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THE TRAINING IN EMPOWERMENT FOR PROFESSIONALS AND PARAPROFESSIONALS FOR ENHANCEMENT OF SUBSTANCE ABUSE TREATMENT, INTEGRATION AND SYSTEMS

A Dissertation Presented

by

JACK SARMANIAN

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1992

School of Education

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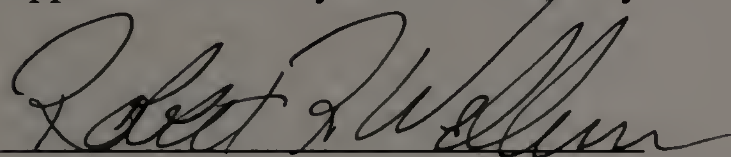
Approved as to style and content by:



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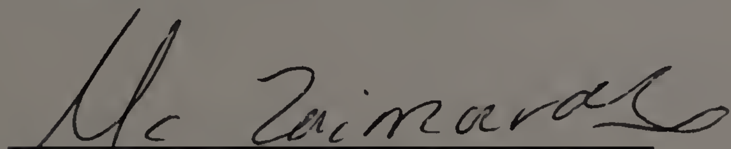

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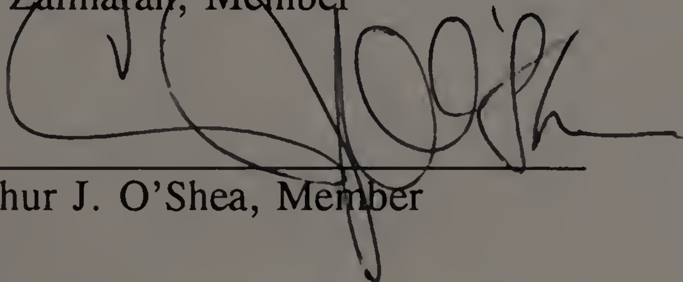

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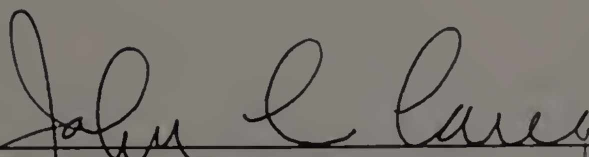

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For her emotional support and optimism, I dedicate this work, an accomplishment in which she truly shares.

ABSTRACT

THE TRAINING IN EMPOWERMENT FOR PROFESSIONALS AND PARAPROFESSIONALS FOR ENHANCEMENT OF SUBSTANCE ABUSE TREATMENT, INTEGRATION AND SYSTEMS

MAY 1992

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This dissertation is a qualitative study on training in empowerment of practitioners that will impact treatment within the substance abuse field. The study explored training of practitioners and presented a model of integrative training that will enhance the state of the art in dealing with the substance-abusing client. Review of the literature in the intervention and treatment of the addictions reflects considerable gaps in the training of professionals and paraprofessionals Although there are a number of training models provided, a consistent approach to the empowerment, professional education and training within this diverse field is not evident. More importantly, there is <u>not</u>, as validated in the literature, an integrative model of training for professionals and paraprofessionals which provides for co-joint training, interactional skill development, and sharing of attitudes which impact positively on the practitioner's ability to engage and treat the substance abuser.

These issues of improving training and education for professionals and paraprofessionals are of significance and are addressed in this study. The study of

training and professional development utilized throughout a multi-method of inquiry, i.e., literature search, surveys, and interviews with practitioners.

The study explores existing training and staff development and the potential needs/gaps noted by treatment staff through questionnaires and focus interviews. Data from all sources are categorized, organized, and summarized by using content analysis on all written and verbal communications. These data establish the existing level of training and identify specialized areas of concentration that are needed to impact professionalism and the delivery of services.

This qualitative approach examines the training and staff development of practitioners--both professional and paraprofessional--and assesses which areas--knowledge, skill development, and attitudinal awareness--must be improved and what type of training designs are necessary to achieve these goals. Crucial in this quest is the method of training for education (pre-service) and staff development (in-service) which impact professionalism. Based on study findings, a training model is created that can impact the state of the art of training in the field of substance abuse.

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CHAPTER I

INTRODUCTION TO THE STUDY

A. Introduction

The intent of this qualitative study is to improve the skills and resources among professionals and self-help personnel offering comprehensive care. These staff members provide intervention and treatment--to meet the needs of diverse substance-abusing populations. In a time of fiscal austerity, low community empathy, and with the debate concerning the etiology and the complex nature of abuse/addiction still fluctuating--the need for competent professional and paraprofessional personnel to intervene and service substance-abusing clients is paramount.

Presently, there are a number of gaps within the delivery of the substance abuse field due to certain phenomena. These factors are: changing symptomatology, legality, substances/pharmaceuticals, schools of thought, and prevailing attitudes regarding substance use, abuse, and addiction. The adverse effects on the individual, family, neighborhood and society influence shifting and contrasting views regarding the field of substance abuse treatment. Various ideologies, schools of thought, attitudes/values, and competitiveness between professionals and self-help groups tend to separate the professional/paraprofessional from the substance abusing person. Moreover, both overt and covert negative attitudes and opinions are emerging about the "Abuser," "Drug Addict," or "Drunk." The "Substance Abuser" is sometimes viewed as dysfunctional, amoral, and a detriment to society [Dean & Rud, 1984]. The recruitment of new trainers and even the commitment of the practicing

professional to comprehensive care has been diminished by the onset of: AIDS/HIV complex, new drug patterns, pregnant substance abusing women, controversy over treatment modalities, i.e., methadone maintenance, urine testing, and mandated therapies, as well as the lack of research and evaluation on substance programming. These problems potentially impact the practicing professional's perspective or biases (ACOA, etc.) and may dampen the desire or willingness to work with the addict or alcoholic.

Severe limits in funding and community support further reinforce the need for specialized training and the competent education of professionals and paraprofessionals for comprehensive care to individuals and their families. Training will offer empowerment through skill development for the professionals/paraprofessionals by reinforcing their knowledge, competency, commitment, and self-confidence in working effectively with the substance abuser and the community through therapeutic intervention [Wood, et al., 1981]. Through this process, professionals will be able to view the abuser/addict (these terms would be synonymous for alcohol abuser or alcoholic) as a person who can be worked with; see themselves as a resource; understand the dynamics of use, abuse, and addiction through a search of their own biases, prejudices, and myths regarding the pathology and/or behavioral dynamics that the abuser emulates. Crucial in this dynamic is the fact that professionals, whether or not they are recovering persons, can contribute to impacting the abuser.

The very nature of the abuser's behavior, symptomatology, and psychopathology defines the need for broad-based training and education for professionals/paraprofessionals [George, 1990; Lewis, 1989]. However, a review of

the literature in the prevention and treatment of the addictions reflects considerable gaps in dealing with the training of professionals and paraprofessionals. Although training models are provided, it is evident that a consistent approach to the empowerment, professional education, and training is needed. More importantly, there is not, as reported in the literature thus far, an integrative model of training for professionals and paraprofessionals which involves co-joint training, interactional skill development, and sharing of attitudes. These skill components are essential to the practitioner's ability to engage, educate, and treat the user, abuser, and addict of alcohol and other drugs. The underlying objective of this study is to explore existing training models through a qualitative design noting the potential gaps and the directions that may need to be implemented. Training, both pre-service and in-service, is the mechanism to develop the manpower that can provide intervention and treatment to substance-abusing clients. Manpower refers to both professionals and paraprofessionals (self-help personnel) that comprise the work force within the substance abuse field.

B. Purpose and Rationale of the Study

The overall purpose of this study, therefore, is to develop the concept of an Integrative Empowerment Training Model for professional/paraprofessional practitioners. This Training Model builds and expands the base of currently practiced elements of professional curricula and training [Burns, 1989; Bibby, 1985; Lewis, 1988] including:

1. General Awareness

   Knowledge, skills, and attitude regarding self, others, professional role;

2. Special Skills Education

Alcohol and other drug content, AIDS/HIV data, etc.;

3. Professional and Paraprofessional Integrative Development

Professional and paraprofessionals involved with integrative and special skills training--didactic, affective, experiential, and group process.

The study of an integrative training model was considered because it can potentially provide a vehicle for professional and paraprofessional development. The interest in exploring this integrative model was derived from the theoretical framework of the substance abuser, review of the literature, professional experience, and from consultation with treatment practitioners (AA, and self-help personnel, and other staff developers) involved in the field of substance abuse.

Specifically, the intent of this qualitative study was to determine the most effective training model for professional and paraprofessional practitioners who are involved in prevention, intervention, and treatment of substance users, abusers, and addicts. The underlying assumption of this study is that professionals/ paraprofessionals who have comprehensive training (both pre-service and in-service) will be more effective practitioners by improving their competencies in knowledge, skills, and attitudinal awareness for work with alcohol and other drug users. The study explored empowerment training and educational models which are practiced and recognized in the substance abuse field. As noted within this qualitative review, it was discovered that training and educational models are geared only to discipline and/or specialty tracks, with the primary focus on competency and skill development within the given track (e.g., medicine, nursing, social work, counseling, ...). A

major gap seen in the literature is that there is not currently, an integrated training model for professional/paraprofessional in the substance abuse treatment field. The present substance abuse dilemma strongly defines the need for more practitioners, either professional or paraprofessional, to service this abusing population:

> More than mere guildism, however, is involved in the attempt to resolve the problem of optimal training programs for provision of therapy. From a societal point of view, arranging for the optimum use of resources to meet the needs of individual clients as well as particular unserved populations is crucial, especially in an era of limited resources. If resources for training programs are limited as well, it is important that they be as effective as possible. [Powers, 1983, pp. 97-98]

There is general agreement that only slight gains have been made by professionals in their task of prevention, intervention, and treatment of substance abuse and addiction. The major reason for this, beyond the ever-changing substance abuse dynamic, is the focus on knowledge by the professional community, rather than on behavior and attitudinal changes. These changes are defined by the process of role modeling, intervention, and empowerment. Another important factor has been negative historical and attitudinal perspectives that have deprived the abuser of prompt, proper, and comprehensive care [Crawford & Heather, 1987; Ewan & Whaite, 1982; Hasselblad, 1984; Philadelphia Inquirer, 1991; Talbot, W., 1989].

This dynamic of perceived barriers is well defined in the literature reflecting on how attitudes, biases, myths, lack of understanding, nihilism towards treatment, fear of confrontation, and denial by treatment personnel and systems interfere with sound professional treatment options available to substance-abusing populations.

There is a self-help axiom, "Don't talk the talk, walk the walk" [Anonymous, 1971], which suggests the concept of positive role modeling for consistency, honesty, and the process of struggling, and/or risk taking from practitioner to client, teacher to student, ... This concept reflects on how practitioners need to utilize not only their theoretical knowledge and skills but also the need to be aware of their attitudes and counter transference issues during the process of intervention and treatment.

In viewing the present drug scene, many issues come to the forefront which have tremendous implications for the field of substance abuse, especially the issues of pre-service <u>education</u> and in-service <u>training</u>.

The impact of the present drug scene has far-reaching effects on all levels of our culture. All indicators demonstrate that substance use and abuse have not decreased but have intensified [OSAP, 1989]. Of major significance is the fact that among minority populations, African-American, Hispanic, Native-American, and Asian are now in the largest group of substance abusers [OSAP, 1990]. The federal government has taken initiatives to help communities mobilize against substance use and to emulate positive lifestyles and drug-free ways of life [U.S. Department of Education, 1987]. The task is to initiate empowerment to foster school and community collaboratives and to develop systems that will assess, plan, implement, and evaluate strategies for prevention, intervention, and treatment in their respective communities.

The present status of substance abuse in our culture reinforces the need for professional involvement and initiatives to treat alcohol and other drug use/abuse. Substance abuse continues to grow, even though some statistical analyses have shown

a decline for specific populations in overall drug use. The High School, College, and Young Adult School Survey, ongoing since 1975, indicates some significant trends [Johnston, et al., 1987]. However, closer analysis shows that the urban inner-city and rural populations, minorities, and school dropouts are affected by the new drugs of choice, i.e., cocaine--crack form and/or methamphetamine--ice, with the potential outcomes of AIDS and violence; increasing the negative impact on individuals, their families, neighborhoods and communities. Some of the solutions for combating substance abuse are centered in local, state, and national initiatives geared towards developing a "No Use Policy" and "Drug-Free School and Community Zones." These educational and prevention policies have been advocated by the U.S. Department of Education [Johnston, 1987].

Drug abuse is a complex sociological process in our culture involving the individual, family, neighborhood, community, state and the nation. The etiology and complex nature of substance abuse must include multiple risk factors, including social, cultural, the community context, the family environment, peer influences, and individual characteristics. Multiple theories, examining cause and effect, and research should be utilized by the professional to determine the extent of the problem, the impact on the individual, and the potential strategies for prevention, intervention, and treatment approaches. The response of professional systems or disciplines to these problems must include: **training, staff development, supervision, and consultation** focused on needs assessment, planning and action development, program implementation, treatment delivery, and evaluation.

A recent research review concludes that multiple action strategies must be defined and implemented by the respective systems responsible for child and adolescent learning and development, specifically families, schools, community groups, and youth themselves [Robinson & Masters, 1989; Backer, 1987; NIDA, 1989; Layne & Grossnickle, 1989; Jones & Maloy, 1988]. Moreover, prevention, intervention and treatment strategies should be founded upon evaluation and research methodologies which utilize pre and postexperimental, quasiexperimental designs, and goal attainment studies involving the comparison of various modalities and initiatives [Hawkins & Nederhood, 1987; Kandel, 1981; Milgram, 1987; Brower & Anglin, 1987].

Prevention, intervention, and treatment evaluation is a relatively new function that is essential within the training of professionals to improve effective prevention and intervention treatment techniques or strategies. As the drug scene changes and evolves, professionals/paraprofessionals must be responsive in the struggle against substance use/abuse. Special emphasis should be placed on training strategies which have the potential to reach, interact, or impact the majority of youth and adults utilizing prevention/education, intervention and treatment methodologies. Professionals/paraprofessionals have the capacity to:

> ...contribute to the prevention and intervention of alcohol and other drug use, as well as other forms of deviant behavior by (1) building intellectual, social, and physical skills; (2) imparting or reinforcing cultural and spiritual values; (3) bonding young people to the school, the neighborhood, and other social institutions; (4) providing a forum for constructive

> social interaction among families; and through these and other activities (5) maintaining or enhancing self-esteem and producing citizens that contribute to society. [Goplerud and Ross, 1990, p. 1]

Evaluation and assessment in prevention, intervention, and treatment strategies is essential and further strengthens training and staff development indicators through recognized research designs and methodologies.

In recent years, youth and adults have sought ways to alleviate developmental struggles and pain, express maturity, and to alter consciousness. The real task of intervention/treatment is to counter the myth that "life can be altered through chemicals" [Ram Dass, 1976; Weil, 1986].

As Weil stated:

> The root of the drug problem is the failure of our culture to provide for a basic human need. Once we recognize the importance and value of other states of consciousness, we can begin to teach people, particularly the young, how to satisfy their needs <u>without</u> drugs. The chief advantage of drugs is that they are quick and effective, producing desired results without requiring effort. Their chief disadvantage is that they fail us over time; used regularly and frequently, they do not maintain the experiences sought and, instead, limit our options and freedom. [Weil, 1986, p. X]

The goal of intervention/treatment is to help people understand their needs and to discover options and personal fulfillment without substances, through enhancement of life skills, social integration, academic success, and self-esteem/worth. The concept of abstinence in a drug-free way of life is the underlying principle of treatment and intervention systems to be offered to individuals in their pursuit of life and happiness.

C. Assumptions of the Study

The very nature of the behavior, symptomatology, and psychopathology (physiological, psychological, and sociological) of alcohol and other drugs reinforces the view that training directly responding to client-identified needs can be justified as an important dimension of the intervention and treatment practice [Barber, 1967; Cohen, 1985; and Lawson, 1989]. A comprehensive training approach, involving pre-service and in-service, geared towards the intervention and treatment of the substance abuser represents a sound theoretical base on which treatment systems can be developed to impact substance abusers and their families [Ewan and Whaite, 1982; NIAAA, 1987; OSAP, 1990; Schlesinger, 1986]. It is assumed that this training should be comprehensive and encompass all spheres of knowledge, skill development; attitudinal awareness and development. Further, it is assumed that training should be integrative, involving both professionals and paraprofessionals in order to best impact the abuser and his or her behavior [George, 1990; Kahn & Stephan, 1981; Tindal & Gray, 1989]. Given the long tradition of professional and system biases towards substance abusers (alcohol and other drugs), a redefinition is required regarding the beliefs and attitudes of practitioners (professional and paraprofessional) toward the abuser [NIAAA, 1985].

The approach to evaluating training is shaped by a number of assumptions paraphrasing Wood and his associates:

1. All treatment practitioners to stay current and effective need and should be involved with in-service throughout their careers;

2. Significant improvement in therapeutic intervention and treatment takes considerable time and is the result of systemic, long-range training and staff development;

3. Training should have an impact on the quality of service delivery and focus on the empowerment of staff to improve their abilities to perform their professional responsibilities;

4. Training should focus on knowledge, skill development, and attitudinal awareness and development on all aspects of use, abuse and addiction of substances (alcohol and other drugs);

5. Training should be integrative involving both professional and paraprofessional within all levels of intervention and treatment service delivery. [Wood, Thompson, & Russell, 1981, pp. 61-62]

Questions arise from these assumptions and are embedded in the lasting effects, both direct and indirect, of practitioner training programs. The primary problem statement of this study is, "What type of training programs exist and what area of improvements are necessary to further impact the substance abuse field?" The survey was distributed to various professional/paraprofessional staff to explore the following questions:

D. Survey Questions

1. What type of service delivery system is your agency? Intervention, treatment--substance abuse, mental illness, comprehensive, outpatient, inpatient, detox, ...?

2. What type of in-service training is offered to your staff for professional development? What specific areas are offered and what is the schedule of such?

3. What do you feel are the most significant training issues facing your staff/agency?

4. Are staff significantly trained to work with alcohol and other drug-abusing clients?

5. What is the level of training for your professionals?

6. What is the level of training for your paraprofessionals?

7. What areas are most significant to the treatment of substance-abusing clients--<u>knowledge</u>, <u>skill development</u>, or <u>attitudinal awareness</u>?

8. What type of training should be offered to professionals or paraprofessionals that would impact treatment of these special populations?

9. What are the most significant areas for training from your perspective?

   a. Psycho-social aspects of client use;
   b. Pharmacological aspects of client drug use;
   c. Intervention/treatment issues;
   d. Management issues;
   e. Knowledge and skill development or attitudinal awareness?

10. What areas are most crucial in training of professionals/paraprofessionals during schooling, pre-service, in-service, or ongoing staff development?

11. Has your agency attempted to do co-joint training (professional/ paraprofessional) to enhance knowledge, skill development, and attitudinal awareness on the part of the trainee?

E. General Hypothesis

This dissertation presents a qualitative study on training in empowerment of practitioners that will impact the delivery of services within the substance abuse field. The study explores the training of professionals/paraprofessionals within the field and presents a model of integrative training to enhance the state of the art in dealing with the substance abusing client. The very nature of the abuser's behavior, symptomatology, psychopathology, and repetitive process of substance use, abuse,

and addiction defines the need for broad-based training and education for professionals/paraprofessionals. As previously noted, the review of the literature in the prevention, intervention, and treatment of the addictions indicates considerable gaps in dealing with the training of professionals and paraprofessionals. Although general training models are reviewed, a consistent approach to the empowerment, professional education, and training does not exist within this diverse field. Specifically, there is not, as validated in the literature, an integrative model for training of professionals and paraprofessionals which provides co-joint training, interactional skill development, and the sharing of attitudes. It is expected that these integrative features will impact positively on the practitioner's ability to treat the substance abuser.

Significant issues in the improvement of training and education for professionals and paraprofessionals within the substance abuse field are addressed in this study. The study explores the following questions to determine what goals or directions are necessary to enhance training and professionalism in the substance abuse field:

1. What type of training exists within the field, both pre-service and in-service?
2. How do these training models or programs focus on knowledge, skill development, and attitudinal awareness/development--impact the delivery of service? Are there commonalities and/or differences? Are there gaps in the training or focus that impact service delivery?
3. What is the educational or experiential makeup of staff to be trained?
4. Are these training programs responsive to innovative concepts and/or integrated approaches to discipline or staff training?

5. Should the field consider specialized approaches, methodalities, or unique designs to enhance the concept of professional/paraprofessional development, especially regarding practitioner attitudes towards the substance-abusing client?

These questions regarding training and professional development are explored through a multi-method of inquiry and data collection, i.e., observation, surveys, interviews, and archival and literature search. These approaches allowed the following assumptions to be tested for the purpose of enhancing training effectiveness:

1. The training design must have the capability to address the ever-changing needs and shifts within the substance abuse scene while allowing for the development of specialized individualized training programs in professional/ paraprofessional education, training, and empowerment.

2. The design must have the capability to address the identified gap in training--specifically, attitudinal awareness, change, and development.

3. The design must be an integrative model bringing together professional and paraprofessional (self-help/recovering persons) to impact the substance user, abuser, and addicted youth, adult and/or families.

This study utilizes a number of treatment programs to explore how staff are trained in their professional development. Key personnel were asked to fill out a survey which gathered data on existing training programs or models. Training needs/gaps were determined and perceptions on the future directions for training were assessed. Several programs were involved in the study, representing varying treatment modalities servicing both alcohol and other drug abusers and addicts (outpatient, comprehensive multimodality, therapeutic community, and specialized women's detox unit, hospital based).

Contact was made with these programs to identify training and staff development policies and to isolate techniques, procedures, and designs utilized to enhance personnel. Programs were chosen that involve a variety of staff--both

professional and paraprofessional--to support comprehensive participation in service delivery--professional, paraprofessional, multi-disciplinary, volunteer, ... Feedback from these sample programs demonstrated existing practices and gaps in training. Also examined is the need for integrated training of professionals and paraprofessionals to impact service delivery. Research methodology and design are specified in the Methodology Section, Chapter III.

F. Relevance of the Study

Implications for Practice and Educational Institutions

First, this study explores current training practices, both within the practice and educational fields, and determined what changes need to be made or should be considered to augment service delivery for the intervention and treatment of substance-abusing clients. Resulting applications will be useful in the prevention field, helping professionals understand the dynamics of substance abuse and by converting these concepts into primary prevention concepts that will impact "at-risk" and potentially "high-risk" youth and adult populations.

Study findings provide data for responsive change in training methods in educational institutions and treatment systems. These data also assist applications in the training area of knowledge, skill development, and attitudinal development. Program changes in schools offering pre-service education may require the implementation of non-traditional approaches and practices. Therefore, training methodology and research is explored within the classroom and field instruction. Faculties will need to consider existing curricula, training approaches, and techniques

that offer knowledge, skill improvement, and attitudinal awareness development with students.

Secondly, **the study explores the continuing need for in-service training or staff development to enhance practitioner performance at all levels of program delivery.** It is anticipated that many will seek to examine this goal and create a process of ongoing training incorporating the integrative designs of knowledge, skill development, and attitudinal awareness. This also provides schools and agencies/ programs with data useful to ongoing education/in-service training programs, thus preparing students/staff for practice applications, while developing professional concepts. The assessment of the Individual Process developed by Skinner [1981] can be adapted in training programs, i.e., a period of self-discovery and enlightenment that recognizes training itself as a powerful intervention.

This study develops the Training in Empowerment for Professionals/Paraprofessionals Model to impact the substance abuse field. It also identifies the productive components of existing training models. A literature search is presented to validate existing concepts and to define the areas of need (gaps) that must be addressed for comprehensive care for the substance abuser.

The basis of this Integrative Empowerment Model for Professionals/ Paraprofessionals is to prescribe potential ways to develop resources through the integration of: (1) theory and conceptual learning; with affective and experiential learning, and (2) utilization of both a cognitive and affective learning process involving both professionals and paraprofessionals, while offering a didactic (theoretical approach) in the group process (affective approach) to enhance team

building, mutual respect, and the cross-sharing of feelings, attitudes, and life experiences.

Secondarily, the design is to improve the competency of the practitioner by offering a training model which presents a knowledge phase (theoretical framework), a skill development phase (case example, conferencing, workups, ...), and an attitudinal awareness/change phase (group process to share attitudes, experiences). The purpose is to integrate all three phases to impact the professionalism and skill level of professionals and paraprofessionals.

The potential of this study and training empowerment model for practitioners is the enhancement of competency and professionalism by creating a knowledge base, skill development, and attitudinal awareness--providing a level of practitioner comfort in the outreach, engagement, assessment, relationship building, and treatment of the substance-abusing client. This model is a generic one, applicable as part of a multidiscipline team, comprising substance abuse and health care providers, educators, criminal justice personnel and corrections officers, ... Crucial to this model is the process of integration between professional and paraprofessional allowing for co-joint exploration, sharing perspectives and working through attitudes/values to attain common goals as resources to impact the substance abuser. An extensive search of literature and training designs has not found existing integrated models of training involving both professional and paraprofessional personnel. This integrated model concept has multi-training implications, i.e., practitioner-client, teacher-student, guard-inmate, ... These situations allow for the sharing of affect, feelings, experience, and perceptions through a group environment. The design empowers

professionals to view themselves in expansive roles and to become multidimensional as practitioners, team members, consultants, and role models/teachers. Underlying the concept of integrated training for the empowerment of professionals is to explore the gaps/needs and to create a model of training that enhances an effective, integrative, and self-directed process. The professional/ paraprofessional can apply this model to utilize, share, and transmit with substance-abusing clients.

The study focuses on the current practices through archival/literature review, field study by questionnaires/surveys, staff interviews, data collection and analysis. This process gathered data on existing training programs or models and also explored training gaps to establish information on how practitioners perceive future training directions or needs. Both professional and paraprofessional staff were involved in the study.

G. Definitions of Core Concepts

The core concepts in this study include: (1) Empowerment; (2) Substances; (3) Substance Use and Abuse; (4) Substance Abuser--Reliance on or Dependency of, Abuse Patterns & Psychic Dependency, and Addiction/Alcoholism; (5) Professional Counselors/Therapists, Interns and/or Practitioners; (6) The Recovering and/or Paraprofessional Person; (7) In-service Training and Staff Development.

For the purpose of this study, the following operational definitions are used:

1. Empowerment

The concept of empowerment is to enhance one's ability and confidence, with the energy, belief and commitment to risk, grow, or perform. Empowerment is the internal source of confidence and power necessary in recognizing the change

dynamics of self and others. It becomes the embodiment of one's dynamic or competence to change one's goal, task, purpose, or existence. Tindall and Gray [1989] defined to be "'empowered' with their reference to Fell and Coplinger..., who suggested that the power of peer group as a socializing agent is in developing positive behaviors. The critical element in the success of the peer program approach may be the sense of connectedness (participation in meaningful activities) and involvement (assumption of responsibility) that the person (author reference) experiences" [1983, p. 41]. In this context, empowerment through training enhances the professional's ability to be a better treatment deliverer and to work through biases, prejudices, and/or shortcomings to help impact the substance abuser. Empowerment is the enhancement of one's internal feelings of empathy-humanness, understanding, warmth, and the expression of these feelings towards the substance abuser to augment and develop relationship building, rapport, and trust for positive change, demand setting, and abstinence.

2. **Substance**

Any substance, chemical or pharmaceutical taken that produces significant changes within the body, mind or both, affecting physiological, psychological, or sociological aspects of behavior. All terms, substance(s), drug(s), or alcohol, used in any amount that alters behavior either overtly or covertly through use, abuse, and/or addiction causing reliance, dependency, dysfunction or withdrawal phenomena will be used interchangeably throughout this descriptive study. It is the author's belief that the separation of ideology between alcohol and other drugs is still a major detriment in the field. This results in the separation of disciplines and their professionals/

paraprofessionals, rather than viewing as a whole the effects of dependency and/or dysfunction on the individual caused by use, abuse, and the addiction of alcohol and drugs alike.

3. **Substance Use and Abuse**

The potential of abuse of substances through use, experimentation, along with the entire gamut of risk behaviors must be included in the definition of substance abuse. Every individual is faced with the responsibility of knowing that any use of a substance has the potential of organic and psychological harm or dysfunction (becoming drunk, use of illicit substances, dysfunctional driving, overdosing, AIDS/HIV potential, and psychotic and/or volatile behaviors, ...). Substance abuse is seen as the physical and/or psychological self-dysfunctional use of any substance capable of altering behavior dynamics, sensations and/or perceptions, including but not limited to nicotine, tobacco, alcohol, marijuana, amphetamines, cocaine, barbiturates, tranquilizers, hallucinogens, opiates, and deliriants. For the purpose of this study, substance abuse (drug and alcohol use and misuse) is the behavior that reflects dependency, divergent behavior and dysfunction caused by the repeated consumption of a substance that alters the dynamics of one's life.

4. **Substance Abuser**

The abuser is seen as any individual (regardless of age, gender, ethnic background, ...) who has begun the process of dysfunctional behavior through the repeated use of substances. The choice of substance, amount, pattern of use, rationale, ..., must be considered as to the effects on the individual, his/her judgment around use, the behavior noted and the emerging dynamics of dysfunction--

physiologically, psychologically, and sociologically. With this initial process, certain patterns of dependency/dysfunction develop:

A. Reliance on or Dependency of

When the user begins to perceive the substances as needed or desired to cope with specific behaviors and/or problem situations--or to maintain normal patterns of function in all aspects of life--developmental, self-identification, academic, vocational, social, and spiritual.

B. Abusive Pattern and Psychic Dependency

Individual cannot function without the substance daily, formulating a psychological attachment known as "Alcohol/Drug Dependency." Every facet of one's behavior is determined by the maintaining substance use regardless of how obtained, choice of amount, dynamics involved to reduce, change, and ameliorate negative concept of self, pain, depression, and a myriad of underlying emotions or effects. These dynamics lead to the last phase of substance abuse that affects all aspects of the individual.

C. Addiction/Alcoholism

This phase involves the organic process defined as addiction or alcoholism which reflects out-of-control, compulsive use caused by the physiological aspects of the addictive process. The abuser has a compulsive pattern of substance abuse involving no choice, is organically determined, and engages in totally dysfunctional behavior to avoid going through the withdrawal process. The addiction or alcoholism is the last stage of abuse requiring medical intervention or detoxification and close observation of all organic/ physiological aspects of the individual to assure

control over this life-threatening process. The disease concept of alcoholism with all its ramifications is valid within this context and reflects the total dysfunction seen without comprehensive intervention being offered. The only successful goal of intervention is total abstinence to begin the process of life readjustment, assessment of one's goals and values, and the re-establishment of identity and pursuit of self-esteem, belief/hope, and realignment to family, peers, and community.

Due to the nature and complexity of the addiction and/or alcoholism phenomena, these formal definitions will be presented:

1. The World Health Organization defines drug addiction as:

   "a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

   a. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means.

   b. A tendency to increase the dose.

   c. A psychic (psychological) and generally a physical dependence on the effects of the drug.

   d. A detrimental effect on the individual and on society."

2. The National Council of Alcohol and Drug Dependence (NCADP) and The American Society of Addiction Medicine (ASAM) define alcoholism as:

> ...a primary, chronic disease with genetic, psycho-social, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notable denial. [NCADP, ASAM, 1990]

An alternative definition of alcoholism utilizes a behavior-adaptive model which Lawson utilizes:

> As an alternative to this approach, a behavioral-adaptive model in which the emphasis is placed on finding what seems to be adaptive and reinforcing for the drinking or drug taking behavior is recommended. Rather than viewing the use of alcohol or other drugs as maladaptive with one ultimate cause, Davis [1987] presented the following three hypotheses:
>
> (1) The abuse of alcohol has adaptive consequences. [No implication is made that adaptive means "good" or "moral" or necessarily desirable.]
>
> (2) These adaptive consequences are sufficiently reinforcing to serve as the primary factors maintaining a habit of drinking, regardless of what underlying causation there may be.
>
> (3) The primary factors for each individual differ and may be operating at an intra-psychic level, intra-couple level, or at the level of maintenance of homeostasis in a family or wider social system. [1989, p. 4]

In relationship to these diagnoses, the professional becomes the role model, intervener, counselor/therapist, direction giver, and support person to enhance the therapeutic goals which offer lifestyle rehabilitation and relapse prevention throughout the process of the dysfunction and throughout the course of treatment.

5. **The Professional Counselor/Therapist and/or Intervener**

For the purposes of this study, the professional staff member, regardless of title--therapist, counselor, physician, nurse, social worker, teacher, prevention specialist, consultant, ...--is any individual who has received a minimum of a Bachelor's Degree from a recognized university or school. The term Professional is

equated to the academic schooling and/or professional training one has received in the field of sciences, medicine, nursing, psychology, ... in the field of substance abuse. The more advanced degree holder--Master's, Doctor of Philosophy, Doctor of Medicine--usually becomes the primary care provider of the abuser/addict. The requirement of formal education and/or professional training is due to the complexities of the organic/physiological, pharmacological, psychological/emotional, and sociological aspects. The professional must assess personality dynamics, diagnose behavioral disorders, estimate motivation, and determine potential prognosis. Several aspects of the individual's dynamics must be explored, including intelligence, family, ethnic, economic, legal, environmental, and peer culture. This definition is generic for all disciplines--medicine, psychology, nursing, sociology, criminal justice, education, ... and would apply to all levels of service delivery--prevention, intervention, and treatment.

Beyond formal education or specialty has been the development of Alcohol and Drug Counselor Certification (CAC, CDC, or CADC). Most state systems have very formal requirements for professional certification, involving certification boards that require specialized education, training, and supervised experience in the substance abuse field. These requirements, varying to some degree depending on specific state locality, would be as follows:

1. Certified Alcohol or Drug Counselor (CADC) would require 6000 work hours, 270 education hours, 300 training hours, and case presentations;

2. Certified Alcohol or Drug Counselor (CAC/CDC), 4000 work hours, 240 education hours, 220 training hours, and case presentation method; and

3. Associate Drug or Alcohol Counselor (ADC/AAC) 1440 work hours, 60 education hours, and limited specialized training hours.

As seen, the training for certification is extensive and varied, and is an attempt to enhance credentials and standards within the field.

6. The Recovering and/or Paraprofessional Person

The term "recovering person" defines the individual who has been an abusing and/or addicted person to either alcohol or other drugs. The term implies the individual is now in abstinence and continues to struggle to be in recovery to prevent relapse and/or regression to alcohol and/or drug use. Recovery is the process that the individual goes through in relinquishing the organic attachment, as well as developing psychic alternatives/strengths to compensate for, overcome, and counter the use and abuse of substances. These processes may also synthesize the Twelve Step process of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), and/or any other integrated approaches that the individual identifies with to reach the goal of abstinence and begin on the path towards recovery--physiologically, psychologically, spiritually, and socially. The Twelve Step process is an important dynamic integrated within the individual's behavior involving "the development of a spiritual program and the 'turning over' of one's worries, anxieties, and resentments to a Higher Power"

[Walfish, Massey, & Krone, 1990]. (Refer to Appendix A--The Twelve Steps of Alcoholics Anonymous.)

The paraprofessional denotes the individual who has not obtained a formal degree from a recognized university or college in the helping fields--psychology, counseling, social work, sociology, and/or related disciplines. Usually, the term paraprofessional is equated to the recovering alcoholic, ex-addict, former substance abuser, or ex-offender, who has experienced substance use, abuse, and addiction. Depending upon choice of substance, level of dysfunction, and degree of involvement within the therapeutic process, the normative is set as to how the individual will be viewed: as either a paraprofessional and/or recovering person.

7. <u>In-service Training/Staff Development</u>

There is general agreement that in-service training or staff development is crucial to practitioner performance in the delivery of services to substance abusing clients. Tremendous emphasis is placed on pre-service academic and professional skill development offered through schools, institutions, and specialty training environments specific to the discipline and/or professional criteria. Ongoing training--in-service and/or staff development--is necessary to assure continued competencies through skill development, especially in the ever-changing field of substance abuse. (Refer to Appendix B, Total Approach to Empowerment for Professionals and Paraprofessionals.)

Training must include three (3) specific areas to be effective for service delivery, professional growth, and reduction of staff burn-out or turnover. These specific areas are: (1) Knowledge--theoretical/conceptual/etiological base of

dynamics; (2) Skill Development--in assessment/evaluation, service delivery, treatment techniques; and (3) Attitudinal Awareness and Development--understanding of one's own biases, prejudices, and values toward the abuser, their culture, ethnic, gender, ... A study done in the field of education, entitled <u>In-service Teacher Education--Report I, Issues to Face</u> [Joyce, et al., 1970], has implications to all practitioners regarding the definition of in-service training:

1. In-service education is defined as all of the experiences undertaken by a teacher after beginning professional practice. This definition would conclude that a variety of experiences is acceptable.
2. In-service education is defined as those experiences which are designed to improve the performance of teachers in assigned responsibilities. In this definition, teacher improvement in specific areas for job competencies is distinguished from teacher's individual and personal goals.
3. In-service education is upgrading the performance of teachers to meet the continuously changing needs and aspirations of students. This is the retraining concept of in-service education.
4. In-service education is the attempt to help the individual teacher become self-actualizing.
5. In-service education is the process by which a teacher may meet the requirements for a license to continue teaching. This is more of an observation than a definition.

CHAPTER II

REVIEW OF RELATED LITERATURE AND RESEARCH

In reviewing related literature, it is clear to this writer that additional training is crucial for improved human services within the substance abuse field. This is further defined by Googins:

> From the available evidence, the record of the professional human service community in general and social work in particular in identifying and treating alcoholics [and drug abusers] is far from admirable. Reflecting the cultural bias in the larger society, the vast majority of human service agencies have ignored alcoholics, joined in the denial of the condition, and treated only that part of the alcoholic's problem that most closely fit the expertise and inclination of the staff. The individual, institutional, and professional barriers to effective treatment are complex and ingrained in a practice that inadvertently works to bar alcoholics [and drug addicts] from the mainstream of human services [1984a, p. 465].

The predominant issues that have created barriers--denial, avoidance, and even unethical practices (systems blocking and resistance)--to effective intervention and treatment further reinforce the need for specialized training are explored through review of the literature. These issues have historically created ambivalence, myths, diverse theories, and a multiplicity of treatment approaches. These dynamics have caused separation of professional from paraprofessional, emerging debate over the disease concept versus that of symptomatic problems of underlying disorders of substance abuse, nihilism of treatment success, and institutional and professional neglect [Googins, 1984b; Kagle, 1987; King & Lorenson, 1989; Schwartz & Taylor, 1989].

The purpose of this chapter is to investigate the literature pertaining to substance abuse issues and dynamics. This will help establish the conceptual framework for the integrated training of practitioners with primary focus upon staff empowerment. Further, there is exploration of previous research in the area of training which has valuable implications for this study. The following objectives more specifically describe the intent and direction of this chapter.

The first objective is to examine pertinent substance abuse trends, dynamics and issues. This data must be inclusive in the rationale and formulation of a comprehensive integrated training program for empowerment of both professional and paraprofessional. The second objective is to review studies and designs of existing training models which enhance professional growth and development as offered by the various disciplines. Careful attention will be given to these related designs in the priority areas of training--knowledge, skill development, and attitudinal awareness and development. In summary, the first objective will focus upon the theoretical concepts of substance abuse issues, dynamics, and trends which affect education, training, and ongoing staff development of practitioners. The second objective will provide a review of specific training models and designs which have important implications for this study.

The domains which reflect the need for pre-service and in-service training are as follows: (A) The prevalence and incidence of alcohol and other drugs; (B) The dynamics, concepts and/or theoretical frameworks that define abuse and addiction of alcohol and other drugs; (C) The biases, myths, and moralistic attitudes concerning alcoholism, drug addiction or abuse that have impacted the delivery of services

throughout the field; (D) The systemic and/or holistic issues facing inner cities, school systems, diverse populations and minorities (African-American, Hispanic, Asian, Mexican-American, Native-American, Women, ...), AIDS/HIV-infected, intravenous drug users, prison inmates, ...; and (E) The burden placed on universities, schools, various disciplines, treatment and self-help resources to develop competent, skilled professionals/paraprofessionals in all phases of training--specialties in degrees, certifications, and ongoing in-service staff development to keep up with an ever-changing field.

A. The Extent and Prevalence of Alcohol and Other Drugs

There is a continuing debate about the prevalence and incidence of substance use and abuse throughout the country. There are indicators that some substances are down within populations, but "high-risk" groups show consistent increases [NIDA, 1989]. These data were derived from national epidemiological surveys and health system data reporting procedures established, mainly through support by the National Institute of Drug Abuse (NIDA) and the National Institute of Alcohol Abuse and Alcoholism (NIAAA): (1) the National Household Survey on Drug Abuse; (2) the High School Senior Survey; (3) the Drug Abuse Warning Network (DAWN); and (4) the National Drug and Alcohol Abuse Treatment Utilization Survey [Rouse, et al., 1985; Johnston and O'Malley, 1985; and Harrell, 1985]. However, there is controversy about the assessment procedures involving methodology and instruments used to determine incidence--self-reporting surveys, needs assessment questionnaires, ethnographic interviewing, ... These have produced misleading statistics, downtrends, and figures that have raised questions on the validity of the reporting,

subjects and research bias. The most recent survey done by NIDA showed a marked decline in marijuana, alcohol, cigarettes, and cocaine use. This survey, however, was refuted by the Center for Substance Abuse Research, University of Maryland, and by Senator Joseph Bidden; these studies showed a marked increase in cocaine and alcohol and challenged the sample population of the NIDA study which did not include the homeless, jail/prison populations, or the 18 percent who refused to participate in the survey [Boston Globe, 1990]. This continuing dialogue focuses on trends and statistics on incidence but does not contribute to the state of the art of what does work and what interventions are necessary to reach "high-risk" populations--inner city, special populations, diverse cultures, ...

With the advent of a new decade, the federal government has taken the initiative to make a major commitment to eliminate substance abuse by passage of omnibus Federal Drug legislation: The Anti-Drug Abuse Act of 1988. One of the major mandates of the U.S. Congress was to "create a drug-free America by 1995." Shortly thereafter, the Office of National Drug Control Policy was established to take on these initiatives, creating Supply Reduction and Demand Reduction Divisions [Office of National Drug Control Policy, 1989].

However, due to the complexities of the substance abuse scene, our present political aura and the economic state of the nation, this mandate has dwindled. The more predominant trend has been to focus on law enforcement, prosecution of casual drug users, and construction of prison cells. The emphasis focuses on stern punishment and personal responsibility with the view that substance abuse is a

criminal issue rather than a medical/psychological one. A reflection on the federal government initiative is as follows:

> A truer measure of progress, however, lies in hard data: for example, numbers of drug-addicted babies, rates of inner-city violence, and transmission rates of AIDS by intravenous drug users. As Rep. Charles Rangel (D-NY), chairman of the House Committee on Drug Abuse, said, during Bennett's 18-month term, "more kids on the street became involved in drugs, more crack babies were born, more kids dropped out of school because of drugs, and violence has increased greatly." [Boston Globe, 1990, p. 7]

This is further collaborated by concerns and initiatives by the White House, Judicial and Federal Systems:

> Together we can do what Americans have always done, band together in the face of evil and beat it. But if we are to succeed, we cannot wait; we cannot equivocate; we cannot minimize the risk. We are in nothing less than a fight for our national life, and we must commit ourselves to success. This cannot be a war of words or containment, but rather action and victory. [The White House Conference for a Drug-Free America, 1988, pp. 1-2]

The judicial system emphasizes how the responsibility of the drug dilemma is within the community:

> Creating acceptance that substance abuse is a community problem requiring comprehensive response is crucial to this nation's "War on Drugs." Only the community can bring about the fundamental changes, attitude and behavior that will significantly reduce our demand for drugs. Only the community can develop and sustain accessible programs that, over time, will successfully prevent and control drug abuse to create a social environment in which all its members can live. [National Council of Juvenile and Family Court Judges, 1988, p. 8]

From a national political perspective, the federal government defines the mandate that will combat or counter the existing drug scene:

> That lesson is clear and simple: no single tactic--pursued alone or to the detriment of other possible and valuable initiatives--can work to contain or reduce drug use. No single tactic can justly claim credit for recent reductions in most use of most drugs by most Americans.... The simple problems with drugs is painfully obvious: too many Americans still use them. And so the highest priority of our drug policy must be a stubborn determination further to reduce the overall level of drug use nationwide --experimental first use, "casual" use, regular use, and addiction alike. [National Office of Drug Control Policy, 1989, p. 7]

To further clarify the impact on negative behavior, the following statistics for substance abusers are presented:

Spousal Abuse	50%
Child Abuse	38%
Traffic Fatalities	50%
Murders	49%
Manslaughter	68%
Drowning	69%
Rapes	52%
Assaults	62%
Suicides	20-35%

[NIAAA, 1987, pp. 1-27]

Figures such as these lead George Gallup, Jr., to say, "America does not have a crime problem. America does not have a problem of job absenteeism and low productivity. America does not have a teenage pregnancy problem. America does not have a problem of broken homes and marriages. America has an alcohol and drug problem" [OSAP, 1989, p. 2].

The various classifications of substances adds to the continuing need for knowledge/information for practitioners due to the ever-changing patterns of drug use, their hazards, and the rapid expansion of both licit and illicit substances [Carroll, 1989a].

> The fluidity and changing nature of the drugs involved in our current drug scene are remarkable. Beginning with LSD and its congeners, we moved on to marijuana and the amphetamines, then heroin, the sedatives and the tranquilizers, the phencyclidine. Now cocaine occupies center stage. It is not that we abandon the original drugs. New ones are overlaid and used jointly or sequentially with the old. Meanwhile, our basic potion, alcohol, underlies them all. Multihabituation, better known by that bastardized word, polydrug abuse, is another new phenomenon. [Cohen, 1985a, pp. xii-xiii]

Nearly sixty thousand (60,000) substances are within the pharmacological and medical characteristics of the five main classifications [Carroll, 1989b]--(1) Opiates--morphine, heroin, etc.; (2) Depressants--barbiturates, tranquilizers, marijuana, alcohol, etc.; (3) Stimulants--amphetamines, cocaine, etc.; (4) Hallucinogens--LSD, phencyclidine, mescaline, peyote, etc.; and (5) Deliriants--volatile fluids (dope, gasoline, paint thinner, etc.). These are also under the Controlled Substances Act (Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II). Choice of drug(s), pattern of use, and the route of administration must be considered to assess the individual degree of dependency, loss of control, psychopathology, dysfunction, and addiction as the initial part of treatment [Nowinski, 1990; Rogalski, 1987; and Skinner, 1981]. The medical, pharmacological, and legal aspects of the individual's behavior are crucial but must not cloud the real goal of treatment--which is to treat the individual's needs: gain control to increase self-esteem and sufficiency, and develop a drug-free way of life.

B. The Dynamics, Concepts & Theoretical Framework that Defines Abuse and Addiction of Alcohol and Other Drugs

Presently, with the extensive theories, concepts and views about substance abuse, there are many gaps separating disciplines. This creates divergent schools of thought among professionals over the etiology, causation, and ultimately the diagnosis, treatment, and evaluation of abuse and addiction of substances. This perspective hasn't changed dramatically over the past twenty (20) years, as seen by the earlier attempts of Einstein [1969]--Figure I--to delineate the <u>other factors than just on the user</u> which would contribute to the body of knowledge that needs to be explored:

Drug Use Patterns
Type
Frequency
Amount

Characteristics of Users
Age
Sex
Race
Ethnicity
Religion
Marital Status
S-E Class

Behavior of Users
Physical and Psychological Functions & Dysfunctions
Social Involvement: Conventional & Deviant

Scientific Knowledge
Classification of:
Drug Users
Drugs
Theory about:
Drug Use
Drug Action
Research

Treatment Programs
Goals
Treatment Modalities
Policies
Procedures
Professional Roles

Public Policy
Laws
Policies
Procedures

Caretaker Staff Attitudes and Values
Stereotypes of Drug Users

Community Attitudes and Values
Stereotypes of Drug Users

Economics
Legal
Production, Distribution and Sale, Entertainment, Taxes, Advertising, Research Projects, Treatment Programs, Penal Programs
Illegal
Value of Stolen Merchandise
Sale of Stolen Merchandise
Illegal Sale of Drug

FIGURE 1. Other Factors Influencing Abuse

SOURCE: Einstein, S. (1969), "The addiction dilemma: Gaps in knowledge, information-dissemination, service and training," The International Journal of the Addictions, 4 (1), 25-44.

The majority of these factors still apply to the dynamics of alcohol abuse and addiction. Of particular interest is that alcohol has been seen as a separate entity unique from drugs, being both legal and socially sanctioned, causing separation of treatment, public policy and research.

A number of questions arise when exploring etiology, cause and effect, and underlying theories of substance abuse which are formulated as:

> ...the drugs (what they do and don't do), the users (who they are, who they aren't, and who is likely to become one), drug use (meaning(s), patterns, consequences, etc.), intervention (foci, goals, strategies, techniques, policies, models, etc.), intervention agents (professionals, paraprofessionals, ex-addicts/users, volunteers, etc.), intervention agencies (treatment, prevention, research, training, policy, law enforcement, etc.). [Einstein, 1983]

Another perspective is to view the etiological factors influencing substance abuse that are categorized as Biological--biochemical, genetic, physiological; Intrapersonal--developmental, personality, affect and cognition, sex differences; Interpersonal--social, familial; Environmental--conditioning, learning, life events; and Cultural--customs and mores, attitudes and social policy [Leigh, 1985; Cohen, 1981, 1985b].

There are many risk factors that contribute to why individuals utilize substances. These factors are represented across all ages, genders, cultural and diverse populations--reflecting the need for a "systems approach" to identify and isolate these variables. These influences--individual, interpersonal and society, and environmental--affect the individual circumstances and contribute to the use of substances. Figure II reflects the complex and integral nature of interdependent dynamics of the multiple variables that affect behavior as potential risk factors:

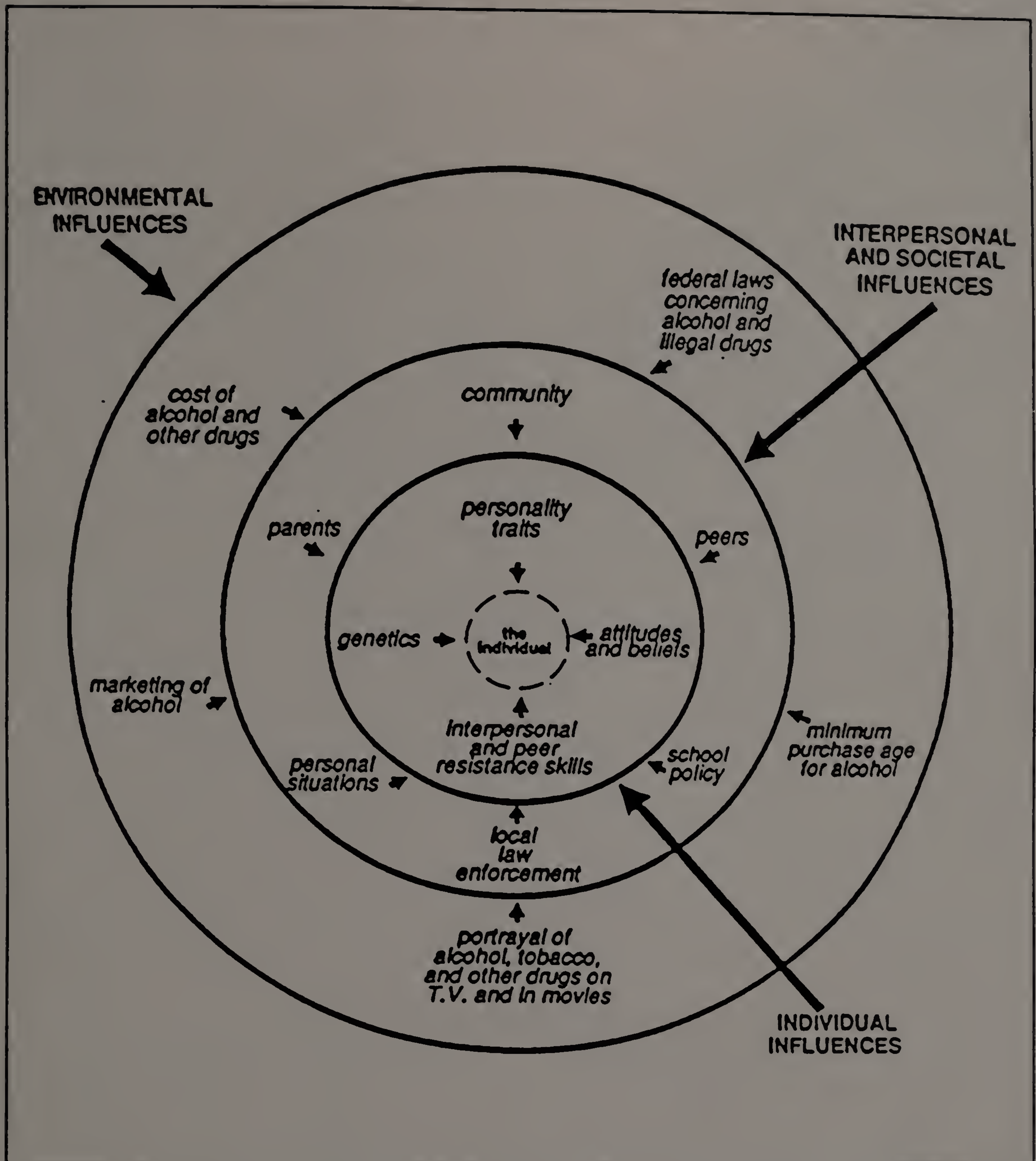


FIGURE 2. Factors that Influence Alcohol and Other Drug Use

SOURCE: Office of Substance Abuse Prevention (1989), Prevention Plus II, (DHHS, Publication No. ADM 89-1649), Rockville, MD, p. 19.

Numerous personal, social, and environmental factors have been attributed to the exposure and maintenance of substance abuse. Such factors include negative peer and family models, poor academic achievement, emotional distress, deviance and lack of social conformity, early alcohol use, perceived adult drug use, perceived peer approval of drug use, perceived parent approval of drug use, absence from school, distrust of teacher drug knowledge, distrust of parent drug knowledge, low educational aspirations, lack of religious commitment, stressful life events and dissatisfaction with life [Newcomb, Maddahian, Skager & Bentley, 1987].

These risk factors not only reflect the burden placed upon professionals but demonstrate the challenge that is at hand--to identify, intervene, and treat alcohol and other drug use by "at-risk" and "high-risk" youth and adults within their communities.

There is a growing number of treatment modalities for the rehabilitation and prevention of drug abuse. Each program has a different approach to rehabilitation, depending on the form of addiction or the need for intervention. Practitioners need to be familiar with a variety of treatment or intervention modalities as well as the factors that contribute to or hinder successful drug abstinence.

> Until relatively recently, there were, in the U.S.A., four major treatment modalities: long-term hospitalization, methadone maintenance, therapeutic communities, and detoxification with methadone and other pharmacological agents followed by outpatient counseling. There was heavy emphasis on the use of professionally trained personnel to provide the treatment and also a strong orientation towards a basically medical model. [Glatt, 1977, pp. 188-189]

In general, methadone maintenance has failed to contribute to a model of treatment geared toward recovery, and some therapeutic communities have failed in similar ways. The key to successful drug treatment should include "the recognition that the

problems of drug abuse are not homogenous, but are symptoms associated with a variety of causes and human problems" [1977, pp. 188-189].

Some treatment techniques have been available for some time in terms of psychological or medical procedures but are now being used as a form of drug treatment. For example, acupuncture, hypnosis, biofeedback, transcendental meditation, and a number of other techniques. "The primary issue in successful drug treatment is how best to apply and make accessible the knowledge and technique we already have available so as to maximize the impact and efficacy of our treatment efforts" [Glatt, 1977, pp. 195-196].

Most substance abusers do not have access to treatment. There was a study of a New York City incident occurring in 1984 where police officers arrested over 4000 addicts from the Lower East Side of the city. Most of these addicts were returned to the streets because there were no treatment or correctional programs available at that time. In addition, the most widespread forms of drug abuse--cocaine and polysubstance abuse--are not susceptible to the most available form of treatment, which is methadone maintenance.

From the therapeutic viewpoint, the practitioner must consider (a) pharmacotherapies--Methadone maintenance, psychotropic medications, and antabuse; (b) Comorbidity--dual diagnosis; (c) Mandated therapies--coercive therapy, urine screening, intensive supervision, drunk driving programs, community-based care under electronic monitoring; (d) Self-help approaches--Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other self-help recovery-based models; and (e) Holistic approaches--acupuncture, behavior modification, biofeedback, transcendental

meditation, ... These issues cause professionals tremendous concern due to the medical, legal, psychotherapeutic, public policy, economic and individual considerations that are part of the dynamics of substance-related behavior.

The primary goals for the practitioner are to effectively research, develop, apply, demonstrate, and disseminate new and improved methods and knowledge of effective strategies to maximize the impact and efficacy of treatment efforts [Glantz, 1977; NIDA, 1985].

Khantzian and his colleagues [1977, 1981, 1986, 1989, 1990] have done extensive work validating the need for contemporary psychodynamic approaches to substance abuse treatment.

> Our growing psychodynamic, clinical, and scientific understanding of addicts suggests that there is growing rationale to apply our therapeutic modalities selectively and differentially based on patients' characteristics and degrees and types of psychopathology. Special attention to the way disturbances in affect recognition/tolerance and self-care disturbances combine to make drug dependence malignantly compelling has important implications for considering the treatment or combination of treatments we employ. We also need to consider when, why, and how the treatments we employ could be harmful and thus contraindicated. Addicts need more than anything else a variety of therapeutic contexts to discover that they can adopt more ordinary human solutions in place of their extraordinary chemical ones. A clinician's understanding of addicts' problems can be vitally important in assuring such an outcome. [1986, p. 221]

These dynamics emerge succinctly in the continued controversy over the etiology of alcoholism--Is it disease based or is it symptomatic of an underlying disorder? Whether alcoholism is seen as an illness or disease [Jellinek, 1960; Chafetz, 1983; Blum and Trachtenberg, 1988] or multivaried responses--alcoholism [Jacobson, 1976] or as an underlying disorder [Bratter & Forrest, 1985; Fingarette,

1988; Lawson & Lawson, 1989, ...] or as willful misconduct [Veterans Administration, 1988]--these issues have had a negative impact on treatment research and public policy. The real key is training--to assist in education and prevention, practice within the treatment community (professional and paraprofessional)--and to become more eclectic in the awareness of the etiology and presenting symptoms of the substance abuser. Essential is the ability of the practitioner to impact the abuser by identification, assessment, and treatment intervention responsive to the individual's need to gain control over substance use and achieve a drug-free way of life.

C. The Biases, Myths and Moralistic Attitudes Concerning Abuse, Alcoholism, and Addiction

A problem to be addressed by training models within the sphere of substance abuse is that of the attitudes and values as experienced by the abuser from the professional, paraprofessional, and lay community [Nowinski, 1990]. There exists an underlying bias regarding the substance abuser which reflects historical, religious, and moral overtones depicting the abuser as weak, inferior, amoral, evil, and dysfunctional.

> These attitudes are particularly a problem for clinicians. Whether moralistic or centered around treatment perceptions, attitudes such as 'Do alcoholics ever get better?' become screening-out mechanisms by which alcoholic [and drug] clients are seen as undesirable, untreatable, and unmotivated. Coupled with these familiar attitudinal barriers are the ambivalences reflected in social policy and agency policy and practices. [Googins, 1984c, p. 163]

This is further illustrated by recent governmental actions and public response to substance abuse through marked decreases in fiscal allocations, redefinition of

"Alcoholism" by the Veterans Administration, and the initiatives to build more prisons.

> In the last ten years, there has been...a movement to again consider addiction a moral failing and a personal weakness to be dealt with (by) interdiction and punishment rather than through treatment. [Wartenberg, 1991, p. 3]

This can have an impact on the motivation of the therapist/ physician, especially in the initial stages of treatment with the abusing client. Multiple factors rooted in societal ambivalence, misinformation and professional denial have interfered with differential diagnosis and intervention [Chafetz, 1983; Rohman, et al., 1987].

There is also evidence that among the general public, there are individuals who accept the disease concept of alcoholism but tend to view the alcoholic as "morally weak" or "weak-willed" [Crawford & Heather, 1987]. More significantly, some practitioners in the allied health fields--physicians, nurses, social workers, counselors--have demonstrated similar behaviors due to lack of competencies, negative attitudes, and questions concerning responsibilities to substance abusers [Barnes, et al., 1984; Bean-Bayog, 1989; Chappel, 1986; Hanlon, 1985; Lewis, 1986; Siegal, Markert & Vojtech, 1986; and Weiner, Rosett & Mason, 1985].

> Studies indicate that many physicians are ambivalent about their role with respect to alcohol and other drug problems, and have a low rate of problem recognition. Reasons cited for physicians' reluctance to intervene with patients with alcohol and other drug abuse problems include negative attitudes about alcoholic and other drug abusing patients, pessimism about the possibility of recovery, and lack of confidence in their clinical ability to manage patients with these problems. [NIAAA, NIDA, 1986, p. 1]

These factors should be considered in relation to the practitioner's alcohol/drug behavior, historical or family substance abusing dynamics (potential COA or ACOA) the high stress factors related to allied health professions [Burns, 1989].

Schwartz and Taylor's [1989] study of present-day attitudes of mental health professionals reaffirmed how these attitudes affect practitioners when they conduct an Alcohol Use History and initiate alcoholism treatment. Earlier studies of comparing attitudes of different professional groups demonstrated:

> ...social workers are more consistent in their attitudes toward alcoholism, favoring the disease concept. Compared to psychiatrists and psychologists, social workers were more highly motivated to work with alcoholics in treatment [Knox, 1973]. Nurses appeared more "moralistic" toward alcoholism than either physicians or social workers [Stern, et al., 1965], and for nursing students, attitudes of authoritarianism correlated positively with less favorable [Chodorkoff, 1969] and more custodial attitudes [Moody, 1970] toward alcoholic patients. **Not surprisingly, among professionals and nonprofessionals both, attitudes reflect the opinions and biases of the community within which the individual works** [Kilty, 1975].
> [Schwartz and Taylor, 1989a, p. 323]

They concluded that future research is necessary to identify particular patient and/or staff variables which aid or interfere with the recognition of alcohol [and drug] dependence.

Miller [1985] defines how specific therapist characteristics--such as hostility, expectancy, and empathy--powerfully influence whether a client will enter, continue, comply with and succeed in treatment. This creates a dynamic interpersonal process whereby the therapist is encouraged to seek interventions for influencing the client's motivation that were once detrimentally attributed to intrapsychic determinism.

Lewis [1989] validates that historical perspectives, lack of adequate training, and negative attitudes also contribute to this phenomenon within medicine. He also recognizes the need for specialized education and training for physicians and allied health care professionals. Lewis defines a number of difficulties that medical educators need to overcome:

- negative attitudes toward the "difficult" patient, self-injurious behavior, and chronic illness
- lack of skills in making a diagnosis and an appropriate referral
- attention to patient needs while neglecting the family
- a view of alcohol and other drug dependence as an acute illness
- lack of contact with recovered patients
- lack of professional and institutional role models. [1989, p. 9]

Another area hindering attitudinal development is the separation between professionals and paraprofessionals due to the lack of understanding of Alcoholics Anonymous (AA) and other self-help philosophies. AA has made considerable gains in recent years as an effective approach to bring about sobriety and long-term recovery [Leach, 1973; Chafetz, 1983; Khantzian, 1986b; McPeake, et al., 1991]. Googins [1984d], Anderson [1987], and Bean-Bayog [1989] view AA as a tremendous resource in helping alcoholics through the concerted group and twelve-step process. The researchers also validate a role for the recovering persons in the new work force to help deal with substance abusing populations and to supplement the shortage of human service workers [Philadelphia Inquirer, 1990].

> An alliance among professional human service providers, self-help groups, and recovering alcoholics will strengthen the agencies' and community's capacity to identify and treat alcoholics and their families. [Googins, 1984, p. 165]

This viewpoint is not universally accepted among human service professionals who perceive the AA or NA model as too rigid, possibly too confrontative, and the spiritual concepts of "surrender" and a "higher power" as part of the twelve-step philosophy contraindicated as a treatment alternative. Systems have been developed to counter these objections, as seen in the behavior modification work of Skinner [1988] and Trimpey's [1990] development of Rational Recovery. At the same time, some AA and recovering members have negative views on medical interventions and the prescribing of psychotropic medications.

> Increased familiarity with AA tenets like the "12-Step Program" and "enabling" can dispel biases of health caregivers toward AA as well as dispel the distrust some AA members have toward "professionals." [Schwartz & Taylor, 1989b, p. 330]

Further evidence and support for addressing these gaps is that this writer did not find in the literature review any integrated training models for the professional and paraprofessional which focus on knowledge, skill building, attitudes, and co-joint integrative processes for improving the field of substance abuse. The Training in Empowerment Model will explore this gap and provide a comprehensive training alternative for the professional/paraprofessional to impact the individual substance abuser, their families, other systems, and the community at large.

D. Systemic Issues that Impact the Drug Culture

Due to the ever-changing phenomena of the drug scene, practitioners need to expand their knowledge base and roles to detect, assess and treat the abuser. This

also requires constant assessment and research regarding intervention and treatment methods, as well as application to assure that meaningful data and focus is being presented in all levels of delivery. This process involves conceptualizing and creating generic approaches rather than teaching specific solutions [Duhl, 1983]. These processes could be applied to the larger systemic issues that could impact the individual, family, community and culture. The more prevalent pervasive problems needing attention are: (1) Inmate substance-related crime, violence and prison conditions; (2) AIDS/HIV-Positive infection; (3) Substance abusing pregnant and postpartum women; (4) Minority and diverse cultures; and (5) Economic trends--poverty, unemployment, underclass status, homeless, etc.

These problems translate into the impact effect that alcoholism, drug abuse/addiction have upon individual dysfunction--flight, aggression, depression, suicidal ideation, addiction; family dysfunction--violence, neglect, sexual abuse, conflict. Another affected area is neighborhood turmoil--increased crime, high victimization, fear, violence, intimidation, and immobilization of individuals, groups and neighborhoods. This dysfunctional behavior intensifies the need for law enforcement, arrests, court proceedings, and incarcerations, further overloading correctional facilities due to increased numbers of substance abusers.

Significantly, 40% of all incarcerated inmates have substance abuse history problems at time of arrest [U.S. Department of Justice, 1988a; Boston Globe, 1991]. The following data indicate the percentage of inmates having alcohol or drug problems compared to the general population:

DATA SOURCE 1975-1985 - % Who Had Ever Used Drugs

	Jail Inmates	Prison Inmates	General Population
Any Drug	75%	78%	37%
Marijuana	72	75	33
Cocaine	38	37	25
Amphetamines	32	37	9
Barbiturates	27	35	6
Heroin	22	30	2

[U.S. Dept. of Justice, 1988b, pp. 365-366]

There has been considerable research probing the links between drugs and crime. There has been significant shifts in crime with the prevalence of drugs, as shown by a team of researchers at University of Maryland and UCLA. Their results show how the intensity of criminal behavior among these addicts--especially property crime--is directly related to their current drug use status. Each of these long-term studies of nine and eight years demonstrated that the addicts' criminality was about four to six times higher, with an average of 2000 crime days [National Institute of Justice, 1985].

Shifts in drug patterns, availability, and more hazardous modes of use, such as freebasing, has increased cocaine use. It is this pattern of regular use that can rapidly escalate to compulsive use. Moreover, freebasing and intravenous use can potentially lead to strong depressive feelings--"The higher the high, the lower the low." Primary drugs of choice are alcohol, marijuana, opiates, cocaine, tranquilizers, hallucinogens, and usually is a combination thereof. Alcohol use is far more prevalent with whites, drugs with minorities; yet incarcerated females show higher alcohol use than males.

Juvenile statistics show even higher percentages of drug usage prior to or at time of arrest [U.S. Dept. of Justice, 1988c].

These figures reflect the enormity of the substance abuse problem that practitioners face within the criminal justice and correctional systems. A representative substance-abusing inmate profile within the correctional population may be as follows:

1. Immature--emotionally and developmentally;
2. Poor self-image/esteem;
3. Poorly integrated family constellation--few positive role models, single-parent household, conflicted family entanglements;
4. Underachiever--academically/cognitively;
5. Limited work history;
6. Early and high rate of criminal activity;
7. Deviant peer group--little or no social bonding;
8. Early exposure to alcohol and drug usage--alcohol and drug history among parents and extended family;
9. Economically disadvantaged;
10. Overall depleted personality structure--no family support system or positive peer environment.

Closer scrutiny of these individuals' dynamics demonstrates the many emotional and personal issues the person must work on--risk to feel, risk to trust, gain mastery of impulse control and drug craving, gain confidence, develop cognitive/academic/work skills, develop positive peer relationships, and work through parental, family, and spousal conflicts.... These are rehabilitative factors that practitioners, both within and outside of institutions, must consider in working to effectively create

community-based, correctional or alternative care systems for the substance-abusing client, offender and/or inmate. These systems must not only deter but also develop a positive environment in which the individual can begin to utilize options to maximize their stay rather than "just do time."

Issues of overcrowding, physical conditions, and the dynamics of the individual substance-abusing offenders/inmates should be addressed to support the dignity of the individual and the effectiveness of the institution.

Another systemic issue of major significance is the Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and chemical dependency through intravenous (IV) drug abuse. The AIDS/HIV epidemic represents formidable challenges to health care professionals, especially for inner-city/urban sites, as well as the disproportionate prevalence of the disease among black and Hispanic populations [NIDA, 1989; PHS, 1985].

The Centers for Disease Control (CDC) defines AIDS or AIDS-Related Complex (ARC) as: <u>an illness characterized by one or more of the opportunistic diseases indicative of underlying cellular immunodeficiency</u>. Other laboratory conditions which indicate underlying cellular immunodeficiency include low T cell count, T helper/suppressor ratio less than 1.0, elevated serum globulins and anergy to mitogens and antigens, to name a few [Ahluwalia, 1988]. These characteristics in Figure III signify the CDC definition of AIDS and AIDS-Related Complex (ARC):

AIDS-Surveillance Definition

The presence of a disease or series of conditions indicative of immunodeficiency in an individual with underlying cause for reduced resistance. Following is a list of diseases involved:

- Kaposi's sarcoma in patients less than 60 years of age
- Primary lymphoma of the central nervous system
- Pneumocystis carinii pneumonia
- Unusually extensive mucocutaneous herpes simplex infection
- Cryptosporidium enterocolitis indicated by severe gastroenteritis for a prolonged period of time (> 4 weeks)
- Esophagitis or Oropharyngitis attributed to Candida albicans, cytomegalovirus (CMV), or herpes simplex virus (HSV)
- Progressive multifocal leukoencephalopathy
- Pneumonia (cause other than Pcp), encephalitis, and/or meningitis

Any one or more of the above infections along with laboratory confirmed HIV test will indicate an exposure to the AIDS virus.

AIDS-related Complex (ARC)

Any three clinical symptoms existing for less than 3 months	AND	Laboratory confirmation of these abnormalities
• Fever > 100F > 3 months		• Helper T cells < 400/mm^3
• Weight loss > 10% or > 15 lbs.		• Helper/suppressor ratio < 1.0
• Persistent lymphadenopathy (> 3 months)		• Elevated serum globulins
• Persistent diarrhea		• Depressed blastogenesis (phytohemagglutinin)
• Debilitating fatigue		• Anergy to mitogens and antigens
• Night sweats		• Other conditions

FIGURE 3. Centers for Disease Control, Definition of AIDS and AIDS-Related Complex

SOURCE: Ahluwalia, I.B. (1988), The epidemiology of AIDS. In K. D. Blanchet (ed.), AIDS: A health care management response. Rockville, MD: Aspen Publishers, p. 33.

The significance of intravenous (IV) drug abuse in the epidemiology of AIDS/HIV infections is tremendous, now being approximately 25 percent of the total cases seen [Boston Globe, 1991a; NIDA, 1990]. The impact of IV use is startling in the heterosexual transmission of infections (HIV) to women and children. Causation is through parenteral use by the women or by the sex partner which causes perinatal transmission in utero [NIDA, 1989, 1990].

Geographically, the major areas impacted are New York City and Northern New Jersey, which reflect about 35 percent of the country's total. Ethnic groups, over-represented among IV drug abusers, are also over-represented among heterosexual IV drug abusers with AIDS/HIV. Blacks make up 51 percent and Hispanic 30 percent of the heterosexual IV drug abuser population [NIDA, 1990].

In attempting to comprehend the effects of AIDS/HIV infection, the impact has major implications for health care delivery, practitioners, the individual, and the community. Programs that distribute clean needles have been created to prevent AIDS/HIV infection through intravenous drug use. The Addiction Research Foundation [Boston Globe, 1991b] reported on the Canadian government program that was initiated in the largest cities--Toronto, Montreal, Vancouver. Its finding was favorable, showing a 17 percent drop in the number of people testing positive. Safer sex practices and distribution of needles have decreased newly reported HIV cases after five years of steady growth. The Canadian government intends to research drug-related AIDS infection and needle-exchange programs in its major cities. This approach, however, has run into considerable opposition in the United States due to a fear of increased drug use. The distribution of clean needles is part of the ongoing

debate on how to deal with the increasing AIDS/HIV-infected population of IV drug abusers.

AIDS/HIV has become the newest area of dysfunction that has surfaced anxiety among practitioners and barriers to treatment, even with the increased awareness regarding AIDS/HIV facts. This has created a clinical challenge as defined by Gemmill [1987] in his review of Walter Reed Army Medical Center HIV Social Worker Program. The noted areas of difficulty in treating these patients are:

1. Case managers were not familiar with the clinical dimensions of AIDS.
2. Case managers were concerned about the contagiousness of AIDS and other countertransference issues.
3. Some patients had dual or even multiple diagnoses, which complicated the provision of services. While patients with dual or multiple diagnoses, such as kidney failure, alcoholism, hemophilia, or cancer in addition to AIDS, were infrequent, when such a diagnostic combination did occur, it severely complicated the provision of services.
4. While case managers were familiar with the psychosocial-emotional components involved in disease, they were often unprepared or overwhelmed by the number and intensity of these components in both infected patients and their families.
5. The devastating impact of the disease on patients, family members, and the health care delivery system made it difficult to identify and mobilize resources for them. In areas of low incidence there were few resources. Some infected individuals requested that their family members not be

> informed of their illness, thereby eliminating a potential source of both financial and emotional support. Other individuals had infected their spouses, and some women had infected children. Several families had become so emotionally paralyzed or physically incapacitated that they were of little help to their ailing family members. Often the very organizations or institutions that traditionally provided health care resources were in the process of defining their own helping role. Therefore, case managers were often unable to locate resources, not because of a lack of resources, but due to uncommitted resources [1987, p. 187].

Smith and his colleagues [1987] focused on the need for training the health care practitioner in dealing with the IV AIDS/HIV-Positive patients.

Ostrow [1987] emphasized a philosophical and social policy perspective against institutional barriers in his presentation, "Barriers to the Recognition of Links Between Drug and Alcohol Abuse and AIDS":

> Mental health providers and chemical dependency treatment specialists have an important role to play in determining the long-term efficacy and positive impact of behavioral changes in response to the AIDS epidemic. Our roles include research, educating our colleagues, providing sensitive and effective therapies, getting involved in community and professional task forces, and demonstrating our own courage and determination in the face of hysterical overreaction. Given the complexity and the magnitude of the barriers to positive changes, performing these roles while meeting our professional and social obligations will not be easy, but in view of the potential negative outcomes for ourselves, our professions, and society at large, we can ill afford not making the necessary efforts to succeed [1987, p. 20].

Refer to Appndix C, the AIDS/HIV Pyramid to reflect the intensity of the problem.

Crucial in working within the substance abuse field is the practitioner's awareness of multicultural and minority issues. Sensitivity in cultural and ethnic difference for treatment personnel is crucial for the unique needs and characteristics of diverse cultures that exist in North America--African American, Hispanic, Native American, Asian, ... This sensitivity is essential for the fulfillment of the practitioner's mission in the equitable intervention and treatment of all persons, women, minorities, including language and cultural diversity. Treatment systems frequently intervene with people from diverse cultures and ethnic groups. To maximize the ability of the treatment field, staff at all levels need to be aware of cultural diversity and specificity and learn how to function in ways that reflect that awareness. Randall-David reinforces this concept advocating the following:

> In the history of human thinking, the most fruitful developments frequently occur at those points where different lines of thought meet. These lines may have their roots in different cultures, in different times, in different religious traditions. If these are allowed to meet . . . a new and interesting way of being will emerge. [Heisenberg, 1974, p. 1]
>
> Like a quilt rich in colors, textures, and patterns, the United States is a nation made up of many ethnic, racial, religious, and cultural groups. The concept of the melting pot, now outmoded, has been replaced by the recognition that this diversity lends strength and uniqueness to the fabric of our society. With the broad range of experience that the various parts of our population bring to everyday life in America comes the need for increased efforts at understanding and valuing our differences as well as our similarities. Since the culture in which we are raised greatly influences our attitudes, beliefs, values, and behaviors, it is important to gain an awareness of the cultural determinants of our <u>own</u>, as well as our clients' thoughts, feelings and acts. [Randall-David, 1989, p. 1]

Since individuals within various populations are treated, these concepts apply to groups that might be viewed as different, atypical, and possibly deviant by

practitioners. Specifically, these biases or negative attitudes are conveyed to homosexual groups--gays, lesbians, bisexual, sexual minorities, transvestites, etc. Professionals must be aware of clients' cultural milieu, behaviors or sexual preferences--to create environments of trust, communication and positive therapeutic alliances.

Close scrutiny of the literature indicates that these diverse groups are predominantly within urban locations--inner city or metropolitan areas which define the largest population base. This concentration reflects not only therapeutic approaches or systems but determines social policy in handling various subcultures, thus influencing funding, service delivery, and resource allocation. Highly neglected in this strata are rural populations or states which reflect economic plight, scarce resources, lack of transportation ..., while maintaining similar statistical trends of substance-abusing behaviors. Table IV displays the Federal Bureau of Investigation's statistical arrest data as compiled by the General Accounting Office:

	Type of Drug					Type of Offense		
Area	Cocaine & Opiates	Marijuana	Synthetic Narcotics	Other Drugs	Total	Sales	Possession	Total
Rural States	20%	63%	6%	10%	100%	25%	75%	100%
Nonrural States	39	49	3	9	100	27	73	100
United States	32	54	4	10	100	26	74	100

FIGURE 4. Drug Abuse Violation Arrest, 1988

United States General Accounting Office (1990). Rural drug abuse: Prevalence, relation to crime and programs, Washington, DC (GAO/PEMD)-90-24), p. 29.

These statistics, through review of survey treatment and arrest data [1990] have produced several consistent findings:

- Alcohol is by far the most widely abused drug in rural areas.
- Prevalence rates for some drugs (such as cocaine) appear to be lower in rural than nonrural areas. Prevalence rates for other drugs (such as inhalants) may be higher in rural areas than elsewhere.
- Total substance abuse (alcohol abuse plus other drug abuse) rates in rural states are about as high as in nonrural states [p.24].

The goal, therefore, is to develop multicultural training that will enhance understanding of the individual within their social context, whether urban, suburban, or rural. This approach broadens the perspective of the practitioner beyond the individual viewpoint with the study of the community, its different ethnic groups, its recent history, its socioeconomic features, neighborhood dynamics--subculture, language, uniqueness, ... [Feldmen, Mandel & Fields, 1989]. This process allows the practitioner to utilize a systems approach to bolster individual and family clinical skills to impact the substance abuser. Their service delivery would include a systems analysis heightening cultural sensitivity and specificity through appreciation of:

1. Demographic features of the community--urban, suburban, and rural;
2. Culture, social and neighborhood aspects of the client's world;
3. Specific traits--ethnic, gender, sexual preference, language, custom, etc.
4. Localized resources (or lack of) that service these diverse populations and need to be part of the analytical process. [1989, p. 115]

Another major systemic issue facing health care professionals is the magnitude of drug use during pregnancy and the resultant effects on the fetus and the neonate. The prevalence and sequelae of both licit (alcohol and prescription drugs) and illicit (heroin, methadone, cocaine, etc.) drugs during pregnancy indicates a significant substance abusing problem facing our country. The National Association for Perinatal Addiction, Research and Education (NAPARE) estimated 375,000 drug-affected babies are born each year in the United States. In 1988, some 600 documented cases within Massachusetts were reported of babies addicted to drugs or neglected by drug-addicted parents. Among these affected babies, 288 were born addicted to heroin or

other opiates, up 52 percent from 1987, as reported by the Department of Social Services [Boston Globe, 1990].

Cocaine use has even more deleterious effects on pregnancy [NEJM, 1986; Chasnoff, 1986, 1987] exposing the infant to greater risk of congenital malformations, perinatal mortality, and neurobehavioral impairments. Cocaine increases the risks of complications during labor and delivery causing precipitous delivery, fetal heart rate abnormalities, fetal meconium passage, and perinatal cerebral infarction [Chasnoff, 1987].

> Medical complications in infants born to drug-dependent mothers generally will be influenced by: (1) inadequacy of prenatal care; (2) the presence of obstetrical or medical complications in the mother; and (3) multiple drug use.... The general medical complications seen in infants . . . encompass those problems seen in low birth weight infants. They include: asphyxia neonatorum, intracranial hemorrhage, pneumonia, septicemia, hypoglycemia, hypocalcemia, hyperbilirubinemia, and respiratory distress syndrome. With the increase of human immunodeficiency virus possitivity in this population of mothers, there is an increased chance of the infants having Acquired Immune Deficiency Syndrome (AIDS)" [Finnegan, 1989 a, p. 178].

Similar to the effects of Fetal Drug Syndrome (FDS) is that of Fetal Alcohol Syndrome (FAS), which is on the same order of magnitude as Down's Syndrome and spina bifida. These three disorders constitute the leading causes of birth defects associated with mental retardation. FAS, though, is unique among the three in having a known teratogenic origin and in being completely preventable [NIAAA, 1987]. Functional criteria to formulate the diagnosis of FAS are: growth retardation with a birth weight below 5 lbs. 5 oz.; Central nervous system abnormalities, including abnormal neonatal behavior and mental retardation; and a cluster of unique facial features. Other organic symptoms include heart, kidney, skeletal and ophthalmologic

problems [Chasnoff, 1987]. Researchers utilizing this diagnostic criteria have determined an incidence rate of FAS ranging between one and three infants per 1000 births. This incidence translates to over 3000 FAS babies born yearly. The prevalence factor markedly increased to 9.8 per 1000 births among one particular high-risk American-Indian population [Chasnoff, 1985; NIAAA, 1987].

The management of maternal and neonatal substance abuse problems is a major challenge to practitioners. There are a number of factors that treatment personnel must address to create the opportunity for substance-abusing pregnant women to be served. As part of the initial intervention and treatment process, their physical, psychological and social status must be assessed to create an environment of trust and advocacy. These women need to be treated in a non-threatening or non-guilt-provoking manner, creating a therapeutic environment decreasing the fear of retaliation, arrest, loss of infant and/or other legal consequences. Over the years, laws were created to limit the availability of drugs and to control users determined to be dangerous to themselves and others with some positive results. However, these mandates brought about the opposite effect to substance-abusing pregnant women, causing fear and intrepidation interfering with medical attention for the pregnancy and their addiction problem. Hospitals began screening all newborns exhibiting symptoms of exposure to a controlled substance.

> Any positive test results might then be used as evidence to prosecute the mothers for illegal drug use, a misdemeanor that unless the offender enters a drug treatment program carries a mandatory sentence of ninety days in jail.

'This new plan draws criticism from many.' The following scenario--a woman has just given birth. Social services becomes involved because the infant is suffering withdrawal symptoms. Social services just wants to help the woman and the child. A law official enters and reads the woman her rights. The woman refuses to be truthful and social services is unable to help. The woman may then risk having her baby taken away because social services may rule she is uncooperative and unable to protect her child.
[LaCroix, 1989, p. 585]

This scenario is further complicated by the dynamics of the woman's personality, family background, addiction and developmental problems hampering the opportunity for appropriate medical intervention for mother and child. Figure V illustrates the potential harm to both mother and child if proper intervention, treatment, and long-term care is not offered:

	FACILITATIVE FACTORS			DETRIMENTAL FACTORS	
	Normal Infant	Normal Mother		Addict Mother	High Risk Infant
PRENATAL COURSE	Regular Care			Irregular, Late or Absent Care	
	Good Maternal Health			Poor Maternal Health	
	Drug Free Good Nutrition		INTRAUTERINE ENVIRONMENT	Multiple Drugs Poor Nutrition	
	Positive Supportive		RELATIONSHIP WITH HUSBAND	Absent Spouse Disturbed Relations	
POSTNATAL COURSE	Supportive Conflicts Resolved		RELATIONSHIP WITH	Deficient Post Caretaking Unresolved Conflicts	
	Minimal Mother-Infant Separations		MATERNAL ATTACHMENT	Prolonged Separation	
	Nurturing Care and Concern		CARETAKING BEHAVIOR	Inability to Gratify Infant Negative Response	

FIGURE 5. Selected Potential Factors Influencing Normal and Addict Mother-Infant Outcomes

SOURCE: Kantor, G. N. (1978), Addicted mother, addicted baby--A challenge to health care providers, The American Journal of Maternal Child Nursing, p. 283.

It is, therefore, essential to develop comprehensive intervention and treatment programs for these high-risk pregnant women and their infants. Services would provide intensive prenatal management, substance abuse and psychological counseling, prenatal/parenting and basic education classes, psychiatric therapy when necessary, and methadone maintenance. The system would provide a therapeutic environment offering treatment in lieu of prosecution under special affiliation with criminal justice systems. Finnegan [1989] developed some specific recommendations for comprehensive care for mother and child:

1. The pregnant woman who abuses drugs must be designated as high risk and warrants specialized care in a perinatal center where she should be provided with comprehensive services including pharmacotherapy for her addiction, when indicated, obstetrical care and psychosocial counselling.

   a. Pharmacotherapy for the addicted pregnant woman may involve voluntary drug-free therapeutic communities, methadone detoxification (depending on the time in pregnancy when it is requested) or methadone maintenance.

   b. The pregnant drug-dependent woman should be admitted to a hospital setting where a complete history and physical examination may be accomplished, including laboratory testing to evaluate her overall health status.

   c. Psychosocial guidance should be provided by experienced counselors who are aware of the medical as well as the social and psychological needs of this population.

2. Careful attention must be given to the assessment and management of the newborn with regard to potential morbidity because of perinatal stresses as well as the onset, progression, and pharmacologic treatment of abstinence.

   a. Mother/infant attachment should be encouraged prenatally and postpartum. To decrease the possibility of child neglect, special emphasis should be on enhancing parenting skills of these women.

b. The continued ability of the mother to care for the infant after discharge from the hospital must be assessed by frequent observations in the home and in clinic settings.

[Finnegan, 1989 b, pp. 180-181]

The necessity for staff training in maternal and neonatal intervention, management and treatment is vital due to the complexities of this dynamic. The following factors create difficulty in assessment and early intervention: motivating the mother to seek prenatal care, potential physiological risks for fetus and mother, legal issues regarding use and/or potential child abuse, and the attitudes that substance-abusing behavior by pregnant women engenders. The challenge to health care professionals is long overdue, having approached this special population with almost benign neglect historically due to the implications of FAS and FDS [NIAAA, 1989, 1991; NAPARE, 1990].

E. The Burden Placed on Universities, Schools, Treatment and Self-Help to Develop Competent Professionals in All Phases of Training

Considering the issues presented concerning the data, information, knowledge, attitudinal and systemic needs facing the practitioner on substance abuse--training becomes a crucial part of professional development. This training must be comprehensive involving knowledge, skill development, and attitudinal awareness/ development at all levels of training, encompassing (1) general awareness, (2) special skills education, and (3) integrative development for both professionals and paraprofessionals. The need for training is well documented because of the disparities and dialogue seen in ideology, etiology of, diverse populations, and systemic issues--affecting every phase of prevention, intervention and treatment of the substance abuser [NIDA, 1985; Googins, 1984d; Levinson & Straussner, 1978; Schlesinger &

Bare, 1986; Schwartz & Taylor, 1989]. In addition, the present substance abuse dilemma strongly defines the need for more practitioners, either professional or paraprofessional, to service this specialized abusing population [George, 1990; Lawson and Lawson, 1989; Ewan and Whaite, 1982]:

> Several personal attributes are essential before a trainer can complete a peer training program successfully. The success of training lay helpers depends upon four attributes:
>
> 1. a belief in the validity and integrity of teaching others helping skills;
>
> 2. a possession of energy necessary to initiate, develop, and complete a training program;
>
> 3. the ability to modify model training procedures to fit the system in which the training takes place; and
>
> 4. the willingness to trust those trainees that have been trained to carry forth the work.
>
> [Tindall & Gray, 1989, pp. 1-2]

The federal government has made a concerted effort to address this need for... "Primary care providers (physicians, nurses, psychologists, social workers, etc.) are in a critical position to prevent, diagnose, and intervene early in drug and alcohol abuse problems. However, studies have shown that provider attitudes along with inadequate training and knowledge are often barriers to effective care of substance abusers. In an attempt to increase the involvement of medical and health professionals, NIDA and NIAAA have, in the past, supported a variety of education programs and activities..." [NIDA, 1985].

Training and Skill Development Models

The response to these issues comes within the sphere of education, training, ongoing in-service and staff development dedicated to the training of professionals and

paraprofessionals. The literature reflects extensive training models that are designed more specifically towards unique skill development or discipline. These training designs and curricula delineated from the primary care models will be initially presented:

1. Health Care Providers Training Models

NIAAA and NIDA assisted six national medical specialty organizations--The American Psychiatric Association, the Society of Teachers of Family Medicine, the Society of General Internal Medicine, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, and the Ambulatory Pediatric Association--to explore training needs for their professionals. These groups conducted surveys of their medical faculties and identified two major needs: (1) increased faculty expertise in alcohol and other drug abuse teaching and (2) the incorporation of clinical skills development as an essential component of a teaching program [NIAAA/NIDA, 1985, 1986, p. 1].

This produced a number of specialized training designs for physicians and other health-related professionals--nursing, social work, ... The project goal was to develop and demonstrate effective models for integrating alcohol and other drug abuse teaching into the medical and nursing education curricula. The model curricula are based upon discipline-specific knowledge and skill objectives addressing undergraduate, graduate, residency and faculty training needs. The project was divided into two phases: (a) Minimum knowledge and skills objectives for alcohol and other drug teaching for the six medical specialty organizations, and (b) Model curricula for alcohol and other drug abuse physician and nursing education [NIAAA,

1989; NIDA, 1986]. Twelve programs were established within universities, medical and nursing schools, and hospitals, as follows: Brown University School of Medicine, Center for Alcohol and Addiction Studies; Society of Teachers of Family Medicine; the Johns Hopkins Hospital; the Johns Hopkins University School of Medicine; Medical College of Virginia; Vanderbilt University; University of Alabama at Birmingham Medical Education Facility; University of Virginia School of Medicine; University of North Dakota School of Medicine; New York University Division of Nursing; The Ohio State University College of Nursing; and the University of Connecticut School of Nursing. All the projects included the following components: (1) A working faculty committee to meet alcohol and other drug instructional needs and develop curriculum objectives; (2) Development of curriculum and test piloting of a selected segment of the curriculum; and (3) A 14-month implementation and evaluation phase [NIAAA/NIDA, 1989, p. iii]. These curricula were developed as model training designs reflecting a wide variety of specialties offering knowledge, skill development, and attitudinal awareness (KSA's) for professionals, students--both undergraduate and graduate, and faculty.

2. <u>Hazelden Counselor Training Program</u>

This training program is a year-long experiential model predominantly for recovering addicts utilizing the concepts of Minnesota model and the Twelve-Step Program of Alcoholics Anonymous. The chemical dependency counselor is assigned to the Hazelden Rehabilitation Program, a 200-bed facility which includes a medical skilled unit, primary and extended rehabilitation and family program. After careful screening and selection, the trainee becomes part of the multidisciplinary team by

observing, interacting, and working in an experiential training process which exposes the counselor to all phases of treatment. The program has four quarters (phases): first, as observer, in all treatment units to develop an understanding of interviewing techniques and paperwork; second quarter on learning case management through observation, co-case management and actual case management; third quarter, developing more proficiency in case management skills, conflict resolution, referrals, etc.; lastly, becoming proficient through required academic units on specialty components. This design is an experiential one requiring specific commitment to the facility for a one-year period and has begun to offer credits towards a degree [Laundergan, Flynn, & Gaboury, 1986]. The experiential training for recovering persons is well founded, as in the "helper-therapy" principle, providing enhancement of self-esteem, role modeling, and esprit de corps of the group members involved [Hahn & Stephen, 1981].

Training Criteria for State-of-the-Art Enhancement

This study explores existing training designs as models and identifies the needs/gaps to be addressed. Development of The Training in Empowerment Model for Professionals/Paraprofessionals is part of this study and will assist practitioners to impact the substance abuse field. The training model incorporates these universal training criteria paraphrased from the OSAP Prevention Manual--Prevention Plus Two [1989] to help professionals/paraprofessionals understand, deal with, and become effective practitioners to treat substance use, abuse, and addiction. The model contains the following elements:

1. Comprehensive Design

The training model uses multiple approaches, diverse and multi-discipline staff, utilizing creative interventions to address affect, biases, myths, general knowledge of substances, epidemiology, terminology, etiology, and treatment options --diagnosis, evaluation screening, and delivery of services--involving primary, secondary, and tertiary prevention of substance abuse.

2. Attitudinal--Affective Based Training

Training includes the enhancement of affective areas--feeling, emotions, prejudices, beliefs, myths, ... of the professional/paraprofessional due to the historical nature of dysfunction, tendency towards regression, and the long chronic struggle of the addict/alcoholic. Design allows for open dialogue, expression of fear, potential failure, and counter transference issues of the practitioner in working with these clients. Due to the dynamics of illicit, criminalistic, violent and/or repeated dysfunctional behavior, the practitioner needs to address the impact of the nature, duration, and potential success and/or failure of treatment. The issue of integration signifying respect and appreciation of each person's role between professional and paraprofessional must be dealt with. This allows for team building, enhancement of treatment focusing on the burden of client services.

3. Incorporate Multiple Alternatives and/or Treatment Options

Training must include assessment/evaluation for treatment determination to explore all types of interventions--professional, self-help and alternative resource and/or systems. Practitioners need to view the diversification of these high-risk clientele while formulating the basis of integration and collaboration between

professional, self-help, and systems--criminal justice, law enforcement, prosecutorial and judicial, treatment personnel, medical/specialty, recovering persons, ... to form teams and networks to work with abusing/addicted clientele.

4. Develop Continuum of Care Models

The training model will help the practitioner understand that the primary client is not only the addict but his/her family, neighborhood and community. All aspects of the person's dynamics and family structure must be included involving the terms pathology, dysfunction, motivation, regressive behaviors, risk factors, and the other variables that affect the person, their behavior and/or situation. Existing theories are explored: physiology, psychology, and sociology of use, abuse and addiction, personality dynamics, medical and disease concepts, environmental and learning theories, and a host of concepts determining cause and effect, public health approaches--prevention of the disease, dealing with the host, agent and the environment.

5. Empirically Based Training for Selecting and Developing Intervention and Treatment Strategies and Implementation

The training model will conduct a review of existing treatment programming and theory through literature review of existing research, evaluation and program assessment to determine successful strategies, programs and options in the prevention, intervention and treatment of at-risk and high-risk substance-abusing populations. Practitioners need to explore "other" concepts of alternatives in the development of their professionalism. Evaluation criteria of process, outcome, and impact assessment

are integrated to familiarize practitioners with research, evaluation, and assessment methodology.

CHAPTER III

METHODOLOGY

A. Overview

The purpose of this study is to determine the perceptions of professional and paraprofessional practitioners regarding training and staff development that directly affects competencies, skills, and service delivery.

A more focused view for the professional/paraprofessional begins to emerge, redefining the practitioner's mandate to develop systems, treatment options, and/or creative alternatives in responding to substance abuse dysfunction. Alcoholism or drug addiction is not only an inner-city or socioeconomic problem but crosses all economic lines, impacting urban, suburban, and rural cultures. It affects all ethnic groups, genders, and ages, signifying the diversity of the problem and its impact upon the individual, family, and community [OSAP, 1989a].

Substance abuse programs need to assess the quality of their services, the expertise of their staff, and the function of staff development. This will enhance treatment services, reduce burnout, increase staff retention, and impact community linkages to best serve substance-abusing clients. Emphasis, therefore, should concentrate on the training of staff both on the pre-service and in-service level to explore the state of the art in the substance abuse field.

It is expected that by systematically studying professional and paraprofessional perspectives of training, especially training practices within their treatment programs, a better understanding of practitioner development will emerge. Rather than testing

staff development through a quantitative paradigm, the goal of this study is to obtain a more comprehensive staff perspective on training activities designed to enhance substance abuse treatment. The findings were generated from questionnaires and follow-up interviews with selected staff and training personnel within a treatment system.

Hammersley and Atkinson [1983] recommend the use of qualitative methods when a generalized account of perspectives and practices of a particular group is under initial investigation. The qualitative research method chosen in this study provided a useful approach for describing and interpreting the perspectives of staff and trainers. Questionnaires and interviews with staff provided rich, contextual information about the practitioners' views and attitudes on training and staff development. Insights on training derived from the descriptions and the meanings attached to them would not be as flexible utilizing quantitative survey methods only [LoFland & LoFland, 1984].

Borich & Jemelka expand on the illumination model of value-oriented inquiry developed by Parlett and Hamilton [1976]:

> This approach to evaluation relies heavily on open-ended observations (but also questionnaires, interviews, and tests) to continuously record ongoing events in order to identify (a) critical and nonobvious characteristics of a program, (b) the tacit assumptions underlying it, (c) interpersonal relationships affecting it, and (d) complex realities surrounding the program [1982, p. 75].

Erickson [1986] has suggested that qualitative or naturalistic research can be useful in interpreting what is really happening within a setting because the participants frequently fail to interpret events and processes as they are occurring. Direct service

providers and trainers require more understanding about the nature of staff development and, in particular, its impact on the client. A holistic view of staff development can be analyzed studying the "rich descriptions" available through qualitative methods [Borich & Jemelka, 1982]. Finally, it is anticipated that increasing professionals' awareness of the premises on which they practice as well as the resulting team participation--will have the potential to promote shared responsibility between professionals and paraprofessionals within the field.

One way to achieve these goals is through integrative training with practitioners (both professional and paraprofessional) at all levels of their education, experiential training, and/or professional tenure. This process can be described as training improvement through qualitative research. It is the intent of this study to explore these areas to determine what potential change, improvement and/or new methodologies are necessary for education and/or training of practitioners.

B. Sample Programs

This study utilized a number of treatment programs to explore their training programs or designs offered as part of staff development. Both administrative/ training and treatment personnel were asked to participate through a questionnaire format used to gather data on existing training practices. It also explored practitioners' perceptions of training needs/gaps for future field training. In addition, a small sample of staff were interviewed to further augment the data gathering process. Several programs were involved in the study, representing various treatment modalities servicing both alcohol and other drug abusers.

The study sample comprises four (4) treatment programs to ascertain training and staff development policies and to isolate methodalities, procedures, and designs utilized to enhance program personnel. Programs chosen involved a variety of staff--both professional and paraprofessional--to ensure that all levels of staff are utilized in the service delivery--professional, paraprofessional, multi-disciplined, experiential, volunteer.... Feedback from these sample programs reflected existing practices with needs or gaps in training while also demonstrating the search for integrated training of both professionals and paraprofessionals to impact service delivery.

The four (4) programs involved in the study are basically urban-based treatment programs offering a variety of services to substance abusing clients. Several were located in urban sites yet offered services in various locations to accommodate accessibility and resources to clients in need of specialized treatments. The types of substance abuse treatment programs involved in this study were:

A. **a hospital-based detoxification and short-term rehabilitation program;**

B. **a free-standing mental health and substance abuse clinic and a specialized Driving Under the Influence (DUI) and Multiple Second Offenders Alcoholism Treatment Program;**

C. **a multidimensional service delivery involving a therapeutic community (TC), several residential programs, a detoxification unit, an outpatient methadone maintenance program and outpatient substance abuse counseling program; and lastly**

D. an urban-based specialized minority program offering residential, outpatient, methadone maintenance, outpatient and specialized correctional-based services.

One participating program was relatively new in origin while the other three have provided services over twenty (20) years. Clientele represented both male and female, adult and adolescent populations, including couples and family systems, culturally diverse groups--African-American, Hispanic, Asian--and special subcultures, gay and lesbians. All socioeconomic and diverse groups were serviced through careful assessment of the individual's need and the presenting problem which determined types of treatment. The more recent populations seen were the diagnosed co-morbid, or dual diagnosed client, the homeless, AIDS and HIV-Positive infected, and substance abusing pregnant women and teens. All programs have fully established networks of referral systems--law enforcement, courts, Department of Social Services, school systems, correctional institutions, hospitals and other substance abuse treatment systems. Of great importance is that all programs utilized self-help programs--Alcoholics Anonymous (AA), Al-Anon, Alateen, Narcotics Anonymous (NA), and other support groups as part of the ongoing treatment and aftercare process.

The primary substance abuse patterns treated were alcohol, marijuana, opiates-heroin, methadone and other derivatives; hallucinogenic drugs--lysergic acid (LSD), phencyclidine (PCP), cocaine (including crack), and other amphetamines, depressants --barbiturates and tranquilizers including valium, librium, thorazine. As defined earlier, poly-drug use is quite predominant, further complicating diagnosis and

treatment goals, medical detoxification, therapeutic efforts, extending treatment duration and phases. The programs treated both voluntary and coerced clients--court-mandated, diversion and/or adjudicated offenders--as part of the judicial mandate. Several of the programs provided assessment/evaluation as well as direct treatment within correctional facilities--The Department of Youth Services, County Jails, and Houses of Correction and Correctional Institutions in the Commonwealth of Massachusetts.

All programs were multidisciplined utilizing professional and paraprofessional staff. The various disciplines noted were psychiatry, medicine, nursing, psychology, social work, counseling, education, vocational and rehabilitation counseling, occupational therapy, and self-help. Although the programs are somewhat different in history and specific services rendered, there appeared to be a commonality in their recognition of the continuing care necessary for positive treatment outcomes. This treatment continuum encompasses the identification of, outreach, assessment/ evaluation, formulating treatment goals and objectives, maintenance of care, termination, aftercare and follow-up. All systems recognized the difficulty of diagnosis, the complexity of poly-drug use, co-morbidity, "dual diagnosis," family dysfunction or disintegration, AIDS or HIV-Positive, homelessness, and at times the extreme resistance and massive denial of the client. These conditions are further exacerbated by a lack of resources through severe fiscal constraints or cutbacks to programs--resulting in staff reductions, service cutbacks and/or terminations.

These systems are operating despite adverse factors--the nomenclature and dynamics of these difficult clients and the present social aura of tight fiscal

constraints, lack of resources, and a community climate that is negative and hostile towards substance abusing individuals.

These trends only heighten the pressure on programs to create sound systems of treatment services that will service client needs while being cognizant of the importance for responsive staff development and in-service training.

C. Instrumentation

Initial research activity consisted of identifying components and elements of training/staff development from the literature and personal inquiry--to develop a questionnaire and focused interview for staff and training personnel. (Refer to Appendices D-H for the Staff and Administrative/Trainer Questionnaire data.) Both the questionnaire and the focused interview were the major methods of data collection in this study. Lofland and Lofland [1984] suggested a flexible, open-ended format for interviews but also endorsed using an outline of questions to ensure the inclusion of key areas. A common core of questions allowed for the comparative analysis of the respondent's answers. Since the questionnaire and the focused interview with a select sample of participants would constitute the major source of data, careful attention was given to the choice of methodology.

As defined, this is a qualitative study utilizing several questions that explore training and staff development within the substance abuse field. The idea grew from the researcher's curiosity as to which factors among staff affect their ability to impact substance-abusing clients. Therefore, the choice of how the researcher can address this issue was considered in determining the methodology to be used in gathering this essential data. The researcher examined several possibilities--survey, experiment,

interview, and observation--with the focus on what approach would maximize the questions and the acquisition of useful data. The purpose of this study was to report the practitioners' views on training and staff development in aspects of their professional work. Following this analysis, it was determined that the most effective way to assess these perceptions was to directly ask participants through an open-ended questionnaire and by in-depth interviewing. This qualitative or experiential methodology was utilized for data collection, allowing both professional and paraprofessional practitioners to share their experiences, concerns and/or needs.

Giorgi [1970] believes that "understanding is gained through intensive description--not merely a report of what is happening, but a combination of the data of experience, its meaning for the subject and most particularly the essence of phenomena." He further adds that this method requires "emphasis on the phenomenon itself exactly as it reveals itself to the experiencing subject in all its concreteness and particularity" [1970, pp. 9-10]. Therefore, the methodology used as part of this qualitative study is within the realm of "...the search for an understanding of experience--both its processes and its content--determines the scientific stance of the experiential researcher" [Rosini, 1976, p. 49].

<u>Development of Questionnaire</u>

The questionnaire was designed as open ended to allow respondents to reflect their thoughts and feelings regarding their own level of skills and expertise. Most importantly, they are able to indicate those areas of training that enhance their knowledge base, skills and attitudes. The eleven (11)-item survey was designed as an open-ended questionnaire in two (2) distinct formats for both administrative/training

and direct treatment personnel. The questions were clustered for data analysis into seven (7) major areas of focus defining (a) respondent's background, title, degree and type of service delivery; (b) types of existing in-service training; (c) most significant training issues; (d) most significant areas for treatment--knowledge, skill development or attitudinal awareness; (e) priority areas for training; (f) areas most crucial in training during pre-service, in-service, or ongoing staff development; and (g) efforts of co-joint training for professional and paraprofessional staff.

The intent of the questionnaire is to create a qualitative or descriptive format for the participants. The open-ended survey and focus interview allow for greater latitude for the participants to reflect on their training, either pre-service or in-service. This approach provides more fluidity and value-oriented data compared to a more defined measurement such as the Likert Scale. Substance abuse treatment personnel need to take more responsibility for their own development, and the open-ended format allows for more descriptive and participatory involvement. This qualitative approach provides a sensitizing instrument which gives "a general sense of direction" and "direction along which to look." Brumer [1969] further elaborates that sensitizing concepts are communicated by:

> ...exposition which yields a meaningful picture, abetted by apt illustrations which enable one to grasp the reference in terms of one's own experience. [cited in Taylor & Bogdan, 1984, p. 133]

Focus Interview

A select number of participants received follow-up interviews to explore the data generated by the questionnaire in greater depth. These focus interviews utilized

the predominant questions from the survey; providing for direct interaction with selected participants in augmenting the data collection process. A background information form was established to create an ethnographic profile of the practitioners interviewed. (Refer to Appendix I.) The profile characterized the role, title, degree, level of experience, sex, ethnicity, type of facility, supervision provided or received, acquired professional status (through degree programs, specialty training, continuing education, or on-the-job training), and professional or paraprofessional status of the participants.

The "focused interview" is used with participants known to have been involved in a recognized experience and when the researcher has already provisionally analyzed that experience. As Merton, Fiske and Kendall [1990]--the developers of the "focused interview"--explain, "The interview is focused on the subjective experience of persons exposed to the preanalyzed situation in an effort to ascertain their definition of the situation" [1990, p. 3].

The interview was semi-structured, open-ended, and initiated by the questions utilized within the survey. The interview guide is not a structured schedule or protocol but is a list of general areas to cover with each respondent [Taylor and Bogdan, 1984]. The survey questions were referred to throughout to ensure that the key topics were covered in the interviews.

The interview began with a brief review of the purpose of the study and an expression of appreciation for the subject's willingness to participate. The subject's rights to control their responses in the study were discussed and the safeguards for confidentiality built into the process were discussed. This initial discussion provided

an opportunity for the researcher to establish rapport and for the participant to be comfortable in responding to their perceptions, attitudes, and needs regarding training. Length of the interview was approximately 30 to 45 minutes.

The researcher conducted the interview, initiating discussion covering the questions utilized in the survey. Areas of inquiry focused on general topics to be covered yet allowed for respondents to address any of their views. The interview ended when the respondent had covered all questions and indicated they had given all their responses to the interview process. During the interview, note taking was used to record the information as per the questions presented. LoFland [1971] recommends taking "sparse notes--key sentences, key words, etc....in the course of the interview itself to keep account of what has already been talked about and what remains to be talked about...for the purpose of remaining 'on top' of what is going on in the interview." Process notes were written immediately after the interview to record impressions and feedback. Taylor & Bogdan comment, "Like the observer, you should make note of emerging themes, interpretations, hunches, and striking gestures and non-verbal expressions essential to understanding the meaning of a person's words" [1984, p. 104].

D. Data Collection

1. Site Selection

As discussed, four (4) treatment programs were selected representing a cross-section of professional and self-help service delivery models to assure a fair sample of programs that serviced substance-abusing clients. All were predominantly urban based treatment systems with multi-dimensional services and staffing patterns.

The process of agency involvement started when preliminary approval was received from Agency Administration through telephone contact. This contact described the intent of the study and requested their involvement by responding to the questionnaire and follow-up interviews. The telephone contact was followed up by a formal letter of request for participation which defined their involvement and the intent of the study. In addition, these items were sent: A) an abstract of the dissertation; B) an Administrative/Training Personnel Questionnaire; C) an Intervention, Therapeutic, Support Personnel Questionnaire; D) a Consent Form; and E) instructions to fill out the questionnaire. (Refer to Appendices.) An appointment was then made to meet directly with the director or key personnel to further orient them to the study and to clarify their participation. Upon final approval, all of the above forms were mailed in sets (approximately 15-20 per program) for staff with an addressed, stamped return envelope to the researcher. All four programs responded positively to the request for participation within the study, indicating that the basic premise of exploring training and staff development was significant to the field. The designated person, either the Executive Director or the Training Director, distributed these documents to direct treatment staff. The number of participants depended on the size of the system and the willingness of staff to be involved.

2. Agency Training Data

Agencies were asked about their training and staff development programs, including schedules, models, curricula, and archival data. Aspects of this data were analyzed to identify factors such as similarities and/or differences in staff development with emphasis on knowledge, skill development, and attitudinal awareness.

3. Participant Involvement

The number of questionnaires returned were 27 out of 50 distributed, for a response level of 54%, and the follow-up interviews numbered 16. These data collection methods were used with administrative/training and therapeutic staff to determine their views on the formal and informal aspects of training including both pre-service and in-service. These data were tabulated to analyze existing feedback, trends, needs/gaps in the concentration of knowledge, skill development, and attitudinal awareness. In addition, participants were asked to express their perceptions on what they needed in substance abuse training--assessing their professional or self-help training, pre-service--education, curricula, specialties, or in-service/staff development--experiential or on-the-job training. The use of questionnaires and focus interviews established baseline data for staff and training personnel. The staff (both professional and paraprofessional) responded to the survey to offer their opinions, values, and experiences or training to determine what issues were most prevalent in their professional development and/or to define potential areas of need.

E. Data Analysis

Data from all sources were categorized, organized, and summarized employing content analysis on all written and verbal responses. First, identifying data of the participants responding to the questionnaire were summarized--position, education, and type of service delivery. The data from the questionnaire were tabulated using the eleven (11) items that participants were asked to respond to. The data were then summarized and clustered in the seven (7) major areas of focus. A sampling of these

responses was presented directly relating to the seven (7) major areas. Any significant trends, outstanding patterns and/or repetitive data were presented and analyzed. This process allowed the data collected to be demonstrated as defined through the participants' perceptions in responding to their experiences and/or needs of training and staff development.

A similar yet more intensive data collection process was followed for the focus interviews due to the close proximity of researcher and interviewee. The focus interviews allowed for more spontaneity and expansion by the participants through in-depth response of their experiences and perceptions regarding professional development. Identifying data was extensive in defining the role, title, ethnicity, level of experience, sex, type of service, facility, supervision provided or received, acquired professionalism (through degree program, specialty training, continuing education, and on-the-job training), certification status, and professional or paraprofessional status of participants. The data from the interviews were tabulated, summarized, and categorized into the seven (7) major areas of focus. A sampling of these responses was presented with any trends or significant data being highlighted.

All responses from the participants, both trainers and staff, were carefully presented and analyzed to determine the findings pertinent to this study. These data analyses explored the existing level of training and noted the needs/gaps or specialized areas of concentration impacting the delivery of service and professionalism offered within the substance abuse field. Both the survey and focus interviews were utilized to enhance both qualitative and quantitative findings of the participant responses and to be categorized within the three (3) major hypotheses of this study.

This qualitative approach to examining training and in-service staff development of practitioners--both professional and paraprofessional--was utilized to determine which domains in knowledge, skill development, and attitudinal awareness and development should be improved and what type of training designs are necessary to achieve this goal. Essential to this quest is the method of training for education (pre-service) and staff development (in-service) which will impact the delivery of services. This approach will help to examine and test the following hypotheses that may impact the state of the art for training in the field of substance abuse:

a. **The training design must examine its capability to address the ever-changing needs and shifts within the substance abuse scene, allowing for the development of specialized individualized training programs for professionals/paraprofessional education, training and improvement.**

b. **The design must examine its capability to address one of the most prevalent gaps in training--that of attitudinal awareness, change and development.**

c. **The design must examine its capability to be an integrative model, bringing together professional and paraprofessional (self-help/recovering persons) to impact the substance user, abuser, and addicted youth, adult and/or families.**

CHAPTER IV

RESULTS AND ANALYSIS OF RESEARCH

A. Introduction

All data gathered in the process of this qualitative study are presented and analyzed in this chapter. Data from each instrument--the open-ended questionnaires and focused interviews--are presented separately. Both narrative descriptions and tables are used to explain the data. As defined, the two methods of data collection were utilized to obtain a fair sampling of administrative, supervisory, training/staff development personnel and direct line practitioners. Both methods involved professional and paraprofessional staff who were engaged in treating the AODA population.

Throughout all levels of inquiry, the researcher experienced excellent cooperation, courtesy, and investment from all four (4) systems. During my visit to programs, and staff orientations, there was a high level of involvement and participation by each practitioner who reflected interest and concern regarding the study. As defined through the data collection process, their responses are presented in this order: (1) identifying data, (2) summarized data within the seven (7) major focus areas, and (3) summarized data within the three (3) major hypotheses addressed by the study.

B. Material Obtained Through the Questionnaire

Characteristics of Total Sample

Twenty-seven (27) practitioners in the four (4) treatment systems responded to the survey instrument representing fifty-four percent (54%) of the total surveys distributed. More specifically, participants responded from the four (4) specific treatment systems in the following way: Hospital detox/rehabilitation--25.9%; outpatient--14.8%; multidimensional service delivery--11.1%; and urban-based specialty minority program--48.2%.

Table 1

Type of Service Facility

		N	%
A.	Urban-based specialty minority program	13	48.2
B.	Hospital-based detoxification and short-term rehabilitation center	7	25.9
C.	Free-standing substance abuse and Driving Under the Influence DUI Outpatient	4	14.8
D.	Multidimensional Service Delivery	3	11.1
	Totals:	27	100

Within the four (4) systems, the specific type of treatment programs offered were: a) Outpatient--55.6%; b) Residential--18.5%; and c) Hospital Detox and Rehabilitation--25.9%.

Table 2
Specific Type of Treatment Programs Offered

		N	%
A.	Outpatient	15	55.6
B.	Hospital Detox & Rehabilitation	7	25.9
C.	Residential	5	18.5
	Totals:	27	100

Within the four (4) systems, the roles of the participants were as follows: Administrative--22.2%; Supervisory--14.8%; Clinical Specialists--7.4%; and Direct Treatment--55.6%.

Table 3
Roles of Participants

	N	%
Direct Treatment	15	55.6
Administrative	6	22.2
Supervisory	4	14.8
Clinical Specialists	2	7.4
Total:	27	100.0

Of the total sample of twenty-seven (27) questionnaires, eighteen (18) titles and/or positions were identified and twelve (12) education degrees were noted. Figure Six denotes the title, educational, and self-help backgrounds of the participants.

Table 4

Participant Title and Educational Background

Title	N	PhD	MSW	MEd	MS	MA	MDiU	MA Nurse	RN Nurse	LPN BA	BS	Assoc	Para.
Executive Director	2			1		1							
Administrator	1					1							
Assistant Director	1												1
Residential Director	2									1		1	
Psychologist	2	2											
Social Worker	1		1										
Outpt. Supervisor	1				1 <-	——	-> (1) same						
Outpt. Counselor	2									1			1
Outpt. Case Manager	1					1							
Residential Counselor	1												1
Residential Case Mgr.	1												1
Nurse	2								2				
Nurse Clinician	1							1					
Sr. Counselor	1				1								
Primary Counselor	1					1							
DUI Counselor	1					1							
Counselor	3				1						1		1
Clinical Director	2		1							1			
TOTALS:	27	2	2	1	3	5		1	2	3	1	1	6

As identified within the eighteen (18) titles and/or positions, the educational backgrounds are as follows: Ph.D.--7.4%; Master's level--40.8%; Nurses (MA's, RN)--11.1%; LPN--3.7%; BA/BS--11.1%, Associate's--3.7%; and Paraprofessional--22.2%.

4a. Educational Backgrounds

	N	%
Master's Level	11	40.8
Paraprofessional	6	22.2
Bachelor of Arts/Science	3	11.1
Nursing--R.N., M.A.	3	11.1
Doctorate of Philosophy	2	7.4
Associate's	1	3.7
Licensed Practical Nurse	1	3.7
Total:	27	100.0

Presentation of the Data

The data collected through the questionnaire and survey phase were summarized in the seven (7) major of focus defined: (1) types of existing in-service training; (2) most significant training issues facing staff; (3) most significant areas for treatment--knowledge, skill development or attitudinal awareness; (4) What types of training to impact special populations; (5) priority areas for training; (6) areas most crucial in training during pre-service, in-service, or ongoing staff development; and (7) efforts of co-joint training for professional and paraprofessional staff. A detailed

sampling of responses will be presented in each major focus area to reflect the opinions, experience, and concerns of the respondents from the four (4) treatment systems. A representative profile will be presented utilizing responses from all twenty-seven (27) surveys. Two of the questions represent the entire sample due to specific responses and will be presented quantitatively.

This data will also be summarized into the three (3) major hypotheses which specifically cover: A) the ever-changing needs and shifts within the field; B) attitudinal awareness, change and development, and C) integration of professional and paraprofessional resources. These responses will be presented to indicate priorities and concerns.

C. Summarization of the Seven Major Areas

1. Type of Existing In-Service Training

- women's issues, incest, aspects of substance abuse
- monthly in-service staff meeting
- clinical issues, medical administration, self-training
- group & individual counseling techniques, AIDS/HIV education, AODA training
- ethics, relapse prevention--model of treatment boundaries
- no one--allowed to go outside seminars
  eating disorders
  women's issues
  substance abuse issues
- topical issues and needs, basic counseling
- coping with loss, facilitating groups, management training

- treatment plans, case management issues, paperwork recording, dual diagnosis

- counseling techniques, AIDS/HIV education, treatment plan writing, theories and models for adoption

- female-specific issues, incest; physical & emotional verbal abuse, eating disorders, dual diagnosis, rational theory, stress/anger management

- no set schedule--on occasion--within hospital monthly

- disease concept, documentation, community agencies, seminars (occasional)--rational therapy, lesbian client, etc., in-hospital (monthly) women's issues, incest, ACOA, group work and group supervision (invaluable)

2. <u>Most Significant Training Issues</u>

- upgrading basic counseling, management skills

- cocaine abuse, dual diagnosis

- dealing with illiteracy, self-esteem building, update pharmaceutical issues (management, shifting)

- writing skills, counseling skills, dealing with turnover, limited salaries

- practical applicable clinical skills, fiscal responsibility to supplant training, proactive advocacy for training

- clients with histories of abusive relationships, recovery issues

- working with court mandated clients, involuntary clients

- pregnant women, eating disorders, post traumatic stress disorder (PTSD)

- counter transference, borderline PTSD characteristics, regression, boundaries

- director open to training suggestions, various topics, safe issues, incest

- criminal justice issues--probation/parole supervision, AIDS/HIV, co-dependency, early sobriety treatment issues

- terminology, stress management

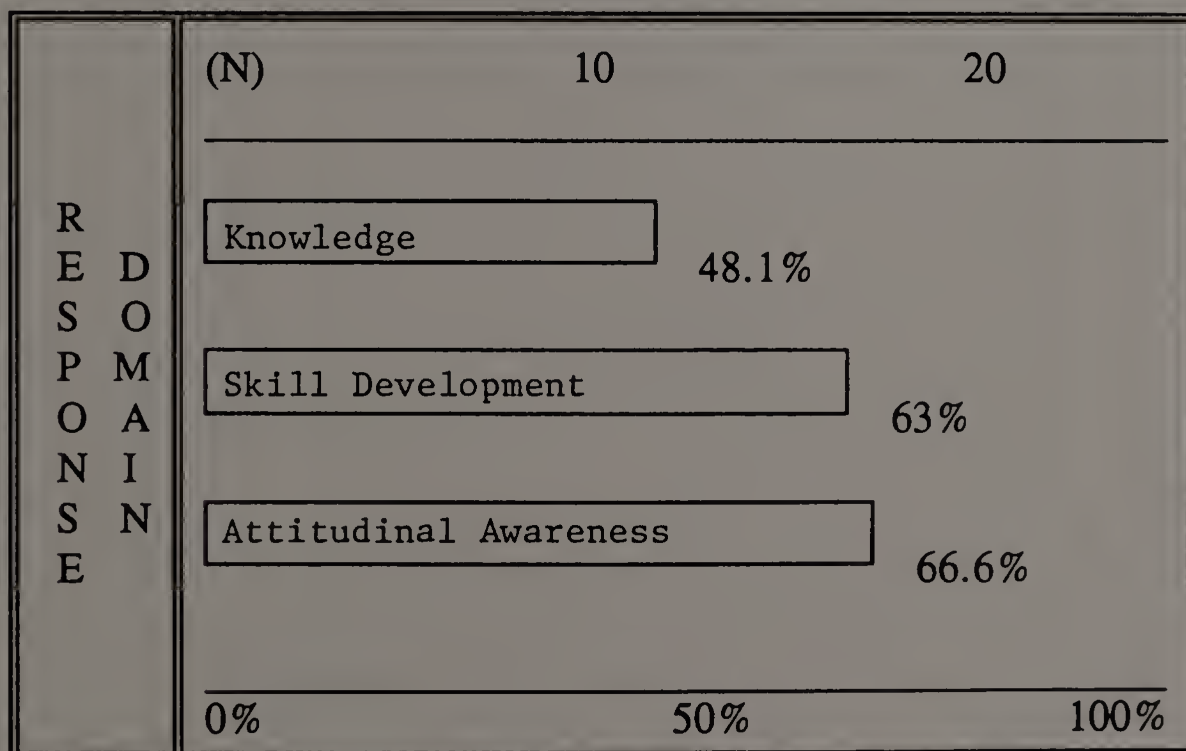
3. Areas Most Significant to the Treatment of Substance Abusing Clients--Knowledge, Skill Development or Attitudinal Awareness

Due to the specific variables in this question, all responses were tabulated and shown in the three (3) specific domains of a) Knowledge, b) Skill Development, and c) Attitudinal Awareness. All responses (N=27) were presented with some additional concepts highlighted. This demonstrated the perceptions of the participants as to which areas are most significant to enhance their treatment competencies. A combined table/bar graph is utilized to define the responses quantitatively.

Table 5

Areas That are Most Significant to Treatment of Substance Abusing Clients

Response Areas



These numbers represent the total sample (N=27) defining each domain, i.e., Knowledge, Skill Development, and Attitudinal Awareness.

Additional responses:

- Self-esteem, acceptance/trust
- Relapse prevention
- Attitudinal awareness is paramount
- Substance abuse, clinical intervention skills, positive attitude, one's ability to control the disease
- Choose attitudinal awareness plus empathy. Other people ask me "How did you get into that kind of nursing?" If you don't empathize, you'd never choose this field.
- First criteria--attitudinal awareness

4. **Types of Training That Should be Offered**

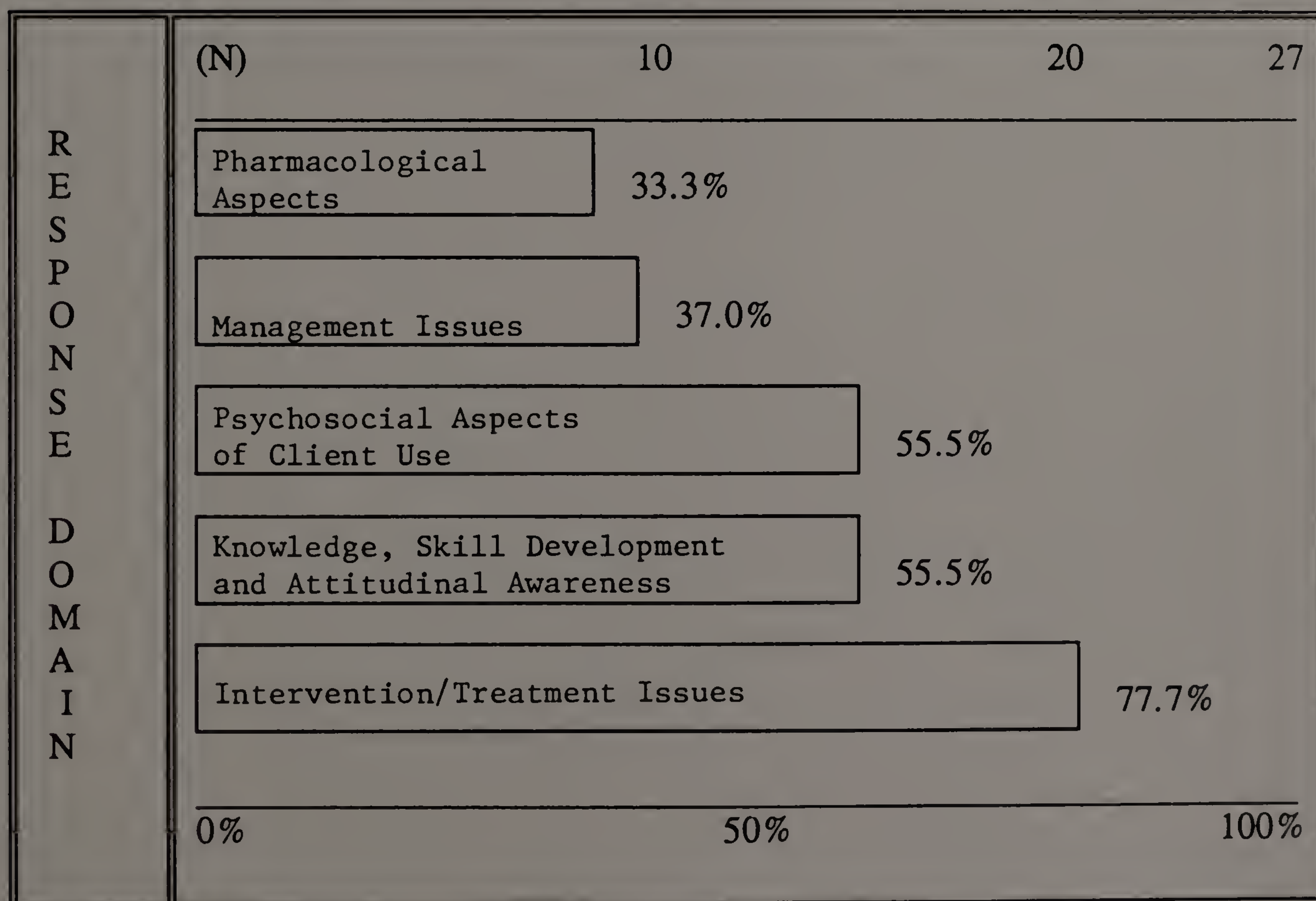
- Attitudinal awareness, gain trust
- Stronger self-esteem building strategies
- Self-esteem building, risk taking
- Skills that impact client change
- Clinical training on AODA, AIDS/HIV-Positive, confidentiality, psychotherapy
- Training focuses on success stories, approaches for clients who do not accept abstinence or AA approaches
- Heightened awareness of own attitudes and issues, particularly as how they play out in countertransference
- In-service on substance abuse issues, clinical skills, positive attitudes
- Behavior contracts, post-traumatic stress disorder, eating disorders
- Alcohol and drugs 101, gender differences, incest/rape, eating disorders, abnormal psychology

- Diverse cultural awareness, updated information on drugs
- More skill development, intervention/treatment issues

5. **What Are Most Significant Areas of Training--Five Variables**

Because of the specific variables in this question, all responses were tabulated and shown as presented: a) psychosocial aspects, b) pharmacological aspects, c) intervention/treatment issues, d) management issues, and e) knowledge, skill development, or attitudinal awareness. The following combined table/bar graph indicates the participants' perception of the most significant areas of training.

Table 6
Most Significant Areas of Training - Five Variables
N = 27



These numbers represent the total sample (N=27) defining each variable: which represent the training areas that practitioners need to enhance their skills. These areas were chosen because of their relative importance within service delivery and comprehensiveness offered to clients.

Additional responses:

- Family of origin; medical association of co-dependency to dependency; breaking the cycle of addiction; tools of management; process of processing emotions, intellect, spirituality; and behavior to deal with life

- Again, have to say as they are all important and interrelated. Choice intervention/treatment for short-term stay as social worker most interested in psycho-social aspects

6. **Areas Most Crucial in Training in Pre-Service, In-Service, or Ongoing Staff Development**

- Being aware of self

- In-service and ongoing staff development, updating pharmacologies

- Self-awareness, process of addiction

- Pre-service--practical applications, more work study, challenging training

- Pre-service--safe detoxification
  In-service--AIDS/HIV-Positive awareness, Pregnant addicts, Homeless populations

- Training both pre-service and in-service:
  Disease model
  Knowledge on substance abuse--drugs and alcohol
  Street drugs
  Family dynamics
  Group work
  Women's issues
  Cultural diversity and differences (race, sexual preference, class)
  Dual diagnosis
  Psychiatric disorders
  Legal system issues
  Department of Social Services

- Attitudes on substance abuse
  Education on intervention/treatment on the disease process

- In-service training
  Rational theory in terms of building and maintaining treatment team as well as in terms of client reality, i.e., women operate within context of relationships and recovery for women--must take this into consideration as opposed to traditional recovery attitude of autonomy

- Pre-service
  Skill needs--to get substance abuse curriculum in nursing and medical schools

- In-service
  Establishing boundaries of therapeutic relationship

- In-service
  To be able to accept constructive criticism

- Pre-service and training on substance abuse crucial.

7. <u>Co-Joint Training for Professional and Paraprofessional</u>

Majority of participants responded in the affirmative due to the construct of the question which can have a "yes" or "no" response. However, the responses were also determined by the work environment of the participant [Kilty, 1975]. This was observed within the responses of the four (4) treatment systems which reflected self-help to outpatient--to comprehensive treatment--to hospital detoxification. Representative staff were paraprofessionals to professionals--recovering persons to highly qualified professional and medical staff. For example, the self-help minority program staff (N=13) responded "yes" to the concept of "co-joint" training, while other programs reflected in the negative, viewing their programs as almost exclusively professional.

The responses are presented as follows: Yes - 17; No - 4. Affirmative (yes) 17--63%; negative (no) 4--14.8%.

Table 7

Co-Joint Training

	N	%
Yes	17	63.0
No	4	14.8
Other	6	22.2
	27	100.0

Additional responses:

- Through the Stone Center (Wellesley College), AIDS Mart and AA groups
- Approach is very much a team approach
- Not to my knowledge
- Sort of
- Co-joint training and staff development
- Attempts to train as well as send to outside training
- Outside training of other agencies
- Constant interaction is encouraged
- Our agency does not differentiate in training opportunities made available to clinical staff on basis of degree or certification.

D. Summarization of the Three Major Hypotheses

In this phase, the survey data will be summarized within the three (3) major hypotheses, specifically: A) The ever-changing needs and shifts within the field, B) Attitudinal awareness, change and development, and C) Integration of professional and paraprofessional resources. This study was designed to address these hypotheses and to explore training and/or staff development impact on staff and their service delivery for the substance abusing clients.

The data from the questionnaires were summarized and categorized through content analysis to test out each specific hypothesis. The first hypothesis explores the training design or program offered to address the ever-changing needs and shifts--with the underlying emphasis of knowledge and skill development needed to enhance the practitioner's level of competency, comfort, and professionalism. Through content analysis and comparative examination of the questionnaires (N=27), all three hypotheses will be presented.

First Major Hypothesis

The training design must examine its capability to address the ever-changing needs and shifts within the substance abuse scene, allowing for the development of specialized individualized training programs for professional/paraprofessional education, training and improvement.

Data are clustered from the questionnaire responses to these hypotheses. These are, specifically: a) type of in-service offered to staff; b) most significant training issues facing the staff or yourself; c) areas most significant to the treatment of substance-abusing clients--knowledge, skill development, or attitudinal awareness; d) most significant areas for training (the five variable responses); and e) area of

training crucial during schooling--pre-service or on-the-job in-service. Specific questions are utilized to analyze the responses of the participants.

1. First Question: Is training adequate, consistent, or a primary part of the practitioner's professional development?

Although all the systems offered training, they were not conducted on a regular basis with an ongoing assessment to determine staff training needs and/or concerns. Several of the programs allowed for the Director of Program to determine in-service training. Few had consistent training schedules, topics, and/or delivery. The larger agencies had whole-agency training (CPR, Documentation, AIDS/HIV-Positive, etc.) but no agency had a training plan or annualized schedule of such. Most of the agencies allowed for outside training, but the cost or reimbursement issue controlled this determinant. Programs would send staff to state-run Bureau of Substance Abuse, Department of Public Health training or special topics. However, there is no uniform schedule or established format, nor is training offered on a repeated or a regional basis.

Throughout, there was strong agreement that training and staff development were important, but other determinants controlled the planning, process or delivery. These included fiscal issues, time and planning constraints, lack of job function--or the specified responsibility of the training designee to assure this function for staff orientation, ongoing in-service, and continued professional development.

2. Second Question: What were the content areas of training offered or needed to be offered for ongoing training as seen by the participants?

Throughout the four (4) systems, the offered training areas were in twenty-eight (28) different topics. Those offered were as follows: Topical issues, Basic counseling, Loss, Group dynamics, Management, Treatment planning, Case management, Paper work, Dual diagnosis, Program structure, AIDS/HIV-Positive, Adoption issues, Clinical issues, Medical management, Ethics, Relapse prevention, Boundaries, Eating disorder, Women's issues, Incest, Physical, sexual and verbal abuse, Rational therapy, Stress/anger management, Disease concept, Adult Children of Alcoholics (ACOA), Self-training, Parenting, Personality theory.

Those courses that should be offered (N-25): Communication, Stress management, Terminology, Criminal justice, Co-dependency, Early sobriety issues, Countertransference, Post-traumatic stress disorders (PTSD), Regression and boundaries issues, Pregnant women, Opiate detox, Involuntary clients, Court-mandated, Abusive relationships, Pre & posttest counseling, Fiscal responsibilities, Certification training, Family dynamics, Burnout, Turnover, Writing skills, Pharmacology, Cocaine addiction, Cultural diversity, and Dealing with illiteracy.

When combined, responses to training total fifty-three (53), which reflects the tremendous variation of topics, content areas and diversity of training needs and/or concerns.

A synthesis of the major areas of concern reflects the following priority training areas: AIDS/HIV-Positive, Cultural diversity, Women's issues, Cocaine addiction, Dual diagnosis, ACOA/COA, as well as updated Pharamaceuticals,

Individual and group counseling, Treatment plan assessment and writing.... Interestingly, as determined through archival study, the first six (6) training topics were not part of the priority training areas as recently as five years ago. Training or staff development, therefore, should respond to changing and shifting priorities in the substance abuse field.

3. Third Question: What areas are most significant to the treatment of substance-abusing clients as perceived by the participants?

As shown in the Table 5, identifying data of the total sample (N=27) has a distribution of responses in knowledge needs (N=13) - 48.1%, skill development needs (N=17) - 63%, and attitudinal awareness (N=18) - 66.6%. These areas were identified as necessary to provide comprehensive treatment to substance abusing clients. Further responses defining the most significant areas of training based on the participants' perceptions (total sample (N=27)) were as follows:

1. Intervention/Treatment issues (N=21) - 77.7%
2. Psychosocial aspects of client use (N=15) - 55.5%
3. Management issues (N=10) - 37.0%
4. Pharmacological aspects of drug use (N= 9) - 33.0%

The significant areas were reinforced by the above responses to the type of training (in knowledge, skill development, attitudes) that would impact treatment of these special populations.

Additional responses included:

- Cultural specificity and diversity, reality therapy, dual diagnosis, physical, mental and spiritual disruption, family dynamics, clinical training, AODA, relapse prevention, enabling, Tough Love, boundaries, abusive relationships, eating disorders, post-traumatic stress disorders (PTSD).

4. **Fourth Question: How did the participants perceive the role of pre-service (schooling) and in-service training to enhance their professional development?**

Within the total sample (N=27), the majority of participants reinforced the need for in-service training and ongoing staff development as crucial to their professional development.

A sample of the responses were: A need for in-service; ongoing staff development crucial; training very necessary; need for practical applications; training needs to be challenging; emphasis should be on skill development; technical training important; need more constant training; group and individual supervision crucial; more skills need development; prevent burnout and turnover....

Some of the topical areas were specified and clustered in the following ways: Theoretical - Disease concept, process of addiction, co-dependency, relapse, self-help philosophy, drug diagnosis; Client Management Issues - confidentiality, boundaries, giving Tough Love, case management, and limit setting; Physiological - safe detoxification, pregnant women, crack cocaine, and AIDS/HIV-Positive; Special Populations - women's issues, recovery for women, abusive relationships, family dynamics, and cultural diversity; and lastly, Dual Diagnosis - co-morbidity, psychiatric disorders, cocaine abuse affecting mental health issues.

With reference to pre-service issues, the following responses were: the need for more work-study programs; development of skill needs--to get substance abuse curriculum into nursing and medical schools, more colleges/universities to offer a Master's level track in substance abuse.

As can be seen through participant responses, training is of major importance to staff due to the ever-changing needs and shifts within the field. Client needs, service delivery, and practitioner requirements place ongoing demands on staff. Preparation of practitioners and continuing staff training is crucial to professional development--servicing the needs of clients and staff.

<u>Second Major Hypothesis</u>

The design must examine its capability to address one of the most prevalent gaps in training--that of attitudinal awareness, change and development.

As defined in the literature, the area of attitudinal awareness, change and development is crucial to the substance abuse field. This dynamic defines how a client is seen in the eyes of the practitioner which determines diagnosis, clinical goals, and treatment outcomes. The attitude towards substance-abusing clients by the general public also determines potential outcomes, dropouts, relapse, and/or recidivicism.

Becoming aware of client dynamics versus one's own biases, prejudices and/or potential negative countertransferences is a major clinical goal for training and staff development. It is the underlying premise that establishes the making of a good practitioner, a sound clinical team, and/or a healthy client-based milieu. Emphasis on self, role, use of appropriate authority, professionalism, empathy, ethics, dignity, and

integrity offered to a client is the potential start for trust, rapport, and relationship building. This is crucial to client's engagement and involvement within the therapeutic process. Without these dynamics, client linkage, engagement and/or behavior change is markedly impaired, leaving the client predominantly on their own resources, limitations and potential to regression or relapse.

Utilizing the survey, the respondents defined attitudinal awareness as the most significant area as to the treatment of substance-abusing clients. This was verified in Table 3 showing it as the largest response of 18 (total sample = 27) for a percentage of 66.6. Skill Development was second (17) - 63%, and Knowledge was third (13) - 48.1%. Other responses throughout the surveys reflected the concern of the staff towards the client and themselves. In Table 4, when asked about the most significant areas of training within the five variables, Intervention/Treatment Issues was ranked first (N = 21) - 77.7%, Attitudinal Awareness was ranked second (15) - 55.5%, along with Psycho-social Aspects of Client Use (15) - 55.5%.

Additional responses were as follows:

There were eighteen (18) responses focusing on attitudinal awareness geared towards themselves and the client. Self-responses were (10) - 55.5%, and client responses (8) - 44.5%, which defined the participants' concern for attitudinal awareness in response to their own professional development. The responses were as follows:

Self - being aware of self, self-awareness building (2),attitudinal awareness, stronger self-esteem strategies (2), group and individual supervision, countertransference, risk taking and "attitude awareness plus empathy--other people

ask me How did you get into that kind of nursing? If you don't empathize, you'd never chose this field."

Client - gain trust, concentrate on relationships, attitudes about substance abuse, recovery for women as opposed to traditional recovery attitudes of autonomy, relational therapy in terms of building and maintaining treatment team as in terms of client reality; in terms of empathy and positive regard as well as how client relationships affect and impact lifestyle changes necessary for recovery, process for processing emotions, intellect, spirituality and behavior to deal with life.

Third Major Hypothesis

The design must examine its capability to be an integrative model, bringing together professional and paraprofessional (self-help/recovering persons) to impact the substance user, abuser, and addicted youth, adult and/or families.

Due to the historical perspective of the substance abuse field, there has been the potential for conflict between the professional and paraprofessional practitioner. There are very few care-giving systems outside the substance abuse field [Lawson, et al., 1984; George, 1990] where people who are recovering from the problem become staff. This aspect requires excellent management within agencies to assure the avoidance of conflict and polarization between recovering and non-recovering personnel. Areas of conflict could be staff motivation, educational differential, formation of cliques, ambiguity of tasks, differing attitudes toward substances, academic vs. craft training [Kalb & Propper, 1976], appropriate modeling behavior vs. emotional catharsis, and level of managerial or supervisory role. This hypothesis addresses that issue by defining the process of co-joint training (professional/ paraprofessional) offered at the four (4) treatment systems.

As defined earlier in Table 6, there was a positive response (17)--63%, negative (4)--14.8%, and other (6)--22.2%. Considering the additional responses defined, it appears that the need for co-joint training is paramount. The field is expanding despite restrictions in funding, salary levels, training resources, and community support and/or commitment. The need for specialization, use of self-help, recovering personnel, and integration of resources reinforces the need for co-joint training and continuous staff development. This concept should begin in the pre-service phase of academic training broadening the base of academic training, credentialing, specialization and resource development. Lastly, the combined process of integrated staffing with innovative approaches in training, which may creatively impact the substance abuse field, needs further study, evaluation and follow-through.

E. Presentation of the Material Obtained Through the Interviews

Introduction

In this section, the interview data are presented. The same format as in the presentation of the questionnaire data will be utilized. First, the demographic and profile data on the interview participants will be presented. This will be followed by a thematic analysis of the seven (7) major areas and, finally, the three (3) major hypotheses.

The sixteen (16) participants in the interview process were selected from among the four (4) treatment systems. Fourteen (14) of the participants were among the 27 questionnaire respondents (52%) who volunteered to be interviewed. Two of the interviewees did not fill out the questionnaire but requested to be part of the interview process. Both were direct line counseling staff members who felt more

comfortable in a face-to-face interview because they could respond more appropriately in a verbal way. This demonstrated an example of the spontaneity of the participants and allowed the researcher to explore, probe, and solicit responses that could moderate the fallacy that Merton et al. defined--that of adhering to fixed questions [Morgan, 1988]. It is noted that throughout the process, the researcher was treated with the utmost courtesy and received maximum cooperation, involvement and high level of interest from the participants. The content of the study was of major concern to all participants regarding training and/or staff development that could impact client delivery and professional development for staff.

Characteristics of Interviewee Sample

Sixteen (16) participants filled out a background information form which contained the following areas: title, gender, ethnicity, years of experience, type of service, supervision provided or received, acquired professional status, certification, and professional or paraprofessional status. The participants were from the four (4) treatment systems: Urban-based specialty minority program--32%; Hospital-based detoxification--25%; Multidimensional service delivery--25%; and Free-standing substance abuse outpatient program--18%.

Table 8
Participants within Service Facilities

		N	%
A.	Urban-based specialty minority program	6	33
B.	Hospital-based detoxification and short-term rehabilitation center	4	25
C.	Multidimensional service delivery	4	25
D.	Free-standing substance abuse and Driving Under the Influence (DUI) outpatient	3	18
	Totals:	16	100

Within the four (4) systems, the titles of the interviewees were as follows: Administrative--38%; Supervisory/Clinical Specialists--31%; and Direct Treatment--31%.

Figure 6 reflects the profiles of all sixteen (16) interviewees and was obtained from the Background Information Form (Appendix I) that was completed prior to the interview process.

Title	Sex	Ethnic	Yrs. in Field	Education	Type of Program	Supervision Rec'd	Supervision Given	Acquisition of Knowledge	Certification	In Recovery	History within Family
1. Program Director	M	Afro-Amer	8	Assoc.	Resid.	Yes	Yes	Cont.Ed; O-J-T	No	Yes	Yes
2. Residential Director	F	Afro-Amer	10	B.A.	Resid.	Yes	Yes	Degree; Cont.Ed; O-J-T	No	Yes	Yes
3. Clinical Director	F	Caucasian	22	B.A.	Outpt.	No	Yes	Spec.Training; Cont.Ed; O-J-T	CAC	Yes	Yes
4. Counselor	M	Afro-Amer	3	Parapro-fessional	Resid.	Yes	Yes	O-J-T	No	Yes	Yes
5. Administrator	M	Afro-Amer	25	M.A.	Compre-hensive	No	Yes	Cont.Ed; O-J-T	No	Yes	Yes
6. Clinical Psychologist	F	Caucasian	6	Ph.D.	Hosp. Detox	Yes	Yes	Cont.Ed; O-J-T	CAC	No	No
7. Senior Counselor	F	Caucasian	10	MSW	Hosp. Detox	Yes	Yes	Spec.Training; Cont.Ed; O-J-T	CADC	Yes	Yes
8. Program Director	F	Caucasian	19.5	R.N./M.A.	Hosp. Detox	Yes	Yes	Spec.Training; Cont.Ed; O-J-T	CADC	Yes	No
9. Registered Nurse	F	Caucasian	4	R.N.	Hosp. Detox	No	No	Cont.Ed; O-J-T	CAC	Yes	Yes
10. Administrator	M	Caucasian	21	M.A.	Compre-hensive	Yes	Yes	O-J-T	No	Yes	Yes
11. Clinical Supervisor	M	Caucasian	17	M.A.	Resid.	No	Yes	Spec.Training; Cont.Ed; O-J-T	No	Yes	Yes
12. Counselor	F	Hispanic	2	B.A.	Resid.	Yes	No	Spec.Training; Cont.Ed; O-J-T	No	No	No
13. Senior Counselor	M	Caucasian	9	M.A.	Resid.	Yes	Yes	Spec.Training; Cont.Ed; O-J-T	CA-DAC	Yes	Yes
14. Executive Director	M	Caucasian	20	M.A.	Outpt.	No	Yes	Spec.Training; Cont.Ed; O-J-T	No	No	No
15. Clinical Director	M	Caucasian	17	MSW	Outpt.	Yes	Yes	O-J-T	No	Yes	Yes
16. Psychologist	M	Caucasian	11	Ph.D.	Outpt.	Yes	Yes	O-J-T	No	No	No

Figure 6. Profile of Respondents

Further analysis of demographic profiles reflects the following: Gender--nine (9) male--56.3%; seven (7) female--43.7%; Ethnicity--Caucasian, eleven (11)--68.8%; African-American, four (4)--25%; Hispanic, one (1)--6.2%; In Recovery--twelve (12)--75%; Non Recovery, four (4)--25%; Certified Counselors--CAC or CADAC, six (6)--37.5%; Non-CAC/CADAC, ten (10)--62.5%. Lastly, the median years of experience of the total group was 12.7 years.

Table 9
Significant Demographics

		N	%
1. **Gender**	Male	9	56.3
	Female	7	43.7
2. **Ethnicity**	Caucasian	11	68.8
	African-American	4	25.0
	Hispanic	1	6.2
3. **Certification**	Non-CAC/CADAC	10	62.5
	CAC/CADAC	6	37.5
4. **Substance Abuse History**	In Recovery	12	75
	Non-Recovering	4	25

Except for the administrators chosen to be interviewed, all other staff were selected by the Administrators. Interestingly, those interviewed demonstrated some unique properties--about 50% male/female; about 33.3% minority versus non-minority; about 33.3% certified CAC or CADAC status, and most significantly, about 75% of the participants were in recovery from both alcohol and other drug abuse. This reflects the number of practitioners, both administrative and clinical, that pursued a career track within the substance abuse field. This factor has importance to

training and staff development with regard to the concept of attitudes and integration of professional and paraprofessional staff. The practitioners provide role models which define their ability to be in recovery yet pursue professional careers in the field. They can be part of the training process and provide supervision, case consultation, and be positive self-help role models for both professional and paraprofessional staff to emulate.

Presentation of the Focus Interviews

The data collected through the focus interviews were summarized in the seven (7) major areas of focus defined: (1) types of existing in-service training; (2) most significant training issues facing staff; (3) most significant areas for treatment--knowledge, skill development, or attitudinal awareness; (4) what types of training to impact special populations; (5) priority areas for training; (6) areas most crucial in training during pre-service, in-service, or ongoing staff development; and (7) efforts of co-joint training for professional and paraprofessional staff. A detailed sampling of responses will be presented in each major focus area to reflect the opinions, experience, and concerns of the respondents from the four (4) treatment systems. A representative profile will be presented utilizing responses from all sixteen (16) focused interviews.

This data will also be summarized within the three (3) major hypotheses which cover specifically: 1) the ever-changing needs and shifts within the field; 2) attitudinal awareness, change and development, and 3) integration of professional and paraprofessional resources. These responses will be presented in rank order to indicate priorities.

F. Summarization of Focus Interviews Within the Seven Major Areas

1. Type of Existing In-Service Training

Through the interview process, the need for training and staff development was identified as crucial to the professionalism of staff and delivery of services. In response to the question of in-service offered, the range of training offered was said to be "ongoing to very sporadic." A very consistent view is that training is tied into the fiscal aspects of the agency. Training was offered but not in a planned manner, tended to be offered when special need or events occurred. External training was allowed but limited to fiscal resources as defined "inexpensive outside training."

All four (4) systems had their own unique ways to provide training for their staff. Because of differences in programming, staff specialties, size and location, training was nearly unique to that particular subsystem. The larger systems allowed specific directors or a development committee to organize, facilitate, and direct training. The comprehensive programs allocated training in terms of specific program training complemented by whole-agency training. The smaller programs offered training as needed, to staff and student interns and to provide orientation for a new program. The hospital-based system had the capacity to integrate within the larger hospital training capacity--a monthly meeting and a grand rounds approach, open to all departments within the total hospital.

Topical areas offered were: AIDS/HIV-Positive (6), Individual Counseling (5), Communication Skills (3), Clinical Issues (2), Confidentiality (2), Pharmaceuticals (2), Psychological Theories/Aspects (2), CPR/First Aid (2), Management Issues (2), Cultural Specificity, Ethics, Treatment Planning, Group

Intervention, Death and Bereavement, AODA, Cocaine, Family Planning, Intervention Issues, Integration of Services, Sexual Abuse, Family Violence, ACOA, Withdrawal, More Philosophical Areas, Relationship Model, Conflict & Disconnectedness, Resistance, Relapse, Referrals, and Case Management.

Important to the study is the issue that all interviewees advocated the need for more training. Administrative personnel stated that they tried to establish more training, based on their view of staff preparation and skills needed to be good practitioners. Interestingly, the staff of these systems indicated that training opportunities were not enough because of planning, fiscal constraints, and time issues. There was no tie-in between external training resources, the State agencies, or other programs. These responses reinforce the importance of training and the need to create such opportunities.

2. Most Significant Training Issues

Responses to the most significant training issues demonstrated considerable affect and opinion regarding the value of training and staff development. Three distinct areas emerged: first, the level of need and preparation of practitioners; second, personal growth and self-awareness; and third, specific subject matter.

The first area defined the need for training because of the limited resource of skilled personnel. Fewer personnel exist to draw from--causing staff shortages, less skilled practitioners, and a depleted resource pool. Levels of skilled practitioners decrease with academic backgrounds that have little practical application. Therefore, training and staff development has became invaluable to provide more skills, better role models, and competent clinicians who can function in various roles necessary

within the service delivery area. Strongly reinforced is the need for funding to assure adequate training and staff development.

The second area is that of the need of personal growth and self-awareness training. Major emphasis was on group supervision, case conferencing, and clinical supervision for team building, role modeling, and appropriate modes for staff supervision. Focus was on development of staff comfort, professionalism, personal growth and skills, as well as personal growth in recovery and motivational training for self. Responses reflecting staff behavior--"as staff do, so do our clients," and attitudinal development--counter-transference issues were often verbalized. This aspect strongly reinforced the need for time, funding resources, and learning opportunities that could be self-directed, personal growth related and geared towards attitudinal awareness, change and development.

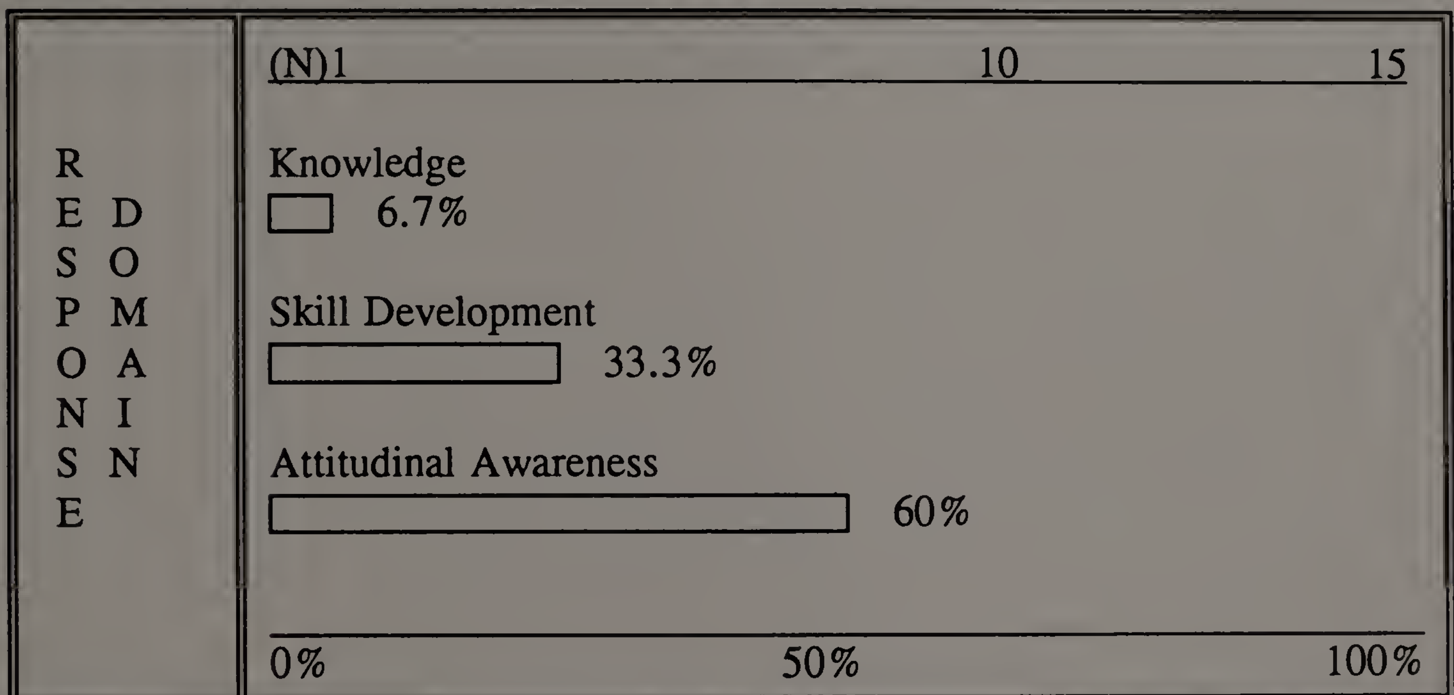
The last area displayed the specific subject matter that concerned the interviewees. The most prevalent was AIDS/HIV-Positive (4), Case Management (3), Cocaine Intervention and Detox (3), Clinical Skills (2), Dual Diagnosis (2), Family Dynamics, Cultural Specificity, Substance Abuse Counseling, Recovery Issues, More Theoretical Aspects, Terminology, Suicidal Behavior, Assessing Dangerous Behavior, Setting Limits, Psychodynamics of Group Relationship Model, Parenting, Nutrition, Post-Traumatic Stress Disorder (PTSD), DSM-III Assessment, Organizational Psychology, Health Care Reimbursement, managed Care, Women's Issues, and What Issues to Document. Again, the diversity of subjects reinforces the need for ongoing training, staff development, and schooling to enhance the staff resources and professionalism.

3. **Area Most Significant to the Treatment of Substance-Abusing Clients--Knowledge, Skill Development, or Attitudinal Awareness**

The majority of the respondents believed that attitudinal awareness was the area most significant to the treatment of substance-abusing clients. Of the 15 respondents, nine (9) endorsed attitudes--60%, five (5) endorsed skill development--33.3%, one (1) chose knowledge--6.7%.

Table 10

Response Domain Most Significant to the Treatment of Substance Abusing Clients



These numbers represent the total sample (N=15) defining each domain, i.e., Knowledge, Skill Development, or Attitudinal Awareness. Many stated that all three domains were important but that Attitudinal Awareness was the most crucial element to impact the treatment of substance-abusing clients. Some of the responses that validated this position were: "A client has to see you as someone who can help;" attitudes provide "a neutrality of the disease;" "provides balance for the team;" "focuses on awareness of client's needs...." A number of responses utilized the term

"countertransference," which is the psychoanalytic term given significance by Anne Reich in 1951 as:

> The necessary part of psychoanalytic therapy, for it is within the framework of counter-transference that the analyst's unconscious perception and understanding of his patient's productions come about, typically by means of partial and short-lived identifications with the patient at which points the analyst gains insight and comprehension of the patient's previously incomprehensible and confusing productions. But the analyst must be able to give up this identification and swing back into his objective role, thus preserving the neutrality of his reactions to the patient's emotions which makes the patient's transference possible. [Hinsie & Campbell, 1960, pp. 164-165]

This is an area that must be developed through every facet of service delivery. Staff perspectives on client behavior, past history, substance abuse, and dysfunction must be discussed utilizing individual and group supervision, case conferencing, and self-reflection techniques. This aspect takes on greater importance when analyzing the number of staff that are in recovery, have gone through self-help, or are adult children of alcoholics.

This finding is of major significance, reflecting how important the concept of attitudes is to the substance abuse field. The work of Lewis [1989] further supports this premise, demonstrating this area as the greatest void within the pre-service training of medical personnel. Knowledge and skill development appear to be more thoroughly taught and assessed at the pre-service level. However, attitudinal awareness still remains underdeveloped, probably due to complexity in teaching and lack of adequate test instruments.

Therefore, training methodologies, techniques, and processes for this domain must be further assessed and evaluated for enhancement. Further study on this

domain is of crucial importance to training, staff development, and professionalism within the substance abuse field.

4. Types of Training that Should be Offered

The respondents were in strong agreement on the need for ongoing in-service training offering a variety of subjects. There was a variety of topic areas noted, but the strongest emphasis focused on "hands-on or experiential" type training. In addition, there was strong emphasis on clinical supervision and group techniques geared towards team building, risk taking, countertransference, and self-awareness. Their concerns were subdivided into administrative/supervisory and direct staff responses to establish current perspectives of practitioners.

<u>Administrative</u>:

- Training needs to be full scope, involve all staff and must deal with terminology and changes
- Should be whole agency and staff together
- Should be on relapse prevention--understanding of, administration of, establish a relationship with client, level of comfort for staff member, boundaries and limit setting
- Self-esteem on the job, risk taking on part of staff, don't have control of finances
- Staff attend AA/NA, need for clinical supervision, treatment interventions
- AIDS/HIV-Positive, court/correction systems, environment and networking issues
- Broad training--nonspecific, relationship building, establish relationship, differences between drugs--i.e., pot vs. cocaine, credibility of staff in client eyes

Clinical and Direct Staff:

- Refresher courses--medical, substance abuse

- Knowledge of therapeutic community, psychosocial aspects

- Observe the treatment system--hands-on experience, working under supervision
    - observation of skills
    - client dynamics
    - community-based recovery
    - community-based meeting
    - help professionals understand AA and NA support system
    - help paraprofessionals understand process

- How to run groups, cultural issues

- Twelve Step experience, knowledge and skills in detox--medical aspects, physiology, help staff understand client's reality--may not be ready for change

- Psychology of women, issues of powerlessness, addiction recovery, time issues

- Connectedness, countertransference

- AIDS/HIV-Positive, limit setting, dealing with denial

- More medical-physiological, pharmaceutical, administrative management, counseling skills--individual/group

These responses reflect some forty (40) different training needs as defined by administrators and staff alike. The format, focus, and variety reinforce the need for training and ongoing staff development to enhance competencies and lessen the burden of staff when dealing with the substance-abusing client.

5. What are the Most Significant Areas of Training--Five Variables

During the interview process, the respondents were asked to rank these five important areas: a) psychosocial aspects, b) pharmacological aspects, c) intervention/treatment issues, d) management issues, and e) knowledge, skill

development or attitudinal awareness. The following rank order listing indicates the respondents' perceptions of their most significant areas of training:

The rank order of the five areas were prioritized as:

1. **Attitudes**
2. **Intervention/Treatment Issues**
3. **Psychosocial Aspects**
4. **Management Issues**
5. **Pharmacological Issues**

As seen, the area given the most significance was that of Attitudes (towards clients, other disciplines, and professional versus paraprofessionals). The next three (3) categories, Intervention/Treatment Issues, Psychosocial Aspects of Client Use, and Management Issues (limit setting, boundaries,...) were on techniques, methods, and processes of how to treat, engage, and control client dynamics. Lastly, the area of least significance seen was that of Pharmacological Aspects of client drug use. Most respondents felt this area was of limited value (except for high-risk pregnant women and/or unusual individual medical status during detoxification) in the treatment of substance-abusing clients.

This rank order prioritization further validates the need for careful assessment and planning of training and staff development. Emphasis needs to be on attitudinal awareness beginning with self and others through hands-on experiences and learning situations (supervision--individual and group, group processing, and team building, integration of staffing patterns, professional or paraprofessional and other innovative ways to enhance self-directed learning). Skill development and knowledge areas can

be reinforced through the ongoing dynamic of training, staff development, and creation of learning environment for team building, enhancing treatment systems and/or disciplines.

6. Areas Most Crucial in Training During Pre-Service, In-Service or Ongoing Staff Development

This question helped determine the respondents' perception of pre-service and in-service programming of professional development. The responses were divided into two categories, pre-service and in-service, with emphasis on perceptions, concerns, or needs that program personnel defined.

Pre-Service:

There was almost universal agreement among respondents that pre-service training was less than effective in the preparation of practitioners in the substance abuse field. A major area of criticism was on the methodology or techniques of teaching which focused predominantly on knowledge and skill development. A major gap noted was that pre-service schooling was not pragmatic enough because of limited experiential training as part of the educational process. The area of attitudinal awareness is seen as a void in pre-service training which later manifests itself within the field of practice. This aspect further reinforces the work of Lewis in defining how attitudinal awareness and development is a component of training that needs major attention. A sampling of the responses on pre-service are presented:

Focus Areas and/or Approaches:

- Must teach whole reality--focus of self, view how we see people we serve
- Need schooling--theoretical background

- Attitudinal awareness--need to develop broader view question, "Who do you want to work with substance abusers?" Must address awareness of the field

- Must emulate real situations--not just ivory tower approach--needs realism

- Academic training crucial--must be integrated with clinical application

- Academic training should be enhanced by:

  a. work study, practicing, internships, field placement, classroom and experiential hands-on training

  b. risk taking, techniques, group process, supervision, appreciation of other approaches--self-help, alternative personnel

  c. more exposure to field--on-site experiences, exposure to recovering persons or systems--AA/NA

  d. more attitudinal focused--professional and paraprofessional development and integration

Content Areas:

- counseling techniques; medical aspects of addiction--physiology, psychology; substance abuse as illness; understanding the core family disease, cultural diversity and gender issues; specificity, class, integration; special areas--AIDS/HIV-Positive; psychology of women; pharmacological dynamics, treatment systems; and a variety of subject areas.

In-Service:

In-service training was deemed very important by all the respondents for their professional and program development. There was strong reinforcement that training and in-service was crucial to the field and to the whole state of the art. However, as defined, training is within the financial domain of agencies which has caused more de-emphasis of internal and external training opportunities. Therefore, training must be

realigned into all levels of service delivery. In-service and staff development must be offered on a regular basis, geared towards enhancement of staff skills and development of an integrated staff/team of both professional and paraprofessional personnel. Training must provide clinical supervision, case conferencing, and group processing geared towards skill development and attitudinal awareness.

A sampling of responses on in-service are presented:

Focus Areas and/or Approaches:

- Needs to be current substance data
- Both on-the-job and off-site training
- Needs formulated thinking--survey of staff "What are their needs?"--developed by supervision and observation
- Training must be good--not just topic but presenter
- Must provide clinical supervision dealing with transference and countertransference issues
- Training to prevent burnout
- Upgrading of technology--a lot of "non-learning"
- Geared towards cohesion of staff--resolve conflicts, relationships between staff as well as deal with resistance from other parts of hospital
- Boundaries of therapeutic relationship--skill and resource development
- Need reimbursement for Master's Degree and Certified Alcohol/Drug Abuse Counseling Programming
- Cultural specificity; family dynamics; intervention; women's issues--parenting, nutrition, pregnancy; crack babies; management processes; early recovery needs; symptoms--early recovery and dual diagnosis; eating disorders; sexual preferences; management of anger; counseling skills and networking of social service systems.

These findings are of major significance to the importance of pre-service and in-service training through the continuum of education and ongoing practice within the field. The need for comprehensive training and education through schooling and ongoing staff development throughout the practitioner's career is reflected in this research. Several themes emerge: that pre-service training must be pragmatic, realistic, and provide the opportunity for hands-on experiential training and that training should be a regular part of service delivery utilizing clinical supervision, team building, and group processes for the enhancement of integrated staff. In the continuum of education and staff development, the focus should be to provide knowledge, skill development, and attitudinal awareness and change.

7. Co-Joint Training for Professional and Paraprofessional

There was strong agreement among the respondents that co-joint training should be a crucial and important part of ongoing service delivery. Two of the programs surveyed were self-help programs utilizing a majority of paraprofessional staff for their treatment systems--e.g., therapeutic residential or outpatient programs. The hospital unit recognized the importance of patient identification, using the Twelve (12)-Step Programming, and originally had designated the original staff as being recovering practitioners. The free-standing outpatient program had leadership who are in recovery, reinforcing the need for co-joint involvement and ongoing training. Respondents stated that co-joint training is necessary allowing for integration of staff (professional and paraprofessional) while enhancing self-awareness, client concern, appropriate staff/client interrelationships, and resolution of staff conflicts. There was also concern that co-joint training is still underemphasized causing separation of the

two disciplines--professional and paraprofessional. Responses demonstrate this concern from both a philosophical and program implementation standpoint:

- Direct care staff and clinical staff need integration. They are subdivided by function, role and status.
- Need more mandated training for their jobs
- Need more training on monthly basis
- This function fiscally related and depends who has control and who makes the decision on training opportunities
- Need co-joint training--staff not risk takers
- Co-joint of major importance--unique unto ourselves--different philosophical framework that impacts staff--provides nurturance that prevents fragmentation and builds team--we are all the same--allows for assertive skills
- Group supervision crucial
- Need day-long retreat--determined by issues of cost, time, coverage, and planning
- Amalgamated training
- Co-joint training--know limitations, set realistic goals and reduce burnout.

These findings reflect the significance of co-joint training which impacts all levels of staff. The potential of fragmentation, separation, and negative attitudes between professional and paraprofessional, clinical, administrative, and direct treatment staff is common unless preventive measures are taken. This requires creative approaches for co-joint training geared towards integration, attitudinal change, and growth through respect and integrity. It also involves a caring and concern for staff as individuals, practitioners, and contributing members of the team that serves substance-abusing clients. The same philosophy is applicable to the

client/staff relationship which allows therapeutic growth in a treatment environment that is safe, people concerned, and offers the utmost professionalism.

G. Summarization of Interview Data Within the Three Major Hypotheses

In this phase, the interview survey data will be summarized within the three (3) major hypotheses, specifically: A) The ever-changing needs and shifts within the field, B) Attitudinal awareness, change and development, and C) Integration of professional and paraprofessional resources. This study was designed to address these hypotheses and to explore training and/or staff development impact on staff and their service delivery of the substance-abusing clients.

The data from the interviews were summarized and categorized through content analysis to test out each specific hypothesis. The first hypothesis explores the training design or program offered--to address the ever-changing needs and shifts with the underlying emphasis of knowledge and skill development needed to enhance the practitioner's level of competency, comfort, and professionalism. Utilizing content analysis and comparative examination of the focus interviews (N=16), all three hypotheses will be presented.

First Major Hypothesis

The training design must examine its capability to address the ever-changing needs and shifts within the substance abuse scene, allowing for the development of specialized individualized training programs for professional/paraprofessional education, training and improvement.

Data from the focus interviews were clustered to assess the capacity of programs to address the ever-changing needs and shifts within the field.

1. **First Question: Is training adequate, consistent, or a primary part of the practitioner's professional development?**

Based on the responses of the interviewees, the perceived importance of training and ongoing staff development was apparent. This is verified by the response to "Are staff significantly trained to work with substance-abusing clients?" The responses indicated that few practitioners were significantly trained and that pre-service was not adequately preparing practitioners for the field. There were strong indications that the lack of preparation of staff only reinforced the need for training and staff development. Most administrators were disappointed about the perceived quality of skills among staff, as well as the lack of personnel to draw from. Therefore, the need for educational and training continuum to assure professional development is of major significance to service delivery, client and staff integration, as well as retention of staff. Issues of funding, planning, scheduling, and assessment/evaluation of training and staff needs must be resolved to establish ongoing training set to accommodate program, staff, and clients. Content--current data and information; Methodology--clinical supervision, group process, staff team and milieu building; and Quality of Training must be continually assessed by administration and staff feedback to enhance in-service training.

2. **Second Question: What were the content areas of training offered or needed to be offered for ongoing training as seen by the respondents?**

As verified by the respondents, the diversity of training is immense, covering a gamut of content areas. As seen, the content area numbers approximately fifty (50), covering major areas of interest of the particular program addressed. The extent

of training reflected administrative, clinical treatment, and staff perspectives in the topical areas of knowledge and skill development.

The respondents defined these specific recommendations as significant to this study:

1. Training must be ongoing, current, and reflective of recent trends, research and/or happenings within the field;

2. Training should be determined both by administrative/clinical supervisors and direct treatment staff;

3. Training should explore medical, psychological, and sociological aspects of substance abuse;

4. Training should cover treatment and therapeutic approaches--individual, group, family, and systems to enhance quality of care;

5. Training should include multiple perspectives to service delivery--medical, psychological, system and self-help approaches to service the substance-abusing client;

6. Training should explore all aspects of treatment delivery--detox, hospitalization, residential, shelters, day treatment, outpatient, methadone maintenance, court-mandated treatment, as well as alternative approaches--acupuncture, rational recovery, use of psychotropic drugs, ...;

7. Training should explore self-help systems--Alcoholics Anonymous (AA), Alanon, Alateen, Alatodd; Narcotics Anonymous (NA), and other self-help approaches--Gamblers Anonymous, Overeaters Anonymous, and other Twelve Step concepts geared towards abstinence and recovery;

8. Training should expose staff to administrative and management concepts--grant writing and exploration of funds, client recruitment, networking, and system development;

9. Training should be an interactive process seeking integration of staff--professional and paraprofessional--where both disciplines can be resources to each other to teach, role model, and assist in attitudinal awareness, change, and development;

10. Training, regardless of program or individual perspective, must be constantly assessed and evaluated for content, methodology, and quality geared towards staff integration (professional and paraprofessional), and staff professionalism.

As defined, the training design must be capable of responding to client, staff, program, and systems needs. Training and staff development are of major significance to treatment delivery, staff enhancement and professionalism.

3. Third Question: What areas are most significant to the treatment of substance-abusing clients?

One of the major areas that training and staff development must focus on is that of staff enhancement. There was general agreement among the respondents that line staff tend to be very passive and are not "risk takers," especially in a large group process. This was verified by the number of line staff who did not respond to the questionnaire nor to the interview process. Several clinical and/or residential directors felt that staff, especially paraprofessionals, tend to be insecure or at least unsure of themselves when it comes to staff dialogue interchange or communication. Similarly, the same happens in regard to clients and, therefore, training needs to emphasize relationship building, boundaries and limit setting, and ongoing interchange and demands. When analyzing the areas of most significant need defined by staff the following areas are identified: intervention/treatment issues, psychosocial aspects of client use, management issues, and pharmacological aspects of drug use.

This data further reinforces that training is not just knowledge and skill development related but also must define ways to enhance the practitioner's level of competency, image of self and ability to be a contributing member of the team

regardless of title, role and/or background. This process is reached by continuous appraisal of content, method, and level of emphasis that training takes throughout the stages of programming.

4. Fourth Question: How did the respondents perceive the role of pre-service (schooling) and in-service training to enhance their professional development?

There was strong agreement that for pre-service to be effective in the training/education of practitioners that there should be far more collaboration between schools and agencies. The programs should be field laboratories through assigned practicums, internships and field placements. Emphasis should be on theoretical dynamics augmented by hands-on observation and trial and error. Programs should provide seminars, learning experiences along with individual and group supervision for students. This interchange allows for practical application of theory based on field observation and testing. Case conferences, clinical observation, mentor training should be offered to students with feedback given back to student and school regarding their readiness, potential, and level of competency to become a professional within the substance abuse field. Exposure to agency staff meetings and issues, taking on a limited case load, processing, recording and case records--intake, progress notes, and correspondence--are necessary aspects to help students understand program perspectives and needs. These dynamics should be discussed within school, providing a learning institute involving the two systems to enhance pre-service schooling for preparation of potential professionals for the field.

These same dynamics should take place within in-service training creating a learning environment for staff that is appropriate, both client and staff related, geared towards team building, communication and enhancement of professionalism at all levels of program.

<u>**Second Major Hypothesis**</u>

The design must examine its capability to address one of the most prevalent gaps in training--that of attitudinal awareness, change and development.

As defined by the respondents, the area of attitudinal awareness, change and development is crucial to their practice. Attitudes impact how clients are perceived and ultimately how they are treated. Attitudinal awareness was prioritized as number one in the rank order listing and reflected 60% of response in Table 10 compared to 33% for skill development and only 6.7% for knowledge. Their focus was on how staff attitudes impacted client delivery and staff relationships. One of the most potent blocks to treatment of alcohol and other drug abuse is the attitude of staff, whether born of anxiety from a lack of knowledge and a moralistic or legalistic view. This aspect is of major concern to administrators and clinical directors and requires constant monitoring and assessment to assure positive and ethical treatment services are offered to clients. Staff attitudes about client symptomology, background, behavior, resistance, and relapse are detriments influencing how staff will engage, relate to, and work with that specific client. These attitudes might be translated into conscious or unconscious dynamics stimulating biases, myths, prejudices, lack of understanding, fear of confrontation, fear of involvement, intrepidation, and/or denial --for example, dealing with a pregnant, cocaine-abusing woman who has been diagnosed as HIV-Positive.

The respondents reinforced that attitudinal awareness should be a major part of training and staff development, defining and expanding on the guidelines set up by American Psychiatric Association and the Society of Teachers of Family Medicine [1985, p. 4, pp. 1-2]. The staff should recognize their own strengths and limitations in treating the substance-abusing population and incorporate the following professional obligations:

- An understanding of professionalism and staff responsibility
- A nonjudgmental and nonmoralistic approach to alcohol and other drug abuse patients
- A realism about alcohol and other drug abuse as an illness and chronic disease
- To become informed about the illness and recognize its effect on the individual, family, and the community
- Appropriate optimism about individual patient's potential
- Ability to exercise compassion, empathy, and understanding
- Ability to accept the alcohol and other drug abuser as appropriate for medical attention and treatment
- To be informed about other professional and lay resources available to manage the illness
- To cooperate with other professional and lay resources for management of the illness.

On a self-reflective basis, practicing staff should develop:

- A willingness to examine one's professional style with patients and other staff
- Revision of old stereotypes and a willingness to explore other alternatives, both professional and self-help
- To participate willfully in one's own personal risk assessment for potential alcohol or drug abuse problem

- To recognize alcohol or other drug abuse in a colleague
- To take appropriate action when alcohol or other drug abuse is recognized in a colleague.

The approach towards attitudinal enhancement becomes the responsibility of training and clinical personnel to assure that the above professional protocols are developed. In-service training must focus on knowledge and skill development (alcohol and drug abuse theory; medical assessment; assessment and diagnosis; intervention, confrontation, and referral; acute and long-term management and treatment; family assessment and integration; and legal aspects...) utilizing a hands-on experiential group process. This group dynamic process, as defined, would specifically include individual and group supervision, case conferencing, staff groups exploring attitudes, transference, and countertransference issues to provide feedback and monitoring to staff. Training options, designs, and opportunities for enhancement of staff attitudes and integration must be continually assessed for their intent and impact on individual staff, or teams dedicated to client delivery.

Another facet of this issue is the responsibility of pre-service training of universities and schools to address attitudinal awareness during the educational phase of professionalism. There was strong agreement among the respondents that schools should form collaboratives with treatment systems to create "pragmatic learning environments" for students. These environments would provide hands-on experiential settings for students through field placements, internships, and work study. This opportunity would provide direct observation, integration with staff, direct clinical experience, clinical supervision--individual and group, and case conferencing. The hands-on experiential learning format would provide an active form of education

[Flynn, Davis and Fleming, 1989] through immersion experiences, internships; formal rotations at residency programs; attendance at self-help group meetings--AA/NA; and reimbursement--work study, fellowships, stipends.... This idea was highly endorsed by all practitioners involved for co-joint learning for students, formal affiliations for programs, and the creation of field laboratories. This collaboration and design will benefit the education and training of students, enhance the professionalism of staff, and provide a resource pool of personnel. This collaborative could provide the design, structure, and evaluative process for knowledge, skill development, and attitudinal awareness contributing to professional and paraprofessional integration and client delivery.

The respondent involvement and interview process supports the need for attitudinal awareness and change that is impacting the substance abuse field. Of significance is that all four (4) systems acknowledged this domain as being the major phenomenon that needs to be addressed. Although the programs have attempted to address this issue, it is on an extremely limited and inadequate basis. This area needs ongoing assessment and evaluation, be it pre-service or in-service, to determine the design, content, and process to impact staff attitudes, relationships and client delivery. Future study of this concept would provide invaluable data to the state of the art within the substance abuse field.

Third Major Hypothesis

The design must examine its capability to be an integrative model, bringing together professional and paraprofessional (self-help/recovering persons) to impact the substance user, abuser, and addicted youth, adult and/or families.

The idea of an integrated staff of professionals and paraprofessionals was strongly reinforced by the respondents. They defined this concept for training personnel as one of their major goals for the future. Most crucial to this response was the fact that manpower resources have been dwindling over the years, reducing the level of personnel within the field. Development of paraprofessional staff would be a potential source of personnel that treatment systems could utilize. Professional staff could augment this process by providing the technical knowledge and skills for enhancement of treatment systems. Clinical trained personnel (MSW, MA/RN, Ph.D.,...) could provide the supervisory, consultative, and theoretical framework that could augment the clinical skills of paraprofessionals.

Underlying this response, however, is the need for understanding and appreciation of each other as individuals, team members, and co-joint professionals. This process of utilizing degree personnel, both undergraduate and graduate, in management and clinical supervisory positions is very common in the medical field, in particular nursing, which utilizes Licensed Practical Nurses (LPN's) and Nursing Assistants under the clinical observation of masters/bachelor level Registered Nurse. Crucial in this approach is the process of integration between professional and paraprofessional, allowing for co-joint involvement, sharing of perspectives, and working through and exploring attitudes/values to attain common goals as team members and as staff resources. Emphasis will be on a self-evaluative process assessing the use of one's role, title, position, education, or experiential background and professionalism--to develop trust and rapport for team building and milieu development through an integrated system.

A number of respondents from the larger systems--Comprehensive and Urban Minority-Based--stated, however, that there was a tremendous gap in co-joint training within the field. Their view was that pre-service training within universities or medical-based hospital systems did not address this issue, nor was there enough leadership among programs to advocate such training. With the ever-changing issues of third-party reimbursements, managed care systems, and long-range fiscal constraints, this situation becomes more precarious and highlighted. The dynamics are changing the perspective of substance abuse treatment, creating the need for credentialing, standardization, certification, and highly specialized educated personnel. Therefore, the capacity for training to develop co-joint integrated staffing patterns must be improved or developed as seen by the practitioners' view.

These data reinforce the lack of--or the extremely limited--training capacity that exists to address co-joint, integrated training for practitioners. It directly supports the earlier finding by this researcher, that presently no formal integrated models of training between professional and paraprofessional could be found in the literature or archival study. Therefore, co-joint integrated training options and design must be assessed and evaluated for development and testing. Further study of this domain is of crucial importance to staff training for enhancement of professionalism and service delivery within the field.

CHAPTER V

SUMMARY AND CONCLUSIONS: A TRAINING MODEL

A. Introduction

As defined, the intent of this study was to determine the most effective training model for professional and paraprofessional practitioners who are providing treatment for alcohol and other drug abusers. The underlying assumption of the study is that professionals/paraprofessionals who have comprehensive training (both pre-service and in-service) will be more effective practitioners by improving their competencies in knowledge, skills, and attitudinal awareness to service their specific populations. The study explored education, training and staff development models which are practiced and recognized in the substance abuse field. As noted within this qualitative review, it was discovered that training and educational models are geared only to discipline and/or specialty tracks, with the primary focus on competency and skill development within the given track. The present status of substance abuse in our culture reinforces the need for integrated and comprehensive training designs to respond to client service delivery, personnel resource enhancement and professionalism.

This chapter defines reflections on methodology, data collection, and significant findings and responses. Through analysis of a thematic process, this writer presents a training design that is responsive to participant feedback, concerns, and needs. The limitations of the study, implications, and future directions will also be presented.

B. Reflections on Methodology

The purpose of the study was to investigate and describe training and staff development as experienced by the staff of four (4) diversified treatment systems that service substance abusing populations. The study consisted of the administration of a questionnaire to 27 volunteer practitioners and the completion of sixteen (16) focus interviews with that population. The intent was to analyze training designs, methodologies, and opportunities specifically focusing on knowledge, skill development, and attitudinal awareness. Those who participated in the study represented administrative, clinical management, and direct treatment staff--both professional and self-help (in recovery). The treatment systems were multidiversified, being highly specialized--a women's hospital-based detoxification and rehabilitation unit, a comprehensive substance abuse treatment system (detoxification, residential, methadone maintenance, outpatient and correctional services), a diversified self-help urban minority program (therapeutic community, residential, outpatient, and correctional services), and a free-standing mental health and substance abuse outpatient treatment program (Driving Under the Influence and Second Offenders Program). The program and participants involved are a practical cross-section of the existing treatment available to service alcohol and other drug abusers. The participants in all four (4) treatment systems, whether directly or indirectly involved, demonstrated strong interest and commitment to the study. Their concern was reflected by responses on how training directly affected their competency, level of comfort, staff involvement, job security, and level of professionalism.

As determined through the survey and focus interviews, a number of staff did not participate. Several clinical supervisors defined this dynamic significant to the performance of line staff. Determining their non-response was directly related to their level of comfort or insecurity. Several participants would not participate "because they had nothing to contribute." These responses demonstrated the need for training to enhance participatory feedback, risk taking, and taking of responsibility for their own professionalism.

As seen in Chapter IV, a substantial amount of information and data were presented defining the role of training and staff development representing the participants' viewpoints. It must be reinforced that the level of professionalism, schooling, experience, and personal openness of the participants was quite diversified, extensive, and impressive--reflecting their personal commitment to the substance abuse field and client care. Their contributions to enhancing professionalism and service delivery were invaluable and have implications for this field and future studies.

C. Significant Finding

The finding of this study indicates that the level of professionalism (competency) and integrated staffing (professional and paraprofessional) may be significantly affected by the quality of training and staff development. This factor is significant to both the pre-service (educational) or in-service (training and staff development) phase of professional development. The data reinforce the role that training and staff development has in relationship to the field--the enhancement of professionalism, co-joint staffing, personnel recruitment and retention, and quality service delivery.

As defined by participants and archival study, attitudinal awareness is the area indicated in need of more concentration. Attitudes that are displayed towards the substance abuser--alcoholic or drug addict--and are transmitted by the program staff views on morality, biases, and countertransference issues. With the diverse client population--drug dysfunction, pregnant women, AIDS/HIV-Positive..., attitudinal awareness is crucial and must be a major area of training within agencies. This important domain must be carefully assessed to determine how the technique and methodology of training schema, staff groups, case conferencing, presentations, and individual-group supervision should be provided in dealing with these issues. Areas of focus include transference, countertransference, and feeling aroused through client exposure, pathology and/or direct therapeutic contact with treatment staff. The influence of this concept takes on greater significance with issues of violence. The battering syndrome, incest, victimization, and domestic conflict are demonstrated in client behavior. This becomes further diffuse when patterns of sexuality emerge--one's own sexual preference, homosexuality, and AIDS/HIV-Positive related data is involved. Issues of safety, powerlessness, hopelessness, and potential anger towards the client sometimes emerge creating a greater gap between client and therapist. Therefore, attitudinal awareness has significance to the treatment of these potentially difficult, dysfunctional and/or terminal clients. The issues of transference and countertransference must be continually addressed through group supervision and process.

The training and staff development recommendations proposed below represent a preliminary response to the training implications of this study. To summarize, these implications are:

1. That training must be comprehensive--be responsive to the ever-changing needs and shifts within the field and should focus on the professionalism of all staff.

2. That attitudinal awareness is the domain that needs the most attention to assure that comprehensive care, integrity, and dignity is offered to substance-abusing clients. This phenomena implies the affective domain--feeling, emotions, prejudices, myths, and countertransference issues of the staff towards clients. Implicit in this process is the acceptance of professional toward paraprofessional and vice versa. The present status of the drug dilemma reinforces the need for a team effort--a co-joint integrated team, professional and paraprofessional. This process of integration signifies the respect and appreciation of each other's role and enhances the potential for team building and creation of a therapeutic mileau.

3. That traditional training witnessed in pre-service education needs to be substantially modified to be appropriate and effective in the development of professionals within the substance abuse field.

4. That training and in-service programs must utilize creative integration of knowledge, skill development, and attitudinal awareness within their design to be current, meaningful, and effective. The role of training is the enhancement of professionalism for the development and retention of staff.

Another benefit is that the in-service training is the mechanism that prevents burnout and assures quality service delivery.

5. That practitioners (professional and paraprofessional) need to take responsibility for their own professional development. This dynamic reflects the assertion that practitioners can be risk takers, be self-reflective, and initiate those training areas that will contribute to their growth.

6. That professionals (degree, certified, or specialized) can contribute to the cognitive and skill development of the paraprofessional through supervision, consultation, and education. Paraprofessionals represent a large resource of personnel that can benefit by the cognitive and educational strengths of professionals.

7. Paraprofessionals can contribute to the enhancement of service delivery. They can be resources to assist professionals to better understand recovery, self-reflection, and the affective domain. Recovering persons are excellent models for clients and can be mentors for these individuals. As significant, they can be resources to professionals as role models and teachers through their own recovery. They can assist professionals to better understand recovery, self-reflection, and the concepts of AA and the Twelve Steps. These dynamics can assist the integration process in demystifying the concepts of alcoholism and addiction. This goal is of major significance in relationship to staffing, service delivery, and professionalism.

8. That in-service training and staff development must be offered as the teaching foundation of treatment systems. Focus is to enhance competency,

skills development, and attitudinal awareness of staff in their struggle to deliver treatment services. Training should not be fiscally determined but should be offered as a routine benefit for recruiting, developing, and retaining staff. Training, thereby, provides the mechanism for future direction of pre-service and in-service goals.

D. Training Model

This training model offers a comprehensive design that will enhance the knowledge, skill and attitudinal awareness of practitioners in the effective treatment of substance abuse and addictions. It is crucial that the knowledge base and role perception of the professional/paraprofessional be enhanced due to the changing perspectives of the clients and their culture. Within this format, attitudinal awareness and change becomes a primary goal of training and staff development. This phase of training when utilizing an interactional process becomes self-directed and reflective, dealing with one's attitudes, biases, prejudices, fears, and morality towards the client. More importantly, it allows the practitioner to acknowledge personal attitudes and/or internal dynamics/background, be it earlier substance abuse experiences or as an Adult Child of an Alcoholic (ACOA).

The process of the training is interactional, creating a therapeutic milieu where staff can deal with dependency needs and perception of self, both as an individual and professional. Treatment issues--transference and countertransference--will be continually assessed and openly discussed to assure sound, ethical practices for both staff and client safety, appropriate demand setting, and clinical follow-through. Enhancement of professionalism will be implemented through staff meetings, groups,

case conferencing, and participatory interaction between all levels of staff--administration, supervisory, and direct line. In addition, individual and group supervision, consultation, case presentations, and other creative teaching methods will be utilized to enhance knowledge, skills, and attitudinal responses. Most importantly, this interactive process will take place between professional (degree) and paraprofessional (self-help/recovering) staff to establish an integrated staffing pattern utilizing the strengths and experiential backgrounds of both. Exposure to a variety of treatment and self-help methodologies would be encouraged, such as involvement with AA or NA or new innovative treatment techniques being offered both on-site and off-site.

This training will be reflective at several levels, utilizing a multidiscipline approach inclusive of professional and paraprofessional. The multilevel model focuses on client-centered, culture-centered, and self-centered objectives and dynamics that will impact the individual practitioner and their professionalism. The design creates an interactional/integrative model for professional and personal growth by providing:

1. Knowledge & Theoretical Focus - Physiological, psychological, emotional, sociological and spiritual aspects of use, abuse, and addiction;
2. Skill Development Focus - Skill development through clinical learning method--case conferencing and presentation, hands-on experiential skill enhancement reinforced through supervision, case consultation, process recording and team teaching;

3. Affective Focus - Attitudinal awareness, experiential introspection and self-directed learning for the enhancement of self--to share one's own affect and commitment to other staff and/or clients;

4. Integrative Focus - Co-joint involvement of professional and paraprofessional, focused on attitudinal sharing with team building for appreciation of each person's skills, resources or experiences. The aim is for team development and sharing of client burden to create supportive networks and resources.

The goals and objectives of this empowerment of training model are:

1. Professional Development

   Knowledge Base--physiological, psychological and sociological aspects of substances and their effects on the individual, family, and the community;

2. Personal Development

   Affective Process--geared towards self-growth and assessment of one's values and attitudes towards the client and other members of the team;

3. Management Development

   Leadership and Supervisory Functions--This aspect is to help staff grow professionally from direct line level to advanced clinical level to administrative level. This concept allows for staff awareness of clinical and management roles as well as creating a team atmosphere geared towards joint membership, grant or proposal writing, and sharing responsibility as team members of the program.

Training Methodology to be Utilized:

1. Educational Component (Cognitive Domain)

This phase of training will be in the cognitive domain to develop the theoretical framework of substance abuse and addiction. The focus is on these areas: terminology; epidemiology and natural history; familial, sociocultural, genetic and biologic risk factors; pharmacology; physiology and psychology of abusers; diagnostic and assessment procedures; selection of treatment goals and objectives; clinical follow-up through all phases of treatment--identification, outreach, diagnosis, treatment, case management, termination and program follow-up; use of external resources, referral advocacy, client care and privacy issues; continuum of care for special populations (minorities...) and issues (AIDS/HIV-Positive...) covering a gamut of topical areas in theory, treatment and service delivery. The training goals are to enhance knowledge, comprehension, application, analysis, synthesis, and evaluation.

2. Process Component (Affective Domain)

This phase of training will be in the affective domain and will address attitudes/values through interactional dynamics, small-group meetings, feeling meetings, individual/group supervision, case consultation and conferences. Focus is on self-esteem building through self-reflection on personal affect, values and perceptions of staff (recovering/self-help) and of client (alcoholic/drug addict). One goal is to assess internal and external perspectives--to be worked through in terms of transference and countertransference issues.

3. Skills Component (Experiential Learning)

This phase of training will be on skill development through experiential (hands-on) techniques. The goal is to allow the practitioner to experience or perform different tasks in acquiring a sense of comfort and professionalism both as a staff member and deliverer of clinical services. Focus will be on involvement with every phase of treatment--initially observation of signs, symptoms, and clinical presentations, assessment/evaluation and diagnosis, establishment of treatment goals, provision of individual, group and family therapy, case management referral and follow-up. The experiential process of service delivery will be utilized--through the processing of psychosocial histories and intakes, writing case records, presentations at case conferences--to further develop the necessary skills as a competent practitioner. Throughout this process, supervision (individual and group), consultation and mentoring will be offered. The training goal(s) is to provide in-depth skill acquisition at every level of performance and role, as clinician, supervisor, team leader, or director.

4. Integrative Component (Co-Joint Process)

This phase of training is utilized to create a multidiscipline staffing pattern or therapeutic milieu. Emphasis is on team building, sharing of responsibility, and mutual respect of all levels of staff regardless of title, degree, and previous experience and/or history. Focus will be on co-joint integrated staffing between professional and paraprofessional for enhancement of program resources, pride, and level of professionalism. Throughout this process, networking, resource building, and sharing of attitudes and values are reinforced. This aspect is one of the most

important functions of training and staff development. It creates a resource pool (self-help), strengthens delivery (peer counseling) and develops a supportive environment (team) to deal with client resistance, denial and/or psychopathology. It also establishes a vital environment of self-reflection and esteem building for individuals and the team involving the sharing of attitudes/values through a group dynamic process.

E. Model Curriculum for Alcohol and Other Drug Abuse and Addiction

Based on the outline of training goals, the following curriculum content sampling is offered:

1. Psychosocial Aspect of Use, Abuse, and Addiction
   a. Psychology of Abuse & Addiction
   b. Life Styles of Abuse & Addiction
   c. Individual-Family-Cultural Dynamics
   d. Risk Factors--"At-Risk," "High-Risk" Perspectives
   e. History of the Addictions--Value & Attitudes toward Alcohol and Other Drugs
   f. Substance-Related Acting Out Behavior and Criminality
   g. Client Motivation--Resistance and Denial
   h. Effects of Substances on Special Populations--Women, Minorities, Urban/Rural Populations
   i. Legal and Ethical Considerations

2. Physiological Aspects of Client Abuse and Addiction

   a. Physiological Effects of Alcohol and Other Drugs--Use, Abuse and Addiction

   b. Prevalence of Problem--Five Main Classifications, Pharmacological Aspects

   c. Identifying Abuse and Addiction

   d. Client Assessment (Diagnosis and Treatment Planning)--Use of Observation, Interviews, Tests, etc.

   e. Medical and Emergency Procedures--Identification, Intervention, Medical Approaches, Detoxification

   f. Substance Abusing Pregnant Women--Potential FAS or FDS Considerations

   g. AIDS/HIV-Positive

3. Intervention/Treatment Issues

   a. Assessment/Evaluation--Diagnosis and Treatment Objectives: Immediate, Short-Term and Long-Term

   b. Development and Use of Referrals (Program Networks, Crisis Intervention, Hot-Lines, Medical Linkage, Detoxification)

   c. Treatment Approaches

      1) individual counseling

      2) group therapy

      3) family counseling (individual, multifamily, support group)

      4) life-skills training

5) education and vocational assessment

6) specialized interventions--cocaine, co-morbidity

7) counseling methodologies and approaches

d. AIDS/HIV-Positive and Intravenous (IV) Use--Identification, Intervention, and Treatment

e. Community-Based Care--Residential, Halfway Houses, Shelters, ...

f. Minority Issues--Bilingual, Diverse Cultures, Gays/Lesbians, ...

g. Institutional--Jail and Prison Populations, Military

4. Self-Help Approaches

a. Alcoholics Anonymous (AA)

1) Twelve Steps Program

2) Alanon, Alateen, Alatot

3) use of sponsors, support groups, meetings

4) Children of Alcoholics (COA)

5) Adult Children of Alcoholics (ACOA)

b. Narcotic Anonymous (NA)

c. Cocaine Anonymous (CA)

d. Rational therapy--Use of self-help/recovering, personal

e. Co-Joint integrated staff--professional and paraprofessional

5. Management Issues

a. Intensive Supervision

b. Mandated Treatment in Lieu of Incarceration--Integration between Criminal Justice and Rehabilitation

c. Use of Urine Surveillance--Use of Sanctions for Non-compliance

d. Staffing Issues--Recruitment and Resource Development, Credentialing, Certifications, Integrated Staff

e. Safety Issues--Client Violence, Victimization, Battering Syndrome

f. Public Policy--Changing Attitudes/Values within the Community

g. Funding Issues--Grant and Proposal Development, Third-Party Reimbursement

h. Confidentiality--Clients' Rights, Privacy, Safety of Information

6. Futuristic Considerations

a. Fiscal Considerations and Directions

1) managed care, privatization

2) government regulations

b. Innovative Staff Recruitment

1) fee for service

2) flex hours, resource pooling, networking

3) use of volunteerism--retired, elderly, ...

c. Training and Staff Development Needs

1) pre-service--specialty training--specific disciplines: physicians, nursing, social workers, counseling, ...

2) in-service--ongoing training and staff development; must be dynamic and comprehensive

3) initiating training and staff development initiatives--staff participation and committees for training needs and direction

4) staff evaluation of training (all phases)

d. Research and Evaluation--Treatment Systems and Approaches

1) process evaluation--systems, programs, and networks

2) outcomes evaluation--client change, improvement (or lack of), tracking, longitudinal follow-up

3) impact evaluation on methodology, approach and longitudinal effects of primary, secondary, and tertiary prevention of service delivery and client care

Group Dynamic Process

The methodology most crucial to augment training and staff development integration of professional and paraprofessionals is the group dynamic process. This approach allows for ongoing group discussion and/or feeling meetings which permit open dialogue between the group members. Sharing of affect backgrounds and goals will enhance the perception of both the populations. The focus of this process is to develop understanding of each other as individuals, being sensitive of the gender, ethnic, culture, language, and individual personality traits. Inherent in this exchange is the appreciation of each person regardless of past background and/or substance abuse dysfunction.

The group dynamic process is utilized to create a co-joint integrated staff (professional and paraprofessional) to provide the best possible treatment team. Co-joint staffing allows for the knowledge and experiential base for augmenting staff competency, skills and resources. Through the group dynamics of communication and integrative techniques--group meeting, case presentations/conferences, group

supervision, role playing, feeling meetings, and lastly, an interchange of affect and attitudes on transference and countertransference issues--an appreciation of the individual staff member's traits, strengths, and perspectives is apparent.

Another process to reach the goals of integrated staffing and attitudinal development is through experiential learning and exposure to a variety of treatment and self-help options. This is an active process involving education and synthesis of new learning utilizing immersion experiences, networking with other treatment programs through interchanges or rotations, and attendance to self-help group meetings [Flynn, Davis & Fleming, 1989]. Staff would attend Alcoholics Anonymous (AA) or Alanon, Alateen, or Narcotics Anonymous (NA) meetings to gain perspectives on the Twelve-Step and Recovery Process. This methodology allows for the integration of ideology--the professional gains understanding of the Recovery Process while the paraprofessional would be exposed to knowledge and competency acquisition through seminars, certification, and formalized schooling (pre-service).

The implications of training and staff development involving comprehensive knowledge, experiential learning, group process and co-joint integrated staffing has great significance to the enhancement of professionalism and service delivery. These experiences can be implemented in pre-service programming and education in the realm of knowledge, skill development and attitudinal awareness.

Evaluation of the Training Design

The training design and curriculum should be assessed to assure its significance, validity, utility, effectiveness, feasibility, and appropriateness to the

present state of the art within the substance abuse field. The following factors are part of this assessment process:

Target audience or prospective learners: to identify current levels of knowledge, attitudes, and behaviors; to determine previous types of training received; to identify special areas of interest among groups.

Time: to determine the amount of time available for planning, implementing, evaluating the activity; to determine the most effective time period for instruction (i.e., one-hour vs. four-hour sessions, etc.).

Resources: to identify materials to aid in the planning, implementing and evaluation of teaching activities; to identify individuals who can facilitate planning, implementing, and evaluating teaching activities.

Relevant Data/Materials: to identify the state of the art in substance abuse teaching; to identify controversies in the field that may impede curriculum development or acceptance; to identify relevant data and materials.

Facilities: to identify treatment facilities in the area that may be used as learning experiences for target audiences; to identify resource organizations for substance abuse information.

Philosophy of Organization: to identify the congruence or divergence of organizational goals versus the proposed goals of the training.

Substance Abuse Patients: to identify the prevalence of alcoholism and other drug abuse among patients/families that interact with your target group(s).

Current Curriculum: to identify in the current model where substance abuse training should, could, or does occur; to identify gaps or overlaps in substance abuse

content currently in the curriculum; to identify typical teaching methodologies used at each level of professional training. [Adger, DeAngelis & McDonald, 1986]

Throughout the training, all phases of the model would be evaluated and assessed for process, outcome and impact effects on the design, curriculum, delivery and goals. The goal will be to develop, implement and evaluate the training model on alcohol and other drug abuse, focusing on the knowledge, skill development and attitude development/change of the professional/paraprofessional trainee. Emphasis will incorporate the Johns Hopkins School of Medicine Evaluation Model to: (1) development of baseline data on the knowledge, skills, and attitudes of the trainees, (2) development of curriculum through ongoing assessment--direct observation, interviewing, surveys, group feedback, trainee assessment of design..., (3) use of faculty role modeling with performance feedback, and (4) appropriate pilot testing and ongoing evaluation on the effectiveness of the training model. The framework for the educational program and the evaluation model conceptualizes three (3) sets of factors: those that predispose (e.g., knowledge), enable (e.g., skills), and reinforce (e.g., feedback) desired performance behavior as seen in Appendix J, The Intervention and Evaluation Model [NIAAA/NIDA, 1989].

The process evaluation will assess all elements of the design: Persons Involved--professional/paraprofessional trainees, the staff and the patients they will be serving; the Curriculum Design--content areas, number of training sessions implemented, etc.; and the Dynamics of the Training such as problem areas, lack of participation, congruence, ... The evaluation will address these **process goals** with reference to approaches, activities, methods, and content offered to the trainees:

1. Determine how the training can be improved;
2. Describe what was done and the level of effort of staff trainees and patients involved;
3. Assess the staff/faculty investment, trainee participation, communication loops, and the interdynamics of the training design and interactive process.

Crucial to this process is the fact that the focus of the training is not just on substance abuse knowledge, but also on attitudinal change, integrative activities, positive peer development, team membership and academic or professional pursuit in the enhancement of servicing the substance-abusing client.

Outcome evaluation through a variety of methods, such as pre and posttests (written and verbal) to determine cognitive competencies, direct observation and practice pattern review for skill-oriented competencies, will be offered. The evaluation will address these **outcome goals** with reference to the trainees' knowledge, skills, attitudes, and behavior:

1. What changes in the trainee's knowledge occurred?
2. What changes in the trainee's skills occurred?
3. What changes in the trainee's attitudes occurred?
4. What changes in the trainee's behavior occurred?
5. What are the long-term impact effects of the training in terms of the trainee's professional commitment, skill orientation, and attitudinal change in working with the substance-abusing population?

Multiple data collection strategies will be utilized--observation, group feedback, surveys, pre and post test instruments, competency exams, attitudinal/opinion

questionnaires, and instruments such as the Competency Certification Assessment, ... The work of the University of Alaska has specified the achievement of skills within their Addiction Curriculum:

> The competency base evaluation is considered the primary evaluation approach. Complementary approaches to specifically assess knowledge gained can be achieved by pre-, post-evaluations, standard examination procedures during the delivery of the course, and by follow-up of how many students achieved state certification and remain employed after varying periods of time. [Segal, Wasserman, Oglietti, 1983, p. 122]

The evaluation is an ongoing process which assesses the intended outcomes of the training--the competencies developed--knowledge acquisition, skill building, and attitude development/change in alcohol and other drug abuse prevention, intervention, and treatment. Evaluation designs and models of the various curricula and specialized training have great significance to improving the state of the art in the substance abuse field.

F. <u>Limitations of the Study</u>

Although this study produced useful baseline data in the training of substance abuse treatment personnel, study limitations must be considered in the analysis and transfer of results.

A primary limitation of the design is the small sample of participants utilized for testing hypotheses. Participants involved were selected through contacted persons --administrators, executive directors, clinical directors--who distributed the surveys. In all four (4) treatment systems chosen to be involved in the study, a number of surveys were given and/or mailed to the primary contact person. Of the possible fifty (50) surveys given out (with letters of explanation, instruction sheets, questionnaires,

consent forms and self-addressed stamped envelopes), only 27 practitioners were returned for a response rate of 54%. Most were mailed back by the participant and the others were picked up at the time of on-site interviews. This return sampling of just over 50% even with constant reinforcement was not dissimilar to other known survey formats utilized in social work-related fields [Penko & Kirk, 1991].

A second limitation of this study is the dependency on the ability to gain access to the introspections of participants. It has been determined in the data collection process that access depends on the willingness of the subject to share his/her own perceptions. Subjective responses cannot be studied directly because each person's experiences remain their own. They can, however, be made more accessible. Communication is possible about experience and personal meaning [Rosini, 1976]. In two specific programs, two clinical directors stated that the non-response of staff was due to their resistance to writing, risk taking, and participating in their own professional development. Several persons contacted the researcher and stated that they chose not to participate. When asked why, both stated that "they had nothing to contribute." Of the two, one is a professional, Master's level social worker, and the other is a paraprofessional counselor. Through the focus interviews, this issue was further explored with trainers, clinical directors, or persons who were responsible for in-service or staff development, quality assurance, and comprehensive treatment outcomes. All interviewees were consistent about the issue of staff resistance to case recording, written responses on training issues, staff development and/or grant involvement. Several defined staff as being "non-risk takers" when it concerns writing about client dynamics, policy issues and/or their own professional

development. This was further reinforced by stated training needs identified in both the surveys and interviews for: staff writing skills, case recording and/or case dynamics--psycho-social histories, DSM III diagnosis, group process and/or staff development issues. As surmised, this was very applicable to paraprofessional staff who have experienced limited formal education and need to develop repertoires of knowledge related to pharmacology, personality dynamics, diagnosis, treatment and management issues, individual and group dynamics.... However, the literature verifies that professionals are also resistant to writing, either from a case perspective and/or professional development.

A third major limitation was that the participants were not perfectly matched by position, education, years in the field and/or program work. It should be considered that the participants were not a randomly selected sample but, rather, selected from a clearly defined subgroup--for example, practitioners both professional and paraprofessional involved in treatment systems. Thus, the results reported may not be typical for others--independent practitioners, recovering persons in AA and/or students seeking professional degrees within academic and/or specialty training programs.

A fourth limitation of the study was the format of open-ended survey and/or the focus interview process which reflected the qualitative design of the study. The format or structure of the questionnaire as designed by the researcher may be open to questions on content terms, areas covered, and the open-ended process which can lead to non-clarity, potential confusion, overlapping of items, time limitations, and biases in the interpretations of the open-ended responses. Another factor is the issue of

subjectivity, both by participant and researcher. A verbal report is not precise, can be misleading, incomplete, or slanted. Vocabulary may be imprecise and dependent on the practitioners' abilities to articulate. "The verbal report is not alone in its failure to be the experience it attempts to signify, and the questions about its validity apply to all types of observations." [Shlien, 1963, p. 32]

G. Future Directions for Research

This study was a qualitative exploration of training and staff development within four (4) distinct substance abuse treatment systems. Through this qualitative design, the researcher inadvertently discovered the lack of a formalized co-joint training design within pre-service programs for both professional and paraprofessional. Therefore, a training model was developed with the hope of contributing to the state of the art for professionalism within the substance abuse field.

This qualitative study generated a substantial body of information to enrich our knowledge and understanding of training and staff development within treatment systems. Recommendations for future qualitative research include the following:

1. A more in-depth study with a larger, more representative sample of participants and/or systems to address the limitations of this study and to give greater applicability to training and staff development concepts as seen in this study.

2. Replications of this study within pre-service training and educational environments for the enhancement of discipline, specialty, and/or degree programs. This potential study should explore all three component areas--knowledge, skill development, and attitudinal awareness--necessary to prepare practitioners to the field.

As defined by NIAAA and NIDA, attitudinal awareness is still the most difficult area to initiate because of the potential difficulty of assessing and developing this domain. Future study of pre-service educational programs would have significance to the development of medical, nursing, psychological, and social work personnel who may contribute to the leadership of the field.

3. Comparative study for self-help/paraprofessional personnel to enhance their talents, capabilities, and/or experiential backgrounds as practitioners in this field. As defined, training and staff development is crucial to a population that needs to advance knowledge and skill development in augmenting the level of self-reflection and esteem. Most paraprofessional recovering personnel have an intuitive self contributing to their ability to impact clients but, as shown with this study, tend to feel insecure and/or withdrawn due to lack of knowledge and/or specific skills. Training, staff development, certification, and pre-service programs could compensate for these deficits through special programs or training designs. Further study of training for paraprofessionals should enhance professionalism and generate a large pool of personnel to engage and contribute in service delivery.

4. Replication of this qualitative study to explore how practitioners learn to risk and become committed in this field. This investigation would enable us to evaluate our current methods for the training of practitioners and clinical managers, as well as permit refinement of these methods. It is reasonable to assume that improvement in the quality of training for practitioners would improve the quality of practitioners, either professional or paraprofessional, in service delivery.

H. Conclusion

English Clergy and Scholar Robert Burton, in 1621, suggested despairingly that "for this disease (depression) him that shall take upon him to cure it...will have to be a Magician, a Chemist, a Philosopher, an Astrologer" [Burton, 1961, p. 390]. Even three centuries ago, the need for knowledge and skills was known. This perspective and study reaffirm the need for training and staff development, whether to treat mental illness or substance abuse.

What we need are not mystical people, but generic, eclectic individuals, both professionals and paraprofessionals, who are committed to the task of treating the alcohol and other drug abuser--as professionals whose training is balanced by integrating knowledge, skill development, and attitudinal awareness. As the ever-changing needs and shifts in the field occur, training and staff development must be initiated for development of professionalism. This position as seen in the literature is validated by the participants of this study. Their constant endeavor and struggle to engage and treat the abuser establishes the potential direction, goals and models for training, both pre-service and in-service. This task is vitally important to the present status of the substance abuse dilemma and its impact on the individual, community and culture. This study reinforces the need for continued investigations of training and staff development to impact professionalism, service delivery, and the evolving discipline of substance abuse professionals. These outcomes will empower staff to develop beliefs, confidence, and skills to impact abusers and contribute to the field.

APPENDIX A

ALCOHOLICS ANONYMOUS

THE TWELVE STEPS

1. We admitted we were powerless over alcohol . . . that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

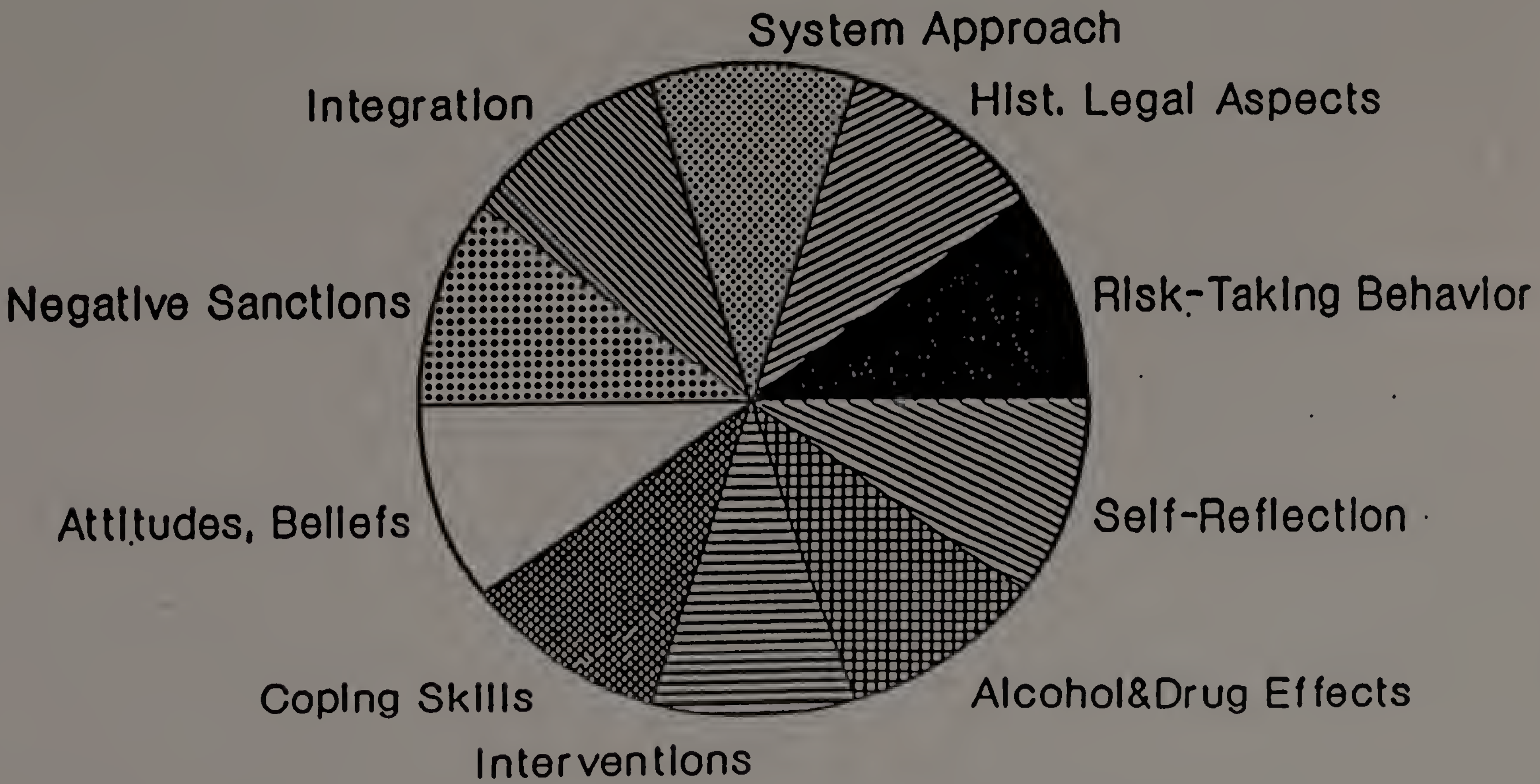
10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

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.

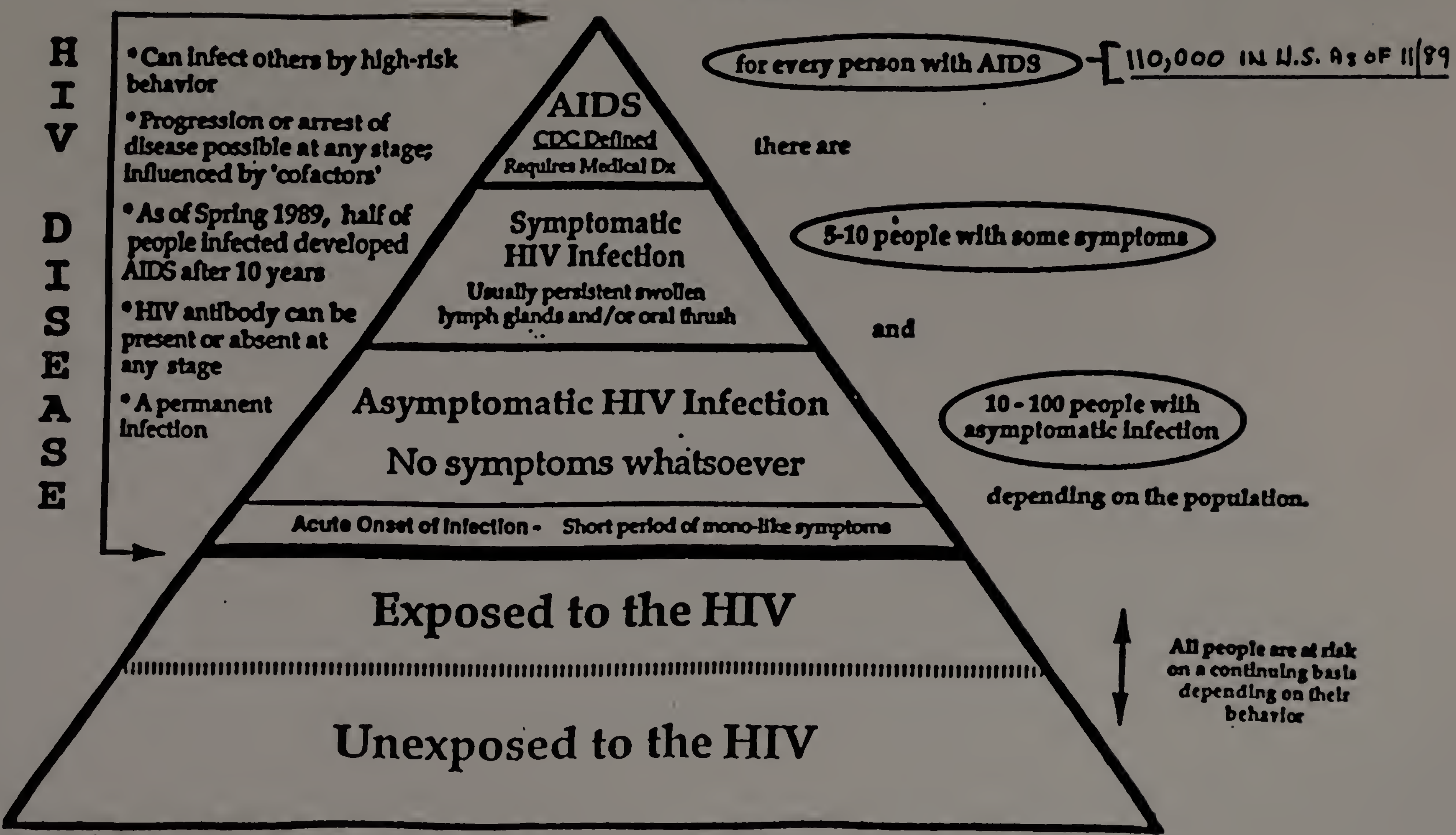
APPENDIX B

TOTAL APPROACH TO EMPOWERMENT FOR PROFESSIONALS AND PARAPROFESSIONALS



The HIV Pyramid

NOVEMBER 1989



CDC=Centers for Disease Control in Atlanta, Georgia

HIV Consultation and Training Service (312) 724-3832

APPENDIX D

LETTER OF INTRODUCTION

Dear

This letter is to request your participation in my dissertation study of "Training of Professionals and Paraprofessionals in Substance Abuse." The study will explore the training needs of practitioners, both professional and paraprofessional, to better impact the delivery of services with abusing and addicted substance abusers (both alcohol and other drugs).

Your participation would be requested in two ways:

1. An eleven (11) item questionnaire, and
2. A face-to-face interview with your training director or yourself and with a number of your designated staff.

Your agency will not be cited in the study but the general finding from your staff and training personnel is to be given to you to assist with your training.

I believe this qualitative study has great import because of the tremendous burdens placed on agencies in providing intervention and treatment services to substance abusers. Training for staff is defined covering specifically these areas: (1) knowledge, (2) skill development, and (3) attitudinal awareness and changes.

Research thus far shows that most training through specialized curricula and discipline training focuses on professional development. Few designs use an integrated design of professional and paraprofessional together which can establish an integrated team to provide an array of service options to substance abusing clients. Therefore, this study will explore existing training and what needs and/or gaps exist in the field that need to be addressed. A number of programs will be interviewed to reflect the agency and practitioner's view of the training needs--both pre-service and in-service--which will contribute to the agency's capacity to respond to both their staff and client needs.

Your response to this request will be most appreciated. I will follow up with a telephone call to set up a time that is convenient to you and your designated staff for orientation to this study. Until then, I remain

Most sincerely,

Jack Sarmanian, LICSW, ACSW
CAGS, Doctoral Candidate

APPENDIX E

WRITTEN CONSENT FORM

The Training in Empowerment for Professionals and Paraprofessionals for Enhancement of Substance Abuse Treatment, Integration and Systems

To Participants in this Study:

I am Jack Sarmanian, a graduate student at the School of Education, University of Massachusetts in Amherst. The subject of my Doctoral Research is: "The Training in Empowerment for Professionals and Paraprofessionals in the Enhancement of Substance Abuse Treatment, Integration and Systems." My field study would include surveying and interviewing substance abuse professionals (Administrators, Training Specialists, and line staff) regarding training and staff development that is available within the service delivery system of the substance abuse field. A number of treatment programs will be included, and you will be one of approximately fifty (50) participants who will be involved directly.

As part of this study, you are being asked to participate by responding to a survey and a follow-up interview. This process will allow you to define your training experiences, both pre-service and in-service, and those training areas you believe need to be developed to enhance your level of professionalism.

My goal is to analyze the data from your interview to understand the types of training you had, in pre-service, and are having presently in-service. While the survey format will provide the structure of the interview, my intent in the interview will not be to seek answers to these questions but, rather, to stimulate discussion on your past and present training experiences within the framework these questions establish.

Our goal is to analyze and compose the materials from your interviews.

In all written materials and oral presentations in which I may use materials from your interviews, I will use neither your name, names of people close to you, nor the name of your program.

You may at any time withdraw from the interview process. You may withdraw your consent to have specific excerpts used, if you notify me at the end of the interview series. If I were to want to use any materials in any way not consistent with what is stated above, I would ask for your additional written consent.

In signing this form, you are also assuring me that you will make no financial claims for the use of the material in your interviews; you are also stating that no medical treatment will be required by you from the University of Massachusetts should any physical injury result from participating in these interviews.

I, ____, have read the above statement and agree to participate as an interviewee under the conditions stated above.

____
Signature of Participant

____
Signature of Interviewer

____
Date

APPENDIX F

SURVEY INSTRUCTION SHEET

SURVEY FOR EXPLORATION OF TRAINING OF PROFESSIONALS/PARAPROFESSIONALS

Please fill out this "Survey on Exploration of Training of Professionals/ Paraprofessionals" for Administration/Training and Staff Personnel.

1. Fill out each specific question as you feel appropriate.

2. Please use additional space (back or additional pages if needed).

3. Please sign written consent form, copy and return with survey.

4. If possible, I will attempt to interview you directly regarding this survey (approximately 15-20 minutes), depending upon your schedule and/or convenience.

5. If there are any questions on the survey, written consent forms, or scheduling, please call me at (508) 443-0055 (O) or my home ((617) 861-5088.

I appreciate your willingness to participate in this Dissertation Study on Training Professionals/paraprofessionals within the Substance Abuse Field. Accept my profound thanks for your contributions.

Most sincerely,

Jack Sarmanian
LICSW/ACSW, CAGS
Doctoral Candidate

Return to:
330 Bedford Street
Lexington, MA 02173

APPENDIX G

SURVEY FOR EXPLORATION OF TRAINING OF PROFESSIONALS/PARAPROFESSIONALS ADMINISTRATION/TRAINING PERSONNEL

1. What type of service delivery system is your agency? Intervention, treatment--substance abuse, mental illness, comprehensive, outpatient, inpatient, detox, etc.?

   ____
   ____
   ____

2. What type of in-service training is offered to your staff for professional development? What specific areas are offered and what is the schedule of such?

   ____
   ____
   ____

3. What do you feel are the most significant training issues facing our staff/agency?

   ____
   ____
   ____

4. Are staff significantly trained to work with alcohol and other drug-abusing clients?

   ____
   ____

5. What is the level of training for your professionals?

   ____
   ____

6. What is the level of training for your paraprofessionals?

   ____
   ____

7. What areas are most significant to the treatment of substance-abusing clients-- knowledge, skill development, or attitudinal awareness?

____
____

8. What type of training should be offered to professionals or paraprofessionals that would impact treatment of these special populations?

____
____
____

9. What are the most significant areas for training from your perspective?

   a. Psycho-social aspects of client use;
   b. Pharmacological aspects of client drug use;
   c. Intervention/treatment issues;
   d. Management issues;
   e. Knowledge, skill development, or attitudinal awareness?

____
____
____
____
____

10. What areas are most crucial in training of professionals/paraprofessionals during schooling, pre-service, in-service, or ongoing staff development?

____
____
____

11. Has your agency attempted to do co-joint training (professional/paraprofessional) to enhance knowledge, skill development, and attitudinal awareness on the part of the trainee?

____
____
____

Name, Title/Degree:______________________________

Jack Sarmanian - Dissertation Study - 1991

APPENDIX H

SURVEY FOR EXPLORATION OF TRAINING OF PROFESSIONALS/PARAPROFESSIONALS INTERVENTION/THERAPEUTIC/SUPPORT PERSONNEL

1. What type of service delivery system is your agency? Intervention, treatment--substance abuse, mental illness, comprehensive, outpatient, inpatient, detox, etc.?

   ____
   ____
   ____

2. What type of in-service training is offered to you for professional development? What specific areas are offered and what is the schedule of such?

   ____
   ____
   ____

3. What do you feel are the most significant training issues facing you within the agency?

   ____
   ____
   ____

4. Are other staff significantly trained to work with alcohol and other drug-abusing clients?

   ____
   ____
   ____

5. What is the level of training for professionals within the program?

   ____
   ____

6. What is the level of training for paraprofessionals within the program?

   ____
   ____
   ____

7. What areas are most significant to the treatment of substance-abusing clients--knowledge, skill development, or attitudinal awareness?

____
____

8. What type of training should be offered to professional or paraprofessional staff that would impact treatment of these special populations?

____
____
____

9. What are the most significant areas for training from your perspective?

   a. Psycho-social aspects of client use;
   b. Pharmacological aspects of client drug use;
   c. Intervention/treatment issues;
   d. Management issues;
   e. Knowledge, skill development, or attitudinal awareness?

____
____
____
____
____

10. What areas are most crucial in training of professionals/paraprofessionals during schooling, pre-service, in-service, or ongoing staff development?

____
____
____

11. Has your agency attempted to do co-joint training (professional/paraprofessional) to enhance knowledge, skill development, and attitudinal awareness on the part of the trainee?

____
____
____

Name, Title/Degree:______________________

Jack Sarmanian - Dissertation Study - 1991

APPENDIX I

BACKGROUND INFORMATION

1. What is your role within your program?

2. How long in the field of substance abuse?

3. SEX: ______(1) Male ______(2) Female

4. ETHNICITY:
   ______(1) American Indian or Alaskan Native
   ______(2) Asian or Pacific Islander
   ______(3) Black, not Hispanic origin
   ______(4) Hispanic
   ______(5) White, not Hispanic origin

5. TYPE OF SERVICE WHICH YOU PROVIDE: Check the type of service in which you spend the <u>most</u> time.

   A. Direct Service

   ______(1) Medical detox
   ______(2) Non-medical detox
   ______(3) Hospital-based rehabilitation
   ______(4) Non-hospital rehabilitation (for example, halfway house)
   ______(5) Outpatient
   ______(6) Other (Specify:________________________________)

6. SUPERVISION:

   A. Are your counseling activities supervised by another staff person?

   ______(1) Yes ______(2) No

   B. Do you supervise other staff?

   ______(1) Yes ______(2) No

7. ACQUISITION OF SKILLS & PROFESSIONAL DEVELOPMENT:

Indicate how you acquired your substance abuse/alcoholism counseling training (Check all that apply):

______(1) Specialty training in substance abuse counseling (for example, intensive training in a 1-week, 2-week, 10-week course/workshop)
______(2) Specialty training as part of a degree program
______(3) Alcoholism counseling course(s) as part of a degree program
______(4) Continuing education course(s)
______(5) On-the-job training

8. CERTIFICATION STATUS: Are you currently credentialed/certified as a counselor?

	Yes (1)	Have Applied For (2)	No (3)	If yes, number years certified (4)
Alcoholism counselor	___	___	___	___
Drug abuse counselor	___	___	___	___
Alcoholism and drug abuse counselor	___	___	___	___

9. ABUSE OF ALCOHOL OR DRUGS:

A. Are you recovered or recovering? _____(1) Yes _____(2) No

B. If yes, what was your primary drug of choice?

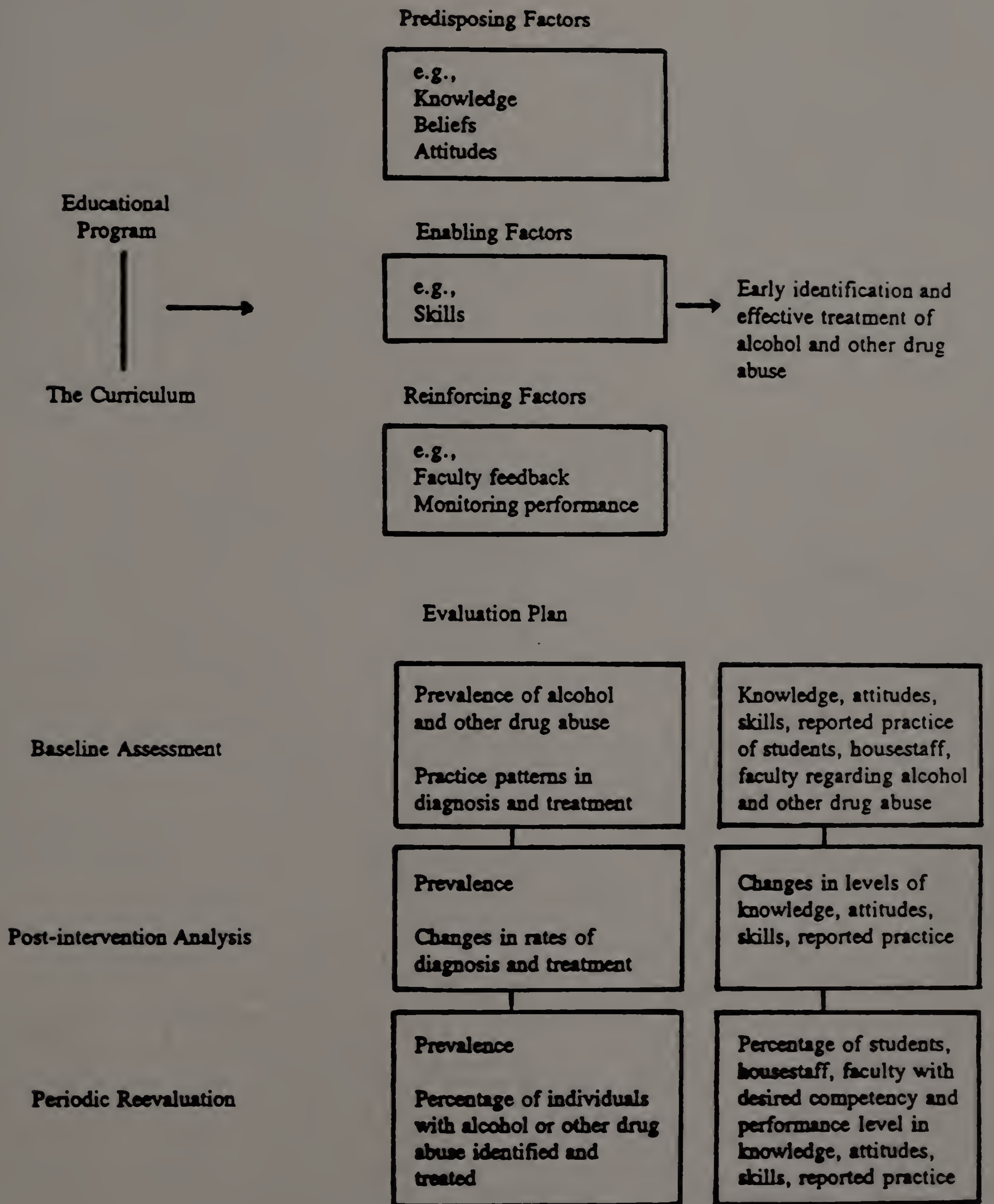
______(1) Alcohol
______(2) Other drug(s)
______(3) Combined alcohol and other drug(s)

C. Do you have a family member or significant other who is/was an alcoholic or other drug abuser?

______(1) Yes ______(2) No

APPENDIX J

THE INTERVENTION AND EVALUATION MODEL



The Johns Hopkins University School of Medicine

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