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Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
Grant # 90-CT-0081 – The Children's Bureau (DHHS)

441258

CD-41326

Following is the FINAL PROJECT REPORT for *PROJECT STRENGTHENING SUPERVISION*

The report is divided according to requested reporting guidelines:

- Summary of the project, including goals & objectives
- A brief discussion of the curriculum focus/content
- Field-testing and evaluation of the curriculum
- The lessons learned, including issues related to the development of the curriculum and coordination with all entities involved

NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION

JAN 12 2004

Please note: The following abbreviations are used within this report:

- AODA = Alcohol and Other Drug Abuse
- ASFA = The Adoption and Safe Families Act of 1997
- CHS = Chestnut Health Systems
- DCFS = Illinois Department of Children and Family Services
- DHHS = U.S. Department of Health & Human Services
- IDHS = Illinois Department of Human Services
- ISU = Illinois State University, School of Social Work
- LI = Lighthouse Institute at Chestnut Health Systems
- PAC = Project Strengthening Supervision Advisory Committee
- POS = DCFS contract (*Purchase of Service*) *agencies*
- PSS = Project Strengthening Supervision

PROJECT SUMMARY

Introduction

Project Strengthening Supervision (PSS) focused on the issue of substance-affected families. Specifically, it addressed the stress and burnout common among child welfare workers that deal with such families.

- Data from the 1996 National Household Survey on Drug Abuse shows that as many as 8.3 million children (11% of the child population of the United States) live in households in which one or both parents have a serious alcohol or other drug problem.

- DHHS has also concluded that "Parental substance abuse is among the factors that have fueled the rising number of abuse and neglect reports and has contributed to the rising number of children in foster care. It remains a key barrier to reunification for many of the children who reside in foster care for extended periods".

- Within Illinois, an IDHS/DCFS needs assessment found that more than half of DCFS-involved parents identified substance abuse problems as their primary reason for contact with the Department.

- A recent survey by the U.S. General Accounting Office of child welfare workers in Illinois found that almost three-quarters of service plans

included a requirement for addressing parental substance abuse problems.

- Working with families that are substance-affected is a highly complex undertaking. These cases are particularly difficult to manage, as addicted clients are generally resistant to substance abuse treatment, and in most cases require a wider range of adjunctive services.

- A 1997 study found that families with substance abuse problems were "significantly more troubled" than other families in the child welfare system, as measured by the existence of other, non-substance abuse-related family problems.

- Dealing with such families is a job replete with both state and federal rules and guidelines. DCFS protocol for working with substance-affected families describes a model of effective case management and service delivery, but it also adds substantially to the tasks that must be undertaken by child welfare workers. Consequently, such workers report that their jobs are characterized by "more work and less time" and by a high degree of stress.

- An equally complex aspect of working with substance-affected families involves the nature of the addicted person and of the disorder of substance dependency.

- Although their addiction may have caused a great deal of pain to themselves and their families, addicted clients often suffer from, a lack of hope that reduces their tendency to seek or accept help. Such attitudes and feelings can be changed, but this process takes time, which child welfare workers and their supervisors may not have.

- ASFA emphasizes timely decision making, requiring that permanency decisions be made within 12 months of the time a case is opened by the child welfare agency, and that agencies move to terminate parental rights once a child has been in foster care for 15 of the previous 22 months, unless there is a compelling reason not to initiate termination. As DCFS has noted "[ASFA] and the Illinois Permanency Initiative require that neglected and abused children be moved to a permanent home in a much shortened time period. By contrast, AODA recovery and relapse prevention are lifelong efforts."

- DCFS recognizes that substance dependency is a chronic, relapsing disease, and that if verifying "substantial progress" in substance abuse

treatment is difficult under any circumstances, doing so within the 12-15 month parameter is even more so.

- In addition, since relapse is always a possibility among substance dependent people – as it is among those who suffer from any chronic disease – it is often difficult for the child welfare worker to determine what level of improvement in parental functioning is sufficient to ensure safety and health of children within the household.

Ultimately, it is the supervisor who bears the responsibility for maintaining the daily functioning of the child welfare system. Therefore, child welfare supervisors comprised the target group for this project. In implementing the project, it was necessary to be aware of several challenges in implementing supervisory training.

Perhaps the greatest challenge involved in training child welfare supervisors is the lack of available time that such individuals typically report. Given this fact, it is unlikely that supervisors will attend training events with any degree of enthusiasm, and openness unless they believe that such attendance will reduce the stress levels of both themselves and their staff members, and contribute in a meaningful way to positive child and family outcomes. Providing comprehensive, relevant training to child welfare supervisors on topics related to substance abuse issues among agency clients may help to reduce burnout, and turnover rates among their staff members. However, the content and design of such training must be carefully developed in concert with DCFS in order for it to be truly effective in assisting supervisors and their staff in managing cases in which substance abuse is an issue. A major challenge in this regard was providing training that did not merely present child welfare supervisors with more facts, but instead contributed in a meaningful way to the day-to-day disposition of cases. For this reason, the training described in this Final Report was much more than "business as usual". It went beyond any other substance abuse training previously provided by ISU and CHS/LI and resulted in the acquisition by child welfare supervisors of knowledge and skills that they find truly valuable and helpful in managing and motivating their subordinates. In addition, the training

provided for on-going technology transfer, since, as noted by the Child Welfare League of America (Young, Gardner and Dennis, 1998), "training is too often treated as a single injection, rather than an on-going process that may require an occasional 'booster shot'".

A further challenge in training child welfare supervisors is that the training plan must include a focus on supervisory transfer of knowledge and skills to caseworkers. Without a concept-to-practice connection, none of the goals and objectives could have been achieved. Some supervisors, regardless of their clinical skills and knowledge of child welfare practice, do not function well in the role of teacher, and must learn generic skills related to the training function. Other supervisors have an innate capability to teach others, but lack the knowledge and skills necessary to effectively transfer information and proficiencies to their staff. Therefore, emphasis was placed on teaching supervisors how to transfer their knowledge to their staff as well as what to include in the content of their transfer of knowledge.

The primary goal of Project Strengthening Supervision was to provide both knowledge and professional skills to child welfare supervisors in order to prepare them and their supervisees more completely to work with substance-affected families. This goal was to be achieved through the implementation of the following project's essential issues:

The three "core" workshops addressed the following:

- **Understanding the "Stages of Change" Model.** Most people who are becoming aware of some aspect of their lives that needs to change follow a relatively consistent process. This process consists of five or six "stages of change". (The sixth stage, termination, is not always relevant to substance abuse recovery). Understanding these stages and knowing which interventions are most effective in each stage can simplify and strengthen the task of assisting a client through the recovery process.

  WORKSHOP: Stages of Change (1/2 day)

- **Using motivational interviewing to reduce client resistance and increase motivation.** Research conducted over the past 20 years indicates that many of the techniques traditionally used to persuade addicted clients to enter treatment – and to assist them through the process of recovery – are often not effective. This is particularly true when the client is "involuntary", in which case the individual is often described as "unmotivated" and "resistant". The technique of motivational interviewing (also referred to as Motivational Enhancement Therapy) is designed to motivate the client, reduce his/her resistance, and allow the client to take a more active role in making treatment decisions.

  WORKSHOP: Motivational Interviewing (1/2 day)

- **Making informed decisions regarding the quality and stability of a parent's addiction recovery program.** The ASFA mandates that permanency and/or parental rights decisions be made in the 12-15 months after a case is opened by the child welfare authority. Yet, recovery from substance abuse is a lifelong process. Child welfare workers need the specific knowledge and skills necessary to make informed decisions in conjunction with the addiction treatment program regarding the quality of a parent's progress in treatment and the stability of their recovery plan.

  WORKSHOP: Advanced Substance Abuse Topics-The Treatment and Recovery Process (2 days)

- **Using a variety of techniques to conduct clinical supervision.** Not all individuals learn in the same way. In order to successfully conduct supervision, a supervisor should have the capability to use the teaching techniques most suited to a particular child welfare worker and that worker's learning style.

  WORKSHOP: Using Non-traditional Methods of Teaching in Clinical Supervision (1 day)

PROJECT GOALS AND OBJECTIVES

- The preeminent goal of this project was to ensure the safety, health and well being of children within substance-affected families.
- Additional goals of this project were:

- To support the policies, practices and changes that are occurring within the child welfare field as the result of ASFA and other recent federal and state legislation.
- To improve the decision-making process among child welfare supervisors in cases where parental substance abuse is an issue.
- To enhance the ability of clinical supervisors to conduct permanency planning in cases in which substance abuse is an identified problem.
- To assist the child welfare supervisor in developing concurrent plans for DCFS-involved children.
- To enhance interdisciplinary cooperation, case management and problem solving between DCFS and POS agencies and providers of substance abuse services.
- To increase referrals from DCFS/POS caseworkers to *Initiative* AODA providers.
- To ensure that addicted DCFS clients are provided with the services and resources necessary to maximize their potential for AODA abstinence and successful recovery.
- To enable child welfare supervisors to transfer the knowledge and skills they developed through project workshops to their subordinates.
- To assist child welfare supervisors in increasing their level of effectiveness in providing supervision to their staff.

Project Objectives. At the conclusion of this series of workshops, the participants should have been able to:

- Clarify his/her personal feelings regarding substance abuse.
- Administer and score an appropriate substance abuse screening tool to a child welfare client suspected of being involved in AODA.
- Identify the five stages of change and provide a brief explanation of each stage.

- Briefly describe two interviewing techniques that are consistent with each stage of change.
- Demonstrate the use of interviewing techniques designed to engage and motivate "involuntary clients."
- Describe the relative importance of pain and hope in motivating a client to enter substance abuse treatment.
- Demonstrate at least two ways in which a child welfare supervisor can use non-traditional methods of teaching in the supervisory process.
- Identify five criteria that can be used to evaluate the status of clients' addiction recovery process.
- Identify at least two types of non-professional recovery support groups or resources other than Alcoholics Anonymous and other "12 step" programs.
- Identify three criteria that can be used to evaluate the nature and/or stability of a client's use of his/her substance abuse recovery support group.
- Describe the potential role of community/indigenous resources in supporting the recovery of an addicted person.
- Define the term "recovery coach" and describe the different ways in which a recovery coach can assist the recovering person in maintaining sobriety and improving his/her psychosocial and parental functioning.
- Briefly describe the four primary levels of substance abuse treatment identified in the ASAM (American Society of Addiction Medicine) *Placement Criteria for the Treatment of Substance-Related Disorders – Second Edition (PPC-2).*
- Identify at least three of the six *PPC-2* dimensions used to make decisions regarding admission to, transfer between, and discharge from different levels of substance abuse treatment.
- Describe a process for continually evaluating the client's progress in treatment from admission to discharge.
- Understand the basic principles of relapse prevention.

- Work effectively with the AODA provider to develop a continuing care plan for recovering clients.
- Describe a process for deciding when a DCFS-involved parent has progressed sufficiently in his/her recovery so that the family may be reunited without risk to the child's safety and well-being.
- Identify factors that interfere with an effective working relationship between the child welfare agency and the substance abuse treatment provider.
- Provide at least one potential solution for each of the factors identified above.
- Describe a process for including the client in the development of expectations within the *Memorandum of Agreement*[1].
- Identify appropriate issues to be discussed with the AODA treatment provider during different phases of the client's treatment.
- Coordinate educational services to DCFS families and significant others regarding the impact of parental substance abuse on children and the family.
- Provide education to the children of DCFS-involved, substance abusing parents regarding what to do if the child feels unsafe and how to implement his/her safety plan.

Curriculum Focus and Content

The complete curriculum and accompanying Power Point presentations are included in the report as Appendix A and Appendix B respectively. Briefly, the focus of the curriculum was divided into three separate training modules with the first emphasizing *Using Stages of Change Theory and Motivational Interviewing with Substance-Affected Families.* This session was presented by Joseph

[1] The Memorandum of Agreement (MOA) is defined by DCFS as "A written agreement of a joint commitment signed by the parent or parents, the DCFS/POS caseworker, and the AODA provider." The MOA specifies the expectations for the parent(s) with respect to AODA treatment, potential consequences of non-compliance, and services that will be made available to the parent to help support him/her in accomplishing these expectations.

Rosenfeld, Psy.D. and Randall Webber, M.P.H. The goal of this workshop was to familiarize participants with the Transtheoretical Stages of Change model developed by Prochaska, Norcross and DiClimente and the concepts and practice of Motivational Interviewing (Motivational Enhancement Therapy) originally developed by Miller and Rollnick.

The second module was a two-day workshop on *Substance Abuse and Child Welfare – Advanced Issues.* This workshop was delivered by William White, M.A. and Randall Webber, M.P.H. The goal of the first part of this module was to provide participants with advanced knowledge regarding important issues related to the use and abuse of illicit drugs and the treatment of addicted individuals. It was divided into three sections with the first one's focus being on signs of client methamphetamine use and caseworker safety. It provided participants with 1) current information concerning the effects of methamphetamine, and 2) knowledge and skills necessary to maintain their safety and well being when working with methamphetamine-involved clients.

The second section involved an Introduction to the American Society of Addiction Medicine (ASAM) *Placement Criteria for the Treatment of Substance-Related Disorders-Version 2* (PPC-2R). This module provided participants with basic familiarity with ASAM and with the ASAM PPC-2R, and with the decision-making process used by substance abuse programs funded by the State of Illinois to place addicted clients in treatment and to discharge and/or transfer them between and from the levels of care.

The third section primarily focused on *Relapse Prevention.* It acquainted participants with issues associated with chemical dependency relapse. The trainer assisted participants with the knowledge and skills needed to identify a comprehensive, individualized relapse prevention plan for clients who are involved in the child welfare system.

A fourth section dealt with the *Drug-Affected Infant and Child.* It 1) acquainted participants with the evolution of scientific research over the past two decades concerning the effect of abused substances on the growth and

development of the fetus, infant and young child, and 2) provided participants with a research update on these topics. Particular emphasis was placed on the effect of maternal cocaine use during the prenatal period on the physical and psychological development and behavior of the infant and child.

A final section of this training module provided participants with advanced knowledge regarding important issues related to the use and abuse of illicit drugs and the treatment of addicted individuals. This session of the Advanced Substance Abuse Issues workshop acquainted participants with 1) essential elements of the substance abuse recovery process; 2) criteria that can assist in the evaluation of clients' progress in recovery; 3) knowledge regarding non-professional support groups and/or resources (other than Alcoholics Anonymous and other "12-step" programs) utilized by recovering individuals to maintain sobriety and improve their psychosocial functioning and parental functioning.

The final module emphasized *Supervision for Optimal Effectiveness*, and was presented by Mark Sanders, L.C.S.W., C.A.D.C. This session focused on the fact that with the issue of substance abuse and addiction among child welfare clients, the supervisor is of utmost importance. This workshop was designed to equip supervisors with additional tools that will enable them to help supervisees work more effectively with addicted clients.

Field-testing and Evaluation of the Curriculum

The training provided in this project was provided at the following sites, as indicated:

2000-2001

June14, 2001-Bloomington	Stages of Change and Motivational Interviewing
August23-24,2001 Bloomington	Advanced Substance Abuse Issues
September27,2001 Bloomington	Supervising for Optimal Effectiveness
October24, 2001-Chicago	Stages of Change and Motivational Interviewing
November 15-16, 2001 Chicago	Advanced Substance Abuse Issues
December 11, 2001 Chicago	Supervising for Optimal Effectiveness

2001-2002

March1,2002 Bloomington	Stages of Change and Motivational Interviewing
April25-26,2002 Bloomington	Advanced Substance Abuse Issues
May 02, 2002-Bloomington	Supervising for Optimal Effectiveness
June 14, 2002- Mt. Vernon	Stages of Change and Motivational Interviewing
July11-12, 2002 Mt. Vernon	Advanced Substance Abuse Issues
August 6,2002-Mt. Vernon	Supervising for Optimal Effectiveness

2002-2003

November08,2002-Skokie	Stages of Change and Motivational Interviewing
December 12-13, 2002 Skokie	Advanced Substance Abuse Issues
January 17, 2003-Skokie	Supervising for Optimal Effectiveness
February03,2003 Bloomington	Stages of Change and Motivational Interviewing
March06-07,2003 Bloomington	Advanced Substance Abuse Issues
April 15, 2003-Bloomington	Supervising for Optimal Effectiveness
May 16, 2003 -Collinsville	Stages of Change and Motivational Interviewing
June12-13,2003 Collinsville	Advanced Substance Abuse Issues
July 11, 2003 -Collinsville	Supervising for Optimal Effectiveness

The final evaluation report that accompanies this report provides specific information on achievement of the objectives cited above. However, a brief review of its conclusions is included here:

- A significant majority of participants involved found *Project Strengthening Supervision* to be "very useful" to "highly useful" in contributing to their job effectiveness; that the training sessions were "fairly well" to "very well" planned, organized, and delivered; the trainers were overwhelmingly see as "very effective" to "highly effective" in their knowledge and training delivery; the training materials were seen to be "mostly applicable" to "highly valuable"; and the content of the training sessions were rated as "mostly applicable" to "highly applicable" to their job activities.

- What appeared to be highlighted by many participants as to what they liked in the trainings were the large and small group participation activities/exercises; opportunities to ask questions; use of videos; case studies or vignettes; personal stories by trainers, real-life experiences or work-related scenarios; real-life applications; written handouts; role playing, and references.
- Participants overwhelmingly recommended the three topical workshops be offered to other professionals with similar job responsibilities.
- In review of all three years' data, it appeared that the *Stages of Change and Motivational Interviewing* workshop provided consistently significant participant knowledge growth from pre-test to post-test. Several problems arose with making comparisons with the other trainings. For example, some of the sessions' pre- and/or post-test data were not available to analyze; and in other cases there were an insufficient number of usable pre- and post-tests available to make any statistical treatment meaningful.
- Respondents reported that the training sessions prepared them in providing more effective supervision of child welfare caseworkers who are working with families in which substance abused has been identified as a major issue.
- Respondents reported that the training sessions enhanced their competencies in several areas in supervising child welfare caseworkers. One competency area most enhanced appeared to be "learning additional strategies and approaches for supervising case workers."
- Respondents reported that their experience from the training impacted their current practices in supervising child caseworkers, particularly in using the "stages of change theory" and "using motivational interviewing."
- It appears that the transfer of learning or application of learning to-the-job was primarily in the form of reading the handout material from the

workshops and sharing information with caseworkers under the supervisor's responsibility.

Pre-Implementation Challenges Anticipated

Several challenges were anticipated prior to the implementation of this project. These are enumerated below and are further addressed in the evaluation report and the *Lessons Learned* section of this report.

- The lack of available time that child welfare supervisors typically report.
- Developing and delivering training events that supervisors believe will reduce the stress levels of both themselves and their staff members, and contribute in a meaningful way to positive child and family outcomes.
- Development of training in concert with DCFS that is truly effective in assisting supervisors and their staff in managing cases in which substance abuse is an issue.
- Delivering training that does not merely present child welfare supervisors with more facts, but instead contributes in a meaningful way to the day-to-day disposition of cases.
- Developing a training plan that provides for an ongoing technology transfer. The Child Welfare League of America has noted that, "training is too often treated as a single injection, rather than an ongoing process that may require an occasional 'booster shot'."
- Implementation of a "concept-to-practice" training plan that includes a focus on supervisory transfer of knowledge and skills to caseworkers.
- Emphasis on teaching supervisors how to train their staff as well as what to include in the content of their training.

Lessons Learned

- **Coordination with DCFS**

  Recruiting Participants. Like most child welfare agencies, DCFS has been under a great deal of pressure to institute changes in practice and policy mandated by the Federal government, the State government, and the changing political entities. Consequently, a myriad of "required" training was pressing upon all employees in Illinois' child welfare system, making it difficult to ensure strong, consistent participation in this "voluntary" training. In the future, it would be ideal if DCFS were able to mandate this type of training for all of its and POS agencies' supervisors.

  Development of the Project Curriculum. The needs, priorities and policies of DCFS must be considered in developing project curricula. It was thought that the utilization of a strong advisory committee made up of highly qualified individuals from within the entirety of the child welfare system in Illinois would ensure this. However, it was not anticipated that the bureaucratic protocol would be a barrier that could hinder the timely progression of a training project like this one. Although ISU ad LI can develop a curriculum with oversight from the advisory committee, because of the bureaucratic structure of DCFS, it is imperative that the protocol is followed from start to finish in order to get the best reception from the Director of DCFS.

- **Selection of Trainers**

  Several criteria were used in selecting PSS trainers. These included knowledge of the professional literature, practical experience with the topic being presented, experience with the Illinois child welfare system, and ability to train effectively. It was very clear that the ability to train effectively was of paramount importance. You can possess the greatest training materials in the world, but if it is to be the most effective, outstanding trainers must deliver it. The quality of the trainers was considered a strength of this project.

- **Standardized Curriculum**

  Developing a standardized curriculum for a multi-year, multiple-workshop training project is a viable goal. It was imperative to recruit a quality Advisory Committee to participate in the curriculum development process. Identifying and recruiting top-quality trainers to deliver project workshops is also viable. Expecting the same trainers to be available at and/or appropriate for every workshop at the time that is most opportune for DCFS purposes is not feasible. This is true for a number of reasons:

  - DCFS' schedule of required training for its employees and employees of POS agencies is extensive and takes precedence over any other training that may be presented by an "outside entity."
  - Because of utilizing trainers that were not employees of one agency, coordination with their schedules can also be a barrier. However, it must be said that the trainers involved in this project were quite accommodating with their personal schedules in order to make this a project a priority for them. This was also evident in their enthusiasm in presenting the training.
  - Even though a standardized curriculum can be developed, the delivery of the curriculum can certainly vary from one presenter to another. Consequently, it is important that any further utilization of this curriculum by others be considered in the context of employing trainers that are capable of effectively presenting the materials. Additions, expansions, adjustments in presentations often take place simply because of the audience and it needs/interactions.

- **Workshop Materials**

  A requirement of all PSS trainers was that they created and made available to participants handout materials which contained copies of all of the presenters' overhead slides as well as detailed notes on all topics addressed in the workshop. Although this is a labor-intensive requirement, the positive response of the participants was evident. All participant

materials were developed by ISU and LI and reviewed and approved by the PAC. They are included with this report as Appendix A (Curriculum) and Appendix B (Power Point Presentations).

It was also evident that the small group atmosphere of the training, current case examples, videos, ample opportunity for questions-and-answers that were individualized, and didactic approach utilized by trainers was a significant benefit of this training.

- **Workshop Marketing and Registration Issues**
  - Although utilization of "combined" lists of contacts within all of the appropriate child welfare agencies in the state was attempted, it is still difficult to cover all of the bases. There were individuals that expressed they could have taken this training, but somehow were not informed of it. Part of the problem exists within the agencies' encouragement of and subsequent communication of these training events to their employees. Part of the problem exists because of the vast child welfare system within the State of Illinois.
  - Providing continuing education units for the certifications and licenses most commonly represented in the child welfare community did help to ensure solid participation.
  - Offering free training does not always guarantee a good participant turnout.
  - Because of offering the training over an extended period of time (4 separate training dates in each training sequence), although deemed best for adult learning purposes, may not ensure that all participants will participate. In other words, just because a person shows up for the first training session does not mean they will return for all of the remaining sessions. However, it does need to be pointed out that several participants were appreciative of this format since it allowed them to utilize the information in practice before coming back for another session.

- **Workshop Follow-up**

  It is clear from the results of the PSS outcome evaluation (discussed fully in the separate Evaluation Report) that although participants enjoyed the workshops and overwhelmingly would have recommended them to others, the long-term training effect was unable to be adequately evaluated. Since funding ends for this type of grant, it is difficult to effectively measure the lasting effects of training beyond the short-term. It would have been helpful to further assess the application of knowledge learned through the training on a longer term with those that participated.

- **Unanticipated Consequences**

  - Because of the involvement of ISU faculty in observation, evaluation, and development of the curricula for the presentation of this training, it was determined that a significant amount of the curriculum could be recommended for incorporation into its graduate and undergraduate social work curriculum. This was particularly true for specific elective courses as well as broadly applicable to the overall curriculum. Since the ISU MSW program is directed primarily to individuals wanting to work with children and families, much of the training content was able to be carried into the classroom. Consequently, this content will be shared with the curriculum committee of the School of Social Work for its review and subsequent introduction where deemed appropriate.
  - Contact with significant entities within the child welfare system in Illinois enabled the School of Social Work to further enhance its stature within the state and the child welfare system at large. Since a new Governor was elected, and subsequently a new Director of DCFS was appointed, it was important to establish credibility with them. Consequently, it was felt that this project's strength was visible and played a part in being quickly accepted by them as indicating an overall viability of ISU's School of Social Work in the child welfare arena.

- A very positive unanticipated, yet greatly appreciated, benefit was the opportunity for supervisors to be heard. Although this is a tenet of good agency management, it is too often a luxury anymore. The exchange between workshop participants and the trainers seemed to allow them to feel valued and gave them an opportunity to present issues that often are not approached in the agency.
- Involvement of the various entities in this project solidified the ability of ISU to continue to be productive in the application for and awarding of similar grants in the future.

APPENDIX

A

CURRICULUM

Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

MOTIVATIONAL INTERVIEWING

Provided through:

Illinois State University
School of Social Work

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J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

Workshop Learning Objectives

At the conclusion of this workshop, participants will be able to:

1. **Describe an operational definition of Motivational Interviewing.**

2. **Discuss the history and importance of Motivational Interviewing in therapeutic settings.**

3. **Identify key terms and concepts.**

4. **Witnessed and practiced Motivational Interviewing techniques.**

I. John Wallace (1974):

A. Addiction and recovery are developmental processes characterized by generally predictable stages and milestones.

B. There are developmental windows of opportunity....

C. Skills and perspectives must be mastered at each stage of recovery before one can move to the next stage.

D. These stages can differ across various clinical sub-populations of addicted clients.

E. Failure in treatment often results from asking clients to do something that they are incapable of at that time.

F. Treatment interventions that are appropriate at one stage of recovery may be ineffective or even harmful at a different stage. (White, 1998).

II. General Principles

A. Express empathy

1. Acceptance facilitates change
2. Skillful reflective listening is fundamental
3. Ambivalence is normal

B. Develop discrepancy

1. Awareness of consequences is important
2. A discrepancy between present behavior and important goals will motivate change
3. The client should present the arguments for change

C. Avoid argumentation

1. Arguments are counterproductive
2. Defending breed defensiveness
3. Resistance is a signal to change strategies
4. Labeling is unnecessary

D. Roll with the resistance

1. Momentum cab be used to good advantage
2. Perceptions can be shifted
3. New perspectives are invited but not imposed

E. Support self-efficacy

1. Belief in the possibility of change is an important motivator
2. The client is responsible for choosing and carrying out personal change
3. There is hope in the range of alternative approaches available

III. The Therapist's Tasks at Each Stage of Change

A. Precontemplation

1. Establish a relationship
   a. Build trust
   b. Ask permission
   c. Be sympathetic
   d. Listen
   e. Don't judge
2. Raise doubts/Create discrepancy between where/who the client wants to be and where s/he actually is.
3. Offer factual information about the client's risks.
4. Explore the pro's and con's of client's behavior/lifestyle.
5. Work with significant others.
6. Maintain the relationship.

IV. Contemplation

A. Explain that being uncertain is normal.

B. Explore the pro's and con's of current behavior/lifestyle.

C. Raise doubts/Create discrepancy between where/who the client wants to be and where s/he is.

D. Focus on the client's strengths; promote self-efficacy and self-esteem.

E. Support pro-treatment statements without arguing about anti-treatment statements.

V. Preparation

A. Help with planning.

B. Work on lowering barriers.

C. Enlist the social support network.

D. Describe the process of treatment.

E. Provide hope.

VI. Action

A. Engage the client in treatment.

B. Don't abandon client if s/he is in treatment elsewhere.

C. Initiate therapy.

D. Educate client.

E. Continue work with social support network.

F. **Reward progress.**

VII. **Maintenance**

A. **Help client identify new sources of pleasure/enhancement of self-esteem.**

B. **Support client's efforts.**

C. **Continue developing client's strengths.**

D. **Maintain your relationship.**

E. **Honestly discuss the possibility of a return to use.**

F. **Watch for emerging issues.**

G. **Continue therapy.**

VIII. **Recycling**

A. **Most people taking action do not successfully maintain their gains on their first attempt.**

B. **Relapse and recycling through the stages occur quite frequently. This "Spiral Model" of change is not linear.**

C. **Outcomes continue to improve over time.**

IX. **Additional Therapist Actions**

A. **Assuming that patient's are in the action phase leads to low utilization and high dropout rates. Develop stage appropriate interventions.**

B. **Match patients to interventions.**

C. **Keep the patient in treatment, and work him/her through the stages; patients who remained in treatment progressed over time.**

D. **Be familiar with using the ten components of the change process (Appendix A).**

X. **FRAMES**

- **F= Patients need to receive *feedback* as to how their drug or alcohol use is affecting them; develop discrepancy.**
- **R= Patients are given the message that they are ultimately *responsible* for their own behaviors, but roll with resistance and avoid argumentation.**
- **A= Patients often seek advice, and should be given *advise* within the context of personal responsibility.**
- **M= Patients can be given a variety (a *menu*) of choices.**
- **E= Use *empathy*.**

- **S= Nurture the patients' *self-efficacy*; their belief that they can change**

XI. Five Early Strategies

A. Ask open-ended questions

B. Listen reflectively

C. Affirm

D. Summarize

E. Elicit self-motivating statements

1. **Problem recognition**
2. **Expression of concern**
3. **Intention to change**
4. **Optimism**

XII. Establishing Rapport at the Outset of Treatment[1]

A. Speak directly, simply, and honestly.

B. Ask about the patient's thoughts and feeling about being in therapy.

C. Focus on the patient's distress.

D. Acknowledge the patient's ambivalence.

E. Explore the purpose and goals of treatment.

F. Discuss the issues of confidentiality.

G. Avoid judgmental comments.

H. Appeal to the patient's areas of positive self-esteem.

I. Acknowledge that therapy is difficult.

J. Ask open-ended questions, then be a good listener.

XIII. Maintaining a Positive Alliance Over the Course of Treatment[2]

A. Ask patients for feedback about every session.

B. Be attentive. Remember details about patients from session to session.

C. Use imagery and metaphors that the patients will find personally relevant.

D. Be consistent, dependable, and available.

E. Be trustworthy, even when the patient is not.

F. Remain calm and cool in session, even if the patient is not.

G. Be confident, but be humble.

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[1] Cory F. Newman, in Onkin, Blaine, & Boren (1997); p. 183.
[2] Cory F. Newman, in Onkin, Blaine, & Boren (1997); p. 191.

H. **Set limits in a respectful manner.**

XIV. **Implications For Training**[3]

A. **Pave the way for a productive client-therapist relationship with the assumption that the client is a reasonable person, but is currently stuck in a difficult situation.**

B. **Deliberately adopt a collaboration metaphor for therapy.**

C. **Teach therapists the process of therapy very early in training. Teach them first to be effective, supportive listeners, instead of teaching diagnosis first.**

D. **Encourage beginning therapists to take seriously the perspective of the problem that the client offers.**

E. **Encourage them to expect that the client will get better.**

F. **The goal of therapy is to support the client's efforts so they can leave therapy and be effective problem solvers on their own.**

G. **Therapists can learn how to recognize and reverse deteriorating therapeutic relationships.**

H. **There are a number of skills and attitudes involved in retaining clients. These can be taught.**

[3] Numbers one through six are derived from Hubble, Duncan, & Miller (1999); p. 121.

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Website

http://www.motivationalinterview.org THE website regarding motivational interviewing: includes a discussion forum, comprehensive bibliography, and lists of training opportunities.

Appendix A

Interventions in the Process of Change[4]

- ☆ **Consciousness raising,- Increasing information about self and problem: observations, confrontations, interpretations, and bibliotherapy. (Precontemplation)**

- ☆ **Dramatic relief,- Experiencing and expressing feelings about one's problems and solutions: psychodrama, grieving losses, role-playing. (Precontemplation)**

- ☆ **Environmental reevaluation,- Assessing how one's problem affects one's physical environment: empathy training, documentaries. (Precontemplation)**

- ☆ **Self-reevaluation,- Assessing how one feels and thinks about oneself with respect to a problem: value clarification, imagery, and corrective emotional experience. (Contemplation)**

- ☆ **Self-liberation,- Choosing and committing to act on a belief in the ability to change: decision - making therapy, New Year's resolutions, logotherapy techniques, and commitment enhancing techniques. (Preparation)**

- ☆ **Counterconditioning,- Substituting alternatives for problem behaviors: relaxation, desensitization, assertion, and positive self-statements. (Action)**

- ☆ **Stimulus control,- Avoiding or countering stimuli that elicit problem behaviors: restructuring one's environment, avoiding high-risk cues, fading techniques. (Action)**

- ☆ **Reinforcement management,- Rewarding one's self or being rewarded by others for making changes: contingency contracts, overt and covert reinforcement, self-reward. (Action)**

- ☆ **Helping relationships,- Being open and trusting about problems with someone who cares: therapeutic alliance, social support, and self-help groups. (Action)**

- ☆ **Social liberation,- Increasing alternatives for non-problem behaviors available in society: advocating for the rights of the oppressed, empowering, and policy interventions. (Maintenance)**

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[4] Prochaska, DiClemente, & Norcross(1992)

Appendix B

Twelve Kinds of Responses That are Not Listening[5]

1. **Ordering, directing, or commanding**
2. **Warning or threatening**
3. **Giving advise, making suggestions, or providing solutions**
4. **Persuading with logic, arguing, or lecturing**
5. **Moralizing, preaching, or telling clients what they "should" do**
6. **Disagreeing, judging criticizing, or blaming**
7. **Agreeing, approving, or praising**
8. **Shaming, ridiculing, or labeling**
9. **Interpreting or analyzing**
10. **Reassuring, sympathizing, or consoling**
11. **Withdrawing, distracting, humoring, or changing the subject**

[5] Thomas Gordon (1970)

Appendix C

Reflective Techniques[6]

1. **Simple reflection**
   - **Simple acknowledgement**
2. **Amplified reflection**
   - **Amplified or exaggerated form**
3. **Double sided reflection**
   - **Present the other side**
4. **Shifting focus**
5. **Agreement with a twist**
6. **Emphasizing personal choice**
7. **Reframing**

[6] William Miller and Stephen Rollnick (1991)

Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

TRANSTHEORETICAL STAGES OF CHANGE

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

I. PRINCIPLE THEORIES OF PSYCHOTHERAPY

THEORY	NOTABLE FIGURES	PRIMARY PROCESSSES OF CHANGE
Psychoanalytic	Freud Jung	Consciousness-raising Emotional arousal
Humanistic/ Existential	Carl Rogers Rollo May	Social Liberation Commitment Helping Relationships
Gestalt- Experiential	Fritz Perls Arthur Janov	Self-reevvaluation Emotional Arousal
Cognitive	Albert Ellis	Countering Self-reevaluation
Behavioral	B.F. Skinner Joseph Wolpe	Environmental Control Rewards Countering

II. TRANSTHEORETICAL STAGES OF CHANGE

A. The stage construct is the key organizing construct of the model.

B. This is important in part because it represents a temporal dimension

1. Change implies phenomena occurring over time.
2. Other theories of change conceive of change as an event (e.g., quitting smoking, drinking, etc.)
3. The Transtheoretical Model construes change as a process involving progress through a series of five stages.

III. PHILOSOPHYOF THE TRANSTHEORETICAL STAGES OF CHANGE (Prochaska, Norcrosse & DiClemente)

A. Time-Dependent

B. Perspectives, Skills, Tasks

C. Change is Stage-Dependent

D. Interventions-Must be Stage Appropriate

E. Any movement from one stage to another is progress

IV. THE STAGES OF CHANGE

A. Pre-contemplation ("Resisting change")

B. Contemplation ("Change on the horizon")

C. Preparation ("Getting ready")
D. Action ("Time to move")
E. Maintenance ("Staying there")
F. Termination ("Ending the cycle of change")

V. PRE-CONTEMPLATION

It is not that they can't see the solution. It is that they can't see the problem
- G.K. Chesterton

Most precontemplators don't want to change themselves, just the people around them
-Prochaska, DiClemente & Norcrosse (*Changing for Good*)

A. Individual may or may not be aware that a problem exists
B. Lacks information about problem
C. Often coerced into treatment by S.O., court, work
D. Often wants others to change (e.g., stop nagging)
E. Precontemplation = not considering change

1. Sees no reason to change
2. Refuses to change
3. Afraid to change
4. Actively resists change
5. Passively resists change
6. Has decided not to change

F. Change is not anticipated within the next six months
G. Denial is common
H. Typical statement: "Problem? What kind of problem?"
I. Counselor response: Do not challenge lack of awareness
J. Advise S.O.'s to not enable
K. Questions to ask precontemplators (Goal: patient will begin thinking about change.

- "What would have to happen for you to know that this is a problem?"
- "What warning signs would let you know that this is a problem?"
- "Have you tried to change in the past?"

VI. CONTEMPLATION

A. Client begins to realize that a problem exists
B. Clients trying to understand problem
C. May be aware that there are solutions to the problem, but is "not ready"
D. Support from others often low
E. Client is

1. Ambivalent about change
2. Sees advantages in both the current behavior and the new behavior
3. Sees disadvantages in both the current behavior and the new behavior

F. Typical client statements:

- "I think I have a problem"
- "Maybe this is worse than I thought"

G. Transition from this stage marked by:

1. Thinking more about solution than problem
2. Focusing more on future than present

H. Client intends to make a change within the next six months

I. Questions to ask contemplators (Goal: patient will examine benefits and barriers to change.)

- "Why do you want to change at this time?"
- "What would keep you from changing at this time?"
- "What are the barriers today that keep you from change?"
- "What things (people, programs and behaviors) have helped in the past?"
- "What would help you at this time?"
- "What do you think you need to learn about changing?"

VII. PREPARATION

A. Most people in the preparation stage are planning to take action within the next month

B. Client begins talking to friends, family, co-workers, counselor about "What works?"

C. Client "shopping around" for the best way to change his/her AOD pattern

D. Has resolved most or all of the ambivalence about change, but remnants may remain

E. Willing to accept advice and direction

F. Anxious about the new behavior—seeks reassurance

G. Some small changes may already have been made

H. Important step is making public intention to change

I. Client may appear ready to take action, but some ambivalence often lingers

J. Typical client statements:

- "How did you do it?"
- "Maybe I should try an A.A. meeting"

K. Plan of action is developed

L. Support from others may be low prior to plan development

M. Premature move into action phase may be counterproductive

N. Change is occurring, but it is less visible

1. attitude/thinking
2. awareness
3. emotions
4. self-image

O. This is the population from which participants for action-oriented programs should be recruited.

VIII. ACTION

A. Client begins trying to change
B. Change has been initiated within the last six months
C. This phase requires more commitment of time and energy
D. Support from others is often high due to visibility of change process
E. Typical client statements:
   - "I'm going to do something about my drinking"
   - "I'm going to an A.A. meeting tonight"
   - "I have an appointment to see a counselor"

IX. MAINTENANCE

A. Primary goals:
   1. maintain changes
   2. work to prevent lapses and relapses
B. Less of a phase or stage than a long-term commitment
C. Support from others often high

X. TERMINATION

A. The ultimate goal of the change process
B. Occurs when:
   1. behavior in question is no longer a temptation or threat
   2. individual can cope without fear of relapse
C. This stage is not always a realistic goal

XI. MOVEMENT BETWEEN STAGES

A. Many individuals who enter the action and/or maintenance stages will relapse, but most will not regress completely (to the precontemplation stage)

XII. INTERMEDIATE & DEPENDENT MEASURES

A. Many change models involve only a single univariate outcome measure of success
   1. Complete cessation of smoking, drinking and total abstinence
   2. Loss of 30 lbs.
B. Univariate measures:
   1. have a low degree of power (the ability to detect change)
   2. are not sensitive to change over all the possible stage transitions (e.g., contemplation to preparation)

C. The Transtheoretical Model

1. proposes a set of constructs that form a multivariate outcome space
2. includes measures that are sensitive to progress through all stages.
   a. Multivariate = There is more than one possible measure
   b. The measures indicate progress throughout the stages, not just in the action phase.

XIII. DECISIONAL BALANCE

A. Reflects the person's relative weighing of the pros and cons of changing.

B. There is a predictable pattern of how pros and cons are seen in the various stages

XIV. SELF-EFFICACY MEASURE

A. Situation specific confidence that people have that they can cope with high-risk situations without relapsing to their unhealthy or high-risk habit

➢ *"Can I do this?"*

B. A sense of self-efficacy is positively related to the probability that the individual will be able to make and sustain desired changes

C. The therapist's belief in the client's self-efficacy is also positively related to the probability that the individual will be able to make and sustain desired changes

XV. SITUATIONAL TEMPTATION MEASURE

A. Reflects the intensity of urges to engage in a specific behavior when in the midst of difficult situations.

➢ *Will I be able to resist?*

B. The converse of self-efficacy

C. The same set of items can be used to measure both self-efficacy and temptation, using different response formats.

XVI. PROCESSES OF CHANGE

A. The covert and overt activities that people use to progress through the stages

B. The independent variables that people need to apply, or be engaged in, to move from stage to stage

C. Nine processes of change that have received the most research:

1. Four "experiential" (primarily early stage)
2. Five "behavioral" (primarily later stage)

D. Experiential Processes

1. Consciousness Raising [Increasing awareness]
   a. increased awareness about the causes, consequences and cures for a particular problem behavior.

b. Interventions that can increase awareness include:

1. feedback
2. education
3. confrontation
4. interpretation
5. bibliography
6. media campaigns

c. Typical client statements

- I recall information people gave me about how to stop using drugs
- I did not realize that tobacco smoking could age my skin

2. Dramatic Relief [Emotional arousal]

a. Initially produces increased emotional experiences followed by reduced affect if appropriate action can be taken.

b. Interventions that can produce dramatic release include:

1) psychodrama
2) role playing
3) grieving
4) personal testimonies
5) media campaigns

c. Typical client statement:

- I react emotionally to TV programs about parental drug use
- That movie about children in a drug-using home made me ashamed of being an addict

3. Social Liberation [Environmental opportunities]

a. Community support for change

b. Increase in social opportunities

c. Alternative opportunities

1. Drug-free housing
2. No smoking policies
3. Salad bars in school lunches
4. Easy access to condoms and other health-related products

d. Typical client statement:

- I have noticed society changing in ways that make drug use less acceptable

4. Self Reevaluation [Self reappraisal]

a. Combines both cognitive and affective assessments of one's self-image with and without a particular unhealthy habit

1. Value clarification

2. healthy role models
3. imagery

b. Typical client statement

- My addiction to heroin makes me feel like I don't deserve to live
- I know I would be happier if I quit using heroin

E. BEHAVIORAL PROCESSES

1. Stimulus Control [Re-engineering]

a. Removes cues for unhealthy habits and adds prompts for healthier alternatives.

1) Avoidance
2) Cue desensitization
3) Strategies for dealing with unavoidable triggers
4) Environmental re-engineering
5) Self-help groups

b. Typical client statement

- I have removed things from my house that remind me of cocaine

2. Helping Relationship [Supporting]

a. Combine caring, trust, openness and acceptance as well as support for the healthy behavior change.

1) Rapport building
2) Therapeutic alliances
3) Counselor calls
4) Buddy systems

b. Typical client statement

- I have someone who listens when I need to talk about my addiction

3. Counter Conditioning [Substituting]

a. Requires the learning of healthier behaviors that can substitute for problem behaviors

1) Relaxation can counter stress
2) Assertion can counter peer pressure
3) Exercise can counter craving

b. Typical client statement

- I find that exercise helps me to not think about using

4. Reinforcement Management [Rewarding]

a. Provides consequences for taking steps in a particular direction

b. Rewards are emphasized (rather than punishments)

1) Contingency contracts
2) Overt and covert reinforcements
3) Positive self-statements
4) Group recognition

c. Typical client statement

- I reward myself when I don't use

5. Self Liberation [Committing]

a. Both the belief that one can change and the commitment and recommitment to act on that belief.

- *I make commitments not to use drugs or drink*

b. Self-liberation can be enhanced by

1) New Year's resolutions
2) Public testimonies
3) Multiple rather than single choices

c. Typical client statement

- I have made a public commitments not to smoke

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READINESS TO CHANGE RULER

NOT PREPARED TO CHANGE **ALREADY CHANGING**

- If your mark is on the left side of the line:

  How will you know when it is time to think about changing?
  What signals will tell you to start thinking about change?
  What qualities in yourself are important to you?
  What connection is there between those qualities and "not considering a change"?

- If your mark is somewhere in the middle:

  Why did you put your mark there and not further to the left?
  What might make you put your mark a little more to the right?
  What are the good things about the way you're currently trying to change?
  What are the not-so-good things?
  What would be the good result of changing?
  What are the barriers to change?

- If your mark is on the right side of the line:

  Pick one of the barriers to change and list some things that could help you overcome this barrier
  Pick one of those things that could help and decide to do by _____ (write in a date)

- If you're changing and trying to maintain that change:

  Congratulations! What is helping you?
  What else would help?
  What are your high-risk situations?

- If you've "fallen off the wagon":

  What worked for a while?
  Don't kick yourself-long term change almost always takes a few cycles
  What did you learn from the experience that will help you when you give it another try?

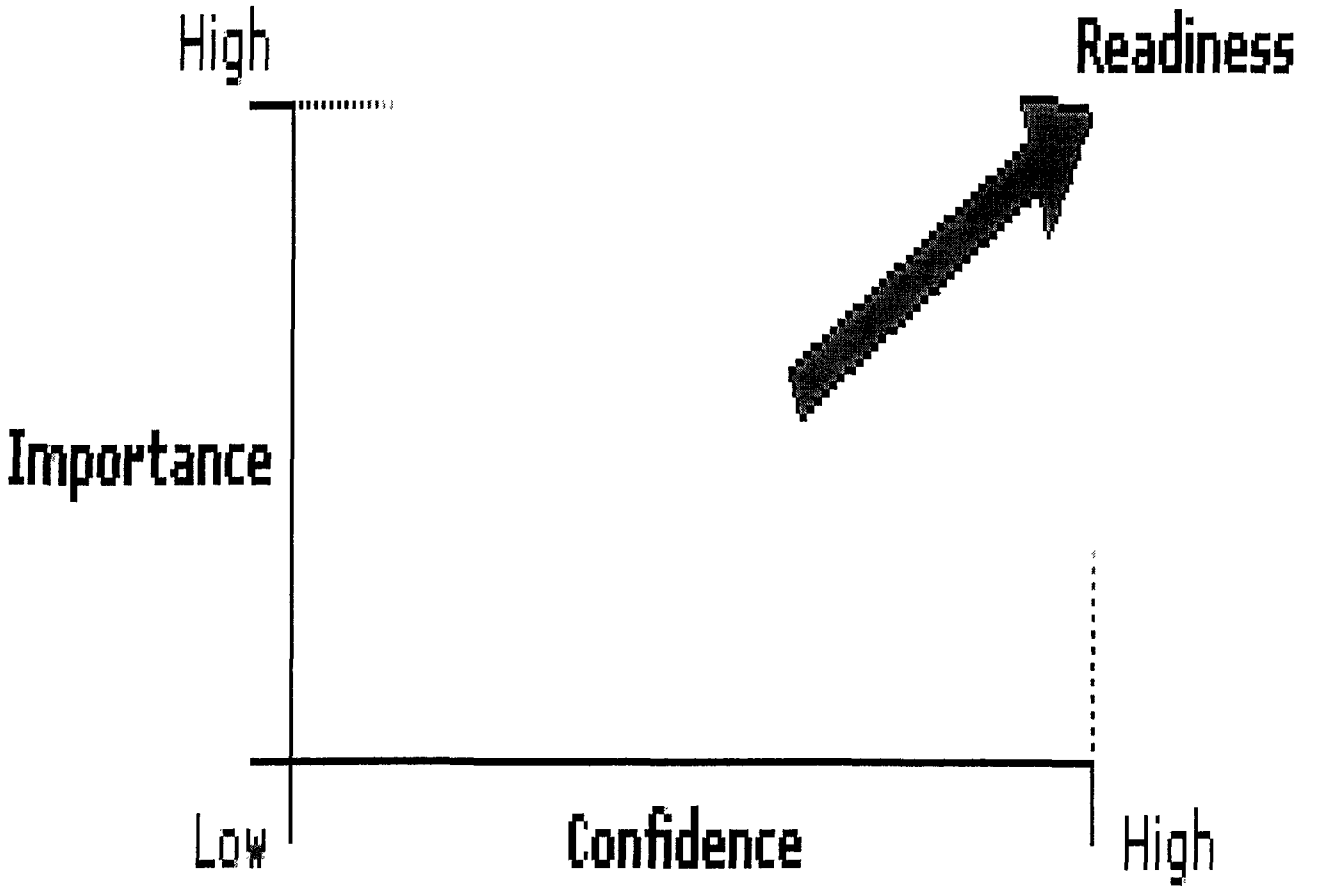
DECISIONAL BALANCE 1

	Pros	Cons
Effects on me		
Effects on others		
How will I feel about myself?		
How will others see me or feel about me?		

DECISIONAL BALANCE 2

	Immediate Consequences		Delayed Consequences	
	Positive	Negative	Positive	Negative
To Change				
Not to Change				

CONFIDENCE V READINESS TO CHANGE



DECISIONAL BALANCE: ALCOHOL AND DRUG USE

How important to you at the present time is each of the following statements. Please rate your level of importance on the following 5 point scale from not important at all (1) to extremely important (5). Your rating should reflect how important each statement is in your decision whether to drink or use drugs at the present time.

If you have not used any drug except alcohol, fill in the column on the right only. If you have used both alcohol and drugs, rate the statements for their importance to your drinking in the column on the right and for your drug use in the column on the left. Please answer every question

1 = Not Important
2 = Slightly Important
3 = Moderately Important
4 = Very Important
5 = Extremely Important

How Important To You In Making a Decision About Drug Taking?		How important To You In Making a Decision About Drinking?
_____	Drinking or taking drugs relaxes me	_____
_____	Drinking or using drugs is bad for my health	_____
_____	I am more pleasant to be around when I'm drinking or taking drugs	_____
_____	My drinking or drug use causes problems with others	_____
_____	I like myself better when I am drinking	_____
_____	I'm foolish to ignore the warnings about the problems caused by alcohol or drugs	_____
_____	Being able to hold your liquor is a tradition in my family	_____
_____	Because I continue to drink or use drugs, some people think I lack the character to quit	_____
_____	Drinking or using drugs helps me deal with problems	_____
_____	I often wake up feeling "hungover" or sick	_____
_____	If I try to stop drinking or using drugs I'll probably be irritable and a pain to be around	_____
_____	People close to me would suffer if I become ill from drinking or using drugs	_____
_____	By continuing to drink or use drugs I feel I am making my own decisions	_____
_____	Having to lie to others about my drinking or drug use bothers me	_____
_____	I would lose my friends if I stopped drinking or using drugs	_____
_____	Some people try to avoid me when I drink or use drugs	_____
_____	Drinking or using drugs helps me to have fun and socialize	_____
_____	Drinking or drug use interferes with my functioning at home	_____

Scoring

Pro Subscales

Utility To Self: #1, 9, 17, 25, 33, 37
Utility To Others: #3, 11, 19, 27
Self-Approval: #5, 13, 21, 29, 35
Others Approval: #7, 15, 23, 31, 39
Special Items: #41, 42

Con Subscales

Utility To Self: #2, 10, 18, 26, 34, 38
Utility To Others: #4, 12, 20, 28
Self-Approval: #6, 14, 22, 30, 36
Others Approval: #8, 16, 24, 32, 40

Alcohol: Self-Efficacy

How tempted you may be to drink in each situation?

Enter the number in the box that best describes the feelings of temptation in each situation at the present time according to the following scale:

1 = Not at all tempted
2 = Not very tempted
3 = Moderately tempted
4 = Very tempted
5 = Extremely tempted

1. When I am concerned about someone _____
2. When I see others drinking at a bar or at a party _____
3. When I am very worried _____
4. When I am in agony because of stopping or withdrawing from alcohol use _____
5. When I have the urge to try just one drink to see what happens _____
6. When I dream about taking a drink _____
7. When people I used to drink encourage me to drink _____
8. When I sense everything is going wrong for me _____
9. When I am physically tired _____
10. When I am feeling depressed _____
11. When I feel like blowing up because of frustration _____
12. When I experience an urge or impulse to take a drink that catches me unprepared _____
13. When I am feeling angry inside _____
14. When I am experiencing some physical pain or injury _____
15. When I want to test my willpower over drinking _____
16. When I am being offered a drink in a social situation _____
17. When I am excited or celebrating with others _____
18. When I am on vacation and want to relax _____
19. When I am feeling a physical need or craving for alcohol _____
20. When I have a headache _____

How confident are you that you would not drink in each situation?

Enter the number in the box that best describes the feeling of confidence in each situation at the present time according to the following:

1 = Not at all confident
2 = Not very confident
3 = Moderately confident
4 = Very confident
5 = Extremely confident

1. When I am in agony because of stopping or withdrawing from alcohol use _____
2. When I have a headache _____
3. When I am feeling depressed _____
4. When I am on vacation and want to relax _____
5. When I am concerned about someone _____
6. When I am very worried _____
7. When I have the urge to try just one drink to see what happens _____
8. When I am being offered a drink in a social situation _____
9. When I dream about taking a drink _____
10. When I want to test my willpower over drinking _____
11. When I am feeling a physical need or craving for alcohol _____
12. When I am physically tired _____
13. When I am experiencing some physical health or injury _____
14. When I feel like blowing up because of frustration _____
15. When I see others drinking at a bar or at a party _____
16. When I sense everything is going wrong for me _____
17. When people I used to drink with encourage me to drink _____
18. When I am feeling angry inside _____
19. When I experience an urge or impulse to take a drink that catches me unprepared _____

STAGE OF CHANGE ASSESSMENT

BEHAVIOR _____

1. Are you considering changing this behavior in the next six months?[1]
2. Are you planning to change this behavior in the next month?[2]
3. Are you now actively changing this behavior?

Question 1	No	Yes	Yes	Yes
Question 2	No	No	Yes	Yes
Question 3	No	No	No	Yes
Your Stage	Precontemplation	Contemplation	Preparation	Action

[1] If you are planning to change this behavior in the next one month or are already changing, answer "Yes"
[2] If you are already changing, answer "Yes"

Alcohol Temptations

Listed below are situations that can lead some people to drink a lot or more than they should. Select the answer that best corresponds to how tempted you are to drink a lot in the following situations

1 = Not at all Tempted
2 = Not Very Tempted
3 = Somewhat Tempted
4 = Very Tempted
5 = Extremely Tempted

1. When I am excited _____
2. When I am with others who are drinking a lot _____
3. When things are not going my way and I am frustrated _____
4. When I am really happy _____
5. When my friends push me to keep up with their drinking _____
6. When I am feeling depressed _____
7. When I am having fun with friends _____
8. When others people encourage me to have a drink _____
9. When I am very anxious and stressed _____
10. When I am offered a drink by someone _____
11. When I am feeling angry _____
12. When things are going really well for me _____
13. If I go to a party where there is a lot of drinking _____
14. When I am anxious about sex _____
15. When there are drinking games going on _____
16. When I have my feelings hurt _____
17. When I am with someone I am attracted to _____
18. When I am with others who are focusing on drinking _____
19. When I am feeling shy _____
20. When I feel like keeping up with my friends' drinking _____
21. When I am nervous about being socially outgoing _____

Scoring

Scores from these 21 items can be summed to compute a global temptations scale.

Four subscales exist for this scale:

Peer Pressure: Items 2,5,8,10,13,15,18,20
Negative Affect: 3,6,9,11,16
Positive/Social: 1,4,7,12
Social Anxiety: 14,17,19,21

Two comparable 8 item short forms have been constructed to compute global temptations
Form A: Items 4,6,7,13,14,16,18,21
Form B: Items: 1,3,8,9,12,15,17,19

Note: This instrument has been developed on non-dependent drinkers and should not be used with dependent populations until further psychometric validations have been conducted. Information regarding the reliability and validity of this instrument can be obtained from Dr. Maddock.

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CONSCIOUSNESS-RAISING SELF ASSESSEMENT

1= Never 2=Seldom 3=Occasionally 4=Often 5=Repeatedly

FREQUENCY:

_____ I look for information related to my problem behavior

_____ I think about information from articles and books on how to overcome my problem

_____ I read about people who have successfully changed

_____ I recall information that people have personally given me about the benefits of changing my problem

_____ = Score

KEY: 1-10= precontemplation 10+ = contemplation or further

Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

SIGNS OF CLIENT METHAMPHETAMINE USE AND CASEWORKER SAFETY PROCEDURES

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

SIGNS OF CLIENT METHAMPHETAMINE USE
AND
CASEWORKER SAFETY PROCEDURES

Workshop Goal: To provide participants with the knowledge and skills necessary to maintain their safety and well being when working with methamphetamine-involved clients.

Learning Objectives: At the conclusion of this workshop, participants will be able to:

- **Describe the dangers associated with being in proximity to methamphetamine users and "chemists."**
- **Identify potential signs of methamphetamine use in child welfare clients**
- **Identify signs that methamphetamine is being "cooked" in or around the client's home**
- **Develop a plan that ensures to the greatest extent possible the safety of the child welfare worker in settings where methamphetamine is being used or "cooked."**

I. Risks associated with the use of methamphetamine

1. Cardiovascular emergencies (e.g., heart attack, coronary artery spasm)
2. Cerebrovascular accident ("stroke")
3. Seizures
4. Hyperthermia
5. Depression (following use)
6. Stimulant psychosis/paranoia
7. Spontaneous recurrences of methamphetamine (MAP)-induced paranoid-hallucinatory states ("flashbacks": Ishiguro, Ikemoto & Kamata, 1999)
8. Memory impairment (possible)
9. Damage to serotonin neurons (possible)

II. Risks associated with the manufacture ("cooking") of methamphetamine

1. Explosion
2. Fire
3. Respiratory problems, up to and including permanent damage
4. Chemical burns
5. Contact with potentially violent chemist(s)/illegal subculture
6. Stimulant psychosis associated with chemist's use of methamphetamine

III. Signs of client methamphetamine use

A. Increased breathing and pulse rate
B. Sweating
C. Rapid/pressured speech
D. Euphoria
E. Hyperactivity
F. Dry mouth
G. Tremor (shaking hands)
H. Dilated pupils
I. Lack of appetite
J. Insomnia/lack of sleep
K. Bruxism (teeth-grinding)
L. Depression ("the crash"-occurs when drug wears off)
M. Irritability, suspiciousness, paranoia
N. Visual and auditory hallucinations
O. Formication ("coke bugs")
P. Presence of white powder, straws, injection equipment

IV. Signs that methamphetamine is being manufactured in the client's home

A. Laboratory equipment
B. Large quantity of pills containing ephedrine or pseudoephedrine (e.g., Tedral®, Primatene®/ Sudafed®)
C. Chemical odor
D. Chemicals not commonly found in a home

1. Red phosphorus

2. Acetone
3. Liquid ephedrine
4. Ether
5. Iodine
6. P2P (phenyl-2-propanone)

E. Unusually high quantities of household chemicals

1. Lye
2. Drano®
3. Paint thinner

F. Chemicals usually found on a farm (e.g., anhydrous ammonia)
G. Residue from "cooking" of methamphetamine

V. Indications of potential/impending client violence toward the child welfare worker

A. Signs of methamphetamine use
B. Client is extremely irritable and/or argumentative
C. Escalation of client irritability, anger
D. Regular client does not appear to know who you are
E. Evidence of client paranoid thinking, delusions
F. Client verbalizes implicit or explicit threat against caseworker
G. Presence of knife, firearm or other weapon in the immediate vicinity

VI. Recommendations for ensuring safety while in proximity to meth users/Components of a safety plan

A. Inform supervisor/co-worker(s) that you will be visiting a client with a history of making/using methamphetamine
B. Arrange for someone to check on you if you do call in by _____
C. If you feel unsure of your safety, leave
D. Do not let client get between you and an exit
E. Park car so that you can not be boxed in
F. Do not argue with or antagonize client
G. Do not position yourself in the client's peripheral vision area or where the client can not see you.
H. Do not move suddenly
I. Tell the client what you are doing and why
J. Ask permission if you want to go to another area of the client's dwelling or look in cabinets (e.g., to ensure food is in the house)
K. Watch for:

1. Symptoms of stimulant use
2. Methamphetamine paraphernalia
3. Signs that client is becoming upset, angry or suspicious
4. Scratch marks or scabs, particularly on client's hands and arms (may be evidence of tactile hallucinations [formication] and indicate a prior episode of stimulant psychosis)

5. **Evidence of hallucinations**
6. **Strong chemical odor (may indicate manufacturing of meth)**
7. **Other indicators (see section IV above)**

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Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) PATIENT PLACEMENT CRITERIA, 2ND EDITION-REVISED

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

Learning Objectives

At the conclusion of this workshop, participants will be able to:

- Demonstrate familiarity with the American Society of Addiction Medicine (ASAM) and the ASAM Patient Placement Criteria, 2nd Edition-Revised (PPC-2R)
- Describe the levels of care concept
- Identify the five major levels of care
- List the six PPC-2R dimensional criteria
- Describe the admission, transfer and discharge decision-making process

I. ASAM PPC-2R

- Changes from PPC-2
  - Meets needs of clients regardless of the availability of third-party reimbursement
  - Responds to the concerns of "public sector treatment programs"
  - No longer focused exclusively on levels of care (LOC) in "traditional programs"
  - Provides greater access to care for 1) dual diagnosis clients, 2) unmotivated clients who are mandated into treatment, 3) clients who had previously only had access to care if they agreed to be in a high-intensity LOC.
  - Takes into account the use of cognitive behavioral strategies, such as motivational interviewing and the stages of change model
  - Changes focus of treatment decision making from program-driven to clinically-driven
  - Emphasis on variable rather than fixed length of service

II. PPC-2R LEVELS OF CARE

- Level 0.5 (Early Intervention)
- Level I: Outpatient Services (Low Intensity)
- Level II: Intensive Outpatient/Partial Hospitalization
- Level III: Inpatient/Residential Treatment
- Level IV: Medically-Managed Intensive Inpatient/Residential Treatment
- Opioid Maintenance Therapy (actually a service rather than a level of care)

III. LEVEL 0.5 (Early Intervention)

- For clients who, for a known reason, are at risk of developing substance-related problems or For those for whom there is not yet sufficient information to document a substance-related disorder

IV. LEVEL I: (Low intensity outpatient services)

- Organized services that can be delivered in a variety of settings
- Services provided in regularly-scheduled sessions and follow a defined set of policies and procedures or medical protocol
- Includes services to persons who would previously have been turned away as not ready for treatment or in denial
- Some clients in level I may be more appropriate for a higher level due to the severity of their addiction, but placement in a higher level would have "hardened their resistance"

V. LEVEL II: (Intensive outpatient/partial hospitalization)

- Organized outpatient programs that deliver services during the day, before or after school or work, in the evenings, and/or on weekendsProvide essential educational and treatment services while allowing clients to apply their newly acquired skills within "real world" settings
- Have the capacity to arrange for medical, psychiatric and psychopharmacological consultation, Rx management and 24-hour crisis services
- Maintain active affiliations with other levels of care
- Can help clients access support services such as child care, vocational training and transportation.

VI. LEVEL III: (Inpatient/residential treatment)

- Provides a planned regimen of care within a 24-hour live-in setting
- Services adhere to a defined set of policies and procedures
- Housed in or affiliated with permanent facilities in which clients can reside safely.
- Staffed 24 hours a day
- Mutual aid and self-help groups usually provide on-site
- Four subcategories of Level III Services
  - III.1 Clinically-managed low-intensity residential treatment
  - II.3 Clinically-managed medium-intensity residential treatment
  - Level III.5 Clinically-managed high-intensity residential treatment

- Level III.7 Medically-monitored inpatient treatment

- Primary Issue in Level III Services
  - The most important characteristic of Level III services is that they serve persons who need a safe and stable living environment in order to develop their recovery skills.

VI. LEVEL IV: Medically-managed intensive residential/inpatient treatment

- Provides a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance abuse disorders in an acute care patient setting.
- Staffed by designated addiction-credentialed physicians (including psychiatrists) as well as other mental health and addiction-oriented clinicians.
- Intended for persons whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care.
- Treatment is provided 24 hours a day
- The full resources of a general acute care hospital or psychiatric hospital are available
- The staffing and availability of support services allow for the conjoint treatment of co-occurring biomedical problems.

VIII. OPIOID MAINTENANCE THERAPY

- A separate service that can be provided at any level of care.
- Currently, methadone is the only opioid that is approved for use in maintenance therapy.
- Approval of buprenorphine, with or without naloxone, is being considered by the U.S. FDA

IX. PPC-2R Criteria Used to Decide LOC

- Diagnosis
- Dimensional Criteria
  - Acute intoxication and withdrawal potential
  - Biomedical conditions and complications
  - Emotional/Behavioral or cognitive conditions and complications
  - Readiness to Change
  - Relapse, continued use or continued problem potential
  - Recovery/living environment

X. Acute Intoxication/withdrawal Potential

- Goals of care
  - Avoidance of the potentially hazardous consequences of discontinuation of alcohol and other drug dependence
  - Facilitation of the client's completion of detoxification and linkages and timely entry into continued medical, addiction or mental health treatment or self-help recovery as indicated
  - Promotion of client dignity and easing of patient discomfort during the withdrawal period
- Assessment considerations include:
  - What risk is associated with the client's current level of acute intoxication?
  - Is there significant risk of severe withdrawal symptoms?
  - Are there current signs of withdrawal?
  - Does the client have supports to assist in ambulatory withdrawal if medically safe?

XI. Biomedical Conditions & Complications

- Assessment considerations
  - Are there current illnesses, other than withdrawal, that need to be addressed because they create risk or may complicate treatment?
  - Are there chronic conditions that affect treatment?

XII. Emotional, Behavioral or Cognitive Conditions & Complications

- Assessment considerations
  - Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?
  - Are there chronic conditions that affect treatment?
  - Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?
  - Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous?
  - Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?

- Is the client able to manage the activities of daily living?
- Can the client cope with any any emotional, behavioral or cognitive problems?
- It is important to note that, when assessing co-occurring disorders, a mental health or substance-related disorder should be considered secondary only if it shows improvement as a result of stabilization in the other disorder.

XIII. READINESS TO CHANGE

- In PPC-2, known as "treatment resistance or acceptance"
- Reflects the importance of the "Stages of Change" model.
- Resistance to treatment "not unexpected" and does not automatically exclude a client from receiving treatment
- The degree of readiness is what determines the setting for and intensity of motivating strategies
- Moves the criteria in this dimension beyond the concepts of denial and resistance.

XIV. RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

- In PPC-2, was "Relapse/Continued Use Potential"
- Renamed in order to include mental health issues
  - Example: Addicted schizophrenic who refuses medication and is thus at risk for substance abuse relapse
- Assignment of LOC after relapse should be made on basis of BOTH history and assessment of current problems.
- Client is not automatically assumed to need a higher LOC than the one at which relapse occurred.
- Assessment indicators:
  - Is the client in immediate danger of continued severe mental health distress and/or AOD use?
  - Does client have any recognition or understanding of, skills in coping with, his or her addictive or mental health disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior?
  - How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?
  - How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or

others?

XV. RECOVERY/LIVING ENVIRONMENT

- Assessment Considerations:
  - Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?
  - Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?
  - Are there legal, vocational, social service agency or criminal justice mandates that may enhance the client's motivation for engagement in treatment?
  - Are there transportation, child care, housing or employment issues that need to be clarified and addressed?

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Criteria Dimensions	Level 0.5 Early Intervention	OMT	Level I Outpatient Treatment	Intensive Outpatient Level II.1	Partial Hospitalization Level II.5	Residential Low Intensity Level III.1	Residential Medium Intensity Level III.3	Residential High Intensity Level III.5	Medically Monitored Intensive Inpatient Level III.7	Medically Managed Intensive Inpatient Level IV
Dimension 1: Intoxification& Withdrawal	The client is not at risk of w/d	The client is physiologically dependent on opiates and requires OMT to prevent w/d	The client is not experiencing significant w/d or is at minimal risk of severe w/d	The client is is at minimal risk of severe w/d	The client is is at moderate risk of severe w/d	The client is not at risk of w/d, or is experiencing minimal or stable w/d The client is concurrently receiving Level I-D (minimal) or Level II-D (moderate) services	The client is not at risk of severe w/d, or moderate w/d is manageable at Level III.2_D	The client is at minimal risk of severe w/d at Levels III.3 or III.5. If w/d is present, it meets Level III 2 D criteria	The client is at high risk of w/d, but it is manageable at Level III 7-D and does not require the full resources of a hospital	The client is at high risk of w/d and requires the resources of a licensed hospital
Dimension 2: Biomedical problems	None or very stable	None or manageable with outpatient medical monitoring	None or very stable, or the client is receiving concurrent medical monitoring	None or not a distraction from treatment. Problem(s) manageable at Level II.1	None or not sufficient to distract from treatment. Problem(s) manageable at Level II 5	None or stable or the client is receiving concurrent medical monitoring	None or stable or the client is receiving concurrent medical monitoring	None or stable or the client is receiving concurrent medical monitoring	The client requires 24-hour medical monitoring but not intensive treatment	The client requires 24-hour medical monitoring & nursing care and the full resources of a licensed hospital
Dimension 3: Emotional, Behavioral, Cognitive Problems	None or very stable	None or manageable in an outpatient structured environment	None or very stable, or the client is receiving concurrent mental health monitoring	Mild severity, with the potential to distract from recovery; the client needs monitoring	Mild to moderate severity, with the potential to distract from recovery; the client needs stabilization	None or minimal; not distracting to recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required	Mild to moderate severity; the client needs structure to focus on recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.	The client demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for the client who is severely and persistently mentally ill.	Moderate severity; the client needs a 24-hour structured setting. If the client has a co-occurring mental disorder, he or she requires concurrent mental health services in a medically monitored setting	Because of severe and unstable problems, the client requires 24-hour psychiatric care with concomitant addiction treatment (Dual Diagnosis Enhanced)
Dimension 4: Readiness to Change	The client is willing to explore how current AOD use may affect personal goals	The client is ready to change the negative effects of opiate use, but is not ready for total abstinence	The client is ready for recovery, but needs motivating and monitoring strategies to strengthen readiness. Or there is high severity in this dimension but not in other dimensions. The client therefore needs a Level I motivational enhancement program	The client is has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times in week to promote progress through the stages of change	The client has poor engagement in treatment, significant ambivalence, or lack of awareness of the substance use or mental health problem, requiring a near-daily structured program or intensive engagement services to promote progress through the stages of change	The client is open to recovery, but needs a structured environment to maintain therapeutic gains	The client has little awareness and needs interventions available only at III.3 to engage and stay in treatment Or there is high severity in this dimension but not in other dimensions. The client therefore needs a Level I motivational enhancement program.	The client has marked difficulty with or opposition to treatment, with dangerous consequences. Or there is high severity in this dimension but not in other dimensions. The client therefore needs a Level I motivational enhancement program.	The client's resistance is high and impulse control poor, despite negative consequences; he or she needs motivating strategies available only in a 24-hour structured setting. Or, if a 24-hour setting is not required, the client needs a Level I motivational enhancement program.	Problems in this dimension do not qualify the client for Level IV services.
Dimension 5: Relapse, continued use or problem	The client needs an understanding of, or skills to change, his or her current AOD use patterns	The client is at high risk of relapse without OMT and structured therapy to promote progress through treatment	The client is able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support	Intensification of the client's addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week	Intensification of the client's addiction or mental health symptoms, despite active participation in a Level I or II.1 program, indicates a high likelihood of relapse or continued use or continued problems without near-daily monitoring and support	The client understands relapse but needs structure to maintain therapeutic gains	The client has little awareness and needs interventions available only at III 3 to prevent continued use, with imminently dangerous consequences.	The client has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences	The client is unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care.	Problems in this dimension do not qualify the client for Level IV services
Dimension 6: Recovery Environment	The client's social support system or significant others increase the risk of personal conflict about AOD use	The client's recovery environment is supportive and/or the patient has skills to cope	The client's recovery environment is supportive and/or the patient has skills to cope	The client's recovery environment is not supportive, but, with structure and support, the client can cope	The client's recovery environment is not supportive, but, with structure and support and relief from the home environment, the patient can cope	The client's environment is achievable if Level III.1 24-hour structure is available	The client's environment is dangerous, but recovery is dangerous and he or she needs 24-hour structure to learn to cope	The clients environment is dangerous and he or she lacks skills to cope uside of a highly structured 24-hour setting	The clients environment is dangerous and he or she lacks skills to cope uside of a highly structured 24-hour setting	Problems in this dimension do not qualify the client for Level IV services.

Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

RELAPSE PREVENTION

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) PATIENT PLACEMENT CRITERIA, 2ND EDITION-REVISED

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

Learning Objectives

At the conclusion of this workshop, participants will be able to:

- Demonstrate familiarity with the American Society of Addiction Medicine (ASAM) and the ASAM Patient Placement Criteria, 2nd Edition-Revised (PPC-2R)
- Describe the levels of care concept
- Identify the five major levels of care
- List the six PPC-2R dimensional criteria
- Describe the admission, transfer and discharge decision-making process

I. ASAM PPC-2R

- Changes from PPC-2
  - Meets needs of clients regardless of the availability of third-party reimbursement
  - Responds to the concerns of "public sector treatment programs"
  - No longer focused exclusively on levels of care (LOC) in "traditional programs"
  - Provides greater access to care for 1) dual diagnosis clients, 2) unmotivated clients who are mandated into treatment, 3) clients who had previously only had access to care if they agreed to be in a high-intensity LOC.
  - Takes into account the use of cognitive behavioral strategies, such as motivational interviewing and the stages of change model
  - Changes focus of treatment decision making from program-driven to clinically-driven
  - Emphasis on variable rather than fixed length of service

II. PPC-2R LEVELS OF CARE

- Level 0.5 (Early Intervention)
- Level I: Outpatient Services (Low Intensity)
- Level II: Intensive Outpatient/Partial Hospitalization
- Level III: Inpatient/Residential Treatment
- Level IV: Medically-Managed Intensive Inpatient/Residential Treatment
- Opioid Maintenance Therapy (actually a service rather than a level of

care)

III. LEVEL 0.5 (Early Intervention)

- For clients who, for a known reason, are at risk of developing substance-related problems or For those for whom there is not yet sufficient information to document a substance-related disorder

IV. LEVEL I: (Low intensity outpatient services)

- Organized services that can be delivered in a variety of settings
- Services provided in regularly-scheduled sessions and follow a defined set of policies and procedures or medical protocol
- Includes services to persons who would previously have been turned away as not ready for treatment or in denial
- Some clients in level I may be more appropriate for a higher level due to the severity of their addiction, but placement in a higher level would have "hardened their resistance"

V. LEVEL II: (Intensive outpatient/partial hospitalization)

- Organized outpatient programs that deliver services during the day, before or after school or work, in the evenings, and/or on weekendsProvide essential educational and treatment services while allowing clients to apply their newly acquired skills within "real world" settings
- Have the capacity to arrange for medical, psychiatric and psychopharmacological consultation, Rx management and 24-hour crisis services
- Maintain active affiliations with other levels of care
- Can help clients access support services such as child care, vocational training and transportation.

VI. LEVEL III: (Inpatient/residential treatment)

- Provides a planned regimen of care within a 24-hour live-in setting
- Services adhere to a defined set of policies and procedures
- Housed in or affiliated with permanent facilities in which clients can reside safely.
- Staffed 24 hours a day
- Mutual aid and self-help groups usually provide on-site
- Four subcategories of Level III Services
  - III.1 Clinically-managed low-intensity residential treatment

- II.3 Clinically-managed medium-intensity residential treatment
- Level III.5 Clinically-managed high-intensity residential treatment
- Level III.7 Medically-monitored inpatient treatment

- Primary Issue in Level III Services
  - The most important characteristic of Level III services is that they serve persons who need a safe and stable living environment in order to develop their recovery skills.

VI. LEVEL IV: Medically-managed intensive residential/inpatient treatment

- Provides a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance abuse disorders in an acute care patient setting.
- Staffed by designated addiction-credentialed physicians (including psychiatrists) as well as other mental health and addiction-oriented clinicians.
- Intended for persons whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care.
- Treatment is provided 24 hours a day
- The full resources of a general acute care hospital or psychiatric hospital are available
- The staffing and availability of support services allow for the conjoint treatment of co-occurring biomedical problems.

VIII. OPIOID MAINTENANCE THERAPY

- A separate service that can be provided at any level of care.
- Currently, methadone is the only opioid that is approved for use in maintenance therapy.
- Approval of buprenorphine, with or without naloxone, is being considered by the U.S. FDA

IX. PPC-2R Criteria Used to Decide LOC

- Diagnosis
- Dimensional Criteria
  - Acute intoxication and withdrawal potential
  - Biomedical conditions and complications
  - Emotional/Behavioral or cognitive conditions and complications

- Readiness to Change
- Relapse, continued use or continued problem potential
- Recovery/living environment

X. Acute Intoxication/withdrawal Potential

- Goals of care
  - Avoidance of the potentially hazardous consequences of discontinuation of alcohol and other drug dependence
  - Facilitation of the client's completion of detoxification and linkages and timely entry into continued medical, addiction or mental health treatment or self-help recovery as indicated
  - Promotion of client dignity and easing of patient discomfort during the withdrawal period
- Assessment considerations include:
  - What risk is associated with the client's current level of acute intoxication?
  - Is there significant risk of severe withdrawal symptoms?
  - Are there current signs of withdrawal?
  - Does the client have supports to assist in ambulatory withdrawal if medically safe?

XI. Biomedical Conditions & Complications

- Assessment considerations
  - Are there current illnesses, other than withdrawal, that need to be addressed because they create risk or may complicate treatment?
  - Are there chronic conditions that affect treatment?

XII. Emotional, Behavioral or Cognitive Conditions & Complications

- Assessment considerations
  - Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?
  - Are there chronic conditions that affect treatment?
  - Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?
  - Do any emotional, behavioral or cognitive problems appear to be an

expected part of the addictive disorder, or do they appear to be autonomous?

- Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
- Is the client able to manage the activities of daily living?
- Can the client cope with any any emotional, behavioral or cognitive problems?

- It is important to note that, when assessing co-occurring disorders, a mental health or substance-related disorder should be considered secondary only if it shows improvement as a result of stabilization in the other disorder.

XIII. READINESS TO CHANGE

- In PPC-2, known as "treatment resistance or acceptance"
- Reflects the importance of the "Stages of Change" model.
- Resistance to treatment "not unexpected" and does not automatically exclude a client from receiving treatment
- The degree of readiness is what determines the setting for and intensity of motivating strategies
- Moves the criteria in this dimension beyond the concepts of denial and resistance.

XIV. RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

- In PPC-2, was "Relapse/Continued Use Potential"
- Renamed in order to include mental health issues
  - Example: Addicted schizophrenic who refuses medication and is thus at risk for substance abuse relapse
- Assignment of LOC after relapse should be made on basis of BOTH history and assessment of current problems.
- Client is not automatically assumed to need a higher LOC than the one at which relapse occurred.
- Assessment indicators:
  - Is the client in immediate danger of continued severe mental health distress and/or AOD use?
  - Does client have any recognition or understanding of, skills in coping with, his or her addictive or mental health disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior?

- How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?
- How aware is the client of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

XV. RECOVERY/LIVING ENVIRONMENT

- Assessment Considerations:
  - Do any family members, significant others, living situations, or school or work situations pose a threat to the client's safety or engagement in treatment?
  - Does the client have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment?
  - Are there legal, vocational, social service agency or criminal justice mandates that may enhance the client's motivation for engagement in treatment?
  - Are there transportation, child care, housing or employment issues that need to be clarified and addressed?

RELAPSE PREVENTION CASE STUDY: KAREN G.

Karen has been in treatment for three months. She began in a Level I program, and was convinced by her peers (most of are in the Level I program as the last component of a "step-down" treatment plan) that she has a methamphetamine problem. The next month was spent in residential treatment, after which Karen was transferred to a Level II.5 "day treatment" program while she lived at home. On most evenings, Karen attended a 12-step meeting and/or visited her children at their grandmother's house. About a week ago, she was transferred to a Level II.1 intensive outpatient program that she is expected to attend four nights a week. Recently her car became undriveable and she says she does not have the money to get it fixed. She has been getting rides to 12-step meetings from a Rick, a man she met at an NA meeting. Rick was mandated to attend treatment after being convicted of heroin possession. In treatment, he disclosed that he supports himself by "cooking" methamphetamine, but that he does not use the drug and does not want Karen to use either. Both Karen and Rick admit to drinking "a little bit," but feel this does not pose a threat to their recovery.

Karen's "mother-in-law" (she and Tom were never married) says that Karen "looks real good" and that her children miss her. However, she refers to Karen's friend Rick as "biker trash" and does not want the children around him. When asked for clarification, she will only say "he's no good."

- What is your opinion of the quality Karen's recovery?

- If you were her counselor, what advice would you give her?

OVER.....

- What do you feel would be the five most important components of Karen's relapse prevention plan?

Project Strengthening Supervision

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THE DRUG-EXPOSED INFANT AND CHILD

Provided through:

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Perinatal Research: 1985-2002

I. Chasnoff, Burns, Scholl & Burns (1985) and Griffith (1988)

A. Depressed interactive behavior
B. Poor state control

II. Woods, Plessinger & Clark (1987)

A. Cocaine use during pregnancy causes uterine vasoconstriction, decreasing oxygen and nutrients to the fetus.
B. Results in poor fetal growth

III. Chasnoff, Griffith, MacGregor, Dirkes & Burns (1989)

A. Babies affected by cocaine have lower birth weight (LBW)

EFFECTS OF NICOTINE ON THE DEVELOPING FETUS

Uterine vasoconstriction

Decreased fetal 0_2 and nutrient supply

Prematurity/Low birth weight

IV. DHHS Office of the Inspector General (1990)

A. Prenatal exposure to crack can lead to

1. Premature birth
2. LBW
3. Birth defects
4. Respiratory and neurological problems
5. Significantly higher rates of SIDS

V. Drucker (1990)

A. The vast majority of infants born to poor, drug-using mothers are as healthy as other infants born in poverty

VI. Mayes, Granger, Bornstein & Zuckerman (1992)

A. The majority of crack-exposed infants are born without significant or pervasive physical or neurobehavioral impairments and show normal development in later infancy.

VII. Mathias (1992)

A. Both prenatal and postnatal interventions can prevent developmental problems

VIII. Haskett, Miller, Whitworth & Huffman (1992)

A. Infants and young children can be extremely difficult to care for and manage due to the medical and behavioral outcomes from prenatal exposure to crack

IX. Hawley, Halle, Drasin & Thomas (1995)

A. A study of prenatally-exposed children of addicted mothers found they did not differ from a comparison group in their language and cognitive development

B. The children did display greater emotional and behavioral problems

X. Frank, Augustyn, Knight, Poll & Zuckerman (2001)

"Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure" (2001). JAMA, 285(13): 1613-1625.

A. Used papers from *Medline* & *Psychological Abstracts* search, 1984-October 2000, that discussed the effect of prenatal cocaine use on:

1. physical growth
2. cognition language skills
3. motor skills
4. behavior, attention, affect & neurophysiology

B. Criteria for inclusion:

1. Published in an English-language journal
2. Included a comparison group
3. Recruited samples prospectively during prenatal period
4. Used masked assessment
5. Did not include a substantial portion of subjects exposed to opiates, amphetamine, PCP or maternal HIV

C. 74 papers out of 36 met criteria

D. 38 papers excluded because:

1. 20 failed to mask investigators to children's cocaine exposure
2. 7 had no control group
3. 26 did not use prospective recruitment for all or some of the subjects
4. 13 recruited children with prenatal exposure to opiates, methamphetamine or PCP
5. 2 reported samples predominantly composed of children of HIV^+ mothers

E. Methodological Complications

1. Difficult to determine with precision how much/how often infants prenatally exposed to cocaine
2. Urine testing or maternal report only measure available when studies were done.
3. Exposure to alcohol, tobacco & marijuana was common
4. Many of the mothers from "economically disadvantaged, medically at-risk" populations, in which high developmental risk exists even without drug exposure

F. Findings

1. Physical growth

a. If exposure to other substances is not controlled, prenatal cocaine exposure seems to be associated with ↓ weight and head circumference in two cohorts but not in another

b. In 2 cohorts that did control for exposure to tobacco and/or alcohol, no negative cocaine-related effects were found in terms of weight, length or head circumference

c. In 1 cohort, full-term unexposed infants were longer than exposed or nonexposed preterm children and also longer than exposed full-term infants

2. Standardized Cognitive Assessment

   a. "There is little impact of prenatal cocaine exposure on children's scores on nationally normed assessments of cognitive function" (Frank, et.al., 2001)

3. Language skills

   a. Three studies of toddlers showed no association between prenatal cocaine exposure and receptive or expressive language score.

4. Motor skills

   a. Of six studies that looked at motor skills, three found "less than optimal" motor scores in the first 7 months of life.

   b. No prospective study found ↓ motor skills after the first 7 months of life

   c. One study has found that mothers' prenatal tobacco use, but not cocaine use, was the major predictor of abnormalities in infant muscle tone at 6 weeks

   d. It is possible but not proven that previously reported positive associations between prenatal cocaine use and less optimal motor development were a misattribution of maternal tobacco effects.

5. Behavior, attention, affect & neurophysiology

   a. Prenatal cocaine exposure, independent of exposure to alcohol, has not been found to be associated with behavioral disturbances detectable by standard scoring of epidemiologic and clinical report measures by parents or teachers.

   b. Infants exposed prenatally to cocaine seem to have a deficit in affective expression.

   c. They show less emotion than unexposed peers.

   d. Two studies have found less than average scores among prenatally exposed children.

6. Methodological problems within these studies may cast doubt on their conclusions.

G. Summary of Findings

1. After controlling for alcohol and tobacco use, effects of prenatal exposure to cocaine have not been shown
2. Independent of environmental risk and exposure to alcohol and tobacco use, researchers have not found a negative association between prenatal cocaine use and developmental scores from infancy to 6 years

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Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure

A Systematic Review

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Tripler Pell, MSc
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Context Despite recent studies that failed to show catastrophic effects of prenatal cocaine exposure, popular attitudes and public policies still reflect the belief that cocaine is a uniquely dangerous teratogen.

Objective To critically review outcomes in early childhood after prenatal cocaine exposure in 5 domains: physical growth; cognition; language skills; motor skills; and behavior, attention, affect, and neurophysiology.

Data Sources Search of MEDLINE and *Psychological Abstracts* from 1984 to October 2000.

Study Selection Studies selected for detailed review (1) were published in a peer-reviewed English-language journal; (2) included a comparison group; (3) recruited samples prospectively in the perinatal period; (4) used masked assessment; and (5) did not include a substantial proportion of subjects exposed in utero to opiates, amphetamines, phencyclidine, or maternal human immunodeficiency virus infection.

Data Extraction Thirty-six of 74 articles met criteria and were reviewed by 3 authors. Disagreements were resolved by consensus.

Data Synthesis After controlling for confounders, there was no consistent negative association between prenatal cocaine exposure and physical growth, developmental test scores, or receptive or expressive language. Less optimal motor scores have been found up to age 7 months but not thereafter, and may reflect heavy tobacco exposure. No independent cocaine effects have been shown on standardized parent and teacher reports of child behavior scored by accepted criteria. Experimental paradigms and novel statistical manipulations of standard instruments suggest an association between prenatal cocaine exposure and decreased attentiveness and emotional expressivity, as well as differences on neurophysiologic and attentional/affective findings.

Conclusions Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity, scope, or kind from the sequelae of multiple other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment. Further replication is required of preliminary neurologic findings.

JAMA. 2001;285:1613-1625 www.jama.com

RECENTLY, THE US SUPREME Court considered *Ferguson et al v City of Charleston*, a Fourth Amendment case (unreasonable search and seizure).[1] This case addresses a policy of the Medical University of South Carolina whereby health professionals, in cooperation with the local prosecutor, selectively screened the urine of medically indigent obstetric patients for cocaine metabolites.[1-3] Medical personnel reported positive results to the police, who would then come to the hospital to arrest prenatal and postpartum patients for possession of an illegal drug, delivery of drugs to a minor, or child abuse.[3,4] In the popular press, *People* magazine reported on C.R.A.C.K. (Children Requiring a Caring Kommunity), a controversial charity that raises money to give mothers with a history of illegal drug use financial incentives to accept long-acting contraception, or, in most cases, sterilization.[5] This charity and the policies at issue in *Ferguson v City of Charleston* reflect popular belief that women who use cocaine while pregnant inflict severe, persistent, and unusual impairments on their unborn children, recently described by a newspaper columnist as "blighted by a chemical assault in the womb."[6]

See also p 1626.

Public expectations of "blighted" children fuel controversial punitive poli-

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cies directed toward addicted mothers.[7] Since 1985, more than 200 women in 30 states have faced criminal prosecution for using cocaine and other psychoactive substances during pregnancy.[7] Scholars and professional organizations have condemned efforts to sterilize or criminally prosecute addicted mothers as ethically and legally flawed, racially discriminatory, and an impediment to providing appropriate medical care to these women and their children.[3,4,7-9]

Recent reviews[10-15] and articles[16-18] show that most initial predictions of catastrophic effects of prenatal cocaine exposure upon newborns were exaggerated. After controlling for confounders, the most consistent effects of prenatal cocaine exposure are small but statistically significant decrements in 1 or more parameters of fetal growth for gestational age[12,13] and less optimal neonatal state regulation and motor performance.[10,11,14] Clinically silent findings on neonatal cranial ultrasounds following prenatal exposure have been found in some studies,[10,16] but not others.[17] Prenatal cocaine exposure without concurrent opiate exposure has not been shown to be an independent risk factor for sudden infant death syndrome.[15,18]

Despite the neonatal data, beliefs about cocaine's teratogenicity impose a stigma on cocaine-exposed infants[19,20] and children at school age.[21] Teachers fear that "crack kids" will be too developmentally delayed or disruptive to be taught in traditional classrooms.[22]

Given the current public concern, health professionals need a critical synthesis of studies of postneonatal outcomes of children exposed to cocaine in utero in 5 domains: (1) physical growth; (2) cognition; (3)language skills; (4) motor skills; and (5) behavior, attention, affect, and neurophysiology.

METHODS

Data Sources

MEDLINE and *Psychological Abstracts* were searched for all human studies published in English from 1984 until October 2000 that included the words *cocaine*, *crack/cocaine*, *crack*, *pregnancy*, *prenatal exposure*, *delayed effects*, *children*, and *related disorders*. Even if cited in MEDLINE, abstracts or nonreviewed proceedings of scientific meetings[23] were excluded. Seventy-four published articles were identified.[24-97]

Study Selection

We first applied selection criteria used by others[98]: all selected studies presented original research published in a refereed English-language journal, used human subjects, and used a control or comparison group. Detailed review was then restricted to studies that also met 3 criteria: (1) samples were prospectively recruited; (2) examiners of the children were masked to their cocaine exposure status; and (3) the cocaine-exposed cohort did not include a substantial proportion of children also exposed in utero to opiates, amphetamines, or phencyclidine, or whose mothers were known to be infected with the human immunodeficiency virus (HIV).

Justification of Selection Criteria

Studies were classified as prospectively recruited if the samples of cocaine-exposed and unexposed mother-infant dyads were identified and enrolled either during pregnancy or immediately after birth. Prospective recruitment obviates recall bias, when caregivers of a child who has experienced an adverse outcome are likely to recall prenatal exposure in greater detail, and selection bias, when caregivers are more likely to enroll children with already suspected developmental impairments. Such biases in retrospective samples can produce an overestimate of the risk of negative developmental outcomes.[99]

In behavioral research, examiners' bias may unconsciously distort measurement of developmental/behavioral outcomes.[99-101] Investigators have shown that evaluators were more likely to code children's videotaped behavior as abnormal if the children were labeled as "crack kids" than if they were not.[19,20]

Lower developmental test scores in infancy and less adaptive behavior at school age have been linked to prenatal opiate exposure.[102] In samples where most cocaine-exposed children are also opiate-exposed, the independent effect of cocaine on outcome cannot be clearly delineated. For the same reason, samples where cocaine exposure was largely confounded with exposure to methamphetamines or phencyclidine were also excluded. Exposure to HIV in utero is correlated with poor developmental outcome not only among infected infants, but also among those who serorevert.[103] If most cocaine-exposed children in a sample are also offspring of HIV-infected mothers, it cannot be determined whether effects are due to cocaine or HIV exposure.

Procedures

Two developmental/behavioral pediatricians (D.A.F., M.A.) and a neuropsychologist (W.G.K.) reviewed all articles. After excluding 38 articles according to the above criteria, the same 3 authors abstracted the data from the remaining 36 articles in detail. If a single article covered outcomes in more than 1 domain (eg, cognitive test scores and behavior), each domain was addressed separately. If there was uncertainty, contact was made with the corresponding author of the article to clarify interpretation of data. Disagreements were resolved by consensus.

Of the excluded studies, 20* failed to mask investigators to children's cocaine exposure status. Seven[24,27,28,36,39,40,53] had no control group. Twenty-six† did not use prospective recruitment for some or all of their subjects. Thirteen‡ primarily recruited children with in utero exposure to opiates, methamphetamines, or phencyclidine. Two[32,44] reported samples predominantly composed of children of HIV-positive mothers.

Data Extraction

The conceptual framework for data extraction was provided by recent theoretical advances in human behavioral teratology[104,105] delineating the implications of various methods of characteriz-

*References 24, 27, 30, 31, 33-37, 41, 42, 48, 49, 52, 53, 55-57, 60, 61.
†References 24-27, 29, 30, 33-38, 40-44, 46-49, 51, 54, 58, 59, 61.
‡References 28, 30, 32, 34, 41, 42, 49, 50, 54, 55-57, 59.

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ing exposure to possible toxicants and of controlling for potential confounders. Many cocaine-exposed newborns are clinically indistinguishable from their unexposed peers,[18,106] so identification of exposed infants depends on maternal report or measurement of cocaine metabolites in biological matrices. Dose response is a critical issue in the study of all potential teratogens[105] but is difficult to ascertain for cocaine in human studies. Recently, infants' meconium and maternal hair have emerged as useful biological markers for estimating the dose of prenatal cocaine exposure.[97,107-111] However, at the time most cohorts available for study in the postneonatal period were recruited, assays of urine from mother or infant for benzoylecognine were the only biological indicators readily available. Urine assays do not reflect cumulative fetal drug exposure. Thus, researchers who address dose response rely on maternal interviews to classify levels of prenatal cocaine exposure, usually classifying 2 or more days a week during pregnancy as "heavier use."[63,66,85] For this review, we classified levels of prenatal cocaine exposure as heavier/lighter or as exposed/unexposed.

Even when their mothers do not use opiates, amphetamines, or phencyclidine, most cocaine-exposed infants are also exposed in utero to varying combinations of tobacco, alcohol, and marijuana.[112] The heaviest prenatal cocaine users are often the heaviest users of these other substances.[109] If prenatal exposure to tobacco, alcohol, and marijuana is not analytically controlled, their effects on neurodevelopment[74,84,113] may be misattributed to cocaine. If these substances are statistically controlled for without regard to the level of use, residual confounding may occur because of overaggregation of light and heavy exposure.[104,114] For this review, we considered whether prenatal tobacco, alcohol, and marijuana exposure are reported or not, are controlled analytically as dichotomous variables (exposed/not exposed), or are statistically controlled in a dose-related manner. However, statistical control in a dose-controlled manner offers the greatest assurance that effects of heavy tobacco, marijuana, or alcohol exposure will not be spuriously attributed to cocaine.

Interpreting cocaine effects is further complicated because the samples studied are, with a few exceptions,[77,90,93,97] drawn from economically disadvantaged, medically at-risk populations, whose characteristics are associated with high developmental risk without any psychoactive substance exposure. The number of environmental and medical variables, the accuracy of their measurement, and their distribution within the sample may influence the estimation of cocaine effects.[104]

The data were derived from 17 independent cohorts from 14 cities. Some cohorts were the subject of multiple articles, either at different ages or with differing analyses of the same data from a single age. Mutually exclusive samples were identified by author and city. For each article, a number of parameters were coded, including number of cocaine unexposed and exposed subjects and the number at varying levels of cocaine exposure if such data were available; how pregnancy exposure to tobacco, alcohol, and marijuana was addressed analytically and whether this exposure was significantly related to outcomes; what other covariates were matched, used as selection criteria, or controlled for statistically; which of these covariates influenced outcomes; and what, if any, statistically significant ($P<.05$, 2-tailed unless otherwise specified) cocaine effects were identified. Of the included articles, 4 do not report attrition.[66,77,78,87] In the others, sample retention from birth to the oldest age reported for the cohort ranges from 39%[70] to 94%.[62] Of these, 14 articles* from 11 cohorts document the characteristics of those retained compared with those lost to follow-up.

RESULTS

Physical Growth

If level of exposure to other substances is not controlled, prenatal cocaine exposure appears to be associated in 2 cohorts with postneonatal decrements in weight or occipitofrontal head circumference,[64,70,78,79] but not in another[89] (TABLE 1). However, in 2 cohorts that did control for dose of prenatal exposure to tobacco and alcohol[84,93] no negative cocaine effect was noted on the children's weight, length, or head circumference. In 1 cohort, full-term unexposed children were longer than exposed or unexposed preterm children and their exposed full-term counterparts.[71]

Standardized Cognitive Assessment

There is little impact of prenatal cocaine exposure on children's scores on nationally normed assessments of cognitive development (TABLE 2). Findings of cocaine effects depend on contextual factors, such as the child's history of prematurity, age at time of assessment, and the effects of prenatal exposure to other substances. Of the 9 studies evaluating prenatal cocaine effects on developmental test scores in infants, 5 found no effect,[71,77,79,85,89] including 1 that classified infants according to level of prenatal exposure to cocaine, tobacco, and alcohol.[85] Chasnoff et al[70] found that the 6-month-old infants whose mothers used cocaine, alcohol, and marijuana attained mean scores lower than infants of controls, but identical to those of infants whose mothers had used alcohol/marijuana without cocaine, suggesting no incremental impact of cocaine use. Mayes et al[91] reported bivariate association of lower psychomotor scores at 3 months with prenatal cocaine exposure, but not after statistical control for potential confounders. Alessandri et al[63] found no main effects of level of prenatal cocaine exposure on test scores at 8 or 18 months, but on post hoc comparisons children with the highest level of cocaine exposure in pregnancy (2 or more days a week) obtained significantly lower mental development scores at age 18 months than unexposed infants.

In very low-birth-weight infants, Singer et al[96] reported a negative association between prenatal cocaine exposure and developmental scores at 16 months corrected age, but in utero ex-

*References 64, 65, 67, 73, 74, 81, 83, 85, 89, 91-93, 96, 97.

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posure to other psychoactive substances was not analytically controlled.

Six reports from 4 cohorts evaluated the association of prenatal cocaine exposure with cognitive test scores in children between the ages of 3 and 6 years.[64,78,82,83,89,93] Two articles presented results in a single cohort of 3-year-olds. In one, Azuma and Chasnoff[64] reported that children whose mothers only used alcohol and marijuana during pregnancy achieved mean IQ scores that were identical to those of children whose mothers had also used cocaine. In a second report of post hoc comparisons from the same cohort, Griffith et al[78] found that children exposed to cocaine in addition to other substances scored significantly lower than unexposed controls on a verbal reasoning scale of the IQ test. However, these scores were not lower than the scores of children who had been exposed to the other substances but not cocaine and were not statistically controlled for tobacco exposure. Another study found no cocaine effect on IQ.[89] In the cohort studied by Hurt et al[82,83] there was no impact of prenatal cocaine exposure on children's cognitive test scores at 48 months. In the oldest prospectively recruited cohort studied to date, Richardson et al[93] found no effect of prenatal cocaine exposure on any IQ scales at age 6 years, including verbal reasoning, and no association with children's academic skills.

The literature on prenatal exposure to cocaine has not shown consistent effects on cognitive or psychomotor development. However, 7 studies show that environmental factors such as caregiver (biological mothers vs kinship care or foster parents),[79,89] whether or not that caregiver received case management or home visiting services,[78,89] quality of the home environment,[63,64,78,83] and maternal IQ[77] were statistically significant correlates of test scores.

Language Skills

Three studies of toddlers[69,81,89] showed no association between prenatal cocaine exposure and receptive or expressive language scores on standardized measures (TABLE 3). Using a naturalistic language sample, Bland-Stewart et al[69] found that cocaine-exposed children produced different semantic categories than matched unexposed children. However, there were too few subjects to permit confounder control.

Motor Skills

Of 6 studies, 3 from 2 cohorts found less optimal motor scores in the first 7 months of life following prenatal cocaine exposure (TABLE 4).[75,76,97] No prospective study has identified a cocaine effect on motor development after age 7 months.[75,76,89] Dempsey et al[74] found mothers' prenatal tobacco use (quantified by urine assays of cotinine rather than by self-report), but not cocaine use (quantified by benzoylecognine levels in meconium), was the major predictor of abnormalities in infant muscle tone at 6 weeks. No other prospective study of motor outcome[75,76,79,89,97] following cocaine exposure used biological markers to measure tobacco exposure. It is not yet clear whether previously reported positive associations between prenatal cocaine exposure and less optimal early motor development may be a misattribution of tobacco effects.

Behavior, Attention, Affect, and Neurophysiology

Heterogeneous techniques used to evaluate behavior, attention, affect, and neurophysiology following prenatal cocaine exposure are not readily comparable across studies (TABLE 5). In the first year of life, visual habituation (an

Table 1. Physical Growth*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Azuma and Chasnoff,[64] 1993	92 + 25 poly 45 –	Both cocaine and polydrug exposed groups had lower OFC	Weight, height, OFC	3 years	R
Chasnoff et al,[70] 1992	106 + 45 poly 81 –	Both cocaine and polydrug exposed had lower OFC than unexposed at all ages measured	Weight, height, OFC	3, 6, 12, 18, and 24 months	R
Coles et al,[71] 1999	25 preterm + 32 full term + 22 preterm – 26 full term –	Full-term negatives longer; otherwise, no cocaine effect	Weight, length, OFC	8 weeks corrected for prematurity	R
Hurt et al,[79] 1995	101 + 118 –	Cocaine associated with lower weight and OFC at all ages	Weight, OFC	6, 12, 18, 24, and 30 months	R
Jacobson et al,[84] 1994	86H 48L 330 –	Cocaine exposure associated with faster postnatal weight gain in first 13 months, no effect on length or OFC	Weight, length, OFC	6.5 and 13 months	DC Correlated with faster postnatal weight gain
Kilbride et al,[89] 2000	111 + 41 –	No cocaine effect	Weight, length, OFC	2, 12, 24, 36 months	C
Richardson et al,[93] 1996	28 + 523 –	No cocaine effect	Weight, height, OFC	6 years	DC

*Across tables, abbreviations are explained at first mention only. Plus (+) indicates exposed to cocaine; poly, exposed to multiple drugs; minus (–), not exposed to cocaine; OFC, occipitofrontal head circumference; R, reported; C, controlled; IVH, intraventricular hemorrhage; H, heavier; L, lighter; DC, dose controlled; and NICU, neonatal intensive care unit.

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indicator of recognition memory and learning) was negatively associated with higher levels of cocaine exposure in 1 cohort[85] but not in 3 others.[63,88,91] No cocaine effect was found on toddler play[80] or on observations of behavioral style during an infant motor assessment.[68] Problem-solving abilities did not differ between cocaine-exposed and unexposed preschoolers.[67]

Differences in affective expression have been correlated with prenatal exposure to cocaine in 4 studies from 3 cohorts of infants younger than age 2 years. Alessandri et al[62] found that 4- to 8-month-old cocaine-exposed children showed less arousal, interest, joy, or sadness during the learning task. In the same cohort, Bendersky and Lewis[66] reported no differences in maternal behaviors, but less joy and more negativity among 4-month-old infants with heavy cocaine exposure following a perturbation of the face-to-face interaction between mother and infant. Roumell et al[94] reported a bivariate association between prenatal cocaine exposure and decreased facial emotion after immunization, uncontrolled for other prenatal exposures. In studies of face-to-face interaction between mothers and infants, Mayes et al[92] found heavy prenatal cocaine use correlated with less optimal maternal behavior and with decreased readiness for interaction among infants at age 6 months but not 3 months.

Diverse techniques have been used to assess neurophysiology in cocaine-exposed and unexposed infants aged 13 months and younger. Cocaine-exposed infants showed lower basal cortisol levels, but normal cortisol increase in response to the stress of venipuncture and no difference in amount of observed crying.[86] On electroencephalographic sleep studies at 12 months, cocaine-exposed children did not differ from unexposed children in sleep architecture, but infants whose mothers continued to use cocaine into the third trimester showed subtle reductions in spectral energies.[95] In 2 reports from a single cohort, assessments of heart and respiratory response to auditory, visual, and social stimulation at age 8 weeks found that cocaine-exposed children showed increased heart rate to social stimulation and a higher baseline respiratory rate, but were not more dysregulated in arousal modulation or observed behavioral state.[65,71] Full-term cocaine-exposed infants showed better arousal modulation than their unexposed counterparts.[65]

Prenatal cocaine exposure, independent of exposure to alcohol, has not been found to be associated with levels of behavioral disturbances detectable by standard scoring of epidemiologic and clinical report measures by parents and teachers.[64,72,73,77,78,87,93] However, 2 studies in 1 cohort (1 study using a study-specific measure[72] and the other[73] using a new and as-yet unreplicated method of scoring the Teacher Report Form of the Child Behavior Problem Checklist[115]) found less-optimal scores among cocaine-exposed children. Another research group[90,93] found, after covariate control, an association between prenatal cocaine exposure and increased errors of omission, but not commission, on a continuous performance task.

COMMENT

Before summarizing our findings, we must acknowledge the limitations of our approach. Studies that meet our methodologic criteria may still lead to overestimation or underestimation of cocaine's impact. Prospective studies may yield biased results if there is differential attrition.[99] Less dysfunctional caregivers may be more likely to sustain study participation, creating differential retention of children with more

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment		
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, gestational age	
R	R	Maternal age ≥19, English speaking, singleton or first-born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breastfed		
R	R	Medicaid, all >34 weeks' gestation		
DC Correlated with both shorter stature and slower postnatal weight gain if mother aged >30	DC	All black, low socioeconomic status, at least 2 prenatal visits, >32 weeks' gestation	Maternal age, welfare, education, parity, prepregnancy weight, birth weight, height, breastfed, prenatal visits, infant age, sex, gestational age	Breastfeeding associated with faster postpartum growth
C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	
DC	DC	All in prenatal care by 5 months of pregnancy	Age, sex, height, ethnicity, current drug/alcohol use	

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favorable outcomes. Alternatively, caregivers of children with obvious impairments may be more willing to return for repeated assessments, leading to an overestimation of risk for poor outcomes.

Reliance on interviews alone to classify exposure, which was the state of the art when the cohorts reported here were recruited, entails unavoidable imprecision.[14] In the absence of cumulative biological markers some cocaine-exposed children may have been misclassified as unexposed. Conversely, women who do admit cocaine use in interviews tend to be heavier users than those who deny use but whose use is detected by hair assays.[111] Generalization from atypical cases at the highest levels of exposure will lead to overestimation of the impact of prenatal cocaine exposure in the broader population of users. However, if a sample contains very few infants heavily exposed to cocaine,[77,93] possible effects of heavier use may be statistically "diluted" by overaggregation of various levels of exposure into a single category.[114]

Table 2. Standardized Cognitive Assessments*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Alessandri et al,[63] 1998	15H 19L 78 –	No cocaine dose effect on PDI, no cocaine main effect on MDI, but interaction of heavy cocaine with age associated with lower MDI	BSID-II	8 and 18 months	DC
Azuma and Chasnoff,[64] 1993	92 + 25 poly 45 –	No cocaine effect	SBIS	3 years	R
Chasnoff et al,[70] 1992	106 + 45 poly 81 –	Cocaine exposed not different from other drugs, but lower on MDI and PDI at 6 months than unexposed	BSID	3, 6, 12, 18, and 24 months	R
Coles et al,[71] 1999	25 preterm + 32 full-term + 22 preterm – 26 full-term –	No cocaine effect	BSID	8 weeks corrected for prematurity	R
Graham et al,[77] 1992	30 + 20 poly 30 –	No cocaine effect	BSID	19.7 months	R
Griffith et al,[78] 1994	93 + 24 poly 25 –	Cocaine-exposed lower than controls on verbal reasoning	SBIS	3 years	R
Hurt et al,[79] 1995	101 + 118 –	No cocaine effect	BSID	6, 12, 18, 24, and 30 months	C
Hurt et al,[82] 1997	71 + 78 –	No cocaine effect	WPPSI-R	4 years	C Negative association with performance IQ
Hurt et al,[83] 1998	72 + 78 –	Neither prenatal nor concurrent maternal cocaine use associated with full-scale IQ ≤90	WPPSI-R	4 years	C
Jacobson et al,[85] 1996	86H 48L 330 –	No cocaine effect	BSID	13 months	DC
Kilbride et al,[89] 2000	111+ 41 –	No cocaine effect	BSID, SBIS	6, 12, and 24 months (BSID); 36 months (SBIS)	C
Mayes et al,[91] 1995	61 + 47 –	Cocaine univariately associated with PDI, but not after multivariate control	BSID	3 months	C
Richardson et al,[93] 1996	28 + 523 –	No cocaine effect	SBIS, WRAT-R	6 years	DC
Singer et al,[98] 1994	41 + 41 –	Lower MDI and PDI among cocaine exposed	BSID	16 months corrected for prematurity	R

*PDI indicates Psychomotor Development Index; MDI, Mental Development Index; BSID-II, Bayley Scales of Infant Development, 2nd ed; SBIS, Stanford Binet Intelligence Scale; HSQ, Home Screening Questionnaire; CBCL, Child Behavior Checklist; BSID, Bayley Scales of Infant Development; WPPSI-R, Wechsler Preschool and Primary Scale of Intelligence-Revised; HOME, Home Observation for Measurement of the Environment; PCIS, Parent Caregiver Involvement Scale; OCS, Obstetrical Complication Scale; WRAT-R, Wide Range Achievement Test-Revised; AFDC, Aid for Families of Dependent Children; BPD, bronchopulmonary dysplasia; and VLBW, very low birth weight.

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Four studies with positive[69,75,76,94] and 1 with negative[68] findings have small sample sizes and must be interpreted with particular caution since they may overestimate cocaine effects due to the impact of a few outliers or underestimate effects because of insufficient power or sampling variation.

While acknowledging these limitations, we conclude that after control for exposure to tobacco and alcohol, effects of prenatal cocaine on physical growth are not shown.[64,70,71,79,84,89,93] Researchers have not found a negative association of prenatal cocaine exposure, independent of environmental risk and exposure to other psychoactive substances, with developmental scores from infancy to age 6 years.* However, sufficient information is not available to elucidate whether there are specific cocaine effects on developmental scores in the context of prematurity.[96]

Prospective data in the language and motor domains are only available for

*References 63, 64, 70, 71, 77-79, 82, 83, 85, 89, 91, 93.

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
DC	DC	All with biological mothers	Environmental risk, neonatal medical risk, sex	Among lightly exposed, increased environmental risk associated with decreased MDI
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	OFC, HSQ, perseverance, CBCL	Poor HSQ and poor perseverance associated with lower IQ
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, OFC	Smaller OFC correlated with MDI at 12, 18, and 24 months, OFC at birth associated with PDI at 6 months and MDI at 24 months
R	R	Maternal age ≥19, English speaking, singleton or first-born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breastfed		
R	C	Tobacco, marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	Maternal IQ associated with MDI
C Analyzed as single category; associated with decreased abstract reasoning		All drug users in prenatal care by 15 weeks and in drug treatment	Caregiver, child's sex, OFC, CBCL, and Summative Attention Scale of SBIS	Drug-free environment associated with better scores on verbal reasoning among cocaine-exposed
C	C	Medicaid, all >34 weeks' gestation, cocaine use in at least 2 trimesters	Congenital syphilis, maternal age and education, foster care	Foster care associated with lower MDI at 18 months
C	C	Medicaid	Maternal age and education, gravidity, parity, prenatal care, sex, foster care	
C	C	Medicaid	HOME, PCIS, sex, child age, foster care, day care/Head Start attendance, parental education, gravidity, parity, prenatal care, current cocaine use	Higher HOME scores and better PCIS associated with full-scale IQs above 90
DC	R	All black, all received prenatal care	Maternal age, depression, prenatal visits, HOME, parity, examiner, sex, age at test, continued maternal drug use	
C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	Birth weight associated with MDI at 12 months; with case management, children cared for by biological mothers have higher SBIS verbal scores; children in care of relatives have highest overall scores
C	C	All with biological mothers	Maternal age and education, OCS, prenatal care, birth weight, birth length, and OFC at birth	
DC	DC	All in prenatal care by 5 months	Maternal ethnicity, IQ, current maternal alcohol/drug use, self-esteem, HSQ, child's grade	
R	R	All black, all receiving AFDC, severity of BPD, all VLBW	Chronological age at testing, IVH, foster placement	

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children up to age 3 years.[69,74-76,78,79,81] No effects on standardized language measures have been shown. Less-optimal motor development before age 7 months but not thereafter has been found by some investigators[75,76,97] but not others.[74,79,89] Recent research suggests that motor findings attributed to cocaine may in fact reflect heavy prenatal tobacco exposure.[74]

Except for the work of 1 investigator,[72,73] prenatal cocaine exposure independent of exposure to alcohol has not yet been found to be associated with levels of behavioral disturbance that are readily detected by standard scoring of epidemiologic and clinical report measures from parents and teachers.[64,72,77,78,87,93] However, sophisticated experimental and physiological paradigms of uncertain clinical importance have detected possible effects of prenatal cocaine exposure. Of these, only the finding of decreased emotional expressiveness has been replicated in more than 1 study.[62,66,92,94]

The differences between our conclusions and those of others show how methodologic rigor influences understanding of prenatal cocaine exposure. For instance, a respected research group recently concluded from a meta-analysis of 6 studies that prenatal cocaine exposure is associated with decreased competence in expressive and receptive language.[98] However, 5 of these studies[29,37,43,46,51] were retrospective; 2 did not use masked assessors.[37,57] In 2 samples, the majority of cocaine-exposed children were also exposed to opiates and methamphetamines.[37,57] Furthermore, none of these studies analytically controlled for the possible effects of prenatal tobacco exposure, an established correlate of language impairment.[113] Nevertheless, newspaper articles used the conclusions of the meta-analysis to declare that "because of cocaine-related receptive language impairments," "crack babies" would cost taxpayers an additional $42 to $352 million per year in special education services.[116]

When prenatal cocaine and tobacco exposure are compared dispassionately, it becomes clear how sociopolitical forces shape discrepant interpretations of similar scientific data. The mechanisms of nicotine and cocaine effects on the developing brain are similar, involving vasoconstriction, hypoxia, and perturbations of neurotransmitter networks.[117] Prenatal tobacco exposure has been associated with in-

Table 3. Language Skills*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use
Bland-Stewart et al,[69] 1998	11 + 11 –	Delays in early semantic development, no effect on SICD-R score	SICD-R language sample	24 months	NR	NR	NR
Hurt et al,[81] 1997	76 + 81 –	No cocaine effect	PLS	2.5 years	NR	NR	NR
Kilbride et al,[89] 2000	111 + 41 –	No cocaine effect	REEL, SICD-R	6, 12, 24 months (REEL), 36 months (SICD-R)	C	C	R

*SICD-R indicates Sequenced Inventory of Communicative Development-Revised; NR, not reported; PLS, preschool language; and REEL, Receptive Expressive Emergent Language Scale.

Table 4. Motor Skills

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Dempsey et al,[74] 2000	40 + 56 –	No cocaine effect	Neurologic examination	6 weeks	DC High doses associated with hypertonia
Fetters and Tronick,[75] 1996	28 + 22 –	Higher total risk on the MAI at 7 months, lower mean percentile on AIMS at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C
Fetters and Tronick,[76] 1998	28 + 22 –	No difference on PDMS, significant differences on prone and standing subscores of AIMS and primitive reflex score of MAI at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C
Hurt et al,[79] 1995	101 + 118 –	No cocaine effect	Tone and reflexes	6 and 12 months	C
Kilbride et al,[89] 2000	111 + 41 –	No cocaine effect	PDMS	6, 12, 24, and 36 months	C
Swanson et al,[97] 1999	48 + COC3 72 + COC12 186 –	Higher full-scale MAI total risk, COC3 associated with less optimal volitional movement than COC12, COC3 at higher risk for neuromotor dysfunction than unexposed but COC12 is not	MAI	4 months	DC

*MAI indicates Movement Assessment of Infants; AIMS, Alberta Infant Motor Scales; PDMS, Peabody Development Motor Scales; COC3, cocaine use in third trimester; and COC12, discontinued cocaine use before third trimester.

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fant mortality,[118] moderate impairment of cognitive functioning,[119] and a range of behavioral problems (which, unlike those associated with cocaine exposure, are detectable on relatively insensitive epidemiologic measures).[120] It has been calculated that low birth weight attributable to maternal smoking annually costs $263 million (1995 dollars) in excess direct medical costs for neonatal care alone.[121] Despite increased health care costs imposed by their tobacco use, there are no sterilization campaigns for mothers who use tobacco. No pregnant women have been charged with child abuse for tobacco use in pregnancy. Teachers do not dread having a "tobacco kid" assigned to their class.

We have focused on cocaine as a suspected behavioral teratogen, since exaggerated views of its teratogenicity have provided the rationale for selectively targeting pregnant women who use cocaine for sanctions even more punitive than those imposed on women who use other illicit substances.[3,8,122] Our focus omits 2 important considerations beyond the scope of this review. First, even if cocaine were as hazardous to a child's development as some claim, established teratogenicity (eg, that of heavy alcohol use) does not justify policies that violate the usual canons of medical ethics and civil liberties.[3] Second, health providers should not ignore that cocaine use in pregnancy is often a marker for a mother-child dyad at risk for poor health and impaired caregiving due to factors ranging from infectious diseases to domestic violence. Addiction to any intoxicant may so impair parents that they abuse or neglect a child.[123] However, presumptive punitive sanctions imposed in pregnancy or at birth do not reduce these risks to the child. On the contrary, fear of prosecution may discourage pregnant and parenting women from seeking prenatal care and drug treatment,[8,124] which have been shown to optimize infant outcome.[125] Stigma and negative expectations generalized from mothers to their children may in themselves impede the children's academic progress.[101] Care of families affected by substance abuse should be comprehensive and not irrationally shaped by social prejudices that demonize some drugs and drug users and not others.[123]

Much is still unknown about the effects of prenatal cocaine exposure. Research on prenatal marijuana and tobacco exposure suggests that, even if no drug effects are found between the ages of 6 months and 6 years, the increasing cognitive demands and social expectations of school or puberty may unmask sequelae of exposure not previously identified.[126,127] Cumulative environmental risk and protective factors may also exacerbate or moderate negative cognitive and behavioral outcomes as children mature.[128] However, among children up to 6 years of age, there is no convincing evidence that prenatal cocaine exposure is associated with any

Selection/Matching Criteria	Controlled Variables	Other Effects
Age, sex, foster care, maternal age and education		
Medicaid		
All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	Case management of children cared for by biological mothers associated with higher SICD-R scores

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
C	C	Birth weight >2000 g, English speaking, maternal age >18, no NICU care	Ethnicity, adequacy of prenatal care, OFC, gestational age, homelessness	
C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care	Hobel score, cumulative risk index, child hospitalization and poor health, maternal education, ethnicity	
C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care		
C	C	Medicaid, all >34 weeks' gestation, cocaine use in at least 2 trimesters	Congenital syphilis, maternal age and education, foster care	
C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	
DC	DC	Maternal age >17, gestational age ≥37 weeks	Prenatal visits, infant sex and age, parity, ethnicity, maternal age and education, marital status, income	Prenatal care decreased association between cocaine exposure and primitive reflexes and volitional movement to nonsignificant

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Table 5. Behavior, Attention, Affect, Neurophysiology*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Alessandri et al,[62] 1993	36 + 36 –	Cocaine associated with fewer positive emotions, less arousal, and less instrumental responding	Instrumental responses and facial expressions during learning	4, 6, or 8 months	R
Alessandri et al,[63] 1998	37H 30L 169 –	No cocaine effect	Habituation	8 months	DC
Azuma and Chasnoff,[64] 1993	92+ 25 poly 45 –	No cocaine effect	CBCL externalizing scale	3 years	R
Bard et al,[65] 2000	27 preterm + 39 full-term + 23 preterm – 29 full-term –	None on behavioral state or heart rate; higher baseline respiratory rate and better arousal modulation in full-term infants, and poorer arousal modulation in preterm infants; preterm exposed are no more dysregulated than full-term unexposed	Arousal and arousal modulation in heart rate and respiratory rate	8 weeks corrected for prematurity	DC Associated with arousal modulation of heart rate
Bendersky and Lewis,[66] 1998	24H 17L 66 –	Heavily exposed showed less joy and more negative expressions during reengagement	Still face paradigm	4 months	DC
Betancourt et al,[67] 1999	7 + 81 –	No cocaine effect	Goodman Lockbox	3.5 and 4.5 years	C
Blanchard et al,[68] 1998	26 + 23 –	No cocaine effect	Qualitative behavioral ratings during motor testing	1, 4, and 7 months	C
Coles et al,[71] 1999	25 preterm + 32 full-term + 22 preterm – 26 full-term –	Increased heart rate to social stimulation	Heart rate response to auditory, visual, and social stimulation	8 weeks corrected for prematurity	C
Delaney-Black et al,[72] 1998	27 + 75 –	1-Tailed cocaine effect on problem behaviors and daydreaming, but no effect on Conners Scale total	Conners Teachers Rating Scale and Problem Behavior Scale	72-90 months (6-7.5 years)	C
Delaney-Black et al,[73] 2000	201 + 270 –	None with standard scoring method, but higher Externalizing-Internalizing Difference Score in cocaine exposed	Teacher Report Form of CBCL	6 years	DC
Graham et al,[77] 1992	30 + 20 marijuana 30 –	No cocaine effect	Vineland Social Maturity	18 months	R
Griffith et al,[78] 1994	93 + 24 poly 25 –	Similar to polydrug effects, but both show more aggressive and destructive behavior	CBCL	3 years	R
Hurt et al,[80] 1996	83 + 93 –	No cocaine effect	Free play	18 and 24 months	C
Jacobson et al,[85] 1996	86H 48L 330 –	Heavy cocaine exposure associated with poor visual memory on Fagan Test at 6 and 12 months and faster responsiveness on Visual Expectancy at 6 months	Fagan Test of Infant Intelligence; Visual Expectancy Paradigm	6 and 12 months	DC
Jacobson et al,[86] 1999	29 + 57 –	Cocaine exposed had lower basal cortisol prestress, but not poststress level	Cortisol levels before and after venipuncture	13 months	DC
Johnson et al,[87] 1999	53 + 37 –	No cocaine effect	CBCL	24 months	NR
Karmel et al,[88] 1996	46 + 147 – 162 – with CNS injury	No cocaine effect	Arousal modulated visual attention	4 months corrected for prematurity	NR
Leech et al,[90] 1999	26 + 582 –	Cocaine associated with increased errors of omission	CPT	6 years	DC Associated with more errors of omission
Mayes et al,[91] 1995	61 + 47 –	No effect on visual habituation, more cocaine-exposed too irritable to start procedure	Visual habituation	3 months	C
Mayes et al,[92] 1997	43 + 17 poly 21 –	Less readiness for interaction at 6 months	Face-to-face interaction	3 and 6 months	C
Richardson et al,[93] 1996	28 + 523 –	No cocaine effect	Teacher Report Form of CBCL	6 years	DC
Roumell et al,[94] 1997	14 + 16 –	Cocaine associated with less facial emotion	Facial expression coding after inoculation	18 months	R
Scher et al,[95] 2000	37 + 34 –	Third-trimester exposure associated with reduced spectral θ energies; no sleep effects	Quantitative EEG	Day 2, 1 year	DC Increased indeterminate sleep, increased arousal

*CNS indicates central nervous system; BAER, brainstem auditory evoked responses; CPT, Continuous Performance Test; EEG, electroencephalogram; and REM, rapid eye movement.

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Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
R	NR	Sex, birth order, maternal age, all with biological mothers, all receiving AFDC, all black, all with ≤high school	Beck Depression Inventory and Life Events Survey	
DC	DC	All with biological mothers		
C	C	All drug users in prenatal care by 15 weeks and in drug treatment		Smaller OFC associated with more externalizing behavior
DC	DC	Maternal age ≥19, English speaking, singleton or first-born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breastfed	Quality of caregiving, maternal psychosocial resources, term status	Term status associated with higher arousal and with arousal modulation of respiratory rate and arousal of heart rate
DC	DC	All with biological mothers	Maternal vocalization, maternal sensitivity, Environmental Risk Score, Contingent Responsivity Score, neonatal medical complications	Maternal sensitivity associated with both joy and negative expression; neonatal medical risk and maternal vocalization associated with joy
C	C	Medicaid, all >34 weeks' gestation	Gestational age, birth weight, IQ, preschool experience	
C	C	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care	Maternal age, parity	Child age associated with examiner's persistence and maternal parity with interruptions
C	C	Maternal age ≥19, English speaking, singleton or first-born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breastfed	Caregiving potential, quality of caregiveing	Caregiving instability explained more variance than cocaine exposure, preterm drug-exposed had least optimal response
DC	NR	All black	Child's sex	
DC Associated with higher total score, increased attention problems, more delinquent behavior	C	All black, all with prenatal care, children with mental retardation excluded	Child's sex, custody changes, exposure to violence, current lead level, current caregiver drug use, socioeconomic status, marital status	Child's sex male, current lead level, exposure to violence, older age, custody change, caregiver marital status, and current caregiver drug use associated with less optimal scores
R	C	Marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	
C Analyzed as single category, associated with aggression		All drug users in prenatal care by 15 weeks and in drug treatment	Child's sex, drug-free caregiver	
C	C	Medicaid	NICU admission, age at testing, foster care	
DC	R	All black, all received prenatal care	Maternal age, depression, prenatal visits, HOME, parity, examiner, infant's sex, age at test	
DC Related to higher basal cortisol, heavy exposure to poststress elevation	DC	All black, all received prenatal care	Milk, teething, pacifier, birth size, maternal verbal ability, age at test, postpartum drug use, ego maturity, caregiver depression	New teeth, maternal depression, AFDC associated with higher basal cortisol; age at visit, maternal verbal ability with poststress cortisol
NR	NR	All Hispanic or black	Ethnicity, maternal stress and social support, maternal depression, child's sex	Maternal stress and social support associated with total internalizing and externalizing behavior; depression with externalizing behavior problems
NR	NR	Cocaine-exposed had normal BAER and cranial ultrasounds	Arousal condition	CNS injury associated with neonatal pattern of attention
DC	DC Associated with more errors of commission, fewer of omission	All in prenatal care by 5 months	Ethnicity, child's sex, illnesses, hospitalizations, SBIS IQ, HSQ, maternal work status, life events, hostility, maternal age, male in household, current caregiver alcohol/drug use	Omission predicted by lower child SBIS IQ and age, and mother more hostile and not working; commission predicted by child's male sex, male in household, and lower SBIS IQ
C	C	All with biological mothers	Maternal age, education, OCS, prenatal care, birth weight, length, OFC	
C	C	All with biological mothers	Maternal age and education, infant's sex, OCS, infant size at birth	
DC	DC	All in prenatal care by 5 months	Ethnicity, child's IQ and grade, current maternal alcohol/drug use	
R	R	Hospital payment, maternal education, all black		
DC Decreased indeterminate sleep and δ energies, increased REM and spectral correlation	DC Increased arousal, decreased β energies	Full-term, Apgar score >5, mother in prenatal care by 5 months, no general anesthesia	Child's sex and age, ethnicity, number of hospitalizations, maternal age	

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developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol* and the quality of the child's environment.†

*References 64, 65, 70, 74, 78, 84, 86, 90, 95
†References 63, 64, 66, 68, 71, 73, 77-79, 83, 84, 86, 87, 89, 90

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Funding/Support: This work was supported by grant DA 06532 from the National Institute of Drug Abuse (Dr Frank).
Acknowledgment: We thank Ruth Rose-Jacobs, ScD, David Bellinger, PhD, Howard Cabral, PhD, Tim Heeren, PhD, and Marjorie Beeghly, PhD, for their thoughtful comments. We also thank Ivana Hanson, BA, and Elizabeth Soares, BS, for their assistance in the preparation of the manuscript. We would particularly like to thank Lisa Blazejewski, MS, for her expert bibliographic and editorial assistance.

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Cocaine and Pregnancy—Time to Look at the Evidence

Wendy Chavkin, MD, MPH

IN THIS ISSUE OF THE JOURNAL, FRANK AND COLLEAGUES[1] present a systematic review of studies assessing possible relationships between maternal cocaine use during pregnancy and several childhood outcomes. The authors are thoughtful and rigorous in their approach and carefully evaluate the physiological plausibility of the outcomes under question and the methodological strengths and constraints of the studies reviewed. They considered 36 studies worthy of review; these reported on 17 prospectively recruited cohorts with examiners blinded to cocaine exposure status.

At the end of their effort, Frank et al conclude that crack/cocaine exposure in utero has not been demonstrated to affect physical growth; that it does not appear to independently affect developmental scores in the first 6 years (although there are insufficient data to assess this for infants born preterm); that findings are mixed regarding early motor development but any effect appears to be transient and may, in fact, reflect tobacco exposure; and that exposure may be associated with modest alterations of certain physiological responses to behavioral stimuli that are of unknown clinical importance. In sum, the data are not persuasive that in utero exposure to cocaine has major adverse developmental consequences in early childhood—and certainly not ones separable from those associated with other exposures and environmental risks. Since many cocaine users also use other illegal drugs, drink alcohol, and smoke cigarettes, it is methodologically daunting to sort out consequences attributable to cocaine alone. Frank et al conclude that even those studies best designed to tackle this challenge fail to demonstrate that cocaine use by pregnant women leads to childhood devastation.

The authors acknowledge limitations to their approach: data on postnatal sequelae must be considered preliminary, any differential attrition could bias results, and classification of exposure based on interview may be imprecise. Moreover, the studies in the meta-analysis do not include follow-up into middle school years and adolescence. However, even if future research reveals cocaine-related harm to the fetus, the modest and inconsistent nature of the findings to date suggest that these harms are unlikely to be of the magnitude of those associated with in utero exposure to the legal drugs tobacco and alcohol.

Why then all the hullabaloo about crack babies? Why then the prosecution of 200 women who used cocaine while pregnant?[2] Why was a program established to pay $200 to crack-using women as an incentive to become sterilized?[2] What's going on? The answer, perhaps, is 2-fold. The "crack baby" became the poster child for 1 side in each of 2 heated controversies in the United States: the war on drugs and the struggle over abortion.

The war on drugs focused on individual moral failing rather than social circumstance, and comprised several basic approaches: an emphasis on drug law enforcement; an increase in severity of criminal justice penalties, including mandatory minimum sentences; and a comparative deemphasis on treatment of drug addiction. The escalation of this war occurred during the Reagan Administration, coincident with the rise of unemployment, homelessness, and urban poverty that fueled the crack epidemic.[2] While cocaine in inhalation form had been a popular drug for the upper middle class in the 1970s, it did not draw the same media or political attention or severity of criminal justice response as did crack smoking by inner-city youth.[3]

There have been dramatic consequences of the war on drugs. The number of incarcerated individuals in the United States has more than tripled, resulting in the United States having the second highest incarceration rate in the world.[4] Average length of sentence for drug offenders has tripled as well, while the proportion of inmates receiving treatment for substance abuse disorders has more than halved.[4] While men still predominate within the incarcerated population, the proportion of women has increased sharply and at nearly double the rate for men.[5] This increase has been most dramatic for minority women. From 1986 to 1991 the number of women incarcerated in state prisons for drug offenses increased by 828% for black women, by 328% for Hispanic women, and by 241% for white women.[2]

There have also been important public health consequences. Research regarding the physiological and behavioral components of addiction and development of treat-

See also p 1613.

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ment approaches has been underfunded and has languished. Advocates of a criminal justice approach to substance abuse have expressed frustration with the usefulness of drug treatment, pointing to relapse as evidence of lack of efficacy. While it is certainly true that treatment for drug addiction needs improvement that further research should address, its efficacy compares with that of commonly used medical treatments for other chronic relapsing conditions such as type 2 diabetes mellitus, hypertension, and asthma.[6] The choice of a criminal justice rather than a public health approach toward drug addiction has also limited implementation of novel efforts (such as needle exchange programs) to curb the spread of human immunodeficiency virus among drug users, and has resulted in a concentration of the epidemic in drug users and their sexual partners.

The "crack baby" has become a convenient symbol for an aggressive war on drug users because of the implication that anyone who is selfish enough to irreparably damage an innocent child for the sake of a quick high deserves retribution. This image, promoted by the mass media, makes it easier to advocate a simplistic punitive response than to address the complex causes of drug use.

The crack baby also has served as a potent symbol in the ongoing struggle over abortion in the United States. Those opposing abortion generally have done so in the name of fetal personhood. This same assertion underlies the charges brought against women who used drugs while pregnant: child abuse/neglect, homicide, and delivery of drugs to a minor. In 29 of the 30 states where such charges have been brought against new mothers, convictions have been overturned on appeal.[2] However, in the 30th state, South Carolina, the state Supreme Court has departed from the prevailing legal interpretation and has contradicted US Supreme Court precedent by declaring that viable fetuses are "persons" and, thus, covered by the state's criminal child abuse law.[2] A related case, *Ferguson v South Carolina*, is now before the Supreme Court.[7]

This concept of fetal personhood that derives from the abortion debate has led to the depiction of the pregnant woman as one whose selfish negligence or hostility toward the "innocent" fetus must be constrained by the outside intervention of the criminal justice system. These prosecutors have not been deterred by evidence from medical experts that many pregnant addicted women are very concerned about the consequences of their drug use for their future children and are eager for treatment, even though that treatment is difficult to access generally, and often specifically unavailable for pregnant women and for the incarcerated.[8]

The war on drugs and the struggle over abortion are profound multifaceted political controversies. Medical and public health experts can try to temper these heated debates by injecting scientifically garnered data, clinical evidence, and insistence on the importance of therapy. Since medicine unequivocally considers addiction to be a compulsive disorder in need of treatment,[9] many medical organizations (American Medical Association, South Carolina Medical Association, American College of Obstetricians and Gynecologists, American Medical Women's Association and more than 20 others) have filed amici briefs in many of these cases, asserting that addiction is a disease; that maternal and fetal interests are intertwined and that the pregnant woman speaks for those interests; that it is in the medical and public health interest to provide treatment and not punishment; and that criminal punishment is not therapeutic and is likely to deter frightened women from seeking needed care.[10]

This next period is likely to bring its own set of complications. There have been recent signs of abatement in the war on drugs. In New York, the governor and legislators have proposed modification of the Rockefeller drug laws to reduce mandatory sentences, offer treatment alternatives, and return discretion in sentencing to judges.[11] Proposition 36, which passed in California this past November, which substitutes treatment for prison for many nonviolent drug possession offenders, and former President Clinton has called for reconsideration of mandatory sentences for federal drug offenses.[12]

However, the situation for poor addicted women has not abated as treatment opportunities for them have been further compromised by recent changes in welfare policy. Since passage of the Personal Responsibility and Work Opportunity Reconciliation Act in 1996,[13] states can exclude individuals with previous drug felony convictions from receiving cash assistance, and attendance at drug treatment programs does not count toward meeting the work requirement on which receipt of cash assistance is now conditioned. Further, drug and alcohol dependence no longer renders one eligible for Supplemental Security Income (SSI), with the resulting loss of such income for approximately 108 000 SSI recipients and 31 000 Disability Insurance recipients as of December 1997.[13-15] Disagreement over abortion shows no sign of lessening, and there will likely be efforts to further limit access to abortion for the young and the poor.

Although the image of the crack baby has stirred partisan passions, the review of the evidence in the meta-analysis by Frank et al indicates that these images are not based on fact. As citizens, we may fall on different sides of these debates on abortion and drug addiction. Yet, as physicians and public health advocates, we can follow the example of Frank et al and raise a calm steady voice for science and therapy.

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Screening Mothers for Intimate Partner Abuse at Well-Baby Care Visits

The Right Thing to Do

Robert S. Thompson, MD

Richard Krugman, MD

IN THIS ISSUE OF THE JOURNAL, MARTIN ET AL[1] REPORT ON the prevalence of physical abuse before, during, and after pregnancy as determined from a random sample of North Carolina women (1997-1998). Women were surveyed by mail and telephone approximately 3.6 months after they delivered live infants. Reported physical abuse before and during pregnancy exceeded 6% and was 3.2% in the postpartum period. Abuse in an earlier period was strongly associated with further abuse in subsequent periods. Mothers reported a mean of 3 well-baby care visits during the first 3.6 postnatal months.

The findings from this study suggest that intimate partner abuse (also termed intimate partner violence or domestic violence) is occurring in the immediate postnatal period, and an opportunity exists for pediatric health care practitioners to identify this abuse. The American Academy of Pediatrics (AAP) issued a policy statement in June 1998 stating, "Pediatricians are in a position to recognize abused women in pediatric settings. Intervening on behalf of battered women is an active form of child abuse prevention. Knowledge of local resources and state laws for reporting abuse are emphasized."[2] This recommendation could apply to all who provide postnatal child care.

Martin et al suggest that abused mothers may have as many as 3 opportunities to be identified at well-baby care visits in the first 3½ months of their new infants' lives. The AAP recommends 3 visits in the first 3 months and 6 visits in the first 12 months of infancy. Utilization data from Group Health Cooperative (Seattle, Wash) indicate that the mean number of encounters for well-baby care in the first 3½ months is 2.5 and that in the first 12 months of life, there are 4.2 such visits (Virginia Immanuel, MPH, written communication, February 21, 2001). Using data provided by Martin et al,[1] the number of women who would have to be screened to detect 1 abused mother would be 14.5 before pregnancy, 16.3 during pregnancy, and 31 during the first 3½ months postpartum.

It is possible to implement this screening opportunity by building some questions into the standard forms used as a routine part of well-baby care. For instance, Group Health Cooperative includes a question about "family history of physical abuse or sexual abuse" on routine questionnaires for neonates or new child family members. Clearly, more in-depth questions are needed, but this example is a start, and previous work in family violence demonstrated that written questionnaires increased abuse screening by 14.3%.[3]

The second part of the AAP recommendation states that "intervening on behalf of battered women is an active form of child abuse prevention." The literature contains solid links between domestic violence and child abuse, and suggests that the link is approximately 50% in either direction.[4-6] Information on the long-term adverse effects of child abuse is also well documented.[7-9] Despite these links, the US Preventive Services Task Force concluded in 1996 that there was "insufficient evidence to recommend for or against the use of specific screening instruments"[10] for detecting intimate partner abuse. Insufficiency issues boil down to instruments for detection of intimate partner abuse, modes

See also p 1581.

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Project Strengthening Supervision

A Training Program for Child Welfare Supervisors

Promoting Recovery and Safety within Substance Affected Families

Provided through:

Illinois State University
School of Social Work

Dennis J. Crowell, Project Director
J. Randall Webber, Training Director

Funded by:
A grant from the Children's Bureau (DHHS)

Learning Objectives

At the conclusion of this workshop, participants will be able to:

- **Describe at least three kinds of styles and patterns of recovery**
- **Identify factors that separate clinical populations from community populations of substance abusers**
- **Discuss the concept of "recovery capital."**
- **Identify the most common medications used to support recovery**
- **Discuss the effect of gender on recovery**
- **Describe the concept of "zones of recovery."**
- **Identify the role of the community in supporting recovery**
- **Describe at least three criteria (other than urine testing for drugs of abuse) that can be used to determine the durability of recovery**
- **List at least three possible treatment outcomes that lead to long-term abstinence**
- **Describe the role of the "recovery guide."**

I. What is Recovery?

A. Sustained Abstinence--Primary Drug

B. Sustained Abstinence--No Drug Substitution

C. Reduction of Drug use to Subclinical Levels

D. Sustained Absence of Drug-related Problems

E. Resolution of AOD Problems within the Umbrella of Global Health

II. Clinical Versus Community Populations

A. Problem Severity & Chronicity

B. Co-morbidity

C. Absence of or depletion of "recovery capital" (Granfield and Cloud, 1999)

III. Styles of Recovery

A. Transformative--"Quantum Change"

1. High Vividness (Intensity)

2. Suddenness (Unintentional)

3. Positiveness and Permanence (Miller and C'de Baca, 2001)

B. Incremental Change (Conscious)

1. Multiple sobriety efforts

2. Longer periods between relapse

3. Decreased intensity and duration of relapse episodes

4. **Increased quality of sobriety**

C. **Incremental Change (Unconscious)**

1. **Drift**
2. **"Maturing Out", "Retirement" (Winick, 1962)**

D. **Natural (Solo) Recovery**

E. **Assisted (Affiliated) Recovery**

F. **Virtual Recovery**

G. **Disengaged Recovery**

IV. **Styles of Addiction/Recovery Affiliation**

A. **Acultural Style**

- **Requires high level of "recovery capital"**

B. **Bicultural Style**

- **Requires higher level of emotional adjustment and social skills**

C. **Enmeshed Style**

- **may be required for those coming out of enmeshed styles of addiction**

D. **Style changes over the course of long term recovery (White, 1996)**

V. **Medication Assisted Recovery**

A. **Aversive Agents**

- **Disulfram (Antabuse)**

B. **Maintenance Agents**

1. **Methadone and LAAM**
2. **Buprenorphine**

C. **Anti-craving Agents**

1. **Naltrexone (Revia)**
2. **Acamprosate**

VI. **Gender and Recovery**

A. **Women have lower rates of alcoholism than men (Alcohol and Health, 1997)**

B. **Women have increased prospects of recovery from drug addiction (Snow, 1973):**

C. **Alcoholic women were 1.63 times more likely to be in stable recovery than alcoholic men 8 years following treatment (Humphreys, et al, 1997)**

D. Heavy drinking for women peaks in their thirties.

VII. Gender Specific Recovery

- Recovering women are more likely to embrace models of change that emphasize taking control of one's life. (Granfield and Cloud, 1996)

VIII. Gender Factors In Recovery Initiation

A. Pregnancy

B. Parenthood

C. Fear of Effects of AOD use on Children

D. Fear of Losing Custody of Children

E. Separating from an Addicted Partner (Chen and Kandell, 1998; Burman, 1997; Waldorf, 1983)

IX. Research on Family Recovery

A. The Alcoholic Family in Recovery: A Developmental Model (Stephanie Brown and Virginia Lewis)

B. Addiction recovery unfolds over time across three arenas of change: The individual, the family as a system, and the family's relationship to the outside environment.

C. "The unsafe, potentially out-of-control environment continues as the context for family life into the transition and early recovery stages...as long as 3-5 years."

D. The family's individual and collective adaptations to cope with addiction result in trauma, developmental delays, and personal and relationship pathology.

E. In recovery this unhealthy family system must collapse.

F. Family members may need support structures to serve as "holding environments" until a healthier family system can be constructed.

G. Without such supports, personal recovery may produce family disintegration.

H. This change process can last for 5-10 years.

I. While recovery alleviates many of the family's historical problems, this early period can also be referred to as the "trauma of recovery": a time of great change, uncertainty and turmoil within the family.

J. This turmoil can be ameliorated through professional and natural support systems.

X. Recovery and Parenting

A. Is the development or resumption of effective parenting an early, middle,

or late stage task of recovery?

B. Transitions from addiction to early recovery

C. From rejection and detachment to overindulgence and over-protection

D. Transition from early to middle recovery

E. From cessation of neglect/abuse to enhanced quality and consistency in mother-child relationship

XI. Durability of Recovery

A. When is a pattern of sobriety deemed to be stable and enduring?

B. Principle: Recovery stability increases with length of sobriety.

C. The risk of relapse dramatically diminishes after the achievement of four-five years of sobriety (Nathan and Skinstad, 1987; De Soto, et al, 1989; Dawson; 1996; Jin, et al, 1998)

XII. Zones of Recovery (White, 1996)

A. Physical Zone

B. Cognitive-Emotional Zone

C. Relationship Zone

D. Lifestyle Zone

E. Spiritual Zone

XIII. Physical Zone of Recovery

A. Achievement/stabilization of Abstinence

B. Management of withdrawal and post-acute withdrawal (craving)

C. Management of drug substitution risks

D. Active response to acute and chronic medical/psychiatric problems

E. Active health management: Diet, sleep, hygiene, exercise.

XIV. Cognitive-Emotional Zone of Recovery

A. 3-stage Change in Preferred Defense Structure (Wallace, 1974)

B. Drug-free management of emotions/impulses

C. Emotional catharsis, story construction, and storytelling (changed view of self/world)

D. Work on emotional control, impulse control and problem solving

E. Work on character defects

XV. Relationship Zone of Recovery

A. Detachment from the culture of addiction (people, places, things)

B. Severing pathology-bonded relationships

C. Development of a sobriety-based support structure

D. Sobriety-based changes in family roles, rules and rituals

E. Sobriety-based management of emotional and sexual intimacy

XVI. Lifestyle Zone of Recovery

A. Cessation of criminal/predatory activity

B. Shedding trappings from culture of addiction: language, dress, symbols

C. Creation of sober sanctuary (home)

D. Development of sobriety-based leisure activities

E. Redefinition of the meaning of work/money

F. Resolving financial and legal problems

G. Restructuring of daily rituals

XVII. Spiritual Zone of Recovery

A. Crisis: Synergy of pain and hope

B. Discovery of power within or outside the self

C. A sudden or gradual sense of rebirth

D. Purging of shame and guilt

E. Forgiveness of self and others

F. Acts of restitution and service

G. Development of daily centering rituals

H. Cultivation of gratitude

I. Clarification of religious/spiritual beliefs and values

J. Cultivation of sacred places, objects and objects

K. Experience of community (of recovery, of shared experience, of faith)

XVIII. Role of Community in Recovery

A. McKnight's Critique

B. Indigenous (accessible, culturally appropriate, reciprocal, non-commercialized, and enduring) Resources

C. Family, extended family/Kinship networks, neighborhood resources, schools, churches, local service organizations

D. Cultural Revitalization Movements

E. Mutual Aid Societies

XIX. Kurtz Resource Guide

A. Variety of Support Structures

B. How to work with Support structures

C. Familiarity with literature

D. Attending meetings open to service professionals

E. Working with local service committees

F. Creating Resources where none exist

XX. Mutual Aid Intensity Effect

A. Outcomes Improve in Tandem with Increased Participation:

1. meeting attendance/speaking,
2. closed meetings and having a "home meeting,"
3. pre-post meeting rituals

B. Outcomes Improve in Tandem with Increased Participation:

1. sponsorship
2. knowledge of literature
3. application of concepts to daily problems,

C. Outcomes Improve in Tandem with Increased Participation:

1. leisure involvement,
2. service activities. (Montgomery, et al, 1995; Humphreys, et al, 1997; Caldwell & Cutler, 1998)

XXI. Mutual Aid and Special Populations

A. Early Criticisms

B. Women and people of color affiliate with AA/NA at the same rates as white men (Humphreys, 1994; Kessler, et al, 1997; Winzelberg and Humphreys, 1999)

C. Over time, participation in AA for African Americans and Hispanics decreases (Tonigan, et al, 1998); This may reflect a transfer of recovery maintenance to indigenous institutions.

XXII. Treatment Outcomes

A. Continual, Uninterrupted Abstinence

B. Sustained Problematic Use at Pre-Treatment Levels

C. Moderated, Sub-clinical Use

D. **Initial Abstinence / Moderated Use Followed by Accelerated Use/Problems**

E. **Initial Use/Problems Followed by Stable Recovery**

F. **Binge/Recovery Cycles**

XXIII. **Post-Treatment Recovery Coaching**

A. **Monitoring**

B. **Feedback**

C. **Stage-Appropriate Recovery Education**

D. **Resource Linkage (Indigenous)**

E. **Early Re-intervention (Treatment)**

F. **Re-engagement and Recovery Priming Following Broken Contact**

XXIV. **Recovery Coach/Guide**

A. **Twin Goals**

1. **Management of Long Term Addiction Recovery**
2. **Enhancement of Parental Effectiveness and Family Health and Safety**

B. **Knowledgeable of about Indigenous and Formal Community Resources**

C. **Capable of engaging the difficult-to-engage client**

D. **Skilled at leading people into relationship with a recovering community**

E. **Skilled at sustaining long-term recovery support relationships**

F. **Skilled at organizing resources where none exist**

G. **Sees possibilities where others see only problems.**

H. **Is personally connected to the "communities within the community"**

I. **Can make things happen because they are trusted within these communities.**

J. **Believe the community is a "reservoir of untapped hospitality"**

K. **Knows the client's engagement with the community begins in when the guide leaves. (McKnight, 1995)**

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PROJECT STRENGTHEN SUPERVISION
SCHOOL OF SOCIAL WORK
ILLINOIS STATE UNIVERSITY

SIGNS OF PROGRESS IN ADDICTION RECOVERY

- **Predictors of Treatment Success**
  - Pre-treatment
  - Family involvement
  - Parenting training
  - Completion of primary treatment
  - Completion of aftercare
  - Evidence of a sobriety-based support structure

- **Assessment of Recovery Stability**
  - Duration of sobriety
  - Number of support group meetings
  - Type of support group meetings
    - 12-Step (A.A., N.A., etc.)
    - Women for Sobriety
    - Rational Recovery
    - Faith-based
    - Others
  - Sponsorship
  - Three-part story
    - How it was/Who I was
    - What happened
    - How it is now/Who I am now
  - Reading and possession of recovery-oriented literature
  - Daily rituals
  - Service work

PROJECT STRENGTHENING SUPERVISION

A Training Program for Child Welfare Supervisors

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OUTLINE

I. Objectives/Outline

II. Critical Challenges in the New Millennium

III. Roles of the Supervisor

IV. 12 Key Behaviors Supervisors Can Model For Staff Who Work With Addicted Clients

V. Personal Awareness – Things That Are Important For Staff Who Work With Chemically Dependent Clients to Explore

VI. Getting the Most From Those You Supervise

VII. Case Vignettes

VIII. Teaching About Boundaries With Substance Abusing Families

IX. Models of Supervision

X. Keeping Staff Motivation High in Working With Substance Abusers

XI. Case Vignettes

XII. Helping Workers Increase Treatment Compliance

XIII. Closure

Learning Objectives

At the conclusion of this workshop, participants will be able to:

- Demonstrate an awareness of strategies designed to help increase effectiveness among supervisors who work with addicted clients.
- Describe six approaches to supervising staff who work with addicted clients.
- Demonstrate an awareness of strategies to help staff maintain boundaries and avoid apathy when working with addicted clients.
- Identify methods of helping supervisors instill motivation to recover in their addicted clients.
- Understand 12 strategies for helping supervisees increase treatment compliance with substance abusing clients.

CRITICAL CHALLENGES IN THE NEW MILLENNIUM

1. **Increased family disintegration**
2. **Multiproblem families**
3. **Use of highly addictive drugs**
4. **Use of drugs at earlier ages**
5. **Diversity**
6. **The need to accomplish results in a shorter amount of time**
7. **Increased stigma of addicts**
8. **Apathy**

Roles of the Supervisor

1. Supporter
2. Educator
3. Skill Developer
4. Resource person
5. Guide
6. Team Captain
7. Umpire/Negotiator
8. Teammate
9. Cheerleader
10. Coach
11. Behavior Modeler

15 Key Behaviors Supervisors Can Model for Staff Who Work With Addicted Clients

1. Acceptance
2. Kindness
3. Detachment with care
4. Looking for the positive
5. Accepting powerlessness
6. Accepting the client's right to self-determination
7. Celebrating recovery
8. Carefrontation
9. Balance/Boundaries
10. Creativity
11. Not having all the answers
12. Diplomatic advocacy
13. Being a lifelong learner
14. Holding clients accountable
15. Flexibility

PERSONAL AWARENESS

Things that are important for caseworkers/counselors who work with chemically dependent clients to be aware of –

1. What are my feelings about addicts?

   A.

   B.

   C.

2. In working with chemical dependence, my definition of success is....

3. In terms of working with chemical dependence, what do I consider to be a difficult case and why?

4. In terms of working with chemical dependence, what are my limits?

5. What do I feel when clients relapse?

6. In working with chemical dependence, what do you feel you need to know more about?

GETTING THE MOST FROM THOSE YOU SUPERVISE

Surveys in the human service field reveal that the supervisor/supervisee relationship is the most critical factor in employee job satisfaction.

PARALLEL PROCESS

1. **Empathy**
2. **Genuineness**
3. **Warmth**
4. **Respect**

WHAT EMPLOYEES WANT MOST

Supervisor Survey	**Employee Survey**
Good Wages	Appreciation
Job Security	Feeling "in" on Things
Promotion Opportunities	Understanding Attitude
Good Working Conditions	Job Security
Interesting Work	Good Wages
Loyalty from Management	Interesting Work
Tactful Discipline	Promotion Opportunities
Appreciation	Loyalty from Management
Understanding Attitude	Good Working Conditions
Feeling "in" on Things	Tactful Discipline

TEN USEFUL THINGS TO KNOW ABOUT THOSE WHO YOU SUPERVISE

1. The reason they work at your agency.
2. What management style works best for them.
3. In supervising them certain things I should never do.
4. What they need when they are having a bad day.
5. Their birthdays.
6. Their kids' names (if they have kids).
7. What they value.
8. What they think is not valuable.
9. How they like to be praised.
10. How to give them feedback.

Take care of basic needs.....

A)

B)

C)

D)

Recovery rates remain constantly low – creative ideas are needed.

How to spark creativity…

A) **Let people know you're looking for creative ideas.**

B) **Take creating brainstorming breaks.**

C) **Reward staff for creative ideas.**

Giving Feedback that produces results….

A) **Establish the relationship.**

B) **Never embarrass.**

C) **Talk About your own mistakes.**

D) **Give suggestions and let the others decide what to do.**

E) **Praise slight improvements.**

CASE VIGNETTES

1. You sense that a supervisee has become apathetic in his/her work with substance abusers as a result of limited success. You overhear the working saying things such as, "What's the use, no one recovers;" "They're just no-good dope fiends;" "These mothers don't care."

    - Why do workers become apathetic in their work with substance abusers?

    - How would you intervene in this specific situation?

    - As a supervisor, what would you do if you sensed that your entire department was pessimistic/apathetic in their work with substance abusers?

2. A supervisee has been assigned to work with the Smith family. DCFS became involved when Mr. Smith, after drinking, physically abused one of the kids. The supervisee's visits usually occur during the day while Mr. Smith is working. Most of the planning has been done between the caseworker, Mrs. Smith, and the children. Mr. Smith goes against the plan. The supervisee accuses him of "sabotage." The supervisee also feels that Mr. Smith has minimized his alcohol/drug use somewhat. They have a heated discussion. Mr. Smith says, "You're against men." The supervisee says, "If you didn't hit your kids, everything would be all right." There are eight months of tension between Mr. Smith and the caseworker, thus affecting reunification.
    - In viewing the case from Mr. Smith's perspective, how do you think he sees things?
    - How does the supervisee view the situation?
    - What are some reasons these situations occur?
    - As a supervisor, how would you help?
    - What work is left to do on this case and how would you advise the supervisee to proceed?
    - How can a supervisor help prepare a department to deal with these kinds of situations?

3. A supervisee is working with an addicted family and is having difficulty with boundaries. The worker has given the family his/her home phone number and spends and exorbitant amount of time with the family. The worker minimizes the impact of substance abuse on the kids, does favors for the family, and speaks of the family in almost familial terms.

    - What are some reasons that boundaries are crossed with substance abusing families?
    - As a supervisor, how would you deal with this specific situation?
    - In general, how can you prepare your staff to maintain appropriate boundaries with substance abusing families?

TEACHING ABOUT BOUNDARIES

Types of boundary violations commonly seen in addicted families:

1. Loose boundaries.

2. Enmeshed boundaries (individuals are robbed of the 5 freedoms)

    - The freedom to feel what you feel rather than what you *should* feel.
    - The freedom to think what you think rather than what you *should* think.
    - The freedom to see what you see rather than what you *should* see.
    - The freedom to want what you want rather than what you *should* want.
    - The freedom to imagine your own self-actualization.

3. Drug related boundary violations:

    - Relatives getting high in your presence.
    - Individuals putting drugs in your hand.
    - Family members asking you to buy them drugs.
    - Relatives giving you alcohol as a gift.
    - Family members constantly bringing up your addiction to make you feel guilty,

4. Triangles
5. Squares
6. Put downs
7. Voice tone
8. Sexual boundary violations
9. Spiritual boundary violations
10. Rigid Family roles
11. Intrusion
12. Abandonment

SKILLS USEFUL FOR STAFF TO HAVE IN ESTABLISHING BOUNDARIES

1. Awareness of the great lengths to which families will go to maintain homeostasis.
2. How to avoid becoming enmeshed.
3. How to establish our own boundaries.
4. Differentiation of self.

MODELS OF SUPERVISION

- Individual Supervision
- Group Supervision
- Case Consultation
- Live Supervision
- Practice
- Multidisciplinary Conference
- Demonstration
- Tapes
- Visits
- Professional Videos
- Use of Articles
- Journaling
- Motion Pictures

KEEPING STAFF MOTIVATION HIGH IN WORKING WITH SUBSTANCE ABUSE

- Testimonials
- Storytelling hour
- The use of alumni
- Celebrations of sobriety
- Encouraging creativity
- Attending self-help open conventions
- Allow for the expression of negative feelings
- Reframe failure
- Teach principles of motivational interviewing
    - A) Acceptance of the client's level of readiness to change
    - B) Helping the client resolve the ambivalence crisis
    - C) Looking for leverage
    - D) Instilling hope
- Teambuilding

CASE VIGNETTES

1. A young caseworker you are supervising is working with a grandmother who currently has custody of her cocaine dependent daughter's children. The caseworker makes several recommendations to the grandmother, including a referral to Al-Anon and special services for the children, who are children of an addicted parent. The grandmother says to the caseworker, "You are so young. I've forgotten more about children that you will ever know." When asked by the grandmother if she had children, the caseworker answered, "No."

   - As the supervisor, what suggestions do you have for the caseworker?

2. A caseworker you are supervising tells you that he thinks a client has relapsed but has no solid proof. The client denies a relapse. The caseworker asks you how he can find out if the client has relapsed.

   - What would you say?

3. A caseworker you are supervising refers an African American male client to an outpatient substance abuse program. The client states that addiction in the Black community is caused by racism and is a form of genocide and therefore outpatient treatment is an inappropriate recommendation. He writes a letter to you, the supervisor, complaining of the caseworker's insensitivity to his needs as an African American client.

   - As the supervisor, what would you do?
   - What can supervisors do to assure that clients receive culturally sensitive services?

4. A caseworker you are supervising is working with a client who refuses to open up, stating that she's had four different caseworkers in the past year. She goes on to say that during the short 28 days that she was in inpatient chemical dependency treatment, she had two different caseworkers who both left for other jobs. The client states, "I'm tired of telling the same story to different people, over and over and over again." The caseworker asks you how she can build a relationship with this client.

   - As he supervisor, what would you suggest?

HELPING WORKERS INCREASE TREATMENT COMPLIANCE

1. Match intervention strategies with the client's level of readiness to change.
2. Increase family involvement – What the research says:
   - Staff are more effective recruiters than clients.
   - The earlier you involve the family in the process the better.
   - Enthusiastic workers who sincerely believe in the value of family involvement are the best recruiters.
   - Allowing family members to openly talk about their hurt, pain, and fear first increases the chance they will participate.

The Family Therapy of Drug Abuse and Addiction, by Stanton Todd

3. Celebrate small victories and encourage the client to do the same.
4. Increase 12-step attendance.
   - Allow the client to openly talk about his/her past 12-step group experience.
   - Allow the client to openly talk about his/her ambivalence about 12-step group experience.
   - Arrive early.
   - Help set up chairs prior to the meeting.
   - Volunteer to read the literature.
   - Stay late.
   - Encourage the client to attend six different groups before deciding if it is valuable.
   - Try to match the meeting with the personality of the client.
   - Keep in mind cultural considerations when you make the referral.
5. Consider developing a successful alumni pool.
6. Look for leverage.
   - External
   - Internal
7. Sharpen assessment and treatment skills
   - Other addictions
   - Dual disorders
   - Trauma
   - Sexual abuse
8. Help clients discover their relapse triggers and figure out ways of dealing with high risk situations.
9. Teach Clients social and living skills.
10. Provide culturally sensitive services.
11. Give the client options.
12. Increase staff knowledge.

RESOURCES

Improving Treatment Compliance, Dennis Daley, Hazelden, MN 1999.

In Search of Excellence: Lessons from America's Best Run Companies, Thomas Peters & Robert H. Waterman, 1988.

The 22 Biggest Mistakes Managers Make and How to Correct Them, James Van Fleet, Parker Publishing Company, New York, 1982.

Leading from the Heart: Choosing Courage OverFear in the Workplace, Kay Gilley, 1996.

New Treatments for Chemical Addictions, Elinore McCance-Katz & Thomas Kosten, American Psychiatric Press, Inc., 1998.

APPENDIX B

Project Strengthening Supervision

Power Point Presentations
to
Accompany Curriculum

Motivational Interviewing & Stages of Change Theory

Motivational Interviewing & Stages of Change Theory

- History
- Principles
- Utilization

John Wallace (1974)

- Addiction and recovery are developmental processes characterized by generally predictable stages and milestones.
- There are developmental windows of opportunity....

John Wallace (1974)

- Skills and perspectives must be mastered at each stage
- These stages can differ across various clinical sub-populations of addicted clients.

John Wallace (1974)

- Failure in treatment often results from asking clients to do something that they are incapable of at that time.
- Treatment interventions that are appropriate at one stage of recovery may be ineffective or even harmful at a different stage. (White, 1998).

FIVE BASIC PRINCIPLES

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal

Develop Discrepancy

- Awareness of consequences is important
- A discrepancy between present behavior and important goals will motivate change
- The client should present the arguments for change

Avoid Argumentation

- Arguments are counterproductive
- Defending breed defensiveness
- Resistance is a signal to change strategies
- Labeling is unnecessary

Roll with Resistance

- Momentum cab be used to good advantage
- Perceptions can be shifted
- New perspectives are invited but not imposed

Support Self-efficacy

- Belief in the possibility of change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

The Therapist's Task: Precontemplation

- Establish a relationship
  - Build trust
  - Ask permission
  - Be sympathetic
  - Listen
  - Don't judge

The Therapist's Task: Precontemplation

- Establish a relationship
  - Raise doubts/Create discrepancy between where/who the client wants to be and where s/he actually is.
  - Offer factual information about the client's risks.
  - Explore the pro's and con's of client's behavior/lifestyle.

The Therapist's Task: Precontemplation

- Establish a relationship
  - Work with significant others.
  - Maintain the relationship.

The Therapist's Task: Contemplation

- Explain that being uncertain is normal.
- Explore the pro's and con's of current behavior/lifestyle.
- Raise doubts/Create discrepancy between where/who the client wants to be and where s/he is.

The Therapist's Task: Contemplation

- Focus on the client's strengths; promote self-efficacy and self-esteem.
- Support pro-treatment statements without arguing about anti-treatment statements.

The Therapist's Task: Preparation

- Help with planning.
- Work on lowering barriers.
- Enlist the social support network.
- Describe the process of treatment.
- Provide hope.

The Therapist's Task: Action

- Engage the client in treatment.
- Don't abandon client if s/he is in treatment elsewhere.
- Initiate therapy.
- Educate client.
- Continue work with social support network.
- Reward progress.

The Therapist's Task: Maintenance

- Help client identify new sources of pleasure/enhancement of self-esteem.
- Support client's efforts.
- Continue developing client's strengths.
- Maintain your relationship.

The Therapist's Task: Maintenance

- Honestly discuss the possibility of a return to use.
- Watch for emerging issues.
- Continue therapy.

The Stages of Change Spiral

- Most people taking action do not successfully maintain their gains on their first attempt.
- Relapse and recycling through the stages occur quite frequently.
- This "Spiral Model" of change is not linear. However, outcomes continue to improve over time.

Additional Therapist Actions

- Assuming that patient's are in the action phase leads to low utilization and high dropout rates. Develop stage appropriate interventions.
- Match patients to interventions.

Additional Therapist Actions

- Keep the patient in treatment, and work him/her through the stages; patients who remained in treatment progressed over time.
- Be familiar with using the ten components of the change process (Handout: Appendix A).

FRAMES

- F= *Feedback*
- R= *Responsibility*
- A= *Advise*
- M= *Menu*
- E= *Empathy.*
- S= *Self-efficacy*

FRAMES

- F= Patients need to receive *feedback* as to how their drug or alcohol use is affecting them; develop discrepancy.
- R= Patients are given the message that they are ultimately *responsible* for their own behaviors, but roll with resistance and avoid argumentation.

FRAMES

- A= Patients often seek advice, and should be given *advise* within the context of personal responsibility.
- M= Patients can be given a variety (a *menu*) of choices.
- E= Use *empathy.*
- S= Nurture the patients' *self-efficacy*; their belief that they can change

FIVE EARLY STRATEGIES

- Ask open-ended questions
- Listen reflectively
- Affirm
- Summarize
- Elicit self-motivating statements

Elicit Self-motivating Statements

- Problem recognition
- Expression of concern
- Intention to change
- Optimism

Interviewing Traps to Avoid

- Question/Answer Trap
- Confrontation/Denial Trap
- Expert Trap
- Labeling Trap
- Premature-Focus Trap
- Blaming Trap

Establishing Rapport at the Outset of Treatment

- Speak directly, simply, and honestly.
- Ask about the patient's thoughts and feeling about being in therapy.
- Focus on the patient's distress.
- Acknowledge the patient's ambivalence.

Cory F. Newman, in Onkin, Blaine, & Boren (1997), p. 153.

Establishing Rapport at the Outset of Treatment

- Explore the purpose and goals of treatment.
- Discuss the issues of confidentiality.
- Avoid judgmental comments.
- Appeal to the patient's areas of positive self-esteem.

Establishing Rapport at the Outset of Treatment

- Acknowledge that therapy is difficult.
- Ask open-ended questions, then be a good listener.

Cory F. Newman, in Orkin, Blaine, & Boren (1997), p. 153

Maintaining a Positive Alliance Over the Course of Treatment

- Ask patients for feedback about every session.
- Be attentive. Remember details about patients from session to session.
- Use imagery and metaphors that the patients will find personally relevant.

Cory F. Newman, in Orkin, Blaine, & Boren (1997), p. 191.

Maintaining a Positive Alliance Over the Course of Treatment

- Be consistent, dependable, and available.
- Be trustworthy, even when the patient is not.
- Remain calm and cool in session, even if the patient is not.

Cory F. Newman, in Orkin, Blaine, & Boren (1997), p. 191.

Maintaining a Positive Alliance Over the Course of Treatment

- Be confident, but be humble.
- Set limits in a respectful manner.

Cory F. Newman, in Orkin, Blaine, & Boren (1997), p. 191.

Implications For Training

1. Pave the way for a productive client-therapist relationship with the assumption that the client is a reasonable person, but is currently stuck in a difficult situation.
2. Deliberately adopt a collaboration metaphor for therapy.

[1] Numbers one through six are derived from Hubble, Duncan, & Miller (1999), p. 121

Implications For Training

3. Teach therapists the process of therapy very early in training. Teach them first to be effective, supportive listeners, instead of teaching diagnosis first.
4. Encourage beginning therapists to take seriously the perspective of the problem that the client offers.

Implications For Training

5. Encourage them to expect that the client will get better.
6. The goal of therapy is to support the client's efforts so they can leave therapy and be effective problem solvers on their own.

Implications For Training

7. Therapists can learn how to recognize and reverse deteriorating therapeutic relationships.
8. There are a number of skills and attitudes involved in retaining clients. These can be taught.

Motivational Interviewing Website

- http://www.motivationalinterview.org
- THE website regarding motivational interviewing.
- Includes a discussion forum, comprehensive bibliography, and lists of training opportunities.

Transtheoretical Stages of Change

TRANSTHEORETICAL STAGES OF CHANGE

TRANSTHEORETICAL STAGES OF CHANGE

- **The stage construct is the key organizing construct of the model.**
- **This is important in part because it represents a temporal dimension**
  - Change implies phenomena occurring over time.

TRANSTHEORETICAL STAGES OF CHANGE

- **Other theories of change conceive of change as an event (e.g., quitting smoking, drinking, etc.)**
- **The Transtheoretical Model construes change as a process involving progress through a series of five stages.**

STAGES OF CHANGE

(Prochaska, Norcrosse & DiClemente)

- **Time-Dependent**
- **Perspectives, Skills, Tasks**
- **Change is Stage-Dependent**
- **Interventions-Must be Stage Appropriate**

STAGES OF CHANGE

(Prochaska, Norcrosse & DiClemente)

- **Any movement from one stage to another is progress**

STAGES OF CHANGE

- **Pre-contemplation** ("Resisting change")
- **Contemplation** ("Change on the horizon")
- **Preparation** ("Getting ready")
- **Action** ("Time to move")
- **Maintenance** ("Staying there")
- **Termination** ("Ending the cycle of change")

PRE-CONTEMPLATION

It is not that they can't see the solution.

It is that they can't see the problem

- G.K. Chesterton

PRE-CONTEMPLATION

MOST PRECONTEMPLATORS DON'T WANT TO CHANGE THMESELVES, JUST THE PEOPLE AROUND THEM.

Prochaska, DiClemente & Norcrosse
Changing for Good

PRE-CONTEMPLATION

- Individual may or may not be aware that a problem exists
- Lacks information about problem
- Often coerced into treatment by S.O., court, work
- Often wants others to change (e.g., stop nagging)

PRE-CONTEMPLATION

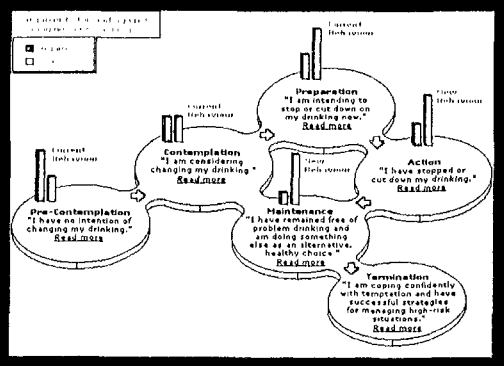
- Precontemplation = not considering change
  - Sees no reason to change
  - Refuses to change
  - Afraid to change
  - Actively resists change

PRE-CONTEMPLATION

- Precontemplation = not considering change
  - Passively resists change
  - Has decided not to change
- Change is not anticipated within the next six months

PRE-CONTEMPLATION

- Denial is common
- Typical statement:
  - "Problem? What kind of problem?"
- Counselor response: Do not challenge lack of awareness
- Advise S.O.'s to not enable



CONTEMPLATION

- Client begins to realize that a problem exists
- Clients trying to understand problem
- May be aware that there are solutions to the problem, but is "not ready"
- Support from others often low

CONTEMPLATION

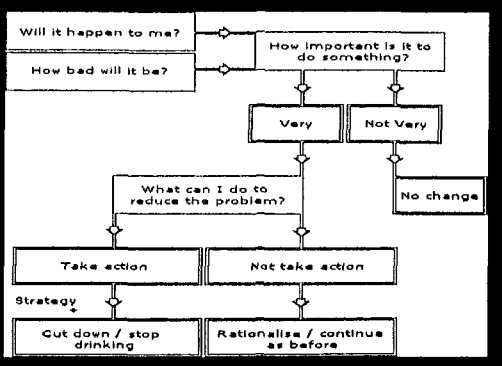
- Client is
  - Ambivalent about change
  - Sees advantages in both the current behavior and the new behavior
  - Sees disadvantages in both the current behavior and the new behavior

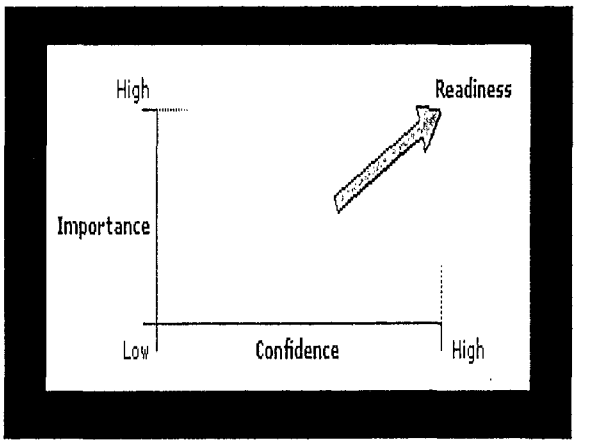
Contemplation

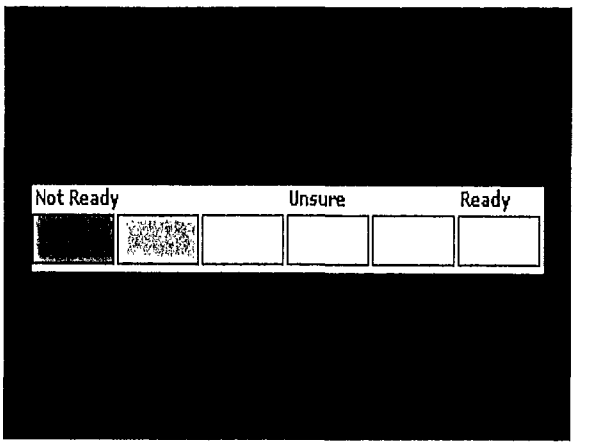
- Typical client statements:
  - "I think I have a problem"
  - "Maybe this is worse than I thought"
- Transition from this stage marked by:
  - Thinking more about solution than problem
  - Focusing more on future than present

Contemplation

- Client intends to make a change within the next six months

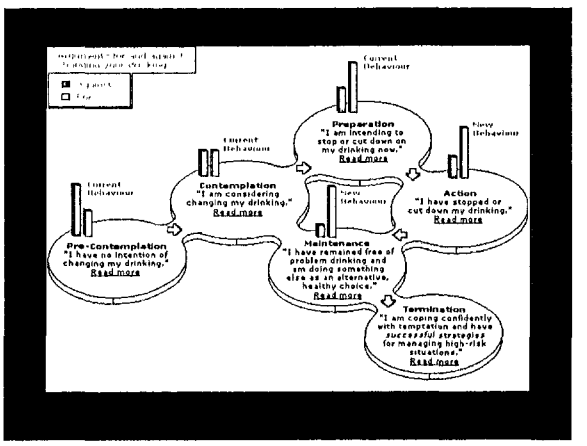






	Pros	Cons
Effects on me		
Effects on others		
How will I feel about myself?		
How will others see me or feel about me?		

	Immediate Consequences		Delayed Consequences	
	Positive	Negative	Positive	Negative
To Change				
Not to Change				



PREPARATION

- Most people in the preparation stage are planning to take action within the next month
- Client begins talking to friends, family, co-workers, counselor about "What works?"
- Client "shopping around" for the best way to change his/her AOD pattern

PREPARATION

- Has resolved most or all of the ambivalence about change, but remnants may remain
- Willing to accept advice and direction
- Anxious about the new behavior—seeks *reassurance*

PREPARATION

- Some small changes may already have been made
- Important step is making public intention to change
- Client may appear ready to take action, *but some ambivalence often lingers*

PREPARATION

- Typical client statements:
  - "How did you do it?"
  - "Maybe I should try an A.A. meeting"
- Plan of action is developed

PREPARATION

- Support from others may be low prior to plan development
- Premature move into action phase may be counterproductive

PREPARATION

- Change <u>is</u> occurring, but it is less visible
  - attitude/thinking
  - awareness
  - emotions
  - self-image
- This is the population from which participants for action-oriented programs should be recruited.

ACTION

- Client begins trying to change
- Change has been initiated within the last six months
- This phase requires more commitment of time and energy
- Support from others is often high due to visibility of change process

ACTION

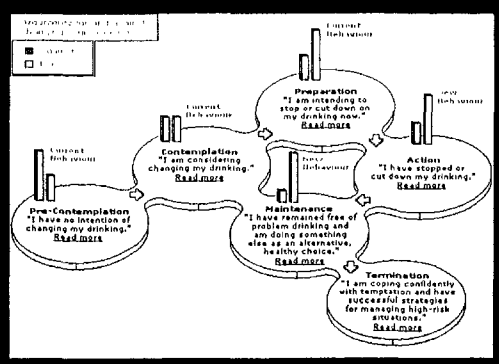
- Typical client statements:
  - "I'm going to do something about my drinking"
  - "I'm going to an A.A. meeting tonight"
  - "I have an appointment to see a counselor"

MAINTENANCE

- Primary goals:
  - maintain changes
  - work to prevent lapses and relapses

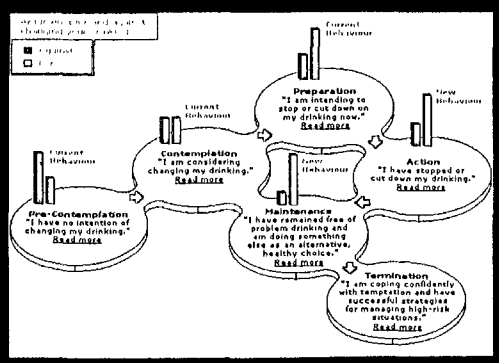
MAINTENANCE

- Less of a phase or stage than a long-term commitment
- Support from others often high



TERMINATION

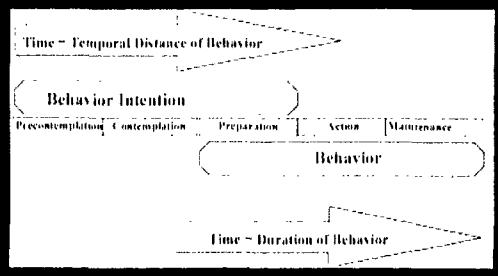
- The ultimate goal of the change process
- Occurs when:
  - behavior in question is no longer a temptation or threat
  - individual can cope without fear of relapse
- This stage is not always a realistic goal



MOVEMENT BETWEEN STAGES

- Many individuals who enter the action and/or maintenance stages will relapse, but most will not regress completely (to the precontemplation stage)

The Temporal Dimension as the Basis for the Stages of Change



INTERMEDIATE & DEPENDENT MEASURES

- Many change models involve only a single univariate outcome measure of success
  - Complete cessation of smoking, drinking and total abstinence
  - Loss of 30 lbs.

INTERMEDIATE & DEPENDENT MEASURES

- Univariate measures:
  - have a low degree of power (the ability to detect change)
  - are not sensitive to change over all the possible stage transitions (e.g., contemplation to preparation)

INTERMEDIATE & DEPENDENT MEASURES

- The Transtheoretical Model proposes a set of constructs that form a multivariate outcome space and includes measures that are sensitive to progress through all stages.

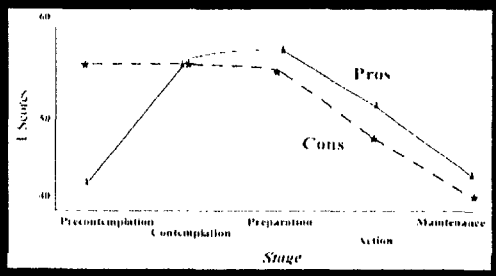
INTERMEDIATE & DEPENDENT MEASURES

1) Multivariate = There is more than one possible measure
2) The measures indicate progress throughout the stages, not just in the action phase.

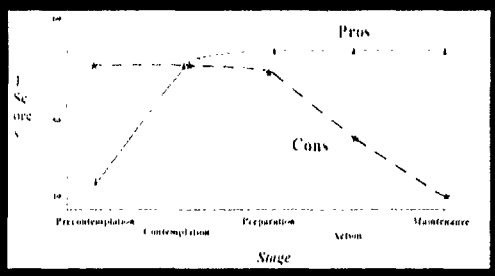
DECISIONAL BALANCE

- Reflects the person's relative weighing of the pros and cons of changing.
- There is a predictable pattern of how pros and cons are seen in the various stages

The Relationship between Stage and the Decisional Balance for an Unhealthy Behavior



The Relationship between Stage and the Decisional Balance for a Healthy Behavior (Exercise)



SELF-EFFICACY MEASURE

- Situation specific confidence that people have that they can cope with high-risk situations without relapsing to their unhealthy or high-risk habit

"Can I do this?"

SELF-EFFICACY

- A sense of self-efficacy is positively related to the probability that the individual will be able to make and sustain desired changes

SELF-EFFICACY

- The therapist's belief in the client's self-efficacy is also positively related to the probability that the individual will be able to make and sustain desired changes

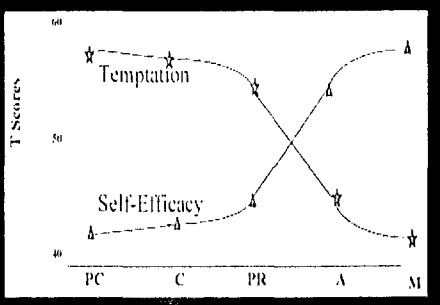
SITUATIONAL TEMPTATION MEASURE

- Reflects the intensity of urges to engage in a specific behavior when in the midst of difficult situations.

SITUATIONAL TEMPTATION MEASURE

- The converse of self-efficacy
- The same set of items can be used to measure both self-efficacy and temptation, using different response formats.

The Relationship between Stage and both Self-efficacy and Temptation



PROCESSES OF CHANGE

- The covert and overt activities that people use to progress through the stages
- The independent variables that people need to apply, or be engaged in, to move from stage to stage

PROCESSES OF CHANGE

- Ten processes of change that have received the most research:
  - Five "experiential" (primarily early stage)
  - Five "behavioral" (primarily later stage)

EXPERIENTIAL PROCESSES

- Consciousness Raising [Increasing awareness]
  - increased awareness about the causes, consequences and cures for a particular problem behavior.

CONSCIOUSNESS RAISING

Interventions that can increase awareness include:

- feedback
- education
- confrontation
- interpretation
- bibliotherapy
- media campaigns

CONSCIOUSNESS RAISING

- Typical client statement
  - I recall information people gave me about how to stop using drugs

EXPERIENTIAL PROCESSES

- Dramatic Relief [Emotional arousal]
  - Initially produces increased emotional experiences followed by reduced affect if appropriate action can be taken.

DRAMATIC RELIEF

Interventions that can produce dramatic release include:

- psychodrama
- role playing,
- grieving,
- personal testimonies
- media campaigns

DRAMATIC RELIEF

- Typical client statement:
  - I react emotionally to TV programs about *parental drug use*

EXPERIENTIAL PROCESSES

- Environmental Reevaluation [Social reappraisal]
  - Combines both affective and cognitive assessments of how the presence or absence of a personal habit affects one's social environment such as the effect of drinking on others.

ENVIRONMENTAL REEVALUATION

- Can also include the awareness that one can serve as a positive or negative role model for others.
  - empathy training
  - media messages
  - *family interventions*

ENVIRONMENTAL REEVALUATION

- Typical client statement
  - I think about how my drug use is hurting the neighborhood

EXPERIENTIAL PROCESSES

- Social Liberation [Environmental opportunities]
  - requires an increase in social opportunities or alternatives especially for people who are relatively deprived or oppressed.

SOCIAL LIBERATTION

- Drug-free housing
- Salad bars in school lunches
- Easy access to condoms and other contraceptives.

SOCIAL LIBERATTION

- Typical client statement:
  - I have noticed society changing in ways that make drug use less acceptable

EXPERIENTIAL PROCESSES

- Self Reevaluation [Self reappraisal]
  - Combines both cognitive and affective assessments of one's self-image with and without a particular unhealthy habit
  - My addiction to heroin makes me feel badly about myself

SELF REEVALUATION

- Self Reevaluation [Self reappraisal]
  - Value clarification
  - healthy role models
  - imagery
- Typical client statement
  - My addiction to heroin makes me feel badly about myself

BEHAVIORAL PROCESSES

- Stimulus Control [Re-engineering]
  - Removes cues for unhealthy habits and adds prompts for healthier alternatives.

STIMULUS CONTROL

- Avoidance
- Cue desensitization
- Strategies for dealing with unavoidable triggers
- Environmental re-engineering
- Self-help groups

STIMULUS CONTROL

- Typical client statement
  - I have removed tbings from my house that remind me of cocaine

BEHAVIORAL PROCESSES

- Helping Relationship [Supporting]
  - Combine caring, trust, openness and acceptance as well as support for the healthy behavior change.
  - I have someone who listens when I want to talk about quitting drug use

HELPING RELATIONSHIPS [SUPPORTING]

- Rapport building
- Therapeutic alliances
- Counselor calls
- Buddy systems

HELPING RELATIONSHIPS [SUPPORTING]

- Typical client statement
  - I have someone who listens when I need to talk about my addiction

BEHAVIORAL PROCESSES

- Counter Conditioning [Substituting]
  - Requires the learning of healthier behaviors that can substitute for problem behaviors

COUNTER CONDITIONING

- Relaxation can counter stress
- Assertion can counter peer pressure
- Exercise can counter craving

COUNTER CONDITIONING

- Typical client statement
  - I find that exercise helps me to not think about using

BEHAVIORAL PROCESSES

- Reinforcement Management [Rewarding]
  - Provides consequences for taking steps in a particular direction
  - Rewards are emphasized (rather than punishments)

REINFORCEMENT MANAGEMENT

- Contingency contracts
- Overt and covert reinforcements
- Positive self-statements and
- Group recognition

REINFORCEMENT MANAGEMENT

- Typical client statement
  - I reward myself when I don't use

BEHAVIORAL PROCESSES

- Self Liberation [Committing]
  - Both the belief that one can change and the commitment and recommitment to act on that belief.
  - I make commitments not to use drugs or drink

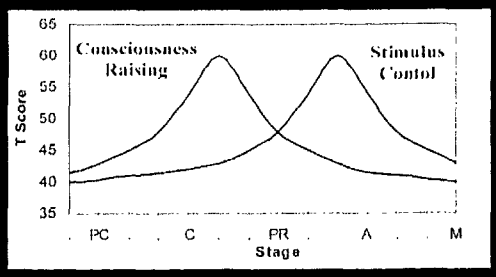
SELF LIBERATION [Committing]

- Both the belief that one can change and the commitment and recommitment to act on that belief.
- Self-liberation can be enhanced by
  - New Year's resolutions
  - Public testimonies
  - Multiple rather than single choices

SELF LIBERATION [Committing]

- Typical client statement
  - I have made a public commitments not to smoke

The Relationship between Stage and Two Sample Processes, Consciousness Raising and Stimulus Control



TYPES OF PRE-CONTEMPLATORS

RELUCTANT

REBELLIOUS

RESIGNED

RATIONALZING

THE REBELLIOUS PRE-CONTEMPLATOR

- Heavy investment in the problem behavior and in making their own decisions.
- Appears hostile and resistant to change

THE REBELLIOUS PRE-CONTEMPLATOR

- Providing choices is best approach
- Challenge for counselor is channeling client's energy into contemplating change

THE RESIGNED PRE-CONTEMPLATOR

- Shows a lack of energy and investment
- Seem to have given up on the possibility of change
- Does not deny that there is a problem
- Denies that s/he can change

THE RESIGNED PRE-CONTEMPLATOR

- Many people in this category are long-term addicts who have failed many times at changing their behavior
- The infusion of hope is a primary strategy

THE RELATIVE IMPORTANCE OF HOPE AND PAIN

- Traditional intervention technology calls for increasing pain in a client's life as a means of persuading him/her to enter treatment

THE RELATIVE IMPORTANCE OF HOPE AND PAIN

- For "empowered" clients who have a high degree of hope in their lives, increasing the level of pain intentionally ("raising the bottom") can be effective

THE RELATIVE IMPORTANCE OF HOPE AND PAIN

- For "unempowered" clients, pain is such a constant in their lives that increasing the pain has little effect
- Such clients "live on the bottom"
- What is missing is hope that things can change

THE RELATIVE IMPORTANCE OF HOPE AND PAIN

- Hope is the key ingredient of successful intervention, not pain

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-*engendering relationships key* ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon *phase in drug relationship.* Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by QR workers can set stage for treatment engagement during crisis.	

THE RATIONALIZING PRE-CONTEMPLATOR

- Think they have all the answers
- Strong belief that their type of substance abuse is not a problem, or that it is a problem for others but not for them
- If interview feels like a debate or a point-counterpoint, person may be rationalizer

THE RATIONALIZING PRE-CONTEMPLATOR

- Similar to rebellious type, but resistance lies in thinking rather than emotion
- Empathy and reflective listening are best approaches
- Doubled-sided reflection may also help

WORKING WITH PRE-CONTEMPLATORS

- Check to make sure that "the problem" means the same thing to you as it does to the client
- "Less is more"

WORKING WITH PRE-CONTEMPLATORS: WHAT *NOT* TO DO

- Push for action
- Nag
- Give up
- Enable

ENABLERS V HELPERS

ENABLERS	HELPERS
Avoid discussions and confrontations	Address specific disruptive & distressing behaviors
Soften consequences by minimizing the importance of events	Ensure that each negative behavior is followed by a consistent consequence

ENABLERS V HELPERS

ENABLERS	HELPERS
Makes excuses, cover for, and even defend problem behaviors	Insist that precontemplators accept responsibility for actions
Indirectly or rarely recommend behavior change	Directly and frequently recommend behavior change

ATTITUDES OF PRECONTEMPLATORS

PRECONTEMPLATOR DEFENSES

- Denial and Minimization ("making the least of it")
- Rationalization ("good excuses")
- Projection & Displacement ("turning outward")
- Internalization ("turning inward")

CONTEMPLATORS' TRAPS

- The search for absolute certainty
- Waiting for the magic moment
- Wishful thinking
- Premature action

THE SEARCH FOR ABSOLUTE CERTAINTY

- Client needs to investigate every aspect of the issue
- Substitute "worry for work"

WAITING FOR THE MAGICAL MOMENT

- Belief that there will be a "magical (perfect) moment" for change to occur
- "After things settle down"
- "Next year"
- "When the kids go back to school"

WISHFUL THINKING

- The most common factor that prevents clients from progressing from contemplation to preparation and action.
- Client wants to continue behavior in question, but with different consequences

WISHFUL THINKING

- "I wish I could get high without losing control."
- "I should be able to eat what I want and not gain weight or raise my cholesterol level."

WISHFUL THINKING

- Wishful thinking and hoping for a solution are different things.
- Wishful thinking is passive and external
- Hope is active and realistic

WISHFUL THINKING

- Hope is active and realistic-One envisions success and then works toward it.
- Is prayer wishful thinking?

THE FOURTH PROCESS
(Emotional arousal)

- Go to the movies
- Making personal propaganda
- Using the imagination

THE RETURN TO CONSCIOUSNESS

- Ask the right questions
- Define goals
- Collect the right data
- Functional analysis

SAMPLE FUNCTIONAL ANALYSIS

Antecedent ⇒	Behavior ⇒	Consequences
Stress	Smoking	Satisfaction
Fatigue		Relaxation
Social discomfort		Calm

WORKING WITH CONTEMPLATORS

- Contemplation is not commitment
- Information and incentives are important to this group
- Provide information which is visible and personally relevant

WORKING WITH CONTEMPLATORS

- "Accentuate the positive"
  - client may be aware of all the negative aspects of their behavior, but not the benefits of continuing the behavior

WORKING WITH CONTEMPLATORS

- Discussion should focus not only on pros and cons of the behavior, but also pros and cons of the change process

WORKING WITH CONTEMPLATORS

- Information about prior attempts to change can be important
- If the client has tried unsuccessfully to change, that experience can be reframed as "some success" rather than failure

WORKING WITH CONTEMPLATORS

- Above can boost self-efficacy
- Ambivalence is the biggest barrier to change

WORKING CLIENTS IN THE PREPARATION STAGE

- Deciding to take appropriate steps to stop a problem behavior or to initiate a positive behavior is the hallmark of this phase
- Commitment to change does not mean that change is automatic

WORKING CLIENTS IN THE PREPARATION STAGE

- Ambivalence is still an issue

WORKING CLIENTS IN THE PREPARATION STAGE

- Important early task for counselor is assessing the the strength and level of commitment to change
- Being adamant about changing may be a sign of weak rather than strong determination to change

WORKING CLIENTS IN THE PREPARATION STAGE

- Indicators of the commitment to change:
  - realistic assessment of the difficulty of change
  - determination to make the change process a top priority in life
  - understanding of the barriers to change

WORKING CLIENTS IN THE PREPARATION STAGE

- Client needs to have identified skills and activities necessary to cope with stress or other aspects of changing
- A working with client on a plan and it's details is an appropriate strategy for this stage

WORKING CLIENTS IN THE ACTION STAGE

- Counseling can be opportunity to:
  - make a public commitment to action
  - get some external confirmation of the plan's viability

WORKING CLIENTS IN THE ACTION STAGE

- Counseling can be opportunity to:
  - obtain support
  - gain self-efficacy
  - create an external monitor of their activity
- Helping clients strengthen their feelings of self-efficacy is critical at this stage

WORKING WITH CLIENTS IN THE MAINTENANCE STAGE

- Major problem for client is realizing the costs of change
- Commitment or self-efficacy may weaken

WORKING WITH CLIENTS IN THE MAINTENANCE STAGE

- Counselor can help client understand:
  - length of time it takes for sustained change
  - fact that "triggers" can bring back undesirable memories

Risks Associated with the Use of Methamphetamine

&

Developing Safety Plans

SIGNS OF CLIENT METHAMPHETAMINE USE

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech
- Euphoria
- Hyperactivity

SIGNS OF CLIENT METHAMPHETAMINE USE

- Dry mouth
- Tremor (shaking hands)
- Dilated pupils
- Lack of appetite
- Insomnia/lack of sleep
- Bruxism (teeth-grinding)

SIGNS OF CLIENT METHAMPHETAMINE USE

- Depression ("the crash"-occurs when drug wears off)
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Formication ("coke bugs")

SIGNS OF CLIENT METHAMPHETAMINE USE

- Presence of white powder, straws, injection equipment

RISKS ASSOCIATED WITH THE USE OF METHAMPETAMINE

- Cardiovascular emergencies (e.g., heart attack, coronary artery spasm)
- Cerebrovascular accident ("stroke")
- Seizures
- Hyperthermia

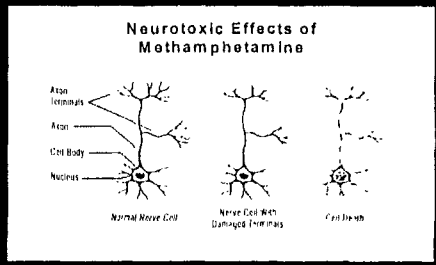
RISKS ASSOCIATED WITH THE USE OF METHAMPETAMINE

- Depression (following use)
- Stimulant psychosis/paranoia
- Spontaneous recurrences of methamphetamine (MAP)-induced paranoid-hallucinatory states ("flashbacks": Ishiguro, Ikemoto & Kamata, 1999)

RISKS ASSOCIATED WITH THE USE OF METHAMPETAMINE

- Memory impairment (possible)
- Damage to serotonin neurons (possible)

METHAMPHETAMINE NEUROTOXICITY



RISKS ASSOCIATED WITH THE MANUFACTURE ("COOKING") OF METHAMPHETAMINE

- Explosion
- Fire
- Respiratory problems, up to and including permanent damage
- Chemical burns

RISKS ASSOCIATED WITH THE MANUFACTURE ("COOKING") OF METHAMPHETAMINE

- Contact with potentially violent chemist(s)/illegal subculture
- Stimulant psychosis associated with chemist's use of methamphetamine

SIGNS THAT METHAMPHETAMINE IS BEING MANUFACTURED IN THE CLIENT'S HOME

- Laboratory equipment
- Large quantity of pills containing ephedrine or pseudoephedrine (e.g., Tedral®, Primatene®/ Sudafed®
- Chemical odor

SIGNS THAT METHAMPHETAMINE IS BEING MANUFACTURED IN THE CLIENT'S HOME

- Chemicals not commonly found in a home
  - Red phosphorus
  - Liquid ephedrine
  - Iodine
  - P2P (phenyl-2-propanone)
  - Acetone
  - Ether

SIGNS THAT METHAMPHETAMINE IS BEING MANUFACTURED IN THE CLIENT'S HOME

- Unusually high quantities of household chemicals
  - Lye
  - Drano®
  - Paint thinner
    - .Chemicals usually found on a farm (e.g., anhydrous ammonia)
- Residue from "cooking" of

SIGNS THAT METHAMPHETAMINE IS BEING MANUFACTURED IN THE CLIENT'S HOME

- Chemicals usually found on a farm (e.g., anhydrous ammonia)
- Residue from "cooking" of methampetamine

INDICATIONS OF POTENTIAL/IMPENDING METHAMPHETAMINE-INDUCED CLIENT VIOLENCE

- Signs of methamphetamine use
- Client is extremely irritable and/or argumentative
- Escalation of client irritability, anger

INDICATIONS OF POTENTIAL/IMPENDING METHAMPHETAMINE-INDUCED CLIENT VIOLENCE

- Regular client does not appear to know who you are
- Evidence of client paranoid thinking, delusions
- Client verbalizes implicit or explicit threat against caseworker

INDICATIONS OF POTENTIAL/IMPENDING METHAMPHETAMINE-INDUCED CLIENT VIOLENCE

- Presence of knife, firearm or other weapon in the immediate vicinity

COMPONENTS OF A SAFETY PLAN

- Inform supervisor/co-worker(s) that you will be visiting a client with a history of making/using methamphetamine
- If you feel unsure of your safety, leave
- Do not let client get between you and an exit

COMPONENTS OF A SAFETY PLAN

- Park car so that you can not be boxed in
- Do not argue with or antagonize client
- Do not position yourself in the client's peripheral vision area or where the client can not see you.

COMPONENTS OF A SAFETY PLAN

- Do not move suddenly
- Tell the client what you are doing and why
- Ask permission if you want to go to another area of the client's dwelling or look in cabinets (e.g., to ensure food is in the house)

COMPONENTS OF A SAFETY PLAN

- Watch for:
  - Symptoms of stimulant use
  - Methamphetamine paraphernalia
  - Signs that client is becoming upset, angry or suspicious

COMPONENTS OF A SAFETY PLAN

- Watch for:
  - Scratch marks or scabs, particularly on client's hands and arms
  - Evidence of hallucinations

COMPONENTS OF A SAFETY PLAN

- Watch for:
  - Strong chemical odor (may indicate manufacturing of meth)
  - Other indicators (see section IV above)

Promoting Recovery and Safety Within Substance-Affected Families

Promoting Recovery and Safety within Substance Affected Families

- Training Focus Will be On:
  - Patterns of Recovery
  - Predictors of Recovery
  - Long Term Recovery Management

Promoting Recovery and Safety within Substance Affected Families

- Training Focus Will be On:
  - Recovery Coaching
  - Family Recovery
  - Role of Community in Recovery

What is Recovery?

- Sustained Abstinence--Primary Drug
- Sustained Abstinence--No Drug Substitution
- Reduction of Drug use to Subclinical Levels

What is Recovery?

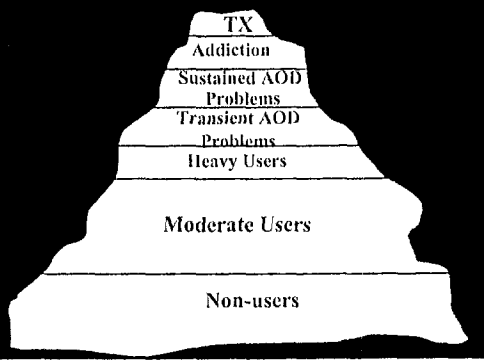
- Sustained Absence of Drug-related Problems
- Resolution of AOD Problems within the Umbrella of Global Health

Clinical Versus Community Populations

- Problem Severity& Chronicity
- Co-morbidity
- Absence of or depletion of "recovery capital" (Granfield and Cloud, 1999)

Resolution of Alcohol and Drug Problems: Visible and Invisible Populations

Alcohol and Drug Problems: Visible and Invisible Populations



Styles of Recovery

- Transformative--"Quantum Change"
  - ◆ High Vividness (Intensity)
  - ◆ Suddenness (Unintentional)
  - ◆ Positiveness and Permanence (Miller and C' de Baca, 2001)

Styles of Recovery

- Incremental Change (Conscious)
  - ◆Multiple sobriety efforts
  - ◆Longer periods between relapse
  - ◆Decreased intensity and duration of relapse episodes
  - ◆Increased quality of sobriety

Styles of Recovery

- Incremental Change (Unconscious)
  - ◆Drift
  - ◆"Maturing Out", "Retirement" (Winick, 1962)

Styles of Recovery

- Natural (Solo) Recovery
- Assisted (Affiliated) Recovery
- Virtual Recovery
- Disengaged Recovery

Styles of Addiction/Recovery Affiliation

- Acultural Style
  - –Requires high level of "recovery capital"
- Bicultural Style
  - –Requires higher level of emotional adjustment and social skills

Styles of Addiction/Recovery Affiliation

- Enmeshed Style--may be required for those coming out of enmeshed styles of addiction
- Style changes over the course of long term recovery

(White, 1996)

Medication Assisted Recovery

- Aversive Agents
  - Disulfram (Antabuse)
- Maintenance Agents
  - Methadone and LAAM
  - Buprenorphine

Medication Assisted Recovery

- Anti-craving Agents
  - Naltrexone (Revia)
  - Acamprosate

Gender and Recovery

- Women have lower rates of alcoholism than men (Alcohol and Health, 1997)

Gender and Recovery

- Women have increased prospects of recovery from drug addiction (Snow, 1973); alcoholic women were 1.63 times more likely to be in stable recovery than alcoholic men 8 years following treatment (Humphreys, et al, 1997)

Gender and Recovery

- Heavy drinking for women peaks in their thirties.

Gender Specific Recovery

- Recovering women are more likely to embrace models of change that emphasize taking control of one's life. (Granfield and Cloud, 1996)

Gender Factors In Recovery Initiation

- Pregnancy
- Parenthood
- Fear of Effects of AOD use on Children
- Fear of Losing Custody of Children

Gender Factors In Recovery Initiation

- Separating from an Addicted Partner (Chen and Kandell, 1998; Burman, 1997; Waldorf, 1983)

Research on Family Recovery

- The Alcoholic Family in Recovery: A Developmental Model
- Stephanie Brown and Virginia Lewis

Family Recovery Principles

- Addiction recovery unfolds over time across three arenas of change: The individual, the family as a system, and the family's relationship to the outside environment.

Family Recovery Principles

- "The unsafe, potentially out-of-control environment continues as the context for family life into the transition and early recovery stages...as long as 3-5 years."

Family Recovery Principles

- The family's individual and collective adaptations to cope with addiction result in trauma, developmental delays, and personal and relationship pathology.

Family Recovery Principles

- In recovery this unhealthy family system must collapse.

Family Recovery Principles

- Family members may need support structures to serve as "holding environments" until a healthier family system can be constructed.
- Without such supports, personal recovery may produce family disintegration.

Family Recovery Principles

- While recovery alleviates many of the family's historical problems, this early period can also be referred to as the "trauma of recovery": a time of great change, uncertainty and turmoil within the family.

Family Recovery Principles

- This turmoil can be ameliorated through professional and natural support systems.

Recovery and Parenting

- Is the development or resumption of effective parenting an early, middle, or late stage task of recovery?

Recovery and Parenting

- Transitions from addiction to early recovery
  - ◆From rejection and detachment to overindulgence and over-protection

Recovery and Parenting

- Transition from early to middle recovery
  - ◆From cessation of neglect/abuse to enhanced quality and consistency in mother-child relationship

Recovery and Parenting	
Stage	*Expectations*
Early Stage 1st 3 months 3 – 12 months	
Middle Stage 1 – 4 years	
5 years +	

Durability of Recovery

- When is a pattern of sobriety deemed to be stable and enduring?
- Principle: Recovery stability increases with length of sobriety.

Durability of Recovery

- The risk of relapse dramatically diminishes after the achievement of four-five years of sobriety (Nathan and Skinstad, 1987; De Soto, et al, 1989; Dawson; 1996; Jin, et al, 1998)

Zones of Recovery

- Physical Zone
- Cognitive-Emotional Zone
- Relationship Zone
- Lifestyle Zone
- Spiritual Zone

(White, 1996)

Physical Zone of Recovery

- Achievement/stabilization of Abstinence
- Management of withdrawal and post-acute withdrawal (craving)

Physical Zone of Recovery

- Management of drug substitution risks
- Active response to acute and chronic medical/psychiatric problems
- Active health management: Diet, sleep, hygiene, exercise.

Cognitive-Emotional Zone of Recovery

- 3-stage Change in Preferred Defense Structure (Wallace, 1974)
- Drug-free management of emotions/impulses

Cognitive-Emotional Zone of Recovery

- Emotional catharsis, story construction, and storytelling (changed view of self/world)
- Work on emotional control, impulse control and problem solving
- Work on character defects

Relationship Zone of Recovery

- Detachment from the culture of addiction (people, places, things)
- Severing pathology-bonded relationships
- Development of a sobriety-based support structure

Relationship Zone of Recovery

- Sobriety-based changes in family roles, rules and rituals
- Sobriety-based management of emotional and sexual intimacy

Lifestyle Zone of Recovery

- Cessation of criminal/predatory activity
- Shedding trappings from culture of addiction: language, dress, symbols
- Creation of sober sanctuary (home)

Lifestyle Zone of Recovery

- Development of sobriety-based leisure activities
- Redefinition of the meaning of work/money
- Resolving financial and legal problems
- Restructuring of daily rituals

Spiritual Zone of Recovery

- Crisis: Synergy of pain and hope
- Discovery of power within or outside the self
- A sudden or gradual sense of rebirth
- Purging of shame and guilt
- Forgiveness of self and others

Spiritual Zone of Recovery

- Acts of restitution and service
- Development of daily centering rituals
- Cultivation of gratitude
- Clarification of religious/spiritual beliefs and values

Spiritual Zone of Recovery

- Cultivation of sacred places, objects and objects
- Experience of community (of recovery, of shared experience, of faith)

Role of Community in Recovery

- McKnight's Critique
- Indigenous (accessible, culturally appropriate, reciprocal, non-commercialized, and enduring) Resources

Role of Community in Recovery

- Family, extended family/Kinship networks, neighborhood resources, schools, churches, local service organizations
- Cultural Revitalization Movements
- Mutual Aid Societies

Kurtz Resource Guide

- Variety of Support Structures
- How to work with Support structures
  - ◆Familiarity with literature
  - ◆Attending meetings open to service professionals

Kurtz Resource Guide

- ◆ Working with local service committees
- Creating Resources where none exist

Mutual Aid Intensity Effect

- Outcomes Improve in Tandem with Increased Participation:
  - ◆meeting attendance/speaking,
  - ◆closed meetings and having a "home meeting,"
  - ◆pre-post meeting rituals

Mutual Aid Intensity Effect

- Outcomes Improve in Tandem with Increased Participation:
  - ◆sponsorship
  - ◆knowledge of literature
  - ◆application of concepts to daily problems,

Mutual Aid Intensity Effect

- Outcomes Improve in Tandem with Increased Participation:
  - ◆leisure involvement,
  - ◆service activities. (Montgomery, et al, 1995; Humphreys, et al, 1997; Caldwell & Cutler, 1998)

Mutual Aid and Special Populations

- Early Criticisms
- Women and people of color affiliate with AA/NA at the same rates as white men (Humphreys, 1994; Kessler, et al, 1997; Winzelberg and Humphreys, 1999)

Mutual Aid and Special Populations

- Over time, participation in AA for African Americans and Hispanics decreases (Tonigan, et al, 1998); This may reflect a transfer of recovery maintenance to indigenous institutions.

Treatment Outcomes

- Continual, Uninterrupted Abstinence
- Sustained Problematic Use at Pre-Treatment Levels
- Moderated, Sub-clinical Use

Treatment Outcomes

- Initial Abstinence / Moderated Use Followed by Accelerated Use/Problems
- Initial Use/Problems Followed by Stable Recovery
- Binge/Recovery Cycles

Treatment Outcome – Service interventions	
Outcome	*Interventions*
1.Continual Abstinence	
2.Sustained use – Pre-treatment levels	
3.Moderated, subclinical use	

Treatment Outcome – Service interventions (cont.)	
Outcome	*Interventions*
4. Initial abstinence followed by problematic use	
5. Initial use/problems followed by stable abstinence	
6. Binge/Recovery Cycles	

Post-Treatment Recovery Coaching

- Monitoring
- Feedback
- Stage-Appropriate Recovery Education

Post-Treatment Recovery Coaching

- Resource Linkage (Indigenous)
- Early Re-intervention (Treatment)
- Re-engagement and Recovery Priming Following Broken Contact

Recovery Coach/Guide

Twin Goals

- Management of Long Term Addiction Recovery
- Enhancement of Parental Effectiveness and Family Health and Safety

Recovery Coach / Community Guide

- Knowledgeable of about Indigenous and Formal Community Resources
- Capable of engaging the difficult-to-engage client
- Skilled at leading people into relationship with a recovering community

Recovery Coach / Community Guide

- Skilled at sustaining long-term recovery support relationships
- Skilled at organizing resources where none exist

The Recovery Coach / Community Guide:

- Sees possibilities where others see only problems.
- Is personally connected to the "communities within the community"

The Recovery Coach / Community Guide:

- Can make things happen because they are trusted within these communities.
- Believe the community is a "reservoir of untapped hospitality"

The Recovery Coach / Community Guide:

- Knows the client's engagement with the community begins in when the guide leaves.

(McKnight, 1995)

Relapse

and

Relapse Prevention

Defining Relapse

Relapse Prevention Principle #1:
If it looks like a duck, walks like a duck, and quacks like a duck, it's a duck. One problem: What's a duck?

Continuum of Relapse

lapse (slip)* → → → → → *relapse

MARLATT'S RELAPSE MODEL

FOCUS: USE AFTER PERIOD OF ABSTINENCE

AVE

SELF-EFFICACY

SEEMINGLY IRRELEVANT DECISIONS

AVE:
Abstinence Violation Effect

Using alcohol or other drugs is inconsistent with the client's self-image as a recovering person.

AVE

A lapse is more likely to escalate into a full-blown relapse when it is attributed to a cause which is:

- **Internal**
- **Stable**
- **Global**
- **Perceived to be uncontrollable.**

SELF-EFFICACY

The belief that one has the ability to execute a behavior that will result in desired outcomes, and

One's perception regarding his/her ability to engage in or avoid a specific behavior at a particular time and place.

Self-Efficacy

Self-efficacy expectations influence

- Whether the recovering individual initiates coping behaviors when a lapse occurs
- How long and how intensely s/he will sustain the coping behaviors in the face of obstacles.

SEEMINGLY IRRELEVANT DECISIONS

The recovering person makes a series of apparently neutral behavioral choices that eventually expose him/her to drug stimuli and the risk of relapse.

OTHER RELAPSE MODELS

CLASSICAL (PAVLOVIAN) CONDITIONING

RELAPSE SYNDROME (GORSKI)

Classical (Pavlovian) Conditioning

Very important in understanding the origin, nature, and impact of internal and external cues on behavior.

Classical (Pavlovian) Conditioning

Elements

- Unconditioned Stimulus
- Response
- Conditioned Stimulus
- Conditioned Response

"Pavlov's Dog"

food→→→→→→→salivation

(unconditioned stimulus) →→ (response)

bell→→→→→food→→→→→salivation

Conditioned stimulus→unconditioned stimulus → (response)

bell→→→→→→→→→→→→→salivation

(conditioned stimulus) →→→→→ (conditioned response)

YOUR CLIENT

presence/availability of drug→drug hunger
(craving, "jonesing", "tweaking")
drug triggers/cues → presence/availability of drug→drug hunger
payday/$ →→availability of cocaine→→cocaine hunger

TRIGGERS

stealing from family to buy drugs→ guilt/shame→→drug use

letter from home while in recovery →→ renewed guilt/shame→→drug use

Relapse Syndrome

Role of subjective distress in the failure to remain abstinent

The precipitating cause of a relapse may be either:

- internal (e.g., negative emotions, painful memories)
- external (e.g., chronic stress, physical pain).

POST-ACUTE WITHDRAWAL SYNDROME

An inability to think clearly

The presence of emotional overreaction

Memory deficiencies (e.g., euphoric recall)

This initial lapse may lead to the AVE and then to a complete relapse

IMPLICATIONS OF RELAPSE SYNDROME

During primary treatment, the client and staff need to identify and resolve any dysfunctions from which the client might suffer

IMPLICATIONS OF RELAPSE SYNDROME

Treatment programs must help clients be aware of cognitive, behavioral, attitudinal, and emotional warning signs that appear before actual substance use occurs (i.e., before the first lapse).

IMPLICATIONS OF RELAPSE SYNDROME

With this knowledge, clients can apply the coping strategies they have learned in treatment and/or from their peers/self-help group

CAUSES OF RELAPSE

Relapse is not simply a physiological response to drug withdrawal.

In most cases, relapse in not an issue of insufficient motivation or lack of willpower.

CAUSES OF RELAPSE

Another critical factor is the client's commitment to complete abstinence.

Clients who are committed to total abstinence were less likely to use, and also less likely to relapse if they did have a lapse.

RELAPSE CONSISTENCY

People who relapse on alcohol, tobacco, cocaine and other drugs tend to relapse under similar circumstances.

SIGNIFICANT FACTORS ASSOCIATED WITH RELAPSE

- Stress
- Negative emotions
- Positive emotions
- Interpersonal conflict
- Social pressure
- Use of other substances

GENERAL RELAPSE PREVENTION APPROACHES

- Social Support
- Lifestyle Change
- Cognitive/Behavioral Approaches

Social Support

Focus on

The client's need for emotional support from family members, friends, and recovery groups

Reduction of interpersonal conflict and stress.

Lifestyle Change

Support for

Development and maintenance of the client's new social identity as a drug-free person

Breaking of ties to the culture of addiction

Lifestyle Change

Support for

Development of new drug-free interests and social contacts

Learning new methods of coping with negative emotions

Cognitive/Behavioral

- *Emphasizes*
  - Identifying internal and external cues associated with craving and relapse
  - Learning how to avoid these cues
  - Preventing unexpected or unavoidable cues from triggering relapse

COGNITIVE APPROACHES

"Reminder cards"

Review reasons for quitting

Reflecting on progress made to date

Using positive mental imagery

BEHAVIORAL APPROACHES

Leaving the situation

Throwing away paraphernalia

Using relaxation skills

Repeating motivational statements aloud

BEHAVIORAL APPROACHES

Writing down thoughts and feelings in a journal

Calling sponsor, peer, counselor for support

Rehearsing planned behavioral in role plays

BEHAVIORAL APPROACHES

Managing lapses

Disclosing relapses

Relapse Prevention Principle # 2:

The use of pharmacologic agents in preventing relapse can in some cases be helpful, as long as they are applied as part of a comprehensive plan.

CURRENTLY USED PHARMACOLOGIC AGENTS

Methadone

Amantadine

Bromocriptine

Tricyclic antidepressants (e.g., desipramine)

CURRENTLY USED PHARMACOLOGIC AGENTS

Fluoxetine (Prozac®)

Disulfiram (Antabuse®)

Naltrexone (Rivea®)

SPECIAL CONCERNS IN RELAPSE PREVENTION

Relapse Prevention Principle # 2: All addictions and addicts are not the same; expect and be prepared for complications

SPECIAL CONCERNS IN RELAPSE PREVENTION

Cocaine dependency

Concurrent Psychiatric Disease

Womens' Issues

SPECIAL CONCERNS IN RELAPSE PREVENTION

Pain Vs Hope as Vehicles for Long-term Recovery

Adult survivors of childhood sexual abuse

THE THERAPEUTIC RESPONSE TO RELAPSE

Confrontation and Confession

- Confront the reality of the relapse
- Identify details surrounding the relapse
- Explore the real and potential consequences of the relapse

THE THERAPEUTIC RESPONSE TO RELAPSE

Confrontation and Confession

- Collect data regarding causative and contributing factors
- Provide the client with an emotional catharsis of feelings regarding relapse.

Recommitment to Recovery

The client may present his/her recommitment to recovery to a group of peers, and ask for their help

Relapse Prevention Plan

A program of strategic action, not of vagueness and generalized slogans

Relapse Prevention Plan

NOT: "I have to start taking one day at a time, and staying out of slippery places."

Relapse Prevention Plan

YES:

I will attend the Wednesday night stress reduction class at the local hospital.

I will not drive by the bar on my way home from work, and I will not go into <u>any</u> bars.

Relapse Prevention Plan

Addresses:

People

Places

Things (e.g., drug paraphernalia, beer clocks, shot glasses, pipes)

Relapse Prevention Plan

Addresses:

Times (weekends, payday, holidays)

Sexuality

Occasions (Christmas, New Years, birthdays, weddings)

Relapse Prevention Plan

Addresses:

Psychiatric issues (depression, anxiety, panic attacks)

Feelings (anger, depression, loneliness, happiness)

Relapse Prevention Plan

Addresses:

Interpersonal relations (rejection, communication, jealousy, unresolved issues related to one or both partners' addiction.

Leisure time activities (what, where, when, with whom)

Relapse Prevention Plan

Addresses:

Job issues (heavy drug/alcohol use at work; employment in industry traditionally tied to drug/alcohol use)

Relapse Prevention Plan

Spirituality

(Do I believe in a higher power?

What is my relationship with this force?

Do I feel too guilty/ashamed to accept forgiveness from my HP?.

The Drug-Exposed Infant and Child

THE DRUG-EXPOSED INFANT AND CHILD

VARYING VIEWPOINTS ON THE EFFECTS OF MOTHER'S USE OF CRACK UPON INFANTS AND CHILDREN

Chasnoff, Burns, Scholl & Burns (1985) and Griffith (1988)

BOTH STUDIES FOUND DEPRESSED INTERACTIVE BEHAVIOR AND POOR STATE CONTROL AMONG BABIES AFFECTED BY COCAINE

Woods, Plessinger & Clark (1987)

COCAINE USE DURING PREGNANCY CAUSES UTERINE VASOCONSTICTION, DECREASING OXYGEN AND NUTRIENTS TO THE FETUS, THEREBY CAUSING POOR FETAL GROWTH

Chasnoff, Griffith, MacGregor, Dirkes & Burns (1989)

THE BIRTHWEIGHT OF BABIES AFFECTED BY COCAINE IS LOWER THAN THAT OF THEIR NORMAL COUNTERPARTS

EFFECTS OF NICOTINE ON THE DEVELOPING FETUS

- Uterine vasoconstriction
- Decreased fetal 0_2 and nutrient supply
- Prematurity/Low birth weight

DHHS Office of the Inspector General (1990)

PRENATAL EXPOSURE TO CRACK CAN LEAD TO PREMATURE BIRTH, LOW BIRTHWEIGHT, BIRTH DEFECTS, AND RESPIRATORY & NEUROLOGICAL PROBLEMS. THESE BABIES ALSO HAVE A SIGNIFICANTLY HIGHER RATE OF SIDS

Drucker (1990)

THE VAST MAJORITY OF INFANTS BORN TO POOR DRUG-USING MOTHERS ARE AS HEALTHY AS OTHER INFANTS BORN IN POVERTY

Mayes, Granger, Bornstein & Zuckerman (1992)

THE MAJORITY OF CRACK-EXPOSED INFANTS ARE BORN WITHOUT SIGNIFICANT OR PERVASIVE PHYSICAL OR NEUROBEHAVIORAL IMPAIRMENTS AND SHOW NORMAL DEVELOPMENT IN LATER INFANCY

Mathias (1992)

BOTH PRENATAL AND POSTNATAL INTERVENTIONS CAN PREVENT DEVELOPMENTAL PROBLEMS

Haskett, Miller, Whitworth & Huffman (1992)

INFANTS AND YOUNG CHILDREN CN BE EXTREMELY DIFFICULT TO CARE FOR AND MANAGE DUE TO THE MEDICAL AND BEHAVIORAL OUTCOMES FROM PRENATAL EXPOSURE TO CRACK

Hawley, Halle, Drasin & Thomas (1995)

THE MAJORITY OF CRACK-EXPOSED INFANTS ARE BORN WITHOUT SIGNIFICANT OR PERVASIVE PHYSICAL OR NEUROLOGICAL IMPAIRMENTS AND SHOW SHOW NORMAL DEVELOPMENT IN LATER INFANCY

Hawley, Halle, Drasin & Thomas (1995)

THOUGH A STUDY OF PRENATALLY-EXPOSED CHILDREN OF ADDICTED MOTHERS FOUND THEY DID NOT DIFFER FROM A COMPARISON GROUP IN THEIR LANGUAGE AND COGNITIVE DEVELOPMENT, THEY DID DISPLAY GEATER EMOTIONAL AND BEHAVIORAL PROBLEMS

FRANK, AUGUSTYN, KNIGHT, POLL & ZUCKERMAN (2001)

"Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure" (2001). JAMA, 285(13): 1613-1625.

FRANK, ET. AL. (2001)

- Used papers from *Medline & Psychological Abstracts* search, 1984-October 2000, that discussed the effect of prenatal cocaine use on:
  - physical growth
  - cognition
  - language skills
  - motor skills
  - behavior, attention, affect & neurophysiology

FRANK, ET. AL. (2001)

- **Criteria for inclusion:**
  - **Published in a peer-reviewed English-language journal**
  - **Included a comparison group**
  - **Recruited samples prospectively during prenatal period**

FRANK, ET. AL. (2001)

- **Criteria for inclusion:**
  - **Used masked assessment**
  - **Did not include a substantial portion of subjects exposed to opiates, amphetamine, PCP or maternal HIV**

FRANK, ET. AL. (2001)

- **74 papers out of 36 met criteria**
- **38 papers excluded because:**
  - **20 failed to mask investigators to children's cocaine exposure**
  - **7 had no control group**
  - **26 did not use prospective recruitment for all or some of the subjects**

EXCLUDED STUDIES

- 13 recruited children with prenatal exposure to opiates, methamphetamine or PCP
- 2 reported samples predominantly composed of children of HIV$^+$ mothers

METHODLOGICAL COMPLICATIONS

- Difficult to determine with precision how much/how often infants prenatally exposed to cocaine
- Urine testing or maternal report only measure available when studies were done.

METHODLOGICAL COMPLICATIONS

- Exposure to alcohol, tobacco & marijuana was common

METHODLOGICAL COMPLICATIONS

- Many of the mothers from "economically disadvantaged, medically at-risk" populations, in which high developmental risk exists even without drug exposure

FINDINGS: PHYSICAL GROWTH

- If exposure to other substances is not controlled, prenatal cocaine exposure seems to be associated with ↓ weight and head circumference in two cohorts but not in another

FINDINGS: PHYSICAL GROWTH

- In 2 cohorts that did control for exposure to tobacco and/or alcohol, no negative cocaine-related effects were found in terms of weight, length or head circumference

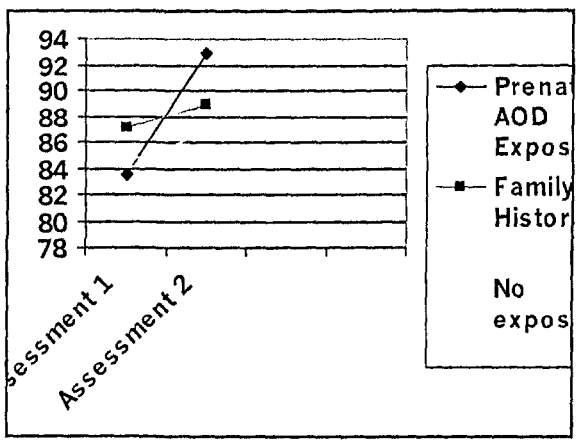
FINDINGS: PHYSICAL GROWTH

- In 1 cohort, full-term unexposed infants were longer than exposed or nonexposed preterm children and also longer than exposed full-term infants

STANDARDIZED COGNITIVE ASSESSMENT

- "There is little impact of prenatal cocaine exposure on children's scores on nationally normed assessments of cognitive function"

  - *Frank, et.al. (2001)*



LANGUAGE SKILLS

- Three studies of toddlers showed *no* association between prenatal cocaine exposure and receptive or expressive language score.

MOTOR SKILLS

- Of six studies that looked at motor skills, three found "less than optimal" motor scores in the first 7 months of life.
- No prospective study found ↓ motor skills after the first 7 months of life

MOTOR SKILLS

- One study has found that mothers' prenatal tobacco use, but not cocaine use, was the major predictor of abnormalities in infant muscle tone at 6 weeks

MOTOR SKILLS

- It is possible but not proven that previously reported positive associations between prenatal cocaine use and less optimal motor development were a misattribution of maternal tobacco effects.

BEHAVIOR, ATTENTION, AFFECT & NEUROPHYSIOLOGY

- Prenatal cocaine exposure, independent of exposure to alcohol, has not been found to be associated with behavioral disturbances detectable by standard scoring of epidemiologic and clinical report measures by parents or teachers.

BEHAVIOR, ATTENTION, AFFECT & NEUROPHYSIOLOGY

- Infants exposed prenatally to cocaine seem to have a deficit in affective expression.
- They show less emotion than unexposed peers.

BEHAVIOR, ATTENTION, AFFECT & NEUROPHYSIOLOGY

- Two studies have found less than average scores among prenatally exposed children.
- Methodological problems within these studies may cast doubt on their conclusions.

SUMMARY OF FINDINGS

- After controlling for alcohol and tobacco use, effects of prenatal exposure to cocaine have not been shown

SUMMARY OF FINDINGS

- Independent of environmental risk and exposure to alcohol and tobacco use, researchers have not found a negative association between prenatal cocaine use and developmental scores from infancy to 6 years

Supervising for Optimal Effectiveness

Supervising for Optimal Effectiveness

Tools to work with

Models of Supervision: How to Get the Most From Those You Supervise

- Individual Supervision
- Group Supervision
- Case Consultation
- Live Supervision
- Practice
- Multidisciplinary Conference
- Demonstration
- Tapes
- Visits
- Professional Videos
- Use of Articles
- Journaling
- Motion Pictures

Supervising for self-esteem

Five strategies

- Establish the relationship
- Never embarrass
- Talk about your own mistakes
- Give suggestions and let the others decide what to do
- Praise slight improvements

Formative Feedback

Keys to producing results

- It is systematic
- It is timely
- It is clear
- It is descriptive
- It is tentative
- It is constructive
- It is selective

It is systematic

- consistent
- reliable
- minimally influenced by subjective variables

It is Timely

- Provided in close proximity to performance to maximize supervisee motivation, reinforcement, and interest in learning

It is Clear

- Based on explicit and objective criteria that are directly related to aspects of the supervisee's performance

It is descriptive

- Focused on supervisee behaviors and actions rather than assessments or judgments of his or her personality

It is tentative

- Offered for consideration rather than presented for acceptance.

It is constructive

- Accompanied by specific suggestions for future application or potentially useful alternative behaviors.

It is selective

- Provided in consideration of when and how much feedback the supervisee can use at a given time.

Team Building

Roles of the Supervisor

Roles of the Supervisor

- Supporter
- Educator
- Skill Developer
- Resource Person
- Guide
- Team Captain
- Umpire/Negotiator
- Teammate
- Cheerleader
- Coach
- Behavior Modeler

Motivating Clients to Change

- Remember Motivational Interviewing ?
  - Acceptance of the client's level of readiness to change
  - Helping the client resolve the ambivalence crisis
  - Looking for leverage
  - Instilling hope

Helping Supervisees Work More Effectively with Addicted Clients

- Things that are important for counselors who work with chemically dependent clients to be aware of –
  - What are my feelings about addicts?
  - In working with chemical dependence, my definition of success is…
  - In terms of working with chemical dependence, what do I consider to be a difficult case and why?
  - In terms of working with chemical dependence, what are my limits?
  - What do I feel when clients relapse?
  - In working with chemical dependence, what do you feel you need to know more about?

Modeling for Staff Who Work With Addicted Clients

- Acceptance
- Kindness
- Detachment with care
- Looking for the positive
- Accepting powerlessness
- Accepting the client's right to self-determination
- Celebrating recovery
- Carefrontation
- Balance/Boundaries
- Creativity
- Not having all the answers
- Diplomatic advocacy
- Being a lifelong learner
- Holding clients accountable
- Flexibility