to build. What would help treatment institutions sustain their own integrity in this venture would be to create something analogous to the Twelve Traditions of AA-a set of principles that could guide the treatment institution's relationship to its clients and the wider community.

Conclusion

This paper explores the evolving relationship, or lack of relationship, between addiction treatment, recovery, and experiences in the wider community. The author calls for a re-conceptualization of recovery as something that happens in the community rather than solely within the context of professionally-directed treatment. What is being proposed is a reconstruction of addiction counseling to claim its social activist and social movement roots-roots that were lost in the professionalization of the role of addiction counselor and the industrialization, commercialization, and regulation of addiction treatment. Addiction treatment needs to move from a self-absorbed bystander to full membership in the culture of recovery. In the next decade, many addiction treatment institutions will not only place themselves fully within this culture but also redefine their role in that culture. This newly defined role will focus on: 1) removing personal and environmental

obstacles to recovery, 2) encouraging the diversity and viability of support structures within the culture of recovery, 3) educating clients and families about the addiction and recovery processes, 4) serving as "community guides" to link clients to support structures within the culture of recovery, 5) responding to the needs of clients with acultural styles of recovery, and 6) developing chronic disease management protocol for relapse-prone, multiple-problem clients and their families.

Where we will likely end up in all this is a position that will challenge two centuries of efforts to find THE cause of addiction and THE treatment for addiction. This position will simply posit that there are factors that inhibit and promote addiction that co-exist at different levels of intensity in the individual, in one's nuclear and extended family, in one's immediate ecosystem (peer associations, neighborhood, school, workplace, church), and in the larger macrosystem (state, country, continent, world). These factors combine with other demographic and clinical characteristics to create quite varied patterns of alcohol- and other drug-related problems. Prevention and intervention strategies that flow out of this model call for interventions at all levels of this ecosystem that simultaneously seek to increase inhibiting factors and decrease promoting factors. What has been missing and what is being called for in this paper is greater attention to this ecosystem in which both addiction and recovery are nested.

Agencies who in their earliest years defined themselves as "community-based" today are more likely to define themselves as businesses. To recapture that founding identity, agencies must find ways to rejoin their communities and discover the natural healing powers that lie within these communities. When universities became too isolated from the communities in which they were born, there were calls for these institutions to move back into the life of their communities-to become "universities without walls." What I am calling for is an analogous process of treatment and recovery without walls.

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NOTES

1. The use of the terms "recovering community" and "recovery community" in this paper does not mean to imply that this is a single, or homogenous community. This community is made up of a diverse patchwork of groups who often speak with conflicting voices about methods but who share a singular passion for helping convey a message of hope and support to addicts and their families.
2. These historical sketches are abstracted from (White 1998).
3. One of the most vivid examples of the healing power of tribal/community renewal can be found in the story of the Shuswap Indian community of Alkai Lake, British Columbia that was vividly portrayed in the film *The Honour of All*.
4. What I am calling for here is a synthesis between the traditional, expert-based "treatment planning" of medical model addiction treatment and the client-based "recovery planning" of social model programs. For a discussion of the distinctions between these models, see Borkman, T. (1997).

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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The Cannabis Youth Treatment Study:

Key Lessons for Student Assistance Programs[1]

William L. White, M.A.[2] and Michael Dennis, Ph.D.[3]

For the past decade, student assistance professionals have been and continue to be at the forefront of responses to resurging illicit drug experimentation in the United States. As they consult with youth and their families and fellow educators, they are often asked about the short or long term effects of drug use and the relative effectiveness of various prevention and intervention programs. These questions intensify when the subject involves cannabis (i.e., marijuana, hashish, blunts) because of the drug's seeming pervasiveness and the propensity by many to still trivialize its use ("It's only marijuana."). This article will use one of the largest studies of adolescent treatment ever conducted to provide brief answers to three questions:

1) What are the major risk factors and characteristics of adolescents seeking treatment for cannabis abuse and dependence?

2) Are there brief, low cost interventions that are effective in treating adolescent cannabis abuse and dependence?

3) What role can the SA professional play in supporting the long term recovery of students following their treatment for cannabis abuse or dependence?

Cannabis is the most prevalent psychoactive substance used by adolescents in the United States. Though the rates of use have leveled off recently, adolescents in the U.S. still report more past-month cannabis use than all other illicit substances combined and more daily use of cannabis than alcohol. Moreover, during the past two decades the age of first use of cannabis has dropped from mid to late adolescence to early and pre-adolescence at the same time the potency of cannabis has increased threefold. While many youth experiment with and then cease marijuana use, certain groups of youth are at much higher risk for developing drug-related problems. These higher risk groups include those who begin use at a younger age and those who experience mental distress (e.g., depression, anxiety, inattentive or hyperactivity disorders, impulsive or violent behavior).

By 1999, 7% of U.S. 18-year old youth met criteria for past-year cannabis dependence, and cannabis is now the leading substance reported in adolescent arrests, emergency room and treatment admissions. From 1992 to 1998, the number of adolescents with cannabis-related problems who presented to the U.S.

public treatment system grew from 51,081 to 109,875 (a 115% increase). Unfortunately, many of these programs were using adult models of treatment. A lack of adolescent treatment resources in many communities and poor clinical outcomes within existing programs left many families, school staff and other professionals pessimistic about the ability to reduce cannabis-related problems among adolescents.

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) responded to the lack of evidence-based approaches for treating adolescent cannabis users by funding a cooperative agreement called the Cannabis Youth Treatment (CYT) study.[45] With 600 families, CYT is the largest randomized experiment of adolescent substance abuse treatment ever conducted in community-based settings. Adolescents were randomly assigned to one of five types of short-term (6 to 13 weeks) outpatient treatment that varied in theoretical orientation, format (individual, group, family), service components and service duration. All treatments were manual-guided to enhance fidelity to the treatments being tested across the study sites. Copies of the five treatment manuals utilized within the CYT study are available at no cost from the National Clearinghouse for Alcohol and Drug Information (1-800-729-6686).

Seventy-one percent of admitted youth completed treatment and 94% were interviewed quarterly for the first year following treatment. Each experiment comparing the effectiveness of the various treatments was replicated in a community-based clinic and in a major medical research center. The adolescents treated had an average age of 16, were most likely to be male (83%), white (61%), enrolled in school (87%), and involved in the juvenile justice system (62%).

During the three-month treatment phase, all interventions reduced the days of cannabis use and the number of substance problems. These reductions were sustained through the twelfth month of follow-up. From intake to 12 months, participation in treatment was also significantly associated with reductions in family problems, inattentive- ness/hyperactivity type behavioral problems, arguing/violence, illegal activity, missing school, and problems at school. We are currently collecting data on 30-month outcomes.

There are many lessons to be drawn from the CYT study, but five lessons have special implications for student assistance programs (SAPs) in the United States.

Lesson 1. *The risk and severity of cannabis-related problems are related to lower age of first use, frequency of use, presence of co-occurring psychological problems, and access (among friends or family members).*

The risk of cannabis abuse or dependence is not uniform within either adolescent or adult using populations. Those who begin drug use before age 15 are six times more likely than those who begin drug use after age 18 to develop adult symptoms of drug dependence. Nearly 85% of the CYT adolescents started using between the ages of 12 and 14. At-risk populations are also distinguished by their frequency and intensity of use. Weekly (or more frequent) users were most likely to develop disorders. In CYT, 71% reported weekly marijuana use (including 38% using daily). CYT participants had serious substance-related and co-morbid disorders reinforcing the growing recognition that people with pre-existing problems are at higher risk to develop marijuana-related problems, and that marijuana use tends to exacerbate or lead to other problems, particularly within social environments characterized by high availability and pro-drug norms.

These findings suggest that SAPs need to increase prevention and early intervention activities in the elementary and junior or middle schools and that SAPs could play an important role in educating staff, parents and adolescents

about the risk factors for developing cannabis-related problems.

Lesson 2. *Cannabis-related disorders constitute serious, debilitating disorders that can dramatically affect the developmental trajectory of adolescents.*

For the past 30 years, the rates of adolescent cannabis use have gone up when it was perceived as relatively benign and gone down when it was perceived as risky. Unfortunately, the current tendency is to trivialize adolescent marijuana use. (The Internet is full of such misinformation.) The rapidly growing research on the effects of marijuana suggests the existence of a subset of people (particularly adolescents and those with co-occurring mental disorders) who are at very high risk of developing cannabis disorders that disrupt normal development and functioning. Weekly or more frequent cannabis users are far more likely than non-users to have problems at home, school, or with the law. The link between cannabis use and these problems is further confirmed by the rapid reduction in these very problems among youth who stopped using marijuana following their treatment in the CYT study.

SAPs have an important role in carrying the message to parents, their professional peers and the wider community that problems related to cannabis use are on the increase and that adolescents who continue to use cannabis in spite of adverse consequences should be recognized as needing intervention on par with adolescents with other drug choices generally perceived as more dangerous than cannabis.

Lesson 3. *Cannabis-related disorders interact synergistically with other problems of youth and families.*

Of the adolescents in CYT, 95% reported one or more other problems (83% had three or more). These included alcohol use disorders, other substance use disorders, internal emotional disorders (major depression, generalized anxiety, suicidal thoughts or actions, traumatic stress disorders), and external behavioral disorders (conduct disorder, attention deficit-hyperactivity disorder). Sixty percent reported a history of victimization. High percentages also reported illegal activity other than just drug possession or use and two thirds reported having previously engaged in acts of physical violence such as assault.

These findings reinforce the need for global (as opposed to categorical) screening and assessment procedures, and the need for multi-disciplinary and multi-agency intervention models that can provide an integrated response to multiple, co-occurring problems. SAPs are in a unique role to encourage and participate in such integrated service models for multiple-problem youth and families.

***Lesson 4**. The severity of adolescent cannabis problems and their response to treatment varies.*

The five CYT treatments were all relatively brief (6-13 weeks), affordable, and able to positively impact many of the youth seeking treatment services. Each was associated with major reductions in cannabis use, symptoms of dependence or abuse, behavioral problems, family problems, school problems, and illegal activity. At 12 months, nearly a third of those youth completing CYT treatment were living in the community without any marijuana use or substance related problems. The good news of adolescent treatment is that brief treatment can have a significant impact on the lives of many young people and their families.

The more ominous side of the treatment outcome story is that for another subgroup of adolescents, cannabis use has become a more chronic condition. In CYT, 41% of the adolescents had failed several prior attempts to quit, a quarter had been to formal treatment before, and a third went back to treatment in the year following their discharge from the CYT study. This does not mean that there is no hope for the resolution of such chronic problems, but it does convey that different models of

intervention over a longer period of time may be required to fully resolve such problems.

SAPs can play an important role in overcoming the current pessimism about treatment effectiveness and help to implement relatively low cost programs that can serve many adolescents. At the same time they also need to recognize that, for some adolescents, cannabis use can constitute a more chronic, relapsing condition. For this group, more sophisticated assessment, and more intensive and longer programs of recovery management will be required.

***Lesson 5**: Nearly half of treated adolescents will vacillate between periods of recovery and periods of drug use and drug-related problems in the year following their first treatment episode. Post-treatment recovery support services could greatly benefit these youths and their families.*

The common view of adolescent treatment as a time-limited event that either works (complete and enduring abstinence following treatment) or does not work (any drug use following treatment) is inconsistent with the actual phenomenon of adolescent recovery. After CYT treatment, we found that 60% had some period of recovery: 29% who went into recovery but later relapsed; 7% who went into recovery, relapsed, but then got back into recovery; 15% who did not respond to treatment right away but did get better during the subsequent months; and 9% who recovered right away and stayed in recovery through the first year following treatment. These different pathways to recovery underscore how fluid and fragile the post-treatment period is for most youth. Such fluidity calls for new service models that resemble not the "diagnose, admit, treat, and discharge" approach of the hospital emergency room, but the approaches used to manage such chronic diseases as diabetes, hypertension and asthma. These latter approaches focus on problem stabilization, recovery education, ongoing monitoring and support, and, when needed, early re-intervention.

SAPs can play a significant role in tipping the scales toward sustained recovery by: a) linking the adolescent to existing community resources that support recovery, b) conducting post-treatment checkups to monitor progress, c) setting up early re-intervention programs to refer youth who need more intensive services, d) creating or facilitating recovery focused support structures (e.g., recovery-themed support groups, classrooms, social activities) and e) working with the school and community to reduce the "stigma" and isolation of youth in recovery.

Conclusion

Adolescent cannabis use is a major problem that SAPs can play an important role in addressing through education, identification, intervention, referral, ongoing monitoring and support, and early re-intervention. Even the empirically-grounded CYT treatments do not replace the need for sustained recovery support systems in the adolescent's natural environment. It is SAPs that can help create a vibrant culture of recovery within the school environment.

Notes:

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EAP Competence and Value

The second of two articles on the need for a revised ethic in employee assistance addresses concerns about the use of subcontractors by national EAP vendors.

by David A. Sharar, M.S., and William L. White, M.A.

A recent study examined how a random sample of employee assistance professionals perceive the state of ethical conduct related to business practices within the EA/managed behavioral health care field (Sharar, White, and Funk, 2001). The survey, conducted in the fall of 2000, was distributed to a diverse mix of members of the Employee Assistance Professionals Association and the Employee Assistance Society of North America.

Forty-three percent of survey recipients responded, a return rate well within rates normally seen in health care ethics surveys. Data analysis included the use of descriptive statistics for variables that could be quantified and qualitative analysis for open-ended questions.

Twenty-two percent of respondents identified the ethics of EA referrals and ownership structures as among the most important or critical business ethical issues facing the field. This article will address some of the concerns expressed by respondents about competence and value among large-scale, national EA vendors.

(Note: It is important to emphasize that the following discussion is based on EA professionals' perceptions of ethical problems, not the actual prevalence of ethical breaches in the EA field.)

Concerns About Competence and Value

Local and regional employee assistance vendors dominated the early EAP industry; today, a few national vendors hold about 75 percent of total EAP enrollment in the United States. These national players tend to be for-profit, insurance-based, and investor-owned companies that offer EAPs and other core products (such as managed behavioral health care and work/life benefits) to large employers. Local and regional vendors, on the other hand, tend to be nonprofit organizations, proprietor-owned practices, or treatment facilities.

National EAP vendors routinely subcontract with practitioners in locations where the vendor does not have a staff office. Responses to the survey indicate that the competence and use of these subcontractors (also known as "affiliates" or "network providers"), especially in cases where referrals are indicated, is a leading ethical concern within the industry.

Survey respondents suggested that many subcontractors, while licensed in their respective behavioral health disciplines, lack a rudimentary understanding of the anatomy of a referral within the employee assistance context. As evidence, respondents cited several common shortcomings among subcontractors, including the following:

- Lack of knowledge of available community resources;
- Reluctance to refer clients, except occasionally to themselves;
- Failing to assess when a referral is in order, particularly in chemical dependency cases;
- Failing to understand the mechanics of a company supervisory referral;
- Confusing the simple task of passing along a phone number with the complete referral of a client; and
- Failing to conduct follow-up activities with the referral resource or client.

A broader ethical concern among survey respondents is a perceived decline in the quality of EA programming in the face of massive consolidation and large-scale national mergers.

At the heart of this concern is a perception that national vendors lack, as a core value, a collaborative, community-based ethos based on geographic proximity, personal communication, community benefit, and outcome rather than cost. This lack of an ethos manifests itself in ways that minimize and dilute some of the potential strengths of local/regional EA firms, such as the following:

- An understanding of local resources and linkages;
- A connection between (or even an integration of) the local EA vendor and the local worksite;

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- The retention of dollars and assets within the community;
- A commitment to finding innovative ways to solve local employers' workplace issues;
- The ability to respond to local employers' concerns and crises; and
- The ability to quickly tailor programs and procedures to meet local employers' unique circumstances.

Local/regional players generally believe they are better situated to form collaborative relationships with area employers and referral resources and develop integrated, innovative, and customized programs (as opposed to using "off the shelf" materials). Local/regional players also tout the fact that they are either nonprofits or small business entities and thus do not have a financial obligation to a third party that is not the employer/purchaser or the employee client. The implication is that the local/regional EAP invests a larger percentage of the premium dollar on direct client care and employer services.

National EA vendors, on the other hand, claim to offer many program features and support capabilities that are especially attractive to large employers with multiple locations. These features include the following:

- Superior access to capital to finance program innovations and improvements, such as on-line platforms for employees or supervisors seeking EA services;
- The ability to afford and implement established or emerging accreditation requirements, such as the managed behavioral health care standards issued by the National Committee for Quality Assurance;
- Sophisticated management information systems and databases that allow for the management of financial risk and the delivery of complex reports;
- Nationwide affiliate networks that enable all locations to be serviced through a single contract between the national vendor and the employer;
- The ability to provide products that can be integrated with an EAP, such as a work/life program or managed behavioral health care service; and
- Economies of scale—and, ultimately, more competitive prices—that are unattainable in local/regional models.

Subsets of national vendors also challenge the claim that their services are not locally focused and community based. Some national vendors have "regionally-based" account management and service center sites that emphasize local integration, coordination, and responsiveness—attributes that local/regional vendors claim as an advantage. This regional management structure has the potential to produce the kind of collaborative, community-based ethos that many respondents perceive as missing in national EA vendor models.

The reality is that work organizations, as purchasers of EAPs, ultimately determine what constitutes a quality program. Decisions about whether an EAP provider will be local or national in scope, for profit or nonprofit, or owned by a parent organization or managed care company are made largely in response to employers' needs and preferences.

A New Professional Ethic?

These are challenging times for the EA field. We perceive a growing disconnect between the historic concept of employee assistance ethics and the changing circumstances and emerging environment in the provision of employee assistance services. The current climate of intense competition for increased market share, operating losses, "merger mania," referral incentives masked as integrated delivery systems, and the blurring of boundaries between EA entities and ancillary products is unlikely to foster an atmosphere that nurtures high standards in referral and business practices.

It seems the EA field is being pulled in one direction by members of the traditional guard, who rail against programs they feel have drifted away from the original mission of employee assistance, and in another by programs and entrepreneurs that are diverse, expansive, and market- or profit-driven. The latter are calling for a new professional ethic that takes into account a broader, more complex set of business-related ethical guidelines and responsibilities.

One place to start is to revise our codes of ethics and conduct. Current codes of ethics and conduct (those of EAPA and EASNA) lay an ethical foundation, but hardly build the whole house. They are minimalist codes that are restricted in scope and unable to provide much guidance to the complex and ambiguous predicaments related to the business practices of EAPs, such as the ethics of referral and ownership.

Our vision is for the leadership of the employee assistance field to engage in ethics-related advocacy by organizing and supporting an "ethics summit" composed of a cross-section of EA leaders, professionals, constituents (employee/employer clients), and representatives from allied fields (e.g., human resources, benefits, labor, managed care, treatment, and so on). This summit would not be a conference but rather a working meeting, with subgroups entering into a dialogue on how to revise the field's ethics codes to be more relevant and informative in the area of business ethics. Another goal of the summit could be to explore ways to develop an independent audit function for all external EAPs. Our hope is that some of the survey findings and interpretations of issues in this article will stimulate interest and discussion (not just "ethics talk") in a way that ultimately affects referral practices and ownership structures in the EA field. **E**

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Declaration of Institutional Interest: Chestnut Health Systems, a private, nonprofit community-based provider, owns and operates a division that provides regional EA services. In addition to employee assistance, Chestnut also provides a wide variety of behavioral health care programs, prevention activities, and research as well as program evaluation and training services. Both authors are employed by Chestnut Health Systems.



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THE ETHICS OF REFERRALS AND OWNERSHIP STRUCTURES IN EMPLOYEE ASSISTANCE: ISSUES, CONFLICTS, AND THE NEED FOR A REVISED ETHIC

David A. Sharar and William L. White
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A recent study examined how a nation-wide random sample of EA professionals perceived the state of ethical conduct related to the business practices within the EA/managed behavioral healthcare field (Sharar, White, and Funk, 2001). Ten percent of a diverse mix of EA professionals, comprised of EAPA and EASNA members, were randomly surveyed in the fall of 2000 and 43% responded, a return rate well within rates normally seen in health care ethics surveys. Data analysis included the use of descriptive statistics for those variables that could be quantified and qualitative analysis for open-ended questions. This article will highlight some findings related to the ethics of referrals and ownership structures along with some interpretation of issues and practical judgments. Specifically, two primary concerns will be addressed: (1) Biased referral patterns among local/regional EA providers, and (2) Concerns of competence and value among large-scale, national EA vendors.

Twenty-two percent of respondents identified the ethics of EA referrals and ownership structures as one of the most important or critical business ethical issues facing the field. It is important to emphasize that the following discussion is based on EA professionals' perceptions of ethical problems, not the actual prevalence of ethical breaches in the EA field.

Biased Referrals to Vested Programs/Practitioners in Local/Regional EAPs

Survey data suggests that over 60% of EAPs are owned and operated by behavioral health agencies, hospitals, or private clinics (e.g. parent organizations). These local and regionally based players tend to be not-for-profit organizations or proprietor owned practices or treatment facilities. Even though these types of EAPs are prevalent, they likely comprise less than 25% of total EAP enrollment in the U.S.

A commonly cited ethical concern was that parent organizations that own and operate EA programs engage in biased referral practices, meaning the parent expects its EAP to generate treatment revenue via a pattern of preferential referral beyond the EAP to vested programs or practitioners. In effect, the parent (implicitly

or explicitly) utilizes its EAP division or department as a business development strategy for the expansion of "feeder" systems and increased market security. Given that an "objective" or "neutral" EA referral is a "cornerstone of an ethical EAP" (EASNA Code of Ethics), the concern is that EA professionals (who work for parent organizations) could base referrals on factors that are not related to connecting the client with the most appropriate helping resource available. Instead, referrals could be based on financial interests that conflict with "neutral" or "objective" assessments of where a client's treatment needs could best be met. This situation creates potential conflicting loyalties for the EA clinician, potentially undermining the clinician's fundamental obligation to serve as a client advocate. An incentive exists for the EA clinician to increase the number of referrals to an affiliated program and yet there is a simultaneous obligation to present the best "independent" treatment options available to the client.

The perception that this biased referral practice of "self-feeding" is pervasive and unethical among EAPs owned by parent organizations was strongly challenged by a sub-set of respondents. This group of respondents called the prohibition against self-feeding "outdated", "impractical", and "overstated", citing the following reasons:

1. Many EAPs, with short-term counseling models, have become inadequate replacements for marginalized (or non-existent) outpatient behavioral health benefits, making referrals more obsolete.
2. Claims denials, delayed payments, reduced fees, and payment hassles have made third party, commercially insured referrals increasingly undesirable, particularly among not-for-profits who are forced to add expensive overhead to their billing/collections departments.
3. Managed care plans, not EAP clinicians, usually determine if and where clients receive on-going treatment beyond the EAP.
4. Managed care plans frequently do not include community-based not-for-profit providers/programs on preferred panels, and even when inpatient/residential referrals are recommended by EAP and authorized by managed care, the service dosage is sharply reduced and tightly monitored.

Are there ways for EA professionals to "ethically" refer clients to other practitioners or programs within their own organizations? Respondents offered the following suggested procedures to mitigate any appearance or accusation of unethical conduct:

- full disclosure is made (to both employer and client) regarding any affiliations with proposed referral options,
- the EA clinician "objectively" presents more than one referral option to the client,
- the referral is clinically justifiable (in the best interests of the client),
- the referring EA clinician does not receive any direct gain or financial remuneration for referring clients to particular programs or practitioners,
- the EAP should institute a peer review approach to monitor and evaluate the quality and appropriateness of referrals, and
- the employer's utilization/service summary report should contain detailed information on patterns/sources of referrals beyond the EAP for continuing care and treatment.

Concerns of Competence and Value in National EAPs

Historically, local/regional EA vendors dominated the EAP industry; this is in marked contrast to present times where a

few nationally based vendors hold about 75% of total EAP enrollment in the U.S. These national players tend to be for-profit, insurance-based and investor-owned companies that offer EAPs to large employers along with other core products, such as managed behavioral healthcare and work-life benefits.

One key ethical concern respondents alluded to is the competence and use of EA subcontractors (a.k.a. “affiliates” or “network providers”) by national vendors when referrals are indicated (national vendors routinely subcontract with practitioners in locations where the vendor does not have a staff office). Respondents suggested that many subcontractors utilized by national vendors, while licensed in their respective behavioral health disciplines, lack a rudimentary understanding of the anatomy of a referral in the EA context. Common mistakes by subcontractors (who are allegedly inexperienced in the distinguishing aspects of EA practice) include: (a) lacking knowledge in available community resources, (b) being reluctant to refer clients, except occasionally to themselves, (c) failing to assess when a referral is in order, particularly with chemical dependency cases, (d) failing to understand the mechanics of a company supervisory referral, (e) confusing the simple task of handing over a phone number with the complete referral of a client, (f) failing to conduct any follow-up with the referral resource or client.

Another ethical concern noted by respondents, which is decidedly more broad and qualitative in nature, is that the quality of EA programming is withering in the face of massive consolidation and large-scale national mergers as the predominant ownership structure in the field. This restructuring of EA providers could compromise the best interests of individuals served by EAPs as well as the long-term interests of companies and overall commitment to the EA field. It is interesting to note that 71% of respondents employed by national vendors cited this concern in addition to 82% of respondents employed by local/regional firms. What is not entirely clear from the survey data is whether or not this could be viewed as a case of national EA vendors indicting themselves.

At the heart of this issue is the perception that national vendors lack, as a core value, a collaborative, community-based ethos based on geographic proximity, personal communication, community benefit, and outcome over cost. In other words, EAPs, employers, employee families, and service providers, under national plans, are “a group only united by a contract, brochure, and rare telephone calls", according to one respondent. This lack of ethos in national vendor models manifests itself in ways that minimizes and dilutes some of the potential “strengths” of local/regional EA firms:

- community knowledge that allows for a local understanding of helping resources and linkages,
- a connection (or even integration) between the local EA vendor and the local work site,
- the retention of dollars and assets within the community itself,
- a commitment to finding innovative ways to solve the local employer’s workplace issues,
- the ability to react responsively to local employer concerns and crises,
- the ability to quickly custom tailor programs and procedures to meet the employer’s unique circumstances.

Local/regional players generally believe they are in better positions to truly form collaborative relationships with area employers and referral resources which leads to more integrated, innovative, and customized programs, as opposed to “off the shelf” programs. One respondent commented that “close, collaborative relations between EAPs, employers, and referral resources can only occur at the local level and are simply not possible with a national vendor who manages services from a distance”.

Local/regional players also tout the fact that they are either not-for-profits or small business entities who do not have "an obligation to a third party stockholder who is not the employer/purchaser or the employee client". That financial obligation requires that a portion of the premium dollar gets shuffled to investors and debt facilities. The perceived implication is that a larger percentage of the premium dollar with the local/regional EAP is utilized to provide direct client care and employer services (e.g. assessment, counseling, follow-up, training, supervisor consultation, account management, etc.). Although all vendors want to ultimately "be in the black", allocation of profits to shareholders is not a fundamental criterion for success among local/regional firms.

Despite these criticisms, national EA vendors claim to offer many program features and infrastructure capabilities that are especially attractive to large employers with multiple locations, as evidenced by their undisputed dominance in the market place. A few of these features include:

- superior access to capital in order to offer program innovations and improvements, such as on-line platforms for employees or supervisors seeking EA services,
- the ability to afford and implement established or emerging accreditation requirements, such as the National Committee for Quality Assurance managed behavioral healthcare standards,
- more sophisticated management information systems and databases which allow for the management of financial risk and the delivery of complex reports,
- expansive, nationwide networks of affiliates which enables all locations to be serviced through a single contract between the national vendor and the employer,
- the ability to provide products that can be integrated with an EAP, such as a work-life program or managed behavioral healthcare service,
- economies of scale that are unattainable in local/regional models which ultimately produce more competitive pricing.

Sub-sets of national vendors also challenge the claim that their services are not locally focused and community-based. Some national vendors have "regionally-based" account management and service center sites which emphasize the same type of local integration, coordination, and responsiveness that the local/regional vendors claim is their unique advantage. This supportive regional management structure, when in place, has the potential to produce the kind of collaborative, community-based ethos that many respondents perceive as missing in national EA vendor models.

Does it make a difference in the quality of the program if the vendor is local/regional or national? It probably does, according to the perceptions and opinions of respondents in this survey, but the quality is not automatically better in one than the other. The reality is that work organizations, as purchasers and decision-makers, not EA professionals, bear the ultimate responsibility for determining what constitutes a quality program in their vendor of choice. Whether an EA provider is local or national, for-profit or not-for-profit, or owned by a parent organization or managed care company is likely a combined response to employer preferences, marketing prowess of the vendor, and perceived relative value and consumer satisfaction.

Conflicts of Interest in Ownership Structure in the EA field

In theory, the predominant ownership structures among EAPs are set up to either (1) encourage referrals for treatment to affiliated programs to generate revenue (e.g. EAPs owned by parent organizations), or (2) discourage referrals for treatment to minimize costs (e.g. EAPs owned by

national insurance or managed care companies). Regardless of one's perspective on the competing ethical virtues and demerits surrounding referral practices and ownership structures, this scenario requires an appreciation for irony, particularly given our "duty" to avoid even the appearance of conflicts of financial interest.

Any financial incentives which are organizationally structured to induce EA professionals to either limit necessary care or encourage unnecessary care has the potential to coincide with the welfare of the client or the interests of the client organization. Ethical problems are more likely when owners encourage certain decisions or referrals by financially rewarding or penalizing EA clinicians or gatekeepers on the basis of their patterns of practice. One of the most notable financial incentive programs employed by owners is to attach a bonus, usually from a pool of withheld funds from a capitated EA payment, to specific utilization goals. Consider, as an example, the case where an EA gatekeeper receives an end-of-year bonus that is tied to reducing admissions and service dosage for intensive and costly treatment services. This type of program could force the gatekeeper to choose between receiving a monetary bonus or providing more care to a client.

Financial incentive programs are not in and of themselves unethical and have the potential to eliminate inefficiency and encourage only optimal and necessary care. Consider another case where an EA clinician receives an end-of-year bonus for achieving high levels of client satisfaction and acceptable clinical outcomes when providing appropriate brief intervention within an eight-session EAP model.

A general rule of thumb, as suggested by the American Medical Association's Council on Ethical Affairs (1998), is to find ways to base incentive programs on indicators associated with quality rather than quantity of services or referrals and avoid linking financial incentives to individual treatment decisions. One problem with this suggestion is that measurements of quality in EAP and behavioral health are rudimentary at best. Our field, and the work organizations we serve, cannot seem to reach consensus on what constitutes a "quality" program. Some examples of quality performance indicators employed by various owners as a financial incentive program include: (a) length of time to schedule routine or urgent appointments, (b) resolution of problems within a short-term counseling model, and (c) client satisfaction with their EA clinician.

What would an EAP look like were it organized and structured to neutralize the incentives to under-serve or over-refer clients and maximize the incentives to provide an ethical program of high quality? Enumerating these organizational features is beyond the scope of this article, although we must, as a field, encourage employers to select EA vendors and models that foster the principled practice of EA programming.

Reflections on the Need for a New Professional Ethic

These are challenging times for the EA field. We perceive a growing disconnect between the historic concept of EA ethics and the changing circumstances and emerging environment in the provision of EAP. The current climate of intense competition for increased market share, operating losses, "merger mania", referral incentives masked as integrated delivery systems, and blurring of boundaries between EA entities and ancillary products is unlikely to foster an atmosphere that nurtures high standards in referral and business practices. It seems the field is being pulled in one direction by members of the traditional guard, who rail against programs that have drifted away from the original mission of employee assistance, and in another by programs and entrepreneurs that are diverse, expansive, and market or profit driven. The latter calls for a new professional ethic, one that is not yet developed or institutionalized, and takes into account a broader, more complex set of business related ethical guidelines and responsibilities. Because of this growing

misfit between traditional concepts of EA ethics and professionalism and dominant ownership structures and referral practices, we argue the field needs a new professional ethic that incorporates these emerging complexities and the ways EAP actually operate.

Two areas addressed in this article that substantiate the need for a new professional ethic are the challenges presented by: (1) the advent of large scale, national models of service delivery, and (2) EAPs owned by parent organizations that need to, at a minimum, confront the appearance of a conflict of financial interest. This article is not proclaiming a type of modern day "David" (righteous local/regionals) versus "Goliath" (money hungry national vendors). Each type of ownership structure, as discussed, has its own version of ethical vulnerabilities derived out of its respective historical context and institutionally driven interests.

One place to start is with this new ethic is to revise our codes of ethics and conduct. Current codes of ethics and conduct (EAPA and EASNA) lay an ethical foundation but hardly build the whole house. They are minimalist codes that are restricted in scope and unable to provide much guidance to the complex and ambiguous predicaments related to the business practices of EAPs, such as the ethics of referral and ownership. Our vision is that the leadership of the EA field engage in ethics related advocacy by organizing and supporting an "Ethics Summit", comprised of a diverse mix and cross section of EA leaders, practitioners, constituents (e.g. employee/employer consumers), and appropriate representatives from allied fields (e.g. human resources, benefits, labor, managed care, treatment, etc.). This Summit would not be a conference but rather a working meeting with sub-groups entering into a dialogue on how to revise segments of the field's Code to be more relevant and informative in the area of business ethics. Another goal of this Summit could be to explore ways to develop an independent audit function for all external EAPs.

In closing, we are reminded of a quote in the Hastings Center Report (1990) by Leon Kass who was commenting on the state of ethics in health care: "Though originally intended to improve our deeds, the reigning practice in ethics, if truth be told, has, at best, improved our speech." Our hope is that some of the survey findings and interpretation of issues in this article will stimulate interest and discussion in a way that ultimately affects referral practices and ownership structures in the EA field and is not just exercise in "ethics talk".

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Declaration of Institutional Interest: Chestnut Health Systems, a private not-for-profit community-based provider, owns and operates a division that provides regionally based EA services. In addition to employee assistance, Chestnut also provides a wide variety of behavioral health care programs, prevention activities, and research, program evaluation, and training services. Both authors are employed by Chestnut Health Systems.



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Leadership in Addiction Treatment: The Coming Crisis

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Could the modern field of addiction treatment die of old age? Professional fields, having survived their birth and developmental years, must nourish new generations of leaders or face extinction. In fact, quite different types of leaders are needed: visionaries, professional and technical innovators, and business entrepreneurs. The fate of a professional field is often influenced by the prevalence of each type of leadership at crucial points in a field's history and the ability of the field to regularly regenerate all three types of leadership. This article will explore past and present concerns about leadership development in the field of addiction treatment.

The First Leadership Crisis

The rise and fall of America's first professional field of addiction treatment is instructive. First came the visionary leaders like Dr. Benjamin Rush, Dr. Samuel Woodward, Dr. James Turner, John Gough, and Francis Murphy who redefined intemperance as a treatable medical disorder, called for the creation of special treatment institutions, or offered themselves as living proof of the redemptive power of recovery. Between 1860 and 1890, a multi-branched field of addiction treatment was born. Inebriate homes, inebriate asylums and addiction cure institutes spread across the American landscape within the organizing umbrella of the American Association for the Cure of Inebriety founded in 1870. After reaching its peak of institutional growth, public credibility and professional productivity in the 1880s and early 1890s, the field went into a state of decline and virtually collapsed in the opening decades of the twentieth century. Of the hundreds of institutions offering treatment for addiction in the nineteenth century, only a handful survived the 1920s.

Many factors led to the fall of these institutions: unforeseen economic depressions; changing social policies toward alcohol and other drugs; contentious professional, religious and political debates within the field; and breaches of ethical conduct by treatment practitioners, to name just a few. Also pivotal, were the professional disengagement, declining health and death of the field's first generation of leaders as well as those leaders of a larger recovery

community: the Washingtonian movement and the recovery societies that followed.

The leaders who birthed and sustained this new professional field in the 1860s and 1870s died in the decades that followed. Among the most prominent were Dr. Charles Jewett (1807-1879), Dr. Willard Parker (1800-1884), Dr. Joseph Turner (1832-1889), Dr. Joseph Parrish (1818-1891), Dr. Albert Day (1812-1894), and Dr. Nathan Davis (1817-1904). Other important figures, such as Dr. T.D. Crothers (1842-1918) and Dr. Lewis Duncan Mason (1843-1927), reduced their practices during this same period due to age and declining health.

A similar pattern characterized the private addiction medicine specialists and the leaders of the addiction cure institutes. Physicians such as H.H. Kane and J.B. Mattison maintained large private addiction medicine practices, but there is no evidence of protégés continuing these practices following their deaths. Dr. Leslie Keeley (1832-1900) oversaw the creation of more than 120 Keeley Institutes in North America and Europe, but his empire of private addiction treatment franchises collapsed following his death, with only two of Keeley Institutes extending their work beyond the 1920s.

These moral, technical and business pioneers collectively birthed a field of professional endeavor, worked in that field for most of their adult lives, then disengaged and died, leaving a vacuum in the field's leadership. When the field of addiction treatment faced some of its most difficult economic, political, and professional challenges in the opening decades of the twentieth century, there were few seasoned leaders available to meet these crises. America's first field of addiction treatment might indeed be said to have died of old age.

The Rebirth of Addiction Treatment

Addiction treatment was reborn in the middle decades of the twentieth century. As before, there were visionaries and moral entrepreneurs like Dwight Anderson (1882-1953), Marty Mann (1904-1980) and Senator Harold Hughes (1922-1996) who laid the conceptual, organizational and political infrastructure for the treatment movement. There were also new sources of energy from a re-emerging recovery community and its leaders: Alcoholics Anonymous and its co-founders, Dr. Robert Smith (1897-1950) and Bill Wilson (1895-1971). There were the technical and professional innovators who set the stage for the emergence of a modern field of addiction treatment: Dr. Norman Jolliffe (1901-1961), Howard Haggard (1891-1959), E.M. Jellinek (1890-1963), Dr. William Silkworth (1875-1959), Dr. Edward Strecker (1886-1959), Dr. Ruth Fox (1922-1988), Mark Keller (1907-1995), Matt Rose, Dr. Nelson Bradley (1917-1983), Dr. Marie Nyswander (1919-1986), and Charles Dederich (1914-1997), to name just a few. There were also philanthropists such as Brinkley Smithers (1907-1994), who infused financial resources into the developing field, and there were business entrepreneurs who replicated the addiction cure franchises of the nineteenth century.

What these pioneers did was create the ideological, financial, organizational and technological infrastructure of the modern field of addiction treatment. Those recruited and inspired by this generation went on to lead our national organizations, our state addiction agencies, and our local addiction treatment programs as this first generation disappeared. For decades, members of this second generation have served as the field's administrative and clinical directors, senior clinicians, trainers and researchers.

The Coming Crisis in Leadership

There is no delicate way to put this. As a field, we are getting old. Several sources suggest this conclusion. The average age of NAADAC membership in surveys of the mid-1990s (NAADAC, 1997) was 49, with only nine percent under the age of 35. Today, there are some 14,000 NAADAC members, 8,438 of whom voluntarily listed their age on their last application (a group that may or may not be representative of the total membership). Of this group, 83 percent are age 45 or over, and 67 percent are age 50 or older (NAADAC

office). Several state surveys of addiction counselors and addiction administrators document similarly alarming trends.

Many addiction treatment organizations present a profile of long-tenured and graying administrators, clinical directors and senior clinicians combined with an exceptionally high (20-40%) annual turnover of younger, front-line direct service personnel. In addressing meetings of directors of state-funded addiction treatment agencies, I have observed more than three-fourths of those present being over age 45. (In Illinois, 81 percent of treatment agency directors are over age 45.) Many of these long-tenured leaders will exit the field in the next decade.

What is the fate of a field when its leaders, who have filled such roles for decades, collectively exit within a few years of one another? The age pattern profiled in this article is that of a field that could, like its nineteenth century predecessor, die of old age if it does not recruit and prepare a new generation of leaders and workers. This effort must begin immediately.

A Call for Action

To respond to this potential crisis in human resources, we need to immediately evaluate the age demographics of the field at national, state, local program/unit levels. We need to examine these numbers for the field as a whole and for specialized roles from training to research. We need to project the potential problems and opportunities created by this imminent loss of leadership. Most importantly, we need plans to re-populate the field and plans for leadership development and succession.

Leadership development strategies could include formalized worker recruitment programs, leadership development institutes, mentorship programs, and plans to retain key individuals as voluntary or paid advisors after their retirement from full time work in the field. In the 1970s, NIAAA and NIDA launched highly successful programs that recruited and trained the physicians, nurses and addiction counselors that filled newly opened treatment programs. That effort must begin anew. We need to recruit and develop a new generation of workers willing to commit a lifetime to this field and its organizations. In the interim, we need to find ways that the oral history and folklore of the modern field of addiction treatment can be recorded before it is irretrievably lost. Pieces of this history and folklore are quite literally dying every day.

For readers who are in the autumn of their career, I would commend you to give thought to how your legacy to this field can be solidified and passed on. The purpose of such reflection is not ego-gratification--assuring that one's accomplishments are recognized and remembered--but assuring the survival of the field's core values and best service technologies. For those in the summer of their career, you need to prepare yourselves to fill this coming leadership vacuum. There will be enormous opportunities for you in the next decade. Are you ready? For those in the spring of their career, you are invited to become part of a vanguard pursuing work in this field not as a job opportunity but as a life calling.

We need a new generation of leaders willing to commit themselves to the continued development of the field of addiction treatment. The baton is about to be passed. Who will be there to accept it?

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The Pricing of EAPs

Viewing the pricing of EAPs in ethical terms can help program vendors break free of the price-driven mentality and help educate employers to purchase programs on the bases of value and quality.

by David A. Sharar, M.S., and William White, M.A.

"Why not go out on a limb? That's where the fruit is."
—*Mark Twain*

J. D. Kleinke, in his book *Oxymorons: The Myth of a U.S. Health Care System* (Jossey-Bass, 2001), argues that managed care is fighting a losing battle on both the quality and cost fronts. Could this also be the case for employee assistance programs?

A recent national study on the most critical ethical issues facing the EA profession suggests that the price-driven market may be the single most influential factor preventing the field from adopting improved business ethics practices (Sharar, White, and Funk, 2002). Respondents viewed underbidding (also known as "low-balling") as one of the most common causes of quality erosion in the EA field. This quality erosion occurs when vendors agree to provide EA services within a capitation rate that is insufficient to fund the program as proposed, adversely affecting the quality of the EAP and contributing to a climate where the EAP is vulnerable to ethical breaches.

Although some EA professionals are reluctant to view the problem of EAP pricing in terms of ethics, looking through the "lens" of ethics may refocus our strategies for addressing this issue and help clarify the professional values that are at stake. By "ethics" we do not mean traditional EAP ethics, which involve codes of conduct that primarily address the counselor-client relationship. Within the context of pricing EAPs, ethics offer a way to examine conflicting values when the financial interests of employers, EA vendors, and individual clients compete with one another.

Current Marketing and Pricing

Even though enrollment in EAPs has risen significantly in recent years, revenue per covered employee per year has actually decreased during the same period (Open Minds, 2001). While rates for employer-sponsored health plans have increased steadily and sometimes dramatically over the past 10 years, the average per-employee per-year (PEPY) price for an EAP has declined. Thus, the growth in EAP enrollment during an era of rising health care premiums has not translated into greater revenues or increases in PEPY rates (Open Minds, 2001).

What is preventing EAPs from raising prices? The pricing problem appears to be due in large part to intense price competition, causing EAPs to wrestle with slim margins and, in many cases, operating losses. The consolidation of large vendors and aggregation among regional vendors should have, in theory, generated significant benefits in terms of economies of scale and a reduction in the oversupply of EAP vendors, thus improving the industry's financial status. But as large vendors have battled for market dominance and local/regional vendors have scrapped for a slice of the market, the employee assistance field has been unable to relate the cost of an EAP to the value it produces.

Just as Wal-Mart is committed to everyday low prices, EAP vendors seem compelled to sell their programs at everyday low prices. According to the U.S. Bureau of Labor Statistics, the Consumer Price Index (CPI) has increased an average of 2.75 percent each year since 1993 and the Employment Cost Index (ECI) has increased an average of 3.4 percent annually for the same time period. The price of an EAP, however, has remained constant, meaning that either increased efficiencies have created greater value or core services have been sacrificed to keep prices low, thereby eroding value.

As a field, we need to ask ourselves why prices do not generally rise as programs improve access or implement innovative forms of service delivery. More importantly, what proportion of the capitated rate is actually spent on direct service delivery versus profit loads and administrative overhead? Is the percentage that is spent on direct services, both for employers and employees, getting bigger or smaller over time? (Paradoxically, if the percentage spent on direct services is getting smaller and program services are eroding, the benefits that EAPs market as their strengths—improved retention and productivity, lower absenteeism, reduced accidents and claims, and enhanced morale—will become weaknesses.)

Purchasers of public-sector managed behavioral health

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care are now so concerned about excess administrative overhead and profit being set aside at the expense of client care that profit/administration caps are commonplace in contracts (Croze, 2000). In the EAP world, however, there is an almost sacrosanct wall of secrecy surrounding the percentage of dollars spent on client care and service, with frequent references to ownership of "proprietary information."

Many respondents in the national study expressed a high level of weariness over continual efforts to persuade employers to buy EAPs on the bases of quality and value when the decision seems always to boil down to price. Consider the following statements offered by respondents:

- "Employers don't usually bother to question exaggerated claims of superiority from one EAP to another. Since so many vendors look the same on paper, they (employers) focus on the lowest price."
- "Since all programs want to avoid a deficit, they end up trimming services in order to make up for lost profits resulting from low bids."
- "The current marketing environment in EAP is 'Sell them what they want, deliver what you got, and assume they won't notice the difference.'"

The tendency to under-price and over-promise seems to occur in the following manner: The employer (purchaser) wants to obtain a really good deal for his or her company and establishes an inadequate expectation of a capitation rate, usually based on an informal market analysis, for the type of EAP s/he wishes to buy. The competing EAP vendors submit proposals and marketing materials that are more alike than different. As the vendors look the same on paper, the purchaser establishes cost as the deciding factor. The eager EAP vendors respond in kind, with the winning vendor submitting an unreasonably low capitated bid in order to capture greater market share and reap the public relations victory of procuring a new contract. The winning vendor then squeezes the program to keep costs within the capitated rate.

Occasionally this formula of "under-price the product and under-resource the program" will return to haunt the vendor, but most times the purchaser is too unsophisticated or apathetic to notice that services are not being provided as promised. An invested and informed purchaser will recognize when an EAP is failing to meet customer needs and will respond by selecting a vendor better able to deliver on the bases of quality and higher standards of service. Most customers, however, terminate and hire vendors on the basis of cost, because EAPs have become commodity products and low price is all too often the deciding factor.

This environment of under-pricing and over-selling is compelling some who market and negotiate EAP contracts to risk some form of deception, concealment, or exaggeration of one's actual intentions, according to more than one in five survey respondents who identified "bidding and fee setting" as the most critical ethical problem facing EAPs. When do EAPs, because of their commitment to being socially responsible, intentionally make decisions expected to result in lower profits (or losses) in order to avoid under-serving or harming clients? Conversely, when do EAPs deliver substandard services in order to minimize financial losses?

Although these questions have not been empirically examined, the capitated model of funding EAPs can place the needs of clients and employers in conflict with the financial interests of the EAP firm. This is not to suggest that capitation is not an effective way to finance EAPs, but rather that the field needs ethical safeguards to determine (a) that the rate of payment is sufficient to provide all services needed to actually be labeled an "EAP," and (b) that the rate reflects the program needs and expectations of the employer customer.

Could our pricing tactics be contributing to the increased disenchantment and growing loss of the best and brightest EA professionals?

Cowboy or Stakeholder Capitalism?

The EAP market, as currently financed and structured, rewards a kind of "predatory competition" and tends to avoid the type of procurement process that is a prod to real excellence and quality. It should be considered that what currently drives growth in EAP enrollment, including the benefits and imperfections of a price-driven market, will not likely curtail our increased vulnerabilities to ethical breaches.

This does not mean that business ethical problems can be diagnosed as stemming from competitive, free market forces. Rather, perhaps the field has succumbed to what Gilmartin et. al. (2002) refer to as "cowboy capitalism," which conceptualizes business (including the business of health and social services) as a competitive jungle characterized by self-interest and an urge for competition in order to survive. This view, which reaches into the deepest recesses of American culture, represents a "free-wheeling, anything-goes" approach to win in the struggle that is new business development.

When cowboy capitalism is applied to the cause of helping the troubled or distressed employee return to emotional health and productivity, the values that led many to choose the EA profession seem cheapened. Few people received training and entered the EA field in the hope of "making up the difference with volume by meeting sales quotas," in the words of one survey respondent.

The demoralization of EA professionals is accelerated when the gap widens between available revenues and resources needed to successfully respond to client problems. While our

marketing materials trumpet the need for employers to invest in their most important asset—their human capital—our own focus seems to be on financial metrics rather than on client services. Could our pricing tactics be contributing to the increased disenchantment and growing loss of the best and brightest EA professionals?

There is no doubt that EAPs are solidly business endeavors, but as practitioners of the "helping" disciplines, do EA professionals have an obligation to operate at a higher moral standard? If the answer is yes, how does our profession practice concepts like fidelity (keeping promises), stewardship (using resources wisely to achieve the greatest good), and honesty (being truthful and factual in making representations)?

In contrast to cowboy capitalism, Gilmartin proffers the concept of stakeholder capitalism, which may be a more useful approach to pricing EAPs. This concept coalesces around the notion that "organizations can be conceived of as interactions of groups who have a stake in the organization" (Gilmartin, p. 9). The stakeholder theory posits that managers and practitioners need to understand the consequences of their actions on all affected parties—i.e., they must "manage for stakeholders." Since business decisions can harm or benefit various stakeholders, business ethics is highly relevant to stakeholder theory, which holds that stakeholders should be a part of the processes that meaningfully affect their lives.

This common-sense approach is plainly evident within superior EAPs, where the establishment of joint EAP committees ensures employees, managers, and key departmental representatives have a voice in evaluating, designing, and promoting the program. When an EAP is relegated to a position of low status with low stakeholder participation and is ancillary to a company's benefit plan and human resources strategy, then low price will probably be the main criterion for selecting an EAP vendor. The authors suspect that EAPs that are sustainable and have higher PEPY rates are partners with employers, not simply outside vendors, and have found ways to innovate and measure achievements that produce lasting, collaborative relationships with stakeholders.

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Breaking Free of a Price-Driven Market

The EA field's challenge is to reform the price-driven market and implement stakeholder capitalism. The field needs more leaders and managers who are willing to "go out on a limb to pick the fruit" by developing business strategies that emphasize a reasonable price based on meaningful performance characteristics, measurable outcomes, and stakeholder engagement.

The crucial test of an EAP is not the size of its profit margins or market share, but rather how well it performs when distressed, anxious, or impaired employees are coping with personal problems and under-performing on the job. Of course, all EAPs want and need to be profitable, but market dominance must be understood as only one measure of organizational performance, not the defining goal of the EA field.

This proposed reform requires persuading employers to buy EAPs on the basis of compliance with quality standards, not the lowest bid. If the field is to save itself from financial suicide, then EA professionals must educate employers that EAPs are worth the investment of additional resources. We also must migrate toward the development of universal standards regarding essential business practices.

Employers may be less inclined to focus on price if EAP vendors provide better measures of quality and value and give employers a reason to have a stake in the future of our field. No amount of new "add-on" products, less expensive alternatives to in-person services, or new marketing and branding campaigns can overcome the ethical problems arising from inadequate capitation rates and no price increases for core service. It's time to identify and celebrate EAPs that are doing the ethical thing by reasonably balancing the competing values of quality and price. And it's time for our field to collect and share data to help our customers and clients better understand the relationship between the price and value of EAPs. E

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Management of the High-Risk DUI Offender

August 2003

William L. White, MA

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Introduction

The state of Illinois invests considerable resources to prevent and contain the threat to public safety posed by alcohol- and other drug-impaired drivers. Those resources have produced significant changes in legislation and a multi-agency system that seeks to further reduce impaired driving and to respond aggressively to contain, rehabilitate and monitor those convicted of driving under the influence (DUI). Between 1982 and 2001, the efforts of these agencies have reduced the alcohol-related fatalities per 100 million miles of travel in Illinois by more than 60 percent (National Highway Traffic Safety Administration, 2002).

One important initiative has been the design and delivery of DUI-related training by the Illinois Department of Human Services Office of Alcoholism and Substance Abuse, the Administrative Office of the Illinois Courts, the Secretary of State, and the Illinois Department of Transportation. For the past fourteen years, the author has worked with these agencies to update judges, prosecutors, evaluators, probation officers, treatment personnel, and administrative hearing officers on the latest findings about what we are learning about impaired driving, the profile of the DUI offender and the most effective approaches to prevention, rehabilitation and containment. The purpose of this monograph is to capture the information provided through that training in writing so that it may reach a larger audience. It is hoped this information will help orient new personnel filling these roles and aid in the development of new trainers who will continue this work in the future.

This monograph has been written with six specific audiences in mind: state's attorney staff who prosecute DUI cases, judges who hear DUI cases, the evaluators who assess DUI offenders and report their findings to the courts, the probation officers who monitor and supervise DUI offenders, the treatment personnel called upon to counsel DUI offenders, and the Secretary of State administrative hearing officers who decide if and when to reinstate driving privileges for persons convicted of DUI.

The monograph will cover the following content areas:

- Substance use trends and their implication for public safety.
- The changing perception of the DUI offender.
- Subpopulations of DUI offenders.

- The high risk DUI offender profile.

- The role of addiction treatment and mutual aid resources in managing and rehabilitating the DUI offender.

- Principles and strategies for managing the DUI offender in the local community.

This monograph incorporates and updates two earlier works: *Evaluation of the DUI Offender* (White, 1997) and *An Ethnographic Profile of the Higher Risk DUI Offender* (White, 2001).

It has been a great privilege to work with the personnel and agencies that have contributed to the dramatic reduction of alcohol-related crashes and deaths in Illinois during my lifetime. I hope this monograph will help further this trend into the future.

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Chapter One
Substance Use Trends and Public Safety

Monitoring trends in alcohol and other licit and illicit psychoactive drugs is a challenging task. Popular reports of such trends are plagued by underreporting of stakeholders wishing to deny local substance-related problems and by the exaggerated reporting of those who have financial or political interests tied to substance-related problems. Fortunately, several systems exist that scientifically monitor alcohol and other drug use trends and their implications. At the national level, the most significant of these include:

- The National Household Survey on Drug Abuse (NHSDA) and specialized surveys related to substance use and driving conducted by the Substance Abuse and Mental Health Services Administration/National Institute on Drug Abuse (NIDA) and the National Highway Traffic Safety Administration (NHTSA).

- The NIDA-sponsored Monitoring the Future Survey that annually samples 43,000 8th, 10th, and 12th graders from 394 schools (http://www.monitoringthefuture.org).

- The Drug Abuse Warning Network (DAWN) that monitors drug-related emergency room admissions and fatalities on behalf of NIDA and the Drug Enforcement Administration.

- Systems for monitoring per capita alcohol consumption, alcohol-related problems and alcohol-related arrests and crash fatalities on behalf of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the NHTSA.

- Drug-related arrests reported by the Federal Bureau of Investigation (FBI).

- Drug-related disease transmission reported by the Center for Disease Control and Prevention (CDC).

- Reports on the demand for addiction treatment and changes in the characteristics of those seeking treatment prepared by the Substance Abuse and Mental Health Services Administration.

This first chapter identifies eight trends related to substance use in the United States using data from these monitoring systems. Each of these trends is

accompanied by a discussion of its implications for those charged with protecting the public safety of Illinois citizens.

Trend # 1: Moderated Alcohol Consumption / Deviant Binge and Heavy Drinking

Annual per capita alcohol *consumption* has declined in recent decades. Such consumption declined 17.4 percent between 1977 and 1999 and further declined 11 percent between 1990 and 1997. Much of this decline is attributable to reduced consumption of distilled spirits, which in 1997 was at its lowest level since 1934. Annual per capita consumption of alcohol in Illinois declined from 2.87 gallons in 1977 to 2.32 gallons in 1997 — still above the 1997 national average of 2.19 gallons (Nephew, et al., 1999). Even among high school seniors, reported lifetime, annual, past 30-day, and daily alcohol use declined between 1975 and 2001 (http://niaaa.nih.gov/databases/dkpat 10.htm, accessed 2003).

Alcohol-related *problems* are also declining in the United States and in Illinois. The rate (per 100,000 population) of deaths from alcohol-related medical disorders has declined from 42.2 in 1979 to 32.3 in 1996 — from 40.3 to 31.5 in Illinois (Stinson, et al., 1996), and liver cirrhosis fatality rates are at an all-time low in American history, half of what they were in 1910 (Yoon, et al., 2002). Alcohol-related crash fatalities have similarly declined from 17,414 in 1977 to 13,050 in 2000, with the percentage of alcohol-related crash fatalities dropping from 43.5 percent of total crash fatalities in 1986 to 31.1 percent in 2000 (Yi, Williams, & Dufour, 2002). The decline in alcohol consumption and alcohol-related problems is a product of what some have christened an era of "new temperance" in the United States (Wagner, 1997).

In spite of this decline, Americans continue to consume more than 482 million gallons of alcohol per year, with Illinois citizens consuming 22.3 million gallons of that total (http://www. niaaa.nih.gov/databases/consum01htm, 2003b). Forty-eight percent of Americans aged 12 or older are current drinkers (consuming at least one drink in the past thirty days). Current drinking rises with developmental age, e.g., 67.5 percent of those age 21 (National Household Survey on Drug Abuse, 2001). As Table 1 shows, levels of recent alcohol intoxication reported by youth have remained relatively stable for the past ten years.

Of greatest concern to public safety is the fact that one fifth — 20.5 percent — of the total population 12 or older report current binge drinking (5 or more drinks at a single setting during the past 30 days) and 5.7 percent report heavy drinking (5 or more drinks on the same occasion on at least 5 different days in the past 30 days). Young adults aged 18-25 report the highest prevalence of heavy drinking and binge drinking of all age groups (NHSDA, 2001). According to the latest

household survey, 10.1 million persons aged 12-20 reported drinking in past month — 28.5 percent of this age group. Of this age group, 6.8 million — or 19 percent — are binge drinkers and 2.1 million — or 6 percent — are heavy drinkers (NHSDA, 2001). Young people ages 12-20 consume one fifth of the nation's alcohol — $22.5 billion of the $116.2 billion total spent on alcohol per year (National Center on Addiction and Substance Abuse, 2003).

There are few geographical differences in drinking patterns among adults but some differences among youth. The rate of heavy drinking for all persons over age 12 varies little from metropolitan to non-metropolitan areas. Among youth aged 12-17, rates of past-month alcohol use and heavy drinking are higher in rural areas than in large metropolitan areas (NHSDA, 2001).

Implications:

- Reduced alcohol consumption by the majority of Americans increases the visibility of the smaller population of binge and heavy drinkers who consume most of the alcohol ingested in this country.

- Binge drinking and heavy drinking by a minority of drinkers poses significant threats to public safety as the percentage of "social drinkers" within the total pool of DUI offenders shrinks.

Table 1: Intoxicated in Past 30 Days

Grade Level	1991	2001
8th graders	7.6 percent	7.7 percent
10th graders	20.5 percent	21.9 percent
12th graders	31.6 percent	32.7 percent

Source: *Monitoring the Future*, 2001

Trend #2: Increased Illicit Drug Consumption

The illicit psychoactive menu has expanded and become more accessible to American citizens. In 2001, 15.9 million Americans — 7.1 percent of the population over age 12 — self-reported current illicit drug use (NHSDA, 2001). Like alcohol, lifetime illicit drug use rises with developmental age, with past-month use peaking in the years between 16 and 26. Following a decline in illicit drug use in the 1980s, such use rose again in the 1990s, reflecting three interacting patterns:

1. A youthful polydrug phenomenon not unlike the 1960s and early 1970s with marked increases in the use of marijuana (37 percent of high school seniors reporting use in the past year), hallucinogens (LSD), sedatives (rohypnol, GHB), and so-called "designer drugs" (e.g., MDMA/ "Ecstasy").

2. Changing patterns of stimulant use marked by increased use of methamphetamine and a new generation of young cocaine users.

3. A surge in opiate addiction among adolescents and young adults sparked by the intranasal ingestion of high potency heroin and the misuse of prescription opiates such as oxycodone and hydrocodone.

Table 2: Lifetime Prevalence Rates: 1991-2001

Any Drug	**1991**	**2001**
8th grade	18.7 percent	26.8 percent
10th grade	30.6 percent	45.6 percent
12th grade	44.1 percent	53.9 percent

Source: *Monitoring the Future*, 2001

Collectively, these trends impacted both lifetime and past-month trends in illicit drug consumption.

The rate of current illicit drug use is highest in New England — 9.2 percent, and the West — 8.3 percent, and lowest in the South — 6.2 percent, and Midwest — 6.8 percent. Rates of illicit drug use are higher in metropolitan areas than in non-metropolitan areas except among youth aged 12-17, for whom illicit drug use is higher in rural areas — 14.4 percent — than in metropolitan areas — 10.4 percent (NHSDA, 2001).

College graduates have higher rates of lifetime illicit drug use, compared to those with less than a high school education, but have the lowest rate of current illicit drug use — only 4.3 percent (NHSDA, 2001). This suggests that college attendance is a risk factor for illicit drug experimentation but a protective factor for sustained drug use and dependence.

There is also considerable correlation between tobacco, alcohol and illicit drug use. The rate of illicit drug use is 9 times higher for youth who smoke cigarettes — 48.0 percent, compared to youth who do not —5.3 percent. Sixty-five percent of youth who are heavy drinkers report illicit drug use, compared to 5.3 percent of youth who report illicit drug use but do not drink.

The increased substance use among youth during the past decade is evident in many data sources. Drug-related juvenile arrests rose from 93,300 in 1970 to

202,500 in 2001, compared to drug-related adult arrests over the same period from 322,300 to 1,384,400. Increased juvenile arrests were driven by the rise in marihuana-related arrests, where adult arrests were driven by arrests related to marihuana, cocaine and other controlled substances. Juvenile drug arrests rose in the 1990s, going from 8 percent of total juvenile arrests in 1990 to 13 percent of total juvenile arrests in 2001(FBI, *Crime in the U.S.*, 2001). Drug-related emergency room visits also increased for juveniles during the 1990s and continued to increase between 1999 and 2000 for patients aged 12-17 — a 20 percent increase, and for patients aged 18-25 — a 13 percent increase (*NIDA Info Facts*, www.drugabuse.gov, accessed 2003).

Implications:

- Concerns about drug-impaired driving will increase in tandem with rising illicit drug consumption. This will stir calls for legislation aimed at drivers impaired with non-alcoholic drugs. Eight states, including Illinois, currently have such laws.

- Rising polydrug use also reinforces the need for more sophisticated evaluation instruments that assess drug use other than alcohol as well as more sophisticated monitoring tools, e.g., urine surveillance.

Trend #3: Multiple Drug Use

There is a shift from single drug use to multiple drug use (concurrent and sequential patterns of alcohol and other drug use). Alcohol in combination with other drugs is the most frequent cause of drug-related emergency room visits (*NIDA Info Facts*, www.drugabuse.gov, accessed 2003). Most people entering treatment for alcohol or other drug-related problems report more than one drug of choice; of the 72,007 admissions to addiction treatment in Illinois in 2001, only 15,363 — 21 percent — presented in the "alcohol only" category (*Substance Abuse Treatment...*, 2001).

Table 3: Past 30 Day Use Rates: 1991-2001

Any Drug	**1991**	**2001**
8th grade	5.7 percent	11.7 percent
10th grade	11.6 percent	22.7 percent
12th grade	16.4 percent	25.7 percent

Source: *Monitoring the Future*, 2001

Implications:

- More DUI events will involve persons using alcohol in combination with other drugs, drugs other than alcohol, and persons whose primary drug of choice is not alcohol.

- This will require assessment instruments and interview protocols that encompass a review of drugs other than alcohol and an expansion of treatment options to encompass drug-specific treatment interventions, e.g., the use of methadone and buprenorphine in the treatment of opiate addiction.

- Law enforcement agencies will be under increasing pressure to add Drug Recognition Expert (DRE) training for their officers.

Trend #4: Increased Drug Potency and Altered Methods of Administration

There is evidence of increased drug potency via increased purity of heroin, new and more potent forms of cocaine, increased THC content of marijuana, and a growing number of alcohol products with higher ethanol content (premium brand liquors, fortified wines, malt liquors and "ice" and "dry" beers) accompanied by an expanded definition of unit dose, e.g., 40 ounce bottles of beer and serving alcohol in pitchers and "bird bath" (size) glasses. There are also more efficient and less stigmatized methods of drug ingestion, e.g., from intranasal ingestion of cocaine to smoking cocaine, inhaling or smoking rather than injecting heroin.

Implications:

- Impaired driving rises in tandem with the speed and intensity of drug intoxication.

- Drug-impaired driving will become increasingly evident as more drivers are stopped for gross impairment who evidence minimal or no alcohol intoxication.

- Heightened potency is causing an expansion and redefinition of who is vulnerable to addiction.

- Increased potency and ingestion efficiency is creating more intractable patterns of drug addiction that require interventions of greater intensity and duration.

- The need for education related to drugged driving is intensifying within the culture.

Trend #5: Lowered Age of Onset

There is a significant trend toward lowered age of onset of regular alcohol and other drug use. In the past four decades, substance experimentation has moved

from being a symbolic rite of passage from late adolescence into adulthood to a rite of passage from childhood into adolescence (White, 1999; Dennis, Babor, Roebuck, & Donaldson, 2002). This lowered age of onset of drug exposure is particularly pronounced in populations of adolescents entering the criminal justice system and addiction treatment programs. Thirty-eight percent of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 — 19 percent before age 10 (U.S. Department of Justice, 1994). In the just-completed Cannabis Youth Treatment Study, more than 80 percent of the 600 youth admitted to the study began regular substance use between the ages of 12 and 14 (Dennis, Titus, et al., 2002).

Implications:

- Lowered age of onset of alcohol and other drug use (onset before age 15) has been linked to increased risks of adult substance use disorders, faster development of drug dependence, greater problem severity, the development of comorbid physical disorders and psychiatric disorders, and poor intervention outcomes (White, Godley, & Dennis, in press). Lowered age of onset of drinking has also been linked to increased lifetime risk of drinking and driving, and involvement in motor vehicle crashes while under the influence of alcohol (Hingson, Heeren, Jananka, & Howland, 2000).

Females will be showing up in increasing numbers as DUI offenders and recidivists.

Comment [COMMENT1]: mld **These rates are very different because originally we divided by everyone but several people criticized us for this so in the 2002 article we subseted only those people who had tried a given substance before calculating the rates of problems and odds ratio.**

- An increasing number of young (adolescent and young adult) DUI offenders will already be in late stages of problem development due to the telescoping, or condensed problem progression, that results from early age of onset.

Trend #6: Greater Gender Parity

In 1939, the percentage of men and women who reported at least occasional use of alcohol was 70 percent and 45 percent respectively; by the mid-1990s, those percentages remained at 70 percent for men but had risen to 61 percent for women (http://www.niaaa.nih. gov/databases/dkpat1.htm, 2003c). For young people aged 12-17, reports of current alcohol use are comparable for males and females — 17.2 percent of males and 17.3 percent of females — while rates of binge drinking and heavy drinking continue to be higher for males than females in all age groups (NHSDA, 2001). The rate of current illicit drug use among youth aged 12-17 is higher for boys — 11.4 percent, than girls — 10.2 percent (NHSDA, 2001), but this gender gap is closing. A review of impaired-driving arrests among women found that such arrests were increasing, as was impaired-driving recidivism

among women, though significantly lower than for men (Shore, McCoy, Martin, & Kuntz, 1988).

In Illinois, women now make up 16 percent of those arrested for DUI (White, 2003).

Implications:

- Females will be showing up in increasing numbers as DUI offenders and recidivists.

- Screening, assessment and treatment and monitoring strategies must meet the test of gender appropriateness and effectiveness.

Trend #7: Changes in Ethnicity

Caucasian Americans use alcohol and illicit drugs at higher rates than ethnic minorities, but ethnic minorities are over-represented among substance-related casualty data. For example, African Americans have an alcoholism-related death rate that is three times that of Caucasian Americans. Native Americans and Hispanics of Mexican origin suffer higher rates of alcohol-related traffic fatalities while Asian-Pacific Islander Americans experience a very low rate of such fatalities (Voas, Tippetts, & Fisher, 2000; http://www.health.org/newsroom/rep/107.aspx). In reviewing the literature on the characteristics of DUI offenders, Ross and colleagues (1991) found that African Americans and Hispanics were over-represented in DUI arrests.

In Illinois, there is significant ethnic minority representation in admissions to addiction treatment — 44.7 percent of Illinois admissions are African American and 9.3 percent are Hispanic (*Substance Abuse Treatment...*, 2001) — and there is growing concern about the increased representation of Hispanics among DUI offenders. Caetano and Raspberry (2001) note that the over-representation of Hispanics in DUI arrests may be related to Hispanic drinking patterns, which include lower frequency of use but higher levels of consumption when use does occur. Roadside surveys have found decreases in the percentages of white drivers with BACs over 0.10 percent, but these decreases were not noted for African American and Hispanic drivers (Lund & Wolf, 1991). It may be that the media vehicles used to change attitudes toward drinking and driving in the 1970s and 1980s did not penetrate communities of color.

Implications:

- Changing attitudes and behaviors related to drinking and driving in ethnic communities may require different strategies than those that have proved successful in the larger American culture.

- Evaluators must be familiar with cultural patterns of drinking, culturally-specific patterns of alcohol-related problems, and culturally-prescribed pathways of problem resolution.

- There is a growing need for culturally congenial approaches to treating African American, Hispanic and Native American DUI offenders with significant alcohol problems.

Evaluators must be familiar with cultural patterns of drinking.

Trend #8: Alcohol/Drug-impaired Driving

The prevalence of driving after drinking and alcohol-related crash fatalities has significantly declined in recent decades (Lund & Wolf, 1991). In spite of this success, recent surveys reveal one in ten Americans aged 12 or older — 25.1 million persons — reporting driving under the influence of alcohol in the past year. In 2001, 16,653 Americans died in alcohol-related crashes and another 275,000 individuals were injured (NHSDA, 2001).

Drinking drivers aged 21 or younger involved in fatal crashes decreased by 61 percent between 1982 — 4,393 — and 1998 — 1,714 (Hedlund, et al., 2001), but survey figures continue to raise alarm. Among young adults aged 18-25, 22.8 percent drove under the influence of alcohol in 2001 (NHSDA, 2001). More 19-year-olds in the U.S. die in alcohol-related crashes than any other single age. A third of 21-24-year-old drivers who died in fatal crashes were intoxicated. Seventy-nine percent of young drivers who died in alcohol-related fatal crashes were unrestrained (NHTSA, 1996b).

In Illinois, 620 people were killed in alcohol-related crashes in 2001, 44 percent of total crash fatalities). That same year, there were 49,676 DUI arrests in Illinois, 18 percent of whom had prior DUI offenses. For the past ten years, Illinois has arrested each year from .58 percent to .66 percent of its 8.5 million licensed drivers for driving while impaired (White, 2002; White, 2003). Under age 21 DUI violations have risen from 2,829 in 1993 to 4,399 in 2001. “Use it & lose it” violations have increased from 2,844 in 1995 to 3,012 in 2001. A total of 20,145 drivers under the age of 21 have lost their driving privileges since the “use it & lose it” policy was implemented (White, 2003). Those aged 16-20 are three times

more likely than those over age 21 to have consumed five or more drinks on their most recent occasion of drinking and driving, and are twice as likely to report driving after using alcohol and other drugs in combination (NHSDA, 2001).

Concern about impairment of driving resulting from drugs other than alcohol increased in the mid-1980s (Simpson, 1985; Cowart & Kandela, 1985) and has continued to grow (Brookoff, et al., 1994). A 1993 study of 1,882 fatally injured drivers found that 52 percent had been drinking and 18 percent had consumed drugs other than alcohol; 64 percent of the latter involved combinations of drugs and alcohol. In this study, illicit drug use was most common in young drivers; prescription drug use was most common in drivers over age 55 (NHTSA, 1993).

In 2001, over 8 million persons aged 12 or older reported driving under the influence of illegal drugs. Sixteen percent of those age 16-20 reported drugged driving compared to 5 percent for those over 20, but rates of drugged driving among those 18-34 increased between 2000 and 2001 (NHSDA, 2001). Impairment from drugs other than alcohol is a factor in as many as 18 percent of drivers involved in vehicular crashes (NHTSA, 1993).

According to the National Household Survey on Drug Abuse (2001), the person most likely to drive within two hours of consuming a drug other than alcohol is a white, unmarried male under 21 years of age who is unemployed or makes less than ten thousand dollars per year, has had prior contact with the criminal justice system, and is most likely to drive impaired on weekends between the hours of 6:00 p.m. and 6:00 a.m. These individuals also perceive themselves as capable of driving while under the influence of drugs and believe they are no more likely to be stopped by police after smoking marijuana than on other occasions.

Public safety responses to driving impairment related to drugs other than alcohol are plagued by several factors.

1. Testing for drugs other than alcohol is more invasive (e.g., requiring blood or urine analysis rather than breath analysis) and its instrumentation is more expensive and less portable.

2. The relationship between other drug concentrations and impairment are more complex and less linear than for alcohol; BAC equivalents do not exist for other drugs.

3. There is no technology to effectively test impairment resulting from drug interactions.

On the other hand, considerable progress has been made in creating the equivalent of the field sobriety test for drugs other than alcohol. The Drug Recognition

Expert (DRE) Program provides law enforcement officers forty hours of structured training followed by field supervision. DRE-trained officers conduct a field evaluation of drug-related impairment and prepare the Standard Drug Evaluation Report based on appearance, manner, attitude, behavioral test performance, vital signs (blood pressure, pulse rate, body temperature), eye signs (nystagmus, strabismus, dilation/constriction, speed of response), and physical signs of ingestion (marks, debris, residue).

Implications:

- As rates of drinking and driving diminish in America, we are left with overlapping groups of youthful, high-risk drinking drivers and hard-core drinking driving recidivists.

- Impairment related to intoxication with drugs other than and in addition to alcohol will become an increasingly visible threat to public safety.

Impairment related to intoxication with drugs other than alcohol will become an increasingly visible threat to public safety.

Trend Summary and Implications

Per capita alcohol consumption has declined and has been accompanied by growing concerns about a subpopulation of binge and heavy drinkers who pose significant threats to public safety. The prevalence of illicit drug use rose in the 1960s and 1970s, peaked between 1979 and 1981, declined from 1982 to 1991, rose during the mid-1990s, crested between 1998 and 2001, and then showed a slight decline in 2002. The most significant changes in the patterns of substance use over the past three decades include an expanded drug menu, changes in drug potency, more efficient methods of drug administration, and the use of alcohol and other drugs in combination. Changing characteristics of alcohol and other drug users are evident in lowered age of onset of use, new patterns of late onset alcohol problems among older adults (see Chapter 4 discussion of special populations), and increased representation of women and ethnic minorities in alcohol- and drug-related casualty data. These trends call for:

1. Efforts to sustain the progress in reducing alcohol-related problems and alcohol-related crashes.

2. A more sophisticated process of assessing impaired drivers across the points of arrest, evaluation, prosecution, sentencing, treatment, probation monitoring, and license reinstatement or denial.

3. Expanded sentencing options that reflect the changing demographic characteristics of DUI offenders.

4. A wider menu of treatment options that reflect the broadened drug choices of impaired drivers in Illinois.

Chapter Two
The Myth of the Social Drinking DUI Offender

The Alcohol Safety Action Program (ASAP) emerged more than three decades ago as the dominant programmatic model aimed at reducing risks to public safety posed by the alcohol-impaired driver. Pioneered in 35 local projects funded by the National Highway Traffic Safety Administration, the ASAP was designed to 1) distinguish problem drinkers from social drinkers within the total pool of individuals arrested for driving under the influence of alcohol, and 2) link the former group to treatment and the latter to remedial education. The ASAP program was widely replicated throughout the United States (White, 1998).

While this system provided an efficient means of processing hundreds of thousands of DUI offenders through the criminal justice system, it came under increasing criticism by the mid-1980s from judicial leaders, victim advocacy groups such as Mothers Against Drunk Drivers (MADD), Blacks Against Drunk Driving (BADD) and Remove Intoxicated Motorists (RID), and from social scientists who evaluated DUI intervention programs. Evaluations revealed that the ASAP programs were lowering recidivism among the less problematic drinkers but were not producing reductions in rates of alcohol-related crashes (Nichols, 1990).

In seeking to explain the limitation of the ASAP model, some suggested that the model was based on the following three myths:

1. The DUI offender is generally a law-abiding citizen; he or she is one of "us."

2. The majority of DUI offenders are not alcoholics or problem drinkers, but social drinkers whose driving while intoxicated represents an isolated error of good judgment.

3. DUI offenders can be educated to moderate their drinking patterns to reduce risks to public safety via future drinking and driving.

Two seminal papers challenged these myths. In 1986, Judge Albert Kramer called for a change in how Americans were viewing and responding to the impaired driver:

> *From a criminal justice point of view, we must face the reality that we in the courts are failing to alter the destructive behavior of the hundreds of thousands of drunk drivers who come before us each*

> *year.... Worse still we must face the grim prospect that these offenders will continue their flagrant misconduct ... before we get a chance to catch them again. It is critical that we take a hard look at what we are doing, or more appropriately, what we are not doing, and make the needed changes without delay.* (Kramer, 1986, p. 26)

Kramer went on to challenge the view of the DUI offender as a non-criminal and educable social drinker and argued that there was a growing body of empirical evidence suggesting that this view was "completely fallacious."

In a similar vein, Alfred Crancer presented a paper in 1986 that similarly challenged what he called the "myth of the social drinking DUI offender." Crancer provided evidence that DUI offenders "are not social drinkers but persons with moderate to serious drinking problems — maybe as high as 90 percent" who, following their first arrest, "repeatedly drive drunk" (p.11). The Kramer and Crancer papers marked a watershed in changed thinking about the DUI offender. The ASAP assumptions came under increasing challenge.

The assumption that the DUI offender was a family member or friend rather than a dangerous criminal allowed the culture to address the problem of impaired driving without stigmatizing the impaired driver. This assumption began to be challenged by studies of DUI offenders that painted a quite different portrait. These studies revealed that 40-70 percent of first-time DUI offenders had prior alcohol- or drug-related criminal offenses, e.g., illegal possession of alcohol or controlled substances, illegal transportation of alcohol, disorderly conduct, larceny, criminal damage to property, resisting arrest, public urination, and assault and battery. One study found that 63 percent of DUI offenders had at least one prior criminal arrest compared to 11 percent of licensed drivers without an arrest for DUI (Taxman & Piquero, 1998). Chang and Lapham (1996) compared prior arrests reported by DUI offenders against official criminal records and found that 65 percent of DUI offenders underreported their prior arrests. There were other studies that revealed striking similarities between the profiles of DUI offenders and persons convicted of other criminal offenses (Kochis, 1997). Collectively, these studies portrayed the DUI offender as anything but a model citizen, and as a significant threat to public safety.

The myth that most DUI offenders are social drinkers who experienced a rare lapse in judgment on the occasion of their DUI arrest was similarly challenged. First, while social drinkers do make rare errors in judgment and drive while intoxicated (see Chapter One), they rarely ever get arrested. The reason for this is found in the number of times an average person must drive intoxicated to generate an arrest for impaired driving. Numerous roadside safety surveys comparing the number of intoxicated drivers with the number of DUI arrests in the U.S. have

concluded that a driver would have to commit between 300 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987). The most conservative estimate by the National Highway Traffic Safety Administration is that only one percent of episodes of impaired driving result in arrest (NHTSA, 2001a). This is perhaps most evident in the fact that most — about two-thirds — of alcohol-related fatal crashes involve drivers with no prior arrest for DUI. In one study, 49 percent of DUI offenders reported driving at least once a week after having consumed two or more drinks (Pollack, 1969). In a 1993 NHTSA study, 52 percent of DUI recidivists reported driving 13 or more times in the past month after drinking (Hedlund, 1995).

In one study, 52 percent of DUI recidivists reported driving 13 or more times in the past month after drinking.

The percentage of drivers registering a detectable amount of alcohol in their bloodstream in roadside safety checks dropped from 36 percent to 17 percent between 1973 and 1996, while the number of deaths from alcohol-related traffic crashes dropped 32 percent between 1982 and 1996, from 25,165 to 17,126 (NHTSA, 1997). Studies in the 1980s found a dramatic reduction in fatally injured drivers with BACs of 0.10-0.19 percent and above 0.20 percent while those with lower (0.01-0.09 percent) BACs increased (Perrine, Peck, & Fell, 1989). Since then, studies have shown that the percentage of lower BAC drinking drivers — the true social drinkers — is shrinking while the percentage of the higher BAC drinking drivers is not (beginning with Lund & Wolf, 1991), suggesting that we are now left with a residual pool of "hard core drinking drivers" (Simpson & Mayhew, 1991).

In a study comparing binge-drinking drivers with other drivers, it was found that the binge drinking drivers:

- Drank more days per week.
- Believed they could drink large amounts of alcohol and drive safely; 68 percent thought they could drive safely after 6 or more drinks and 28 percent thought they could drive safely after 10 or more drinks.
- Reported a much higher frequency of driving after any consumption of alcohol; 57 percent reporting driving after drinking three or more times in the past month).

- were twice as likely to have experienced a vehicular crash after they had been drinking (Nelson, Kennedy, Isaac, & Graham, 1998).

More than one third of those arrested for DUI have elevated enzyme (glutamyltranspeptidase) levels indicating chronic excessive alcohol consumption (Dunbar, et al., 1985).

When the author was first trained to evaluate DUI offenders in the early 1970s, I was told that my job was to find the hidden minority of alcoholic DUI offenders — estimated at about 15 percent — camouflaged within a sea of social drinking drivers. By the mid-1980s, the estimate of the percentage of DUI offenders who met diagnostic criteria for alcohol abuse or dependence had climbed to 30-50 percent and some researchers (Miller, et al., 1986) reported that three quarters of DUI offenders met diagnostic criteria for alcohol abuse or alcohol dependence. There is growing evidence that the majority — most studies now suggesting between 70-80 percent — of DUI offenders are experiencing significant problems in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, et al., 2001). My experience confirms that the majority of DUI offenders already have a serious problem in their relationship with alcohol or other drugs, are in the process of developing such a problem at the time of their arrest, or will go on to develop such a problem in the years following their first arrest.

The percentage of social drinkers in the DUI pool is shrinking as more people choose to abstain from drinking, as American drinking patterns moderate and as drinking and driving becomes increasingly stigmatized within the culture (Yi, et al., 2002a). The percentage of late-night weekend drivers with blood alcohol concentrations of 0.10 percent or greater declined significantly between 1973 and 1986 and has continued to decline in the intervening years as the use of "designated drivers" has increased (Lund & Wolf, 1991). The percentage of Illinois citizens who reported driving after consuming alcohol dropped from seven percent in 1984 to two percent in 1999 (Center for Disease Control and Prevention, 1999) — a percentage consistent with national levels of reported drinking and driving obtained in health surveys of the American public (Liu, et al., 1997).

The assumption that the risk DUI offenders pose to public safety could be eliminated via a brief intervention (10-12 hours of remedial education in the ASAP model) also was challenged. The most methodologically rigorous evaluation of the early ASAP programs concluded that remedial education provided no measurable reductions in DUI recidivism or crashes when compared to persons who did not participate in remedial education (Nichols & Ellingstad, 1978; Nichols, Ellingstad, & Reis, 1980). Remedial education increased measurable levels of knowledge about the effects of drinking and driving but there was no evidence that this increased knowledge resulted in reductions in

drinking and driving, re-arrest and alcohol-related crashes (Golden, 1979). The changing view of the DUI offender has helped explain why remedial education approaches have not been found in controlled studies to be effective in altering the drinking behavior of those DUI offenders (the majority) with significant alcohol or other drug-related problems.

In short, there is growing evidence that our 30-year experiment of DUI intervention has been based on what Crancer has called the "myth of the social drinking DUI offender." If the majority of DUI offenders are experiencing serious substance use disorders, as a growing number of studies reveal, then how could so many of these individuals have been assessed through community substance abuse agencies and determined to not be "alcoholic?" The problem appears to have been in the misapplication of traditional alcoholism assessment technology.

New assessment and treatment technologies are emerging to respond to different populations of DUI offenders.

During the early 1970s, a well-developed assessment and treatment technology evolved to address the needs of the traditional alcoholic clients who found their way to self-help groups and/or alcoholism treatment. Like software written for unique capacities and characteristics of a particular brand of computer, this technology (assessment and treatment software) was based on clients who shared a fixed set of characteristics. They were male. They were white. They began significant drinking in early- to mid-adolescence, experienced a progressive loss of control over their relationship with alcohol, and entered recovery in their forties and fifties. They were drawn from the working and professional classes. They were literate and sometimes highly educated. They used alcohol as their primary, and most often exclusive, drug of choice. They did not have significant psychiatric impairment that predated the onset of alcoholism. They represented the dominant pattern of alcoholism in the United States. And they consistently presented themselves to self-help or treatment in very late stages of alcoholism. Assessment instruments and treatment protocols were designed to fit these characteristics, and when applied to clients who shared these characteristics, were quite effective at identifying alcohol problems. However, when this technology was applied to DUI offenders with very different characteristics, that effectiveness was compromised.

There is a growing awareness that the majority of DUI offenders have significant problems in their relationship with alcohol and/or other drugs. There is further recognition that within this total population of offenders can be found numerous and diverse patterns of alcoholism and drug addiction and patterns of alcohol- and drug-related problems that can significantly impair life functioning and pose

threats to public safety via alcohol- and drug-impaired driving. New assessment and treatment technologies are emerging to respond to these different populations of DUI offenders and reduce their threat to the health and safety of others. The next chapter will explore the nature of these subpopulations, the various patterns of substance use with which they are involved and the different treatment approaches that may be required to address their problems and lower their threat to public safety.

Chapter Three
The Varieties of Substance Disorders and Public Safety

There is not one alcoholism but a whole variety.
Dr. E. M. Jellinek, in *The Disease Concept of Alcoholism,* 1960.

This chapter will identify and describe eight major subpopulations of DUI offenders based on differences in the driving forces (etiological pathways) behind the onset of excessive alcohol and other drug use. Appropriate treatment interventions and settings applicable to each will also be described. For judges, prosecutors and probation officers, the chapter will convey the distinct personalities and patterns behind what seems like an endless stream of DUI offenders and will emphasize the importance of individualized approaches to sentencing and case supervision. For evaluators and treatment personnel, this chapter will provide a detailed guide to assessment, treatment planning and recovery planning (the plan for post-treatment recovery support services).

A Multiple Pathway Model of Alcohol and Other Drug Problems

Traditional alcoholism assessment technology assumes that alcoholism springs from a single etiological cause, presents itself in a consistently and narrowly defined profile of clinical characteristics (you either have it or you don't), responds to a narrow treatment approach (philosophy and techniques), and is characterized by a single pathway of long term recovery. In contrast to this view, multiple pathway models are based on the following propositions:

- There are numerous etiological pathways that form the motivating forces behind the onset of excessive alcohol consumption, in general, and the act of driving under the influence of alcohol, in particular.

- These etiological pathways lead to subpopulations of persons with serious alcohol problems (and subpopulations of DUI offenders) who present with very different patterns and profiles.

- These profiles encompass persons with primary addictive diseases (alcoholisms and other drug addictions) and persons with patterns of alcohol and other drug-related problems whose intensity and duration pose threats to public safety but which do not constitute addiction as it is traditionally defined. The evaluation of DUI offenders must extend alcoholism assessment technology to patterns of excessive, problematic and life-threatening alcohol and other drug problems.

- DUI offender evaluation technology must go beyond alcoholism assessment to identify areas of comorbidity (dimensions of psychopathology, e.g., depression, anxiety, hostility, risk-taking behavior, antisocial behavior) that increase the risk of future drinking and driving and future alcohol- and other drug-related crashes.

- The recommendation of treatment modality and setting must take into account the differential needs of these subpopulations.

- The distinguishing characteristics of all patterns of excessive alcohol use begin to diminish with chronic use, as issues of physiology begin to dominate other etiological influences. The multiple pathway model is particularly apt in guiding interventions with individuals at early and middle stages of problem development.

The following sections will briefly outline an approach to differential diagnosis, treatment planning and criminal justice management of different DUI offenders. There is no single cause of excessive alcohol use and alcoholism. Factors of physiology, psychology, culture and economics constantly interact to influence drinking patterns and drinking consequences. What is needed and what this model attempts to show is how specific etiological factors, when dominant, shape particular clinical and criminal profiles and how such profiles can be modified through combinations of particular treatment approaches and criminal justice sanctions.

Species I: Physiopathological Vulnerability

A. Etiology and Patterns. DUI offenders within Species I share an abnormal biological relationship with alcohol or other drugs. The driving force behind the onset of excessive alcohol use is rooted in an aberrant response that makes alcohol more physically reinforcing or more impairing than it is to other humans possessing a normal physical response to the drug. The magic and poison of the person-drug relationship in this species occurs at the cellular and metabolic level. This pattern has been referred to as "gamma species alcoholism" (Jellinek, 1960), "Type B" alcoholism (Babor, et al., 1992), "Type II alcoholism," "male-limited alcoholism" (Cloninger, 1987), and "primary alcoholism" (White, 1996). This pattern, described by Cloninger (1987) as male-limited or Type II alcoholism is characterized by earlier onset of alcohol use and alcohol problems and is thought to be more genetically influenced.

This pattern is characterized by heritability (revealed by extensive family histories of alcohol and other drug-related problems), early onset, high problem severity and early failed attempts at self-resolution. There are also persons who were not

genetically high risk for addiction, who once maintained a normal nonproblematic relationship with alcohol but who, following illness or trauma, experienced an altered and increasingly problematic relationship with alcohol. These two populations whose vulnerability is of physiological origin look quite different in the DUI incident. The gamma species alcoholic can demonstrate an extremely high BAC without gross signs of intoxication (including passing field sobriety tests) while the physically traumatized person may show profound levels of intoxication with a very low BAC. One has atypically high tolerance, the other atypically low tolerance. There are also persons who experience a toxic, allergic reaction to alcohol — a very rare condition called idiosyncratic intoxication in which small amounts of alcohol in a neophyte drinker can produce a toxic organic psychosis characterized by explosive violence or self-injury, with subsequent amnesia of the drinking event.

The very definition of alcoholism in the United States is a depiction of gamma species alcoholism.

The pattern of excessive drinking called "gamma species alcoholism," of all the patterns described below, warrants the moniker "alcoholism" and the descriptor "disease." Its etiology is primarily physiological. It is chronic and progressive. There are biological markers and medical sequelae that mark its advancement and frequently cause premature death. It is marked by severe psychological, legal, social, family and occupational complications.

B. Assessment Indicators. The very definition of alcoholism in the United States is a depiction of gamma species alcoholism, as is the pattern of alcoholism identified through nearly all of the traditional alcoholism assessment instruments. The major descriptors of this pattern include the following:

- A family history of heavy alcohol use and related drug problems spanning multiple generations.

- Teetotalism (alcoholism in one generation spawning radical abstinence in the following and alcoholics stopping drinking at an early stage in the progression of alcoholism).

- Intergenerational patterns of accidental deaths and deaths by suicide.

- Intergenerational history of alcohol related medical illnesses, e.g., gastritis, pancreatitis, and liver disease.

- Family history of psychiatric illness (primarily affective disorders).

- Developmental markers preceding drinking, e.g., diagnosis of attention deficit disorder or hyperkinesis in childhood, mild sociopathy.

- Early onset of drinking.

- Euphoric recall of first drink.

- Atypically high alcohol tolerance from onset enhanced by acquired tolerance, e.g., high BAC without signs of gross intoxication.

- Minimal early drinking consequences, e.g., hangovers.

- Physical craving for alcohol.

- Loss of control over alcohol (inability to predict the quantity to be consumed once drinking begins).

- Radical personality change while drinking (Dr. Jekyll/Mr. Hyde).

- High risk-taking, sensation-seeking, aggression.

- Predictable progression of symptomatology, e.g., increased frequency/ duration of blackouts, failed efforts to control drinking, failed promises and resolutions, attempts at geographical escapes.

- An elaborate cognitive defense structure (denial, minimization, rationalization, projection) designed to sustain drinking and escape the consequences of drinking.

- Increased intensity of guilt and remorse.

- Fear of insanity.

- Pervasive impairment across areas of life functioning, e.g., deteriorations in physical and emotional health, intimate and social relationships, vocational functioning.

C. Intervention and Treatment Principles. The major components of the alcoholism treatment system in the United States have been erected specifically in response to, and out of experience with, gamma species alcoholics. The framework of Alcoholics Anonymous (AA) and the assessment and treatment technology of traditional AA-oriented inpatient and outpatient alcoholism treatment programs, although they have come to embrace numerous patterns of alcoholism, were designed specifically to fit the needs and characteristics of

gamma species alcoholics. And this technology works remarkably well! There are hundreds of thousands of persons who are in long term, stable recovery from alcoholism as a result of their experience in AA and traditional alcoholism treatment. When persons fit the dominant pattern of alcoholism in the United States, they should be provided access to the treatment structures that have proved successful with its treatment.

Gamma species alcoholism can be successfully treated in both outpatient and inpatient treatment modalities with the latter generally indicated under the following circumstances:

- The client presents a history of prior unsuccessful treatment in outpatient treatment settings.
- The client requires detoxification or presents concurrent acute medical and/or psychiatric problems that require medical supervision in an inpatient setting.
- The client demonstrates no prior history in his or her ability to maintain even short periods of self-imposed sobriety.

There are hundreds of thousands of persons who are in long term, stable recovery from alcoholism as a result of their experience in A.A.

- The client is in a family and/or social milieu that has a history of undermining and sabotaging efforts at sustained abstinence.
- The client needs to be removed from the current environment for his or her own physical protection.

The major elements of traditional outpatient or inpatient treatment of gamma species alcoholism include:

- Neutralization of enabling behaviors in the family and social network that have prevented the alcoholic from experiencing the full consequences of his or her drinking.
- Exposure to hope-instilling and empowering relationships, including exposure to recovering role models.
- Therapeutic weakening of the cognitive defense structure to reduce denial, minimization, projection, etc., and create acceptance of alcoholism as a personal reality.

- A three-stage shift in identity from denial of alcohol problems to that of alcoholic and finally to that of recovering alcoholic.

- Focus of all treatment efforts on total abstinence, with recognition of risks of abuse for secondary drugs.

- Linkage and encouragement for long-term affiliation with a self-help structure, e.g., Alcoholics Anonymous.

- Utilization of early steps of AA to create acceptance of disease, generation of hope, and reduction of guilt and remorse.

- Reorganization of pathology-shaped family roles and rules and reduction of family pain.

- Detachment of client from alcohol-dominated social network and reconstruction of client's social, vocational and leisure rituals.

- Development of an active plan for relapse prevention and external monitoring of recovery progress, e.g., probation supervision with breath/urine testing.

This traditional, mainstream treatment technology should be used heavily in our response to the impaired driver because gamma species alcoholics are heavily represented in the total population of DUI offenders. As we shall see shortly, however, there are other patterns of alcoholism and alcohol-related problems for which this traditional technology is less effective.

Species II: Self-Medication of a Diagnosed or Undiagnosed Physical Illness

A. Etiology and Patterns. The onset of excessive alcohol and drug use of DUI offenders within Species II is tied to the self-medication of painful or otherwise discomforting symptoms of diagnosed or undiagnosed medical problems. While such self-medication can produce a transient relief of symptoms, the cumulative effect of this pattern may be serious alcohol-drug related problems in the lives of these clients. At the earliest stages, this is clearly a pattern of alcohol/drug abuse. In its most extreme forms, this pattern can take on the characteristics of a primary addictive disorder, particularly when alcohol is combined with other prescribed sedatives and narcotic analgesics.

Subpopulations found within this species of substance abuse include:

- Persons experiencing severe and painful medical illness or trauma who were introduced to analgesic drugs through legitimate medical treatment but who

eventually began a pattern of compulsive drug seeking and drug using behavior in search of symptom relief.

- Aged persons experiencing chronic intractable pain from a variety of debilitating illnesses.

- Women who experience severe physical and emotional discomfort related to PMS. (Women may be at increased risk within this species due to their increased propensity in this culture to receive prescriptions for sedative and analgesic medications.)

- Persons with unusual, and often undiagnosed, medical disorders who discover the effects of alcohol or drugs to be normalizing or performance enhancing.

There are other patterns of alcoholism and alcohol-related problems for which traditional technology is less effective.

B. Assessment Indicators. The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- The presence of alcohol-related problems in the absence of core symptoms of gamma species alcoholism, e.g., family history, loss of control.

- The consumption of prescribed and/or over-the-counter drugs in addition to alcohol in the DUI incident.

- A medical history revealing presence of chronic (or acute at time of DUI incident) pain from illness or injury.

- Atypical drug choices, atypical drug combinations, atypical tolerance (e.g., extended use of amphetamines without escalating dosage), and atypical patterns (timing, frequency, setting of use).

- Marked absence of euphoric effects from drug use.

- Propensity to use in isolation from other users and outside normal social rituals of use.

- Marked absence of denial related to use. (Users consciously aware of the self-medication process may defend their use with an air of self-righteousness and anger at the failure of traditional medicine to relieve their symptoms.)

- Emotional regression produced not by the alcohol/drug use but as a

consequence of chronic intractable pain.

- Atypical symptoms in detox — emergence and escalation of symptoms of the primary disorder or injury.

C. Intervention and Treatment Principles. Assessment and treatment approaches to DUI offenders reflecting the Species II pattern include the following:

- Given the likelihood of a number of mood-altering medications, often received from different physicians, a single physician may need to be involved to assess the total pattern of drug consumption as part of the DUI assessment to determine whether the offender is a high risk to public safety even if they don't drink while driving.

- This client is best referred to a medically based treatment program where the history and current status of the physical illnesses/injuries and the intensity and chronicity of substance abuse can be adequately assessed. The treatment foci in early to middle stage patterns of abuse is on developing alternative and more effective methods of symptom management and substance use/abuse education; in late stages, clients may be appropriate for primary addictive disease models of treatment.

- Aborting the pattern of dysfunctional alcohol and drug use is contingent on effective treatment or at least symptom management of the primary medical illness.

- Effective treatment regimes often involve traditional (exploration of nonsteroidal anti-inflammatory alternatives to narcotics, stretching and toning exercises, transcutaneous electrical muscle stimulation) and nontraditional (acupuncture, acupressure, hypnosis, visualization, muscle relaxation, breathing techniques) methods of pain management or referral to specialized pain control programs in conjunction with substance abuse education. The medical condition of many of these individuals would make abstinence from all mood-altering medication unrealistic.

- Specialized support groups, focusing on pain management as the primary issue, and support from treatment staff may be essential to encourage the client to explore non-drug alternatives to pain management and to prevent relapse. The relapse prevention plan must incorporate pathways of contact and support when medical symptoms worsen and pose risks of return to abusive patterns of drug consumption.

- Prevention of DUI recidivism entails not only primary treatment, but also specific education focusing on the effects of prescribed medications on

driving performance. "Knowing when to say when" for this client must encompass prescribed and over-the-counter medications in addition to alcohol.

Species III: Substance Abuse and Psychiatric Illness

A. Etiology and Patterns. There are three distinct relationships between primary psychiatric disorders and secondary patterns of excessive substance use, all of which can result in a DUI offense. In the first relationship, excessive alcohol and drug use serves to mask or hide the existence of a psychiatric illness. The function of the drug use is more symbolic (identity and esteem salvaging) than pharmacological. In the second relationship, excessive alcohol or drug use is simply one element within a cluster of symptoms that reflect the presence of a primary psychiatric disorder, e.g., excessive alcohol use as a symptom of a broader pattern of sensation-seeking and risk-taking. In the third and most common relationship, excessive alcohol and drug use serves to self-medicate discomforting symptoms of a primary psychiatric disorder.

There are three distinct relationships between primary psychiatric disorders and secondary patterns of excessive substance use.

Typical subpopulations found within the self-medicating population of DUI offenders include the following:

- *Unipolar and Bipolar Disorders.* Persons self-medicate both mania and depression with alcohol. The disinhibiting and judgment impairing effects of alcohol interact with dimensions of the psychiatric illness (sensation-seeking, risk-taking, increased aggressiveness) to elevate risks of drinking and driving and potential risks of using an automobile for suicide.

- *Schizophrenia.* Community mental health centers have long noted the propensity of the chronically mentally ill to supplement their psychotropic medication with alcohol and cannabis. Many clients with schizophrenia have learned to titrate doses of alcohol and cannabis as a supplement or alternative to their prescribed medication to relieve anxiety and fear and to sedate themselves into sleep.

- *Anxiety and Phobic Disorders.* Alcohol and cannabis have both been used by anxiety-ridden and phobic persons for their tranquilizing and disinhibiting effects.

B. Assessment Indicators. The indicators of this pattern of excessive substance use in DUI offenders include:

- A family history of psychiatric (serious mental illness) rather than substance use disorders.

- A history of psychiatric impairment that predates the onset of excessive alcohol or drug use.

- A history of psychiatric treatment, psychiatric hospitalizations and prescribed psychotropic medication.

- A weak or brittle cognitive defense structure to deny or justify use; flamboyant exaggeration of alcohol and drug use present among those masking psychiatric impairment.

- Alcohol and drug use not governed by social norms.

- Evidence of compromised mental status at time of the DUI evaluation.

C. Intervention and Treatment Principles. Assessment and treatment approaches to DUI offenders reflecting the Species III pattern include:

- Assessment and treatment is best conducted by an interdisciplinary team involving psychiatric and addiction specialists.

- Treatment at a center specializing in treating dually diagnosed clients or concurrent referral for addiction and psychiatric treatment is recommended.

- The risks to public safety must be assessed separately and distinct from the issue of diagnosable alcoholism, e.g., extent of driving impairment produced by medication, frequency and intensity of risk-taking behavior, potential use of vehicle in suicide.

- Appropriate medication and social support systems may be essential in removing the pattern of self-medication.

- Alternatives to nontraditional self-help structures should be explored, e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery, GROW, etc. (See appendix and www.bhrm.org for a directory of recovery support groups.)

The potential impact of recognizing co-occurring disorders within the DUI offender population is indicated by a study by Wells-Parker and Williams (2002) in which they were able to lower DUI recidivism 35 percent by screening for depression and adding an enhanced program (individual counseling).

Species IV: Substance Abuse and Personality Disorders

A. Etiology and Patterns. Excessive alcohol and drug use for Species IV DUI offenders emerges out of a broader pattern of antisocial behavior. Excessive alcohol and drug use is simply one element within an excitement-seeking, authority-challenging and high risk-taking lifestyle.

Excessive alcohol and drug use for Species IV DUI offenders emerges out of a broader pattern of antisocial behavior.

B. Assessment Indicators. The indicators of this pattern of excessive alcohol and drug use in DUI offenders include the following:

- Personality and behavioral profile characterized by high impulsivity, excessive risk-taking, excitement seeking, superficial charm, inability to sustain non-exploitive relationships, marked absence of guilt and remorse. disdain for authority, and propensity for aggressive and violent behavior.

- History of antisocial and criminal behavior that predates onset of substance use.

- Predatory behavior unrelated to the need for drug supply or drug intoxication.

- Legal and driving history that often reflects many non-alcohol related offenses indicative of risk-taking behavior, e.g., fleeing an officer, resisting arrest, excessive speeding tickets, running red lights, driving too fast for conditions, driving without a license.

C. Intervention and Treatment Principles. Assessment and intervention approaches to Species IV patterns of alcohol and drug use include the following:

- Use of strong and sustained external controls, e.g., two-years-plus of court supervision.

- High frequency and high visibility monitoring systems, e.g., frequent urine drops, unannounced home visits by the probation officer, high frequency of reporting, intensive forms of probation for recidivist in the community.

- High intensity and sustained duration of treatment as opposed to traditional short term treatment interventions; use of therapeutic community treatment as alternative to incarceration for recidivist.

- There is some evidence of maturing out or decreasing intensity of this style with aging; for many, our task is to minimize the risk to public safety posed by these individuals from ages 14-35.

Species V: Self-Medication of Emotional Pain

A. Etiology and Patterns. For the Species V DUI offender, the onset of excessive alcohol and drug use (and often the DUI incident) is tied to the self-medication of emotional pain related to a major developmental crisis. This subpopulation is indicated by studies noting that DUI offenders experience particular stressors in the year prior to their DUI arrest not experienced by the general population (Veneziano, Veneziano, & Fichter, 1994). Crises that have been linked to a gradual or sudden escalation of alcohol and drug consumption include the death of a parent, child, sibling, or close friend; breakup of marriage or other intimate relationship; physical loss (mastectomy, hysterectomy, onset of physical disability); sudden unemployment; or loss of land (for farmers). In most of these occurrences, alcohol and drugs are used to self-medicate the emotional pain of unresolved grief. In other cases, alcohol is used to self-medicate anxiety produced by the experience of multiple stressors within a short time frame.

Species V is a pattern of problematic alcohol use at its earliest stages that, when sustained over time, can take on many of the characteristics of a primary addictive disease, e.g., late stage gamma species alcoholism.

B. Assessment Indicators. The indicators of this pattern of alcohol and drug problems among DUI offenders include the following:

- A pattern of heavy drinking superimposed on a history of minimal and/or non-problematic alcohol use (no evidence of progression).

- Identifiable traumatizing life events that are concurrent to the onset of excessive alcohol/drug use.

- Stress-related medical problems present at the onset of self-medication, e.g., headaches, skeletal-muscular pain, chronic fatigue, disordered sleep, gastro-intestinal disorders, sudden weight changes.

- DUI event is concurrent with or shortly following a period of emotional crisis.

- A weakened defense structure, e.g., minimal efforts to hide, minimize, or rationalize use.

- Evidence of poor judgment and deterioration of overall cognitive functioning, e.g., impaired memory and concentration, increased confusion and disorientation.

- High severity when losses leave the survivor emotionally and socially isolated.

C. Intervention and Treatment Principles. Assessment and treatment approaches to Species V substance use problems include the following:

- Where the client has experienced significant loss, e.g., death of child or spouse, the evaluator should assess the intensity and duration of depression in the client and identify the presence and intensity of suicidal ideation.

Intervention with Species V substance use problems must focus on the resolution of emotional pain.

- The intervention must focus on the resolution of emotional pain. Referral to an outpatient therapist with concurrent referral for substance education would be highly appropriate for clients in early stages of this pattern.

- An essential component of the treatment intervention is an environmental manipulation to increase social supports and decrease the stressors being experienced by the client.

- The treatment strategy in addition to the resolution of grief focuses on teaching the client healthier patterns of managing stress and loss. The formal teaching of stress management techniques may be appropriate to incorporate into this treatment process.

- The role of substance education is to inform and to stigmatize drinking (and drinking and driving) as a method of problem solving.

- Alternative self-help groups are warranted when available, e.g., Parents Without Partners, SHARE.

Species VI: Family-Oriented Substance Problems

A. Etiology and Patterns. Initiating factors in the onset of substance problems among Species VI DUI offenders are rooted in family system dynamics rather than physical or psychological pathology. The driving forces and rewards for alcohol/drug misuse rest not within the individual but with the meaning and function such behavior has for the family system. Alcohol and drug problems in this species emerge from a dynamic in which the family needs symptomatic behavior (e.g., excessive substance use) to serve as a diversion from a much more painful and potentially destabilizing issue.

This pattern is particularly prevalent among adolescents, who have long been known for their proclivity to act out family system disturbances. In such cases, the misuse of alcohol does not represent a primary addictive disease process but instead represents a red flag for help for the family and a pressure valve to discharge toxic energy from the family system. Primary family system disturbances that typically create explosive adolescent substance abuse of this variety include: addiction of one or both parents, an acute medical or psychiatric illness of a key family member, sexual infidelities of one or both parents, the impending breakup of the marital dyad, family violence, and incest.

B. Assessment Indicators. The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- The intensity of the alcohol/drug use pattern is in direct proportion to the intensity of family dynamics that demand symptomatic behavior: where dysfunction is extreme, alcohol and drug use behaviors can be excessive and life-threatening, e.g., overdose, DUI related accident.

- A pattern of exaggerated and flamboyant use rather than denied or minimized use.

- Explosive onset and rapid family/community visibility, without progression or historical context.

- Emotional pain of the client is usually tied to family dynamics rather than as a consequence of alcohol/drug use.

- Alcohol and drug use may be accompanied by other acting out behaviors unrelated to the drug use, e.g., runaway behavior, sexual promiscuity, antisocial behavior.

C. Intervention and Treatment Principles. Assessment and treatment approaches to Species VI patterns of alcohol/drug abuse include the following:

- Family assessment of all DUI offenders under 18 and all DUI offenders living with their family of origin is recommended to potentially identify this pattern.

- The treatment of choice is concurrent family counseling and substance education.

- Where family pathology prevents effective engagement, focus of client counseling should be on detaching the client from his or her role in family pathology; when this strategy is used, the service agency or self-help groups may have to perform a role of surrogate family for the client.

- Family centered support groups may be particularly helpful in the long-term emotional health of these clients and families.

Emotional pain of the Species VI client is usually tied to family dynamics rather than as a consequence of alcohol or drug use.

Species VII: Peer-Oriented Abuse

A. Etiology and Patterns. The onset of excessive alcohol and drug use among DUI offenders in Species VII is tied to affiliation with a peer culture that promotes excessive drinking and/or drug use as a primary group ritual. The needs met by the excessive use of intoxicants relate to social rewards of approval, status, identity, esteem, and a sense of acceptance and belonging. Subcultures in the U.S. that have often spawned peer-oriented patterns of use include adolescent subcultures, colleges and universities, the military, and occupational or neighborhood networks that promote excessive alcohol and drug use as a group norm. Some may promote drinking but stigmatize drinking and driving, while others promote both excessive drinking as well as drinking and driving. Due to the repetitions of drinking and driving, individuals in the latter group are likely to enter the DUI offender pool.

B. Assessment Indicators. The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- Use occurs in and is sustained by group rituals.

- The DUI event is often associated with a group-related drinking event.

- Periods of absence from the group or exit from the group, e.g., military discharge or graduation, are accompanied by reduction or cessation of alcohol/drug use. The frequency and intensity of drug use are shaped by the social environment rather than by physical or psychological need.

C. Intervention and Treatment Principles. Assessment and treatment approaches to Species VII patterns of substance abuse include the following:

- Group-oriented education and treatment activities.
- Stigmatization via education about drinking-driving.
- Ego-strengthening activities, e.g., values clarification and transmission and assertiveness training.

Species VIII: Culture-Oriented Abuse

A. Etiology and Patterns. The onset and maintenance of excessive drinking for DUI offenders in Species VIII are tied to membership in, and participation in, drinking rituals of a particular ethnic or cultural group. This pattern of alcoholism is the dominant one in many European countries, e.g., Northern Italy, France, and Germany and constitutes a subcultural pattern of alcoholism in the U.S.

B. Assessment Indicators. Indicators of this pattern of drinking among DUI offenders include the following:

- Daily alcohol consumption interspersed with explosive "fiesta drinking," e.g., weddings, funerals, holidays.
- No pattern of progression.
- Inability to abstain rather than loss of control.
- Most areas of life functioning remain intact, e.g., vocational functioning.
- Marked absence of cognitive and affective defense structure, e.g., denial and guilt.
- Marked absence of key gamma species symptoms, e.g., failed efforts to control, failed promises and resolutions, geographical escapes.

Two of the most frequent problems bringing attention to this pattern are DUI arrest and the onset of serious alcohol-related medical problems.

C. Intervention and Treatment Principles. Assessment and treatment approaches to DUI offenders reflecting Species VIII patterns include the following:

- The critical questions in the treatment of cultural patterns of alcoholism are:

How does the client in his or her culture maintain status and esteem as a nondrinker? How does the culture provide permission not to drink?

- Culturally sanctioned pathways (rationales) to abstinence can vary widely, e.g., medical, religious beliefs, political beliefs.

- Educational and treatment interventions must utilize and reinforce culturally approved pathways to abstinence or at a minimum intensely stigmatize the connection between drinking and driving.

Implications of Multiple Pathway Research

This chapter has outlined a typology of DUI offenders based on the etiological roots and drinking patterns of each group. It is hoped that it conveys to the reader the diversity of profiles that make up the total pool of DUI offenders. States often undergo three stages in their understanding and response to such diversity.

It is hoped that this chapter conveys to the reader the diversity of profiles that make up the total pool of DUI offenders.

In the first stage, which most states went through in the 1960s and 1970s, DUI offenders were viewed as a dichotomous population of social drinkers and alcoholics. The evaluation task was to identify and segregate the latter group for special sentencing and rehabilitative strategies.

The lack of uniformity of evaluation tools, the high variability of evaluator competence, and ethical abuses related to a low level of problem identification for the financial profit of the evaluator led to a second stage of system standardization. This stage was marked by state-generated requirements to use a particular assessment instrument, standardized reporting formats, evaluator licensing and training requirements, and complaint and investigation processes related to unethical or incompetent conduct by evaluators. Most states experienced this standardization process in the 1980s and 1990s.

While this stage of standardization eliminated some of the earlier problems, it generated its own criticisms. Judges complained that report summaries had become so standardized that they didn't provide an adequate picture of who was being sentenced. There were concerns that problem levels were being based on one or two benchmarks (e.g., number of prior DUI arrests or BAC) rather than a comprehensive evaluation of the offender. There were concerns that the system of independent evaluators had inadvertently resulted in a decline in the rigor of

evaluations, as the most competent and rigorous evaluators were punished by decreased referrals whereas some of the least competent evaluators financially thrived in what amounted to their employment by defense attorneys.

The DUI assessment instruments gave some indication of the existence or intensity of alcohol problems but did not: 1) address drugs other than alcohol, 2) adequately identify other related problems, 3) assess future threat to public safety, and 4) provide clear recommendations for sentencing or type of treatment intervention. There were also concerns about the growing fragmentation of the DUI system and calls to create a more sophisticated system of evaluation that brought together the multiple agencies and parties charged with responding to the DUI offender.

This call for greater sophistication and coordination that most states are currently experiencing has resulted in parallel calls for more sophisticated evaluation instruments, enhanced competency of evaluators, and an integrated system that combines the resources of multiple state and private agencies to prevent and respond to alcohol- and drug-impaired driving. As states call for subtyping and more individualized approaches to prevent recidivism, it is important to note what such subtyping can and cannot achieve.

Subtyping of DUI offenders into clinical subpopulations is helpful in understanding the development and course of alcohol and other drug problems and in planning appropriate interventions (Saltstone & Poudrier, 1989), but subgroupings like the "species" outlined above do not in themselves predict DUI recidivism (Donovan, et al., 1986). Risk factors for recidivism, which we will discuss later, cross these subpopulations. As Voas (2000) suggests,

> *...individuals with one or more DUI offenses are not a homogenous group but vary from those with clear alcohol problems (high risk drinkers who drive) to those who are principally bad or reckless drivers (high-risk drivers who drink).* (p. 125)

Where we seem to be going in the United States is a growing recognition of DUI first offender subpopulations and an understanding across those populations of the factors that are most predictive of future re-arrest or involvement in a future alcohol-related crash. There is an effort to both expand the menu of DUI sentencing/intervention options and to match particular types of interventions to particular subpopulations while creating a database to evaluate the impact (recidivism rates) of these interventions on various subpopulations of offenders. This desire to provide a more sophisticated response to all DUI offenders is being joined by an emerging consensus on the need to define and contain the highest risk DUI offender. Before profiling this high-risk offender, we will examine a few other special populations of DUI offenders.

Chapter Four
Special Populations of DUI Offenders

As the last chapter noted, there are many subpopulations of DUI offenders who present with different patterns of substance abuse and who may require specialized approaches to sentencing, treatment and monitoring. In this chapter, we will briefly discuss six subpopulations of DUI offenders who can present special challenges for the DUI evaluator, the courts and treatment personnel. These subpopulations include:

- Women.
- Youthful offenders.
- Aging offenders.
- Ethnic minorities.
- Persons with medical/psychiatric disorders.
- Veterans with PTSD (Post Traumatic Stress Disorder).

Women

The increasing number of women being arrested for DUI in Illinois requires that DUI evaluators have an understanding of unique aspects of substance use disorders in women and the special needs they bring to treatment. This is particularly true in light of the fact that traditional assessment and treatment technology was based almost exclusively on experiences with men. A recent review of the literature on substance use problems among women (White, Woll, & Webber, 2003) underscores the differences in substance use problems in men and women.

- Reach higher peak blood alcohol levels than men even when weight differences are considered.

- Experience different blood alcohol levels across their menstrual cycle (women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset).

- Report drinking binges beginning or drinking increasing during the premenstrual phase.

- Develop complications of alcoholism, e.g., liver disease, after shorter periods of drinking and at lower levels of alcohol intake than men.

- Are more likely than men to be using other drugs in conjunction with beverage alcohol.

- Have patterns of alcoholism different from those exhibited by men. Phases of alcoholism for women are less distinct, begin at a later age, take less time, and are different — some early stage symptoms for men are late stage symptoms for women.

- Are much more likely to have the onset of alcoholism associated with a particular event, e.g., childbirth, breast removal, hysterectomy, family problems, death of a family member.

It is important for the DUI evaluator to understand that women may present with serious problems in their relationship with alcohol and yet the pattern of their alcohol use may look very different from traditionally defined alcoholism. Not all alcoholic women, for example, exhibit loss of control or radical personality change while drinking. Many traditionally defined symptoms of alcoholism — grandiose and aggressive behavior, geographical escapes, increased preoccupation with power and control — may be culturally shaped male adaptations to decreasing competence rather than symptoms of a disorder shared by both men and women. The focus for the evaluator should be on the consequences of drinking and drug use, rather than the frequency or quantity of drinking or congruence with a preconceived style of problem drinking.

The dominant profile of the female DUI offender is a woman between the ages of 20 and 39, single or divorced, and either employed in a service occupation or unemployed at the time of the arrest. The arrest most likely occurs between midnight and 4 a.m. and is more likely than for men to occur on a weekday rather than a weekend (Shore, McCoy, Martin, & Kuntz, 1988). Studies of female DUI offenders reveal high substance use severity and a high incidence of co-occurring psychiatric disorders (Parks, et al., 1996).

In discussing referrals for treatment services for women, the evaluator should be cognizant of the many treatment barriers for women: family enabling, financial dependence, lack of adequate childcare resources, transportation, and discomfort with male-oriented treatment philosophies and approaches. In identifying treatment resources for women, preference should be given to programs which:

- Provide case management services to address treatment obstacles, e.g., daycare, transportation, acute medical problems.

- Offer gender specific treatment and aftercare groups.

- Have treatment protocols designed to address issues of codependency and

posttraumatic stress disorder (PTSD) related to childhood sexual abuse. From 50 to 75 percent of alcoholic women report parental alcoholism; many are involved intimately with an alcoholic or addict at the time they enter treatment; and as high as 95 percent of alcoholic women report being sexually abused in childhood. (White, Woll and Webber, 2003).

- Are well-linked to women's self-help groups, e.g., women's groups in AA, Women for Sobriety.

- Provide strong family- and children-oriented services. Many authors have also noted the high incidence of depression and anxiety in alcoholic women and have proposed a self-medication of affective disorder hypothesis as the etiology of alcoholism for such women. Where concurrent psychiatric symptoms and alcohol abuse exist, referral to a program with expertise in dual disorders or simultaneous referral for substance and psychiatric evaluation would be warranted.

Women have a lower prevalence of alcoholism than men and enhanced prospects of natural or professionally assisted recoveries.

Women have a lower prevalence of alcoholism than men (*Alcohol and Health*, 1997) and, when they develop alcoholism, have enhanced prospects of natural or professionally-assisted recoveries (Anthony & Helzer, 1991; Copeland, 1988). Humphreys and his colleagues found in a follow-up study of clients eight years following discharge that the female clients were 1.63 times more likely than male clients to be in stable recovery (Humphreys, et al., 1997).

Youthful Offenders

The rise in youthful drug experimentation during the 1990s led to a dramatic increase in the number of adolescents entering treatment. Although less than 10 percent of substance dependent adolescents currently receive treatment, addiction treatment admissions for adolescents in the United States increased 53 percent between 1992 and 1998, from 96,787 to 147,899 admissions (Dennis, et al., under review; Hser, et al., 2001; OAS, 2000).

The evaluation of adolescent DUI offenders can be particularly difficult. As a culture, we have an idea of what problematic (deviant) drinking is for adults because we have social norms that prescribe such drinking in terms of timing, location, frequency and quantity and we have experience with most adults who maintain an episodic, non-problematic relationship with alcohol. Adult deviant

drinking becomes easier to identify because our picture of normal drinking is a clear one. But when we turn attention to adolescents, we are faced with the question: "What is 'normal' drinking for a 17-year-old?" While most adults would say that no drinking is normal, we are left with data in Chapter One confirming that a large percentage of adolescents do consume alcohol and yet not all of these young people have a substance use disorder or need alcoholism treatment. It is this ambiguity, and the broad range of etiologies that can produce excessive drinking (and driving) in adolescents, that pose special problems in the evaluation process.

Alcohol-related problems among adolescent DUI offenders can reflect peer-oriented patterns of abuse, can reflect family scapegoat behavior (acting out problems of family dysfunction), can emerge in response to psychiatric illness, or may indicate signs of a primary addictive disease process. Treatment interventions for all of the above patterns may be appropriate, but it is the last pattern for which we have the best-developed treatment resources. Are there warning signs that would indicate that a 17- or 19-year-old DUI offender is high risk for, and in the earliest stages of, a primary addictive disease? The author has found the following indicators predictive of this risk:

- A family history (3-5 generations) of: alcohol, drug abuse, and teetotalism; alcohol related medical problems; disproportionate number of deaths by accident and suicide; and proclivity for female family members to marry alcoholics.

- Atypically high tolerance from the onset of drinking; consistent ability to maintain a high BAC without gross signs of intoxication; atypical absence of severe hangovers during early drinking career.

- Euphoric recall of the first contact with alcohol.

- Physical attraction to a broad variety of psychoactive drugs.

- Early episodes of loss of control and radical personality change while drinking (particularly evident with early age of onset of drinking).

- Drinking outside the boundaries and rituals of the peer culture.

- The development of an elaborate cognitive defense structure (denial, rationalization, projection, etc.) to justify and minimize consequences related to drinking behavior.

Where such symptoms are evident, referral to formal 12-step oriented addiction treatment programs is highly warranted even for a young adolescent. Where the

above symptoms do not exist, the pattern of excessive alcohol use may be more appropriately addressed within the framework of substance education, affective education (activities that focus on values clarification, self-esteem enhancement, assertiveness training, etc.), or group or family counseling that includes but is not totally focused upon substance abuse.

Two recent reviews of adolescent treatment (White & Dennis, 2002; Risberg & White, 2003) drew several lessons that underscore the import and difficulty of working with the adolescent DUI offender.

- *Substance-related disorders interact synergistically with other problems of youth and families.* The co-occurrence of substance use and other personal and family problems is the norm among adolescent DUI offenders. The two primary implications of such problem co-occurrence are the need for global assessment instruments and processes and the need for treatment that can address multiple problems.

The co-occurrence of substance use and other personal and family problems is the norm among adolescent DUI offenders.

- *Many adolescents mature out of substance-related problems in the transition into adult role responsibilities.* The line between volitional substance experi-mentation and the emergence of a serious substance use disorder characterized by compulsivity and chronicity is not well understood, making it difficult for the evaluator and the courts to determine which youthful offenders would most benefit from treatment-oriented interventions.

- *For other adolescents, excessive substance use constitutes a chronic, debilitating disorder whose resolution will require multiple interventions over time.*

- *What distinguishes youth who mature out of substance use and those who go on to develop significant and prolonged substance-related problems is that the latter exhibit greater personal vulnerability (e.g., family history of substance problems, lower age of onset), experience greater problem severity, have significant co-occurring problems, and have lower levels of positive family and peer support.* In the presence of these factors, substance-involved adolescents may need significant and ongoing support to initiate and sustain recovery.

- *The earlier the intervention (in terms of age and months/years of use) with a substance use disorder, the better the clinical outcomes and the shorter the*

addiction career. These research findings suggest the potential utility of early identification and treatment of substance-related problems via the DUI evaluation process.

- *There are evidence-based, brief therapies that are effective for many substance-involved adolescents, but responses to treatment are highly variable.* Post-treatment adjustment measured by substance use patterns includes five subgroups:
  a. Continued post-treatment abstinence.
  b. Continued use at same or accelerated level.
  c. Early abstinence followed by sustained relapse.
  d. Early relapse followed by sustained recovery.
  e. Vacillation between recovery and relapse.

- *Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved functioning in the family, school, and community) and reduced substance use (to approximately 50 percent of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use*. The implication of these findings is not that treatment is ineffective for the majority of adolescents, but that, like other chronic disorders, multiple episodes of intervention may be required to resolve severe and persistent substance use disorders.

- *Most adolescents are precariously balanced between recovery and relapse in the months following treatment.* The period of greatest vulnerability for relapse is in the first 30 days following treatment; the adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment. The stability of recovery is enhanced by post-treatment monitoring and periodic recovery checkups.

- *The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome.* Adolescents who experience major relapse have the highest density of drug users in their post-treatment social milieu.

- *The post-treatment home environment also plays a significant role in recovery /relapse outcomes.*

- *All treatment programs are not the same*. Those programs with the best clinical outcomes:
  a. Treat a larger number of adolescents.
  b. Have a larger budget.
  c. Use evidence-based therapies.
  d. Offer specialized educational, vocational, and psychiatric services.

e. Employ counselors with two or more years of experience working with adolescents.
f. Offer a larger menu of youth-specific services, e.g., art therapy, recreational services.
g. Are perceived by clients as empathic allies in the recovery process.

- *Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates and their effect is dependent upon intensity and duration of participation.*

The Elderly

Many signs of alcoholism among older adults are interpreted as normal aging, e.g., cognitive impairment, depression, poor nutrition, neglect of hygiene, and impaired balance. As a result, life-threatening substance use problems are often "underestimated, underidentified, underdiagnosed, and undertreated."

Many signs of alcoholism among older adults are interpreted as normal aging.

In general, volume of alcohol consumption declines with advancing age, but alcohol exposure remains high. Community surveys reveal that more than 60 percent of adults between 60 and 94 consume alcohol. Heavy drinking is reported in 13 percent of men and 2 percent of women over 60. Some 15 percent of older alcoholics also suffer from concurrent drug dependence, e.g., benzodiazepines (Rigler, 2000). Heightened alcohol sensitivity — NIAAA recommends no more than one ounce of alcohol a day for persons over 65 — and the resulting alcohol-related injuries, e.g., vehicular accidents, hip fractures from alcohol-related falls, suicide attempts, synergistic drug interactions, antagonist drug interactions, and neutralized effectiveness of crucial medication are all hazards faced by the older alcoholic (National Institute on Alcohol Abuse and Alcoholism, 1998).

About two-thirds of elderly DUI offenders are aging alcoholics whose DUI arrest is simply one of many symptoms signaling the advanced progression of a disease process that has probably been occurring over several decades. Most of the offenders in this group began drinking at an early age and their alcohol-related problems have increased with time. Such persons often exhibit classic symptoms of alcoholism that are easily identifiable using traditional assessment instruments and procedures (Rigler, 2000). There are, however, other populations of aging DUI offenders (about one-third of older problem drinkers) who do not fit this pattern. What they share in common is a lack of risk factors (family history of alcoholism), a non-problematic relationship with alcohol through early and midlife, and the emergence of identifiable problems and consequences related to

drinking late in life (Rigler, 2000). Sometimes referred to as "late onset alcoholism," these patterns of problematic drinking vary greatly from the dominant pattern of alcoholism in the United States. Four subpopulations of aging DUI offenders are described below.

The physical capacity to metabolize alcohol and other drugs can diminish with the aging process, creating idiosyncratic or paradoxical effects. This changing tolerance to alcohol may be exacerbated if the individual is also consuming other prescribed and over-the-counter medications. The aging person's decreased efficiency in metabolizing alcohol and drugs can lead to a toxic buildup of drugs in the body, unexplained synergistic reactions between drugs and alcohol, and the sudden onset of altered alcohol tolerance, e.g., small amounts of alcohol producing profound intoxication. This person may be a long-time social drinker who suddenly finds himself or herself — in spite of the lack of change in the frequency or quantity of alcohol consumption — experiencing problems related to drinking, e.g., DUI arrest. This person's lack of a problematic drinking history, lack of prior DUI arrests and frequently low BAC will probably result — very appropriately — in placement in a remedial education program where hopefully specialized information can be provided on alcohol and aging.

The next three populations are in need of more intense intervention. With the first of these, we have individuals who are often managing chronic progressive and painful illnesses or are managing pain related to recovery from physical trauma who discover that an increase in alcohol consumption decreases their physical discomfort. This self-medication of diagnosed or undiagnosed physical illnesses with alcohol, which was described in Chapter Three, can be particularly problematic with the elderly. Changing capacities to detoxify alcohol, life-threatening synergistic drug interactions, increased vulnerability for alcohol-related medical illnesses, and the reinforcing effects of pain reduction all can create significant problems in the life of the physically impaired elderly.

Another group of high-risk elderly begin a pattern of excessive drinking to self-medicate the emotional pain of developmental losses. The onset of this pattern can be tied to the death of a spouse, the loss of children, the loss of identity via loss of employment or retirement, or the loss of one's intimate social network through death, retirement or relocation. This excessive drinking may be tied to a pathological grief and mourning reaction or may provide solace for the pain and loneliness of social isolation.

A third variation of this pattern can be seen in the socially isolated elderly who fill this social vacuum by participation in a heavy drinking subculture, e.g., local bars. These persons, who may have had little drinking history through most of their lives, may seek out drinking late in life in a bar culture or other drinking social group that fills the void of loss and loneliness. Individuals in all three groups may

find themselves in a DUI incident or experiencing other problems and consequences related to their alcohol use.

The evaluation interview should ascertain whether the pattern of alcohol problems in the elderly offender is characterized by chronicity and progression or whether the onset is of relatively recent origin. With the latter, it may be necessary to broaden the focus of the evaluation process to include a determination of the appropriate service interventions that can address both the pattern of alcohol misuse or alcoholism and the individual's risk to public safety via future drinking and driving. The following principles related to treatment of alcohol abuse and alcoholism among the elderly should help shape appropriate treatment recommendations.

The good news is that treatment outcomes for persons over 60 are as good as for those under 60.

- Assume and evaluate the presence of physical and psychiatric comorbidity (physical signs include gastrointestinal disease and bleeding, immunosuppression, elevated risk of stroke and cancer — the latter magnified by high smoking rates).

- Assess the degree of alcohol-related and age-related cognitive impairment. Older problem drinkers may require a longer duration of treatment contact due to alcohol-induced cognitive deficits.

- Look for unresolved grief and social isolation.

- Assess problems related to housing, transportation, or lack of financial resources, and evaluate expertise in self-advocacy related to health and human service systems (e.g., needs for case management).

- Try to create service integration utilizing formal and informal helping agencies and persons.

- Don't forget the critical role of the primary health care physician in long-term recovery management.

- Use pharmacotherapy, where indicated, e.g., neuroleptics in the treatment of delirium, anxiolytics and antidepressants for affective disorders, anti-craving agents (i.e., naltrexone) to reduce risk and duration of relapse.

- Utilize nutritional and megavitamin therapies to reverse malnutrition and speed reversal of alcohol-related physical pathologies.

- Like other adults, assess the family and peer social support network. Construction of an age-appropriate, sobriety-based social network is an essential element of treatment interventions for the elderly.

The good news is that treatment outcomes for persons over 60 are as good as for those under 60. Outcomes are more favorable for persons with shorter drinking histories and there is some evidence for enhanced outcomes with specialized treatment with elder focus (NIAAA, 1998).

Ethnic Minorities

There are several points that are important when working with DUI offenders who are members of an ethnic minority group. First, the DUI event must be evaluated in terms of the cultural context in which it occurs. Drinking practices and alcohol-related problems vary widely across ethnic groups (NIAAA, 2002). This drinking behavior surrounding a DUI event can reflect an ethnic pattern of drinking (e.g., what Jellinek called "fiesta drinking") or mark a break from subcultural drinking norms. Evaluating a DUI offender of Asian descent, for example, is best done with an awareness that excessive drinking, drinking problems and drinking and driving are much more rare (but increasing) among Asians than all other ethnic groups. Recognizing unique factors that may contribute to alcohol problems among ethnic minorities (e.g., acculturation stress, high density of alcohol outlets in minority neighborhoods) adds an important dimension to the evaluation of the DUI offender.

Second, ethnic minority status (and primary language and legal status) of the person being evaluated interacts with the ethnic background of the evaluator to enhance or inhibit the evaluation process. Being aware of how cultural differences can influence the interview process and using culturally congruent interview techniques will enhance the quality and outcome of the interview process.

Third, and perhaps most important, is the recognition of cultural pathways for resolving alcohol- and drug-related problems. Most cultures have evolved indigenous healers and institutions to provide aid for such problems and have evolved cultural prescriptions on how such problems can best be resolved. There is, for example, a long history of abstinence-based religious and cultural revitalization movements that have served as a conceptual framework and sobriety-based support structure for Native American alcoholics. Studies in Illinois (White, Woll, & Webber, 2003) have similarly documented the role of the church as a sobriety-based support structure for addicted African American women. For the person facing serious problems in their relationship with alcohol

and other drugs, the evaluator needs to ask, "What cultural pathways would legitimize abstinence from alcohol and other drugs for this person and allow them to maintain their membership and identity within this social world?" In some ethnic cultures, the physician can play an enormously influential role in the shift from addictive drinking to abstinence-based recovery while in other cultures their influence on this problem is negligible. Intervention and treatment outcomes will be enhanced to the extent we can align ourselves with these natural sources and styles of problem resolution.

Veterans with PTSD

DUI evaluators have long observed the over-representation of Vietnam veterans within the total pool of DUI offenders. While some veterans have substance-related problems whose etiological roots and progression are unrelated to and unaltered by their wartime experiences, other veterans may present a pattern of substance-related problems whose origin is tied to the physical and emotional trauma of war. The former group will quite likely respond to traditional intervention and treatment; the latter group may need some specialized treatment interventions. The diagnostic question for the evaluator is whether the veteran DUI offender has a pattern of chronic or delayed posttraumatic stress disorder (PTSD) that fuels excessive alcohol or drug use and/or poses a significant obstacle to treatment responsiveness and long-term recovery. Signs of PTSD that may emerge from the DUI evaluation interview include the following:

DUI evaluators have long observed the over-representation of Vietnam veterans within the total pool of DUI offenders.

- The existence of emotional trauma experienced during the war and/or upon one's re-entry into civilian life.
- A chronic recapitulation of the emotional trauma through intrusive recollections, nightmares, or flashbacks (fleeting feelings that one is back in the wartime environment) triggered by sensory or emotional cues.
- Social and emotional disengagement, psychic numbing, and constricted affect.
- Hyper-alertness and exaggerated startle responses.
- Guilt about having survived war.

- Unprovoked incidents of aggressive and violent behavior.

- Impulsive behavior, impairment of ability to sustain intimate relationships.

- Deterioration in cognitive and vocational functioning.

Many veterans with PTSD have developed a pattern of self-medicating symptoms of this disorder with excessive alcohol and drug use. When such a pattern exists, it can lead to unpredictable and ill-timed episodes of excessive drug use and personality change that resemble but are quite different from the dominant pattern of alcoholism in the United States. This pattern of PTSD self-medication is not the "loss of control" and "radical personality change while drinking" associated with "gamma species" alcoholism. In individuals who have developed this pattern of self-medication, symptoms of PTSD may escalate with sustained sobriety, increasing the likelihood of relapse. Without specialized supports to find non-drug mechanisms of symptom management, the long-term prognosis for sustained sobriety is poor.

Where patterns of PTSD exist, the DUI evaluator way wish to:

- Recommend a formal assessment of the potential existence of PTSD as a component of the DUI evaluation.

- Recommend placement in a substance abuse treatment environment that has experience working with Vietnam veterans.

- Recommend concurrent substance abuse and psychiatric treatment.

- Recommend concurrent involvement in 12-step support structures and support groups for veterans with PTSD.

Persons with Medical or Psychiatric Disorders

Occasionally a DUI evaluator interviews an offender whose medical and/or psychiatric symptoms or history are so complicated that they feel additional assessment data is essential for the court to make an informed adjudication of the pending DUI case. As noted in Chapter Three, there are clients who self-medicate symptoms of acute medical and psychiatric illnesses with alcohol and other psychoactive drugs who do not fit the traditional pattern and criteria of alcoholism, but who do pose a significant threat to public safety via driving under the influence of intoxicants. In such cases, it may be appropriate to arrange for a physical or psychiatric evaluation to accompany the evaluator's report to the court or Secretary of State. Signs that would raise the potential need for such additional evaluation would include the following:

- The offender presents a complicated medical and/or psychiatric history that raises the possibility that a pattern of self-medication exists that is not within the rational control of the offender.

- The offender presents at the time of the interview symptoms of severe physical or psychiatric illness that have not been appropriately evaluated or treated.

- There is evidence of atypical drug choices and atypical drug consumption patterns.

- The offender was medicated at the time of the DUI offense and is maintained on medication that, alone or in combination with even small quantities of alcohol, severely impair driving performance. (Cases exist in which DUI offenders are maintained on such high doses of mood altering drugs — often several concurrent prescriptions from different physicians — that these individuals are a threat to public safety while driving even if they don't drink. The evaluator must sound a warning bell in such cases.)

- The physical, emotional, and social functioning of the client deteriorates rather than improves during episodes of sustained sobriety.

- There is a marked absence of denial and evidence of grandiosity and the potential for fabrication related to self-reported drug history.

Where such signs exist, additional evaluation data may be essential to the formulation of appropriate sentencing and treatment recommendations. There are a growing number of referral sources around the country designed specifically for persons with substance-related problems that have developed out of or in tandem with physical and psychiatric illnesses.

The next chapter will discuss what is known about the most difficult DUI offender population: the multiple DUI recidivist.

Chapter Five
The Highest Risk DUI Offender

Nationally, about one-third of those arrested for DUI have a prior DUI arrest (NHTSA, 1997). Put another way, one-third of first time DUI offenders will continue to drink and drive and be re-arrested in the future. This has raised concerns about how to contain the "hard-core drinking driver" and how this high-risk individual might be identified and provided more intensive intervention the first time he or she passes through the criminal justice system on a DUI charge (Voas & Fisher, 2001).

All individuals who drive under the influence of alcohol and other drugs are "high risk" in the sense that they pose a threat to public safety, but a subgroup of these individuals pose particular high risks due to the frequency (number of repetitions of drinking and driving) and intensity (combining drinking with aggressive and reckless driving) of such behavior. In this chapter, we will try to explore the profile of this highest risk DUI offender: defining risk in terms of probability for future drinking and driving, future re-arrest for DUI and future involvement in an alcohol/drug-related crash involving injury or fatality.

The first point we should make here is that DUI recidivists and those involved in alcohol-related fatal crashes share many characteristics with DUI first offenders. Some investigators have even suggested that there are no distinguishable differences, that first offenders are simply problem drinking drivers who have not yet had a second offense and who pose as great a risk to public safety as the identified recidivist (Arstein-Kerslake & Peck, 1985). What separates single versus multiple offenders is not a set of characteristics present in one but not the other, but characteristics that exist in different degrees. For example, both groups may exhibit greater risk taking than the general population, but the recidivist may exhibit this characteristic to a much higher degree than the offender arrested for DUI who does not recidivate. Shope and Bingham (2002) have concluded that impaired driving is not an isolated behavior but is a behavior imbedded within a larger cluster of high-risk behavior (drinking driving, drugged driving, risky driving) and interlinked problems.

The profile outlined below is based on a review of the available literature. The following sources were particularly helpful in the construction of this profile: Kennedy, 1993; Hedlund, 1995; NHTSA, 2000; Timken, 1999; Perrine, Peck, & Fell, 1989; Caviola & Wuth, 2002. Items listed below without citation come from these sources or are drawn from the author's own experience over the past 30 years.

Demographic Profile

Gender. The DUI recidivist is overwhelmingly male (90-95 percent). It has been suggested that women find the legal process much more shaming than do men and thus have lower recidivism rates across most crimes (Shore, et al., 1988). Having stated this, it is important to note that the representation of women in this population has grown during the past decade. We need to discover if risk factors for women entering the recidivist pool are different from those risk factors for men.

Age. Most DUI recidivists range in age from 21 to 45; more than 75 percent are under age 40 and only 10 percent over age 50. This pattern of natural attrition or maturing out suggests strategies of containment during peak years of threat to public safety and raises the need to identify what factors lead to movement into and out of this population.

Most DUI recidivists range in age from 21 to 45; more than 75 percent are under age 40 and only 10 percent over age 50.

Education. DUI recidivists have less education (nearly half have less than a 12th grade education) than their non-recidivist counterparts. This may not be a function of lower intelligence as much as their inability to tolerate structure and authority.

Employment. DUI recidivists are more likely than their non-recidivist counterparts to present with histories of occupational impairment, e.g., patterns of unemployment, frequent job change, or seasonal or self-employment that preclude sustained supervision by others. DUI recidivists are more likely to work in non-white collar occupations; more than 70 percent have annual incomes of less than $25,000. Like education, this is not a reflection of lack of skill as much as recurring problems with authority figures. Lower educational levels also reflect lower annual income.

Marital Status. DUI recidivists are more likely than their non-recidivist counterparts to present with a history of impaired intimate relationships, e.g., inability to sustain friendships and intimate relationships as well as a pattern of conflict in such relationships. Although more than 60 percent of DUI recidivists have children, 75 to 80 percent are unmarried (single, separated, divorced or widowed) at the time of their arrest. Single, divorced and widowed offenders have higher re-arrest rates than those who are married (Lapham, Skipper, Hunt, & Chang, 2000). The pattern of failed and strained intimate relationships is also evident in some overlap between DUI recidivist and domestic battery recidivists.

Social Network. Binge-drinking drivers tend to socialize with individuals who also drink frequently and heavily (Nelson, et al., 1998).

Driving and Criminal Justice History

Prior Criminal Record. DUI recidivists have a higher percentage of prior criminal records (exclusive of impaired driving arrests) than do non-recidivists. Between 20-25 percent of prior convictions for DUI recidivists are for crimes against persons. A study of DUI recidivism in the state of New York found that prior criminal history other than prior DUI offenses was a predictor of future DUI recidivism (Nochajski, Miller, & Wieczorek, 1989).

Prior AOD-related Arrests. DUI recidivists are more likely than their non-recidivist counterparts to have prior alcohol- or other drug-related arrests that predate their first DUI arrest, e.g., illegal consumption, illegal possession, illegal transportation, criminal damage to property, disorderly conduct, public urination, assault, etc.

Number of Prior DUIs. The risk of DUI recidivism goes up in tandem with the number of prior DUI arrests (NHTSA, 1996b). Adult drivers ages 35 and older who have been arrested for impaired driving are 11 to 12 times more likely than those who have never been arrested to die eventually in crashes involving alcohol (Brewer, et al., 1994).

Driving Record. DUI recidivists are more likely than their non-recidivist counterparts to have high-risk driving records (e.g., moving violations, accidents involving personal injury or property damage, loss of insurance) and to be involved in more traffic crashes than other drivers in general and non-recidivist impaired drivers ("Drivers with," 1994). DUI recidivists are over-represented among drivers involved in fatal crashes. (The driving profile indicates a general disregard for community norms and a high degree of sensation-seeking, risk-taking, competitive speed, and driving-related hostility.) Recidivism increases with the number of DUI arrests and with the number of moving violations. There is growing evidence of an overlap between the pool of DUI recidivists and the larger pool of high-risk drivers (Wells-Parker, et al., 1986; Taxman & Piquero, 1998).

Driving on a Suspended License. DUI recidivists are more likely than their non-recidivist counterparts to not just drive on a suspended/revoked license, but to do so in ways that indicate a disregard for community norms and a high degree of sensation-seeking, risk-taking, and interpersonal aggression.

Community Response to Prior DUI. DUI recidivists are more likely to have had prior cases of arrest for DUI that resulted in long processing time before disposition and were disposed of without a conviction (Yu & Williford, 1995).

Multiple offenders are often very "system sophisticated." They have learned how to manipulate both the criminal justice system and the treatment system to avoid the consequences of their drinking and driving behavior.

Drinking and Driving Beliefs

DUI recidivists are more likely than those who do not drink and drive or one-time offenders to:

- Believe they can drive safely after consuming large quantities of alcohol as long as they drive more carefully (Caudill, et al., 1990; Nelson, et al., 1998). Those who believe they can drive safely after heavy drinking are 61 percent more likely to be re-arrested for DUI (Hingson, Hereen, & Winter, 1998).

DUI recidivists are more likely to believe they can drive after consuming large quantities of alcohol as long as they drive more carefully.

- Underestimate their level of intoxication (Beriness, Foss, & Voas, 1993).
- Make no alternative transportation arrangements before drinking (Nelson, et al., 1998).
- Experience less social disapproval from friends related to drinking and driving (Nelson, et al., 1998).
- Disagree that penalties for impaired driving should be more severe (Nelson, et al., 1998).
- See their DUI arrest as a function of bad luck or victimization by the police rather than a consequence of their own irresponsible decision to drive after drinking.

The Arrest Event

Perception of Driving Capability. Both first time and recidivist DUI offenders believed they were "okay" to drive at the time of their arrest for DUI (NHTSA, 1996).

Time of Arrest. DUI recidivists are more likely to be arrested during the day and on a weekday than their non-recidivist counterparts. Some studies have found no difference between one-time and multiple offenders on time of arrest (Yu & Williford, 1995).

Activity Prior to Arrest. DUI recidivists are more likely than their non-recidivist counterparts to be drinking alone or in groups of men and to be driving alone at the time of the arrest. Most DUI recidivists are on their way home at the time of the arrest.

Collateral Charges. DUI recidivists are more likely than their non-recidivist counterparts to have collateral charges tied to their DUI arrest, e.g., fleeing, resisting arrest, drug possession.

Blood Alcohol Content. DUI recidivists are more likely than their non-recidivist counterparts to have excessively high blood alcohol content (BAC) — .25 or greater — at the time of the arrest (*National Commission Against Drunk Driving*, 1986). The average BAC for the DUI recidivist is .20 compared to a BAC of .17 for first offenders. More than half of fatally injured DUI recidivists have a BAC of .20 or greater. Higher BAC has been shown to be a risk factor in recidivism (Simpson & Mayhew, 1991; "Drivers with," 1994) in most studies, although the difference between the BAC in first offenders and recidivists is slight in more recent studies. In a study by Davignon (2001), the average BAC for first offenders was 0.148 percent and for multiple offenders was 0.158 percent. (The mixed findings suggest the potential benefit but also the potential limitations of establishing separate sentencing sanctions and other intervention strategies for people who reach these high BACs.) What does seem to be clear is the relationship between high BAC at the time of arrest and subsequent diagnosis of alcoholism. In a study of 327 alcohol-impaired drivers, Brinkmann and colleagues (2002) found that 80 percent of those with BACs of 0.19 percent or greater met diagnostic criteria for alcohol dependence.

BAC and Signs of Intoxication. DUI recidivists are more likely than their non-recidivist counterparts to exhibit high BACs without gross signs of intoxication, e.g., less impairment in field sobriety tests in relationship to their BAC.

Refusal. DUI recidivists are more likely than their non-recidivist counterparts to refuse a Breathalyzer test and to exhibit a high degree of knowledge (or pseudo-knowledge) regarding DUI laws. Refusals increase with the number of DUI arrests and those refusing chemical testing are more likely to be re-arrested for DUI in the future. This reveals involvement in what might be called a DUI subculture through which methods of avoiding apprehension reach a remarkable degree of sophistication. The multiple offender is likely to be a member of an elaborate culture of addiction whose collective knowledge of judicial and treatment systems can be tapped to produce a well-coached performance in the evaluation interview, in the courtroom, or the treatment center.

Clinical Profile

Family History. DUI recidivists are more likely than their non-recidivist counterparts to have family trees indicating a high degree of alcohol/drug pathology, e.g., high rates of parental alcoholism, higher numbers/percentages of family members with identifiable alcohol-drug problems, and greater propensity for accidents, suicides and alcohol/drug-related medical problems as causes of death within the family tree. DUI recidivists are more likely than their non-recidivist counterparts to exhibit family histories marked by patterns of abuse and abandonment or patterns of overindulgence and overprotection.

Age of Onset. DUI recidivists are more likely than their non-recidivist coun-terparts to exhibit early age of onset of alcohol/drug use, euphoric recall of their first contact with alcohol/drugs, and higher tolerance from onset of use.

DUI recidivists are more likely to be involved in multiple drug use.

Alcohol Consumption. DUI recidivists are more likely than those without a DUI conviction or only one DUI conviction to drink more frequently, consume more alcohol per drinking episode, report having more problems related to drinking, and report that they need to cut down their drinking (Hedlund, 1995). DUI recidivists are more likely than their non-recidivist counterparts to be involved in a daily social lifestyle of male-based bar drinking.

Beer/Spirits. Most DUI recidivists prefer beer as their primary alcoholic beverage, but are more likely than the general population and their non-recidivist counterparts to consume distilled spirits as either their primary or secondary drug of choice. This preference reflects their high tissue tolerance and the need to use products with high alcohol concentrations to maintain cellular/psychological comfort.

Other Drug Use. DUI recidivists are more likely than their non-recidivist counterparts to be involved in multiple drug use — licit recreational drugs, prescribed psychoactive drugs, and illicit drugs (Osborn, 1997). While the vast majority of all DUI offenders smoke (Taxman & Piquero, 1998), the recidivist may be marked by the early onset of smoking, the amount of smoking (more than 30 cigarettes per day), high intensity of nicotine craving, smoking within five minutes of waking up, and lack of attempts to cut down or quit (John, et al., 2003). This pattern of multiple drug use suggests that the recidivists' risk to public safety is even greater than their BACs would indicate and opens the potential for the selective use of drug screens (urine) as a surveillance device for the multiple DUI offender.

Alcohol/Drug Problems. DUI recidivists are more likely to have problems with alcohol and other drugs and to have more severe problems than non-recidivists (Perrine 1990).

Prior Substance Abuse Treatment. DUI recidivists are more likely to have had prior treatment for alcohol or other drug problems, to have been noncompliant with that treatment (Peck, Arstein-Kerslake, & Helander, 1994; Nochajski, et al., 1994), and to have viewed such treatment as a "waste of time" (Timken, 1999).

Psychiatric Status/Treatment. DUI recidivists are more likely than their non-recidivist counterparts to have mental health problems and to have had some (often coerced) contact with mental health authorities. The most frequent diagnoses reflected in these histories include affective disorders (depression and bipolar disorder) and personality disorders (Cluster B: antisocial personality, borderline personality, narcissistic personality, and histrionic personality). Female DUI recidivists exhibit significant alcohol/drug and psychiatric pathology; women DUI recidivists have inordinately high representations of sexual abuse in their developmental histories — histories marked by numerous traumagenic factors (an early onset, long duration, multiple perpetrators, etc.). Such histories raise the possibility that the female DUI recidivist's excessive alcohol consumption may be tied in part to self-medication of posttraumatic stress disorder (PTSD). If confirmed, this finding would also suggest the need for more gender-specific intervention strategies.

Medical History. DUI recidivists are more likely than their non-recidivist counterparts to present with medical histories reflecting accidents, higher frequency of emergency room visits, worker compensation and disability claims.

Personality (Characterological Risks). DUI recidivists, like the entire pool of first-time DUI offenders, are made up of numerous subpopulations, but there are some shared characteristics that are over-represented in the recidivist group. The most prominent of these characteristics include:

- Diminished capacity for empathy, rendering this person inappropriate for sanctions such as a victim impact panel.

- Diminished capacity for self-observation and insight.

- Diminished capacity for emotional expression.

- An elaborate cognitive defense structure characterized by denial, minimization, rationalization, resentment, projection of blame and aggression (Caviola & Wuth, 2002).

- Impaired problem-solving, e.g., limited capacity to generate choices, diminished capacity to analyze — project outcomes and select from multiple options.

- High impulsivity combined with sensation and risk-seeking, e.g., fatalities of impaired drivers is high in part to their failure to wear seat belts (Hedlund & Fell, 1995; Caviola & Wuth, 2002).

- Minimal goal orientation.

- Diminished capacity for guilt and remorse (Farrow, 1989; Reynolds, et al., 1991).

Impaired Drivers Involved in Fatal Crashes

Profiles of drivers with prior DUI convictions who were later involved in fatal crashes reveal similarities to the DUI recidivist in numerous areas.

Profiles of drivers with prior DUI convictions who were later involved in fatal crashes reveal similarities to the DUI recidivist in numerous areas, e.g., gender (91 percent male), age (59 percent between 21 and 34; 28 percent between 35 and 54), BAC (63 percent had a BAC of 0.10 percent or higher), vehicles (older cars and trucks), type of crash (55 percent single-car crashes), timing of crash (42 percent on weekend nights), and failure to use seatbelts (75 percent) (Hedlund, 1995).

There is growing consensus that more sophisticated approaches are needed to examine how particular risk factors interact to predict DUI recidivism and future involvement in alcohol-related crashes (C'de Baca, Miller, & Lapham, 2001). This is triggering growing calls for more sophisticated evaluation instruments and processes used to evaluate DUI offenders.

The multiple offender brings not only severe alcohol problems but also a chronic self-defeating style of avoiding drinking consequences that is likely to sabotage forced attempts at rehabilitation. The goal is that the evaluation can result in an appropriate intervention that can disrupt such self-defeating styles of "doing treatment," alter the developmental trajectory of the client's alcohol and other drug problems, and eliminate the client's risk to public safety. Some key suggestions related to framing treatment recommendations for repeat offenders would include the following:

- Avoid placing the repeat offender in treatment modalities or settings that have already proven unsuccessful.

- The choice of treatment site should be made by the evaluator or court, not the offender. Offenders given a choice will "treatment shop" to find the setting that has the least potential to alter their life and lifestyle.

- Make sure that the duration and intensity of recommended treatment has a reasonable chance of success given the chronicity and intensity of the offender's pattern of substance use.

- Recommend placement in treatment settings in which staff have substantial experience and success in confronting self-defeating styles of "doing treatment."

- Communicate via your reporting that this offender needs strong external controls and monitoring to have any reasonable chance at successful treatment and to prevent future DUI offenses. (A reasonable time frame spanning movement through progressively less restrictive treatment environments and external monitoring via the court should be framed in years rather than weeks or months.)

An expanded discussion of principles for managing the high risk DUI offender can be found in Chapter Seven.

Chapter Six
Treatment and Recovery Resources and Effectiveness Research

The purpose of this chapter is to provide a brief overview of treatment and mutual aid resources that can aid in the rehabilitation of those DUI offenders who are experiencing severe problems in their relationship with alcohol and other drugs. The chapter answers some of the most frequent questions the author receives from the criminal justice, clinical and administrative personnel involved with DUI offenders.

Won't some offenders simply mature out of substance use without the aid of professional treatment or self-help groups?

Only a small portion (less than 25 percent) of those who recover from addiction do so through the vehicle of professionally-directed treatment (Knupfer, 1972; Vaillant, 1979; Sobell, et al., 1996), but there are significant differences between those who experience natural recovery (resolve these problems on their own) and those who require significant involvement with professional treatment and mutual aid groups. Natural recovery is most common in individuals with shorter and less severe drinking careers and those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell et al., 1996; Larimer & Kilmer, 2000). Treatment and mutual aid populations are distinguished by greater personal vulnerability (family history of substance-related problems, lower age of onset), greater problem severity and chronicity, co-occuring medical and psychiatric disorders, and lower "recovery capital" — internal and external resources that can help initiate and sustain sobriety (Room, 1989; Weisner, 1993; Bischof, et al., 2001; Granfield & Cloud, 1996, 1999; Tucker & Gladsjo, 1993). In summary, the greater the level of problem severity, the greater the likelihood that a DUI offender will need professional treatment and mutual aid resources to sustain sobriety and lower his or her threat to public safety.

What types of treatment are provided to persons experiencing alcohol and other drug problems?

There are more than 11,000 addiction treatment programs in the United States that specialize in the treatment of persons with alcohol and other drug problems. These programs provide services in different settings (hospitals, free-standing residential programs, outpatient clinics) and through a wide variety of methods.

The placement of individuals in different types of programs is influenced by two diagnostic and placement schemes.

Substance use disorders are catalogued in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. By defining the diagnostic criteria for various substance use disorders, the DSM-IV forms the basis for determining whether an individual has a substance use disorder and the type and severity of that disorder. Treatment approaches to these disorders are defined in the American Society of Addiction Medicine's *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders.* The ASAM Placement Criteria define five levels of care in addiction treatment:

- Level 0.5, Early Intervention.
- Level I, Outpatient Treatment.
- Level II, Intensive Outpatient/Partial Hospitalization
- Level III, Residential/Inpatient Treatment.
- Level IV, Medically-Managed Intensive Inpatient Treatment.

Within these broad levels of service is a range of specific levels of care. Admission criteria are defined for each level of care based on the following dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment.

Addiction treatment exists on a continuum from high structure and intensity (inpatient medical detoxification) to low structure and intensity (weekly outpatient counseling) and from brief interventions that span a few hours of professional contact to interventions that may last for years (methadone maintenance). Inpatient services are generally indicated for those individuals who present with:

- Substance use disorders of great intensity and/or chronicity.
- Acute medical/psychological problems that require close monitoring or care during detox and early recovery.
- A family/social environment that inhibits the initiation of sobriety, or
- A prior history of failure in outpatient addiction treatment modalities.

What occurs in treatment?

Treatment activities often consist of monitored detoxification; treatment of substance-related medical problems; nutritional and activity therapies; client and family education; individual, group and family counseling; treatment of co-occurring psychiatric disorders; linkage to community mutual aid groups such as Alcoholics Anonymous or Narcotics Anonymous; abstinence monitoring (via drug testing) and development of relapse prevention and recovery promotion plans.

What supports exist when treatment ends?

Most treatment programs offer formal aftercare groups and participation in alumni associations and also encourage continued support through local recovery mutual aid societies. There are also halfway houses, recovery homes and sober houses that help clients sustain their sobriety during the early months and years of recovery. Participation in continuing care following primary treatment is associated with improved outcomes at follow-up (Ornstein & Cherepon, 1985; Walker, et al., 1983; Cross, et al., 1990; Hawkins & Catalono, 1985; Ito & Donovan, 1986; Johnson & Herringer, 1993), but participation in aftercare groups is very low — about 20 percent of those discharged from treatment. New approaches to assertive continuing care are being pioneered that place a greater emphasis on post-treatment monitoring and recovery support services. (See later discussion.)

New approaches to continuing care are being pioneered that place a greater emphasis on post-treatment monitoring and recovery support.

What drugs are used in the treatment of addiction?

There are a growing number of pharmacological adjuncts in the treatment of addiction. These include aids in detoxification (benzodiazepines), stabilization agents (methadone, LAAM, buprenorphine), aversive agents (Antabuse-disulfram), neutralizing agents (naltrexone in the treatment of opiate addiction), anti-craving agents (naltrexone [ReVia] and acamprosate) and a variety of agents used to treat co-occuring psychiatric disorders.

How effective is addiction treatment?

Studies evaluating the effectiveness of addiction treatment have consistently found the following treatment outcomes:

- Cessation or reduction in alcohol and other drug use.
- Reduction in alcohol- and other-drug-related medical problems.
- Cessation or reduction in alcohol- and drug-related criminal activity.
- Improvements in educational and vocational functioning.
- Improvements in parental and family functioning.

This summary, however, obscures the fact that responses to treatment are highly variable. As noted in our earlier discussion of adolescent treatment outcomes, there are several distinct effects of treatment. Treatment follow-up studies find multiple outcome groupings, including those who:

- Remain continually abstinent following treatment (sustained abstinence effect).
- Remain continually abstinent and function at levels superior to those preceding onset of substance use disorder (amplified effect).
- Immediately return to pre-treatment levels of substance use (no effect).
- Decrease their use to subclinical levels (moderated effect) or experience less severe problems than before treatment (partial effect).
- Abstain initially but return to pre-treatment levels of substance use (transient effect).
- Relapse following treatment but migrate to a pattern of stable recovery (delayed effect).
- Recycle between periods of recovery and periods of relapse (ambivalent effect).
- Accelerate substance use following treatment (iatrogenic effect).

The National Institute on Drug Abuse recently released the following thirteen research-based principles of effective addiction treatment:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.

3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.

4. An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment.

Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

7. Medications (methadone, naltrexone) are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

10. Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.

12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.

13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

How can the quality of a treatment program be evaluated?

There are several benchmarks that indicate quality in the provision of addiction treatment services. Some of the most significant of these include:

- State licensure.
- Joint Commission on Accreditation of Health Organizations (JCAHO) accreditation.
- Medical/psychiatric services or linkage.
- Multidisciplinary staff; direct service staff certified as addiction counselors; supervising staff trained at M.A. to Ph.D. level.
- Prior experience with drug choice, age, ethnicity, clinical profile of client being referred.
- Use of global assessment instruments and processes.
- Diversity of treatment modalities (full continuum of care).
- Intensity of family involvement.
- Intensity of linkage to mutual aid groups and other recovery support services.
- Intensity and duration of aftercare program; presence and strength of alumni association.
- Specialized services for clients with special needs, e.g., adolescents, women, clients of color, dually diagnosed, relapsed clients.

What can the criminal justice system do to improve treatment outcomes?

The criminal justice system can exert its influence in a number of ways to improve treatment outcomes for the DUI offender. The most significant of these include:

- Using external coercion to engage the DUI offender in an assessment and treatment process.
- Monitoring treatment engagement to insure an adequate dose of treatment and to enhance the probability of successful completion of a primary course of treatment.
- Encouraging and facilitating family involvement in the treatment process.
- Monitoring and encouraging participation in a structured program of aftercare following services.

The criminal justice system can exert its influence in a number of ways to improve treatment outcomes for the DUI offender.

- Encouraging the development of a sobriety-based social support system.
- Monitoring post-treatment functioning and providing feedback, linkage to recovery supports and, when needed, early re-intervention.

Several reviews (e.g., Westermeyer, 1989) of factors affecting treatment outcome make special note of the potential role of monitoring in long-term outcomes. Such sustained monitoring takes on added significance in light of "treatment careers" research (Hser, et al., 1997), new recovery management models (White, Boyle, & Loveland, 2002), and recent studies on the potential value of post-treatment monitoring and recovery support services. These innovative studies underscore several key points:

- A single, acute intervention rarely has sufficient effect to initiate stable and enduring recovery in those with severe and persistent alcohol and other drug problems.
- Multiple episodes of treatment may be viewed not as failures but as incremental steps in the developmental process of recovery.
- Treatment effects not visible following a single episode become discernable when viewed over the longer history of treatment and recovery.

- Treatment episodes may have effects that are incremental and cumulative.

- The treatment of individuals with severe substance use disorders needs to shift from serial episodes of brief intervention to a model of sustained recovery management, e.g., active engagement, motivational enhancement, support for treatment retention, post-treatment monitoring and recovery support services, stage appropriate recovery education, active linkage to local communities of recovery, recovery checkups, and, when needed, early re-intervention and re-engagement in treatment.

What role do mutual aid societies play in the recovery process?

Alcoholics Anonymous is the most widely used community resource in the United States for the resolution of alcohol-related problems (Room, 1989; Room & Greenfield, 1993; Weisner, Greenfield, & Room, 1995). In a 1990 household survey, 3.1 percent of those interviewed reported having attended AA sometime in their life for an alcohol problem and, of those, 1.5 percent reported having attended AA in the past year — a figure that far exceeds AA's report of its current membership (Room & Greenfield, 1993). Mutual aid involvement can play a significant role in the movement from addiction to recovery for both adults (Timko, et al., 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Timko, et al, 1999; McCrady & Miller, 1993; Emrick, et al., 1993; Tucker, et al., 1994; Morgenstern, et al., 1997) and adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000).

The positive effect of mutual aid comes not from exposure alone (e.g., mandated AA attendance), but by what might be called an intensity effect. Recovery outcomes improve with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Humphreys, Moos, & Cohen, 1997; Chappel, 1993; Snow, 1992). This dose effect is significant in light of the fact that dropout rates in AA are reported to be in the range of 35-68 percent (Emrick, 1989). Other measures of intensity of involvement include active application of program concepts (e.g., "working the steps"), meeting participation (attendance, speaking, interacting, leading, having a home group), participation in pre- and post-meeting rituals, use of mutual aid network for fellowship and leisure, reading program literature, being sponsored, sponsoring others and involvement in other service work (Sheeren, 1988; Cross, et al., 1990; Johnson & Herringer, 1993; Emrick, et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, & Cohen, 1997). This intensity effect of mutual aid involvement has been found to apply to adolescents as well as adults (Margolis, Kilpatrick, & Mooney, 2000).

Aren't AA and other Twelve Step groups less effective for special populations, e.g., women, ethnic minorities?

While the original membership of AA during its formative years (1935-1939) was almost exclusively white, middle-aged men, criticisms that AA/NA and other 12-step groups are not appropriate for women, ethnic minorities, and other special populations have not held up under scientific investigation (Gilbert, 1991). Women and cultural minorities affiliate with AA/NA at the same rates as white men (Humphreys, et al., 1994) and at least one report suggests women may have an easier time affiliating with 12-step groups than men (Denzin, 1987). Recent surveys of 12-step group participation reveal no racial differences in levels of affiliation or participation (Kessler, et al., 1997; Winzelberg & Humphreys, 1999). Population surveys have revealed that AA is widely known in minority communities and recommended as a resource for alcohol problems (Caetano, 1993). AA membership surveys reveal that four percent of AA members are Hispanic and five percent of AA members are African American (Alcoholics Anonymous, 1997).

Specialized recovery mutual aid resources may enhance recovery for those who bring special obstacles or vulnerabilities to their attempts to initiate recovery.

Specialized recovery mutual aid resources may enhance recovery for those who bring special obstacles or vulnerabilities to their attempts to initiate recovery (Laudet, et al., 2000). Double Trouble in Recovery (DTR) groups or professionally directed support groups may enhance recovery for the dually diagnosed who may not be comfortable or welcomed in regular AA/NA meetings (Noordsy, et al., 1996). There is, however, recent survey evidence to suggest that individuals with comorbid psychiatric illness do affiliate with AA and that participation in AA is positively associated with stable recovery (Quimette, et al., 2001).

The assumption that the those with no or low religious orientation would not do well in 12-step programs — a practice that has led to decreased referrals of atheists and agnostics to AA (Winzelberg & Humphreys, 1999) — has been challenged by research revealing that those with low religious orientation affiliate with AA at rates similar to those with high religious orientation (Winzelberg & Humphreys, 1999) and, in some studies, do not seek out non-spiritually-based alternatives to AA/NA/CA even when available (Weiss, et al., 2000). In contrast to these findings, Tonigan, Miller, and Schermer (2002) found that atheists and agnostics were less likely to attend AA and more likely to disaffiliate from AA following initial exposure.

Kelly, Myers, and Brown (2002) conducted a study of 12-Step group affiliation among adolescents. They found that 71.6 percent of youth completing a Minnesota Model treatment program attended at least one 12-Step meeting in the first three months following treatment. It was concluded that affiliation and the positive effects from such affiliation were linked to youth with more severe AOD problems.

What about people who don't feel comfortable in AA or other 12-Step groups?

There is a growing variety of adjuncts and alternatives to 12-Step recovery groups in the United States. These include religious frameworks (Alcoholics Victorious, Mountain Movers, Alcoholics for Christ, various recovery ministries), secular frameworks (Secular Organization for Sobriety, LifeRing Secular Recovery), gender-specific support (Women for Sobriety), culturally nuanced frameworks (the Red Road, Free N' One) and moderated recovery frameworks (Moderation Management) of problem resolution. The appendix includes a guide to these mutual aid resources that is regularly updated and posted at www.bhrm.org.

Are there support services or special support meetings for particular occupational groups?

Yes. Most of these are for professions in which individuals would face special stigma if it were known that they had an alcohol or other drug problem. These groups include the Impaired Nurse Network (National Nurses Society on Addiction), Peer Assistance Network for Nurses (Illinois Nurses Association), Dentists Concerned for Dentists, Lawyers Assistance Program, Lawyers Concerned for Lawyers, International Lawyers in Alcoholics Anonymous, International Pharmacists Anonymous, Illinois State Medical Society Impaired Physician Program, and International Doctors in Alcoholics Anonymous. (See Appendix.)

What is known about the process of addiction recovery?

Recovery can reflect a process of sudden transformation or a process of incremental change. Most people resolve severe and persistent AOD problems through multiple efforts — self-resolutions, mutual aid support, and professionally directed treatment — spanning an extended period of time before final resolution is achieved (Vaillant & Milofsky, 1982). But there are individuals (as many as one-third in surveys of recovered people) whose abstinence decision occurred "immediately" rather than incrementally (Sobell, et al., 1993; Burman, 1997). Miller and C'de Baca (2001) found that this type of "quantum change" or "transformative change" is usually marked by high vividness (intensity), suddenness (unintentional), positiveness, and permanence of effect. Some of these "spontaneous" recoveries reflected quite extraordinary conversion-like exper-

iences, while others represented a seemingly insignificant experience that was the proverbial "straw that broke the camel's back." It is clear that the priming dose of negative consequences and hope-infusing experiences necessary to ignite recovery can come climactically or incrementally.

Addiction recovery often involves stages of change, processes (strategies/ mechanisms) of change, and levels (arenas, e.g., cognitive, relational) of change (DiClemente, et al., 1992). Klingemann's (1991) three-stage recovery model (motivation, action, maintenance) and Prochaska and colleagues' (1994) six-stage recovery model (precontemplation, contemplation, planning, action, maintenance, and termination) underscore the fact that the process of recovery begins *before* AOD use is moderated or terminated. They further contend that while a single, linear movement through these stages is possible, the more common pattern is a spiral pattern of repeated movements through these stages before permanent recovery is achieved.

The stability and durability of addiction recovery increases with the length of continuous sobriety.

When is a pattern of sobriety permanently sustainable?

Short periods of sobriety are not predictive of sustained sobriety. The stability and durability of addiction recovery increases with length of continuous sobriety (Vaillant, 1983). A growing number of studies are suggesting that the point at which most recoveries become fully stabilized is between four and five years (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, et al., 1989; Dawson, 1996; and Jin, et al., 1998). While relapses can and sometimes do occur in those with five or more years of sobriety, the rate of relapse is low — below 15 percent — after the achievement of five years of stable recovery.

Recovery durability differs by drug choice. Studies of heroin addicts have confirmed the instability of periods of abstinence. Studies of recovered heroin addicts found that while five years of abstinence significantly reduced the risk of future relapse, the subsequent relapse rate was higher with heroin addiction than the rates reported for alcoholism (Duvall, et al., 1963; Maddux & Desmond, 1981; Hser, et al., 2001). Those at greatest risk of relapse following the achievement of five or more years of sobriety are those with the greatest characterological problems and adverse drinking-related social consequences (Jin, et al., 1998). Once attained, recovery is more durable for those with late onset alcohol problems compared to those with early onset alcohol problems (Schutte, et al., 1994).

The best indicators of recovery stability are time, reconstruction of personal identity (presence of a 3-part story style, e.g., my life before, what happened to change it, my life now), and reconstruction of one's social network.

Won't some DUI offenders resolve their drinking problems and related legal problems without having to permanently abstain from drinking?

The ability to resolve alcohol problems through moderation rather than abstinence strategies is highly influenced by problem severity. As problem severity increases, the likelihood of a successful, sustained moderated resolution declines. A recent review (Larimer, et al., 1998) of the research on moderated outcomes for alcohol problems drew the following four conclusions:

1. Even in traditional abstinence-oriented treatment programs, some alcohol-dependent clients choose and achieve moderation goals.

2. Even when they are trained in controlled drinking, many alcohol-dependent individuals choose abstinence. Over time, rates of abstinence (as compared to controlled drinking) tend to increase.

3. Offering a choice of goals tends to result in greater treatment retention and recruitment of a broader range of problem drinkers, without increasing the risk of relapse to uncontrolled-drinking states.

4. Client characteristics, goal choice, and severity of dependence may all be related to treatment outcome (abstinence, moderation, or relapse); when given a choice, individuals tend to choose the goal that is most appropriate for them.

The fact that those who resolve alcohol problems through moderation differ from those who resolve such problems through abstinence is a crucial point further confirmed by studies of Moderation Management (MM). Klaw and Humphreys (2000) found that one-third of MM membership would not meet diagnostic criteria for an alcohol use disorder, and that of those who did, nearly all met the criteria for alcohol abuse rather than alcohol dependence. Given the earlier data presented on the level of problem severity among most DUI offenders, abstinence goals would seem most indicated for those offenders whose history indicates a significant problem with alcohol or other drugs. Individuals seeking reinstatement of driving privileges through the Secretary of State bear the burden of proof that their resolution goal (abstinence or moderation) is congruent with the intensity and duration of their drinking history/problems and that this resolution (abstinence or moderation) marks a sustainable pattern of stability rather than a brief, externally posed hiatus in their drinking career.

Chapter Seven
Managing the DUI Offender: Intervention Principles and Practices

The purpose of this last chapter is to summarize the intervention principles that the author has presented this past decade within Illinois' training programs for DUI prosecutors, judges, probation officers, evaluators and Secretary of State hearing officers. The chapter will:

- Review a large menu of strategies being used to prevent impaired driving and lower DUI recidivism and alcohol-related crashes.

- Summarize the research on the effectiveness of such strategies.

- Detail principles that can guide sentencing and monitoring, with a particular emphasis on the high-risk offender.

Unless otherwise indicated by citation, the principles are drawn from the author's own experience and the NHTSA's 2000 report, *Research on Repeat DWI Offenders* (2000b).

DUI-related public policy initiatives; public education campaigns; law enforcement, judicial, and correctional interventions; and offender-focused educational and rehabilitation approaches have multiple goals. The sentencing of DUI offenders, for example, serves multiple and different functions with different offenders: punishment, incapacitation, specific deterrence (reduction of DUI recidivism), and general deterrence (prevention of DUI offenses by the general public), and rehabilitation (NHTSA, 1996). Below is a brief summary of some of the strategies that have been used to address the threat to personal and public safety posed by alcohol- and drug-impaired driving and what research reveals about the relative effectiveness of these strategies.

I. Social Policy and Environmental Interventions

A. Alcohol Taxation. There is evidence that increases in alcohol taxes decrease traffic deaths by lowering gross alcohol consumption (Cook, 1981; Saffer & Grossman, 1987; Chaloupka, et al., 1993).

B. Density of Alcohol Sales. There is some evidence that the greater the number of per capita alcohol outlets within a community or neighborhood, the greater the

rate of alcohol-impaired driving. One study calculated that a city of 50,000 residents in Los Angeles County with 100 alcohol outlets would experience an additional 2.7 crashes for each new alcohol outlet opened (Scribner, et al., 1994).

C. Minimum Drinking Age Laws. By 1988, all states, under considerable federal encouragement, had laws declaring the legal drinking age to be 21. This reversed a trend toward the lowering of legal drinking age in the 1970s. Studies of the effect of these laws have consistently shown that raising the drinking age was accompanied by significant reductions in underage alcohol use (more than 50 percent), underage purchasing of alcohol (as much as 70 percent), and progressive reductions in impaired driving by those under age 21 (Yu & Schaket, 1998). Minimum drinking age laws that moved the legal drinking age to 21 have prevented more than 16,500 traffic deaths since 1976 (NHTSA, 1996).

D. Criminal Per Se Laws. Criminal per se laws state that it is a criminal offense to drive with a BAC above the state's legal limit. Per se laws decrease the rate of alcohol-related traffic deaths, especially when combined with administrative license revocation laws (Hingson, 1996; Rogers, 1994).

E. Zero Tolerance Laws. Laws making it illegal for individuals under age 21 to drive with any level of alcohol in their system have been passed in 49 states. A study of the effects of the first 12 states implementing zero tolerance laws found that the fatality rate for drivers between the ages of 15 and 20 dropped in comparison to neighboring states that had not implemented such laws (Hingson, et al., 1994). Overall, zero tolerance laws have produced a 20 percent reduction in the fatalities of young drivers (NIAAA, 2002).

F. Graduated Licensing. Phased assumption of full driving privileges has been used as a strategy to lower alcohol- and non-alcohol-related crashes among young people. Few systematic evaluations of graduated licensing have been conducted, but preliminary studies reveal a 5 percent to 10 percent reduction in crashes involving young drivers following state adoption of graduated licensing (Jones and Lacey, 1991; McNight, et al., 1990; Frith, et al., 1989).

G. .08 BAC Laws. Recent laws lowering the legal level of intoxication from 0.10 percent to 0.08 percent have been found to lower alcohol-related crash deaths by six percent in the years following the change in law (Hingson, 1996, Johnson & Fell, 1995; Hingson, Hereen, & Winter, 2000).

H. Penalties for Higher BACs. Some states are passing legislation that enhances the penalties for DUI offenders who are found to be driving with high BAC levels. Little research exists yet on the effects of such legislation.

I. Public Education Campaigns. Major public education campaigns were launched in the 1970s and 1980s to alter American views about drinking and driving. The success of these campaigns is indicated in the data summarized in chapter one noting the reduction in the percentage of drivers stopped at sobriety checkpoints who have been drinking, the increased use of designated drivers, and the dramatic decline in alcohol-related crashes and fatalities. Programs that involve multiple strategies focused on an entire community are a promising means for reducing alcohol-related problems. For example, fatal crashes involving alcohol dropped by 42 percent and fatal crashes in which the driver was legally intoxicated declined by 47 percent in the six Massachusetts cities participating in the Saving Lives Program, compared to the rest of the state (Hingson, et al., 1996).

J. Sobriety Checkpoints. Sobriety checkpoints have been found to reduce alcohol-related traffic crashes (Stuster & Blowers, 1995; Lacey, et al., 1997), but their effectiveness seems to hinge on the amount of publicity surrounding the checkpoint program (Lacey, et al., 1997). A sobriety checkpoint program in Tennessee decreased alcohol-related fatal crashes by 20 percent.

The effectiveness of sobriety checkpoints seems to hinge on the amount of publicity surrounding the checkpoint system.

K. "Dram Shop" Laws. Laws making it illegal to serve alcohol to patrons of bars and restaurants who are intoxicated can reduce alcohol-related crashes (Wagenaar & Holder, 1991). More than 40 states currently have such laws. These laws have spurred another strategy, server training, which is aimed at preventing intoxicated patrons from being provided additional amounts of alcohol and dissuading intoxicated patrons from driving.

L. Server Intervention Training. Field evaluations of server training have found that trained servers can generate the following results when compared to untrained servers: 1) greater number of interventions to reduce impaired driving, 2) a reduction in the number of intoxicated patrons, and 3) a reduction in overall alcohol consumption at the server site (Geller & Lehman, 1988; Saltz, 1986). Nighttime, single-vehicle crashes decreased 11 percent in the year following Oregon legislation that mandated server training (Holder & Wagenaar, 1994).

M. BAC Feedback. Providing drinkers with education and feedback about their BAC levels while they are drinking via trained interventionists and portable breathalyzers has been found to exert no influence on drinking decisions —

moderation in use — or decisions to drink and drive even when BAC levels exceeded legal limits and alternative transportation is available (Leland, 1989).

N. Controlling the Location and Quantity of Alcohol Consumption. Some states and municipalities have experimented with bans on selling cold beer at gasoline stations and bans on happy hour sales of alcohol (Hingson, 1995).

II. Interventions Aimed at Driving Privileges

A. License Suspension. States suspend the driving privileges of DUI offenders in two ways: administratively — confiscation by the arresting officer on behalf of the state license authority — or civilly — via judicial order following conviction (NHTSA, 1996). Administrative license suspension — confiscation of the driver's license of individuals arrested for impaired driving through an administrative rather than criminal process — has been found to lower DUI recidivism and alcohol-related crash fatalities (NIAAA, 2002). Administrative license suspension combined with treatment has been found to reduce recidivism by as much as 50 percent (NHTSA, 2000). The NHTSA (1996b) reports that the optimum period for suspension of driving privileges is 12 to 18 months. License suspension is *the* most effective means of reducing DUI recidivism (DeJong, et al., 1998; Voas, 2000). License suspension is more effective than license restriction or treatment, but suspension plus treatment is more effective than suspension alone**.**

The argument that license suspension/revocation is ineffective because "everyone drives on a suspended license" doesn't hold up under close analysis. While a majority of offenders with suspended/revoked licenses do drive sometime during their suspension, there is evidence to suggest that they do so with a heightened degree of caution to avoid detection — an action that also decreases the threat to public safety (Ross & Gonzales, 1988; Jacobs, 1989; Ross, 1992; Williams, et al., 1984).

B. Partial Driver's License Suspension. The use of daytime-only driving permits for convicted DUI offenders, combined with addiction treatment, have been found to be more effective in preventing future alcohol-related crashes than full driver's license suspensions (Wells-Parker, et al., 1995).

III. Vehicular Interventions

A. Automobile Immobilization, Impoundment or Seizure. Voas and colleagues (1996) found that impoundment and immobilization reduced DUI recidivism in Ohio both during and following the period of impoundment. When combined with license suspension, vehicle impoundment can reduce DUI recidivism by as much as 50 percent (Voas, 2000). Impoundment may have particularly enhanced effects on lowered recidivism of the multiple DUI offender (Voas & DeYoung, 2002).

B. License Plate Stickering. The author found no studies on the practice of issuing DUI offenders special license plates, but studies of Washington's and Oregon's "Zebra Tag" laws showed a deterrent effect in Oregon but not in Washington (Voas, & DeYoung, 2002).

C. Registration and License Plate Seizure. Plate confiscation and destruction at the time of arrest has been found to reduce recidivism by multiple DUI offenders (Rodgers, 1994), but recent studies note that there are numerous problems related to its implementation and use, e.g., legal questions regarding DUI offenders arrested driving vehicles that belong to someone else — 32 percent of DUI offenders in a study in Minnesota (Ross, Simon, & Clearly, 2003).

Many states have enhanced penalties for impaired driving with a recent focus on penalty enhancement for multiple offenders.

D. Breath Ignition Interlock Devices. Ignition interlock is an effective deterrent to drinking and driving while the interlock device remains on the vehicle of the DUI offender (Beck, et al., 1997; Cohen and Larkin, 1998) and has enhanced effectiveness when combined with other interventions such as treatment (Marques & Voas, 1995; Timken, 1999). Implementation of interlock programs has been plagued by low use as a sentencing option, failure of those sentenced to get interlock devices installed, the use of multiple, undeclared vehicles by the repeat offender, and reduced deterrent effects once the device is removed (DeYoung, 2002).

IV. Interventions (Containment and Rehabilitation) of the DUI Offender

A. Enhanced Penalties. Many states have enhanced penalties for impaired driving with a recent focus on penalty enhancement for multiple offenders.

B. Lower BAC Laws for DUI Offenders. An evaluation of Maine's law reducing legal level of intoxication to 0.05 percent for convicted DUI offenders resulted in reduced alcohol-related fatalities in this group (NIAAA, 2002).

C. Dedicated Prosecutors, Judges and Probation Officers. There is a clear trend in Illinois to supervise a larger number of DUI offenders within the framework of a specialized probation caseload — nearly 30 percent of DUI offenders in 1997 were monitored by a probation officer with a specialized DUI caseload (Olson, 1999b). Overall, DUI offenders are good candidates for probation. They have the lowest rate of probation revocation and re-arrest of any category of criminal

offense. An Illinois study to identify risk factors to predict recidivism and re-arrest found only one factor — prior criminal offense — predictive of probation failure for DUI (Olson, 1999a).

D. Intensified Probation. Programs in which DUI offenders are rigorously evaluated, linked to treatment and provided sustained, high intensity monitoring by addiction-trained probation officers have been found to reduce recidivism by nearly 50 percent (Jones, et al., 1996). Where the frequency and intensity of contact is low, there is no effect on recidivism (Voas & Truppetts, 1990). In some studies, rigorous monitoring has had an effect almost equal to that of treatment in reducing recidivism (Voas & Tippetts, 1990). While short-term follow-ups of probation supervision for DUI offenders sometimes reveals no effect, the longer-term — 6-9 years — evaluations do show an effect on lowering recidivism (Landrum, et al., 1982).

E. Fines. In spite of the widespread use of fines to punish DUI offenders, little research exists to measure the effect of the amount of the fine on DUI recidivism (Voas & Fisher, 2001). In one study, Yu (1994) concluded that the poor enforcement of fine collection has eroded the potential effect of fines as a sanction in DUI cases.

F. Electronically Monitored House Arrest. Containment of DUI offenders in their own homes except to go to work and participate in treatment and mutual aid groups has been found to reduce DUI recidivism (Baumer & Mendelsohn, 1992). Some jurisdictions are experimenting with house arrest and electronic monitoring with a remote Breathalyzer to enforce no drinking probation orders.

G. Jail. Jail has been shown to have little impact on reducing DUI recidivism (Voas, 2000; Voas & Fisher, 2002) but may serve two other functions: 1) protecting the community from high-risk offender behavior for a prescribed period of time, and 2) creating a broader deterrent effect among drinking drivers not yet arrested for DUI. When jail and comparable periods of residential treatment are compared, the jail-only group has twice the recidivism rate of the treatment group (McCarty & Argeriou, 1988).

H. Victim Impact Panels. Studies of the effect of victim impact panels (VIPs) on DUI offender recidivism have produced mixed results (NIAAA, 2002), with some studies showing cost-effective changes in attitudes and intentions and lowered rates of recidivism (Badovinac, 1994; Fors & Rojek, 1999) and other studies showing minimal or no effect (Shinar & Compton, 1995). Where effects on recidivism have been shown, they are for persons with lower problem severity without prior DUIs (Timken, 1999). One recent study suggests that VIPs may have a negative effect in terms of recidivism risk in female repeat offenders (C'de Baca, et al., 2001).

I. Intensified Assessment/Intervention. The Weekend Intervention Program (WIP) in Ohio uses an intensive assessment process and an individualized remediation/treatment plan developed over the course of a weekend. For offenders with serious substance-related problems, the weekend is followed by linkage to more extensive treatment. WIP participants have been found to have lower recidivism rates than matched control groups (Siegel, 1985).

J. Remedial Education. The NHTSA, in its review of the effectiveness of remedial education in lowering DUI recidivism, concluded that remedial education can reduce recidivism — by about 10 percent — among those social drinkers least likely to re-offend but that remedial education has no significant impact on the majority of DUI offenders who have alcohol or other drug problems (NHTSA, 1996b). In the most vigorous evaluation of early remedial education programs, it was discovered that there were no significant reductions in re-arrest rates compared to offenders who did not have remedial education (Nichols & Ellingstad, 1978). Educational interventions are much more appropriate for low-problem offenders than high-problem offenders (Foon, 1988).

Educational interventions are much more appropriate for low-problem offenders than high-problem offenders.

K. Treatment. Wells-Parker and colleagues (1985) conducted a meta-analysis of 225 DUI treatment outcome studies and concluded that treatment could reduce the recidivism rate of DUI offenders by about seven to nine percent. While there is growing interest in dedicated detention or rehabilitative confinement (treatment while incarcerated) of the multiple DUI offender, few studies exist to measure the effectiveness of such a combination. Treatment has a greater effect on first offenders with alcohol problems than on multiple offenders. What effect treatment does exert on multiple offenders is also less sustained than the effects on first offenders (Voas & Tippetts, 1990), leading reviewers such as Taxman & Piquero (1998) to conclude that remedial education and treatment have little effect on reducing DUI recidivism and future alcohol-related crash involvement.

L. Mandated Exposure to a Recovery Mutual Aid Group. There have been several studies of the effects of mandated AA attendance for DUI offenders. A 1991 New Jersey study found that mandated AA was a cost-effective means of lowering DUI recidivism and that its effect on recidivism was equal to that of treatment (Green, et al., 1991). Mandated AA exposure should be selective rather than

indiscriminate to both enhance the probability of rehabilitative effect and to prevent potential disruption of local AA meetings (NHTSA, 1996).

M. Alcohol and other Drug Testing. Drug testing is viewed as an effective monitoring tool but studies are lacking regarding its precise effect on recidivism and crashes.

N. Public Shaming. Several efforts have been undertaken to try to shame individuals out of certain behaviors by publicly exposing their breach in social etiquette. While printing the names or photographs of those arrested for certain crimes — e.g., shoplifting, prostitution — has been linked to decreased offenses, no such decrease has been reported when the names or photographs of those arrested for DUI are printed in local newspapers (Ross & White, 1987).

O. "Scared Straight." There are no evaluations of programs that try to scare offenders out of drinking and driving via such sanctions as mandated time in an emergency trauma center.

P. Community Service. Studies of the effectiveness of community service programs have not found any direct effects on reductions in DUI recidivism (Popkin & Wells-Parker, 1994).

Q. Victim Restitution. There are no controlled studies of the effects of having DUI offenders pay financial restitution to the victims of their offense (Popkin & Wells-Parker, 1994).

The High Risk Offender: Intervention Principles

The *1996 Guide to Sentencing DUI Offenders* prepared by the NHTSA listed five keys to lowering DUI recidivism:

1. Evaluating offenders for alcohol-related problems and recidivism risk.

2. Selecting appropriate sanctions and remedies for each offender.

3. Including provisions for appropriate alcoholism treatment in the sentencing order for offenders who require treatment.

4. Monitoring the offender's compliance with treatment.

5. Acting swiftly to correct noncompliance.

These keys are crucial for all DUI offenders but there are additional principles that may be helpful to those working with high-risk DUI offenders — defined as

those most likely to be re-arrested or involved in future alcohol-related crashes involving injuries or fatalities. The author would like to leave the reader with some final thoughts on such principles.

Visibility Principle (Re-engineering Community Norms)

The effectiveness of DUI-related social policy changes is often linked to the intense publicity surrounding the change and the subsequent intensification of public disapproval of drinking and driving. Intensified or new approaches (e.g., sobriety checkpoints) to enforcement seem to be effective (impacting DUI incidence and alcohol-related crash and fatality rates) only to the degree extensive publicity changes the perception of likelihood of arrest for drinking and driving and further shifts community norms against drinking and driving. With this in mind, prosecutors, judges and other court personnel, treatment personnel and Secretary of State personnel should take every opportunity to stigmatize drinking and driving at the level of the media.

The intensity and duration of sanctions and rehabilitation activities need to reflect the severity and duration of the substance-related problem.

Dose Principle

The intensity and duration of sanctions and rehabilitation activities need to reflect the severity and/or duration of the substance-related problem (NHTSA, 1996). Treatment effectiveness — like antibiotic treatment — is dependent on achieving a baseline dose. For those presenting with high problem severity, the treatment and monitoring process should reflect high structure, high intensity (frequency of contact), and long duration of active treatment and post-treatment monitoring.

Intensity Principle

Remedial education programs are most effective at reducing recidivism with educated, social drinkers. Lecture-type educational programs are not effective with problem drinkers. Behavioral change often occurs in context of a crisis of emotional intensity in which there is a fundamental redefinition of the person-drug relationship. These crises usually involve aspects of both pain and hope. Our job with the DUI offender with serious substance use problems is to help provoke just such a crisis and to create interventions that demand a high level of personal participation by the offender. At all costs, we must avoid palliatives that allow the serious offender to “do treatment” via superficial compliance.

Combination Principle

I am frequently asked variations on the following question: "Which is the most effective sentence for a DUI offender: licensure suspension, a fine, a jail sentence, probation, treatment, community service or a victim impact panel?" I usually respond, "Any combination of those." The reason is that DUI offenders and DUI recidivists are not homogenous populations and that different approaches work better with different offenders. The problem is that we have yet to develop effective technology that scientifically matches each offender to the ideal sentence and rehabilitative strategy. As a result, combinations of interventions are always more effective in the long run than single interventions. Recommended approaches to multiple offenders involve a combination of license suspension/revocation, treatment, and criminal sanctions. Mandated and monitored treatment should be viewed as an adjunct to, not a replacement for, other court sanctions. Remember, combinations of interventions generate better outcomes than any single intervention.

Motivation Principle

Popular wisdom says that people must want to change before change can occur. There is little research support for requiring expressed motivation as a precondition for entry into treatment. The presence or absence of such motivation is not a predictor of treatment outcome. Many studies have found that those who were "forced" into treatment had outcomes similar to those who supposedly "volunteered" for treatment. Motivation is important for recovery but it is something that can emerge out of the treatment process rather than be a requirement for treatment admission.

An environmental context for recovery can be set by refusing to tolerate or dismiss consequences of irresponsible behavior — a refusal to enable by protecting or rescuing — while keeping a doorway of hope open by making the length and severity of consequences contingent upon pro-recovery and pro-social behaviors. We can provide meaningful consequences while continuing to express an expectation for change, express confidence in the offender's ability to change, monitor the presence or absence of significant change and, where necessary, re-intervene with rewards contingent upon recovery adherence.

Multiple Points of Accountability

One of the most effective methods of managing higher risk DUI offenders in the community is through a system that requires multiple points of accountability with rewards and punishments contingent on clearly defined behavioral objectives, e.g., drug test results, aftercare meeting attendance, employment,

restitution payments, etc. Most high-risk offenders have little internal locus of control of their behavior, due to their impaired decision-making abilities, impulsivity and propensity for risk-taking and sensation-seeking. Multiple points of accountability provide strong and sustained "external locus of control." This can be provided via "multiple call-backs or assignment to intensive probation" — a strategy not needed for all DUI offenders but one that is recommended for the highest risk offenders being supervised in the community.

Drinking Relapse versus Drinking and Driving Relapse

Managing relapse is a difficult process for both court personnel and treatment personnel. Here are some brief thoughts on this subject. First, most people in successful recovery from alcohol and other drug problems experienced one or more episodes of relapse before achieving stable sobriety. Recovery is a long-term process that for many involves reduced number, frequency, intensity and duration of relapse episodes that precede continuous sobriety. At the same time, the court cannot tolerate clients who continue to defy its orders and pose a threat to community safety. Given these dual realities, I suggest the following. Consider differential consequences between a drinking relapse and a drinking and driving relapse. The former can be responded to with minor consequences and admonitions to reactivate and strengthen recovery activities, where a clear "no tolerance" message should accompany the latter. The goal is to drive a wedge between the act of drinking and the act of drinking and driving. Where the latter may require the courts' most immediate and severe sanctions, the former can be responded to via: 1) sentence with portion to be served or dropped contingent upon recovery activities and results of urine drops, 2) increased urine surveillance, 3) more intense monitoring and support, 4) progressive discipline (announcing next consequence ahead of time), 5) requiring a drug-free living environment, and 6) recommending a higher level of care in treatment.

Managing relapse is a difficult process for both court personnel and treatment personnel.

Containment Principle

The final principle is based on the recognition that there are some DUI offenders for whom no rehabilitative strategies will reduce the frequency or intensity of their alcohol or drug use and their related threats to public safety. The goal for this group is to contain them for the maximum periods of time with no illusion of rehabilitative effect. The goal is to protect the community for the longest period of time with the hopes that such high-risk behavior will dissipate with age and accumulating consequences. When jail is used under these circumstances, it is

used with the understanding that the offender's threat to public safety will be just as great or greater on the day that he/she re-enters the community as when he/she left it. Some judges are finding creative ways to construct sentences so that there is actually external monitoring that begins at this point of community re-entry, e.g., combining jail and probation sentences for different offenses.

For high-risk offenders in the community, the goal is to combine interventions to reduce the frequency and quantity of alcohol and drug use (e.g., urine testing, remote Breathalyzers), contain where drinking occurs (house arrest), reduce the risk of drinking and driving (e.g., vehicle seizure, interlock devices), and reduce larger threats to community safety (e.g., intensive probation).

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Appendix
The Kurtz Guide to Mutual Aid Resources

Note: The following Guide was retrieved from the Behavioral Health Recovery Management Web site (www.bhrm.org) on May 7, 2004, and is reprinted here in its entirety with permission from the authors. The information in the Guide is updated periodically.

Guide to the Development of Mutual Aid Groups

Acknowledgement

This guide to utilizing mutual aid groups was developed by Linda and Ernie Kurtz for the Behavioral Health Recovery Management project. Linda Kurtz, D.P.A., is the author of *Self-help and Support Groups: A Handbook for Practitioners*; Ernest Kurtz, Ph.D., authored *Not God: A History of Alcoholics Anonymous* and is co-author of *The Spirituality of Imperfection*.

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This page was last updated May 4, 2004.

Problems at the time of the last update: None

Worth special notice:

- On Dr. John Grohol's site Grohol there is an excellent specialized search engine, Enpsychlopedia, that offers a Google-based search interface to Psych Central, as well as a dozen other mental health and psychology Web sites. It allows for easy, targeted queries on specific health topics, such as narrowing a search to only symptoms or treatments.

- Women for Sobriety announce their Annual Weekend Conference to be held at DeSales University, Center Valley, PA, the weekend of June 4-6, 2000. See WFS Site.

- The Methadone Anonymous site, run by the Advocates for the Integration of Recovery and Methadone A.F.I.R.M. currently features a letter from founder Fredrick W. Christie. Meanwhile a new group, the National Alliance of Methadone Advocates has begun a website: National Alliance of Methadone

Advocates As its name indicates, "The primary objective of NAMA is to advocate for the patient in treatment by destigmatizing and empowering methadone patients." As these are relatively new groups to us, we ask for comments on anyone's experience with these groups. mailto:kurtzern@umich.edu

- The J.A.C.S. site currently offers "New Statistics about Addiction in the Jewish Community" New Statistics about Addiction in the Jewish Community

Contents:

- Group-Based Mutual Aid Resources
- Internet-Focused Mutual Aid Resources
- Evidence of Mutual Support Group Effectiveness
- Encouraging Local Group Development
- Problems and Pitfalls In Working With Mutual-Aid Groups
- Indicators of Mutual Help Involvement
- Aids to Working With Mutual-Aid Groups
- The Question of Responsibility
- Recommended Reading
- References

Group-Based Mutual Aid Resources

Al-Anon Family Groups

International. 32,000 + groups. Fellowship of men, women and children whose lives have been affected by the compulsive drinking of a family member or friend. Contact: Al-Anon Family Groups, Inc., 1600 Corporate Landing Parkway, Virginia Beach, VA 23454-5617. Call (757)563-1600 or (888)-4ALANON (meeting information, M-F, 8 AM-6 PM ET) FAX: (757)563-1655. Web: Online http://www.al-anon.alateen.org. **Refer**: In general Al-Anon groups prefer that only family and friends of alcoholics attend their meetings. In Al-Anon, the focus is on the participant, not the alcoholic. All family members children, spouses, parents and friends or employers are welcome.

Alcoholics Anonymous

International. 98,710 groups. Founded 1935. Fellowship of men and women who come together to share their experience strength and hope. General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163. Call (212)870-3400; FAX: (212)870-3003. Web: http://www.aa.org. **Refer**: Despite much research, there have never been reliable guidelines about which people do well in AA. Those with higher group affiliation needs have an easier time bonding; referring a less group-oriented person requires extra effort on the clinician's part. Always refer to a person rather than sending to a meeting,

especially those who have low needs for group membership.

Deaf and Hard of Hearing 12 Step Recovery Resources

A web site rather than a group, this site provides information on AA groups and activities that offer American Sign Language services for the deaf and hard of hearing. It links to online meetings, offers information on how to construct a meeting for deaf and hard of hearing persons, provides an information packet, and suggests guidelines and literature on alcoholics with special needs . It may be found at http://www.dhh12s.com/index.htm.

Cocaine Anonymous

International, with an estimated (1996) 30,000 members in over 2,000 groups. "Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from addiction. The only requirement for membership is a desire to stop using cocaine and all other mind-altering substances." The same guidelines apply to CA as to AA when making referrals Further information is available at http://www.ca.org/

Depression and Bi-Polar Support Alliance

National. 275 chapters. Founded 1986. Mutual support and information for persons with depressive and manic-depressive illness and their families. Public education on the nature of depressive illnesses. Annual conferences, chapter development guidelines. Quarterly newsletter. Bookstore, catalog, mail orders. Contact: Depression and Bipolar Support Alliance, 730 N. Franklin, Suite 501, Chicago, IL 60610. Dues $20 for client; $100 for professional. 60610. Call (800)826-3632 or (312)642-0049; FAX: (312)642-7243. Web: http://www.dbsalliance.org/. The home page of this web site offers screening tools for Bipolar Disorder and Depression. **Refer**: The Alliances's membership includes patients with the diagnosis, family members, and professionals. Anyone with a diagnosis of Affective Disorder (Manic Depressive, Major Depression) is eligible as are families and concerned professionals. Although persons currently not stable on medications are allowed, referral should be limited to those who are relatively stable.

Double Trouble in Recovery

Founded in 1993 and with groups in seven states, Double Trouble in Recovery (DTR), "a recovery group for the dually diagnosed," is a twelve-step fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problems and help others to recover from their particular addiction(s) and manage their mental disorder(s). **Contact**: http://www.doubletroubleinrecovery.org/. This site is rich in resources, including a "Pamphlet for Professionals" and some excellent material on sponsorship in recovery. This group may also be reached at Double Trouble in Recovery, Inc.,

261 Central Avenue, Albany, New York 12206, 1-866-836-7251. **Refer**: "... those recovering from mental disorders and addiction problems. . .[they] also address the problems and benefits associated with psychiatric medication."

Dual Recovery Anonymous

International. 312 chapters listed on website. Founded in 1989 in Kansas City, Missouri. DRA is an independent, twelve step, self-help organization for people with a dual diagnosis. Contact Dual Recovery Anonymous World Service Central Office, P.O. Box 218232, Nashville, TN 37221-8232. Toll Free 1-877-883-2332. Web: http://draonline.org Local meetings are listed on the website by state. Refer: People who are chemically dependent and also affected by an emotional or psychiatric illness.

Emotions Anonymous

International. 1200 chapters. Founded in 1971. 12-Step fellowship of people who come together for the purpose of working toward recovery from emotional difficulties. Contact: E.A., PO Box 4245, St. Paul, MN 55104. Phone: (651)647-9712. Web: http://www.EmotionsAnonymous.org. **Refer**: EA is most suitable for clients who are dually diagnosed and already attend AA or NA and clients who want to use the 12 steps for emotional concerns not limited by diagnosis. It is not the best group for people with serious and persistent mental illness, but EA groups are accepting of these clients if they are stable.

Families Anonymous

International, over 500 groups, founded in 1971 and headquartered in Culver City, CA, "Families Anonymous (FA) is a Twelve-Step, self help, recovery program and fellowship of support groups for relatives and friends of those who have alcohol, drug or behavioral problems." **Contact**: Its literature is available from FA, Inc., P.O. Box 3475, Culver City, CA 90231-3475, and its World Service Office can be reached at 1-800-736-9805, between 10 AM and 4 PM PST, or by e-mail at famanon@FamiliesAnonymous.org. The Families Anonymous website, http://www.familiesanonymous.org/, offers information on meetings, literature, and an e-meeting. **Refer**: Parents concerned with drug and alcohol abuse to minor behavioral problems, runaways, hostility, delinquency, truancy, low self-esteem, and other related topics.

Gamblers Anonymous

International. Approximately 1200 chapters. Founded 1957. Fellowship of men and women who share experience, strength and hope with each other to recover from compulsive gambling by following a 12-step program. Chapter development kit. Monthly bulletin for members. Contact: G.A., P.O. Box 17173, Los Angeles, CA 90017. Call (213)386-8789; FAX: (213)386-0030. Web: http://www.gamblersanonymous.org. **Refer**: The same guidelines apply to GA as to AA in making referrals.

Gam-Anon Family Groups

International. 500 groups. Founded 1960. 12-step fellowship for men and women who are husbands, wives, relatives or close friends of compulsive gamblers who have been affected by the gambling problem. Purpose is to learn acceptance and understanding of the gambling illness, and to use the program to rebuild lives, and give assistance to those who suffer. Contact: Gam-Anon, P.O Box 157, Whitestone, NY 11357. Call (718)352-1671 (Tues. and Thurs., 9am-5pm); FAX: (718)746-2571. Web: http://www.gam-anon.org/ **Refer**: Follow same guidelines as Al-Anon Family Groups.

GROW, Inc.

GROW, Inc.International. 143 groups in IL, NJ and RI. Founded in 1957. 12-step (not the same steps as AA) mutual help program to provide know-how for avoiding and recovering from depression, anxiety and other mental health problems. Caring and sharing community to attain emotional maturity, personal responsibility, and recovery from mental illness. GROW, International was organized in Australia; it has no official website for the international organization, however, there is a website for GROW in Australia at http://www.growint.org.au/ Leadership training and consultation to develop new groups. Contact: GROW, Inc., 2403 W. Springfield Ave., Box 3667, Champaign, IL 61826. Call (217)352-6989; FAX: (217)352-8530. Refer: GROW was organized for seriously mentally ill people and if you are in an area where there are groups, this is probably the self-help group most adapted to serving the client with serious mental illness and most difficulty with community living. GROW uses some paid organizers who are committed to developing a supportive community for members.

J.A.C.S.

Jewish Alcoholics, Chemically Dependent Persons and Significant Others. International. c. 50 groups. Aims to help Jews understand alcoholism and especially how to integrate Alcoholics Anonymous with their Judaism. Contact J.A.C.S., 850 Seventh Avenue, New York, NY 10010. Phone: 212-397-4197; Fax: 212-489-6229; Web: http://www.jacsweb.org. **Refer**: Jewish clients with alcohol and/or drug problems, especially if they have difficulty with the spirituality of A.A. or N.A.

LifeRing Secular Recovery

International; c. 50 groups; split off from Secular Organizations for Sobriety (see below) in 1997; LifeRing offers meetings in many States as well as Canada and Europe. Web: http://www.unhooked.com, which contains explanations of LifeRing's basic philosophy, the three "S" of Sobriety, Secularity, Self-Help. "LifeRing Secular Recovery (LifeRing or LSR) is a non-religious self-help recovery network for individuals who seek group support to achieve abstinence from alcohol and other addictive drugs, or who are in relationships where chemical dependency is a problem." **Refer:** Those dissatisfied with more classic

modalities of recovery. LifeRing encourages crosstalk and direct feedback at meetings.

Moderation Management

National. 50 groups. Founded 1993. Support for problem drinkers who want to reduce their drinking and make other positive lifestyle changes. For those who have experienced mild to moderate levels of alcohol-related problems. Literature, support group meetings, on-line support group and handbook available. Assistance in starting new groups. Contact: Moderation Management Network Inc., PO Box 3055, Point Pleasant NJ 08742, Phone: 732-295-0949, E-mail: moderation@moderation.org. Web: http://moderation.org. **Refer**: MM is for people who want to limit their alcohol intake without total abstinence. Refer anyone who chooses this goal. MM requires that participants begin with abstinence for 30 days and recommends AA or another abstinence program for those who cannot fulfill this requirement. It is not intended for use by alcoholics. MM has few groups nationwide and is more available on line.

N.A.M.I. (National Alliance for the Mentally Ill)

National. Over 1200 affiliates. Founded 1979. Network of self-help groups for relatives and individuals affected by mental illness. Emotional and educational support. Bi-monthly newsletter, affiliate development guidelines. Anti-discrimination campaign. Contact: National Alliance for the Mentally Ill, Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042; Toll Free HelpLine-1-800-950-NAMI (6264); Front Desk-(703)524-7600; FAX-(703)524-9094; TDD 703/516-7227; Web: http://www.nami.org **Refer**: NAMI is composed of parents and other family members of persons with serious mental illness (Schizophrenia, Affective Disorders, Borderline Personality) and of persons with mental illness. Most members (80 %) are parents of adult children with mental illness. This organization is primarily oriented to support and advocacy and is most effective with parents of newly diagnosed individuals. They receive needed information, support, and advocacy in obtaining the best treatment available.

Narcotics Anonymous

International. 21,000+ groups. Founded 1953. Fellowship of men and women who come together for the purpose of sharing their recovery from drug abuse. There are no dues, fees, or registration requirements. The only requirement for membership is the desire to stop using drugs. Uses 12-Step program adapted from AA. Information is available in several languages, on audio tapes and in Braille. Contact: N.A., P.O. Box 9999, Van Nuys, CA 91409. Call (818)773-9999; FAX: (818)700-0700 Web: http://www.na.org. **Refer**: Anyone who abuses alcohol or other drugs is welcome in NA. In general, the NA membership is younger and more diverse than is AA, but otherwise the same guidelines apply to NA as to AA in making referrals.

Nicotine Anonymous

"Nicotine Anonymous is a fellowship of men and women helping each other to live our lives free of nicotine. . . . The only requirement for membership is the desire to stop using nicotine." What information is available on this group may be obtained from http://www.nicotine-anonymous.org/ or by contacting Nicotine Anonymous World Services, 419 Main Street, PMB#370, Huntington Beach, CA 92648. (415) 750-0328 or by e-mail at info@nicotine-anonymous.org.

Obsessive-Compulsive Foundation, Inc.

International. 8 chapters. Founded 1986. Support and education for people with obsessive-compulsive disorder (OCD) and related disorders, their families, friends and professionals. Supports research into the causes and effective treatments of these disorders. Bi-monthly newsletter, free packets with treatment and support group information, annual conference, books, audio and video tapes. Trains mental health professionals in the latest treatment techniques. Contact: Obsessive-Compulsive Foundation, Inc., 337 Notch Hill Road, North Branford, CT 06471; Voice: 203:315-2190; Fax: 203:315-2196; E-mail: info@ocfoundation.org. Web: http://ocfoundation.org. **Refer**: The OC Foundation maintains a wide variety of group types; some are 12-Step, some mutual help, some professionally facilitated. They are for clients with obsessive-compulsive disorders of any kind, however, some groups are specific to a particular type of obsession/compulsion. It is best to consult with the online directory for the closest group and then to check if that group is appropriate for your client.

Recovery, Inc.

International. 700+ groups. Founded 1937. A community mental health organization that offers a self-help method of will training; a system of techniques for controlling temperamental behavior and changing attitudes toward nervous symptoms, anxiety, depression, anger and fears. Publication for members. Information on starting groups. Leadership training. Contact: Recovery, Inc., 802 N. Dearborn St., Chicago, IL 60610. Call (312)337- 5661; FAX: (312)337-5756. Web: http://www.recovery-inc.com. Recovery offers a special site with links to literature for professionals at http://www.recovery-inc.com/professionals.html **Refer**: Recovery, Inc. is most suitable for people who have high anxiety, depressed mood, a problem with anger or with irrational fear. Clients should be able to read aloud. This association is effective with all diagnostic categories.

Schizophrenics Anonymous

International. 70+ chapters. Founded in 1985. Offers fellowship, support and information for people with schizophrenia using a 6-step program. Contact: Schizophrenics Anonymous c/o MHA in Michigan, 15920 W. Twelve Mile, Southfield, MI 48076. Call: (810) 557-6777 OR (800) 482-9534; FAX: (810)557-5995. Web: http://www.schizophrenia.com/help/Schizanon.html . **Refer**: Refer anyone with a diagnosis of schizophrenia. It is best if the client is stable on

medications and/or non-psychotic. Meetings are structured and focus on six steps. Meetings are supportive, non-demanding, and educational. Press the "Home" button at the bottom of this page for more information and groups.

Secular Organization for Sobriety/Save Our Selves (S.O.S.)

International. c. 750 groups. Founded (as Secular Sobriety Groups) in 1985. Web: http://www.cfiwest.org/sos/ Contact: SOS, 5521 Grosvenor Blvd., Los Angeles, CA 90066; Call: (310)821-8430; FAX (310)821-2610; E-mail: SOS@CFIWest.org. **Refer**: Alcoholics who have difficulty with the spirituality or "religion" of Alcoholics Anonymous. "Secular Organization for Sobriety/Save Our Selves (SOS) is a nonprofit network of autonomous, non-professional local groups dedicated solely to helping individuals achieve and maintain sobriety. SOS takes a self-empowerment approach to recovery and maintains sobriety is a separate issue from all else."

SmartRecovery®

International. c. 100 groups. SmartRecovery split off from Rational Recovery (see also A.V.R.T) in 1994. Contact: SMART Recovery, 7537 Mentor Avenue, Suite #306, Mentor, Ohio 44060. Phone: 440-951-5357. FAX: 440-951-5358. Web: http://www.smartrecovery.org/. "SMART Recovery is an abstinence-based, not-for-profit organization offering a self-help program for people having problems with drinking and using. No one will label you an "alcoholic" or an addict. You are neither diseased nor powerless, and if you do not believe in a religion or spirituality, that's fine, too. We teach common sense self-help procedures designed to empower you to abstain and to develop a more positive lifestyle." **Refer**: Those who have difficulty with "spirituality" who might benefit from a Rational Emotive Behavior Therapy approach.

Women for Sobriety

National. Founded 1976. c. 200 groups. Contact: WFS, Inc., P.O. Box 618, Quakertown, PA 18951-0618, Phone/fax: (215)536-8026; Web: http://www.womenforsobriety.org/. "Based upon a Thirteen Statement Program of positivity that encourages emotional and spiritual growth, the 'New Life' Program has been extremely effective in helping women to overcome their alcoholism and learn a wholly new lifestyle." Many online groups. **Refer**: Women put off by the sexism of many AA and other meetings. Many WFS members also attend AA, using WFS for their "women's issues."

Internet-Focused Mutual Aid Resources

Online Intergroup of Alcoholics Anonymous

Internet only. The Online Intergroup of Alcoholics Anonymous was formed to serve all online AA Groups in the rapidly growing online Fellowship. It offers links to international sites in several languages and sponsors real time meetings,

email meetings, events calendar, information and links to other sites and groups. **Contact**: http://aa-intergroup.org/ **Refer**: Membership in the Intergroup is open to all online AA groups and all AA members. There are no dues or fees for membership.

A.V.R.T. (Addictive Voice Recognition Training) -- also known as Rational Recovery

International. No groups: sees groups of addicted people as the problem. Founded 1986 as "Rational Recovery." Web: http://www.rational.org/. **Refer**: People incapable of participating in groups. Reach the RR main office at (530)621-4374, or (530)621-2667, weekdays, 8 AM - 4 PM, PST. Write to Rational Recovery Systems, Inc., Box 800, Lotus CA 95651 FAX: (530)622-4296."

Bi-Polar Disorder -- also known as Manic-Depression

Harbor of Refuge Organization, Inc. -- Peer to Peer Support for People with Bipolar disorder and those that care about them. "Philosophy: Harbor of Refuge members believe in the principle that each member must find and adhere to an effective plan of treatment for herself or himself that includes qualified medical care, regular and proper rest, and moderate exercise. Additionally, we believe that in helping others to navigate the sometimes stormy waters of this illness, we also help ourselves.

"The Harbor of Refuge strives to provide a safe refuge for interaction between bipolars, their families, and close friends -- without judgment, condemnation, or outside enforcement. We encourage and nurture each other as we seek to overcome this illness through good medical and self-care strategies. However, we know that each one of us must be responsible for our own actions and their impact on our emotional and physical well-being." http://www.harbor-of-refuge.org/

Bi-Polar Significant Others

Internet only. "The information presented on this site is intended to provide information and support to the families, friends and loved ones of those who suffer from bipolar disorder (manic-depression). These resources have helped many of us inform ourselves, cope with behaviors that sometimes arise from the illness, better understand our own reactions, and determine how we may best support our loved ones in their efforts to understand and live with this often terrible disease." **Contact**: To Subscribe to the BPSO List, send an e-mail message to: majordomo@lugdunum.net with this message: subscribe bpso. Do not include anything else in the message. This message will be forwarded to the BPSO list manager, who will contact you as soon as possible. Go to web site at: http://www.bpso.org/. **Refer**: BPSO is a private, closed and unmoderated internet mailing list for those who are involved in a loving, caring, intimate and/or nurturing relationship with someone suffering from bipolar affective disorder (manic-depression). Unlike internet newsgroups, BPSO is accessible only to

members.

Bipolar World

"A website for individuals diagnosed with Bipolar Disorder (Manic Depression) and for the families and friends who care for them. 'We have walked many miles in your moccasins' and understand the need for information and support."

This net-only, virtual group can be found at http://www.bipolarworld.net/ In addition to offering News and good information on Diagnosis, Treatment, etc., it offers an opportunity to "Ask the Doctor" and offers links to Message Boards and Chat Rooms on such topics as Dual Diagnosis, Veterans with PTSD, Teens, and Parents of Bipolar Children.

As this site notes, "Many individuals who have been diagnosed with Bipolar Disorder have no one to turn to, to discuss their feelings about the illness. Many have questions that they feel are 'silly' and they don't want to bother their psychiatrist with. The internet has proven to be a wonderful resource for meeting with others with the same diagnosis."

Depressed Anonymous

"A 12 Step Program of Recovery": "Depressed Anonymous was formed to provide therapeutic resources for depressed individuals of all ages. We work with the chronically depressed and those recently discharged from health facilities who were treated for depression.

"We also seek to prevent depression through education and by creating a supportive and caring community through support groups that successfully keep individuals from relapsing into depression."
http://www.depressedanon.com/index.html

Dissociative Identity Disorder -- also known as Multiple Personality Disorder

17 online forums, divided into three areas. "MosaicMinds Interactive Community Forums are considered 'self-help' and community support networks. MosaicMinds employs no professionals to monitor or interact in these forums."
http://www.mosaicminds.org/Community/index.shtml

More information may be found at http://www.mosaicminds.org/inside-mm.shtml

Methadone Anonymous

International. Founded 1991. Self-help group for, and led by, current and former methadone maintenance treatment patients. "Have you ever attended a 12-step meeting and were not allowed to 'share' because you are a methadone patient? Have you ever gone to one of these meetings and felt like you could not be honest about being a methadone patient because there were things you needed to talk about? If so, Methadone Anonymous may be for you." Phone: (516) 897-1330 (days); (516) 889-8142 (evenings); Fax: (516) 897-1149. Web: http://www.charityadvantage.com/AFIRMFWC/Home.asp **Refer:** Recovering

addicts who wish to follow a 12-Step program while on methadone maintenance.

National Alliance of Methadone Advocates
We have little information on this group beyond what may be found at its website: National Alliance of Methadone Advocates

Prescription Anonymous
Founded 1998 in Atlanta, Georgia. "Rx Anonymous is a voluntary fellowship of men and women who have taken a pledge of responsibility to carry our message of hope to the millions of people who suffer from prescription addiction and/or other mood-altering substances. Our primary focus is to learn how to stop our abuse and to successfully create a life of peace and understanding. We listen to others and feel relieved to know that someone else can identify. We learn how to let go of our fears, cry when the moment comes and share our stories without judgement or criticism. We are not therapists or doctors. Our qualifications are only that we have successfully stopped abusing prescription medications and mood-altering substances. Our hope is to share with others our way of life." http://www.prescriptionanonymous.org/

Rational Recovery
See **A.V.R.T.**, above.

Self-Injury: You are NOT the only one
Internet only. Seven weekly moderated chats on topics ranging from issues facing men and women who self-harm to support for families and friends to how faith affects the experience of self-harm. The site includes numerous informative links to aspects of self harm, types, diagnosis, therapy, reading lists etc. There are self tests for diagnosis and links to frequently asked questions. A desire to stop self injury is **not** a requirement for membership. **Refer**: Those who injure themselves intentionally and who want more information and support from fellow sufferers. Contact: http://www.palace.net/~llama/psych/injury.html Use of the site is free; it belongs to Deb Martinson and is based in Seattle, WA. E-mail: mailto:llama@palace.net

Sober 24
Internet only. "12 step support groups combined with 'Virtual Fellowship' and recovery management tools make Sober 24 a safe, anonymous recovery environment for those suffering from alcoholism and drug addiction. The site contains "bulletin boards and chat rooms where you can get support when you need it, and offer your own support to those who can benefit from it. They offer virtual meetings on a regular basis. . . ." The site also offers reading material and lists local meetings. **Contact**: http://www.sober24.com/. **Refer**: Those in recovery from alcohol and drug abuse and their friends and family. The site is password

protected and charges a $32 membership fee after a free trial period of 24 days.

SoberDykes Hope Page

This web-only site, located at http://www.soberdykes.org/ aims at "women in recovery for substance abuse" and focuses on Dual Diagnosis: "Those of us who have a dual diagnosis often have our mental health issues disregarded by mental health professionals because they think that our drinking/using is the cause of our problems. Our brothers and sisters in recovery often tell us to give ourselves to the recovery program we attend and, when we still don't get "well", we are told that we just aren't doing a good enough job."

This site may be of special use to lesbian women in rural or other areas where they find it difficult to find "community." Its goal and hope is "that here, with other women in recovery, you will find a safe home."

Among resources offered are treatments on Self-Medicating, Finding Support, and On-line Dual Diagnosis Meetings on SoberDykes. There is also a link to many resources on "Gay/lesbian recovery resources."

Evidence of Mutual Support Group Effectiveness

It is not easy to capture the value of self-help groups through quantitative, empirical studies. But some researchers have partnered with self-help groups to find appropriate methods of evaluation. What follows summarizes the extant research.

Extensive evaluations using before-after measures, comparison groups, and time-series designs, have found that more intense and longer term participation in a wide variety of self-help/mutual-aid groups contributes to better outcomes. These outcomes include reduced psychiatric symptoms, reduced use of professional services, increased coping skills, increased life satisfaction, and shorter hospital stays. Members of health-related groups reported better adjustment, more effective coping skills, higher self- esteem, and improved acceptance of the illness than self-assessments of less active and nonmembers (Kyrouz, Humphreys and Loomis (2002) Kyrouz, Humphreys and Loomis (This article is in Adobe Acrobat. Acrobat Reader can be obtained, free, at Emotions Anonymous.) For specifics, see this study, the results of which are summarized in the next five paragraphs:

1. Patients DISCHARGED FROM A PSYCHIATRIC HOSPITAL who participated in a Community Network Development (CND) Program required one-half as much rehospitalization, ten months after discharge, as a comparable group of non-participating ex-patients. CND ex-patients also required one-third as many patient days of rehospitalization (7 vs 25 days) and a significantly smaller percentage of them needed to continue to attend Community Mental Health Centers and other mental health agencies for services (48% vs 74%).

2. VOLUNTEER LEADERS IN RECOVERY, INC., a self-help group for people who have been treated for mental health problems (half of whom had been hospitalized for mental illness) rate their overall satisfaction with life and health, as well as their satisfaction with work, leisure, and community as high, equivalent to the general public's levels of satisfaction.

3. CHILDREN OF PARENTS WITH DRINKING PROBLEMS who participated in Alateen, a self-help group sponsored by Al-Anon, suffered less emotional and social disturbance than peers who did not belong.

4. Participants in a national self-help group for parents of young drug and alcohol abusers -- (PRIDE - Parent Resources Institute for Drug Education) -- reported that their participation was associated with improvement in their children's DRUG PROBLEM. A majority of the participants also reported improvements in their children's general discipline problems and in adjustment outside the home.

5. Participating in a self-help group for FAMILIES OF PSYCHIATRIC PATIENTS reduced the family's sense of burden. Members found the group helpful because it provided them with information about schizophrenia and coping strategies that professionals did not provide. Participation also helped parents to develop supportive social bonds with others who were experiencing similar problems.

Recent studies by reputable researchers have supported 12-STEP GROUP effectiveness (Project Match Research Group, 1997). A multi-state, rigorous research project funded by the NIAAA contrasted outcomes of three treatment conditions, one of which was 12-Step facilitation. The sole objective of 12- Step facilitation was to connect with and reinforce use of community AA. Findings showed that persons who received this treatment approach were as successful in reaching treatment goals as those who received the two other professional treatments. Another study found that individuals treated in a 12-Step-oriented program have higher levels of engagement with 12-Step programs and 64% lower utilization of professional mental health services than patients treated where there was little emphasis on 12-Step principles and involvement. (Humphreys, K. & Moos, R. (2001). Can encouraging substance abuse patients to participate in self-help group reduce demand for health care? A quasi-experimental study. Alcoholism: Clinical and Experimental Research, 25 [5] (May 2001), 711-716.)

All studies suggest that success in any program correlates with more intense mutual help involvement. Therefore, encourage your client to become as active as possible. A listing of indicators of involvement intensity appears below and can be reached directly from the "Contents" list.

Encouraging Local Group Development

1. Don't Re-invent the Wheel

Find a national group that already exists and request a starter packet or "how to" guide. Ask nearby group leaders to help. Attend meetings of that association in other locations to get a feel for how they operate; borrow from their successful techniques.

2. Find a Suitable Meeting Place and Time

Try to obtain free meeting space at a local church, library, community center, hospital, or social service agency. Chairs should be arranged in a circle; avoid a lecture set-up. Consider holding initial meetings in members' homes. Also, try to set a convenient time for people to remember the meeting, e.g., the first Tuesday of the month or every Tuesday at 7:30 p.m.

3. Publicize and Run your First Public Meeting

To reach potential members, consider where they might go to seek help and get the word out to those persons and places. Don't start before you have a core group of committed founders. The first meeting should be arranged so that there will be ample time for you and other core group members to describe your interest and work, while allowing others the opportunity to share their view of how they would like to see the group function. Identify common needs the group can address. Make plans for the next meeting; have an opportunity for people to talk and socialize informally after the meeting.

4. Future Meeting Tasks

Establish the purpose of the group. Is the purpose clear? Groups often focus upon providing emotional support, practical information, education, and sometimes advocacy.

Also determine any basic guidelines your group will have for meetings (e.g., insure that group discussions are confidential, non-judgmental, and informative).

Membership: Who can attend meetings and who cannot? Do you want membership limited to those with the problem? Will there be membership dues? If so, how much?

Meeting Format: How will the meeting be structured? How much time will be devoted to business affairs, discussion, planning future meetings, socializing? What topics will be selected? Can guest speakers be invited? If the group grows too large, consider breaking down into smaller sub-groups of 7 to 12.

Roles and Responsibilities: Continue to share and delegate the work and responsibilities in the group. Who will be the phone contact for the group? Do you want officers? Consider additional roles members can play in making the

group work. In asking for volunteers, it is sometimes easier to first ask the group what specific tasks they think would be helpful.

Phone Network: Many groups encourage the exchange of telephone numbers or an internal phone list to provide help to members between meetings. Ask your membership if they would like this arrangement.

Use of Professionals: Consider using professionals as advisors, consultants, or speakers to your groups, and as sources of continued referrals and information.

Projects: Always begin with small projects, then work your way up to more difficult tasks.

Problems and Pitfalls In Working With Mutual-Aid Groups

1. Taking Over the Peer Helper Role

Do not do for the client what the community can do. Assist your clients to find peers who can help them instead of keeping clients dependent on you. Think of your role as one of linking your clients to a life of continuing growth, not as merely a treatment provider who will produce a finished product at the end of your treatment plan.

2. Over-identification with Resistence

Beware of over-identifying with your client's resistance to attending meetings. You must be firm in insisting that the need for lifestyle change includes finding a new support system.

3. Problems with Religion

One common problem with AA/NA affiliation is objection to the religious atmosphere in some 12-Step groups. It is important to be knowledgeable about the differences between spiritual and religious and to read the chapter in the Big Book, "We Agnostics" (AA, 1976). Some groups are more openly religious than others. AA's beginnings were rooted in evangelical Protestantism, but its teachings are compatible with Catholicism, Judaism, and Islam. For example, there is an organization called JACS (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) headquartered in New York City that helps Jewish addicts understand the 12-Step program as compatible with Judaism. They can be contacted at JACS, 850 Seventh Ave., New York, NY 10019. Phone: (212)397-4197. Web: http://www.jacsweb.org

4. Gender Issues

Women often express discomfort about AA/NA groups, although this difficulty is diminishing as more women are becoming AA members. The most recent survey indicates that one-third of members are women (AA, 1999). One way to help a woman client adjust to AA is to link her to an all-women's group or

to a group with a large number of women in attendance. It is also appropriate to help the client learn to deal with male prejudice and sexist comments.

5. Discomfort in groups

An important characteristic of successful members is capacity for group dependency. One researcher found that people with high affiliation needs bond quickly with groups, whereas those with low affiliation needs do not. Some people described themselves as "loners" or "misfits." For such people integration into the mutual-aid social world can be more difficult. Those who pay attention to what is said in meetings and read the literature are able to participate more and to engage in dyadic relationships within groups. Continued attendance allows the less extroverted members to become involved and develop a sense of belonging. A dyadic relationship is often required before the less sociable person is able to be involved in an AA group.

6. Lack of transportation and other logistical barriers

Such things as no transportation and other barriers to attendance need to be considered and resolved. Rides can be obtained to deal with transportation problems. One definition of an AA meeting is simply "one drunk talking to another." Anywhere you can find one other person who has a story to tell, you can find a meeting. Thus, your client might find someone who he or she can talk to in person or by telephone at times when a regular meeting is not available.

7. Working at Cross Purposes With the Group

One of the biggest problems that can occur when a professional's client belongs to a peer support group is the possibility that what you are doing with your client may be undermined by peer helpers. This happens most often with the issue of the use of medication for psychiatric disorders. While it is true that addicts tend to use chemicals to solve their problems, it is also true that some addicts need medications of various kinds. An AA pamphlet states, "It becomes clear that just as it is wrong to enable or support any alcoholic to become re-addicted to any drug, it's equally wrong to deprive an alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems" (AA, 1984, p. 13). Despite this warning in AA's own literature, some newcomers may be instructed by peer helpers not to use their medications. You can do two things to remedy this. First, you can obtain the AA brochure quoted above and share it with your clients. Secondly, you can recommend to your clients that they not discuss medications in their groups or informally with the friends they meet in AA or NA.

Indicators of Mutual Help Involvement

- Meeting attendance
- Participation in social activities

- Service roles: elected to office, contributions of refreshments, setting up meeting rooms, etc.
- Telephone calls to members
- Friendships with members
- Reading literature
- Following group recommendations written exercises, taking inventories, prayer and meditation
- Having a sponsor
- Being a sponsor.

Aids to Working With Mutual-Aid Groups

There exist a vast variety of resource aids, many of them available online or easily ordered online. Virtually all the web sites listed above contain many articles and recommend other readings. Many of these sites also offer links to chat-rooms and virtual meetings as well as further detailed information. Below are some resources that we have found especially helpful.

General

American Self Help Clearinghouse Self-help Sourcebook online: http://mentalhelp.net/selfhelp/

Champaign, IL, area: http://www.prairienet.org/selfhelp/homepage.phtml. Note: This site may have to be "Reloaded" or "Refreshed" in order to appear properly in some browsers.

National Mental Health Consumers' Self-Help Clearinghouse: http://www.mhselfhelp.org/

This is a consumer-run technical assistance center. It provides training materials for advocacy and starting new groups. It disseminates information on legislation, provides links to government resources and to other related organizations. Links on this site provide an amazing amount of free training materials.

Chemical Dependency

AA: AA World Services publishes books, pamphlets, videos, periodicals, and workbooks. Periodicals include a newsletter, BOX 459 (News and Notes from the General Service Office of A.A.); About AA: A Newsletter for Professionals; and the AA Grapevine ("our meeting in print"). The first offers news about the AA organization such as number of members and groups, decisions made in conferences, and the like. About AA contains information about the fellowship that might be of interest to professionals, such as results of member surveys, information about AA's history, available literature and other products. The AA

Grapevine contains writings by members that reveal aspects of their spiritual journeys in recovery. AA's General Service Office can be reached by mail at A.A. World Services, P.O. Box 459, Grand Central Station, New York, NY 10163. Phone: (212) 870-3400. See http://www.aa.org/ We suggest also checking out "Your First AA Meeting: An Unofficial Guide For the Perplexed" at http://www.bma-wellness.com/papers/First_AA_Meeting.html

NA:Narcotics Anonymous World Services is headquartered in Van Nuys, California. It also publishes literature: books, booklets, pamphlets, handbooks and guides, directories, audio cassettes and one video, Just For Today. NA also publishes The NA Way Magazine: The International Journal of Narcotics Anonymous. The magazine's mission is to provide service information, recovery-related entertainment related to current issues and events relevant to and written by members. You can order from NA at their address: N.A., P.O. Box 9999, Van Nuys, CA 91409. Call: (818)773-9999.

Mental Illness

EA: EA publishes a text, Emotions Anonymous, and numerous pamphlets. A catalog of its publications may be found at http://www.mtn.org/ea/catalog1.html

Grohol, J.M.: PsychCentral and other resources: http://www.grohol.com/

GROW: Publishes numerous books and pamphlets. Contact their headquarters for informational packets and assistance in developing groups.

NAMI: Publishes local and state newsletters as well as the NAMI Advocate, a bi-monthly newsletter that reports on national mental health policy news, organizational news, book reviews, order forms for NAMI publications. Available to all dues-paying members.

NDMDA: Publishes the National DMDA Newsletter containing news of national public policy and organizational news and sells brochures and articles with information on manic depressive illness. See web site to order.

Obsessive-Compulsive Foundation, Inc.: Publishes a bi-monthly newsletter, free packets with treatment and support group information, annual conference, books, audio and video tapes. Trains mental health professionals in the latest treatment techniques. See http://ocfoundation.org/ocf1100a.htm

Recovery, Inc.: Publishes a basic text, Mental Health Through Will Training by founder Abraham Low, Selections from Dr. Low's Works, Peace Versus Power in the Family. Also a bi-monthly publication, The Recovery Reporter, containing many examples of recovery practice. There are also pamphlets, a group directory, and other aids to Recovery leaders. The headquarters office has videos for helping new groups get started. Recovery offers a special site with

links to literature for professionals at http://www.recovery-inc.com/professionals.html

The Question of Responsibility

Some have asked questions concerning the responsibility of a professional for what happens to people one has referred to a non-professional site or group. We suggest the following principles:

(1) The professional is responsible for being knowledgable about the group or the website so that harm is unlikely to occur;

(2) the professional should make it clear to the person being referred that the group is a non-professional, mutual aid group made up of non-professionals with similar problems;

(3) the professional should remain available to the person if something potentially harmful happens.

When possible, this Guide provides group mission statements and suggestions about whom to refer to groups. One of the most harmful things we have seen professionals do is to refer someone to a group for which they were not really qualified; i.e, they did not share the problem with which the group deals. We have seen this in happen often in Al-Anon when someone who was depressed came in referred by a professional who thought Al-Anon was a nice group of supportive people and did not know of a group for people with depression. The innocent person, who is in pain, goes to the group and is asked to leave. The group is also harmed because they have had to struggle with whether to include someone for whom they have nothing to offer or reject them thus increasing the level of pain for the newcomer. When this occurs, a group member usually takes the person aside and tried to soften the rejection, but the harm is done.

As noted elsewhere in this Guide, there is no credible evidence that any of the groups listed here have been harmful to any person or category of persons. It is, however, important to monitor your referee's experience. Any individual group could develop destructive group dynamics that could be harmful to individual members.

The groups listed above as "Group-Based" generally have proven track records and are generally well-known. Those listed above as "Internet-Focused" are in general newer, or are geographically limited, and we have less information about them and no direct experience with them. We nevertheless think that they are likely to be helpful. We ask that you inform us if your experience with these groups provides information you deem helpful to others.
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Recommended Reading

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The Evolution of Employee Assistance: A Brief History and Trend Analysis

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Workplace responses to employees experiencing performance-impairing problems have undergone remarkable changes over the past 250 years. This paper: 1) describes the evolution of such responses through five historical periods, 2) analyzes the major trends across these periods, and 3) speculates on the future directions of employee assistance (EA) as a professionalized endeavor. It is our hope that this paper will stir discussion and debate about the EA field's evolving identity and its future as a professional specialty.

The History of Employee Assistance

Alcohol Promotion/Suppression. Alcohol was integrated into the early American workplace as it was integrated into all aspects of American colonial life. Concern about problems created by alcohol-impaired workers grew as per capita alcoholic consumption rose dramatically between 1790 and 1830 (Rorabaugh, 1979). The resulting temperance movement played a major role in removing alcohol from the workplace and sobering up the American workforce. By the end of the nineteenth century, this major cultural movement and the growing awareness of alcohol-related accidents within the country's increasingly mechanized industries combined to suppress the open use of alcohol in the workplace. It was then that concern shifted from alcohol consumption by all workers to the problem of a small number of workers for whom alcohol continued to produce significant impairments in productivity and health (Levine, 1978).

Informal Paternalistic Intervention The first significant efforts of organizations to help individual employees resolve alcoholism and other personal problems that might impair their performance began in the nineteenth century. Typical of these efforts were informal policies of police and fire departments that encouraged alcohol-impaired employees to sign a pledge of abstinence, involve themselves in temperance groups, or to undergo a period of care in an inebriate home or inebriate asylum (Baumhol, 1991). One of the earliest inebriate homes, the Chicago Washingtonian Home, was birthed in 1863 out of a successful experiment of Robert Law who rehabilitating one of his alcoholic employees by moving the employee into

Law's own home (White, 1998). Such efforts were part of the "rescue work" that emerged within the American temperance movement, and were aggressively pursued within companies whose leaders viewed themselves as the head of the company "family." The growth of medical and personnel departments within American business and industry grew, in part, out of such paternalism.

Industrial Alcoholism Programs As American businesses and industries became larger and more depersonalized in the opening decades of the twentieth century, companies responded to alcohol-impaired employees in one of two ways: They were either fired, or they were retired on the job. It was in this context that occupational counseling programs rose in the 1940s. These programs were frequently rooted in the informal assistance offered to alcoholic employees by other employees who had sobered themselves through involvement in Alcoholics Anonymous (Trice and Schonbrunn, 1981; White, 2000a). The desire to reach a larger number of alcohol-impaired employees led to a formalization of these efforts within companies such as Eastman Kodak, Allis Chalmers, and Kennecott Copper Company (Steele, 1989; Presnall, 1981).

These more formalized programs were christened "industrial (or occupational) alcoholism programs," and spread through the efforts of a rising "alcoholism movement" led by the Yale Center of Alcohol Studies and the National Committee on Education on Alcoholism. The Yale Plan for Business and Industry promoted a nine step plan for implementing an occupational alcoholism program: 1) education of top management, 2) assignment of program responsibility to an existing department, preferably the medical department, 3) selection and training of a coordinator to administer the program, 4) mobilization of internal intervention resources, 5) development of a company-wide policy regarding relationship of treatment to discipline, 6) linkage to alcoholism treatment services, 7) supervisory training, 8) employee orientation and education, and 9) periodic surveys to assess the extent of the problem within the company (Henderson and Bacon, 1953).

Internal Employee Assistance Programs During the 1950s, companies such as Consolidated Edison, Standard Oil of New Jersey, and American Cyanamid extended their alcoholism programs to also cover employees that were experiencing mental health problems. This marked the beginning evolution from industrial alcoholism programs to workplace employee assistance programs (Presnall, 1981, Roman, 1981; Steele and Trice, 1995). The pivotal event in this transition was the establishment of an Occupational Programs Branch within the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the early 1970s. Will Foster and Donald Godwin pushed the position within NIAAA that workplace intervention should not be focused on alcoholism but on the broad spectrum of behavioral health problems encountered by employees. One of the goals of NIAAA leadership from its earliest inception was to break down the stereotype of the alcoholic as a Skid Row wino and take the issue of alcoholism to the heart of middle-class America (Roman, 1981). NIAAA funded two "Occupational Program Consultants" (OPCs) within each state whose responsibility was to organize occupational alcoholism programs in business and industry. These first OPCs became known as the "Thunderin' Hundred," and their efforts led to a dramatic rise in the number of occupational alcoholism programs in the U.S. The emergence of occupational alcoholism as a professional specialty was marked by the 1971 founding of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA). The rapidly evolving philosophy that guided the OPCs led first to a shift in emphasis from identifying alcoholic employees to identifying employee performance problems and then to a transition in identity of these programs from alcoholism intervention programs to "broadbrush" employee assistance

programs (EAPs). As they spread, the focus of these new EAPs shifted from the alcoholic employee to employees encountering a broad spectrum of behavioral health problems (Roman, 1981; Wrich, 1974, 1980).

External Employee Assistance/ Managed Care/Work-Life Programs During the evolution from industrial alcoholism programs to employee assistance programs, there was also a shift in where such programs were placed. The trend was from placement of these programs within a company to the practice of contracting for such services from local or national behavioral health organizations (Oss and Clary, 1998). A large number of community-based agencies and proprietor-owned organizations involved themselves in the delivery of EAP services, and contributed to the rise of new local and national organizations specializing in the delivery of contractual EAP services. During the 1980s, these vendors helped support a drug free workplace movement that saw the widespread introduction of drug testing (and mandatory referrals to EAP) in the American workplace. The “zero tolerance” philosophy that buttressed this movement created a new kind of role tension. EA professionals who had long played a role in the “rescue and recovery” of substance-impaired individuals within the workplace now found themselves participating in the exclusion and extrusion of these individuals from the workplace (Bennet, et al., 1994). The mission-diversification of EA was further extended with growing concerns about workplace violence. In response to this concern, EAPs provided violence-related training, consultation, crisis intervention and critical incident debriefing services. As EA professionals redefined their “customer” as the corporation, they offered a growing variety of organizational development and consultation services that went far beyond their original role of assisting individual employees.

A more recent trend is the role EAPs are assuming in helping companies directly manage their behavioral health care costs. This role ranges from screening and selecting behavioral health care providers, gatekeeping employee access to behavioral health services, approving types and duration of services, and providing aggressive case management of the whole service delivery process. A small number of EA/managed care firms who now control 70% of the cumulative managed behavioral health market share, as well as a growing number of smaller, regionally based vendors, are pushing this trend toward providing all behavioral health services on a carved-out basis, using a discrete contracted network and a staff of behavioral specialists who manage care (Oss, 2000, Jeffrey and Riley, 2000). For plans that “integrate” EAP with the managed behavioral health benefit, this model shifts the traditional EAP role from one of assessing needs and brokering service connections to the role of behavioral health plan administrator. It also erodes the distinction between the EA service and outpatient counseling or therapy with the prevalence of six and eight visit EAP models replacing the original “assess, refer, and follow-up” EA model (Jeffrey and Riley, 2000). These short-term EA counseling models imply that EA clinicians generally function as private practice therapists, providing one to eight visits about 60-70% of the time, preventing “costly” referrals beyond the EAP to the benefit plan.

Another recent trend in the EA field is the potential integration, if not mutation, of EAP and Work-Life (W-L) into a single unified program. Both EA and W-L share the mutual goal of addressing issues that hinder employee performance, although W-L provides assistance with “normal life events” such as child/elder care, adoption, college placement, financial/legal concerns, pregnancy and parenting, and consumer affairs. Unlike EAP, W-L can trace its roots to the “Great Society” when the federal government formed county-based child care coordinating councils designed to coordinate child care resources in close proximity with Head Start centers (Herlihy, 2000). Similar to the way EAPs moved from occupational

alcoholism to “broad brush”, these child-care resource and referral programs expanded to include elder care and other life event services. Given that the operational components (call centers, assessment and counseling, education and referral) of EA and W-L are similar, and many employers seem to believe this combination reduces stigma and implementation/ communication costs, there is a growing consensus that integration is more beneficial than two distinct programs (Williman, 2001, Herlihy et al, 2002). Despite this natural “fit”, W-L and the “behavioral health” related disciplines are traditionally two separate areas of training and disciplines and have held separate organizational “turf” with employers. The inclusion of benefits management and W-L within the EA umbrella mark a further migration of the EA field away from its historical expertise in intervening with the substance-impaired employee.

Growth and Stability of EAP’s The growth of EAPs has been quite phenomenal. The number of companies with formal occupational alcoholism programs rose from a handful in the 1940s to approximately fifty in 1959 to more than 175 in 1965. Three Hundred new EAPS were initiated in the first year of NIAA’s OPC efforts in the early 1970s. By 1979, 59% of Fortune 500 companies had established formal employee assistance programs and estimates of the number of American companies with formal EAPs at the end of the 1970s ranged from 2500 to 4,000 (Roman, 1981; Milgram and McCrady, 1986). This estimate climbed to 12,000 by 1985 (Blum, Roman, Tootle, 1988), and presently over 65 million U.S. citizens are covered by an EAP or integrated EAP/managed behavioral health carve-out (Oss, 2001). Today more than 7,000 professionals work in an arena that less than twenty worked in during the 1960s. In the second half of the 20th century, industrial alcoholism programs were born, were transformed into broadbrush employee assistance programs, were professionalized, grew explosively, incorporated a drug free workplace movement, and then further expanded their mission to include behavioral health care management and work-life/dependent care programs.

Despite the impressive growth in EAP enrollment and number of working EA professionals, several trends threaten the character and future of the field.

1. Intense competition and an oversupply of EA vendors have caused an extended period of restraint on price increases and significant consolidation among larger vendors and smaller vendors aggregating regionally (Oss, 2001, Findlay, 1999, Sharar and White, 2002).

2. With the infusion of low-wage workers and public welfare recipients into the workforce, EAPs are attempting to serve greater numbers of multi-problem, at-risk populations (e.g. poor single mothers, older workers, persons with co-occurring disorders) via serial episodes of brief interventions (Maiden, 2001).

3. With significant declines in employer spending on behavioral health benefits (Jeffrey and Riley, 2000), EAPs are at risk of becoming an inadequate service replacement for employers with minimal or no benefits for outpatient behavioral health services.

4. Telephone and Web-based interventions are increasingly viewed as a primary clinical medium rather than as a screening, educational, or motivational medium in spite of the fact that very little is known about how clinical outcomes of these less costly telephone or computer mediums compare to “in-person” intervention.

5. The original focus of EAPs is being obscured by a wide spectrum of related services and products, causing consumers and employers to see EAPs as “ill-defined and amorphous” (Blair, 2002), despite the field’s two professional associations, program standards, a Core Technology, an

accreditation process, and a practitioner-oriented certification process.

Trend Analysis

Our discussion of the major trends within the history we have just reviewed as well as our discussion of the future of the EA field will focus on six questions that address the mission of EA, the role of labor in the EA field, the organizational placement of EA services, the qualifications of EA service providers and programs, the financial future of the EA field, and the effectiveness of EAPs. Our speculations about the future are observations that we hope will stir examination about the present and future status of the field. In trying to predict future evolutions in EA, we are guided by a recognition that trends tend to generate their own excesses and set the stage for readjustments that are often depicted as pendulum swings. For example there are many fields in which there are predictable cycles of organizational centralization/decentralization and generalist/specialist role preferences.

If there are certain predictable cycles within the long history of professional fields, then perhaps we could predict some future trends, or at least some adjustments or corrections that will grow out of current excesses within the EA field.

What is the Primary Mission of EA Field?

One of the clearest trends in the above-encapsulated history is the progressive expansion of the scope of employee assistance as an activity and a discipline. We have charted the evolutionary shifts from a single specialized problem (alcoholism) to a boundaryless spectrum of employee problems; from substance-impaired employees to substance-using employees (via the drug free workplace movement); from problem-intervention to problem prevention, wellness promotion, and life events management; and from employee recovery (health) and retention to cost-containment, risk management, benefits management, and critical incident management. The history of the employee assistance field could thus be portrayed in three stages; it's incubation within the alcoholism field, its emergence and professionalization, and its territorial expansion (See Figure 1).

(Figure 1: Funnel diagram showing widening scope of mission)

This expansion reflects both quantitative shifts (the number of activities embraced within EA contracts) and qualitative shifts (e.g., the shift in focus from the recovery and retention of substance-impaired workers to the detection and control of substance using employees). As the primary "client" (ultimate loyalty) shifted from the employee/family, it should not be surprising that the dose (intensity and duration) of services provided by and through EAPs declined in tandem with this shift.

New professions face two threats to their long-term survival. They can fail to thrive due to overspecialization or they can rapidly diversify until they encounter and are devoured by more powerful forces within their operating environment. The mission of the EA field has become so diffuse that one could argue that the weakened identity and lost boundaries of the field have left it ripe for colonization (or that such colonization has already occurred). If the speed of boundary erosion and diversification continues, we envision the potential collapse (progressive dissipation) of the EA field as a specialized professional field. The most likely scenario would be a loss of the field's historical core functions with the continued illusion that the EA field can maintain its identity and mission fidelity in the midst of this ever-expanding menu of services. Even employer purchasers seem confused about how these moving pieces once called "EAP", each with its own rate structure, fit into a cohesive behavioral health/life management plan that saves them time and money while improving clinical efficacy and performance outcomes.

Rapid diversification poses the risk of eroding the quality of one's original core products and services. It has been argued that the EA field is less capable of salvaging the substance-impaired employee today than it was twenty-five years ago (White, 2000). We have entered a time when more and more company managers and union leaders, having lost direct knowledge of and participation in successful recoveries, see the employee with a behavioral health disorder as a nuisance and an unacceptable cost and safety risk. If there really are natural cycles of specialization and generalization, then we would predict a day in the future when progressive employers will tire of losing some of their best and brightest employees to alcoholism and will call for a program of intervention to restore them to productivity. Perhaps this new program will be called something befitting its form and function–something like occupational alcoholism program (White, 2000b).

What is the Role of Labor in the EA Field?

The history of EA as a field is marked by the diminishment of the role of labor within the field. Labor leaders have played a significant role in addressing the problem of substance-impaired workers. As early as, 1827, American labor leaders advocated a ban on alcohol use in the workplace, and American labor leaders such as Leo Perlis played a significant role in the rise of union-based alcoholism programs and union-management collaboration in the development of alcoholism intervention programs. The emphasis on labor involvement in the design and operation of employee assistance programs waned as the EA client shifted from the employee and his/her dependents to the company. Also, the now prevalent external vendor model of using a contractual network of "EAP Affiliates" has resulted in a shift away from the natural web of support historically provided by recovering employees and labor-based peer volunteers to short-term counseling with a professional in a consulting room. Ironically, this shift represents less of a community-based, work-site focus and has contributed to the gradual erosion of connecting troubled employees to indigenous community and workplace recovery support systems in favor of professionally directed therapy (White, 2002).

The authors see two potential adjustments to this trend: 1) a renewal of the relationship between the EA field and national and local labor leaders, or 2) a dramatic increase in the number of labor unions that organize their own labor assistance programs as a backlash against the growing coerciveness of the EA program and ineffectiveness of company-contracted EA services to rehabilitate and retain employees with behavioral health disorders.

What is the best organization and location of EA Services?

We see several trends in the locus of EA services, each of which moved the point of contact of assistance further away from the line employee. First, there was the transfer of indigenous "wounded healers" from their normal work responsibilities to a specialized helping role within the company. While this move provided more time for work with troubled employees, it removed the helper from the network of natural peer relationships in which they were closely connected to and trusted by other employees and created status barriers that had not existed before professionalization of this role. Eligibility for EA services was also extended from the employee to the employee's dependents, and, in a prophetic milestone of demedicalization, EA services were gradually moved organizationally from company medical departments to their human resources or benefit departments.

The next trend was to outsource EA services to local, then regional, then national and, more recently, to international vendors. The expansion by national vendors is reaching its saturation point in the U.S., leaving growth opportunities for these mega-companies only through the acquisition of smaller, local contracts, the expansion of EA

services outside the U.S., or the expanding the service scope (and income) from existing contracts. Many of these companies are investor-owned and insurance-based and "bundle" an EAP as a "cheap" add-on to a managed behavioral health plan, work-life program, health insurance plan, or disability management program. EAPs are simply one "menu" item in the "one-stop shopping" behavioral health/life management marketplace, and occasionally viewed as a "loss leader" in an effort to sell more lucrative service lines that complement EAP.

The trend toward nationalization and centralization has had three consequences: 1) the EA service provider has been removed from the work site, 2) the EA service provider is less knowledgeable about the resources of the local communities in which employees reside, and 3) the problem identification and resolution process is shifting from a face-to-face relationship to a telephone conversation or on-line connection. Acknowledging the profound and important impact of communications technology and centralized efficiency does not diminish the need for personal human contact and the comfort of another human being's physical presence as a remedy for stress, personal problems, and behavioral health disorders. What the historical EAP provided, particularly for employees requiring sustained or episodic support, was continuity of in-person contact in a primary helping relationship and an intimate knowledge of the changing availability and quality of local resources. That continuity has been replaced with an EA service process marked by remoteness, impersonality, transience, and reduction in the physical presence of a helper offering personalized comfort and support.

As larger, external vendors have garnered control of the marketplace, EA services have migrated to an out-of-area call center and the controlled use of sub-contracted affiliate clinicians who have no real connection to the workplace and are frequently not even know to the local employer, manager, or union. Many local affiliates complain that some external EA vendors actually forbid contact between the affiliate and the local work-site, inhibiting the ability of the affiliate to gain the trust of local employees and management and be integrated into the organizational culture (Sharar, White, and Funk 2002).

We anticipate a growing challenge to national/regional vendors and predict a relocalization of certain EA functions and a growing emphasis on organizing support systems inside the workplace and inside local communities. To survive such challenges, national/regional vendors will need to re-engineer EA services to combine elements of national and local service delivery models and be both "high tech and high touch". Vendors who implement geographically diverse, multi-location programs will need to ensure improved, constructive involvement with the local employer and attempt to align the goals and expectations of the local employer and EA affiliate with the vendor headquarters and account management process. Vendors also need to examine their increased reliance on telecounseling, especially when serving out-of-area employee clients, and evaluate when it compromises community-based quality of care and needed collaboration with the local EAP affiliate.

The authors predict that employer purchasers will begin to question the theoretical connection between the size and location of the vendor and claims of performance related to outcomes or responsiveness. What is the connection, if any, between size, market dominance, location, medium of service, and superior outcomes in EAP? If the EA field cannot sustain ownership of its current functions within all locations of business and industry, and integrate with the local work site, we suspect that many of these services will be provided by occupational medicine or primary care physicians and the growing interdisciplinary teams that will surround them. Sustaining (or restoring) these core functions will require EA vendors (local and national) to move away from feudalism and

suspicion of competitors to the most significant human capital management change that business has witnessed in 40 years…the move toward collaboration (Fitz-enz and Davison, 2002). The field cannot just declare itself to be collaborative partners with both customers and local affiliate providers. Partnerships must be earned by acquiring and demonstrating the necessary communication skills and links between the various stakeholders, regardless of clinical mediums and location of service.

Who is Qualified to Provide EA Services and Call Themselves an EA Program?

The early staffing of the EA field grew out of a "wounded healer" tradition which assumed that people who had resolved a particular problem were credentialed by experience to help others who were facing that problem. Staffing occupational alcoholism programs with recovered alcoholics reflected this belief. The credential of personal recovery became less credible in the transition from occupational alcoholism programs to broadbrush EAPs.

Since 1986 the Employee Assistance Professionals Associations (EAPA) has offered a voluntary certification credential, "Certified Employee Assistance Professional" (CEAP) as a way to qualify the competency of EA practitioners. As a competency-based credential, the CEAP has no formal educational requirement and relies on EA work experience, mentoring, and a knowledge test focused on the Core Technology. As a "stand-alone" credential, the CEAP is based on the premise that certified practitioners can perform both "non-clinical" organizational skills, such as management consultation, and individual clinical skills, such as a screening for chemical dependency. With such a wide variation of diverse backgrounds in the EA field, EAPA and its certification commissioners chose to include non-licensed practitioners. Specifically, there were real concerns that non-educated recovering counselors, labor-based peer counselors, and non-clinical practitioners with expertise in organizational intervention would be systematically excluded from holding the credential.

This decision to include non-licensed practitioners resulted in many EA professionals who were licensed clinicians to question why they needed to supplement their license with a certification. This sub-group of licensed professionals also criticized the CEAP as being "too easy and lenient" and cited examples of CEAPs without graduate degrees or licenses performing complex clinical activities such as post-positive drug test "fitness-for-work" assessments, forensic type assessments for threats of workplace violence, and return-to-work evaluations following leaves for psychiatric disability(Sharar, White, and Funk, 2002).

National EA vendors who contract with EAP affiliates to provide services on an "as needed" basis may value practitioners who have earned the CEAP but certainly do not usually require it to perform EA assessment and counseling. The main requirement to join an EA affiliate network is a graduate degree in a helping profession and an unrestricted license to practice, not evidence that affiliates have even a rudimentary understanding of EAP Core Technology. In fact, many vendors combine their EA affiliate network and managed behavioral health network into a single blended network, diluting what is distinct or specialized about counseling in the EA context (Jeffrey and Riley, 2000). This practice is a declaration that the CEAP is not needed to do the majority of EA work that takes place and that all practitioners credentialed in the vendor's network can provide EA services, outpatient therapy, or both. It is mere speculation if or when an EAP affiliate will assess the employee's problem within the context of work and job performance or utilize an "early intervention/workplace wellness" perspective as opposed to a tertiary, psychotherapeutic perspective. The authors suspect the former perspective is occurring less and less in today's EAP climate, even

with the advent of the CEAP as a specialized credential for EA practice.

The CEAP is simply one measure that an EA practitioner has some basic awareness of the distinguishing aspects of EAP practice, not evidence of competence to evaluate a variety of mental health or addictive disorders, find the very best provider match for a particular condition, or consult with management on the potential referral of a poorly performing employee. The CEAP has found itself in a conundrum; it needs to elevate its own criteria to further enhance the field's credibility without alienating its constituency and revenue base. It is also not clear whether this debate about EAP credentials is important to anyone outside the field, particularly employer purchasers or service consumers.

A related issue is what are the requirements for a program to label itself an "EAP"? Programs that call themselves an EAP but are in reality quasi telephone-based services, have little workplace emphasis, no supervisory training or management referrals, and fail to meet the definition of "EAP Core Technology" as originally identified by Roman and Blum (1988), may merely be camouflaged as EAPs. The danger here is that employer purchasers are limited by their lack of knowledge and information to determine whether or not EA services meet minimum standards of quality to actually function as an EAP or be labeled an EAP. In an effort to address this concern, both the field's professional associations, Employee Assistance Professionals Association (EAPA) and Employee Assistance Society of North America (EASNA) promulgated "two" sets of standards, provided support to "two" different accreditation organizations to administer "two" accreditation processes whereby an independent third party evaluates the EAP based on one of these two sets of generally accepted standards. The plan is to use EAP accreditation, as offered by the Council on Accreditation (COA) or Rehabilitation Accreditation Commission (CARF) as a way to separate those EAPs that meet minimum of standards of quality from those that do not, along with a method to recognize the EA field as having a unique and essential knowledge base and set of skills. The accreditation of EAPs is viewed by its proponents as having the potential to improve quality, accountability, and reduce abuses associated with the mislabeling of the name "EAP" and its functions. The COA began accrediting EAPs in 1992 and reports that over 100 EAPs are COA accredited, many of them Canadian-based vendors (Stockert, 2002). CARF has offered EAP accreditation since 1998 and over 20 EAPs are CARF accredited (Migas, 2000). COA and EASNA, as supported and funded by the Center of Substance Abuse Prevention of Substance Abuse Mental Health Services Administration, and with the help of Masi Research, Inc. have recently ran tests on a revised set of standards at five "Beta Sites" including both national EA vendors and internal programs (Haaz, 2002).

It remains unclear whether or not accreditation will be an integral part of improving the quality of EAPs as well as an important means of demonstrating quality to company decision-makers. If accreditation encourages the field to migrate towards the adoption of universal standards, then perhaps it can play a vital role in restoring some fidelity to the original core technology model that combines to address employee personal concerns that overlap with workplace productivity. Achieving this noble goal requires that advocates and sponsors of accreditation collaborate to resolve a myriad of challenging issues:

1. Making accreditation affordable for an industry that is already wrestling with slim margins or operating losses.

2. Making the accreditation process sensitive to the wide variation and diversity of EA models and levels of implementation across multiple "host" organizations and yet still have a meaningful accreditation process.

3. Making sure both the standards and the accreditation process do not favor one type of vendor or program at the expense of another type, creating real or imagined perceptions in the field that certain vendors have an unfair advantage.

4. Convincing employers, as funders of EAPs, that requiring accreditation will be an important measure of quality and best practices.

5. Countering the confusion over multiple EAP accreditation standards and processes.

6. Convincing EAPs based in multi-service organizations that are already accredit their managed behavioral health care services or treatment/behavioral health care services through the National Committee of Quality Assurance or Joint Commission on Accreditation of Healthcare Organizations that there is value in having their EAP departments or divisions participate in a separate and distinct accreditation process.

What is the financial future of EA Services?

Despite an extended period of unprecedented growth in EAP enrollment, the field has not benefited from price increases in well over a decade. While the U.S. economy of the past twenty years expanded, prospered, contracted, stagnated, crashed, and stabilized, with marked inflation in health care costs, average EAP rates remained relatively unchanged (Melek, 2000). In a highly competitive market, EAP vendors routinely submit unreasonably low bids in order to capture market share and then under-resource the program in order to contain costs within the "per-employee-per-year" capitated rate structure (Sharar, White, and Funk, 2002). Lower utilization of EA services equals higher margins for the vendor, so vendors are tempted to deliver substandard levels of service in order to make up for lost profits resulting from low capitated bids. EAPs are under-priced and over-sold, contributing to a type of gradual financial suicide and the hope of making up losses by offering collateral products as a new source of revenue that end up diluting the definition and expectation of what an EAP should be.

The one side effect of rapid diversification of services within EA contracts is that it's focus and value may become less clear. As long-tenured client company executives, managers, and human resources professionals leave who still attribute high value to EA services because of the program's known tangible impact over the course of their career, a new generation of managers without such history and facing bottom line accountability of their own performance, may view EA services as a discretionary expense that can no longer be justified. These new managers may take a hard look at EA contracts and discover phantom EAPs whose expensive marketing materials and boasts of high employee "contacts" turn out to be more smoke and mirrors than substance-- resources that exist on paper but are rarely used because they increase the EA contractors operating costs and lower profits.

Reforming this price, commodity driven market by educating purchasers to choose EAPs on the basis of quality, value, and outcomes, rather than price, may be the single most important step to preventing the field from being absorbed by other services. Getting the attention of senior managers and human resource executives, and providing return-on-investment data above and beyond subjective testimony, will preserve and enhance our economic base as well as our historic mission. The authors forecast that if this strategy is not aggressively pursued and supported by a clear vision from the field's leadership, the EA field will not survive as a distinct profession. As a field, we urgently need to analyze why commodity pricing has become the "rule" rather than the exception and help employer purchasers differentiate between EA programs based on factors other than price.

How effective are EA Services?

There is a strident call in many health and behavioral health fields to bridge the gap between clinical practice and clinical research, but the EA field finds itself in an unusual position. It lacks a foundation of rigorous scientific studies (Roman, 1996; Arthur, 2002) and has no identified academic discipline at its foundation. There is less methodologically sound research in the EA field than any comparable field of behavioral health or social service. There are no federal institutes supporting multiple-site, randomized clinical trials to test the efficacy and effectiveness of EA models and all of the published research on EA effectiveness has significant design flaws, e.g., the absence of control groups. There are no accepted standard benchmarks used to measure performance across EA models and programs. Even where research has shown a positive effect of EA programs, no effort has been made to disassemble such programs within the evaluation designs to identify the potent ingredients of these programs (Roman, 2002). EA services have competed so intensely in the arena of service costs, product enhancements, and market dominance that the true outcomes of EA services have been virtually ignored. When outcomes are reported, it is nearly always a one-group pretest/posttest design with a short follow-up period where the impact of the EAP is confounded with the treatment effect when referrals beyond the EAP are made.

It is time the EA field stopped citing out-of-date, methodologically weak studies that evaluated EA models that no longer even exist within the EA landscape, and began constructing a scientific infrastructure that can compete with the marketplace in shaping the design of EA products and services. It is time to foster the development of EA professionals who will conduct and publish EA research rather than just engage in EA practice.

Summary

The EA field has evolved from: 1) a focus on rescuing alcoholic employees to an ever-widening scope of employee problems and needs, 2) a localized, peer-led model of intervention to an external, national/regionalized professionally-directed model, 3) high dose/intensity services to low dose/intensity services; and 4) a focus on employee health and performance to a focus on benefits management and other company needs. Depending on one's vantage point, these trends represent a dynamically evolving field that has continually re-engineered itself within a turbulent behavioral health marketplace, or a field in decay that in its search for professional credibility and financial security and profit has become detached from its historical roots and its core values and technologies. The authors confess leaning toward the latter position, but any pessimism that view might bring is offset by our anticipation of a renewal movement within the EA field that will re-link the field to its historical mission as is moves through the early twenty-first century. That renewal movement will: 1) reinstall interventions with addiction and other behavioral health disorders at the center of the field's mission and competencies; 2) rebuild the partnership between management and labor in responding to the impaired employee; 3) re-localize the delivery of EA services and the development of EA service networks; 4) persuade colleagues and employers to sell and buy EAPs on the basis of compliance with generally accepted quality standards rather than the lowest bid, and 5) create a research infrastructure that can place the EA field on par with other arenas of behavioral health care.

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The Addiction Counselor/Supervisor as Trainer

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Abstract

Addiction counselors and supervisors are increasingly being called upon to teach and train their clients, their professional peers, and the general public. This article provides tips on how counselors and supervisors can design and deliver effective inservice training programs. Inservice training is viewed as a means through which the field can strengthen the oral folklore through which our knowledge has been historically transmitted.

Fully developed addictions professionals are also trainers. As the aides in 19th century inebriate asylums, the lay therapists of the Emmanuel Movement, the counselors on alcoholism in psychiatric hospitals of the 1950s, and as modern addictions counselors and supervisors, we have been the conduits for the transmission of information, ideas, skills, values, care, and hope. We have carried these precious gifts to the addicted, to their families, to our professional peers, and to our communities.

In the past two decades, the training aspects of the addictions professional role have become more focused as counselors have taken on greater responsibilities in client and community education. With the tightening budgets of our current era, another training role has increased. Where a decade ago, an agency sent four counselors to a workshop, today's fiscally frugal agency sends one counselor to a workshop or conference with the admonition to return and conduct an inservice training session on what was learned for those staff who didn't attend. The purpose of this article is to provide addiction counselors and supervisors with some practical tips on the design and delivery of such inservice training.

Counseling and Training

While many counselors are intimidated by the training role, the fact is that there are many counseling skills that constitute the foundation for successful training. The ability to listen, read nonverbal behavior, pose meaningful questions, speak clearly and concisely, and teach through story and metaphor are as essential to training as they are to counseling. Those of

you with extensive work facilitating groups and family counseling sessions will bring even greater natural aptitudes for the trainer role. It is important to see training not as a new role but an extension of what you already do well.

Selecting Training for Potential Replication

When asked to go to a conference or workshop and bring back what you've learned, it is important to realize that not all training is appropriate for replication or adaptation for inservice training. Some training is far too technical to replicate, other training is far too experiential, while still other training has too little substance to warrant replication. Make sure that you and your supervisor select training that can stand up to this replication demand. Choose training conducted by presenters known for their rich content, training that has clearly defined learning objectives that seem transferable to the inservice format, and training that comes with handouts—the best indicator you have of a trainer's preparation and organization.

Attending Training of Trainer Courses

Participating in training that you yourself will later present brings different responsibilities than when simply attending training for your own personal learning. Some counselors go to a training and then come back and share, almost as an afterthought, a few interesting things they learned with other staff in an inservice training. This isn't training; it's leftovers. This method can be dramatically improved by the following procedures:

1) Before attending the training, use a few minutes in a staff meeting to announce that you are going to be attending the training and will be returning to share what you learned with others. Ask the staff if they have particular concerns or questions related to the training topic. Your goal is to create a shopping list of interests. You will then be going to training on behalf of all your peers—seeking out information and asking questions on their behalf as well as your own.

2) Before the training begins, ask the sponsors and the presenter for permission to tape record the session and for permission to reproduce any handouts. Emphasize that these recordings will only be used for purposes of inservice training within your agency. Professional trainers get such requests all the time and are usually quite agreeable to such requests. During your forthcoming inservice, you can share the handouts and note that you have a full recording of the session if any staff are interested in listening to it.

3) Take notes at the training and edit these notes into a brief synopsis of the major points made in the training. These notes can then become part of your handouts for the inservice training. The tapes, handouts, and edited notes should become part of the agency's permanent inservice library.

The Uniqueness of Inservice Training

The counselor or supervisor who conducts inservice training is in one of the most unique training settings. There are many things that work against the success of inservice training sessions. First, the counselor/supervisor trainer standing in front of his or her peers is a known quantity. There is none of the mystique and "halo effect" that tends to accompany an outside trainer, nor is there any expectation that staff will be on their best behavior as they would more likely be with an outside trainer. Second, inservice training is plagued by short time constraints, people arriving late and leaving early, and, in some agencies, innumerable interruptions. These conditions are the professional nightmare of the most experienced trainer.

There are, however, special advantages to the inservice training format. There are usually lower expectations for such training because all of us share the training responsibilities and don't enter the role as either an alleged content expert or training delivery expert. The biggest

advantage is that, as a trainer, you will never have a greater knowledge of a trainee audience than in the inservice format. You will know your audience better than any professional trainer could—their strengths and weaknesses, their special interests, their ideological sensitivities, and their learning styles. The design and delivery of successful inservice training requires an understanding of the unique constraints and advantages of this format.

Designing Inservice Training

Some simple design considerations for inservice training include the following:

1) Keep it simple. Define what you can and cannot do within the prescribed time frame. Don't try to cram the one-day workshop you attended into a one-hour inservice—that's what the availability of tapes and handouts is to avoid. Select a few learning objectives that seem appropriate to your group and to the time restrictions.

2) Keep it specific. Include special topic references that link your general topic to what you know to be the special interests of key staff. It reinforces the fact that you are there not to show off what you know but to respond to their needs and interests.

3) Keep it logical. Organize the inservice so that there is a clear beginning, middle, and end.

4) Get everyone involved. Design the inservice with a focus on inclusion and participation. Ask open-ended questions, use a quick brainstorming and reporting out exercise, solicit a case example, use structured learning experiences guided by written handouts (worksheets). Do anything, but get'em involved.

5) Stimulate their senses. Involve as many senses in the learning process as possible. Vary the media and use different media to convey the same material. You want them to hear, speak, see, touch, and, if possible, taste and smell your topic.

Training Delivery

There is a simple motto for training delivery: preparation avoids perspiration. What this motto emphasizes is that the most important elements of training delivery occur before you begin training: preparing, organizing the training space, checking and rechecking all equipment and supplies and, last but not least, checking yourself physically and mentally. The importance of the last item can be gleaned by asking any group of professional trainers to share their worst training experiences. You will hear stories about having a slide projector breakdown in the middle of your keynote address to 400 people, ripping the seat out of your pants just before you are to begin training, having someone in the front row slip you a note while you're presenting that says your dress is stuck in the back of your pantyhose, or forgetting to turn off your portable microphone when you enter the restroom during a break in training. These are the kinds of experiences that really build character in a trainer and make the best trainers compulsive about the training environment and their own presentation of self.

When you are ready to begin training, three things should be completed: 1) your preparation of the room, equipment/supplies, and yourself, 2) an outline of the content of what you are about to do, and 3) an outline of the training process. The latter might be a single sheet of paper that lists the sequence of training activities that you are going to use and their approximate times.

We noted earlier that good training has a clear beginning, middle, and end. In the beginning you want to achieve three things: 1) introduce yourself, the topic, and the boundaries of your knowledge of the topic, 2) define the learning objectives that will be the focus of the inservice, and 3) get everyone involved. Introducing yourself may seem silly for an inservice training when you are training staff who already know you. But it is important to share with them what you are bringing to this particular topic, some of which may include experiences that predate your current position. You also want to

diminish your power in the trainer trainee relationship by shifting the framework of training from that of expert-to-student, to that of a mutual exploration of a critical issue. The goal of getting people involved is to quickly avert the propensity for trainee passivity before it has a chance to set in. If your inservice topic is on solvent abuse, you might ask by a show of hands how many staff have served as a primary counselor for a client whose drug of choice was volatile solvents, or with a very experienced group of staff, you might ask people to brainstorm some of the special obstacles they have encountered counseling solvent abusers.

The middle of the training involves the content of the training and the activities you have built in to explore that content. Experienced trainers build menus of potential activities from which they can make selections depending on the response of the trainees. The selection of training delivery techniques hinges both on the topic and what kind of skills you bring to the training process. Some counselors are excellent speakers and can rely on more formal presentations of information. Other counselors will bring greater strengths in the area of group facilitation and may wish to provide training on topics that lend themselves to this style of training delivery. It is best to start with your natural strengths and then begin to develop an expanded repertoire of skills.

The successful closure of an inservice training session should: 1) provide a concise summation of key points, 2) provide everyone an opportunity to personalize the information and its relevance to their role and the program, and 3) provide each participant an opportunity to evaluate the training. The latter can be achieved through either a group evaluation exercise or through use of a standard inservice evaluation form.

On Training Terror and Training Intoxication

Being the center of attention in the trainer role can be as terrifying as it can be intoxicating. For those whose experience comes closer to terror, the trick is to channel the fuel generated by the fear into an ally in the training process—to transform anxiety into positive energy. For those particularly vulnerable to such stage fright, two techniques may prove helpful. First, design and utilize facilitation focused training (as opposed to presentation focused training) that keeps the bulk of the attention on the trainees rather than on yourself Secondly, master some simple rituals that allow you to get positively focused—you know, the kind you teach your clients all the time. I have been training for 25 years and I still use such techniques to get myself centered. I remind myself that what I am about to do is not about ego but about message. I try to reduce my ego consciousness by focusing on the importance of what I'm about to do rather than on what people are going to think of me. I refer to this as humbling myself before the training gods. The training gods do need help, however. Ultimately, the best antidote for nervousness in the role of trainer is meticulous preparation.

A few cautions are in order for those who find themselves drawn to the limelight of training like an insect to fire. Personal charisma and great speaking rarely constitute good training. While these natural talents may serve some of us well in other arenas, there tends to be hidden harm when personal charisma and spell binding speech are brought into the training environment. Trainees often leave such an event impressed, overwhelmed, even worshipful. Their gushing praise can be dangerously intoxicating for the neophyte trainer. But trainees often leave such an event awe struck by their new guru, but feeling worse about themselves—less capable, less confident, less powerful. (The corollary to this point, by the way, is that great evaluations do not necessarily reflect great training.) The key to training is not to impress trainees with our brilliance and our skills but to elicit the best ideas and best skills from within each trainee.

Training Techniques, Training Style and Knowledge of Your Audience

As someone who has spent most of the last two decades traveling 120 days a year as a professional trainer, I can assure you there are no training delivery techniques or styles applicable to all audiences. Technical knowledge will not make up for a lack of knowledge about those to whom you are speaking. And just because you work with a group of people doesn't mean that you know them as trainees. In the past month, I have made presentations to a small group of AIDS case managers, a group of Chicago Probation Officers, a large group of physicians, several shifts of police officers, a group of civil engineers, and several groups of addiction counselors. Can you for a moment think about the differences between these groups in how you introduce and qualify yourself, the differences in general learning styles, and the differences in the relative balance between cognitive, affective, and behavioral dimensions of training?

The research unit of which I am a part contains analytical thinkers who learn primarily through cognitive maps and who would consider exercises commonly used in counselor training as bizarre and a waste of time. They are research-based learners. They look for evidence. The counselors for whom I regularly provide inservice training within the broader organization of which I am a part learn very differently. They learn through sharing stories and through seeing new behaviors modeled. They learn affectively as well as cognitively. They look for experience. This is all to say that the selection of particular training techniques and even formulation of a training style for a particular training event requires some precision. Using a blank sheet of paper, jot down in as much detail as possible what you know about your staff and their styles of learning. Think about their ages, their gender mix, their cultural backgrounds, their developmental experiences, and their educational and professional backgrounds. Given your observations, describe how you might approach designing and delivering training to this group.

On Enthusiasm

When asked what I consider the most important quality of a successful trainer, I discard numerous possible answers. First, I discard technical knowledge because I know many exceptionally intelligent individuals who are terrible trainers. I also discard being a great counselor because some of the most skilled clinicians fall short in their abilities to train other counselors. I quickly discard physical attractiveness because many of the best trainers would never win a beauty contest. There are many qualities that contribute to making a great trainer but which would still fall short of being THE most important quality. When all is said and done, I think what the great trainers bring to their work is an insatiable curiosity and an unquenchable enthusiasm about their field of study. That's what I think each of you who is called upon to train must reach inside to find. You must find a way to bring passion and excitement to the learning process so that even the most resistant learners get caught up in the process in spite of themselves. That means that you must find within each topic that which moves and excites your own interest and passion and then bring that energy to your design and delivery of the material.

Answering Questions

The general guideline for answering questions in training is: answer the question as clearly as possible, as briefly as possible, and give the questioner an opportunity for a brief follow up response. The fear of questions intimidates many a would-be trainer, and often leads to avoiding training opportunities or to over preparation. There is in the trainer role this fear of being humiliated—the fear that we will be asked something we don't know and that our response will embarrass us in front of our peers. But there is a very simple antidote to such fear, and that is an open acknowledgment of our limitations. (We, of all people, should now this. Bill Wilson once referred to this as "the sublime paradox of strength coming out of weakness."2) The most important and underutilized phrase in the trainer's vocabulary is, "I don't know."

When posed a question to which you have no knowledge whatsoever, say first and foremost those magical words. The follow-ups to that pronouncement can be as varied as, "I'll have to see what I can find out about that and let you know" to "Does anyone else have anything they could add as a response to this question?"

The Ethics of Inservice Training

Yes, there are ethical dimensions of training. The most important ethical guidelines for conducting inservice training include the following:

1) Know your limits. Stay within the boundaries of your education, training, and experience in your role as a trainer.

2) Respect the source. Trainers are notorious for stealing from each other, but we try to do it respectfully. Respect involves not claiming others ideas as our own and giving credit where it is due.

3) Distinguish fact from opinion. Separate (by appropriately labeling) the presentation of fact from the presentation of opinion.

4) Strive for professional objectivity. Present as objectively as possible the multiple sides of complex issues.

5) Protect your audience. Remain constantly cognizant of the physical and psychological safety of trainees.

The Question of Self Disclosure

There are some direct parallels between the use of self-disclosure in counseling and the use of self-disclosure in training. Both involve three questions: 1) Is self-disclosure at this time, in this context, with this person (or these people) an effective strategy? (Will it achieve a positive outcome?) 2) Is self-disclosure at this time, in this context, with this person (or these people) ethical? (Is there any inadvertent harm that could occur as a result of such self-disclosure?), and 3) Am I using self-disclosure as a shortcut to acceptance by trainees?

The question of the effectiveness of self-disclosure varies greatly from audience to audience and varies according to what purposes are to be achieved by the trainer, e.g., knowledge or skill acquisition versus attitudinal/value changes. The ethical question involves exploring the nature of the trainer trainee relationship. This relationship, like the counselor client relationship, is a fiduciary relationship, implying that one party assumes a special duty and obligation for the care of another party. It means that the needs that will drive the decision-making process will be those of the client/trainee and not those of the fiduciary agent—the counselor/trainer. For trainers, this means that self-disclosure must be used, if at all, strategically to enhance the learning of trainees and not to meet the needs of the trainer for emotional catharsis.

Some of the best trainers are inveterate storytellers and weave wonderful personal and professional anecdotes into their presentations. But as spontaneous as such stories may appear, they are usually carefully selected and sculpted to meet particular training goals. The general rule on self-disclosure in training is threefold: weigh such disclosure carefully, use brief strategic disclosures that do not break your emotional contact with the audience, and NEVER, NEVER, NEVER disclose personal or professional material of immediate emotional intensity in training. We must be careful not to exploit the privilege of the lectern to shift the focus of the interaction from the needs of trainees to our own needs. Trainees are there to learn, not to provide the social backdrop for the trainer's own therapy.

The Training Autopsy

For those of you interested in developing yourself as a trainer, take a few moments after each training opportunity to evaluate everything related to its preparation and delivery. You may even find it helpful to keep a journal of your various presentation experiences. What is captured in the journal is what you learned from each training

experience—learned about your audience, learned about the trainability of particular material, learned about yourself as a trainer.

Improving Training Skills

There are three primary ways to improve your training skills. The first is to attend one or more training of trainer courses. These provide an excellent introduction even for those persons who bring great natural skills as a trainer. The second method is to search out master trainers (persons who have achieved an incredible degree of training skill) and watch them work. Find master trainers and focus your attention, not on the content of what they train, but on how they organize and deliver their material. Watch their every move—including before training starts, at breaks, and when the training is over. What you are looking for are aspects of technique and style that fit your own temperament and your own training formats. The third, and most important, method of improving your training skills is to train, and to train at every possible opportunity.

If one is really serious about pursuing the area of training as a dimension of one's identity as an addictions counselor/supervisor or as an activity that supplements and complements this role, it is helpful to develop a network of other individuals who share this interest. It is also helpful to include within one's mentor relationships one or more individuals who bring special training expertise.

Training Coordination

In many small and medium sized programs, a counselor may be asked not only to deliver an inservice training session but to organization and coordinate such sessions. Such coordination can either be done by intuition or quite systematically. The latter involves conducting needs assessment surveys to determine the most important inservice training topics, recruiting, and assisting staff in presenting these sessions, and evaluation the inservice training program. An increasing number of programs are finding creative solutions to maintaining high quality training in the face of tightening program budgets. One approach involves creating a wider network through which agencies can exchange staff resources for inservice training. This bartering system provides a variety of experts that are traded back and forth between programs with no fiscal resources required. A more formal version of this method involves creating multi agency training consortia or networks through which resources can be pooled to bring in outside trainers that no single agency could afford.

On Our Responsibility to Write and to Teach

The effectiveness and integrity of our whole system of addiction treatment ultimately rests on the knowledge, skill, judgement, and ethics of those who sit face-to-face with addicts and their families. The Achilles heel of our whole field lies in the lack of preparation, orientation, training, and retention of those who are charged with this most central task. The addictions field is handicapped in its efforts to support counselors by an underdeveloped technology for transmitting the field’s knowledge and folklore. The oral traditions we have relied on to transmit such knowledge and folklore are breaking down due to the rapid changes within the field. We are a field in motion whose collective experiences—our perceptions, understandings, methods—are being bled out regularly through excessively high turnover. Inservice training programs and inservice training libraries of literature, handouts, and audio and video recordings are vehicles that can capture the best of what we are and what we do for future generations of counselors. Francis Bacon once wrote that all people are debtors to their professions. Embracing the role of inservice trainer is one way that each of us can repay our debt to those who came before us and delivered the field into our hands. This is a torch that we each have a professional and moral obligation to reach out and grasp.



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The Historical Essence of Addiction Counseling

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What distinguishes the profession of addiction counseling from the array of helping roles that have preceded and have followed it? What would be lost if the specialized knowledge and functions performed by the addiction counselor disappeared? This essay will explore these questions by attempting to define the historical essence of addiction counseling. The distinctiveness of this role lies in the unique way alcohol and other drug (AOD) problems and their solutions have been defined within the addictions field. It also lies in nuanced views of the addiction counselor's relationship to self and his or her relationship to the addicted client/family, other service professionals and the community.

Theoretical Foundation

There are four defining premises of addiction counseling that historically separate the addiction counselor from other helping roles. These premises are that:

1. severe and persistent alcohol and other drug problems constitute a primary disorder rather than a superficial symptom of underlying problems
2. the multiple life problems experienced by AOD-impacted individuals can be resolved only within the framework of recovery initiation and maintenance
3. many individuals with high problem complexity (biological vulnerability, high severity, co-morbidity) and low "recovery capital" (internal assets, family and social support) are unable to achieve stable recovery without professional assistance, and
4. professional assistance is best provided by individuals with special knowledge and expertise in facilitating the physical, psychological, socio-cultural and often spiritual journey from addiction to recovery.

If AOD problems could be solved by physically unraveling the person-drug relationship, only physicians and nurses trained in the mechanics of detoxification would be needed to address these problems. If AOD problems were simply a symptom of untreated psychiatric illness,

more psychiatrists, not addiction counselors would be needed. If these problems were only a reflection of grief, trauma, family disturbance, economic distress, or cultural oppression, we would need psychologists, social workers, vocational counselors, and social activists rather than addiction counselors. Historically, other professions conveyed to the addict that other problems were the source of addiction and their resolution was the pathway to recovery. Addiction counseling was built on the failure of this premise. The addiction counselor offered a distinctly different view: "All that you have been and will be flows from the problem of addiction and how you respond or fail to respond to it."

Addiction counseling as a profession rests on the proposition that AOD problems reach a point of self-contained independence from their initiating roots and that direct knowledge of addiction, its specialized treatment and the processes of long-term recovery provide the most viable instrument for healing and wholeness. If these core understandings are ever lost, the essence of addiction counseling will have died even if the title and its institutional trappings survive. We must be cautious in our emulation of other helping professions. We must not forget that the failure of these professions to adequately understand and treat addiction constituted the germinating soil of addiction counseling as a specialized profession.

Use of Self

Virtually all of the helping professions speak of the "use of self" in the helping process, but addiction counseling brought many unique dimensions to this process. First, the addictions field is the source of the very concept of "wounded healer"—the idea that experiencing and overcoming an affliction bestows certain powers to understand and heal others similarly afflicted (White, 2000). The wounded healer tradition in addiction counseling begins with the abstinence-based, Native American cultural and religious revitalization movements of the 18th century, spans the 19th century recovery activists (e.g., Washingtonian and Reform Club missionaries) and early 20th century lay alcoholism therapists, and re-emerges in the modern addiction counselor. Perhaps more than any other therapy discipline, addiction counseling has respected the notion of "calling" in the choice of this profession.

The profession of addiction counseling has not made the experience of addiction and recovery a required ticket of entrance, but it has called for a greater level of experiential authenticity than that found in allied counseling professions. Ernie Kurtz alluded to this when he spoke of the shared characteristics of those not in recovery who made great contributions to the modern alcoholism recovery movement: "They were not alcoholic, but they did have something in common: each, in his or her own way,… had been emptied out…. Each had encountered and survived tragedy" (Kurtz, 1996).

The calling and commitment that has historically characterized addiction counseling is reflected in the relationship between the counselor and client. What the addiction counselor brings in addition to their skills is their whole person—their life. This is reflected in a less hierarchical relationship and a higher level of self-disclosure than is found in allied helping professions. Courtenay Baylor, the first (1913) recovered alcoholic to work as a professionally paid lay alcoholism therapist, went so far as to negotiate a reciprocal agreement of confidentiality with his clients. This greater emphasis on mutual vulnerability, mutual self-disclosure and mutual honesty (more directly expressed) reflects a greater use of self in addiction counseling. At the same time, the counselor has been admonished to separate his or her own experience from the client's recovery processes—a paradoxical demand for personal involvement and detachment not seen in allied professions that place greater emphasis on therapeutic distance and objectivity.

Providing hope is a crucial dimension of all helping professions, but unique among these professions is the addiction counselors' role in offering themselves as "living proof" of such hope. The addiction counselor's responsibilities historically have

included providing the evidence of the potential for long term recovery through their own personal/family story or by guiding the client's exposure to a vibrant community of recovering people.

Another unique quality of the addiction counselor is the capacity to absorb losses and use such losses as rituals of rededication. The high mortality rate of alcoholics and addicts means that addiction counselors experience many losses, some of them quite horrific. To sustain oneself in the face of such losses requires the ability to use these experiences to deepen one's understanding of the nature of addiction and to recommit oneself to finding new ways to reach those who have not yet achieved stable recovery. To fail to master this ability is to open oneself up to emotional injury and the protective detachment or over-involvement that such injury can spawn. Seasoned addiction counselors are acutely aware that they are involved with their clients in a life or death struggle for recovery. The stakes involved in this work are very high and that awareness brings its own burdens and rewards.

Relationship with Clients

> *The first requirement for successful counseling of the alcoholic is the correct attitude….If you don't have this, then it doesn't matter how many techniques you use, they aren't going to work.* --Marty Mann, 1966

> *Contempt, often mutual, is an enduring and often troubling theme in the historical relationship between helping professionals and addicts…What recovered people brought to this field* [addiction counseling] *was, first and foremost, the capacity for moral equality and emotional authenticity.* –Author, 1998.

One could argue that a specialized addiction field was born in great part due to the contempt in which alcoholics and addicts where held by other helping professions. Whatever technical skill the addiction counselor may possess that is lacking in these other professions, that skill may not be as important as the addiction counselor's ability to transcend this history of contempt. When one spends time with the pioneers of modern addiction counseling (e.g., Mel Schulstad), one is struck by the deep acceptance and affection that marks their relationships with people addicted to alcohol and other drugs. It is not that they fail to see the crude veneer that addiction has wrought; it is that they are able to see the person masked by this characterological armor. Alcoholics and addicts have not fared well in service relationships in which they sense an air of moral superiority. What the role of addiction counselor brought, at its best, was a capacity for acceptance and a willingness for being with, rather than doing to or for. This kind of empathic identification and alliance is important in all helping professions, but the characterological excesses and shenanigans of the addicted render them less lovable and more easily extruded from traditional service systems.

What the addiction counselor knows that other service professionals do not is the very soul of the addicted—their terrifying fear of insanity, the shame of their wretchedness, their guilt over drug-induced sins of omission and commission, their desperate struggle to sustain their personhood, their need to avoid the psychological and social taint of addiction, and their hypervigilant search for the slightest trace of condescension, contempt or hostility in the posture, eyes or voice of the professed helper.

The relationships between the addiction counselor and his/her clients have much in common with other therapeutic disciplines, but there are qualitative differences. Addiction counseling has had a greater respect for the power of unseen forces in the recovery process, particularly processes of sudden, transformative change (see Miller & C'de Baca, 2001). The field has also had a sustained interest in stages of change processes (see Wallace, 1974). Studies of addiction have generated the models of change that have are now being applied to many other problems (Prochaska, DiClimente, & Norcross, 1992). One also finds interesting areas of emphasis in the addiction treatment world that are less

visible in other disciplines, e.g., the value of catalytic, sense-making metaphors; the importance of narrative reconstruction of personal identity and interpersonal relationships (via story reformulation and storytelling); positive and culturally-nuanced reframing of abstinence; and a deep appreciation for paradox (e.g., strength coming out of weakness, winning by admitting defeat).

Like other counseling-based professions, addiction counselors have long been preoccupied with the mastery of clinical technique and have tried, since Peabody's 1931 *The Common Sense of Drinking*, to manualize the process of addiction counseling so that the skillful execution of clinical procedures could be passed on to others. Addiction counselors have also, perhaps more than any other therapy-based discipline, believed that their clients could be formally educated to self-manage their own recoveries. There is a long history of the use of bibliotherapy in addiction counseling, and giving lectures to clients about addiction and recovery dates to the 19th-century inebriate homes and asylums. It was Ray McCarthy at the Yale Center for Alcohol Studies who in the 1940s rebirthed the modern use of group lectures as a therapeutic tool in addiction counseling (McCarthy, 1946). Casting service consumers in the role of "students" rather than "patients" is a unique thread within the history of addiction counseling.

If there is a therapeutic stance most unique to addiction counseling, it is perhaps the virtue of humility. Alcoholics and addicts have long possessed ingenious ways of instilling such humility in therapists who saw themselves in control of the therapeutic process. While seasoned addiction counselors muster the best science-based interventions, they do so with an awareness that recovery often comes from forces and relationships outside the client and outside the therapeutic relationship. It is in this perspective that the addiction counselor sees himself or herself as much a witness of this recovery process as its facilitator. In the end, the job of the addictions counselor is to find resources within and beyond the client (and the counselor) that can tip the scales from addiction to recovery. To witness (and be present within) that process of transformation is the most sacred thing in the field, and what would most need to be rediscovered if the field collapsed today.

The history of addiction counseling can be divided into two eras: the discovery of commonalities and the discovery of differences. In the first era, the field catalogued what people with alcohol and drug problems shared in common and through that process defined addiction and its diagnostic criteria. The common needs and change processes of people seeking to resolve these problems further led to clinical protocol that addressed these common needs and facilitated those change processes. The second era was marked by the recognition of differences—different patterns of AOD use, different etiological pathways to problem development, differential responses to treatment interventions, and multiple long-term pathways and styles of recovery. We are today in transition from herding clients through "programs" to the recognition of "special populations" (demographic, cultural, and clinical subpopulations) to the development of highly individualized approaches to clients within these subpopulations. The essence of addiction counseling is to recognize the shared needs a client may experience based on their gender, developmental age, culture, sexual orientation, drug choice, psychiatric diagnosis, living environment (urban, suburban, rural), and religious orientation, but to not entrap and lose the client's individuality within these categories. When you strip away the theory and the technique, the procedures and the paper, addiction counseling remains a unique interpersonal encounter.

In addition to a theoretical foundation and a body of technical/cultural knowledge and skill, helping professions are distinguished by fiduciary relationships with their clients that are guided by a set of ethical principles and guidelines. Such ethical sensitivities and standards in addiction counseling have a very short history (perhaps dating from the 1987 publication of Bissell and Royce's *Ethics for Addiction*

Professionals) and have borrowed heavily from the disciplines of psychiatry, psychology and social work. It is only recently that the field has begun to refine its ethical codes to reflect the unique vulnerabilities of its clients, service providers and service institutions. What the field has recognized is its power to do harm in the name of good, and it is that awareness that is driving the heightened emphasis on ethical decision-making in addiction counseling.

Relationship with other Professionals

On the road from "paraprofessional" to professional, addiction counselors entered into partnership with other service professionals to create multidisciplinary service teams. The model for such collaboration was set by Francis Chambers, a Peabody-trained lay therapist, who was the first addiction counselor to work within a multidisciplinary alcoholism treatment team. In 1935, Chambers began a sustained collaboration with prominent psychiatrist, Dr. Edward Strecker, at the Institute of the Pennsylvania Hospital in Philadelphia (Strecker & Chambers, 1938). Since that time, lay therapists and then alcoholism/addiction counselors have found ways to replicate Chambers' model of collaboration. The best of these collaborations have been based on mutual respect and a commitment that each member of the multidisciplinary team would practice within, and only within, the boundaries of his or her education, training, and experience.

Chambers and other early twentieth-century lay therapist also pioneered a unique pattern of intraprofessional collaboration. Mentoring other lay therapists (e.g., recruiting and training former clients with aspirations and aptitude for such a role) was an essential part of each lay therapists responsibilities. That tradition declared that one's professional career responsibilities had not ended until new people were mentored to fill the space created by one's impending absence. Given the aging of addiction counselors and others working in the addictions field, we would do well to re-emulate that tradition.

Relationship to Community

If there is an individual who most represents the addiction counselor's understanding of the power of community in the recovery process, it is Matt Rose. Rose pioneered a community development model of alcoholism counseling within the anti-poverty programs of the 1960s and was in 1972 one of the founding members and first director of the National Association of Alcoholism Counselors and Trainers (NAACT)—NAADAC's precursor. What Rose understood, perhaps more than anyone before or after him, was the importance of anchoring and strengthening recovery within the context of a larger community of recovering people. For Rose, recovery, to be sustainable, had to be nested within the natural environments in which people lived out their lives. His focus was not on building treatment institutions, but on building and expanding cultures of recovery within the very fabric of local communities. He believed there was a hidden reservoir of recovery support in the larger community that could be tapped to spark and sustain the recoveries of those seeking help. In his view, the alcoholism counselor was more a guide into this community relationship than a traditionally defined therapist. What the addiction counselor, at his or her best, contributes that is lacking in other human service disciplines is a detailed knowledge of local cultures of addiction and cultures of recovery. That knowledge is crucial in facilitating clients' journeys between two psychological and social worlds.

There is also a lost dimension of activism within the role of addiction counselor. Historically, that activism confronted AOD promotional forces that targeted vulnerable populations (e.g., AOD advertising aimed at adolescents), mobilized support for local continua of addiction treatment services, and helped organize peer-based recovery support services and recovery support groups (e.g., recovery homes, recovery training and work projects,

alumni support groups). In the wake of the recent restigmatization, demedicalization and recriminalization of addiction, counselors are re-involving themselves in recovery advocacy organizations to counter the effects of such stigma on yesterday, today, and tomorrow's clients.

Pace Yourself: It's a Marathon

> *One must be careful in carrying light to the community to not leave one's own home in darkness.* –Advice from a wise father on his son's decision to pursue a career in addiction counseling

The final thing that addiction counselors brought to the professional table was an ability to sustain themselves over time working with alcoholics and addicts and their families. That capacity for survival and health in the face of constant confrontations with trauma and pain is noteworthy. I have been writing for more than two decades about what it takes to sustain oneself in this most unusual of occupations, and my answers to that question have changed little. The four things that mark the essence of daily life in recovery are also the sources of sustenance for the best addiction counselors. These core activities include 1) centering rituals (acts of prayer, meditation, self-reflection) that help keep one's "eyes on the prize," 2) mirroring rituals (reaching out to kindred spirits for support and inspiration), 3) acts of self-care (taking care of oneself and one's intimate circle physically, emotionally and spiritually), and 4) unpaid acts of service (reaching out to others outside the context of our professional duties in ways that elevate our spirits).

There is an inevitable process of homogenization of human service roles. What has distinguished addiction counselors from other service professionals is worth cherishing and protecting.

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Calling a New Generation of Leaders

William L. White and Lonnetta Albright

A generational passing is unfolding in the world of addiction treatment. The field's long-tenured leaders in policy development, administration, clinical supervision, clinical practice, research, education and training are beginning to disengage. Their mass exodus in the next decade will mark a major milestone in the history of the field. The future of addiction treatment and recovery in America rests on the preparation and willingness of a new generation of leaders to step forward to fill this emerging void.

On behalf of the men and women who are approaching the twilight of their careers in this field, we extend an invitation to the younger readers of *Addiction Professional* to step forward to accept this mantle of leadership. Some readers will feel they are not suited or ready for such responsibility. Most of the leaders from the authors' generation were not ready either when the field asked us to step forward. This essay offers thirteen prescriptions for enhancing such readiness.

Leadership Development Prescriptions

Fully Commit Yourself to the Field: People enter the addictions field through many pathways and remain or leave for equally diverse reasons. The degree of long-term commitment to the field varies from individual to individual and in the same individual over time. The exodus of current leaders opens an era of increased vulnerability and opportunity. A vanguard of new leaders is needed who are committed to the field's future. Might you become a member of this vanguard? Consider the following questions:

1) Do I feel in my heart that service to this field is what I am personally destined to do with my life?
2) Do I feel there are better ways to respond to the needs of the new generation of clients that are entering addiction treatment?
3) Am I willing to commit myself to the future of this field at a level that transcends particular job roles and organizational affiliations?

If your answers to all three questions are affirmative, perhaps it is time to formalize this commitment and intensify your leadership preparation.

Orient Yourself to the Field: A crucial early step in leadership preparation is getting yourself fully oriented to the field. This involves stepping outside your role and your organization to acquire knowledge of:

- The history of the field (White, 1998).
- The core ideas, values and service technologies that distinguish addiction treatment from other human service disciplines (White, 2004).
- The field's organizational infrastructure, including:
  --key federal/state agencies(see http://www.niaaa.nih.gov,http://www.nida.nih.gov, http://csat.samhsa.gov)
  --national trade associations (see http://www.nasadad.org, http://www.naatp.org, http://www.adpana.com, http://www.asam.org, and http://naadac.org).
  --national program accreditation bodies (see http://www.jcaho.org/accredited+organizations/behavioral+health+care/index.htm and http://www.carf.org).
  --national addiction counselor trade associations and credentialing bodies (see http://naadac.org and http://www.icrcaoda.org).
  --national advocacy groups (see http://ncadd.org and http://www.facesandvoicesofrecovery.org/main/index.php).
  --recovery mutual aid societies (http://facesandvoicesofrecovery.org/resources/support_home.php).
- The core people, organizations, ideas and service technologies that are pioneering new approaches to the treatment of women, adolescents, seniors, people of color, lesbian, gay, bisexual and transgendered people as well as people recovering from co-occurring medical and psychiatric disorders (see http://www.nattc.org and http://www.treatment.org/Externals/tips.html for key resources).
- The core people and institutions that shape drug policy and treatment strategy at the federal level (see http://www.whitehousedrugpolicy.gov).

Leadership preparation requires transcending what may have been a parochial involvement in the field, grasping a vision of the field as a whole, and getting a sense of the state of the field's infrastructure and emerging needs (See McLellan, Carise, & Kleber, 2003 for a recent review of the latter).

Develop a Personal Leadership Vision: Having committed and oriented oneself to the field, the question remains, "Committed to do what?" Aspiring leaders can formulate their own personal leadership vision by exploring six questions:

1) What core values and core service technologies of the treatment field need to be protected from future dilution, corruption or abandonment?
2) What unmet needs must the field address as it moves into the future?
3) How can we best reach the next generation of clients entering addiction treatment?
4) What unique assets do I possess that can nurture the future development of the field?
5) What issues and activities energize me at the deepest levels?
6) What major contributions or lasting legacy would I like to leave the field by the end of my career?

A personal leadership vision can be formulated out of the intersection of the emerging needs of the field, what we do best, and those issues about which we are most passionate.

Study the Great Leaders: The best leaders do their homework—not only on technical subjects but also on the art of leadership itself. We recommend three kinds of reading as leadership preparation. We recommend the biographies and autobiographies of people who have left a positive imprint on the world, such as Abraham Lincoln, Frederick Douglass, Tatanka Yotanka (Sitting Bull), Mahatma Gandhi, Nelson Mandela, Martin Luther King Jr., Cesar Chavez, and Mother Teresa. We recommend the biographies or writings of recovery mutual aid pioneers (e.g., Bill Wilson and Jean Kirkpatrick), treatment pioneers (e.g., Dan Anderson and Marie Nyswander), science-to- practice advocates (e.g., William Miller and Tom McLellan), and public education and policy pioneers (e.g., Marty Mann and Harold Hughes). Finally, we recommend broader works on leadership. Ask leaders you admire what they have read that has inspired and guided them.

Expect Obstacles: Being a leader is not easy. Many obstacles will divert you from your leadership vision. You must face and overcome those rising from inside you—fear, reluctance, procrastination, and a sense of unworthiness (to name a few)—and those obstacles the world injects. Working your way through these roadblocks builds the courage, discipline and strength of character you will need as a leader. No one becomes a leader without being tested.

Expand Your Educational and Experiential Credentials: Once you have formulated a personal leadership vision, you can identify the new knowledge and skills you will need to acquire. The opportunities for career advancement in the next decade in the addictions field will be enormous, but many of today's workers will be thrust into positions for which they are unprepared. Now is the window of opportunity for such preparation. If you have considered advancing your educational/professional credentials or receiving specialized training, now is the time. For those seeking specialty training in addiction studies, a national directory of these programs can be found at http://www.nattc.org/degrees/search.asp. Questions to consider in this credential building process include the following:

1) What specialty degree or training will most empower me to fulfill my personal leadership plan?
2) What educational and training resources are geographically and financially accessible to me?
3) To what extent will my current employer support my continued education?

There is also a level of experiential knowledge that will enhance your future as a leader in addiction treatment. Many of us have risen through the ranks within particular types of programs that provided great depth of experience but were limited in their scope. Answering the following questions can help identify such limitations.

1) What organizational settings (rural, urban, suburban) have I not worked within?
2) What treatment philosophies and modalities do I need to understand more fully?
3) With what client populations am I least familiar, e.g., adolescents, women, and people with co-occurring disorders?
4) Are there particular ethnic cultures about which my knowledge and direct experience is limited?

Deficiencies can be rectified via new jobs or job assignments or arranging orientation visits or brief internships within programs that will broaden your experience.

Actively Participate in Professional Associations: One of the things that distinguishes true leaders is their ability to rise above personal and institutional interests to represent the broader needs of the field and its service constituents. One way of transcending these parochial interests is activism within professional associations. If you aspire to be a leader in the treatment field, it is time you became active in one or more of these associations. Consider the following questions:

1) What national, state or local professional associations have the greatest potential influence on the future of addiction treatment and recovery in America?
2) What associations have current or potential influence on those issues about which I am most concerned?
3) How could I influence these associations in the coming years?

Cultivate Professional Mentors: Cultivating mentorship relationships with existing leaders is a particularly effective method of leadership preparation. Such mentorship experiences can vary from the very focused and time-limited to those that evolve into sustained professional collaborations. As you explore the development of a mentorship network, consider the following questions:

1) If you could receive focused education and professional guidance from any existing leaders, whom would you choose? (Remember, the Internet has eliminated problems of geographical access.)
2) What would you most want from these individuals? (Be as specific as possible.)
3) Is there a logical sequence of your work with these individuals, e.g., learning from one that would prepare you for work with another?

Participate in Formal Leadership Development Institutes: Leading organizations within the addictions treatment field are recognizing the coming leadership crisis and are responding with a variety of leadership development and succession planning initiatives. These efforts include formal leadership development institutes that recruit aspiring leaders and provide structured training and mentorship opportunities. Participation in a leadership development institute can be an intensely stimulating and rewarding experience. CSAT-funded Addiction Technology Transfer Centers (http://www.nattc.org/leaderInst/index.htm), state addiction treatment agencies, addiction studies programs and private foundations have launched leadership development institutes. Contact your state agency or regional ATTC to identify leadership development programs in your area (See http://www.nattc.org/regCenters.html for a listing of the ATTCs).

Build Networks of Influence: Leadership is the strategic use of one's self and one's sphere of relational influences to affect the world. Aspiring leaders build relational networks within their own organization, within the larger field and within the field's operating environment. Network building and maintenance are arts and skills that take a lifetime to fully develop. Those leaders with the greatest long-term impact on their fields often develop this capacity early in their careers. The multiple purposes of network building by aspiring leaders include gaining access to and influence upon those already in positions of power, opening leadership opportunities and creating networks of people who can act in concert to influence treatment policies and funding. In light of the importance of this dimension, consider the following questions:

1) Where are my relational networks weakest: inside my own organization, inside the communities I serve, inside the larger field of addiction treatment or inside the field's larger political and cultural environment?

2) What relationships are at risk of falling from my network due to lack of maintenance on my part?
3) What key relationships do I need to develop in order to extend my sphere of influence?

Recognize and Manage Toxic Personal and Organizational Processes: Leadership evolves in tandem with one's own personal development and in the context of evolving political, economic, cultural and organizational processes. Aspiring leaders need to recognize windows of vulnerability (developmental crises, personal impairment, lapses in one's ethical guidance system) that can lead to falls from grace. (All leaders are prone to the Curse of Icarus: a plunging fall to earth following infatuation with oneself and one's achievements and power.) It is also important to recognize toxic organizational processes that can weaken one's integrity and undermine the health of one's organization. There are also cultural processes within stigmatized groups that contribute to the internal scapegoating of organizational leaders and the sabotage of such leaders by culturally dominant institutions. Aspiring leaders should become students of such organizational and cultural processes. We would recommend studies of the rise and fall of the most historically notable treatment institutions (and their leaders), including the conflict-ridden demise of the New York State Inebriate Asylum (Crowley & White, 2004), the implosion of Synanon (Janzen, 2001), and the over-extension and financial collapse of Parkside Medical Services (White, 1998).

Strengthen Your Health and Character: Leadership demands exerting sustained pressure that can compromise one's physical, emotional and relational health. Such pressure can also magnify minor character defects in ways that can wound individuals, organizations and the larger field (Remember the Curse of Icarus.). Successful leaders consciously protect and enhance their health and cultivate rituals of daily living that strengthen their personal character. Such activities include:

- cultivating daily habits of health maintenance,
- balancing one's professional and personal life,
- developing decompression rituals that smooth the transition between work and home,
- using time-out periods for physical, emotional and spiritual renewal,
- building and nurturing one's family and social replenishment network,
- maintaining centering rituals that keep one focused on life priorities (value-focused reading, prayer, meditation, self-reflection),
- developing rituals of interaction with kindred spirits (people who share your aspiration values), and
- participating in unpaid acts of service to the community.

Conduct Yourself as a Role Model: The leader's day-to-day behaviors exemplify or undermine the aspirational values of his or her organization and the larger field. To aspire to leadership is to accept a mantle of responsibility to conduct one's life in a way that elevates those around us. Such a responsibility entails:

- eliminating excessive and toxic behaviors (e.g., smoking),
- sustaining respectful, nurturing, non-exploitive relationships in our personal and professional lives, and
- exhibiting a high level of ethical sensitivity and skills in ethical decision-making (See Bissell & Royce, 1987; White & Popovits, 2001).

Create a Personal Leadership Plan: Leadership can happen by happenstance or by design. We recommend creating a personal leadership plan that integrates many of the potential activities identified above and prioritizes and sequences them. This plan should answer two basic questions:

1) What type of role do I want to be serving within the field five years from now?
2) What are the steps I need to take to reach that goal?

The purpose of such a plan is to provide purpose and direction to your professional life. Your plan will require regular revision as your goals become more refined and as the world decides to close some doors and open others for you. Many leaders look back and see careers that more closely resemble improvised jazz than scored music, and yet they see a thread of order in the milestones of their careers that set the stage for their ultimate contributions to the field.

Continually Re-assess Yourself: Constantly self-evaluate yourself and ask people who you trust and admire for their candid opinions about your evolving capabilities and performance. What you are looking for is not flattery but feedback that is honest, brutally specific and useful. Most leaders have a zone of effectiveness, and regularly drift toward or beyond the boundaries of this zone. Self-assessment and feedback activities constitute an important professional guidance system. Successful leaders have the ability to utilize these activities to re-engineer themselves several times over the course of their careers.

Study and Engage the Next Generation: The best leaders study and engage the generations below them. They leave a living legacy through their influence on those they have developed. (They also learn a great deal from those coming behind them.) Look closely to see if you can spot the bright and rising stars around you. Who should you be taking with you on your leadership journey?

Tentative Steps

For those early in your career or at a point of mid-career re-evaluation, the move toward leadership can begin with small acts: joining or becoming more active in a professional association, subscribing to a journal that will help you stay abreast of developments in the field, using the Internet to connect with the larger currents and debates in the field, reading some of the field's classic or new texts, visiting or volunteering at a program other than where you work, making a professional presentation, or authoring a journal article.

An Invitation

Two closing points are warranted given the number of the above prescriptions. First, no leader ever fully achieves their optimum level of knowledge, sensitivity, and skill, nor do they perfectly apply the assets they possess. Second, while the burdens of leadership may seem excessive, they are offset by the deep satisfaction that leadership in this field can bring.

The ultimate goal of the addictions treatment field is to provide a portal of entry into the world of recovery and to prepare individuals and families for the long-term recovery process. Witnessing the miracles of individual and family recovery and knowing one played a role in such transformations are among the most sacred experiences in this field. Assuring that these miracles continue is worth the burden of leadership. The authors' generation is about to pass the torch of leadership. Are you prepared and ready to accept it? The clock is ticking.

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Evaluating, Treating and Monitoring the Female DUI Offender.

William L. White and Maya Hennessey

The number of females arrested and re-arrested for driving under the influence of alcohol or other drugs has increased in the past two decades. Increased female representation within those arrested for driving under the influence (DUI) of alcohol or other drugs suggests the need for more nuanced approaches to their evaluation, treatment, sentencing and supervision. The purpose of this short monograph is to briefly review what is known about: 1) the prevalence of female drinking and driving, 2) the profile of the female DUI offender, 3) gender-specific patterns of alcohol and drug dependency, 4) special approaches to the treatment of the female DUI offender, and 5) patterns of long-term recovery for women. The monograph includes recommendations drawn from the scientific literature and the authors' experience treating addicted women and evaluating gender-specific treatment programs.

Women and the State of Alcohol and Drug Studies

The number and quality of studies of alcohol- and drug-related problems, addiction and recovery among American women have significantly increased over the past two decades. In our review of the scientific literature on substance-impaired driving among women, we found that that majority of these studies had been published since 1990 and that the methodological rigor of these studies had significantly increased since 2000. These studies are generating findings with significant implications for the design of intervention programs for females arrested for driving under the influence (DUI). For years, female patterns of DUI were obscured in the much larger sea of male offenders. Science has begun to open a window on this previously invisible population of women and point the direction to more effective approaches to evaluation, treatment, sentencing and supervision.

Consumption Patterns

The best source of data available on adult patterns of alcohol, tobacco and other drug use is the regular National Survey on Drug Use & Health conducted by the Substance Abuse and Mental Health Service Administration. The most recent of these

surveys (2003) revealed that 74.5 million (61%) females aged 12 or older and 30.0 million (70%) males aged 12 or older consumed alcohol during the past year. This same survey revealed that 15.2 million (12%) females and 19.8 million (17%) males had used an illicit drug during the past year. Data on alcohol and other drug consumption patterns of younger females is available through the annual Monitoring the Future Survey sponsored by the National Institute on Drug Abuse. 52.3% of female twelfth graders report consumption of alcohol in the past 30 days and 24.4% of females (versus 33% for males) report having consumed 5 or more drinks in a row in the past two weeks. In 1975, the spread between males and females on this last figure was 23 percentage points, reflecting the subsequent leveling of differences in alcohol consumption patterns between women and men. Similar trends are occurring for illicit drug use with 30.1% of female high school seniors (compared to 34.3% of male high school seniors) report having consumed an illicit drug in the past twelve months (Johnston, 2006). Older women are more likely than younger women to consume only alcohol or to consume alcohol and prescription drugs. Younger women are more likely to combine alcohol and illicit drugs (Lex, 1994).

Changes in psychoactive drug consumption by women, particularly young women, have been linked to broader changes in gender roles and to promotional targeting of women by the alcohol, tobacco and pharmaceutical industries special products and appeals linking these products to beauty, wealth, social popularity, sophistication, sexuality and, perhaps most offensively, with liberation ("You've come a long way, Baby!") (White & Kilbourne, 2006). Increases in DUI arrests for women reflect both changes in social norms about women and alcohol, but also the fact that more women are driving and driving more frequently and more miles (Popkin, 1991). It is interesting to note that increased substance use among women and increased driving does not convert into risky driving decisions to the degree seen in men. The greater risk for men for DUI and DUI recidivism may well be linking to their increased propensity for impulsivity, risk-taking and aggression than differences in substance consumption (Elliott, Shope, Raghunathan & Waller, 2006). Females seem to drive more cautiously with or without alcohol in their systems (Zador, Krawchuk, & Voas, 2000).

DUI Prevalence Rates among Women

In the National Survey on Drug Use and Health, 11.4% of women aged 21 or over (compared to 22% of men aged 21 or over) reported driving under the influence of alcohol or other drugs in the past year (NSDUH Report, July 1, 2005). However, “as consumption increases, the male-female difference decreases and, in the heaviest drinking group, the rate of driving while intoxicated is almost as high among women as it is for men” (Johnson, Gruenwald & Treno, 1998). While the total volume of female DUI arrest rates is far lower than those for men, DUI arrests constitute the largest category of alcohol-related crimes that bring women into contact with the criminal justice system (Parks, Nochajski, Wieczorek & Millerm 1996). As such, these arrests events constitute a significant opportunity to intervene with women who are experiencing significant alcohol problems. Yet, in Illinois, so few women are referred to women specific treatment.

Looking at the specific issue of drug-impaired driving, 3% of females age 12 or older (compared to 6% of males) report driving under the influence of a drug (NSDUH Report, September 16, 2003).

The gender discrepancy in these rates is further indicated in fatal crash data revealing that male drivers involved in fatal motor vehicle crashes are almost twice as likely as female drivers to be intoxicated with a blood alcohol concentration (BAC) of 0.08% or greater (NHTSA 2004b), however the percentage of male drivers in alcohol-related fatal crashes has decreased while female drivers in such crashes have increased (Waller & Blow, 1995; Abdel-Aty & Abdelwahab, 2000). Several studies have also concluded that females are at greater risk of involvement in fatal crashes at lower levels of intoxication than are males (Waller & Blow, 1995).

In Illinois, 17% of those arrested for DUI are women (DUI Fact Book, 2004), but DUI arrest for women have risen both nationally and in Illinois in recent decades (Parks, Nochasjski, Wieczorek & Millerm 1996).

Studies of the DUI recidivist report that female DUI offenders are less likely to be re-arrested than are male DUI offenders. In a follow-up study of 3,425 DUI offenders, Wells-Parker and colleagues (1991) found males twice as likely to recidivate as females. Most studies of DUI recidivists conclude that 90-95% of recidivists are male (White & Gasperin, in press).

Profile of Female DUI Offenders

Only a small number of studies have focused specifically on the profile of the female DUI offender, and even fewer that profile the female DUI recidivist. Major findings from existing studies reveal that the female DUI offender is likely to:

- Be unmarried, separated or divorced (Wells-Parker, et al, 1991; Chang, Lapham & Barton, 1996)
- Unemployed and seeking employment (Wells-Parker, et al, 1991)
- Be drawn from wide age span (20-50) (Wells-Parker, et al, 1991)
- Be arrested secondary to a vehicular crash rather than for erratic driving (Waller & Blow, 1995).

Compared to young male DUI offenders, younger female DUI offenders are likely to exhibit greater alcohol, marijuana and tobacco use and report more strained relationships with their parents and parental disapproval of their friends (Farrow & Brissing, 1990).

Clinical classification differences exist between men and women arrested for DUI. Wells-Parker and colleagues (1991) found that 47.3% of female DUI offenders were classified as “high-problem-risk” compared to 57% of male DUI offenders. These figures underreport alcohol problems for both men and women due reliance on self-reported information whose validity is significantly compromised by fear of legal repercussions. A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders (compared to 91% of male offenders) met lifetime criteria for alcohol abuse or alcohol dependence, and that 32% of female offenders (compared to 38% of male offenders) met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C’de Baca, Chang, Skipper, Baum, & Hunt, 2001). A study of 1,105 DUI offenders in New Mexico found that of those with alcohol use disorders, 32% of females (compared to 38% of males) also had a drug use disorder and that 50% of women (compared to 33% of men) had an additional psychiatric diagnosis (Lapham, Smith, C’deBaca, Chang,

Skipper, Baum & Hunt, 2001). These studies underscore the high percentage of female DUI offenders that are experiencing alcohol problems and the severity and complexity of those problems.

Few studies have compared the profiles of the male and female DUI recidivist. The best data available suggests the following:

- Male and female DUI recidivists are similar in ethnicity, levels of education, BAC at time of arrest, and lifetime substance use.
- Female recidivists reported higher rates of parental alcohol problems.
- Female recidivists reported higher rates of having hit or thrown something at their spouses (Lampham, Skipper, Hunt & Change, 2000).
- Younger female recidivists are more likely to share traits of rebellion and anti-social behavior similar to male DUI recidivists (Moore, 1994).
- Female recidivists have high rates of alcohol dependence and high rates of past year use of other psychotropic drugs (Lex, Sholar, Bower & Mendelsoln, 1991)

Given the limited number of studies available on female DUI offenders, we have highlighted below some of the broader studies on addiction, treatment and recovery among American women that have implications for the evaluation, treatment, sentencing and supervision of female DUI offenders.

Female Alcohol/Drug Physiology

There are pronounced differences between men and women related to the metabolism and physical effects of alcohol. Here are the key differences:

Metabolism: Women reach higher blood alcohol concentrations and become more impaired than men after drinking the same amounts of alcohol. This is related to the fact that women have lower mean body water volume than men (creating higher alcohol concentrations) and greater difficulties metabolizing alcohol (resulting from lower levels of the gastric alcohol dehydrogenase required in the metabolism of alcohol) (Lex, 1991; Blume, 1992; NIAAA, 1999).

Effect of Menstruation: Blood alcohol levels for women vary across phases of the menstrual cycle. Women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset. Such variation is minimized for women taking oral contraceptives. The onset and intensity of binge drinking has also been linked to pre-menstrual distress (Rusell and Czarnecki, 1986).

Alcohol-related Medical Problems: Women develop alcohol-related physical problems faster than do men. Women develop alcohol-related liver disease (alcoholic hepatitis with and without cirrhosis), hypertension, anemia, gastrointestinal hemorrhage, and ulcers after shorter periods of drinking and at lower levels of alcohol intake than men. The risks for alcoholic cirrhosis and cancers of the head and neck are elevated for women who consume more than 2-5 drinks per day (Wilsnack, 1984; Gearhart, 1991; Gomberg, 1993). The medical risks of alcohol consumption extend beyond the woman herself. Fetal Alcohol Syndrome / Fetal Alcohol Effect (FAS/FAE) is a preventable form of developmental disability caused by excessive alcohol consumption during pregnancy.

Alcohol-related Mortality Rates: Alcohol dependent women have higher (50-100%) mortality rates than either non-alcoholic women or alcoholic men (Hill, 1986; Gomberg and Nirenberg, 1993). Primary causes of death for alcohol dependent women include diseases of the digestive and circulatory systems, accidents (particularly alcohol-sedative combinations), suicide and death by violence (Lex, 1991).

Incidence and Risk of Substance Use Disorders in Women

The Substance Abuse and Mental Health Service Administration's National Survey on Drug Use & Health defines substance dependence or abuse using criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).* These criteria include such symptoms as recurrent drug or alcohol use resulting in physical danger, trouble with the law due to drug or alcohol use, increased tolerance to drugs or alcohol, and giving up or reducing other important activities in favor of drug or alcohol use. Based on the latest of these surveys, 5.9% of women aged 18 or older met criteria for abuse of or dependence on alcohol or an illicit drug in the past year. 15.7% of females aged 18-25 and 26.3% of males aged 18 to 25 met criteria for either dependence or abuse. Among those aged 26 or older, males were twice as likely as females to be dependent on or abusing alcohol or an illicit drug. The rate of substance dependence or abuse for persons age 50 or older was 4.9% for males and 1.5% for females (SAMHSA, 2005).

The higher rates of alcohol dependence for males was long thought to be based on greater genetic vulnerability for alcoholism among men, but recent studies of the heritability of alcoholism have concluded that a substantial (over 50%) of the risk of female alcoholism is genetically influenced (Kendler, et al., 1992; NIAAA, 1999). Many addicted women admitted to addiction treatment, particularly those entering through a DUI referral mechanism, present with multiple etiological factors: genetic risks related to intergenerational family histories of alcoholism, a history of physical and sexual abuse; a history of emotional deprivation, and anxiety and depression that make frequent mood alteration desirable; and involvement in intimate relationships and social groups that promote excessive drinking.

Onset of AOD Problems

Compared to men, the onset of alcohol and other drug problems in women occurs at a later age and is more likely to be associated with a particular life event (e.g., childbirth, breast removal, hysterectomy, family problems, divorce, physical or sexual assault, or the loss of a parent, spouse, or child through death (White, Woll & Webber, 2003; Beckman and Amaro, 1986).

Female Patterns of Substance Dependence

There are many clinically relevant gender differences in substance dependence. The course of alcohol and drug dependence in women is different than men in its symptomotology and is marked by a faster progression–the latter often referred to as "telescoping" (Smith and Cloninger, 1981). Such accelerated effects were first noted in women addicted to alcohol (Corrigan, 1980; Hesslebrock, et al., 1985; Stabenau, 1984).

These early studies confirmed that women become physically addicted to alcohol more rapidly than men and with less volume of alcohol consumed (Spiegel, 1986). Later studies also discovered that women developed heroin addiction more quickly than men (Hser, et al., 1990). Studies of men and women addicted to cocaine reported women had earlier onset of use, higher rates of daily use, higher risk methods of ingestion (smoking or intravenous), more concurrent alcohol use, and an earlier age of entry into treatment (Griffin et al., 1989; Wechsberg, et al., 1998; McCance-Katz, et al., 1999).

In spite of the severe medical consequences of alcoholism in women, women alcoholics consume less alcohol that do male alcoholics and report less daily drinking and binge drinking (Blume, 1992). The phases of alcoholism are less distinct (Lisansky, 1957) and the symptoms and stages of alcoholism differ somewhat for women. Beginning with the work of James (1975), studies have documented that several early stage symptoms of alcoholism in men constitute late stage symptoms of alcoholism in women. For example men begin to choose substances over relationships during early stages of problem development while women cling to relationships well into the later stages of dependence.

Addicted women are more likely than men to be using other drugs in conjunction with beverage alcohol. They frequently present patterns of multiple concurrent and/or sequential drug use (Edwards, 1985; Celentano and McQueen, 1984). Multiple drug use places women at a higher risk for cross-addiction, toxic drug interactions and fatal overdoses.

Differences between male and female substance use patterns have been diminishing in recent years (Green, 2006).

Ethnic/Gender Differences

White, Woll & Webber (2003) reviewed the characteristics and consequences of addiction across ethnic groups and found substantial differences. African-American women tend to be clustered at the extremes of abstinence and heavy drinking, with more African American women totally abstaining than White women (Gary and Gary, 1985). Mexican-American women abstain from alcohol or drink moderately. While the pattern of alcohol abstinence has been consistently reported for immigrant Mexican American women, there are more recent reports of moderate and heavy drinking by Mexican-American women born in the U.S. (Caetano, 1985; Gilbert, 1987). Native American women experience the highest proportion of alcohol deaths. The alcoholic cirrhosis death rate for Native American women, ages 15-34, is 36 times the rate for White women; the rate for African-American women is 6 times the rate for White women (Malin, et al., 1978). The addictions literature is almost completely silent on the drug consumption patterns and problems of Asian-American women.

Addiction and Psychiatric Illness

Where addicted men are more likely to experience co-morbid personality disorders, addicted women are more likely to experience co-morbid affective disorders (Wilsnack, Wilsnack and Klassen, 1984). Addicted women are twice as likely to report major depression than addicted men (Wechsberg, et al., 1994) raising the potential that

some women may self-medicate affective disorders with alcohol and other drugs. The co-occurrence of eating disorders (particularly bulimia) and substance use disorders has also been noted in the clinical literature (Katzman, et al., 1991; Holderness, et al., 1994). A 1996 NIMH-funded study of women detainees in Cook County Jail found that over 80% of the 1272 detainees met criteria for one or more lifetime psychiatric disorders. (*Arch Gen Psychiatry*/Vol 53).

Victimization as a Risk Factor

The relationship between childhood sexual abuse and/or subsequent sexual trauma and the onset and course of alcohol and other drug problems is a complex one. Key research and clinical findings include the following:

- Women with substance use disorders report higher rates of childhood sexual abuse compared to non-addicted women (67 percent compared to 28 percent) (Blume, 1992; Forth-Finnegan, 1991, 1984; Rachel, 1985; Covington, 1986), and reports of childhood sexual abuse among addicted women seeking treatment range between 75-90 percent (Rohsenow, Corbett and Devine, 1988; Zweben, 1996).
- The link between developmental victimization and the subsequent development of substance use disorders may be intensified with the presence of key traumagenic factors, e.g., early onset of abuse, long duration of abuse, victimization by family members, multiple perpetrators, and failure to protect following early disclosure (White, Woll & Webber, 2003).
- Addicted women often present patterns of serial victimization–childhood sexual abuse followed by later episodes of physical and/or sexual assault (Miller, et al., 1989).
- Addicted women with histories of sexual victimization have a higher incidence of health problems and health care utilization than do addicted women without such histories (Liebbschultz, Mulvey and Samet, 1997).
- The sexual victimization of addicted women is often clinically nested within a larger cluster of problems, including feelings of depression, worthlessness, and powerlessness; suicidal thoughts; toxic, abusive intimate relationships, impaired mother-child relationships, and environmental chaos (Gomberg, 1993).
- The sexual abuse of addicted women may contribute to many of the clinical issues often noted in women's treatment programs: fear and distrust, shame and guilt, feelings of unworthiness; conflict about sex role identity; self-doubts about adequacy as a women; and sexual dysfunction (Wilsnack, 1973; Kirkpatrick, 1986).
- The preponderance of addicted women with a history of physical and sexual abuse suggests by itself the need for special approaches to their treatment (Skorine & Kovach, 1986).

It was long thought that a sexual abuse history was predictive of poorer treatment outcome, but this assumption is being challenged by recent studies. These studies note that women with sexual abuse histories report numerous problems (depression, anxiety,

low self-esteem, low decision-making confidence) at treatment admission and at follow-up, but that they are more likely than women without such histories to consume less illicit drugs following treatment, be in counseling for psychological problems and to be taking psychotropic medications under the direction of a physician (Bartholomey, Courtney, Rowan-Szal & Simpson, 2005).

Obstacles to Treatment

Women encounter greater obstacles to initiating and completing treatment for a substance use disorder than do men (Green, 2006). These obstacles include intense social stigma attached to addicted women (particularly addicted mothers), female socialization (e.g., learned helplessness, passivity), multiple role responsibilities, inadequate insurance and financial resources, fear of loss of custody of children and legal punishment (for pregnant, addicted mothers), and lack of child care, transportation and sober housing (NIAAA, 1983, Gomberg, 1988, Schliebner, 1994, Burman, 1992, Finkelstein, 1994)

Treatment Entry Decisions

There is growing evidence for gender-specific factors related to the initiation of recovery (e.g., pregnancy) and in obstacles to successful recovery (e.g., intimate involvement with an addicted husband or partner) (Anglin, et al., 1987). The entry of addicted women into treatment is associated with 1) perception of alcohol or drugs as a problem, 2) life events (consequences) that precipitate a crisis and need for change, 3) the anticipation or experience of hope that treatment can produce positive change, 4) the perception that the treatment agency has programs that can respond to her special needs and the needs of her family, and 5) a social network that supports entry and continued involvement in treatment (Thom, 1984). Waldorf (1983) found women separating from addicted husbands/paramours (often subsequent to their arrest) as a major factor in initiation of natural recovery in addicted women. Similarly, Wilsnack and her colleagues (1991) found divorce or separation associated with improved post-treatment outcomes among treated, married women (Wilsnak, et al., 1991).

Admissions of women to treatment have until recently been linked to health or family concerns (pregnancy, effect of use on children) than the occupational or legal issues that tend to bring men to treatment (Blume, 1992; Burmanm 1997). Pregnancy and/or concern about parental adequacy are major motivators for women seeking entry into addiction treatment (Rosenbaum and Murphy, 1990l Chen & Kandel, 1998), but the increased involvement of women in the criminal justice system has sparked a dramatic increase in women, particularly younger women, entering addiction treatment.

The use of indigenous outreach workers is effective in engaging women in addiction treatment who have previously resisted seeking out such services (Groos and Brown, 1993; White, Woll & Webber, 2003).

Female Treatment Admissions

Females made up 30% (565,400) of the 1.9 million addiction treatment admissions in the United States in 2002. Females admissions were an average of 33 years of age and were more likely to report problems with opiates or cocaine (fewer problems with alcohol or marijuana), be self-referred, be unemployed at admission, and more likely to be separated, divorced or widowed (DASIS Report, May 20, 2005).

Assessment and Treatment Process

The multiplicity of problems that characterize the lives of addicted women require a redesign of traditional evaluation and treatment processes. Assessment instruments and processes for addicted women need to be global as opposed to categorical and continuing rather than an intake activity (Wechsberg, 1995). The treatment itself needs to focus on the whole spectrum of problems presented by the addicted woman rather than focusing narrowly on the problem of addiction (Brown, Huba, and Melchior, 1995; Wechsberg, 1995). The nature and number of these problems may dictate a longer period of indicated treatment for women. For example, time and physical healing may be required for alcoholic women to recover from alcohol-induced neuropsychological deficits before intensive psychotherapies can be used effectively (Hill, in Wilsnack, 1984).

Traditional confrontational approaches in addiction treatment may be highly inappropriate and even injurious for many addicted women (Murray, 1989; Nelson-Zlupco, 1995; Zweben, 1996). Such traditional approaches require substantial modification for clinical appropriateness and effectiveness (Brown, et al., 1996). Motivational enhancement strategies offer a tested alternative to such clinical tactics (Miller and Rollnick, 1991).

In 1986, a sweeping review of the addiction treatment research concluded that there was little research evidence to support the efficacy of any particular treatment approaches for addicted women (Vannicelli, 1986). Since then, there has been an accumulation of research that is defining the major elements of an evidence-based, gender-specific and family focused model of addiction treatment. Women-specific addiction treatment programs differ significantly in the variety, comprehensiveness, design, duration and cost of services (Grella, et al., 1999). More specifically, they:

- provide outreach services (Reed, 1987)
- focus on addiction as one of multiple problems that require service attention (Nichols, 1985; Wallen, 1992; Zweben, 1996)
- collaborate with multiple helping agencies during the treatment process (Reed, 1987)
- concentrate services in a single, non-stigmatizing service environment (Kaplan-Sanoff and Leib, 1995; Finkelstein, 1993)
- focuses on the needs of the woman and her children
- treat gynecological and medical problems (Burman, 1992)
- provide child care, transportation and housing services (Beckman and Amaro, 1986)
- link clients to domestic violence services

- provide strong female recovery role models (DiMatteo and Cesarini, 1986; Reed, 1987),
- provide all-female groups and female therapists, outreach workers and case managers (Ruggels, et al., 1977; (Woodhouse, 1990)
- place emphasis on client empowerment via the goals of personal and economic self-sufficiency and an emphasis on choices throughout the treatment process (LaFave and Echols, 1998)
- provide women-only, peer support groups within the treatment milieu encouraging sexual autonomy related to desires, preferences, and limits (Nelson-Zlupko, 1995),
- provide case management services to address personal and environmental obstacles to recovery
- provide a longer duration of treatment involvement with a structured program of family-focused aftercare, and
- provide pregnancy-related services

Treatment Outcomes

Addiction treatment outcomes for women are influenced by both client characteristics and program characteristics (Morrissey, Ellis, Gatz, et al, 2005).

Women who complete treatment have nine times the abstinence rates as follow-up as women who did not complete treatment, whereas the abstinence rates of men completing treatment is only three times greater than men who do not complete treatment (Green, 2006).

In spite of the popular conceptions (myths) that women are hard to treat and have poor treatment outcomes, early research suggested that women do as well as men in addiction treatment (Vannicelli, 1984; Annis & Liban, 1980; Toneatto et al, 1992). More recent studies have concluded that women have better post-treatment recovery outcomes than men (Walitzer & Dearing, 2000; McCance-Katz, Carroll &Rounsaville, 1999; Hser, Evans & Huang, 2005; Green, 2006). The latter findings included treatment outcome studies for cocaine and methamphetamine dependence.

Studies of women-only versus gender-mixed treatment programs have produced conflicting results, with some gender-specific programs showing enhanced outcomes (Dahlgren and Willander, 1989), while others revealed no difference in outcome (Copeland et al., 1993).

There is evidence that women-only treatment programs are able to reach those women that otherwise would not seek or complete addiction treatment (Reed and Leibson, 1981). What is most clear from treatment outcomes studies of women is that women have higher retention rates and better post-treatment outcomes in programs in which great numbers of women are treated and which provide a more comprehensive range of gender-specific services (Grella & Greenwell, 2004).

Poorer treatment outcomes for women have been associated with: 1) presence of a disturbed or violent parent during childhood, 2) depressive symptoms, 3) alcohol abuse and violence in partner at time of follow-up, 4) removal of children from home by authorities during follow-up period, and 5) problems handling aggressive impulses (Hover, 1986; Hover, 1987; Bergman, 1985; Walitzer & Dearing, 2000). Involvement with an addicted partner is a major etiological factor in the onset of excessive alcohol and drug

use for women and a major barrier preventing the addicted woman from entering treatment or sabotaging her on-going recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCrady and Raytek, 1993). Involvement in methadone treatment has been shown to provide structure and stability in the life of opiate-addicted women, but that many women of these women express concerns about the stigma related to their continued use of methadone (Rosenbaum and Murphy, 1990).

Two just-completed reviews of addiction treatment outcome studies on women (Sun, 2006; Greenfield, Brooks, Gordon, et al, 2006) draw the following conclusions:

- Women with AOD problems are less likely to enter treatment than men with such problems.
- Treatment retention and completion rates are similar for women and men.
- Women as a group do better in residential modalities than modalities of lower intensity.
- Women do better in treatment programs that offer regular individual counseling in addition to non-confrontational group counseling.
- Retention and longer length of treatment is associated with better treatment outcomes for both men and women.
- Provision of child care services increases retention and the positive effects of treatment.
- Provision of case management services improves retention and outcomes.
- Women have better long-term outcomes following treatment than do men.
- Gender-specific treatment is effective but study findings vary on the question of whether gender-specific treatment is more effective than mix-sexed treatment.

Processes and Stages of Recovery

Women have shorter alcoholism careers. Fillmore (1987) found that heavy drinking for women peaked in their thirties and then dropped sharply during their forties and beyond, with a substantial number of women ceasing alcohol consumption after age 60. Fillmore concluded that, in comparison to men, remission of heavy drinking is more likely and more likely to occur earlier. There is further evidence that women have greater prospects for long-term recovery than do men. Humphreys and his colleagues found in a follow-up study of clients eight years post-discharge that women were 1.63 times more likely to be in stable recovery (Humphreys et al., 1997). Mohr, et al., (2001) attributes these enhanced outcomes to the fact that alcoholic women entering treatment have more non-drinking friends who are supportive of their recovery process than do alcoholic men. Recovery friendships and supportive social support networks are a significant motivator toward self-directed recovery for many women. The greater prospects of recovery may also extend to women addicted to drugs other than alcohol. Snow (1973) reported that women addicted to opiates had better long-term recovery rates than men with similar addiction patterns.

Recovery without Treatment/Moderated Recovery

Many young women aged 21-34, who as a group report the highest incidence of alcohol-related problems, will resolve these problems without treatment (Wilsnack, 1989). Such "natural recovery" (the achievement of recovery from addiction without the aid of professionally-directed treatment or sustained involvement in mutual aid groups) is more common in women than in men. In a recent study of natural recovery in women, Copeland (1998) found three themes in the resolution for change decisions: 1) concern for current and future health, 2) a lost sense of self, and 3) concern over the welfare of their children. Strategies that women use to self-manage their own recovery process include management of withdrawal, short-term drug substitution, severing drug-dominated intimate and social relationships, developing new social activities and relationships, and the cultivation of new health-promoting behaviors, e.g., nutrition, fitness, alternative medicine (Copeland, 1998). Those women who cannot achieve natural recovery when compared to those who do are found to have greater problem severity, greater psychiatric co-morbidity, and fewer family and social supports.

Gender differences are also noted in the literature about persons with alcohol problems who resolve such problems through moderating their use rather than by complete abstinence. Sanchez-Craig and her colleagues (1984, 1991) and others (Miller and Joyce, 1979; Elal-Lawrence, et al., 1986; Helzer, et al., 1985) have noted that women more likely than men to achieve successful moderation outcomes. Again, this may be related to the Mohr study (2001) findings that women had richer non-drinking social relationships than men and that such relationships enhanced not only successful abstinence but also served to lower the number of drinks per drinking day among those who did drink. Successful moderation is linked to lower personal vulnerability (e.g., absence of family history, later onset of alcohol/drug use), absence of co-occurring medical/psychiatric illness and significant family and social support (White & Kurtz, in press).

Developmental Stages of Recovery

Recovery for most addicted women is a time-involved, developmental process. Confirming these observations was a recent study (Brown, et al., 2000) concluding that women may be at different stages of change for different problems, e.g., substance use, high risk sexual behaviors, violent relationships, child neglect, and that such change processes must be simultaneously managed. Relapse is often part of the early recovery process for many women. Such relapses can involve the primary drug to which the women was addicted or the use of secondary drugs. Willie (1978) reported that recovered heroin addicts used drugs such as alcohol and cannabis in the first year to cope with the challenges of early recovery. Willie framed such use not as substitute addiction but as an "intermediary stage" of recovery. Similar findings occurred in Copeland's (1998) study of natural recovery in women. All of the women noted to have developed an initial problem with a substituted drug later resolved this problem. While there is a very real danger of transferring dependencies e.g., from heroin to cocaine or alcohol, episodes of drug substitution are best seen as part of the early recovery process requiring active management than an indicator of either the untreatability of the client or the failure of a particular treatment method.

Recovery Support Structures

Women and cultural minorities affiliate with AA/NA at the same rates as White men (Humphreys, et al., 1994) and at least one report suggests that women may have an easier time affiliating with 12-step groups than do men (Denzin, 1987). This may be related to the fact that alcoholic women are more socially isolated (tell fewer individuals about their drug-related problems) and have less support from their partners for recovery (Bischof, et al., 2000). The percentage of women among AA members has increased from 15 percent in 1955 to 33 percent in 1996 (White, 1998). Special women's groups within AA grew during these same years. There are feminist-based alternatives to AA (Kirkpatrick, 1976), and AA's steps have been refined for greater applicability for women (Kasl, 1992; Lerner, 1990). There is also evidence that women, particularly African-American women, may use the church as a sobriety-based support structure (White, Woll & Webber, 2003).

Substance Use and Partner Violence

Alcoholic women tend to select mates who come from family backgrounds similar to their own (Rimmer & Winokur, 1972). This process is referred to as "assortative mating" (Lex, 1991) and has been linked to the victimization histories of addicted women. The research literature on addicted women portrays a picture of unstable marital/intimate relationships characterized by low levels of emotional satisfaction and increased levels of marital conflict that can escalate into the emotional/physical abuse of the alcoholic woman. This picture must be viewed in the context of the high rate of victimization of these clients. Research has confirmed the propensity of traumatized women to "repeat and re-enact subordination and victimization in their interpersonal attachments" (Bollerud, 1990). Breaking these cycles of victimization requires specialized treatment approaches (Herman and Schatzow, 1984).

Sentencing Issues

Few studies have distinguished the effectiveness of particular DUI sanctions by gender. One notable exception to this rule was a study of the effects of victim impacts panels on DUI recidivism. That study found that female repeat offenders who were referred to victim impact panels were twice as likely to recidivate as female repeat offenders not referred to a panel (C' De Baca, Lapham, Liang & Skipper, 2001). The authors suggested the possibility that victim impact panel could actually have a negative effect on the female repeat offender. The potential effectiveness or ineffectiveness of remedial education for the female DUI offender may well be an issue of timing. We suspect that early exposure to an impact panel may elicit too much empathy for women already steeped in self blame and may increase her risk of drinking due to shame and guilt, while introducing it later might prove beneficial.

Tips for Enhancing Recovery among Women

Police officers, evaluators, treatment specialists, prosecutors, judges, probation officers and Secretary of State Hearing Officers all have opportunities to interact with women who have driven under the influence of alcohol and who have significant alcohol and other drug related problems. These interactions offer tremendous opportunity to influence movement toward sustained recovery. In this section, we offer a few simple tips to reduce your stress, enhance your effectiveness, increase her accountability, and improve outcomes for addicted women.

Establish Rapport and Safety A helping alliance includes respect, rapport and safety. With histories of physical and or sexual abuse that spanned early developmental years through their adult lives, addicted women carry deeply embedded messages that the world is not a safe place, and that people, especially authority are cruel. Women in recovery talk about kindness from authority as if it were a rare and precious commodity. With harshness her anxiety level soars, she closes up and loses the capacity to hear you--she's frantically trying to defend herself. In an environment of safety and kindness she opens up and wants to comply with your expectations. Your stress level and hers will go down, and outcomes will improve.

Set Clear Expectations and Monitor Performance. Communicate in behavioral and measurable terms what is expected, acknowledge positive recovery-related activities and continue to monitor her compliance with positive feedback and support.

Convey Hope and Praise. Hope and affirmation are the lifeblood of recovery for women. Most addicted women have been socially stigmatized, victimized and blamed by systems they've reached out to. Hungry for approval from authority, acknowledging her positive efforts will motivate her and other women witnessing such praise. Recognizing and complimenting does not take a degree in counseling, but the payoff is tremendous.

Educate Yourself about the Stages of Recovery. We recommend several resources to enhance your education on the recovery process. The first is the book *Changing for Good* by John Prochaska, John Norcross and Carlo DiClemente, which demonstrates that timing in partnership with the appropriate intervention can interrupt addictive patterns. The second is an essay entitled The Varieties of Recovery Experience by William White and Ernest Kurtz that is included in a monograph entitled Recovery Management that is distributed by the Great Lakes Addiction Technology Transfer Center. A third resource is an essay on the developmental stages of recovery for addicted women that summarizes a study of recovering women in Illinois' Project SAFE sites—an award winning program that treated women with histories of addiction-related abuse or neglect of their children. This essay is included as an appendix to this monograph.

Discover and Ignite Her Motivators Every woman will easily reveal what motivates her, when we set aside our own biases, values and beliefs. If you don't believe us, try this, for the next week, ask every woman you meet the same question, nothing deep or personal, but something as simple as

- Best birthday you ever had
- Something you enjoy

As she answers, she will reveal her values, beliefs, and motivators. Just as each woman has a unique face and personality, each possesses a unique set of values, beliefs, strengths, weaknesses and interests. By listening carefully you will discover her unique motivators and how to ignite those. She will easily share those ***when she feels safe, and when she feels heard.***

Help Each Client Increase Her Recovery Capital. Recovery capital is the internal and external resources that can be mobilized to initiate and sustain recovery. Here are examples of four categories of recovery capital:

- Social Capital – Social relationships that and encourage and support recovery.
- Physical Capital - Financial such as income, savings, a home, investments.
- Human Capital - Knowledge, skills, health, problem solving abilities.
- Cultural Capital - Beliefs, behavioral patterns, qualities that emanate from membership in a particular culture that encourage recovery.

We can help woman expand their recovery support resources by recognizing and enhancing their recovery capital, and suggesting simple assignments linked to her motivators. Here's an example of an assignment for a women who wanted to get her GED but suffered from testing anxiety.

- *Go to the library and request information on getting a GED. Don't sign up yet if you feel overwhelmed, just get the information.*
- *Ask women in AA who got their GED's in recovery to share when, where, how and any obstacles they overcame to get their GED.*

This assignment helps her understand the GED process and allows choices about when to begin. Studying for the GED builds confidence, enhances motivation and instills hope that she can learn, grow and change. Talking to other women helps build a recovery support network. These are examples of building recovery capital.

Where Possible, Shift Your Paradigm to "No Failure. Just Feedback" A key to ongoing recovery is the ability to explore what doesn't work and try new strategies. Relapses & acts of non-compliance can be important sources of feedback. Women in early recovery are suffering from the combined effects trauma, withdrawal and cognitive impairment of early recovery. Lake County and Cook County in Illinois both committed resources to establish specialized services for DUI Women and secured specialized training on gender specific models for their staff. Rather than attributing deviant behavior as a product of personal failure, well trained staff will further assess and adapt approaches before imposing sanctions.

Visit Local Treatment Programs for Women. Visiting local treatment programs that have gender competent services for women will breathe life into the knowledge you've acquired about women and addictions. Collaboration improves treatment outcomes, eases the referral process for you, and will help you align your goals and her goals in treatment. Considering that women who complete treatment have nine times the abstinence rates as women who didn't complete treatment, it's well worth it to have a good working relationship with treatment programs.

Visit Open Recovery Support Meetings. We recommend acclimating yourself to local recovery support groups by reviewing literature and web sites of such groups (see www.facesandvoicesofrecovery.org, click mutual aid resources) and attending open meetings. You can contact AA (and often NA) through the Yellow Pages of the phone book. Your work will be enriched by hearing the powerful stories of women in long-term recovery whose lives, now meaningful and productive, were once as chaotic and problem-ridden as those of the women clients you now serve. Your ability to understand the core ideas, language and rituals of recovery groups will dramatically enhance your ability to link women to these groups and monitor their participation. You'll meet women today who are honest, hard working, reliable, a mother, wife, and friend, because someone just like you saw beyond their problems, held them accountable and encouraged them to hang in there for the miracle of recovery.

Attend Meetings And Hear Her Story Encourage current and former clients to invite you when they share their story at an open meeting. Most women will appreciate your interest and be proud to have you there. You will be surprised to learn new things about her as she pours out her truth the AA way. What you learn from her is sure to improve your interactions with other women on your case load.

Start a Women's Self Help Group In communities that do not have women's meetings of AA, NA, etc., you may want to help develop such a meeting by inviting AA / NA volunteers to start up meetings and conduct them. Developing such resources can be aided by working with current Hospital and Institution Committees within AA or NA or by setting up an AA/NA advisory group.

Explore Group Supervision Lake County, Illinois and Cook County, Illinois train their staff on conducting group supervision. Groups range from women's groups, co-ed groups and groups organized by severity/risk, groups for women who have reached abstinence, and those still struggling. Because women are very relationship oriented, they do very well in groups. But, because relapse is common in early recovery, groups for women who are still using get the best outcomes when staff is trained in women's issues, addiction interruption techniques, and running effective groups. Once mastered, these skills can be important recovery support resources, particularly in communities lacking women's groups in AA and NA.

Future Directions

Having reviewed the available research literature on women DUI offenders and the broader literature on the treatment of women and having interviewed women DUI offenders and those providing services to these women, we would offer the following ten recommendations related to enhancing the quality of evaluation, education, treatment and supervision of female DUI offenders in the State of Illinois.

1. Evaluation Instruments: Develop gender norms for existing evaluation instruments and/or develop an instrument or subscales based specifically on research with, at best, female DUI offenders, and at least, community and clinical samples of women.
2. Gender Competent Evaluators: Require all DUI evaluators to complete gender-specific training and hold IAODAPCA's forthcoming certificate for gender competence.
3. Recidivist Risk Profile: Develop a DUI recidivist risk profile that is based exclusively on research with women DUI offenders.
4. Gender-specific Risk Education: Audit and revise existing remedial education programs to assure gender competence. Segregate women into specialty groups when there are enough women.
5. Gender-specific DUI Treatment Models: Develop models for treating female DUI offenders that incorporate current research findings.
6. Gender-specific Treatment Specialty: Encourage the development of gender-specific DUI treatment services to assure enough referrals to organize women's groups.
7. Women's Recovery Support Groups: Develop a directory of women's recovery support groups in Illinois and that are available Online. Establish guidelines for establishing local liaison committees between the courts, treatment agencies and recovery mutual aid groups. Develop women's recovery support groups in communities where they do not exist. Recruit AA/NA volunteers to orient new judges, probation officers and other service roles to local recovery support groups.
8. Alumni Volunteers: Recruit, train and supervise a cadre of women in recovery who came through the DUI system who can serve as volunteer recovery coaches to women currently entering the system.
9. Consumer Feedback on Services: Conduct a survey of female DUI offenders to solicit feedback related to evaluation, treatment and probation services they have received.
10. Gender-research: Encourage all studies done on DUI in Illinois to analyze data for gender differences.

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Evaluating, Treating and Monitoring the Female DUI Offender.

William L. White and Maya Hennessey

The number of females arrested and re-arrested for driving under the influence of alcohol or other drugs has increased in the past two decades. Increased female representation within those arrested for driving under the influence (DUI) of alcohol or other drugs suggests the need for more nuanced approaches to their evaluation, treatment, sentencing and supervision. The purpose of this short monograph is to briefly review what is known about: 1) the prevalence of female drinking and driving, 2) the profile of the female DUI offender, 3) gender-specific patterns of alcohol and drug dependency, 4) special approaches to the treatment of the female DUI offender, and 5) patterns of long-term recovery for women. The monograph includes recommendations drawn from the scientific literature and the authors' experience treating addicted women and evaluating gender-specific treatment programs.

Women and the State of Alcohol and Drug Studies

The number and quality of studies of alcohol- and drug-related problems, addiction and recovery among American women have significantly increased over the past two decades. In our review of the scientific literature on substance-impaired driving among women, we found that that majority of these studies had been published since 1990 and that the methodological rigor of these studies had significantly increased since 2000. These studies are generating findings with significant implications for the design of intervention programs for females arrested for driving under the influence (DUI). For years, female patterns of DUI were obscured in the much larger sea of male offenders. Science has begun to open a window on this previously invisible population of women and point the direction to more effective approaches to evaluation, treatment, sentencing and supervision.

Consumption Patterns

The best source of data available on adult patterns of alcohol, tobacco and other drug use is the regular National Survey on Drug Use & Health conducted by the Substance Abuse and Mental Health Service Administration. The most recent of these

surveys (2003) revealed that 74.5 million (61%) females aged 12 or older and 30.0 million (70%) males aged 12 or older consumed alcohol during the past year. This same survey revealed that 15.2 million (12%) females and 19.8 million (17%) males had used an illicit drug during the past year. Data on alcohol and other drug consumption patterns of younger females is available through the annual Monitoring the Future Survey sponsored by the National Institute on Drug Abuse. 52.3% of female twelfth graders report consumption of alcohol in the past 30 days and 24.4% of females (versus 33% for males) report having consumed 5 or more drinks in a row in the past two weeks. In 1975, the spread between males and females on this last figure was 23 percentage points, reflecting the subsequent leveling of differences in alcohol consumption patterns between women and men. Similar trends are occurring for illicit drug use with 30.1% of female high school seniors (compared to 34.3% of male high school seniors) report having consumed an illicit drug in the past twelve months (Johnston, 2006). Older women are more likely than younger women to consume only alcohol or to consume alcohol and prescription drugs. Younger women are more likely to combine alcohol and illicit drugs (Lex, 1994).

Changes in psychoactive drug consumption by women, particularly young women, have been linked to broader changes in gender roles and to promotional targeting of women by the alcohol, tobacco and pharmaceutical industries special products and appeals linking these products to beauty, wealth, social popularity, sophistication, sexuality and, perhaps most offensively, with liberation ("You've come a long way, Baby!") (White & Kilbourne, 2006). Increases in DUI arrests for women reflect both changes in social norms about women and alcohol, but also the fact that more women are driving and driving more frequently and more miles (Popkin, 1991). It is interesting to note that increased substance use among women and increased driving does not convert into risky driving decisions to the degree seen in men. The greater risk for men for DUI and DUI recidivism may well be linking to their increased propensity for impulsivity, risk-taking and aggression than differences in substance consumption (Elliott, Shope, Raghunathan & Waller, 2006). Females seem to drive more cautiously with or without alcohol in their systems (Zador, Krawchuk, & Voas, 2000).

DUI Prevalence Rates among Women

In the National Survey on Drug Use and Health, 11.4% of women aged 21 or over (compared to 22% of men aged 21 or over) reported driving under the influence of alcohol or other drugs in the past year (NSDUH Report, July 1, 2005). However, “as consumption increases, the male-female difference decreases and, in the heaviest drinking group, the rate of driving while intoxicated is almost as high among women as it is for men” (Johnson, Gruenwald & Treno, 1998). While the total volume of female DUI arrest rates is far lower than those for men, DUI arrests constitute the largest category of alcohol-related crimes that bring women into contact with the criminal justice system (Parks, Nochajski, Wieczorek & Millerm 1996). As such, these arrests events constitute a significant opportunity to intervene with women who are experiencing significant alcohol problems. Yet, in Illinois, so few women are referred to women specific treatment.

Looking at the specific issue of drug-impaired driving, 3% of females age 12 or older (compared to 6% of males) report driving under the influence of a drug (NSDUH Report, September 16, 2003).

The gender discrepancy in these rates is further indicated in fatal crash data revealing that male drivers involved in fatal motor vehicle crashes are almost twice as likely as female drivers to be intoxicated with a blood alcohol concentration (BAC) of 0.08% or greater (NHTSA 2004b), however the percentage of male drivers in alcohol-related fatal crashes has decreased while female drivers in such crashes have increased (Waller & Blow, 1995; Abdel-Aty & Abdelwahab, 2000). Several studies have also concluded that females are at greater risk of involvement in fatal crashes at lower levels of intoxication than are males (Waller & Blow, 1995).

In Illinois, 17% of those arrested for DUI are women (DUI Fact Book, 2004), but DUI arrest for women have risen both nationally and in Illinois in recent decades (Parks, Nochasjski, Wieczorek & Millerm 1996).

Studies of the DUI recidivist report that female DUI offenders are less likely to be re-arrested than are male DUI offenders. In a follow-up study of 3,425 DUI offenders, Wells-Parker and colleagues (1991) found males twice as likely to recidivate as females. Most studies of DUI recidivists conclude that 90-95% of recidivists are male (White & Gasperin, in press).

Profile of Female DUI Offenders

Only a small number of studies have focused specifically on the profile of the female DUI offender, and even fewer that profile the female DUI recidivist. Major findings from existing studies reveal that the female DUI offender is likely to:

- Be unmarried, separated or divorced (Wells-Parker, et al, 1991; Chang, Lapham & Barton, 1996)
- Unemployed and seeking employment (Wells-Parker, et al, 1991)
- Be drawn from wide age span (20-50) (Wells-Parker, et al, 1991)
- Be arrested secondary to a vehicular crash rather than for erratic driving (Waller & Blow, 1995).

Compared to young male DUI offenders, younger female DUI offenders are likely to exhibit greater alcohol, marijuana and tobacco use and report more strained relationships with their parents and parental disapproval of their friends (Farrow & Brissing, 1990).

Clinical classification differences exist between men and women arrested for DUI. Wells-Parker and colleagues (1991) found that 47.3% of female DUI offenders were classified as “high-problem-risk” compared to 57% of male DUI offenders. These figures underreport alcohol problems for both men and women due reliance on self-reported information whose validity is significantly compromised by fear of legal repercussions. A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders (compared to 91% of male offenders) met lifetime criteria for alcohol abuse or alcohol dependence, and that 32% of female offenders (compared to 38% of male offenders) met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C’de Baca, Chang, Skipper, Baum, & Hunt, 2001). A study of 1,105 DUI offenders in New Mexico found that of those with alcohol use disorders, 32% of females (compared to 38% of males) also had a drug use disorder and that 50% of women (compared to 33% of men) had an additional psychiatric diagnosis (Lapham, Smith, C’deBaca, Chang,

Skipper, Baum & Hunt, 2001). These studies underscore the high percentage of female DUI offenders that are experiencing alcohol problems and the severity and complexity of those problems.

Few studies have compared the profiles of the male and female DUI recidivist. The best data available suggests the following:

- Male and female DUI recidivists are similar in ethnicity, levels of education, BAC at time of arrest, and lifetime substance use.
- Female recidivists reported higher rates of parental alcohol problems.
- Female recidivists reported higher rates of having hit or thrown something at their spouses (Lampham, Skipper, Hunt & Change, 2000).
- Younger female recidivists are more likely to share traits of rebellion and anti-social behavior similar to male DUI recidivists (Moore, 1994).
- Female recidivists have high rates of alcohol dependence and high rates of past year use of other psychotropic drugs (Lex, Sholar, Bower & Mendelsoln, 1991)

Given the limited number of studies available on female DUI offenders, we have highlighted below some of the broader studies on addiction, treatment and recovery among American women that have implications for the evaluation, treatment, sentencing and supervision of female DUI offenders.

Female Alcohol/Drug Physiology

There are pronounced differences between men and women related to the metabolism and physical effects of alcohol. Here are the key differences:

Metabolism: Women reach higher blood alcohol concentrations and become more impaired than men after drinking the same amounts of alcohol. This is related to the fact that women have lower mean body water volume than men (creating higher alcohol concentrations) and greater difficulties metabolizing alcohol (resulting from lower levels of the gastric alcohol dehydrogenase required in the metabolism of alcohol) (Lex, 1991; Blume, 1992; NIAAA, 1999).

Effect of Menstruation: Blood alcohol levels for women vary across phases of the menstrual cycle. Women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset. Such variation is minimized for women taking oral contraceptives. The onset and intensity of binge drinking has also been linked to pre-menstrual distress (Rusell and Czarnecki, 1986).

Alcohol-related Medical Problems: Women develop alcohol-related physical problems faster than do men. Women develop alcohol-related liver disease (alcoholic hepatitis with and without cirrhosis), hypertension, anemia, gastrointestinal hemorrhage, and ulcers after shorter periods of drinking and at lower levels of alcohol intake than men. The risks for alcoholic cirrhosis and cancers of the head and neck are elevated for women who consume more than 2-5 drinks per day (Wilsnack, 1984; Gearhart, 1991; Gomberg, 1993). The medical risks of alcohol consumption extend beyond the woman herself. Fetal Alcohol Syndrome / Fetal Alcohol Effect (FAS/FAE) is a preventable form of developmental disability caused by excessive alcohol consumption during pregnancy.

Alcohol-related Mortality Rates: Alcohol dependent women have higher (50-100%) mortality rates than either non-alcoholic women or alcoholic men (Hill, 1986; Gomberg and Nirenberg, 1993). Primary causes of death for alcohol dependent women include diseases of the digestive and circulatory systems, accidents (particularly alcohol-sedative combinations), suicide and death by violence (Lex, 1991).

Incidence and Risk of Substance Use Disorders in Women

The Substance Abuse and Mental Health Service Administration's National Survey on Drug Use & Health defines substance dependence or abuse using criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).* These criteria include such symptoms as recurrent drug or alcohol use resulting in physical danger, trouble with the law due to drug or alcohol use, increased tolerance to drugs or alcohol, and giving up or reducing other important activities in favor of drug or alcohol use. Based on the latest of these surveys, 5.9% of women aged 18 or older met criteria for abuse of or dependence on alcohol or an illicit drug in the past year. 15.7% of females aged 18-25 and 26.3% of males aged 18 to 25 met criteria for either dependence or abuse. Among those aged 26 or older, males were twice as likely as females to be dependent on or abusing alcohol or an illicit drug. The rate of substance dependence or abuse for persons age 50 or older was 4.9% for males and 1.5% for females (SAMHSA, 2005).

The higher rates of alcohol dependence for males was long thought to be based on greater genetic vulnerability for alcoholism among men, but recent studies of the heritability of alcoholism have concluded that a substantial (over 50%) of the risk of female alcoholism is genetically influenced (Kendler, et al., 1992; NIAAA, 1999). Many addicted women admitted to addiction treatment, particularly those entering through a DUI referral mechanism, present with multiple etiological factors: genetic risks related to intergenerational family histories of alcoholism, a history of physical and sexual abuse; a history of emotional deprivation, and anxiety and depression that make frequent mood alteration desirable; and involvement in intimate relationships and social groups that promote excessive drinking.

Onset of AOD Problems

Compared to men, the onset of alcohol and other drug problems in women occurs at a later age and is more likely to be associated with a particular life event (e.g., childbirth, breast removal, hysterectomy, family problems, divorce, physical or sexual assault, or the loss of a parent, spouse, or child through death (White, Woll & Webber, 2003; Beckman and Amaro, 1986).

Female Patterns of Substance Dependence

There are many clinically relevant gender differences in substance dependence. The course of alcohol and drug dependence in women is different than men in its symptomotology and is marked by a faster progression–the latter often referred to as "telescoping" (Smith and Cloninger, 1981). Such accelerated effects were first noted in women addicted to alcohol (Corrigan, 1980; Hesslebrock, et al., 1985; Stabenau, 1984).

These early studies confirmed that women become physically addicted to alcohol more rapidly than men and with less volume of alcohol consumed (Spiegel, 1986). Later studies also discovered that women developed heroin addiction more quickly than men (Hser, et al., 1990). Studies of men and women addicted to cocaine reported women had earlier onset of use, higher rates of daily use, higher risk methods of ingestion (smoking or intravenous), more concurrent alcohol use, and an earlier age of entry into treatment (Griffin et al., 1989; Wechsberg, et al., 1998; McCance-Katz, et al., 1999).

In spite of the severe medical consequences of alcoholism in women, women alcoholics consume less alcohol that do male alcoholics and report less daily drinking and binge drinking (Blume, 1992). The phases of alcoholism are less distinct (Lisansky, 1957) and the symptoms and stages of alcoholism differ somewhat for women. Beginning with the work of James (1975), studies have documented that several early stage symptoms of alcoholism in men constitute late stage symptoms of alcoholism in women. For example men begin to choose substances over relationships during early stages of problem development while women cling to relationships well into the later stages of dependence.

Addicted women are more likely than men to be using other drugs in conjunction with beverage alcohol. They frequently present patterns of multiple concurrent and/or sequential drug use (Edwards, 1985; Celentano and McQueen, 1984). Multiple drug use places women at a higher risk for cross-addiction, toxic drug interactions and fatal overdoses.

Differences between male and female substance use patterns have been diminishing in recent years (Green, 2006).

Ethnic/Gender Differences

White, Woll & Webber (2003) reviewed the characteristics and consequences of addiction across ethnic groups and found substantial differences. African-American women tend to be clustered at the extremes of abstinence and heavy drinking, with more African American women totally abstaining than White women (Gary and Gary, 1985). Mexican-American women abstain from alcohol or drink moderately. While the pattern of alcohol abstinence has been consistently reported for immigrant Mexican American women, there are more recent reports of moderate and heavy drinking by Mexican-American women born in the U.S. (Caetano, 1985; Gilbert, 1987). Native American women experience the highest proportion of alcohol deaths. The alcoholic cirrhosis death rate for Native American women, ages 15-34, is 36 times the rate for White women; the rate for African-American women is 6 times the rate for White women (Malin, et al., 1978). The addictions literature is almost completely silent on the drug consumption patterns and problems of Asian-American women.

Addiction and Psychiatric Illness

Where addicted men are more likely to experience co-morbid personality disorders, addicted women are more likely to experience co-morbid affective disorders (Wilsnack, Wilsnack and Klassen, 1984). Addicted women are twice as likely to report major depression than addicted men (Wechsberg, et al., 1994) raising the potential that

some women may self-medicate affective disorders with alcohol and other drugs. The co-occurrence of eating disorders (particularly bulimia) and substance use disorders has also been noted in the clinical literature (Katzman, et al., 1991; Holderness, et al., 1994). A 1996 NIMH-funded study of women detainees in Cook County Jail found that over 80% of the 1272 detainees met criteria for one or more lifetime psychiatric disorders. (*Arch Gen Psychiatry*/Vol 53).

Victimization as a Risk Factor

The relationship between childhood sexual abuse and/or subsequent sexual trauma and the onset and course of alcohol and other drug problems is a complex one. Key research and clinical findings include the following:

- Women with substance use disorders report higher rates of childhood sexual abuse compared to non-addicted women (67 percent compared to 28 percent) (Blume, 1992; Forth-Finnegan, 1991, 1984; Rachel, 1985; Covington, 1986), and reports of childhood sexual abuse among addicted women seeking treatment range between 75-90 percent (Rohsenow, Corbett and Devine, 1988; Zweben, 1996).
- The link between developmental victimization and the subsequent development of substance use disorders may be intensified with the presence of key traumagenic factors, e.g., early onset of abuse, long duration of abuse, victimization by family members, multiple perpetrators, and failure to protect following early disclosure (White, Woll & Webber, 2003).
- Addicted women often present patterns of serial victimization–childhood sexual abuse followed by later episodes of physical and/or sexual assault (Miller, et al., 1989).
- Addicted women with histories of sexual victimization have a higher incidence of health problems and health care utilization than do addicted women without such histories (Liebbschultz, Mulvey and Samet, 1997).
- The sexual victimization of addicted women is often clinically nested within a larger cluster of problems, including feelings of depression, worthlessness, and powerlessness; suicidal thoughts; toxic, abusive intimate relationships, impaired mother-child relationships, and environmental chaos (Gomberg, 1993).
- The sexual abuse of addicted women may contribute to many of the clinical issues often noted in women's treatment programs: fear and distrust, shame and guilt, feelings of unworthiness; conflict about sex role identity; self-doubts about adequacy as a women; and sexual dysfunction (Wilsnack, 1973; Kirkpatrick, 1986).
- The preponderance of addicted women with a history of physical and sexual abuse suggests by itself the need for special approaches to their treatment (Skorine & Kovach, 1986).

It was long thought that a sexual abuse history was predictive of poorer treatment outcome, but this assumption is being challenged by recent studies. These studies note that women with sexual abuse histories report numerous problems (depression, anxiety,

low self-esteem, low decision-making confidence) at treatment admission and at follow-up, but that they are more likely than women without such histories to consume less illicit drugs following treatment, be in counseling for psychological problems and to be taking psychotropic medications under the direction of a physician (Bartholomey, Courtney, Rowan-Szal & Simpson, 2005).

Obstacles to Treatment

Women encounter greater obstacles to initiating and completing treatment for a substance use disorder than do men (Green, 2006). These obstacles include intense social stigma attached to addicted women (particularly addicted mothers), female socialization (e.g., learned helplessness, passivity), multiple role responsibilities, inadequate insurance and financial resources, fear of loss of custody of children and legal punishment (for pregnant, addicted mothers), and lack of child care, transportation and sober housing (NIAAA, 1983, Gomberg, 1988, Schliebner, 1994, Burman, 1992, Finkelstein, 1994)

Treatment Entry Decisions

There is growing evidence for gender-specific factors related to the initiation of recovery (e.g., pregnancy) and in obstacles to successful recovery (e.g., intimate involvement with an addicted husband or partner) (Anglin, et al., 1987). The entry of addicted women into treatment is associated with 1) perception of alcohol or drugs as a problem, 2) life events (consequences) that precipitate a crisis and need for change, 3) the anticipation or experience of hope that treatment can produce positive change, 4) the perception that the treatment agency has programs that can respond to her special needs and the needs of her family, and 5) a social network that supports entry and continued involvement in treatment (Thom, 1984). Waldorf (1983) found women separating from addicted husbands/paramours (often subsequent to their arrest) as a major factor in initiation of natural recovery in addicted women. Similarly, Wilsnack and her colleagues (1991) found divorce or separation associated with improved post-treatment outcomes among treated, married women (Wilsnak, et al., 1991).

Admissions of women to treatment have until recently been linked to health or family concerns (pregnancy, effect of use on children) than the occupational or legal issues that tend to bring men to treatment (Blume, 1992; Burmanm 1997). Pregnancy and/or concern about parental adequacy are major motivators for women seeking entry into addiction treatment (Rosenbaum and Murphy, 1990l Chen & Kandel, 1998), but the increased involvement of women in the criminal justice system has sparked a dramatic increase in women, particularly younger women, entering addiction treatment.

The use of indigenous outreach workers is effective in engaging women in addiction treatment who have previously resisted seeking out such services (Groos and Brown, 1993; White, Woll & Webber, 2003).

Female Treatment Admissions

Females made up 30% (565,400) of the 1.9 million addiction treatment admissions in the United States in 2002. Females admissions were an average of 33 years of age and were more likely to report problems with opiates or cocaine (fewer problems with alcohol or marijuana), be self-referred, be unemployed at admission, and more likely to be separated, divorced or widowed (DASIS Report, May 20, 2005).

Assessment and Treatment Process

The multiplicity of problems that characterize the lives of addicted women require a redesign of traditional evaluation and treatment processes. Assessment instruments and processes for addicted women need to be global as opposed to categorical and continuing rather than an intake activity (Wechsberg, 1995). The treatment itself needs to focus on the whole spectrum of problems presented by the addicted woman rather than focusing narrowly on the problem of addiction (Brown, Huba, and Melchior, 1995; Wechsberg, 1995). The nature and number of these problems may dictate a longer period of indicated treatment for women. For example, time and physical healing may be required for alcoholic women to recover from alcohol-induced neuropsychological deficits before intensive psychotherapies can be used effectively (Hill, in Wilsnack, 1984).

Traditional confrontational approaches in addiction treatment may be highly inappropriate and even injurious for many addicted women (Murray, 1989; Nelson-Zlupco, 1995; Zweben, 1996). Such traditional approaches require substantial modification for clinical appropriateness and effectiveness (Brown, et al., 1996). Motivational enhancement strategies offer a tested alternative to such clinical tactics (Miller and Rollnick, 1991).

In 1986, a sweeping review of the addiction treatment research concluded that there was little research evidence to support the efficacy of any particular treatment approaches for addicted women (Vannicelli, 1986). Since then, there has been an accumulation of research that is defining the major elements of an evidence-based, gender-specific and family focused model of addiction treatment. Women-specific addiction treatment programs differ significantly in the variety, comprehensiveness, design, duration and cost of services (Grella, et al., 1999). More specifically, they:

- provide outreach services (Reed, 1987)
- focus on addiction as one of multiple problems that require service attention (Nichols, 1985; Wallen, 1992; Zweben, 1996)
- collaborate with multiple helping agencies during the treatment process (Reed, 1987)
- concentrate services in a single, non-stigmatizing service environment (Kaplan-Sanoff and Leib, 1995; Finkelstein, 1993)
- focuses on the needs of the woman and her children
- treat gynecological and medical problems (Burman, 1992)
- provide child care, transportation and housing services (Beckman and Amaro, 1986)
- link clients to domestic violence services

- provide strong female recovery role models (DiMatteo and Cesarini, 1986; Reed, 1987),
- provide all-female groups and female therapists, outreach workers and case managers (Ruggels, et al., 1977; (Woodhouse, 1990)
- place emphasis on client empowerment via the goals of personal and economic self-sufficiency and an emphasis on choices throughout the treatment process (LaFave and Echols, 1998)
- provide women-only, peer support groups within the treatment milieu encouraging sexual autonomy related to desires, preferences, and limits (Nelson-Zlupko, 1995),
- provide case management services to address personal and environmental obstacles to recovery
- provide a longer duration of treatment involvement with a structured program of family-focused aftercare, and
- provide pregnancy-related services

Treatment Outcomes

Addiction treatment outcomes for women are influenced by both client characteristics and program characteristics (Morrissey, Ellis, Gatz, et al, 2005).

Women who complete treatment have nine times the abstinence rates as follow-up as women who did not complete treatment, whereas the abstinence rates of men completing treatment is only three times greater than men who do not complete treatment (Green, 2006).

In spite of the popular conceptions (myths) that women are hard to treat and have poor treatment outcomes, early research suggested that women do as well as men in addiction treatment (Vannicelli, 1984; Annis & Liban, 1980; Toneatto et al, 1992). More recent studies have concluded that women have better post-treatment recovery outcomes than men (Walitzer & Dearing, 2000; McCance-Katz, Carroll &Rounsaville, 1999; Hser, Evans & Huang, 2005; Green, 2006). The latter findings included treatment outcome studies for cocaine and methamphetamine dependence.

Studies of women-only versus gender-mixed treatment programs have produced conflicting results, with some gender-specific programs showing enhanced outcomes (Dahlgren and Willander, 1989), while others revealed no difference in outcome (Copeland et al., 1993).

There is evidence that women-only treatment programs are able to reach those women that otherwise would not seek or complete addiction treatment (Reed and Leibson, 1981). What is most clear from treatment outcomes studies of women is that women have higher retention rates and better post-treatment outcomes in programs in which great numbers of women are treated and which provide a more comprehensive range of gender-specific services (Grella & Greenwell, 2004).

Poorer treatment outcomes for women have been associated with: 1) presence of a disturbed or violent parent during childhood, 2) depressive symptoms, 3) alcohol abuse and violence in partner at time of follow-up, 4) removal of children from home by authorities during follow-up period, and 5) problems handling aggressive impulses (Hover, 1986; Hover, 1987; Bergman, 1985; Walitzer & Dearing, 2000). Involvement with an addicted partner is a major etiological factor in the onset of excessive alcohol and drug

use for women and a major barrier preventing the addicted woman from entering treatment or sabotaging her on-going recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCrady and Raytek, 1993). Involvement in methadone treatment has been shown to provide structure and stability in the life of opiate-addicted women, but that many women of these women express concerns about the stigma related to their continued use of methadone (Rosenbaum and Murphy, 1990).

Two just-completed reviews of addiction treatment outcome studies on women (Sun, 2006; Greenfield, Brooks, Gordon, et al, 2006) draw the following conclusions:

- Women with AOD problems are less likely to enter treatment than men with such problems.
- Treatment retention and completion rates are similar for women and men.
- Women as a group do better in residential modalities than modalities of lower intensity.
- Women do better in treatment programs that offer regular individual counseling in addition to non-confrontational group counseling.
- Retention and longer length of treatment is associated with better treatment outcomes for both men and women.
- Provision of child care services increases retention and the positive effects of treatment.
- Provision of case management services improves retention and outcomes.
- Women have better long-term outcomes following treatment than do men.
- Gender-specific treatment is effective but study findings vary on the question of whether gender-specific treatment is more effective than mix-sexed treatment.

Processes and Stages of Recovery

Women have shorter alcoholism careers. Fillmore (1987) found that heavy drinking for women peaked in their thirties and then dropped sharply during their forties and beyond, with a substantial number of women ceasing alcohol consumption after age 60. Fillmore concluded that, in comparison to men, remission of heavy drinking is more likely and more likely to occur earlier. There is further evidence that women have greater prospects for long-term recovery than do men. Humphreys and his colleagues found in a follow-up study of clients eight years post-discharge that women were 1.63 times more likely to be in stable recovery (Humphreys et al., 1997). Mohr, et al., (2001) attributes these enhanced outcomes to the fact that alcoholic women entering treatment have more non-drinking friends who are supportive of their recovery process than do alcoholic men. Recovery friendships and supportive social support networks are a significant motivator toward self-directed recovery for many women. The greater prospects of recovery may also extend to women addicted to drugs other than alcohol. Snow (1973) reported that women addicted to opiates had better long-term recovery rates than men with similar addiction patterns.

Recovery without Treatment/Moderated Recovery

Many young women aged 21-34, who as a group report the highest incidence of alcohol-related problems, will resolve these problems without treatment (Wilsnack, 1989). Such "natural recovery" (the achievement of recovery from addiction without the aid of professionally-directed treatment or sustained involvement in mutual aid groups) is more common in women than in men. In a recent study of natural recovery in women, Copeland (1998) found three themes in the resolution for change decisions: 1) concern for current and future health, 2) a lost sense of self, and 3) concern over the welfare of their children. Strategies that women use to self-manage their own recovery process include management of withdrawal, short-term drug substitution, severing drug-dominated intimate and social relationships, developing new social activities and relationships, and the cultivation of new health-promoting behaviors, e.g., nutrition, fitness, alternative medicine (Copeland, 1998). Those women who cannot achieve natural recovery when compared to those who do are found to have greater problem severity, greater psychiatric co-morbidity, and fewer family and social supports.

Gender differences are also noted in the literature about persons with alcohol problems who resolve such problems through moderating their use rather than by complete abstinence. Sanchez-Craig and her colleagues (1984, 1991) and others (Miller and Joyce, 1979; Elal-Lawrence, et al., 1986; Helzer, et al., 1985) have noted that women more likely than men to achieve successful moderation outcomes. Again, this may be related to the Mohr study (2001) findings that women had richer non-drinking social relationships than men and that such relationships enhanced not only successful abstinence but also served to lower the number of drinks per drinking day among those who did drink. Successful moderation is linked to lower personal vulnerability (e.g., absence of family history, later onset of alcohol/drug use), absence of co-occurring medical/psychiatric illness and significant family and social support (White & Kurtz, in press).

Developmental Stages of Recovery

Recovery for most addicted women is a time-involved, developmental process. Confirming these observations was a recent study (Brown, et al., 2000) concluding that women may be at different stages of change for different problems, e.g., substance use, high risk sexual behaviors, violent relationships, child neglect, and that such change processes must be simultaneously managed. Relapse is often part of the early recovery process for many women. Such relapses can involve the primary drug to which the women was addicted or the use of secondary drugs. Willie (1978) reported that recovered heroin addicts used drugs such as alcohol and cannabis in the first year to cope with the challenges of early recovery. Willie framed such use not as substitute addiction but as an "intermediary stage" of recovery. Similar findings occurred in Copeland's (1998) study of natural recovery in women. All of the women noted to have developed an initial problem with a substituted drug later resolved this problem. While there is a very real danger of transferring dependencies e.g., from heroin to cocaine or alcohol, episodes of drug substitution are best seen as part of the early recovery process requiring active management than an indicator of either the untreatability of the client or the failure of a particular treatment method.

Recovery Support Structures

Women and cultural minorities affiliate with AA/NA at the same rates as White men (Humphreys, et al., 1994) and at least one report suggests that women may have an easier time affiliating with 12-step groups than do men (Denzin, 1987). This may be related to the fact that alcoholic women are more socially isolated (tell fewer individuals about their drug-related problems) and have less support from their partners for recovery (Bischof, et al., 2000). The percentage of women among AA members has increased from 15 percent in 1955 to 33 percent in 1996 (White, 1998). Special women's groups within AA grew during these same years. There are feminist-based alternatives to AA (Kirkpatrick, 1976), and AA's steps have been refined for greater applicability for women (Kasl, 1992; Lerner, 1990). There is also evidence that women, particularly African-American women, may use the church as a sobriety-based support structure (White, Woll & Webber, 2003).

Substance Use and Partner Violence

Alcoholic women tend to select mates who come from family backgrounds similar to their own (Rimmer & Winokur, 1972). This process is referred to as "assortative mating" (Lex, 1991) and has been linked to the victimization histories of addicted women. The research literature on addicted women portrays a picture of unstable marital/intimate relationships characterized by low levels of emotional satisfaction and increased levels of marital conflict that can escalate into the emotional/physical abuse of the alcoholic woman. This picture must be viewed in the context of the high rate of victimization of these clients. Research has confirmed the propensity of traumatized women to "repeat and re-enact subordination and victimization in their interpersonal attachments" (Bollerud, 1990). Breaking these cycles of victimization requires specialized treatment approaches (Herman and Schatzow, 1984).

Sentencing Issues

Few studies have distinguished the effectiveness of particular DUI sanctions by gender. One notable exception to this rule was a study of the effects of victim impacts panels on DUI recidivism. That study found that female repeat offenders who were referred to victim impact panels were twice as likely to recidivate as female repeat offenders not referred to a panel (C' De Baca, Lapham, Liang & Skipper, 2001). The authors suggested the possibility that victim impact panel could actually have a negative effect on the female repeat offender. The potential effectiveness or ineffectiveness of remedial education for the female DUI offender may well be an issue of timing. We suspect that early exposure to an impact panel may elicit too much empathy for women already steeped in self blame and may increase her risk of drinking due to shame and guilt, while introducing it later might prove beneficial.

Tips for Enhancing Recovery among Women

Police officers, evaluators, treatment specialists, prosecutors, judges, probation officers and Secretary of State Hearing Officers all have opportunities to interact with women who have driven under the influence of alcohol and who have significant alcohol and other drug related problems. These interactions offer tremendous opportunity to influence movement toward sustained recovery. In this section, we offer a few simple tips to reduce your stress, enhance your effectiveness, increase her accountability, and improve outcomes for addicted women.

Establish Rapport and Safety A helping alliance includes respect, rapport and safety. With histories of physical and or sexual abuse that spanned early developmental years through their adult lives, addicted women carry deeply embedded messages that the world is not a safe place, and that people, especially authority are cruel. Women in recovery talk about kindness from authority as if it were a rare and precious commodity. With harshness her anxiety level soars, she closes up and loses the capacity to hear you--she's frantically trying to defend herself. In an environment of safety and kindness she opens up and wants to comply with your expectations. Your stress level and hers will go down, and outcomes will improve.

Set Clear Expectations and Monitor Performance. Communicate in behavioral and measurable terms what is expected, acknowledge positive recovery-related activities and continue to monitor her compliance with positive feedback and support.

Convey Hope and Praise. Hope and affirmation are the lifeblood of recovery for women. Most addicted women have been socially stigmatized, victimized and blamed by systems they've reached out to. Hungry for approval from authority, acknowledging her positive efforts will motivate her and other women witnessing such praise. Recognizing and complimenting does not take a degree in counseling, but the payoff is tremendous.

Educate Yourself about the Stages of Recovery. We recommend several resources to enhance your education on the recovery process. The first is the book *Changing for Good* by John Prochaska, John Norcross and Carlo DiClemente, which demonstrates that timing in partnership with the appropriate intervention can interrupt addictive patterns. The second is an essay entitled The Varieties of Recovery Experience by William White and Ernest Kurtz that is included in a monograph entitled Recovery Management that is distributed by the Great Lakes Addiction Technology Transfer Center. A third resource is an essay on the developmental stages of recovery for addicted women that summarizes a study of recovering women in Illinois' Project SAFE sites—an award winning program that treated women with histories of addiction-related abuse or neglect of their children. This essay is included as an appendix to this monograph.

Discover and Ignite Her Motivators Every woman will easily reveal what motivates her, when we set aside our own biases, values and beliefs. If you don't believe us, try this, for the next week, ask every woman you meet the same question, nothing deep or personal, but something as simple as

- Best birthday you ever had
- Something you enjoy

As she answers, she will reveal her values, beliefs, and motivators. Just as each woman has a unique face and personality, each possesses a unique set of values, beliefs, strengths, weaknesses and interests. By listening carefully you will discover her unique motivators and how to ignite those. She will easily share those ***when she feels safe, and when she feels heard.***

Help Each Client Increase Her Recovery Capital. Recovery capital is the internal and external resources that can be mobilized to initiate and sustain recovery. Here are examples of four categories of recovery capital:

- Social Capital – Social relationships that and encourage and support recovery.
- Physical Capital - Financial such as income, savings, a home, investments.
- Human Capital - Knowledge, skills, health, problem solving abilities.
- Cultural Capital - Beliefs, behavioral patterns, qualities that emanate from membership in a particular culture that encourage recovery.

We can help woman expand their recovery support resources by recognizing and enhancing their recovery capital, and suggesting simple assignments linked to her motivators. Here's an example of an assignment for a women who wanted to get her GED but suffered from testing anxiety.

- *Go to the library and request information on getting a GED. Don't sign up yet if you feel overwhelmed, just get the information.*
- *Ask women in AA who got their GED's in recovery to share when, where, how and any obstacles they overcame to get their GED.*

This assignment helps her understand the GED process and allows choices about when to begin. Studying for the GED builds confidence, enhances motivation and instills hope that she can learn, grow and change. Talking to other women helps build a recovery support network. These are examples of building recovery capital.

Where Possible, Shift Your Paradigm to "No Failure. Just Feedback" A key to ongoing recovery is the ability to explore what doesn't work and try new strategies. Relapses & acts of non-compliance can be important sources of feedback. Women in early recovery are suffering from the combined effects trauma, withdrawal and cognitive impairment of early recovery. Lake County and Cook County in Illinois both committed resources to establish specialized services for DUI Women and secured specialized training on gender specific models for their staff. Rather than attributing deviant behavior as a product of personal failure, well trained staff will further assess and adapt approaches before imposing sanctions.

Visit Local Treatment Programs for Women. Visiting local treatment programs that have gender competent services for women will breathe life into the knowledge you've acquired about women and addictions. Collaboration improves treatment outcomes, eases the referral process for you, and will help you align your goals and her goals in treatment. Considering that women who complete treatment have nine times the abstinence rates as women who didn't complete treatment, it's well worth it to have a good working relationship with treatment programs.

Visit Open Recovery Support Meetings. We recommend acclimating yourself to local recovery support groups by reviewing literature and web sites of such groups (see www.facesandvoicesofrecovery.org, click mutual aid resources) and attending open meetings. You can contact AA (and often NA) through the Yellow Pages of the phone book. Your work will be enriched by hearing the powerful stories of women in long-term recovery whose lives, now meaningful and productive, were once as chaotic and problem-ridden as those of the women clients you now serve. Your ability to understand the core ideas, language and rituals of recovery groups will dramatically enhance your ability to link women to these groups and monitor their participation. You'll meet women today who are honest, hard working, reliable, a mother, wife, and friend, because someone just like you saw beyond their problems, held them accountable and encouraged them to hang in there for the miracle of recovery.

Attend Meetings And Hear Her Story Encourage current and former clients to invite you when they share their story at an open meeting. Most women will appreciate your interest and be proud to have you there. You will be surprised to learn new things about her as she pours out her truth the AA way. What you learn from her is sure to improve your interactions with other women on your case load.

Start a Women's Self Help Group In communities that do not have women's meetings of AA, NA, etc., you may want to help develop such a meeting by inviting AA / NA volunteers to start up meetings and conduct them. Developing such resources can be aided by working with current Hospital and Institution Committees within AA or NA or by setting up an AA/NA advisory group.

Explore Group Supervision Lake County, Illinois and Cook County, Illinois train their staff on conducting group supervision. Groups range from women's groups, co-ed groups and groups organized by severity/risk, groups for women who have reached abstinence, and those still struggling. Because women are very relationship oriented, they do very well in groups. But, because relapse is common in early recovery, groups for women who are still using get the best outcomes when staff is trained in women's issues, addiction interruption techniques, and running effective groups. Once mastered, these skills can be important recovery support resources, particularly in communities lacking women's groups in AA and NA.

Future Directions

Having reviewed the available research literature on women DUI offenders and the broader literature on the treatment of women and having interviewed women DUI offenders and those providing services to these women, we would offer the following ten recommendations related to enhancing the quality of evaluation, education, treatment and supervision of female DUI offenders in the State of Illinois.

1. Evaluation Instruments: Develop gender norms for existing evaluation instruments and/or develop an instrument or subscales based specifically on research with, at best, female DUI offenders, and at least, community and clinical samples of women.
2. Gender Competent Evaluators: Require all DUI evaluators to complete gender-specific training and hold IAODAPCA's forthcoming certificate for gender competence.
3. Recidivist Risk Profile: Develop a DUI recidivist risk profile that is based exclusively on research with women DUI offenders.
4. Gender-specific Risk Education: Audit and revise existing remedial education programs to assure gender competence. Segregate women into specialty groups when there are enough women.
5. Gender-specific DUI Treatment Models: Develop models for treating female DUI offenders that incorporate current research findings.
6. Gender-specific Treatment Specialty: Encourage the development of gender-specific DUI treatment services to assure enough referrals to organize women's groups.
7. Women's Recovery Support Groups: Develop a directory of women's recovery support groups in Illinois and that are available Online. Establish guidelines for establishing local liaison committees between the courts, treatment agencies and recovery mutual aid groups. Develop women's recovery support groups in communities where they do not exist. Recruit AA/NA volunteers to orient new judges, probation officers and other service roles to local recovery support groups.
8. Alumni Volunteers: Recruit, train and supervise a cadre of women in recovery who came through the DUI system who can serve as volunteer recovery coaches to women currently entering the system.
9. Consumer Feedback on Services: Conduct a survey of female DUI offenders to solicit feedback related to evaluation, treatment and probation services they have received.
10. Gender-research: Encourage all studies done on DUI in Illinois to analyze data for gender differences.

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Recognizing, Managing and Containing the "Hard Core Drinking Driver"

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The 1.5 million persons arrested each year for driving under the influence of alcohol or other drugs (DUI) constitute a growing portion of the caseloads of the nation's probation officers (Federal Bureau of Investigation, 2002). The sheer volume of these cases poses the challenge of determining which DUI offenders pose the greatest threat to public safety and require more rigorous monitoring and case management. There is growing consensus that more sophisticated approaches are needed to examine how particular risk factors interact to predict DUI recidivism and future involvement in alcohol-related crashes (C'de Baca, Miller, & Lapham, 2001). This article responds to that challenge by reviewing the research on the highest risk DUI offenders, introducing the Hard Core Drinking Driver Checklist, and discussing principles probation officers can utilize to effectively manage the hard core drinking driver (HCDD).

Changing Perceptions of the DUI Offender

During the mid-twentieth century, both the American public and service professionals viewed the DUI offender as an otherwise law-abiding social drinker who made an isolated error in judgment that could be permanently corrected through brief remedial education. According to this view, the challenge for the criminal justice system was to identify and manage the small percentage of alcoholic DUI offenders who constitute a high recidivism risk (Vingilis, 1983). This "needle in the haystack" view of the high risk DUI offender was subsequently challenged by judicial activists (Kramer, 1986) and researchers (Crancer, 1986) who suggested that the entire system of reducing alcohol impaired driving rested on a mythical conception of the social drinking DUI offender. Further studies of the DUI offender have challenged this myth.

- Between 40-70% of first-time DUI offenders have prior alcohol- or

drug-related criminal offenses (Taxman & Piquero, 1998; Chang and Lapham, 1996; Kochis, 1997).

- A driver would have to commit between 200 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987; Beitel, Sharp, & Glauz, 2000).
- Most alcohol-impaired drivers treated in hospital emergency departments are not arrested and convicted of the impaired driving that produced their injuries (Soderstrom, Ballesteros, Dischinger, Kerns, Flint, & Smith, 2001).
- The percentage of non-problematic, social drinkers within the DUI arrest pool has declined due to the cumulative effects of successful DUI educational campaigns (NHTSA, 1997; Lund & Wolf, 1991; Yi, et al., 2002).
- Significant problems exist with the accuracy of diagnosis of alcohol use disorders among DUI offenders, with the rate of retrospective alcohol dependence diagnoses tripling in five-year follow-up studies (Lapham, C'de Baca, McMillan, & Hunt, 2004).
- More than 80% of DUI offenders have a significant problem in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, et al., 2001; Brinkmann, Beike, Köhler, Heinecke, & Bajanowski, 2002; See Lapham, et al, 2004 for a review). A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders and 91% of the male offenders met lifetime criteria for alcohol abuse or alcohol dependence and that 32% of females and 38% of males met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C'de Baca, Chang, Skipper, Baum, & Hunt, 2001).

Seen as a whole, most DUI offenders have, are developing, or will go on to develop a serious substance-related problem. Within this larger pool of DUI offenders exists a subpopulation of drinking drivers who pose inordinate threats to public safety based on their frequency of drinking and driving and their levels of debilitation when drinking and driving. These individuals have been christened "hard core drinking drivers."

The "Hard Core Drinking Driver"

The emerging definition of the hard core drinking driver (HCDD) is an individual who, despite education, threats, and punishments, drives frequently (at least monthly) at high BAC levels (above 0.15%) (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Recent surveys reveal that 3% of licensed drivers account for 80% of the total number of impaired driving trips (Beirness, Simpson, & Desmond, 2002, 2003). HCDDs pose exceptionally high threats to public safety due to their frequency of drinking and driving and their high level of intoxication while driving. Because of these twin threats, HCDDs are at high risk for re-arrest for driving while impaired and for future involvement in a drinking-related crash. The challenge for the probation officer is to identify individuals in this

highest risk category and develop special monitoring and management strategies based on their unique characteristics (Voas & Fisher, 2001).

The Hard Core Drinking Driver Profile

Hard core drinking drivers share many characteristics with the larger pool of DUI offenders (Arstein-Kerslake & Peck, 1985) but exhibit these characteristics to a much higher degree than non-recidivating offenders. HCDDs also reflect characteristics that distinguish them from impaired drivers who are arrested once but who are neither re-arrested for DUI nor involved in a future alcohol-related crash.

Demographic Profile

The general profile of the HCDD is that of a male (90-95 percent), aged 25 to 45 (more than 75 percent are under age 40 and only 10 percent over age 50), with 12 grades or less education employed in a non-white-collar occupation (with a history of occupational instability), and lower socioeconomic status (Simpson, et al, 2004). Most HCDDs have a history of impaired intimate relationships, e.g., the inability to sustain friendships and intimate relationships as well as a pattern of conflict in such relationships (e.g., domestic violence). DUI recidivists are more likely to have prior domestic violence offenses than first time DUI offenders (Syrcle & White, 2006). More than 60 percent of DUI recidivists have children, but 75 to 80 percent are unmarried (single, separated, divorced, or widowed) at the time of their arrest. Single, divorced, and widowed offenders have higher re-arrest rates than those who are married (Lapham, Skipper, Hunt, & Chang, 2000). Many HCDDs socialize with individuals who also drink frequently and heavily and who also drink and drive (Nelson, et al., 1998).

Substance Use History

HCDDs, when compared to the larger pool of DUI offenders, are more likely to present with a family history of alcohol and other drug problems, including family modeling of drinking and driving (Jessor, 1987; Gulliver & Begg, 2004). They report an early age of onset of alcohol/drug use (Hingson, Heeren, Levenson, Jamanka, & Voas, 2002), euphoric recall of their first contact with alcohol/drugs, atypically high tolerance from the onset of drinking (White, 2004), and a pattern of high school binge drinking (Wechsler, Lee, Nelson, & Lee, 2003). Individuals reporting onset of drinking before age 14 are seven times more likely to be in an alcohol-related crash than those who begin drinking after age 21 (Hingson, et al, 2002). Most HCDDs are involved in frequent, heavy drinking and prefer drinking in venues outside their homes (e.g., bars/restaurants) that are accessible by car (Gruenewald, Johnson, & Treno, 2002). They may also exhibit patterns of drinking in automobiles (Snow & Wells-Parker, 2001), which is reflected in early charges for illegal possession of alcohol, illegal transportation of alcohol, or an open bottle or can at the time of the DUI arrest. They show signs of severe drinking-related problems (half meet diagnostic criteria for alcohol dependence) (Simpson, Mayhew, & Beirness, 1996) and self-report a need to cut down on their drinking (Hedlund, 1995: Perrine, 1990).

Most HCDDs report beer as their primary beverage of choice

(Gruenewald, Johnson, Millar, & Mitchell, 2000), however, supplementation with distilled spirits is common, particularly as alcohol tolerance increases (White, 2004). HCDDs are more likely than others to report a sustained pattern of multiple drug use including alcohol and tobacco, prescribed psychoactive drugs, and illicit drugs (Osborn, 1997). While the vast majority of DUI offenders smoke (Taxman & Piquero, 1998), the HCDD is often marked by the early onset of smoking, the amount of smoking (more than 30 cigarettes per day), high intensity of nicotine craving, smoking within five minutes of waking up, and lack of attempts to cut down or quit (John, et al., 2003). HCDDs often report prior treatment for alcohol or other drug problems, but records reveal noncompliance with sentencing conditions and treatment (Peck, Arstein-Kerslake, & Helander, 1994; Nochajski, et al., 1994). Interviews with HCDDs reveal the perception that treatment was a "waste of time" (Timken, 1999).

Driving and Criminal Justice History

HCDDs have a higher percentage of prior criminal records (exclusive of impaired driving arrests) than the larger pool of DUI offenders (Syrcle & White, 2006). Between 20-25 percent of prior convictions for DUI recidivists are for crimes against persons. At least one study found that prior criminal history other than DUI offenses was a predictor of future DUI recidivism (Nochajski, Miller, & Wieczorek, 1989). HCDDs are more likely than their non-recidivist counterparts to have prior alcohol- or other drug-related arrests that predate their first DUI arrest, e.g., illegal consumption, illegal possession, illegal transportation, criminal damage to property, disorderly conduct, public urination, or assault. The risk of future DUI arrest rises in tandem with the number of prior DUI arrests (NHTSA, 1996a). Adult drivers ages 35 and older who have been arrested for impaired driving are 11 to 12 times more likely than those who have never been arrested to eventually die in crashes involving alcohol (Brewer, Morris, Cole, Watkins, Patetta, & Popkin, 1994).

HCDDs are more likely to have high-risk driving records (e.g., moving violations, failure to wear seat belts, accidents involving personal injury or property damage, loss of insurance) and to be involved in more traffic crashes than other drivers in general as well as non-recidivist impaired drivers (Baum, 2000; Begg, Langley, & Stephenson, 2003; "Drivers with…", 1994). There is growing evidence of an overlap between the HCDD and the larger pool of high-risk drivers (Wells-Parker**,** Landrum, & Cosby, 1985; Taxman & Piquero, 1998). HCDDs commonly drive on a suspended/revoked license and do so in ways that indicate a disregard for community norms and a high degree of sensation-seeking, risk-taking, and interpersonal aggression. A study by Simpson and Mayhew (1991) revealed that 21% of drivers who were killed at a time they had a BAC over 0.20% did not have a valid drivers license at the time of the crash.

HCDDs are more likely to have had prior cases of arrest for DUI that resulted in long processing time before disposition and the avoidance of DUI conviction (Yu & Williford, 1995). HCDDs are often characterized as "system sophisticated" due to their ability to manipulate both the criminal justice system and the treatment system in order to avoid the consequences of their

drinking and driving behavior as well as the consequences for their non-compliance with sentencing conditions (Robertson & Simpson, 2003; Simpson, et al., 2004).

Drinking and Driving Beliefs

HCDDs are more likely than those who do not drink and drive or one-time offenders to believe they can drive safely after consuming large quantities of alcohol (Caudill, Kantor, & Ungerleider, 1990; Nelson, et al., 1998; Hingson, Hereen, & Winter, 1998). They fail to make alternative transportation arrangements before drinking (Nelson, et al., 1998) and underestimate their level of intoxication at the time they decide to drive (Beirness, Foss, & Voas, 1993). HCDDs trivialize drinking and driving in part because they are often enmeshed in heavy drinking subcultures that provide little social disapproval for drinking and driving (Nelson, et al., 1998). HCDDs do not support severe penalties for impaired driving (Nelson, et al., 1998) and tend to see their DUI arrest as a function of bad luck or victimization by the police rather than as a consequence of their poor decision-making.

The Arrest Event

In comparing the arrests of the HCDD to that of the larger pool of DUI offenders, the HCDD is more likely to be drinking alone or in groups of men prior to the arrest and to be driving alone at the time of the arrest. They are more likely to have collateral charges tied to their DUI arrest, e.g., fleeing, resisting arrest, drug possession. They are also more likely to have an excessively high BAC — .25 or greater — at the time of their arrest (National Commission Against Drunk Driving, 1986). More than half of fatally injured DUI recidivists have a BAC of .20 or greater, which in itself is a risk factor for recidivism (Simpson & Mayhew, 1991; "Drivers with…", 1994) and a predictor of alcoholism (Brinkmann, Beike, Köhler, Heinecke, & Bajonowski, 2002). The high alcohol tolerance developed from prolonged heavy drinking can also result in high BACs without gross signs of intoxication, e.g., less impairment in field sobriety tests than one would expect from their BAC levels. HCDDs are also more likely to refuse a Breathalyzer test (Syrcle & White, 2006) and to exhibit a high degree of knowledge (or pseudo-knowledge) regarding DUI laws.

Broader Clinical Profile

Clinical assessment of the HCDD reveals a broader pattern of problems and a characterological profile that contributes to their risk for recidivism. HCDDs frequently report a history of co-occurring psychiatric problems (e.g., depression, posttraumatic stress disorder, antisocial personality)(C'de Baca, Lapham, Skipper, & Hunt, 2004) as well as complex medical histories marked by accidents, emergency room visits, workers' compensation claims and disability claims (Soderstron, et al, 2001). HCDDs often reflect minimal goal orientation; diminished capacity for empathy, guilt, and remorse; an elaborate cognitive defense structure characterized by denial, minimization, rationalization, resentment, projection of blame, hostility, and aggression (Caviola & Wuth, 2002; Farrow, 1989; Reynolds, Kunce, & Cope, 1991; Simpson, et al, 1996); impaired problem-solving skills; and impulsivity, sensation-seeking, and risk-taking (Yu & Williford, 1993;

Hedlund & Fell, 1995; Caviola & Wuth, 2002).

It is this overarching characterological profile that seems to link alcohol-impaired driving, drugged driving, and risky driving (Donovan, 1993). It is this same profile that produces high follow-up mortality rates, particularly among drivers arrested with high BACs (Mann, Anglin, Wilkins, Vingilis, & MacDonald, 1993; Skurtveit, Christophersen, Grung, & Mørland, 2002). The high auto fatality rate of HCDDs is related to both their risk-taking behavior while intoxicated and their failure to wear seat belts. A recent Illinois study comparing first-time DUI offenders and multiple DUI offenders found a driving risk-taking cluster among the latter as indicated by higher rates of prior arrests for speeding, improper lane usage, failure to stop/yield, seat belt and child safety violations, and prior collisions (Syrcle & White, 2006).

Individuals arrested for DUI before age 18 have been found to experience high rates of psychiatric illness as well as high rates of arrest for violent crimes (Rasanen, Hakko, & Jarvelin, 1999). Regarding the latter, some studies have found that aggressiveness at age 18 combined with alcohol dependence at age 21 constitute a predictor of future involvement in an alcohol-related crash (Begg, Langley, & Stephenson, 2003). Aggression as a risk factor for future DUI recidivism and other public safety risks is further indicated by recent findings of alcohol problems among those involved in road rage incidents (Mann, Smart, Stoduto, Adlaf, & Ialomiteanu, 2004).

Profile Implications

There are a number of important implications for probation officers that could be drawn from the emerging profile of the HCDD.

System Sophistication: The studies reviewed here portray a subgroup of HCDDs who are quite knowledgeable about DUI enforcement, evaluation, and adjudication and who seek to manipulate that system (e.g., underreporting their substance use histories and their prior criminal histories)(Chang and Lapham, 1996). One of the most significant flaws in the current system of evaluating DUI offenders is its over-reliance on data self-reported by the offender. The probation officer would be well advised to base his or her assessment of the level of risk of a DUI offender on data sources other than the offender's self-disclosure (e.g., criminal record, driving record, arrest report, BAC, drug tests, laboratory reports, and collateral interviews).

Age of Onset: The early age of onset of drinking among HCDDs creates a twofold trajectory. First, such early onset of drinking increases the risk, severity, and complexity of adult substance use disorders (Grant, 1998) and is a predictor of future driving after any drinking, driving after five or more drinks, riding with an intoxicated driver, and involvement in alcohol-related crashes (Hingson, Heeren, Levenson, Jamanka, & Voas, 2002; Hingson, Heeren, Zakocs, Winter, & Wechsler, 2003). Second, early onset prevents the HCDD from developing internal and external assets that can later serve as the foundation of sustained recovery. This shortage of "recovery capital" (assets/hope) suggests the need for greater habilitative resources that could make up for these deficits, e.g., a focus on social and technical skills development, the development of pro-recovery social networks, and remedial

approaches to education and occupational opportunities.

Co-occurring psychiatric and medical problems: The HCDD's use of drinking to manage negative emotional states suggests interventions that include the assessment and treatment of these problems as well as improved problem solving and stress management skills (Woldt & Bradley, 2002). Psychiatric and medical evaluations as well as involvement of psychiatric and medical personnel in a multi-disciplinary, multi-agency case management team are clearly indicated for some of the highest risk HCDDs.

Criminal profile: The criminal histories of HCDDs suggest a need for the criminal justice system to rethink how these individuals are perceived. It is clear that many HCDDs present a threat to public safety that far transcends their drinking and driving behavior. Clearly recognizing this broader pattern will help avoid/diminish the tendency to not see the DUI offender as a "real criminal." The HCDD is a real criminal and needs to be viewed and managed as such.

Aging Out: One of the most provocative findings in recent DUI research is the apparent aging out of the HCDD profile beginning at age 35 and rising sharply between age 40-50 (Shope & Bingham, 2002). This would suggest that the long-term role of the probation department (and the larger criminal justice system) is to provide sustained periods of external supervision until the majority of HCDDs mature out of this pattern. Given the seeming intractability of the HCDD pattern in late adolescence and young adulthood, it will be important to experiment with and evaluate combinations and sequences of sanctions and interventions that can speed up this maturing out process.

Social Network Reconstruction: The fact that many HCDDs are not nested in families and are enmeshed in alcohol/drug-saturated social networks has special implications for the probation officers and treatment personnel who are involved with them. The challenge is to remove alcohol and other drugs from the life of the HCDD and to remove the HCDD from a milieu that reinforces anti-social behavior and replace that milieu with one that supports pro-social behavior. Recovery mutual aid societies and new recovery support services (e.g., recovery homes, recovery support centers) can play a particularly helpful role in the habilitation of the HCDD because of the pathways of entry they provide to pro-recovery social networks and activities.

Multiple Drug Use: The propensity for multiple drug use among HCDDs suggests the potential use of random chemical testing as an effective monitoring tool for this group of DUI offenders. We suspect that the number of DUI offenders whose primary drug of choice is something other than alcohol has been grossly underestimated. This is confirmed by a study of DUI offenders reporting that only 6% of DUI offenders were diagnosed with drug abuse or dependence at the point of initial screening, but that 28% retrospectively reported drug abuse or dependence at the time of initial screening when interviewed five years later (Lapham, C'de Baca, Chang, Hunt, & Berger, 2002). Recent studies in Cook County, Illinois showing 18-26% of DUI offenders testing positive for drugs other than alcohol at the time of their evaluation offer some confirmation of this suspicion (Central States Institute of Addiction, 2003). Further confirmation comes from Illinois treatment admission data noting

that 9% of DUI offenders entering the treatment system identified a primary drug other than alcohol (Illinois Division of Alcoholism and Substance Abuse, 2004).

Errors in Thinking: It is obvious from the data presented here that HCDDs inaccurately perceive themselves and their relationship to the world. Treatment approaches that focus on exposing faulty thinking and improving problem solving are clearly indicated for HCDDs. Repeated episodes of impaired driving rest upon a foundation of faulty assumptions that must be revised if the behaviors that flow from them are to be altered. Cognitive behavioral approaches currently in vogue within probation departments around the country may be particularly well-suited for the HCDD, as some preliminary studies suggest (Little, Robinson, & Burnette, 1990; Ross, 1995).

Characterological Profile: Research paints a picture of the HCDD as a person lacking internal locus of control and suffering from impulsivity, aggression, and an attraction to sensation-seeking and risk-taking—all of which are amplified under the influence of alcohol. This profile alone would suggest the need for strong systems of external monitoring and control. The volume of DUI arrests in this country would preclude the use of specialized DUI courts for all DUI offenders, but aggressive judicial case management combined with intensified probation services, appropriate treatment services, and periodic incarceration (in response to non-compliance) may constitute a potent habilitative combination for HCDDs. The profile outlined in this paper would also preclude the use of certain interventions for the HCDD, e.g., remedial education programs, victim impact panels.

Treatment: HCDDs have significant alcohol and other drug problems but may be ill-suited for acute models of addiction treatment that are characterized by brief, psycho-educational experiences. The characterological profile of the HCDD would indicate a style of treatment that is much more behaviorally focused and involves rigorous and sustained post-treatment monitoring and support, assertive linkage to local communities of recovery, and early re-intervention in response to any substance use. We envision a future in which integrated teams of judges, specialized probation officers, and treatment professionals will be involved in such sustained safety monitoring and recovery management. Such models would resemble the "containment model" currently used in the supervision of sex offenders (English, 1998).

Substance Relapse versus Impaired Driving Relapse: The severity of substance use problems among the HCDD population makes some episodes of relapse likely following primary treatment. Some short lapses are not unusual on the way to achieving stable recovery, but it is very important that the community and its representatives send a message of zero tolerance of drinking and driving to the HCDD. The goal is to drive a wedge between the act of drinking and the act of drinking and driving. While the former can be managed in the context of a recovery process, punishment for the latter must be certain, immediate, and severe.

Strategies and Principles

The National Highway Traffic Safety Administration's *Guide to*

Sentencing DUI Offenders (1996b) lists five keys to lowering DUI recidivism:

1. Evaluating offenders for alcohol-related problems and recidivism risk.
2. Selecting appropriate sanctions and remedies for each offender.
3. Including provisions for appropriate alcoholism treatment in the sentencing order for offenders who require treatment.
4. Monitoring the offender's compliance with treatment.
5. Acting swiftly to correct noncompliance.

We concur with these points, but would note several additional principles that may be helpful to those working with high-risk DUI offenders (White, 2004).

V*isibility Principle:* The HCDD's trivialization of drinking and driving must be challenged via an unequivocal and highly visible cultural/community message of zero tolerance for alcohol and drug impaired driving. Representatives of criminal justice and treatment agencies must be consistent carriers of this message and enlist media resources to help transmit this message visibly and repeatedly. This principle is grounded in findings that heightened perception of risk for future accidents or police stops reduces future risk of DUI recidivism (Greenberg, Morral & Jain, 2004).

Dose/Intensity Principle: Clinical treatment of the HCDD must be characterized by high intensity of personal involvement and a minimal dose below which outcomes are compromised. Such services may involve multiple levels of care (inpatient, outpatient, continuing care), but extend, in total, over at least three months time (NIDA, 1999).

Combination Principle: Combining multiple interventions—e.g., combining license suspension/revocation, treatment, and criminal sanctions—is more effective than any single intervention used in isolation in containing the HCDD. The goals are to combine interventions to reduce the frequency and quantity of alcohol and drug use (e.g., urine testing, remote alcohol monitoring, treatment, mutual aid groups), contain where drinking occurs (e.g., house arrest), reduce the risk of drinking and driving (e.g., vehicle seizure, interlock devices), and reduce larger threats to community safety (e.g., monitoring via DUI court and intensive probation).

Motivation/Behavior Principle: Those who are "forced" into addiction treatment have similar outcomes to those who "volunteer" for treatment. The lack of initial motivation for change does not preclude long-term positive outcomes from treatment services.

Accountability Principle: Effective methods of managing the HCDD rely on multiple points of accountability with rewards and punishments contingent on clearly defined behavioral objectives, e.g., drug test results, aftercare meeting attendance, employment, restitution payment schedule. Many HCDDs do change their behavior when the punishment for continued drinking and driving is certain, severe, and quick (Wiliszowski, Murphy, Jones, & Lacey, 1996). We expect this principle to be integrated into a significant expansion of

specialized DUI courts in the coming decade.

Containment Principle: There are HCDDs for whom no rehabilitative strategies will work, leaving a confinement strategy to protect the community via incarceration for the longest period of time with the hopes that such high-risk behavior will dissipate with age and accumulating consequences.

Summary

There is growing recognition of a subgroup of hard core drinking drivers that pose significant and sustained threats to public safety. Probation officers play a critical role in identifying and supervising this group of offenders. This article has summarized research on the hard core drinking driver, provided a checklist to aid identification of this high risk profile, and offered principles that can help probation officers supervise this high risk group of offenders.

The instrument below has been designed as a tool to help judges and probation officers quickly identify which DUI offenders pose the highest risk for re-arrest and future threat to public safety via impaired driving. Each item below has been identified as a risk factor in studies of DUI recidivism and through clinical observation of DUI recidivists. Those items in bold type in each area are those that seem to be the best predictors of recidivism.

Many of the items in this checklist have been confirmed in studies of Illinois DUI offenders, including the recent ASUDS-RI Pilot Study (Syrcle & White, 2006). It is our hope that the continued follow-up of those re-arrested for DUI in the ASUDS-RI pilot study will allow us to rank and numerically score the risk factors contained in this checklist.

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Hard Core Drinking Driver Profile Checklist

Demographic/Social Profile

___ **Male (90-95% of recidivists)**
___ **Age 25-45 (75% of recidivists under age 40)**
___ Education (half of recidivists have less than 12 years)
___ Non-white-collar employment
___ Occupational instability
___ Lower socioeconomic status (annual income less than $25,000)
___ **Impaired intimate relationships (75-80% divorced)**
___ **Social network containing other heavy drinkers and drinking drivers**

Substance Use/Treatment History

___ **Family history of AOD problems**
___ **Exposure to drinking and driving by parent and peer models**
___ **Early age of onset of regular drinking (age 14 or earlier)**
___ **Frequent, heavy drinking at venues accessible by car**
___ History of drinking in automobiles
___ **Past year consumption of drugs other than alcohol**
___ **Early onset of smoking, heavy smoking, no effort or failed efforts to stop**
smoking
___ **Meets DSM-IV criteria for substance abuse or substance dependence**
___ Prior addiction treatment or involvement in addiction recovery mutual aid group
___ **Prior failure to comply with terms of sentencing (e.g., failure to complete mandated treatment, community service, etc.)**

Driving & Criminal Justice History

___ **Prior (often AOD-related) criminal arrests predating first DUI arrest**
___ Prior crimes against persons
___ **Prior DUIs (Risk of recidivism rises with number of prior DUIs)**
___ **High-risk driving record (moving violations, prior crashes, prior loss of driving privileges, or high risk insurance or lack of insurance)**
___ Prior aggravated driving without a valid license (e.g., high speed/recklessness, DUI, crash)
___ Prior DUI arrests in which consequences were avoided, delayed, or minimized

Drinking/Driving Beliefs

___ **Believes he or she can drive safely after consuming large amounts of alcohol**
___ **Underestimates his/her level of intoxication**
___ Makes no alternative transportation arrangements before drinking
___ Expresses likelihood of drinking and driving in the future
___ Believes penalties for impaired driving should be less severe
___ Perceives DUI arrest as product of bad luck or targeting by police

Arrest Event

___ **BAC greater than .15**
___ **High BAC without gross signs of intoxication**
___ Collateral charges with DUI
___ Current or past history of refusal of Breathalyzer test
___ Not wearing a seat belt at time of arrest; does not generally use seat belts

Broader Clinical Profile

___ **Symptoms of, and/or prior treatment of, psychiatric illness (depression, PTSD)**

___ Medical/criminal history reflecting injury to self and others

___ Personality characteristics that include diminished capacity for empathy, guilt and remorse, failure to take personal responsibility (e.g., projection of blame), impulsivity, risk-taking, and aggression

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Selected Papers of William L. White

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Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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The Power of Families to Influence Addiction Recovery
An Interview with Dr. Robert Meyers

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Introduction

One of the major clinical innovations in the modern treatment of addiction is the Community Reinforcement Approach and Family Training (CRAFT) intervention developed by Dr. Robert Meyers. CRAFT is an evidence-based, non-confrontational approach that can be used by concerned significant others (CSOs) to promote help-seeking and recovery initiation for a family member experiencing alcohol- or other drug-related problems. I recently (December 2014) had the opportunity to interview Dr. Meyers about the development, evaluation, and future of CRAFT. Please join us in this engaging discussion.

Personal Background

***Bill White*:** Dr. Meyers, you have a personal story related to your attraction and contributions to the addictions field. Could you begin by sharing that story?

***Dr. Robert Meyers*:** Sure. I think I was destined, in a way, to be in the addictions field. When I was a young child, my father had a horrible drinking problem, and my mother experienced depression and other types of problems related to that. My father wasn't around to discipline me and my brother, so we ran wild. My mother tried to discipline us with a broom handle or a belt, and it became a real struggle for us to dodge my mother. I think the reason I was such a good wrestler in high school was because I was so used to scrambling around the floor on all fours and going in and out underneath tables to escape my mother's tantrums. She died very young at the age of forty-five when I was only twenty-three. It was really hard on my family, particularly on one of my sisters who still lived at home as my father's drinking worsened over time. By that time, I had escaped into the military. I joined the Navy to avoid going to Vietnam and, of course, that's where they sent me.

The one thing I learned to do well in the military was use drugs. The home port for my first ship was in Alameda, near San

Francisco, and in ’68 when I returned from Vietnam, I went down to Haight-Ashbury and started using drugs with my other shipmates. Before it was all over, I was really addicted to lots of different things. I used marijuana, downers, and cocaine, and a variety of opiates. It got so bad, Bill, that when I got out of the Navy and went home, my parents wouldn’t let me stay at the house. They knew I was in crisis with using drugs, so they kicked me out. I was on the street at that point, just hanging out with friends and living with other people who did as many drugs as I did or more.

What then happened was that one New Year’s Eve, which was actually my birthday, I got so high I didn’t know where I was. I ended up running into a friend who said, “My God! You look horrible. What’s wrong? You look crazy.” I said, “I am. I’m scared. I’m using drugs and I don’t know what to do.” And he said, “Hey, you were in the military. I was in the military, too, and I’m going to school on the GI bill. Why don’t you do something like that?” And that’s actually how I started going to college. My first big discovery at school was that I wasn’t very good at anything. I had to get tutors for English and Math because of those turbulent high school years. I ended up at Southern Illinois University for my B.S. and M.S. While in the B.A. social work program, I had to do practicums and my first practicum was at an alcohol treatment center. I was offered and took a job in the addictions field before my BA was completed, but continued my school, completing my bachelor’s and master’s degrees.

***Bill White*:** Your early description of entrance into the field just really intrigues me. We talk about multiple pathways of recovery within the field, but you’re describing a recovery pathway through a combination of epiphany and education. Did you see yourself or identify as a person in recovery at that point?

***Dr. Robert Meyers*:** On that New Year’s Eve, I woke up realizing that I was totally, absolutely out of control and scared. I knew I wasn’t going to do drugs anymore. I stopped doing drugs in this epiphany, “I can’t do this, I’m going to die.” I had no support system around me whatsoever. There was no support to understand a family ravaged by alcoholism, no support to understand being physically abused, no support to address all I had witnessed and experienced in Vietnam. I just turned my back on drugs and never told anybody about this once I started going to college. I had abused drugs. I probably was addicted and would have met several DSM categories. But I never talked about that all through my career until I retired from CASAA. I feared the stigma of the label. I didn’t want to be defined by my problem. I wanted to be defined as a person who was compassionate and a good therapist rather than have my past addiction define me. I was also afraid to tell anybody for fear that they would look at me in a different way or that the University might even find a way to fire me because of my history. At this point in my life, I can disclose this because I don’t worry any longer about any of those things.

***Bill White*:** It sounds like working in this field was part of your personal destiny.

***Dr. Robert Meyers*:** I was doing a free community workshop in Japan a year ago and one of my interpreters was a Maryknoll Japanese Catholic nun. There were about three hundred people at the community meeting, and it was real hot so I was sweating like a madman, and jet lagged so I was telling some jokes and stories and the crowd really enjoyed themselves. When it was all over, the nun came walking toward me. I started to bow and she grabbed my neck and pulled me close to her and whispered in my ear, “Bob, this is your calling. You have to keep doing it.” It blew me away; I had to fight back tears. I

understood very clearly that from a spiritual perspective, I had to do this. It was my calling.

Early State of the Field

***Bill White*:** Take us back to the first program you worked in. What was it like?

***Dr. Robert Meyers*:** I first worked at a program with Dr. Mark Godley in a community alcohol program, and at one point, we collaborated with Anna State Hospital in Southern Illinois. It was at Anna State that I met Dr. Nate Azrin and his team and first learned the community reinforcement approach (CRA) to alcoholism treatment. Mark and I, along with members of Dr. Azrin's team, helped develop the first outpatient CRA program in the late 1970s. Working with Mark and Nate turned out to be one of the best things I ever did in my life because I really learned addiction treatment, and I learned it in a really positive way. In those days of confrontation within the larger field, I learned not to judge people and to try to find the positive parts of their life that could be built upon—a strengths-based and recovery orientation before such language was used.

***Bill White*:** How would you describe the larger field at the time you began working with Mark and Nate?

***Dr. Robert Meyers*:** When I first got into the field, it was dominated by AA. A lot of the people who were working with me at Anna State Hospital during my social work internship were people in recovery who had a long history of using drugs and alcohol. I always thought that was strange in that I was going to school to get a professional credential, but that most of the people I was learning from had no such credentials. Under the influence of Nate Azrin, I was learning about behavioral treatments and what would become behavioral therapy, and it seemed to me that this offered a technology of change beyond what the AA program offered. I believed that there were people who could do really well in AA—people who self-select AA and feel very comfortable in AA. CRA and CRAFT are open to anything to help somebody get sober. Community reinforcement means that you use anything in the community to help people get sober and stay sober. The field I entered in the 1970s relied on AA and little else, and there was considerable tension as the field sought to integrate science-based interventions as an adjunct or alternative to AA. In those early years, I had to apologize for being a behaviorist and for not being an AA member, which is interesting since given my history, I could have easily been an AA or NA member.

The Roots of CRAFT

***Bill White*:** How did the early work at Anna State Hospital heighten your interest in families?

***Dr. Robert Meyers*:** It first heightened my understanding of my own family and my own development. I began to understand my mother's response to my father's drinking problems. Once I started working with folks that were having problems with substance use, everything just started to click, and I got very interested in family responses to alcoholism. Working with Mark Godley doing community reinforcement for eight years was my training ground. Part of my work was doing the couples counseling section of the community reinforcement approach. As I progressed, I realized that the spouses had potentially far more influence over the drinker than one might expect. It was an influence I never saw growing up, only the arguing and fighting about the drinking. As I worked with spouses, I began to wonder if we could work with spouses and help them learn strategies to get their husbands into

treatment. My colleagues were egging me on and saying, “You can do it. Let’s try it.” I would process working with the spouse with a colleague from Azrin’s lab named Bob Sisson. We would look at some of those cases and talk about how the concerned significant other (CSO)—usually a wife or family member—might be able to leverage help-seeking of their husband or other family member. CRAFT began when we started engaging the husbands in treatment through the efforts of their wives. This was all new stuff and we were doing it in the late ’70s and early ’80s.

***Bill White*:** The development of CRAFT goes back much farther than I thought.

***Dr. Robert Meyers*:** Most people don’t know this early story. It began with Bob Sisson, Mark Godley, and I doing what we called the Concerned Significant Others Program. We started it but didn’t have the wherewithal at that time to do anything like a clinical trial.

New Mexico and CASAA

***Bill White*:** What was the next milestone in your career?

***Dr. Robert Meyers*:** After eight years into the work with Mark in Southern Illinois, I decided to move to New Mexico, where my brother and his family lived. There, I worked in different programs, including serving as Director of a three-county Mental Health Center, where I continued to develop addiction treatment services. Eventually, I was recruited to work as Deputy
Director in what was then called “The Alcohol and Drug Programs of the Mental Health Center,” of the University of New Mexico—later The Center on Alcoholism, Substance Abuse, and Addictions (CASAA)—run by the Medical School & Main Campus.

One of the first people I met there was Dr. Bill Miller, who has become a lifelong friend and one of the best human beings I’ve ever met in my life. The second time I ran into him, he said, “Hey, you’re that Bob Meyers that did that CRA study down there with Dr. Azrin, aren’t you?” When I acknowledged this past work, he asked if I was interested in writing a grant to study CRA, to which I quickly agreed. That was the beginning of our work together in 1987.

After some years at CASAA working with the medical school and main campus staff, there was a separation from the medical school, who took the treatment section out of CASAA and started a new program called Albuquerque Substance Abuse Programs or (ASAP), and left us researchers to continue on with the name CASAA. The medical school was on the north campus with the nursing school and the pharmacy school, while Bill and a lot of the people from psychology and sociology who contributed to what would continue to be CASAA were all from the main campus. There was a shuffle of deans and provosts and we ended up eventually divorcing the Medical School to become CASAA. Bill Miller came on board full-time even though his affiliation was with the Department of Psychology. I switched to CASAA because I believed in Bill and what we were doing. In that process, I went from hard money onto soft grant money. That meant we were awarded grants or I wouldn’t have a job. I took a leap of faith going on to soft research money, but it did have a happy ending.

CASAA played an important role in the development of CRAFT. While we were still working on Project Match, I told Bill about working with families within what was then community reinforcement therapy (CRT). I still remember diagraming what CRAFT would look like as a clinical trial on a whiteboard in Bill’s office and Bill’s eyes lighting up. I could tell he was excited. By the next day, he’d already written a small proposal to the CASAA Executive Committee describing what he and I would like to do. We changed the title to CRAFT for the added family training component. They gave us the green light, and that’s how we started getting the CRAFT grants at CASAA.

***Bill White*:** Now, the approach you and Bill Miller were proposing was still very different from the mainstream field at this point, correct?

***Dr. Robert Meyers*:** Absolutely. The mainstream family approaches were Al-Anon and the Johnson Institute model of intervention. In our first randomized controlled studies of CRAFT, the control groups that we used were Al-Anon and the Johnson Institute Intervention. The latter were the two helping models for families used by most treatment centers.

What Bill and I were trying to do was provide a broader range of treatment goals and methods to address the whole spectrum of alcohol and drug problems. In the field at that time, there was no alternative to the abstinence now and for life stance for all people seeking treatment. For example, when I first started at the State Hospital in Anna, Illinois back in 1975, they said I had to say these words when I saw my client: "You're in here because you're an alcoholic and that means you can never, ever drink again as long as you live." Now sometimes I was saying that to a twenty-five or thirty year-old young man who's looking at you with that "You've got to be kidding me" expression on his face. There was no harm reduction perspective in those days, no incremental models of change, no models of client choice, and no alternatives to the confrontation approaches to therapy. I was convinced that we had to figure out ways to help people gravitate toward sobriety because they were finding things they liked about their life while not using rather than begrudgingly have abstinence forced on them by others. It would be nice if everyone with a drinking problem had a great epiphany—what Bill Miller called quantum change—and never drink again, but that's not usually how it works, and small epiphanies can help people find things in their life that are meaningful and fun and exciting that do not involve alcohol and drug use. What we do in the treatments that I have helped develop over the years is help people find what things in their life that they can gravitate toward that will help them moderate or stop using alcohol and other drugs**.**

I've spent a lot of time in Europe, and the European countries have a greater harm reduction orientation than we see here in the U.S. They have more relaxed and flexible options for treating substance use disorders. Like there, I think sometimes we need to give people a little more slack as opposed to judging them for not immediately achieving the now and forever abstinent goal that we impose. I think it is clinical arrogance to see clients for an hour or so and then say, "Okay, you have to do X, Y, and Z." I've suggested a much slower process of giving each client the opportunity to talk to us and help us learn from them about what approach might work best for them. After all, this process is about them, not about us.

The CRAFT Approach

***Bill White*:** For readers unfamiliar with CRAFT, could you describe this approach?

***Dr. Robert Meyers*:** The CRAFT approach is based on trying to help family members learn more positive, effective ways to interact with one another. So, let's just take a husband and a wife who have been married for ten years and have a certain way they interact with one another. If he's been drinking copiously and getting in trouble, she likely has ways of discussing that with him that includes such things as getting angry and saying negative things about his drinking. What we teach family members to do in response to intoxication is to not yell or nag, but to say, "Well, I can see you're having a hard time, Bill, I love you so much, it hurts me to see you this way. I think I need to go to bed now. We can talk in the morning if you want." The goal is to disengage from the intoxication to eventually help extinguish

this behavior. We're not condemning them, we're not judging them, we're explaining our own feelings—saying it hurts us, and we walk away. And at the same time, we teach the spouse and other family members to reinforce the positive behavior when the husband comes home sober and in a good mood. The wife, without overdoing it, might say, "I understand it's been difficult for you, but I think you look really great today. I love being with you when you haven't been using."

When the drinker or the drug user says to the wife, "What are you doing? Something's different about you. What's going on?" we teach them to say, "I'm going to therapy to help myself. I'm going to therapy to try to help our relationship and our family. We don't bring up alcohol and drugs; we just talk about relationships." Then, if he says, "Well, if you think I'm going to quit my drinking, forget about it," she says, "You don't have to do anything you don't want to do or that you're not ready to do, but I really would like you to visit my therapist once to see what we do down there." The idea of having somebody come in one time to talk about whatever they want to talk about is quite different than saying, "You have to enter a thirty-day alcohol and drug treatment program." The CRA approach avoids such extremes and often begins with a procedure called sobriety sampling and sampling of other alcohol and drug-free activities. CRAFT with family members dramatically increases the odds that the person with a substance use disorder will enter and sustain their involvement in treatment.

CRAFT Evaluation Studies

***Bill White*:** And there have been several studies of CRAFT?

***Dr. Robert Meyers*:** Correct. Some were done by Bill Miller, Jane Smith, and myself and others from CASAA, and several studies of CRAFT have been done by other people, including the Treatment Research Institute in Philadelphia (TRI) and the Oregon Research Institute (ORI).

***Bill White*:** Have there been any surprises related to who the CRAFT model works best with?

***Dr. Robert Meyers*:** There was one surprise. We found in our studies that mothers of adult children do extremely well at getting those individuals into treatment using CRAFT, which is very strange in that this was not our original target group for this approach. I see these mothers come in to our treatment programs and they're depressed, they're anxious, they're angry, and they have a lot of negative physical symptoms, like migraine headaches and cramps, stomach aches, vomiting and on and on. What our studies have shown us is that these symptoms decline through their participation in CRAFT and continue to decline after they leave treatment. A lot of women, Bill, come into our studies from around the world all thinking they did something wrong—that if they were a better mother, their son or daughter or husband wouldn't have this problem. The first thing CRAFT does is get rid of all those myths. We let them know how courageous they are for staying with and trying to support their family. We acknowledge their efforts and their fortitude. We make them feel good about themselves.

Over a period of time, by teaching them positive communication skills and helping them elicit support from friends, they shed the guilt and shame, and become effective change agents within their own families. And they break out of the isolation that guilt and shame produced. We teach them strategies about how to go out and re-connect with people in a positive way. The future health of the person with a substance use problem often begins in this way with the increased health of other family members.

CRAFT Dissemination

***Bill White*:** Have you been surprised at the spread of CRAFT internationally?

***Dr. Robert Meyers*:** I have been amazed at how many times I've been to six of the seven continents over the last 7 or 8 years teaching the CRAFT program. I've been to Africa, Australia, Canada, Chile, England, Ireland, Japan, Germany, Scotland, the Netherlands, and Wales. For example, there are more trained CRAFT therapists in Ireland than there are in the entire United States. I conduct CRAFT training in the United States, but far less than I do in other countries. CRAFT hasn't caught on in the U.S. like it has in other countries.

***Bill White*:** What do you think it's going to take to implement CRAFT as a science-based practice in the United States?

***Dr. Robert Meyers*:** Well, I think things are starting to move in that direction. I've recently been contacted by Dr. Joseph Lee, Medical Director for the Betty Ford Center and Hazelden Foundation, to explore training their staff in CRAFT. I think if people see Hazelden and the Betty Ford Center using CRAFT, and other prominent treatment centers adopting CRAFT that a wider adoption in the field could move rapidly. I think the treatment system in America has to start opening and broadening its approaches as opposed to staying with what we've been doing. We now have lots of great evidence-based protocols—most developed here in the United States. It's time we started using them as standard practices in the field. We are even seeing legislatures and funding bodies demanding use of these practices. That will eventually increase the use of CRAFT.

***Bill White*:** The popular media has been captivated by the drama of confrontation-style intervention, even with its questionable effectiveness. The fact that CRAFT is skill-based and lacks that drama seems to have prevented its acknowledgement in the popular culture.

***Dr. Robert Meyers*:** When CRAFT was first developed, it did get some coverage in the HBO special on addiction, and Oprah actually called, but I never did get on her show. But another person called—I won't say what show it was—and wanted me to come and have the family member in one room and the addicted person in the other room in some hotel or whatever and have me run back and forth. My response was, "Look. I'm a scientist. I'm not going to prostitute my work and turn it into a circus so you can have a good show." They hung up on me.

CRAFT Resources

***Bill White*:** Could you highlight some of the key resources for training people in the CRAFT approach?

***Dr. Robert Meyers*:** Yes. All the major books on CRAFT are on my website—See https://www.robertjmeyersphd.com/craft.html. The one that many people find most useful is *Get Your Loved One Sober: Alternatives to Nagging, Pleading, and Threatening.* CRAFT is a very accessible method. For example, One of Bill Miller's graduate students did a study for her dissertation comparing formal CRAFT group therapy with a group who just read *Get Your Loved One Sober*. They were followed up six months later, and the people who went to the CRAFT group therapy got seventy-one percent of their loved ones into treatment. What was surprising was that forty percent of the people who just read the book also got their loved one to go to treatment. The folks from the Center for Motivation and Change in New York City wrote a book called *Beyond Addiction* that outlines CRAFT and motivational interviewing. They buy cases of *Get Your Loved One Sober* and they give

them to all their clients, including the parents of kids that are having trouble with substance use.

My wife Jane, who is Chair of the Psychology Department at the University of New Mexico, and I wrote another book entitled *Motivating Substance Abusers to Enter Treatment* that is a therapist manual. It outlines all of the CRAFT protocols for therapists who want to learn the skills. The books can be supplemented by training and certification where therapists send us audiotapes of their sessions and we critique them using a 200+ page coding manual and additional coaching of the therapist to improve their use of CRAFT. That has helped maintain fidelity to the CRAFT model.

The Future of CRAFT

***Bill White*:** What do you see for the future of CRAFT?

***Dr. Robert Meyers*:** Well, right now, I'm working with the Treatment Research Institute in Philadelphia and the Cadence Company to develop an online version of CRAFT. I'm very excited about having an online treatment program for CRAFT. Secondly, the Change Company has asked me to do a CRAFT interactive journal and so we've started working on that. I've also written two veterans' manuals with Bill Miller. They're called the *Coming Home Series* and are for returning war veterans. I talk about my own story in this series. I feel I need to give something back to support this latest generation of veterans.

Career Reflections

***Bill White*:** Dr. Meyers, as you look back over what to date has been a very long and productive career, what do you feel personally best about as you reflect on these years?

***Dr. Robert Meyers*:** Well, I feel very good about the fact that I kept climbing the ladder. I wasn't the smartest or the best-looking or the best at this or that, but I never stopped trying to find better ways to help people. I persevered in southern Illinois, and I have persevered here in New Mexico and my work in other countries. I feel best about my contributions in developing adolescent CRA, outpatient CRA, and CRAFT. I found a way to do workshops and trainings around the world that are engaging and informative. I want to help all people affected by substance abuse wherever they may live.

***Bill White*:** You are in a unique position to influence younger people entering the field or considering entering the field. What kind of advice or guidance would you offer to someone thinking about entering the field with hopes of having the kind of influence you have achieved?

***Dr. Robert Meyers*:** I get emails from young people and one of the things I miss the most about retiring from the University is working with young people. I think what young people need to do is to keep their eyes open, to be open to new innovations in treatment, but also to be critical and carefully evaluate what people are telling you to see how it works for you and those you are working with. Another thing I always tell young people is to be aware that you might be over your head doing something and to recognize that and get help from somebody else. Don't think you can treat every single individual or help every single patient. It really takes more than that; it takes a lot of people to get it right. Do what you're best at and if you find yourself in trouble, get somebody to help you, or take over the case. Keep your eyes and ears open. Evaluate what's going on and try different treatments. Use the innovations of others, but be yourself. And it's OK to make a mistake, but it's also important then to find a mentor or supervisor to help you get it right the next time.

***Bill White*:** Dr. Meyers, thank you for taking this time to reflect on your life and work.

***Dr. Robert Meyers*:** It's been a pleasure, Bill.

Resource Note: Readers—parents and therapists might also be interested in the online Parent CRAFT program. Parent CRAFT is a research-supported online course that teaches parents how to effectively interact with their children in order to change drug and alcohol behavior (see www.CadenceOnline.com)

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Appendix: Key CRAFT Studies/Resources (These and related resources are available at https://www.robertjmeyersphd.com/forms.html)

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Books

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Smith, J.E. & Meyers, R.J. (2004). *Motivating Substance Abusers to Enter Treatment: Working with Family Members*. New York, NY: Guilford Press.



Selected Papers of William L. White

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Focus on Family Recovery: An Interview with *Sharon Wegscheider Cruse*

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Before the 1980s, family members interacting with addiction professionals were more likely to be viewed as contributors to addiction or hostile interlopers in the treatment process than people in need of recovery support services. (Click HERE for a detailed history of attitudes in family therapy.) That began to change when a vanguard of advocates challenged such attitudes and focused attention on the effects of addiction on families and the family recovery process. Those pioneers included people whose interviews have appeared earlier in this Pioneer Interview Series, including Dr. Claudia Black, Dr. Stephanie Brown, Dr. Robert Meyers, Jerry Moe, and Sis Wenger. One of the most important of these pioneers is Sharon Wegscheider Cruse, whose landmark books in the 1980s exerted a profound influence on the addiction treatment field and the broader arena of recovery support services for families. I recently (June 2016) had the opportunity to interview Sharon about her life's work and the lessons she hoped to pass on to a new generation of addiction professionals and family advocates. Please join us in this engaging conversation.

Early Career

***Bill White*:** Sharon, perhaps we could start by just tracing some of the influences that led to your entrance into the addictions field.

***Sharon Wegscheider Cruse*:** I came into studying about addiction later in life. I postponed going to college until my children went to school and then I went for nine years. In that process, I was drawn to the first chemical dependency certification program in the nation, which was in Minnesota. I was drawn to that program because I believed that I had issues related to people drinking too much in my family even though at the time I would not have called that alcoholism. This counselor certification program opened me up, both in my personal and professional life. While in this training program, I got very depressed because the knowledge I was gaining was so spot on with what I had experienced in my family. I sought help for

the depression from psychologists, psychiatrists, counselors, and clergy. I was told the same story across the board: "You've got to grow up and forget about that."

I knew my parents were different from the other people in the family. They were wonderful, loving people but I knew they were different and the only thing I could figure out as a young child and even as an older woman was that they drank a lot and smoked cigarettes. Then someone told me there was a treatment center in North Dakota that would help people with alcohol problems, and I thought that perhaps they could help my depression. So, I entered a 28-day alcoholism treatment program. I was not alcoholic; I didn't drink, but I thought, "Maybe they know something that could help me." That experience opened my eyes to what happens to, not only addicts and alcoholics, but what happens to their families. When I came out of that program in the early 1970s, I said to myself, "I will not stop until there's some place for family members to go. They are the forgotten people."

***Bill White*:** How would you describe the state of the field's response to families at that point?

***Sharon Wegscheider Cruse*:** There was a feeling of hostility and underneath a feeling of fear. When I was looking for help and seeing all these helping professionals, I tried to go to Al-Anon in Minneapolis, Minnesota, but I was told I couldn't attend because I wasn't married to an alcoholic. So, I was not accepted there. In college, I had read a couple of papers by a woman who was not yet published. She talked about families in general, not alcoholic families, in a way that mirrored my experience. It was the most powerful thing I had ever read, and on the bottom was the name Virginia Satir. I tried to find her without success. You have to know this is before internet or cell phones and before she had published her book, *People-Making*. I tried to find her every way I could, but there was no way to find her. And then one night, I had a flat tire and I went up to a house, which one would never do today probably. I went up to a house and the people inside invited me in to use their phone. They said, "You may use our phone. It's over there. We're getting ready to go to Canada to meet Virginia Satir." I thought I had died and gone to heaven. I began pursuing how to get into the Canadian workshop. I pestered them by phone for almost a month until they said, "If you don't tell anyone, you can come, and you can come free of charge. We don't even want you on our roster. Just don't call our office anymore." And that's how I met Virginia Satir in 1972.

***Bill White*:** What were some of the early career positions you held in the field?

***Sharon Wegscheider Cruse*:** When I graduated from my certification program in addiction, Tom Zawadski and I were given a state car to travel the state of Minnesota to attend AA and Al-Anon meetings to engender their support for the expansion of formal treatment programs in their area. We traveled the state for a whole summer, attending Twelve-Step meetings and assuring people that treatment centers were on their side. There were no places for families to go at that time; there were barely places for addicts to go. I took on the task of creating something for families, and I also wanted to do something for children of alcoholics.

I had worked in a church setting for a long time doing retreats. I knew how to bring people together. I knew how to create a community, and I knew how to bring the best out in people. So what I did was put together the first children of alcoholics support group. I found someone to donate a church where we could meet. The groups grew and grew. I learned how to speak in schools and other places. By then, I was getting to be known in the AA and Al-Anon communities so they contacted me when they wanted help for their children. I think we had almost 300 kids

in treatment in ’73. We called it the Friendship Club.

I didn’t want to identify them as children of alcoholics back then because of the stigma at that time. As soon as people saw what was happening with young kids, there were a couple newspaper articles about what was happening about this strange center for children. Other people started wanting to know if I could I do something for their older kids. So by 1974, I just had countless young children’s group and adult children groups.

I was keeping track of what I was seeing in these children and things were falling into patterns. I had studied family therapy. I’d studied addiction. I knew that in my mind this was a family illness and that everyone played a role, including the addict. And then there became that debate between “Is it a primary disease that causes family illness or is it a family illness that causes people to become addicts?” Well, I was trained, and still believe to this day that addiction is a primary illness. Addicts don’t cause family illnesses and family illnesses don’t cause addicts. Addiction is a primary disease. Taking that stand cost me a lot in the family therapy field. They did not want to hear that, including my dear, dear mentor, who I could never have had a career without, Virginia Satir. She did not want to believe it was a primary disease, but she taught me almost everything I knew about family systems so she remained an important force in my life, and I think I became that for her. Before she died at a young age, Joe [Cruse] and I were able to take her to the Betty Ford Center. We introduced her to Betty Ford, and she sat in workshops at the Annenberg Center, after which she said to me, “I think you have a point.”

***Bill White*:** I remember this being a time in family therapy when the family was viewed as the causative agent of addiction and that there was talk of curing addiction through family therapy.

***Sharon Wegscheider Cruse*:** Yes, and that was the stand of the family therapy field. Virginia [Satir] used to tell me, “Sharon, you give me any alcoholic family that’s out there and I’ll take them into the woods and camp with them for a week and they’ll come back and all addictions will be cured.” She really believed that it was a family issue.

***Bill White*:** The early experiences that you’re mentioning led to your involvement with the Johnson Institute. Could you describe how your role at the Johnson Institute evolved over time?

***Sharon Wegscheider Cruse*:** I sure can. For a time, I was very involved with the Johnson Institute and really believed in the intervention model. Now, how did I get there? I had a four-month internship in the college I went to and I chose the Johnson Institute as the place I wanted to do my internship and was accepted there. I learned all about intervention but I also learned a lot about family systems, not quite the way I viewed family systems later, but they were the only game in town doing interventions and involving the family as part of the treatment team. I did my internship there and then I left and formed the Family Factory to expand my children of alcoholics groups. Later on, I formed the The House, which added services for adult men and women.

The Minneapolis Star and Tribune did a major story on The House in their Variety section of the paper. When that happened, there were a couple of people at the Johnson Institute who really wanted to make family therapy a bigger part of the Institute. Vern Johnson, God bless his soul, did not want that. He thought it would be too threatening to the alcoholic and that services to the alcoholic should be the primary focus of Johnson Institute. So two people from the Board of the Directors came to me and said, “We want to bring you to the Johnson Institute to develop a family focus--a family school, a family program, a whole family emphasis. However, you will not come in favored by the President, Vern Johnson. So,

we're asking you to take on a dual role. One, we're asking you to be a voting member of the management team, which means Vern Johnson's a voting member, you're a voting member, and we want you to head up this department and you can bring the first clinical background to the Institute we've ever had."

The way it worked out was that I did go in as an Executive of Johnson Institute with a full vote, and I brought half of The House with me—a team that instantly became the first family care program of the Johnson Institute. The other half went on and continued at The House. It was a tough go for me all the while that I was there because Vern Johnson did have a different picture and a different view. I never say one negative thing about that because I think he goes down in history as the father of family intervention, but it was a tough row to hoe there as long as I stayed. One of the things that incited some of the people even more was a request for Johnson Institute to serve as consultants to the Air Force in Europe, but they would only sign the contract if I was part of the contract. They didn't want just interventions; they want interventions and family therapy. As my role there grew larger and the larger my role got, tension increased among the Board and the staff. So, one day, I heard myself in a school talking about people needing to make changes in their lives and I just simply quit. I believed the Johnson Institute could re-group and someone had offered me the possibility of a new start. I left the Johnson Institute and formed Onsite--a family focused treatment program.

Seminal Work

***Bill White*:** Let me take you to the early and mid-1980s, which was an extremely prolific period of your career, including such books as *Another Chance*, *Codependency*, *Family Trap*, and *Choice-Making*, that exerted a tremendous impact on the addiction treatment field. Is there a story behind how you came to develop all of that work in such a short period of time?

***Sharon Wegscheider Cruse*:** Well, it seems on the surface like an overnight explosion, but it was a long, long night given that I started this work in '71 and '72. I'd had ten years of being in the trenches and starting The House, starting the Family Factory, earning respect among the addiction field and among family therapists. When I took a stand, I took a stand in the direction of addiction therapy rather than family therapy. I mean, I'm a good family therapist. I created Onsite, which is family-focused, but I stand behind my belief that addiction needs to be addressed as a primary disorder. By the early 1980s, I had ten years of experience and I had the support of a lot of people. Minnesota had earlier passed what was called the Governors' Bill to help start programs in the area of addiction so Minnesota early on became known for its network of alcoholism treatment programs. Then there was the big Freedom Fest rally in 1976 that brought together 26,000 recovering alcoholics and their families at the Minneapolis baseball stadium. So the setting was perfect for starting Onsite.

Onsite was incorporated in 1977 and service began in 1978. It came to fruition because of all the work that had been done before. I started documenting key ideas and approaches we were using. My first book, *Another Chance*, *Hope and Health for Alcoholic Families*, was released in 1976 by Virginia Satir's publisher, was made into a movie in 1989, and subsequently sold more than 250,000 copies. I had travelled on the road with Virginia for almost five years and he became my friend through that process. He said, "You write the book and I'll see to it that it gets published." *Another Chance* was published in '81, but I'd started that book ten years before when I started this work because nothing was documented. I saw in all that work with children of alcoholics the four roles I eventually described in 1976 in my book *The Family Trap*. There were three

in the beginning: Hero, Scapegoat, and Mascot. And the reason there was only three roles is because we forgot about the other kids—those who filled the Lost Child role. Those four roles have now gone around the world. It doesn't matter what culture I'm in, it doesn't matter what language people are speaking, they speak the four roles.

Out of that came in bits and pieces my own story, which was shared in the book *Choice-Making. Choice-Making* and *Learning to Love Yourself* were part of my recovery. Meeting Joe Cruse and having such a relationship was the basis of *Couple-ship*, which was published in 1988. Then we began to understand codependency. Whenever there was a concept that I thought really, really worked, I tested it at Onsite. I was beginning to see that people who went to my programs got well and some of them got better than they'd ever been in their life. I have life-long relationships with people that I've had for 40 years. I have witnessed growth across three generations now and they're not dealing with addiction anymore. They're not dealing with codependency. They talk about evidence-based treatment; I have treatment-based evidence. Back in those days, people didn't document like they do now. I can write an article right now and if I use the internet and what I know, I can have endless references. There were no references back then.

NACoA

***Bill White*:** You played an important role in the founding of the National Association of Children of Alcoholics (NACoA). What memories do you have of this milestone?

***Sharon Wegscheider Cruse*:** Oh my goodness! I have lots, and Joe Cruse has even more that he recently shared with Bob Ackerman. Three weeks ago, I was in Nashville and I had a marvelous experience with some of the founders of NACoA. That was a very pleasant experience for me. What do I remember? Well, I have to go to the beginning if I'm going to remember my portion of it. Some people will have different beginnings because everybody came in at a different time. For my portion, I had heard about a woman in California who was worried about children of alcoholics and I'd always wanted to meet her, but never had. Her name was Claudia Black. Claudia and I both laugh about this today—we're good friends—but they always put Claudia and I on at the same time to speak at conferences. We'd fly in and do our workshop and leave and we never had an opportunity to meet.

Then Joe Cruse invited Claudia Black, Kathleen Brooks, who at that time was Cilla Brown, Stephanie Brown, and I to speak at the Annenberg Center in California for a Betty Ford Center conference. We didn't know what each other did. We first met as Joe was trying to teach us this very sophisticated podium. He turned around as we were getting ready to start this conference for several hundred doctors, and we were all crying. We had finally met like-minded people. It was fantastic. Joan Kroc attended that meeting and came up to the four of us afterwards and said, "People in the world need to hear what you guys know and I'm inviting you all to the Kroc Ranch. I will cover all your expenses to come to the Kroc Ranch and spend a weekend together." Well, obviously, we all jumped at that chance and so we went to the Kroc Ranch. Joan said, "All I ask for is that you give me at the end of that meeting a report about what you would say to the nation if you had a forum?" And so we gathered for that weekend and it was just an absolute golden time, but we didn't come up with anything. We got so involved with each other that we just didn't come up with anything for the report. Joan was very kind about it and said, "Well, I'll tell you what, I'm going to invite you back one more time and each of you get to bring one more like-minded person with you."

We all went home, chose our people, and came back for that second meeting. That group became the original founding board of the National Association of Children of Alcoholics, and I was fortunate enough to become the first Chairman of the NACoA

Board. We were really go-getter people, but we were all untreated children of alcoholics. So, we started out very dysfunctionally, in terms of our board meetings. We carried on and couldn't agree on things, but we loved each other. We knew we would have a life-long bond and we have. We've kept that bond, and I think that we made significant changes in the world. Getting Sis Wenger in as our Executive Director was one of the most powerful things that could have ever happened to NACoA. She has dedicated her life to this organization. I had met Sis back when I had my Family Factory and The House. I couldn't afford to hire staff. I couldn't afford to go out and get counselors. So I trained and accepted any helping professional that had a mission and a big heart and understood addiction. Some of my group leaders were from the Junior League. Some of my group leaders were intern at schools. Some of them were clergy. Sis Wenger had a very respectful job in Detroit, Michigan, and I went and spoke to her. She represented the Junior League and when we thought of a Director for NACoA, I thought this woman can get it done. So, I invited her to become the first Executive Director of NACoA and she's handled it with charm and skill ever since. I think NACoA has made a difference in more lives than people will ever know. I'm so proud to have been a part of its beginning.

Codependency

***Bill White*:** What started out as a family-focused treatment movement morphed into a focus on codependency, which became something of a cultural phenomenon in the '80s. What are your perspectives on the codependency movement and the cultural backlash that it elicited?

***Sharon Wegscheider Cruse*:** I don't know for sure is my biggest answer to that. It came about as people began to understand the full dynamics of what was happening in the family. The early name for that was "para-alcoholic" or "co-alcoholic" and it first referred to the partner, the enabler, the wife, the girlfriend, the parent of an addict, and it didn't go beyond that into the rest of the family system. There were a lot of people exploring this at that time. Janet Woititz had her adult child focus, J. L. Greenleaf had the para-alcoholic, and Melody Beattie came out with her book on codependency, which was an important contribution. The word, "co," I think, came out of being the partner too or the enabler of the alcoholic.

When Joe and I started working at Onsite, we began to see that we could identify actual symptoms of a particular kind of syndrome that everyone in the family carries. There were three symptoms and three complications of what we came to see as codependency. There was denial, repression, and obsession that resulted in social, spiritual, and physical complications. We found that we could describe and treat it and that people started getting well—really well. Based on that experience, we wrote a book called, *Understanding Codependency* that got a lot of attention. Before long, the concept took off. It was mentioned in a movie, it was on *Saturday Night Live*, it was mentioned on the *Johnny Carson Show*. Codependency became an entity.

I think the reason that it lost its momentum was that there were so many approaches to it. It lost its specificity and could no longer stand alone. I think codependency is a describable process that can be treated successfully, but this is different from the loose way the term came to be used. I attended a forty-person meeting a few years ago to come up with a definition of codependency and it was never defined because it was too broad. People jumped on the codependency wagon without being specific as to what it was. It became easy to both see it and dismiss it at the same time.

***Bill White*:** Was the work that you did around codependency serve as a jumping off point for your subsequent work on women, couples, healing after divorce, self-development, and grand-parenting?

***Sharon Wegscheider Cruse*:** I recall coming from three basic beliefs and all of my work branches off these three beliefs. First, I really do believe in family systems theory. Secondly, I believe in addiction as a primary illness, and third, for me, the Twelve-Step way of life and a Higher Power is the third leg of the stool I stand on. My own life, my own recovery, I see as an actual miracle. If I can do it, so can anyone, and that has led to my latest book, *Becoming a Sage.* I think everybody's got a story, and mine's just one.

The Story of Onsite

***Bill White*:** Sharon, let me take you back to Onsite. We talked about the birth of Onsite but we haven't talked much about how it's evolved over time. Could you talk about some of the various programs at Onsite and how they've changed over the years?

***Sharon Wegscheider Cruse*:** Well, it's interesting. I spent a day at Onsite ten days ago, and it was such a marvelous experience for me. I don't know if you know Miles Adcox, who is the current owner of Onsite, but many of the programs are exactly the same way they were when it started. A big part of the program was developed with the support and help of Joe. We co-developed the Living Center Program (LCP), which is the heart of Onsite and its primary treatment program. Many of the programs have stayed the same since the early '80s. Virginia Satir, through teaching me the basic "reconstruction" process, had a huge influence on the programs. From 1977 to 1982, most of the programs were my version of the newly developed reconstructions adding the impact of addiction and codependency, and then, when Joe joined me at Onsite in '82 or '83, he added programs that are still there. Together, we wrote the Couple-ship program. Miles has added some marvelous programs, including one called Milestone that is relatively new. But the core program is still the LCP program. I think there have been 46,000 people through the program. I think that is absolutely remarkable, and it includes all the people treated or trained in that program. Those thousands of people treated at Onsite used to come in groups of ten. So, going back there is like a spiritual homecoming for me. It's absolutely wonderful.

Mentoring

***Bill White*:** You have played such an important role as a teacher, trainer, and mentor for so many years, are there are any lessons you've learned in these roles that you could pass on to other people who are just now beginning to mentor the next generation coming forward?

***Sharon Wegscheider Cruse*:** Yes, there are lessons. Honor your past, take the best from it, learn from it, and look toward the future, but live in the present. That's true for professionals, but it's also true for all people. We all stand on the shoulders of somebody. I certainly stood on a lot of shoulders. We have to, in the present, still continue every single day to live one day at a time and make ourselves the best person we can for that day because people are watching and people are listening. I think it's the gift we give our families and I think it's the gift we give professionally.

Another lesson is to know when to quit. Know when your life is taking you in a new direction. Know what enough means in your life. Know when you have had enough education. Know when have had you had enough seeking. Know when you have enough money to live and be responsible. Know when you have enough satisfaction in your life in one direction and need another direction. Be willing to change, but know when to quit. I retired 20 years ago, but I kept writing, and I switched into mentoring women.

I'm alive, awake, and aware every day with what I want to share with women, listen to from women, and so forth. But I needed to retire because I was prolific in the '80s and I worked really hard, in the '70s, '80s, '90s, and early 2000s. I needed to take

time to be with my family. My family's always been a big focus for me. If it had not been for wanting my children to have experiences that I had had, I probably never would have helped found NACoA. And then when my first grandchild was born, it changed my life. I wanted the time to do the things I'd done professionally but not with my family. And I've had that time now. A major lesson learned is to not forget your family and friends. Know when it's enough. Give it all your best and make those shoulders that people stand on strong. Don't succumb and choose to succumb to workaholism, to any one focus that feeds your ego. Don't do that—get out and live your life.

Working with the Media

***Bill White*:** You've had extensive contact with the national media. Do you have any insights or suggestions for people about working with media?

***Sharon Wegscheider Cruse*:** I have one insight that's not a big one but it was important to me and my family. When I wrote my latest book, I chose not to write about my family, even though they're such a big part of my life. They want me as parent, not as a star. They just want me to be their parent. I cast a shadow sometimes when I go somewhere. When they were younger, people would come up to them and say, "Oh, aren't you proud of your mother? Your mother's doing this, or your mother was in the newspaper last week." That casts a shadow and I've learned not to bring your children up in a shadow. My children aren't in my shadow. They've all grown into beautiful individuals with interests of their own and families of their own and that took a concentrated effort. I think one of the biggest joys for me recently is that two of my children, one couldn't make it because she's so far away, came to my keynotes at a national conference and sat in the second row. And you know what? Those are the two people along with Joe I really noticed in that audience. So, help them walk their path, but keep your personal path to yourself. And I've done that. They've given me the space to have an incredible career and they've supported me all the way through. And some of my grandchildren, to be honest, don't even know I have another life. They just know me as Grandma. The media can entice with its sensationalism and be very ego-filling, just as it can be very controlling. So my advice is to keep your life to yourself and give the people that you care about space away from that world.

International Work

***Bill White*:** Are there insights you developed about families that you drew from your international work as you stepped outside of our culture and began to look at families around the world?

***Sharon Wegscheider Cruse*:** I did and some of those might jump out at me. Hawaii and the Polynesian areas are very big on family and they have this tradition of talk story. I noticed that in native countries or people with tribal ancestry, they come to some of this healing naturally, but the more they become like us, they begin to have more issues within their families. Traditionally, they do talk story, and I've gone to Hawaii to do talk stories with families. There's a natural family union that could and should be recognized and built upon. They would have my family roles hanging up in their houses. They didn't follow a book or anything but they know those roles and they would get together and have talk stories two and three nights a week.

In my international travel, I also noticed that I met with lots of mothers and children. One thing I learned is that mothers love their children--everywhere I went, no matter what language it was. There is something special about giving birth; I think fathers love their children too, but in a different way. But there is an instinct in the way birthing mothers love their children. I think adoptive mothers also love their

children. There is an instinct of love that I think can be nurtured. If we stay away from diagnosing, people can heal themselves if they have the right setting and the right support. I'm into letting people heal within an understanding of their own system. Now, that brings me to Virginia Satir. I traveled a lot in Mexico with her and Virginia never spoke Spanish, but she could do a three-hour workshop by the looks on people's faces. She would put them into postures. She had the style of working that taught me so much. I hope I've taught it to the addiction field at Onsite. But you can read people's body languages and how they connect. Virginia never spoke Spanish, but I saw her do masterful work in family therapy in Mexico.

***Bill White*:** That's remarkable.

***Sharon Wegscheider Cruse*:** It was absolutely remarkable. As the world shrinks, I hold out for hope for communities of many different types of people. The family system model is one of the reasons Onsite took off with a flourish and a flash. I knew a lot of powerful people in Minneapolis, and so they would ask me, first of all, "Can you work with my family?", and, of course, I would, and things would change and then they'd say, "Can you work with my company?" So Onsite actually, as it came together, became a corporate-based helping company because we would bring our programs to your corporation. I would go in and work with boards of directors like they were a family system and the board cleaned up and cleared up. That had a huge impact in the City of Minneapolis.

Becoming a Sage

***Bill White*:** If there are central threads that permeate your work, I would have to say one would be the value of story-telling. In your latest book, *Becoming a Sage*, was your first effort to focus on your own story. Was the experience of writing this book different than all the other publications that you've done?

***Sharon Wegscheider Cruse*:** It was very different. When I was writing other books, I always had a content that I wanted to share--concepts, teaching, and information. Sometimes, I had to coin new words to convey this information for the first time. I invented the word *choice-making*, and I invented the word *couple-ship* to put a framework around some things that are naturally a part of our lives but which need to be understood in a new way. But when it came to *Becoming a Sage*, the content was less important to me than the style. I wanted to write a book that wasn't necessarily about me, although that's what I used as a platform for the book. I wanted to write it in a way that people would read a short story and then think about their own life. I wanted to be a source of inspiration for everyone to believe that their story matters. Somehow when I started to write my experiences, it turned out to be a story, and I think that's true for everybody. I started out in the beginning wanting to leave a legacy for my family. *Becoming a Sage* shares some of my life experiences, but it turned into a larger story about how you can go through really rough times but still make it to the other side. What I came out of the book with was more acceptance, courage, and wisdom. I know a prayer like that. My story turned out to be that lived prayer. I thought if I can do that, then people can write their own stories through that prayer.

Career-to-Date Reflections

***Bill White*:** What are some of the rewards you've experienced working in the addictions field over these many years?

***Sharon Wegscheider Cruse*:** Oh, untold. There's so many. I think I have a sense of authenticity with myself. I'm pretty clear with myself and that has come only from going into the depths and using that to go forward to understand life's lessons and then using that to hear other people's life lessons and to

become involved with them as a professional and learn from their life lessons. I learn every day from others, but I have a framework to put it in because I'm at home with myself. In this field, you meet the nicest people. You meet the most courageous people. I wrote in the book about how I stepped outside of my field for a while and became very active. I realized that there's a big world out there beyond addiction, but that it includes addiction. For seven years, I donated my time and facilitated a group for mothers who had lost children. Without this profession, I would never have met what I think are some of the bravest people in the world. And I learned how to tap dance and became a tap dancer for 15 years. And physically, I'm in very good shape, compared with many other people I know that are my age. I think you meet the brightest, most caring, most courageous people which is a big part of why this is such an incredible field to go into. This is also an evolving, ever-changing field to work in. It's rewarding, it's exciting, and it's hard work.

***Bill White*:** Pushing the field toward more family-oriented care has been quite a challenge. Do you have any final advice for people who want to carry forward the legacy of your work?

***Sharon Wegscheider Cruse*:** That's a really important question, and it is hard to push family oriented care just as it is hard to push addiction treatment to the larger culture. It's very hard to get these programs out in front of the public eye. I think your question raises a bigger question that we do not yet have answers for. There are some wonderful programs out there such as the work Jerry Moe is doing in California, and he is just doing miracle-making work. But there aren't enough Jerrys to go around. People would like to do that work, but finding a way to pay for it is difficult as it is for so many wonderful things at this current time. Sometimes you have to find another way to support yourself and sometimes you simply have to do a lot of volunteer work. Right now, there's not a clear path of how to fund programs focused on families and children. That's just reality. The children, to this day, get left out. We have to keep advocating on their behalf. I want to assure people that whether you're the person trying to find funding or whether you're the person who has to come up with something creative, if everybody worked locally, we wouldn't have a national problem. So, do what you can where you can and have faith that such efforts will get tied together somehow. With commitment, loyalty, and faith, something should and can happen. In the meantime, stay connected to what exists now, such as NACoA. Volunteer, make noise, and join with others to create coalitions to bring people together for common cause. We don't need stars; we need people who will work together as a team until we meet this challenge.

***Bill White*:** Sharon, this has been fabulous. Thank you for taking this time to reflect on your life and your prolific career.

***Sharon Wegscheider Cruse*:** Thank you, Bill.

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Books, publications, videos, and related resources of *Sharon Wegscheider Cruse* can be reviewed at http://www.sharonwcruse.com/books-by-sharon/

Advances in Addiction & Recovery

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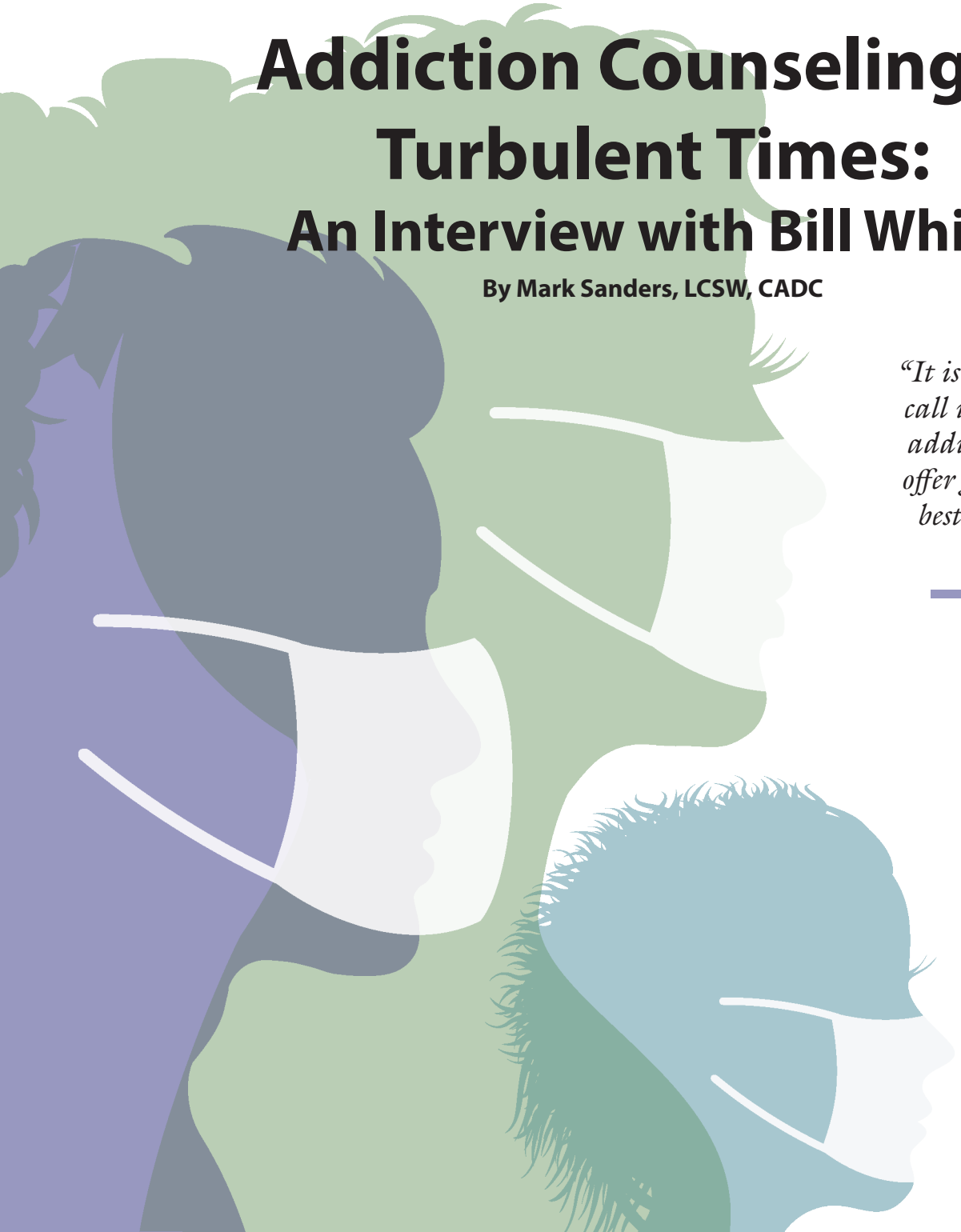
Addiction Counseling in Turbulent Times:

An Interview with Bill White

By Mark Sanders, LCSW, CADC



"It is during this time that we call upon William White, the addiction field's historian, to offer guidance on how we can best navigate these difficult times."



William L. White



Mark Sanders, LCSW, CADC

The U.S. is experiencing a historic pandemic. The U.S. unemployment rate has not been as high as it has been over the past year since the Great Depression of the 1930s. The death of George Floyd has sparked unprecedented levels of protest in the U.S. Individuals with substance use disorders are challenged during these difficult times, as are the workers and institutions charged with their care. People in recovery, due to the pandemic, have lost many of the face-to-face resources that have supported their recoveries, and drug overdose deaths are on the rise at a time when addiction treatment facilities are closing because of the economic recession triggered by COVID-19.

It is during this time that we call upon William ("Bill") L. White, the addiction field's historian, to offer guidance on how we can best navigate these difficult times.

COVID-19

Mark Sanders: Bill, the COVID-19 pandemic is exerting profound effects on the addiction field. Are there any historical precedents to the challenges COVID-19 is posing for the addiction field?

Bill White: The more than 200-year history of addictions treatment in the United States spans numerous infectious disease epidemics, but there are many unique aspects to what we are presently experiencing. Infectious diseases such as yellow fever, smallpox, tuberculosis, and the Spanish Flu of 1918-1920 did not dramatically affect early inebriate homes, inebriate asylums, or private addiction cure institutes, nor did the infectious diseases that arose through the mid-twentieth century. The primary precedent we have to COVID-19 is the addictions field's earlier responses to the rapid spread of HIV/AIDS and Hepatitis C.

MS: What makes COVID-19 unique?

BW: Our knowledge of the long-term course of COVID-19 at clinical and population levels remains limited, but there are several unique dimensions of the challenges COVID-19 poses to the field of addiction treatment.

Infectious diseases follow variable patterns of social contagion including local outbreaks, epidemics (substantial spread), and pandemics (transnational spread). What is unfolding with COVID-19 is what could be termed a syndemic: two or more epidemics or pandemics combining synergistically to amplify morbidity and mortality, and their political, economic, and social costs. I am referring specifically to the imposition of COVID-19 on a landscape already reeling from an opioid epidemic (an epidemic still taking more than 45,000 lives each year) and the continued spread of other infectious diseases among people with substance use disorders, e.g., AIDS and Hepatitis B and C. The concurrent or sequential experience of these disorders poses a grave threat to people with substance use disorders and a challenge to long-term recovery management.

COVID-19 possesses several distinguishing and troublesome characteristics, including its mode of transmission (airborne), its degree of infectiousness, its wide variability in disease course (from asymptomatic or mild to extremely severe/lethal), the high rate of asymptomatic transmission, the speed of its population penetration, and its potential lethality as evidenced by the growing death toll in the U.S. and globally. The potential long-term effects of COVID-19 infection are unclear but reports of such effects are quite troubling. Also of concern is the risk of nosocomial transmission—infection spread within health care facilities to other patients and health care workers. Where protection of workers from transmission of HIV or HCV could be managed by standard infection control procedures, there is no precedent within the history of the addiction field to the level of infection control required for COVID-19.

[N]o prior infectious disease has so transformed the delivery of addiction treatment services while simultaneously threatening the financial stability of addiction treatment institutions and the field as a whole.

Finally, no prior infectious disease has so transformed the delivery of addiction treatment services while simultaneously threatening the financial stability of addiction treatment institutions and the field as a whole.

MS: How will COVID-19 affect the nature of alcohol and other drug problems in the United States?

BW: AOD problems are intensifying due to two COVID-19 factors. First, a portion of people now in recovery will experience destabilization of their recovery due to increased stressors and a loss of recovery-focused social supports. Those with the least recovery capital and the shortest periods of recovery stability will be particularly vulnerable for addiction recurrence. Second, the pandemic will accelerate AOD problem progression and increase SUD vulnerability among a larger pool of people self-medicating pandemic-related distress. Such telescoping or problem progression is a function of both increased stressors and the loss of daily support structure and routines.

Recovery support needs will increase as a direct and indirect consequence of COVID-19 for those presently in recovery and for this larger population of people vulnerable for the development of substance use disorders. This increase in problem severity is not now resulting in treatment seeking due to fear of COVID-19 exposure, but it is evident in rising rates of overdoses and overdose deaths since March 2020. We are creating a backlog of need for treatment that could threaten to overwhelm what will likely be a smaller number of addiction treatment resources when the COVID-19 pandemic ebbs.

We do not yet know all of the prolonged effects of COVID-19 that will continue after acute symptoms have subsided. This is a particular concern for many people in recovery who carry acute and chronic health issues into the recovery process. Research to date confirms that adults with a lifetime or recent substance use disorder are at increased risk for COVID-19 infection, COVID-19 hospitalization, and COVID-19 death compared to people without such a history. A residual effect of COVID-19 may be a greater degree of health issues presented by people entering addiction treatment. This will require more comprehensive physical exams and greater collaboration with primary care physicians and health care clinics.

COVID-19 and Addiction Treatment Organizations

MS: Could you elaborate on what you see as the short and long-term effects of COVID-19 on addiction treatment organizations?

BW: The immediate effects of COVID-19 involve three questions: 1) how do we identify and treat or refer asymptomatic

and symptomatic patients who test positive for COVID-19 as they seek admission to addiction treatment, 2) how do we reduce the risk of COVID-19 infection for patients and staff within the addiction treatment milieu, and 3) how do we deliver addiction treatment services while limiting face-to-face social contact?

The speed at which addiction treatment programs have addressed these questions is quite commendable. Particularly notable is the speed at which treatment organizations radically altered service delivery models and traditional infection control procedures in response to COVID-19. The transition from face-to-face counseling to e-counseling and telehealth formats has occurred with lightning speed and will leave a lasting impact on the field, even if COVID-19 disappears in the months ahead. The same might also be said for numerous COVID-related adaptations of clinical services—from screening/intake procedures and milieu management to post-treatment recovery checkups.

MS: **Bill, people are wondering how long the COVID-19 pandemic will last and what the effects on the field will be if it continues well into the future.**

BW: We simply do not know at present. The more prolonged the pandemic, the greater will be the negative effects on addiction treatment organizations. The most profound effects will be the demise of those organizations that are not sufficiently capitalized to survive a sudden loss of service income, including some programs that have pursued their service missions for decades. This will be a great loss to the field and to affected individuals, families, and communities, as well as affected workers. Those closures will increase recovery support service demands on surviving institutions. I suspect, even in the best scenario, that the economic effects of COVID-19 will extend deep into 2021 and 2022 and restrict available funding for addiction treatment due to prolonged state and local fiscal austerity measures. The addictions field may look very different when this pandemic becomes a closed chapter of history.

The central residual story will be the collision between increased service needs and limited financial resources to meet those demands. I suspect the economic impact of the coronavirus pandemic will be far greater and more prolonged than presently anticipated, which will do two things. First, it will by necessity force addiction treatment programs toward greater diversification of their funding sources and mixed models of paid and volunteer service staff. Secondly, it will extend the historical focus of addiction treatment programs and recovery communities on emotional and social support into the arenas of physical health management as well as financial and employment assistance.

MS: **Could the addictions field emerge stronger in the aftermath of COVID-19?**

BW: Culling the weaker organizations could strengthen the overall field, even though it will handicap some local communities until stronger, more resilient treatment organizations emerge. The rapid experiments with new service delivery models will spark future innovations and stir renewed conversations about the quality of the treatment experience for both service recipients and service providers. That is a badly needed conversation. Experimentation with new service delivery models will speed the movement of "treatment without walls"—creative approaches to the delivery of clinical and peer-based recovery support services. The movement of recovery support to a primarily digital culture and the expansion of e-treatment and e-recovery support services will accelerate exponentially, exposing the value, limitations, and -- in some cases -- unintended consequences of this shift.

We're all listening to public health experts. Increased knowledge of public health concepts and technologies will spur increased interest in population-based interventions to prevent and mitigate alcohol and other drug problems across the spectrums of severity, complexity, and chronicity. The former will allow us to shift from exclusively intrapersonal models of addiction and recovery to models that more clearly address the ecology of addiction and recovery and the long-term stages of personal and family recovery. The latter extension has enormous potential for the field, particularly in developing interventions designed for people with low to moderate AOD problem severity.

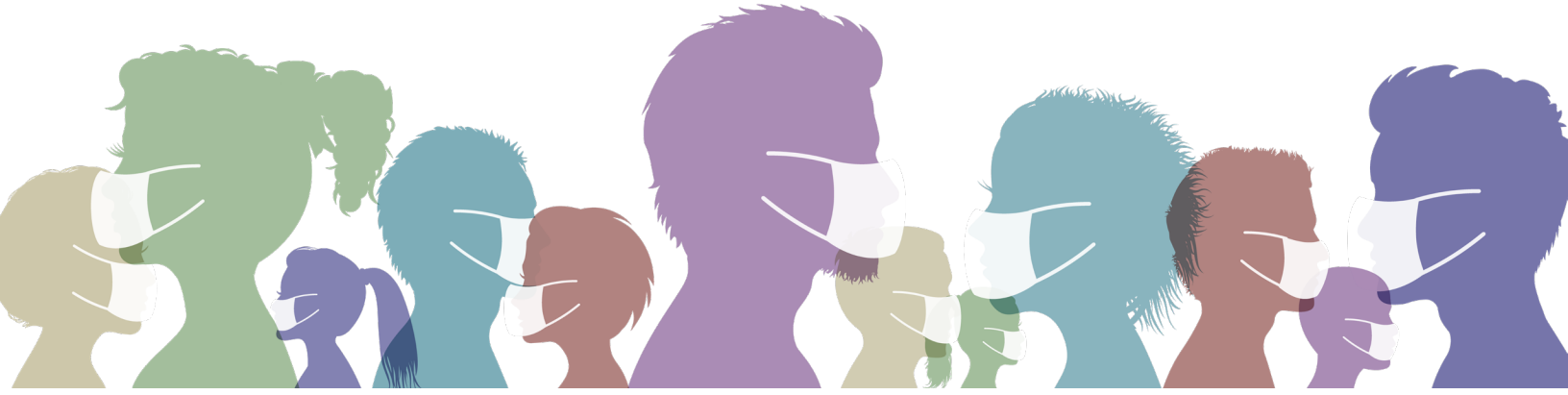
I think the elevated status of scientists and science-grounded professional helpers emerging from the pandemic will spur increased expectations for research and reporting of addiction treatment outcomes and may spur a backlash against highly promoted products and services confirmed by scientific studies to be unhelpful or harmful. This could help the field get itself ethically re-centered amidst increased allegations of ethical misconduct related to the field's business and clinical practices.

So, yes, the COVID-19 pandemic poses threats to the field, but it also poses opportunities for renewal and advancement of the field.

Black Lives Matter

MS: **The Black Lives Matter (BLM) movement is also of potential historical import. How do you view this movement through the lens of your interest in the history of social movements?**

BW: I think the Black Lives Matter movement will generate profound and prolonged ripples throughout our culture and in other countries. Several factors will contribute to its enduring influence.



Since the filmed beating of Rodney King, the racial underbelly of contemporary policing in America has been exposed. We have reached a critical mass of such incidents and their traditional aftermath of failed policing accountability— failures to indict, failures to convict, failures to discipline, failures to fire—all sending the message that Black lives do not matter. Black Lives Matter was founded in 2013 by Alicia Garza, Patrisse Khan-Cullors, and Opal Tometi in response to the murder of Trayvon Martin and his killer's acquittal. Other deaths followed, including Mike Brown, Tamir Rice, Tanisha Anderson, Mya Hall, Walter Scott, Eric Garner, Freddie Gray, Sandra Bland, Ahmaud Arbery, and Breonna Taylor. The discussions now unfolding flow from a race-tainted drug war, the mass incarceration of men and women of color, and the recent militarization of community police departments. These conditions and incidents long known within communities of color are now being vividly exposed to the whole culture.

What makes the BLM movement sustainable is the broader context in which it arose. It has drawn fuel from the emergence of new forms of musical expression (hip hop); new styles of representing Black people in theatre (Hamilton), film (Black Panther), and literature, including landmark histories on the effects of institutional racism on the criminal justice system (Michelle Alexander's The New Jim Crow); activism of Black athletes (Colin Kaepernick, NBA stars wearing "I can't breathe" warmup t-shirts); the election and re-election of the first Black president and an unprecedented number of elected Black officials; the critical mass of Black men and women working within the criminal justice system and other major social institutions, and the mainstreaming of Black history and culture (Smithsonian National Museum of African American History & Culture, the Martin Luther King Jr. Memorial on the National Mall, the 1619 Project). All of these things were precursors of or provided contextual influence upon the BLM movement.



These contexts contributed to the incubation and subsequent mobilization of the BLM movement, but all movements need a catalytic spark. The eight minutes and 46 seconds America watched George Floyd die profoundly shifted something; not in America's mind, but in her belly. For people of color, it was a breaking point that ignited BLM into a dynamic (cathartic and then strategic), rapidly expanding social movement led by younger voices that were articulating new agendas for urgent social change. For everyone, it brought a visceral understanding of racism that no book, lecture, or film could provide. Cell phones and other recording media (e.g., surveillance video and body cams) constituted the spark that allowed all these other preparatory processes to ignite. While BLM rose in response to police killing of Black people, its focus quickly extended to confronting racism in all of its cultural contexts and within the broader lens of class, gender, sexual orientation, gender identity, and immigrations status.

Transformative social movements have a long historical trajectory. Think of the changes that have resulted from a generation of young people who were profoundly influenced by the social movements of the 1960s and 1970s. Today's young people are experiencing events at this moment that will shape their lives and our culture for decades to come. A new generation of Black leaders is rising as we speak. Less recognized is the re-energization of social justice activism that the BLM is stirring among other communities of color, other historically marginalized people, and White youth.

By historical osmosis, racism has seeped into very bone marrow of institutional practices in America. BLM is distinct in its aim of transforming such practices at a policy and institutional level rather than a narrower focus on influencing the personal attitudes elicited from such structures. This "systems" focus promises a depth of social change that could create a far more inclusive, resilient, and vibrant American culture. Like other social movements, the BLM movement will have to weather internal dissension and external backlash and master the challenges of sustainability. That said, I think every arena of American life will be touched by the BLM movement, including the addiction treatment field. Would you agree?

MS: **Bill, I am calling these times The Trifecta: When a pandemic, economic recession, and racial conflict meet. Following the death of George Floyd, there were more consecutive days of marching and protests than at any time in U.S. history. Even in the 1960s, when Malcolm X, Martin Luther King, Jr., and President John F. Kennedy were assassinated, there were not as many consecutive days of protest. If we were only dealing with COVID-19, we would be advised to stay in isolation. If we only dealing with an economic recession, people would pursue additional work. If we were only dealing with the police shooting of an unarmed African American, our history would predict a few days of protest. When all three of these events came together at once, it created a synergistic effect: 1 + 1 + 1 = 100! Quarantined people all over the world watched, over and over and over again, the video of a police officer on George Floyd's neck for eight minutes and 46 seconds. That image sparked worldwide discussions in every industry, including our own. How do you think the addictions field will be impacted by the BLM movement?**

BW: I think the BLM movement will prompt the addictions field to conduct a "searching and fearless moral inventory" of the effects of current treatment philosophies, policies, and practices on people of color. We will be asked about the level and authenticity of representation of people of color at federal, state, and local addiction treatment policy tables. We will be asked about the relationship between addiction treatment and criminal justice institutions (and the coercive role of the latter as a profit feeder for the former). We will be asked to look at disparities between the demographics of the addiction treatment workforce and the demographics of those served in addiction treatment. The culture of our treatment milieus will be critiqued on the degree to which they are welcoming to people of color. Our intrapersonal (biological and psychological) models of the cause and resolution of addiction will be critiqued for failing to address environmental contributors to addiction and obstacles to recovery. We will be challenged to understand the influences of racism (historical and contemporary trauma) on addiction and recovery. We will be confronted with potential racial disparities in attraction, access, admission, and retention in addiction treatment. We will be challenged

When the viral dust settles and the body count is complete, the health disparities between Black and White and between the wealthy and poor and working-class people will expose wrenching realities we as a culture can no longer ignore.

to address the role of racial countertransference in the administrative discharge of Black people from addiction treatment. We will be asked about the relationships (or lack of them) between our treatment institutions and indigenous healers and institutions that often play important roles in recovery initiation and long-term recovery support among people of color.

These are all important questions, and the resulting conversations will challenge and elevate the quality of addiction treatment in the U.S. All of this also relates to our earlier discussion of COVID-19. When the viral dust settles and the body count is complete, the health disparities between Black and White and between the wealthy and poor and working-class people will expose wrenching realities we as a culture can no longer ignore. Health inequities involve far more than the personal choices of individuals. They reflect structural conditions that differ greatly across the dimensions of gender, race, and class. Those structures are apt targets of the BLM movement.

MS: **I agree. Just as Dr. King extended the Civil Rights movement to a poor-people campaign, BLM will become extended and more specialized. We're already seeing signs that say Black LGBTQ Lives Matters, Black Transgender Lives Matter, and Black Children's Lives Matter (the latter in response to children being shot and killed in gang crossfire). We will likely see Black Student Lives Matter (a fight for equality in the classroom), Black Employees Lives Matter (equality in hiring), and Black Lives Matter (when the shooter is another black person). Black Addicted Lives Matter will carry this movement into the heart of the addictions field.**

BW: Yes. Some will view this extension as a splintering of the movement, but I think that process will be a testament to the movement's vibrancy and sustainability.

Implications for Addiction Professionals

MS: **How are these major social and economic changes we have discussed affecting the state of addiction counseling and the status of addiction counselors?**

BW: At a professional level, COVID-19 will push addiction counselors to embrace new media to reach those we serve, and I think that advancement will leave a lasting imprint on addiction counseling long after the ebb of this pandemic. At a personal level, it reinforces in stark terms the need for self-protection and self-care in our professional conduct and in our private lives.

As for the BLM movement, it could help us reach back to the early roots of addiction counseling and NAADAC. The modern rise of that role and the founding of the organizational precursors of NAADAC can be traced to the alcoholism treatment services of the 1960s that were provided through the anti-poverty programs within Black communities. Under the leadership of Matt Rose and the Office of Economic Opportunity, these programs marked precious roots—ideas, sensitivities, and service practices—that were lost in the professionalization and commercialization of addiction treatment.

The BLM movement also provides an opportunity for self-reflection of every person working in the addictions field. Each of us needs to explore how the racism imbedded in the cultural oxygen we inhale every day affects what we bring into the counseling relationship. If I have lived for decades in a culture that distorts the perception of Black people and other people of color, the question is not if I have been affected by such exposure, but rather how can I purge the inherited vestiges of such influences. It helps no one to pretend such cultural air has not entered us. Like addiction, it can only be transcended when its presence is recognized. This is not a question of the character of the counselor; it is an issue of owning and then purging toxic cultural influences, and it is about altering the objective conditions in which people seek their personal and collective destinies. Recovery has as much to do with these external conditions, as it does intrapersonal factors. The BLM movement is a call to every addiction professional to help create space within local communities—neighborhood by neighborhood—where recovery can flourish. That was the original vision of Matt Rose that we can rekindle.

MS: **These conversations may be difficult for addiction professionals to have. Some of us will have to deal with the issues we bring to the table, including anger, rage, guilt, fear, and privilege. If clients with substance use disorders are impacted by social injustice, is there room for social justice work in the addictions professional?**

BW: Yes. I think justice is an ethical principle that deserves greater attention among addiction professionals. Each of us has a responsibility to address the challenges of our times within the context of our profession and in our larger service activities within local communities. Racism is a stain of shame that has deformed the American character. The shame is so deep within our history that it is unspeakable. That is why we have such trouble with conversations about race in this country. Racism has left all of us with a wounded culture in need of a sustained recovery process, and we, as addiction professionals, can help inform that recovery process. The agenda for Euro-Americans is to conduct a full inventory of past injuries to people of color, publicly acknowledge such harms, seek forgiveness of the unforgivable, make amends for such injuries (pay our historical debt), and promptly admit future harms when they occur. We will then be challenged with purging the legacies of that history, and we will only be able to do that in partnership with communities of color.

Racism is not just about personal animosity toward a race; it is about laws, policies, and practices driven by decisions at key points in history. Such machinery of control can only be dismantled by a later set of conscious decisions. As a culture, we now have an opportunity to make these decisions and all of us need to be part of it. My hope is that we, as a profession, will stand tall at this point in history. We can begin that by asking people of color with addiction and recovery experience and those working in the field to share their experience or perception of addiction treatment through a BLM lens. Our first acts of social justice as a field must be to listen and enter into a collaborative partnership to elevate the quality of the treatment experience for people of color and other historically marginalized people.

MS: **In that listening, I think we will discover a need to anchor recovery in African American and other communities of color, honor multiple pathways of recovery that are preferred within various communities, and connect persons seeking recovery with indigenous healers as well as professional resources within these communities.**

COVID-19, its economic aftershocks, and the social changes unfolding in the United States are challenging and will continue to challenge the adaptive capacities of our organizations, our workers, and the individuals, families, and communities we serve. We will rise to meet these challenges.

What do you see as the role of peers and recovery-oriented systems of care to address these challenges?

BW: Peer-based recovery support services can play a significant role in enhancing recovery outcomes and help extend the present acute care model of addiction treatment. They can help us reach people earlier and extend support well past the early stage of recovery initiation and stabilization. We could see a misuse of such services in the current environment. The financial austerity unfolding in many areas of the country could lead to the deprofessionalization of addiction counseling. Financially distressed organizations will be tempted to replace trained addiction counselors with peer services rather than seeing the latter as a valuable adjunct to addiction counseling.

MS: **These are traumatic times. Are there things we can learn from Native Americans about healing trauma and recovery?**

BW: Native American tribal communities have guided our understanding of the effects of historical trauma and the processes required to personally and collectively transcend such trauma. I hope we, as a culture, will turn to Native elders to assist us in how to best move forward with this healing process. The concepts of time ("seven generations"; "seasons"; "cycle of life") and space ("healing forest") as represented in the Medicine Wheel may help us begin and sustain this healing.

MS: **The pace of change faced by addiction counselors is potentially overwhelming. What guidance can you offer on how we can sustain our health and professional integrity through this period?**

BW: Four daily rituals can help keep us centered on the larger meaning of our work as well as help sustain our personal health and perspective. Centering rituals, whether in the form of prayer, formal meditation, or just quiet reflection, help us "keep our eyes on the prize" and allow us to remain grounded. They help us narrow the gap between aspirational recovery values (humility, honesty, integrity, tolerance, gratitude, forgiveness, etc.) and our daily actions. Mirroring rituals allow us to commune with kindred spirits for mutual support, for feedback on the quality of our service efforts, and to rekindle our passion for service. Acts of self-care and personal responsibility provide time for self-repair and caring for the needs of our families and others of importance in our lives. Unpaid and unacknowledged acts of service help keep our egos in check and allow us to remain focused on the value of service to others.

MS: **What practical guidance would you offer to addiction counselors who lose their jobs due to the economic effects of COVID-19?**

BW: If you lose your job amidst the economic shocks of COVID-19, seek alternative positions within the field and stay connected to the field—even if it is in a volunteer role—while you are seeking new opportunities. Many positions will return in the near future as communities rebuild infrastructures injured by the pandemic. If you need to work in allied fields, then take your knowledge of addiction treatment and recovery and infuse it into these new arenas. Many allied service fields need such expertise. For some, this will also provide a window of opportunity to return to school to pursue continued education.

MS: **Bill, any closing words?**

BW: COVID-19, its economic aftershocks, and the social changes unfolding in the United States are challenging and will continue to challenge the adaptive capacities of our organizations, our workers, and the individuals, families, and communities we serve. We will rise to meet these challenges. That is what we have done in the past, what we are doing now, and what we will do in the future.

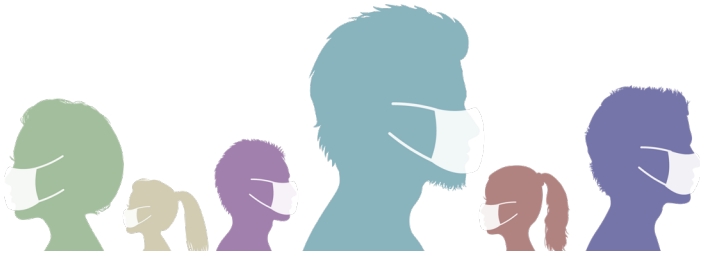
MS: **Thank you, Bill. It is always a pleasure.**



Mark Sanders, LCSW, CADC, an international speaker and consultant, is the Editor of Substance Use Disorders in African American Communities: Prevention, Treatment, and Recovery, and chair of the NAADAC Clinical Issues Committee. He is the author of 5 books on recovery and Curator of the Online Museum of African American Addictions Recovery. You can visit the museum at www.museumofafricanamericanaddictionsrecovery.org. He has also had two stories published in the New York Times Best Selling Book Series, Chicken Soup for The Soul. Sanders is the recipient of numerous awards including: The Barbara Bacon Award for outstanding contributions to the Social Work Profession as a Loyola University of Chicago alumni, Health Care Alternative Systems Leadership Award and The Professional of The Year Award from the Illinois Addiction Counselor Certification Board. He is past Board President of the Illinois Association of Addictions Professionals and Co-Founder of Serenity Academy Chicago, the only recovery High School in Illinois.



William ("Bill") L. White is an Emeritus Senior Research Consultant at Chestnut Health Systems / Lighthouse Institute and past-chair of the board of Recovery Communities United. White has a Master's degree in Addiction Studies and has worked full time in the addictions field since 1969 as a streetworker, counselor, clinical director, researcher and well-traveled trainer and consultant. He has authored or co-authored more than 400 articles, monographs, research reports and book chapters and 20 books. His book, Slaying the Dragon – The History of Addiction Treatment and Recovery in America, received the McGovern Family Foundation Award for the best book on addiction recovery. Bill was featured in the Bill Moyers' PBS special "Close To Home: Addiction in America" and Showtime's documentary "Smoking, Drinking and Drugging in the 20th Century." White's sustained contributions to the field have been acknowledged by awards from NAADAC, the Association for Addiction Professionals, National Association of Addiction Treatment Providers, the National Council on Alcoholism and Drug Dependence, the American Society of Addiction Medicine, and the Native American Wellbriety Movement.





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