Foreword

The Center for Substance Abuse Treatment (CSAT) and the National Rural Institute on Alcohol and Drug Abuse (NRIADA) are pleased to jointly sponsor this publication, which is a compilation of papers submitted to the 1994 Award for Excellence contest. The Award for Excellence called for papers addressing the special challenges of providing quality treatment services to substance abusers in rural and frontier areas.

Papers were particularly solicited in the following areas:

- Experiences, ideas, practical measures, and recommended actions for implementing health care reform initiatives in rural areas (such as regional cross-State provider arrangements)
- Innovative strategies, policies, and programs for improving the delivery of substance abuse, health, and public health services in rural and frontier areas
- Proposals for political and economic solutions that would expand the development of services in rural/frontier areas
- Strategies for building rural coalitions and networks
- Approaches for special issues related to substance abuse, such as rural crime, gangs, and violence, including family violence
- Research studies and needs assessment data showing the prevalence of AOD abuse problems in rural and/or frontier settings, as well as their effects on rural crime, family life, and social, cultural, and economic conditions
Cost-benefit analyses showing the impact at the Federal and State levels from resolving substance abuse and public health needs of rural and frontier communities.

The papers presented here are a remarkable portrait not only of the daunting AOD problems that face rural and frontier America but, more importantly, of the viable approaches to those problems that are being created in rural and frontier areas.

The top three winners of this contest illustrate three successful approaches to helping substance abusers in rural and frontier areas deal with their problems. Riedel, Hebert, and Byrd describe an innovative program in their paper, "Inhalant Abuse: Confronting the Growing Challenge." Our Home, Inc., in Huron, South Dakota, has unlocked the doors of treatment to rural, inhalant-abusing youths—mostly American Indian youths—who did not before have access to treatment. This comprehensive residential treatment program provides a length of stay between 90 and 120 days. The treatment gives these young inhalant abusers, who are an average of 13 years old, the opportunity to detoxify, reduce impairment in neurocognitive functions, improve academic performance, and stabilize emotionally and behaviorally.

Tanya Tatum describes two substance abuse programs designed to address the needs of Appalachian women in Ohio. "Rural Women's Recovery Program and Women's Outreach . . . Serving Rural Appalachian Women and Families in Ohio" is designed to take advantage of the strengths of these women, as well as their wealth of culture and spirit of perseverance. Appalachian women have specific cultural barriers, which include "a mistrust of outsiders, fear of the 'system,' the conscious exclusion of specific groups in a bureaucracy, a tradition of self-sufficiency and taking care of one's own, and geographic and social isolation."

Tatum's group found that the key to delivering effective programs was to gain acceptance from the community and client population. They built on the personal and collective strengths of individuals and of the communities to be served.

A successful rural coalition in Northwest New Mexico is the subject of a paper by Raymond Daw and Herb Mosher. "The Bridges of McKinley County" describes a county that had the highest composite rate of alcohol-related problems of all counties in the United States from 1975 to 1985. The rural coalition that Daw and Mosher describe initiated The March of Hope, a journey made by a group of citizens who walked 200 miles in 10 days from Gallup to the State Legislature in Santa Fe. This rural coalition has been the catalyst to a regional response that has closed drive-up liquor windows, built a detoxification and assessment center, reformed State driving-while-intoxicated laws, and offered new prevention and treatment services.

Successful strategies and insights into the AOD problems facing rural and frontier Americans are mirrored in the other papers submitted to the Award for Excellence. These papers illustrate the difference that can be made for people suffering from alcohol and other drug problems in rural and frontier America.

Award for Excellence Review Panel
Inhalant Abuse: Confronting the Growing Challenge

Steve Riedel, M.S. Ed.
Associate Director
Our Home, Inc.

Tim Hebert, M.S.
Paul B. Byrd, Ph.D.
Our Home, Inc.
Huron, South Dakota
Abstract

The purpose of this paper is to describe the innovative programming of the Our Home, Inc. Inhalant Abuse Treatment Program and to review its outcomes. This project has implemented a comprehensive treatment program for rural, inhalant abusing youth. Prior to this effort, affected youths did not have access to treatment services. Thus, the overall project significance rests in the accomplishment of unlocking the doors of treatment for this special population. This paper does the following:

- Summarizes the program’s distinctive treatment procedures
- Defines the objective methods used to assess outcomes
- Highlights the test and retest procedures used to obtain neurocognitive and academic achievement outcome measures
- Reviews patient utilization and retention data

Related literature indicates that inhalant abuse is an increasing concern in the United States. The literature also indicates that it is a severe form of substance abuse. Historically, nonintervention has been applied to this problem, and wide gaps have been evident in the treatment system. Finally, the literature suggests that biopsychosocial factors hold implications for treatment. Neurocognitive impairment of users is a particular concern.

Findings indicate that a significant population of youth with inhalant abuse problems does exist in this rural catchment area in South Dakota. The project activities have led to enhanced patient identification, treatment access, and treatment retention. We have found supporting evidence of problem severity. Neurocognitive deficit scores among the collective patient population have been reduced by as much as 28 percent during treatment. Composite academic achievement gains range from 1.01 to 1.06 years. Posttreatment findings suggest that at least 34 percent of the patients report no inhalant abuse at the 6-month point after discharge.

Inhalant abuse has been an overlooked and severe form of substance abuse in rural catchment areas. Youths with inhalant abuse problems can be identified, referred to, and retained in treatment. Treatment participation results in positive and objective outcomes. It is recommended that the current policy of nonintervention should not continue. This growing inhalant abuse problem must be challenged. The problem should be given the consideration of governmental, planning, and service providing entities, so that comprehensive approaches responsive to inhalant abuse can be implemented. Finally, the programs implemented should be objectively evaluated, so that comparisons among approaches can be made.

Purpose of the Project
The purpose of the Our Home, Inc. Inhalant Abuse Treatment Program is to challenge the problem of inhalant abuse by making a comprehensive treatment program available to affected youth.

In 1987, H.G. Morton wrote that "solvent abuse appears to be an embarrassment to children's services; rather than accepting the challenge of inhalant abuse, a policy of nonintervention exists and this policy is unacceptable." Dyer (1991) noted that "treatment facilities set up for inhalant abusers are nonexistent." Jumper-Thurman and Beauvais (1992) noted the "lack of even a rudimentary treatment model." Despite such commentaries in the literature, adolescent inhalant abuse has been by and large been underacknowledged by the prevention and treatment delivery systems. A specific void has been particularly evident in comprehensive inhalant abuse treatment services.

In an attempt to fill this service void, Our Home, Inc. successfully sought an Office for Treatment Improvement (now the Center for Substance Abuse Treatment [CSAT]) grant. The project sought to "unlock the treatment doors to a population of moderate and severe drug users (inhalant abusers) whose treatment needs have been ignored at national and local levels." This mission continues to be the project's primary purpose.

A critical but coexisting purpose also existed. This second purpose was to develop an inhalant abuse treatment model that would address the wide range of social, psychological, academic, and neuropsychological deficits associated with inhalant abuse. Developing a program in the absence of other models also called for objectively measuring treatment outcomes as part of the model implementation process.

**Methods**

The discussion of methods addresses two areas. First, we discuss the distinctive treatment and patient identification methods utilized in the project. Second, we review the specific methods applied in measuring treatment outcomes.

**Initial Steps**

The following steps were taken in establishing the project:

1. First, it was necessary to create a treatment facility. An increased treatment capacity was created through the CSAT grant application process and through support from community economic development funds. A facility with a potential 16-bed capacity was obtained and renovated. As a step toward financial independence, the bed capacity has been managed so that a percentage of the beds are available as prepaid slots and a percentage are available under purchase-of-service agreements.

2. To stimulate systemwide prevention and intervention responses, it was necessary to increase professional awareness of the inhalant abuse problem. Increased awareness was promoted through a variety of methods, including:
• Formulating an advisory board that represented the service delivery systems which would be impacted.
• Conducting subject matter workshops at local, national, and international events.
• Arranging for news releases and media awareness activities throughout the region. Because the program has a target population requirement of 75 percent American Indian youth, a specific radio station targeting Indian audiences was involved.
• Developing and distributing (via training-of-trainer workshops) a comprehensive educational video curriculum about inhalant abuse and its dangers. As there was a void in resources, this was also done to place an educational resource in the hands of varied professionals across the region. Approximately 300 video curriculums have been released.

3. It was necessary to develop and implement a comprehensive treatment model designed for the inhalant abusing patient. Programmatically, this entailed considering the patients’ unique needs and problems, especially with regard to neurocognitive functioning. The unique methods ultimately incorporated have been numerous. The provision of individual/group counseling, a history and physical examination, psychological evaluation, balanced diet, recreation, family programming, and aftercare coordination are assumed to be routine and are not discussed in this paper. This discussion is confined to the most distinctive methods implemented and includes:
• Providing an extended length of stay, allowing for a minimum patient stay of 90 days that can be extended to 120 days.
• Providing complete neurocognitive assessment based on the procedures and instruments included with the Halstead-Reitan Neuropsychological Test Battery (Reitan 1959). This assessment is given at the approximate 2-week point after intake and is used to assess neurocognitive impairment and to develop an individual prescriptive neurocognitive rehabilitation program. The assessment is repeated at discharge for outcome evaluation purposes. The Kaufman Test of Educational Achievement (K-TEA) is used to assess and retest academic skills.
• Providing neurocognitive rehabilitation—Reitan Evaluation of Hemispheric Abilities and Brain Improvement Training (REHABIT) (Reitan and Senac 1983)—to those assessed as in the "impaired" range of neurocognitive functioning and to those assessed as in the "normal" range but who may have a specific impairment.
• Providing a full academic day during the course of treatment. Academic programming has the patient participating in school at any of the three individually assigned levels. Academic attendance assigned levels are assigned as "does not attend school," "attends school part time," or "attends school full time." Another specific method is "video group," in which patients and counselors watch prerecorded classroom behavior in order to assist in behavioral classroom adjustment.
• Providing specialized inhalant abuse education with other comprehensive health/drug and alcohol education.
• Providing cultural activities and ceremonies within the customs and beliefs of the American Indian population. In doing so, the first step was to appoint advisory board members reflecting the interest of the Indian Health Service System and the Tribal Court System. Other multiple activities were also undertaken. A consultant was employed to initiate a process of cultural growth and enhancement. Periodic consultation visits stimulated programming. Activities such as "sweat ceremonies," smudge purification
rituals, and the use of elders and daily prayer were incorporated. Staff recruitment and employment practices have been enhanced to culturally complement the program.

Enhanced methods applicable to family services, transitional care, community-based aftercare, abuse and neglect counseling, and patient supervision are also used.

**Test and Retest Procedures**

Objective treatment outcome data have been obtained by test and retest procedures. The methods used, as well as the data handling procedures, are briefly outlined here. A Halstead-Reitan Neuropsychological Test Battery (HRNTB) is administered to all patients at approximately the 14-day point. The Intermediate Booklet Category Test (Byrd 1985) and Booklet Category Test (DeFelipis and McCampbell 1979) are used as opposed to the electromechanical slide versions of the category tests. Through this battery, a Neurocognitive Deficit Score (NDS) (Reitan and Wolfson 1988) is determined for each patient. The NDS reflects the extent of the neurocognitive impairment that each patient is experiencing at admission and discharge. The NDS for each patient population is tabulated and converted to a mean NDS for the total patient population. The difference between the intake and discharge NDS is derived and recorded as improved or regressed neurocognitive functioning. HRNTB norms require that subjects ages 14 and younger be considered "children," and subjects ages 15 or older are considered "adults." Data for each classification are separated by age group. The project restricts admission to those ages 10 through 17.

In addition to the two age groups, clients are also classified as "impaired" or "nonimpaired," based on their NDS. The pretreatment and posttreatment NDS scores for each age group and diagnostic classification (impaired/nonimpaired) are also compared. These comparisons allow the program to assess the differences in the response to treatment between and within the age and diagnostic groups.

A Kaufman Test of Educational Achievement (K-TEA) is also administered at intake and discharge. The individual age-equivalent achievement results are converted into a mean achievement for the patient group. The results reflect the improved or regressed level of academic achievement. Data are handled so that results are presented for the two age groups.

Finally, the project reviews patient functioning at 6 and 12 months after discharge. This followup collects subjective and anecdotal data regarding posttreatment functioning. Inhalant use, other alcohol and drug use, school attendance, legal contacts, and living arrangements are monitored. Data are collected by personal contact, by telephone interview, or in writing. Data are accepted from the patient, the parent/guardian, or the referral/aftercare worker.

**Content Area**

The 1993 National Institute on Drug Abuse *Monitoring the Future Study* announced a shifting trend in the drug use patterns of the nation's youth (*NIDA Capsules* 1993). Between 1992 and 1993, use of inhalants among the nation's eighth graders increased from 17.4 percent to 19.4 percent. Inhalants are now the "most widely abused substance (after alcohol and tobacco) among
this age group," and it is now estimated that one in five eighth graders has used inhalants such as glues, aerosols, gasoline, and solvents. The deadly and destructive nature of inhalant abuse is well documented throughout the literature. Death can result from "sudden death syndrome" and other direct causes.

**The Situation in Rural South Dakota**

While the national trend toward increased inhalant use should serve as a call to attention, the problem has been a longstanding one in many rural areas; this was the case within the project catchment area. In 1990, the South Dakota Senior Survey indicated that 18 percent of the Caucasians and 22 percent of the American Indians surveyed had lifetime experience with inhalants. Also in 1990, 55 percent of the youths in the South Dakota Juvenile Correction System had a history of inhalant use. Eighty-five percent of the youths within the State's most restrictive correctional facility (the South Dakota State Training School) had a history of inhalant use. Finally, given that seven reservations fall within the geographic boundaries of the target area, the estimated inhalant exposure among American Indian populations may be nearly double the national average (Beauvais and Oetting 1985).

Despite such data, professional services directed toward the problem within the catchment area were at best limited. Treatment services were nonexistent and, consistent with Morton's 1987 observation, a policy of "nonintervention" applied. Our Home, Inc. perceived that a significant population of moderate to severe substance abusers were being overlooked and sought to help them.

**Record of Unsuccessful Treatment**

As early as 1979, Mason suggested in a NIDA monograph that when inhalant abusing patients did enter treatment, they tended to perplex the system rather than be successfully served by it. Specifically, the monograph indicated that "inhalant abusers constitute the greatest dropout rate among substance abusers served." Smart (1986) noted that "probation, foster homes, and training schools were found to be unsuccessful for four of five male sniffers." Dyer (1991) noted that generally "counselors are not equipped to deal with the wide range of problems" presented by inhalant abusers. Jumper and Beauvais (1992) indicated that programs were not adapting to meet the needs of inhalant abusing patients. Our Home, Inc. acted on the need to develop specialized programming conducive to patient retention and successful treatment.

It was also recognized that other sociodemographic factors were likely to affect the delivery of care. These factors were: age (the average age of the patient admitted to date is 13.2 years); income levels (48 percent of the patients have annual family incomes of $5,000 or below); geographic isolation; and the racial composition of the patient population.

**Clinical Issues In Providing Treatment**

Beyond demographics were clinical issues that raised questions about the delivery of treatment services. Fornazzari (1988) noted that "lack of treatment effectiveness is due to lack of parent/family support, but also because the inhalant abuser is started too early in treatment
programs. Detoxification of 2 weeks is recommended to allow for neurocognitive repair." Referring to chronic solvent abusers, Fornazzari stated, "Our experience suggests that the detoxification period be as long as possible. At least 2 weeks of close observation is necessary for the brain of these young persons to be rid of the effect of the solvent." A need for extended lengths of stay was indicated and implemented in the specialized programming.

Mason (1979) estimated that 30 percent of experimental users and 60 percent of regular inhalant users presented with measurable neurocognitive impairment. Other authors, such as Cooper and colleagues (1985), Ron (1986), Allison and Jerrom (1984), and King and colleagues (1985) have acknowledged neurological and neurocognitive consequences of inhalant abuse. Evidence of such neurological and neurocognitive symptoms suggested that any treatment approach developed must consider such matters. In response to this background context, the Our Home, Inc. program incorporated neurocognitive assessment and rehabilitation services.

The neurocognitive implications also held implications in relation to the young person's ability to perform academically. Mitic and McGuire (1987) cited school as a main source of stress for inhalant abusing youths. In 1990, Our Home, Inc. did an internal comparative analysis of 16 patients who had an inhalant abuse history, compared with 16 other substance abuse treatment patients without such a history. The comparison indicated that patients who had an inhalant abuse history came to treatment at a younger age (3.3 years younger than other substance abusing patients). They were also more than 1 year further behind in comprehensive academic achievement as tested by the K-TEA. It was apparent that academic adjustment and academic deficits needed to be considered in the treatment approach.

**Objective Measures for Monitoring Outcomes**

Finally, and since this project stood as the most comprehensive treatment effort pursued with this special population, Our Home, Inc. sought to evaluate treatment outcomes objectively. Changes in patient neurocognitive functioning and academic achievement were selected as the most objective measures. More subjectively, routine data reflective of patient posttreatment functioning have been pursued. Thus, questions about the benefits of treatment and the project might be considered.

In summary, a variety of questions were evident around the issues of patient treatment readiness and receptiveness. Our Home, Inc. sought to address these questions by modifying the treatment protocol and evaluating objective treatment outcomes.

**Findings**

The findings must be considered within the context of the patient population served. The following introductory and definitive information about the project catchment area and the patient population provide this context.

While the project's referral base has included a limited number of patients from across the United States, most of the patients served have been from the project's primary catchment area: South Dakota. CSAT defines South Dakota as a "Frontier State." (Note that the terms "frontier" and
"rural" are used interchangeably throughout this paper). Seven Indian reservations have boundaries that overlap with South Dakota, and some of these reservation communities constitute the most impoverished areas in the United States.

Referral patterns suggest that older and chronic inhalant abusers have not been referred to the treatment program. Rather, younger patients who have a less progressed but regular pattern of use have been referred. In the process of determining intake appropriateness, the histories of all patients admitted have been compared to the American Psychiatric Association's *Diagnostic and Statistical Manual* criteria for inhalant abuse or dependence. The patient sample has been 75 percent male and 25 percent female.

Finally, because of project funding mandates, the findings are based on an 85 percent American Indian sample. Sample size is 101 unless otherwise specified. Project findings are presented below in general as they relate to the identified project purposes.

**Project Findings**

**Section 1**

*Purpose 1. "Unlocking the treatment doors to a population of moderate to severe drug abusers" (inhalant abusers).*

**Program utilization findings.**

During the initial 25-month project period to date, the project has provided treatment services to 101 youths. The utilization of the 16-bed capacity has progressively increased. For years 1, 2, and 3, respectively, the average census has been 10.0, 11.4, and 14.1.

It should be noted that we have received numerous generic program inquiries. During the 25-month project period, the project has handled 344 documented inquiries from across the United States and Canada. The patient treatment retention ratio for the project has been 80 percent. The most often-noted deterrent to patient retention has been parents' withdrawing of voluntary placements. This withdrawal takes place after the patient has disclosed a pretreatment history of physical or sexual abuse (usually inflicted by a family member). While this trend is difficult to quantify objectively, it is estimated that it applies in 50 percent of the nonretention cases. By the time treatment is completed, 60 percent of the patients have reported a pretreatment history of physical abuse and 52 percent a history of sexual abuse. Average length of treatment stay has been 97 days.

**Severity of drug use patterns.**

The severity of the patient drug use patterns also needs to be defined. Indications of early chronicity among this population of rural inhalant abusers should be identified. Age of first use stands as one pointed indicator. The average age of first use has been 10.2 years of age, and average age at admission has been 13.4 years. Thus, a "typical" patient has used inhalants for an
estimated 3.2 years before entering treatment. During that 3.2-year time span, the typical patient is likely to have used five different inhalants.

Preferred products have been:

- Gasoline (43 percent)
- Rubber cement (22 percent)
- Spray paint (16 percent)
- Correction fluid (7 percent)
- Other (12 percent)

Frequency of use is as follows:

- Binge use (3.9 percent)
- Daily use (15.8 percent)
- 3 to 6 times weekly (28.7 percent)
- 1 to 2 times weekly (18.8 percent)
- 1 to 3 times monthly (14.8 percent)
- No use in the past month or unknown (17.7 percent)

This final percentage is related to referrals from detention and other holding facilities. Eighty-six percent of the youths treated indicate that they have made unsuccessful efforts to stop inhaling before treatment. Ninety-seven percent of the youths report having experimented with alcohol or other drugs.

**Neurocognitive impairment.**

Evidence of morbidity in the form of neurocognitive impairment is a critical indication of problem severity. While it is not entirely possible to rule out other causative factors, such as head injuries, fetal alcohol effects, or inadequate diet, the project assumes significant impairment is related to inhalant use. To date, the project has collected neurocognitive assessment and retest data from 50 youths. From this total, 44 percent have tested with measurable impairment. The insidious nature of the problem is evident in the fact that 36.1 percent of the younger group (ages 10 to 14) have fallen within the impaired range, while 64.2 percent of the older youth (ages 15 to 17) have been within the impaired range. Academic findings also reflect the severity of impairment. Based on K-TEA findings, the average admitted patient has a composite deficit of 2.5 years in reading and of 3.1 years in math.
These findings suggest that the project has clearly unlocked the treatment doors for a population of moderate to severe substance abusers.

Section 2

Purpose 2. Constructing a comprehensive model of treatment specifically designed for the inhalant abusing patient.

Project findings focus on project outcomes as measured by neurocognitive test and retest measures, academic test and retest measures, and on the posttreatment followup data collected. The project has conducted complete neurocognitive test/retest procedures on a total patient group of 50 youths. Findings are presented in two subsamples for "children" (table 1) and "older youths" (table 2).

Table 1. Treatment pretest and posttest neurocognitive performance among children ages 10 to 14
Current sample size = 36

<table>
<thead>
<tr>
<th>Deficit score: Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or B</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor functions</td>
<td>166</td>
<td>103</td>
<td>63</td>
<td>38</td>
</tr>
<tr>
<td>Sensory-perceptual functions</td>
<td>233</td>
<td>151</td>
<td>82</td>
<td>35</td>
</tr>
<tr>
<td>Alertness and concentration</td>
<td>94</td>
<td>71</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Immediate memory and recapitulation</td>
<td>45</td>
<td>26</td>
<td>19</td>
<td>42</td>
</tr>
<tr>
<td>Visual-spatial skills</td>
<td>178</td>
<td>120</td>
<td>58</td>
<td>33</td>
</tr>
<tr>
<td>Abstract reasoning and logical analysis</td>
<td>113</td>
<td>56</td>
<td>57</td>
<td>50</td>
</tr>
<tr>
<td>Level of performance total</td>
<td>829</td>
<td>527</td>
<td>302</td>
<td>36</td>
</tr>
<tr>
<td>Dysphasia and related variables total score</td>
<td>141</td>
<td>118</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Left-right differences</td>
<td>346</td>
<td>299</td>
<td>47</td>
<td>14</td>
</tr>
</tbody>
</table>
Table 1 details the treatment pretest and posttest of neurocognitive performance among children ages 10 to 14. Findings indicate that a mean average reduction (improvement) of 28 percent in NDS has been measured during the treatment stay.

Table 2 details findings for the older youth group, ages 15 to 17. While the older group has not reached the level of improvement attained by the children's group, a 23 percent improvement in NDS has been noted.

The neurocognitive deficit score is obtained from the entire sample group; therefore, these percentages reflect a total patient population outcome measure. Findings that compare impaired patients to their nonimpaired counterparts have also been considered. These findings indicate that impaired children have been found to show a slightly greater reduction (7 percent) in NDS as compared with those children who are not impaired, as depicted in tables 3 and 4.

<table>
<thead>
<tr>
<th>Deficit score: Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or -</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of performance</td>
<td>239</td>
<td>164</td>
<td>75</td>
<td>31</td>
</tr>
<tr>
<td>Pathognomic signs total</td>
<td>33</td>
<td>19</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>Patterns total</td>
<td>20</td>
<td>23</td>
<td>-3</td>
<td>-15</td>
</tr>
<tr>
<td>Left right differences—total</td>
<td>130</td>
<td>117</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Total general neurocognitive deficit score (NDS)</td>
<td>422</td>
<td>323</td>
<td>99</td>
<td>23</td>
</tr>
<tr>
<td>Impairment index</td>
<td>3.9</td>
<td>2</td>
<td>1.9</td>
<td>49</td>
</tr>
</tbody>
</table>
Table 3. Impaired children
Current sample size = 13

<table>
<thead>
<tr>
<th>Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or -</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor functions</td>
<td>111</td>
<td>76</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Sensory-perceptual functions</td>
<td>152</td>
<td>83</td>
<td>69</td>
<td>45</td>
</tr>
<tr>
<td>Alertness and concentration</td>
<td>48</td>
<td>34</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Immediate memory and recapitulation</td>
<td>21</td>
<td>10</td>
<td>11</td>
<td>52</td>
</tr>
<tr>
<td>Visual–spatial skills</td>
<td>84</td>
<td>58</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Abstract reasoning and logical analysis</td>
<td>61</td>
<td>30</td>
<td>31</td>
<td>51</td>
</tr>
</tbody>
</table>

| Level of performance total    | 477                   | 29                    | 186               | 38            |
| Dysphasia and related variables total score | 86           | 71                    | 15                | 17            |
| Left-right differences        | 148                   | 126                   | 22                | 15            |

Total neurocognitive deficit score | 711 | 488 | 223 | 31 |

Table 4. Nonimpaired children
Current sample size = 23

<table>
<thead>
<tr>
<th>Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or -</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor functions</td>
<td>62</td>
<td>40</td>
<td>22</td>
<td>35</td>
</tr>
</tbody>
</table>
Tables 5 and 6 demonstrate that impaired older youth show a 9 percent greater reduction in NDS than do nonimpaired youth. However, in comparing impaired older youth to impaired children, the impaired older youth demonstrate 5 percent less improvement during the course of treatment. During the course of treatment, 30 percent of the patients tested progress enough that they move from an impaired level of functioning to the normal range.

Table 5. Impaired older youth
Current sample size = 9

<table>
<thead>
<tr>
<th>Deficit score: Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or -</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of performance</td>
<td>188</td>
<td>128</td>
<td>60</td>
<td>32</td>
</tr>
<tr>
<td>Pathognomic signs total</td>
<td>29</td>
<td>15</td>
<td>14</td>
<td>48</td>
</tr>
<tr>
<td>Patterns total</td>
<td>15</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Left right differences—total</td>
<td>92</td>
<td>82</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Total general NDS</td>
<td>324</td>
<td>240</td>
<td>84</td>
<td>26</td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Impairment index</td>
<td>3.5</td>
<td>1.6</td>
<td>1.9</td>
<td>54</td>
</tr>
</tbody>
</table>

**Table 6. Nonimpaired older youth**

Current sample size = 5

<table>
<thead>
<tr>
<th>Deficit score: Neurocognitive performance area</th>
<th>Admission Total score</th>
<th>Discharge Total score</th>
<th>Difference + or -</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of performance</td>
<td>51</td>
<td>36</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>Pathognomic signs total</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patterns total</td>
<td>5</td>
<td>6</td>
<td>-1</td>
<td>-20</td>
</tr>
<tr>
<td>Left right differences—total</td>
<td>38</td>
<td>35</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Total general neurocognitive deficit score</td>
<td>98</td>
<td>81</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Impairment index</td>
<td>.4</td>
<td>.4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

In order to determine if there were statistically significant differences between the impaired and nonimpaired clients’ NDS before and after treatment, a multivariate analysis of variance was conducted. As shown in table 7, the pre- and posttreatment NDS was compared for the two age groups and within each age group. The results indicate that for the children ages 10 to 14, there is a significant difference between the impaired and nonimpaired clients (F=59.398, p<.000). The results also indicate a statistically significant difference between the pre- and posttreatment NDS for clients ages 10 to 14 (F=61.029, p=.000).

**Table 7. Comparison of pre- and posttreatment NDS for impaired and nonimpaired patients**

<table>
<thead>
<tr>
<th></th>
<th>Ages 10-14 (N=36)</th>
<th>Ages 15-17 (N=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretreatment NDS/Posttreatment NDS</td>
<td>*F=59.39806 p#.000</td>
<td>*F=10.78967 p#.006</td>
</tr>
<tr>
<td>Impaired NDS/Nonimpaired NDS</td>
<td>*F=61.02932 p#.000</td>
<td>*F=12.86740 p#.003</td>
</tr>
</tbody>
</table>
When the clients ages 15 to 17 were compared, the results indicate that again there is a significant difference between NDS of those clients who are impaired and nonimpaired (F=12.867, p<.003). The results also indicate a significant difference between the pre- and posttreatment NDS for this age group (F=10.790, p<.006). Although there is a significant difference between the impaired and nonimpaired pre- and posttreatment NDS for children ages 10 to 14 (F=11.131, p<.002), no significant difference was found between the impaired and nonimpaired pre- and posttreatment NDS for the 15- to 17-year-old clients. This is likely due to the limited number of clients served so far in the 15- to 17-year-old group (n=14).

Academic outcome findings are presented in Tables 8 and 9. The results indicate that the average composite academic gain of the children's group is 1.01 years during the course of treatment. The older group has gained 1.06 in academic years.

Followup findings (based on 35 youths to date) suggest that 34 percent of the patients have not used inhalants 6 months after discharge. An additional 12 percent report that they "use less often than before attending treatment." Patient tracking has been difficult, and the project has not been able to track 54 percent of the discharged patients. The status of these youths must be viewed as unknown. Followup findings are presented in brief form in table 10.

Tracking problems appear to be related to the frequent moving of project participants. Project intake data suggest 81 percent of the patients have moved one or more times in the 3 years prior to treatment. Twenty-nine percent of the discharges indicate no use of alcohol or other drugs following treatment, and 14 percent indicate that they use other chemicals less often. Such data have helped the project act constructively in that it has secured funding through the Single State Agency to enhance aftercare services in two target communities. This is being accomplished through contracts for service with community providers. The impact of this approach is yet to be determined. Arrest data, school attendance data, and participation in aftercare service data can be made available to the interested reader.

## Conclusions

Wide-ranging conclusions can be made from this comprehensive treatment project. The following significant conclusions are based on project experience. Project experience has established that:

1. Inhalant abuse stands as a frequent and severe form of substance abuse within the rural catchment area served. National trends and project experience strongly suggest that similar rural communities are likely to have a comparable or greater problem.
2. The frequency and severity of the inhalant abuse problem merits heightened attention in the rural areas served. In view of the frequency and severity of the problem, a policy of nonintervention is truly unacceptable. The social, emotional, and financial consequences of
failing to act on a form of substance abuse so clearly associated with mortality and morbidity need to be addressed.

3. A policy of nonintervention is simply not necessary. These youths can be identified, referred to, and placed in treatment before they shift predominant using patterns to other chemicals or congest correctional facilities. In a similar vein, it seems a logical conclusion that the earlier the intervention the better. The earliest possible intervention is likely to forestall adverse consequences and enhance the likelihood of favorable treatment outcomes, especially in relation to neurocognitive impairment. Given the severity and frequency of physical and sexual abuse among the patient population, treatment and child protection networks must be enhanced to serve these children adequately and to reduce continued risk factors.

4. Inhalant abuse patients can be retained in treatment for lengths of stay that are conducive to patient detoxification and to the demonstrated reduction of impairment in neurocognitive functions, along with improved academic performance and emotional behavioral stabilization.

5. The comprehensive treatment model utilized results in multiple and favorable treatment outcomes. The patient recovery and treatment outcomes with this population go far beyond the basic question of posttreatment substance use. Residential care appears to be central to patient stabilization and early recovery. Aftercare is likely to require extensive enhancement because of current resource limitations and patient demands. The project has also established objective measures that can be utilized to implement and compare other approaches used with similar populations.

**Recommendations**

While the project has led to certain conclusions, it has also raised broad questions. Seeking answers to such questions might provide further direction on issues such as length of stay, learning and academic approaches to be applied, and patient aftercare planning. Despite a host of unanswered questions, some broad recommendations can be made:

1. Federal, State, and tribal planning jurisdictions must thoroughly assess the inhalant abuse problem in order to:
   - Determine its human and economic impact
   - Plan for sufficient, appropriate, and comprehensive intervention responses, so that a continuum of care extending from prevention through aftercare exists to address the problem.

2. Governmental entities and service providers must cooperate to secure and implement these approaches as they are developed. The general void in services that continues to exist in most areas should be challenged.

3. All approaches should be implemented in conjunction with individual project and systemwide methods of objective measurement, so that approach and impact comparisons may be made.

*This problem must not be ignored, given the growing body of evidence about the dangers of inhalant abuse, its impact on youth, and its consequences.*

**References**


**Rural Women's Recovery Program and Women's Outreach. Serving Rural Appalachian Women and Families in Ohio**

Tanya Tatum  
Coordinator of Women's Programs  
Health Recovery Systems, Inc.  
Athens, Ohio

**Abstract**

Rural Women's Recovery Program (RWRP) and Women's Outreach Program are two substance abuse programs designed to address the specific treatment, prevention, education, and intervention needs of women and families in rural Appalachia. Both programs work extensively with other community agencies and have become part of the community network providing services in a poverty-stricken region. The programs strive to deliver services that are financially and physically accessible to area residents, culturally and psychologically acceptable, and effective in meeting the multiple and complex needs of substance abusing women and their families.

An underlying theme is knowledge of and respect for Appalachian culture, values, and traditions. The programs were designed with this framework in mind to reduce the multitude of barriers that women face in accessing services. The programs handle daily the traditional obstacles faced by many community-based substance abuse programs: client inability to pay for services, lack of transportation, unsafe and inadequate housing, and child care needs. Additional cultural barriers to be overcome include a general mistrust of outsiders, fatalistic life attitudes, and a tradition of self-sufficiency. Both programs operate with financial support from the State of Ohio Department of Alcohol and Drug Addiction Services and from local Alcohol, Drug Addiction, and Mental Health Services boards. The programs have experienced considerable success: RWRP has admitted over 136 residential clients since January 1990, and Women's Outreach has provided prevention, education, and intervention services for 9,198 rural residents since July 1991.

The Nation's attention on health care problems is at a record high. We have been inundated with numerous versions of plans to improve our health care system. The Clinton plan, the Cooper bill, the Chafee bill, and the Mitchell bill were all submitted to Congress for consideration during the 1994 congressional session. Of the four health care plans mentioned, only the Clinton plan specified provision of substance abuse services. There appears to be a pervasive sense that substance abuse problems are law enforcement problems—not health care problems. Federal
drug policy places a priority on law enforcement and interdiction rather than on treatment services. Consequently, Federal funding has followed along those same lines.

Even though we don't like to think about it, substance abuse is our Nation's number one health problem. A recent California cost effectiveness study estimated that victims of crime committed by drug abusers cost $1.3 billion in medical costs, damaged or stolen property, and lost work. The sum of $440 million was spent on health care for these California drug abusers. This study covered a 12-month period and was conducted on a random sample of 145,515 persons enrolled in treatment services. To ignore the role addiction plays within the context of and debate over health care reform is illogical and self-defeating.

In rural areas, many residents are anxiously awaiting the outcome of health care reform. "When are we going to see more doctors and clinics?" "Will there be a doctor in town who takes a Medicaid card?" "Will I still have to wait 3 months for an appointment?" "How far away is that treatment program?" Typically small, remote, and with relatively small populations, rural areas are often neglected in the creating of national political agendas or plans for reform and change. Rural areas are usually handled as the exception to the rule in the development of strategies, regulations, and programs designed to meet the needs of large urban and wealthier suburban populations. The problems of substance abuse affect all segments of society, but prey most heavily on the disadvantaged. These populations—minorities and the poor—have the fewest resources to deal with problems of substance abuse. They have the least access to services, both financial and physical; have the greatest incidence of impairment, disability, and death; and usually end up in our criminal justice and child welfare systems.

**Background: Appalachia Today**

Appalachia today is a region of contrasts: tradition versus progress, stability versus growth, regional markets versus international markets, agriculture versus industry, and family versus the individual. Appalachia is often synonymous with poverty. The Federal Government identifies the region as a geographic area defined by economic conditions. This definition clearly leaves out the identifiable and distinct cultural aspects that influence to a large degree the success or failure of efforts to improve the region. In truth, much of Appalachia today remains a poverty-stricken, economically depressed, and underserved area. Former president Lyndon B. Johnson's War on Poverty in the 1960s helped, but it merely addressed the symptoms and neglected the source of regional socioeconomic problems.

However, in spite of the extreme regional poverty, there is a wealth of culture, human strength, and a spirit of perseverance. These are the very strengths we relied on to develop programs to address the needs of substance abusing women and their families in Ohio's Appalachia.

While we deal with the same problems faced by many substance abuse providers serving women—extreme poverty, lack of transportation, lack of child care, inability to pay for services, family violence, and low self-esteem—there are additional barriers found in Appalachia. These cultural barriers include a mistrust of outsiders, fear of the "system," the conscious exclusion of specific groups in a bureaucracy, a tradition of self-sufficiency and taking care of one's own, and geographic and social isolation. Additional obstacles to successful programming are providers
who fear hostility or rejection from the service population or who have preconceived perceptions of clients, and providers who are reluctant to change service delivery models to be more responsive to the needs of the client population.

We found that the key to delivering effective programs is to gain acceptance from the community and client population. To do this, we had to listen to individuals and then identify and build on the personal and collective strengths of individuals and of the communities to be served. Rural Women's Recovery Program (RWRP) and Women's Outreach are two programs designed to address the gender-specific and cultural needs of substance abusing rural Appalachian women and their families. The work of these programs plays an important role in helping to provide opportunities for health and hope for many in Southeast Ohio.

**Methods**

**Rural Women's Recovery Program**

The first consideration in developing this program was to identify community needs. This was begun during the process of creating an application for funding. Upon notification of award of funding from the State of Ohio, we set about formalizing the clinical and program parameters for the residential treatment program, RWRP. (Women's Outreach was not started for another year.) Every effort was made to find out what social and health services were currently available within the community. We contacted the following programs:

- The WIC program for client referrals and nutrition education
- Planned Parenthood for assistance with prenatal care and family planning services
- Local school boards to assist with tutoring and GED programs
- Ohio State Cooperative Extension Service to assist with life skills education for clients
- Department of Human Services for information about public assistance programs available to clients
- The local mental health agency for making referrals and to assist with staff training
- The Area Health Education Center for resource materials
- A domestic violence shelter for making client referrals and staff training
- The homeless shelter for emergency housing
- Many other agencies and organizations

While none of the agencies has large operating budgets or excess staff, all were willing to share information and resources and generally were willing to help out. A cooperative spirit exists in the area. We help our own to provide for our own.

After amassing a wealth of information and offers to assist, we developed the new program. Because the agency had been providing residential treatment services for substance abusing adolescents for 10 years, we were able to work with an experienced administrative and senior clinical staff to develop this program. The new program was designed to have a rural orientation that would acknowledge the multiple and often conflicting roles that women have. The program would also utilize available outside resources. The goal was to interrupt the process of active
addiction, to give the clients new coping skills and develop their personal resources, and to reinvest them in their families and communities whenever possible.

**Providing Appropriate Staff and Facilities**

The first task was to develop staff capable of using a rural approach to deliver services. This does not mean unprofessional or inadequate. It means placing a focus on the individual person, acknowledging and supporting identified personal strengths, and refraining from imposing on clients our own personal and sometimes middle-class or urban-oriented values and measures of success. Many women in the program speak of success as being able to return home to care for their family (aging parents, children, and partners). Success does not always entail completing college and getting a good job. Every effort is made to hire local individuals to staff the facility; such staff help create a sense of safety for clients and provide honest and believable role models.

The program itself is housed in a log home located outside the city limits, but within the county on a high ridge on a gravel road. You have to know where you are going to get there. There were many challenges in turning a four-bedroom home into a treatment facility, but they were worth it in the sense of peace and safety the house created. The building was very reassuring to family members bringing clients into the home. Children of clients were also reassured to see that Mom wasn't going to jail or back to the hospital (psychiatric or medical). As much as clients were ready to come in, yet not wanting to be there, the appearance of the building helped to relieve some of the early distress of being in treatment. RWRP is not a facility with tile floors, stainless steel fixtures, and communal showers. It is a home in a country setting that provides clients with the physical security they need to do the hard work asked of them.

**Providing Staff Training**

Once the staff were hired and the building secured, staff were required to attend a week-long training program. The training program included the following sessions:

- Delivering treatment services with a feminist perspective
- Respect and knowledge of Appalachian culture, health, and safety issues
- An overview of the program schedule, house rules, and teamwork
- How the clients get here—admissions from initial phone call to intake
- Program collaboration with other community services
- Provider self-care
- Documentation and billing

Ongoing staff training addresses issues of women's treatment and works to develop the cultural competence of the staff, as well as stay abreast of innovative clinical techniques.

Special attention is given to medical and psychological services for the program. We found out very quickly that current literature was right in stating that women, prior to coming into treatment, have typically progressed much farther than men in their addiction. For us this meant many physical and medical complaints. In addition to a full-time nurse, we contracted with a physician to deliver primary care services and to attend weekly treatment team meetings. The
agency psychologist provides immeasurable assistance in evaluating clients on admission and in providing needed psychological services.

The physical upkeep, daily housekeeping tasks, and meals are handled by both staff and clients. We created a chore list to eliminate arguments over whose turn it is to take out the trash. Staff are expected to work alongside of clients. This provides clients with specific responsibilities for household operations; staff help clients learn how to complete chores that they are no longer able to perform.

For many clients, helping to make up the grocery list for the house is a terrifying prospect, not to speak of actually doing the shopping. Client chores are seen as a key part of the program. It makes the clients responsible for and respectful of their own living space, renews or teaches homemaking skills, enables clients to establish supportive relationships with other women, and provides them with a sense of accomplishment, no matter how small the task. The physical environment is used to help establish community norms for social interactions and client behaviors.

**Women's Outreach**

The Women's Outreach program was first funded in 1990. This program began as a client-finding mechanism for the residential program. This was not found to be very effective with the single position we were able to fund. There were also many obstacles presented by the community's lack of awareness about women's need to seek treatment services. During the second year of funding, the program was redesigned to respond to the unmet need for gender- and culture-specific prevention, community education, and intervention services in three rural Appalachian counties. The program focused on reducing the consequences of maternal alcohol and other drug use and on reducing the incidence of fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE). A variety of strategies were developed to accomplish program goals and objectives. These activities include:

- Client education groups for women awaiting admission to treatment services
- Screening, education, and referral for public assistance recipients
- Networking and specific project collaborations with other providers of services to women (such as WIC, Planned Parenthood, and Children's Services)
- One-time educational presentations to community social and civic groups
- Staff training programs and technical assistance for other social service agencies
- Community awareness projects (county fairs, community festivals, parades, and local campaigns, i.e., Red Ribbon campaigns for AIDS awareness)
- Special programs for communities outside county seats (very rural and isolated communities)
- A public information campaign

The basic tenets of program planning are the same as for RWRP.

- Chemical dependency affects women differently from men.
- The program must be responsive and accessible to rural clients.
- The program should view women positively.
- Clients have the right of self-determination.
The program needs to provide healthy, acceptable, and believable role models.
The program needs to acknowledge the complexity of clients’ lives: children, partners, income level, housing situation, education, employment or lack of it, and values and traditions.

Content Area

Women’s Health and Poverty

The health care crisis for women is staggering, and the relationship between poverty and health status is inextricably intertwined. Poverty increases the chance of poorer health status. Lower income leads to increased health risks, and increased health risks lead to lower life expectancy and high rates of chronic disease, including alcoholism and other drug addiction. Preventable hospitalizations (bacterial pneumonia, cellulitis, kidney/urinary infections, dehydration, gastroenteritis, asthma, COPD, congestive heart failure, angina, and diabetes) among poor adults is two to four times as high as for high-income adults (Codman Research Group). Poor women are three times as likely to have problems obtaining prenatal care, and close to 30 percent fewer poor women obtain prenatal care during their first trimester as compared to non-poor women (Center for Health Economics Research 1988).

The substance abuse-domestic violence connection and the substance abuse-HIV connection are well documented. In 1984, Wilsnack reported that more than 50 percent of all domestic violence and 40 to 74 percent of child abuse cases are related to alcohol and other drug use. She also reported that more than 70 percent of female addicts/alcoholics report a history of sexual abuse. In the State of Ohio, women now make up 8 percent of all reported AIDS cases (Ohio AIDS Surveillance Section 1993).

Alcohol and drug use during pregnancy severely compromises both maternal and fetal health. Robin LaDue, an expert on fetal alcohol syndrome, refers to alcohol as the only known teratogenic agent (cancer-causing agent) in the United States with its own lobby in Washington, D.C. Fetal alcohol syndrome attributed to maternal alcohol use is an entirely preventable condition.

In the four rural counties that served as the initial client referral base, 41 percent of women ages 18 and older are on public assistance, and 27 percent of the total population lives in poverty. Regional poverty, an inadequate number of primary care providers, and poor health-seeking and wellness behaviors among residents (rural adults are less likely to engage in preventive behaviors, according to Bushey) all contribute to the overall poor health status, especially among women. Adverse living conditions, poor education, and poverty are associated with higher rates of alcoholism and other drug addiction (DHHS 1990). Poor health, lack of access to primary care services, and the multiple drug use often seen in women (women have a tendency to use multiple drugs and alcohol, along with use of over-the-counter and prescription drugs) have a cumulative effect on the progression of addiction in women.
Barriers to Treatment for Appalachian Women

Many barriers exist in the region that inhibit and prevent women from obtaining needed services. Women, who constitute a significant portion of the medically indigent, lack the financial resources to pay for care. The lack of child care, lack of available treatment slots, lack of transportation, and discrimination are major hurdles for women anywhere to overcome before they can obtain substance abuse services. Individuals in rural areas must cross additional hurdles that are not typically present in urban and suburban areas, such as not having telephones to ease their access to service. Intrinsic sociocultural obstacles also keep rural women from obtaining care. These obstacles include differences in lifestyle, language, education, values, and beliefs.

Traditional Appalachian values of family solidarity, self-reliance, and pride have held families together in the face of overwhelming problems, yet these same characteristics pose problems for service providers who are promoting healthy lifestyle changes. Cultural beliefs that influence one's view of life, health, illness, and death were very important factors in designing the programs. The "what will be-will be" attitude and a fatalistic perception of how one's life unfolds have a critical impact on a client's health behavior. They also affect our ability to offer acceptable and effective intervention and treatment strategies.

Lastly, there are institutional barriers to be overcome. For residents of Southeastern Ohio, these include a reluctance to go into town (i.e., the county seats) for services, rude and indifferent receptionists, the stigmatization of low-income persons, a general fear of medical and other service providers, long clinic waits, and long waiting lists due to a limited number of providers (all but one of the counties are designated as Health Profession Shortage Areas). Providers must address the need to successfully overcome rural isolationist attitudes, a general lack of trust in institutions, and the need to ensure that agency and program communications overcome barriers of geographic isolation, readability, and cultural differences.

Overview of the Service Area

The target service area for the Rural Women's Recovery Program and Women's Outreach consists of Athens, Hocking, Vinton, and Meigs counties, which make up a portion of the federally recognized region called Appalachia in Ohio. The counties are identified as primarily rural, with a predominantly white population, and with several small Native American communities. The racial minority and ethnic population in the counties can generally be identified as students, faculty, or staff at Ohio University and Hocking College located in Athens County. Minority representation in the area accounts for approximately 3 percent of the total population.

Appalachia is an area plagued with a chronically depressed economy, geographic isolation, and extreme poverty. The heart of regional problems lies in the fact that, historically, businesses were primarily extraction industries (coal, oil, timber) that made little or no significant investment in local communities. When these industries disappeared, small towns and villages were left with no jobs, development, or infrastructure (transportation, water, waste, and sewage). With the global economy of today, there is little call for development in an area that lacks a trained
workforce and the political and physical infrastructure to support technology-dependent economic growth.

Limited economic development, high unemployment, and high poverty rates typify the region. The State unemployment rate is 7.7 percent, and unemployment figures in the target counties range from 6.4 to 10.6 percent (Ohio Bureau of Employment Services 1992). Women in this geographic region are not adequately represented in the workforce; many stay at home to raise families or are grossly underemployed. The more traditional the community, the more limited are the employment opportunities for women. The pink collar jobs (service industries that include housekeepers, beauticians, waitresses, and child care providers) and the part-time positions that may be available rarely offer healthcare benefits. For women with children, the choice may be either to accept low wages without adequate healthcare or to remain unemployed and on public assistance with assured medical coverage for themselves and their children. In spite of welfare reform efforts, there remains little incentive to stay employed without adequate healthcare benefits.

The extreme poverty of the region is perhaps the most distressing problem. In the State of Ohio, 15 percent of families live below the Federal poverty level. The poverty rate in Athens County—32 percent—is the highest in the State (Council for Economic Opportunities in Greater Cleveland 1993). Unfortunately, extreme poverty is not the exception in Appalachia, but the rule. The poverty rate is 27 percent in Vinton County, 17 percent in Hocking County, and 28 percent in Meigs County.

In a region that values tradition, the wife in a husband-wife household is especially vulnerable to poverty when the single wage earner loses his job (Tickamyer 1976). Single women holding families together are often the least capable of providing economic security. Across Ohio there are 19.8 percent more female than male heads of households with children. In the target area, the rate of female heads of households with children runs from 23.4 to 36.8 percent, as compared with single men running households with children (1990 U.S. Census data). The most important segments of our population—women with children—are at greatest risk to the dangers of alcohol, nicotine, and other drugs and the related problems of birth defects, mental impairment, incarceration, accidents, violence, physical disability, and death. The daily struggle for survival in Appalachia is clearly visible as alcohol and other drug use become a common way to escape from the harsh realities of living.

Financial and Political Support

Economically speaking, a sparse population limits the number and array of services that can be offered in a given region. The per capita costs of providing special services often make them prohibitive to implement. Yet cost in and of itself does not diminish the need for those kinds of services by the people who live in a rural area.

—Angilene Bushey 1993

Bushey’s statement represents the primary problem in providing health care services in most rural areas—money. The State of Ohio, through the Ohio Department of Alcohol and Drug Addiction Services, has made an outstanding effort to address the need for substance abuse services for women and to address the disparity of available services in rural areas of the State.
Federal block grant funds designated for women's services have been held separately from the general pool of block grant money.

States have several options for fund distribution. Ohio has chosen to maintain the integrity of the Federal set-aside monies for women's programming and has offered a competitive grant program. This funding mechanism has promoted the development and implementation of specialized programs that specifically address the prevention and treatment needs of women and of women with children.

In addition to State support, the Alcohol, Drug Abuse and Mental Health Service Boards in Athens, Hocking, Vinton, and Gallia, Jackson, and Meigs (agencies legally responsible for oversight of State funding for alcohol and other drug treatment programs) have provided financial, political, and administrative support. Efforts on behalf of these political bodies to recognize the unique needs of rural areas and to secure adequate funding for programs have been invaluable to the success of the Rural Women's Recovery Program and Women's Outreach.

Service Delivery Model

The medical model approaches drug treatment primarily from a physical impairment perspective. While this is important, the model does not recognize the complex and multifaceted lives of women. A sociological model of treatment acknowledges the physical aspect, but also looks at substance abuse from within the context of personal economics and power—or the lack of power. The sociological model demands that one examine and respond to the social and cultural influences and pressures of clients. It was from this model that the treatment and outreach programs were designed. The programs allow women clients to examine how substance abuse is different for them and enable the women to deal with the double standards that exist in many treatment programs, child service agencies, and law enforcement. The program staff and clients need to acknowledge the stigma attached to substance abusing women.

The residential program is committed to assist indigent and low-income women. An 800 number and telephone intakes permit ease of access. Length of stay is typically 90 days, but this is determined by the treatment team for each individual client. Services provided to clients include:

- Individual and group counseling
- Life skills
- Personal health presentations
- Recreation
- Case management
- Parenting
- GED assistance
- Art therapy
- Psychotherapy
- Communication skills
- Conflict resolution
- Special topic presentations and discussion groups (such as incest/rape survivor, eating disorders, pregnancy, HIV, and co-dependency)
The primary counselor helps the client to ferret out her priorities for treatment. Dependency issues are a big item in almost all client treatment plans. Our goal is to help the client believe in her own strengths, in her capacity to care for herself, and to support her taking responsibility for her own recovery and for her life. Group and didactic presentations look at the many competing issues of substance abusing women. We try to help clients recognize that everyone is not a Suzy Homemaker or a June Cleaver, and then help to reestablish a sober mom back into a family unit. Issues around sexuality and intimacy are always addressed. While there are relatively conservative views of sex in the area, sex and relationships are clearly relapse issues for most of our clients. Clients are given the freedom to discuss sex and intimacy openly to get accurate information and honest feedback.

Case managers have the task of helping clients to reconstruct their outside worlds. This includes working on financial counseling, obtaining public assistance, obtaining a primary care physician, securing safe and affordable housing, working with other family members, and child care concerns. All clients being discharged help to create their discharge and aftercare plans. Clients are expected to follow up with outpatient counseling or to comply with other referrals made upon discharge. A monthly alumnae meeting allows former clients to return to the house to share insights with current clients. This meeting also serves to introduce current clients to potential sponsors.

The program has a strong Twelve-Step focus and provides transportation to meetings. Not all women's substance abuse programs and providers feel that traditional Twelve-Step groups are responsive to the needs of women. However, we are committed to help the clients establish as many sober support systems as possible in their home communities. Alcoholics Anonymous is usually the only nonprofessional group available in our rural counties. Cultural strengths and traditional values are also tapped to re-create healthy responses for clients, including:

- Religion—this is a feelings disease with a spiritual base
- Self-reliance—this involves learning how to care for one's self
- Family system—this involves learning how one can create healthy families

In both the residential and outreach programs, activities and plans are examined to ensure that services are acceptable to clients. Maintaining client confidentiality and anonymity in a small town is difficult, but a priority. Women's Outreach operates with a small community, neighborhood, and person-to-person approach. Taking programs to communities instead of expecting people to come to your office goes far in overcoming client reluctance to deal with bureaucracies and "the government." This approach also helps staff learn to relate to residents and clients within the context of their environments, to actually see what their day-to-day realities are. A provider may decide not to see a client because of body odor, but the case quickly takes on another dimension when you understand that person has no running water or electricity.

The reality of living in rural Appalachia is that many people face a day-to-day struggle for basic needs. This reality forms the foundation for our ongoing program development in the Rural Women's Recovery Program and in Women's Outreach.

**Findings**
A typical client at Rural Women's Recovery Program is 30 years old, divorced or separated, has two minor children, is extremely low-income (50 percent report no source of income—including public assistance—prior to treatment), and has no marketable or vocational skills. Fifty percent of clients have had children removed from the home by child welfare agencies, 99 percent report a history of incest or sexual abuse, 56 percent have an eating disorder, 35 percent have been diagnosed with chronic depression and have been prescribed medication, 50 percent have been prescribed psychotropic medication, 74 percent report alcohol as their drug of choice, and 26 percent report cocaine as their drug of choice.

It is believed that attention to the following areas is what makes these two programs successful:

- The program is psychologically accessible; efforts have been made to eliminate or reduce barriers of perception.
- The program is financially accessible.
- The program is culturally acceptable, with culturally appropriate interventions that address barriers to access.
- The program is based on a holistic approach to health and to self-care directed by client-driven treatment goals.
- Staff exhibit a willingness to learn from clients.
- The program provides both structured and informal programming.
- The community has been incorporated into various aspects of the programs (for example, through a community beautification planting project and recycling efforts).
- Local staff is hired whenever possible.
- Communities are allowed to decide what outreach services they need and what they feel will work for them.
- Community spirit is fostered, as well as a sense of purpose aimed at addressing substance abuse concerns.

Early program outcome evaluations conducted in 1991 document that, at 6 months after treatment, 64 percent of clients were abstinent and 90 percent reported being satisfied with the program. Of clients completing the program, 91 percent reported they were regularly attending counseling sessions or attending self-help groups. After treatment, there was an increase in outpatient health care visits (this was a desirable outcome) and a decrease in emergency hospitalizations. At 6 months after discharge, program completers also reported fewer arrests than did clients not completing the program. Since opening in January 1990, Rural Women's Recovery Program has had 136 client admissions. Women's Outreach has reached more than 9,198 residents, providing education, substance abuse screenings, and referrals.

**Conclusions**

Rural Women's Recovery Program and Women's Outreach are two programs that address the substance abuse needs of women and families in rural Appalachian communities. Obtaining funding, political, and administrative support from the State and local Alcohol and Drug Abuse and Mental Health Boards allowed us to develop a residential program and a prevention/education outreach program built on the personal and collective strengths of Appalachia. The spirit of the community is evidenced by support from other agencies and
programs. Other providers in the State of Ohio who serve women have also shared their trials, tribulations, and successes to help each new program along the way. While Appalachians are not officially recognized as a minority population, our programs are designed to address the specific cultural needs of this population. Substance abuse treatment, prevention, and education really do work.

In 1994, the residential program was expanded to provide space for up to 11 women. The house includes three family units, so mothers of young children may bring their children into treatment with them. We hope to have an even greater impact on entire family systems. Recovery is not a process one does alone. The more positive influence we can have on the family unit, the greater the client's chance of maintaining sobriety.

The outreach program has seven elements for successful programming.

- Lay a foundation for trust; become involved in the community.
- Identify key community leaders; plan activities around community-identified needs.
- Start with what you have; start small.
- Provide programming even when a lot of people don’t show up.
- Understand that flexibility and persistence are essential.
- Develop participant and community volunteers.
- Value your key resource—human capital.

"Culture is what a people does, says, lives, dies, and celebrates."
—Deanna Tribe

**Recommendations**

- There is a need for additional and more secure funding streams for substance abuse programs. In addition, we must be willing to provide sufficient funds to develop new programs and to sustain adequate funding levels.
- Program providers need to find more ways of disseminating information about interventions and programs that are successful. Many of us in rural areas administer, manage, and sometimes see clients in our programs. Finding the time to present or write articles about what we do is often a luxury that we do not have.
- Rural substance abuse providers need to provide assistance to all other programs that are attempting to serve other rural populations.
- The Federal Government should rethink how it defines minority groups. Consideration should be given to raising the status of low-income and rural populations, particularly Appalachians.

**References**

Bushey, A., ed. *Proceedings from the National Rural Health Association Conference.* 1993

The Bridges of McKinley County: Building Rural Recovery Coalitions

Raymond Daw, M.A.
Executive Director
Na'Nizhoozhi Center, Inc.
Gallup, New Mexico

Herb Mosher, M.A., M. Ph.
Rehoboth McKinley Christian Hospital
Gallup, New Mexico

Abstract

From 1975 to 1985, McKinley County, New Mexico, had the highest composite rate of alcohol-related problems of all 3,106 counties in the United States, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Between 1973 and 1992, the only incorporated municipality in the county had been picking up an average of 32,000 publicly intoxicated individuals each year and placing them in "protective custody." After a series of national media reports that labeled the region "Drunk City," a small group of individuals began meeting at Rehoboth McKinley Christian Hospital. This group built bridges to span the canyons of ignorance and indifference regarding rural alcohol and other drug use.

In the winter of 1989, this coalition began the March of Hope, which culminated in several thousand people joining a group of citizens who walked 200 miles in 10 days from Gallup to the State legislature in Santa Fe. Subsequently, the rural coalition has been the catalyst for a regional response that has closed all drive-up liquor windows in the county; passed a local 5-percent liquor excise tax, receipts from which help fund prevention and treatment services; constructed and operated a 150-bed detoxification and assessment center; and reformed State driving while intoxicated (DWI) laws.

The purpose of this paper is briefly to describe the response of a small group of people in rural Northwest New Mexico to an epidemic of alcohol and other drug abuse problems.

A County Under the Influence

McKinley County is located in the northwest region of New Mexico not far from the point where the Four Corners of Arizona, New Mexico, Colorado, and Utah touch each other. With a
population of about 61,000, McKinley County covers an area larger than the combined States of Connecticut and Rhode Island. Population density ranges from 4 to 14 persons per square mile. The county contains approximately 43,000 Native Americans who are members of the Navajo Nation or the Pueblos of Zuni, Laguna, or Acoma. Standards of living range from upper middle class households with two incomes and three cars to a large number of dwellings without indoor plumbing, where 50 percent of the families earn less than $10,000 per year.

Gallup is the only incorporated municipality in McKinley County. As a major trading center for Indian jewelry, art, rugs, and other crafts, Gallup attracts more than 100,000 people on weekends. Since alcoholic beverages are illegal in the Navajo Nation and Zuni Pueblo, Gallup has more than 60 restaurants, bars, and retail outlets that dispense wine, beer, and other forms of alcohol. As a result of Gallup's proximity to Interstate 40 and the Santa Fe Railroad, illegal drugs are readily available. McKinley County is especially vulnerable to a high incidence of alcohol-related problems, including driving while intoxicated (DWI), because of the combination of easy access to alcohol and other drugs, long travel distances, poor roads, limited medical services, a young population, and a long history of alcohol abuse.

NIAAA's *U.S. Epidemiological County Problem Indicators* found McKinley County had the highest composite index (910) of alcohol-related problems of all 3,106 counties surveyed from 1975 to 1985. During this period, death rates from cirrhosis of the liver in McKinley County were 3 times higher than the national average; alcohol-related traffic accidents were 7 times higher; and chronic alcoholism rates were 19 times higher than national averages.

From 1987 to 1993, a total of 255 persons died in McKinley County motor vehicle crashes. Of this total, 188 fatal crashes, or 74 percent of the deaths, were alcohol related. According to the New Mexico Traffic Safety Bureau, McKinley County ranked first among the State's 33 counties for alcohol-related crashes on a per-capita basis. During this same period, McKinley County ranked among the top five counties in America for per-capita DWI fatalities.

From 1973 to 1992, the Gallup Police Department operated a protective custody system that picked up public inebriates and put them in the local jail. Gallup protective custody logs record an average of 32,000 protective custody pickups per year for public intoxication in a city of only 22,000 residents. The magnitude of the problem attracted regional and national media attention. In the fall of 1988, the *Albuquerque Tribune* conducted a 3-month investigative report. In the following months, the region's problems were the subject of lengthy feature stories produced by ABC's *20/20*, NBC's *Today* show, and PBS' MacNeil/Lehrer *Newshour*.

**March of Hope—Journey for Jovita**

In the summer of 1988, the chief executive officer of Rehoboth McKinley Christian Hospital (RMCH), Dave Conejo, invited a small group of health care professionals and concerned citizens to meet informally about the hospital's commitment to the community. From these sessions came a core group of people who were committed to changing the situation in McKinley County. Dr. Tom Carmany, the hospital's Chief of Pathology, urged the group to look at Gallup through the hospital's mission statement, which says that RMCH will provide "a Christian-based health care
system which is responsive to all peoples." Dr. Carmany asked core group members, "How long are you willing to step over the bodies?"

With the assistance of Gallup's mayor, Ed Munoz, the core group began meeting with elected officials, tribal leaders, schools, parents, health providers, and even representatives of the liquor industry. Initially, many people discouraged the coalition from trying to change the status quo. The Speaker of the New Mexico House of Representatives said, "You are not going to change things in Gallup, and the legislature has no money for you."

Several members of the community coalition met with Tim Gallagher, editor of the Albuquerque Tribune. Mr. Gallagher was aware of the epidemic in Gallup and wanted to "put a human face on it." The Tribune assigned a team of investigative reporters who produced an exhaustive six-part series, "A Town Under the Influence." The series provoked outrage, statewide attention, and a national award for the paper.

In January of 1989, Robbie Christie drove his pickup truck head-on into a van. He had been drinking all afternoon and had a blood alcohol count (BAC) of .35. The crash killed Mr. Christie and four members of a Navajo family, including a 3-month-old baby. The death of little Jovita Vega electrified the community coalition. Within 4 weeks, the March of Hope: Journey for Jovita left Gallup with several dozen walkers. Ten days later, more than 2,000 marchers converged on the State Capital in Santa Fe to present Governor Gary Carruthers with a reform package.

**We Can Make a Difference**

The March of Hope enabled the local community coalition to bridge the gap between what was historically perceived by State leaders as a local "Gallup Indian problem" and the more global concerns of regional and State lawmakers regarding the health and safety of all citizens. The coalition convinced many New Mexicans that after a century of suffering and indifference, a core group of leaders surrounded by a large group of supporters were going to stick together to end the epidemic of alcohol and other drug abuse.

The precise moment when both sides crossed the new bridge of understanding was captured in a picture of two women hugging each other before the entire New Mexico State Legislature. Mrs. Christie was the wife of the dead DWI driver whose fatal crash killed four people. Mrs. Vega was the mother of Jovita Vega, the tiny infant killed in the DWI crash along with her uncle, aunt, and niece. After their separate presentations to State lawmakers, Mrs. Vega and Mrs. Christie joined hands and embraced before State legislators. The bridge that spanned their shared grief helped move State lawmakers to enact the following measures.

1. **A local option referendum to allow McKinley County to close all of its drive-up liquor windows.** After vigorous opposition from the powerful State liquor lobby, this measure passed and was enacted in McKinley County by a vote of 3 to 1.
2. **A local option referendum to allow McKinley County to impose a 5 percent local liquor excise tax.** This tax measure was approved by more than a 4-to-1 vote and now generates approximately $675,000 per year for local prevention, treatment, and education programs within the county.
3. A seed money grant of $300,000 to design a facility to replace the inhumane "drunk tank" of the Gallup Jail. These monies were augmented by a Federal allocation of $1.2 million per year for program operation. Na'Nizhoozhi Center, also referred to as the Gallup Alcohol Crisis Center, developed out of concern about the inhumane conditions under which public inebriates were being detained.

The Navajo Nation, Zuni Pueblo, city of Gallup, and McKinley County formed a planning committee to coordinate efforts to obtain construction and operational funding for a facility that would replace the "drunk tank." Treatment providers, primary care providers, and law enforcement agencies were engaged to assist in design of the facility. Meanwhile, the Congressional delegation from New Mexico was able to obtain Federal funding for the proposed center's operational costs.

The city of Gallup passed a municipal bond that made possible the construction of the facility. Not long thereafter, voters in McKinley County passed a 5 percent excise tax on alcohol sales. A portion of these funds is being used to retire the bond within 10 years. In 1992, the 5 percent liquor excise tax was up for renewal and was overwhelmingly passed by 70 percent of the voters.

During September 1992, the Planning Committee for the Gallup Alcohol Crisis Center reorganized into Na'Nizhoozhi Center, Inc. (NCI). The four governmental entities are represented on the board of directors, which has a total of 11 members. A local private health care provider, Rehoboth McKinley Christian Health Care Services (RMCHCS) was approached to assist the board in implementation and management of the project. Rehoboth McKinley Christian Health (RMCH) Care Services and the Na'Nizhoozhi Center board collaborated in all aspects of project implementation. RMCH had established networks with substance abuse, mental health, and primary care providers in the region's continuum of care network, which easily accommodated NCI and its clients.

On January 1, 1994, the board of directors took full control of the project and hired an executive director to manage Na'Nizhoozhi Center. The Navajo Nation and Indian Health Services have assumed monitoring and technical assistance roles. In return, NCI has provided training opportunities for regional providers in conjunction with RMCH.

The facility embodies in its name the spirit of harmony that brought about the original community coalition. The word "na'nizhoozhi" is the Navajo term for "bridge." It is also the traditional Navajo way of referring to the city of Gallup. These activities have greatly enhanced service delivery within the region.

4. The State legislature also passed a statute banning open containers of alcoholic beverages. This statute paved the way for DWI reform, which has included tougher penalties, mandatory screening, and a lower BAC for presumed intoxication.

Miles To Go Before We Sleep
For the first time in more than a century, the different ethnic and economic groups are expanding the McKinley County coalition to include partners from the entire Navajo Reservation, eastern Arizona, most of New Mexico, and four pueblos. Subsequently, we have formed a Regional Continuum of Care (see figure 1) that includes assessment, medical intervention, residential treatment, halfway house programs, and a variety of community-based outpatient recovery support systems.

Admissions to protective custody here dropped from an average of 32,000 admissions per year to 19,000 admissions in the past 12 months. We can also identify the substance abuse cycle (shown in figure 2); sources of admissions by client residence; BAC ranges (figure 3); age groups (figure 4); and community of origin.

The New Mexico Alcohol Issues Consortium has adopted McKinley County's policies for statewide replication. Last year, the combined coalition's efforts resulted in DWI reforms that:

- Mandate screening
- Lower blood alcohol levels
- Impose mandatory jail sentences for repeat offenders
- Increase annual DWI funds by approximately $10 million per year

A portion of this funding was recently approved for McKinley County to add a DWI screening and assessment unit for Magistrate Court and to establish an Intensive Outpatient Rehabilitation (IOR) Program for DWI offenders in McKinley County.

In 1992, the enhanced coalition received a Robert Wood Johnson Foundation grant of $3.2 million to establish a Fighting Back Program. Northwest New Mexico was the only rural Fighting Back initiative funded by the Foundation. Program components include intercultural treatment strategies; specialized services for Native American women at risk of having children with fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE); and a campaign to reduce demand for solvents, inhalants, and "Ocean" (hairspray and water). The Fighting Back Program has also initiated the region's only computerized management information system (MIS) and case management system.

The expanded coalition has enabled the Pueblo of Zuni to establish prevention and treatment services through a partnership between local Zuni agencies, the Center for Substance Abuse Prevention (CSAP), and the Indian Health Service (IHS). The expanded coalition has also worked with the Navajo Nation to obtain a 5-year grant from the Center for Substance Abuse Treatment (CSAT) that is designed to improve access to treatment services at the local level throughout the Navajo Reservation.

**Recommendations**

In order to continue building bridges, the regional coalition has asked Na'Nizhoozhi Center to formulate specific recommendations that include all interested parties. The following recommendations address the alcohol and other drug issues that face our future:
1. Strengthen and enforce alcohol prohibition policies, or
2. Develop and enforce strict legalization policies.
3. Develop a voucher system of disbursing entitlements: food stamps, general assistance, and social security. This would decrease abuse of financial payments and ensure compliance with the purpose of entitlement programs.
4. Set aside alcohol-related court fines to fund construction and staffing of residential facilities for intervention and treatment of, for example, bootlegging, public intoxication, and DWI.
   a. Have 1-week inpatient programs for infrequent public intoxication offenders.
   b. These 1-week programs would be funded by offenders and partially staffed by bootleggers.
5. Require 90-day intensive outpatient treatment for all first-time DWI offenders.
   a. The 90-day program for first-time DWI offenders may be funded by DWI fines levied.
   b. For repeat offenders, require 30-day residential treatment.
6. Require bootleggers to go through 30-day residential treatment at their own cost and to perform community service at substance abuse treatment programs.
7. Strengthen veterans' substance abuse programs to include intervention for posttraumatic stress and family therapy (not counseling). Establish intensive family outpatient programs at each agency for veterans and dependents.
8. Establish facilities like NCI for predetoxification at each major Navajo community for screening, assessment, referral, and tracking of chronic alcoholics.

Substance abuse programs receiving tribal funds would be required:

1. To have affiliation agreements in place with all providing programs in the agency. Tribal evaluation of programs would monitor the programs' compliance with those agreements and, for continued funding, would also monitor the effectiveness of implementation.
2. To participate in the monthly utilization meetings in each agency area. This participation would be included in the programs' monthly reports to health boards and agency councils. This would ensure:
   - **Case management collaboration**, by indicating who receives services where, and allowing each individual client to be tracked throughout the entire service delivery system.
   - **Treatment outcome evaluation**, by assessing the changes that occur in clients throughout treatment in the regional continuum of care after their referral from NCI.
   - **Quality assurance collaboration**, by monitoring compliance with performance standards in the delivery services.
   - **Needs and resource assessment**, by describing the utilization of existing resources and identifying gaps in the service delivery system.
3. To have family intervention through collaboration with substance abuse program staff. Staff would contact family members of clients at NCI and set up intervention and family treatment plans in order to provide education, assistance, and support in dealing with alcoholism, co-dependency, and other issues.
4. To provide aftercare services/relapse prevention. These would offer structured services for clients who are completing rehabilitation, subsequent to their referral to residential treatment from NCI and their return to their home communities.
5. To offer day treatment (outpatient), after clients' transport from NCI to agency offices. Groups of identified clients would be accepted at each agency and provided with prevention and treatment modalities.
6. To assist in transportation of clients from NCI to the client's residence or agency offices for immediate intervention and placement in an appropriate treatment component.

7. To provide intake and assessment services for clients from the relevant agency catchment area, either on arrival at agency offices from NCI, or immediately after arrival.

8. To rotate substance abuse staff through NCI for supervised clinical internships for durations greater than 5 days, to learn more directly the physical, mental, social, and spiritual effects of alcohol.

9. To provide or coordinate agency training with the area organizations on a regular basis to develop more relevant training for area providers.

10. To provide effective clinical supervision (not administrative supervision) including:
   - An emphasis on supervisor-counselor interaction on a 1-to-1 basis.
   - 1-week internships at area residential programs for clinical supervision methods and procedures.
   - A reduction in administrative workload for clinical supervisors; administrative functions belong with administrators.

11. To establish pay rates that encourage hiring and retention of experienced and qualified counselors. Current pay rates are not adequate, except in Federal programs.

A Case Management Model Utilizing In-Home Treatment Services for Rural AODA Clients: The Family and Children's Center Model

Kathleen M. Adams, M.S., C.A.D.C. III
Colin C. Ward, M.S., C.A.D.C. III
Family and Children's Center
La Crosse, Wisconsin

Abstract

Traditional alcohol and other drug abuse (AODA) treatment paradigms not only overutilize and poorly manage AODA intervention services, but fail to meet the unique needs of rural Americans. This paper describes an alternative AODA treatment model developed to meet the needs of a rural clientele. By developing a broad continuum of outpatient and in-home service options, the needs of rural Americans who have AODA concerns can be better met by means of an intensive case management model, treatment rather than diagnostic assessments, and quality assurance procedures. Chemical abuse and mental health care providers need to recognize that chemical abuse problems are complex and that they exist on a wide spectrum of intensity. In-home intervention services are often the most effective mode of addressing AODA issues with rural populations.

This paper describes the alternative alcohol and other drug abuse (AODA) treatment model developed at the Family and Children's Center in La Crosse, Wisconsin. This model grew out of the crucible of change created when we were challenged to create a better way of assessing needs and of developing and delivering services specific to the unique AODA needs of a rural clientele.
Content Area

Family and Children’s Center (FCC) is a regional, private, not-for-profit mental health care agency that has served the needs of La Crosse and surrounding rural communities for more than 100 years. As part of a large continuum of programs designed to keep families together and promote individual well-being, FCC provides outpatient and in-home mental health and chemical abuse treatment services, as shown in figure 1.

Funding for services is broad based and includes the United Way, medical assistance, donations, private pay, and health insurance. In the mid-1980s, FCC began contracting with insurance companies to provide comprehensive managed mental health care services. Through selected affiliation with other mental health and medical services, we complemented our own already broad continuum of care. The components of this expanded continuum of care are shown in figure 2.

The move into managed mental health care in the mid-1980s created a crucible of change for us. In addition to requiring extended affiliations, managed health care demanded:

- Prospective and retroactive utilization review
- Quality assurance procedures
- Assumption of financial risk

Utilization review and quality assurance discussions quickly began challenging many of our assumptions about chemical dependency treatment. We discovered that traditional 28-day inpatient programs were overutilized and that criteria for inpatient admission were unclear and imprecise. Assessments that determined the presence and progression of “disease” were often done only after inpatient admission. The subsequent treatment plans were often rigid, with little if any consideration given to cost effectiveness. Hospital-based treatment programs failed to provide the accessibility needed to appropriately meet the demands of a rural clientele. Both distance and their daily commitment to farming activities made traditional AODA treatment services an ineffective match for the needs of rural clients.

As our traditional assumptions were being challenged, we explored the literature and progressive program trends, and our own philosophy of chemical dependency treatment began to evolve. We began developing an alternative model of treatment.

This alternative model of treatment was based on the assumptions that:

- The complex interaction of psychological, social, and biochemical factors leads to chemical abuse.
- Patterns of chemical abuse often begin as coping responses developed to manage emotional distress or trauma.
- Chemical abuse is a complex issue that seldom, if ever, exists independent of other psychosocial stresses.
- Chemical abuse problems vary greatly in their intensity.
- Chemical abuse problems are not necessarily progressive in nature.
Watching the needs of our rural and other clientele go unmet, it became clear that treatment interventions needed to be matched closely to each individual's needs. We focused on creating a service delivery model emphasizing:

- Accessibility of assessment and treatment
- Assessment focused on determining treatment recommendations rather than diagnosis
- Highly individualized treatment in the least restrictive environment
- Utilization of a broad continuum of medical and mental health services
- Aggressive case management

**Methods**

Managers of mental health care benefits are often viewed as "gatekeepers," whose function is to authorize and limit services. We developed a differing philosophy: that benefits management is a matter of quality assurance and preutilization review, not gatekeeping. Quality treatment, in the least restrictive environment, should be provided before insurance benefits are exhausted.

**Case Management**

In the context of this philosophy, the challenge was to provide quality clinical case management that was client centered and emphasized aggressively managed individualized treatment plans.

The case manager is someone who can initiate and maintain a process that can help substance abusers identify and access the right interventions at the right time. The assumption of case management is that most people with substance abuse problems can best be served by access to a range of resources, rather than by a single counselor/case manager trying to provide direct help with all the person's problems.

—Bois and Graham 1993

In their 1993 article, Bois and Graham described the basic principles of the case management approach. We have adapted them as follows:

- **Empowerment**: The client is involved in identifying his or her own needs and is actively involved in the entire process of assessment and treatment.
- **Individualization**: Because each client's strengths and needs are unique, each assessment and treatment plan is client centered and different.
- **Adaptability**: As the client and his or her environment changes, the case manager must reevaluate the client's treatment plan.
- **Least restrictive**: Assessments and interventions that work with the structures of the client's life will be most effective.
- **Professional expertise**: The case manager should have advanced training and professional expertise.
- **Transformational**: The case management model functions as a change agent both for the individual AODA client and for the AODA treatment system as a whole.
We created a model that utilizes existing rural support networks and medical services, combined with the added development of specialized AODA services. The additional services include outpatient detoxification services and home-based counseling services focused on AODA treatment. In emphasizing aggressively managed individualized treatment plans that utilize a broad continuum of services, we were freed to develop treatment options specific to the needs of our rural clients. This clinical case management approach soon demonstrated its clinical and fiscal value. The advantages of this approach were made available to all clients, regardless of funding source.

Assessment

Effective assessment is a process of exploration that empowers the client and effects change. Our experience was that an assessment process focused on diagnosis was of minimal value, often reducing the individual's level of motivation and promoting rigidity. Additionally, the diagnostically focused assessments seldom took into consideration the psychosocial stresses unique to rural clients.

Assuming that chemical use functions within the broader context of any individual's lifestyle, we developed a treatment-focused assessment process. This process is designed to develop a dynamic treatment plan individualized for each client. Diagnosis is secondary, and each client is actively involved in developing a treatment plan specific to his or her needs.

These comprehensive assessments are provided by a clinical case manager who has AODA certification at the highest level by the State of Wisconsin (Certified Alcohol Drug Counselor III) and more than 3,000 hours of supervised clinical experience beyond the master's degree. Comprehensive assessment is possible because assessments are done by a clinical case manager with solid mental health expertise in addition to chemical dependency training. In addition to exploring the history and pattern of substance abuse (amount, duration, and frequency of use), the case manager explores the following other essential areas with the client:

**Physical health**

- Assess for physical complications related to chemical use
- Explore withdrawal history
- Explore any chronic pain patterns related to chemical use history
- Refer to family physician for physical examination if the client has had no recent physical examination

**Polydrug use**

- Assess for use of multiple types of chemicals and use patterns
- Analyze the psychosocial component of problematic use

**Self-medication**

- Assess how chemical use facilitates the client's management of emotional and social discomfort
Stress management

- Assess the stresses, both internal and external, that appear to be alleviated by chemical use

High-risk situations

- Explore the individual's awareness of high-risk situations—situations specific to the individual in which that person's risk of abusing chemicals is high

Critical shift point

- Explore how the individual experienced the critical shift point—that point at which individuals become aware that their chemical use is a problem for themselves or others

Stated use goal

- Explore the individual's use goal—abstinence, occasional use, regular controlled use, etc.
- Understand and assess the language the individual uses to describe urges or moments of craving for chemicals—a source of valuable information about the function of the individual's chemical use. (Traditional thought interprets urges and cravings as statements of failure or as a first step toward relapse. We believe that urges can best be interpreted as statements expressing the individual's struggle to soothe unmet physical, psychological, social, and spiritual needs.)

Mental health

- Assess the client's mental health. In addition to the clinical interview, there are many excellent tools available for assessment of clinical depression and other mental health issues.

Social and family history

- Assess for trauma history and explore ways that chemical use may be functioning as a survival response

Availability for treatment

- Assess family, vocational, and travel dynamics that impact the individual's availability for differing treatment options

In-Home Individual and Family-Focused Services

Many rural clients experience problems of isolation and inaccessibility to treatment. A model of service delivery that emphasizes in-home treatment addresses these problems. In addition, home-based services facilitate the initial first step of accessing mental health services, a step that is often difficult for rural clients because of fears about social stigma or the scheduling demands of a farming lifestyle.
The FCC case manager is able to integrate any combination of the following in-home services into any treatment plan:

- Intense systemic AODA assessment to determine both emergent care issues and ongoing individual and family treatment needs
- Individual and/or family counseling
- Family support services focused on support or crisis intervention
- In-home detoxification, including home nursing care and ongoing medical monitoring by a registered nurse

**Outpatient/In-Home Detoxification Program**

The factors that determine a client's appropriateness for outpatient/in-home detoxification are:

- Physical condition
- Support system
- History of and intensity of withdrawal symptoms
- Accuracy of self-report information
- Client's comfort level

If it is determined that the client is appropriate for outpatient/in-home detoxification, the clinical case manager refers him or her to a physician for an immediate medical evaluation. A number of physicians have agreed to be on call for such circumstances. If the client has a primary care physician and wants this doctor to handle all medical services, the client's wishes are supported.

In consultation with the physician, the clinical case manager arranges an immediate schedule of home visits by a registered nurse. The home health care nurse will consult regularly with the physician and will provide ongoing monitoring of:

- Blood pressure
- Respiration
- Temperature
- Medication management
- Progression of withdrawal

Inpatient medical treatment is available at any time deemed necessary by the consulting physician.

The clinical case manager continues to provide ongoing coordination of services, therapeutic support, AODA and mental health assessment, and daily review with the home health care nurse. Additionally, all outpatient/in-home detoxification cases are contemporaneously reviewed by a psychiatrist.

Additional services, available outside the home, are typically coordinated with the in-home services. These outside services include:

- Individual, family, or group outpatient psychotherapy
• Psychiatric or psychological evaluation and medication management
• Intensively structured outpatient group treatment
• Intensive day treatment
• Residential treatment
• Treatment foster care services
• Inpatient medical treatment
• Support groups

The following case review demonstrates this case management model in action.

*Case Review*

A 9-year-old male was brought in to the emergency room by both of his parents, who were seeking to have him hospitalized for escalating behavioral problems and for threatening to harm himself and others. The hospital social worker did an initial assessment and telephoned the clinical case manager who was on call with the following information:

• The family had never accessed either inpatient or outpatient mental health services in the past.
• The father had a significant problem with alcohol abuse.
• The parents were divorced and shared custody and placement.
• There was one younger sibling.
• The mother had an unresolved history of childhood sexual trauma and clinical depression.
• There was significant conflict between the parents.

Additionally, the 9-year-old had recently been diagnosed with Attention Deficit Hyperactivity Disorder by his primary care physician, who had prescribed a medication intervention of methylphenidate hydrochloride (Ritalin). Because of perceived social stigma, the parents had been reluctant to follow through with medication management and had not administered the methylphenidate hydrochloride.

As the local hospitals do not have a psychiatric facility for children, hospital staff were eager to explore solutions other than the following limited options they were initially faced with:

• Admit the child to the adult psychiatric unit
• Refer the child to the State mental health institute 2-1/2 hours away
• Refer the child to the police and a secured juvenile detention facility

In consultation with the social worker and emergency room physician, the clinical case manager determined that the child needed:

• Stabilization in a secure environment
• Psychological evaluation
• Consultation with the family physician who had prescribed the methylphenidate hydrochloride
• Assessment of individual and family struggles with AODA and depression, and the impact of these on the current crisis
It was determined that these needs could be met in a less structured environment than the hospital, secured detention, or the State hospital. The following recommendations concerning assessment and treatment of the boy were made and followed:

- One week of stabilization and evaluation of the child in a licensed treatment foster home
- A psychological evaluation within 24 hours
- Consultation with the family physician
- In-home, family-focused assessment of the family dynamics, AODA, and other factors that enabled the crisis to develop
- Home-based family therapy upon the child's discharge from the treatment foster home; this family therapy would be designed to facilitate reintegration of the child into the family and to preclude future destabilization
- Outpatient psychotherapy recommended for the parents to address the father's chemical abuse patterns and the mother's maladaptive coping patterns

The treatment foster parents picked up the child in the emergency room and he remained in their home for 1 week. Exit interviews with the providers and the parents confirmed that this intensive, family-focused intervention of counseling and treatment foster care services was successful in stabilizing the patient and in providing psychological evaluation of individual and family issues. Secondarily, the funding saved was estimated to be at least $3,000 to $4,000. Home-based services and outpatient psychological and psychotherapy services were subsequently provided to the family.

**Findings/Conclusions**

The unique needs of rural AODA clients are best met by a broad continuum of services that emphasize outpatient and in-home service options. Psychotherapists and family physicians can utilize case-managed intensive outpatient and in-home services for both crisis intervention and ongoing AODA treatment. Structured quality assurance and utilization review (QAUR) procedures ensure that the Family and Children's Center maintains its commitment to excellence in clinical service. QAUR procedures also provide FCC with regular feedback, which is immediately integrated into the dynamic case management process.

**Recommendations**

The disease paradigm, and the consequent reliance on inpatient treatment, functioned to move chemical abuse problems out of the moral arena and into the medical arena. Looking to the future, it is important to recognize that chemical abuse problems are very complex, that they exist on a wide spectrum of intensity, and that the treatment arena must therefore include a wide spectrum of creative service responses. In rural America, and elsewhere, where the impact of chemical abuse is hard felt in the home, treatment services should be available in the home.

**Reference**
Strategies for Building Rural Coalitions and Networks

Jim Armstrong, C.S.A.C., C.A.S.
Administrative Director
Fountainhead Treatment Program and Counseling Center
Bullhead City, Arizona

Abstract

This paper proposes solutions to the long-term problem that rural areas have in providing substance abuse treatment modalities for residents of small communities. In the past, many people with a substance abuse problem have been sent to larger cities, where the large treatment centers are located. One of the main problems which arises is that, after the person finishes treatment, that person returns home with no aftercare available. It is hard for most of these patients to travel back and forth for their aftercare, and family members are seldom able to participate in family programming under such circumstances.

This paper is designed to help those concerned about treating substance abusers in rural areas to:

- Create innovative strategies, policies, and programs for improving delivery of substance abuse services
- Provide workable strategies for building rural coalitions and networks to make these treatment delivery systems successful

This paper is based upon personal experience. Having worked in large and small communities, I have been able to examine the needs specific to rural populations and to try many different approaches to fill these needs. The methods suggested here have been proven—they work.

When I first arrived in the Tri-State area at the intersection of Arizona, Nevada, and California (see figure 1), only a few counseling offices were available. Most of the substance-abusing population was sent to larger cities—Las Vegas, Nevada or Phoenix, Arizona. The problem in this community, as well as in other small communities, is that rural coalitions and networks needed to be built to provide proper, professional treatment.

Figure 1. This map shows the service delivery area (in the circle) of The Fountainhead Treatment Program and Counseling Center located at Bullhead City, Arizona. This program serves a Tri-State area in Arizona, Nevada, and California. [Not currently available]
Setting Up a Treatment Network

Mohave County (13,341 square miles), where our program is located, is the fifth largest county in the United States. When an area like ours has many small communities, most professionals will not relocate there because of the lack of large-scale business. When you create a proper network, a solution is created for everyone—the caregiver and the community.

Before developing a coalition or a network, one of the first priorities is to take an assessment of the needs in the community. The first step is to contact employers, insurance representatives, and nearby State mental health facilities about what is lacking in the community and surrounding areas. In the past in our area, numerous professionals relocated here to open offices, but most had to close their practices and move away because of lack of funds. Also, many left because they had not networked with any of those professionals who were having reasonable success. Two major treatment centers had set up satellite offices in this area, but they only lasted 6 months before closing. The reasons for these closures were the same as for the professional practitioners.

Professional substance abuse treatment in rural areas can be accomplished, of course, provided that there are adequate substance abuse benefits. However, that is only part of the solution. Having benefits without having available treatment options is one of the many problems to look at when creating a treatment/counseling center.

Providing Office Space

In setting up a treatment/counseling center, check with the community hospital in your area with regard to possible office space available either in the hospital or close to it. Considering the number of substance-abusing patients admitted or seen in their emergency rooms, most hospitals could and probably would be interested in having a professional close by to help assess and possibly treat these patients. In our community, our small hospital sees approximately 800 patients a month through the emergency room alone. Imagine what percentage of these cases are related to substance abuse!

Providing Professional Counselors

In most small communities, counseling services for substance abuse and related issues are in demand. Many professionals practicing in large cities would be willing to relocate to a rural area if steady employment were available. And such steady employment can be made available by creating rural networks that provide all modalities of treatment.

If only one professional is available to serve a small, populated 50-mile area, one solution could be that the professional travel to each community on a regular basis. At one time, two professionals from Las Vegas would spend 2 days a week in our area, stay in a motel, and see patients most of the day. These professionals contacted physicians in the area for referrals, which worked quite well until the demand for their services heightened. They worked for a managed care company to provide services for their clients. When I contacted these professionals about possibly providing these services for them, they were agreeable because of the cost of their travel and lodging expenses. These professionals have since become a major referral source.
State-funded facilities are also a good resource when networking. Their staffs usually have a good knowledge of what the needs are in their geographic area.

**Providing a Meeting for All Professionals**

In rural areas, when a person wants and needs help, where does that person go? Many will not seek help because it is too far and they will be away from work and family for too long. In a rural area, you need to designate a 50-mile radius to work on, then contact counselors, psychologists, and other healthcare professionals and set up a meeting for all. If there are a limited number of Ph.D. practitioners in the area, see whether they have at least 1 day a week when they can come to your office to see clients. In our area, there was a lack of psychiatric help and we invited a psychiatrist to see people in our offices 2 days a week. This worked well. Community hospitals within rural areas might also want to refer patients to such a therapeutic source.

**Setting Up an Outpatient Treatment Program**

Today, the cost for opening intensive inpatient programs in rural areas is cost prohibitive. But if a community hospital is available in the area to provide detoxification supervised by the medical director of your center, then intensive outpatient and day treatment is the answer.

If you are going to be starting an outpatient treatment program, you will be able to treat patients on a daily basis who live within a 50-mile radius. First, contact physicians in the area and find an interested physician to provide histories, physicals, and medication monitoring, who is willing to become the medical director for an outpatient program. The physician will also be a primary referral source for the program. Also, when contacting other professionals in this 50-mile radius, be sure that clients will be referred back to the original referring professional upon discharge from the program. Otherwise, you will not receive continuing referrals.

**Planning With Professional Colleagues**

After the initial contact with professionals in your area, plan to meet these professionals on a face-to-face basis to provide information on your strategies, secure information on theirs, and to determine comfortable solutions that will meet both of your needs while building a full scope of treatment modalities for rural area residents. A rural populace should not be lost in terms of finding available treatment, and working together with other professionals will provide services for this population.

Meeting space should be provided so that all professionals in the area can meet once a month to share information regarding their modalities. The idea behind these meetings is to fill the unmet needs of rural communities. This can only be accomplished if there is a willingness by professionals to work as a team to provide quality care.

**Finding Answers when Professionals Are Not Available**

How do we give quality, affordable treatment in small communities that do not have an available staff of professionals? Mainly the answer is to look at the services that can be provided, then
enhance these services and add to them by building networks and coalitions to provide these services. It is not a simple task; it takes a person who is concerned about the substance abuse population and is willing to devote some effort and time to coordinating the proper modalities for treatment.

The Future of Rural Treatment Under a National Healthcare Plan

Will there be a need for the State-funded substance abuse treatment services if there is a national healthcare plan? Probably not. What would be the need if everyone has benefits? For all treatment, there would be an insurance billing under substance abuse benefits. Of course this would not happen immediately. But projecting into the near future, the chemically dependent would have a choice in their treatment, rather than only one option dictated by lack of benefits or financial support.

With a national healthcare plan, many positive things would occur with regard to treatment that would have an immense impact on the substance-abusing population of the United States. Research shows that substance abusers evidence a 33 percent higher rate than others in their use of healthcare benefits. Research also shows that, after completing treatment and staying off mind-altering drugs, most substance abusers have become productive members of society. So cost effectiveness for the employer and society is an issue in healthcare reform.

In our center over the past couple of years, we have had many success stories illustrating the cost-effectiveness of treatment. After being referred by their employers for substance abuse treatment, we have had three clients receive Employee-of-the-Month awards, one receive an Employee-of-the-Year award, and two have been promoted to supervisory positions. This does not include our unemployed clients who became employed and the separated families that became whole again. Substance abuse treatment works, and with the proper modalities it works well. Creating these modalities in rural areas can only be done by building rural coalitions and networks to provide and enhance treatment for all.

Conclusion

Drug and alcohol abuse in our society is not decreasing but instead is increasing for all age groups. The only proven method for overcoming this problem is treatment, which must include education in schools, in the home, and in the workplace. Imagine what it means—if it's even close to being true—that 1 of every 10 Americans has a problem with alcohol or drugs and that each one of these substance abusers affects 10 people around them, such as family, friends, and coworkers.

Then how much of the population of the United States is affected by substance abuse? For a problem of this magnitude, can treatment really be made available in rural areas without networking and coalitions? Statistics and experience prove that it cannot be done. Additionally, the magnitude of this problem means there is no need for professionals to compete for patients;
there are far too few competent professionals in the substance abuse field as it is. Working together and problem solving is the answer.

In the near future, changes will be made in our area, as in most areas of the United States. The Department of Veterans Affairs and the Indian tribal communities are looking at contracting services for substance abuse treatment to outside agencies. The opportunities for rural programs to provide these treatment services are there through proper networking techniques. Coalitions in rural areas can play a major role in providing these services.

If we can provide quality treatment services in rural areas, perhaps one day there will not be so many children born into substance-abusing families and communities. And through the positive influences and support of their environment, they will have a better chance of living a life free of substance abuse.

Collaborative Strategies for Reaching At-Risk Youth in a Frontier Setting

Ernest Bantam, Ed.S.
Paul Higbee, M.A.
Black Hills Special Services Cooperative
Spearfish, South Dakota

Abstract

Western South Dakota is a frontier region claiming 5.1 people per square mile, little industry, and the Nation's poorest and fourth poorest counties. Only one community has a population greater than 10,000, and the region lacks many human services taken for granted in urban America. Sparse population and scarce funding have driven school districts, courts, law enforcement, and social service agencies to form unusual partnerships for reaching at-risk youth. This paper describes how the Black Hills Special Services Cooperative—a public sector cooperative of school districts—successfully led the way in establishing a drug and alcohol transitional facility, alternative school, youth residences, mental health clinic, vocational training programs, risk prevention programs, and more.

This paper describes efforts by the Black Hills Special Services Cooperative (BHSSC) to deliver collaborative services for at-risk youth in western South Dakota. This entire 35,000 square mile area (South Dakota west of the Missouri River) is frontier, with 5.1 people per square mile, according to the 1990 U.S. Census. This ethnographic paper describes an evolution of programs over a 14-year period, quoting key participants.

Challenges

Human service providers in western South Dakota live not only with an awareness of poverty surrounding them, but with the knowledge that funding constraints can always become tight for
their own programs. The year 1994 has been a case in point. A property tax rollback initiative on the November ballot could cut the State's education revenue in half. South Dakota already ranks last or nearly last in most school funding categories, including teacher pay. Unexpectedly, in the summer of 1994, the State Supreme Court ruled video gambling unconstitutional. Although South Dakota has used this form of gambling to raise revenues since only 1989, it has become heavily dependent on that income. The court ruling has meant seriously considering $55 million in budget reductions, which could cut education and human services programs and close public broadcasting, the State library, State museums, and the State arts council.

Such crises compound longstanding problems:

- Western South Dakota lacks many programs and services found in more populated areas. Most towns have trouble recruiting physicians, counselors, and other human service providers. The problem is even worse in highly specialized fields. Until recently, for example, this 35,000 square mile region had just one neurologist.
- Jobs that pay much more than minimum wage are scarce, and many of those are seasonal. Families in which both parents work at minimum wage jobs are common, and they have difficulty providing basic needs. The problem is worse still for single parents. Not surprisingly, school counselors report a connection between periods of general economic stress and increases in adult substance abuse and cases of child abuse and neglect.
- Poverty is profound in and around the State's reservations. In 1994, the U.S. Census Bureau rated Shannon County as the Nation's most impoverished. Per-capita personal income in Shannon County in 1991 was $7,335, and about 70 percent of children there grow up living below the poverty level. Todd County, also in western South Dakota, is the Nation's fourth poorest county.
- Alcohol is the drug of choice in terms of drug abuse. Some counties estimate 95 percent of youth are affected by alcoholism. Lack of social activities means that adults sometimes deliberately ignore adolescent group drinking, says one school counselor. The late Governor George Mickelson declared fetal alcohol syndrome to be South Dakota's number one health problem in 1990, and added, "The top priority in South Dakota is at-risk youth."
- Geographic distances, Indian-white cultural distances, and political divisions in a State where most of the population is clustered in the east further complicate service delivery to at-risk youth.

**Black Hills Special Services Cooperative**

It was another property tax initiative, in 1978, that led to the formation of school cooperatives in South Dakota. Education leaders realized that school district cooperatives would enable districts to pool resources, which would be vital should school revenues fall and beneficial if they remained the same. Cooperatives were seen to be especially significant to the special education field. They would allow districts to share professionals, such as therapists, and ensure that all children received a meaningful education as federally mandated by Public Law 94B142. In 1980, Black Hills Special Services Cooperative was organized, governed by a board of elected school board members from participating school districts. BHSSC's first order of business was the establishment of day and residential programs for children with severe developmental disabilities.
Start-up of Services to At-Risk Youth

Then in 1981, its second year, BHSSC opened separate day and residential services for at-risk youth. It defined "at-risk" on an entirely individualized basis. Some youths were at risk of early death due to drug abuse, suicide, or other violence. Others were at risk of not having an education that would lead to an independent, employable adulthood. Most students could trace some of their problems to forms of drug abuse by family members or themselves. Two factors figured into this program's rapid development. First, there was not another program exactly like it in South Dakota, and referrals came from across the State, not just from member school districts. About half the referrals were from juvenile courts. Second, as a "noncategorical" State, South Dakota could spend special education money for individuals by demonstrating an educational need and did not have to fit them into disability categories.

Early BHSSC services for at-risk youth included an alternative high school, onsite vocational training, group and individual counseling, an employability curriculum, foster homes, group homes, supervised apartments, and recreational activities. By 1988, 100 adolescents of both sexes were annually spending all or part of the school year enrolled at BHSSC. The organization's success won wide attention, and BHSSC received national honors, including the Secretary's Award from the U.S. Department of Education in 1983.

But the real payoff was how BHSSC's early success put it in a solid position to lead other joint efforts. It can certainly be stated that every child in western South Dakota is at risk of growing up underemployed, if not unemployed, due to the local economy. The risk is greater still for those dealing with substance abuse issues. In partnership with private business and industry, and with the State Department of Labor, BHSSC established the following programs to improve the well-being of individuals and their communities in general:

- Two career learning centers, now serving about 500 adults annually, helping them gain skills to enter the workforce or to advance to better jobs
- Manufacturing worksites, where at-risk youth can be integrated into employment alongside adults who are good role models
- Employability and vocational assessment activities in western South Dakota schools, with special emphasis on at-risk and disabled populations

BHSSC has assumed management of Northern Hills Community Development, Inc., a business recruitment and development council representing eight communities. It is certified to promote and close Small Business Administration loans.

"While none of our jobs programs and economic development programs will, by themselves, turn our economy around, they do contribute greatly to the lives of individuals served," says Randy Morris, Black Hills Special Services Cooperative's executive director for its entire history. "Further, these programs have contributed to the tax base which funds public services. They are examples of a proactive community spirit, which makes for a better environment in which to deal with at-risk youth."

New Transitional Residential Center
These programs demonstrated that unusual partnerships could provide results where other efforts had failed. In 1989 and 1990, BHSSC led a community partnership campaign to revitalize a long-stalled attempt to open a transitional residential center in Rapid City, serving youth coming out of drug treatment. Individuals and organizations raised money and donated time and materials. A surplus county building was moved to a city-owned lot, and its interior was completely rebuilt. The center opened as a coeducational residence in October 1990. Within 2 years, the St.James Street House was averaging 14 residents. For youth coming out of drug treatment, the typical stay was 30 to 45 days, with a goal of getting back into a school routine, finding an appropriate peer group, and maybe obtaining an after-school job.

Three years after its opening, the St. James Street House attracted the attention of U.S. Attorney General Janet Reno, who arranged for a personal visit. Much of her time at the house was spent listening to residents' insights into reaching other, unserved youth.

"Listening to these young people is central to our philosophy," says executive director Morris. "They're articulate about factors that have affected their lives and are affecting their peers. Listening also keeps our staff focused on these people as individuals, which is how we develop strictly individualized programming."

**New Directions in the Nineties**

As is generally true in rural places in the West, people here do not place great faith in governmental institutions. Those feelings date back to early this century, when the Federal Government usually produced policies that favored Eastern bankers and railroads at the expense of Western farmers, ranchers, and merchants. Those feelings are intensified in western South Dakota because of the population imbalance in the State; with two-thirds of South Dakota's population (and even more of the State's wealth) east of the Missouri River, western South Dakotans often feel overlooked and underserved by their own State government.

For BHSSC, this has meant that the development of public policies and public partnerships is best accomplished by staff with strong, personal credibility, rather than institutional credibility. An example is Dave Scherer, a BHSSC employee with a master's degree in social work from New York's Yeshiva University and also a law enforcement background in South Dakota and Wyoming.

"The people Dave works with know he is well trained academically, and that he also has a wealth of knowledge and ability gained in the field as a law enforcement professional," says Morris.

Scherer has worked with judges, county commissioners, States attorneys, and court services workers to establish a multicounty collaboration for juvenile justice work. "In a region with sparse population, pooling resources at the county level is cost effective and efficient," Scherer says. "If we're working together, not every rural county has to have its own juvenile facility."

Participating counties have signed a joint powers agreement to fund a study of regional juvenile services. Within counties, holdover sites staffed by volunteers have been developed. The
counties have built better connections between law enforcement, parents, and schools and have provided training for special foster homes.

**Programs As They Operate in 1994**

BHSSC's alternative school and residence—the programs that date back to 1981—continue to serve about 100 at-risk youths annually. Although the numbers have remained constant for several years, the adolescents have changed. A decade ago, the student population was made up of young people who had obvious emotional or behavioral problems that schools in their hometowns did not feel comfortable handling. Now, those same schools seem much better equipped to handle such students, and students referred to BHSSC are mostly those needing a true educational alternative rather than working through issues with the aim of returning home.

Today's students generally exhibit less acting out, and often they are motivated to get some form of education—a GED certificate or specific job skill—and move on to adulthood. The school spends more time on academic studies (mastery learning has proven a successful strategy), as well as more time exploring life options and personal responsibility. While this is positive in many ways, it also seems to reflect a society in which children grow up fast and in which there is sometimes no family structure for them to fall back on. Substance abuse issues, of course, continue to play large roles in the case histories of these adolescents.

**Multicounty Collaborative Efforts**

BHSSC's multicounty collaboration efforts are growing in importance. Seven counties joined forces to build a new, $3.45 million juvenile services center in Rapid City. The 60-bed facility will open in October 1995. The seven counties are Butte, Custer, Fall River, Harding, Lawrence, Meade, and Pennington; the counties have signed a 20-year bond to build and operate the center. Each county's bond payment will be based on population. Noting that this is to be the first formal agreement of its type in South Dakota, Seventh Circuit Judge Jeff Davis praises its efficiency and fairness. "I'm convinced," Davis says, "that this is the absolute best answer."

Perhaps the most unusual partnership into which BHSSC has entered recently is that with Mental Health Consultants of Spearfish. BHSSC provides this private counseling business with permanent office space, secretarial help, and financial management. Mental Health Consultants, in return, work with BHSSC students while also continuing to work with private caseloads. The result, for the general public, is mental health services at a lesser cost, since BHSSC absorbs much of the overhead. In an economically depressed area, this is a significant boost.

**Community Models for Diversion**

Community-based mental health services, the alternative school, and multicounty cooperation are all vital in light of what BHSSC considers its main thrust currently for at-risk youth: diversion. Diverting first-time juvenile offenders from the justice system and into community-based assistance is reducing juvenile court caseloads. Along with enforcement of the Federal Juvenile Justice and Delinquency Prevention Act of 1974 (Statewide placement of juveniles in
adult jails has dropped by 96 percent since 1987), diversion is having a great impact on how juveniles encounter the justice system. Multicounty cooperation has let local leaders see models for diversion in their communities: substance abuse education, crisis intervention programs, family needs assessment systems, refusal skills development programs, peer pressure role playing groups, and more. From January through August, 1994, 186 juveniles entered diversion programs in Pennington County. The recidivism rate for those youths was 5.9 percent before diversion completion, and 4.5 percent after diversion completion.

In 1994, diversion success meant there was no longer a role for the St. James Street House as it had operated for 4 years. Approximately 400 youths had spent time there since 1990, although there was never a large enough population of youth coming out of drug treatment to use the house exclusively for that purpose. It also served youths who needed short-term emergency placement, or who had long-term placement needs for reasons other than transitioning out of drug treatment. The housing of residents who had a variety of primary needs was healthy at times and reminded staff that the basic needs of all adolescents are the same, regardless of the individual problems. Closing the St. James Street House was a victory in one way, but nonetheless difficult for BHSSC. The house will undoubtedly open for a different population in the future, based on needs the community expresses.

Findings and Conclusions

The success of the programs described can be traced to two constants. Each effort was led by individuals with personal credibility who made collaboration possible. Each effort took into consideration the unique nature of the community served and did not degrade existing community leadership and institutions.

Individuals who led these efforts shared these characteristics:

- They were comfortable with collaboration and cooperation; they did not feel they needed to be publicly visible leaders.
- They had a sense of who made decisions within communities.
- They understood the traditions, history, values, and human and financial resources of the communities.
- They were people not trapped in the past, but rather individuals with an eye on the future, particularly in the areas of technology, economics, and human services trends.

Counties and communities were approached for participation with a belief that people in rural areas have traditions about solving their own problems, about personal responsibility, and about volunteerism. It would have been a mistake to come into these areas and bypass existing leadership and institutions. Rather, it was necessary to ask for meaningful input and to invite meaningful—not token—participation. The St. James Street House effort, for example, involved about 300 volunteers, most of whom defined their own roles in the project.

Recommendations
There is so much variance between rural communities that the establishment of broad rural policies seems destined to fail. Too often, State policies are interpreted in rural communities as being really geared to larger population areas and bypassing local leadership and institutions. What worked in western South Dakota was for communities to define their needs and work out solutions for their at-risk youth through longstanding institutions like schools and courts, and for credible local leadership to encourage new partnerships between schools, social service agencies, courts, law enforcement, and the private sector.

**A Rural, Community-Based Program of Day Treatment Wraparound Services for At-Risk Youth**

Kristine A. Bricker, I.C.S.W., C.A.D.C. III, N.C.A.C. II  
Clinic Director  
The Bricker Clinic, Inc.  
Saukville, Wisconsin

Michael G. Bricker, M.S., C.A.D.C. III, I.C.A.D.C.  
The STEMSS Institute, Inc.  
Saukville, Wisconsin

**Abstract**

During its first months of operation, the Adolescent Day Program of the Bricker Clinic, Inc., located in rural Saukville, Wisconsin, appears to be successful in providing cooperative, wraparound services to high-risk youth in this rural community. The At-Risk Youth Development Program is a truly community-based initiative, bringing together a consortium of schools, county social services, corrections and law enforcement, local churches, and community organizations to support the alcohol/drug and family therapy interventions of the Bricker Clinic. The program utilizes several innovative techniques, including Sylvia Rimm’s Parenting Curriculum, computer-assisted alcohol and other drug abuse (AODA) education, special education services, and a voluntary community service component. The program sequentially addresses both Erikson’s stages of psychosocial development and the high-risk factors for youth identified by the Center for Substance Abuse Prevention.

When the Bricker Clinic, Inc. opened a year ago, a needs assessment survey was conducted to identify services perceived as needed by the community and to target development toward those services. In an effort to avoid duplication of existing services and "plug the holes" in the continuum of care, the survey asked for input from business leaders, the local Council on Alcohol and Other Drug Abuse, treatment providers, the school system, Ozaukee County social services, law enforcement, third-party payors, and parent groups. One identified need was to be able to provide an alternative to either incarceration or hospitalization for high-risk youth.

**The Need for an At-Risk Youth Program**
The target population of adolescents 14 to 18 years of age tend to be multiple-problem, multiple-system clients from troubled families. These young people have several defining characteristics:

- Low academic skills and motivation
- Alcohol and other drug abuse (AODA) problems
- School discipline problems, truancy, and/or expulsion
- Repeated contacts with social services and law enforcement
- Family of origin problems
- High-risk sexual behaviors

In looking at the array of available services for this population, we found some excellent programs available within our systems: a Student Assistance Program here, an excellent adolescent AODA counselor there, and good Exceptional Education services at another school. But there were no providers who could coordinate programs across systems to help youths maximize and generalize gains in all life areas. Improvement in functioning tends to be short lived for these youths, because they are psychosocially delayed, heavily influenced by a troubled peer group, and often unable to maintain new skills within a dysfunctional family system. There appeared to be a need for wraparound services to bridge the transition points between service systems.

**Planning the New Program**

In June 1994, the authors convened a Community Advisory Board to address this perceived need for a program to serve high-risk youth. This board was comprised of representatives from Ozaukee County social services, the Cedarburg School District, the Saukville police, the Ozaukee County Council on AODA, local businesses, and churches. Over the course of several meetings, a consensus was forged on the following requisite characteristics that a successful program should include:

- An Exceptional Education component so youths could continue to earn academic credits
- Counseling on AODA and mental health issues
- Education on HIV and high-risk sexual behavior
- Family therapy and parenting skills classes for parents
- "Sane and sober" recreational skills to help adolescents forge healthy peer relationships
- Opportunities for both emotional and physical expressive therapy
- Close coordination with existing programs and services
- Transportation services
- Services available after school and on weekends
- A "community volunteer service" component to help instill the intrinsic value of work

Representatives agreed to investigate and make available a modest amount of discretionary funding to support the program. The Bricker Clinic, Inc. agreed to provide staffing and site support. This is a clinic committed to address community needs in the area of mental health and AODA services. The Bricker Clinic mission is to offer effective, cost-efficient treatment that is community based and family focused. The staff of the program provided by the Bricker Clinic includes one full-time AODA-certified Independent Clinical Social Worker (the principal
Because of the requirements of State licensure (such as provision of meals) and limitations of the clinic site, it was decided not to license the program as Adolescent Day Treatment. Rather, a flexible continuum was designed for service delivery that includes intensive outpatient (up to 6 hours per day), outpatient, and continuing care (for the program schedule, see figure 1). The program was initiated in September 1994 and currently has an enrollment of one full-time and five part-time youths.

As a background to developing program strategies, staff reviewed research done by the Center for Substance Abuse Prevention (U.S. Department of Health and Human Services, 1987) under the High-Risk Youth Demonstration Grant Program. Staff also elicited ideas from many Ozaukee County groups, including the Council on AODA, Ozaukee County Department of Health and Human Services, various church leaders, special education and regular education staff, and the Saukville police department. The following risk factors seemed common among the Ozaukee County at-risk population:

- Individual-based risk factors
- Family-based risk factors
- School-based risk factors
- Peer group-based risk factors
- Community-based risk factors

Obviously, no single initiative can hope to address the many issues stemming from divorce, economic dislocation, the significant decrease in family and community cohesion, and a significant rise in the number of families in which both parents are employed outside the home. However, it is hoped that a program jointly designed and monitored by the Ozaukee schools, the Ozaukee Department of Health and Human Services, and the staff of the Bricker Clinic—with continued input from community businesses, churches, and police forces—can be the most effective and cost-conscious means for providing service to this at-risk population.

<table>
<thead>
<tr>
<th>Figure 1. The Bricker Clinic Adolescent Program Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Program Schedule</td>
</tr>
<tr>
<td><strong>Monday</strong></td>
</tr>
<tr>
<td>11:30 – 1:00 Pick-up and transport from home/school</td>
</tr>
<tr>
<td>1:00 – 2:00 Art therapy or dual diagnosis group</td>
</tr>
<tr>
<td>2:00 – 2:15 Break/snack</td>
</tr>
<tr>
<td>2:15 – 3:45 Study skills group</td>
</tr>
<tr>
<td>3:45 – 4:00 Break/snack</td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>4:00 – 5:00</td>
</tr>
<tr>
<td>5:00 – 5:30</td>
</tr>
<tr>
<td>5:30 – 6:30</td>
</tr>
<tr>
<td>Tuesday</td>
</tr>
<tr>
<td>11:30 – 1:00</td>
</tr>
<tr>
<td>1:00 – 2:00</td>
</tr>
<tr>
<td>2:00 – 2:15</td>
</tr>
<tr>
<td>2:15 – 3:30</td>
</tr>
<tr>
<td>3:30 – 4:00</td>
</tr>
<tr>
<td>4:00 – 5:00</td>
</tr>
<tr>
<td>5:00 – 5:30</td>
</tr>
<tr>
<td>5:30 – 6:30</td>
</tr>
<tr>
<td>Wednesday</td>
</tr>
<tr>
<td>5:30 – 6:30</td>
</tr>
<tr>
<td>6:30 – 7:30</td>
</tr>
<tr>
<td>Thursday</td>
</tr>
<tr>
<td>5:30 – 6:30</td>
</tr>
<tr>
<td>6:30 – 7:30</td>
</tr>
<tr>
<td>Friday</td>
</tr>
<tr>
<td>11:30 – 1:00</td>
</tr>
<tr>
<td>1:00 – 4:00</td>
</tr>
<tr>
<td>4:00 – 4:30</td>
</tr>
<tr>
<td>5:30 – 6:30</td>
</tr>
<tr>
<td>Saturday</td>
</tr>
<tr>
<td>9:00 – 10:00</td>
</tr>
<tr>
<td>9:00 – 10:00</td>
</tr>
<tr>
<td>10:00 – 10:15</td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>10:15 – 11:30</td>
</tr>
<tr>
<td>11:30 – 1:00</td>
</tr>
<tr>
<td>1:00 – 5:00</td>
</tr>
</tbody>
</table>

**Intensive Outpatient Adolescent Program Schedule**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>3:45 – 4:00</td>
<td>Break/snack</td>
</tr>
<tr>
<td></td>
<td>4:00 – 5:00</td>
<td>Dual diagnosis group or art therapy</td>
</tr>
<tr>
<td></td>
<td>5:00 – 5:30</td>
<td>Goal setting for the evening/next day</td>
</tr>
<tr>
<td></td>
<td>5:30 – 6:30</td>
<td>Individual/family session</td>
</tr>
<tr>
<td>Tuesday</td>
<td>3:30 – 4:00</td>
<td>Travel to work site</td>
</tr>
<tr>
<td></td>
<td>4:00 – 5:00</td>
<td>Work adjustment group</td>
</tr>
<tr>
<td></td>
<td>5:00 – 5:30</td>
<td>Goal setting for the evening/next day</td>
</tr>
<tr>
<td>Wednesday</td>
<td>See Monday schedule.</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>See Tuesday schedule.</td>
<td></td>
</tr>
</tbody>
</table>

**Continuing Care Adolescent Program Schedule**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>4:00 – 5:00</td>
<td>Dual diagnosis or art therapy group</td>
</tr>
<tr>
<td></td>
<td>5:00 – 5:30</td>
<td>Goals group</td>
</tr>
<tr>
<td>Wednesday</td>
<td>See Monday schedule.</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td>9:00 – 10:00</td>
<td>Adolescent STEMSS group</td>
</tr>
</tbody>
</table>
Figure 2 depicts the Bricker Clinic's developmental approach to community interventions for at-risk youth and their families. The following are strategies being developed at the clinic that are specifically designed to address the five types of identified risk factors for these youth.

1. **Individual-based risk factors:** Risk factors identified include inadequate life skills, lack of self-control, poor assertiveness and peer-refusal skills, low self-esteem and self-confidence, emotional and psychological problems, favorable attitudes toward alcohol and other drug use, rejection of commonly held values and religion, school failure, lack of school bonding, and such early antisocial behavior as lying, stealing, and aggression, often combined with shyness or hyperactivity.

   **Strategies**
   - Social and life-skills training
   - Alternative activities
   - Dual-diagnosed individual/group therapy

   These interventions help develop communication, problem solving, and decision-making skills; help youth find ways to control their anger and aggressive impulses; and help them identify, access, and verbalize their emotions with congruent statements of need.

   Alternative interventions include the following:
   - Monthly nature appreciation classes and activities at Riveredge Nature Center
   - Weekly tai chi classes
   - Quarterly interaction with community police (such as jail/morgue visits with an AODA focus and police-patrol rides)
   - Monthly community volunteer activities sponsored by area churches and the Chamber of Commerce
   - Weekly individual and group art therapy
   - Daily individual and group therapy focused on AODA and mental health
   - Weekly peer tutors and homework support activities

2. **Family-based factors:** Risk factors identified include family conflict and domestic violence; lack of family cohesion; heightened family stress, such as financial and career strains; social isolation of families; family attitudes favorable to drug use; ambiguous, lax, or inconsistent rules and sanctions regarding drug use; poor child supervision and discipline practices; and unrealistic developmental expectations.
Strategies

- Family therapy
- Family skills training
- Play therapy
- A parent training program
- A parent involvement program

Alternative interventions include:

- Structural/functional, intergenerational family therapy with a dual-diagnosis perspective for AODA/mental health issues
- Weekly multifamily parenting classes focused on AODA/mental health (the model used is the Sylvia Rimm Parenting Curriculum with group leaders certified as Parent Trainers); these classes include built-in AODA education and group therapy for support of clients in dealing with specific problems that exist concurrent to programming
- Peers contacted by Families Anonymous/Parents Anonymous to accompany family members to their first support group outside of therapy
- Structured family involvement outings to enhance parenting education and to encourage family involvement and networking, as well as stress reduction, as a way of receiving ongoing community support

3. School-based risk factors: Risk factors identified include availability of tobacco, alcohol, and other drugs and youths’ lack of bonding to school.

Strategies

- Cooperative learning
- Peer tutors
- Enhancement of school bonding

Alternative interventions include:

- Audiovisual study assignment alternatives to the regular didactic teaching methods
- Interaction directly with teachers in working toward specific classroom behaviors and/or specific assignment goals that may be different from the norm
- Individualized study assistance with a focus on the strongest modality for the student
- Peer tutoring in a supervised setting
- Community service volunteer activities that may result in attaining academic credits
- Random urine screens to ensure drug abstinence

4. Peer group-based risk factors: Risk factors identified include association of youths with delinquent, drug-using peers; association with peers who have favorable attitudes toward drug use; and being susceptible to peer pressure.

Strategies
Positive peer groups
Correcting youths’ perceptions of group social norms
Peer resistance training
Positive peer models
Peer leadership and counseling interventions

Alternative interventions include:

- Participants will practice life skills, alternative activities, and attend family-focused events designed to increase cultural awareness and help support health-promoting choices
- Accurate information will be presented concerning peer norms (most kids are not users) and this will decrease the pressure to use
- Interactive role-plays will teach saying "no" to alcohol and other drugs, as well as to antisocial behaviors
- Youth will learn to identify negative family, peer, or media pressure and to practice different ways of resisting old behavior and in getting themselves to a safe place
- Arrangements will be made to provide participants with nonusers or former drug users who will serve as Big Brothers and Sisters for positive peer modeling
- Participants will help facilitate prevention activities for younger youth within the school system

5. **Community-based risk factors:** Risk factors identified include communities that lack the fiscal resources to create drug-free opportunities for children and families, thus setting up an environment in which drug problems are most likely to develop; communities in which young people do not feel as though they belong—for example, where youth do not identify with neighbors, where they feel as though people do not care about their welfare, where they have difficulty in finding positive role models, and where there is a lack of cultural pride; communities in which large numbers of adults believe that AOD use is acceptable; communities where it is relatively easy for youths to obtain alcohol and other drugs; and communities that offer inadequate youth services and opportunities for prosocial involvement.

**Strategies**

- Cultural enhancement activities
- Orientation to community services
- Development of community responsibility
- Positive drug-free youth/family groups
- Community service activities
- Community media education activities
- Safe haven activities

Alternative interventions include:

- Interaction with the Historical Society in preparing for next year’s Saukville "Rendezvous"
- Assessment of parent/child awareness of community services; development of access to these resources
- Field trips to community art exhibits, historical sites, area parks, and places where recreation can occur without the use of mood-altering chemicals
• Development of a drug-free alternative handbook for teen recreation that spans a four-county area and will eventually be distributed to area schools
• Development of a peer-facilitated Support Together for Emotional/ Mental Serenity and Sobriety (STEMSS) support group
• Volunteer activities, such as assisting at nursing homes, assisting specific families in need as identified by area churches, cleaning up parks, and helping with area food pantries
• Teaching/supporting already existing prevention activities
• Development of multimedia campaigns opposing drug use and promoting healthy lifestyles

Conclusion

The At-Risk Youth Development Program of the Bricker Clinic, Inc. has several unique and defining characteristics:

1. It is the result of a collaborative community effort to provide a linkage of wraparound services.
2. It is the result of a collaborative community effort to provide a linkage of wraparound services.
3. The program provides for psychosocial development based on the research of Erik Erikson.
4. The program offers unique benefits to the participants, their families, and the community through volunteer community service.

Since the program has been in operation only a short time, it would be premature to draw definitive conclusions. However, initial reactions from the participants are encouraging. We hope that this initiative will spark the interest of other rural communities and encourage them to investigate starting such a program. For other areas as well as ours, a multifaceted, intersystem cooperative effort may be a practical method for providing cost-efficient wraparound services for at-risk youth and their families.

The STEMSS Supported Self-Help Model for Dual Diagnosis Recovery: Applications for Rural Settings

Michael G. Bricker, M.S., C.A.D.C. III
Executive Director
STEMSS Institute and Bricker Clinic
Saukville, Wisconsin
Abstract

Support Together for Emotional/Mental Serenity and Sobriety (STEMSS), a supported self-help model for "dual diagnosis" recovery developed in 1984, is currently being used with success in numerous communities across the United States and in Canada. This paper discusses the theoretical constructs of this recovery model, its defining characteristics, and its applicability to rural areas. The STEMSS model has proven its adaptability in treatment centers around the country, as well as in community support programs in Wisconsin and West Virginia, in homeless shelters in Las Vegas and Milwaukee, and by means of "circuit riders" who go from village to village in Alaska. The model is being used extensively in rural areas throughout Illinois, North Dakota, and upstate New York and has been translated into Spanish at the request of a program in Texas.

STEMSS is a psychoeducational group intervention designed to enhance recovery from the combination of addiction and mental illness. It is designed to complement and amplify the gains available through participation in 12-Step and mental health support groups by addressing the areas of confusion where the two diseases overlap and interact. The STEMSS concept is predicated on an Interactive Disease/Synergetic Recovery Model for conjoint addictive and mental disorders, which emphasizes the empowerment of consumers in their own recovery. To this end, the STEMSS model utilizes graduated professional assistance toward the goal of peer leadership and consumer governance of individual group meetings.

The numerous difficulties inherent in the case management of dually diagnosed consumers are further complicated in rural areas by such factors as geographical dispersal of the clientele. The flexibility of the STEMSS model makes it uniquely adaptable to the challenge of cost-effective rural service delivery. This model has proven to be an innovative program for bringing quality recovery services to an underserved segment of an underserved population: the rural dually diagnosed consumer.

The 1980s witnessed the growth of a burgeoning literature that describes and bemoans the complexities of defining and treating the "dual diagnosis" of chemical dependency and major mental illness. This population has been described by various authors as:

- Rapidly growing
- Highly mobile
- Vastly underserved
- "Revolving door" patients who are chronic overusers of inappropriate and expensive emergency services because they are "drinking, drugging, and disturbed"
- Extraordinarily treatment-resistant to traditional modalities

Turf issues among service providers and paradigm clashes between the theoretical constructs of the addiction and mental health treatment fields have made for a confusing map to follow in attempting to bring needed services to this population. This challenge is complicated even further by the difficulties inherent in providing services to clients in exurban and rural areas, such as geographical dispersal of the clientele, a diffuse infrastructure for service delivery, underfunding...
relative to urban catchment areas, lack of specialized training opportunities for staff, continuity of care with other health providers, stigmatization, and community prejudice (Larson et al. 1993).

Rationale for the STEMSS Model in Rural Areas

The STEMSS supported self-help model can provide a fertile field for "dual recovery" to flourish in rural areas. It is community-based, participant-driven, requires little—if any—institutional funding, and is self-sufficient with minimal support from local resources. STEMSS is a model of "sustainable mental health care delivery" in the tradition of the Alliance for the Mentally Ill (AMI) and 12-Step fellowships. As such, it is an innovative program of proven value, which can function as a linkage point across systems in serving a special population of rural clients experiencing chemical abuse and mental illness.

The STEMSS model grows out of the author's 18 years of experience in the mental health and addiction treatment field, as well as the collective wisdom and experience of the consumers who have shared this journey. The model attempts to focus state-of-the-art methodology from both disciplines in ways that will allow consumers to empower themselves in moving along the path from "dual diagnosis" to "dual recovery."

Since its inception in 1984, the STEMSS model has been adopted by no fewer than 80 sites across the United States and Canada. It has demonstrated its effectiveness across the entire continuum of care, from inpatient hospital units to residential treatment programs, outpatient clinics, aftercare groups, community drop-in centers, homeless shelters, and autonomous community support groups.

Attributes of the STEMSS Model

The STEMSS model is psychoeducational in format. It uses a set of six steps as a springboard for peer exploration of dual recovery from both addiction and mental illness (see figure 1). The centerpiece of the model is the STEMSS group, which provides a caring and supportive environment in which consumers can meet and interact with others who are on the same "dual recovery" path. Under the guidance of a facilitator, the group works together toward mutually selected goals of education, low-stress group process, and the opportunity to interact with trained professionals as an adjunct to their own recovery program.

Members are encouraged to pursue their own ongoing therapy and support group regimen—particularly Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and mental health groups. The emphasis is on accepting responsibility for one's own recovery and coming to grips with the emotional growth necessary to break the cycle of dependency, disease, and despair. The medical aspects of mental health are emphasized, and members are encouraged to discuss their symptoms, medications, and side effects as full partners in the treatment partnership. The goal is to help members stay psychiatrically stable and chemically free, so that they can achieve serenity and sobriety as functional participants in society.
The STEMSS model does not attempt to supplant the many existing resources for recovery from addictive and mental disease. It celebrates and welcomes the contributions of the 12-Step fellowships, the Depressive and Manic-Depressive Association (DMDA), MIRA (Mentally Ill Recovering Alcoholics), GROW, Inc., Schizophrenics Understood, MICA (Mentally Ill Chemical Abusers), Recovery, Inc., and mental health advocacy groups. Figure 2 shows a comparison between STEMSS and other 12-Step recovery programs.

Members are actively encouraged to pursue their "dual recovery" using all the richness these varied fellowships bring to the process. The model recognizes the role of pharmacology in mental health treatment and acknowledges the ease of confusion between a "med" and a "drug." STEMSS honors the contributions from differing perspectives of psychotherapy. It provides a "level field" upon which the consumer can examine alternatives and, with the guidance of professionals and the support of peers, explore the commonalities of apparently different points of view.

The STEMSS group is perhaps best described as "closer to an AA meeting than group therapy, and closer to group therapy than an AA meeting." While most groups begin with a trained facilitator, and many maintain a central role for this facilitator, the STEMSS model encourages peer facilitation to the greatest extent possible. The "support" in Supported Self-Help refers to the minimal amount of facilitator and professional involvement used to maintain the stability of each group, allowing the group to pursue mutually agreed upon goals. The stated objective of the model is for professionals to be resources rather than the "driving force." Their role is to provide accurate information and guidance to assist the group toward self-empowerment, peer leadership, and self-governance to the greatest extent practical. Thus, the author views the STEMSS model as solidly in the mainstream of the consumer empowerment movement as promulgated by the Alliance for the Mentally Ill.

Figure 1. STEMSS Six Steps

1. I admit and accept that my mental illness is separate from my chemical dependency, and that I must work a "double-recovery" program.

2. As a result of this acceptance, I am willing to accept responsibility for my life and help for my recovery.

3. As a result of this acceptance I came to believe that, with help and understanding, recovery is possible.

4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery process. This may include prescribed medications taken as directed.

5. As part of this recovery process, I accept the fact that I must maintain a lifestyle free from all "recreational" chemicals...including alcohol and drugs.
6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.

NOTE: These Steps are designed to complement (not replace!) those of Alcoholics and Narcotics Anonymous.

### Figure 2. STEMSS and 12-Step Recovery Programs: A Comparison

<table>
<thead>
<tr>
<th>Core Concept</th>
<th>STEMS</th>
<th>General 12-Step Recovery Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptance</strong></td>
<td>1. I admit and accept that my mental illness is separate from my chemical dependency, and that I have a dual illness.</td>
<td>1. We admitted we were powerless over our addiction—that our lives had become unmanageable.</td>
</tr>
<tr>
<td><strong>Surrender</strong></td>
<td>2. As a result of this acceptance, I am willing to accept help for my illnesses.</td>
<td>3. We made a decision to turn our will and our lives over to the care of God as we understood him.</td>
</tr>
<tr>
<td><strong>Hope</strong></td>
<td>3. As a result of this willingness, I came to believe that, with help and understanding, recovery is possible.</td>
<td>2. We came to believe that a Power greater than ourselves could restore us to sanity.</td>
</tr>
<tr>
<td><strong>Need for BOTH medication and therapy</strong></td>
<td>4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery program.</td>
<td>4–11. Includes all the remaining recovery steps as worked through in therapy and AA/NA program participation.</td>
</tr>
<tr>
<td><strong>Abstinence</strong></td>
<td>5. As part of this recovery program, I accept the fact that I must maintain an alcohol-and drug-free lifestyle.</td>
<td>1. We admitted we were powerless over our addiction—that our lives had become unmanageable.</td>
</tr>
<tr>
<td><strong>Recovery as the key to the FUTURE</strong></td>
<td>6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.</td>
<td>12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.</td>
</tr>
</tbody>
</table>

Note that the STEMSS and 12-Step recovery models are complementary and designed to be used together. By "working" both programs simultaneously, they offer the promise of recovery.
The Core Concepts of the STEMSS Model

The author has posited elsewhere (Bricker 1985, 1987) an Interactive Diseases Model for the dual diagnosis of chemical dependency and major mental illness. The underlying assumption of this model is that there are separate disease processes which coincide within an individual, but which interact in complex and synergistic ways. When carried to its logical conclusion, this absurdly common-sensical approach embraces the three core concepts of the STEMSS model. Figure 3 lists the 12 parallels between chemical dependency and mental illness, as reflected in the STEMSS model.

Concept 1. The STEMSS model suggests that these disease processes are conjoint, co-occurring primary disorders with distinct genotypes, etiologies, courses, and outcomes. This is a key assumption, since consumers—and occasionally clinicians!—become mired in "chicken-and-egg" arguments about which problem "caused" the other. The confusion arises because the primary symptoms of each disease tend to exacerbate symptoms of the other; each disorder predisposes to relapse in the other disease.

Concept 2. This gives rise to the second premise of the model: That the diseases must be "treated separately together." There are clearly defined interventions of choice for each disorder. The "revolving door" syndrome results from the temptation to treat the so-called "primary" disease first, in the hope that this will stabilize the "secondary" problem . . . which then becomes the primary disorder, which . . . etc., etc., etc. The only hope for lasting recovery is to treat both diseases aggressively at the same time and to provide stabilizing supports to maintain treatment gains in each disease. Treatment and support for each disease will in turn help forestall relapse in the other disorder.

Concept 3. The third theoretical underpinning of the model is that both diseases result in developmental deficits; these become the primary destabilizing factors in the relapse process for either or both disorders (Bricker 1990, 1991). In other words, the consumer's normal psychosocial development is arrested by the onset of the disease process(es). This suggests that the central task of recovery is to develop more nearly age-appropriate coping skills for the inevitable stressors in the growth process (Bricker 1991).

Figure 3. The 12 Parallels Between Chemical Dependency and Mental Illness

1. Both are physiological diseases with a strong genetic/hereditary component.
2. Both are physical/mental/spiritual diseases which result in global affliction of the person.
3. If left untreated, the course of both illnesses is progressive, chronic, incurable, and potentially fatal.
4. Denial of the disease process(es) and noncompliance with attempts to treat are cardinal symptoms of the disorder.

5. Both diseases manifest loss of control in behavior, thought, and emotions. Both are often seen by self or others as a "moral issue."

6. Both diseases afflict the whole family as well as all relational systems.

7. Growing powerlessness and unmanageability lead to feelings of guilt, shame, depression, and despair.

8. Both are diseases of vulnerability and isolation; the victim is exquisitely sensitive to psychosocial stressors.

9. Both the primary symptoms of each disease AND loss of control in behavior/thought/emotion are reversible with treatment.

10. Recovery consists of:
   - Stabilization of the acute disease
   - Rehabilitation of body, mind, and spirit
   - Launching upon an ongoing program of recovery

11. The risk of relapse in either disease is always high, and relapse in one disease will inevitably trigger a relapse in the other.

12. The only hope for life-long recovery lies in working our program(s) ONE DAY AT A TIME.

From Bricker 1989

The logical corollary of the Interactive Diseases Model is that the recovery processes are synergistic as well. The developmental gains made in response to the challenges of each disorder will also strengthen the recovery program for the other disorder. The aim of the model is to reduce the recovery from each disease to a maintenance issue, so that normal personality development can resume (see figure 4).

**The STEMSS Supported Self-Help Meeting**

When we began to apply these theories to a "self-help" meeting for those dually diagnosed, some problems were immediately apparent. Consumers had little to offer other than complaints, "drunkenalogues," and euphoric recall of fun times. The need for professional guidance became clear early in the development process.
In keeping with the ideal of consumer empowerment and personal responsibility, it was decided to limit the role of support to facilitation rather than "leadership" by a therapist. While most institutions sponsoring the supported self-help model provide a staff member as facilitator, this staff member's role is to begin developing peer leadership as quickly as possible. The staff member then becomes a resource person and source of accurate educational information on such subjects as medication, side effects, and recovery concepts.

Many staff facilitators are trained clinicians: therapists, nurses, and/or addiction counselors. However, a number of STEMSS groups have discovered that a para-professional with a "gift" for working with this population can be extremely effective. One meeting was facilitated for years by the facility's Maintenance Director! Other meetings are led by nursing assistants, social workers, and community support program personnel. This can be helpful in getting around the trust issues consumers may have with clinicians and it weakens the "us/them" dichotomy. A progression the author has used successfully is to begin with a clinician, who trains a paraprofessional; this paraprofessional then develops peer leadership and becomes a stabilizing participant until the group becomes self-sustaining.

This progression allows each individual group to seek its own level along the continuum between a staff-led therapy group and an autonomous self-help group. This continuum is illustrated in figure 5.

Many groups across the country have moved quite naturally along this continuum by starting out as an inpatient therapy group, which later becomes part of the aftercare support for consumers who are discharged. As more alumni become stable, a formal aftercare group is split off with a paraprofessional facilitator. As peer leadership is cultivated, this level of staff support can be gradually reduced until the membership is stable enough to become a mutual help meeting (see Osterstrom 1994).

**Methodology Used by STEMSS Groups**

The common denominator of all STEMSS groups is the set of six steps (see figure 1). Most are designed as "open-entry, open-exit" groups; at any given meeting, there may be newcomers as well as seasoned members. A few STEMSS sites have developed some sort of "level system" to track progress toward recovery goals, starting with a group format that is heavy on education and then "graduating" members into a discussion group. The STEMSS model is adaptable to a number of formats and hybrid approaches. Some of the most commonly used—moving from least to most interactive—are discussed below.

1. The *Step Education Group* is closest to an educational format and is a non-threatening way to introduce the model and the steps. The facilitator may teach about the steps; later, members may volunteer to speak on a step. "Class discussion" can be used to begin modeling group skills. A variation on this is the *Speaker Meeting*, in which an invited guest gives a presentation on a topic of interest.
2. Some facilitators have developed *Step Exercise Groups* to help members look at recovery concepts; these groups use simple pen and paper worksheets to examine the steps. This format can be fun and helps consumers get to know each other, as well as the steps.
3. In the *Step Discussion Group*, one of the six steps is selected (in rotation) for discussion by each member in turn. This is similar to a 12-Step meeting, and consumers familiar with AA will feel comfortable with this format. Newer and less vocal members will be inclined to "pass" and may need to be drawn into the process. This is probably the most commonly utilized format for STEMSS groups around the country and occupies the middle range of the continuum described in figure 5.

4. The *Step Process Group* goes into both steps and group process in greater depth. It is a good model for advanced consumers to get feedback on personal issues and to work on relapse prevention skills. It is more interactive than the group formats described above and requires a certain level of skill in facilitation, if not a trained clinician.

5. The last portion of the continuum is occupied by the *Open Topic Process Group*, which is closest to a therapy group with rounds and agenda-setting by members. This group is often led by a therapist in treatment programs and used as a "feeder group" for other types of STEMSS meetings.

Numerous hybrid combinations are possible. For example, many sites will have a speaker meeting once a month, with step discussion the rest of the time. The setting in which meetings are held is also highly variable. Some are held in a church basement, while other groups prepare and eat a meal as a prelude to the meeting. Numerous sites have discovered that coffee and cookies have a salutary effect on attendance, especially when a group is getting started.

Figure 6 shows a list of suggested basic rules for STEMSS groups to follow. This figure also recommends guidelines for group norms, which will be variable and best decided by each group.

**Recommendations for Using the Model in Rural Areas**

The flexibility of the STEMSS model can be helpful in addressing some of the following complicating factors in rural mental health delivery:

- **Geographic dispersal of clients and diffuse infrastructure:** Since nothing is needed for a STEMSS group but the clients, copies of the STEMSS materials, and a facilitator, groups can be located wherever the need exists. STEMSS groups meet in church basements, community support program offices, 4-H clubs, and community centers.

- **Underfunding of rural programs relative to urban catchment areas:** Since STEMSS is not reliant on "tight" affiliations and subsidies with a treatment program, funding requirements are minimal. Often dedication of a portion of a staff member's salaried time to do startup and training of paraprofessional facilitators is sufficient. Some programs use a "circuit rider" concept, wherein a designated staff person may travel and be a resource to several peer-facilitated groups that are geographically dispersed.

- **Lack of specialized training for staff "generalists":** Since the STEMSS model is not predicated on "expert therapeutic intervention" for maintenance of recovery gains, enthusiastic generalists who are willing to learn from their clients can be extremely effective. Moreover, comprehensive training materials are available at minimal cost, as well as focused consultation by the author.

- **A linkage point across service delivery systems:** Since the STEMSS groups are not dependent on institutions or "funding" in the usual sense, they tend to minimize the "turf issues" and function as common ground between agencies (see figure 7).
Community prejudice and client stigmatization: Since the STEMSS model is designed to be community-based and consumer-empowering, it tends to minimize problems of prejudice and of stigmatizing clients.

Figure 6. STEMSS Group Norms and Rules

To some extent, each STEMSS group will be shaped by the administrative character of the sponsoring organization. The writer's experience has been that the less restrictive the environment, the better.

Suggestions for Rules

1. Meetings start on time, end on time.
2. Anyone under the influence of mood-altering chemicals will be asked to leave and invited to return for another meeting.
3. Anyone in psychiatric crisis will be encouraged to seek appropriate care and welcomed back for a future meeting.
4. "Cross talk" is encouraged, but group members will treat each other respectfully ... one conversation in the room at a time, please.
5. No physical acting-out or verbal aggression will be tolerated.
6. Anonymity and confidentiality foster trust ... "What's said in the room, stays in the room!"
7. So that everyone may have a chance to work on their recovery, a "5-minute rule" may be suggested by group conscience.

Guidelines for Group Norms

The group norms will be more variable and are best decided by the peers and facilitator as the group is forming. Some good guidelines include:

1. The group is open to all who are willing to work a "double-recovery" program of sobriety and psychiatric stability.
2. Members will be encouraged, but not required, to participate.
3. The group members, with the help of the facilitator, will decide how the meeting is to run.
4. Members may feel the need to move quietly around the room, but are encouraged to stay with the group process until closure.

Different STEMSS groups adopt different traditions. For instance, the "Feelin' Good" group from Buffalo has written a Preamble based on that of AA which they read to open the meeting. This consumer initiative is greatly encouraged. The greater the level of involvement, the greater
Perhaps the greatest strength of the STEMSS model is that it encourages and empowers consumers, facilitators, and sponsoring institutions to adapt and create powerful solutions to their unique challenges. It offers a unique opportunity to offer experience, strength, and hope for the "doubly-troubled" in rural areas.

References


Bricker, M.G. The operation was a success, but the patient died: The phenomenon of relapse on Axis II. TIE Lines: Journal of the Information Exchange 7(1), 1990.


Late-Onset Alcoholism: Gaining Understanding

Marie E. Cowart, Dr. P.H.
Professor of Urban and Regional Planning and Pepper Institute on Aging and Public Policy
Florida State University
Tallahassee, Florida

Mary Sutherland, Ph.D.
Professor of Curriculum and Instruction
Abstract

Although little attention has been given to alcoholism in the elderly, particularly late-onset alcoholism, more is becoming known about its origin and effects. This paper discusses the natural history of late-onset alcoholism with considerations for practitioners and others who work with the elderly. First, using an epidemiologic approach, we discuss the determinants of this late-onset condition and its predictors, using a host, agent, and environment framework. Second, we present ramifications and sequelae to the disorder. Third, we outline implications for those who work with the elderly. Hopefully, increased knowledge about alcoholism in the elderly will help to open discussion about this little talked-about condition.

Origins and Effects of Alcoholism Among Older Persons

Although little attention has been given to alcoholism among the elderly, more is becoming known about its origins and effects. In this paper, we discuss the natural history of late-onset alcoholism, focusing on information useful for practitioners and others who work with the elderly.

About 20 percent of all persons treated for alcoholism are older than age 55 (Petersen 1983), but since many drinkers are not known to health care providers and others, this number underrepresents drinking among older persons (Kermis 1986; USDHHS 1990). Most researchers report that there is a higher prevalence of drinking among men than women, but except for a few
persons, the evacuated residents were women. We can assume that underreporting may pertain more to older women drinkers than to the older male population.

Alcoholism is a chronic, progressive, and potentially fatal disease with a progressive onset and hidden symptoms. It is also characterized by the need to drink alcohol on a continuous basis. Sometimes referred to as situational alcoholism, late-onset alcoholism may be associated with age-related stress and elimination of work expectations after retirement (Kermis 1986). This condition is defined as the onset of the first alcohol problem at or later than age 60 (Atkinson et al. 1990). When compared with early-onset or chronic alcoholics, the late-onset alcoholic consumes less alcohol and functions better (Brennan and Moos 1991). Parrella and Filstead (1988) recommend describing late-onset alcoholism as a developmental process.

**Determinants of Late-Onset Alcoholism**

Although research shows that alcohol consumption is lower and alcohol abuse is less prevalent among persons older than age 60 compared with younger persons, little attention has been given to the problem of heavy drinking among the elderly. In particular, the problem of late-onset alcoholism is little researched. While it is estimated that two-thirds of older drinkers begin their habit early in life, the remainder begin later as a response to stressful life experiences. This late-life onset of heavy drinking may occur more frequently among persons of high income levels (USDHHS 1990; Wade 1988). Because little is known about late-onset alcoholism, it presents a significant problem in how to prevent or intervene in these cases. This review begins with an examination of early determinants of the condition, using an epidemiologic framework as a basis for identifying some relevant risk factors.

Early factors in the etiology of late-onset alcoholism for older persons will include the situation in the physical and social environment. Access to alcohol may be considered the agent of the condition. Human factors are the third dimension of late-onset alcoholism in the elderly.

**Environmental factors.**

There are some differences in the prevalence of drinking alcohol that can be associated with geographic areas. Reported rates of alcohol consumption by geographic area are clouded by such anomalies as tourism or low tax rates on alcohol in neighboring States. The highest per capita consumption of alcohol is in the New England and Pacific States, and when considering the consumption per drinker, the highest consumption per drinker is in the mountain and southern states, or dry areas of the country (USDHHS 1990). Since these rates are for the general population, one cannot assume that higher late-onset alcoholism among the elderly follows the same pattern.

Persons living alone may be more prone to late-onset alcoholism, particularly if the individual has previously lived in a household with others. When the situation of living alone occurs late in life, the individual may resort to drinking to overcome loneliness.

Since drinking is a learned behavior, patterns of association with others may have a relationship to late-onset alcoholism. There is some risk of drinking problems in older women experiencing
situations of having husbands with drinking problems, entering the empty nest period, and of employment (USDHHS 1990). In other instances, family or social contacts may reinforce the older person's drinking (Bienenfeld 1987).

For younger persons, local attitudes and norms about drinking influence acquired patterns of alcohol usage ((USDHHS 1989; USDHHS 1990). Related to these norms are the marketing of alcohol and the way use of alcohol is portrayed in the media (for example, television and movies). Whether these values have an effect on the prevalence of late-onset alcoholism is not known.

**Agent factors.**

Accessibility to alcohol has a logical relationship to late-onset alcoholism. To cite an extreme example, an older person who is institutionalized in a nursing home or adult congregate living facility may not have ready access to alcohol and therefore would have difficulty consuming alcoholic beverages. Another access constraint might be lack of transportation to the store that sells alcohol. However, the older person might be able to circumvent this obstacle by engaging home delivery or having a friend or relative obtain a regular supply of alcohol for consumption. A very real obstacle is money, since regular use of alcohol can be costly (USDHHS 1990).

**Host factors.**

Human factors play a central role in late-onset alcoholism. Alcohol often becomes the means for coping with the stress of loss experiences in later life. Thus, dealing with stress becomes the basis for the onset of late life alcoholism. Elders face certain common experiences that lead to late life stress and can precipitate late-onset alcoholism.

Common stressors experienced late in life are related to loss situations (Finlayson 1988; Kermis 1986; Young 1988). Therefore, persons who have had family members, in particular children, leave home may be prone to this form of alcoholism. Loss of a spouse is another common loss. Persons who divorce will experience loss and may cope with their new role by drinking. For older persons whose life work provided meaning to their lives, retirement or job loss may trigger late-onset alcoholism. Some elders may find themselves experiencing financial difficulties or reduced income, another loss that can initiate drinking.

Loss of good health, particularly the onset of chronic conditions or the experiencing of chronic pain or disability, are other causes of stress leading to situational or late-onset alcohol misuse. While alcoholism often leads to depression (Bienenfeld 1987; Fries 1989), the depressed older person may be predisposed to misuse alcohol, thus further aggravating the depression—a chicken-egg situation.

Younger alcoholics may exhibit such personality traits as neuroticism, self-centeredness, or deviant behavior. Longstanding or chronic alcoholics may be depressed and have a history of marital, work, or police problems. In contrast, the late-onset alcoholic has experienced loss or trauma, but does not exhibit the personality traits of the earlier onset conditions (Kermis 1986).
Contributions to Other Health Risks

Major distinguishing characteristics between late-onset alcoholism and chronic alcoholism are the effects that occur to body systems from years of abuse. Longstanding abuse of alcohol behaves like a toxin to multiple body systems. It primarily affects the cardiovascular, digestive, neurological, and skeletal systems. These changes rarely occur in the late-onset alcoholic— unless the habit begins in the early elderly years and persists as heavy drinking.

Perhaps the most common side effect of late-onset alcoholism is malnutrition. Since overuse of alcohol provides calories but no nutrients, malnutrition often accompanies alcohol use without weight loss or other overt signs. Alcohol also interferes with absorption of vitamins and minerals. Impairment of vitamin B metabolism is the major effect that occurs, resulting in tremors and cerebral deterioration, including clouded consciousness, memory impairment, and imagining (Kermis 1986; Dychtwald 1986).

Depression is common in heavy drinkers. Incompatibility of alcohol and drugs can further exacerbate signs of depression (Busse and Blazer 1980; Fries 1989). Memory impairment, confusion, or mood swings are other common mental health effects of this and other forms of alcohol overuse (Bienenfeld 1987; USDHHS 1990).

In addition to contributing to the development of unwanted chronic conditions in the individual, late-onset alcoholism can have serious effects on the family and on society. The single most hazardous risk is drinking while driving (Fries 1989). When driving under the influence of alcohol is compounded with poor night vision, slowed reaction time, and other impairments of the elderly, increased risks of automobile or even pedestrian accidents are a probable outcome.

Once the abuse of alcohol is established, the natural history of the condition progresses and evidence of the abuse can be discerned. The effects of the condition are often insidious but the impacts can be serious. Yet many persons with the condition go unrecognized.

Implications for Those Who Work With the Elderly

For those who work with the elderly, even on a day-to-day basis, the recognition that an individual has late-onset alcoholism is frequently a surprise; the condition is often identified during a contact with the elderly individual for some other reason. Just as the high-rise apartment staff were caught off guard when the displaced residents sought their evening drinks, many cases of late-onset alcoholism are found during hospitalization for an unrelated condition. Because of the associated hazards of the condition, it is important that health providers and others who work with the elderly on a regular basis identify persons with late-onset alcoholism, so that the underlying causes for this means of coping with stress can be identified and treated. Assessments of the elderly will need to include observations for the subtle behaviors that are associated with the condition, so that monitoring for other effects and treatment of the underlying cause of the problem can begin.
Assessment

Some research has found that health care practitioners often overlook problems with alcohol in clients who do not fit the stereotypic profile of a male of lower socioeconomic status, with acknowledged alcoholism as a problem. Moore et al. (1989) compared newly admitted adult hospitalized patients for the presence of alcoholism with the findings of the admitting physician; they learned that admitting physicians significantly underdiagnose alcoholism findings. The highest correlation was for psychiatric patients, while the lowest correlations were for surgical and gynecological patients. Thus, practitioners and others working with the elderly have a need to improve their assessment skills for alcoholism and, in particular, for late-onset alcoholism. Lack of such skills can mean a lack of recognition of signs of alcohol abuse or an interpretation of such signs as changes related to aging (USDHHS 1990).

Researchers indicate that late-onset alcoholism may be a response to stressful life experiences (e.g., bereavement, poor health, economic change, retirement) and may occur more frequently among elders of higher socioeconomic status and higher educational levels (Atkinson 1988; Schoenfeld et al. 1987). Such knowledge indicates that persons experiencing loss are at risk for this condition and should be regularly screened. An exception to the prevalence of late-onset alcoholism in higher income groups is the homeless. Since the homeless are more likely to exhibit chronic rather than late-onset alcoholism, screening for late-onset problems in this group would be productive in those who are recently displaced or unemployed.

In addition to health providers who may initiate screening during a regularly scheduled office visit or hospital admission, persons who are in regular contact with elders in the community must also learn to observe for signs of alcohol abuse. Such individuals may be housing managers, service providers, pharmacists, ministers, and others in regular contact with the elderly.

Components of the assessment.

Routine assessments for late-onset alcoholism will need to determine the stressors that are of concern to the elderly, and how the older person is coping with the stress. Identification of personal confidants and social supports are important dimensions of coping.

The most common assessment approach to determining heavy drinking is to ask the individual about his or her alcohol consumption (USDHHS 1990). However, self-reported information about drinking may omit such sources of alcohol as liquid medicines or tonics, and may be distorted because of poor memory or the hesitancy to accurately report because of perceived or actual social values about drinking. Denial is another factor that can affect the accuracy of self-reporting on the quantity of alcohol consumed.

Indirect approaches to identifying problems.

Because of the frequency of denial in admitting a problem with heavy drinking, an indirect approach is needed to gain knowledge about the prevalence of late-onset alcoholism. Less direct approaches that can point to problems with drinking may include difficulty in interpersonal relationships and in performing employment, volunteerism, or decisionmaking activities of daily
living. Repeated falls are another indicator. The older person presenting in the local emergency room or clinic may exhibit bruising that would indicate both falling and increased peripheral vascular permeability. Self-neglect is another common sign of late-onset alcoholism. This sign can occur as a result of the accompanying depression, isolation, or malnutrition of late-onset alcoholism (Fries 1989). If the older person is alone much of the time or tends to isolate one's self, such factors may not be recognized as being related to the person's alcohol intake (USDHHS 1990).

One approach to assessment may be to ask elders to complete a self-rating form. Questions that may be included are morning drinking, driving while drinking, receiving a traffic ticket for drinking and driving, automobile accidents related to drinking, drinking to forget problems, drinking that worries relatives and friends, stomach ulcer or gastritis, interference with sleep, and drinking alone (Fries 1989). Such an approach can help combat denial and promote the individual's self-recognition of problems with alcohol.

Early physical signs to look for include tremors, anxiousness, or memory impairment (Kermis 1986; Bienenfeld 1987). The individual who bruises easily may have peripheral vascular changes.

The non-health professional who is in regular contact with elders in the community may look for the purchase of alcoholic beverages or the practice of requesting others to purchase alcohol. Routine inspections of apartments or other living quarters for fire code compliance can include observation for signs of excessive consumption of alcohol.

**Monitoring Alcohol and Other Conditions**

Once individuals are identified as late-onset problem drinkers, regular monitoring of drinking patterns is important. Observing for alternative coping patterns may indicate that the individual is lessening their drinking practices. On the other hand, isolation, a lack of interest in outgoing behaviors, and depression may point to continued alcohol abuse. Routine monitoring can be a part of routine health checkups.

**Treatment Choices**

Treatment of the late-onset alcoholic may be a matter of personal choice for the person whose habit does not have an impact on others (Dychtwald 1986). Since self-choice plays a large part in the decision to change coping behaviors or to receive treatment, addressing awareness can play a large part in late-onset alcoholism. Such awareness can occur at two levels: general public information and individual teaching and counseling.

Effective treatment must address the source of the alcohol abuse, loss, and coping. Counseling that assists the individual to understand the relationship between the stress of loss and his or her pattern of drinking will help in achieving a first step toward combating the problem. In group living settings, staff can build elements into the social and physical environment that will reinforce stress reduction activities, promote discussion, and encourage group activities and gatherings rather than isolation. Persons who do not join in on group activities may be called on
to contribute in meaningful ways to lessen their isolation. Late-onset alcoholism can respond positively to preventive approaches directed at stress reduction and coping skills (Lawson 1989).

Because of the nature of the cause of late-onset alcoholism, individuals with this condition may respond to health promotion approaches. Such approaches include:

- Assuming individual responsibility for personal lifestyle
- Substituting improved nutrition, exercise and fitness, and stress control for current behavior patterns
- Reducing alcohol intake for improved overall health and well-being (Dychtwald 1986)

The late-onset alcoholic may have an occasional episode of intoxication or uncontrolled drinking. In that case, it is important to provide medical care or brief inpatient therapy to withdraw the toxin and restore fluid and electrolytes, including B complex vitamins (Busse and Blazer 1980).

Health professionals and persons in regular contact with older adults who have late-onset alcoholism play an important role in detecting the condition. Regular monitoring and preventive interventions can do much to reduce the risks associated with this condition.

**Conclusions and Recommendations**

Over the past 20 years, the number of older persons living alone has increased by 20 percent, so that in 1990 more than 30 percent of persons older than age 65 were living alone. There is a wide disparity between men and women, since 16.2 percent of men and 40.6 percent of women reside alone (U.S. Bureau of the Census 1981, 1991). Rural elders tend to stay in their own housing, even when younger family members leave for more urban areas (Krout 1986), implying that there may be greater numbers of elders living alone in nonmetropolitan areas. With the population aging both by actual numbers and by longevity, this trend is expected to increase. Long-term policy that emphasizes home and community-based care will further encourage older persons to remain at home in their later years. While at home, they will be coping with chronic conditions and other losses associated with aging that predispose one toward late-onset alcoholism. From these trends, one can infer that the prevalence of this condition will become more widespread, with the third of the older population who live alone being at particular risk.

The small amount of research and clinical literature on late-onset alcoholism points to the need for research about the condition. Prospective study approaches can expand the understanding of the etiology of the condition, as well as the effectiveness of various interventions (Atkinson 1987). Certainly the absence of knowledge also raises concerns about how practitioners and others who work with the elderly will be educated and learn about the condition. Only with awareness will such workers be alerted to the subtle signs that point to late-onset alcoholism.

Often, reported data about drinking habits are based on the total or younger population and may not apply to the elderly (USDHHS 1990). Much late-onset drinking is underreported. Yet, as the percentage of the population who are older increases, health practitioners and persons who work with the elderly will need to learn to recognize problems associated with this age group. Late-
onset alcoholism is a preventable condition. When brought to the attention of the older adult by sensitive persons who regularly work with the elderly, it is a condition that can be corrected by self-awareness and changes in lifestyle.

References


**Providing Needed Treatment Options in the Face of Managed Care**

Jim Lohmeyer, M. Div.
Program Director/Chaplain
Family Recovery Center
Clara Barton Hospital
Hoisington, Kansas
Abstract

This paper describes a treatment program structure and staffing pattern which we have found to be effective in the face of managed care. Family Recovery Center in Hoisington, Kansas made the decision to develop two outpatient day treatment programs with an inpatient program at the heart of both programs. This would require only one team of three full-time counseling staff plus nursing staff, totaling 7.2 full-time equivalent positions, with flexibility downward in the nursing staff and flexibility of responsibilities in the counseling staff. The result is a team that can cover a continuum of services from inpatient/intermediate treatment to outpatient day treatment, continuing care, and Family Focus Week.

This approach has been welcomed by managed care coordinators and State funding sources alike. We recommend this approach to rural and other small markets as a way to provide the continuum of care locally, while allowing support for patients and staff throughout the continuum.

The purpose of this paper is to describe the approach taken by one treatment center to gain needed flexibility within the current treatment market: a market that faces providers with limited resources and with outside funding sources that dictate at what level our patients will be treated. We developed this staffing pattern prior to the advent of managed care. But we found this approach helped us to make the transition to managed care rather easily, while others around us struggled with putting an outpatient program in place.

Background of the Approach: Changing To Survive

If necessity is the mother of invention, then survival is its midwife. In 1986, the Family Recovery Center at Clara Barton Hospital in Hoisington, Kansas faced a crisis of survival. We had just watched our nationwide chemical dependency management corporation leave us for greener pastures. We were faced with the stiff competition of a couple of aggressive hospitals in the area that were vying with us for patients in our largely rural counties of western and central Kansas.

We looked at our situation and asked what services we could provide that would be both unique to the area and yet effective. An outpatient day treatment program to complement the inpatient program seemed to be a natural. Such a program provides several advantages:

- Outpatient day treatment is more affordable than inpatient treatment.
- It provides the structure that many patients need and still allows them to maintain commitments to work and family.
- It also requires the patients to begin practicing the principles of recovery from the first day of treatment, because they continue to function in the world where they will need to stay sober after treatment.

There was, however, no money for extra staff. The solution was to use existing staff.
The Program Plan

Family Recovery Center made the decision to develop two outpatient day treatment programs with the inpatient program at the heart of both programs. We started this approach by looking at the inpatient program’s day schedule; we noted that there were two basic treatment activity times. One lay at the heart of the day, from 9:00 a.m. to 3:30 p.m. Monday through Friday. The second was early evening.

The Family Recovery Center had a program director, a day counselor whose work began at 8:00 a.m., and an evening counselor who began the work day at 1:00 p.m. With some slight modification of the inpatient program, we could develop an outpatient day program for unemployed patients and night workers on the daytime schedule and could develop a second program for day workers from 6:00 p.m. to 10:00 p.m. Monday through Friday evenings.

Our subsequent experience is that some schedule modifications have to be made from time to time to meet an individual’s employment and commuting needs. For example, patients who go to work before 3:00 p.m. may need an 8:00 a.m. to noon schedule. But generally, these are workable schedules for most patients.

Implementing the Program

We began with some very flexible criteria for admission to each program. Persons considered to be a good risk for outpatient day treatment were those who were either a first-time patient or had had a period of quality sobriety, especially recently. If the person was a daily drug user with poor structure in his or her life, we might begin treatment in the inpatient program for 10 days to 2 weeks before transferring the person to outpatient day treatment.

This approach—a shortened inpatient period followed by outpatient day treatment—was a novel approach that became very useful in dealing with managed care programs. Obviously, this new approach also brought more specific and defined criteria for admission and continued care in each level.

The New Era of Managed Care

Shortly after we instituted the new approach, managed care came into the rural medical treatment market with the health maintenance organization (HMO); managed care has now been instituted in the practice of most third-party payers. The goal of managed care is to reduce the expense of medical care by funding the least extensive (and expensive) therapy necessary for the patient.

Impact of Managed Care on Treatment Providers

For chemical dependency treatment providers, this meant that the tried-and-tested practice of inpatient treatment (usually providing 3 to 6 weeks of inpatient treatment) was being challenged. The challenge came because of a study which stated that patients in outpatient treatment had results comparable to those receiving inpatient treatment. In order to meet these demands for outpatient treatment, some rural programs added an outpatient program while continuing to
maintain their inpatient program. For instance, one 16-bed treatment program in our area added two more counselors to run their outpatient program side-by-side with their inpatient program. Within months, both modalities were closed. The cost of added staff brought an end to many treatment programs in our area.

In the "good old days" before managed care, western Kansas (west of Highway 81 and excluding Wichita) had at least 11 inpatient treatment programs, most of them hospital-based. Some had histories going back almost 20 years; some were filling unused beds in rural hospitals. In the same area today, there are only four inpatient treatment programs, including Larned State Hospital. Those that remain have drastically reduced their level of service or have received State funding.

**Advantages of an Outpatient Day Program**

In the beginning, Family Recovery Center regularly sent 50 to 75 applicants away annually because they were not able to pay for treatment. In 1988, our Center was helped when we sought to expand our income and service base by offering services to the State of Kansas Alcohol and Drug Abuse Services (ADAS). ADAS agreed to partially fund Family Recovery Center, primarily because of the outpatient day treatment program, which could also provide a component of up to 10 days of intermediate treatment. Intermediate treatment is nonmedical residential care.

The advantage of such an outpatient day schedule is that when managed care emptied our beds, we were prepared with an alternate program. Like most inpatient units, our inpatient admissions have gone down drastically since the advent of managed care. Inpatient treatment dropped from 813 to 333 days during the same period in which the number of outpatient day sessions provided climbed from 749 to 1,623. Figure 1 shows the evolving pattern in utilization of outpatient, inpatient, and intermediate care days between 1987 and 1993, with ADAS support beginning in 1988.

**Figure 1. Evolving pattern in utilization of outpatient, inpatient, and intermediate care days** [Not currently available]

We have reduced inpatient length of stay from about 15 days in 1987 to just over 4 in 1993 (see figure 2). Our experience has shown that, when correctly referred, patients who complete outpatient day treatment have about the same level of recovery as inpatient treatment patients, but there are definitely times when treatment in a residential program is important. The added structure is often necessary, whether it is because of relapse in the outpatient programs, for health reasons, emotional stabilization, or the need to separate from a "less than supportive" support system.

**Figure 2. Length of stay** [Not currently available]
Moving Patients Among Treatment Modalities

Because Family Recovery Center is able to maintain the inpatient/intermediate treatment modalities, we do not have to refer those patients who are not able to remain chemical-free in the outpatient program. History has shown us that when we refer patients out of the facility—unless there is a big legal hammer hanging over their heads or they are otherwise highly motivated—we lose a larger percentage than if we are able to move these patients to inpatient care for stabilization and then return them to outpatient treatment. All our staff members work with all our patients, and many patients from the various modalities work in groups, sharing lectures and the family program with one another. This shared experience of staff and patients improves the development of trust levels for transferred patients.

In addition to outpatient day and inpatient/intermediate treatment programs, Family Recovery Center offers a continuing care program and a Family Focus Week. Continuing care consists of weekly support groups for alumni led by a counselor or counselor trainee. The monthly Family Focus Week consists of 20 hours of support for the patient and family members.

Handling Staff Levels and Costs

Family Recovery Center has been able to maintain the two outpatient day treatment programs and inpatient/intermediate treatment, plus a continuing care program and a Family Focus Week using 7.2 full-time equivalents (FTE) of direct care staff. (Full-time equivalents are the equivalent staff needed to staff the program in a given week.) This staff includes a program director, a day counselor, and an evening counselor, plus a registered nurse and nurse's aides. Since we are housed in a hospital, we usually share 1.4 FTEs with nighttime nursing staff on the medical wing, which has a physical view of the facility from the nurse's station.

We have been able to endure many changes in patient load and in the treatment climate without being overwhelmed by staff costs or staff cuts. We are able to continue to provide inpatient treatment, a needed service for some, without having the expense of maintaining the inpatient treatment center cost us out of business.

We share indirect salary costs with the hospital, such as meals and laundry, administration, and housekeeping; this affords further staff cost savings. The number of admissions to all programs averages 94 patients per year or 9.8 per month, although in the real world nothing is average. Monthly admissions have been as few as 2 and as many as 20. We can find ourselves sitting around wondering when the next referral source is going to call, or we can find ourselves checking in four patients in a day with assessments, treatment plans, and discharge summaries to do.

Flexibility of Staff

One of the reasons Family Recovery Center is able to maintain these programs along with two sessions of Continuing Care and a monthly Family Focus Week is because of the willingness of the staff members to wear more than one hat and to be flexible in scheduling. For instance, the program director and the evening counselor have both worked with families and, depending on
needs, can easily cover the Family Focus Week program. Both counselors can take care of afternoon groups, depending on patient load. The program director is in a position to cover administrative needs, as well as to cover clinical needs when the staff and patient load require it.

Patients find this flexibility helpful as well, because even though we may have only one patient in our inpatient/intermediate program, he or she is not stuck in a group of one. Patients work together with other patients. Outpatients can be supportive of the inpatients. Inpatients can lend insight to outpatients, who are sometimes caught up in the dailiness of their lives.

**Findings and Recommendations**

While outpatient treatment has become the modality of choice in the days of managed care, there remains a need for inpatient treatment. In order to maintain an inpatient program while serving our patients with an outpatient day treatment modality, Family Recovery Center has been able to combine all modalities and use one team to staff these modalities. Such an approach requires a talented, multifaceted team with a willingness to be flexible to program needs and supportive of one another. While this may seem counterproductive to staff stability, the same team members worked together from the development of this concept until the untimely death of the program director last year. Today, one of the team members has moved into the program director’s position and another has come to fill his place.

Our treatment team would wholeheartedly recommend our approach to those with existing programs who wish to expand their continuum of services or to initiate program services in a rural area. It has been a supportive approach for the patients, who can maintain trust while moving from modality to modality in the continuum of care and can work together in groups of workable sizes. Our approach has also been supportive for staff, providing the flexibility of a shared team approach.

**Of Huffers and Huffing: A Survey of Adolescent Inhalant Abuse**

Dan Malesevich, M.S.
Tom Jadin, M.S.W.
Winnebago Mental Health Institute
Winnebago, Wisconsin
Abstract

The authors surveyed 1,400 agencies serving youth in Wisconsin, interviewed staff who treat inhalant abusers, and surveyed current literature on inhalant abuse. They found that inhalant abuse seems to be on the rise, that treatment providers have found no single treatment strategy to be most effective, and that there are distinct differences between inhalant abusers and other drug abusers.

The purpose of the research was to: (1) gain a sense of the extent of the inhalant abuse problem in Wisconsin, (2) survey how adolescent inhalant abusers are receiving treatment in Wisconsin, and (3) ascertain the differences between inhalant abusers and other adolescent drug abusers.

Methods

In order to gain a sense of the inhalant abuse problem and its treatment in Wisconsin, 1,400 surveys were sent to agencies serving youth.

In order to ascertain differences presented by inhalant abusers compared with other drug abusers in treatment, interviews were conducted with staffs of treatment programs that treat inhalant abusers. Current literature was searched.

Content Area

During the first half of 1993, a series of events led the Anchorage Program (an inpatient, adolescent alcohol and other drug abuse [AODA] treatment program at Wisconsin's Winnebago Mental Health Institute) to become concerned that, although the population of inhalant abusing youngsters is small, it may be growing. First, Anchorage census data showed an increased number of referrals for inhalant abuse. Second, the most recent school survey by the Wisconsin Department of Public Instruction showed some increase in inhalant use. Third, news stories had reported a number of deaths in Wisconsin, generally at a very young age, from inhalant abuse. Finally, national statistics showed that, over the past 10 years, the percentage of youth ages 12 to 17 who have used inhalants has risen from 6.4 percent to 8.8 percent.

These events, together with the Anchorage experience that inhalant abusers were most often undetected until their problems were of a very serious nature, led the Anchorage program director and the Institute's program development coordinator to research inhalant abuse. During the fall of 1993, they met with staffs of programs that treat inhalant abusing youngsters.

Findings

The survey respondents included 7 Indian tribes, 8 prevention centers, 13 private facilities, 14 court-related services, 23 schools, 24 inpatient AODA facilities, 26 residential AODA facilities, 45 human services departments, and 53 AODA outpatient programs.
Respondents were asked whether inhalant abuse was a serious problem in their county; 53.5 percent felt it was, 26.5 percent felt it was not a problem, and 20 percent were not sure. (See figure 1).

When asked the number of cases they had treated in the past 5 years, respondents reported:

- 38.2 percent said they had treated 1 to 5 cases
- 24 percent said they had treated 6 to 10 cases
- 11.1 percent had treated 11 to 15 cases
- 17.5 percent had treated 16 or more cases

In response to a question regarding the age group of the majority of cases treated, 72.8 percent said that patients were between the ages of 13 and 16. When asked if any program in their county had been providing treatment for inhalant abusers during the past year, 27.6 percent said yes, 27.2 percent said no, and 40.1 percent were not sure.

The survey asked whether inhalant abusers presented brain impairments or other treatment concerns that differentiated them from other drug abusers; 40.6 percent responded yes, 18.4 percent responded no, and 21.7 percent responded unsure. (See figure 2.) Asked if clients in their agency may have undiagnosed or underdiagnosed problems with inhalant abuse, 51.8 percent said yes, 12.9 percent said no, and 24.4 percent were unsure.

Respondents were asked if they felt inhalant abusers needed to be treated in a specialized program, and 38.2 percent said yes, 16.1 percent said no, and 40.6 percent were unsure.

When asked what type of program models, if any, they had found to be effective, the respondents gave a variety of answers including:

- 8—mentioning the 12-Step approach
- 7—inpatient treatment
- 5—outpatient treatment
- 3—individualized treatment
- 3—behavior modification
- 3—psychiatric care
- 3—long-term residential
- 2—family involvement
- 1—cognitive experimental therapy
- 1—similar to cocaine treatment
- 1—short-term hospitalization
- 1—relapse prevention
- 1—education/awareness
- 1—90-day intensive individual/group interaction
- 1—jail for control/detoxification
- 1—group home

Most respondents to this survey reported they had found no program models to be effective. However, one respondent reported: "We have been dynamic in our multidisciplinary approach
with this population. "We use wraparound services, including juvenile court order/supervision, outpatient therapy (alcohol/drugs); special education placement; and family intensive in-home services."

**Differences Between Inhalant and Other Drug Abusers**

The interviews with staff who treat inhalant abusers and a survey of the current literature both pointed to some dramatic differences between inhalant abusers and other drug abusers.

First, inhalant abusers tend to be younger. The literature states that they are among the youngest who abuse during the most critical years. They are likely to have been using drugs for a longer time and show consequences at an earlier age. Our Home, Inc. (a program specializing in inhalant abuse treatment in Huron, South Dakota, and the subject of the first paper in this volume) has found that the mean age of inhalant abusers referred to their program is 13.2 years compared with 17.0 years for noninhalant-using drug abusers. The average age for first use for the inhalant abuser is 10.8 years compared with 12.5 years for those drug abusers with no mention of inhalant use.

**Medical problems associated with inhalant abuse.**

Medical problems associated with inhalant abuse include respiratory, cardiovascular and hematological complications, liver abnormalities, renal failure, cerebellar impairment, and inhalant-induced sudden death syndrome. While the complex physiological processes that occur in this syndrome are not fully understood, the reported cases follow a similar pattern: the user is involved in an inhalation episode and cardiac arrhythmia develops, followed by a sudden panic and a burst of physical exertion, such as spontaneous running. Cardiac dysfunction progresses and the user collapses in death.

**Neurocognitive and developmental problems.**

Damage to the central nervous system is the most widely recognized consequence of inhalant abuse. Thus far, the most frequently measured neurocognitive deficits among the Our Home population (in rank order) have been in (1) social judgment and common sense reasoning, (2) verbal concept formation, (3) long-term memory, (4) alertness and concentration, and (5) nonverbal reasoning. To date, approximately 40 percent of Our Home admissions aged 14 and under and 50 percent of admissions aged 15 and older have presented with measured neuropsychological deficits.

The literature also shows inhalant abusers are likely to be experiencing neurocognitive impairment. When given neuropsychological testing, 30 percent of experimental inhalers and up to 60 percent of regular inhalant abusers function in the "impaired" range. The deficits resulting from inhalant abuse include decreased memory, decreased nonverbal intelligence, decreased attention span, and decreased ability to concentrate.

The literature shows inhalant abusers experience high levels of psychosocial dysfunction. Compared to noninhalant abusers, studies have shown that inhalant abusers experience more
withdrawal, isolation, and dissociation, as well as a higher incidence of depression and potential danger to self and others. There is also a relationship between inhalant abuse and juvenile crime. Studies show that 65.1 percent of inhalant abusers have had a history of prior arrests and are arrested at a significantly younger age than noninhalant abusers (11.6 compared with 13.0 years). South Dakota has found that 45 percent of the juveniles within its correctional facilities have a history of inhalant abuse.

**Treatment issues for inhalant abusers.**

These developmental and neurocognitive problems make it difficult for inhalant abusers to be included with other adolescents in treatment. They tend to be victimized by older patients because of their impairments and because "huffers" are considered to be at the low end of the drug abuse pecking order.

Similarly, these problems lead to the inhalant abuser being much more violent, aggressive, and impulsive than other adolescent drug abusers. While the Our Home, Inc. capacity is 16, for example, they prefer to have a census around 8 for the best treatment milieu and find it necessary to have 3 staff persons on duty at all times with this census.

Our Home, Inc. finds the inhalant abuser, on average, to be 2 years behind academically, and many show left frontal lobe (language) impairment from the inhalants. This, together with the impulsive and violent behavior described above, makes it impossible for them to be rapidly immersed in intensive treatment. Patience seems to be critical when treating inhalant abusers. Chemical cleansing may require more time than routine detoxification. Behavioral and emotional stabilization are likely to require extended treatment time frames as well. For example, Our Home, Inc. takes 2 weeks to ease the patient into school; the average length of stay is 127 days. They have found that it takes 14 to 30 days for the solvents to pass through the body, and therefore a 28-day program is not effective.

**Conclusions**

Examination of the survey data seems to reaffirm the concept that inhalant abuse is a hidden problem. This survey confirmed that the majority of Wisconsin service providers felt inhalant abuse was underdiagnosed or undiagnosed by their agency. The result seems to be that those individuals suffering from inhalant abuse issues do not come to anyone's attention until they are at the chronic stage.

Tribal respondents to the survey all recognized that inhalant abuse is a serious issue on most of the reservations in Wisconsin. This survey, as well as national data, also shows that, while inhalant abuse often impacts selected minority and impoverished populations, it is not confined to any demographic boundaries, such as race, age, or sex.

**Treatment Needs**

Treatment needs to be highly individualized. Inhalant abusers often show multiple physical, neurocognitive, and psychosocial effects and environmental disorganization. Compared to other
drug abusers, their thinking appears to be unusually concrete and generally slower. It is not possible for them to show consistent progress. Inhalant abusers need to have comprehensive assessments, not only to understand their treatment needs but also to assess their treatment readiness and receptivity. Because the patients are young, there is an increased chance that they are still influenced heavily by their families. More family-oriented treatment is often called for.

Inhalant abusers present special needs, and staff who work with them need special training, sensitivity, and patience in developing individualized treatment plans for this population. Most inhalant abusers have a longer length of stay than other drug abusers in an inpatient setting. This longer length of stay seems to help them to clear cognitively, and staff expectations for their performance seem to increase with each passing week.

**Maturity Levels**

Maturity levels are often a concern in treating inhalant abusers. Most are approximately 13 years of age when they become identified as being candidates for treatment. Their young chronological age—plus the immaturity resulting from their chemical use—cause these patients to have an especially difficult time in a structured treatment program. Nonetheless, it appears that patients whose primary drug of choice was inhalants are able—with patience and special treatment plans—to be successfully treated, educated, and reintegrated back into their home communities.

Perhaps a quotation from *Preventing Inhalant Abuse: A Training Manual* by Mark Groves and Linda Welch sums up inhalant abuse and abusers best.

> It appears that inhalant abuse is of significant, though not epidemic proportions. Even though the abuse of solvents may not be increasing to any great extent, it is a problem that requires serious attention. Although the mortality rate is low, sniffers are often young children who are usually more deeply involved with chemical use. They are likely to have more emotional and behavioral problems than do nondrug users or other types of drug users. The consequences of solvent abuse early in life may lead to markedly dysfunctional adults because of neurological and learning deficits developed during their maturation.

**Recommendations**

The authors have several recommendations.

First, information about inhalants needs to be included in prevention education, especially with younger children. Often it is not. Inhalants are the gateway drug, with the average age of first use reported to be 10 years.

Second, early intervention needs to be encouraged. Without intervention, inhalant abuse will not be simply outgrown. Inhalants damage quickly, and early intervention not only protects the child but also offers the best prognosis. Included in this recommendation is the urging that those working with youth at all levels need to be made more aware of inhalant abuse and its symptoms. Education on inhalant abuse in general needs to be made more available to the general public.
Once in treatment, inhalant abusers need both a longer detoxification time and extended treatment time frames. Similarly, comprehensive assessment and programming need to be assured for these youth. Treatment staff need particular training to help sensitize them to the special needs of this population.

In the longer term, perhaps one model for addressing inhalant abuse can be seen in the goals developed by the Minneapolis Inhalant Abuse Task Force—a group created to deal aggressively with this problem. Their goals include the following:

1. Create public awareness throughout the State regarding inhalant abuse, especially among children
2. Develop strategies for programming and intervention
3. Obtain a training and education coordinator to train helping professionals, law enforcement, school personnel, parents, and others throughout the State
4. Develop a lockup law restricting the sale of various solvents of abuse

Reference


Case Management With Maternal Substance Abusers in Rural Communities: The "WRAP" Experience

Teri L. Nelson, C.C.S.W., A.C.S.W.
Director, Recovery Services
Community Mental Health Center, Inc.
Lawrenceburg, Indiana

Kimberly Brockman, B.S.N., R.N.
Case Management Supervisor
Women's Recovery Alternative Program
Community Mental Health Center, Inc.
Lawrenceburg, Indiana
Abstract

The Women’s Recovery Alternative Program (WRAP) was developed by the Community Mental Health Center, Inc. (CMHC) in response to the growing need for services to addicted women and their children. The program is under the auspices of the Recovery Services Department at CMHC and is funded in part by a grant from the Indiana Division of Mental Health. The program began accepting clients in mid-October 1993 and is staffed by one case management supervisor and three community caseworkers. The program has served 23 families since its inception.

The program serves women and their children from five predominantly rural counties in southeastern Indiana with a total population of 98,000 residents in a 1,498-square-mile area. CMHC, Inc. is the only provider of alcohol/drug services in the five-county area. The Recovery Services Department provides the following programs: an early intervention component, outpatient assessment and treatment, intensive outpatient services, and WRAP.

WRAP is unique in its therapeutic approach. It is a blend of outpatient and intensive outpatient addictions treatment with assertive case management. The concept is one that focuses on the empowerment of women to develop necessary skills for long-term sobriety, to improve parenting skills and relationships with their children, and to encourage education and job skills that will enhance family self-sufficiency. Women served by the program have stated that the case management services have been instrumental in developing needed support for sobriety and improved family relationships.

As a parallel treatment component to the women's services, children are involved in therapy groups that allow an opportunity to address the impact of parental chemical dependency. This has been well received both by the children participating in the program and by parents, who comment on the improvement in communication and relationships between parent and child.

The intent of this paper is to enhance the body of professional knowledge concerning treatment of maternal substance abusers in rural communities. The paper provides information for those interested in utilizing innovative and creative treatment strategies to address the multiple needs of rural substance-abusing women.

Introduction to the Agency and Community

Founded in April 1966, the Community Mental Health Center, Inc. (CMHC) is a private, nonprofit organization that provides a comprehensive range of services to residents in a five-county area of southeastern Indiana. CMHC is governed by a board of directors who represent a cross-section of the service area population. The primary mission of CMHC is to efficiently provide high-quality services that will enhance and maximize the mental health of the citizens of the service area. The services provided reflect the needs of the service area. Most services are reasonably available to all citizens through satellite offices located in each of the five counties served.
CMHC services are provided in an environment that recognizes and respects the rights of individual consumers. CMHC functions as an integral and competitive part of the delivery network for mental health and health services in the service area. The Center makes a commitment to provide selected services that are consistent with the agency’s mission, demonstrated community needs, and the prudent utilization of available resources. Available services through CMHC include the following:

- Inpatient psychiatric hospitalization
- Community support services to seriously mentally ill adults
- Rape crisis services
- Psychiatric/medical services
- Contracted clinical services to youth
- Residential programs for seriously mentally ill and homeless
- A deaf and hard-of-hearing program
- Outpatient services
- An outpatient chemical dependency program

Mental health services are provided by a multidisciplinary staff of 91 that includes psychiatrists, psychologists, social workers, nurses, qualified mental health professionals, residential counselors, and mental health technicians.

**Area and Client Demographics**

The CMHC service area has characteristically been composed of a population disadvantaged by a lack of industry and economic growth. The five-county region in southeastern Indiana is a 1,498-square-mile section of the State that borders Ohio and Kentucky. The population is approximately 98,000 persons according to the 1990 census data. One of the counties in the region, Ohio County, is the smallest in land mass and population in Indiana. The largest population base is centered in Dearborn County, which has approximately 38,000 residents and, of all the counties, is in closest proximity to Cincinnati, Ohio.

The rate of chemical dependency is slightly higher than the national average because of such factors as the poor economic climate, limited availability of comprehensive treatment services, and the cultural acceptance of alcohol abuse in particular. The per-capita income in the service area is significantly below the State average of $15,830; it ranges from $10,506 in Switzerland County to $14,692 in Ripley County. The number of food stamp recipients increased by 8.7 percent from 1989 to 1990 in Dearborn County, where the largest population base is located. In four of the five counties, Medicaid claims increased by a range of 8.1 percent to 15.2 percent during the same period (1989 to 1990). A review of CMHC’s client demographics for the period of 1990 to 1993 indicated at least 90 women with a substance abuse diagnosis who had dependent children; 78 women had annual incomes below $10,000.

**The Gap in Services for Chemically Dependent Women**

It is within this backdrop of area and client demographics that the Recovery Services Department of CMHC, Inc., specializing in addiction treatment, identified a significant gap in providing
services adequate to meet the needs of chemically dependent women. The Recovery Services Department, until implementation of WRAP in September 1993, provided outpatient, intensive outpatient, and early intervention programs with four staff therapists. The main services were provided at CMHC's administrative offices in Lawrenceburg, Indiana, with satellite outpatient offices staffed 1 day per week in three other counties. The frustration in attempting to provide treatment services in a traditional model to chemically dependent women continued to increase. This frustration was fueled by problems inherent in a rural area, including the lack of public transportation, poverty level incomes, and the lack of a comprehensive range of available addiction services within the service area.

It is widely acknowledged that addiction services in a rural area are a challenge in the best of circumstances. In an area that has few available resources and generally is one of the most economically disadvantaged areas of Indiana, there are a wide range of elements that have an adverse impact on the delivery of treatment services. Addressing the special needs of addicted women with dependent children further amplified the challenge facing the Recovery Services Department staff. For a number of years, the clients served were predominantly males who had frequently been court-ordered to attend treatment as a condition of probation. The percentage of women receiving services was, at best, approximately 30 percent.

Although women represented an average of one-third of the total client population, women typically did not remain in treatment beyond the initial three or four sessions. Most often, the initial sessions were crisis-oriented. When the crisis ended, women discontinued treatment only to be seen several months to several years later, once again in crisis, with a more advanced progression of chemical dependency and increasingly regressive functioning in themselves and their families. It was evident that the traditional outpatient model was not effective with maternal substance abusers. However, there were no other known models of treatment for addressing the unique needs of women.

Development of the WRAP

In 1993, the Indiana Family and Social Services Administration, through the Division of Mental Health, announced a request for proposals that would address the specific treatment issues surrounding services to maternal substance abusers. This offered an opportunity to identify possible methodologies that could provide more substantive treatment services to this underserved population. A primary concern in developing the proposal was to identify a treatment approach that would support the ability of women to remain abstinent and enter recovery. This was particularly important given the lack of residential and inpatient services that could accept women and their children. The closest facility for providing such a service is more than 125 miles away. In developing the proposal application, several ancillary factors were considered.

The low income of many families in the area prohibited many women from having access to needed services. Another issue of clinical importance to the Recovery Services Department was the need for a method of intervening with the children in the family. This was seen as vital to the success of any program that would attempt to work with maternal substance abusers. The third
issue that was a factor in developing what would become the Women's Recovery Alternative Program (WRAP) was how to improve the self-sufficiency of families.

After 4 months of research and development, the Recovery Services Department of CMHC submitted a proposal to the Division of Mental Health in March 1993. In April 1993, the program was notified of the funding award of $200,000 to support a $379,000 budget. The following section describes the methodology developed in the design of the WRAP program and reviews the program's implementation.

**Methodology**

The WRAP program is an innovative concept that blends outpatient treatment for chemically dependent women and their children with a community-based case management component. The target population is women with dependent children and pregnant women with a chemical abuse/dependency diagnosis. The program grant supports provision of services to those who are indigent; however, CMHC makes the services available on a sliding-scale fee basis to all women who qualify regardless of income. The goals of the program are to:

- Assist families in obtaining the necessary community services and life skills to enhance abstinence from alcohol and other drugs
- Improve the quality of family life

By reducing barriers to addiction treatment and advocating for the needs of maternal substance abusers, families have greater opportunities for becoming self-sustaining and breaking the intergenerational cycle of chemical dependency and associated family problems.

A case management model was the treatment approach chosen as having the greatest potential for success with addicted women who have dependent children. The model blends outpatient with intensive outpatient treatment from the existing Recovery Services programming. This case management model is adapted from community-based approaches that had been successfully used with other client populations, particularly the seriously mentally ill. The major difference in the case management model used in the WRAP program is that it emphasizes case management with the women and their children through community- and home-based interventions. These interventions are designed to enhance the family's capacity for independence and self-sufficiency after they have completed the program.

**Content/Program Design**

The WRAP program is built upon three primary components. These are (1) community case management; (2) structured outpatient treatment for women and their children; and (3) family networking to enhance recovery.

**Community Case Management**

The function of case management is designed to assist women and their children to:
The program design allows for the most intensive level of service to be home- and community-based, rather than facility-based as in traditional models of addictions treatment. This encourages maximum growth and empowerment of the family by strengthening their ability to have an impact on their own environment. The program is designed to provide an average of 16 hours per month in case management services.

**Help in assessing community resources.**

The community case management concept focuses on assisting women to access community resources that will enhance their family's capacity for independent functioning. This includes:

- Accessing entitlement programs
- Linkage with employment and education resources
- Maximizing health and child care services
- Accessing adequate housing

The case management reduces barriers to treatment and improves the chance of sustained recovery by linking women with organizations that can provide services and assistance to improve their level of functioning and quality of life.

The importance of this component for the quality of client outcome cannot be underestimated. The linkage of community case management with structured outpatient treatment is an innovative strategy as applied to this population. It is also one that has proved to be successful in the year since the program was implemented. It is a treatment approach that develops natural linkages within communities to promote family growth while addressing the mother's chemical dependency; this is the backbone of program success. Availability of case management in this disadvantaged, rural locale promotes improved chances of successful recovery, enhanced family functioning, and greater access to adequate health care for women and children.

**Living support for families.**

Another integral part of the program is family living support to offset the basic costs of child care and living necessities. Because many of the clients in the program are below Federal poverty income guidelines, the families are frequently living in impoverished settings without minimally adequate living and housing resources. Family support is based on the costs of child care, housing, and other basic necessities. The family support is closely monitored and is payable only to vendors and not to service recipients as income. A maximum amount is determined based on the family's size and the basic expenses necessary to maintain a minimally adequate standard of living.
Outpatient Chemical Dependency Treatment

The second component is an extended outpatient treatment model based on an average of 6 to 9 hours per week of addiction treatment. Because the service area has no inpatient or residential care available, a structured and intensive approach to treatment is vital to client success. Providing transportation to those families that do not otherwise have the means to access services resolved one significant barrier to treatment in this rural area of Indiana.

The treatment is coordinated through the Recovery Services outpatient program. Utilizing primarily group therapy, the treatment focuses on increasing competency in various life areas to support abstinence and active recovery. These include:

- Improving the relationships with family and children
- Improving parenting
- Addressing women's health issues through education groups and improved access to health care services
- Encouraging emotional well-being
- Choosing healthy partners
- Providing a holistic approach to address physical, psychological, and emotional needs

The initial treatment plan for mothers and children.

After a three-session assessment, each family is presented at weekly Recovery Services Department clinical staff meetings. This multidisciplinary team, which includes a consulting child psychiatrist, offers recommendations for the initial treatment plan. Recommendations are made for both mother and children and may include ancillary services, such as individual and family therapy, psychological testing as indicated, psychiatric evaluation, and interface with schools, welfare departments, and the legal system if warranted.

Intensive outpatient and outpatient groups are frequently the most utilized form of treatment with the WRAP clients. Since the program is designed for a minimum 1-year length of stay in outpatient treatment, it allows the WRAP staff to follow the progress of individual clients as well as families over a longer period than is customary in traditional chemical dependency treatment. This has, we believe, been responsible for the level of success demonstrated by the WRAP program. Another significant factor has been the ability of the outpatient and WRAP staff to coordinate treatment and interface throughout various treatment phases. Both of these clinical components have contributed to the success we have seen to date in the WRAP program.

The children's treatment component.

A children's treatment component parallels the treatment for mothers. Groups were developed for each developmental age of the children participating in the program. These groups utilize diverse age-appropriate approaches, including play therapy and education about the disease of chemical dependency. The emphasis is on:

- Encouraging self-esteem
• Providing opportunities to enhance behavior impulse control
• Developing communication and nurturing relationships between parent and child

A portion of the children's treatment component includes the parent and child working together to improve communication and to develop quality time together. The program works with parents to promote understanding of child development needs and appropriate parenting responses.

**Component for pregnant mothers.**

Also included is a component for pregnant mothers that focuses on early childhood development and infant care. To date, the WRAP program has had two pregnant women, both of whom remained abstinent and delivered healthy babies. The crucial components in working effectively with pregnant, chemically dependent women have involved providing these women with access to, and an understanding of the importance of, adequate prenatal care as well as support for abstinence. Childbirth education has also been provided by the WRAP Case Management Supervisor for both women.

**Networking Among Families**

The third component involves assisting families in developing a network and interface among themselves to strengthen the basis of a recovering family community. This is accomplished both formally and informally. The WRAP program offers monthly support meetings and a minimum of four to six "family outings" per year. These formal activities have included an outing to a natural history museum, several trips to local and State parks in the area, swimming, and restaurants.

The purpose is to help families in the development of drug-free recreational and lifestyle skills through interaction in a drug-free environment. It also strengthens the support system among the women and children, who often are isolated because of multiple problems inherent in active addiction. Women and children have begun to learn they are valued and respected, and not judged because of their addictive disease.

Informally, the women and children have learned from one another in the casual interaction that occurs naturally in the process of providing transportation and participating in groups together. This has been a significant help in beginning to eliminate the sense of shame that most addicted women experience. The improved self-concept of the women and children participating in the program is obvious in their interactions with their families, one another, and with program staff.

The WRAP program has also been able to provide age-appropriate activities for the children involved with the program. Some of the activities the children engaged in this year were community library programs, participation in water safety classes, and an educational trip to a local volunteer fire station for preschool-age children to learn about fire safety. As a result of WRAP sponsorship, one adolescent was involved with a summer career camp offered by the Indiana State Police.
Program Staffing

The WRAP program is staffed by one case management supervisor, a position currently filled by a bachelor's-degreed nurse who has professional psychiatric and chemical dependency experience. Three bachelor's-level case managers provide much of the actual case management to families in the community and home. The staff-to-client ratio is kept at a maximum of one case manager to five families. This ratio facilitates the structure and intensity of treatment support necessary to effectively meet the needs and goals of recovery and improved functioning of the families.

The Recovery Services staff, which provides the treatment portion of the program, consists of three master's-level and one bachelor's-level therapists. The entire Recovery Services program, including the WRAP component, is supervised by one master's-level program director, and clerical support is provided by one secretary.

Findings

WRAP began accepting clients in mid-October 1993. Marketing of the program to the five counties served by CMHC resulted in identifying several families who were eligible for the program even before funding had been allocated. The response of the communities to the WRAP component has been quite enthusiastic and supportive. Many of the initial referrals to the program came through the local welfare departments. The relationships previously established between welfare departments and CMHC assisted in the appropriate referral of these families within a brief period after the inception of WRAP.

By the end of the fiscal year in June 1994, the program had served a total of 23 families. This included 23 women and 22 children. In at least three cases, women were working toward reunification with their children, who were wards of the local welfare departments because of the mother's chemical dependency and neglect. In at least two of these cases, the children have been returned to their mothers and continue to participate in WRAP.

In some instances, women were assisted in accessing a women's 60-day residential program that also accepted children. The WRAP staff provided transportation, without which admission would have been nearly impossible for women who have very few resources. After completion of more restrictive treatment, the families were referred back to WRAP, which provided the basis of continuing care through case management and outpatient followup treatment.

All but one family fell 200 percent or more below Federal poverty income guidelines. Most families are receiving AFDC and Medicaid benefits, while some of the women are minimally employed to try and maintain their families. All of the women have been encouraged to make appropriate use of employment and educational resources to increase their ability to be more financially self-sustaining. The case management component of WRAP has been responsible for encouraging women to consider new options in these areas.
Client Demographics

The following information describes the clients who have participated in the WRAP program in the first 9 months of operation. These aggregate data provide an overview of the demographics of the clients served and the type and volume of services provided by the WRAP staff.

Ages of women: Ranges between ages 24 and 40, with a 60 percent concentration between ages 24 and 32.

Ages of children: Ranges from 9 months to 14 years, with a 62 percent concentration between the ages of 5 and 10 years. These data do not include the two babies delivered after June 30, 1994, by two pregnant women in WRAP.

Services provided:

1. Case management—996 hours
2. Group therapy—1,054 hours
3. Individual support/assessment—273 hours
4. Total hours of service delivered—2,323

Of the 22 families served through June 1994, 11 were discharged from the program. Of the 11 discharges, 6 families were successfully discharged, 2 were referred for more intensive residential treatment, and 3 were discharged for repeated program noncompliance.

Client Outcomes

WRAP clients have remained in chemical dependency treatment much longer than those who had previously entered more traditional treatment programs. As a result, they have attained more success in recovery, which we believe is due to the combined case management efforts and structured treatment. The clients have achieved enhanced levels of functioning, both individually and as families. Abstinence rates have improved dramatically for this client population, which again we believe is a direct result of the treatment approach inherent in the program design. By recognizing and attending to the barriers to treatment and active recovery, WRAP has achieved a measure of success with maternal substance abusers.

The financial support of WRAP through the Indiana Division of Mental Health has been supplemented by Medicaid Rehabilitation Option (MRO) revenues for case management services to Medicaid-eligible families. This revenue has been instrumental in the continued viability of WRAP in an economic climate where State and Federal funding is uncertain. We are currently exploring alternate sources of revenue so we can continue this type of case management-based programming.

Conclusions

WRAP has been successful with the limited number of clients who have participated in the program services to date. Success with this limited number of participants lends credence to the
belief that creative and diverse strategies can be effective with populations that do not respond to more traditional forms of chemical dependency treatment. The advantages of this program design also speak to the need to enhance the effectiveness of addictions treatment by developing methodologies that unite innovative concepts with the wisdom of traditional settings.

The Importance of Addressing Children's Needs

One of the reasons this design was originally chosen was because of the community support available to enable the recovery of addicted women and their families. What the Midwest region sorely lacks in the currently available continuum of care are treatment programs that accept women and children, particularly in residential care. This is crucial to entering active recovery. It is also a factor in breaking the intergenerational cycle of chemical dependency.

Making available specific programs for women that also attend to the needs of their children is critical in reducing barriers to treatment. Because of the lack of resources for child care, many women do not seek treatment. This is true across the spectrum of treatment modalities.

The Importance of Addressing Basic Needs

Another critical issue is the interface of treatment with other resources, especially health care and entitlement programs. Case management assists women in obtaining these services. Without these coordinated efforts, the remainder of the treatment program is rendered ineffective. When basic, fundamental needs are not being met, addiction recovery is hampered. The benefit of providing the case management service is that the women are empowered by learning to meet these basic needs of themselves and their families. When women can be assured that the basic living needs of their children are being met, recovery becomes a realistic and attainable goal.

Recommendations

The case management approach warrants further study and possible replication in other locations to determine the general effectiveness of this approach in treating maternal substance abusers. While WRAP appears to be effective in reducing barriers to treatment in a rural area where few resources exist, additional research into the combined case management/treatment approach in other locales might provide more evidence as to its efficacy. The success of the WRAP program within the first year does offer some rationale for developing additional programming to meet the needs of this population. It also offers hope about the potential viability of innovative methodologies—hope to treatment professionals and to those women who have struggled with addiction and experienced varied outcomes.

We will develop a retrospective program evaluation of the WRAP component within the next year. We anticipate that part of the research design will incorporate a 2-year followup study of the clients who participated in WRAP. This may provide additional data to demonstrate further the benefits of this treatment approach.
Alcohol Recovery Center Intensive Residential Treatment Program

Jack Peterson
Director
Alcohol Recovery Center
Ontario, Oregon

The delivery of quality residential treatment requires three essential ingredients. Each is indispensable. These ingredients include:

- Understanding the dynamics of the illness
- Formulating all treatment methods toward direct treatment of the disease
- Maintaining a highly motivated treatment team

These are what determine the success of a treatment program.

Abstract
Alcoholism and chemical dependency are discussed in the context of the Alcohol Recovery Center Intensive Residential Treatment Program. Three elements essential to the delivery of quality residential treatment are discussed: understanding the dynamics of the illness; formulating all treatment methods toward direct treatment of the disease; and maintaining a highly motivated treatment team. Alcoholism and chemical dependency are typical medical diseases that contain components of mental and emotional compulsions that recur even when active drinking or drug use is arrested. Drawing on the teachings of Father Joseph Martin, the author states that alcoholism and drug addiction teach its victims how to be afraid; one gets rid of fear by learning to love again. Treatment is a process in which clients are placed in a position of learning to love. Self-sacrifice, delayed gratification, and ego deflation are all key elements of success in intensive residential treatment. It is important for a counselor to act in a mature manner and not sacrifice honesty for the client's approval. The author advises that counselors should not compare themselves to, compete with, or criticize other counselors.

Understanding the Dynamics of Alcoholism and Chemical Addiction

Alcoholism and chemical dependency are typical medical diseases which contain components of mental and emotional compulsions that recur even when active drinking or drug use is arrested. Dr. Frederick A. Montgomery, addictionologist and author of Alcoholism and Chemical Dependence, states:

Psychoactive prescription drugs constitute a large number of drugs available for medical use. These drugs may be prescribed for persons who are chemically dependent and/or alcoholic;
consequently, the issue of prescription drugs and their interactions with alcohol and other chemicals becomes important. Commonly, people who become dependent upon prescription drugs have an underlying genetic predisposition for alcoholism. Their initial prescription drug dependence moves gradually into alcohol dependence as well, because prescription drugs and alcohol satisfy physiologic needs in the same fashion. Polydrug dependence is a common occurrence in most alcoholism treatment facilities. Many of these drugs are prescription drugs easily obtained by the chemically dependent person.

**Role of Prescription Drugs**

The abuse of prescription drugs results in more injuries and deaths to Americans than all illegal drugs combined. In 1983, there were 1.5 billion prescriptions dispensed and several hundred million pills were diverted to illicit use. Prescription drugs are involved in almost 60 percent of drug-related emergency room visits, and 70 percent of drug-related deaths are commonly associated with alcohol. In almost every case of prescription drug abuse, there is also a dependence on other drugs and/or alcohol.

People who are genetically prone to the development of alcoholism may inadvertently find themselves dependent on medications prescribed for legitimate reasons. Physicians view many of these drugs as being relatively harmless. But to those persons who are genetically predisposed, the medications become gateways to drug dependence and/or alcoholism. Abstinence from all psychoactive drugs is the only reasonable method to deal with chemical dependency.

**Accepting the Violation of Personal Values**

Violations of conscience can be considered to be "invoking precedence." Once an invoking precedence has occurred, a psychological phenomenon takes place in the subconscious that conditions the alcoholic/chemically dependent person to learn to live with the fact that one's behaviors have fallen below one's own values. This type of situation makes it easier with each recurrence for the client to live with the behaviors that violate his or her personal values.

With inhibitions chemically altered, the alcoholic/addict does not have the same level of psychological defenses that would normally prohibit unacceptable behaviors. As the illness progresses, there tends to be a progressive diminishment in the effectiveness of the inhibitions. Each unchecked violation of values will promote the capacity for even greater violations.

The client becomes mentally ill as he or she begins to cope with the implications of the depth and seriousness of those violations. Rationalizing becomes a way of life as the client tries to block out the psychic pain. The client blames something or someone else . . . the same process he or she uses concerning denial of the drinking and drug problem.

Once the unacceptable behavior is established and "owned" through a process of "condoned" repetition, it becomes attitudinal and eventually hardens into a state of being. The client has developed rational defenses to protect himself or herself from the psychic pain corresponding with that self-knowledge. Rather than using the defenses as he or she once did—to stop the self from committing the act that was unacceptable—the client begins to use defenses to explain
away personal responsibility. This is an important shift in emphasis. At this point, the defenses are no longer the tool; they are the master. The shift in emphasis is not noticed, because the behaviors are perceived by self to be condoned. What is not seen is that the behaviors are in direct conflict with the client's own values. It has been said that the alcoholic drinks because he—or she—can't not drink. The alcoholic acts the way he—or she—acts because he—or she—can't not act that way.

The Process of Affixing Blame

Whether the alcoholic/addict is using or not, whatever behaviors have been solidified into a state of being are now "acceptable" options, because the client has effectively hardened or shielded self from the truth that would make the person feel bad about it. With the passage of time, that same person will forget the fact that the violations of personal values had anything to do with chemical use. The greater the pain, and the higher the number of unacceptable incidents of values-violation, the greater the deception has to be. With time and distance placed between the chemically addicted person and that person's behavior comes a natural lack of comprehension of cause and effect.

The chemically addicted person has a free-floating mass of negative emotions long detached from the incidents that caused them. Once this has followed the course to its end, the person is left with several potential target objects for blame. Some blame self and undergo all types of self-destructive changes, usually manic or depressive in nature. Many are often diagnosed as having unipolar or bipolar disorders. Some blame others and become antisocial or psychopathic. Still others are not quite sure who or what is to blame and begin to manifest behaviors similar to a paranoid schizophrenic. Others may blame the system or the government, become very anti-authoritarian, and join various hate groups and organizations that are anti-establishment. Some blame God and develop all manner of spiritual troubles. Their guilt, shame, and remorse for past misdeeds prohibit them from approaching the truth they fear. The question might well be asked, "What kind of punishment can a person warrant whose guilt is greater than the misdeeds?"

People coming into contact with a person suffering from any one of the mentioned delusions will often unwittingly support that negative assumption, because many aspects of the person's belief system seem plausible. In fact, if the beliefs had not been plausible, they would not have been adopted.

The Significance of a Sense of Self

Some youth begin drinking or taking drugs when their personalities are still in the developmental stage. This is the other destructive situation where the psychological phenomenon develops of invoking precedence through a violation of the client's values. Society makes a definite distinction between a juvenile record and an adult record for good reason. A child needs to learn the limitations in which he or she must abide, and that takes some testing of limits. Driving fast, fighting, stealing, cursing, lying, and pretending are natural in adolescence . . . but are quite inappropriate at age 25 or 30. Sometimes we see cases of arrested adolescence, where the client has not yet established his personality. This same person may well have violated his or her own
values before starting to drink "in search of self," and that created the invoking precedence that
carried over into adult life, making the person feel and act inappropriately as weighed against his
or her own values.

I do believe that if the client becomes more aware of himself or herself as a worthwhile
productive person, that client will less obsessively focus on past unacceptable acts and will pay
more attention to present behaviors and values. Rather than closely examining causes and
motivations for behaviors that occurred before, during, and after drinking and drug-taking
episodes, it is better to require a client to begin to examine "Who am I?" Then, the answer to the
dilemma will lie in the process of learning once again to function within the confines of his or
her personal values. Though the client may well be legally responsible for his or her actions, the
person is in no way morally responsible for doing things he or she did not "want" to do, for those
actions were obviously against the client's will. Proof of that statement is observed easily through
identification of conflicts. The proof of conflict shows the value violations, and that is much
easier to establish than the true cause of the unacceptable behaviors.

1. Since periods of abstinence without active involvement in the recovery process do absolutely
nothing to forestall the antisocial or criminal behaviors, a person who is just not drinking or
using chemicals cannot be considered to be in recovery.
   - When not involved in the recovery process, the alcoholic/addict who does things that
     conflict with his or her values is still simply manifesting alcohol/drug-related behaviors.
     The behaviors should not be viewed as the client's "true" personality. Although it is
     necessary to hold such a person legally responsible for these behaviors, the client is not
     morally to blame for recurrent behaviors adopted in the practicing/addictive cycle of
     behavior.
   - We should not only be aware of the possibility of the recurrence of unacceptable
     behaviors in the chemically dependent person prior to recovery, but we should be
     trained to expect it.

2. Once the unacceptable behavior is established and owned through repetition, it becomes
attitudinal . . . and eventually hardens into a state of being. The same process works in reverse
for productive behaviors that are practiced and accepted over an adequate period of time to
establish the behaviors as first attitudinal and then as the person's subconscious state-of-being.
   - The client cannot be morally responsible for his or her conduct until stable recovery has
     been established.
   - If recovery is not promoted, we are enabling the client to continue manifesting
     behaviors that were established while the person was drinking or using drugs. We each
     have some responsibility in that regard. As representatives of the helping profession, we
     need to get the person involved in behaviors and activities that are conducive to
     recovery and to shield the client from behaviors and activities that are consistent with
     the illness and in conflict with the client's own values.

3. Whether the alcoholic/addict is using or not, whatever behaviors have become established as a
state of being are now an acceptable option to that person, because the client has effectively
hardened or shielded the self from the truth that would make the client feel bad about it. After
the precedent has been set, self-worth drops to the level of the violation.
   - Treatment is required to help rehabilitate the client's defense system to its former
     sensitivity.
Only restoration of the client's defense system will allow the client to act within the confines of his or her true value system.

4. The greater the alcoholic/addict's pain and the higher the number of acceptable incidents of values-violation, the greater the deception has to be. With time and distance placed between the chemically addicted person and the unacceptable behaviors comes a natural lack of comprehension of the true cause and effect. The client has a mass of free-floating negative emotions long detached from the incidents that caused them.

- Residential treatment should focus on the reestablishment of cause and effect through clarification of what really happened when the alcoholic/addict used. The Alcohol Recovery Center (A.R.C.) uses the first-step preparation as a tool for that purpose. The "blame" will accurately be shifted from self, others, the system, or the government to alcohol or drugs.
- Once the cause and effect have been clarified, the client will be out of denial. Aftercare needs to be an ongoing process of maintaining that clarification. Self-help meetings are very important. Without ongoing maintenance of tractable ego, the client will soon revert to his or her former personality. The ego will inflate and cause a return of the delusion created by that client's defenses, and the client will start blaming self, others, the system, and so forth, and use again.

The person who, once started, cannot control use of chemicals, is the one who creates the most problems for our society. Such an individual may show periods of control but, once he or she returns to chemical use, problems inevitably occur. It is just a matter of time. Such persons are the most resistant toward accepting treatment and the most apt to be misdiagnosed unless there is a thorough chemical addiction history. That dilemma is through no fault of the consulting physician, since the chemically dependent (addicted) person is unable or unwilling to level with the doctor. The chemically addicted person is grossly deluded by his or her psychological defense system. Typically, these individuals are in their early twenties and feel that other people are picking on them. Any attempt to help the individual is viewed as interference, unless it is monetary in nature with "no questions asked."

The chemically addicted person will have developed a support system of people willing to "enable" that person to continue using drugs or alcohol. He or she will continue to have crisis after crisis that requires financial support. The crises will appear real, but in actuality are stories made up for the purpose of obtaining money to support the addiction.

Interestingly, the person who becomes the chief enabler becomes just as deluded as the chemically addicted person. That often complicates the possibility of the addicted person getting the help that he or she needs. Ironically, the chief enabler is a highly responsible person in other areas of life and can become a rather formidable "opponent" when one is trying to help the chemically addicted person. Treatment for both is available and appropriate. If the chemically addicted person is not to blame, how much more not to blame is the person or persons who have been adversely affected by the client's illness?

**Treatment of Alcoholism and Chemical Addiction**
Father Joseph Martin said that alcoholism and addiction teaches its victims one thing: *how to be afraid.* It is not surprising to learn that at the base of all anger is some unconscious fear. People with alcohol and drug problems are fearful, angry people.

By the time a client arrives at treatment, there has been an enormous amount of pain associated with out-of-control behaviors. Loss of control produces enormous fear. Clients fear losing loved ones, losing freedom, losing financial security, health, reputation, and, at times, even sanity. When people do things they deem to be bad, they feel that they are losing their personal moral integrity.

Out-of-control behaviors cause disruption in society. Police often intervene to protect the rights of others. If we have children, social service agencies intervene to protect those children. If we use illegal drugs, we often are stopped by drug enforcement officers. Many of us have had to go to jail, and pay fines, and have been placed on probation because of our drug- and alcohol-related behaviors. All these interventions have one thing in common—authority. It seems logical that we develop a resentment toward people in authority. We often feel picked on, singled out, or set up. We often begin to believe that our main problem is with the system. We often feel that if they would just leave us alone, things would be all right.

Most of us did not come to treatment because we wanted to. We often came because we felt we had to. Our first response to treatment is often similar to our response to policemen, jailers, or narcotics officers. We rebelled against the possibility of "them" finding out things about us because we didn't trust them. It has been our experience that anything we said could be used against us in a court of law.

Father Joseph Martin said, "We are meant to love." A person caught up in chemical addiction is not able to love in a mature way, because addiction demands that we take. Love is giving. The primary ingredient in love is self-sacrifice. It is doing something for someone else at sacrifice of self. How can we reach out to others and share with them something we haven't got? Chemical addiction robs us of our openness. It robs us of our trust. It makes us doubt other people's motives. It makes us accuse those we love of things we know deep down are not true. It often makes us avoid being around those we love. We hide from them. We are afraid to let them know us as we really are, because we don't like ourselves and know that if they really knew us, they wouldn't like us either.

How does one get rid of fear? By learning to love again. All of us seem to have one of two choices, to love others or to fear others.

Some people have the idea, "You've got to learn to love yourself before you can learn to love others." Self-love is the alcoholic's main problem. The alcoholic's selfishness and self-centeredness (caused by overdeveloped defenses) block him or her off from loving others. I think alcoholism and drug addiction are extreme examples that prove selfishness and self-centeredness stem from vain attempts to experience love through the process of loving one's self.

Treatment is a process whereby clients are placed in a position of learning to love. Clients are constantly asked to share with others their experiences, strength, and hopes. They are asked to
speak when they would rather not. When a client does something he does not "want" to do, isn't that client sacrificing of self? This is an expression of love. Self-sacrifice, delayed gratification, and ego deflation are all key elements of success in intensive residential treatment.

It sounds too simplistic. It is simple, but it is not easy. A lifetime of selfishness is not easy to break. It requires a change in attitude, a change in focus, and mostly a change of heart.

**Maintaining a Qualified and Motivated Treatment Team**

Work in the field of alcoholism and drug addiction brings with it certain difficulties. One dilemma I have noted is that the very factor which motivates many people to want to work in this field often proves to be the major factor leading a sincere person to leave the career of his or her choice. We are all changing (for the better or worse) as we adapt to new situations. For persons who are starting careers in the alcoholism or drug addiction field, there actually needs to be change in the basis of their motivation. We all want to get to know our clients, get involved in their lives, and help them along the road to recovery. One of the major causes of stress and burnout is getting too close to the client. Getting involved in too much small talk, too much personal disclosure (on the counselor's part), or too much inappropriate joking and laughter erodes the professional ethics of counseling.

A client whose life has been selfish, self-centered, and out of control suffers from many problems, maybe the most obvious being emotional immaturity. I believe there needs to be an imaginary gulf (not a wall) between the client and counselor, especially in the beginning of the treatment process. I believe it to be necessary that there is a contrast between maturity and immaturity. When a counselor engages in conversation (even nonverbal) that is basically immature, two major things occur:

1. You have descended to the emotional level of the client, and you are being counseled to the extent and degree that you remain in the immature setting or allow it to progress.
2. You are unwittingly becoming part of the problem because you are merely reflecting what they are. When this occurs, their opinion of you is diminished.

A client whose life has been a series of superficial relationships soon gets the feeling that you are no different than they, and therefore may have little to offer. This creates a situation Dr. Steven Glen describes by the term "naive clarity," wherein no positive changes occur—you just reflect what they are.

**Qualities of the Mature Counselor**

A mature counselor familiar with traps of co-dependency in the treatment setting will not sacrifice honesty for the client's approval. A mature counselor is not in the business to find and make new friends, even though that is often the long-term result. A mature counselor insists on sharing with the client at a level of maturity and expects the client to rise to the occasion. When this occurs, counseling is in the mode conducive to change in the client. Neither the client nor the counselor is diminished in a therapeutic setting in which information is exchanged at a level of maturity.
Once the client becomes aware of who you are, the client will respond accordingly. A counselor needs to create an imaginary gulf between himself or herself and the client who is talking nonsense, if for no other reason than that it simply doesn't work. Personal integrity is the counselor's hallmark. With it, when you speak the client will listen. The client will listen seriously. The client will listen intently. Without establishing a personal integrity of maturity between counselor and client, no matter what is said, it is taken with a grain of salt. The client cannot trust himself or herself and feels that, if you are not somehow different, he or she won't trust you, either.

When the counselor requires that the client be addressed with maturity, inevitably the client responds similarly and is counseled. The majority of counseling is not in the group setting, in one-to-ones, or in lectures, but is in impressions gathered prior to the actual counseling session. How we present ourselves, how we interact with other staff members, and the manner in which our client sees us handling ourselves—all combine to create an impression of integrity or an impression of immaturity.

Father Joseph Martin's "Chalk Talk" shows the personality of the alcoholic represented by the formula E/I (emotions predominating over the intellect). As long as the client's emotions are in primary control, there will be immaturity. That does not mean we are to treat clients like children. That is their problem; others have treated them like children for too long. Clients need to be approached as adults, treated as adults, and expected to act and react like mature responsible adults. A part of treatment's responsibility is to diminish immature out-of-control behaviors and to foster a degree of self-control and self-discipline representative of adult behavior.

**Attitudes Counselors Need to Avoid**

Initially, counselors doing their job will not be liked by the clients. However, they will be respected. It is more important to win their respect than to win their friendship. With the passage of time, clients who act responsibly begin to reap the positive benefits of their actions. Their view of the counselor will change as their views of themselves change. They will ultimately appreciate the counselor's work, respect the counselor's judgment, and learn to love the counselor, as the counselor has taught them how to love others.

We all have a hidden desire to be the one to get someone well. To realize we each have played a part in that process is inspiring. But, to feel responsible for independently bringing about that change can be disastrous. The counselor who finds himself or herself taking credit for someone's achieving or maintaining sobriety will soon find himself or herself taking responsibility for the client who doesn't. When a counselor takes credit for positive changes, that same counselor suffers with/for the client who chooses to drink or use drugs again. To allow a client to credit a counselor with his or her sobriety is a setup. A successful counselor is a person who is well trained, a team player, cooperative, inspirational, a positive example, and willing to work consistently within the parameters of her or his limitations. The primary limitation that must be faced early on in the career of a counselor is: "I am powerless over the alcoholic/addict" and "I cannot manage the alcoholic/addict."
Before a client reaches A.R.C., he or she has been through about 90 percent of what is required to get well. We know that, because we understand the characteristics of the illness. Clients have done exhaustive "research" into their drinking/drug taking. They have had loved ones go the extra mile for them. They have had crises. They have lost loved ones. They have been given hundreds of "second chances." They have tried everything—with the exception of what it really takes to get well. They have not accepted the truth about themselves nor have they accepted the truth about their condition. Our job is to see that they receive the unadulterated truth. We know the truth will hurt. They sense the truth will hurt. We know the truth will not be immediately accepted, but we have the responsibility to present the truth as often as we see error.

**Knowing the Limits of Helping**

We teach clients how to love others, so that their experience of having love will be manifested in every area of their lives. As they begin to embrace reality with all the fervor they did the bottle or drug, the desire to drink or use drugs will be removed.

I must focus on my area of expertise. I am primarily a drug and alcoholism counselor. I understand alcoholism and drug addiction to be primary to the solving of other problems caused by the disease.

A counselor must not waste precious treatment time trying to control people, situations, and conditions of the client's external life. The futility of this is apparent in the sense that, if those problems were eliminated, the client would not feel the need for change. Every client's psychosocial history represents the futility of his or her attempts to change life to allow for continued drinking and using drugs. Every newly sober alcoholic honestly believes conditions drove him or her to drink. To the extent that we buy into this lie, we reinforce the client's obsession to "somehow, someday, control and enjoy my drinking." It has not worked over the past many years and it will not work for us!

We must continually work to increase the client's conscious awareness of blaming people, situations, and conditions for what was caused by the disease of alcoholism and drug addiction. The counselor who remains within his or her field of expertise and displays maturity and empathy in the conveyance of truth is always impressive. The old adage: "To thine own self be true" illustrates where the primary focus must be.

**Working as a Team**

The simple formula that has helped considerably throughout my 15 years of counseling is the "three Cs" as explained to me by Gordon Lucky. Applied to other counselors, it simply teaches, don't compare (yourself to)—don't compete (with)—and don't criticize other counselors. We must each develop the method of teaching clients the truths we know based on our own personalities. We see a vast diversity of personalities in treatment. We have a vast diversity of personalities among staff.

Cooperation and forgiveness will help the team function in a cohesive manner. That is what we all want, and that is what we all must do.
Identification and Treatment of Senior Citizens With Addiction Problems

Donna Pinter, Ph.D.
Psychological Services Clinic
Sunbury, Pennsylvania

Abstract

This paper addresses service delivery in rural Northumberland County, Pennsylvania, in the prevention, identification, evaluation, treatment, and aftercare of senior citizens with addiction problems. Project SWAP (Seniors With Addictions Problems) is an interagency effort (Area Agency on Aging [AAA], Single County Authority [SCA], Outpatient Clinic) to formulate a collaborative network to best serve the elderly population with substance abuse problems. An integral component of this program is the ongoing training of AAA personnel on addiction issues to assist in correct and timely identification of elderly clients with substance abuse problems. A holistic approach includes a mental health training component to address the specific life issues facing the elderly population. From the inception of SWAP in 1992, the number of senior citizens referred to the SCA has increased from a few per year to upward of five per week. Essential variables in this significant increase of alcohol and other drug (AOD) referrals from the elderly population appear to be the training of AAA staff, in-home services, timely intervention by agencies, and interagency prompt communications.

This interagency effort addresses the identification and treatment of Seniors with Addictions Problems (SWAP) in rural Northumberland County, Pennsylvania. The objective of this program is to combine the knowledge and services of area agencies. Agencies involved in this joint effort to improve the delivery of substance abuse, mental health, and related public health services to the elderly population of Northumberland County include the Northumberland County Area Agency on Aging (AAA), Northumberland County Single County Authority (SCA), and Psychological Services Clinic. This effort is based on the premise that, through interagency networking, a broad range of expertise can be shared to enhance the lives of our elderly population.

Introduction

In Northumberland County, the traditional approach to identifying, evaluating, and treating substance abusers was not effective for senior citizens with addiction problems. We therefore designed an in-home program with a holistic approach in hopes of meeting the unique problems of senior citizens who have alcohol and/or other drug (AOD) problems. Our overall philosophy is consistent with that of the Administration on Aging, which is to help older people live more meaningful, independent, and dignified lives in their own homes and communities for as long as possible.
Purpose

The overall goal of the SWAP program is, in a timely manner, to identify, intervene with, treat, and provide aftercare for substance-abusing senior citizens in Northumberland County, Pennsylvania. We provide these services in the homes of the identified elderly clients. This is accomplished through the cooperation of an interagency network that strives to provide appropriate services to senior citizens who have addiction problems. The goals for the SWAP program are:

- To provide ongoing trainings of AAA staff on addiction issues in order to assist with appropriate identification of senior citizens who have addiction problems
- To set up a referral system that will expedite treatment services for the targeted population
- To maintain an interagency network to best serve clients
- To provide ongoing and accessible information on healthy life skills to the elderly population
- To provide a holistic approach to the treatment of this population through collaborative efforts

Methods

U.S. statistical projections indicate that the number of individuals older than age 65 will increase from 9 percent of the total population recorded in 1960 to 13 percent of the total population in the year 2000. Further projections indicate that 20 percent of the U.S. population will be age 65 and older by the year 2040. According to the 1990 census, there were 2.4 million people aged 60 and over living in Pennsylvania. In Northumberland County in 1990, 25 percent of residents were already 60 or older (24,000 residents of the total 97,000). In the surrounding county of Montour, 21 percent are older Americans; Columbia County registered a 21 percent older population; Snyder County had 21 percent older persons; and Union County recorded 17 percent older residents. Overall, this rural area has a significantly larger percentage of older Americans than the country’s norm.

Traditionally, this has been a rural farming region with a long history of coal mining, particularly in Northumberland County. The majority of the population was born in these small communities, married locally, and raised their families here. Those individuals who have left the area, for employment or other reasons, often return for their retirement years. There are 459.9 square miles in this mainly rural county, with small towns dispersed throughout the region. Historically, these small communities were basically self-contained entities with their own ethnic backgrounds, religions, and cultures. While modern times are breaking down these barriers, there still exists, particularly in the coal regions, a wariness of "outsiders." This belief system is still very much in evidence among the elderly population. With the heyday of coal as king having passed, many residents, particularly the elderly, live at minimum economic levels below State and national norms.

Statistics indicate that medication misuse among the elderly may be conservatively estimated at approximately one-third of the elderly population. This misuse is generally considered to be unintentional, but still serious. Research indicates that behavioral and physical symptoms that are related to medication misuse and alcohol abuse may be misinterpreted as signs of aging (Shipman 1990, p. 21). Therefore, it is critical that staff who provide services to older adults be...
knowledgeable about AOD issues. Frequently, staff rely on their own subjective judgment and reports from family members to identify substance abuse problems among the elderly. Case histories frequently do not include substance abuse histories. Studies indicate there is a fairly universal deficiency in drug and alcohol education for staffs who provide services to the elderly population (Schonfeld et al. 1993).

Background of County Services

In 1978, Psychological Services was established as a nonprofit outpatient mental health clinic with approval from the Department of Public Welfare and ODAP (Office of Drug and Alcohol Programs). A broad range of outpatient services (individual, family, group therapies) are rendered at the Sunbury office and at the Montour County satellite office which is in Danville, 22 miles from the Sunbury location. The establishment of the clinic makes evident the difficulties that many rural counties were having in obtaining treatment services for residents. Fifteen years ago, this clinic began a comprehensive range of services on site to Sullivan County (75 miles north). Trainings and consultations are provided on location to companies and agencies throughout the region.

In 1992, the Northumberland County Single County Authority (SCA) Director, Sam Williamson, met with the Clinical Director of Psychological Services to discuss the possibility of establishing a program in Northumberland County that would specifically address drug and alcohol problems among the elderly population of this county. Williamson, who had recently become SCA Director, was attempting to introduce innovative programs into what had previously been a conservative approach to drug and alcohol treatment. While it was hypothesized that addiction problems among the elderly must exist, referrals of elderly persons to the SCA were virtually nonexistent. Likewise, referrals of elderly clients to the mental health component of Psychological Services Clinic were minimal. The clinic had served some elderly clients in crisis situations. Severe depression and suicidal ideation were prevalent presenting problems in these referrals. Even in these crisis cases, the referred elderly clients vocalized their discomfort at coming to a mental health clinic.

Start-up of the Pilot Project

With the support of the Drug and Alcohol Advisory Board, a small sum of money was designated for a pilot project to be used for educational outreach addictions trainings and in-home treatment for the elderly. These services would provide AOD education to the staff of the Northumberland County Area Agency on Aging (AAA). Concurrently, meetings of the Single County Authority and Psychological Services Clinic took place with the executive staff of Northumberland County AAA. Staff of the AAA heartily agreed that such AOD education would be beneficial to them. It was further agreed that such training would be given to all AAA staff including bus drivers, senior citizens' center personnel, and all AAA individuals who had contact with senior citizens.

It was anticipated that, through this AOD education of AAA staff, more elderly clients with addiction problems would be identified and referred to the Northumberland County SCA for referral and appropriate treatment. It was mutually agreed that all services rendered would be
done in the homes of the elderly clients. It was also agreed that elderly clients had to be dealt with in a somewhat different manner from the younger AOD clients. A strong mental health component would have to be an integral part of treatment.

**Ensuring Comprehensive Treatment**

Throughout our interagency meetings, all parties agreed that a strong need existed to provide effective prevention, intervention, treatment, and aftercare programs to the elderly population of Northumberland County. It was also mutually agreed that such a comprehensive program would need to include a strong mental health component.

As part of this proposed program, the need for training all levels of AAA staff was deemed critical for accurate identification of addiction problems. The treatment segment would have to be conducted in the homes of designated clients, and staff training would also need to be brought to the many remote AAA sites. Furthermore, this collaborative network would need to establish a plan for timely communications that would include regular meetings, phone calls, and fax transmissions.

To ensure the most comprehensive treatment and the success of this SWAP program, the following target areas were identified:

1. *Potential elderly clients needed to be correctly identified by AAA staff.* To accomplish this goal, staff of Psychological Services began the outreach process of going to AAA sites to meet with staff for shared learning and training. For example, Psychological Services staff rode AAA buses to train AAA bus drivers.

2. *The concept of shared knowledge would be applied to surrounding communities.* On May 5, 1993, a joint interagency conference, "Alcohol and Drug Abuse/Misuse Among the Elderly," was held at Mt. View Manor in Shamokin, Pennsylvania. The Pennsylvania Council of Addictions Certification Board (PCACB) granted C.A.C. credits for attendance. AAA staff from several counties, public health nurses, and mental health workers attended. Participants numbered over 100. Mental health issues of the elderly (suicide, depression), drug and alcohol problems of the elderly, and problems of caregivers were discussed. Among the presenters was a recovering alcoholic who is an active AOD counselor and, also, 70 years young. A physician from a nearby teaching hospital (Geisinger Medical Center) discussed the physiological ramifications of drug and alcohol abuse on the elderly. Participant evaluations of the workshop indicated very positive responses and a need for similar educational training in the future.

3. *The population of senior citizens who are relatively isolated and stay at home needed to be addressed.* They all receive monthly AAA newsletters, and this medium would be utilized for educational purposes. Staff of Psychological Services write articles for the monthly AAA newsletter. With longevity often come issues of significant loss, dramatic changes in lifestyles, diminished capacities, loneliness, boredom, and feelings of helplessness. Some elderly individuals develop drinking problems later in life in an effort to cope with these stressors. The articles address these issues and provide suggestions for healthy ways to cope with the stressors that many senior citizens face.

4. *To disseminate as much educational outreach as possible, senior citizens' centers would be targeted for onsite visits.* SWAP has found that going to senior citizens' centers to provide AOD training to AAA staff is an effective way to transmit needed education. SWAP staff have also
spoken to groups of senior citizens at these centers about stress management, alternative life skills, and grieving. Participants asked for more training, which we take as a positive response.

5. The provision of continuing current information on research and programs for the elderly needed to be an integral component of this project. Staff of Psychological Services agreed to obtain current information accessible through the library of Bucknell University; this information would be shared with all agencies.

6. A timely, concise referral system needed to be established to ensure that comprehensive services would be implemented. The referral system for the SWAP program follows these procedures:

- The Northumberland County Area Agency on Aging notifies the Northumberland County Single County Authority (usually by telephone, but sometimes in person or by fax) about an AAA client in need of possible AOD services.
- A designated SCA representative makes phone contact with the AAA client referral, and asks if this individual would like to be seen (at home).
- If the AAA client responds that he or she does wish this, the SCA representative schedules an appointment and meets in the home of the AAA client.
- At the time of this meeting, the SCA representative does an intake (fiscal, personal information, prior AOD experience, presenting problem, assessment of type of treatment needed). In addition, pertinent releases of information are signed (i.e., to AAA, former treatment facilities if any, Psychological Services Clinic, and doctors).
- If an AOD problem is evidenced, the SCA representative asks the AAA client if he or she wishes to pursue recommended treatment. If the answer is yes, collected information is processed at the SCA. Authorizations for treatment are generated to Psychological Services. The Clinic Director assigns the AAA client to the appropriate Drug and Alcohol (D&A) staff.
- The clinic D&A staff calls the AAA client to schedule a D&A psychosocial appointment (at the client's home). If further treatment is then recommended, clinic D&A staff will administer outpatient counseling in the home of the AAA client. If inpatient treatment is deemed appropriate, clinic D&A staff will refer the client back to the Northumberland County SCA.
- With the AAA client's written consent, significant parties will be contacted (e.g., AAA, doctors) to formulate a consistent treatment for the AAA client. As in all treatment, timeliness is critical and treatment is implemented within 2 weeks of the initial referral.

7. A crucial component of the SWAP program was determined to be onsite counselors possessing a comprehensive AOD background and a solid knowledge of mental health and specific issues of the elderly. Psychological Services Clinic would provide these counselors and assume the responsibility for ongoing supervision and training of personnel participating in the SWAP program.

Project Findings

Prior to the inception of the SWAP program, senior citizens in this area who had addiction problems were frequently not being identified and referred for treatment. In the small number of prior referred cases, these clients were in crisis situations, with major depressive episodes and often suicidal ideations being the initial presenting problems. Substance abuse issues were then discovered after the fact.
The difficulties in accessing treatment facilities are significant in a rural community. Northumberland County has no public transportation services available between small towns. Additionally, senior citizens who do drive are reluctant to travel outside their small communities. Another major factor is that senior citizens regard going to treatment or prevention sites as a stigma. They often view having AOD problems and/or mental health issues as shameful. Without exception, their response to in-home services has been extremely positive.

We have also discovered that the type of professional rendering services to the elderly is of utmost importance in treatment success. The traditional hard-line AOD treatment is, at the least, not effective. The treating professional must be knowledgeable in alcohol and other drug abuse, mental health, and the specific issues of the elderly, as well as being compassionate. Trust and security are major components of successful treatment with the geriatric population.

Our project also gained a heightened awareness of the lack of AOD knowledge among the various professionals who work with the geriatric population. The amount of "doctor shopping" and ensuing prescription abuse was notable. Among many physicians, there was a noteworthy lack of awareness about their elderly patients' abusing of medications and frequent abuse of alcohol.

Through frequent interagency communications, SWAP began to formulate comprehensive profiles of elderly clients; these profiles are crucial to successful treatment. With their newly acquired knowledge of AOD signs and symptoms, caregivers could identify AOD issues significantly more frequently, as evidenced by the dramatic increase in referrals to the Single County Authority.

**Conclusion**

The SWAP project has seen a significant increase in AOD referrals of elderly clients, going from no referrals in the beginning to between three and seven referrals per week. Because of the AAA personnel's heightened awareness and expertise on drug and alcohol issues resulting from their training, more elderly clients are being referred for services.

Responses of the AAA staff continue to be positive, as is their realization of the need for continuing education of AAA personnel. Training of senior citizens on a one-to-one basis and in groups has received positive feedback. This component includes education on AOD issues and on developing positive life skills.

The continuation and extension of collaborative networks is essential to the maintenance and growth of these programs. Shared learning and training benefits all. The importance of a holistic approach to prevention, intervention, treatment, and aftercare programs is vital to the continuing success of SWAP.

**Recommendations**
The overall recommendation of this project is to provide more education for professionals, policymakers, and the general public on AOD issues among our elderly population. The consensus among the participating agencies in this project is that, at best, there exists a minimal knowledge of these issues. It is anticipated that education will create a heightened awareness of the tremendous costs, direct and indirect, of AOD problems among the elderly. Through the education of families of the elderly and the general public about AOD issues facing our geriatric population, we anticipate that faulty belief systems will change. The addiction problems of our rural elderly population must be viewed as part of the community as a whole, not in isolation.

Based on the experience of this project, we recommend the following:

- Extend the network of AOD/elderly information on the county, State, and national levels
- Develop more life-skills trainings and activities for the elderly as alternatives to substance abuse
- Identify those inpatient AOD facilities that contain specific rehabilitation programs for the elderly population with addictions problems, and educate facilities that lack such programs about the significance of specialized programming
- Continue to collect data on the usage and effectiveness of SWAP
- Educate more physicians on the high incidence of prescription abuse among their elderly patients
- Continue to recruit qualified staff who have the expertise to work effectively with the elderly population, and who are willing to travel

References


Treatment Perspectives on Criminal Personalities in a Rural Setting

Boyd D. Sharp, M.S., L.P.C.
Clinical Director
Powder River Correctional Facility
Kathi J. Beam
Consultant
Abstract

This paper describes the Powder River Alcohol and Drug (PRAD) Treatment Program, now in its fifth year of operation. It is an intensive residential treatment program for 50 male inmates of the Powder River Correctional Facility, a 150-bed minimum security prison for males at Baker City, Oregon. This description includes a discussion of the philosophy that drives the program—the focus on an inmate's "criminal thinking errors" and criminality as well as on his addiction. The paper also describes components of the therapeutic culture and provides details about the program's stratified, hierarchical structure.

The second portion of the paper describes the studies that have been conducted to date on the Powder River Alcohol and Drug Treatment Program by the Oregon Department of Corrections, the 1992 Search for Excellence panel, and the Baker County Council on Alcohol and Drug Problems, Inc. (BCCADPI). We examine these outcome studies and the latest demographic data on PRAD participants compiled after 4 complete years of program operation. The paper ends with a series of recommendations concerning next steps for this program, including its replication in other rural prisons and jails.

The Baker County Council on Alcohol and Drug Problems, Inc. (BCCADPI) was incorporated as a nonprofit corporation in 1967 to address the alcohol and other drugs (AOD) service needs of rural eastern Oregon. This region comprises 17 counties of mountains and high desert measuring 61,134 square miles, an area larger than 29 States and just slightly smaller than the State of Washington, its neighbor to the north. In this region reside 307,000 persons, fewer by 133,000 than the population of Portland, Oregon's largest city. The region's entire population averages 7.58 persons per square mile, but only the populations of 6 counties are actually above that number; 11 are below it, and 8 counties average fewer than 3 persons per square mile.

Program Description

Since our incorporation in 1967, we at the BCCADPI have worked hard to develop programs specifically designed to help individuals in rural areas achieve and maintain abstinence from, and reduce or eliminate problems related to, abuse or dependency on alcohol and other drugs. We have been particularly interested in assisting persons recovering from substance abuse to become socially integrated and economically productive members of their communities.

Consequently, we are proud of the success shown by our 50-bed intensive residential treatment program inside the Powder River Correctional Facility, a 150-bed minimum security prison in Baker City, Oregon. When we began contracting with the Oregon Department of Corrections to implement and maintain this program in February 1990, it was the first such program in the State of Oregon and one of only a few programs of this type in the Nation. Four years later, it continues to attract the attention of AOD professionals throughout the United States. It is being used as a model for similar programs in other States because of its success in reeducating and rehabilitating criminals with histories of substance abuse.
Treatment Philosophy

The BCCADPI philosophy on which the Powder River Alcohol and Drug (PRAD) Treatment Program is based is that alcoholism and drug addiction are diseases that affect all areas of a person's life. Consequently, our approach to treatment is holistic and focuses on repairing the damage done by this disease on an inmate's (in program vernacular, a "resident's") physical well-being and mental health.

Part of our philosophy deals with the external environment beyond the prison. We believe that alcoholism and drug addiction are family diseases that affect everyone in contact with the alcoholic/addict resident. It is, therefore, essential that, whenever possible, the family be involved in therapy at the same time the resident is receiving treatment. We feel it is then much more likely that the resident being released from the program will return to a positive environment where he will find the support he needs in the critical early stages of his recovery.

But the most important part of BCCADPI's philosophy concerns a resident's internal, attitudinal environment and is based on the published studies of Yochelson and Samenow, The Criminal Personality (1976, 1977, 1986). We believe that criminals commit crimes because their thinking rationalizes and justifies their behavior, and that criminal behavior is the result of erroneous thinking. Criminals' thinking leads to their feelings, the feelings lead to their behavior, and their behavior reaffirms their thinking. To use the words of Alcoholics Anonymous, the criminal is afflicted with "stinking thinking," which includes rationalization, excuse-making, blaming, accusing, being a victim, justification, and more.

Much of the research literature in print on criminals and society addresses causation. There are a tremendous number of theories that attempt to explain why an individual develops a criminal personality–social inadequacies, lack of nurturing in early childhood, family dynamics and dysfunction, addiction to drugs and alcohol, and so on. Our program does not focus on any particular theory of causation. In the PRAD model, the emphasis—in the way staff interacts with residents and the way residents interact with staff and with one another—is on choice. We believe that each resident in the program, regardless of his childhood or parentage, his economic or social status, his living or working conditions, made individual choices to get where he is. The choice of whether to benefit from the program and make positive changes in his life is his alone, too. What brought him to this program, what—other than his alcohol and/or other drug addiction— resulted in his conviction and incarceration, is not initially addressed. While we hope that he will examine all the factors closely, using the tools we make available to him, this should be accomplished later on in treatment.

Accountability for personal actions.

Although it may appear insensitive and cold to some, this attitude is absolutely essential to maintain in the prison treatment environment if the program's structure and level of expectation are to be preserved. One of the criminal's chief survival mechanisms is to avoid responsibility at all costs; one of his first refuges as he tries to avoid facing up to who he is and what he has done is to blame others for his plight. To allow a resident to excuse his criminal behavior by blaming an alcoholic mother or an abusive father is to give him permission not to accept responsibility for
his own actions. We believe that optimum opportunity for success in the program requires that
the resident be held accountable for all his actions, past, present, and future.

A second reason for not factoring in causation when dealing with the criminal personality is that
the criminal is all too eager to buy into the concept that really, his criminal behavior is not his
fault, because this sets the stage for him to manipulate situations and exploit other people. If a
PRAD counselor were to communicate agreement with the resident that abuse in childhood, for
example, had led him to a life of crime, the resident would attempt to exploit that counselor's
sympathies and would try to manipulate every possible situation using his sorry history. Within
no time, if this sort of thing were allowed to take place, the criminal would defocus from his
problem to other areas to avoid changing his behavior.

**Criminal thinking.**

The "criminal thinking" component is the therapeutic heart of the program. It is examined and
addressed in all group and individual counseling sessions, in leisure time and work activities,
during recreation and fun. In other words, the resident's "criminal thinking and behavior" is
addressed 24 hours a day. To take full advantage of this program, the resident is asked to take
responsibility for his thinking by being honest. As he remains drug- and alcohol-free and
practices all of the activities of this program, he learns to identify and relate to his thinking as a
direct means of understanding himself. As his thinking changes, his feelings will change. When
his feelings change, his behavior will change.

We use a variety of tools to guide the resident in scrutinizing his criminal thinking errors.
Initially, we present Yochelson's and Samenow's list of 36 "Thinking Errors Characteristic of the
Criminal Personality" (1976). The residents focus on each error and address these in group
discussions, role play, and in individual assigned papers. In similar fashion, we present the 18
"Tactics Obstructing Effective Transactions in Treatment" and "Criminal Masks" (Yochelson
and Samenow 1976). The resident is thus cognizant from the very beginning that we understand
his thinking patterns, and that he is unlikely to pull the wool over the eyes of any member of the
PRAD staff. This is very important in that it disarms the resident and makes him more receptive
to treatment.

For much the same reason, we make certain from the resident's first day in the program that he
begins to admit he is a criminal. We use the word "criminal" the way we use the word
"alcoholic." The alcoholic must admit and accept that he is an alcoholic in order to begin
recovery. We believe the criminal must also admit and accept the fact that he is a criminal in
order to begin recovery. Elsewhere the thinking is that the use of the word "criminal" might be
offensive and counterproductive to positive results in the area of self-esteem. However, we
believe that in order for a resident to benefit from the PRAD program, he must always face
everything about himself with total honesty. Most inmates of penitentiaries will swear their
innocence and deny that they had any hand whatsoever in the circumstances that led to their
incarceration. When an inmate enters the PRAD program, he must overcome this denial about
his criminality, just as he must overcome his denial about his addiction to drugs and alcohol,
before he can begin to make true progress.
Admission Criteria

Referrals into the PRAD program come from other prison facilities around the State, most often but not always from the Eastern Oregon Correctional Institution (EOCI), a medium security facility in Pendleton, Oregon. Approximately 60 percent of the referrals into the PRAD program come from Oregon counties classified as either rural or frontier. An inmate referred to the program ordinarily has no choice but to enter treatment. However, because of the small facility and financial constraints on the program, some inmates are excluded.

The criteria for an inmate's admission to the Powder River program are as follows:

1. The candidate for admission to the program must have a history of substance abuse problems. He must be identified as an individual whose use of alcohol and drugs following parole would very likely cause a resumption of antisocial behaviors that would lead to his reincarceration.
2. The candidate for admission to the program must qualify for incarceration in a minimum custody setting and require only minimal supervision.
3. The candidate for admission to the program must have no less than 6 months nor more than 15 months of his sentence remaining to serve until his release.
4. The candidate for admission to the program must not be currently suffering from a mental illness. He must not require detoxification or be psychotic to a degree of severity that would preclude him from appropriate participation in the program.
5. The candidate for admission must be medically approved for entry into the Powder River Correctional Facility and require no medical supervision or nursing care.
6. The candidate for admission to the program must have no detainers.
7. Priority consideration is afforded offenders from central/eastern Oregon.
8. The candidate for admission to the program must make a commitment to honor and adhere to the program treatment philosophy and schedule.

Program Structure

The Powder River Alcohol and Drug Treatment Program is intensive, with a rigid structure. Inmate participants, referred to as "residents," are supervised by BCCADPI therapists and counselors 16 hours per day, 7 days per week. BCCADPI staff members are required to be trained in corrections procedures as a condition of employment in the Powder River Correctional Facility.

The quality of the alcohol and drug staff and the cooperation of corrections personnel have played a role in the success of this program, but success is due largely to the program's design. Based on education, structured around a resident's "level system" of work task distribution, and driven by incentives and rewards, the program's design has been seen as instrumental in the residents' acquisition of positive self-esteem and new attitudes. These attitudes aid in an individual's achieving success in the program and avoiding a return to the correctional environment.

The following sections describe the phases and components of the PRAD treatment program. Residential treatment at Powder River is built on a 6- to 15-month schedule with two parts. Each
part directs resident activity, as well as measuring treatment progress. Aftercare follows the resident's graduation from the program.

**Assessment Phase (0-60 days)**

New alcohol and drug treatment residents are admitted to a separate assessment area where the focus is on assessing and preparing them for treatment. Prior to his admission to the PRAD program, we have examined the inmate's visitation record and obtained background information from the Department of Corrections. Using this information, we are better able to determine whether the inmate will be appropriate for the program, depending on:

- Indicators of alcohol/drug problems in his history
- Evidence of a support system of either a nuclear or extended family to which he can turn during treatment and to which he can return after treatment. (This is not to say that an inmate is excluded from the program because of the lack of a family support system or the family's inability to participate due to justifiable reasons.)

**Family questionnaire.**

As part of the inmate's initial assessment, a questionnaire is sent to his family in which they are asked to identify family problems, both current and historical. Family members, including mother, father, brothers, sisters, wives, and/or friends, are all encouraged to become involved in the resident's treatment by showing support and by addressing their own issues that may be responsible for causing or exacerbating the resident's problems. The PRAD program has family counselors on duty 7 days a week to conduct family therapy sessions and to be on hand should issues arise during normal visitation times. Family counselors are also ready to help the resident should he need to discuss family-related issues at other critical junctures in his treatment process.

**Random urinalysis.**

On program acceptance, the resident immediately is included in the random urinalysis program to assure that he is consistently free of chemicals. He is assigned a primary counselor to guide him through this phase. Each new resident is given a copy of the *Powder River Correctional Facility Alcohol and Drug Resident Orientational Handbook* to read; this clearly sets forth all of the rules and procedures associated with the program, as well as penalties for infractions. If the resident needs clarification on any part of the handbook, this will be provided to him by his primary counselor. The resident is tested on his understanding of the rules and regulations governing the PRAD program.

From the beginning, much of the resident's time is devoted to intense educational therapy on drugs, alcohol, criminal thinking, and addiction. He begins writing his autobiography, which treatment staff use to determine appropriate treatment protocols. The assessment phase also prepares the resident for participation in group and family therapy by allowing him to explore thoughts and feelings under a variety of circumstances. During this crucial period, trust in the treatment process is developed and nurtured with honest, caring direction and feedback.
Introduction to the resident community.

The new arrival is introduced to the resident community in the assessment phase. An orientation is conducted by residents in treatment. Each new resident is assigned to complete one-on-ones with three different treatment residents. A buddy from the treatment side is assigned to each assessment side resident and helps him settle in. Treatment residents act as role models during the times that all residents share: community meetings, meals, recreation, Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings, and graduations.

When an inmate is admitted to the program, the primary counselor assigned to him begins immediately to assess and evaluate the individual to determine the nature and extent of his problems. The information gathered is placed on a problem list, which covers each major area of the resident's life.

The Individual Treatment Plan.

The resident works with his primary counselor to develop an Individual Treatment Plan (ITP) formulated from his problem list. Together, they determine problems to be worked on, formulate goals and objectives for resolving those problems, and devise strategies and timelines for meeting their goals.

The ITP is reviewed by the resident and his primary counselor every 30 days, and by a supervisor periodically, for as long as the resident remains in the program. When the ITP is reviewed, the resident is included in discussions of any problems and before any modifications are made. Further information about a resident is added to his file in the form of weekly progress notes, staff and peer behavioral rating sheets, and data from family therapy sessions. All of these sources of information are included when the resident's ITP is reviewed.

Whenever possible, the resident's family is involved in the resident's treatment. Whether or not the family has become dysfunctional as the result of living with an alcoholic/addict, the family nevertheless is involved in the problem and is encouraged to be involved in the solution.

A resident is ready to move into the treatment phase of the PRAD program when:

- He has begun to overcome his denial about his alcohol and/or drug addiction
- He has begun to overcome his denial about his criminality
- He has become willing to accept the therapeutic community design

Treatment Phase (Months 2 through 15)

While in the treatment phase, residents pursue personal growth and emotional awareness through all treatment and community activities. Progress during this phase is measured in the resident’s community status and behavioral and psychological change. Community status reflects the degree to which the resident reveals personal growth, e.g., maturity, openness, insight, self-awareness, emotional stability, and self-esteem.
Components of the treatment phase.

The treatment phase is divided into three components. First, the resident drafts his autobiography, to help him and his primary counselor identify the problems in his life that have been caused by his addiction and criminal thinking errors. During this segment, the resident is further encouraged to break through the denial and identify the specific areas he needs to work on to make a positive change in his assumptions about the world. He also identifies the steps he needs to take to stop his addiction.

In the second component of the treatment phase, the resident undergoes cognitive restructuring, to train him to recognize thinking errors and to acquire the basic knowledge needed to stop the addiction process. He also is taught the concepts of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and alcohol and drug education, and he begins to accept and practice the solutions learned. Included in this second segment are family therapy and the identification of both alcohol and drug relapse symptoms and thinking error interventions, so the resident can determine the external and internal deterrents that need to be established.

In the third component of the treatment phase, the resident and his primary counselor focus on formulating a maintenance care plan prior to the resident's discharge. Among the tasks clustered in this segment are obtaining a temporary AA or NA sponsor and making appointments with counselors for outpatient treatment, vocational rehabilitation, and/or employment.

To enable a resident to move through the components of the treatment phase, he is required to follow a structured schedule and to be involved in supervised activities from 6 a.m. to 10 p.m. every day. These activities include group therapy, family counseling, recreational activities—primarily aerobic workouts for cardiovascular fitness and interactive games to teach residents to work together as a unit—self-help groups, and aftercare planning.

Family and educational therapy.

Family therapy is encouraged and promoted for those residents whose families can come to Powder River. Each family therapy plan is specific to the family, but includes information on addiction, thinking errors, co-dependency, family roles, relapse, denial, self-help groups, and aftercare. Family therapy can be arranged for any time; however, Saturdays and Sundays are reserved for family treatment. The lead counselor will initiate family therapy discussion and coordinate with the family counselors to deliver family therapy. The lead counselor will remain involved, receive feedback from the family counselor, and may lead the therapy. For those residents whose families cannot come to Powder River, sessions will be held on the above subjects for them as well. Counselors will work with each resident to assist his family members to get involved in treatment and self-help groups within their communities.

One of the most valuable tools in the PRAD program is educational therapy and the use of edu-therapy modules. Of all the edu-therapy modules currently in use—such as Adult Children of Alcoholics (ACOA), alcohol and drug education, anger management, co-dependence, criminality, HIV/AIDS, self-esteem, sexuality, stress management, and values—none is more important to the resident's recovery than criminality and cognitive restructuring (thinking errors).
These edu-therapy modules, which focus on the core of criminality, guide the resident to examine in depth the thinking errors common to criminals, and to write papers drawing correlations between the offenses for which he was convicted and the thinking errors that led to his commission of the crime(s). The resident spends 50 percent or more of his time dealing with and correcting his own criminal issues.

Through the Department of Corrections, the resident has access to many scholastic educational opportunities, including the GED; English as a second language; a high school diploma; some college courses; "Breaking Barriers" and "Pathfinders" classes; and training in first aid, CPR, and job skills development.

**Work and responsibility.**

Perhaps the most important integral part of the entire PRAD program is the work and responsibility component. This component is designed and monitored by PRAD staff, but the residents manage it. Because its configuration is stratified and hierarchical, and residents earn the right to give instructions to other residents, it often is the most difficult part of the program for outsiders to grasp and for newcomers into the program to get used to.

A resident's work responsibilities begin with his entry into the PRAD Program. He is immediately assigned to a work crew, as a member of which he initially performs the many housekeeping chores associated with institutional living. Later he may be assigned to one of several departments, such as Orientation, Recreation, Education, and Inspiration and Beautification.

When he demonstrates his ability and willingness to perform tasks, comply with rules, handle responsibilities and authority, and participate in program activities, he is promoted. If he proves himself adequately, he can advance from crew member to crew chief, from crew chief to department head, and finally to coordinator and senior coordinator. The Coordinating Council, comprised of residents who have succeeded in reaching the top of the program hierarchy, meets regularly with PRAD staff and provides input from the residents on problems, suggestions, and other matters.

Residents are encouraged to be aware of the atmosphere of the community, of each other's strengths and weaknesses, and to resolve any problem areas whenever possible. The community itself serves as a teacher and mentor, but the responsibility to follow the directions always falls back on the individual resident. He must decide to support and comply with the larger community's code of conduct. Voluntary conformity to the expectations of the community is the desired goal. The staff expects residents in positions of responsibility to keep the staff informed of individual, departmental, or community problems. They do this through:

- Routine evaluations
- Daily and weekly departmental status reports
- Discussion with staff
- Bringing issues to group
Through these avenues and direct observation, staff keep aware of the status and atmosphere of the community, the departments, and the individuals.

**Opportunities within and outside the facility.**

Residents may apply for promotions, treatment responsibilities, and work opportunities when they become eligible. However, there must be an opening at a higher level. All promotions and appointments are made by staff. A resident may be demoted and his status reduced if his performance and behavior fall below program expectations, as indicated by behavioral ratings and conduct.

But if the resident commits himself to treatment, education, and change, he can earn better jobs and pay, more privileges (such as assignments to special community service work details outside the prison, trips to the YMCA swimming pool, and outside Alcoholics Anonymous meetings), a possible reduction in his sentence, and greater status and respect within his peer group in the therapeutic community. He cannot progress up the ladder alone. From the beginning, to succeed, he must be a partner in the program with his fellow residents, as well as with program staff and corrections officers. However, responsibility for his success or failure, and that of the entire program, rests squarely on his shoulders.

As a resident demonstrates progress in the program and compliance with all the rules and requirements of his job, opportunities to engage in activities outside the facility become available to him. When the resident successfully completes the treatment phase, he is released from prison. However, his obligation to the PRAD program does not end there. For a year following his parole, he must be part of an aftercare program supervised by his alcohol and drug service providers or mental health professionals in his home community.

**Aftercare**

Aftercare is very important when a resident is graduated from the PRAD program. The graduate’s continued involvement in treatment in his community will greatly improve his ability to remain alcohol- and drug-free, as well as crime-free. This is a program of recovery, not of cure. An aftercare plan is developed prior to a resident's graduation from the program. Aftercare planning is a joint effort of the lead counselor and the resident; the plan is developed based on the resident's needs and the resources available. The resident's primary counselor assists with resources, establishing the plan in each client's home community, and with followup.

Prior to release, a conference call is conducted that includes the resident, Department of Corrections staff, the parole officer, the alcohol and drug counselor, and the community treatment counselor. After release, the alcohol and drug counselor does followup calls to the resident and his parole officer. These calls occur after 14 days and 28 days away from the program. Thereafter, written followup is required monthly from the community treatment provider and quarterly from the parole officer.

Also prior to the resident's release from the program and correctional facility, family members or significant others are contacted and, if possible, included in the aftercare planning phase. It is
critical to the resident's continued recovery from the disease of alcoholism/drug addiction that he not return to the same negative environment that led to his criminal behavior and incarceration. When a resident receives treatment and begins to make positive life changes, and is then returned to a family that has not received treatment and continues to be dysfunctional, the resident's chances for relapse are very great. So is the likelihood of his returning subsequently to prison. If the resident's family has not been involved in treatment during his stay in the Powder River program, the program will look at placing him in a halfway house situation following his release.

For 60 days following his release from the program, the BCCADPI contracts with a provider in the graduate's home community. This provider oversees his aftercare program, provides counseling in relapse prevention, and supplies recovery support in general.

The Therapeutic Culture

The nurturing and maintenance of the therapeutic culture within the treatment community are essential to the success of the PRAD program. Although the residents play important roles in maintenance of the culture, program success depends on the dedicated involvement of PRAD staff. Every day PRAD supervisors and counselors meet for 30 minutes in what is called the daily interchange, to talk about areas in the program that need work. Once a week, the entire PRAD staff meets to discuss issues with residents, paperwork bottlenecks, and other problems. Twice monthly, counselors from both the assessment and treatment sides meet to discuss residents and review treatment progress. And on a monthly basis, the supervisor reviews the content of a resident's record with the responsible counselor to ensure that all pertinent items are included and that proper procedures are being followed.

In 1993, the BCCADPI began a program to State-certify all of its alcohol and drug counselors. The funding for this program came from $25,000 obtained when the PRAD program won a First Place award in the 1992 National Search for Excellence In Chemical Dependency Treatment competition sponsored by the JM Foundation and the Scaife Family Foundation.

Of course, it would not be possible to maintain the therapeutic culture at all were it not for the cooperation of the Oregon Department of Corrections (DOC). During the 4 1/2 years that the BCCADPI has provided the PRAD program at the Powder River Correctional Facility, our management council and staff have worked closely with the DOC to:

- Coordinate services
- Assure smooth operations and communicative working relationships among BCCADPI staff and Powder River corrections personnel
- Maintain the highest level of professionalism and greatest rates of success possible within the program at all times

To reach these objectives, all BCCADPI staff are required to undergo training in adherence to prison procedures prior to beginning employment at the prison. In addition, BCCADPI/PRAD staff have given presentations about the PRAD program to Department of Corrections personnel and have traveled to most of the 36 counties in Oregon to explain the program to representatives of State and community corrections, law enforcement, and legal communities. The Powder River
Corrections Facility holds weekly management meetings that the BCCADPI executive director, assistant director, and program director attend. The Corrections Facility staff meets monthly with BCCADPI staff; BCCADPI PRAD supervisors meet periodically with Corrections Facility sergeants; and BCCADPI PRAD staff persons sit on the Corrections Facility safety and training committees.

Outcomes

Because the Powder River Alcohol and Drug Program was the first of its kind in Oregon and is one of only a few programs of this type in the Nation, it has been under intense scrutiny since its implementation in early 1990. Those concerned about outcomes of the program include substance abuse treatment professionals, as well as those in the law enforcement, justice, mental health, human resources, and legislative communities. All have watched the PRAD program closely for signs that intensive residential treatment–when it incorporates work disciplines and education with cognitive restructuring–can decrease recidivism and increase the number of productive, law-abiding individuals returned from prison into society.

In March 1992, a Preliminary Outcomes Study of the PRAD program was conducted on 52 subjects–both completers and noncompleters–by Gary Field, Ph.D., Alcohol and Drug Services Manager for the Oregon Department of Corrections. This study assembled data on the criminal activity of the 52 subjects for the 1-year period following their release from prison. The results were encouraging, but the small numbers and relatively short timeframe of the followup study made these results inconclusive.

In December 1992, encouraged by the first emerging evidence of reduced recidivism rates among program graduates, the PRAD program's parent organization–the Baker County Council on Alcohol and Drug Problems, Inc.–submitted data on its program participants to the 1992 Search for Excellence in Chemical Dependency Treatment competition sponsored by the JM Foundation and the Scaife Family Foundation. Although the submitted sample included data on only 84 participants–55 who completed the program and 29 who did not–the findings were significant. The PRAD program scored as follows:

- In the 94th percentile for graduates who had maintained total abstinence through a 6-month followup
- In the 93rd percentile for graduates achieving total or limited abstinence
- In the 57th percentile for inmates completing the treatment program
- In the 64th percentile for graduates active in self-help groups at followup
- In the 51st percentile for graduates employed, in school, or in training at the time of followup

The PRAD program received an Excellence rating within the top 10 percent of all residential program entries and was awarded first prize in the competition.

In January 1993, 10 months after publishing his initial Preliminary Outcomes Study on the PRAD program, Field published an addendum to the study with a significantly larger subject pool of 121 inmates–77 completers and 44 noncompleters. Although the numbers were still
small, a discernible trend seemed to be developing, and Field said, "The [PRAD] program appears to be reducing criminal activity of program participants as measured by arrest, conviction, and reincarceration rates. Offenders who completed the program show a 52 percent decrease in arrests and a 72 percent decrease in convictions following treatment." It was further noted that the recidivism rate for graduates with more than 5 months of treatment was only 8 percent following their first year after release.

Field is planning to conduct an updated outcomes study of the PRAD program in January 1995.

Recent Findings

In the summer of 1994, the BCCADPI decided to conduct a study of its own. By now, 334 inmates had been referred to the program. Sixty had been deemed inappropriate, leaving a total subject pool of 274 participants.

Although much of the information of the kind used by Field was not yet available, we reviewed the records of all 186 graduates and 88 nongraduates of the PRAD program from its inception in February of 1990 through December 31, 1993. We hoped to determine whether any significant demographic indicators existed that would define an inmate's personality as being more receptive to the program and likely to increase his chances of success or failure in the program. Factors examined included:

Whether the participant used alcohol only, alcohol in combination with other drugs, or other drugs only

- Age
- Race
- Education level
- Length of treatment
- Frequency of incarceration
- Rural or urban orientation
- Whether the crime(s) committed had been against persons, property, or both

The accumulated 4 years of statistics is shown in table 1.

At the onset, the results of our study were compelling. Of all program participants, 67.9 percent completed treatment. Among the program graduates in all 4 years, the recidivism rate during the 18 months following release from prison was 10.8 percent—certainly an indicator of success when compared to the recidivism rate of between 40.7 percent and 70 percent (depending on the study) experienced among prison populations in nontreatment, traditional environments.

Table 1. Powder River Correctional Facility Alcohol and Drug Treatment Program Combined Results—Graduates and Nongraduates
[Not currently available]

From the data, program participants appeared more likely to succeed if:
• They used only alcohol (although the numbers are small)
• They were older than 30 years of age
• They were white or Hispanic
• They possessed a 12th grade education or better (however, there is an anomaly concerning the 9th grade)
• They had been in treatment longer than 7 months (again, there is an anomaly for the group in treatment for 3 to 4 months)
• This was their first incarceration (although another anomaly appeared in the group that had six to nine incarcerations)
• They had entered prison from rural rather than urban counties
• They were in prison for crimes against property rather than crimes against persons

Conclusions

The data suggest that a program designed and modeled after the Powder River program will be highly successful with Caucasian and Hispanic male prisoners; that it will be moderately successful with black male prisoners; and that it will encounter decreased success with Native American male prisoners. However, the data shows that even for the least successful group—Native Americans—almost half (45 percent) successfully completed the program.

The program would include—among other areas—the therapeutic community model, criminality training, therapy, family treatment, educational opportunities, integration into the community, extended aftercare, and an intense followup.

The data also suggests that the BCCADPI study could be greatly enhanced by continued research. Some areas not addressed to date include:

1. Cross-referencing between profile data of successful residents with regard to such factors as age, race, drug of choice, prior incarcerations, length of treatment, and urban versus rural orientation. This cross-referencing could tell us exactly, for example, which black men are successful in this program.
2. Data have not been gathered on age of first use, primary drug of abuse, only one drug (nonalcohol) used, marital status, and frequency of use. These data would increase the predictability of success.

This paper and the three separate studies (Field, Search for Excellence, and BCCADPI) highlight several additional areas that would benefit from further exploration. These are:

1. Considering that we know all the black participants in the study came from urban Oregon counties, is the comparatively poor success rate of blacks related to their orientation or to other factors?
2. What factors make it less likely for a Native American inmate to succeed in the program than a Hispanic inmate?
3. Did special factors not immediately apparent from the data collected create the anomalies in the "frequency of incarceration," education, and length of treatment categories?
4. What special factors cause the nongraduates to fail after more than 7 months in the program?
5. Does the fact that most of the PRAD treatment staff are rural rather than urban make a difference in how they relate to, and are related to by, program participants?
6. Traditionally, the PRAD program has not looked at causative factors in drawing a profile of a participant most likely to succeed, but are there contributing factors—such as childhood spent in a single parent or foster home; a childhood history of physical, sexual, and/or emotional abuse; a family history of alcoholism, drug abuse, criminal behavior, domestic violence—that upon examination might reveal additional indicators for success and nonsuccess in the program?

**Recommendations**

1. It is recommended that additional programs be established to replicate the Powder River Program in rural prisons and jails.
2. The budgets of these programs should include funding for research. The research would address the questions raised in this paper as well as the areas addressed in the three Powder River studies.
3. In addition, it is recommended that the BCCADPI seek a research grant to study the questions not answered in this paper.
4. It is further recommended that findings and conclusions regarding program cost effectiveness be pursued, to include an analysis of positive cost benefits resulting from low recidivism rates as graduates of the Powder River program return to their home communities. These cost benefits should be examined at county, State, and Federal levels.
5. This paper has limited its attention to male prisoners. The question is often asked, "Will this model work for female prisoners?" To answer this question, it is recommended that this program also be replicated with female prisoners on an experimental basis. The focus, in addition to the other ingredients of the program, should include gender-specific issues.

**References**


**Continuum Development Through Coalition Building: A Survival Technique for Rural Programs**

Patricia Jean Tikkanen, A.C.S.W.
Program Director
Addiction Rehabilitation Center
Marquette General Hospital
Abstract

The Addiction Services Consortium of Upper Michigan (ASCUM) is an alliance of six treatment providers that have joined together to create a nonprofit corporation with a shared mission—to develop and maintain a quality, cost-effective, seamless continuum of addiction treatment services in the 15 rural counties of Michigan's Upper Peninsula. The major impetus for this development has been the impact of managed care models in our area. These models have shortened or eliminated inpatient stays and forced a reliance on outpatient programs, necessitating a major redesign of services and the forging of new relationships.

The development of the continuum called for in the mission statement became the cornerstone for the Consortium as it brought clarity to the desired organizational structure, resolved issues of membership, and shaped the goals that ultimately dictated the action plan for the members. It is also the primary focus of marketing to managed care organizations—both public and private—that is being done by the Consortium.

Factors that supported the successful development of the Consortium are:

- The previous relationship that existed, since all programs were part of the publicly funded system
- A low level of competition between members
- The proven innovativeness of members
- Stable program leadership
- External support from "customers"
- The perceived threats of an unstable environment

The long-term success of the Consortium is yet to be determined. But current conclusions are that this model has proved to be valid for this region and may have relevance for other rural regions as one way of positioning rural programs to survive in the managed care environment.

In both urban and rural settings, a rapid rate of change has affected the addiction treatment field in the past few years, primarily due to the new paradigm of managed care with its emphasis on cost containment and outcome measures. However, addiction treatment programs in rural regions face particular obstacles in structuring a new care continuum in this paradigm. These include the following obstacles:

- A reliance on outpatient service models with limited adaptability for rural areas, which have long distances between communities and a scattered population
- An emphasis on the accreditation of programs and certification of staff in programs that have often been underfunded; this underfunding results from the reliance on public sources of funding in areas characterized by high rates of poverty and uninsured families
Demands from managed care companies and other customers that client care be highly individualized, when small programs have traditionally been organized around structured services with preestablished lengths of stays or predetermined numbers of visits.

**Background: Michigan's Upper Peninsula**

Programs in Michigan's Upper Peninsula have been struggling with these challenges, along with the additional stress factor of having an unstable political situation in the State bureaucracy for the past 4 years. There have been frequent threats that the regional planning and coordinating agencies which contract the public funds to programs may be eliminated. Various plans have also been proposed to transfer the responsibility for substance abuse treatment services at the State level from the Department of Public Health to the Department of Mental Health. It is widely anticipated that if this plan is ever activated, then the current system of programs would be threatened by the channeling of substance abuse funds through the community mental health boards, with which there is traditionally a lack of cooperation and trust.

However these situations are ultimately resolved, it is clear that the managed care model is now being implemented in the public sector. For the past year, programs seeking State assistance for residential and intensive outpatient care for a client (either from grant funds or Medicaid) have been required to obtain prior authorization from a central diagnostic and referral service. A coalition of mental health boards, which would implement managed care for Medicaid clients in the mental health system, has made a proposal that originally included substance abuse services as well as mental health services. It is felt that this type of system will be utilized if a transfer of responsibility is ever made at the State level. The State is also encouraging the development of health maintenance organizations (HMOs) and clinic plan systems for Medicaid clients. In these systems, the responsibility for arranging any substance abuse care rests with the HMO or clinic plan administrators, who may contract with substance abuse providers.

**Agencies Involved in Planning**

In response to this environment, the Addiction Services Consortium of Upper Michigan was organized in 1993. Originally there were five licensed programs involved in the planning. These were:

- The regional medical center in Marquette that provides hospital-based care (detoxification, inpatient treatment, and partial hospitalization programs) as well as outpatient care at five clinics in five counties—two in the western region and three in the eastern region
- Two district health departments that each operate multiple outpatient clinic sites and provide a variety of prevention and educational services
- A freestanding residential facility with services for adults (males and females) in two communities and one adolescent facility
- A Native American tribe that provides outpatient services and outreach for its members in three counties

A sixth member was added soon after the group was incorporated. This is a provider of specialized residential treatment for Native Americans (serving three States), which is operated
by another tribe in the region. This facility also provides outpatient services to the general population in its home county.

All programs are accredited, which became a requirement for receiving State funding in Michigan as of fiscal year 1994. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) accredits the hospital and one tribe. The remaining programs are accredited by the Commission for Accreditation of Rehabilitation Facilities (CARF). All programs are well-established providers in the region with origins going back to the 1970s, when services were first being established.

The five original programs are all under contract with the regional planning and coordinating agency that serves the eastern part of the region. The original concept was developed through an informal program directors' group that meets regularly to share ideas and includes the director of the regional coordinating agency. The support of the regional coordinator proved to be essential in obtaining formal authorization from program boards to join the Coalition, since there is overlapping board membership between the coordinating board and the health department boards. The sixth program—the resident Native American Program—is located in the western part of the region. The regional coordinating agency for that district has not been involved in any meaningful way with the Coalition development, but has been kept informed.

While all agencies receive public funding, third-party payments have become an increasingly important proportion of all budgets. Prior to the Consortium's being developed, there had already been fairly extensive redesign of services within several of the agencies.

All current program directors have several years of experience in the leadership role in their programs, with one having over 20 years, two serving over 10 years, and the other three averaging 3 to 4 years. All had either extensive clinical or administrative experience prior to taking their current positions.

Description of the Region

The Upper Peninsula stretches across the northern part of Michigan, separated from the rest of the State by Lakes Michigan and Huron and connected only by the Mackinac Bridge that spans the Straits of Mackinac. The region is approximately 350 miles in length from east to west and 100 miles north to south. There are 15 counties in the peninsula, varying in population from approximately 2,000 residents in Keweenaw, a bony finger of land jutting into Lake Superior in the far northwest area, to Marquette in the north central area with 74,000. Total population of the region is under 325,000. The city of Marquette—at 24,000—is the largest population center. The geographic location of the area is illustrated by the fact that Marquette is 400 miles from the State capitol in Lansing—an expensive commute by air or a lengthy 8 hours by car.

The region was originally settled following the discovery of rich deposits of both copper and iron ore, and iron mining remains one of the leading economic sectors in the central Upper Peninsula. Other large industries are primarily based on forest products, including a number of paper mills throughout the southern and western sections. In the past 10 years, the region has also become
the site of extensive State-operated corrections facilities, with more than 2,000 employees working in a variety of minimum- and maximum-security facilities.

The Native American tribes are the only minority population of any size. There are five federally recognized tribes in the region. The largest ethnic groups are from Finnish and Italian backgrounds, with substantial representation from French, English, Slavic, and Swedish groups.

There is a commonly held belief that heavy drinking and rates of dependency and abuse are high in the region. However, there is little research evidence to support this, because little research has been done. The only formal survey ever conducted regionwide was done in 1982 by the Michigan Department of Public Health. This survey was part of the Michigan Opinion: Behavioral Risk Factors, a statewide survey of an adult sample that broke out data for four State regions, including the Upper Peninsula. This study did show that rates of heavy drinking (defined as consuming 14 or more drinks a week) were higher in the Upper Peninsula (14.7 percent) as compared to the Lower Peninsula (6 percent). This was even more dramatic in the 18- to 24-year-old age group, where the rate was 30.5 percent in the Upper Peninsula as compared with 3.2 percent in the Lower Peninsula and 11.7 percent in the Detroit metropolitan region (Michigan Department of Public Health 1983).

While alcoholism is the most common diagnosis in all treatment programs in the region, there is also a significant use of other drugs in the dependent population. These patterns would generally be the same as in other rural regions of the country, including:

- A high abuse of prescription drugs especially in the older, the disabled, or the dual-diagnosed client
- Marijuana use and abuse in many of the younger and middle-aged groups
- Polydrug abuse in younger and adolescent clients

In the late 1980s, treatment professionals became concerned with the number of children and adolescents who had started presenting with histories of significant inhalant abuse. In 1993, a drug survey done in the Marquette schools noted a rate of inhalant abuse significantly higher than in the State as a whole. In the middle to late 1980s, residential programs experienced a sharp increase in clients who had cocaine addiction. For a few years, cocaine addiction accounted for about 10 percent of the client population. This percentage has now declined, but another, and more unique, phenomenon has replaced cocaine as the stimulant of choice. In the early 1990s, the Upper Peninsula became the first site for widespread manufacturing of methcathinone—an amphetamine-type drug made in home laboratories. Still, clients abusing or addicted to this substance remain a small proportion of the client population. Fortunately, most Upper Peninsula drug addicts prefer to snort these substances rather than injecting them, which has kept the problems associated with intravenous drug abusers to a minimum in the region.

**Organization Process**
Developing the Mission

The first discussion of what was to become ASCUM was at a program directors' meeting with a representative of the Superior Health Alliance, a clinic plan for Medicaid recipients that was then being organized in the eastern part of the region. The initial idea was to create some sort of network that could contract as a group with this, and other, managed care organizations. The planning group was limited to the five agencies accredited in the eastern Upper Peninsula planning district and under contract to serve publicly funded clients. The reasons for these initial exclusions were that accreditation was already required for programs being reimbursed with Medicaid funds, and because this particular clinic plan was not envisioned as covering families outside of the district for some time. It was also decided to exclude from initial discussions the other two accredited programs in the eastern region that are not a part of the publicly funded system. Originally, it was thought that once a mission statement and organizational details were completed, these programs would be invited to join the Consortium. As it turned out, this has not been the case, as will be discussed later.

The mission of the group began to expand almost immediately, partly helped by the concepts in a pamphlet, *Community Care Networks*, which was published and distributed by the American Hospital Association (AHA 1993). Their concept of a "seamless continuum of care" became particularly relevant for the planning group.

The community care network would provide: (1) a full continuum of health and related social services, (2) care coordination among provider organizations, (3) interorganizational planning, and (4) integrated systems (information, financial, clinical, administrative) that track patients and assist caregivers to manage care.

—American Hospital Association 1993

While this was a vision for a network of many types of providers, it also seemed relevant for this specialized network. It addressed a number of problems that individual programs were currently dealing with on their own. For example, during the previous year, the hospital program had discovered that even transfers to its own clinic sites were resulting in large amounts of duplicated paperwork; the program staff had subsequently spent 6 months developing one recordkeeping system to be utilized in all service sites. Several outpatient programs reported a high degree of staff frustration with the inability to get clients admitted to any type of inpatient or short-term residential care. Staffs were also frustrated with the short lengths of stay that were being provided even when an admission could be arranged. All programs were trying to implement client followup systems to replace a system discontinued because of lost funding. This previous system had been developed by the State and implemented through the regional planning and coordinating agency.

And so, in attempts to develop a mission statement, it became clear that simply contracting as a group was not the answer. The mission statement that was eventually adopted reads as follows:

The mission of the Addiction Services Consortium of Upper Michigan is to organize and maintain a quality, cost-effective, seamless continuum of substance abuse care that is available to all families in the Upper Peninsula and which promotes:
Intervention in the disease as early as possible
Long-term abstinence from nonprescribed mood-altering substances
Decreases in coexisting physical, emotional, spiritual, social, and family problems

This led to development of the following seven goal statements, of which only one addresses issues of reimbursement:

1. Ensure and strive for continuous improvements in the quality of client care through an interagency quality improvement program.
2. Promote certification and accreditation efforts of agencies and professionals in the network.
3. Develop an efficient service delivery system that minimizes duplication of services.
4. Provide for ongoing casefinding and education programs to serve health and human service providers, court and law enforcement agencies, and employers in the region.
5. Ensure a diversity of services designed to meet the special needs of specific population groups in the region.
6. Strive for reimbursement of services that will increase the financial stability of the programs involved in the network.
7. Collect outcome data to demonstrate the effectiveness of substance abuse services in the health care system.

Organizational Structure

The vision behind the mission and goals of the Consortium was used to shape its bylaws, and these in turn provided the structure of the organization. It was decided by the group that all programs should adhere to a single Code of Ethics, and that this code would need to be developed. The bylaws would need to reflect the programs' adherence to the code. This code focuses more on administrative behavior than on clinical conduct. However, one of its tenets is that a program will require professionals to adhere to an acceptable code, such as that of the National Association of Alcoholism and Drug Abuse Counselors. Other standards address financial policies, promotional materials, maintenance of national accreditation, the treatment of other programs and professionals, abstinence as the treatment goal for the dependent client, and maintaining the client's interest and welfare as the primary concern in clinical decisions. A copy of the Code of Ethics is shown in table 1.

<table>
<thead>
<tr>
<th>Table 1. Addiction Services Consortium of Upper Michigan (ASCUM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The primary responsibility of the program is the provision of quality treatment services to clients and their families. The client's interest and welfare will always be of primary concern in decisions regarding treatment modality, referral, and discharge.</td>
</tr>
<tr>
<td>2. The program shall treat other substance abuse programs and agencies and professionals in other fields with respect, courtesy, and fairness. When problems arise between programs, the Director will seek resolution through direct discussions. If such communication does not result in resolution, the Directors shall seek mediation from the Consortium.</td>
</tr>
<tr>
<td>3. The program shall require that all staff members adhere to an acceptable Code of Professional Conduct such as the code of the National Association of Alcoholism and Drug Abuse Counselors or an internal code that addresses the issues of confidentiality, discrimination, professional competence, moral standards, and the maintenance of professional relationships with clients.</td>
</tr>
</tbody>
</table>
4. The program shall adopt financial policies that safeguard the interests of clients and the program. The program shall not engage in any fee-splitting or receive or provide any commission for the referral of clients to another program or professional.

5. The program shall maintain a nationally recognized accreditation and shall encourage the certification of all counselors as Certified Addiction Counselors.

6. Services provided by the program shall be established based on current state of the art techniques and knowledge in the addiction treatment field that will promote abstinence as the treatment goal for the client diagnosed as alcoholic or dependent on other drugs.

7. The program shall not offer services that are outside of the program’s competencies and areas of expertise.

8. Promotional materials for the program shall be accurate and report honestly the scope of services, limitations, and expected outcomes.

9. The program shall recognize its role and obligation in advocating for change in policies and legislation that promote opportunity and choice for all persons and families affected by the disease of alcoholism and other addictions.

10. The program shall recognize its role and obligation to inform the public about the diseases of alcoholism and addiction and the treatment services that are available.

11. The program shall not use its affiliation with the Addiction Services Consortium for purposes that are not consistent with the stated purposes of the Consortium.

12. The program shall not market its individual programs to those entities with which the Consortium is negotiating on behalf of the entire organization.

The actual structure of the organization is simple, with each member organization having one seat on the board of directors regardless of the number of service sites or State licenses held. It was felt that this needed to be done to ensure that smaller programs had a full voice in the Consortium and that charges of dominance by one or two programs could not be made.

Decisions about the recruitment of additional members were also made in light of the mission and bylaws, and targeted only those counties and communities not currently covered by a Consortium member. This was contrary to earlier discussions in which the intent was eventually to ask all qualified (accredited) programs in the region to join. The reason for this change in sentiment came as the group realized that, if the Consortium was to achieve its goals, these programs needed to have a high degree of commitment to the mission of the organization. It was felt that inviting competing organizations to join would weaken the organization unless the competition was managed in constructive ways.

Competition exists only to a limited degree among current members, with one community in the region being served by outpatient clinics from two member organizations. However, in this case the programs had already done significant joint planning to avoid any conflict. Such planning was not necessarily true of other communities where competing clinics operate.

Using certain criteria, the Consortium added its sixth provider—the Native American residential program and community outpatient services in a county not covered by another member. The criteria for adding new members are:
• The services offered by another agency must be needed to complete a part of the continuum within the particular area
• The program must be accredited
• The program must be willing to be committed to the goals of the Consortium, including making an investment of staff time

At this point there remains only one area of the region not covered, and the sole provider in that area is being recruited. If this provider chooses not to join, then members will be encouraged to develop services in that county to complete the initial continuum. Figure 1 shows service sites.

To join the Consortium, there are initial membership dues of $500. These fees are used to develop some working funds for the group, as well as to ensure that there is some financial commitment from each member.

Continuum Development

In many ways, the first year of development of the Consortium was easy, compared to the current focus of attention on continuum development. From the beginning, the directors realized that, while they could create the organization, it would be necessary to sell this concept not only to the boards and administrative structures of their organizations but also to the clinical staffs. For this reason, current activity is focused on establishing the committees needed to move toward the "seamless" ideal that has guided the organization thus far. The first step being taken is a planned retreat for clinical leaders and directors from all member organizations with the following objectives:

1. Understand the forces of change in the addiction field today
2. Appreciate the needs of our new managed care consumers
3. Develop a shared vision of recovery and the recovery process
4. Generate a service model based on this vision of recovery rather than on specific modalities of service
5. Define the terms of the relationship that ASCUM members will need to work together in this model
6. Identify changes that need to happen to realize this relationship

Several managed care providers, including the hospital Employee Assistance Program (EAP), the Superior Health Alliance, and the regional coordinator who has supported ASCUM, will also participate. As a result of this retreat, the plan is to establish two committees that will include both directors and clinical staff. The first will be the joint quality improvement group, which will focus on the issue of transfers as its first task. The second group will work on developing two pieces of the recordkeeping system that the board would like to standardize between programs—the initial screening and intake form and the treatment planning form.

Marketing

In a sense, marketing began before the organization was ever created. In fact, one of the first contracts was with the Superior Health Alliance group; the director of this organization was consulted several times during the organizational phase. Marketing has also been helped by the
hospital's EAP, which developed a managed care product that covers one major employer in the southern part of the region. The ASCUM group thus became the addiction service provider for this plan. Another fortunate event that is helping the ASCUM group was a decision on the part of the State of Michigan to contract out managed care for behavioral health to new providers this year. This has allowed ASCUM to apply to be the provider group for both companies that were awarded contracts; these applications are still pending.

Reaction to the ASCUM concept has been positive on the part of all the managed care companies approached so far. The idea of one continuum is very attractive, particularly because it does cover almost all communities in a region where it has not always been easy for such companies to find suitable providers.

**Results and Conclusions**

While the ASCUM endeavor is still relatively new in its development, it has had a number of positive results to date. First, there has been a strengthening of relationships among the member organizations, as evidenced by a greater willingness to share information and clients. The work has been energizing for the directors involved, who view this as a proactive and protective measure for their programs. It has also had educational benefits as the group has worked together to market their services. One director from a smaller program commented that she has received more than the initial $500 in education about managed care.

It is also apparent that managed care companies like such networks. One of the companies to gain a State contract has never before worked in Michigan and certainly not in the Upper Peninsula. When the ASCUM group was able, at the meeting with this company's representatives, to show them a map of the region that designated all their covered employers and how the ASCUM network would serve them, there was both surprise and gratitude expressed. There was no way that this could have happened if each program had approached the company separately. Clearly, making the clinical process work as well will also be a challenge, but there is optimism that this will also work and that the results will be better care than has ever been provided.

In summary, creating a consortium between programs in a rural area that focuses not just on the marketing of services but on the development of a treatment continuum can create a number of positive advantages. It can:

- Strengthen relationships between programs
- Provide a new focus for marketing
- Give direction for the improvement of clinical care

**Recommendations**

We make the following recommendations for programs in rural areas interested in developing a consortium.
1. Develop a mission that focuses on continuum development, which will ensure that the effort remains client- and customer-driven and will also assist in marketing efforts.
2. Keep competition to a minimum through the selection of providers or by negotiating clear "niches" when possible.
3. Involve only those programs that support the mission and are willing to make time investments in the organization.
4. Recognize that clinical staff will ultimately need to be involved in the planning.
5. Involve "customers" in the planning when appropriate.

References


**Innovative Strategies for Improving the Delivery of Substance Abuse Services in a Rural Area**

Sylvia Wilber, B.S.E.
Program Director
Sigrid Congros, B.S.
Grant Writer
Maehnowesekiyah Treatment Center
Gresham, Wisconsin
Abstract

The Maehnowesekiyah Treatment Center has developed unique strategies for delivering alcohol and other drug (AOD) treatment services on the Menominee Indian Reservation in Wisconsin. Program operators have identified the universal factors contributing to AOD problems on the reservation as cultural identity conflicts, generational problems of shame and AOD abuse, and the poverty that is woven into the fabric of the community.

The treatment program utilizes a comprehensive and ongoing evaluation system to determine client needs, gaps in services, and to make changes in services provided. This has resulted in development of numerous support services, including family therapy, parenting, domestic violence therapy for perpetrator and victims, independent living skills, co-dependency and women's therapy groups, child care, and plans for an occupational therapy component. These components are designed to have their own distinct curriculum so that nontreatment clients may participate freely. This service makes the treatment center a more functional agency within the community. Through evaluation, the agency continues to grow in services, effectiveness, and acceptance within the community.

Maehnowesekiyah further addresses problems of stigma and accessibility of treatment through comprehensive outreach and transportation services. Outreach includes a community education component that has directly increased use of treatment services. Maehnowesekiyah also operates youth prevention programs that seek to reduce the impact of generational AOD use, as well as stopping youthful abuse of substances in its early stages. The treatment center is able to address financial needs through active seeking of grants and successful pursuit of a broad client base.

The Maehnowesekiyah Treatment Center is the alcohol and drug abuse treatment and prevention agency for the Menominee Indian Tribe of Wisconsin. The center provides comprehensive services for the AOD treatment needs of the Menominee tribal members and others with unique strategies for efficient service delivery. Maehnowesekiyah (Mano-SAY-key-ah) is a Menominee expression meaning, "We will all feel better." It signifies the cultural sensitivity and goals for community wellness that are incorporated into the existing treatment programs at the Maehnowesekiyah Treatment Center.

Challenges Faced by a Rural Program

Rural program operators such as Maehnowesekiyah face many challenges, including client accessibility to services, the stigma and prejudice surrounding alcohol and drug treatment, and the maintaining of a sufficient client base with its interrelated financial stability. We also have a very important asset, which is knowledge and sensitivity concerning the local community and culture. Treatment providers must use this knowledge if they are to develop a successful program that comprehensively meets the needs of the people they serve. This can be accomplished by continually evaluating and upgrading the services provided, and by pursuing the resources necessary to meet the needs identified.

As written in our philosophy statement:
Maehnowesekiyah Treatment Center affirms that all people—red, white, black, or yellow—experience a unique culture based on their own values, history, and spiritual ways. We are witnesses to the destructive effects Alcohol and Other Drugs have on this culture and tradition. We realize that if abusers are educated on the effects and consequences of Alcohol and Other Drug Abuse, they will recognize that there is a better way of life, and they will desire that better way of life. We believe that a variety of approaches are successful in assisting our clients in attaining this better way of life, and recognize the individuality of our clients in walking down the path to recovery. Maehnowesekiyah strives to provide services to the client with respect, care, and patience. We seek to heal holistically by treating the chemical abuser and the family that the abuse affects.

Comprehensive provision of services and a sensitivity to community attitudes, customs, and beliefs are integral components of a rural treatment program. To provide clients with the tools to maintain a drug-free lifestyle, we must address their social, educational, medical, personal, interpersonal, and psychosocial areas. It is only by addressing the total person that we believe a drug-free lifestyle will be possible for our clients.

Maehnowesekiyah has won accreditation from the national Commission on Accreditation of Rehabilitation Facilities. In a rural area, the lack of options in choosing facilities and services necessitates high standards in available services. Maehnowesekiyah continually seeks to upgrade its services through staff training, program evaluation, and implementation of support services that are unavailable in the community.

The Staff Development Program was implemented in 1991 in cooperation with the University of Wisconsin-Stevens Point and Green Bay to serve the continuing education needs of our AOD staff. The program promotes teamwork among the staff while enhancing individual abilities. The ongoing education program provides continuing education credits for staff who are progressing in personal counseling skills and certification status, and exposes administrative and therapy staff to the operating concepts, problems, and importance of each individual area. The structure of the program has created a sensitivity and appreciation for the contributions of fellow staff and has enhanced staff abilities, motivation, and interpersonal relations. Training includes education on the Menominee culture and tradition to assist non-Native counselors in developing a sensitivity to the culture. It is helpful to the counselors to have this groundwork in order to separate the traditional cultural elements from the behaviors that have been precipitated by years of injury and damage to the culture.

**Ongoing Program Evaluation**

An ongoing system of evaluation is used to determine which services will be provided. These service decisions are based on a systematic process of objective evaluation, data collection, and program monitoring. The internal process evaluation at Maehnowesekiyah includes a weekly administrative review of the program in which counselor coordinators consult with chief administrators and other staff as requested. The counselor coordinators supervise progress on treatment plans and client file entries. Consultants used in this process include a clinical psychologist, who participates in bimonthly client staffing sessions, and the medical director of
the Tribal Clinic, who conducts an assessment review. Additionally, counselor coordinators meet weekly with their respective department staff to discuss program procedures and issues, as well as client progress and changing needs of the individual. All meetings and consultant sessions provide direction for program services and activities, while monitoring the changing needs of the individual and the availability of community services to meet those needs.

The University of Wisconsin–Madison Center for Health Policy and Program Evaluation, a contracted consultant, has developed monitoring forms for a computerized data base system. Intake forms summarize the following:

- Demographic information
- AOD treatment history
- Assessment results
- Criminal justice history
- Mental health treatment history
- Source of referral
- Type of housing
- Source of income
- Primary and secondary drug choice with frequency of use

Client discharge forms document the following information:

- Type and frequency of services provided
- Units of service delivered
- Referrals to outside agencies
- Average time in treatment per client

These data are then entered into a specially designed computer program which has the capacity to provide up-to-date process information and periodic analysis of outcome information. Forms include all grantor reporting requirements.

Clients also complete a discharge survey that asks them to identify their perception of the strengths and gaps in the services provided to them during their course of treatment. This information enters the review process directly through discussion at the weekly administrative meetings and is also documented for further review upon tabulation with a larger number of clients.

Through the evaluation process, Maehnowesekiyah has identified several key problem areas commonly found among patients who present with AOD issues in the Maehnowesekiyah community. Service to these special needs has been responsible for the rapid growth in Maehnowesekiyah treatment programs since 1990. By the system of review already described, we identify client needs and make decisions about how those needs will be met. Since this policy of review was implemented, several dominant areas of client need have emerged, including family relationships and poor parenting practices, co-dependency, homelessness, domestic violence, independent living skills, and vocational rehabilitation. In its years of service to the reservation community, Maehnowesekiyah has identified certain universal factors contributing to the continued problems of alcohol and drug abuse. These include:
- Cultural identity issues
- Widespread generational problems of addiction
- Poverty

These factors must be addressed in order to successfully provide treatment to everyone in need.

**The Maehnowesekiyah Treatment Philosophy**

Maehnowesekiyah's core treatment program is a culturally sensitive adaptation of the Alcoholics Anonymous 12-Step program. The Native American Self-Actualization Process by Sidney A. Stone revolves around the resolution of cultural identity conflicts. Cultural identity conflicts are common among Menominees because of the confusion resulting from their forced relocation, termination, discrimination, and assimilation. Therefore, this method of conflict resolution is a culturally sensitive and appropriate approach.

Treatment concepts focus on the Rational Behavior Therapy (RBT) guidelines, which offer clients a means to think and behave rationally and eventually to solve/resolve their own emotional problems, using their ability to think. Counselors offer this therapy in two ways. First, for the duration of the client's treatment experience, the counselors demonstrate how the therapy works in day-to-day life in addressing the client's daily issues, life problems, etc. Secondly, by using the established 13-unit program that teaches clients very specifically how to manage themselves and their issues, these clients learn a skill they may use long after their treatment is completed. The counselors at Maehnowesekiyah have been trained to use these materials through the ongoing Staff Development Program.

**Conflicts in Individual and Cultural Identity**

The clients of our treatment program are unique in having individual identity conflict issues that arise because they are part of a minority group with varying levels of cultural identity. Our method of approaching and addressing the cultural needs of clients is to assess their cultural position and educate. Using the standard definition of culture to mean "socially transmitted behavior patterns, arts, beliefs, and all other products of human work and thought," we educate the clients as to their traditional and spiritual mores.

Native Americans often enter treatment as very wounded and violated individuals, and they seldom possess the strength necessary to stand up for themselves and/or set boundaries. Past generations of Native Americans were put down for being Indians to the point of becoming instantly ashamed any time they were in the presence of non-Native people. This has become a multigenerational problem, since the perception of shame is passed from parent to child, even though the child may not have experienced shame directly. Consequently, clients often go along with group activities merely because they don't have the courage to decline or do not believe they have the right to. We do not, therefore, expose clients to situations or decisions which demand that they decline a practice possibly universal among their peers, especially when that practice is very much identified with "being an Indian."
All clients come with some degree of cultural identity that falls within a continuum of Native American identity. Education and discussion of what they discern as Indian values, beliefs, and practices helps them to identify their placement on the continuum. Clients begin to understand that they are "traditional" and they do possess "traditional values." This creates within each client a strong sense of pride for who and what they are, as they become better connected to their identity as Indian People.

**Community Denial of Substance Abuse**

The Menominee Indian Reservation has a significant problem with community denial of the substance abuse problem. The widespread problem of addiction within the local Menominee community presents a need to assist clients in seeking or developing a supportive environment for their continued recovery. After generations of AOD abuse, the problems and issues of alcoholism have become ingrained in the culture; these could take generations to remove. Maehnowesekiyah operates under the assumption that we do not have that much time. The ever-present damages from death by injury and illness continue to perpetuate problems associated with grief, denial, and self-destruction. In 1992, 12.4 percent of all hospitalizations were alcohol related. In 1990, 60 percent of all injuries requiring medical attention, including assault and suicide, were also alcohol related.

The reservation itself is considered a high-risk environment for abuse of alcohol and other drugs because of poverty, insufficient housing, and the community acceptance of alcohol and other drug abuse. This is substantiated by statistics on our youth population. A 1992 survey of Menominee youth (Teen Assessment Program) shows that by age 11B12, 49 percent of males and 61 percent of females use alcohol. According to *Healthy People 2000* statistics, the average age of first use on a national level is 13.1 years of age.

**Program Services**

Maehnowesekiyah offers a comprehensive array of services for the Menominee community. These services, described below, include family therapy, parenting, support for children from substance-abusing families, treatment for pregnant and postpartum women, domestic violence therapy for perpetrator and victims, independent living skills, co-dependency and women's therapy groups, child care, and emergency housing and shelter.

**Special Needs of Substance Abusing Families**

Persons in the Menominee community have frequently been raised in an AOD environment and their families are not in recovery; this situation requires intensive reeducation in the family system. In response to this, Maehnowesekiyah has implemented a family therapy component within the treatment program and provides parenting classes to the community at large as well as within the treatment programs. During family therapy, significant others are brought into the treatment plan. Families discuss the effects of co-dependency, grief, and healing as they recognize family roles and age- and sex-appropriate responsibilities. They discuss family rules, communication within the family, and family contracts. During their treatment and recovery, they learn reorganization of the whole family and new expressions of love and anger as well as
sober family fun. Tools used in this process include role playing, guided and self-directed imagery, play therapy, and transactional analysis focusing on inner parent, adult, and child interactions. Family groups are flexible, with priority given to issues requested by the family. Additionally, clients receive education and therapy in healthy relationships, sexuality, and health education.

The children of substance abusers have special needs which, if unattended, create an even higher risk for substance abuse problems in their adult life. It has been shown that adolescent children who have first- and second-degree alcoholic relatives have higher rates of alcohol and other drug use, begin using gateway drugs at an earlier age, and have more AOD problems.

**Provision of Child Care Services**

Child care services are available for all outpatient treatment programs and for the new treatment program for pregnant and postpartum women who are in treatment with their children. Children of treatment clientele benefit from improved family structure, day care, and school services that promote their physical, social, and cognitive development. The Child Care program follows a daily plan for development of the children's fine and gross motor skills as well as socialization activities. Our day care program is working toward licensure as a day care provider.

Implementation and review of the child care services has led to upgrading of staff qualifications in the program. The Child Development Coordinator has a B.S.E. with early childhood certification. This staff person keeps individual files on the children in our care and notes any unusual behaviors as well as changes in behaviors. The coordinator participates in staffing sessions with the child's parent(s) and assigned counselor; in these sessions, they discuss improvements made by the child and possible activities to meet the child's needs. Services have been expanded to include therapy groups for the children, enabling them to discuss the changes that occur as their parents progress through the treatment program. These services will increase the children's resiliency to AODA and enhance their adjustment in social and academic environments.

**Parenting Education**

Parenting education is available to clients in treatment as a tool for strengthening a lifestyle in recovery. Parents discuss their priorities in communicating ideas and lifestyles to their children and learn behavior management techniques that emphasize concepts of praise, encouragement, and consistency. The sessions explore realistic expectations for the child as well as the parent, and emphasize the impact of role modeling for the children. Upon our solicitation, the Tribal Courts are using our Parenting I curriculum of 16 sessions as a tool in sentencing cases of child abuse and neglect.

**Therapy for Domestic Violence**

Our domestic violence program also demonstrates our continual refining of services. To meet the needs of our predominantly male clientele, we initially addressed issues of anger and violence within the treatment program. Tribal Court officials inquired about the possibility of a prescribed
course of domestic violence therapy which could be used for sentencing purposes by the court when adjudicating perpetrators of domestic violence. We structured the services to provide an open-ended course of eight therapy sessions.

Expanding treatment services to women through the Residential Treatment Program for Pregnant and Postpartum Women caused us to develop a similar therapy group for victims. Implementing this new service quickly led us to the realization that the women shared many of the perpetrator issues. We now operate a single domestic violence group, with men and women dividing into separate groups for the latter half of each session to discuss their gender issues.

**Women's and Youth Groups**

The themes of relationship, sexuality, and cultural identity are also presented to women's discussion groups, co-dependency groups, and the youth prevention/intervention groups managed by Maehnowesekiyah prevention programs. The women's group is a nonthreatening discussion group utilized by women from the community who need support in pursuing positive solutions to problems of daily living. The co-dependency group helps women involved in a relationship with an alcoholic, women who may have an alcohol or drug problem of their own, or others who simply need support in taking independent action on their own behalf. Co-dependency and women's groups are open to the general public. Shelter clients frequently identify these issues as problems areas in their own lives.

**Emergency Housing and Shelter**

Problems with housing have been addressed by the creation and funding of an Emergency Shelter/Transitional Housing Program. Over the past 3 years, 43 percent of our residential treatment clients had no independent housing arrangement at the time they entered treatment. Upon completion of treatment, these same clients frequently accept shared housing with families and friends, linking them to the high prevalence of abuse of alcohol and other drugs in the community. The dysfunctional environments to which these clients frequently returned were interfering with successful recovery.

To address this need, a small start-up grant for Emergency Shelter/Transitional Housing was received in 1992. This has developed into a valuable resource for supportive service and treatment needs. Clients may use the shelter when they leave treatment, and it also stands as a separate service available to community members. Community members seeking shelter are expected to pursue a plan for resolving the problems that led to their homelessness and are frequently referred to the parenting, domestic violence, and/or co-dependency groups. They are encouraged to seek employment or further their education and, when appropriate, an AOD assessment is recommended. Statistics show that 80 percent of the shelter clientele have AOD abuse issues.

**Independent Living Skills**

Independent living skills are an important component of the treatment program, because these skills serve to reduce the stress in a recovery lifestyle. The social worker assists the clients on a
one-to-one basis with money management, basic cooking and shopping skills, health and hygiene, transportation, job seeking/keeping skills, resources, social skills, legal issues, and overcoming housing problems.

While participating in these program areas, the client is making plans for discharge: housing applications, budgeting, and applications for financial assistance as necessary. Housing counseling is conducted with the families regarding renter rights and responsibilities, where to find rental opportunities, and budgeting the money to set up housing.

**Education and Employment**

Those who choose to further their education receive assistance through a staff social worker. This staff person works with the local technical school counselor (includes GED services), university admissions staff, and the local Menominee Community College to help the client pursue his or her career choice. Clients seeking employment are assisted with "personal data sheets" and with the job search process.

**Strategies for Providing Comprehensive Services in Rural Areas**

Our one-step approach to treatment and recovery needs is accomplished by referral and followup to available services, or through development and provision of the needed services. Efforts to meet the special identified needs have resulted in creation of several independent programs serving clients in treatment, including parenting education, family therapy, co-dependency, domestic violence therapy for perpetrators as well as victims, an emergency and transitional housing program, and transportation and child care services.

Provision of this range of services in a rural setting requires unique strategies for efficient service delivery. As compared with urban programs, the volume of services must be maintained by a limited number of staff for small numbers of clients. In order to make these services viable, we have linked them directly to the community. When possible, the supportive services developed to serve the clients offer a distinct curriculum that can also serve community members directly. Clients of the transitional housing program participate in the co-dependency, parenting, and women's groups, as well as in treatment programs. Tribal Courts use parenting and domestic violence groups for sentencing perpetrators of domestic abuse or child abuse and neglect. The parenting program is particularly active in recruiting community members for this education component.

The remote nature of a rural community creates greater challenges for treatment providers when they try to address problems concerning the stigma of treatment and difficulties in accessing treatment services. Because of the close-knit social structure that makes up these communities, the stigma and prejudice that surround AOD treatment can effectively stifle the provision of treatment services. Maehnowesekiyah is breaking the barriers to acceptance of treatment services through outreach and through providing related educational services within the community. The
administrative and counseling staff team up to present informative sessions to staff and supervisors at area businesses and service agencies. These sessions cover such topics as:

- AOD symptoms as they present in the workplace
- Use of the Tribal Employee Assistance Program (EAP)
- General effects of AOD abuse on the community, youth, and families

These services have had a direct impact on utilization of the EAP, doubling the use of EAP treatment services in the first three quarters of FY94 as compared to all of FY93. The number of clients served by the EAP in FY93 (13) should not be underrated. This figure is quite respectable, since it represents the startup period for a functional EAP service that was meeting clients at all levels of need, not just the most desperate of situations.

**Prevention/Education Services**

As our education services became known, they inspired new requests for services specific to AOD-related problems at individual agencies, including client interview methods for problem areas and techniques for nonjudgmental enforcement of regulations. Maehnowesekiyah also responded to a request from the school system to provide options to expulsion for students who were disruptive in the classroom and/or at risk of failure. Although youth are referred because of behavior problems, a common thread among the majority of these students is use of alcohol and drugs. By the students’ own admission, use of chemicals is contributing to their school adjustment problems.

**ATOD education.**

Through the program established, Maehnowesekiyah serves the alcohol, tobacco, and other drug (ATOD) health education and prevention needs of troubled Menominee youths referred to our services. We address three areas in this special component of the prevention programs, including:

- Basic ATOD education
- Strengthening the individual
- Assisting students to identify their support systems

ATOD education includes the physical and emotional effects of alcohol and drugs on the person's educational, family, and social environments. Individuals are strengthened as counselors explore the self-concept/self-esteem issues in AOD use/abuse and instruct youth in communicating their feelings and practicing assertiveness. This education enables youths to be more cognizant of factors in their family and social environment that may contribute to their potential for AOD problems, including family AOD abuse issues and social associations.

**Counseling for Troubled Youth.**

Identifying their support systems strengthens the individual, because this makes secondary support available. Individuals can be instructed to reason, look at available choices, and make
positive decisions in their own best interests. Because some of these decisions may cause
difficulty in a person's life situation (such as difficulty with friendships, peers, and/or family),
counselors also help students to identify their support systems. For youth who are referred, our
adolescent counselor provides counseling services on a one-to-one basis and also for family
sessions.

The initial result of this intervention with youth showed fewer referrals to the office for
participating students. This evaluative information is very encouraging. We have been requested
to expand the services into lower grade levels, and also to assist with classroom ATOD
education. Our community involvement on the prevention level establishes a direct link to early
referral and intervention in an alcohol or drug abuse situation.

Our prevention program received State certification this past year as a provider of ATOD
prevention services. This is based on comprehensive coverage of all alcohol, tobacco, drug, and
mental health education activities. Safety, wellness, sexuality, culture, community, adolescent
development, and family participation are also required elements of this education program.
Activities must also be presented using age-appropriate materials. The prevention program
utilizes three full-time staff with supervision provided by a certified AOD counselor and our
consulting clinical psychologist. Maehnowesekiyah has also incorporated the prevention
programs into its evaluation system.

The existing prevention programs at Maehnowesekiyah are funded by State and Tribal funds,
with added support from the Indian Health Service. The Testing Realities and Investigating
Lifestyles (T.R.A.I.L.S.) and adolescent health programs reach children aged 5 to 18 and provide
health education (including AOD awareness) and alternative recreational activities. They operate
their own youth group meetings in the four communities on the Reservation and also provide
similar services to the Latch-Key Program within the school district.

**New Volunteer Activities**

This past year, Maehnowesekiyah developed the structure for a volunteer program that is
beginning to accumulate volunteer hours. This activity further connects us to the community and
provides an additional avenue for clients to identify positive activities for leisure time.
Volunteers assist with planning and preparation for community events, food service, and as
recovery witnesses.

**Facing Barriers of Transportation and Financing**

Maehnowesekiyah is addressing two distinct barriers to receiving treatment in this impoverished
rural area—transportation and financing. Grant funds provide supplemental operating costs
necessary to maintain vans that transport clients to treatment groups. Maehnowesekiyah provides
transportation from the adjacent reservation communities and extended area for clients
participating in support groups or continuing with other group treatment services. Clients
schedule their individual therapy sessions in a manner that allows them to utilize Menominee
public transportation. We also arrange for area medical transport services for our clients assessed
as needing inpatient services. For the present, successful grant seeking and tribal support have alleviated the limitations that poverty imposes on our ability to provide treatment to individuals.

While we are able to collect third party reimbursement for services, the great extent of poverty in our community—combined with the numbers who are ineligible for medical assistance—demands that we find additional financial support for our programs. Otherwise, we cannot treat all who are in need. Last year we "wrote off" $947,000 in treatment services, but were able to maintain our momentum through diverse grant support at the Federal, State, and local levels. These sources include the Indian Health Service, the Center for Substance Abuse Treatment (CSAT), the Administration for Children and Families, four programs from the State Department of Health and Human Services, and the Menominee Tribe.

Diversity in client resources is another element in creating and maintaining stability in treatment services. A treatment center such as Maehnowesekiyah, dedicated to serving Native Americans, must also be creative in this approach. Through establishing itself as a Community Corrections Facility, Maehnowesekiyah has entered into service contracts with the Federal Bureau of Prisons. We accept clients of prisoner status through the Federal Bureau of Prisons, as well as State probation and parole clients who have AOD issues. Maehnowesekiyah maintains service contracts with the Veterans Administration for readjustment services related to posttraumatic stress disorder. We serve the Wisconsin Probation and Parole office with urinalysis testing services, and in turn receive referrals for treatment services. The Indian Health Service assists with intertribal referrals, and we also have service agreements with two neighboring tribes for residential treatment services.

The identification of community needs, combined with the achievement of top quality treatment services, has also enabled Maehnowesekiyah to receive grant funding for a new Residential Treatment Program for Pregnant and Postpartum Women funded through CSAT. This major component of our treatment funding would not have been possible without the knowledge of community needs and dedication to the achievement of high standards of treatment. CSAT has encouraged us to plan for an expanded program in FY95, by doubling our service capacity to pregnant and postpartum women.

The holistic array of services provided by Maehnowesekiyah assure the best chance for recovery that can be provided to our rural Native American population. Comprehensive provision of services and community support, together with effective blending of community needs with program needs and services, has brought about an increasing level of acceptance by the community for the Treatment Center and the healing community that it represents. In so doing, the community residents have gained an increased understanding of the commonalities between their personal issues and those who seek treatment for addictions. Reducing the barriers of treatment stigma through community education and interaction has made Maehnowesekiyah a dynamic force for change on the Menominee Indian Reservation.

**Plans for the Future**

Maehnowesekiyah has no plans for leveling off the growth in program services. The unprecedented level of tribal support has provided this agency with a new $1.6 million office and
therapy complex. By renovating our vacated office space, we are using this opportunity to expand the transitional housing units and also to serve the expansion of the Pregnant and Postpartum Women program. Maehnowesekiyah is pursuing available grant resources for assistance in construction of additional transitional facilities, and further support for the increase in supportive services that will be required of an expanded program.

We are currently planning an occupational therapy component for clients in all treatment programs. Staff training has been funded and scheduled for this fall. The role of occupational therapy can further assist clients to realize how their self-image has been affected by substance abuse, how the pattern of substance abuse has affected and even controlled their daily routines, and how to use the life skills they identify to support their recovery.

The treatment center has just contracted with an M.D. addictionologist from the Milwaukee area to serve as a medical consultant. The doctor will provide inservice training to staff and consult with our present medical director and clinical psychologist on a new area of health care that will promote physical healing from the damages of addictions. It is expected that these new efforts will enhance the recovery from addictions by addressing the physical needs of withdrawal, the nutritional losses suffered during the addiction, and the general physical condition.

The broad range of support therapy, services, and education offered at Maehnowesekiyah promotes wellness and reintegration skills as it provides clients with the needed strength to pursue recovery or prevent addictions. The holistic treatment program continues to evaluate program approaches with a focus on the client and his or her treatment needs. Maehnowesekiyah is constantly evolving, and will continue to do so until the alcohol and drug problem in our community is in hand. The energy created by the changes occurring in this community is self-perpetuating and continues to reward further effort at treatment improvement.

**Intensive Outpatient Vocational Rehabilitation Program**

Prevention Program Supervisor  
Fayette County Drug and Alcohol Commission, Inc.  
Uniontown, Pennsylvania
Abstract

This innovative program—a first for Pennsylvania—is being piloted in rural and economically depressed Fayette County. The intensive nature of the program is expected to have a greater impact on program participants than standard outpatient programs. Through this program, participants examine holistically the complicated issues of the drug and alcohol recovery process that can lead to competitive employment. These include physical, mental, and spiritual issues; emotional issues; family and relationship issues; and vocational issues.

In today's world, programs such as Intensive Outpatient Vocational Rehabilitation Program (IOVRP) must be developed. Not only are these multi-sponsored programs economically necessary, but they are better equipped to handle the recovering client as a whole person. Such programs not only help to avoid duplication of services, but also allow clients to receive needed services in a more organized way. As clients progress through various stages of the IOVRP, their feedback has remained consistently positive. Seventy-five percent of participants who have completed or remained in the IOVRP have achieved measurable success.

The Intensive Outpatient Vocational Rehabilitation Program (IOVRP) in Fayette County, Pennsylvania is designed to treat recovering clients in a holistic way. The program has the following major purposes:

- To provide a vocationally based intensive outpatient treatment program for alcoholics and other addicts while developing their work adjustment/readjustment skills
- To prepare recovering addicts to enter/reenter the workplace
- To give recovering addicts the opportunity to reenter the workplace with the extra support of the program staff and thereby increase the chances of a successful experience
- To give program participants, who are recovering residents of an economically depressed area, a sense of hope for the future

Program Overview

Rural Fayette County, Pennsylvania, has fallen deeper and deeper into economic depression as the coal and steel industries that once sustained it continue in a downward spiral. A sense of oppression has settled glumly over the county's 147,000 inhabitants. Oppression's companions—loss of self-esteem, depression, and alcohol and other drug use—are growing concerns. A heavy-drinking area for years (at 6 percent, only 9 of Pennsylvania's 67 counties rank higher), crack cocaine has hit Fayette County hard.

The delivery of human services has always been a challenge here. Lying just north of the West Virginia border in the northern tip of the Appalachian Mountains, 21 percent of Fayette County's citizens live below the poverty level. Transportation is one of the bigger hurdles, with mass transit practically nonexistent. Concerns like these keep human services agencies talking. In the summer of 1993, the Fayette County Drug and Alcohol Commission, Inc. and the Washington, Pennsylvania, District Office of Vocational Rehabilitation (OVR) started talking about how they could best serve clients who needed the services of both agencies. By joining forces with yet
another human services agency, Goodwill Industries, it was possible to develop an innovative pilot program which is now underway. The Intensive Outpatient Vocational Rehabilitation Program (IOVRP) was designed to provide a vocationally based program of recovery for alcoholics and other addicts as they prepare to enter or reenter the workplace.

This innovative program is a first for Pennsylvania and is being piloted in rural and economically depressed Fayette County. The intensive nature of the program is expected to have a greater impact on program participants than standard outpatient programs. The program helps participants examine holistically the complicated issues of the drug and alcohol recovery process leading to competitive employment. These include physical, emotional, and spiritual issues; family and relationship issues; and vocational issues.

The IOVRP is housed in Goodwill's shelter workshop located just outside the county seat of Uniontown's business district and is, at this point, funded by the OVR. In this structured environment, program participants follow a daily schedule that includes alcohol and other drug education, especially as it relates to their recovery and gaining employment; group therapy; individual therapy; and personal work adjustment training (PWAT).

**Content/Methods**

**Phase I**

Phase I of the IOVRP consists of several segments that constitute what is generally described as an intensive outpatient or partial hospitalization program. Each group is limited to approximately 10 members. This affords participants the amount and type of attention they need and ample opportunity for participation. The overall schedule design for the IOVRP is shown in table

**Education Sessions**

Although IOVRP participants are streetwise, they often operate under a certain naiveté regarding alcohol and other drugs. They also may continue to be in some denial or to lack understanding regarding the extent of the effect their usage has had on their lives. The education sessions are designed to give accurate, up-to-date information about alcohol and other drugs, addiction, and recovery issues.

Examples of lesson topics are:

- Physiological effects of alcohol and other drugs
- Genetic factors and progression of the disease of addiction
- Coping skills and stress management
- Developing support systems
- Life management skills for maintaining sobriety
- Family and relationship issues
- Communication skills
A certified prevention specialist who is employed by the Drug and Alcohol Commission conducts the education sessions in an informal classroom manner. Varying instructional and experiential techniques are used to accommodate different learning styles and ability levels. At every juncture, care is taken to include the importance of these topics and how they will come into play in the workplace.

**Group Therapy**

Group therapy aids participants in learning to apply the concepts taught in the education sessions to their lives. Participants also benefit from the feedback and collective wisdom of the group itself. Group is planned to allow interaction and to deal with both individual and group issues. Often there is a topic for the day that has been agreed upon by the group in advance.

**Individual Therapy**

Individual therapy provides individualized addiction treatment for program participants. It gives an opportunity to deal with recovery and other issues on a more personal level, one to one with a trained drug and alcohol therapist. The therapist also works with each individual to establish personal goals that he or she hopes to achieve while in the program. These particular goals are usually in areas such as personal growth, family or relationship issues, solidifying the recovery process, or relapse prevention. A certified addictions counselor who is employed by the Drug and Alcohol Commission conducts both the group and individual therapy sessions.

**Personal/Work Adjustment Training (PWAT)**

Personal/Work Adjustment Training (PWAT) is where IOVRP participants spend most of their time. It is intended to provide an atmosphere where behaviors that are unacceptable or inappropriate for the workplace can be examined and modified. PWAT is also an opportunity for both social and vocational training as participants work alongside others who are having similar problems and who are working toward the same goal—employment.

Goodwill Industries has appointed a program specialist who is responsible for the overall onsite management of the IOVRP and who facilitates the majority of the PWAT.

*A Practicum Approach.* As participants enter phase I of IOVRP, they are encouraged to view the program as a job. They are required to report they will be out in the event of illness or emergency just as they would if they were employed. They must also make arrangements to handle personal business, such as doctor or other appointments, in advance. Keeping a regular schedule is, in and of itself, a challenge for program participants; some of whom have reached their mid-thirties and never held a job. In their active addiction, they rarely had to be anywhere at a certain time and attendance itself is an adjustment for them. However, these are adjustments that must be made if they hope to achieve and maintain competitive employment.

In addition to preparing these recovering addicts for the responsibility of employment, common workplace policies are reviewed, highlighting such current workplace issues as sexual
harassment. There are opportunities to hone new skills, such as strategies for managing stress and anger.

Because the program is located within Goodwill Industries shelter workshop and retail operation, participants have the opportunity to work at different job stations. There they can practice getting along with coworkers and supervisors, learning to follow a schedule and instructions, and coping with situations that may arise in the workplace.

<table>
<thead>
<tr>
<th>Table 1. Schedule Design</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday through Friday—8:30 a.m. to 4:30 p.m.</strong></td>
</tr>
<tr>
<td><strong>Monday and Wednesday</strong></td>
</tr>
<tr>
<td>8:30 – 9:30</td>
</tr>
<tr>
<td>9:30 – 9:45</td>
</tr>
<tr>
<td>9:45 – 11:30</td>
</tr>
<tr>
<td>11:30 – 1:00</td>
</tr>
<tr>
<td>1:00 – 4:30</td>
</tr>
<tr>
<td><strong>Tuesday and Thursday</strong></td>
</tr>
<tr>
<td>8:30 – 4:30</td>
</tr>
<tr>
<td><strong>Friday</strong></td>
</tr>
<tr>
<td>8:30 – 9:00</td>
</tr>
<tr>
<td>9:00 – 10:00</td>
</tr>
<tr>
<td>10:00 – 10:15</td>
</tr>
<tr>
<td>10:15 – 11:30</td>
</tr>
<tr>
<td>11:30 – 1:00</td>
</tr>
<tr>
<td>1:00 – 4:30</td>
</tr>
</tbody>
</table>

Support from Staff. It is significant to understand that these opportunities occur while participants have the extra support of the program staff. Problems, questions, and concerns are thoroughly processed. Staff are careful to provide positive feedback along with noting any areas that are in need of improvement.

PWAT also provides an opportunity for program members to set personal employment goals. They develop a résumé and are helped to identify obstacles to getting or holding a job. They may need to complete a GED, renew or apply for a driver's license, make plans to purchase clothing
or a car, or look for housing nearer to job opportunities. The Goodwill program specialist assists them in making these arrangements.

Group members participate in mock interviews, giving each other feedback and suggestions. Actual interviews have also been arranged during phase II.

**Family Day**

Based on the understanding of addiction as a family disease, a Family Day is held during the fifth week of the IOVRP's initial phase. Participants are strongly encouraged to bring an adult family member that day. An introduction and overview of the program is given, and both participants and family members have the opportunity to speak. Group members review some of the subject areas that have been covered and skills they have learned. A separate session is then held for family members during which they are encouraged to learn more about the effects of addiction on them and to learn about support groups and counseling.

**Support Group Meetings**

An important part of IOVRP has been the requirement that participants attend regular support group meetings. Because of Goodwill's proximity to a local recovery club, the group can attend lunchtime meetings together. Each participant is required to bring documentation of attendance at weekend support group meetings.

**Staffings**

Staffings are held individually with each client during the third and sixth weeks of the program. Staff from each agency are present and, along with the client, they review progress towards achievement of goals, recommend changes/improvements, and highlight strengths.

**Phase II**

This phase of the IOVRP includes a participant needs assessment and review of goals established during the first phase of the program. Job development, placement, job site training, and sustained job-site followup are also provided by the Goodwill program specialist and the Office of Vocational Rehabilitation (OVR).

*Temporary or Supported Employment and Continuing Care*

Participants continue as clients of the Drug and Alcohol Commission and are provided with continuing care groups and individual therapy on-site at the Goodwill facility for up to 4 months. After that, they may continue in therapy at the Drug and Alcohol Commission offices for as long as is therapeutically necessary.

**Findings and Recommendations**
The IOVRP is currently in its fifth cycle. In the first four groups, 27 participants completed the program, while 7 dropped out.

**Initial Positive Results**

Preliminary results are positive. Although each participant started at different points in terms of sobriety, maturity, and enthusiasm, each has achieved some measurable and/or observable growth. Several have actually flourished in the supportive environment.

Because of the ongoing assessment built into the program, we have uncovered underlying issues that may be compromising a client's recovery. In these cases, referrals for other services have been made and, in several instances, referrals to inpatient settings were indicated. This circumstance was viewed in a positive light by program staff, because clients were able to recognize the need for even more in-depth care and were able to contact needed resources (including IOVRP staff) as a result of their experience in the IOVRP.

**Service Added Based on Program Experience**

The continuing care groups were added at the completion of the fourth cycle. Program staff determined that some members of earlier groups floundered with only the individual counseling that was being offered during phase II. This indicates that perhaps group participants need to be "weaned" from the intensive support they receive during the initial phase of the program.

One weakness in the program was recognized as a pattern by the end of the third cycle that of the care of IOVRP participants as a community. Probably as a result of their similar lifestyles as addicts and their experience with support groups, most participants were familiar with group process. Add to that the element of rural and small town inhabitants often being acquainted and the amount of time spent together in IOVRP, and the result is that our new groups seem to mesh rather quickly. A mechanism was needed for the staff and participants to interact as a community.

To this end, the concept of community will be enhanced during the fifth cycle and, borrowing an idea from inpatient settings, a "community meeting" will be held weekly. This will ensure that a forum exists where participants can raise concerns, discuss problem areas, ask questions, plan, make suggestions, etc. It will also further the point that the staff work as a team, even though they represent different agencies. Staff will avoid using session time to deal with issues that are not necessarily appropriate for that setting. A mayor who can act as a spokesperson for the group will be appointed by the staff. The mayor will change periodically, with changes generally made for therapeutic reasons.

**Other Lessons Learned**

Because of addiction and the lifestyle they have led, most participants struggle with a lack of self-esteem and negative self-image. They often fail to recognize their strengths and skills. On several occasions, it has been near the end of phase I before staff have discovered that a participant holds a specialized job certification or license, such as plumber or forklift operator.
Because such information can be important to job development, staff have learned to ask specific questions regarding this subject early on in the program. They then work with participants to identify job-related as well as personal strengths.

Staff have also recognized participants' goal setting as an area that needs improvement. Group members can set goals but cannot identify the steps necessary to achieve that goal. The addictive "I want it and I want it now" thinking mode seems to blur the vision of the step-by-step process to achievement. Oddly enough, most participants can understand and utilize a 12-Step approach in recovery, but fail to make that connection in other areas of their lives. During the fifth cycle, the staff will work with participants more closely to establish realistic goals both for career and personal life, and will assist participants in identifying the steps/process to reach these goals.

**Importance of Staff**

And finally, but perhaps most important to assure the success of the IOVRP, is the selection of staff. The representation and interaction of three different agencies can be a delicate matter. Fayette County, rural as it is, has achieved communication among its human services agencies that its urban counterparts can only imagine. This does not mean that all is consanguinity—but there is an air of cooperation. Staff involved in such cooperative ventures as the IOVRP must believe that such ventures can work. A staff member who is simply going through the motions can undermine the success of the program. Insincerity is quickly recognized by group members.

Obviously, staff involved in such programs must possess better than average interpersonal and organizational skills. The best therapist may not possess the skills to iron out programmatic details that involve two other agencies. At any rate, perhaps the most important ingredient to the IOVRP's apparent success thus far is the communication that has developed among the three agencies involved. Since the program is still in its pilot year, there have been the basic startup issues to work out, in addition to the usual complications of running such a program. The staff has worked as a team, each respecting the others' areas of expertise. Participants' problem areas as well as achievements are thoroughly reviewed by all four staff members; this is discussed with new group members on the first day and release forms are signed.

**The Record of Success**

Of course, the bottom line question is, Has this program met its goals? To date, responses on participant evaluations have been positive—most are pleasantly surprised at the amount of recovery work they get to do. Some highlights follow:

- A participant who had maintained employment and entered IOVRP via an employee assistance program endured a difficult workplace incident with self-assurance and without relapse. (In her case, regular workplace visits by the Goodwill program specialist were substituted for the PWAT portion of the program.)
- One group member who had a college degree was hired by Goodwill and has already received a promotion.
- A participant who had completed phase I relapsed, became suicidal, and called IOVRP; staff were able to intervene.
One participant was referred to a specialized inpatient program for sexual abuse issues and is now employed.

Overall, of the 26 persons who completed IOVRP, 12 are now in permanent jobs, 7 are in temporary employment, and 2 have entered college. To the best of our knowledge, all 21 of these are maintaining sobriety. Three of the remaining six have dropped out of the program; the others are at various stages of being in between programs, jobs, and sobriety.

This means that over 75 percent of participants who completed or have remained in the IOVRP have achieved the stated goal of becoming employed or have moved on to further their education. Initial data indicate, therefore, that the IOVRP is a workable formula for assisting recovering addicts in maintaining sobriety and reentering the competitive employment market.