

Interventions with a Reasonable Chance of Supporting Change

For: Alcohol and Other Drug Addiction

Excerpted from National Institute for Drug Abuse, NIDA InfoFacts: Treatment Approaches for Drug Addiction. <http://www.nida.nih.gov/infofacts/treatmeth.html> 12/20/06.

According to the National Institute of Drug Abuse, drug addiction is a complex but treatable brain disease. It is characterized by compulsive drug craving, seeking, and use that persist even in the face of severe adverse consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence. As a chronic, recurring illness, addiction may require repeated treatments to increase the intervals between relapses and diminish their intensity, until abstinence is achieved. Through treatment tailored to individual needs, people with drug addiction can recover and lead productive lives.

The ultimate goal of drug addiction treatment is to enable an individual to achieve lasting abstinence, but the immediate goals are to reduce drug abuse, improve the patient's ability to function, and minimize the medical and social complications of drug abuse and addiction.

Scientific research since the mid-1970s shows that treatment works. Research from the Substance Abuse and Mental Health Services Administration suggests that treatment can cut drug abuse in half, reduce criminal activity up to 80 percent, and reduce arrests up to 64 percent.* Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. Studies show that treatment does not have to be voluntary to be effective.

Based on research, key principles have been identified that should form the basis of any effective treatment program:

- No single treatment is appropriate for all individuals.
- Treatment needs to be available when the individual is willing to enter.
- Medical management of withdrawal syndrome is only the first stage of addiction treatment and by itself does little to change long-term drug use.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The recommended treatment period is three months (90 days). In practice, this is often achieved by enrolling in consecutive treatment modalities (e.g., intensive outpatient followed by regular outpatient).

- Counseling and other behavioral therapies are critical components of virtually all effective treatments for addiction.
- For certain types of disorders, medications are an important element of treatment, especially when combined with counseling and other behavioral therapies.
- As is the case with other chronic, relapsing diseases, recovery from drug addiction can be a long-term process and typically requires multiple episodes of treatment, including "booster" sessions and other forms of continuing care.
- Effective treatment attends to multiple needs of the individual, not just his or her drug addiction.
- Addicted or drug-abusing individuals with coexisting mental disorders (dual diagnosis) should have both disorders treated in an integrated way.

Effective Treatment Approaches

Medication and behavioral therapy, alone or in combination, are aspects of an overall therapeutic process that often begins with detoxification, followed by treatment and relapse prevention. Easing withdrawal symptoms can be important in the initiation of treatment; preventing relapse is necessary for maintaining its effects. Sometimes, as with other chronic conditions, episodes of relapse may require a return to prior treatment components.

Medications can be used to help with different aspects of the treatment process:

Withdrawal: Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted withdrawal is not in itself "treatment"—it is only the first step in the treatment process. Patients who go through medically assisted withdrawal but do not receive any further treatment show drug abuse patterns similar to those who were never treated.

Treatment: Medications can be used to help re-establish normal brain function and to prevent relapse and diminish cravings throughout the treatment process. Currently, there are medications for opioid (heroin, morphine) and tobacco (nicotine) addiction, and are developing others for treating stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction. Methadone and buprenorphine are effective medications for the treatment of opiate addiction. Acting on the same targets in the brain as heroin and morphine, these medications block the drug's effects, suppress withdrawal symptoms, and relieve craving for the drug. This helps patients to disengage from drug-seeking and related criminal behavior and be more receptive to behavioral treatments.

Behavioral treatments help patients engage in the treatment process, modify their attitudes and behaviors related to drug abuse, and increase healthy life skills. Behavioral treatments can also enhance the effectiveness of medications and help people stay in treatment longer.

Outpatient behavioral treatment encompasses a wide variety of programs for patients who visit a clinic at regular intervals. Most of the programs involve individual or group drug counseling. Some programs also offer other forms of behavioral treatment such as:

- Cognitive Behavioral Therapy, which seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.
- Multidimensional Family Therapy, which addresses a range of influences on the drug abuse patterns of adolescents and is designed for them and their families.
- Motivational Interviewing, which capitalizes on the readiness of individuals to change their behavior and enter treatment.
- Motivational Incentives (contingency management), which uses positive reinforcement to encourage abstinence from drugs.

Residential treatment programs can also be very effective, especially for those with more severe problems. For example, therapeutic communities (TCs) are highly structured programs in which patients remain at a residence, typically for 6 to 12 months. Patients in TCs may include those with relatively long histories of drug addiction, involvement in serious criminal activities, and seriously impaired social functioning. TCs are now also being designed to accommodate the needs of women who are pregnant or have children. The focus of the TC is on the re-socialization of the patient to a drug-free, crime-free lifestyle.

The role of Social Support in Substance Abuse Treatment (excerpted from Substance-Abusing Child Welfare Parents: Treatment and Child Placement Outcomes, Gregoire, Kathryn A. and Schultz, Delray J., *Child Welfare*; Jul/Aug2001, Vol. 80 Issue 4)

Family and friends influence the decisions of persons with substance abuse problems to get help, complete treatment, and maintain sobriety. A study of people who had recently entered outpatient substance abuse treatment or Alcoholics Anonymous found that the groups who sought help had more encouragement to seek help and less encouragement to drink from family and friends (George & Tucker, 1996).

Men are more likely to get support for treatment and recovery than are women; women are more likely to receive opposition to treatment from family, spouses, paramours, and friends than are men (Beckman & Amaro, 1986; Kane-Cavaiola & Rullo-Cooney, 1991; Reed, 1987).

In Gregoire and Schultz's study of 167 child welfare clients referred for substance abuse assessment, thirty-five (21.0%) clients were described as having significant others who

supported the substance abuse assessment and treatment; 132 (79.0%) did not have the support of significant others. Further analysis of the non-supportive significant others revealed that 61 (36.5%) of the 167 clients had neutral significant others, and 71 (42.5%) had opposing significant others.

Significant others' support was positively associated with assessment completion (27.8% v. 5.8%) and treatment completion (33.3% v. 17.0%). Sobriety was also associated with significant others' support (43.6% v. 11.6%).

Significant others' support emerged as having a strong relationship with treatment and custody outcomes. Gender differences existed, with females less likely to receive support than males. Concurrently, females were also more likely than were males to have substance-abusing spouses or paramours, which may in part account for this lack of support. These women were also younger and had lower incomes, increasing their vulnerability to remaining with these non-supportive men.

Strategies that appear to hold promise require shifting the focus from the substance-abusing parent to the total family context, including significant others (Magura & Lauder, 1996), and the provision of ongoing support services for clients and their families in recovery. According to Finkelstein (1994), the role of significant others must be recognized if substance abuse interventions are to be successful and recovery is to be maintained. Caseworkers should assess the needs and roles of significant others before any intervention is done with addicted persons. More than half of the substance-abusing clients in Gregoire's and Schultz's study were involved with someone who had drug and alcohol problems. Significant others are not likely to provide support for someone else's recovery until they have committed to their own recovery.

Given the obstacles to recovery and the power of addiction, clients and their significant others need multiple sources of support. In the early stages of recovery, child welfare caseworkers, substance abuse professional and paraprofessional treatment personnel, and other recovering people who are part of aftercare programs and 12-step groups are in key positions to provide support. Caseworkers can increase the likelihood of recovery for addicted persons and their families by making referrals to inpatient and outpatient treatment programs that provide family counseling (Rotunda & O'Farrell, 1997)/

To assist clients with ongoing recovery, workers can strengthen existing support systems and link clients with new ones. Single parents or those with oppositional partners especially benefit from formal programs. Parenting classes and groups, particularly those designed for persons in recovery, offer support as well as education. Often, faith-based organizations can address both the spiritual and social needs of clients in a safe environment. Former substance-abusing clients who have successfully integrated into the community are able to serve child welfare families as paraprofessionals, offering hope and modeling recovery.

Family-Centered Substance Abuse Treatment Programs

Families in which one or both primary caregivers is chemically dependent typically face challenges in a number of domains, including economic, legal, and medical. Mothers report concerns about their children's health, behavior, and education, as well as the need for child care in order to participate in substance abuse treatment. Research shows that programs that address multiple family needs ("one stop shopping") report higher success rates in terms of length of stay and achievement of abstinence. Offering benefits to the children of participants may work in three ways: removing barriers to participation (i.e., lack of child care), helping parents face their guilt about the effects of their substance abuse on their children by linking the parent's participation to child benefits, and improving the family's overall health and well-being. (Schottenfeld, R. et al., in Besharov, D. ed. *When Drug Addicts Have Children*, CWLA (1994))

The Process of Substance Abuse Recovery

(Steps in the Change Process)

As a chronic, recurring illness, addiction may require repeated treatments to increase the intervals between relapses and diminish their intensity, until abstinence is achieved.

Recovery involves not only attaining and maintaining abstinence but also changing one's **thinking** and **behavior**. The following describes what to look for in terms of changes in patterns of use, thinking and behavior, in each of the **four phases of recovery**.

Appropriate caseworker interventions (**implications for case planning**) are suggested for each of the four phases.

Phase One: Denial

The parent denies the connection between their drug use and the problems facing their family, including child protection involvement. Denial is a powerful defense mechanism which helps the parent avoid an awareness of their addiction and the accompanying shame, guilt, and fear. The parent is in Prochaska's "pre-contemplation" stage of change.

Changes in Thinking:

Not yet, even if the parent is cooperating with screening and assessment or has enrolled in treatment under pressure.

Changes in Behavior:

Parents may participate in substance abuse screening and assessment.

In some cases, the parent enters treatment under pressure.

Implications for Case Planning: Because the parent has not accepted the need to change, there is a high risk that they will fail to enter or quickly leave treatment.

The case manager can support getting into and staying in treatment by :

- working diligently to remove barriers to getting into and staying in treatment, such as payment, child care and transportation
- reminding the parent of the possible consequences of failure to enter treatment (such as being taken to court or losing custody of the child(ren))
- offering a hopeful view of the parent's ability to change and the effectiveness of treatment.

Phase Two: Transition

Changes in Thinking: The parent's task is to accept the need to address the relationship of their life problems and drug and/or alcohol use. The process of changing one's thinking occurs gradually as the result of education on addiction, counseling, mutual support meetings.

Parents move from "pre-contemplation" to "contemplation" by acknowledging that they have a problem even if they aren't ready to do anything about it. They move into the "preparation" phase when they commit to trying to reduce their use or make plans to enter treatment.

Parents begin to confront their defense mechanisms and accept responsibility for the destructive behaviors and consequences associated with drug use

The parent may have periods of ambivalence about treatment.

In the period following immediate drug withdrawal, parents may still experience intense hunger, cravings, long but disturbed sleep, tiredness, irritability, moderate to severe depression, and anxiety reactions. They may report or may be observed to have some foggy thinking.

Changes in Behavior:

For parents who have not yet entered treatment, the transition phase is the time when the parent completes the substance abuse screening process, completes a formal assessment, and enters treatment.

The parent will attend substance abuse education, begin to engage with the substance abuse treatment counselor, and develop an individualized substance abuse treatment plan with his or her counselor.

Parent may use drugs intermittently and may attend treatment inconsistently. It may still take several weeks or a month of treatment before the parent can attain abstinence from alcohol and drug use.

Implications for Case Planning:

It is important for case managers to understand the physical reactions to discontinuing drug use, to support the parent in continuing treatment and to consider the parent's ability to manage other case plan requirements during the first month following drug withdrawal. It can be very helpful to the parent for the child welfare and substance abuse workers to have early communication about service needs and treatment planning, so that the parent is not overwhelmed and tasks and resources are coordinated.

If the parent leaves treatment or continues to use drugs in treatment, it may be that the treatment modality did not provide enough structure or support. The client may need to be “stepped-up” to a more intensive treatment, such as day treatment or residential treatment, or to a program that provides special support for women, or for dually diagnosed clients (substance abuse and mental illness).

Phase Three: Early Recovery

Changes in Thinking:

Parent’s self-esteem usually improves with the acknowledgement of a one month period of abstinence.

The parent is able to discuss personal triggers for drug use, including situations, people, and intense feelings that may initiate cravings or actual drug use.

The parent will be working on changing destructive thinking patterns and negative emotional reactions which have served as triggers.

Parents are now able to discuss the impact that addiction has had on their personal lives. They are probably not able to fully acknowledge or discuss the impact of addiction on the lives of their families.

Changes in Behavior:

Parent participates regularly in substance abuse treatment, reducing and eventually discontinuing drug use.

A major hallmark of the early recovery phase is when the parent is able to attain a significant period (30 or more days) of abstinence.

Improvements in personal hygiene should be seen, if they were lacking.

Relapse – a return to the drug of choice or another drug – can occur at any time and is an expected part of recovery. The significance of a relapse episode depends upon the length of the relapse, the person’s ability to self-report, and the individual’s willingness to participate in a relapse intervention process and reengage in treatment.

Implications for Case Planning:

Once the parent has achieved 30 days of abstinence, the caseworker can focus on improving the quality of interaction in parent-child visitation.

The parent is now usually able to benefit from enrolling in parent skills training classes.

Some underlying mental illnesses, such as depression or personality disorders, may not be accurately diagnosed until the parent has achieved a period of abstinence during the early recovery phase. While most substance abuse programs assess mental health status, most programs do not provide full assessments or on-site mental health services. If symptoms of mental illness are noted, the case manager should consider a full assessment at this time.

Because most treatment programs are of relatively short duration, parents typically complete formal treatment during the early recovery phase. Wherever possible, the parent should be encouraged to continue in “step-down” treatment; that is, to move from more to less intensive treatment modalities (intensive outpatient or regular outpatient) before leaving formal treatment.

Time between treatment modalities, and the time following completion of formal treatment, are times of high risk for relapse. Prior to the parent’s discharge, the case manager should communicate with the substance abuse treatment provider to develop the discharge plan and to specify roles in supporting the parent’s transition to aftercare activities, including formal aftercare services, AA, NA and other recovery support groups, and other supportive community or faith-based support groups. The case manager should know the exact date of discharge and work with the parent to assure that there is not a two or three week gap in services and supports, a situation which could lead to relapse.

Reunification: When parental substance abuse is the primary problem and has resulted in removal of the child from the parent’s care, it will generally be appropriate to begin reunification services when a parent has made five or six months of progress in early recovery. Before the child is returned to a parent’s sole care, there should be proof of stability demonstrated by sustained abstinence and sustained changes in behavior. Earlier reunifications may be appropriate with more family support for the child’s daily care and safety.

Child safety planning: Parents, significant others, children and extended families should develop a written safety plan which identifies warning signs of relapse and abuse or neglect, and which specifies who will take what steps to assure the children’s safety if these warning signs occur. Steps could include a child calling someone if the parent appears drunk or high.

Phase Four: Ongoing Recovery

The parent has nine to twelve months of recovery experience (which may have included brief relapse and reengagement). The task in ongoing recovery is to maintain the recovery progress, reinforce and expand support systems make significant changes in relationships and lifestyle, and address long term life goals.

Changes in Thinking:

The parent acknowledges that recovery is a life-long process which requires ongoing active involvement with mutual support systems, sustained relapse prevention planning and anticipation of stresses which could increase the risk of relapse.

Changes in Behavior:

Parents works on repairing relationships -- with spouses or significant others, children, family and friends -- that were damaged by active drug abuse.

Parents who have not been working or who have the need for more vocational and educational training can be fully engaged in these pursuits in ongoing recovery.

Implications for case planning:

The parent/child relationship should be a major focus. The parent should be supported in improving the quality of the relationship and in addressing a healing process with the child or children. For children who have been removed, the case manager can assist by planning quality visits which allow the parent to apply parenting skills training. Parents with long drug histories may require information and feedback about appropriate developmental expectations for their children.

Family roles must often be re-negotiated, as drug-free parents assume parental responsibilities which they had previously abdicated to, for example, older children. The family members may require counseling to address family problems.

Isolation from family, friends and support networks is often an early warning sign of relapse. The family team should be aware of this warning sign and have a plan in place for helping the parent re-connect with support and/or treatment.

Recovery does not guarantee improved parenting. Parents who began abusing drugs during their early or middle teen years may have immature needs because their normal development from adolescence to adulthood was stunted. These parents may be very interested in meeting their own vocational or educational needs but may not appear sufficiently interested in assuming increased parenting responsibilities. This may manifest in not showing up to visits or, if the children are home, not following through on the children's needs. It is important for parents to participate in vocational training or

work to support their families; at the same time, it may be appropriate to increase the caregiving demands made upon such parents and if they persist in not meeting them, to open up a discussion about alternative permanency options for the children.

At the same time, most families in the child welfare system experience crises and have difficulty meeting their family's basic needs and establishing balance in the various areas of their lives. It is likely that recovering families will need a variety of in-home supportive services for a substantial period of time.

A matrix for measuring progress in substance abuse recovery is included in the resource materials.

What the Family Team Can Do to Support Change:

- **Attend family substance abuse education programs/family nights while the parent is in treatment to learn about the process of addiction and recovery**
- **Understand the warning signs of relapse and be part of the parent's relapse prevention plan**
- **Be part of the children's safety plan**
- **Provide round-the-clock backup care to allow for earlier reunification**
- **Support the parent in developing an alcohol and drug-free lifestyle.**